2005-2007

AGING STUDY COMMISSION

MINUTES

NC STUDY COMMISSION ON AGING
MEMBERSHIP LIST

Senator Charlie S. Dannelly, Co-Chair
16 W. Jones Street. Room 2010
Raleigh, NC 27601-2808
charlied@ncleg.net
(919) 733-5955 (919) 733-5253 (F)

Senator Austin M. Allran
PO Box 2907
Hickory, NC 28603
austina@ncleg.net
(828) 322-1410 (828) 324-0498 (F)

Senator Stan W. Bingham
292 North Main Street
Denton, NC 27239
stanb@ncleg.net
(336) 859-0999 (336) 857-3939 (F)

Senator Katie G. Dorsett
1000 N. English Street
Greensboro, NC 27407
katied@ncleg.net
(336) 275-0628 (336) 272-6853 (F)

Senator Vernon Malone
2124 Lyndhurst Drive
Raleigh, NC 27601
vernonm@ncleg.net
(919) 828-5853 (919) 828-1562 (F)

Mr. Brad Allen
4629 Independence Drive
Lumberton, NC 28358
ncsgbrad@mindspring.com
(910) 608-2525 (919) 851-5456 (F)

Mr. Sam Marsh
PO Box 7728
Rocky Mount, NC 27804
smmarsh@autumncorp.com
(252) 443-6265 (252) 443-2703 (F)

Ms. Judy Pelt
301 N. Herman Street, Box HH
Goldsboro, NC 27503
Judy.pelt@waynegov.com
(919) 731-1149 (919) 731-1334 (F)

Representative Beverly Earle, Co-Chair
312 S. Clarkson Street
Charlotte, NC 28202
beverlye@ncleg.net
(704) 333-7180 (919) 754-3158 (F)

Representative Alice Bordsen
411 S. Fifth Street
Mebane, NC 27302
aliceb@ncleg.net
(919) 563-5264 (919) 754-3135 (F)

Representative Debbie A. Clary
105 D-02 Northshore Court
Cherryville, NC 28021
debbiec@ncleg.net
(704) 480-1407 (919) 754-3144 (F)

Representative Bob F. England, MD
PO Box 908
Ellenboro, NC 28040
bobe@ncleg.net
(282) 453-8807 (919) 754-3200 (F)

Representative Jennifer Weiss
2221 Legislative Building
Raleigh, NC 27601-1096
jenniferw@ncleg.net
(919) 678-1367 (919) 733-2955 (F)

Ms. Regina Duffy Fisher
1120 S. Fulton Street
Salisbury, NC 28144
regina.fisher@ymcacharlotte.org
(704) 633-4638 (704) 716-4801 (F)

Ms. Linda Howard
600 Fullwood Lane
Matthews, NC 28105
ljhoward@aol.com
(704) 841-4920 (704) 841-4700 (F)

Ms. Florence Gray Soltys
707 Greenwood Road
Chapel Hill, NC 27599
fgsoltys@email.unc.edu
(919) 962-6541

Ex-Officio Member
Mr. Jackie Sheppard
Deputy Secretary for Long Term Care and Family Services
NC Department of Health and Human Services
2001 Mail Service Center, Raleigh, NC 27699-2001
919-733-4534 919-715-4645 (F)
jackie.sheppard@ncmail.net

STAFF:

Theresa Matula, Legislative Analyst - theresam@ncleg.net
Ben Popkin, Staff Attorney – benp@ncleg.net
Shawn Parker, Legislative Analyst – shawnp@ncleg.net
Room 545 LOB (919) 715-5460 (919) 715-8365 (F)

COMMISSION ASSISTANTS:

Dee Hodge – dannellyla@ncleg.net (919) 733-5955 (919) 733-5253 (F)

Ann Raeford – earlela@ncleg.net (919) 715-2530 (919) 754-3158 (F)

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.
120-184. Commission; reimbursement.
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120-186.1. Commission; Alzheimer's Subcommittee, Long-Term Care Subcommittee, and other subcommittees.
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§ 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.
History

§ 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.

NORTH CAROLINA STUDY COMMISSION ON AGING

2005-2006 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. 10/18/05

ATTENDANCE

Committee: **NC STUDY COMMISSION ON AGING**

DATES / NAMES	11/2/05	11/16/05	12/29/05	1/4/06	1/18/06	2/1/06	2/15/06	3/15/06	3/29/06	4/4/06	9/12/06	9/27/06	10/11/06	11/15/06	1/3/07	1/23/07
Senator Charlie Dannelly, Co-Chair	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓
Senator Austin M. Allran	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓
Senator Stan W. Bingham	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	
Senator ~~Julia Boseman~~ Dorsett 8/13	✓	✓	✓	✓	RESIGNED				–	–	✓		✓		✓	✓
Senator Vernon Malone	✓	✓	✓	✓		✓	✓	✓	✓	✓					✓	
Mr. Brad Allen		✓				✓	✓	✓	✓	✓			✓	✓		✓
Mr. Sam Marsh	✓	✓			✓	✓	✓	✓			✓			✓	✓	✓
Ms. Judy Pelt	✓	✓		✓		✓		✓	✓	✓	✓		✓	✓	✓	✓
Rep. Beverly Earle, Co-chair	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓
Rep. Alice Bordsen	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
Rep Debbie A. Clary	✓	✓	✓	✓	✓		✓		✓		✓	✓	✓		✓	✓
Rep. Bob F. England, MD	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓
Rep. Jennifer Weiss	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Ms. Linda Howard		✓	✓	✓				✓	✓	✓	✓	✓		✓		✓
~~Ms. Katherine Fox Price~~, RN	✓			RESIGNED												
Ms. Florence Gray Soltys		✓		✓	✓	✓			✓	✓		✓	✓		✓	✓
Mr. Jackie Sheppard, Ex-Officio	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓
STAFF																
Theresa Matula	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ben Popkin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Shawn Parker	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dee Hodge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ann Raeford	✓	✓	✓		✓		✓		✓							
Carol Shaw												✓	✓			
Regina Duffy Fisher first mtg. 3/29/06									✓			✓				

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

October 20, 2005

MEMORANDUM

TO: Members - NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the **NC Study Commission on Aging:**

DATE: Wednesday, November 2, 2005
and
Wednesday, November 16, 2005

TIME: 10:00 a.m.

LOCATION: Room 415
Legislative Office Building
Raleigh, NC

Please advise Dee Hodge, Commission Clerk, at (919) 733-5955 or email dannellyla@ncleg.net if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, November 2, 2005
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions
Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Overview of Commission Responsibilities
Presentation of Commission Budget
Theresa Matula, Commission Staff, Research Division, NCGA

III. Status of 2005 Study Commission Recommendations
Shawn Parker, Commission Staff, Research Division, NCGA

Brief Overview of 2005 Legislation Related to Aging
Theresa Matula, Commission Staff, Research Division, NCGA

IV. Medicare Prescription Drug Coverage
Carla Obiol, Seniors' Health Insurance Information Program (SHIIP), Department of Insurance

V. Senior Care to Medicare Transition
Jerry Boylan, NC Senior Care

Senior Care Medication Management Centers
Vandana Shah, Health and Wellness Trust Fund

VI. Next Meeting:
November 16, 2005 at 10:00 a.m. in Room 643

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES
NOVEMBER 2, 2005
10:00 AM
ROOM 643

The North Carolina Study Commission on Aging held its first meeting on November 2, 2005 in Room 643. Representative Beverly Earle, Co-Chair, called the meeting to order at 10:05 am. She thanked every for coming and also thanked the House & Senate Sergeant-at-Arms. She then asked all of the members of the commission to introduce themselves and staff members. The following members were present: **Representative Beverly Earle, Co-Chair, Senator Charlie Dannelly, Co-Chair, Representative Debbie Clary, Representative Alice Bordsen, Representative Bob England, Representative Jennifer Weiss, Ms. Katherine Fox Price, six Senators were present, Mr. Sam Marsh, Ms. Judy Pelt and Jackie Sheppard, Ex-Officio Member. Staff Members: Theresa Matula, Shawn Parker, and Ben Popkin, Commission Clerks: Ann Raeford and Dee Hodge.**

Theresa Matula, Research Division, presented to the commission an overview of the commission's responsibilities and the commission's budget. She gave a brief overview of future meeting and things the commission plan to do. The commission plans to have three public hearing for 2006, starting in the spring. Please refer to your notebooks for a copy of the budget.

At this time **Mr. Shawn Parker, Research Division**, handed out the **"2005 Recommendation Status Report".** In the report were the thirteen recommendations for the 2005 General Assembly Regular Session. All thirteen recommendations were drafted in possible legislation. Recommendations 1-7 were put into Senate Bill 622. See Attachment III for all the recommendations and the results.

Theresa Matula, came back to the commission to present a handout entitled: **"Summary of Substantive Legislation Related to Aging."** She went over all legislation that has been enacted. Some of the enacted legislation is as follows: Criminal Records Checks/Long Term Care Changes; Adult Protective Services Task Force/Collaborate; License Assisted Living Facilities/Elderly; Jury Exemptions/72 and Older; Exploitation/Elderly or Disabled Adult; Senior Prescription Drug Access

Program Funding; Senior Cares Program Administration/Automatic Enrollment Medicare Prescription Drug Program and many, many others. See Attachment IV for all enacted legislation. There were no questions or comments at this time.

The next presenter was **Ms. Carla Obiol, Senior Health Insurance Information Program (SHIIP), Department of Insurance**. Ms. Obiol presented just the facts about Medicare Part D: Prescription Drug Plan Benefit. To get more information on this program go www.ncshiip.com. The enrollment for the Medicare Prescription Drug plan began on November 15, 2005 and ends May 15, 2006. If anyone enrolls before December 31, 2005, the new Medicare Prescription Drug coverage will begin on January 1, 2006 or if you enroll after December 31, 2005, there will be a delay on the coverage. Anyone that enrolls after May 15, 2005 may result in a 1% per month penalty for every month you delayed enrollment. In North Carolina there are 16 approved companies who will offer a total 38 PDP plans. Ten of these plans will offer national coverage, which is especially important for beneficiaries who have residences in more that one state.

There were many questions about the Medicare Part D Program. One of the main issues was the phone center. Many people are complaining that they cannot reach anyone at the phone center. The problem seems to be that there are not enough people there to handle the volume of calls. There is also a website that is available for the citizens of North Carolina. There will be assistance available for people with Medicare who have limited incomes and resources. If anyone has an income of below $14,355 for singles or $19,245 for a couple and you have to have assets of lower that $10,000/$20,000.

Medicare beneficiaries can have enrollment assistance through the SHIIP program by calling 1-800-443-9354, which you may have to call several times. The Department of Insurance is asking that you do not get discourage if you have to wait. Some counties are offering workshops to inform citizens of the new program. Check the website at www.ncshiip.com for scheduled enrollment clinics in your local community. This program is for all people who are eligible for Medicare Part A and Part B. See Attachment V for the facts. The commission members asked many questions.

Mr. Jerry Boylan, North Carolina Senior Care presented to the commission the transition from the Senior Care Program to the Medicare Part D: Prescription Drug Plan Benefit Program. All transitional assistance programs end December 31, 2005. CMS grant received to transition to Part D: is supporting SHIIP, call center personnel and train the trainer workshops across the state. Four to five hundred pharmacists are training across the state. Local counties are coordinating sites to provide face-to-face assistance during the transition of 2006, and they are there to clear up confusion about choices and the process. The state is now focused on how to help our Senior Care enrollees make an informed decision on how to best choose their prescription drug

coverage under Medicare Part D. See Attachment VIII for transition information from the Senior Care Program.

Ms. Vandana Shah, Policy Director, Health and Wellness Trust Fund presented to the commission an update on the Medication Assistance Program (MAP). This program offers 69 grants (68 community-based grants and 1 statewide grant) funded by the North Carolina Health and Wellness Trust Fund at $14 million to assist low-income citizens in obtaining prescription drugs and to counsel seniors about their safety and their effectiveness. See Attachment X for HWTF Medication Assistance Program Grant Awardees. MAP has granted sites with over $48,486,232.82 worth of free medications to 39,886 patients from January 2003 through August 2005 and they have also received medication management services.

Representative Beverly Earle thanked everyone for attending the meeting and announced that the next meeting will be on November 16, 2005 in Room 643. The meeting was adjourned.

Representative Beverly Earle, Presiding
Senator Charlie Dannelly

Ann Raeford, Commission Assistant

Attachments

Attachment I	**Agenda**
Attachment II	**Commission Budget**
Attachment III	**2005 Recommendation Status Report**
Attachment IV	**Enacted Legislation Related to Aging**
Attachment V, VI, & VII	**Medicare Part D: Prescription Drug Program**
Attachment VIII	**Senior Care Update**
Attachment IX	**NC Senior Care Enrollment by County**
Attachment X	**HWTF Medication Assistance Program Grant Awardees**

I

Agenda

North Carolina Study Commission on Aging

Wednesday, November 2, 2005
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VI. Next Meeting:
November 16, 2005 at 10:00 a.m. in Room 643

II

NORTH CAROLINA STUDY COMMISSION ON AGING

2005-2006 COMMISSION BUDGET ESTIMATE

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8.	Supplies	$250
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10.	Reserve	$27,861
TOTAL		**$50,000**

Rev. 10/18/05

III

2005 Recommendation Status Report

North Carolina Study Commission on Aging
Recommendations
to the
2005 North Carolina General Assembly, 2005 Regular Session

Prepared by Staff for the
North Carolina Study Commission on Aging

November 2, 2005

2005 RECOMMENDATION STATUS REPORT

RECOMMENDATION	RESULT
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.**	House Bill 44 was introduced, received a favorable report in the House Committee on Aging, and was re-referred to the House Committee on Appropriations. On a related note, S.L. 2005-276, Sec. 10.20 (SB 622, Sec. 10.20) requires the Department of Health and Human Services, Division of Medical Assistance, to study developing a new system for reimbursing the Community Alternatives Program. The new system must: • Use a case-mix reimbursement system, similar to the one used by nursing facilities and home health agencies, to determine the level of care provided and the amount paid for the care provided; • Incorporate into the case-mix system the home environment and social support systems; and • Use the Resource Utilization Groups-III (RUG-III) to determine the level of need for Community Alternatives Programs services except for CAP-MR/DD program services. The Division must report not later than May 1, 2006, 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 the development of the new system, including an implementation schedule. Full implementation of the new system must be not later than January 1, 2007.
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.**	Section 10.40A.(a), S.L. 2005-276 (Section 10.40A.(a), SB 622) requires the North Carolina Medical Care Commission to adopt rules defining geographic service areas for in-home aide services and staffing qualifications for licensed home care agencies for the purpose of ensuring effective supervision of in-home aide staff and the timely provision of services. Changes also include a requirement for the Department of Health and Human Services to inspect each home care agency at least every **three** years Section 10.40A.(m), S.L. 2005-276 (Section 10.40A.(m), SB 622) defines a "geographic service area" as the geographic area in which a licensed agency provides home care services. The budget also provided staff for the required inspections every three years. Item 42 on page G-6 of the Joint Conference Committee Report, provides that $218,495 in recurring funds was appropriated to support five Facility Survey Consultants and an additional $5,469 in non-recurring funds was appropriated for 2005-2006.

RECOMMENDATION	RESULT
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.**	Section 10.40A.(a), S.L. 2005-276 (Section 10.40A.(a), SB 622) allows the North Carolina Medical Care Commission to adopt rules prohibiting licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry. Section 10.40A.(q), S.L. 2005-276 (Section 10.40A.(q), SB 622) directs 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, including unlicensed health care settings, that should be contained in the Health care Personnel Registry and listed in G.S. 131E-256. The Department is required to report findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.
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.**	Section 10.40A.(a), S.L. 2005-276 (Section 10.40A.(a), SB 622) allows the North Carolina 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	RESULT
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.**	Section 10.40A.(n), S.L. 2005-276 (Section 10.40A.(n), Senate Bill 622) establishes the Home Care Clients' Bill of Rights. The Bill of Rights includes: legislative intent, declaration of clients' rights, notice to client, implementation, enforcement and investigation, and confidentiality. *Declaration of Home Care Clients' Rights.* – Each home care agency client has the following rights: • To be informed and participate in his or her plan of care. • To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. • To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations. • To voice grievances about care and not be subjected to discrimination or reprisal for doing so. • To have his or her personal and medical records kept confidential and not be disclosed without appropriate written consent. • To be free of mental and physical abuse, neglect, and exploitation. • To receive a written statement of services provided by the agency and the charges the client is liable for paying. • To be informed of the process for acceptance and continuance of service and eligibility determination. • To accept or refuse services. • To be informed of the agency's on call service. • To be informed of supervisory accessibility and availability. • To be advised of the agency's procedures for discharge. • To receive a reasonable response to his or her requests of the agency. • To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended. • To be advised of the agency's policies regarding patient responsibilities. *Notice to Client.* – During the initial evaluation visit or before furnishing services, an agency must provide each client with: • A copy of the declaration of home care clients' rights. • A copy of the agency's policies regarding client responsibilities as it relates to safety and care plan compliance. • The address and telephone number for information, questions, or complaints about services provided by the agency. • 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. *Enforcement and Investigation.* – The Department of Health and Human Services is responsible for enforcement of the home care provisions and must investigate complaints within a reasonable period of time, not to exceed 60 days. When the Department receives a complaint pertaining to client care or safety, an investigation must be initiated: • Immediately upon receipt of the complaint if the complaint alleges a life threatening situation. • Within 24 hours if the complaint alleges abuse of a client as defined by law. • Within 48 hours if the complaint alleges neglect of a client as defined by law. • Within two weeks in all other situations. Investigations by the Department must be completed within 30 days. Within 72 hours, a home care agency must investigate complaints made to the agency by a home care client or the client's family and must document the existence of the complaint and the resolution. *Implementation, Confidentiality, and Rules.* – Home care agency directors are responsible for implementing changes and each agency must provide appropriate training. The Department must maintain the confidentiality of persons registering complaints and of medical records. The North Carolina Medical Care Commission must adopt rules defining the scope of permissible advertising and promotional practice by home care agencies.

RECOMMENDATION	RESULT
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.**	Section 10.40A.(l), S.L. 2005-276 (Section 10.40A.(l), SB 622) requires the Department to impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty is the amount prescribed for a Type A Violation. (Note: this provision also increased penalty amounts.)
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.**	Under S.L. 2005-276 (SB 622), the appropriations for Senior Games include a recurring amount of $175,000 and a $100,000 non-recurring appropriation 2005-06.
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.**	House Bill 43 was introduced and referred to House Appropriations. Senate Bill 38 was introduced and referred to Senate Appropriations/Base Budget

RECOMMENDATION	RESULT
Recommendation 9 **The North Carolina Study Commission on Aging recommends that the General Assembly re-enact the Long-Term Care Insurance Tax Credit.**	House Bill 118 and Senate Bill 37 were introduced on behalf of the Commission and referred to House and Senate Finance Committees. These bills were not enacted and the tax credit no longer exists for taxable years beginning on or after January 1, 2004.
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.**	S.L. 2005-23 (HB 45) was enacted and requires the Department of Health and Human Services, Adult Protective Services Task Force, to collaborate with stakeholders and other persons interested in improving adult protective services. The Department is required to report findings and recommendations to the North Carolina Study Commission on Aging and the Legislative Study Commission on State Guardianship Laws on or before April 1, 2006.
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.**	House Bill 119 was introduced, received a favorable report in the House Committee on Aging, and was re-referred to the House Committee on Appropriations.

RECOMMENDATION	RESULT
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 geriatricians, geriatric-social workers, geriatric pharmacists, geriatric allied health workers, and graduates specialized in geriatric nursing and geriatric dentistry; 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 and to report their findings to the North Carolina Study Commission on Aging on or before January 6, 2006.**	House Bill 183 was introduced, received a favorable report in the House Committee on Aging and was re-referred to the Committee on Rules, Calendar, and Operations of the House.
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.**	S.L. 2005-4 (Senate Bill 41) was enacted and became effective March 23, 2005. The act modifies the existing law requiring criminal history background checks for employees of long-term care facilities to clarify that the Department of Health and Human Services will only indicate to an employer whether the criminal history record has information that might affect the applicant's employability under the law. Specific results of the national criminal history record check will not be shared with the employer. The act also modifies the definition of "area authority" to make conforming changes with mental health and Department of Justice statutes reflecting under mental health reform, area authorities have assumed administrative roles and are no longer service providers.

IV

Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2005 Session

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

November 1, 2005

Enacted Legislation

Criminal Records Checks/Long Term Care Changes

S.L. 2005-4 (SB 41) modifies the existing law requiring criminal history background checks for employees of long-term care facilities to clarify that the Department of Health and Human Services will only indicate to an employer whether the criminal history record has information that might affect the applicant's employability under the law. Specific results of the national criminal history record check will not be shared with the employer.

The act also modifies the definition of "area authority" to make conforming changes with mental health and Department of Justice statutes since area authorities have assumed administrative roles and are no longer service providers.

This act became effective March 23, 2005.

Adult Protective Services Task Force/Collaborate

S.L. 2005-23 (HB 45) directs the Department of Health and Human Services, Adult Protective Services Task Force, to collaborate with stakeholders and other persons interested in improving adult protective services and to report findings and recommendations to the North Carolina Study Commission on Aging, and the Legislative Study Commission on State Guardianship Laws, on or before April 1, 2006.

This act became effective April 28, 2005.

License Assisted Living Facilities/Elderly

S.L. 2005-66 (SB 572) deletes the assisted living residence category, "homes for developmentally disabled adults," as these homes are now licensed under Chapter 122C, and creates a new category, "adult care homes that serve only elderly persons." This change permits homes to be licensed to serve only this category of client. For purposes of this category, "elderly person" is defined as:

- Any person age 55 or older who requires assistance with activities of daily living, housing, and services; or
- Any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia that requires assistance with activities of daily living, housing, and services.

The Medical Care Commission is directed to adopt rules to implement the act.

This act became effective May 26, 2005.

Jury Exemptions/72 and Older

S.L. 2005-149 (SB 321) allows a person who is 72 or older and summoned as a juror to request either a temporary or permanent exemption. The judge or trial court administrator has discretion to accept or reject either, including substituting a temporary exemption for a requested permanent exemption.

This act became effective October 1, 2005, and applies to persons summoned for jury service on or after that date.

Exploitation/Elderly or Disabled Adult

S.L. 2005-272 (HB 1466) expands the offense of exploitation of an elder or disabled adult and increases the penalty for that offense.

The act repeals 14-32.3(c), the current exploitation offense, and creates a new G.S. 14-112.2, which does the following:

- Prohibits a person who stands in a position of trust and confidence, or a person who has a business relationship with, an elder or disabled adult to knowingly, by deception or intimidation, obtain or use, or endeavor to obtain or use, the elder or disabled adult's funds, assets, or property with the intent to temporarily or permanently deprive them of the use, benefit, or possession or to benefit someone other than the elder or disabled adult.
  - Violation of this provision is as follows:
    - A Class F felony for funds, assets, or property valued at $100,000 or more.
    - A Class G felony for funds, assets, or property valued at $20,000 or more but less than $100,000.
    - A Class H felony for funds, assets or property valued at less than $20,000.
- Prohibits any person who knows or reasonably should know that an elder or disabled adult lacks the capacity to consent, to obtain or use, endeavor to obtain or use, or conspire with another to obtain or use the adult's funds, assets, or property with the intent to temporarily or permanently deprive the elder or disabled adult of the use, benefit, or possession, or to benefit someone other than the elder or disabled adult.
  - Violation of this provision is as follows:
    - A Class G felony for funds, assets, or property valued at $100,000 or more.
    - A Class H felony for funds, assets, or property valued at $20,000 or more but less than $100,000.
    - A Class I felony for funds, assets or property valued at less than $20,000.

This act becomes effective December 1, 2005, and applies to offenses committed on or after that date.

Senior Prescription Drug Access Program Funding

S.L. 2005-276, Sec. 10.3 (SB 622, Sec. 10.3) provides that if there is a shortfall of funds from the Health and Wellness Trust Fund, the Director of the Budget may use up to $1.5 million in the 2005-2006 fiscal year to fully fund the Senior Prescription Drug Access Program through December 31, 2005.

This section became effective July 1, 2005.

Senior Cares Program Administration/Automatic Enrollment Medicare Prescription Drug Program

S.L. 2005-276, Sec. 10.4 (SB 622, Sec. 10.4) authorizes the Department of Health and Human Services (Department) to administer the "Senior Cares" prescription drug access program, approved by the Health and Wellness Trust Fund Commission and funded by the Health and Wellness Trust Fund, until the program expires December 31, 2005. The Department is authorized to conduct activities after December 31, 2005 that are related to closing the program and paying claims incurred before, but received after, December 31, 2005.

This provision also authorizes the Department to automatically enroll in the Medicare Part D Prescription Drug Program, current and future participants in the Senior Cares prescription drug assistance program whose income is not more than 135% of the federal poverty level. However, prior to automatic enrollment, the Department must give the individual the opportunity to decline automatic enrollment.

This section became effective July 1, 2005.

County Medicaid Cost Share – Adult Care Homes

S.L. 2005-276, Sec. 10.13(b) (SB 622, Sec. 10.13(b)) continues the statutory requirement that the county share of the cost of Medicaid Personal Care Services paid to adult care homes must be decreased incrementally each fiscal year until the county share reaches 15% of the nonfederal share.

This section became effective July 1, 2005.

Expand Community Care of North Carolina Management to Additional Medicaid Recipients

S.L. 2005-276, Sec. 10.17 (SB 622, Sec. 10.17) directs the Department of Health and Human Services to expand the scope of the Community Care of North Carolina management model to apply to Medicaid and dually eligible individuals chronic conditions and long-term care needs. The Department will conduct community-wide pilot programs and expand successful models for statewide application. The Department will review the impact of this expansion and report its findings 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 by March 1, 2007.

This act became effective July 1, 2005.

Medicaid Personal Care Services Limitations

S.L. 2005-276, Sec. 10.19(a) (SB 622, Sec. 10.19(a)) requires the Department of Health and Human Services, Division of Medical Assistance (Division), to reduce the cost of providing personal care services under the Medicaid program by $13,711,542 for the 2005-2006 fiscal year and $16,115,389 for the 2006-07 fiscal year. The reduction must be accomplished through the implementation of a utilization management system for Personal Care Services and Personal Care Services Plus. This system may include reducing personal care services to 50 hours or otherwise managing personal care services. The Division is required to work with Community Care of North Carolina (CCNC) to determine how CCNC can help with the review of the need for and utilization of personal care services.

This section became effective July 1, 2005.

See also Studies, Referrals to Departments, Agencies, Etc. subheading in this document for Study Additional Utilization/Prior Authorization Systems for Personal Care Services and Other Home-and Community-Based Services.

Verification of State Residency for Medical Assistance

S.L. 2005-276, Sec. 10.21A (SB 622, Sec. 10.21A) requires applicants for medical assistance benefits to prove that they are North Carolina residents. The Division of Medical Assistance will not pay for any medical assistance provided to an applicant unless they have met the proof of residency requirements.

This section becomes effective January 1, 2006.

Medicaid Estate Recovery to Include Liens on Real Property

S.L. 2005-276, Sec. 10.21C (SB 622, Sec. 10.21C), as amended by S.L. 2005-345, Sec. 16 (HB 320, Sec. 16) provides that to the extent allowed by section 1396(p) of Title XIX of the Social Security Act, the Department of Health and Human Services (Department) may impose liens against real property, including the home, of a recipient of medical assistance. To the extent that allowable Medicaid claims are not satisfied as a result of the execution of any liens held by the Department, the Department is a fifth-class creditor. The act specifies that the recipient of medical care services paid for by the North Carolina Medicaid Program may be:

- Any age and receiving medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution and cannot reasonably be expected to be discharged to return home; or
- 55 years of age or older and receiving nursing facility services, home and community-based services, hospital care and prescription drugs related to nursing facility services or home and community-based services, personal care services, Medicare premiums, private duty nursing, home health aide services, home health therapy, and/or speech pathology services.

A "home" is defined as property, consisting of the recipient's dwelling and the land used and operated in connection with the dwelling, in which a recipient has, or had immediately before or at the time of the recipient's death, an ownership interest or legal title.

This provision adds new sections to the law to:

- Allow the Department to postpone or waive its claim, including execution of a lien, when enforcement would work an undue hardship to an heir or beneficiary of the Medicaid recipient.
- Establish the criteria for an undue hardship.
- Require that a claim of undue hardship to an heir or beneficiary be made in writing to the Department within 30 days after the receipt of notification of the Medicaid lien or claim.
- Outline when estate recovery is not cost effective.
- Provide for notice of estate recovery.
- Require the county department of social services administering medical assistance to gather and provide the Department with the information and administrative or legal assistance needed to recover medical assistance and provide that the county will be paid an amount equal to 20% of the nonfederal share of recovery collected.

This section becomes effective July 1, 2006, and applies to recipients of medical assistance on or after that date. The act became effective July 1, 2005.

Long-Term Plan for Meeting Mental Health Developmental Disabilities, and Substance Abuse Services Needs

S.L. 2005-276, Sec. 10.24 (SB 622, Sec. 10.24) directs the Secretary of the Department of Health and Human Services in consultation with interested advocacy groups and affected State and local agencies to develop a long-range plan for addressing the mental health, developmental disabilities, and substance abuse services needs of the State. The plan must be consistent with G.S. 122C-102 and must address the following:

- The services needed at the community level within each LME in order to ensure an adequate level of services to the average number of persons needing the services based on population projections.
- The full continuum of services needed for each disability group within an LME, including:
  - Which services could be regional or multi-LME based
  - What percent of the population each LME would expect to use State-level facilities

- An inventory of existing services within each LME for each disability group, and the gaps that exist
- Projected growth in services for each disability group within each LME or region that can reasonably be managed over the ensuing five-year period.
- Projected start-up costs and the total funding needed in each year from the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs to implement the long-range plan.

This section became effective July 1, 2005.

Senior Center Outreach

S.L. 2005-276, Sec. 10.37 (SB 622, Sec. 10.37) requires that of the funds appropriated to the Department of Health and Human Services, Division of Aging and Adult Services (Division), for the 2005-2007 fiscal biennium, the Division must enhance senior center programs as follows:

- 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 pursuant to this section for start-up funds for a new senior center, the county commissioners of the county in which the new center will be located must:

- 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, this section requires that funds be allocated by October 1 of each fiscal year and prevents State funding from exceeding 75% of reimbursable costs.

This section became effective July 1, 2005.

State-County Special Assistance

S.L. 2005-276, Sec. 10.38 (SB 622, Sec. 10.38) provides that effective October 1, 2005, the maximum monthly rate for residents in adult care home facilities is $1,118 per month per resident, unless adjusted by the Department of Health and Human Services (Department). The maximum monthly rate for residents in Alzheimer/Dementia special care units is $1,515 per month per resident unless adjusted by the Department.

This section became effective July 1, 2005.

Special Assistance In-Home

S.L. 2005-276, Sec. 10.39(a) (SB 622, Sec. 10.39(a)), as amended by S.L. 2005-345, Sec. 18 (HB 320, Sec. 18), allows the Department of Health and Human Services (Department) 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. The provision includes the following:

- Allows payments to be made for up to 1,000 individuals during the 2005-2006 fiscal year and the 2006-2007 fiscal year.
- Provides that the standard monthly payment to individuals enrolled in the Special Assistance in-home program must be 75% 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.

- Specifies that for State fiscal year 2005-2006, qualified individuals are not allowed to receive payments at rates less than they would have been eligible to receive in State fiscal year 2004-2005.
- Requires the Department 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.
- Requires the Department's policies and procedures to include the use of a functional assessment.
- Requires the Department to make the in-home option available to all counties on a voluntary basis.
- Requires that to the maximum extent possible, the Department must consider geographic balance in the dispersion of payments to individuals across the State.

This subsection became effective October 1, 2005. The act became effective July 1, 2005.

See also Studies, Referrals to Departments, Agencies, Etc. subheading in this document for Special Assistance In-Home Report.

Regulatory Changes To Improve Quality and Safety In Home Care Services, Mental Health Facilities, Adult Care Homes, and Certain Hospital Facilities

S.L. 2005-276, Sec. 10.40A(a-b) and (i-p)) (SB 622, Sec. 10.40A(a-b) and (i-p)) makes a number of changes affecting in-home care services and health care facilities.

Home Care Rules and Inspection. – The North Carolina Medical Care Commission may adopt, amend, and repeal all rules necessary for the implementation of the Home Care Agency Licensure Act and the Home Care Clients' Bill of Rights. Rules authorized include those that:

- Recognize the different types of home care services and specific requirements of the provision of each type of home care service.
- Establish staff qualifications, including professional requirements for home care agency staff. The rules may require that one or more staff of an agency be licensed or certified, may establish minimum training and education qualifications for staff, and include the recognition of professional certification boards for professions not licensed under law provided that the professional board evaluates applicants on a basis that protects the public health, safety, or welfare.
- Define geographic service areas for in-home aide services and staffing qualifications for licensed home care agencies for the purpose of ensuring effective supervision of in-home aide staff and the timely provision of services. (A "geographic service area" is the geographic area in which a licensed agency provides home care services.)
- Prohibit licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry.
- Require 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.

Changes also include a requirement for the Department of Health and Human Services (Department) to inspect each home care agency at least every three years and a requirement that agencies provide each client with a written notice of the Division of Facility Services hotline number in advance of furnishing care to the client or during the initial evaluation visit before the initiation of services.

Home Care Clients' Bill of Rights. – The Home Care Clients' Bill of Rights is established and includes: legislative intent, declaration of clients' rights, notice to client, implementation, enforcement and investigation, and confidentiality.

- *Declaration of Home Care Clients' Rights.* – Each home care agency client has the following rights:
  - To be informed and participate in his or her plan of care.
  - To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.
  - To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.
  - To voice grievances about care and not be subjected to discrimination or reprisal for doing so.
  - To have his or her personal and medical records kept confidential and not be disclosed without appropriate written consent.
  - To be free of mental and physical abuse, neglect, and exploitation.
  - To receive a written statement of services provided by the agency and the charges the client is liable for paying.
  - To be informed of the process for acceptance and continuance of service and eligibility determination.
  - To accept or refuse services.
  - To be informed of the agency's on call service.
  - To be informed of supervisory accessibility and availability.
  - To be advised of the agency's procedures for discharge.
  - To receive a reasonable response to his or her requests of the agency.
  - To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.
  - To be advised of the agency's policies regarding patient responsibilities.
- *Notice to Client.* – During the initial evaluation visit or before furnishing services, an agency must provide each client with:
  - A copy of the declaration of home care clients' rights.
  - A copy of the agency's policies regarding client responsibilities as it relates to safety and care plan compliance.
  - The address and telephone number for information, questions, or complaints about services provided by the agency.
  - 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.
- *Enforcement and Investigation.* – The Department of Health and Human Services is responsible for enforcement of the home care provisions and must investigate complaints within a reasonable period of time, not to exceed 60 days.

  When the Department receives a complaint pertaining to client care or safety, an investigation must be initiated:
  - Immediately upon receipt of the complaint if the complaint alleges a life threatening situation.
  - Within 24 hours if the complaint alleges abuse of a client as defined by law.
  - Within 48 hours if the complaint alleges neglect of a client as defined by law.
  - Within two weeks in all other situations.

  Investigations by the Department must be completed within 30 days.

  Within 72 hours, a home care agency must investigate complaints made to the agency by a home care client or the client's family and must document the existence of the complaint and the resolution.
- *Implementation, Confidentiality, and Rules.* – Home care agency directors are responsible for implementing changes and each agency must provide appropriate training. The Department must maintain the confidentiality of persons registering

complaints and of medical records. The North Carolina Medical Care Commission must adopt rules defining the scope of permissible advertising and promotional practice by home care agencies.

Adult Care Home Licensure, Monitoring, and Inspection. – Amends the law concerning the licensing of facilities to include a requirement that the Department issue a license for a facility not currently licensed as an adult care home for a period of six months. The Department is required to issue a license for the balance of the calendar year if the licensee demonstrates substantial compliance with laws pertaining to licensing and to the Adult Care Home Residents' Bill of Rights, and with rules.

This section also deletes some requirements pertaining to the monitoring of adult care homes and replaces them with new requirements. New requirements include the following:

- *Monitoring and Inspection.* – The Department must ensure that adult care homes requiring a license are monitored for licensure compliance on a regular basis. The provision specifies that all licensed facilities, including adult care units in nursing homes, are subject to inspections at all times by the Secretary of the Department of Health and Human Services. The Division of Facility Services is required to inspect all adult care homes and adult care units in nursing homes on an annual basis, effective July 1, 2007 and thereafter. Further, the Department must ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.
- *Routine Monitoring by County Departments of Social Services.* – The Department is required to work with county departments of social services for routine monitoring in adult care homes and to ensure compliance with State and federal laws, rules, and regulations. The Division of Facility Services will oversee the monitoring and perform any required follow-up inspection. The county departments of social services must document in a written report, all on-site visits, including monitoring visits, revisits, and complaint investigations, and must submit to the Division of Facility Services written reports of each facility visit within 20 working days of the visit.
- *Annual Reviews and Intervention with the County Departments of Social Services.* – The Division of Facility Services is required to conduct and document annual reviews of the county departments of social services' performance. The Department is allowed to intervene when monitoring is not done in a timely manner or when there is failure to identify or document noncompliance. Departmental intervention must include one or more of the following:
  - Sending staff of the Department to the county departments of social services to provide technical assistance and to monitor the services being provided by the facility.
  - Advising county personnel as to appropriate polices and procedures.
  - Establishing a plan of action to correct county performance.

  The Secretary of Health and Human Services determines when the Department must assume the county's regulatory responsibility for the county's adult care homes.
- *Training for Adult Home Specialists and Supervisors.* – County departments of social services' adult home specialists and their supervisors are required to complete the following:
  - 8 hours of prebasic training within 60 days of employment;
  - 32 hours of basic training within 6 months of employment;
  - 24 hours of postbasic training within 6 months of the basic training program;
  - 8 hours (minimum) of complaint investigation training within 6 months of employment; and
  - 16 hours (minimum) of statewide training annually by the Division of Facility Services.
- *Monitoring of Air Circulation, Ventilation, and Room Temperature.* – The Department is required to regularly monitor the enforcement of rules pertaining to air circulation,

ventilation, and room temperature in resident living quarters. These rules must include a requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit. (These requirements were deleted from a previous subsection in the law and simply recodified in a new location.)

- *Administrator Directory.* – The Department is required to keep an up-to-date directory of all persons who are administrators. An "Administrator" is defined in the law as a person approved by the Department who has the responsibility for the total operation of a licensed domiciliary home. (This provision was deleted from a previous subsection in the law and simply recodified in a new location.)

The section also contains a requirement that adult care homes conspicuously post the Division of Facility Services' complaint hotline number in a public place in the facility.

Adult Care Home Penalties. –

- *Penalty Changes.* – Penalties for violation of Residents' Rights, or State and federal laws and regulations are increased as follows:
  - A civil penalty for each Type A Violation in a home with 6 (previously 9) or fewer beds must be imposed for not less than $500 (previously $250) nor more than $10,000 (previously $5,000). The Department must impose a civil penalty in an amount not less than $1,000 (previously $500) nor more than $20,000 (previously $10,000) for each Type A Violation in facilities licensed for 7 (previously 10) or more beds.
  - A plan of correction for a Type B Violation cannot exceed requirements imposed by existing rule or law.
  - Where a facility has failed to correct a Type A Violation, the Department must assess the facility a civil penalty in the amount of up to $1,000 (previously $500) for each day that the deficiency continues beyond the time specified in the plan of correction.
  - Where a facility has failed to correct a Type B Violation within the time specified for correction, the Department must assess the facility a civil penalty in the amount of up to $400 (previously $200) for each day that the deficiency continues beyond the date specified for correction.
  - The Department is required to impose a civil penalty on any applicant for licensure that provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty must be as prescribed for a Type A Violation.
- *Penalty Review Committee Changes.* – The penalty review committee, established by law to review administrative penalties, is required to meet at least semiannually. The committee will provide a forum for residents, guardians or families of residents, local departments of social services, and providers, will make recommendations to the Department on changes in policy, training, or rules as a result of its review and publish a report. One member of the Department outside the Division of Facility Services, and one member not affiliated with the Department will cochair the committee. The Secretary of the Department of Health and Human Services administers the work of the committee and provides meeting notice to the following:
  - The licensed provider.
  - The local department of social services that is responsible for oversight of the facility involved.
  - The residents affected.
  - The families or guardians of the residents affected.

  The Department is required to notify families or guardians of affected residents of the right to request a penalty review committee review of the Department's penalty decision before the decision becomes final. Within 60 days of

receipt of a request from a family member or guardian for review of the Department's penalty decision, the penalty review committee must meet to conduct the review and must inform the family member or guardian of the results of the review.

Quality Improvement Consultation Program for Adult Care Homes. – The Department's Division of Aging and Adult Services (Division) is required to develop a Quality Improvement Consultation Program for Adult Care Homes (Program). During development of the Program, the Division must consult with adult care home providers, county departments of social services, consumer advocates, and other interested stakeholders. The purpose of the Program is to promote better care and improve quality of life in a safe environment for residents in adult care homes through consultation and assistance with adult care home providers. County departments of social services are responsible for implementation of the Program with all adult care homes located in the respective county.

The Department must submit a progress report addressing the following topics:

- Principles and philosophies that are resident-centered and promote independence, dignity, and choice for residents;
- Approaches to develop continuous quality improvement with a focus on resident satisfaction and optimal outcomes;
- Dissemination of best practice models that have been used successfully elsewhere;
- A determination of the availability of standardized instruments, and their use to the extent possible, to assess and measure adult care home performance according to quality of life indicators;
- Utilization of quality improvement plans, that include agreed upon time frames for completion of improvements and identification of needed resources for adult care homes, and that identify and resolve issues that adversely affect quality of care and services to residents;
- Training required to equip county departments of social services' staff to implement the Program;
- A distinction of roles between the regulatory role of the Department's Division of Facility Services and the quality improvement consultation and monitoring responsibilities of the county departments of social services; and identification of staffing and other resources needed to implement the Program.

The Division must conduct a pilot of the Program. No more than four county departments of social services can participate in the pilot and geographic balance and size must be considered in carrying out the pilot. At the conclusion of the pilot, the Division must make recommendations regarding the effectiveness of the Program. If the Division recommends expansion of the pilot, the report must include the cost and a proposed timetable for implementing the recommendations, including identification of any statutory or administrative rule changes.

The progress report must be submitted on or before April 1, 2006, to the North Carolina Study Commission on Aging, to the Senate Appropriations Committee on Health and Human Services and the House of Representatives Subcommittee on Health and Human Services. The recommendations regarding expansion of the Program must be made to the Secretary of the Department of Health and Human Services, the North Carolina Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and the House of Representatives Subcommittee on Health and Human Services.

The portion of the section that pertains to issuing a license for a period of six months to a facility not currently licensed as an adult care home, becomes effective July 1, 2007, except that the Division may conduct inspections more frequently than annually prior to July 1, 2007, as funds and personnel permit. The portion of the section that pertains to training required of the county departments of social services' adult care home specialists and their supervisors becomes effective July 1, 2006. Specialists and their supervisors employed on or before July 1, 2006, must complete the required training components or those portions of the training components they

have not completed prior to the effective date within 12 months. The remainder of the section became effective August 13, 2005.

Licensure of Facilities for the Mentally Ill, the Developmentally Disabled, and Substance Abusers. – The State law regarding the "Licensure of Facilities for the Mentally Ill, the Developmentally Disabled, and Substance Abusers" is amended. The act amends inspection and licensure practices and doubles the civil penalties that may be assessed for violations. Inspections will be conducted annually for residential facilities and every two years for licensable facilities. License periods are shortened – initial licensure may not exceed 15 months and is renewed on an annual basis thereafter. One time provisional licenses of no more than six months duration may be issued to allow facilities to demonstrate substantial compliance, either when they are initially licensed or in cases where they have fallen out of compliance and the noncompliance poses no "immediate threat to the health and safety of the individuals in the licensable facility." Additionally, facilities not serving clients for a twelve-month period are not eligible for renewed licensure.

Section 10.40A(q) contains a study. For additional information, see Studies, Referrals to Departments, Agencies, Etc. subheading in this document.

Use of Medication Aides to Perform Technical Aspects of Medication Administration in Skilled Nursing Facilities

S.L. 2005-276, Sec. 10.40C (SB 622, Sec. 10.40C) amends the Nursing Home Licensure Part of the Health Care Facility Licensure Act to allow the use of medication aides to perform technical aspects of medication administration for facilities licensed and medication administration services provided under this Part.

The North Carolina Medical Care Commission is required to adopt rules to include the following:

- Training and competency evaluation of medication aides.
- Requirements for listing under the Medication Aide Registry.
- Requirements for supervision of medication aides by licensed health professionals or appropriately qualified supervisory personnel.

The Board of Nursing must:

- Establish standards for faculty requirements for medication aide training.
- Provide ongoing review and evaluation, and recommend changes, for faculty and medication aide training requirements to support safe medication administration and improve client, resident, and patient outcomes.

This section also requires the Department of Health and Human Services to establish a Medication Aide Registry containing the names of all health care personnel in North Carolina who have successfully completed a medication aide training program that has been approved by the North Carolina Board of Nursing and passed a State-administered medication aide competency exam. Employers are required to access the Medication Aide Registry prior to allowing an individual to serve as a medication aide and are not allowed to use an individual as a medication aide unless the individual is listed on the Medication Aide Registry. Employers must note each incidence of access in the appropriate business file. Employers must also access the Health Care Personnel Registry prior to employing a medication aide and any substantiated action listed against the medication aide will disqualify the medication aide from employment in a covered facility or agency.

The North Carolina Board of Nursing and the Department of Health and Human Services must report on implementation not later than March 1, 2006 and annually thereafter, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services and the Fiscal Research Division.

This section becomes effective July 1, 2006.

Department of Health and Human Services and Community Colleges Study Use of Medication Aides to Perform Technical Aspects of Medication Administration

S.L. 2005-276, Sec. 10.40D (SB 622, Sec. 10.40D) directs the Secretary of Health and Human Services and the President of the Community Colleges System to jointly convene a study group to review and consider the use of medication aides to perform the technical aspects of medication administration.

The study group shall consist of members representing at least the following entities and licensed health care facilities and providers:

- Appointed by the Secretary of Health and Human Services:
  - Adult care homes
  - Home care agencies
  - Ambulatory surgical centers
  - Hospitals
  - Facilities providing mental health, developmental disabilities, and substance abuse services
  - Nursing homes
  - The nursing profession, as recommended by the Board of Nursing
- Community colleges appointed by the President of the Community Colleges System.
- The Secretary of the Department of Correction
- Others as may be appointed by the Secretary of Health and Human Services or the President of the Community Colleges System

The study group must address at least the following in its study and its recommendations regarding medication aide performance of the technical aspects of medication administration:

- Training and competency evaluation of medication aides
- Training standards
- Ongoing review and evaluation of medication aide training
- Requirements for supervision of medication aides

The Secretary of Health and Human Services and the President of the Community Colleges System must report the progress and recommendations of the study group to the 2006 Regular Session of the 2005 General Assembly upon its convening, and the 2007 General Assembly upon its convening.

This section became effective July 1, 2005.

Plan for Star-Rating System for Adult Care Homes

S.L. 2005-276, Sec. 10.41 (SB 622, Sec. 10.41) requires the Department of Health and Human Services to develop a plan for implementing a star-rating system for adult care homes and by not later than January 1, 2007, to report on the details and status of the 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.

This section became effective July 1, 2005.

Studies

Referrals to Departments, Agencies, Etc.

Study Additional Utilization/Prior Authorization Systems for Personal Care Services and Other Home and Community-Based Services

S.L. 2005-276, Sec. 10.19(b) (SB 622, Sec. 10.19(b)) requires the Department of Health and Human Services, Division of Medical Assistance, to study and determine additional utilization/prior authorization systems for personal care services and other home and community-based services that can be provided to individuals who meet medical criteria. These systems must be able to be implemented when the new Medicaid Management Information System goes into effect. The Division must report 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 the plan for implementation, including costs, not later than May 1, 2006.

This section became effective July 1, 2005.

See also Enacted Legislation for Medicaid Personal Care Services Limitation.

Community Alternative Programs Reimbursement System

S.L. 2005-276, Sec. 10.20 (SB 622, Sec. 10.20) requires the Department of Health and Human Services, Division of Medical Assistance, to study developing a new system for reimbursing the Community Alternatives Program. The new system must:

- Use a case-mix reimbursement system, similar to the one used by nursing facilities and home health agencies, to determine the level of care provided and the amount paid for the care provided;
- Incorporate into the case-mix system the home environment and social support systems; and
- Use the Resource Utilization Groups-III to determine the level of need for Community Alternatives Programs-Mentally Retarded/Developmentally Disabled program services except for CAP-MR/DD program services.

The Division must report not later than May 1, 2006, 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 the development of the new system, including an implementation schedule. Full implementation of the new system must be not later than January 1, 2007.

This section became effective July 1, 2005.

Medicaid Study

S.L. 2005-276, Sec. 10.21E (SB 622, Sec. 10.21E) requires the Department of Health and Human Services (Department) to study Medicaid services for individuals who are dually eligible for Medicaid and Medicare. In particular, the study must include the Medicare Part D impact on these services, the financial impact on the State of Medicare clawback provisions, and efficiencies that can be realized in services for this dually eligible population. The study must also include the impact on the Medicaid program as a whole. The Department must report the results of the study 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 not later than May 1, 2006.

This section became effective July 1, 2005.

Special Assistance In-Home

S.L. 2005-276, Sec. 10.39(b-c) (SB 622, Sec. 10.39(b-c)) requires the Department of Health and Human Services (Department) to report 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, on or before January 1, 2006, and on or before January 1, 2007. The report must include the following:

- 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.
- The amount of case management that 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.

The Department must 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). The Department must utilize national standards to the extent they are available.

This section became effective July 1, 2005.

See also Enacted Legislation this chapter for Special Assistance In-Home.

Regulatory Changes To Improve Quality and Safety In Home Care Services, Mental Health Facilities, Adult Care Homes, and Certain Hospital Facilities

S.L. 2005-276, Sec. 10.40A(q)) (SB 622, Sec. 10.40A(q)) directs the Department of Health and Human Services (Department) to study whether there are additional "health care facilities" and "health care personnel" that are employed in health care settings, including unlicensed health care settings, that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. The Department must report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

This section became effective July 1, 2005.

See also Enacted Legislation for a summary of the remainder of this section.

V

Seniors' Health Insurance Information Program

North Carolina
Department of Insurance
Jim Long, Commissioner

Medicare Part D: Prescription Drug Plan Benefit

Just the Facts

1-800-443-9354 • www.ncshiip.com

Revised September 27, 2005

THE MEDICARE PRESCRIPTION DRUG PLANS ARE HERE.....

Enrollment for the Medicare Prescription Drug plans begins November 15, 2005 and ends May 15, 2006. If someone enrolls by December 31, 2005, the new Medicare Prescription Drug coverage will begin on January 1, 2006. Enrolling after December 31, 2005, will delay the coverage effective date. Postponing enrollment after May 15, 2006, may result in a 1% per month penalty for every month you delayed enrollment. The Medicare Prescription Drug plans will be sold by private companies whose plans have been approved by Medicare. These plans will be called Medicare Prescription Drug Plans or PDPs. You can identify an approved plan by the MedicareRx logo.

All people with Medicare are eligible to enroll in a PDP, regardless of income or assets. Options and features will vary from plan to plan such as drug lists with generic and brand name medications, drug prior approval requirements, and deductible and co-payments structures. You can only select one PDP plan. All of these differences will have a direct impact on the plan premium. The monthly premiums for PDPs in North Carolina range from under $20 - $68. Beneficiaries will want to compare plans and select the one plan that best meets their individual needs; such as, all prescriptions are on the plan's list of drugs, that you can use your preferred pharmacy, and the premium is affordable. After selecting a plan be assured that Medicare has put into place an appeal process should a physician prescribe a medication that is not on your PDP's drug list. For assistance in understanding and enrolling in a PDP, please refer to your **Medicare & You 2006 Handbook**, which is published by the Centers for Medicare and Medicaid Services (CMS), or contact SHIIP.

In North Carolina there are 16 approved companies who will offer a total 38 PDP plans. Ten of these plans will offer national coverage, which is especially important for beneficiaries who have residences in more than one state. Some plans are sold as stand-alone insurance products while others will be offered through Medicare Advantage options such as HMOs, PPOs, and Private-Fee-For-Service (PFFS) plans. All plans may not be identical, but companies are required to offer benefits that are at least equal to Medicare's Standard PDP model of coverage outlined below.

MEDICARE'S STANDARD PDP COVERAGE OUTLINE

All plans must at least provide the following benefits but may offer more:

2006 Basic/Standard Medicare Prescription Drug Plan

Actual Drug Costs	Medicare Pays	Beneficiary Pays	Cumulative Beneficiary Out-of-Pocket Total
$0 - $250	$0	$ 250 (drug deductible)	**$ 250**
$250.01 - $2,250	$1,500 (75%)	$ 500 (25%)	**$ 750 ($250+$500)**
$2,250.01 - $5,100	$0	$2,850 (100%)	**$3,600 ($750+$2,850)**
$5,100.01 +	about 95%	about 5%	**varies**

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

THERE IS EXTRA HELP FOR THOSE WHO NEED IT MOST

There is assistance available for people with Medicare who have limited incomes and resources. If they qualify, they can receive assistance with premiums, deductibles and co-payments for their prescriptions. If someone has an annual income of below $14,355 as an individual or $19,245 as a couple and assets lower than $10,000/$20,000 they can visit their local Social Security office or request extra help assistance application by contacting SHIIP. Remember a person that receives extra help will need to enroll in a PDP or make application on www.socialsecurity.gov.

NOTE: If someone applied for extra help and received a letter stating that they did not qualify for assistance, they are still eligible to enroll in a PDP but will have the responsibility to pay the premiums, deductibles, and co-payments.

MEDIGAP PLANS

People with Medigap plans A-G can choose to select a plan from any company selling a PDP. However if a person is covered under a Medigap H, I, or J plan they currently have prescription drug coverage. They may choose to maintain this coverage or have the prescription drug benefit removed from their policy and enroll in a PDP. Another option is to select another Medigap plan and enroll in a PDP. Medigap companies are required to send notification to their H, I and J plan members advising them of their options and the consequences of their choices. For example, if they keep their current coverage and the Medigap premium increases in the future they may want to change coverage at that time and buy a PDP. This is allowable but will result in the 1% penalty previously discussed in this publication.

EMPLOYER SPONSORED PLANS

Many employers will be participating with Medicare Part D by continuing to offer the prescription drug coverage they currently offer to retirees. This coverage has been evaluated to be "equal to or better than" Medicare's coverage and therefore will not be subject to the 1% penalty should this coverage be cancelled in the future. They do not need to take action at this point, but should look for notification from their employer advising them of the status of their coverage. Examples of this coverage are TRICARE for Life, VA, Federal Employees' Health Plans and the NC State Health Plan.

MEDICARE ADVANTAGE PLANS

People with Medicare who have joined a Medicare Advantage plan that includes prescription drug coverage will only be allowed to choose from their plan's specific Medicare Prescription Drug plan options. People with Medicare who have joined a Medicare Advantage PFFS plan have three options: 1) check with your Medicare Advantage plan to see if it will be selling stand-alone plans; 2) switch to another Medicare Advantage plan that better meets their needs for prescription drug coverage; 3) return to Original Medicare and enroll in a PDP plan.

ENROLLMENT ASSISTANCE IS AVAILABLE

Medicare beneficiaries can have enrollment assistance through the SHIIP program by calling 1-800-443-9354. We can provide a Medicare Prescription Drug Plan finder tool that will allow you to identify the medications you are prescribed and your preferred pharmacy. You may then return the information to us, and we will determine which PDP plans cover your medications and the pharmacies participating with the plan, or you may visit your local counseling site for face-to-face assistance. Check the SHIIP website at www.ncshiip.com for scheduled enrollment clinics in your local community.

111 Seaboard Avenue • Raleigh, NC • 27604 • 1-800-443-9354 • 919-733-0111 • www.ncshiip.com

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VI

Seniors' Health Insurance Information Program

Jim Long, Commissioner
North Carolina Department of Insurance

MEDICARE PART D PRESCRIPTION DRUG PLAN FINDER TOOL

The Seniors' Health Insurance Information Program (SHIIP), a division of the North Carolina Department of Insurance, is able to help you find a Medicare Prescription Drug Plan that will meet your needs and assist you with enrolling in a plan. The following questionnaire provides the necessary information that SHIIP staff and volunteers need to be able to prepare a report for your consideration.

Once completed, please mail to: **111 Seaboard Avenue, Raleigh, NC, 27604** or take the completed form to a counseling clinic in your local county.

Please provide us with contact information about yourself:

Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____)_____

Do you reside in North Carolina year round? ☐ **Yes** ☐ **If No, State of** _____

Please tell us about your current health insurance coverage:

Do you have a Medicare Advantage Plan (HMO or PPO or PFFS)?
☐ **Yes** ☐ **No**

If yes, please list name of the Plan _____

Do you have other insurance coverage for prescriptions? Please check any that apply.

☐ Medicaid

☐ TRICARE for Life

☐ Medigap/Medicare Supplement

☐ Federal Employees Health Benefit Plan

☐ VA

☐ Other_____
(retirement, private, other than Medicare Advantage)

Please provide us with information on your prescriptions and pharmacy. NOTE: you may be able to obtain a computerized listing from your pharmacist/pharmacy to attach. If not, please complete the chart below.

NAME OF DRUG Example: *Lipitor*	STRENGTH Example: *10 mg.*	DAILY DOSAGE Example: *Twice Daily*

I prefer to have my prescriptions filled at this pharmacy(s)_____

☐ **I would be willing to use a different pharmacy.**

☐ **I prefer to use a mail order pharmacy.**

☐ **I live in a Long - Term Care Facility.**

111 Seaboard Avenue • Raleigh, NC 27604 • 1-800-443-9354 • 919-733-0111 • www.ncshiip.com

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Form No. PDP01 (10-05)

VII

North Carolina Stand-Alone Prescription Drug Plan Organizations
As of 10/13/05

Organization Name/Plan Name	Beneficiary Total Drug Plan Premium	Tiered Co-Payments for Drugs	Drug Deductible		
			Zero	Reduced	Standard ($250)
Aetna Life Insurance Company * 1-800-529-5586 www.aetna.com					
Aetna Medicare Rx Essentials	$37.24	X			X
Aetna Medicare Rx Plus	$48.45	X	X		
Aetna Medicare Rx Premier	$64.48	X	X		
Blue Cross and Blue Shield of NC 1-800-661-5518 www.bcbsnc.com					
Medicare Prescription Drug Plan–Standard	$52.03				X
Medicare Prescription Drug Plan–Plus	$59.60	X	X		
Connecticut General Life Insurance Co. * 1-800-735-1459 www.cigna.com					
Cignature RX – Value Plan **	$35.53	X			X
Cignature RX – Plus Plan	$40.65	X	X		
Cignature RX – Complete Plan	$48.69	X	X		
Coventry Health and Life Insurance Co. * 1-800-882-3822 www.AdvantraRx.com					
AdvantraRx Value **	$23.23	X	X		
AdvantraRx Premier **	$33.95	X	X		
AdvantraRx Premier Plus	$46.62	X	X		
Humana Insurance Company 1-800-281-6918					
Humana PDP Standard **	$13.27	X			X
Humana PDP Enhanced **	$18.05	X	X		
Humana PDP Complete	$65.03	X	X		
Medco Containment Life Insurance Co. * 1-800-758-3605 www.yourxplan.com					
YOURx Plan **	$34.32	X			X
MemberHealth Inc. * 1-866-684-5353 www.communitycarerx.com					
CCRX Basic **	$32.24	X			X
CCRX Choice	$40.34	X			X
CCRX Gold	$44.26	X		X	
Pacificare Life and Health Insurance Co. * 1-800-947-9185 www.prescriptionsolution.com					
Pacificare Saver Plan **	$31.56	X	X		
Pacificare Select Plan	$47.10	X	X		
Pacificare Comprehensive Plan	$52.68	X	X		

*** Indicates National Plan(s) Available**

**** For those people who are deemed eligible and approved for low-income subsidy/extra help, plan premium should be covered in full on these plans.**

Organization Name/Plan Name	Beneficiary Total Drug Plan Premium	Tiered Co-Payments for Drugs	Drug Deductible		
			Zero	Reduced	Standard ($250)
Pennsylvania Life Insurance Company **1-800-766-3233** **www.rxpathway.com**					
Prescription Pathway Bronze Plan **	$32.19				X
Prescription Pathway Silver Plan	$41.50	X			X
Prescription Pathway Gold Plan	$52.54	X	X		
RXAmerica, LLC **1-877-279-0370** **www.meds4medicare.com**					
Advantage Star Plan **	$32.27	X			X
Advantage Freedom Plan **	$34.95	X			X
Silverscript Insurance Company *					
SilverScript ** **1-866-552-6106**	$30.90	X			X
SilverScript Plus **1-866-235-4582**	$59.71	X		X	
Sterling Life Insurance Company **1-888-858-8572**					
Sterling Prescription Drug Plan	$60.04	X		X	
UNICARE * **1-866-892-5335**					
Medicare RX Rewards **	$31.30	X			X
Medicare RX Rewards Plus	$38.73	X	X		
Medicare RX Rewards Premier	$51.67	X	X		
United American Insurance Company **1-866-524-4169** **www.uamedicarepartd.com**					
UA Medicare Part D Prescription Drug Cvg	$38.59	X	X		
United Healthcare Insurance Company *					
AARP MedicareRx Plan ** **1-888-867-5564** **www.aarpmedicarerx.com**	$28.27	X	X		
United Medicare MedAdvance ** **1-888-566-6657**	$31.53	X	X		
Wellcare Health Plans * **1-888-423-5252**					
www.wellcarepdp.com					
WellCare Signature **	$24.87	X	X		
WellCare Complete	$45.22	X	X		
WellCare Premier	$48.99	X	X		

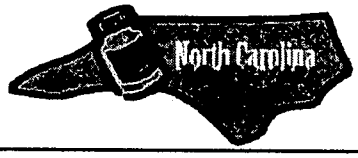
*** Indicates National Plan(s) Available**

**** For those people who are deemed eligible and approved for low-income subsidy/extra help, plan premium should be covered in full on these plans.**

VIII

Senior Care Update

Presented by North Carolina Senior Care



NORTH CAROLINA Health Wellness TRUST FUND

Beginnings

- Began in 2002
- First Use of tobacco settlement monies as proposed by the HWTF Commission and the Governor.
- To provide assistance to low income seniors for their prescription drugs. Covered 60% of the first $1000.00 in drug costs.
- Covered individuals up to 200% FPL.
- Heart, lung disease or diabetes.
- 3 year commitment.

Medicare Modernization Act of 2003

- Medicare Approved Drug Discount Cards – Transitional Assistance.
- CMS allowed SPAP to auto enroll those under 135% FPL into a MADDC offering $600.00 credit from CMS.
- Senior Care paired with CCRx in 2004 and the $600.00 savings allowed Senior Care to open and expand the benefit.
- Benefit expanded to $1200.00 per year, covering 90-95% of drug costs with no diagnosis restrictions and an expanded formulary.
- Benefit offered to those under 250% FPL.

Senior Care Promotion 2004

- Statewide Promotion Campaign
- Senior Care Signup Day
- Local AAAs, Medication Management sites, Senior Centers, etc.
- Enrollment went from 34,000 in September 2004 to 130,000 in 12 months.
- Tapped into $40 million in federal money to supplement the benefit as over half were auto-enrolled in the federal MADDC program.

Senior Care 2005

- All transitional assistance programs end December 31, 2005 – MADDC and most SPAPS.
- CMS grant received to transition to Part D:
  - Supporting SHIIP – call center personnel and Train the Trainer workshops across state.
  - Pharmacist trainings across the state (4-500 pharmacists reached)
  - Outreach – Local Outreach Coordinator sites in every county of state. List of Senior Care enrollees in county and providing face to face assistance during the transition to 2006
  - Clear up confusion about choices and the process.

Senior Care Future

- Part D taking the place of most SPAPs
- Possible wraparound being evaluated.
- Benefits will be considered based on the current environment and funding available.
  - CMS's position on options available to SPAPs is changing and evolving.
- Now focused on how to help our Senior Care enrollees make an informed decision on how to best choose their prescription drug coverage under Medicare Part D.

IX

North Carolina Senior Care
Enrollment by County as of 10/28/05

County	Enrollees
ALAMANCE	2369
ALEXANDER	1128
ALLEGHANY	272
ANSON	592
ASHE	1163
AVERY	384
BEAUFORT	812
BERTIE	580
BLADEN	760
BRUNSWICK	2176
BUNCOMBE	3160
BURKE	2071
CABARRUS	2511
CALDWELL	3002
CAMDEN	65
CARTERET	747
CASWELL	443
CATAWBA	3397
CHATHAM	871
CHEROKEE	904
CHOWAN	371
CLAY	363
CLEVELAND	2605
COLUMBUS	1455
CRAVEN	1228
CUMBERLAND	2006
CURRITUCK	144
DARE	205
DAVIDSON	3340
DAVIE	355
DUPLIN	1250
DURHAM	2042
EDGECOMBE	1202
FORSYTH	2069
FRANKLIN	953
GASTON	4383
GATES	114
GRAHAM	150
GRANVILLE	658
GREENE	386
GUILFORD	4362
HALIFAX	1676
HARNETT	1542
HAYWOOD	1137
HENDERSON	1534
HERTFORD	445
HOKE	436
HYDE	110

IREDELL	2252
JACKSON	561
JOHNSTON	1849
JONES	305
LEE	867
LENOIR	1204
LINCOLN	1687
MACON	1138
MADISON	428
MARTIN	605
MCDOWELL	1522
MECKLENBURG	4651
MITCHELL	528
MONTGOMERY	700
MOORE	1347
NASH	1651
NEW HANOVER	2704
NORTHAMPTON	860
ONSLOW	1139
ORANGE	708
OTHER	72
PAMLICO	296
PASQUOTANK	435
PENDER	1068
PERQUIMANS	275
PERSON	788
PITT	1369
POLK	498
RANDOLPH	2806
RICHMOND	1167
ROBESON	1941
ROCKINGHAM	2356
ROWAN	2670
RUTHERFORD	1836
SAMPSON	1704
SCOTLAND	611
STANLY	1890
STOKES	641
SURRY	1709
SWAIN	269
TRANSYLVANIA	466
TYRRELL	96
UNION	1914
VANCE	871
WAKE	4096
WARREN	419
WASHINGTON	271
WATAUGA	549
WAYNE	1739
WILKES	1834
WILSON	1458
YADKIN	745

YANCEY	423
Z-OTHER	3
	129919

HWTF MEDICATION ASSISTANCE PROGRAM
GRANT AWARDS

The Medication Assistance Program (MAP) includes 69 grants (68 community-based grants and 1 statewide grant) funded by the NC Health and Wellness Trust Fund at $14.4 million to assist low-income citizens in obtaining prescription drugs and to counsel seniors about safe and effective

Medication Assistance Program -- Program Components		
Local and Statewide Grants	$ 14,444,393	Details provided below
Technical Support for Grantees	$ 610,000	
AHEC Professional Training for Pharmacists	$ 62,344	
Balance for Grant Expansion	$ 12,305	
Program Support Funds (i.e., legal fees, PSCs, etc)	$ 243,158	
Total Investment in Medication Assistance Program	$ 15,372,200	

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
1	Alamance Regional Medical Center (AlaMAP)	Alamance, Caswell	$ 322,500	$ 55,000	$ 377,500	Grantee has extensive experience with both medication management and prescription assistance and will continue to provide services as a peer mentor to other medication assistance programs statewide.
2	Albemarle Hospital Foundation	Camden, Chowan, Currituck, Dare, Gates, Pasquotank, Perquimans	$ -	$ 127,310	$ 127,310	The Clinic will expand pharmacy services from 300 patients to approximately 500 low-income patients by funding 3 prescription assistance coordinators (PAC) and a part-time pharmacist.
3	Angel Medical Center	Macon	$ -	$ 50,000	$ 50,000	The volume of low-income patients and need for enhanced program management demand a full-time position. Trained volunteers will continue to provide many support services for the senior and indigent patients.
4	Betsy Johnson Regional Hospital	Harnett	$ -	$ 50,000	$ 50,000	Expansion of staffing will provide services to additional patients within 200% of the federal poverty level (FPL) guidelines and provide the longer term medication management services many seniors need.

Updated: 11/3/2005

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
5	Black River Health Services, Inc.	Pender	$ -	$ 50,000	$ 50,000	This grant will provide funds for a full-time PAC who will oversee services at 3 sites. The addition of this position will reduce the workload on the nurses currently providing the service, allowing them to focus on nursing duties, reduce the wait time for prescription assistance services, and increase the number of low-income patients that receiving services.
6	Bladen HealthWatch	Bladen	$ 280,768	$ -	$ 280,768	Grantee is an award winning Healthy North Carolinians project with a good track record using the current DHHS software to help indigent patients access Prescription Assistance Programs ("PAP"). Grantee collaborates with the local hospital and Bladen Medical Associates.
7	Cabarrus Health Alliance	Cabarrus		$ 50,000	$ 50,000	Due to an overwhelming demand for services, the grantee will expand their medication assistance program to offer services to a broader range of patients. This program will assist residents who are between 125% and 200% of the FPL.
8	Caldwell Senior Center	Caldwell	$ 176,500		$ 176,500	Grantee is a senior center working in collaboration with local hospital, Kerr Drugs, free clinics and physicians to cover Caldwell County. Grantee has a full service plan where Kerr Drug provides medication management services with a half time Prescription Assistance Coordinator (PAC).
9	Cape Fear Council of Government AAA	New Hanover, Brunswick, Columbus, Pender	$ 398,000		$ 398,000	Grantee is regional Area Agency on Aging that covers New Hanover, Brunswick, Columbus and Pender Counties. Grantee provides medication management and prescription access services in collaboration with local aging agencies and Department of Social Services in Brunswick County.
10	Care Connection Pharmacy of Wilkes Regional Medical Center	Wilkes		$ 250,000	$ 250,000	Additional funding will expand hours for a part-time pharmacist, PAC and pharmacy technician, increasing the number of patients served. Four community partner agencies will conduct "brown bag" evaluations of patients' prescription drug needs.

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
11	Carolina Family Health Centers, Inc.	Edgecombe, Nash, Wilson	$ 389,000	$ 250,000	$ 639,000	The grantee will extend services from 2 clinics in Wilson and rural Nash Counties to Edgecombe County, which is a gap county.
12	Carolinas Poison Center	Statewide		$ 50,000	$ 50,000	The grantee will create printed and on-line information regarding the safe use of medications by seniors, proper methods of taking medications and common adverse drug events and interactions. Outreach educational efforts will target seniors statewide through contacts with state-level groups whose focus is on the aging population.
13	Cherokee County Health Department	Cherokee, Clay, Graham	$ 444,696		$ 444,696	Grantee is a collaboration between the county health departments of Cherokee, Clay and Graham Counties. Grantee uses a Registered Nurse to screen 97% of all clients requesting services after which a pharmacist will review all of this data and follow up where appropriate.
14	Community Care Center/Doctors Care Inc.	Stokes, Davie, Forsyth		$ 50,000	$ 50,000	The program will expand from primarily volunteer-based staff to include a part-time pharmacist. This change will allow the physicians to focus on patient medical services, increasing the number of patients served and decreasing wait time for services.
15	Community Care Clinic of Rowan County	Rowan	$ 140,000	$ 210,000	$ 350,000	In addition to the standard medication assistance program, the grantee will provide bilingual services and documentation through use of a part-time Spanish interpreter during the grant period. Grant funds will continue services in this high need county, currently funded through HWTFC.
16	Community Free Clinic	Cabarrus	$ 130,000	$ 197,500	$ 327,500	The grantee is working to increase capacity to meet the immediate, high volume needs of this county caused by large-scale layoffs. Grant funds will continue services in this high need county, currently funded through HWTFC.
17	Crisis Control Ministry	Forsyth		$ 252,500	$ 252,500	Grant funding for the pharmacist, PAC and 2 pharmacy staff will strengthen the existing program and expand services to additional low-income patients. Local healthcare professionals provide additional support to the clinic.

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
18	Cumberland County Hospital System, Inc.	Cumberland	$ 450,000	$ 250,000	$ 700,000	CCMAP will hire 2 additional PACs and a part-time pharmacist to allow more low-income patients to receive medication management services and prescription assistance. Other expanded services will include disease management education, one-on-one counseling, enhanced brown bag reviews and information on specific disease management.
19	Davidson Medical Ministries	Davidson		$ 252,500	$ 252,500	Hours for the current part-time pharmacist and PAC will be expanded to provide a more comprehensive program.
20	Diakonos, Inc.	Alexander, Catawba, Davie, Iredell, Wilkes, Yadkin		$ 128,896	$ 128,896	The pharmacist's hours will be increased from 8 hours per week to 15 hours per week, increasing the number of patients served. In addition, the pharmacist will provide "brown bag" medication reviews at least annually, or as necessary.
21	Duplin County Services for the Aged	Duplin		$ 65,083	$ 65,083	Grantee provides medication management and prescription access services in Duplin County.
22	Duplin Medical Association	Duplin, Sampson		$ 30,160	$ 30,160	The grantee will serve a larger low-income population base to include all age groups and increase the efficiency of the program through increased PAC staff time. In addition, the clinic will establish an outreach campaign, to increase awareness of the availability of services in the area.
23	Eastern Carolina Council AAA	Craven	$ 374,637		$ 374,637	Grantee is a regional Area Agency on Aging that covers Craven County. Grantee provides medication management and prescription access services through two pharmacists and one PAC.
24	FirstHealth of the Carolinas	Moore, Montgomery, Richmond		$ 249,766	$ 249,766	A part-time pharmacist and 2 PACs will provide medication assistance to low-income and older adult populations in Moore and Montgomery Counties, expanding into Richmond as needed.
25	Gaston Family Health Services, Inc.	Gaston, Lincoln	$ 232,750	$ 50,000	$ 282,750	Additional funding will expand medication assistance services in Gaston and Lincoln Counties.
26	Good Samaritan Clinic, Inc.	Burke		$ 52,500	$ 52,500	Grant funding will increase paid staff time from two part-time registered pharmacy technicians and 21 part-time volunteer pharmacists to include part-time paid pharmacists and PACs.

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
27	Greene Council on Aging	Greene		$ 22,406	$ 22,406	One pharmacist and one PAC provide medication management and prescription access services in Greene County.
28	Guilford County Department of Public Health	Guilford	$ 448,957	$ 250,000	$ 698,957	Two other prescription assistance programs in the county will lose their funding in the spring, therefore the grantee will expand services to the patients on the wait list and the patients expected to be referred from the closing programs. The funds will provide for additional pharmacist and PAC staff time.
29	HealthQuest of Union County	Anson, Union		$ 52,500	$ 52,500	The program will increase the number of patients served. Outreach targeted to inform low-income, minority populations of the services available will include print, radio and other media and outreach efforts.
30	Hertford County Public Health Authority	Hertford		$ 125,000	$ 125,000	The grantee will increase the part-time pharmacist to full-time and add a pharmacy technician to provide medication management services.
31	Hyde County Health Department	Hyde		$ 47,831	$ 47,831	By adding a contracted pharmacist funded through the grant, medication assistance services will be made available to additional low-income or senior patients.
32	Isothermal Planning AAA	Rutherford, Cleveland, Polk, McDowell	$ 541,521	$ 90,000	$ 631,521	The program will be expanded to serve more senior residents of McDowell County. These services will be provided by hiring an additional PAC and increasing the pharmacist's hours.
33	Jones County Health Department	Jones		$ 14,801	$ 14,801	Grantee provides medication management and prescription access services in Jones County.
34	Kinston Community Health Center, Inc.	Craven, Duplin, Greene, Jones, Lenoir, Pitt, Wayne		$ 50,000	$ 50,000	Grant funding to add a second PAC will increase the number of indigent patients receiving medication assistance services. The program also utilizes interpreters to assist with services for the high number of Spanish-speaking patients in the Kinston community.
35	Lenoir Memorial Hospital	Lenoir		$ 64,638	$ 64,638	Hospital pharmacist and one PAC provide medication management and prescription access services in Lenoir County.
36	Leon Mann Jr. Enrichment Center	Carteret		$ 64,864	$ 64,864	Grantee provides medication management and prescription access services in Cartaret County.

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
37	Lumber River Council of Governments	Robeson, Bladen, Hoke, Richmond and Scotland	$ 416,000	$ 50,000	$ 466,000	Due to its size, Robeson County needs increased funding to provide adequate services to additional seniors. Because of its geographical location, the grantee provides services to large numbers of Native American, Latino and African American individuals.
38	Martin-Tyrrell-Washington District Health Department	Washington, Martin, Tyrrell	$ 409,000		$ 409,000	Grantee is a three-county health department that provides medication management and prescription access services in all three counties through use of two registered nurses and contracts with local pharmacists. This area has a high density of indigent seniors who are in need of these services. The registered nurses also make home visits.
39	MedAssist of Mecklenburg	Mecklenburg	$ 303,000	$ 302,500	$ 605,500	The grantee will expand its licensed pharmacy program to serve more patients than current funding allows through medication assistance and education services. The grantee has extensive experience with both medication management and prescription assistance and will continue to provide services as a peer mentor to other medication assistance programs statewide.
40	Metropolitan Community Health Services	Beaufort, Pamlico		$ 50,000	$ 50,000	The medication assistance program will provide a network of services to seniors and low-income residents, through establishment of a multidisciplinary drug utilization committee, contracting with a pharmacist to expand medication assistance services, and dedicating staff to provide PAC services.

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
41	Mid-East Commission AAA	Beaufort, Bertie, Hertford and Pitt	$ 456,960		$ 456,960	Grantee is a regional Area Agency on Aging that collaborates with ECU-BSOM-Geriatrics, Eastern AHEC, Hertford Health Department, among others. Grantee covers Beaufort, Bertie, Martin, Pitt and Hertford Counties by establishing new sites in Beaufort, Bertie and Martin and expanding its current programs in Pitt and Hertford using a pharmacist and Pharmacy Technician as well as a PAC in each county.
42	Mission Healthcare Foundation, Inc.	Buncombe, Madison, Mitchell, Yancey	$ 396,000	$ 185,100	$ 581,100	Grant funding will expand PAC staff time for services to additional low-income and senior patients.
43	Mt. Olive Family Medicine Center, Inc.	Duplin, Sampson, Wayne		$ 50,000	$ 50,000	The addition of a drug program administrator will expand the number of low-income patients served in this Health Professional Shortage Area.
44	NCHICA	Rockingham		$ 50,000	$ 50,000	The grantee recently initiated the Community Medication Management Project, a program to deliver a merged medication list to health care providers electronically to avoid errors and reduce inefficiencies associated with lack of access to complete drug information. Grant funding will extend the service to the Rockingham County Health Department.
45	New Hanover Regional Medical Center	Bladen, Brunswick, Columbus, Duplin, New Hanover, Onslow, Pender		$ 47,181	$ 47,181	By adding an additional part-time PAC, the center will increase medication assistance services within the hospital and at the Coastal Family Medicine Clinic and Tileston Outreach Health Clinic, a free clinic providing services to the uninsured population in the area.
46	Onslow County Senior Center	Onslow		$ 97,000	$ 97,000	One pharmacist and one PAC provide medication management and prescription access services in Onslow County.
47	Pamlico County Senior Service	Pamlico		$ 24,447	$ 24,447	One pharmacist and one PAC provide medication management and prescription access services in Pamlico County.
48	Piedmont Health Services	Caswell, Chatham, Durham, Lee, Orange, Person		$ 236,688	$ 236,688	The grantee will expand the number of patients served through 6 federally-qualified community health centers, including expansion of the medication management service.

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
49	Piedmont Triad Council of Government AAA	Montgomery	$ 45,000		$ 45,000	Grantee is an Area Agency on Aging collaborating with Caswell and the Piedmont Pharmacy Care Network. They provided full service medication management and prescription assistance programs for Montgomery and Randolph Counties delivered by one PAC and a half time pharmacist. Program ended June 30, 2004. Remaining funding was transferrred to Randolph Senior Adult Services to cover Randolph County.
50	Randolph Senior Adult Services	Randolph		$ 100,000	$ 100,000	Grantee provides full service medication management and prescription assistance programs for Randolph County delivered by one PAC and a half time pharmacist.
51	Region L Council of Governments	Edgecombe, Nash		$ 52,500	$ 52,500	The addition of another part-time case manager to help with the delivery of the medication assistance services will increase the population served; 80% reside in the rural areas of Halifax, Northampton and Edgecombe Counties.
52	Resources for Seniors, Inc. (MEDS Program)	Wake, Franklin, Johnston, Lee	$ 466,000	$ 252,500	$ 718,500	The grantee will expand the number of patients served, including expansion of the medication management service.
53	Rockingham County Council on Aging-RxAP	Rockingham		$ 50,000	$ 50,000	Grant funding will enable the program to provide a pharmacist to assist with expanded medication assistance home visits and provide additional office support.
54	Rockingham County Department of Public Health	Rockingham	$ 130,000	$ 195,000	$ 325,000	The grantee will add additional staff (pharmacist and assistant) and "mobilize" to meet the needs of under-served areas of the county. Grant funds will continue services in this high need county, currently funded through HWTFC.
55	Rural Health Group, Inc.	Halifax, Northampton	$ 412,200		$ 412,200	Grantee is a rural health center that collaborates with the health department and the local hospital to cover Northampton and Halifax Counties.

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
56	Saluda Medical Center, Inc.	Henderson, McDowell, Polk, Rutherford, Transylvania		$ 17,400	$ 17,400	Increasing the PAC's hours and improvement of the efficiency of the program through grant funding will enable the prescription assistance program to increase the number of patients served. Outreach to the rural communities will also be increased.
57	Scotland Neck Family Medical Center	Halifax		$ 50,000	$ 50,000	The addition of staffing will address the 2-year wait list and enroll new patients from southeastern Halifax County which has a large population of seniors and low-income, unemployed residents and has been underserved by existing prescription assistance programs in the county.
58	Senior PHARMAssist, Inc.	Durham	$ 208,000	$ 2,500	$ 210,500	Grantee is an independent non-profit with proven track record providing all of the services requested under the RFP. Grantee provides prescription drug coverage for seniors below 200% of FPL in Durham County through its own card.
59	Surry County Senior Services	Surry		$ 50,000	$ 50,000	Grant funding will allow the center to establish a much-needed medication assistance program to assist seniors and low-income individuals with prescription assistance services.
60	The Greater Hickory Cooperative Christian Ministry	Catawba		$ 52,500	$ 52,500	Grant funds will expand the medication assistance program serving low-income and senior citizens in Jackson County into Swain and Haywood Counties. Expansion of services will be achieved by adding a pharmacist, coordinators and support staff.
61	The Hunger Coalition	Ashe, Avery, Watauga	$ 336,000		$ 336,000	Grantee is a local nonprofit that covers Ashe, Avery and Watauga Counties through its store-front location and Country Roads Mobile Pharmacy. Grantee provides medication and disease management and has a good track record working with PAP software.
62	Thomasville Medical Center	Davidson		$ 50,000	$ 50,000	Additional funds will enable a contract pharmacist to be hired, ensuring more regular clinic hours and services at the free healthcare clinic and pharmacy.

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
63	UNC School of Pharmacy (includes hotline)	Orange, Chatham	$ 256,846		$ 256,846	Grantee is a collaboration between the hospital, the aging agency and Kerr Drugs. Grantee provides comprehensive services including home visits and a hotline that covers gap counties.
64	Urban Ministries of Wake County, Inc.	Wake		$ 50,000	$ 50,000	Grant funds will provide for a PAC and 4 brown bag evaluations per year in the Thomasville area of Davidson County.
65	Watauga Medical Center/Appalachian Healthcare Project	Avery, Watauga		$ 50,000	$ 50,000	To better serve the rising number of uninsured individuals, the grantee will increase the number of patients served by extending the clinic's existing medication assistance program to include acute patients with chronic illnesses and by enhancing outreach efforts.
66	Wayne Action Group for Economic Solvency, Inc. (WAGES)	Wayne		$ 158,016	$ 158,016	The grantee is the lead agency in the Appalachian Healthcare Project, a collaborative effort to provide healthcare for the low-income, uninsured residents of Watauga and Avery Counties. Grant funding will enable the program to maintain current staff and increase staff time to a full-time position.
67	West Caldwell Health Council, Inc.	Alexander, Ashe, Avery, Burke, Caldwell, Catawba, Watauga, Wilkes		$ 50,000	$ 50,000	The grantee will provide medication assistance services to low-income seniors, including brown bag reviews of medications.
68	WestCare, Inc.	Haywood, Jackson, Swain		$ 241,471	$ 241,471	Grant funding will be used to expand staffing by adding a full-time PAC, resulting in increased patients serviced at 2 rural health centers.
69	Winston-Salem Urban League	Forsyth	$ 262,000		$ 262,000	Grantee has a strong outreach and health promotion-focused program targeted at the African-American community of Winston-Salem. It collaborates with the area AAA, Wake Forest Medical School and Winston Salem State University Nursing School.
		Total Grant Awards	$ 8,426,335	$ 6,018,058	$ 14,444,393	

Medication Assistance Program (MAP)

North Carolina Study Commission on Aging
November 2, 2005

Vandana Shah
Policy Director
NC Health and Wellness Trust Fund

Why MAP grants ?

- HWTF's vision to help seniors not only gain access to prescription drugs but also receive counseling on safe use of their medications to prevent drug interactions etc.
- Original *Senior Care* program covered drugs only for 3 disease states and local grants helped fill gaps in coverage

MAP Background

- Grantees serve both seniors and other low-income patients
- Grantees provide prescription assistance and medication management through trained pharmacist
- Technical assistance to grantees using MARP software provided by Office of Research, Demonstrations and Rural Health Development (ORDRHD)
- 15 grantees using other software get technical assistance directly from HWTF staff

MAP Funding

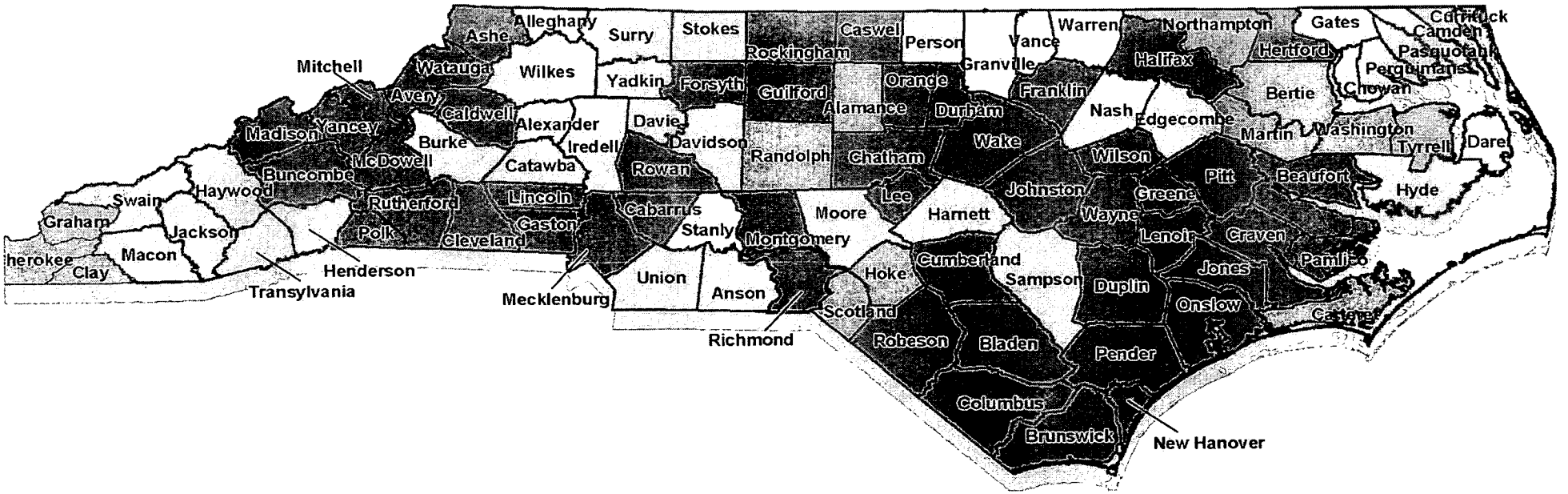
Currently, there are **61** organizations receiving $15 million in MAP grants

Phase I :
23 grants (over 3 yrs) totaling $8.7 million made in October 2002
3 additional grants totaling $400,000 (over I year)
in high-need areas in October 2003 following layoffs

Phase II :
44 grants totaling $4.7 million (over 2 years) made in April 2004,
of these **28** were limited grants receiving
$25,000 per year; 18-month extensions of **3** high-need grants;
2 mentoring grants totaling $175,000

NC Health and Wellness Trust Fund
Medication Assistance Program (MAP)

Counties Served by Grantees



- Counties covered by Phase I grants (awarded October 23, 2002 and October 24, 2003)
- Counties covered by Phase II grants (awarded April 26, 2004)
- Counties covered by Phase I and Phase II grants
- Gap counties covered by the UNC School of Pharmacy Hotline

NORTH CAROLINA Health Wellness TRUST FUND

Updated: 11-01-05

Grantee Background

Grantees represent many organizational type and include

- area aging agencies
- senior centers
- health departments
- hospitals
- community health centers
- free clinics

Most of the grantees had no prior experience with PA or MM

What do the numbers show?

- MAP grantee sites have provided over $48,486,232.82 worth of free medications to 39,886 patients from January 2003 thru August 2005.
- Represents a 7:1 return on HWTF's grant investment.
- In addition 8,825 of these patients also received medication management services.

Medication Management: What are the outcomes?

- Value intuitively obvious, but difficult to measure
- Many factors other than drug regimen often affect clinical outcomes
- UNC School of Public Health evaluated MM services as a secondary component of its *Senior Care* outcomes analysis. No definitive conclusions could be drawn because of insufficient data.
- Some individual MAP grantees providing medication management have conducted program-level evaluations and report positive outcomes.

Grantee outcomes on Medication Management

- HWTF's MAP grantee is Alamance county, AlaMAP is part of the Alamance Regional Medical Center (ARMC).
- In its first year with HWTFC grant funding, AlaMAP reported a 50% reduction in emergency room and overnight hospital stays for 200 seniors who were receiving medication management at their clinic.

Grantee outcomes on Medication Management

- Senior PHARM*Assist*'s first program evaluation demonstrated the percentage of participants using the emergency room decreased by 31% and those who had been hospitalized overnight decreased by 29% over a one year period
- 2nd evaluation (to be published in American Journal of Health Systems Pharmacy) demonstrates that medication therapy management along with access to medicines, tailored community referral, and "patient activation" improves health and decreases health services utilization
  - Emergency room visits went down from 56% to 41% and hospital admissions went down from 47% to 23% over two years

MAP legacy

- First statewide network of medication assistance centers
- NC Institute of Medicine listed HWTF's MAP program as a significant safety net for the uninsured in its North Carolina Healthcare Safety Net Report 2005

MAP Grants : Future

- HWTF is considering funding a third phase as all grants expire June 2006.
- Phase III grants would be primarily focused on helping those under the age of 65 since the federal Medicare program would start in January 2006.
- In addition, MAP grants would also assist seniors figure out their best federal plan option as well as help them find assistance for covering gaps in the federal drug coverage.
- Possible opportunities for grantees to be involved in provision of Medication Therapy Management services (MTMS) under federal plan

Medication Assistance Program (MAP)

North Carolina Study Commission on Aging
November 2, 2005

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Medication Assistance Program (MAP)

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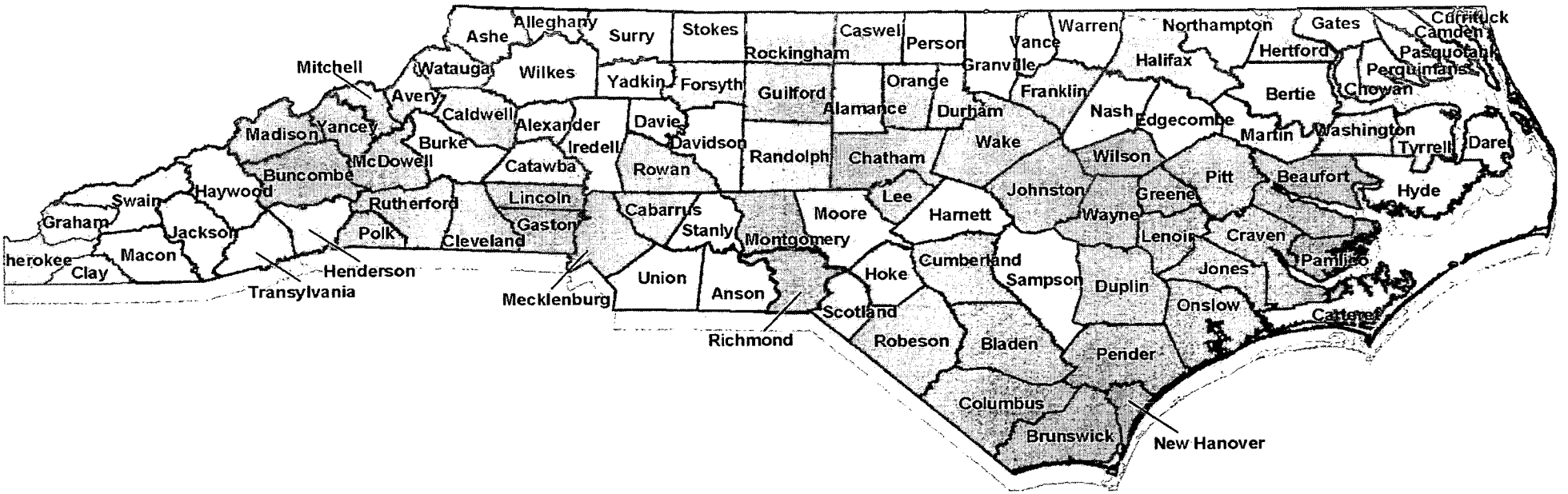

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- In its first year with HWTFC grant funding, AlaMAP reported a 50% reduction in emergency room and overnight hospital stays for 200 seniors who were receiving medication management at their clinic.

Grantee outcomes on Medication Management

- Senior PHARM*Assist*'s first program evaluation demonstrated the percentage of participants using the emergency room decreased by 31% and those who had been hospitalized overnight decreased by 29% over a one year period
- 2nd evaluation (to be published in American Journal of Health Systems Pharmacy) demonstrates that medication therapy management along with access to medicines, tailored community referral, and "patient activation" improves health and decreases health services utilization
  - Emergency room visits went down from 56% to 41% and hospital admissions went down from 47% to 23% over two years

MAP legacy

- First statewide network of medication assistance centers
- NC Institute of Medicine listed HWTF's MAP program as a significant safety net for the uninsured in its North Carolina Healthcare Safety Net Report 2005

MAP Grants: Future

- HWTF is considering funding a third phase as all grants expire June 2006.
- Phase III grants would be primarily focused on helping those under the age of 65 since the federal Medicare program would start in January 2006.
- In addition, MAP grants would also assist seniors figure out their best federal plan option as well as help them find assistance for covering gaps in the federal drug coverage.
- Possible opportunities for grantees to be involved in provision of Medication Therapy Management services (MTMS) under federal plan

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

October 20, 2005

MEMORANDUM

TO: Members - NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the **NC Study Commission on Aging:**

DATE: Wednesday, November 2, 2005
and
Wednesday, November 16, 2005

TIME: 10:00 a.m.

LOCATION: Room 415
Legislative Office Building
Raleigh, NC

Please advise Dee Hodge, Commission Clerk, at (919) 733-5955 or email dannellyla@ncleg.net if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, November 16, 2005
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Follow-up on Medicare Part D

- **Additional Handouts from Last Meeting**
- **Quick Resource Reference on Medicare Part D**
- **Additional Reports on Medicare Part D Efforts**
- **SHIIP Contact Information by County**
- **Draft Letter to Congressional Delegation**

Theresa Matula, Commission Staff, Research Division, NCGA

III. Brief Remarks by Associations and Organizations Representing Older Adults

(Note: Those wishing to make remarks should sign-up on the sheet in the back of the room. Names on the list will be called by the chair and each individual will have three minutes to address the Commission. When your name is called, please identify the organization or association that you represent. If possible, please furnish hard copies of your remarks to the Commission clerk.)

IV. Next Meeting:
December 20, 2005 at 10:00 a.m. in Room 415

January and February Meetings: Room 643

The Commission tentatively plans to meet on the first and third Wednesdays in January and February.. Below are the tentative meeting dates for January and February:

January 4
January 18
February 1
February 15

North Carolina Study Commission on Aging

MINUTES
Wednesday, November 16, 2005
10:00 AM
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Wednesday, November 16, 2005, at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were: Senator Charlie Dannelly, Co-Chair; Rep. Beverly Earle, Co-Chair; Senators Austin Allran, Stan Bingham, Julia Boseman, and Vernon Malone; Representatives Debbie Clary, Bob England, and Jennifer Weiss; Mr. Brad Allen, Mr. Sam Marsh, Ms. Judy Pelt, Ms. Linda Howard, and Ms. Florence Soltys.

Senator Charlie Dannelly presided. He called the meeting to order and asked members and staff to introduce themselves.

PRESENTATIONS

Follow-up on Medicare Part D

Ms. Theresa Matula, Commission Staff, was the first presenter. She briefly reviewed the additional handouts from the last meeting. She stated that Sen. Bingham mentioned exploring the possibility of using a prison hotline type system to provide additional assistance to the Seniors' Health Insurance Information Program (SHIIP). However, after discussions with agencies involved, they decided the information that seniors share is of a confidential nature and this system would not be the best solution at this point. They have pledged to monitor the call volume on the SHIIP hotline and are committed to adding two new positions if necessary.

Next, Ms. Matula referenced information placed behind the tab for today's meeting. The first was a one page Quick Reference Resource Sheet. (See Attachment I) The second sheet was Additional Reports of Medicare Part D Efforts Across the State. (See Attachment II) The next reference was the Seniors' Health Insurance Information Program Coordinators Listing. (See Attachment III)

Ms. Matula referenced the congressional delegation letter that had been placed on each member's desk. (See Attachment IV) She stated that Senator Malone suggested including another sentence stating that the penalty would be a permanent rate increase for the very citizens who need the services the most. Senator Allran asked a question

regarding the penalty. He wanted to know if the penalty would be one percent or *at least* one percent as the information received today states. Mr. Shawn Parker, Commission Staff, stated that he would research the issue further for clarification. Senator Malone offered a motion that the letter be approved and sent to the delegation. The motion carried unanimously.

Next, commission members heard brief remarks by associations and organizations representing older adults.

Western Carolina Alzheimer's Association

Mr. Len Erker, Director of Respite and Mountain Policy with the Western Carolina Alzheimer's Association, gave a brief description of a program called Project C.A.R.E. – Caregiver Alternatives to Running on Empty. The project serves 10 western counties and has brought support to over 800 low-income rural and minority families who care for loved ones at home diagnosed with Alzheimer's disease or other dementias. Mr. Erker told commission members that he was seeking support of their efforts to expand the Project C.A.R.E. statewide. The remainder of Mr. Erker's comments are reflected in Attachment V. Ms. Florence Soltys, Commission Member, asked what the budget is for the project and the cost per individual served. Mr. Erker stated that the budget currently is $96,400 serving six counties in the Asheville area and serves 52 families at a rate of $2000 per family. Ms. Linda Howard asked if the $2000 was per family, per year. Mr. Erker stated yes, $2,000 per fiscal year and the family does not pay anything.

Association of Home and Hospice Care of North Carolina

Mr. Jim Edgerton, Director of Government Relations with the Association of Home and Hospice Care of North Carolina, stated that this organization represents approximately 700 home health care and hospice care providers across the state. Mr. Edgerton furnished members with a list of initiatives that the organization wants addressed during the upcoming legislative session. (See Attachment VI) He requested that the legislature lift the freeze on Medicaid reimbursement rates and provide additional appropriations to increase direct care workers' salaries and transportation costs. The agency would also like to see the ceiling on the state In-Home State/County Assistance lifted and funds appropriated to support adequate staff to administer the program.

Mr. Edgerton referenced legislation the commission recommended in 2004 to require an institutional bias study. Phase 1 of the report has been completed and a lot of the organizations have had a chance to review it. Some biases were reported for home care that would require legislative changes. He also stated that the Medicare Part D prescription drug benefit is going to have an impact on home health clients, especially in the CAP-DA program because of the spend down policies. He recommended that this policy change be addressed.

Mr. Edgerton told commission members that there is also a bill that the community colleges sponsored last session that was approved by the House (HB 833) that gave

community colleges authority to do criminal background checks on nurses, students, nursing assistants and certified nurse aids. They have found that a lot of the applicants for home care agencies do have criminal backgrounds and he hopes this bill will be pass.

At this point, Senator Dannelly told commission members that at the December 20th meeting we would have a report on the Medicare Part D impact on CAP-DA.

Senior Tarheel Legislature

Mr. Lamar Moore, delegate to the Senior Tar Heel Legislature from Davidson County told commission members their priorities include the following:

- Increasing the Home and Community Care Block Grant by $5 million.
- Re-enacting the long-term care insurance tax credit
- Increased funding for Senior Centers of $3 million.
- Steps to better support grandparents and older family members raising minor relatives.

Mr. Moore left members with copies of the 2005 Priorities. (See Attachment VII)

North Carolina Senior Games

Ms. Judith Moss representing the NC Senior Games Program told commission members that the Senior Games is a year round health promotion and wellness program for residents of NC who are 55 years of age and older. She stated that it is one of the few programs that focus on the prevention of health problems of seniors. The program serves about 65,000 seniors in 53 local organizations throughout the state. Please see Attachment VIII for further comments.

North Carolina Center for Hospice and End of Life Care

Ms. Judith Brunger, Director of The Carolinas Center for Hospice and End of Life Care told the commission that the Center is a 29 year-old organization working to improve end of life care in NC through promoting Hospice care. She stated that 87% of persons surveyed stated that it was important die in their own home. She stated that continued support for and promotion of hospice services in NC is an essential component of any plan to meet the future needs of older adults.

Ms. Brunger then began itemizing a list of priorities for the Carolinas Center. These items were listed on the handout furnished to each member (See Attachment IX, page 2).

Triangle Older Women's League

Ms. Rosemarie Downie, representing the Triangle Older Women's League, Polly Williams and the NC Justice Center stated that their first issue involves funding for wrap-around for Medicare Part D. She told commission members that predictions are that 70% of the program's beneficiaries will be eligible for subsidies under the Medicare Part D

drug benefit. However, of the 130,000 persons who have received up to $1200 this year in aid for prescription drugs, 39,000 will lose any subsidy. She mentioned that Gina Upchurch of Senior PHARMAssist has a proposal for additional funding from the state for some low-income Medicare beneficiaries. She asks that consideration be given to her proposal and others that are presented so that there is some wrap-around funding provided.

Ms. Downie stated that the second issue was the problem of mixed populations. She stated that mental patients are being deposited in adult care homes. Assessment for appropriate placement is needed and provisions for more facilities in which mental patients can find activities and trained aides suited to their needs is recommended.

Ms. Downie also stated that they hope the legislature will see fit to consider the Study Commission recommendations from last session which were not addressed – in particular, raising the funding for the Home and Community Care block Grant and re-enacting the Long Term Care Insurance Tax Credit. (See Attachment X)

North Carolina Association on Aging

Ms. Roxanne Bragg-Cash, President of the North Carolina Association on Aging told the commission that the Association on Aging represents professionals in the field of aging who provide home and community based services and advocate for quality programs that enable older adults and their families to live as independently as possible in their own communities. Members include departments and area agencies on aging, senior centers, adult day care centers, adult social services, health departments and other providers of home and community-based services. Ms. Bragg-Cash stated that with the increasing number of older adults, North Carolina must expand on the Senior Centers and other services. (See Attachment XI)

North Carolina Coalition on Aging

Ms. Jean Reaves, President of the NC Coalition on Aging stated that older adults desire to remain in a safe and positive community setting for as long as possible. In order for this to happen, she stated the following must be accomplished:

- Expansion of CAP-DA and the Special Assistance In-Home Project
- Fair and equitable reimbursement rates for Adult Day Health under CAP-DA
- Realistic transportation funding for all community based programs
- Quality programs and resources in a variety of formats within their neighborhoods
- Senior friendly communities and safe affordable housing
- A Homestead Property Tax Exemption
- Senior housing complexes that are convenient to other services
- Transportation systems that are affordable and senior friendly
- A NC tax credit for long-term care insurance

Ms. Reaves asked the commission to look at many other states that have successfully addressed these issues and learn and perfect their successful programs. For more details

of Ms. Reaves' presentation, see Attachment XII. Ms. Reaves furnished copies of comments from two other day care services that were unable to attend the meeting. (See Attachments XIII & XIV)

Senator Bingham asked the status of the Homestead Property Tax Exemption. Ms. Matula, Commission Staff, stated that she would ask Ms. Cindy Avrett, NCGA Research Division to follow-up with him because she is informed on that issue.

Friends of Residents in Long Term Care

Mr. Bill Lamb, Chairman of the Board of Friends of Residents in Long Term Care told the commission that this is a private not for profit membership organization of individuals and associations committed to improving the quality of life for over 80,000 NC citizens in long term care settings. They have a Public Policy Committee that proposes legislation that will improve direct care staffing, ensure adequate training and increase facility accountability. See Attachment XV for a copy of the short and long term public policy goals drafted in January of 2005.

Governor's Advisory Council

Ms. Ann B. Johnson, Chair of the Governors Advisory Council on Aging was the next presenter. Her comments and recommendations from the Council are attached as Attachment XVI.

AARP

Ms.Von Valletta, State President for AARP North Carolina recommended the following:

- Additional funds appropriated for the Home and Community Care Block Grant
- Adequate safe and affordable housing
- Assistance with prescription drug costs for older adults in low income groups
- Re-enacting a tax credit for the purchase of long term care insurance

The remainder of her proposed comments can be found in Attachment XVII.

At this point, Senator Dannelly asked Ms. Karen Gottovi to give brief remarks on the White House conference on Aging to be held on December 10, 2005. Ms. Gottovi stated that every ten years or so a White House Conference on Aging is held. The theme of this year's conference is "The Booming Nature of Aging", drawing attention to the fact that the first baby boomers will be 65 in 2010 and there will be increasing concern for the aging population. They will be focusing on six areas 1) long-term care; 2) economic security; 3) healthy aging; 4) the workforce of the future; 5) livable communities and the 6th area she could not recall at the moment. They will be asked to look at 150 resolutions that have come to the Policy Committee that they have chosen to review from all over the country. Those will be narrowed down to 100 and recommendations sent to Congress and the President.

Mr. Brad Allen asked if there is an update on securing of federal funds to increase the number of long-term care ombudsmen. Ms. Gottovi stated that there has been no good resolution to that issue.

Rep. Weiss asked about the status of the DHHS study of the mixed population issue. Ms. Matula, Commission Staff, stated that there is a report that the commission asked for in 2004 to study a range of issues related to mentally ill residents in long-term care facilities. It was supposed to be submitted Oct. 1, 2005 but they are still working on it and have asked for an extension until Jan. 1, 2006.

Next, Mr. Shawn Parker, Commission Staff, gave a clarification on the *at least* one percent penalty discussed earlier. His research found that the amount of penalty has to be the greater of either one percent of base beneficiary premiums, or the amount that the Secretary of DHHS determines to be actuarially sound for each uncovered month. Sen. Allran suggested amending the letter to the Congressional Delegation to state that we object to having an open-ended penalty. Senator Dannelly asked if the one percent is over actuarially sound, can the Secretary reduce the penalty. Mr. Parker stated that as written, the penalty would be at least one percent.

Rep. Weiss asked that the commission schedule some time for DHHS make a detailed report of their findings.

Rep. Clary asked if the commission has the report coming back from DHHS regarding the status of Medicare Part D Impact on CAP/DA. Staff stated that it would be on the agenda of the December 20th meeting.

The meeting adjourned at 11:20 am.

Charlie S. Dannelly

Senator Charlie Dannelly, Co-Chair
Presiding

Beverly Earle

Rep. Beverly Earle, Co-Chair

Dee Hodge

Dee Hodge
Commission Assistant

ATTACHMENT I

Quick Resource Reference for Medicare Part D

PREPARED BY STAFF OF THE NORTH CAROLINA STUDY COMMISSION ON AGING

Important Dates

November 15, 2005- Enrollment begins

December 31, 2005 - Deadline for coverage beginning January 1, 2006

January 2006- May 15, 2006 - Open enrollment continues-
April, 2006- Reminders sent for those who have not enrolled in a plan.

May 15, 2006 – Deadline to enroll without penalty

November 15- December 31- Each year-Open enrollment for selecting or modifying plan, effective January 1 of the following year.

Typical questions

When can I join and how often can I switch plans?

First time to join is November 15, 2005 through May 15, 2006, after that period enrollment can take place November 15- December 31 of each year. You can choose to switch current plan during this period each year. *Dual eligible recipients can change plans at anytime.

Who is eligible?

Anyone with Medicare regardless of income, health status, or prescription drug usage.

Can I be penalized for not enrolling in a plan?

In most cases, if you don't join by May 15, 2006, *and you do not currently have a drug plan that, on average, covers at least as much as standard Medicare prescription drug coverage,* you will have to wait until the next enrollment period to join. When you do join, your premium cost will go up at least 1% per month for every month you wait to join and the penalty will exist for as long as you have coverage.

When can I join if I miss the May 15, deadline?

Applicants will be able to enroll November 15- December 31 of each year. Coverage will begin January 1, of the following year. If the applicant did not enroll when first eligible then a penalty may apply.

Contact Information

Medicare

www.medicare.gov
1-800-MEDICARE (1-800-633-4227)
TTY-1-877-486-2048
24 hours a day 7 days a week

Social Security Administration

www.socialsecurity.gov
1-800-772-1213
TTY 1-800-325-0778
Mon- Sat (7am –Midnight), Sunday (7am – 6pm) (EST)

North Carolina SHIIP

www.ncshiip.com
1-800-443-9354
TTY 1-800-835-2962

Local
(919) 733-0111
TTY-919-715-0319
Mon- Fri (8am-5pm) (EST)

Elder Care Locator

www.eldercare.gov

Eldercare Locator, a public service of the U.S. Administration on Aging. The Eldercare Locator connects older Americans and their caregivers with sources of information on senior services. The service links those who need assistance with state and local area agencies on aging and community-based organizations that serve older adults and their caregivers.
1-800-677-1116
Mon– Fri (9am – 8pm) (EST)

ATTACHMENT II

Additional Reports of Medicare Part D Efforts Across the State

AARP

Mary Bethel, Associate State Director for Advocacy

As an active member of the state Medicare Drug Law Coordinating Committee, AARP has coordinated with other Committee partners to develop a plan and to carry out a strategy for Medicare Part D education and outreach. AARP has helped to sponsor State level events such as the November 15 Medicare Prescription Drug Plan Expo in Greensboro, has sent out letters about the "extra help" benefit to over 75,000 AARP members who might possibly quality for this; has purchased ads about "extra help" through the North Carolina News Network which reached over 300,000 listeners, has purchased ads in radio and print media outlets about "extra help" targeted and/or owned by minorities, and has assisted with specific outreach and education events in communities across the state. In September, 30 AARP volunteers received speaker training related to Part D. These volunteers are making presentations to civic groups, at AARP chapter meetings, and at other community events to raise awareness about Part D. AARP North Carolina has also sponsored numerous forums across the state at which AARP staff and coordinating partners have made presentations. AARP North Carolina has distributed many thousands of written publications about the Medicare prescription drug program. These include brochures on the discount card program, a booklet entitled "The New Medicare Prescription Drug Coverage - What You Need to Know" and a booklet entitled "The New Medicare Prescription Drug Coverage: Extra Help for People with Limited Income". The November edition of the AARP Bulletin which is sent to 550,000 households in the state contains a special eight page insert entitled "Medicare Drug Coverage: The Basics – All Your Questions Answered". In addition, there have been special AARP sponsored inserts on Medicare prescription drug coverage in Parade Magazine, a popular section in many North Carolina Sunday papers that reach thousands of our state's citizens, twice in the last two months. AARP has also produced an audio news release promoting U.S. DHHS Secretary Michael Leavitt's visit to Charlotte about Part D on November 10, produced an audio news release highlighting the problems of escalating drugs costs and the upcoming Part D rollout, and participated in a WUNC-TV program highlighting the Part D rollout.

Area Agencies on Aging

Mary Barker, President of the NC Association of the Area Agencies on Aging

All the Area Agencies on Aging are heavily involved in Medicare Part D outreach. Many of us are assisting clients directly to apply for the "extra help" and to choose the prescription drug plan that is best for them. All of us are helping to arrange and/or host outreach events to let Medicare Beneficiaries know about Part D. All of us are helping to arrange and host training events for our agency staff, volunteers, Departments of Social Services, Home Health, Hospital Discharge Planners, Prescription Assistance Program staff, and others who will be assisting clients.

Association for Home and Hospice Care of North Carolina

Jim Edgerton, Director of Government Relations

The Association for Home and Hospice Care of NC sent the following to all of our Providers that are Medicare certified: Information on a variety of training materials and tools; Medicare Prescription Drug Questions and Answers; and a list of Train-the-Trainer courses by AAA region. The Association has also offered to blanket email members with any information that SHIIP would like to have them send out.

North Carolina Association on Aging

Roxanne Bragg-Cash, President

NCAOA has not done anything formally because most of our members are SHIIP providers and they are getting much direction through that. We have talked about it and discussed it with membership.

North Carolina Coalition on Aging

Jean Reaves, President

NC Coalition on Aging has had numerous conversations as a part of our monthly meetings regarding Medicare Part D. As a membership organization of over 40 member groups each of those organizations have then progressed with referrals and detailed training of their own.

Long-Term Care Facilities

North Carolina Assisted Living Association

Jerry Cooper, Executive Director

The North Carolina Assisted Living Association has held Regional Meetings for our members with representatives of the Centers for Medicare & Medicaid Services (CMS) and the Division of Medical Assistance (DMA), Department of Health and Human Services, addressing the issue of Medicare D. At our Fall Conference in October we held a 1/2 day seminar for all management staff of our Assisted Living buildings - speakers at this event included provider pharmacists, state DMA folks and a representative from CMS in Atlanta. We have also encouraged all provider members to hold family night meetings and utilize the provider pharmacy to address various family questions.

North Carolina Association of Long Term Care Facilities

Lou Wilson, Executive Director

Efforts to date include:

1) We have been working with five LTC pharmacies that provide meds to about 10,000 residents in an effort to take training directly to residents and families in the facilities.

2) NCALTCF staff has participated in Train-The-Trainer Seminars.

3) NCALTCF staff has participated in a forum to help train Ombudsman to assist residents and families.

4) Information, web-site addresses, brochures etc. has been emailed to our member contacts.

5) Three educational meetings for providers have been planned across the state starting this Thursday to give info and answer questions.

North Carolina Health Care Facilities Association

Stacy Flannery

As an Association have been passing along information to our members regarding Medicare Part D. However, most the work is being done at the facility level where the financial folks have been receiving training and education about the changes. Many of our facilities have offered information sessions, for residents and their families as well as people in the community. I know that many of those sessions have been standing room only. Feedback from those facilities has been positive, in terms of attendance. But they have signaled that there is a lot of confusion among the public and concern about how the changes will affect them. Our facilities will continue to offer these information sessions as the changes are implemented.

Seniors' Health Insurance Information Program – Efforts with Long Term Care Facilities

Carla Obiol and Debbie Pittard

SHIIP has given presentations at meetings involving long-term care ombudsman and the trade associations for long term care facilities. Many of these residents are on Medicaid, therefore they will be auto enrolled in a plan. The Division of Medical Assistance was involved in the LTC ombudsmen training and gave a presentation at the NC Assisted Living Association state conference last month. Medicaid clients will be automatically enrolled into a Prescription Drug Program if they do not choose one before 12/31/05. We have sent information to clients in their Medicaid ID cards and provided counties information on how to answer their clients' questions.

SENIORS' HEALTH INSURANCE INFORMATION PROGRAM
COORDINATORS LISTING
November 1, 2005
*Counties that have had the LTCI Advanced Training
Highlighted address is the main mailing address

COUNTY/LTCI	PHONE	COORDINATOR	AGENCY	ADDRESS
ALAMANCE*	336-222-5135	**(Ask for SHIIP Help)** Judy Whitfield	John Kernodle Senior Center	PO Box 1358 Burlington 27216 1535 S. Mebane St. Burlington 27215
ALEXANDER*	828-632-1717	**(Ask for SHIIP Help)** Scott Ross	Alexander Senior Center	730 Seventh St. SW Taylorsville 28681
ALLEGHANY	336-372-4640	**(Ask for SHIIP Help)** Karon Edwards	Council on Aging	PO Box 416 85 E. Whitehead Street Sparta, NC 28675
ANSON	704-694-6616	Bernice Bennett	Senior Center	199 Hwy 742 South Wadesboro, NC 28170
ASHE	336-246-4347	Louise Caudill	Ashe County Services for the Aging, Inc.	PO Box 9 180 Chattyrob Ln. West Jefferson, NC 28694-0009
AVERY*	828-733-8220	R. D. Daniels	Avery Senior Center	PO Box 447 165 Schultz Circle Newland, NC 28657
BEAUFORT	252-943-2992	Victoria E. Paul	Belhaven Seniors' Resource Center	274 East Main Street Belhaven, NC 27810
BERTIE	252-794-5315	Irma Jean Robbins or Venita Thompson	Bertie Council of Aging	103 W. School Street Windsor, NC 27983
BLADEN	910-862-6930	Sue Kennedy	Bladen County Division on Aging	PO Box 520 608 McCleod Street Elizabethtown, NC 28337
BRUNSWICK*	910-253-2610	Pearl W. Stanley	Cooperative Extension	PO Box 109 Bldg. N, County Government Complex, Business Route 17 Bolivia, NC 28422
BUNCOMBE*	828-277-8288	Jacquie Buttles	Council on Aging of Buncombe County	1617 Hendersonville Rd. Suite 2514 Asheville, NC 28803
BURKE*	828-430-4147	Philip Adams	Morganton-Burke Senior Center	501 North Green St. Morganton, NC 28655
CABARRUS	704-920-3484	Jolene Isom or Chasity Schooley	Cabarrus County Dept. of Aging	PO Box 707 Concord, NC 28026-0707 331 Corban St, Concord, NC 28025
CALDWELL	828-758-2883	**(Ask for SHIIP Help)**	Caldwell Senior Center	650-A Pennton Avenue Lenoir, NC 28645
CAMDEN	252-338-1919 x229 or x248	Danelle Barco or Michaelene Sawyer	Cooperative Extension	PO Box 129 120 N. Highway 343 Camden, NC 27921

COUNTY/LTCI	PHONE	COORDINATOR	AGENCY	ADDRESS
CARTERET*	252-222-6359	Regenia Bell or Hal Taylor	Carteret County Cooperative Extension	303 College Circle Morehead City, NC 28557
CASWELL	336-694-7447	Jeannine Everidge	Caswell County Senior Center	PO Box 1405 142 Main St. Yanceyville, NC 27379
CATAWBA*	828-328-2269	Mary Mode	West Hickory Senior Center	PO Box 835 400 17th St., SW Hickory, NC 28603
*	828-485-2300	Ellen Husvar	Catawba Valley Medical Center	1960 Hwy 70 SE, Suite 158 Hickory, NC 28602
CHATHAM*	919-542-4512	Evelyn White	Chatham County Council on Aging	PO Box 715 Pittsboro, NC 27312 1794 Epps Clark Rd, Pittsboro, NC 27344
CHEROKEE	828-837-2467	Kay Martin	Cherokee County Senior Services	J. Robert Penland Center 69 Alpine Street Murphy, NC 28906
CHEROKEE RESERVATION (ECBI)	828-497-7462	Dusti Bradley	Cherokee Reservation	PO Box 666 23 John Crowe Hill Road Cherokee, NC 28719
CHOWAN	252-482-6585	Shari Farless	Cooperative Extension	730 North Granville Street Suite A Edenton, NC 27932
CLAY	828-389-9271	Kathy Tant	Senior Center	PO Box 118 196 Ritter Road Hayesville, NC 28904
CLEVELAND*	704-482-3488	Katherine C. Cobb	Senior Center	100 T.R. Harris Drive Shelby, NC 28150
*	704-734-0447	Carolyn Bell	Senior Center	PO Box 429 Kings Mountain, NC 28086
COLUMBUS	910-640-6607	Carolyn McCain	Cooperative Extension	45 Government Complex Rd., Suite A Whiteville, NC 28472
CRAVEN	252-633-1477	**Ask for SHIIP Help** Kelly Canupp	Craven Cooperative Extension Center	300 Industrial Drive New Bern, NC 28562
CUMBERLAND	910-484-0111 Ext. 21	Ellouise Garvin	Coordinating Council on Older Adults	339 Devers Street Fayetteville, NC 28303-4750
CURRITUCK	252-232-2261	Georgia Kight	Cooperative Extension	PO Box 10 153 Courthouse Road Room 211 Currituck, NC 27929
DARE*	252-475-5635	Joyce Edwards	Senior Center	PO Box 1000 Manteo, NC 27954 300 Mustian Street Kill Devil Hills, NC 27948

COUNTY/LTCI	PHONE	COORDINATOR	AGENCY	ADDRESS
DAVIDSON*	336-242-2290 (Lexington) 336-474-2754 (Thomasville)	**(Ask for SHIIP Help)** Angela Miller	Davidson County Senior Services	211 West Colonial Drive Thomasville, NC 27360
DAVIE*	336-751-0611	Barbara Thornton	Davie County Senior Services	622 N. Main Street Mocksville, NC 27028
DUPLIN	910-296-2140	Liz Davis	Services for the Aged	PO Box 928 213 Semenary Street Kenansville, NC 28349
DURHAM*	919-688-8247	Lynne Chamblee	Council for Senior Citizens	807 Duke Street Durham, NC 27701
*	919-560-0521	Deborah McGiffin	Cooperative Extension	721 Foster Street Durham, NC 27701
EDGECOMBE	252-641-4263	Alberta Pettaway	E. L. Roberson Center	305 W. Baker St. Tarboro, NC 27886
FORSYTH*	336-748-0217	**(Ask for SHIIP Help)** Sam Matthews	The Shepherd's Center of Greater Winston-Salem	1700 Ebert Street Winston-Salem, NC 27103
FRANKLIN	919-496-1131	Don Ward	Louisburg Senior Center	127 Shannon Village Louisburg, NC 27549
	919-494-5611	Patrick Woods	Franklinton Senior Center	602 East Mason Street Franklinton, NC 27525
GASTON*	704-922-2120	Marilyn Gore	Cooperative Extension	1303 Dallas-Cherryville Hwy, Dallas 28034 PO Box 1578 Gastonia, NC 28053
GATES	252-357-1400	**(Ask for SHIIP Help)**	Cooperative Extension	PO Box 46 112 Court Street Gatesville, NC 27938
GRAHAM	828-479-7977	Wanda Hill	Graham Co. Senior Center	PO Box 575 115 Moose Branch Road Robbinsville, NC 28771
GRANVILLE	919-693-1930	Kathy B. May or Angela Wright	Senior Center	120 B Orange Street Oxford, NC 27565
GREENE	252-747-5831	Shenile Ford	Cooperative Extension	Greene County Government Complex 229 Kinggold Blvd. Suite. E Snow Hill, NC 28580
	252-747-5436	Belinda Hilbourn	Greene County Senior Center	PO Box 36 104 Greenridge Road Snow Hill, NC 28580
GUILFORD*	336-373-4816 (Greensboro) 336-884-4816 (High Point)	**(Ask for SHIIP Help)** Jenni Hitchcock	Senior Resources of Guilford	PO Box 21993 301 E. Washington Street Greensboro, NC 27420
HALIFAX	252-583-1212	Lonnie Hedgepeth	Halifax County Council on Aging	PO Box 159 26 King Street Halifax, NC 27839
HARNETT	910-893-7579	Nancy Wright	RSVP	309 Cornelius Harnett Blvd. Lillington, NC 27546
HAYWOOD	828-452-2370	Alesia Ledford	The Mountain Area Resource Center	81 Elmwood Way Waynesville, NC 28786

COUNTY/LTCI	PHONE	COORDINATOR	AGENCY	ADDRESS
HENDERSON*	828-692-4600	Jill Geis	Pardee Health Education Center	Blue Ridge Mall 1800 Four Seasons Blvd. Hendersonville, NC 28792
HERTFORD	252-358-7856	Elsie Powell	Hertford County Senior Center	408 South Camp Street Winton, NC 27986
HOKE	910-875-8588	Dennis Bowen	Senior Services of Hoke County	PO Box 637 423 East Central Avenue Raeford, NC 28376
HYDE	252-926-4489	Natalie Wayne	Cooperative Extension	PO Box 219 1430 Main Street Swan Quarter, NC 27885
IREDELL	704-873-8568	Phyllis Deal	Iredell County Council on Aging	PO Box 344 Statesville, NC 28687 344 E. Front St Statesville, NC 28677
JACKSON	828-586-8562	Helen Bryson	Department on Aging	PO Box 596 59 Central Street Sylva, NC 28779
JOHNSTON*	919-934-6066 x222	Kimberly Tilghman	Johnston County Council on Aging	PO Box 2235 1363 West Market St. Smithfield, NC 27577
JONES	252-448-9621	Ivy Reid	Cooperative Extension	110 S. Market Street PO Box 218 Trenton, NC 28585
LEE	919-776-0501	Janice Holmes	The Enrichment Center	1615 S. Third Street Sanford, NC 27330
LENOIR*	252-527-1545 or 252-523-9339	Carolyn Gray or Anne Gaddis	Lenoir County Council on Aging	112 E. Blount St. Kinston, NC 28501
LINCOLN	704-736-8461	Melinda Houser	Cooperative Extension	115 W. Main Street Lincolnton, NC 28092
MACON	828-349-2124	Diane Holbrook or Sharon Moslet	Macon County DSS	1832 Lakeside Drive Franklin, NC 28734
MADISON	828-649-2722	Penny Buckner	Marshall Senior Center	462 Long Beach Rd. Marshall, NC 28753
MARTIN	252-792-1027	Christie Herring	Martin County Senior Center	PO Box 1023 201 Lee Street Williamston, NC 27892
MCDOWELL	828-652-8953	Weyland Prebor	McDowell County Senior Center	PO Box 338 100 Spaulding Road Marion, NC 28752
MECKLENBURG*	704-365-1995	Flora Robinson	The Shepherd's Center of Charlotte	PO Box 6052 Charlotte, NC 28207 3115 Providence Road Charlotte, NC 28211
*	704-522-6222	**(Ask for SHIIP Help)**	Charlotte-Mecklenburg Senior Center	2225 Tyvola Road Charlotte, NC 28210
MITCHELL	828-688-4811	Denise M. Baker	Mitchell County Cooperative Extension	10 S. Mitchell Ave. Bakersville, NC 28705
MONTGOMERY	910-572-4464	Theresa Thomas	Troy/Montgomery Senior Center	315 N. Main Street Troy, NC 27371

COUNTY/LTCI	PHONE	COORDINATOR	AGENCY	ADDRESS
MOORE*	910-947-2881	Jill Sherman	Moore County Dept. of Aging	Box 487 302 Monroe Street Carthage, NC 28327
NASH	252-446-0411	Connie Richardson	Upper Coastal Plain Council of Governments	PO Box 2748 1309 S. Wesleyan Blvd. Rocky Mount, NC 27802
	252-459-9810	Janice Latour	Cooperative Extension	Nash County Agricultural Center Room 102 Ag Center Dr. Nashville, NC 27856
NEW HANOVER*	910-452-6400	Cheryl Hoffman	RSVP	2222 S. College Road Wilmington, NC 28403
NORTHAMPTON*	252-534-1012	Rebecca Bayse	J. W. Faison Senior Center	PO Box 634 110 Ridgecrest Lane Jackson, NC 27845
ONSLOW*	910-455-2747	Sara King	Onslow Senior Services	PO Box 982 4022 Richlands Hwy. Jacksonville, NC 28540
ORANGE*	919-968-2082	Katherine Leith	Orange County Dept. On Aging	400 A-1 S. Elliott Rd. Chapel Hill, NC 27514
PAMLICO	252-745-7196	Linda Potter	Pamlico Senior Center	PO Box 184 800 Main Street Alliance, NC 28509
PASQUOTANK*	252-337-6662	Sue Norton	EC/PC Senior Center	200 E. Ward Street Elizabeth City, NC 27909
*	252-338-3954	Yvonne Mullen	Cooperative Extension	PO Box 1608 Elizabeth City, NC 27906 1209 McPherson St. Elizabeth City, NC 27909
PENDER	910-259-9119	Kay Warner	Pender Adult Services	PO Box 1251 901 S. Walker Street Burgaw, NC 28425-1251
PERQUIMANS	252-426-7697	Jewel Winslow	Cooperative Extension	PO Box 87 601-A South Edenton Road Street Hertford, NC 27944
PERSON	336-599-7484	Doretha Whitt	Person County Senior Center	PO Box 764 121-A Depot Street Roxboro, NC 27573
PITT*	252-752-1717	Christal Curran	Council on Aging	PO Box 7272 1717 West 5th Street Greenville, NC 27835
POLK	828-749-9245	Donna Carson	Saluda Senior Center	64 Greenville Street Saluda, NC 28773
RANDOLPH	336-625-3389 1-800-252-2899	Jo Ellen Needham or Margie DiDona	Randolph County Senior Adults	P. O. Box 1852 Asheboro, NC 27204-1852 133 West Wainman Avenue, Asheboro NC 27203

COUNTY/LTCI	PHONE	COORDINATOR	AGENCY	ADDRESS
RICHMOND	910-997-4491	Ernest Watts	Rockingham/Richmond County Senior Center	PO Box 340 225 South Lawrence St. Rockingham, NC 28380-0340
ROBESON*	910-618-5533	Jennifer McLeod	Lumber River Council of Govts/Area Agency on Aging	4721 Fayetteville Rd. Lumberton, NC 28358
ROCKINGHAM*	336-349-1088	Cindy Baynes	Senior Center	201 N. Washington Avenue Reidsville, NC 27320
ROWAN*	704-636-2344	Pam Leonard	Senior Services of Rowan County	1120-A South Boundary Street Salisbury, NC 28144
RUTHERFORD	828-287-6409	Patsy Wilson	Rutherford County Dept. on Aging	193 Callahoon Koon Rd. #132 Spindale, NC 28160-2219
SAMPSON	910-592-7161	Anna Peele	Sampson Co. Cooperative Ext.	369 Rowan Road Clinton, NC 28328
SCOTLAND*	910-277-2585	Shannon Newton	Scotland County Parks and Recreation	PO Box 1668 1210 Turnpike Road Laurinburg, NC 28353
STANLY	704-983-3987	**(Ask for SHIIP Help)** Lori Ivey	Cooperative Extension	26032E Newt Road Albemarle, NC 28001
STOKES	336-593-8157	Darlene Nelson	Stokes County Senior Services	PO Box 29 700 North Main Street Danbury, NC 27016
SURRY	336-401-8025	**(Ask for SHIIP Help)** Carmen Long	Cooperative Extension	PO Box 324 210 N. Main St Dobson, NC 27017
SWAIN	828-488-9211 x3024	Mary Barker	Area Agency on Aging	P.O. Drawer 850 50 Main Street Bryson City, NC 28713
TRANSYLVANIA	828-884-3109	Kathy Thorpe	Cooperative Extension	203 E. Morgan Street Brevard, NC 28712
TYRRELL	252-796-1581	Dee Furlough	Cooperative Extension	PO Box 209 407 Martha Street Columbia, NC 27925
UNION*	704-289-1797	Jennifer Engel	Council on Aging	PO Box 185 Monroe, NC 28111 216 N Hayne Street Monroe, NC 28112
VANCE	252-430-0523	Carolyn Sumners or Marian Blackwell	Senior Center	126 S. Garnett Street Henderson, NC 27536
WAKE*	919-733-0111 or 1-800-443-9354	Rhonda Towns	SHIIP Office	111 Seaboard Avenue Raleigh, NC 27604
WARREN	252-257-3111	Carolyn Williams or Nancy Williams	Senior Center	435 West Franklin Street Warrenton, NC 27589

COUNTY/LTCI	PHONE	COORDINATOR	AGENCY	ADDRESS
WASHINGTON	252-793-7642	Gail Spiewak	Washington Co. Chapter, Senior Circle	PO Box 707 Washington County Hospital 958 NC Hwy 64 E. Plymouth, NC 27962
WATAUGA*	828-265-8090	Sherry Harmon	L.E. Harrill Senior Center	132 Poplar Grove Connection Suite A Boone, NC 28607
WAYNE	919-731-1591	Yvonne McLamb	Services for the Aged	204 East Walnut PO Box 227 Goldsboro, NC 27530
WILKES	336-670-2644	**(Ask for SHIIP Help)** Angela Williams	Senior Center	PO Box 2695 North Wilkesboro, NC 28659 128 Mulberry School Road North Wilkesboro, NC 28697
WILSON	252-237-0112	Candace Murray	Cooperative Extension	1806 SW Goldsboro Street Wilson, NC 27893-6508
YADKIN	336-526-1087	Lisa Martin	Yadkin Valley Senior/Community Center	121 Delos Martin Drive Jonesville, NC 28642
YANCEY	828-682-6011	Nina Hughes	Yancey County Committee on Aging	10 Swiss Avenue Burnsville, NC 28714

ATTACHMENT IV

DRAFT LETTER FROM THE STUDY COMMISSION ON AGING TO NC CONGRESSIONAL DELEGATION

North Carolina Study Commission On Aging

November 16, 2005

Dear

As the chairs of the North Carolina Study Commission on Aging, we are writing on behalf of the Commission to request changes to the Medicare prescription drug program enacted under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The North Carolina Study Commission on Aging was created by statute in 1987 and is charged with studying, evaluating, and recommending services to meet the current and future needs of older adults. Membership on the Commission includes members of the North Carolina Senate and House of Representatives and planners or providers of health, mental health, or social services to older adults. The Commission conducts its study during the interim between legislative sessions and makes annual recommendations to the Governor and the General Assembly. A large number of older adults do need assistance with prescription drug costs and the Commission wants to ensure that every eligible individual has an opportunity to receive, review, and understand the information on the prescription drug program and to make an informed decision about the option that is best for them.

With regard to Medicare Part D, the Commission's desire is that every eligible North Carolina citizen be fully aware and informed of the program and the plans approved for sale in North Carolina. However, the demographics associated with North Carolina's older adult population pose a challenge to our desired outcome. Below are the changes that we believe are vital to insuring that all eligible adults in North Carolina have access to the information and the time necessary to make an appropriate decision based on their situation.

Requests for Medicare Part D Changes

Due to the characteristics of North Carolina's older adult population and because the consequence of inaction results in a penalty, the North Carolina Study Commission on Aging respectfully requests the following changes:

1. Extend the open enrollment period to give eligible individuals one full year to sign up, effectively allowing individuals until November 15, 2006, to purchase a prescription drug policy without penalty. This change will allow, at particular time intervals, the identification of individuals that may need additional assistance or resources.

2. Phase in the penalty rate, so that the rate increases as the distance from the individual's enrollment cut-off date increases (i.e. .50% of the average monthly premium for each of the first 6 months past the enrollment deadline, .75% of the average monthly premium per month for months 7-12 post deadline.)

3. By a specified date, require CMS to verify from a specified percentage of the eligible population: an affirmative enrollment in a plan, or a response from an eligible individual declining enrollment. This will help to ensure that individuals did receive the information and did make a conscious determination of their options.

The North Carolina Department of Health and Human Services, Division of Aging and Adult Services has furnished the Commission with older adult population data to assess the challenges and thereby underscoring the need for the above changes. According to the 2002 American Community Survey, *41.1% of North Carolina's age 65 and older (65+) population lives in a rural setting* (12th highest in the US), *22.4% of the 65+ population have self-care or mobility limitations* (10th highest in the US), and *29.9% of those age 75 and older have no driver's license.* According to the survey only 14.2% of the 65+ population has a bachelor level education or higher. Yet, according to data from the National Institute for Literacy, *22% of North Carolina's population age 16 or older are at Level 1 Literacy* which is the lowest level of literacy and is defined as, "the adult population that can perform many tasks involving simple texts and documents but display difficulty using certain reading, writing, and computational skills considered necessary for functioning in every day life." Additionally, access to the list of drugs covered under each policy is a crucial component of the decision making process, but depends on Internet access or access to someone with Internet access. *North Carolina has the 10th lowest Internet usage rate among the fifty states.*

The Commission applauds the efforts that are being made by the Social Security Administration, North Carolina's Seniors' Health Insurance Information Program (SHIIP), and many other agencies and associations that serve older adults. However, based on the above data, the Commission is concerned that many older adults in North Carolina will not be able to attend a workshop or information session, will not have Internet access to the list of drugs covered under each policy, and many will not possess the level of reading and analytical skills required to evaluate the Medicare Part D options. In order to avoid placing individuals at greater risk of penalty for failure to comply by the current deadline, it is vital that we have more time to reach each eligible citizen.

The changes that the Commission is requesting will allow periodic assessment of efforts to reach older adults in North Carolina and will allow the network of agencies and associations that support this portion of the population to focus on those individuals that are struggling with a Medicare Part D decision. These changes will also help to ensure that sufficient time and resources are dedicated to reaching eligible citizens and will not unnecessarily burden them with a penalty until they have had time to make these important decisions. We appreciate your efforts in assisting us with this issue.

Sincerely,

Senator Charlie S. Dannelly
Co-Chair

Representative Beverly M. Earle
Co-Chair

Report: NC Study Commission on Aging
Date: 11/16/2005
By: Len Erker, Director of Respite and Mountain Region Policy, WC Alzheimer's Association

Good afternoon. My name is Len Erker. I am here as a representative of the Western Carolina Alzheimer's Association, which serves families living in the 49 western counties of North Carolina. My purpose for coming today is first, to give you a brief description of the work of a successful program called Project C.A.R.E., and secondly, to request your support in our efforts to expand Project C.A.R.E. statewide. Project C.A.R.E. - *Caregiver Alternatives to Running on Empty*, now in its 5th year, serves 10 counties and has brought critical respite support to over 800 low-income, rural and minority families who care at home for loved ones diagnosed with Alzheimer's disease or other dementias. This Alzheimer's Demonstration program is currently funded by the federal Administration on Aging. Key partners include the state Division of Adult and Aging Services, the Duke Family Support Program and Mecklenburg County DSS. The program works closely with the NC Family Caregiver Support Program as well as many other state and community programs.

As the Director of Respite Services and Project C.A.R.E., it is a pleasure to be associated with a program that does so much good in the community, for families who would otherwise be alone as they face the challenge of Alzheimer's. The Project C.A.R.E. design is very personal, bringing a Family Consultant into the home, to discuss and solve problems firsthand, and to encourage isolated families to accept the help that is available. One result is the timely arrangement of funding that allows families on fixed incomes to utilize a wide range of respite options, especially in-home personal care, or adult day services. Dementia caregivers get the break and the rest that they need, and by making use of other existing community programs and services, are able to keep their love one at home longer. Project C.A.R.E. is cost-effective and a boost to local economies as it builds strong community networks and partnerships.

Alzheimer's is called the "caregivers disease" because of the all-to-common deterioration of health that results from intense and long-term physical, financial and emotional stress. There are no "typical" families as each is unique in the resources they can bring to the challenge of Alzheimer's. Yet the responses of families, after experiencing the assistance of Project C.A.R.E. are a testimonial to the effectiveness of our work. Numerous letters from these caregivers attest to how Project C.A.R.E. "helped me to have a life again", and how "without you we couldn't have made it through this crisis". A frequent expressed hope by families is that this program continue to be in place for the many other families affected by Alzheimer's.

Various regional and national awards and honors include the Southeast Regional Geriatric Best Practice award, the Alzheimer's Association National Program Clearinghouse award and the upcoming presentation of Project C.A.R.E. at the National State Legislatures Meeting in December, as a model for grassroots systems change.

If the intent of this commission is to find and highlight programs that work, that address the needs of a growing constituency in an efficient and cost-effective way, then I think Project C.A.R.E. is an appropriate choice. I will be happy to answer questions and provide further information about Project C.A.R.E. Again, thank you for your time.

ATTACHMENT VI

Legislative Issues For The 2006 Short Session
November 15, 2005

Budget Adjustments

- In the 2005 Legislative Session the Legislature froze Medicaid Reimbursement Rates. This rate freeze should not be continued in SFY 2006-2007 and funds should be provided for inflation increases.
- Additional funds should be appropriated for direct care workers salary increase.
- Additional funds should be appropriated for transportation cost increases due to gasoline price increases.
- The ceiling on In-Home State/County Assistance clients should be removed and funds appropriated or re-aligned to support adequate staff in the local DSS programs to administer the program.

Legislation

- Aging Study Commission recommended legislation was passed in 2004 to require the DHHS to engage a consultant 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. Phase I of the report has been completed and several policy related biases and recommendations have been identified that would require legislation. <u>These policies should be addressed by the 2006 Legislature.</u>

  Phase II of the report is under study and will address North Carolina's Medicaid LTC rate-setting practices, provider licensing and regulations.

- The Medicare Part D Prescription Drug benefit will cause several CAP-DA clients to loose their Medicaid eligibility because of the Medicaid medically needy spend down policies. <u>This policy change should addressed by the 2006 Legislature since it could force many current CAP-DA clients into more costly Institutional Care.</u>

- House Bill 833 was initiated by the Community College System and passed by the House in 2005. This bill would authorize the Community Colleges to set nonacademic criteria for admission into certain programs. In accordance with G.S. 131E-265, the home care agencies cannot fill a Certified Nurse Aide position without conducting a criminal records check. Home Care Agencies are finding that many nurse aides that have been certified by the Community Colleges and other entities have criminal backgrounds and cannot be hired. <u>The bill is eligible for consideration in the short session and should be passed since it would allow the Community Colleges to conduct criminal background checks before the student is admitted to the program.</u>

- Telehealth technology is an appropriate means of implementing an effective disease management program. Telehealth technology allows the care provider to establish daily, bi-directional

2005 PRIORITIES OF THE SENIOR TAR HEEL LEGISLATURE

Increase funding for home and community based services for older adults by increasing the Home and Community Care Block Grant by $5 million. 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 125,000 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 is almost 2% less now than it was in FY2000-01. During the last four 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. Numerous counties in the state are reporting over 200 seniors on waiting list for key home and community base services.

Re-enact the long-term care insurance tax credit as recommended by the N.C. Study Commission on Aging. 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 results in a public benefit of having and increased number of people paying privately for long-term care services. The credit was 15% of the premium paid, not to exceed $350 for each qualified long-term care insurance contract. It was effective for the tax year which began on January 1, 1999. The Legislation is needed to re-enact the tax credit which is referenced in G.S. 105-151.28 and G.S 105-160.3(b) (7).

Increase funding for senior centers by $3 million. There are 160 senior centers in North Carolina currently operational or under development in 97 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. The current recurring state appropriation for senior centers is limited to $1,415,316. 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 funding constraints.

Take steps to better support grandparents and other family members raising minor kinfolk (children). Statistics from the 2000 Census show that in North Carolina over 135,000 children under the age of 18 live in grandparent-headed households. Another 39,000 live in homes headed by relatives other than grandparents. The growing number of grandparents or other family members raising minor children is a social phenomenon not limited to any particular ethnic group, geographic location, or economic circumstances. Substance abuse, illness, death, divorce, abandonment, child abuse or neglect, job loss, incarceration and other circumstances contribute to reasons children are being raised by relatives other than their parents, either permanently or temporarily. Several current State Statutes need to be modified to better provide adequate legal authority for "kinship caregivers" to parent these children including the following:

- G.S. 115C-366(a3) – pertains to assignment of students,
- G.S. 115C-113- pertains to diagnosis and evaluation and an individualized education plan,
- G.S. 90-21.1- pertains to when a physician may treat a child without consent of parent, guardian or person in loco parentis.

Legislation is also needed to expand subsidies for child care (before and after school) to include kinship caregivers and to enact a "de facto custodian" law to allow a court to declare a relative or non-relative caregiver as a child's de facto custodian.

JUDITH L. MOSS, AMBASSADOR
N.C. SENIOR GAMES 11/16/05

ATTACHMENT VIII

It is good to see you again and to thank the Study Commission on Aging and the General Assembly for their support of the North Carolina Seniors Games program.

The Senior Games is a year round health promotion and wellness program for residents of North Carolina who are 55 years of age and better and it is one of the few programs in our state that focuses on the prevention of health problems in our senior population. It encourages senior adults to engage in activities that help them to live more healthy lives and to have fun at the same time. This is vital as our senior adult population continues to grow in our state and the nation.

I have brought a picture taken of a participant at the Senior Games State Finals held here in Raleigh in the Fall. I think it shows what Senior Games is all about - staying active and engaged in life, sometimes in spite of limitations. Our program also depends on hundreds of volunteers, many of whom are young adults and teenagers. They are learning early that healthy lifestyles and staying active are important.

North Carolina has the most comprehensive Senior Games program in the country, incorporating both sports, recommended activities such as walking, and the arts, all of which help to keep us healthy both physically and mentally. Healthy lifestyles go a long way in minimizing medical problems of the aging. Prevention is less expensive than treatment and is much more fun.

Each year participation in the Senior Games increases. We're getting the word out. This program now serves about 65,000 seniors in 53 local organizations in our 100 counties. This Fall there were close to 3000 participants at the State Finals. This is done with approximately the same amount of money needed to keep 3 residents in a nursing facility for the same one year period. We are helping to keep health care costs lower with health promotions, education, and recreation opportunities for our seniors.

I would like to thank the General Assembly for the one time appropriation Senior Games received last year. It will help provide opportunities for more participation among low income seniors and will allow us to increase awareness of the program in rural areas and among the diverse groups in our state.

Thank you for believing in Senior Games, for supporting it, and for helping us continue to promote health and wellness for our seniors in North Carolina.

ATTACHMENT IX

NORTH CAROLINA
PO Box 4449
Cary, NC
27519-4449

PHONE
919 677 4100

FAX
919 677 4199

TOLL FREE
800 662 8859

SOUTH CAROLINA
PO Box 6009
West Columbia, SC
171-6009

NE
803 791 4220

FAX
803 791 5664

Issues Affecting Older Adults and End of Life Care to the North Carolina Study Commission on Aging

November 16, 2005

The Carolinas Center for Hospice and End of Life Care is a 29-year-old organization dedicated to building capacity in North Carolina for high quality end of life care for all. We do this primarily by supporting and promoting hospice care and for the past 6 years we have also been the NC End of Life Statewide Coalition. In collaboration with The Carolinas Center, planning for end of life care in North Carolina has been included in the NC Aging Services Plan, the NC Cancer Control Plan and as a health objective recommended by the Governor's Task Force for Healthy Carolinians. Good end of life care planning is a **Quality of Life** issue—one that helps to ensure that we will live fully in ways that we choose until the last breath we take.

- In 2004, approximately 72,800 people died in North Carolina -- 52,000 of those were 65 or older. Only **29%** were cared for by hospice—the gold standard in end of life care
- 87% of those surveyed in NC say it is important or somewhat important to die in their own home, however:
  - 22.9% die at home
  - 50.6% die in hospitals
    (Nationally, of those that die in hospitals, 15% die in the ER)
  - 21.8% die in nursing homes
- Of all <u>hospice patients</u> in NC:
  - 57% die in their own home
  - 7% die in the hospital
  - 18% die in nursing homes

Because of advances in medical science there is no longer a clear distinction between living and dying-for many of us our aging will most likely bring with it a course of dealing with serious illness that will follow a trajectory of periods of remission and sickness that will eventually lead to death. Death is inevitable for us all, dying badly is not.

Continued support for and promotion of hospice services in NC is an essential component of any plan to meet the future needs of older adults.

Priority issues for The Carolinas Center affecting end of life care services to older adults are in the following areas:

- Increase the use of hospice and palliative care by promoting the development and dissemination of delivery models to reach underserved populations such as those in rural areas of the state, those with developmental disabilities, and African Americans. We must significantly increase the use of hospice care in our aging adults from the current 29%.

- **Barriers to good end of life care in all settings must be studied** and addressed. Changes in reimbursement must occur to allow for new models of care to assure that all settings and facilities have the capacity (internally or via contract) for continuity of care through the end of life.

- A much greater use of home and community-based care of the chronically ill and frail elderly will be essential for coping with the increased aging population. There is a need for demonstration projects that may lead to changes in reimbursement policies which integrate new clinical service delivery models such as palliative care given concurrently with aggressive cure oriented treatment for patients with advanced illness. Such projects will likely reveal, as they have in other states, cost effectiveness and in increase in quality of care. The keystone to these demonstration projects is care management that is provided by hospice programs.

- Without changing any statute or laws—pain management and end of life care can improve with education on these issues to healthcare professionals, public policy leaders and consumers. It is important to healthy aging to focus on staying engaged in life. Aging adults in pain and suffering with debilitating symptoms cannot engage in life. All medical schools should be required to have end of life care curricula to teach pain and symptom management and medical ethics related to aging and end of life care. Physicians need to be taught how to communicate prognosis and treatment options for their aging patients.

- Preparation and education for long-term and adult care home personnel to provide comprehensive end of life care to residents is essential. Estimates are that in the near future there may be 40% of us cared for in settings other than our own homes.

- We must empower older adults to know their options for care at the end of life and to make their wishes known. In 2004, a survey completed by The Carolinas Center and AARP-NC on End of Life Care indicated that 51% of respondents have completed an advance directive although only 11% have talked with their primary physician about their wishes. A comprehensive healthcare decisions law similar to the one in West Virginia may help to address this disparity. We must work to ensure that the care specified in the advance directive is consistent with the care actually delivered.

- High quality bereavement care is an essential component to promotion of healthy grieving and alleviation of stress related illnesses associated with grief and loss. It is estimated that 400,000 caregivers, family members and loved ones will be affected by the grief associated with the deaths of the 52,000 people over 65 who died in 2004.

The list is a challenging one. Thank you for this opportunity to share with you The Carolinas Center for Hospice and End of Life Care's agenda for improvement in services to older adults in North Carolina.

Submitted by:

Judith B. Brunger
President and CEO

FOR: Public Hearing, 11/16/05, Legislative Study Commission on Aging

FROM: Rosemarie Downie, Triangle Older Women's League and Polly Williams, NC Justice Center

Funding for wrap-around for Medicare Part D: As you know, the prediction from Senior Care is that 70 percent of the program's beneficiaries will be eligible for subsidies for the Medicare Part D drug benefit. This is good news; however, some quick arithmetic indicates that of the 130,000 who have received up to $1200 this year in aid for prescription drugs, 39,000 will lose any subsidy. Even if the number is smaller, thousands of North Carolinians will lose this benefit, and as we all know, no ill person gets better when medical care is reduced. Gina Upchurch of Senior PHARMAssist has a proposal for additional funding from the state for medication management and for some subsidies for premium support for certain low-income Medicare beneficiaries. We hope that you will give her proposal and others that may come to you careful consideration and that you will recommend some wrap-around funding so that low-income persons in our state will be able to take full advantage of the Medicare benefit.

Problem of mixed populations: Residents in adult care homes are often cognitively impaired or mentally ill and yet are well accommodated to life in the home. But more recently, mental patients, often much younger than the other frail elderly residents, are deposited in adult care homes where they do not find the activities and services that they need. They are bored and frustrated with life among the elderly. Some are aggressive young males; there have been two recent cases in which a young male resident in assisted living brutally beat and strangled to death an elderly woman resident. As a first step, a means of assessment for appropriate placement is badly needed; the next step is provision of more facilities in which former mental patients can find activities and trained aides suited to their needs.

We also hope the legislature will see fit to consider the Study Commission recommendations from the last session which were not addressed--in particular, raising the funding for the Home and Community Care Block Grant, re-enacting the Long Term Care Insurance Tax Credit, and appropriating funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings. These were valuable recommendations; they need action.

ATTACHMENT XI

Study Commission on Aging
11/16/2005

I am Roxanne Bragg-Cash, current president of the North Carolina Association on Aging.

Thank you for allowing me to come before you today to talk to you about aging issues in North Carolina.

The North Carolina Association on Aging represents professionals in the field of aging who provide home and community based services and advocate for quality programs that enable older adults and their families to live as independently as possible. Members are typically a part of the Aging Network, such as local councils, departments and area agencies on aging, senior centers, adult day care centers, adult social services, health department and other providers of home and community-based services.

Most people do not understand that times are starting to change. The make up of the population is changing. Because of the 'Baby Boom' 60 years ago, the majority of the population is now made up of older adults. That means a lot of our concentration has to be on older adults.

Years ago, North Carolina started preparing for this older population growth. They started putting money into senior centers and services for older adults. Now we have senior centers that are becoming focal points in all counties.

They are certified according to their level of service. (Excellent or Merit) Senior Centers are the identifiable place for these older adults to come to get their needs met. Needs meaning they get information, services, activities and socialization. Years ago, North Carolina started the infrastructure. Now, with the increasing numbers of older adults, North Carolina must expand on those Senior Centers and services. We need to look into putting more funding into those programs to match the population growth.

There are so many important things Senior Centers do for the aging population. From Transportation, Nutrition, Adult Day Care, In-Home Aides, Home improvement, Meals on Wheels to Medicare part D.

I sincerely hope you realize the position this state is in concerning serving the group that makes up the majority of our population. I hope you will look at the system you have already spent so much money and energy putting in place and build upon it.

Thank you

My name is Jean Reaves and I come to you today as the President of the North Carolina Coalition on Aging. This is by far not the first time that I have had the opportunity to address this commission. There will be many others here this morning that you will recognize as strong advocates for seniors. As I prepared for my comments today I thought back on previous presentations that I had personally offered as well as the presentations of so many of North Carolina's seniors and their caregivers. The resounding message that that always stands out is that we, and yes as a baby boomer I say WE, repeat over and over again that WE desire the capacity to remain in a safe and positive community setting for as long as is possible.

In order for this to happen we need expansion of such programs as CAP-DA and the Special Assistance In-Home Project. We need fair and equitable reimbursement rates for Adult Day Health under the CAP-DA program. We need realistic transportation funding for all community-based programs including Adult Day Care. Seniors and their caregivers need and are entitled to quality programs and resources in a variety of formats within their neighborhoods through the local senior center. In order that WE can remain in our communities as long as possible WE need senior friendly communities and safe affordable housing. We need a Homestead Property Tax Exemption. We need the where with all to add ramps on existing housing, to provide weatherization and simple things like shower stalls and grab rails. We need senior housing complexes in areas that are convenient to other services and yes transportation systems that are affordable and senior friendly.

Finally I must address the need for a NC tax credit for long-term care insurance. This type of insurance will provide the senior with a potential revenue source to support the needed community services that allow one to remain in that safe community environment. LTC insurance is not just a relief for those who choose or need nursing care through a nursing home. The long term continumn of care most often begins with a mixture of community based services. It very often begins at a congregate meal site within the senior center and can then grow to include everything from in-home aide services to adult day care and home renovations. All of these are long term care and many are allowable within LTC insurance policies.

We are mindful of budgets but we are also aware of the growing older adult population and of the never ending waiting lists for services. Challenges lie before us as North Carolinians to find a way to answer not just the desires but the needs of our citizens. I will close by asking you to look at many of our other states who have successfully addressed these issues and let's us learn and perfect their successful programs.

Thank you for your time this morning. Please do not hesitate to call on the North Carolina Coalition on Aging if we can be of any further assistance in accomplishing these goals.

Jean Reaves
President

November 2005

To: NC Study Commission on Aging

From: Ann K. Umstead, Executive Director

Re: Adult Day Services

1. On behalf of our participants, their family caregivers, our staff, and the Board of Directors, thank you for your interest in and support of sustainability for Adult Day Services in North Carolina.

   The Adult Center for Enrichment ended FY 2003-04 with a significant deficit of over $30,000. Whether we would still be in existence to benefit from the training and the study results you initiated in 2004 was a valid question this time last year. However, we did survive and completed FY 2004-05 with over $30,000 revenue in excess of expenditures (or a $60,000+ for the year).

   At least half of this was the direct result of the $5 per unit increase in reimbursement for the NC Adult Day Care Funds and the HCCBG Adult Day Care and Adult Day Health Funds. A small amount made a significant difference in the survival of one day service agency. Thank you for any role you may have played in facilitating this increase.

2. Another significant factor was the training. Please note that as director very little of the information was new. However, staff had privilege to attend (the directors of each center). And for the first time they truly heard the messages that could make the difference in our sustainability, because they heard them together and I was not the one providing the information. Thank you for this opportunity, one that would have not been possible without the "scholarship" availability for each program.

3. The current status of the report is of great interest to all of us at the Adult Center for Enrichment. We believe intensely in the community based long-term option of adult day services. We have seen first hand the difference our services make in the lives of the participants and in the lives of their caregivers. Attached is one of the many stories from caregivers about the value of adult day services in their caregiving journey.

Adult Center for Enrichment
The Difference Made
By Mary Scarlette, President
Board of Directors and Family Caregiver

Let me introduce you to a man who made the purpose and vision of the Adult Center for Enrichment meaningful.

This "gentle man" was a financial wizard who held an MBA from the University of Chicago School of Business. He was an outstanding communicator, an avid tennis and chess player, witty, jovial, politically correct, culturally astute, a deacon in the church and a man who could have modeled for GQ magazine. He was a wonderful teacher who could "make a way-faring fool" understand a complicated mathematical formula; he was a loving father, a devoted husband – who although older than his wife, readily told people that "he would rather smell perfume than liniment."

Shortly after his retirement from a career as a college business manager, this "gentle man" became confused, forgetful, disoriented, non-communicative, dependent and often angry. On a day that appeared to be a "good day" he left home to purchase razor blades at a nearby Eckerds and was found 7 ½ hours later that night by the highway patrol at a checkpoint 35 miles from his home.

This "gentle man" no longer knew the sum of 2+2, how to shave or toilet himself properly; he rarely knew his wife or the names of his children. In that his daughters were away in college, his wife had full responsibility for his care. Additionally, his twin sister was in an assisted living facility.

His wife had a full time job as a college administrator plus the added tasks of managing the home, family and being a caregiver 24/7. Needless to say that it became too much for her. The mental, emotional and physical side effects of being a full-time caregiver took their toll.

A chance conversation with a health professional resulted in an interview with the Director of the Adult Center for Enrichment at Bardolph. Shortly thereafter, this "gentle man" began to attend the Adult Center on a regular basis. Now instead of dropping children off at a day care, his wife brought him to Bardolph in the mornings and picked him up around five in the afternoon.

What a difference the Adult Center made in the life of this "gentle man" and his caregiver – his wife. What a relief for the daughters who were away in college to know the quality of life for their parents was improving. The days were not as long or hard as they had been.

The staff of the Adult Center were the first to recognize the onset of Parkinson's Disease and soon Beverly/Starmount Health Care became home for this "gentle man."

I hate to think what the outcome would have been for this family without the Adult Center; I hate to think what the quality of life would have been without the Adult Center.

The Adult Center for Enrichment will always have a special place in my heart and life because the "gentle man" was my late husband, James J. Scarlette.

Bill Lamb, Chairman, Friends of Residents in Long Term Care
Aging Study Commission
November 16, 2005

Representative Earle, Senator Dannelly, members of the Study Commission, thank you for the opportunity to speak with you today about critical issues to be addressed to meet the present and future needs of older adults in North Carolina.

My name is Bill Lamb and I am speaking to you today as chairman of the board of Friends of Residents in Long Term Care. I also want you to know that I have been and am now a caregiver for my mother who currently resides in a nursing home in Raleigh and I am a member of the Adult Care Home Community Advisory Committee here is Wake County. Over the years I have had the opportunity to see long term care provided in a wide variety of settings—in-home, community based, and institutional care.

Friends of Residents in Long Term Care is a private not for profit membership organization of individuals and associations committed to improving the quality of life for over 80,000 North Carolina citizens in long term care settings. We carry out our work through direct assistance to individuals, training and consultation, and through our public policy committee work. Our Public Policy Committee proposes legislation that will improve direct care staffing, ensure adequate training and increase facility accountability. I am attaching a copy of our short and long term public policy goals drafted in January of 2005. These goals will remain in effect until the end of this current session of the General Assembly.

I do not intend to read all of our public policy goals to you, but I would like to draw your attention to a few:

I. We believe the best quality influence long term care consumers can have is choice in alternatives. This starts with home and community based care and an adequate set of services for the elderly in each county. You all know about the institutional bias in our funding before you read the report from the Lewin Group. We need to protect and expand programs like CAP-DA and the SA Demonstration Projects as well as assure adequate funding for the Home and Community Care Block Grant.

II. We need to continue to promote quality of care. We are very supportive of the quality initiatives undertaken in the past few years through the Real Choice efforts and through the New Organizational Mission Awards (NOVA). We've been pleased that work is beginning on a rating system for long term care facilities. In addition to community alternatives, consumers need ways to evaluate out of home options. Ultimately, however, quality in long term care is a function of adequate numbers of stable, well-trained staff providing care consistent with residents needs. There are a long series of recommendations stemming from the 2001 Long Term Care report of the Institute of Medicine directed at addressing our long term care workforce requirements which still need to be addressed.

III. In North Carolina we manage quality through a system of carrots and sticks. Recently we've been focusing on the carrots and that's good. When facilities are doing the right thing, we need to reward them. But we can't forget the need for the stick. In the past year we have all but done away with the penalty review process; there is not a statewide standard for adult home specialists and additional responsibilities could erode their capacity and effectiveness; the system of fines and appeals in adult care homes is arcane and can stretch out over years and years without resolution; there is often not immediate and direct consequences to poor performance. We should really address the needs of oversight of our most vulnerable populations.

IV. We remain concerned about the needs of residents with physical care needs living along side residents with mental health needs. Staff training in adult care homes is often directed at serving a frail, elderly resident, rather than a younger resident with some form of mental illness. We need to improve our assessment, diversion capability, and availability of residences with specialized

services to adequately address the needs of persons with mental illness. An adult care home is not a mental health treatment facility and we are rapidly turning them in to exactly that. We might consider a separate licensing of facilities with larger numbers of residents with mental illness. In the absence of services, we certainly don't need to be considering placement of restrictions on residents' rights to control behavioral issues.

V. Finally with the recent disasters in the mid-west, we are reminded how important it is to have an up to date disaster plan for special needs populations and we would urge you to look at improving the disaster planning of emergency services to plan for special medical needs populations in long term care facilities or those living at home during times of natural disasters.

Thank you. I appreciate the time you have given me and given to the other aging interest groups.

FRIENDS OF RESIDENTS IN LONG TERM CARE

883-C Washington Street, Raleigh, NC 27603 email: friends@foritc.org
(919) 782-1530 or toll-free (888) 411-7571 website: www.foritc.org

FRIENDS OF RESIDENTS IN LONG TERM CARE

Short and Long Term Advocacy Goals

January 2005

I. CONSUMER CHOICE/NO INSTITUTIONAL BIAS

- **Consumer choice**
  - Remove limits for the Community Alternative Programs (CAP) and in-home assistance; consumers should not be forced into an institution because CAP slots are not available.
  - Maximize non-institutional options.
- **Funding Streams**
  - Expand Home and Community Care Block Grant (HCCBG) to encompass individuals who are close to Medicaid eligible, but not currently eligible.
  - Expand Community Alternative Programs for Disabled Adults (CAP/DA).
  - Expand in-home care/Special Assistance (SA).
  - Expand Medicaid outside of a waiver program to include adult day health as a regularly covered service without having to be eligible for CAP/DA.
  - Expand eligibility for Medicaid-funded personal care to individuals in adult day care.
- **Institute pre-admission screening.**
  - Mandate pre-admission screening for both full pay and Medicaid before a resident enters a long term care facility.
  - Require financial screenings to be conducted initially by a qualified independent reviewer. If it is determined that maintaining an individual in his/her home exceeds the cost of institutional care, then screening would be terminated.
- **Develop an adequate core set of services for the elderly in each county.**
  - Implement a core services plan developed by the Division of Aging and Adult Services in the Department of Health and Human Services.
  - Ensure adequate funding to implement the core services plan.
- **Make complete information available on line about facilities, facilities' ownership, performance audits, and violations/penalties within 30 days after staff in the Department of Health and Human Services becomes aware of such information.**

II. ENFORCEMENT/MONITORING

- **Keep monitoring of adult care homes at the local level.**
- **Develop minimum staffing and training and maximum workload standards for adult homes 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 the use of Medicaid funds.**
  - Ensure the institution of biannual audits of adult care homes conducted by the State Auditor and include the financial implications of related enterprises operated by the same corporation that operates the facility.
  - Ensure the development of objective cost models for adult care homes that determine actual cost of care and the development of reimbursement models based on the cost models.
- **Require each county's office of emergency services develop an emergency/disaster plan for special medical needs populations residing in the county, whether located in long term care facilities or at home.**
- **Fund and use the current temporary management law.**
- **Require the Division of Facility Services to deny a license to homes that are part of chains with persistent problems of noncompliance and inadequate care.**

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 requirements to provide sufficient staff to meet the needs of residents.
- **Mandate drug testing for all long term care employees in an effort to reduce medication errors and drug diversions.**
- **Improve staff working conditions to include limiting the number of consecutive hours worked by registered and licensed nurses, medication technicians, and certified nursing aides/assistants.**

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 such populations.**
- **Address the need for mental health facilities for those who cannot live at home.**
  - 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, an adult care home or nursing home should serve that person.
  - To meet the needs of aggressive persons or sexual offenders, a Pre-Admission Screening and Resident Review (PASARR)-type evaluation should be conducted to determine how best to meet that person's needs.
- **Define clearly the meaning and operation of special care units.**
  - Where locked units or groupings of patients with Alzheimer's or related dementias exist, requite that the locked units be deemed special care units so that all such units will be required to have 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 availability.

1/16/05 Legislative Study Commission
Governors Advisory Council on Aging
Ann B. Johnson, Chair

Intro -

Thank you! I compliment the commission for todays process of broad input and appreciate the invitation to participate. The Gov. Adv. Council has been very active.

The Council has formulated a Legislative Agenda; held two forums - one on Transportation and one on Housing - with recommendations from each.

A copy of the Legislative Agenda and Forum Recommendations are ~~with me for your Commission~~ being sent to you by the Div. of Aging.

In addition, the Council held a pre-White House Conference on Aging Forum. Since the recommendations are beamed to national (as compared to State) policy they are not included in this presentation.

Obviously, the three minute limit makes a full, detailed presentation impossible, so I have selected two areas to highlight for you today.

certified and 34 centers of merit and excellence have been designated.

In summary -
Under Housing - funds of 50 million are needed for an array of living arrangement services including R+R, supportive services and Indoor Plumbing!

Under Infrastructure - restore the reductions made to senior center allocations and add 10 million to speed up the quality assurances within the designation of merit and excellence centers and certification of center managers. This will provide support for the concept of the senior center as a focal point response system to the needs of all older adults in a geographic service area.

Governor's Advisory Council on Aging
Recommendations for 2005

Ensure that North Carolina has strong input into the 2005 National White House Conference on Aging

Expand and strengthen programs, services, and benefits

- Appropriate $2 million to expand funding for the Home and Community Care Block Grant which funds services for older adults at the local level such as home delivered meals and in-home aide services.

- Reinstitute the tax credit for long-term care insurance which expired January 1, 2004.

- Increase funding for Senior Centers of Merit and Senior Centers of Excellence which seek to make their communities more senior friendly. There are 161 senior centers in 97 counties.

- Strengthen transportation services for older and disabled adults. (Note: In April of 2004, the Council held a forum on addressing the transportation challenges that face older adults in the State. Recommendations for addressing transportation needs were developed and widely distributed).

- Expand the State/County Special Assistance In-Home program so that any older or disabled adult who qualifies for adult care home level of care has the option of participating in this program. Currently the program is limited to 1000 slots.

- 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.

- Study the laws in the state relative to guardianship and seek needed legislative changes to these laws.

- Increase funding for adult day care/adult day health care services in the state and continue to enhance the staff capacity of adult day care/adult day health care programs. There are currently 108 programs in the state.

(over)

- Create an Office of Housing in the Department of Health and Human Services so as to focus increased attention to the housing needs of older and disabled adults as well as other persons in need.

- Appropriate $2 million each year of the biennium to provide indoor plumbing for older adults without these facilities. According to 2000 Census data, 8,184 persons 60 and older in the state do not have complete plumbing.

- Increase the Homestead Property Tax Exemption for low-income elderly and disabled adults by increasing the income eligibility level for the exemption to $25,000. Help protect the counties from the revenue loss due to the exemption by having the State pick up 50% of the loss.

- Ensure the continuing viability of the Community Alternatives Program for Disabled Adults (CAP/DA), a Medicaid waiver program which allows adults 18 and older who qualify for nursing home care to remain in their homes.

Improve the quality of care in long-term care facilities

- 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.

- Continue efforts to strengthen the long-term care direct care workforce.

- Study the mixing of older adults and younger mentally ill adults in long-term care facilities.

Presentation to the N.C. Study Commission on Aging
Von Valletta, State President
AARP North Carolina

Representative Earle, Senator Dannelly, and Members of the Commission. I am Von Valletta, State President for AARP North Carolina. I am pleased to be here today to share with you what AARP, which has 973,000 members in North Carolina, believes are the most important issues facing older adults in our state as well as our recommendations for legislative action to address the challenges and problems that confront our older citizens.

A key issue facing our state is the fact that although almost all older adults want to stay in their communities and be as independent as possible, **many counties in our state still lack services or have long waiting lists for many services** which will allow seniors to do just that. The Division of Aging and Adult Services tells us that as of this past Monday, November 14, their waiting list data base - which is utilized by 55% of local providers who receive Home and Community Care Block Grant funding - reports 9,700 older adults waiting for services funded by the Block Grant. Services funded by the Block Grant include core home and community based services such as home delivered meals, in-home aide service, and transportation assistance. It is also projected that demand for key in-home aide services funded by the Block Grant may increase significantly in the next few months because of a Medicaid policy change that went into effect this month which results in many thousands of older adults who received Medicaid Personal Care Services (PCS) losing eligibility for this benefit. **AARP asks that additional funds be appropriated for the Home and Community Care Block Grant to help at-risk older adults stay at home.**

If older North Carolinas are to remain in their communities, they also **need to have adequate safe and affordable housing**. A 2004 report by the North Carolina Housing Finance Agency notes that 41% of elderly rental households and 23% of elderly owner households have housing problems. Resources to improve the housing stock for older North Carolinians are inadequate. One resource that has been used to support housing for older adults is the Housing Trust Fund. The General Assembly appropriated $5 million in non-recurring funds this last legislative session for the Trust Fund. Many agencies and organizations, including AARP, are joining forces to

advocate for $50 million in recurring funds for the Housing Trust Fund. In addition to helping many older adults with housing needs, funding in this amount would generate over 3,000 new jobs each year, increase state and local tax revenues by over $30 million each year, and leverage $200 million for housing development and preservation.

Another issue related to housing which many older and disabled adults face is **paying their property tax.** This is particularly a problem for those on fixed incomes whose taxes are increasing as a result of rising real estate market values. The last time action was taken by the General Assembly to increase the Homestead Property Tax Exemption was in 2001. **Addressing property tax relief for low-income older and disabled adults** is another priority issue. Several bills were introduced in the last legislative session which would provide relief including Senate Bill 852 which would defer Homestead property taxes and House Bill 36 which would increase the tax credit.

In lieu of a federal prescription drug benefit, older North Carolinians have been very fortunate to have had an excellent State prescription drug program, N.C. Senior Care, which benefited almost 130,000 seniors in our state. AARP, like many other groups, is now waiting for the start of the new prescription drug benefit under the Medicare program in January of 2006. We are concerned, however, that **with the advent of the new Medicare prescription drug benefit there will be many Medicare beneficiaries who can not afford the cost-sharing structures** that are in place for this program. We ask that the **state consider a wrap-around program** to assist low-income individuals who do not qualify for the full "extra help" subsidy assistance under Medicare.

In the last legislative session, the General Assembly considered eliminating or limiting Medicaid eligibility and services for thousands of aged, blind, and disabled persons. With approximately 13% of our older population with incomes below the poverty level, **the role of Medicaid in paying for health care services for seniors is critical**. In particular, Medicaid is crucial to our state's ability to serve many people in need of long term care services, both services delivered in the community as well as those provided in institutions. The Long Term Care Plan issued by the N.C. Institute of Medicine Task Force on Long-Term Care in 2001 noted that Medicaid finances almost four-fifths of the long term care expenditures for older adults in our state. AARP

North Carolina asks that this **Commission work to preserve Medicaid eligibility and services for vulnerable adults** in our state.

AARP North Carolina also feels that **our state needs to do more to encourage our citizens to plan for and take responsibility for their long term care**. One method that can encourage this practice is to offer a tax credit for the purchase of long term care insurance which assists with the cost of in-home and nursing home care. The General Assembly passed legislation in 1998 which was effective for the tax year that began January 1, 1999, to allow individuals who purchase a long term care insurance policy to claim a state income tax credit. The credit was 15% of the premium paid, not to exceed $350 for each qualified long term care insurance contract. The legislation had a sunset provision and the credit expired at the end of the 2003 tax year. This Commission proposed legislation last session to **re-enact the long term care insurance tax credit**. We ask that you get behind this measure again in the short legislative session.

Thank you again for giving AARP North Carolina this opportunity to address the Commission and share these issues and our recommendations for action.

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — November 16, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Horne Odom	self
Karen Bottori	Div. of Aging + Adult Svcs
Ann B. Johnson	Gov. Advisory Council on Aging
Jean Reeves	NC Coalition on Aging
Von Valentine	AARP N.C.
M Butler	AARP-NC.
Bill Lamb	Friends of Residents in LTC
Roxanne Bragg-Cook	North Carolina Association on Aging
Judith L. Moss	N.C. Senior Games
Kimberly Hill	Lt. Gov. Perdues Office
Jim Elgin	DHHC

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — November 16, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
KARISA DERENCE	NC DAAS - 2101 Mail Service Center Raleigh, NC 27699
LEN ERKER	NC Alzheimer's Association 31 Colley Place, Suite D320 Asheville, NC 28801-2644
ROSEMARIE DOWNIE	TRIANGLE OLDER'E WOMEN'S LEAGUE 919 HAMPSHIRE CT CARY NC 27511
JUDY Brunger	The Carolinas Center for Hospice and End of Life Care PO Box 4449 Cary, NC. 27519-4449
Suzanne Merrill	NC Division of Aging & Adult Services
Sam Hubbard	NC Division of Aging + Adult Services
Yoko Crume	NC Division of Aging & Adult Services
Sharon Becker	Student - UNC-CH
Charlene Carey	NC Right to Life
LAMAR MOORE	SR. TAR Heel Legislature
Carolyn S. King	Older Women's League

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — November 16, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Abby C. Emanuelson	NMSS
Suzie Williamson	NCANPHA
DAVID BARNES	Poyner + Spruill
Lyn Newton	NCALTCF
Evelyn Diaz Moore	EHGR
Jill Bone	Bone & Assoc.

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

November 18, 2005

MEMORANDUM

TO: Members - NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the **NC Study Commission on Aging:**

DATE: Tuesday, December 20, 2005

TIME: 10:00 a.m.

LOCATION: Room 415
Legislative Office Building
Raleigh, NC

Please advise Dee Hodge, Commission Clerk, at (919) 733-5955 or email dannellyla@ncleg.net if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Tuesday, December 20, 2005
10:00 a.m.
Legislative Office Building
Room 415

I. Welcome and Introductions
Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Summary of 11/16/05 Association Presentations
Theresa Matula, Commission Staff, Research Division, NCGA

III. White House Conference on Aging Report
Karen Gottovi, Division of Aging and Adult Services, DHHS

IV. Overview of Aging Services in North Carolina
Karen Gottovi and Dennis Streets, Division of Aging and Adult Services, Department of Health and Human Services(DHHS)

V. State Funding for Services and Programs for Older Adults
Andrea Russo, Fiscal Research Division, NCGA

VI. Report on Pilot Project for Local Long-Term Care Coordination (S.L. 2003-284, Sec. 10.8F)
Steve Freedman, Division of Aging and Adult Services, DHHS
Dr. Mary Anne Salmon, CARES, UNC School of Social Work

VI. Medicare Part D Impact on CAP/DA
Tracy Colvard, CAP/DA, Division of Medical Assistance, DHHS

VII. Next Meeting:
January 4, 2005 at 10:00 a.m. in Room 643

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES
DECEMBER 20, 2005
10:00 AM
ROOM 415

The North Carolina Study Commission on Aging was called to order by Representative Beverly Earle at 10:10 am. Representative Earle introduced staff members and asked if any of the members had any remarks.

The following members were present: **Representative Beverly Earle, Co-Chair, Senator Charlie Dannelly, Co-Chair, Representative Debbie Clary, Representative Alice Bordens, Representative Bob England, Representative Jennifer Weiss, Ms. Linda Howard, Ms. Katherine Fox Price, five Senators, Jackie Sheppard, Ex-Officio, Staff Members: Theresa Matula, Shawn Parker, and Ben Popkin.**

The meeting begins with Ms. Theresa Matula, Research Division, with a handout entitled: **Summary of 11/16/05 Association.** Fourteen presenters presented to the Commission with written remarks. The presenters were: Alzheimer's Association, Western Carolina Chapter, NC Senior Tar Heel Legislature, The Carolinas Center for Hospice and End of Life Care, NC Association on Aging, Friends of Residents in Long Term Care, AARP, North Carolina, NC Association of Area Agencies on Aging, Association for Home and Hospice Care of North Carolina, NC Senior Games, Triangle Older Women's League, NC Coalition on Aging, Governor's Advisory Council on Aging, NC Adult Day Services Association and NC Health Care Facilities Association. Each organization presented their legislative priorities. (Refer to handout)

The next presenter was Ms. Karen Gottovi and Dennis Streets, Division on Aging and Adult Services, DHHS. Ms. Gottovi discussed the White House Conference on Aging Report. There were a total of 1,200 delegates from North Carolina and other states. The main item on the agenda was the Top 10 Resolutions that were announced and to be voted on. All delegates from North Carolina voted on the resolutions. The top 10 resolutions as voted by the delegates are:

- ✓ **Reauthorize the Older Americans Act With in the First Six Months Following the 2005 White House Conference on Aging.**
- ✓ **Develop a Coordinated, Comprehensive Long-Term Care Strategy by Supporting Public and Private Sector Initiatives that Address Financing, Choice, and Quality. Service Delivery, and the Paid and Unpaid Workforce**
- ✓ **Ensure that Older Americans Have Transportation Options to Retain Their Ability and Independence**
- ✓ **Strengthen and Improve the Medicaid Program for Seniors**
- ✓ **Strengthen and Improve the Medicare Program**
- ✓ **Support Geriatric Education and Training for All Healthcare Professionals, Paraprofessionals, Health Profession Students, and Direct Care Workers**
- ✓ **Promote Innovative Models of Non-Institutional Long-Term Care**
- ✓ **Improve Recognition, Assessment, and Treatment of Mental Illness and Depression Among Older Americans**
- ✓ **Attain Adequate Numbers of Healthcare Personnel in All Professions Who are Skilled, Culturally Competent, and Specialized Geriatrics**
- ✓ **Improve State and Local Based Integrated Delivery Systems to Meet 21st Century Needs of Seniors**

By statue, the final report from the conference will be presented to the President and Congress by June 2006. See a listing of the 50 resolutions, www.whcoa.gov. She also talked about the implementation of the strategies for the 6 policy areas. The ended her presentation with a discussion on Adult Day Care and Adult Day Health Care issues.

State Funding for Services and Program for Older Adults was presented by **Andrea Russo, Fiscal Research.** She spoke on Community Care of North Carolina. Community Care is NC is a statewide program in which local networks of primary-care providers coordinate prevention, treatment, referral, and other services for Medicaid recipients. Adult Care Homes was funded with a total of 31 additional positions for annual inspections of adult care homes in the Adult Care Licensure Section of the Division of Facility Services. Also funded were additional positions in the Construction Section of DFS for life safety inspections of adult care homes every two years. Home Care Agencies was funded 5 additional positions in the Licensure and Certification Section of DFS for inspections of home care agencies every 36 months.

Mr. Steve Freedman, Division of Aging and Adult Services, DHHS and Dr. Mary Anne Salmon, CARES, UNC School of Social Work, was the next presenter. They presented to the commission a powerpoint presentation entitled: Evaluation of the DHHS Communications and Coordination Initiative to Strengthen Long-Term Care. Session Law 2003-397, Section 10.8F called upon the Department of Health and Human Services to implement a communications and coordination initiative, to seek voluntary participation, pilot the establishment of local lead agencies to support local coordination of long-term care, to aid in the development of core services and to improve access to services. (See Handout for the full report).

The final presentation was **by Tracy Colvard, CAP/DA, Division of Medical Assistance, DHHS** to present **Medicare Part D Impact on CAP/DA.** The basics are if individuals with medical needs and incomes is greater than $798 per month may become Medicaid eligible by meeting a Medicaid deductible also known as a "spend down". Medicaid eligibility becomes effective on the day that the deductible is met. Medicare Part D will cover prescription drugs effective January 1, 2006. There will be approximately 645 CAP/DA recipients are dually-eligible and have deductibles. This represents about 5.7% of the 11,300 CAP/DA recipients. And about 400 of the 645 CAP/DA recipients have deductibles over $500. The current status is that many recipients will be able to meet their deductibles using other medical expenses. Current federal and state regulations do not allow exceptions for individual program participants in matters relative to eligibility.

Representative Beverly Earle asked for questions from the commission at this time. Presenters answered all questions.

The meeting was adjourned.

Beverly Earle

Representative Beverly Earle, Presiding Chair
Senator Charlie Dannelly, Co-Chair

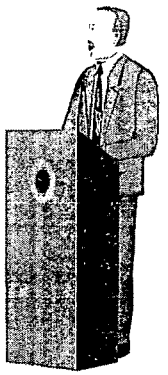
Ann Raeford

Ann Raeford, Commission Assistant

Attachments

Agenda	
Attachment I	**Summary of Presentation by Organizations Representing Older Adults**
Attachment II	**White House Conference On Aging Report**
Attachment III	**State Funding for Services and Programs for Older Adults**
Attachment VI	**Report on Pilot Project for Local Long-Term Care Coordination**
Attachment V	**Final Report To The Legislative Study Commission on Aging**
Attachment VI	**Medicare Part D and the Community Alternative Program for Disabled Adults**
Attachments VII	**Visitors Registration**

Summary of Presentations
by
Organizations Representing Older Adults



Prepared for the
North Carolina Study Commission on Aging

December 20, 2005

The following organizations presented information to the North Carolina Study Commission on Aging on November 16, 2005

Alzheimer's Association, Western Carolina Chapter
Len Erker

NC Senior Tar Heel Legislature
LaMar Moore

The Carolinas Center for Hospice and End of Life Care
Judith Brunger

NC Association on Aging
Roxanne Bragg-Cash

Friends of Residents in Long Term Care
Bill Lamb

AARP, North Carolina
Von Valletta

NC Association of Area Agencies on Aging
Mary Barker (not present/comments provided)

Association for Home and Hospice Care of North Carolina
Jim Edgerton

NC Senior Games
Judith Moss

Triangle Older Women's League
Rosemarie Downie

NC Coalition on Aging
Jean Reaves

Governor's Advisory Council on Aging
Ann Johnson

NC Adult Day Services Association
Ann Umstead (not present/comments provided)

NC Health Care Facilities Association
Stacy Flannery (not present/comments provided)

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:

- **Support for/Restoration of Funding for the Home and Community Care Block Grant (HCCBG)** *(7)*
- **Restoration of the Long-Term Care (LTC) Insurance Tax Credit** *(6)*
- **Support Special Assistance (SA) In-Home Program** *(4)*
- **Support for Home & Community-Based Care Programs** *(4)*
- **Concerns About Mixed Populations in Long-Term Care (LTC) Facilities** *(4)*

	Alzheimer's Assn., Western	Assn. For Home & Hospice Care	NC Senior Tar Heel Legislature	NC Senior Games	Carolinas Center for Hospice and End of Life Care	Triangle Older Women's League	NC Assn. On Aging	NC Coalition on Aging	Friends of Residents in LTC	Governor's Advisory Council on Aging	AARP	NC Assn. Of Area Agencies on Aging	NC Adult Day Services Assn.	NC Health Care Facilities Assn.
COMMUNITY-BASED ISSUES														
Support for/Restoration of Funding HCCBG *(7)*			x			x			x	x	x	x	x	
Support for Senior Center Funding (including Centers of Merit & Excellence) *(2)*			x							x				
Support Transportation Services Funding (including for Community Based Programs, & Adult Day) *(3)*		x						x		x				
Support for Adult Day Training *(1)*													x	
Increase Adult Day Funding *(3)*								x		x			x	
Expand Use of Medicaid Funds for Adult Day Services *(1)*									x					
Address Medicare Part D Impact on CAP/DA *(1)*		x												
Support/Expand CAP/DA *(3)*								x	x	x				
Implement Core Services Plan *(1)*									x					
Support SA In-Home *(4)*		x						x	x	x				
Remove/Address Institutional Bias *(2)*		x							x					
Funding Support for NC Senior Games *(1)*				x										
Fund Indoor Plumbing for All Older Adults *(1)*										x				
Support for Respite Care Programs (i.e. Project C.A.R.E.) *(1)*	x													
Support for Home & Community-Based Care Programs *(4)*					x		x		x		x			
FACILITIES ISSUES														
Concerns About Mixed Populations in LTC Facilities *(4)*						x			x	x				x
Support Pre-Admission Screening for LTC Facility Admission *(1)*									x					
Support Statewide Standard for Adult Home Specialists *(1)*									x					
Support for Rating System *(1)*									x					
Define Meaning and Operation of Special Care Units *(1)*									x					
WORKFORCE ISSUES														
Allow Community Colleges to Conduct Criminal Record Checks on Nurse Aides (HB 833) *(2)*		x												x
Increase Salaries and Benefits for Direct Care Workers *(3)*		x							x			x		
Support Workforce Quality Initiatives *(1)*									x					
Strengthen LTC Direct Care Workforce (adequate training, improve working conditions, staff – to resident ratios, etc) *(2)*									x	x				

	Alzheimer's Assn., Western	Assn. For Home & Hospice Care	NC Senior Tar Heel Legislature	NC Senior Games	Carolinas Center for Hospice and End of Life Care	Triangle Older Women's League	NC Assn. On Aging	NC Coalition on Aging	Friends of Residents in LTC	Governor's Advisory Council on Aging	AARP	NC Assn. Of Area Agencies on Aging	NC Adult Day Services	NC Health Care Facilities Assn
OTHER ISSUES														
Restore LTC Insurance Tax Credit *(6)*			x			x		x		x	x	x		
Increase Asset Limit for Medicaid Eligibility For Aged, Blind & Disabled *(2)*										x	x			
Preserve Medicaid Eligibility and Services for Vulnerable Adults *(1)*											x			
Increase Funds for Medicaid Reimbursement Rates *(1)*		x												
Increase Medicaid Personal Needs Allowance *(1)*														x
Telehealth - Support for DHHS Pilot *(1)*		x												
Support Grandparents Raising Minor Children *(1)*			x											
Continued Support/Promotion of Hospice Care *(1)*					x									
Support for Senior Friendly Communities *(1)*								x						
Support Safe Affordable Housing *(2)*								x			x			
Establish DHHS Office to Address Housing Needs of Vulnerable Citizens *(1)*									x					
Medicare Part D Impact on Low Income Beneficiaries *(2)*						x					x			
Increase Funding for Housing Trust Fund *(1)*											x			
Support Homestead Property Tax Exemption *(3)*								x		x	x			
Property Tax Relief for Low Income Older & Disabled Adults *(1)*											x			
Require Updated Disaster Plans for Special Needs Populations *(1)*									x					
Implement SB 10 – Focus on Quality of Care, Protection, and Strengthening Oversight of LTC Industry *(1)*										x				
Study Guardianship *(1)*										x				
Increase State Funding for Administrative Support for Area Agencies on Aging *(1)*												x		

State Funding for Services and Programs for Older Adults

North Carolina General Assembly

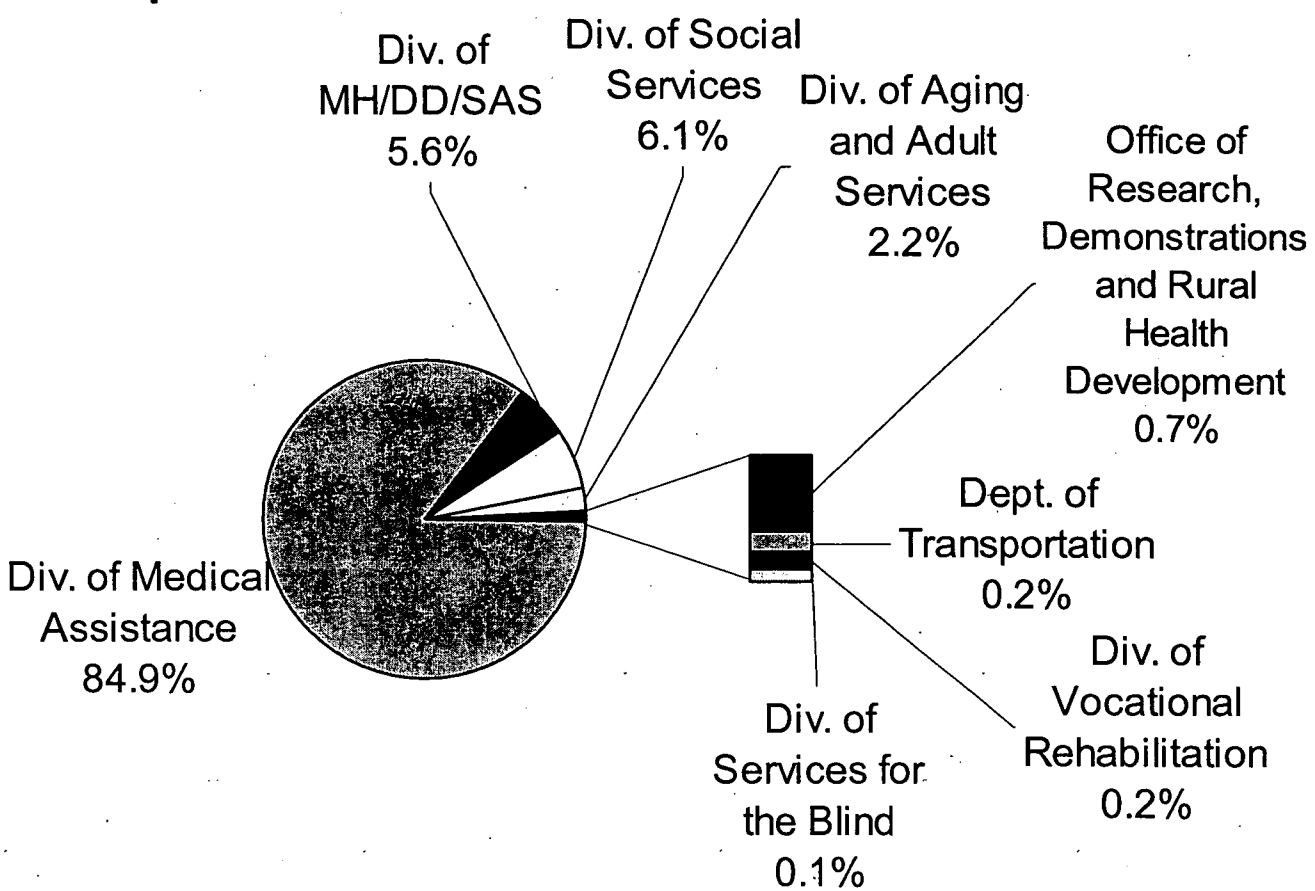
Fiscal Research Division

December 20, 2005

Current Funding

State of North Carolina

Reported Expenditures for Individuals Aged 60+ (SFY 03-04)

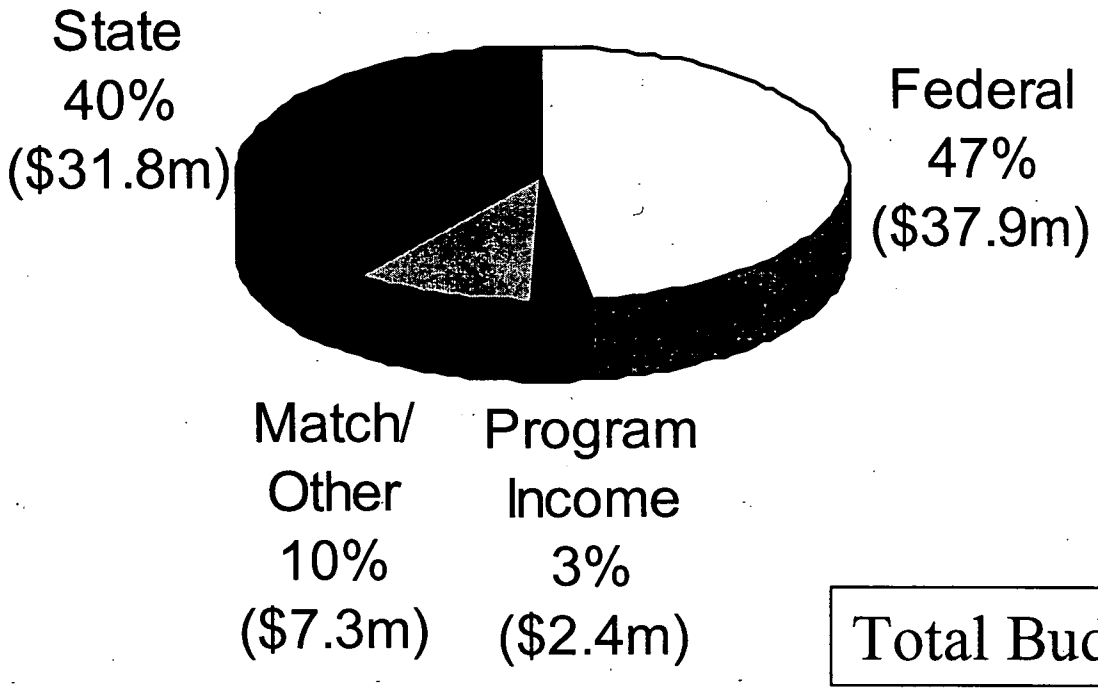


Total Expenditures: $2,725,993,864

Note: These are the expenditures only for the following 6 categories: adult care homes; economic support; hospitals, physicians, and other health care; home health and in-home care; institutional care; and social supportive services.

Division of Aging and Adult Services

Funding Sources SFY 04-05

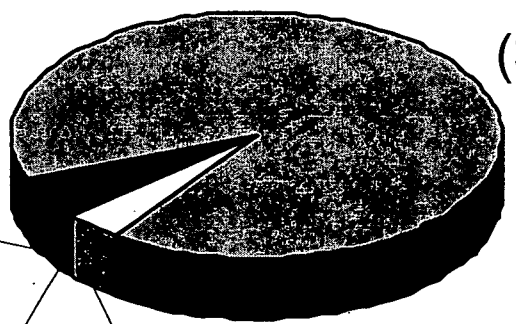


Total Budget: $79,908,350

Note: This does not include funding administered by the Division of Aging and Adult Services located in the Division of Social Services budget.

Division of Aging and Adult Services

Funds by Purpose SFY 04-05



Total Budget: $79,908,350

Home and Community Care Block Grant

Funding by Service

Service	04-05 Actual
In-Home Aide	17,465,933
Home Delivered Meals	10,680,965
Congregate Meals	9,187,516
General and Medical Transportation	6,129,398
Adult Day Care/Adult Day Health Care	3,179,672
Senior Center Operations	2,734,397
Information and Assistance	1,749,031
Care Management	894,316
Housing and Home Improvement	965,573
Group and Institutional Respite Care	313,054
Other Services	314,051
Total	**$53,613,906**

Total Unduplicated Clients Served in SFY 04-05	**59,849**

From 2005 Appropriations Act (S.L. 2005-276, SB 622)

Community Care of NC

- Community Care of NC is a statewide program in which local networks of primary-care providers coordinate prevention, treatment, referral, and other services for Medicaid recipients.
- Expanded to Medicaid recipients who are Aged, Blind, and Disabled.
  - Budget included $22m in savings and $3m in appropriations in SFY05-06 from this expansion ($32m in savings and $6m in appropriations in SFY06-07).

Senior Games

- Received an additional, non-recurring $100,000.
- $175,000 in recurring budget.

State-County Special Assistance

- Rate increased from $1,084 to $1,118.
- $2.7m in SFY05-06 and $3.1m in SFY06-07 in state funds appropriated for the increase.
- If the Department lowers the SA rate in accordance with Section 10.38(e), new language authorizes the Department (upon CMS approval) to disregard a limited amount of income for individuals whose countable income exceeds the adjusted SA rate.

Special Assistance for Residents of Special Care Units

- Special Assistance rate for residents in Alzheimer/Dementia Special Care Units (SCUs) established at $1,515 .
  - $285,632 appropriated in SFY 05-06 and $380,843 in SFY 06-07.
- Appropriation also made to increase the number of hours of Adult Care Home – Personal Care Services for SCUs.
  - Scheduled to begin October 1, 2006.
  - $1,744,186 in SFY 06-07.

Special Assistance In-Home

- Increased from 800 slots to 1,000 slots.
- Increased maximum payment to 75% of what recipient would have received in adult care home (from 50%).

Adult Care Homes

- Funded a total of 31 additional positions for annual inspections of adult care homes in the Adult Care Licensure Section of the Division of Facility Services (DFS).
- Also funded additional positions in the Construction Section of DFS for life-safety inspections of adult care homes (and other residential facilities) every two years.

Adult Care Homes

- Section 10.40A(p) requires the Division of Aging and Adult Services to develop a Quality Improvement Consultation Program for Adult care Homes.
  - The Department transferred one of the 31 new positions for the Adult Care Licensure Section of DFS to the Division of Aging and Adult Services for this program.
- Section 10.41 requires DHHS to develop a plan to implement a star-rating system for adult care homes to improve quality of care.

Home Care Agencies

- Funded 5 additional positions in the Licensure and Certification Section of DFS for inspections of home care agencies every 36 months.
- Section 10.40A implements a number of changes for home care agencies in licensure, hiring, training, and patients' rights.

Questions?

Contact Information:

Andrea Russo

andrear@ncleg.net

733-4910

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Staff contact:
Harold Berdiansky

North Carolina Division of Aging and Adult Services

Expenditures by County, Agency and Service for SFY 2003-2004

Alamance	Alexander	Alleghany	Ashe	Anson	Avery	Beaufort	Bertie	Bladen
Brunswick	Buncombe	Burke	Cabarrus	Caldwell	Camden	Carteret	Caswell	Catawba
Chatham	Cherokee	Chowan	Clay	Cleveland	Columbus	Craven	Cumberland	Currituck
Dare	Davidson	Davie	Duplin	Durham	Edgecombe	Forsyth	Franklin	Gaston
Gates	Graham	Granville	Greene	Guilford	Halifax	Harnett	Haywood	Henderson
Hertford	Hoke	Hyde	Iredell	Jackson	Johnston	Jones	Lee	Lenoir
Lincoln	Macon	Madison	Martin	McDowell	Mecklenburg	Mitchell	Montgomery	Moore
Nash	New Hanover	Northampton	Onslow	Orange	Pamlico	Pasquotank	Pender	Perquimans
Person	Pitt	Polk	Randolph	Richmond	Robeson	Rockingham	Rowan	Rutherford
Sampson	Scotland	Stanly	Stokes	Surry	Swain	Transylvania	Tyrrell	Union
Vance	Wake	Warren	Washington	Watauga	Wayne	Wilkes	Wilson	Yadkin
Yancey								
	All Counties		**State Totals by Agency**				**Title III-B Report**	

Last updated March 7, 2005

Table IIIB
SFY 03-04

Schedule of Reported Expenditures By Agency and Major Service Category

Funding Source	1. Adult Care Homes	2. Economic Support	3. Hospitals, Physicians & & Other Health Care	4. Home Health & In-Home Care	5. Institutional Care	6. Social Supportive Services	Totals	Per Cent
Division of Aging and Adult Services			1,697,245	31,946,330		26,998,489	60,642,064	2.22%
Division of Medical Assistance	87,539,718	170,455,277	724,061,051	383,102,157	949,713,640		2,314,871,844	84.92%
Division of Mental Health/Developmental Disabilities/Substance Abuse Services			10,097,322		143,627,702		153,725,024	5.64%
Division of Services for the Blind	26,053		1,865,451	509,262		206,369	2,607,135	0.10%
Division of Social Services	84,083,671	52,733,509		7,756,526		20,376,589	164,905,296	6.05%
Division of Vocational Rehabilitation			2,466,288			1,666,003	4,132,291	0.15%
Office of Research, Demonstrations and Rural Health Development			19,749,102				19,749,102	0.72%
Transportation Department of						5,316,108	5,316,108	0.20%
Totals	171,649,442	223,188,786	759,936,458	423,314,275	1,093,341,342	54,563,558	2,725,993,864	100.00%
Percent	6.30%	8.19%	27.88%	15.53%	40.11%	2.00%	100.00%	

Table III A Expenditures by Funding Source and Service for Clients 60+ Years of Age: SFY 2003-2004

Funding Source: Department of Transportation

	Category	*Clients*	*Expenditures*
Elderly and Disabled Transportation Assistance Program	6		$5,316,108
		Total	*$5,316,108*

Funding Source: Division of Aging and Adult Services

	Category	*Clients*	*Expenditures*
Adult Day Care	4	615	$1,501,055
Adult Day Health	4	554	$1,359,542
Care Management	6	260	$899,951
Congregate Nutrition	6	27883	$10,127,650
Family Caregiver Support-Access	6	1338	$505,793
Family Caregiver Support-Counseling/Support groups/Training	6	1048	$212,258
Family Caregiver Support-Information	6		$1,235,576
Family Caregiver Support-Respite Care	6	1442	$1,249,488
Family Caregiver Support-Supplemental Services	6	499	$112,880
Group Respite	6	75	$62,923
Health Promotion/Disease Prevention	3		$683,341
Health Screening	3		$20,683
Home Delivered Meals	4	20487	$11,098,857
Home Health	4	35	$27,149
Housing & Home Improvement	6	1036	$830,268
In Home Aide Level 1	4	3721	$5,281,423
In Home Aide Level 2	4	3854	$9,526,891
In Home Aide Level 3	4	1015	$3,023,957
In Home Aide Level 4	4	13	$14,985
Information & Assistance	6		$1,663,023
Institutional Respite	6	95	$235,623
Legal	6		$426,089
Senior Center	6		$3,951,733
Senior Companion	4	54	$112,471
Transportation, General	6	10748	$5,304,510
Transportation, Medical	3	3493	$993,221
Volunteer Program Development	6		$180,724
		Total	*$60,642,064*

Table III A Expenditures by Funding Source and Service for Clients 60+ Years of Age: SFY 2003-2004

Funding Source: Division of Medical Assistance

	Category	*Clients*	*Expenditures*
ACH-PCS Basic/Enhanced	1	18152	$84,700,530
ACH-Transportation	1	17871	$2,839,188
CAP/AIDS	4	7	$75,727
CAP/DA	4	9354	$156,976,809
CAP/MR	4	216	$10,283,631
Clinics	3	35998	$20,939,138
Dental	3	40036	$12,303,111
Health Check/EPSDT	3	1722	$10,382
HMO	2	102	$293,643
Home Health	4	54826	$45,093,421
Hospice	4	2911	$21,919,519
ICF-MRC	5	446	$43,559,985
Inpatient Hospitals	5	25838	$79,227,494
Inpatient Mental Hospital	5	254	$7,178,981
LAB&XRAY/Physicians	3	170928	$79,566,283
Medicare Part A&B Premiums	2	190320	$170,161,635
Nursing Homes	5	39431	$819,747,180
Other Care	3	45634	$6,566,065
Other Practitioners	3	54043	$2,623,141
Outpatient Hospitals	3	90615	$58,036,746
Prescribed Drugs	3	167380	$544,016,185
Regular Personal Care (PCS)	4	26863	$148,753,050
		Total	*$2,314,871,844*

Funding Source: Division of Mental Health/Developmental Disabilites/Substance Abuse Services

	Category	*Clients*	*Expenditures*
Alcohol Rehabilitation Centers	5	31	$212,840
Developmental Disabilities	3	833	$5,370,153
Mental Health	3	17281	$3,774,159
Mental Retardation Centers	5	604	$49,101,534
Psychiatric Hospitals	5	1310	$94,313,328
Substance Abuse	3	2469	$953,010
		Total	*$153,725,024*

Table III A Expenditures by Funding Source and Service for Clients 60+ Years of Age: SFY 2003-2004

Funding Source: Division of Services for the Blind

	Category	Clients	Expenditures
Adjustment Services for the Blind and Visually Impaired	6		$206,369
Health Support	3	72	
Independent Living Rehabilitation Program	3	1033	$711,313
Individual and Family Adjustment	6	884	
In-Home Services Level I (Home Management)	4		$509,262
Medical Eye Care Program	3	496	$487,131
Rehabilitation Program	3	499	$667,007
Special Assistance for the Blind	1	51	$26,053
		Total	*$2,607,135*

Funding Source: Division of Social Services

	Category	Clients	Expenditures
Adult Care Home Case Management/Screening	1	5095	$1,398,957
Adult Day Care	4	729	$1,618,273
Adult Day Health	4	312	$904,602
Adult Placement	6	756	$2,743,639
Adult Protective Services	6	5566	$2,827,346
At-Risk Case Management	6	2142	$1,150,603
Energy Assistance	2	47117	$3,533,361
Food Stamps	2	78650	$49,200,148
Guardianship	6	1844	$1,686,507
Housing & Home Improvement	6	141	$8,621
In-Home Aide	4	5726	$5,132,304
Other	6	10126	$10,798,601
Preparation & Delivery of Meals	4	1084	$101,347
Special Assistance	1	18635	$82,684,715
Transportation	6	6358	$1,161,272
		Total	*$164,950,296*

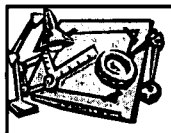
Funding Source: Division of Vocational Rehabilitation

	Category	Clients	Expenditures
Independent Living Skills	3	1364	$2,466,288
Vocational Rehabilitation	6	1567	$1,666,003
		Total	*$4,132,291*

Funding Source: Office of Research, Demonstrations and Rural Health Development

	Category	Clients	Expenditures
Senior Care (Prescription Drug Assistance Demonstrations)	3	32773	$19,749,102
		Total	*$19,749,102*

Grand Total $ 2,725,993,864



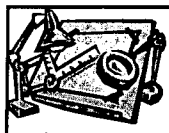
Evaluation of the DHHS Communications and Coordination Initiative to Strengthen Long-Term Care

A Report to the Study Commission on Aging

December 20, 2005

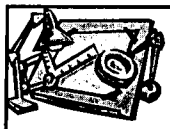
Steve Freedman, Service Operations Section Chief
Division of Aging and Adult Services

Mary Anne Salmon, Research Associate Professor
Jordan Institute for Families, UNC Chapel Hill School of Social



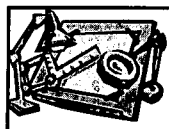
Origin of the Initiative

- **Session Law 2003-397, Section 10.8F** called upon the Department of Health and Human Services to
  - implement a communications and coordination initiative
  - seek voluntary participation
  - pilot the establishment of local lead agencies to
    - support local coordination of long-term care
    - aid in the development of core services
    - coordinate local services
    - Improve access to services



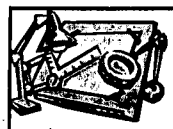
Inspiration for the Initiative

- NC Institute of Medicine
  A Long Term Care Plan for North Carolina: Final Report (January 2001)
  Recommendation 11
  Recommendation 16



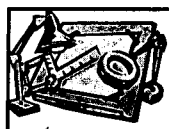
Resources to Support the Initiative

- Core Service Evaluation Tools
  Self-assessment process for 22 services
- *Planning Basics Notebook: A Guide for Developing Community Long-Term Care Options*
  - Notebook with readable text and references
  - Print and on-line versions available
- Training and Technical Assistance



Recruiting Participants

- Request for Proposals (RFPs)
  - Released June 4, 2004—Due July 23, 2004
  - Required endorsement letter from County Commissioners and list of commitments
  - **No funding attached**
- Lead Agencies selected by LTC Cabinet
  - Mecklenburg County DSS
  - New Hanover Department of Aging



Process Evaluation

- Outputs Produced by Both Sites
  - Written plan
  - Beginning of implementation
- Evaluation focused on Process
  - Strategies
  - Barriers
  - Lessons learned
- Source of data
  - Written surveys of key informants
  - Follow-up telephone interviews

Sites Differed in Scope and Timing

- Mecklenburg site built on work in progress
  - Year of community-wide planning and report prior to RFP
  - Community planning infrastructure in place
  - City/County commitment to large-scale *senior-friendly* initiative
- New Hanover site built on history/relationships
  - Began work at the time of selection
  - County endorsement but no resources
  - Focus on small-scale "achievable" change in *services and service coordination*

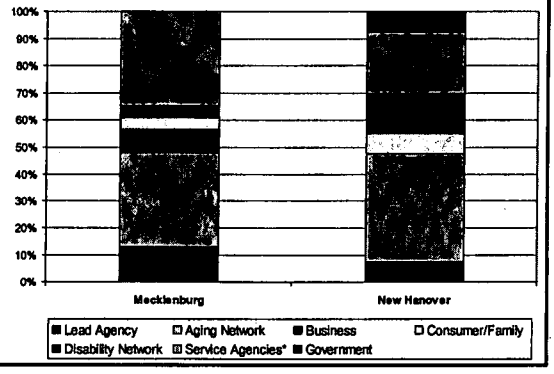
Planning Structure

- Mecklenburg site hierarchical
  - Executive advisory board—community clout
  - Executive committee—coordinated initiative
  - Steering committee—primary work of initiative
    - Subcommittee chairs on steering committee
- New Hanover site flat
  - Large team
    - Subcommittees made up of members
  - Decision making by consensus

Lesson Learned: 1

- Despite differences, each took 1 year to
  - educate themselves about current services
  - identify service gaps
  - assess service adequacy, accessibility, efficiency, equity, and quality.
- Each culminated 1 year with an event for consumers & larger community.

Composition of Initiative Teams, by Site



Bringing Aging and Disability Community Together

- Mecklenburg put disability work on hold
- New Hanover reached advocates but no success with younger consumers
  - older adults and younger adults with disabilities had many of the same issues—especially transportation and housing
  - both groups did not want services together
    - Did not want to be housed near each other (independent units or facilities)

Lesson Learned: 2

- Both groups were dominated by service professionals and professional advocates.
- Limited success in recruiting older adult consumers (except to attend community event)
- No direct input from younger consumers with disabilities (NH had some from their advocates)
- There are formidable challenges in bringing aging and disabled consumers to the same table

Mission: Differences and Similarities

- Mecklenburg
  - Engage the community
  - Create a dynamic plan
  - Enhance quality of life for older adults
    - Cites dignity and independence
  - Focus resources on needs of older adults
- New Hanover
  - Partner with consumers, families, providers and community
  - Create a responsible plan
  - Enhance independence, choice, and dignity for older and disabled adults

Working Groups

- **Mecklenburg**
  - Transportation
  - Facilities and Institutions
  - Food and Nutrition
  - In-Home Support Services
  - Leisure, Recreation, and Socialization
- **New Hanover**
  - Transportation
  - Housing
  - Home Health
  - In-Home Aide
  - Mental Health

Core Service Evaluation Tools Used

- **Mecklenburg**
  - Adult Day Services
  - Care Management
  - Home Health
  - Information and Assistance
  - In-Home Aide
  - Respite Care
  - Social, Recreational, and Leisure Services
- **New Hanover**
  - Home Health
  - Housing
  - In-Home Aide
  - Mental
  - Health
  - Transportation

How Were the Tools Used?

- Both sites used all 6 dimensions
  - Existence
  - Adequacy
  - Accessibility
  - Efficiency
  - Equity,
  - Effectiveness/Quality

How Were the Tools Used? (continued)

- **Mecklenburg**
  - Used most questions
  - Some workgroups scored individual items
  - Scored dimensions by consensus, not additions
- **New Hanover**
  - Used all questions
  - Scored individual items
  - Scored dimensions by consensus, not additions

Data Use

- **Mecklenburg**
  - Sought "most important"
  - Found some (not most)
  - Used some DAAS data
  - Survey of providers
  - Consumer event "listening session"
  - Felt they had adequate data
- **New Hanover**
  - Consumer perceptions
  - 4 of 5 used provider perceptions
  - 4 of 5 providers shared in-house data
  - 2 found "most," 3 found "some"
  - 1 used DAAS data
  - Survey of providers
  - Not enough data on housing and transportation

Communications with State Team (LTC Cabinet)

- Both sites reported appropriate amount of contact and assistance—especially DAAS
- New Hanover found materials supplied by DAAS more helpful
  - Timing appropriate because New Hanover began in project year
  - Mecklenburg spokesman praised materials—especially planning notebook

Threats to Sustainability

- Mecklenburg
  - Absence of money
  - Limited ability to engage business community
  - Absence of formal entity to continue work (proposed forming such an entity)
- New Hanover

  "People's time—their being able to get away from their other duties. I'm already beginning to see that. There are so many meetings that people have to go to. Even though our meetings are at a set time, people have conflicts that they can't get out of, so I think keeping the group together will be the biggest challenge." —New Hanover Spokesperson

Lessons Learned: 3

- Heavy demands on resources of lead agency
- In New Hanover lead agency and AAA carried a particularly heavy proportion of work load
- Lack of resources seen by both groups as the greatest challenge to sustainability

Vision of the Future

- Both groups felt that initiative had helped them make progress on some, but not all, of LTC-planning goals in IOM report
- Both groups are working to implement their plans
- Both groups seek creation of a new entity to continue work of the initiative

Contact Information

- Steve Freedman, Service Operations Section Chief
  Division of Aging and Adult Services
  - 2101 Mail Service Center
    Raleigh, NC 27699-2101
  - 919-733-0440, ext 235
  - steve.freedman@ncmail.net
- Mary Anne Salmon, Research Associate Professor
  CARES, Jordon Institute for Families
  UNC Chapel Hill School of Social Work
  - 301 Pittsboro Street, CB 3550
    Chapel Hill, NC 27599-3550
  - 919-962-4362
  - masalmon@email.unc.edu

Final Report to
The Legislative Study Commission on Aging

Evaluation of the DHHS Communications and Coordination Initiative
(S.L. 2003-397 Section 10.8F)

NC Division of Aging and Adult Services
NC Department of Health and Human Services

November 1, 2005

Executive Summary

Session Law 2003-397, Section 10.8F: Session Law 2003-397, 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 [to] 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 was directed to submit an interim report on the pilot project by October, 2004 and the final report by October 2005. The interim report was submitted to the 2003 Legislative Study Commission on Aging on October 1, 2004 and was presented at the December 1, 2004 meeting of the Legislative Study Commission.

The Communications and Coordination Initiative: In response to this legislative mandate, recommendations by the North Carolina Institute of Medicine's Task Force on Long-Term Care, 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.

The Initiative was designed to assist two *volunteer* pilot communities (no funding was available for participation in the Initiative) in evaluating their LTC services and in identifying and implementing strategies to strengthen LTC services for older and disabled adults. It was also anticipated that the Initiative would promote coordination between the state and local levels.

The LTC Cabinet chose New Hanover (lead agent: New Hanover Department on Aging) and Mecklenburg Counties (lead agent: Mecklenburg County Department of Social Services) to participate, based on their capacity and willingness to undertake such a project (for contact information, please see Appendix A). The Division of Aging and Adult Services and the State Team developed Core Service Evaluation Tools to assist the sites in evaluating their LTC services and developing action steps for change. In addition, the Division produced a *Planning Basics Notebook* to guide counties in developing planning processes.

Evaluation of the Initiative: It is the purpose of this document is to describe, contrast, and compare how the two pilot communities organized and conducted the planning process to help inform other counties and State about the merits and necessary resources for such an effort. It draws information primarily from a structured process documentation tool completed by one spokesman from each site in October 2004, a follow-up telephone interview in November 2004, and the planning documents produced by the two county project teams.

Despite considerable differences in scope, structure, and process, both counties found that it took about a year for a cross-agency team of professionals with no funding to educate themselves and each other about the services already available in the community. Identification of service gaps as

well as issues of adequacy, accessibility, efficiency, equity, and quality was also included in this education.

Workgroups: Both groups developed mission and vision statements, reflecting "independence" and "dignity" for older adults. The Mecklenburg site attempted to cover nearly every area of life for older adults (or at least life affected by public and not-for-profit services) in broad categories. Its workgroups consisted of:

- Transportation;
- Facilities and Institutions (including licensed nursing homes, assisted living residences, and continuing care retirement communities);
- Food and Nutrition (including home-delivered meals and congregate meals);
- In-Home Support Services (including in-home aide services, home health services, caregiver respite and support/training, information and referral, medical alert systems, home improvement and modification, and case management); and
- Leisure, Education, Recreation, and Socialization.

The New Hanover site, by contrast, organized their work groups around specific services which they believed were less than optimum in some way:

- Transportation;
- In-home aide services;
- Home health;
- Housing; and
- Mental Health Services.

Resources: Mecklenburg's lead agency, the Department of Social Services, estimated that it spent more than 50 hours a month on leadership for the Initiative, or 600 hours during the year. Its estimated leadership costs for the 600 hours during the pilot year were $30,000– ***this estimate solely includes leadership time at the Department of Social Services and does not include support staff time, the time of the Area Agency on Aging, the time of the Steering Team members, the time of the workgroup members, printing costs, meeting costs, travel costs, etc.*** The Centralina Council of Governments' Area Agency on Aging estimates that it spent 30 hours per month, or 360 hours per year, providing support and technical assistance to the Initiative. All of the other agencies involved in the Initiative in Mecklenburg combined contributed another 346 hours per month (for a conservative total of over 4,152 hours per year). Mecklenburg County was also fortunate to be able to hire a consultant, the Lee Institute, at $25,000 for the full pilot year to expedite the process. The total estimate in community time spent working directly on the Mecklenburg Initiative is 5,112 hours (not including the consultant's time).

New Hanover's lead agency, the New Hanover Department of Aging, *conservatively* estimated that it spent 46.5 hours a month, or 558 hours per year, on the Initiative. There were several responsibilities of the lead agent that New Hanover Department of Aging said were, "difficult to estimate." The Initiative leadership costs of the New Hanover Department of Aging is estimated to be close to $11,200 per year – ***again, solely estimating the staff time of the Department of Aging and not including support staff time, the time of the Area Agency on Aging, the time of the Steering Team members, the time of the workgroup members, printing costs, meeting costs, travel***

costs, etc. It also estimates that the Cape Fear Council of Governments' Area Agency on Aging spent 22 hours a month (or 264 hours per year), and all other agencies combined spent 67.5 hours a month for a total of 810 hours per year (consistent with the flatter structure of the New Hanover Initiative and the more modest goals in their first year). The total estimate in community time spent working directly on the New Hanover Initiative is 1,632 hours.

The Mecklenburg and New Hanover sites were in different phases of planning – Mecklenburg County had started its planning efforts a year prior to the beginning of the pilot project – likely accounting for some of the difference in the time commitment of "other organizations."

Priorities and Recommendations from the Pilot Sites: Each pilot site produced and presented to their communities a written plan that described their LTC system, evaluated selected service areas using the State-produced Core Service Evaluation Tools, highlighted the most crucial issues identified by the committees, and made recommendations for action.

Leading areas of concern about services and correlating recommendations cited by the **Mecklenburg site** are:

(1) Concern: Fragmentation among services provided to older adults due to a lack of a centralized structure within the county to organize ongoing research, coordinate planning, and ensure accountability.

Recommendation: Establish a multi-functional organization that will serve as a "focal point" for the aging network's strategic planning, information and assistance, care/case management, education and communication, and advocacy.

(2) Concern: Lack of knowledge regarding available services within the older adult and caregiver populations.

Recommendations: Establish a new multi-functional organization that will serve as a "focal point" for the aging network's strategic planning, information and assistance, care/case management, education and communication, and advocacy; and

Develop systematic, integrated approaches for educating and communicating with key stakeholders about the implications of aging and the availability of resources.

(3) Concern: Restrictions on the number of LTC options available to older adults due to income eligibility requirements, inflexible programs, waiting lists, and critical workforce shortages.

Recommendation: Redistribute resources for the LTC system by promoting the availability of home care as an alternative to nursing home care and by eliminating multiple gaps in the system for middle-income older adults who do not meet income eligibility requirements and who cannot afford LTC services.

(4) Concern: The need for sustained support for caregivers.

Recommendation: Magnify the role of the informal and family caregiver in the community through a public education campaign, to promote self-identification of caregivers, and to develop educational opportunities for caregivers.

(5) Concern: Current services for older adults are limited in scope and do not provide options to meet the current and projected interests, skills, and needs of an increasingly diverse population.

Recommendation: Multiply options for older adults across service areas by enhancing existing services and developing new approaches, including expanding transportation options, promoting the use of nontraditional senior nutrition sites such as YMCAs and business cafeterias, integrating multi-cultural elements across areas, and promoting intergenerational experiences.

(6) Concern: Fear of crime within the older adult population.

Recommendation: Launch a crime prevention and education campaign in high-crime areas with a focus on older adults, including engaging the Police Department in planning and providing training to First Responders on recognizing abuse, neglect, and exploitation.

(7) Concern: Limited access to vital services for older adults who do not drive or who have special needs.

Recommendation: Transform the transportation system to create an expanded and coordinated range of senior-friendly travel options.

The full report can be viewed at:

http://www.charmeck.org/Departments/DSS/Services+for+Seniors+and+the+Disabled/statusofseniors.htm.

Leading areas of concern and associated recommendations cited by the **New Hanover site** include:

(1) Concern: A lack of knowledge of the services available for older adults and adults with disabilities within the community.

Recommendations:

- Conduct an annual Community Forum at the Senior Center;
- Conduct area speaking engagements to civic, church groups, and other community events four times a year; and
- Provide ongoing information on services for older adults to the county, city, and university media.

(2) Concern: Accessibility of fixed route and para-transit transportation services throughout the county for older adults and adults with disabilities.

Recommendations:

- Survey older adults and adults with disabilities within housing communities outside of city limits to determine current levels of services and the need for new and/or expanded services;
- Continue agency dialogue with WAVE transit (combined Wilmington city- and New Hanover County transportation system) to provide more cost-effective, efficient trips for older adults and adults with disabilities; and
- Educate and advocate for change to the WAVE Transit Advisory Board on the needs of older adults and adults with disabilities.

(3) Concern: A general lack of education regarding "livable communities" and universal design among housing developers, architects, and builders.

Recommendation:

- Meet with and educate developers, county and city planners, architects, and builders on the need for accessible environments.

It is anticipated that the New Hanover Initiative will work to implement all of the above recommendations in the next year.

The Future of the Pilot Projects: When asked about barriers to sustainability, Mecklenburg's spokesperson identified the absence of funding, their limited ability to engage the business community, and the absence of a formal entity to organize and continue the work. New Hanover's spokesperson noted that time is the most serious barrier for their participants.

The Mecklenburg site is now looking forward to implementing its recommendations and seeing actual outcomes of their planning – seeing things change for the older adults in the county. They will also be working on two new planning areas: adults with disabilities and the physical environment. The New Hanover site is also excited about moving from planning to action, especially in increasing community awareness and beginning to work with transportation staff to address issues identified by both older adults and younger adults with disabilities. The site is also continuing its efforts to recruit consumers onto the committee.

Both sites expect to continue their collaborative planning processes indefinitely into the future.

Findings: As a result of the experiences in Mecklenburg and New Hanover counties, NC DAAS has concluded that:

1. **The *NC DHHS Communications and Coordination Initiative* can assist willing counties in fulfilling recommendation 16 of the NC Institute of Medicine's *A Long Term Care Plan for North Carolina: Final Report* (January 2001), which was endorsed by the NC DHHS Long-Term Care Cabinet.** Through participation in the *Communications and Coordination Initiative*, both the Mecklenburg and New Hanover sites fulfilled four of the six objectives outlined in recommendation 16 (1) reviewing and analyzing service utilization data through county data packages; 2) identifying barriers to a comprehensive system of care and services; 3) determining the need for additional LTC services; and 4) communicating findings to local, state, and federal policymakers). At this time, the other two recommendations – 1) tracking the flow of consumers from referral to disposition through core service agencies and 2) designing the uniform portal of entry – is beyond the scope of the pilot project although some information to guide future work in these areas was garnered.
2. **Successful local LTC planning and implementation efforts require a significant allocation of time and resources.** In order to be successful, local LTC planning processes, and resulting implementation activities, require strong support from all areas of the community – the lead agent, all pertinent stakeholders including service providers and consumers, the Board of County Commissioners, the media, and agencies such as the Area Agencies on Aging that are capable of providing technical assistance on planning structures and methods, data collection and analysis, service-specific information, etc. The lead agent in Mecklenburg County, the Mecklenburg County Department of Social Services, estimated that it spent 50 hours a month solely on leadership activities, estimated by the lead agent at $2,500 per month in leadership costs. This results in 600 hours a year, valued at $30,000 per year in lead agent leadership time. **This cost estimate *solely includes leadership time at the Department of Social Services and does not include support staff time, the time of the Area Agency on Aging, the time of the***

Steering Team members, the time of the workgroup members, printing costs, meeting costs, travel costs, etc. The Centralina Council of Governments' Area Agency on Aging contributed another 30 hours, on average, per month, or 360 hours per year. Other stakeholders in Mecklenburg (including the Executive Committee, the Steering Committee, and work group members) contributed an estimated 346 hours per month, or 4,152 hours per year. Mecklenburg County had over 150 community stakeholders participating in their workgroups while New Hanover had an estimated 30, thus accounting for the large difference in time from "other stakeholders."

In New Hanover County, the Department of Aging (the lead agent), ***conservatively estimated*** that it spent 46.5 hours per month (or 558 hour per year) on lead agent activities, valued at close to $930 in staff time per month (or close to $11,200 per year). In addition, it estimates that the Cape Fear Area Agency on Aging spent 22 hours per month providing technical assistance and support. All other stakeholders (committee members) in New Hanover contributed 67.5 hours per month or 810 hours per year.

In summary, it would require a significant amount of local commitment and support to replicate the *Communications and Coordination Initiative* across the state. In addition, a large amount of state staff time would be required to educate counties on planning methods and the use of the Core Service Evaluation Tools, provide written resources to participating counties, distill and provide county-specific data, and travel to counties to provide hands-on technical assistance.

3. **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. As shown by the experience in Mecklenburg and New Hanover counties, conducting successful local efforts requires significant amounts of time and resources. 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.

4. **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, Home and Community Care Block Grant, and DSS planning bodies). Because many state agencies require local advisory/planning committees, these state agencies should explore how a multipurpose LTC planning process can serve as the required advisory/planning vehicle for various specific programs. In addition, flexibility and innovation at the state level is necessary to tackle any "roadblocks" in state policy that impose restrictions on planning at the local level.

Final Report to
The NC Legislative Study Commission on Aging
on the *DHHS Communications and Coordination Initiative*

At the recommendation of the 2001 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 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 2003-397, Section 10.8F

Session Law 2003-397, Section 10.8 F, called upon 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. 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 was directed to submit an interim report on the pilot project by October, 2004 and the final report by October 2005. The interim report was submitted to the 2003 Legislative Study Commission on Aging on October 1, 2004 and was presented at the December 1, 2004 meeting of the Legislative Study Commission.

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,
- 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 was designed to assist two *volunteer* pilot communities (no funding was available for participation in the Initiative) in evaluating their LTC services and in identifying and implementing strategies to strengthen LTC services for older and disabled adults. It was also anticipated that the Initiative would promote coordination between the state and local levels.

Pilot Site Selection

On June 4, 2003, Lynda McDaniel, former Assistant Secretary for LTC and Family Services, released a Request for Proposals (RFP) 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 a proposal:

- 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.

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:

- ***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 (see below).
- ***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 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.
- ***The DHHS Communications and Coordination Initiative Webpage:*** The Division of Aging and Adult Services created a webpage off 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 two resources listed above (the Core LTC Service Evaluation Tools and a link to the 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

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.

Process Evaluation

The Communications and Coordination Initiative to Strengthen Long-Term Care Services had a specified output—a document reflecting community planning for meeting the long-term care needs of older adults and adults with disabilities. Although they differed in focus, scope, and detail, both counties produced such documents (Mecklenburg's document can be found at http://www.charmeck.org/Departments/DSS/Services+for+Seniors+and+the+Disabled/statusofseniors.htm. New Hanover's document is not on-line, but can be obtained by calling Annette Crumpton, Director of the New Hanover Department of Aging, at (910) 452-6400).

The ultimate test of success will come when these plans are implemented in the community. That is the point at which community outcomes can be measured. However, that is outside the scope of the Communications and Coordination Initiative to Strengthen Long-Term Care Services as currently defined.

The purpose of this document is to describe, contrast, and compare how the two pilot communities organized and conducted the planning process. It draws information primarily from a structured process documentation tool completed by one spokesman from each site in October 2004, a follow-up telephone interview in November 2004, and the planning documents produced by the two county project teams.

Project Overview

Timing

Mecklenburg County applied for participation in this project after a year of working as a community on identifying the needs of older adults and producing a report to be shared with their community. This advanced work allowed them to progress further in the strategic planning process in 2003–2004 than would have otherwise been possible. An unfortunate byproduct of this early work was that the community collaborative felt unable to incorporate the needs of younger adults with disabilities into their first year of work under the initiative. Instead, they planned to phase in a new subcommittee on the issues of people with disabilities in their second year of the initiative (their third year of working together).

The aging network in New Hanover County had a history of effective collaboration among public, not-for-profit and for-profit entities serving older adults—including, but not limited to, the Raise Older Adults Rights (ROAR) project. However, unlike Mecklenburg County, they did not begin work on the NC DHHS Communications and Coordination Initiative until the Long Term Care Cabinet selected their proposal and they met with staff members from the Division of Aging and Adult Services for orientation. Starting work under initiative guidelines, they worked to include the disability community from the beginning.

Although it is not possible to generalize from only two examples, it is interesting to note that the New Hanover initiative (Building a Responsive Community or BARC) reached approximately the same place in their first year of work that the Mecklenburg initiative (Mecklenburg County Status of Seniors Strategic Planning Initiative) had reached in their pre-initiative year. Despite considerable differences in scope, structure, and process, both counties found that it took approximately a year for a cross-agency team of professionals with no funding for salary buy-out or hiring support staff to educate themselves and each other about the services already available in the community and to identify service gaps as well as issues of adequacy and accessibility. It is illustrative of this timeframe that the Mecklenburg initiative began its first year of the NC DHHS Communications and Coordination Initiative with a large community event (November 2003), while the New Hanover initiative ended their first year with one (September 2004).

Structure

There were both similarities and distinctive differences in structure between the first two pilot site initiatives. Differences may stem from differences in the community, organizational culture of the lead agencies, and the timing issue discussed above.

The Mecklenburg site team was very structured in its approach. Work in the pre-initiative year culminated in the production of the Status of Seniors Report. Members of the DSS staff were responsible for the actual writing and production of the report, but the content areas of the document were selected and the work guided by a team including representatives of United Way of Central Carolinas; the Centralina Council of Governments Area Agency on Aging; the Mecklenburg Department of Social Services; the Charlotte-Mecklenburg Council on Aging, and the Charlotte-Mecklenburg Aging Coalition, which originally grew out of the Mecklenburg Home and Community Block Grant (HCCBG) planning committee and is open to anyone in the community. Following the delivery of the Status of Seniors report, the group began recruiting a strategic planning committee that was renamed the steering committee. At the same time the group recruited a chair and co-chair for an executive advisory board. These two appointed leaders recruited additional members from among people with clout in the community. Their purpose was to "give visibility and voice to the project" using their positions as community leaders, while the steering committee, a large body with broad representation, would do the actual planning, based on the work of the issue subcommittees. The steering committee also chose an executive committee consisting of leaders from the Status of Seniors work group (director and special projects coordinator of the Services for Adults Division of Mecklenburg DSS; chair of the Older Adult Wellness Program, United Way of Central Carolinas; and aging program administrator, Centralina Council of Governments) to coordinate and facilitate the work of the larger group. Work groups were chaired by steering committee members and included people who volunteered at the community event in November, but they were encouraged to recruit additional members from the community as needed.

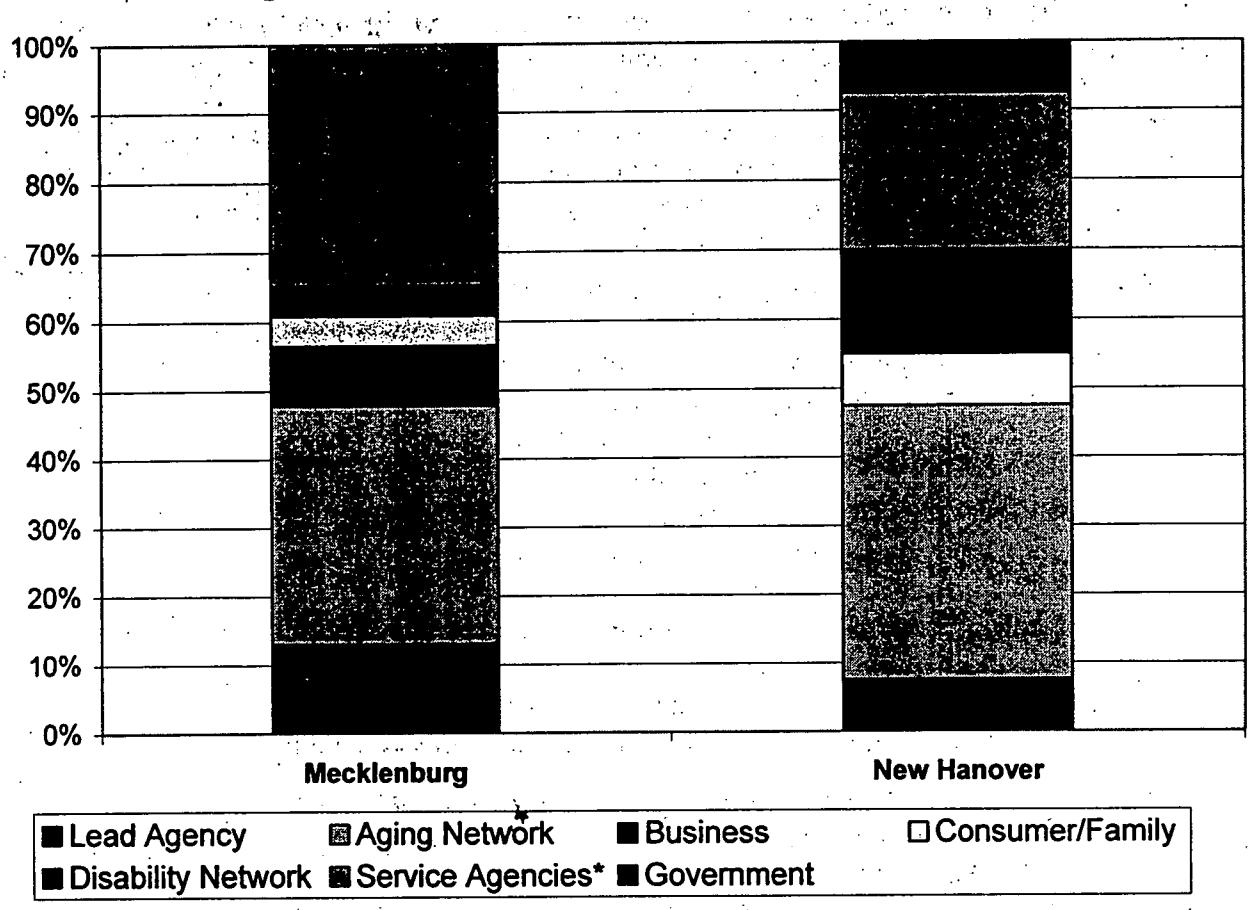
At the New Hanover site, the lead agency and the AAA recruited among all agencies serving older adults or adults with disabilities to create a large team. They started by mailing, e-mailing, or telephoning all of the aging professionals and consumers who had been active in the ROAR project and asked them to come and/or send a representative. The lead agency director had some contacts with the disability community through her work on the Wilmington Transportation Board. She invited the members of the community she knew through these contacts and used the "snowball" technique of asking these people to contact other agencies and consumers, especially in parts of the disability community not represented on the transportation board.

General meetings of the team were usually facilitated by the director of the New Hanover Department of Aging (lead agency), with assistance from the AAA administrator from the Cape Fear Council of Government located in Wilmington. When the group applied for Robert Wood Johnson funding, they elected a chair and co-chair (both retiree consumers with professional backgrounds in health and aging issues) for purposes of that project. However, when that application was not funded, they continued to function without any real officers. Decision-making was almost entirely by consensus. Issue-based work groups were made up of and facilitated by members of the larger team. Each group was chaired or co-chaired by a professional from a public or private provider of services relevant to the field but included a diverse membership.

Project Staff Composition

The Mecklenburg steering committee was made up of 23 members, including the four members of the executive committee. (Note: There were a total of 7 people who served on the executive committee over the course of the initiative, but no more than 4 at any one time.) The steering committee included the leaders and some, but not all of the members of the topic area work groups. Mecklenburg's work groups included over 150 community members. New Hanover's BARC team was made up of 40 people including most, if not all, of the members of their topic area work groups.

Figure 1. Composition of Project Teams by Site



*Service agencies are those entities that provide services for multiple age groups and populations such as health, mental health, transit, and other human services providers.

As Figure 1 shows, there were both striking similarities and notable differences in the composition of the teams for the two project sites. Both site representatives from the lead agency and from members of the traditional aging services network (not including the lead agency, but including their regional Area Agency on Aging) together made up just under half (48 percent) of the committee. Members of other service entities that serve broader populations, such as health, mental health, hospitals, United Way, and social services (not including lead agency) were the second largest source of membership at both sites, though their numbers were greater in Mecklenburg (35 percent compared to 23 percent in New Hanover).

Both groups drew fewer than 10 percent of their membership from consumers and their families, relying instead on their large community events to elicit opinions and ideas from the consumer and caregiver communities. Mecklenburg's consumer is a businessman with public relations experience to bring to the group. An additional consumer worked with the project for the first year or more, and the Chair of the Council on Aging serves a dual role as council member and consumer. Of New Hanover's three consumers, all had different connections to health or aging services. One was a retired RN, one an RSVP volunteer, and one a hospice clergyman over age 60. There are both advantages and disadvantages of working with consumers who have connections to the system of care. They are already knowledgeable about the issues and procedures in the current system, which helps them to participate fully very quickly. On the other hand, their very knowledge may prevent

them from bringing the new eyes and fresh ideas to the system that consumers with less agency experience might bring.

Some differences between the two sites may have been more apparent than substantive. The New Hanover site claimed no representatives of "business," but several members of the aging network represented private, for-profit service providers such as home health agencies, assisted living facilities, and a hospital. Mecklenburg's steering committee also had for-profit agencies among its aging network members. Those listed as business representatives were the managing editor of a for-profit publication for older people and the executive director of the better business bureau foundation. Similarly, the New Hanover site had attendance from two members of their US Representative's office, while Mecklenburg did not include any representatives of government per se, but used their executive advisory board to keep local government apprised of their activities.

As expected, the Mecklenburg site had fewer members of the disability community. Although that site had decided to postpone work on the needs of younger adults with disabilities, as discussed above, their steering committee included the executive director of Programs for Accessible Living, who would convene the work group on disabilities in the second year. Their in-home work group also included representatives from autism services, mental health, services for the blind and services of the deaf and hard of hearing. Fifteen percent of the New Hanover team were from the disability community, including representatives from the ARC, services for the blind, services for the deaf and hard of hearing, and groups like the Center for Independent Living that work primarily with younger people who have a variety of disabilities.

Self-Guiding Documents

Both groups developed mission and vision statements, but only Mecklenburg developed ground rules and guiding principles. The need for these additional guiding documents may have been related to their later stage in strategic planning or their larger, more complex structure.

Nor surprisingly, the mission and vision statements of both groups make reference to engaging or partnering with the broader community and creating a plan that reflects their charge from the LTC Cabinet in undertaking this project. Both projects include assuring "independence" and "dignity" for older adults as the ends to which this community planning is undertaken and both make reference to "needs." There are, however, some differences. The New Hanover site specifically addresses the needs of disabled adults as well as elders and talks about being "responsive." Both their mission statement and their vision speak to providing "choices" for older and disabled adults. The Mecklenburg site, by contrast, talks about creating a senior-friendly community and enhancing quality of life, though it also speaks of focusing resources on needs. In their guiding principles, they make references to intergenerational issues and the value of caregivers.

Table 1. Between Site Comparison of Guiding Documents

	New Hanover	Mecklenburg
Mission	To partner with consumers, families, providers and community to create a responsible plan that enhances and values independence, choices and dignity for elderly and disabled adults.	To engage the community in creating a dynamic plan that enhances the quality of life for older adults by focusing resources on their needs
Vision	To build a responsive community that recognizes the needs and choices of the	To foster a senior-friendly community that values dignity and independence for all

elderly and disabled adults. older adults

Mecklenburg Only

Ground Rules

- Monitor your participation (anyone can pass; more verbal hold back and more quiet speak up).
- Test assumptions and inferences.
- After the meeting, accurately represent the decisions of the group to others.
- Discuss the "un-discussable." (Respect and honor requests for confidentiality.)
- Realize interdependence.
- Treat each other with mutual respect and all ideas are valid (start on time; one person talk at a time; cell phone off or vibrate).
- It's o.k. to have fun.
- Suspend predetermined positions to allow the collective intelligence to emerge.

Guiding Principles

1. **The goal is that Mecklenburg County become a "*Senior Friendly Community.*"**

This means that the community provides a wide range of social and economic opportunities and supports all citizens including seniors. The community:

- 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; and
- Enhances its capacity for caring.

2. **The community should allow seniors the opportunity to "*Age in Place*" whenever it is reasonably possible.**

It is acknowledged that individual situations may preclude the ability to "Age in Place" if basic comfort and safety cannot be met. According to the *Journal of Housing for the Elderly*, "Aging in Place" does not have to move from one's present residence to secure necessary support services in response to changing needs.

For the purposes of this planning process, the term "aging in place" refers to living where you have lived for many years or to living in a non-healthcare environment and using products, services and conveniences to allow or enable you to grow older without having to move.

For many, the opportunity to age in place is associated with a higher quality of life. Some 70 percent of older adults spend the rest of their lives in the place where they celebrated their 65th birthday.

3. **The Initiative's intent is to review the existence, adequacy and accessibility of needed services for seniors of all income levels.**

Ability to pay should not assume that there are no issues regarding access to services. Further, ability to pay should not preclude options for seniors to age in place or otherwise access needed services.

Areas of Focus (Work Groups)

The Mecklenburg site attempted to cover nearly every area of life for older adults (or at least life affected by public and not-for-profit services) in broad categories. The New Hanover site, by contrast, organized their work groups around specific services, which they believed were less than optimum in some way. These may be said to represent two different perspectives on long-term care. For Mecklenburg, the entire older adult population was treated as relevant to long-term care. In New Hanover, planning for long-term care was focused on supporting people whose health and independence were compromised by illness or disability.

Work Group Topics

Table 2. Between-Site Comparison of Work Groups

Subcommittee/Issue	Site(s)	Comments
Transportation	Both	
Facilities and Institutions	Mecklenburg	Included mental health services, but only for older adults in facilities
Food and Nutrition	Mecklenburg	
In-Home Support Services	Mecklenburg	Encompasses 2 areas selected by New Hanover—in-home aide and home health.
Leisure, Recreation, and Socialization	Mecklenburg	
Home Health	New Hanover	Included in Mecklenburg's in-home support services
Housing	New Hanover	
In-Home Aide	New Hanover	Included in Mecklenburg's in-home support services
Mental Health	New Hanover	Included in the discussion in Mecklenburg's Facilities and Institutions work group

As noted in the table above, transportation was seen as a key service, requiring its own work group, at both sites. In-home aide service and home health services were also considered key, though they were addressed by separate work groups at the New Hanover site, and by a single work group on in-home support services in Mecklenburg. Mental health was considered to be a community service in New Hanover, but was only discussed in the context of the mental health needs of those in nursing homes and assisted living facilities in Mecklenburg. Only the New Hanover site addressed community-housing options for older and disabled people, and only the Mecklenburg site addressed food and nutrition and leisure, recreation, and socialization. This last topic did not reflect a core-service recommendation of the IOM report, but was drawn from the matrix of issues that appear in the North Carolina Division of Aging and Adult Services' *Senior Friendly Community* brochure (NC Division of Aging and Adult Services, 2003). Mecklenburg specifically aims to go beyond long-term care planning to plan for a senior-friendly community

In Mecklenburg, the spokesperson for the site reported that the work issues were "partly, but not entirely" the same as they identified in their proposal. According to a spokesman for the Mecklenburg project, the proposal contained a "laundry list" of issues related to aging and long-term care, broadly defined. In early November 2003, before their large community planning event, the steering committee and executive advisory board met to identify the areas they felt that the community needed to address. They initially identified 13 areas, derived from the continuum of care services listed in the Institute of Medicine's *A Long-Term Care Plan for North Carolina: Final Report* (Institute of Medicine, 2001) and the *Senior Friendly Community* brochure (NC Division of Aging and Adult Services, 2003). They then assigned priorities to the 13, arriving at the five topic areas above. These were presented at the community forum.

In New Hanover, the group reported that they had worked on the same issues that they had identified in their proposal. In writing their document, the leadership and staff members of the lead agency and the Area Agency on Aging drew on their own knowledge of local aging services issues as well as the community work associated with the ROAR project to put forward potential focus areas. In the October and November full meetings of the BARC initiative, members were given a list of the services for which the Division of Aging and Adult Services had developed Core Service Evaluation Tools (which, in turn, grew out of Institute of Medicine's *A Long-Term Care Plan for North Carolina: Final Report,* with some additions) and asked to assign priorities to these issues. Because there were substantial differences in the groups in attendance for the two months, the lead agency and AAA compiled the results from all participants who submitted them at either meeting (1 per participant). They took the list of the top 5 back to the next meeting and asked the group to confirm or modify that list. As it turned out, the large group selected issues that the proposal authors had selected as those most important to older and disabled adults in New Hanover County.

Schedules and Tasks

In New Hanover the work groups met at least monthly from June through August 2004 using the Core Services Evaluation Tools as a springboard for identifying issues and concerns. (A separate section of this report is dedicated to the use of the Core Evaluation Tools. Please see page 19.) The larger committee did not meet during those summer months. Some work groups chose to work during the time usually scheduled for the full committee, and others preferred a different time. Each group produced a written summary that described the system, presented scoring on the appropriate Core Services Evaluation Tool, and highlighted the most crucial issues as identified by the committee. Their findings were presented at the community event and incorporated into the BARC final report. After the community event the work group members stopped meeting independently but most continued to work with the larger group.

The Mecklenburg work groups met once or twice a month from November 2003 to March 2004. The transportation and leisure, recreation and socialization work groups continue to work on the community awareness/education activities growing out of their planning efforts. Members of the other work groups returned to their roles on the steering committee. Most of the issue identification/ needs assessment work had been completed in the previous year and put forward in the Status of Seniors Report. Instead, these work groups focused on developing objectives and recommendations. These are summarized in the main body of *Mecklenburg County Status of Seniors Initiative Strategic Planning Report* (Status of Seniors Initiative Executive Committee, 2004).

Accomplishments and Plans

Despite their differences in starting point, interests, and style, there are some clear commonalities in the goals that these projects believe they have met and those they intend to meet. The first and perhaps most important common theme, though not one listed directly in the achievements and goals of either, is that both groups expect to continue in this collaborative activity indefinitely into the future. Second, although the scope is different, both also expect to create a new entity to serve the community (an advocacy group in New Hanover and a center for aging in Mecklenburg.) Each also acknowledges the importance of broad community commitment and an effective community education campaign.

Believing that lack of information about available services among both professionals and consumers was a serious problem in and of itself, BARC dedicated 5 meetings (1 per topic area) to educating the whole planning group about available services and issues around the five selected work areas. After these educational meetings, the work groups began assessing the services using the Core Services Evaluation Tools. At the end of the first year, the outcomes that BARC reported achieving were all in the area of increasing engagement and knowledge about the issues within the provider community serving older and/or disabled adults, and raising awareness of these issues and resources in the community. These activities culminated in the large community event that moved the group from data gathering and assessment to setting goals and developing the broad strokes of an action plan. The goal of producing "a written document of the Building a Responsive Community partnership's work that will act as a blueprint for a long range plan to address the needs of the senior and disabled adults, establish an ongoing group to advocate for the needs of older and disabled adults, and to educate the community about services available for these two groups," which was still anticipated at the end of the first year's reporting period, was completed in March 2005.

Having already collected substantial information and presented it in the Status of Seniors Report in May 2003, Mecklenburg was able to recruit their executive advisory board and steering committee and plan their first community workshop before the official project period began. Thus, the project year began with a large community workshop. They produced the Status of Seniors Initiative (SOSI) Strategic Planning Report in May 2004 and were successful in getting it on the County Board of Commissioners' annual agenda. They also presented it to the Charlotte City Council and the United Way of the Central Carolinas. However, this work did not include any activities around the needs of younger disabled adults. In the coming year of this project, the Steering Committee and Executive Advisory Board expect to finish developing strategies for the recommendations in their strategic planning report; develop recommendations and strategies for two new areas—physical environment and adults with disabilities; initiate additional work groups to address additional areas of concern on the Senior Friendly Communities Matrix; create a Center for Aging organization; and secure funding from multiple sources for the Center for Aging.

Table 3. Achievements and Plans as Reported in Autumn 2004 (end of year 1)

	Building a Responsive Community New Hanover	Status of Seniors Initiative Mecklenburg
Achievements	A committed membership that is truly concerned about issues senior and disabled adults face today and will face in the future	Engaging the community in the process through recruiting the Executive Advisory Board and Steering Committee
	A clearer understanding of the status of services to seniors and disabled persons	Community commitment to an ongoing planning process
	A successful community forum	Getting a Status of Seniors Initiative update report on the Board of County Commissioners *annual* agenda
	Good media coverage of the forum in the local newspaper	Production of the Status of Seniors Report in May 2003 (pre-project)
		Production of the Status of Seniors Initiative (SOSI) Strategic Planning Report in May 2004
Achieved Since November 2004	A written document of the BARC partnership's work that will act as a blueprint for the a long range plan to address the needs of senior and disabled adults (This was completed in March, 2005)	Finished developing strategies for the first year's recommendations
	Establishment of an on-going committee	Developed work groups for two new priority issues (physical environment and services for adults with disabilities)
	Begun education efforts of the community and county officials on services available to older and disabled populations	Initiated additional work groups to address other areas of concern on the Senior Friendly Communities matrix
In the Future	Continue addressing two new priority issues each year	Create a Center for Aging
	Begin implementation activities to address several recommendations	Secure funding from multiple sources for the Center for Aging
	Hold one community forum per year	Implement many of the recommendations
	Increase the number of consumers represented on BARC	

Core Service Evaluation Tools

One of the resources provided to each site of the initiative was a set of paper instruments designed to help the community assess the strengths, areas needing improvement, and overt gaps in specific long-term care services. These were described in this project's Interim Report (NC Division of Aging and Adult Services, 2004) in the following terms:

> "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."

All 22 tools can be found at http://www.dhhs.state.nc.us/ltc/localplanning.htm. In addition, a sample tool is provided in Appendix B. The Communications and Coordination Initiative to Strengthen Long-Term Care Services represents the first occasion in which these tools were used to help a community assess its environment for long-term care planning purposes. It should be noted that the tool on social, leisure, and recreation services for older and disabled adults was created especially for the Mecklenburg project site because of their desire to include a broader approach to long-term care planning that included prevention.

Tools Chosen

As mentioned in the discussion of work group formation (please see pages 16-17), the New Hanover site organized its work groups to correspond with the five Core Service Evaluation Tools corresponding to areas of greatest need in the county. In Mecklenburg, some work groups used multiple tools and others chose not to use any, even though there were specific tools available for services relevant to their work. The tools, like other resources, came belatedly for some of the work in Mecklenburg because of the full year of work completed before formal entry into this project. Figure 4 shows the tools used at each project site.

Table 4. List of Core Service Evaluation Tools Used, by Site

Mecklenburg	New Hanover
Adult Day Services	Home Health
Care Management	Housing
Home Health	In-Home Aide
Information and Assistance	Mental Health
In-Home Aide	Transportation
Respite Care	
Social, Recreational, and Leisure Services	

How the Tools Were Used

Both the Mecklenburg and New Hanover sites reported that they used all six dimensions of the core evaluation tools that they chose as appropriate for their group work (existence, adequacy, accessibility, efficiency, equity, and effectiveness/quality). New Hanover used the scoring of all six dimensions to illustrate their final report. Mecklenburg reported that all groups who used the tools used "most of the questions" in each dimension while New Hanover reported that they used "all of the questions."

Although staff members from the Division of Aging and Adult Services presented a number of ways of scoring the tools, both sites used discussion and consensus building to score each dimension rather than summing individually assigned scores. It would appear from the written reports that in New Hanover, groups reached consensus on individual items as well as the final dimension score, while in Mecklenburg some work groups scored individual questions and others scored only the dimension as a whole.

The Mecklenburg site reported that for each of the tools it scored, it used data in the same way: (1) tried to get data/information only for the questions they thought most important; (2) searched for and found *some* (not most) of the information referenced on the tools; and (3) used some of the data/information from the packets provided by the Division of Aging and Adult Services. Although there were common threads, the five work groups at the New Hanover site reported some differences in the way they used data. The one common element common to all five New Hanover work groups, but different from Mecklenburg was that each said that consumers shared impressions from their experience. Four of the five New Hanover work groups (all except the transportation group) also reported that service providers shared a combination of data/information and impressions from their experience. The New Hanover transportation and home health work groups said that they looked for and found *most* of the data referenced on the tools while the housing, mental health, and in-home aide groups said that they looked for and found *some* of the information. The New Hanover home health work group was the only one that reported using data from the packets provided by the Division of Aging and Adult Services.

Both project sites conducted some data gathering of their own from local service providers. Three of the Mecklenburg work groups (facilities and institutions, nutrition, and in-home) conducted telephone surveys of service providers. They developed a matrix of questions that was used by all three groups. The in-home group also asked questions from the home health and in-home aide core service evaluation tools. They also considered the community event held early in the first project year to be a form of "listening session" or "community hearing" for consumer input. When asked about the benefits and challenges of collecting their own data, a project spokesman said, "Knowing where to go and having time to collect the data were the challenges. The benefit was having the latitude to collect just what we needed and not get what we didn't need."

At the New Hanover site, the in-home aide work group developed a written survey and sent it by mail to local providers. A project spokesperson estimated the response rate as 35 to 40 percent. She said that some agencies didn't want to give salary information, but that, over-all, the committee was pleased with the information they were able to obtain. When asked about the benefits and challenges of collecting their own data, the same spokesperson said that the benefit was receiving quality information that they could not get elsewhere. The challenges were the pressure to complete the work very quickly to keep the group moving forward and the reluctance of for-profit groups to share information about salaries.

The Mecklenburg site felt that they were able to get all of the data they needed. However, the New Hanover group felt that they were not able to get full data on housing and transportation needs in the disability community. They felt that the information they had was adequate about specific programs, but that it did not present the complete picture for the community. For example, in transportation they were only able to get data about services that relied on Elderly and Disabled Transportation Assistance Program (EDTAP) funding. In the area of housing they got the number of public housing units serving individuals with disabilities, and independent living units in mental

health and long-term care facilities' residential units. While this is relevant information, it does not fully answer the committee's questions about housing availability, adequacy, or other dimensions.

Lead Agency

When asked how their agency was chosen to be the lead agency for the initiative, spokesmen from both sites seemed slightly surprised by the question. In both cases, it was more-or-less assumed that this agency had the interest and capacity to bring the community together.

In Mecklenburg, leadership and staff members from the Department of Social Services had already demonstrated their commitment by providing leadership, writing, and production skills for the initial Status of Seniors report. As the site spokesman said "We had the capability, in terms of financial resources, management capability, and staff time. There was never really any question—no big discussion—it was just assumed that DSS would do it."

In New Hanover, the director of the Cape Fear Council of Governments Area Agency on Aging (Region O) first learned about the initiative and asked the director of the New Hanover County Department of Aging if she was interested. The director of the Department of Aging reports directly to the assistant county manager who, along with the county manager and the management team, was very supportive of the application.

The Work of the Lead Agency

The initiative's call for proposals included a list of tasks for which the lead agency would be responsible, including:

- Identifying and recruiting appropriate members of the planning team;
- Facilitating meetings;
- Orientating and updating project team members;
- Orienting and updating the community about the project;
- Publicity, such as developing marketing materials and contacting the media;
- Support tasks such as taking minutes, sending out minutes and meeting reminders, and documenting actions and decisions;
- Managing conflicts, keeping morale high, and keeping all stakeholders involved in the process;
- Conducting surveys, focus groups, public hearings, and other direct data gathering;
- Researching and compiling existing data for completing the Core Service Evaluation Tools and other planning activities;
- Helping with project evaluation;
- Creating reports about the progress in you county (presentations, emails, and documents);
- Participating in Initiative communications, teleconferences, meetings, phone calls, and list serves;
- Grant writing and fundraising;
- Arranging or providing training for the planning team;
- Developing a strategic action plan; and
- "Other" activities as necessary.

The Initiative evaluation team used that list as a starting point for developing questions about the tasks performed and the time commitment made by lead agency staff members. In both counties, the lead agency was able to delegate a number of the tasks, as appropriate for a collaborative effort.

Of course, some activities continued throughout the project while others were intense at some phases of the work and limited or nonexistent at others. The differences in the two counties' timelines and general approaches make comparison difficult. However, for Mecklenburg, the activities that appeared to take up the most amount of time included orientating the community, publicity efforts, conducting surveys/focus groups/public hearings, researching and compiling data, and creating reports and presentations. In New Hanover, identifying and recruiting members for the planning team, grant writing and fundraising, and creating reports and presentations seemed to be the most time-consuming activities.

Mecklenburg's lead agency, the Department of Social Services, estimated that it spent more than 50 hours a month on leadership for the Initiative, or 600 hours during the year. Its estimated leadership costs for the 600 hours during the pilot year were $30,000– ***this estimate solely includes leadership time at the Department of Social Services and does not include support staff time, the time of the Area Agency on Aging, the time of the Steering Team members, the time of the workgroup members, printing costs, meeting costs, travel costs, etc.*** The Centralina Council of Governments' Area Agency on Aging estimates that it spent 30 hours per month, or 360 hours per year, providing support and technical assistance to the Initiative. All of the other agencies involved in the Initiative in Mecklenburg combined contributed another 346 hours per month (for a conservative total of over 4,152 hours per year). Mecklenburg County was also fortunate to be able to hire a consultant, the Lee Institute, at $25,000 for the full pilot year to expedite the process. The total estimate in community time spent working directly on the Mecklenburg Initiative is 5,112 hours (not including the consultant's time).

New Hanover's lead agency, the New Hanover Department of Aging, *conservatively* estimated that it spent 46.5 hours a month, or 558 hours per year, on the Initiative. There were several responsibilities of the lead agent that New Hanover Department of Aging said were, "difficult to estimate." The Initiative leadership costs of the New Hanover Department of Aging is estimated to be close to $11,200 per year – ***again, solely estimating the staff time of the Department of Aging and not including support staff time, the time of the Area Agency on Aging, the time of the Steering Team members, the time of the workgroup members, printing costs, meeting costs, travel costs, etc.*** It also estimates that the Cape Fear Council of Governments' Area Agency on Aging spent 22 hours a month (or 264 hours per year), and all other agencies combined spent 67.5 hours a month for a total of 810 hours per year (consistent with the flatter structure of the New Hanover Initiative and the more modest goals in their first year). The total estimate in community time spent working directly on the New Hanover Initiative is 1,632 hours.

Compared to Mecklenburg County, New Hanover's participation in hours by "other agencies" (87 hours per year in New Hanover compared to 4,152 hours per year in Mecklenburg) reveals a higher proportion of the work being done by the lead agency, consistent with the flatter structure of the New Hanover initiative and the fact that Mecklenburg had started its planning process a year earlier than New Hanover. Mecklenburg County had over 150 community stakeholders participating in their workgroups while New Hanover had an estimated 30, thus accounting for the large difference in time from "other stakeholders."

Strategic Plan Results

Each pilot site was asked to produce a strategic action plan for LTC as part of their participation in the *Communications and Coordination Initiative*. Both sites produced and presented to their communities a written plan that described their LTC system, gave scoring on the appropriate Core Service Evaluation Tools, highlighted the most crucial issues identified by the committees, and made recommendations for action.

Leading areas of concern and correlating recommendations cited by the **Mecklenburg site** are:

(1) Concern: Fragmentation among services provided to older adults due to a lack of a centralized structure within the county to organize ongoing research, coordinate planning, and ensure accountability.

Recommendation: Establish a multi-functional organization that will serve as a "focal point" for the aging network's strategic planning, information and assistance, care/case management, education and communication, and advocacy.

(2) Concern: Lack of knowledge regarding available services within the older adult and caregiver populations.

Recommendations: Establish a multi-functional organization that will serve as a "focal point" for the aging network's strategic planning, information and assistance, care/case management, education and communication, and advocacy; and

Develop systematic, integrated approaches for educating and communicating with key stakeholders about the implications of aging and the availability of resources.

(3) Concern: Restrictions on the number of LTC options available to older adults due to income eligibility requirements, inflexible programs, waiting lists, and critical workforce shortages.

Recommendation: Redistribute resources for the LTC system by promoting the availability of home care as an alternative to nursing home care and by eliminating multiple gaps in the system for middle-income older adults who do not meet income eligibility requirements and who cannot afford LTC services.

(4) Concern: The need for sustained support for caregivers.

Recommendation: Magnify the role of the informal and family caregiver in the community through a public education campaign, to promote self-identification of caregivers, and to develop educational opportunities for caregivers.

(5) Concern: Current services for older adults are limited in scope and do not provide options to meet the current and projected interests, skills, and needs of an increasingly diverse population.

Recommendation: Multiply options for older adults across service areas by enhancing existing services and developing new approaches, including expanding transportation options, promoting the use of nontraditional senior nutrition sites such as YMCAs and business cafeterias, integrating multi-cultural elements across areas, and promoting intergenerational experiences.

(6) Concern: Fear of crime within the older adult population.

Recommendation: Launch a crime prevention and education campaign in high-crime areas with a focus on older adults, including engaging the Police Department in planning and providing training to First Responders on recognizing abuse, neglect, and exploitation.

(7) Concern: Limited access to vital services for older adults who do not drive or who have special needs.

Recommendation: Transform the transportation system to create an expanded and coordinated range of senior-friendly travel options.

The full report can be viewed at:
http://www.charmeck.org/Departments/DSS/Services+for+Seniors+and+the+Disabled/statusofseniors.htm.

Leading areas of concern and associated recommendations cited by the **New Hanover site** include:

(1) Concern: A lack of knowledge of the services available for older adults and adults with disabilities within the community.

Recommendations:

- Conduct an annual Community Forum at the Senior Center;
- Conduct area speaking engagements to civic, church groups, and other community events four times a year; and
- Provide ongoing information on services for older adults to the county, city, and university media.

(2) Concern: Accessibility of fixed route and para-transit transportation services throughout the county for older adults and adults with disabilities.

Recommendations:

- Survey older adults and adults with disabilities within housing communities outside of city limits to determine current levels of services and the need for new and/or expanded services;
- Continue agency dialogue with WAVE transit (combined Wilmington city- and New Hanover County transportation system) to provide more cost-effective, efficient trips for older adults and adults with disabilities; and
- Educate and advocate for change to the WAVE Transit Advisory Board on the needs of older adults and adults with disabilities.

(3) Concern: A general lack of education regarding "livable communities" and universal design among housing developers, architects, and builders.

Recommendation:

- Meet with and educate developers, county and city planners, architects, and builders on the need for accessible environments.

New Hanover's plan is not on the Internet. However, copies of the plan can be obtained by calling Annette Crumpton, Director of the New Hanover County Department of Aging, at 910-452-6400.

Communication with the State Team and the Division of Aging and Adult Services

Both sites gave the responsiveness of the Division of Aging and Adult Services (DAAS) the highest possible score on responsiveness to their needs [5 on a 5-point scale from very unresponsive (1) to very responsive (5).] When asked about specific interactions, both sites describe a relationship in which each side reached out to the other. Both sites indicated that DAAS called them to offer general technical assistance and that DAAS offered and provided training or consultation at one or more of the project meetings at the site, that they sent general information and resources, and that they visited the project site. The sites, in turn, said that they called DAAS to ask questions, attended meetings in Raleigh and telephone conferences about the project, and requested specific resources. The Mecklenburg site also said they called at least once to discuss a specific problem or issue, while the New Hanover site said they did not need to do this. Both sites said that over the course of the project, they were in touch with DAAS 1 to 3 times a month and that they felt this frequency to be the right amount (neither too often nor not often enough). In addition, DAAS provided in-depth assistance to both sites in applying to the 2004 Robert Wood Johnson Foundation's Community Partnerships Program, a highly competitive funding program designed to assist communities in planning for LTC and related supportive systems to meet the needs of their current and future older adults. Out of 486 applicants, both sites were one of only 28 who were asked to submit full proposals. Although neither site was funded, the process assisted each site in fully developing its community process and goals.

If the two sites were nearly identical in their contact with DAAS, they were quite different in their contact with the remainder of the Long-Term Care Cabinet agencies that made up the state team. The Mecklenburg site reported little contact with state agencies other than DAAS, with its main contact being at an orientation meeting (including DAAS staff, the State Team members, the lead agents, and their invited committee members including their respective Area Agency on Aging Director) at the beginning of the project. The New Hanover site, communicating by e-mail, got information and technical assistance in the areas of transportation and housing from appropriate state agencies. This included assistance in providing materials needed for writing an application for a Robert Wood Johnson grant. Although the site spokesperson said she had contact with these team members less than 4 times during the year, she felt that the amount of contact was appropriate.

Both groups said that there were no resources that they wanted from either DAAS or other state team members that they did not receive. Mecklenburg identified funding for the initiative as the one exception to this blanket statement.

Ratings of Specific Help Provided

Both sites received four training offerings from the state team: (1) an orientation meeting for the two sites jointly in Raleigh; (2) a planning meeting with each site separately; (3) training on the Long-Term Care Service Evaluation Tools at each site for the whole project team; and (4) training on vision, mission, and team readiness to plan at each site for the whole project team. Although both sites gave positive ratings to all four offerings, the New Hanover site was generally more positive. Both sites rated the "Vision, Mission, Team Readiness" training as "4" on a 5-point scale in which 5 = "very helpful." Mecklenburg also rated the other three offerings "4," while New Hanover rated them "5." Scoring was similar for written materials. The Core LTC Service Evaluation Tools and the written instructions for completing them were rated 5 by the New Hanover site and 4 by the Mecklenburg site. The spokesperson from Mecklenburg amplified that both the

meeting/training and the written materials, including draft sections of the *Planning Basics Guide* still under preparation when the interviews were conducted, were well-organized and contained important information. They were not as helpful as they would otherwise have been, simply because Mecklenburg was already far along in its process by the time these were offered. A similar consideration may have caused New Hanover to rate the "mission and vision" training as less useful than other events and materials, because at the time they received it they were already working toward their vision, even though it might not have been formally stated, and they had considerable experience collaborating on projects and initiatives. It will be valuable to see how counties undertaking this process in the future rate the same materials when they are made available from the beginning.

In addition to the training and written materials, New Hanover identified three other areas in which the state team had provided "very helpful" assistance—assisting in writing grant proposals, attending/supporting project meetings, and supplying data.

Bringing Together Older Adults and Younger Adults with Disabilities

Spokespersons from both sites were asked to rate the involvement of various constituencies in the planning team on a scale of 1 to 5 in which 5 indicates "very involved" and 1 indicates "not involved at all." For purposes of the question, respondents were given this definition: "Involvement means, at a minimum, that more than one or two attended meetings and shared information and opinions." Neither group was able to attract younger adult consumers with disabilities, and Mecklenburg also had no family members or caregivers of younger disabled people, but they were not yet beginning work on planning for the needs of this group.

At the New Hanover site family caregivers of both older adults and younger adults with disabilities were perceived as minimally involved ("2" on the 5-point scale), while older adult consumers were modestly involved ("3" on the same scale). The advocates, on the other hand were "very involved," or "5" on the scale, regardless of whether they were in the aging network or the disability network

At the Mecklenburg site older consumers, caregivers to older adults, and advocates from both networks were all rated "4" on the 5-point scale, suggesting a fairly high level of involvement. However, it is clear from the answers to other questions that consumers and caregivers were not heavily involved in the steering committee in Mecklenburg, nor were they in New Hanover. As in other cases, the difference seemed to stem from the different timeframes of the project. Because the project year in Mecklenburg began with their large community event, they were able to get older consumers and caregivers involved immediately. Their spokesperson estimated that about half of the people who attended the event ended up contributing to one of the work groups. New Hanover elicited consumer comment and participation at their community event as well, but this came at the end of the project year, and when answering the question, their spokesperson did not include participation in that event as involvement. Consumers in New Hanover requested a "follow-up event" six months later to report on progress and discuss future directions.

Neither site made any special provisions to allow consumers or caregivers to participate in the committee meetings, but New Hanover did provide free transportation to consumers and caregivers for their community event.

The spokesperson for the New Hanover project said that she was disappointed in the number of consumers who became involved. "During the forum, I thought we had recruited a couple of new consumers, but then they did not come to future meetings," she reported. She went on to say, "As

we work on marketing and education sessions, we will reach out to consumers. We will also try to work through agencies to identity and invite consumers, especially those in the disability community. With caregivers, their answer was 'I can't take on anything else!' because of all of their responsibilities; but there have to be some who want to contribute—even long-distance caregivers—we need their voice."

Common Interests and Areas of Disagreement between Older and Younger Adults

At the time of the interviews, the Mecklenburg site had recruited an individual who directs programs for accessible living as the chair for a committee that will begin assessing issues related to services for younger adults with disabilities. Some members of the steering committee had volunteered, and the chair was recruiting members for that group. She has convened an informal meeting with those members of the steering committee who volunteered to serve. There had not been sufficient activity to identify areas of common interest or of disagreement with older adult consumers or the aging network.

In New Hanover some common interests were identified by advocates for both younger and older people with disabilities. Transportation was a service for which both groups expressed a need, and their specific issues and concerns were very similar. In many cases they also expressed similar concerns about housing, in particular the limited supply of affordable, accessible housing. When advocates discussed design of housing units, there were both differences and similarities. However, both groups (younger and older disabled people) were adamantly against the development of housing complexes that would serve both populations. They cited differences in interests—music, backgrounds, every aspect of their lives. The experience of mixing these two populations in facility care has not been positive for either group, and this has reinforced a reluctance of both populations to share housing.

One of the very positive results of the initiative, from the participants' perspective, was the sharing of information between the two service communities. "The two communities truly didn't know anything about each other's services and issues," said the New Hanover site's spokesperson. "Both groups learned a lot just by being in the same room together."

Long-term Care Reform

Among the recommendations of the Institute of Medicine for the reform of long-term care in North Carolina were seven structural changes [document these in IOM report]:

- 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.

The two sites were asked to rate the degree to which they had made progress in these aspects of reform, and whether or not this progress was facilitated by their participation in the Communications and Coordination Initiative to Strengthen Long-Term Care Services.

The Mecklenburg site reported that through the project they had made some progress in three of the areas—developing or strengthening core services; improving coordination/consolidation of local planning; and enhancing the commitment of public officials to the reform of long-term care. Their spokesperson felt that they had made little or no progress in reducing barriers created by the differences in funding sources. The other three areas (improving coordination of services, streamlining access to services, and enhancing public awareness of issues or services) were ones in which he believed the county had made progress, but this progress was not due to the Communications and Coordination Initiative.

The spokesperson from New Hanover felt that through the initiative they had made great strides in developing or strengthening core services and in improving coordination/consolidation of local services. Although they did not think they had yet made progress in the other five areas, they believed that their continued work on the initiative would bring at least some progress on all of them.

Areas of Pride

When asked to talk about areas in which the site could be especially proud, the Mecklenburg spokesperson cited two areas. The first was bringing the older adult service community together more than they ever have been—bringing together people who had never been involved. "I think that it was more successful than we thought it would be. The effort was well-received and reasonably well publicized." The second area of pride was in the publicity the initiative was able to achieve, which proved very helpful in educating and informing the broader community as well as the aging community. The spokesperson characterized it as "a lot by steering committee standards but pitiful by the broader community perspective." As an example of the amount of publicity needed to be effective, he made reference to the *Just One Call* I&R service. "That program spends $100,000 per year to market as well as making use of lots of *pro bono* publicity efforts. Yet, they are still not well known in community. Their $100,000 is just a drop in the bucket. Those figures are amazing and discouraging."

When asked what the lead agency was most proud of, he referred to the support of the commissioners, but the greatest area of pride was how people in the lead agency were really supportive of it being a *community* project rather than an *agency* project. They were willing and effective in sharing leadership and responsibility for the initiative.

The spokesperson for the New Hanover site felt that both the initiative and the lead agency had the same sources of pride. "We are most proud of and excited about having the diversity and commitment of all the agency people who came together. I am extremely pleased with this. I am also pleased that people are interested in really moving forward, not just going around in a circle—to really make a difference in some areas. I think we really can make a difference in universal design (of housing) and in transportation—though it will take some time." She went on to say that both the agency and the community were really proud of the community event that was the climax of their first year of work. "We all felt good about the time we had spent and the work we had done. I said at the forum we don't see a lot of new money coming down, so we are on a very realistic, affordable path. We can do it with money in our agencies. I think we can accomplish it. That's what we're doing right now. Maybe we should do pie-in-the-sky sometimes, but right now the *realistic* things are what we are trying to achieve."

The Initiative Experience

As a way of assessing the experience of participating in the initiative and filling the lead agency role, a spokesperson from each project was asked "If you could go back in time, but retain the knowledge and experience that you have gained in this initiative, would you apply to participate in this initiative? Would you apply to be the lead agency?" The New Hanover spokesperson was much more enthusiastic than the spokesperson from Mecklenburg, answering "5" on a 5-point scale in which 5 indicates "Yes, definitely" and 1 indicates "Definitely not." On that same scale the Mecklenburg spokesperson gave a "3" for both questions.

His reason for this modest enthusiasm for participation in the Initiative, like that for the training and materials, lay in the richness of resources available in Mecklenburg and in the fact that the county was well on its way in the planning process before the initiative began. "We were relatively far along by the time the state got their book together," he said, referring to *The Planning Basics Guide*. "I wish we had that at the beginning. We continue to be impressed with the instruments we received. We were already well along to planning the November meeting by the time of the first project meeting. If we had had the planning book, which I am very impressed with, that would have made our lives a lot easier, I think."

Anticipating the Future

In general, both initiatives were enthusiastic and optimistic about their ongoing work begun with the Communications and Coordination Initiative to Strengthen Long-Term Care Services, but they were not naïve about potential barriers.

Potential Barriers to Sustainability

When asked about anticipated difficulties in keeping the work going after the initiative is over, the Mecklenburg spokesperson identified the absence of money, their limited ability to engage the business community, and the absence of a formal entity to continue the work, though organizing such an entity is one of the goals toward which this site is working.

In New Hanover, where planning had focused on changes that could be made with existing resources, time is the most serious barrier. "People's time—their being able to get away from their other duties," offered the site spokesperson. "I'm already beginning to see that. There are so many meetings that people have to go to. Even though our meetings are at a set time, people have conflicts that they can't get out of, so I think keeping the group together will be the biggest challenge. That's part of why I say we'll probably go into small groups rather than the one large one."

Visions of Success

As the project entered its second year, the Mecklenburg project looked forward to having some actual outcomes of their planning—to see things begin to change for older adults. At the time of the interviews the project was starting work on implementing the first seven recommendations of the plan. They would also be working on their two new planning areas—adults with disabilities and the physical environment. The site spokesperson explained, "We have learned a lot about how to organize what we do. Previously, we sometimes found ourselves making it up as we went along, and I think we've learned a lot about how to do it right. Some of that is with the help of the book the state put together [*The Planning Basics Guide*]."

Community agencies in Mecklenburg have used both the Status of Seniors Report and the Status of Seniors Initiative Strategic Planning Report in their presentations to the United Way and the county commissioners.

The New Hanover site was also excited about beginning to move from planning to action, especially in increasing community awareness and beginning to work with transportation staff to address issues identified by both older adults and younger adults with disabilities. The site is continuing its efforts to recruit additional consumers. "We'll get some new consumers in," the site spokesperson asserted. "That would be a nice change. I feel like we will probably spin off into smaller working groups instead of the large group."

Findings

As a result of the experiences in Mecklenburg and New Hanover Counties, NC DAAS has concluded that:

1. **The *NC DHHS Communications and Coordination Initiative* can assist willing counties in fulfilling recommendation 16 of the NC Institute of Medicine's *A Long Term Care Plan for North Carolina: Final Report* (January 2001), which was endorsed by the NC DHHS Long-Term Care Cabinet.** Recommendation 16 of the NC Institute of Medicine's Final Report says that:

   "The NC General Assembly should encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level. The local planning initiative should broadly represent agencies involved in the provision of LTC services...the local planning committee should be required to:

   - Review and analyze service utilization data through county data packages;
   - Track the flow of consumers from referral to disposition through core service agencies;
   - Identify barriers to a comprehensive system of care and services;
   - Determine how to design the uniform portal of entry;
   - Determine the need for additional core long-term care services; and
   - Communicate findings to local, state, and federal policymakers..."

   Through participation in the *Communications and Coordination Initiative*, both the Mecklenburg and New Hanover sites fulfilled four of the above six requirements (excluding tracking the flow of consumers from referral to disposition through core service agencies and determining how to design the uniform portal of entry). The Core Service Evaluation Tools were designed by the Division of Aging and Adult Services and the State Team to assist counties in reviewing and analyzing service utilization data through county data packages provided by the Division of Aging and Adult Services, identifying barriers to a comprehensive system of care and services, and determining the need for additional LTC services in a structured and efficient manner. In addition, the Core Service Evaluation Tools prompt counties to go further than simply analyzing the data given in the county data packages, and extend their data collection and analysis to all available state and local data relevant to the pertinent issues being evaluated by the committee. Both sites conducted local surveys to supplement available data. DAAS provided technical assistance to both sites in obtaining and analyzing data, and an entire section is devoted to data collection and analysis in the *Planning Basics Notebook* for any interested community to download.

Also, as a requirement of participation in the *Communications and Coordination Initiative*, pilot sites were required to develop a strategic action plan and communicate and publicize their findings to policymakers. As indicated earlier, both sites developed plans that described the LTC system in their county, used appropriate Core Service Evaluation Tools, highlighted the most crucial issues identified by the committees, and made recommendations for action. Both sites have made presentations to their respective Boards of County Commissioners, conducted public hearings, and created media attention regarding the strategic plans and planned implementation activities. The LTC Cabinet has also been kept abreast of issues related to the *Communications and Coordination Initiative*.

At this time, the other two recommendations – tracking the flow of consumers from referral to disposition through core service agencies and designing the uniform portal of entry – is beyond the scope of the pilot project.

2. **Successful local LTC planning and implementation efforts require a significant allocation of time and resources.** In order to be successful, local LTC planning processes, and resulting implementation activities, require strong support from all areas of the community.

   As previously stated on page 24 of this report, Mecklenburg's lead agency, the Department of Social Services, estimated that it spent more than 50 hours a month on leadership for the Initiative, or 600 hours during the year. Its estimated leadership costs for the 600 hours during the pilot year were $30,000– ***this estimate solely includes leadership time at the Department of Social Services and does not include support staff time, the time of the Area Agency on Aging, the time of the Steering Team members, the time of the workgroup members, printing costs, meeting costs, travel costs, etc.*** The Centralina Council of Governments' Area Agency on Aging estimates that it spent 30 hours per month, or 360 hours per year, providing support and technical assistance to the Initiative and all other agencies contributed another 346 hours per month (for a conservative total of 4,152 hour per year. The total estimate in community time spent working directly on the Mecklenburg Initiative is 5,112 hours (not including the consultant's time valued at $25,000).

   Again as previously stated, New Hanover's lead agency, the New Hanover Department of Aging, *conservatively* estimated that it spent 46.5 hours a month, or 558 hours per year, on the Initiative. The Initiative leadership costs of the New Hanover Department of Aging is estimated to be close to $11,200 per year – ***again, solely estimating the staff time of the Department of Aging and not including support staff time, the time of the Area Agency on Aging, the time of the Steering Team members, the time of the workgroup members, printing costs, meeting costs, travel costs, etc.*** The Cape Fear Council of Governments' Area Agency on Aging spent and estimated 22 hours a month (or 264 hours per year), and all other agencies combined spent 67.5 hours a month for a total of 810 hours per year. The total estimate in community time spent working directly on the New Hanover Initiative is 1,632 hours.

   The Mecklenburg and New Hanover sites were in different phases of planning – Mecklenburg County had started its planning efforts a year prior to the beginning of the pilot project – likely accounting for some of the difference in the time commitment of "other organizations."

   Mecklenburg County was beginning its second year of planning when it started participating in the *Communications and Coordination Initiative*. The lead agent and the leadership of the committee had already developed a planning structure, educated committee members, conducted significant preliminary research (including a large survey to collect new data with

assistance from UNC-Charlotte), and identified priority issues. At the beginning of the second year, the Mecklenburg site was ready to hold a large community event, during which they were able to recruit over 150 community members to contribute their time and serve on its work groups. In comparison, New Hanover County was starting at the beginning – they had only identified stakeholders within the older adult service network through a prior planning project but had not yet even made contact with the stakeholders.

As shown by this evaluation report, at the end of the pilot project year, New Hanover was at the exact same place as Mecklenburg when it started the pilot project (at the beginning of their year 2) - ready to hold a large community event. Although the differences in starting points cannot account for the entire differences in expended time and resources, it is anticipated that planning, if done successfully and continuously, does require increased community support as well as community resources in subsequent years as committees get more involved and in-depth with its evaluation activities, take-on more priority issues for analysis, and start implementation activities.

In addition, a large amount of state staff time was required to educate the pilot sites on planning methods and the use of the Core Service Evaluation Tools, distill and provide county-specific data, and travel to counties to provide hands-on technical assistance. Currently, all of the materials are available for download, along with instructions, on the DHHS Long-Term Care website and staff at the NC Division of Aging and Adult Services are available to assist with technical questions and provide limited hands-on assistance.

3. **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. As shown by the experience in Mecklenburg and New Hanover Counties, fulfilling the role of lead agency requires a significant amount of time and resources. In addition, a successful local LTC planning process requires the buy-in and participation of a large number of community stakeholders. 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.

4. **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 is necessary to tackle any "roadblocks" in state policy that impose restrictions on planning at the local level.

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Appendix A
Pilot Site Contact Information

NC DHHS Communications and Coordination Initiative
Pilot Site Contact Information

Mecklenburg County

Lead Agent: Mecklenburg County Department of Social Services, Services for Adults Division

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

Gayla Woody, Director, Centralina COG Area Agency on Aging
1300 Baxter Street, Suite 450, Charlotte, NC 28235
704-372-2416
gwoody@centralina.org

Project website:
http://www.charmeck.org/Departments/DSS/Services+for+Seniors+and+the+Disabled/2statusofseniors.htm

New Hanover County

Lead Agent: New Hanover County Department of Aging

Contact information:
Annette Crumpton, Director, New Hanover County Department of Aging
2222 South College Road, Wilmington, NC 28403
910-452-6400
acrumpton@nhcgov.com

Jane Jones, Director, Cape Fear COG Area Agency on Aging
1480 Harbour Drive, Wilmington, NC 28401
910-395-4553, ext. 209
jjones@capefearcog.org

Appendix B

Sample Core Service Evaluation Tool

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 Para transit 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	1 2 3 4 5

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?)	
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 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?)	1 2 3 4 5
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 Para transit 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	1 2 3 4 5

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?)	
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 charge? Does the community have a written policy on ADA accommodations? What other provisions does the community make for assisting disabled riders?)	1 2 3 4 5
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?	1 2 3 4 5

What % of Medicaid-eligible people receive medical transportation services?)	
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?	1 2 3 4 5

(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?)	
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 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?)	1 2 3 4 5
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 DOT Public Transportation Division?)	1 2 3 4 5
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 communicate unmet needs to county commissioners, planning bodies, and other agencies?	1 2 3 4 5

(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:

NCHCFA
North Carolina Health Care Facilities Association
5109 Bur Oak Circle, Raleigh, NC 27612 • (919) 782-3827 • Fax (919) 787-8418
e-mail: nchcfa@nchcfa.org • website: www.nchcfa.org

November 28, 2005

To: Co-Chairs of NC Legislative Study Commission on Aging

From: Stacy H. Flannery, Director of Legislative Affairs

RE: Important Issues Facing Skilled Nursing Facilities in NC

Thank you for the kind invitation to address the Commission on November 16th and I am truly sorry that my schedule prevented me from attending and personally presenting comments to you and the members of the Commission. As I have mentioned to Theresa Matula, the North Carolina Health Care Facilities Association (NCHCFA) and the more than 400 license skilled nursing facilities in this state are facing several serious issues that would be relevant to your discussions in the coming months. I hope you will consider this brief list as you set your upcoming agendas.

Personal needs allowance for residents of skilled nursing facilities. Currently, Medicaid beneficiaries that reside and receive services in NC's skilled nursing facilities are allowed to keep only $30 per month of personal funds. These limited funds are intended to cover personal expenses not allowed by Medicaid such as hair coloring, clothing, personal products, etc. Legislation was filed in the 2005 Session to raise the personal needs allowance to $50. This bill was never considered during the appropriations process.

Criminal background checks for nurse aide students in community colleges. NC's skilled nursing facilities (and other long-term care providers) are required to conduct extensive background checks and screenings prior to hiring any unlicensed person. The facilities that operate nurse aide training courses typically conduct these screenings prior to admitting an individual to the program, thus ensuring that upon completion of the training and required competency testing, the individual will be eligible for employment. Community colleges, which operate nurse aide training programs and contract with facilities for clinical space, do not screen student prior to admission or on-site clinical training. This poses several problems:

1. A facility that allows a student on site for clinical training is responsible for the care provided to all patients and should be assured that the student does not have a criminal history that might pose a threat to patients or other staff members.
2. As we face a significant nurse staffing crisis now and in the future, every available resource must be used wisely. Resources spent training a nurse aide that would not be eligible for employment in must health care settings is wasteful.

We strongly recommend that community colleges be authorized and required to conduct criminal background screenings for nurse and nurse aide programs prior to admission.

Mental health services in long-term care facilities. During previous Commission work, challenges associated mental health patients and services in LTC facilities was discussed, and legislation was subsequently adopted that required DHHS to study various issues and make recommendations for action. The work of that study group is mostly complete and a draft report has been circulated. While we have many questions and concerns about the report as a whole, we are please with three recommendations made that specifically address challenges related to caring for patients with mental health issues in skilled nursing facilities.

1. The Department of Health and Human Services should work with provider representatives to establish partnerships with general hospitals to create Long Term Acute Care Hospitals specializing in the care of older people who have both medical and acute behavioral or psychiatric care needs or "swing beds" designed specifically for people with nursing care needs and acute behavioral or psychiatric care needs. The average length of stay of a long-term acute hospital is around 28 days. This length of stay would lend itself to the observation, stabilization, and intervention time necessary to return the older adult to the nursing facility. Examples of issues to be addressed include:
    a. Applicable Federal and State policies and regulations
    b. Assess the feasibility of both the creation of Long-Term Acute Care Hospitals for gero-psychiatric residents and the use of "swing beds" for such residents
    c. Potential funding sources and the development of cost estimates

2. The Department of Health and Human Services should work with provider representatives to develop partnerships with nursing facilities to create specialized long term geriatric behavioral units for nursing facility residents who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents. Examples of issues to be addressed include:
    a. Applicable Federal and State policies and regulations
    b. Potential funding sources
    c. Review the available programmatic experience in North Carolina with the establishment of one unit of this type
    d. Potential funding sources and the development of cost estimates

3. The Department of Health and Human Services should develop a plan to increase the availability and accessibility of outpatient psychiatric evaluation and treatment for nursing facility residents and to increase the availability case consultation and training for nursing facility staff to address residents' behavioral needs in order to continue to provide care, treatment and services to residents safely and appropriately within the facility. Examples of issues to be addressed include:
    a. Current capacity of workforce specializing in the provision of geriatric mental health services and identification of workforce development needs
    b. Geographic distribution of appropriate geriatric workforce

c. Ability to provide services in nursing facilities for residents who can not be transported to an office
d. Exploration of the expansion of services such as geriatric mental health specialty teams with the capacity to provide case consultation, staff training, and assistance with referrals to mental health treatment
e. Potential funding sources and the development of cost estimates

Thank you for taking time to review and consider these issues. Please contact me if you have any questions or would like to discuss further any of these issues or others.

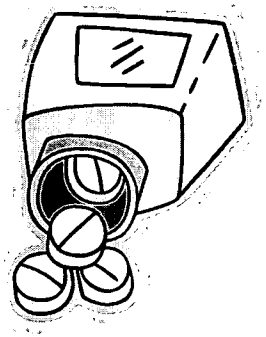
With kindest regards,

Stacy H. Flannery
Director of Legislative Affairs

Medicare Part D and the Community Alternatives Program for Disabled Adults

Division of Medical Assistance

December 20, 2005



Tracy Colvard, DMA CAP/DA, PCS Manager

The basics:

- Individuals with medical needs and incomes >$798 per month may become Medicaid eligible by meeting a Medicaid deductible, also known as a "spend down".
- Medicaid eligibility becomes effective on the day that the deductible is met.

Deductible is determined by:

- Subtracting the Medically Needy Income Limit (MNIL), which is $242 per month, from the countable monthly income to determine the monthly excess income.
- Example: $1000 income

  - 242 MNIL

  $ 758 Deductible

What can be applied to deductible?

- Unpaid medical bills
- Hospital charges
- Physicians, dentists, therapies
- **Prescription drug charges**
- Some "over the counter" medicines
- Eyeglasses, hearing aids, medical equipment, dietary supplements, etc.

Medicare Part D impact

- Medicare Part D will cover prescription drugs effective January 1, 2006.
- Because Medicare is now covering the cost of prescription drugs for the dually eligible, these costs cannot be used to meet the Medicaid deductible.

Part D Impact

- Prescription drugs are a major expense and often can alone satisfy the entire deductible.
- Prescription drugs can usually be obtained on the first day of the month → deductible met on first day of the month → Medicaid eligible the first day of the month.

Part D Impact

- Medicaid recipients accustomed to applying prescription drugs to the deductible will have to use other medical expenses to apply to the deductible.
- Most other expenses cannot be incurred on the first day of the month (unlike prescription drugs).

Part D Impact

- Individuals may not be able to meet deductible on the first day of the month → Medicaid eligibility will not be effective the first day of the month → individuals will not be able to receive Medicaid services, including CAP/DA, UNTIL deductible is met.

How many CAP/DA recipients are impacted?

- Approximately 645 CAP/DA recipients are dually-eligible (also Medicare) AND have deductibles.
- This represents about 5.7% of the 11,300 CAP/DA recipients.
- About 400 of the 645 (62%) CAP/DA recipients have deductibles over $500.

Possible solutions to be considered

- Increase the $242 Medically Needy Income Level (MNIL)
  - Would affect all Medically Needy recipients
  - Would require legislative action
  - Minimum cost to:
    - State = $143,437,783
    - Counties = $25,005,620

Possible solutions to be considered

- Increase the allowable income from $798 (100% of poverty) to $1061 (133% of poverty)
  - Would affect all Medically Needy recipients
  - Would increase the number of N.C. residents eligible for Medicaid
  - Financial implications would likely exceed the cost of raising the MNIL.

Current Status

- Local service providers and CAP/DA case managers are working diligently to identify other care options to assist those who are negatively impacted.
- Many recipients will be able to meet their deductibles using other medical expenses.

Current Status

- Current federal and state regulations do not allow exceptions for individual program participants in matters relative to eligibility.

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 and Adult Services [pages 1-7]
Facility Services [pages 7-8]
Medical Assistance [8-12]
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 [page 15]
Vocational Rehabilitation [page 15]

Offices:

Citizen Services [page 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 and Adult Services

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

Home and Community Services

Working with 17 Area Agencies on Aging (AAAs) and more than 460 public and private local organizations, the Division of Aging and Adult Services 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 and Adult Services. 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 and Adult Services. 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 December 20, 2005, there were 54 centers certified to provide both adult day care and adult day health care, 50 centers certified to provide only adult day care, and 3 centers certified to provide only adult day health care—for a total of 107 centers in 58 counties. As of December 2005, there were 91

older adults reportedly waiting for adult day care services under the HCCBG, and 40 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 and Adult Services. In SFY 2004-05, 65 county departments of social services spent nearly $3.3 million from the State Adult Day Care Fund to support 925 older and disabled clients of adult day care and 419 clients of adult day health. In SFY 02-03, 1,053 clients received adult day care services and 367 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. As of December 2005, 59 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 2004-05, 26,918 people (down from 28,591 in SFY 01-02) were served. Participants contributed a total of $1,097,595, which helped extend the service to others. As of December 2005, congregate nutrition services had a waiting list of 296 older adults. The Division of Aging and Adult Services is also continuing to work with the North Carolina Department of Agriculture to operate the Senior Farmers' Market Nutrition Program that provided about 3,000 low-income congregate participants with free fruit and vegetables in 19 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. 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 addition, Title III-D of the Older Americans Act supports **Health Promotion and Disease Prevention** programs that offer 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 25.35% 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 2004-05, 19,655 people (up from 18,230 in SFY 01-02) were served. Participants contributed a total of $702,772 which helped extend the service to others. Across the state, 3,209 older adults were waiting for home-delivered meals as of December 2005.

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.

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. As of December 2005, 730 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-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. As of December 20, 4,274 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. Respite is considered to be a "core long-term care service." As of December 20, 29 older adults were waiting for institutional respite under the HCCBG.

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 Adult Services, and AAAs, allocate a percentage of the Older Americans Act funds to provide such legal services.

Mental Health Counseling incorporates care consultation, evaluation, and outpatient treatment to older adults who are experiencing mental health problems. In SFY 2004-05, 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 and Adult Services 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 2004-05, $100,000 was allocated for Senior Center Outreach and $1,265,316 for Senior Center General Purpose. This funding goes to 161 centers in 97 counties [3 counties do not have a senior center—Gates, Hoke, and Transylvania]. Currently the Division has certified 37 centers—30 Senior Centers of Excellence and 7 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).

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. As of December 2005, 31 older adults were on waiting lists for medical transportation and 97 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.

Family Caregiving

The Division of Aging and Adult Services received $2,916,628 in 2001 to start the Family Caregiver Support Program under the Older Americans Act, as amended in 2000. For FFY 2004-05, these federal funds increased to $3,653,062. In implementing the Family Caregiver Support Program, North Carolina has focused on partnering and leveraging the somewhat limited caregiver funds through its work with the state's 17 AAAs.

The North Carolina Division of Aging and Adult Services 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 and Adult Services 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. 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. As of December 2005, there are 1,167 such volunteers statewide, with committees in 99 counties (Tyrrell does not have licensed facilities).

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 Adult Services 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 and Adult Services 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 and Adult Services 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. Both seniors and school children benefit from this intergenerational program.

Senior Community Service Employment Program. The Division of Aging and Adult Services administers the Senior Community Service Employment Program (SCSEP) through six (6) area agencies on aging in 32 counties. National sponsors administer the Program in the remaining 68 counties. About 1,500 older workers participate in the program (state and national) in North Carolina. 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.

Benefits Navigator Program. Through the Benefits Navigator Program (formerly named the Seniors Plus Program), the Division of Aging and Adult Services offers public benefits training to interested volunteers across the state to help seniors and adults with disabilities who may be eligible for additional sources of income and other assistance due to their limited resources.

Advocacy

The Division of Aging and Adult Services 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 are citizens 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 and Adult Services 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 and Adult Services 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.

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.

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 Aging and Adult Services manages the DHHS public agent guardian program, and trains all public agent guardians, including county departments of social services, area mental health programs, local health departments, and county departments of aging. The DHHS Blanket Bond Data Base for all incompetent adults with a public agent guardian is also managed by the Division of Aging and Adult Services.

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.

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.

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.

Counseling and Case Management. An array of services provided by county departments of social services designed to help meet the medical, social, psychological, educational, and financial management needs of older and disabled adults and their families. Included in the array are Health Support Services, Personal and Family Counseling, Individual and Family Adjustment Services, Representative Payee Services, Employment and Training Support Services, and Community Living Services.

State/County Special Assistance for Adults. The Division of Aging and Adult Services 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.

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 72 counties. To qualify, the individual must meet the eligibility criteria for Medicaid and meet all other SA eligibility requirements.

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.

Complaint Intake Unit

The Complaint Intake Unit receives and prioritizes complaints and entity reports for health care providers licensed by the Licensure and Certification, Mental Health Licensure and Certification and Adult Care Licensure Sections within the DFS. These providers include nursing facilities, adult care and family care homes, acute care hospitals, home health agencies, end stage renal disease facilities, hospitals, suppliers of x-ray services, providers of outpatient physical therapy or speech pathology services, rural health clinics, comprehensive outpatient rehabilitation facilities, ambulatory surgical clinics, abortion clinics, cardiac rehabilitation programs, home care, hospice, nursing pool agencies, clinical laboratories, psychiatric hospitals and psychiatric units of acute care hospitals, intermediate care facilities for mentally retarded, substance abuse facilities, and programs and 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. Special restrictions apply to abortions, hysterectomies, and sterilization. Hospital services are paid on the basis of diagnostic-related groupings (DRGs). Inpatient hospital services are those items and services ordinarily furnished by the hospital for the care and treatment of inpatients. These must be provided under the direction of either a physician with privileges or a dentist in an institution maintained primarily for treatment and care of patients with disorders other than mental disease.

The inpatient hospital also provides services to individuals awaiting nursing facility placement in swing beds or lower level of care beds. These are beds that are designated for individuals who no longer need acute care placement for which there is not an available nursing facility bed in the community. ~~For SFY 2004-05 $52,945,366 was paid for inpatient hospital services for Medicaid eligible persons regardless of age.~~

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.

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. ~~For SFY 2004-05, 626,546,311 was paid for nursing home care for Medicaid-eligible persons regardless of age.~~

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 covered home health services include medically necessary skilled nursing care, specialized therapies (physical therapy, occupational therapy, and speech therapy), home health aide services, and medical supplies needed for diagnosis, treatment or rehabilitation of a patient's illness in the home setting when provided by a Medicare Certified Home Health Agency. The services may be provided in the patient's private residence or in an adult care home (ACH) with an exception of home health aide services in the ACH. The services are considered part time and intermittent and must be under a plan of care authorized by the recipient's physician. 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 2004-2005 there were 38,825 Medicaid recipients who received home health services at a cost of $110,507,956.~~

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 non-emergent medical transportation from the facilities in which they reside. Medicaid reimburses the nursing facility or adult care home a per diem amount on behalf of each Medicaid-eligible resident.

Optional Services

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

Home Infusion Therapy (HIT). HIT coverage provides for infusion nursing services, pharmacy services, medical equipment, supplies and training. HIT is self-administration (by the recipient or unpaid caregiver) of a drug or nutrition therapy such as total parenteral nutrition, pain management or antibiotics. The route of administration may be intravenous, enteral, parenteral, intrathecal or epidural. HIT coverage is for recipients who live in a private residence or an adult care home. For SFY 2004-2005 there were 2,271 Medicaid recipients that received HIT services at cost of $7,012,322.

Hospice. Hospice is a benefit package of medical and support services for terminally ill individuals which is elected by the recipient. An individual is considered terminally ill if he or she has a medical prognosis of a six month or less life expectancy as certified by a physician. The services include nursing care, medical social services, counseling, the professional care of a physician, home health aide and homemaker services, physical and occupational therapy, speech-language pathology, medical appliances and supplies, drugs and biologicals, and short-term inpatient care (general and respite) when related to the terminal illness. The services are

provided in a private residence, an adult care home, a hospice residential care facility or a hospice inpatient unit. The services also may be provided in a hospital or nursing facility under arrangement with the hospice agency. For SFY 2004-2005 there were 4,804 Medicaid recipients that received hospice care at a cost of $42,375,218

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.

Personal Care Services. Personal Care Services (PCS) covers the services of an aide in the recipient's private residence to assist with the recipient's personal care needs that are directly linked to a medical condition. The services must be authorized by the recipient's primary care physician, physician's assistant, or nurse practitioner working under the supervision of the physician (as set forth in the licensing regulations of the North Carolina Boards of Medicine and Nursing). PCS is a paraprofessional service and does not include skilled medical or skilled nursing care. This program is restricted to no more than 3.5 hours per day or 60 hours per month. For SFY 2004-05, $277,716,888 was paid for PCS and PCS-Plus recipients.

Personal Care Services-Plus (PCS-Plus). Personal Care Services-Plus (PCS-Plus) is an enhancement to the PCS program. PCS-Plus is for recipients who have a qualifying medical condition and personal care needs that exceed the service limit for PCS. Services include assistance with personal care tasks such as bathing, toileting, ambulating, and monitoring vital signs. In addition, services such as housekeeping and home management tasks may be provided if they are essential to the personal care task(s) necessary for maintaining the recipient's health. 80 hours of care per month is offered with no daily limits. For SFY 2004-05, $277,716,888 was paid for PCS and PCS-Plus recipients.

Personal Care Services Provided in an Adult Care Home. During the 1995 legislative session, personal care services were authorized to be provided in an Adult Care Home (ACH). Beginning January 1997, DMA was authorized to fund enhanced personal care services for residents needing extensive or total assistance with eating, toileting, ambulation/locomotion or any combination of the three. Residents are approved for this enhanced personal care service by a county department of social services or local mental health authority case manager. This approval also makes the resident eligible for adult care home case management services. For SFY 2005 the NC Medicaid program paid $146,146,909 for personal care services provided in an adult care home.

Non-Emergent Medical Transportation. The NC Medicaid Program also pays a daily rate to ACH providers for the provision of non-emergent medical transportation. This allows recipients to have transportation to medical appointments and other health related appointments. For SFY 2005 $4,413,715 was expended on this program.

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 $3.00 per prescription co-payment applies, except for certain exempt groups. Payment for drugs is based on the average wholesale price less 10 percent, the State Maximum Allowable Cost, or the Federal Upper Limit 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.

Private Duty Nursing (PDN). PDN coverage is for recipients who live in a private residence and require substantial, complex and continuous skilled nursing care as ordered by the attending physician. PDN services require prior approval by DMA nurse consultant and must be supported by a physician's letter of medical necessity. For SFY 2004-2005 there were 371 recipients who received PDN services at cost of $43,591,732.

Dental Services. Most general dental services are covered, such as exams, cleanings, restorations, extractions, x-rays, partial and

complete dentures, denture adjustments, denture relines, denture repairs, and full mouth scaling and root planing. 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.

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. Staff at mental health centers are enrolled and mental health services require prior approval after 8 visits per calendar year. Area programs are paid the same rates as direct enrolled mental health practitioners. Visits to independent psychiatrists and physicians are covered for mental health services, as well. Prior approval is required for outpatient visits after the first eight are completed. Visits to a private practice psychiatrist for 90862 medication management or visits billed with E&M codes count against the annual 24 visit outpatient limit and a $3.00 copayment applies. 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 elderly and disabled adults (CAP/Choice), 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. Services such as a in-home aide, telephone alert, home mobility aids, medical supplies, and oral nutritional supplements are available under this program. All 100 of North Carolina's counties currently offer the CAP/DA program. For SFY 2004-05, $225,918,930 was paid for CAP-DA services for 13,620 individuals.

Community Alternatives Program for Choice (CAP/Choice). CAP/Choice is an alternative to the existing traditional Home and Community-Based Services (HCBS) waiver program, Community Alternatives Program for Disabled Adults (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 allows recipients (consumers) who prefer to select their individual workers, more fully direct their care, and have more flexibility in tailoring plans of care to their home care requirements. In assuming these responsibilities, the recipient necessarily takes on risk that was previously assumed by provider agencies and program managers. Recipients who participate in this program will therefore enter into agreements with the lead agencies which outlines, the rights, risk, and responsibilities. This form of self directed care will be coordinated locally through lead agencies which function as the local entry point for CAP/DA and provide local oversight. Lead agencies include

the departments of social services, health departments, aging agencies and hospitals. The lead agencies will provide both Financial Management and Care Advice services and will manage consumer-designated funds. This program is currently being provided in 2 pilot counties, Duplin and Cabarrus. Program expenditures are included in the figures for the CAP/DA program.

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.

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 mission of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services is to provide people with, or at risk of, mental illness developmental disabilities and substance abuse problems and their families the necessary prevention, intervention, treatment, services and supports they need to live successfully in communities of their choice. The division operates four regional psychiatric hospitals for those who need inpatient psychiatric services. It operates a special care center for older people with serious medical and

mental health problems. The division provides residential services at four regional developmental 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 has been reorganized as a skilled nursing facility for people with cognitive disabilities who are aging and have high medical needs or are medically fragile. The Division also oversees residential and outpatient treatment at three alcohol and drug abuse treatment centers.

Community based mental health, developmental disabilities, and substance abuse services are provided through a network of area authorities or county programs that cover the state's 100 counties. Anyone can seek services through the public system. The system's response includes screening, triage and referral, prevention and crisis services if needed. The publicly sponsored mental health, developmental disabilities and substance abuse specialty system is committed to serving individuals with the most severe disabilities. For individuals not in the target population who have the personal resources (insurance and ability to pay), the system's response could also include linking those persons to private providers for longer term services.

An example of a special approach being used to help older adults remain in their communities is the geriatric mental health specialty team model. Each of the current 21 teams consists of at least a registered nurse and master level therapist both with expertise working with older individuals with mental illness. The teams provide technical support, training and consultation to the staff working at nursing homes and adult care homes that serve older individuals with mental illness. The teams also provide consultation and training to caregivers of older individuals with mental illness living in their home. The purpose of the teams is to assist staff and caregivers in preventing psychiatric hospitalization. The teams assist the liaisons to state hospitals and other service providers in to develop plans for individuals to return to their communities with appropriate services. The teams also can provide education and training to staff at Senior Centers, Hospice and Home Care staff.

Through a contract with the Arc/NC, the Division supports the *LIFE Guardianship* 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/)

The North Carolina Arthritis Program, Physical Activity & Nutrition (PAN) Branch

The North Carolina Arthritis Program is collaborating with the North Carolina/South Carolina Chapter of the National Arthritis Foundation (NAF) and the Centers for Disease Control and Prevention (CDC) to reduce the occurrence, disability, activity and work limitations, social isolation, and improve quality of life for the more than 2.4 million North Carolinians living with arthritis and other rheumatic conditions. The program goals are being met by educating people about arthritis, providing tools to manage their arthritis, and by working with community partners. The Program offers arthritis management certification trainings to increase awareness across the State about the importance of early detection, diagnosis, treatment and management of arthritis. Those programs include the Arthritis Foundation Exercise Program (AFEP), Arthritis Self-Help Program (AFSHP), and the Arthritis Foundation Aquatic Program (AFAP). The North Carolina Arthritis Program also has an Advisory Board that promotes and supports arthritis efforts in North Carolina. The three committees of this Board include 1) Communications and Public Awareness, 2) Evidence-Based Interventions, and 3) Policy and Advocacy. The NC Arthritis Program will be launching a communications campaign in spring 2006 highlighting the CDC message of "Physical Activity: The Arthritis Pain Reliever." To learn more about this Program, visit our website at http://www.ncarthritis.com/.

North Carolina DPH in partnership with DAAS successfully obtained a jointly funded small-grant from CDC and AOA in 2005. NC was one of 11 states to administer a SENIOR Grant Program to demonstrate effective collaboration of State Health Departments and State Units on Aging to implement local evidence-based health promotion and disease prevention programs for older adults.

The NC program implemented PACE (People

with Arthritis Can Exercise) program, targeting the African American population of Mid-Carolina Area Agency on Aging. Objectives included: creating a pool of qualified PACE instructors who will offer PACE programs to African Americans in Cumberland County, design culturally appropriate participant recruitment strategies, and evaluate the effectiveness of the program in order to create a successful model for other communities to follow. Evaluation of the program will be based on record keeping systems, participant/leader input, and a follow-up action plan to promote ongoing communications. This is a pilot program to encourage statewide participation in reaching minority populations with regard to physical activity.

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 legally residents of adult care homes.

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 (EBT cards). The Food Stamp Program is an entitlement program, so all eligible individuals and households can receive assistance. In November 2005, 73,150 persons age 60 and older received Food Stamps. A Food Stamp Program demonstration project was launched in late summer 2005 focusing on reaching SSI households aged 65 and older who do not currently get Food Stamps. Through October 2005, more than 8,000 new Food Stamp cases have been approved using an abbreviated application form and standardized benefits of $38 or $62 per month depending on shelter expenses.

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 February 2005, 49,113 persons age 60 and older received Energy Assistance.

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 in the Community Services Section—with the goals of promoting employment and independence for persons with disabilities through customer partnerships and community leadership.

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 vocational rehabilitation services. 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. The Office of Citizen Services and the Division of Information Resource Management are co-leading a new initiative to develop a statewide, web-based Information and Referral service called *NC Care Link* that will be of value to both consumers and service providers.

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.

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 used 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 helped 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, one 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/).

Office of Research, Demonstrations, and Rural Health Development

The Office of Research, Demonstrations, and Rural Health Development has administered 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, has paid 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 has coordinated a medication management program in 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. These Centers have also contributed in the education of Medicare beneficiaries about the new Part D prescription drug assistance program of Medicare.

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 Office of Research, Demonstrations, and Rural Health Development is currently expanding the scope of its Community Care of North Carolina program—at the direction of the General Assembly—to include the Aged, Blind and Disabled. The Office will be developing pilots for this expansion.

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, 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. Staff of the Commission have also helped an annual North Carolina Indian Senior Citizens Conference, sponsored by the North Carolina Indian Senior Citizens Coalition.

Council for Women and Domestic Violence Commission

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 persons find jobs. Because of funding constraints, local ESC offices no longer have older worker specialists.

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
(http://www.ncccs.cc.nc.us/Basic_Skills/ncccLiteracyResourceCenter2.htm)
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/)

During the year ending October 31, 2005, 1,540 persons aged 50 and older entered North Carolina's correctional system. To help meet the needs of an older prison population, the Department of Correction has a 55-bed health and long-term care 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. It has served as the state's primary resource for educating Medicare beneficiaries about Medicare changes—most notably the recent creation of the Part D prescription drug assistance program. 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 thousands of volunteers who undergo an extensive 24-hour training course to serve as SHIIP counselors. Some of these volunteers receive additional training to become certified 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.

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 and Medicaid Services. 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 Adult Services, 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.

SHIIP also administers **Medicare Lookout**, a federally funded grant program, to provide education and outreach to Medicare beneficiaries designed to prevent improper payments in the Medicare and Medicaid programs and to preserve these public health programs for future generations. 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.

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).

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. EDTAP is one transportation program that provides important assistance to older adults without access to a vehicle.
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.

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 Volunteerism and Community Service
(http://www.volunteernc.org)

North Carolina Americorps/Vista (Volunteers in Service to America)

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)
(http://www.nationalservice.gov/about/role_impact/state_profiles_detail.asp?tbl_profiles_state=NC)

More than 10,000 seniors in North Carolina contribute their time and talents in one of three Senior Corps programs. **Foster Grandparents** serve one-on-one as tutors and mentors to more than 2,200 young people who have special needs. **Senior Companions** help more than **840** homebound seniors and other adults maintain independence in their own homes. **Retired and Senior Volunteer Program (RSVP)** volunteers conduct safety patrols for local police departments, participate in environmental projects, tutor and mentor youth, respond to natural disasters, and provide other services through more than 1,200 groups across 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.

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.

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 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.

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 Adult Services, and AARP, are co-chairing the North Carolina Senior Consumer Fraud Task Force (see http://www.dhhs.state.nc.us/aging/fraud/alert.htm).

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. Today, there are over 50,000 participants in 53 Local Games programs that serve all 100 counties across the state. 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, corporate sponsors, and many coordinating and endorsing agencies such as the Division of Aging and Adult Services, Health Services, Parks and Recreation, AARP, and the medical profession.

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 education programs 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. IOA also houses the Center for Aging and Diversity and the NC Healthy Aging Network.

News from the 2005 White House Conference on Aging

For Immediate Release
Wednesday, December 14, 2005

Moya Benoit Thompson, 301-443-239
Brian Wesolowski 202-414-0779

******* PRESS RELEASE *******

2005 WHITE HOUSE CONFERENCE ON AGING CLOSES
Top 10 Resolutions Announced

WASHINGTON, DC – The 2005 White House Conference on Aging (WHCoA) officially closed today, with delegates sharing recommendations to be sent to the President and Congress on the pressing aging issues of today and the future. Delegates in attendance selected the top 50 resolutions to present and participated in working groups to develop strategies for implementing the resolutions. The top 10 resolutions as voted by the delegates are:

- Reauthorize the Older Americans Act Within the First Six Months Following the 2005 White House Conference on Aging
- Develop a Coordinated, Comprehensive Long-Term Care Strategy by Supporting Public and Private Sector Initiatives that Address Financing, Choice, Quality, Service Delivery, and the Paid and Unpaid Workforce
- Ensure that Older Americans Have Transportation Options to Retain Their Mobility and Independence
- Strengthen and Improve the Medicaid Program for Seniors
- Strengthen and Improve the Medicare Program
- Support Geriatric Education and Training for All Healthcare Professionals, Paraprofessionals, Health Profession Students, and Direct Care Workers
- Promote Innovative Models of Non-Institutional Long-Term Care
- Improve Recognition, Assessment, and Treatment of Mental Illness and Depression Among Older Americans
- Attain Adequate Numbers of Healthcare Personnel in All Professions Who are Skilled, Culturally Competent, and Specialized Geriatrics
- Improve State and Local Based Integrated Delivery Systems to Meet 21st Century Needs of Seniors

By statute, the final report from the conference will be presented to the President and Congress by June 2006.

For a full listing of the 50 resolutions, visit www.whcoa.gov.

-MORE-

About The White House Conference on Aging

The 2005 WHCoA is the fifth WHCoA in history. Its purpose is to make recommendations to the President and Congress to help guide national aging policies for the next ten years and beyond. The 2005 WHCoA will focus on the aging of today and tomorrow, including 78 million baby boomers who will begin to turn 60 in January 2006. For more information about the WHCoA, please visit www.whcoa.gov.

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Media Notes: For more information on the White House Conference on Aging please contact Moya Thompson at 301-443-2394, moya.thompson@whcoa.gov; or Brian Wesolowski at 202-414-0779, brian@susandavis.com; or Jennifer Devlin at 703-876-1714, jennifer.devlin@cox.net. Please note that the conference is open to credentialed media only. Space is limited and pooling may be required.

50 RESOLUTIONS
As Voted by 2005 WHCoA Delegates
Monday, December 12, 2005
(unranked)

Res. 1 Provide Financial and Other Economic Incentives and Policy Changes to Encourage and Facilitate Increased Retirement Savings

Res. 4 Establish Principles to Strengthen Social Security

Res. 5 Foster Innovations in Financing Long-Term Care Services to Increase Options Available to Consumers

Res. 7 Strengthen Law Enforcement Efforts at the Federal, State, and Local Level to Investigate and Prosecute Cases of Elder Financial Crime

Res. 9 Modernize the Supplemental Security Income (SSI) Program

Res. 10 Strengthen the Social Security Disability Insurance Program

Res. 11 Remove Barriers to the Retention and Hiring of Older Workers, Including Age Discrimination

Res. 12 Promote Incentives for Older Workers to Continue Working and Improve Employment Training and Retraining Programs to Better Serve Older Workers

Res. 14 Expand Opportunities for Developing Innovative Housing Designs for Seniors' Needs

Res. 15 Encourage Redesign of Senior Centers for Broad Appeal and Community Participation

Res. 17 Reauthorize The Older Americans Act Within The First Six Months Following The 2005 White House Conference On Aging

Res. 18 Encourage Community Designs to Promote Livable Communities that Enable Aging in Place

Res. 19 Create a National Strategy for Promoting Elder Justice Through the Prevention and Prosecution of Elder Abuse

Res. 21 Support Older Drivers to Retain Mobility and Independence through Strategies to Continue Safe Driving

Res. 22 Ensure That Older Americans Have Transportation Options to Retain Their Mobility and Independence

Res. 23 Enhance the Availability of Housing for Older Americans

Res. 24 Enhance the Affordability of Housing for Older Americans

Res. 25 Encourage the Development of a Coordinated Federal, State, and Local Emergency Response Plan For Seniors in the Event of Public Health Emergencies or Disasters

Res. 26 Support Older Adult Caregivers Raising Their Relatives' Children

Res. 28 Promote Economic Development Policies that Respond to the Unique Needs of Rural Seniors

Res. 29 Promote Enrollment of Seniors into the Medicare Prescription Drug Program

Res. 30 Develop a Coordinated, Comprehensive Long-Term Care Strategy by Supporting Public and Private Sector Initiatives that Address Financing, Choice, Quality, Service Delivery, and the Paid and Unpaid Workforce

Res. 31 Apply Evidence Based Research to the Delivery of Health and Social Services Where Appropriate

Res. 32 Evaluate Payment and Coordination Policies in the Geriatric Healthcare Continuum to Ensure Continuity of Care

Res. 33 Promote the Importance of Nutrition in Health Promotion and Disease Prevention and Management

Res. 34 Improve The Health And Quality Of Life Of Older Americans Through Disease Management And Chronic Care Coordination

Res. 36 Improve Recognition, Assessment, and Treatment of Mental Illness and Depression Among Older Americans

Res. 37 Prevent Disease and Promote Healthier Lifestyles Through Educating Providers and Consumers on Consumer Healthcare

Res. 39 Improve Health Decision Making Through Promotion of Health Education, Health Literacy, and Cultural Competency

Res. 40 Attain Adequate Numbers of Healthcare Personnel in All Professions Who are Skilled, Culturally Competent, and Specialized in Geriatrics

Res. 41 Support Geriatric Education And Training For All Healthcare Professionals, Paraprofessionals, Health Profession Students, And Direct Care Workers

Res. 42 Promote Innovative Models of Non-Institutional Long-Term Care

Res. 43 Ensure Appropriate Care for Seniors with Disabilities

Res. 44 Reduce Healthcare Disparities Among Minorities by Developing Strategies to Prevent Disease, Promote Health, and Deliver Appropriate Care and Wellness

Res. 46 Promote Innovative Evidence-Based and Practice-Based Medical And Aging Research

Res. 47 Encourage Appropriate Sharing Of Healthcare Information Across Multiple Management Systems

Res. 48 Ensure Appropriate Recognition and Care For Veterans Across All Healthcare Settings

Res. 50 Strengthen and Improve the Medicaid Program for Seniors

Res. 51 Strengthen and Improve the Medicare Program

Res. 52 Educate Americans on End of Life Issues

Res. 53 Improve Access To Care For Older Adults Living In Rural Areas

Res. 55 Improve Patient Advocacy to Assist Patients in and Across All Care Settings

Res. 56 Develop a National Strategy for Promoting New and Meaningful Volunteer Activities and Civic Engagements for Current and Future Seniors

Res. 59 Reauthorize the National and Community Service Act to Expand Opportunities For Volunteer and Civic Engagement Activities

Res. 61 Promote the Integration of Health and Aging Services to Improve Access and Quality of Care for Older Americans

Res. 62 Develop Incentives to Encourage the Expansion of Appropriate Use of Health Information Technology

Res. 67 Develop a National Strategy for Supporting Informal Caregivers of Seniors to Enable Adequate Quality and Supply of Services

Res. 69 Implement a Strategy and Plan for Accountability to Sustain the Momentum, Public Visibility, and Oversight of the Implementation of 2005 WHCoA Resolutions

Res. 71 Improve State and Local Based Integrated Delivery Systems to Meet 21st Century Needs of Seniors

Res. 72 Review Alignment of Government Programs That Deliver Services to Older Americans

Implementation Strategy Session Rooms will be identified by 6:30 a.m., Tuesday, December 13, 2005. Please check the plasma screens in the WHCoA registration area. Hard copies will be available at the WHCoA registration desk.

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Implementation Strategies for the 6 Policy Areas

Workplace of the future

- Keep older workers engaged in the community both at work in new or changed jobs, and as volunteers.
- Remove age discrimination.
- Reauthorize the Older Americans Act Title V. Ease the income eligibility limit, and lower age of eligibility to 50. Maintain dual structure of Community Service and lower the requirement to move to unsubsidized employment.
- Greater collaboration with the Workforce Investment Act.

Our Community

- Reauthorize the Older Americans Act with a substantial increase in funding.
  Create a new title to help communities prepare for the aging of baby boomers.
  Involve State Unites on Aging, AAA's, and Tribal Units.
  Fully integrate nutrition services to assist families.
  Give caregiver support across all generations.
- Elevate tribal services by creating a deputy American Indian position at AOA
- Innovative Housing designs that incorporate universal design.
  Change zoning requirements to allow communal living, walkable communities, access to services.
  Use tax incentives to build affordable housing.
  Support a Federal Housing Trust Fund and remover regulatory obstacles to encourage affordable and suitable housing.
- Encourage redesigned Senior Centers, expanding their role as focal points and integrate them with other resources. Create and fund a new title of the Older Americans Act to support Senior Centers.
- Resolution 19 – Elder Justice Act: Build capacity of Adult Protective Services and Ombudsman program.
  Create a postage stamp – "Stamp Out Elder Abuse."
- Resolution 21-22: Transportation. Require that public transportation services participate in disaster preparedness.
  More senior friendly road and vehicle designs. Help people continue to drive based on ability, not age.
- Resolution 25: Encourage Emergency Response Planning:
  Track vulnerable individuals via technology (GIS), create buddy system.
  Clarify roles and responsibilities of all personnel involved.
  Create a system for ensuring that emergency resources build on the existing network.
- Support older adult caregivers raising relatives' children by lowering the age limit of the caregiver and raising the age limit of the child in the National Family Caregiver Support Program.

Planning Along the Lifespan

- Increase retirement savings through strengthening financial literacy.
  Use the tax code to promote Long Term Care Insurance, IRA's and 401K's.

Create a $1000 birth account to use for long life needs.

- Make Social Security stronger, but do not privatize it. #11
  Raise the cap on Social Security taxable income and include all employees.
  Restructure the Social Security Disability Insurance Program to modernize it.

Health and Long Term Living

- Establish a coordinated national Long Term Care policy. Fund more home and community based services.
- Create a single point of entry.
- Use the Aging and Disability Resource Center model in all states, all localities.
- Use a comprehensive needs assessment to map out a care plan.
- Develop and use chronic care management systems.
- Develop a plan for health literacy across all ages
- Address health care disparities based on gender, race, ethnicity, and sexual preference.
- Support end of life care.
- Assure adequate care of veterans in all settings.

Care and Services in Rural Areas

- Make greater use of Telemedicine and other technologies and standardize information sharing across settings.
- Use a PACE model in rural areas.

Medicaid

- Create a seamless system of health, Long Term Care including elimination of Medicaid institutional bias.
  No block grants in Medicaid.
  Full funding of care needs.

Medicare

- Create part E – a comprehensive, lifetime Long Term Care benefit for all Americans of All Ages.
- Simplify Part D.

Geriatric Workforce

- Reinstate financial support to train geriatricians, and all the allied and supportive staffs needed to care for older Americans.

Civic Engagement

- Resolutions 56 and 59:
  Reauthorize the National Volunteer and Community Service programs and increase slots for Foster Grandparents program, and other community service programs.
  Have an RSVP program in every county.
  Use Senior Centers as community centers.
  Give tax credits for volunteer time.
  Eliminate the volunteer driver liability.
  Promote corporate citizenship.
  Create a Blueprint for tapping baby boomers and older adults as social capital.
  Stimulate a national volunteering campaign.

Technology and the Marketplace

- Recognize that technology will be critical in the future.
  Promote integrated health and aging services.
- Create a new title of the Older Americans Act for Aging and Disability Resource Centers.
- Have a virtual electronic database that is shared among providers.
- Facilitate an improved standardized information exchange for client care.
- Expand insurance coverage for Telehealth – electronic communication between Dr. and patient.
- Reduce cost of Malpractice insurance for telehealth.
- Use telehealth widely in rural and medically underserved areas.

Crosscutting items

- Develop Innovative Strategies in all settings
- Care for Veterans in all settings.
- Support Family Caregivers. Consider a credit for care-giving in Social Security.
- Review alignment of programs for older Americans to promote efficiency and effectiveness. Integrate funding streams and promote sharing of information and data systems.
- Support Aging –related research.
- Support community preparedness for an aging population toward the goad of "aging well in livable communities."
- Encourage accountability for implementing the 2005 White House Conference on Aging recommendations through a funded bi-partisan commission.
- Consider convening an American Indian White House Conference.

Presentation to NC Study Commission on Aging—An Overview of the Home and Community Care Block Grant (HCCBG)

December 20, 2005

- General Assembly established the 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

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
Health Promotion and Disease Prevention	Institutional Respite Care	Volunteer Program Development

- Focus is on supporting frail elderly at home, improving physical and mental health, assisting with access to services and information, providing family caregiver relief, and helping seniors remain active

Making a Difference—Who Was Served during SFY 2004-2005?

- 72%—women (as compared to 58% of population aged 60+)
- 35%—minority (as compared to 18%)
- 58%—age 75+ (as compared to 34%)
- 49%—live alone (as compared to 28%)
- 72%—unable to manage on their own (as compared to 12%)
- 66%—at risk of malnutrition
- 48%—reportedly low income (as compared to 13 at or below poverty and 36% at or below 200% of poverty)

Making a Difference—Are the funds used wisely?

- Of the 18 services, 13 are clearly 'core' long-term care services
- 93% 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

- Negligible Federal increase since 2000 while State support has decreased by $200,000
- Statewide utilization/expenditure rate is very high (99% as of SFY 2004-2005)
- Service unit costs have generally increased by 10.5% since SFY 2000-2001
- Decline in clients served and service units (9% decrease in clients since SFY 2000-2001); some decrease in counties offering services
- 8,334 clients were waiting for at least one of 9,792 service needs at the end of SFY 2004-2005; contrasted with 6,442 clients and 6,847 service needs at the end of SFY 2003-2004

Intrastate Funding Formula

- Uses best available data (2000 Census-based)
- Provides a $60,000 base amount to each county to support minimum capacity
- Uses the following factors and weights: population aged 60 and older (50%); population aged 60+ living in poverty (30%); population aged 60+ who are minority (10%); population aged 60+ who live in rural area (10%).
- Protects counties from substantial changes in funding with 5% cap on loss

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
- Changes in other funding sources and services

What It Will Take to Respond—What Happens If We Don't

- $13.3 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

"Increase funding for home and community based services for older adults by increasing the Home and Community Care Block Grant by $5 million."—2005 Legislative Priority of the NC Senior Tar Heel Legislature

Profile of HCCBG Services [as of SFY 04-05]

Below is a list of the services funded under the HCCBG for which clients are reported to the Division of Aging and Adult Services 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 ($9,570 in SFY 2004-2005). 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 (70%), economically needy (65%), has limitations with 1+ ADLs (70%) and 3+ IADLs (71%), and is at risk of malnutrition (71%).* 37% are cognitively impaired. Among ADC clients, 67% report that the services they receive relieve their caregiver. 37 counties funded ADC under the HCCBG.

Adult day health (ADH) services add health care to the ADC service. *The average client is 80 years old, female (69%), economically needy (55%), has limitations with 2+ ADLs (65%) and 3+ IADLs (83%), is cognitively impaired (51%), and is at risk of malnutrition (80%).* Among ADH clients, 70% report that the services they receive relieve their caregiver. 29 counties funded 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 (72%), has limitations with 3+ ADLs (64%) and 3+ IADLs (93%), and is at risk of malnutrition (93%).* 10 counties funded 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 75 years old, female (70%), and does not have limitations in ADLs or IADLs.* Nearly half (46%) live alone and 46% are at risk of malnutrition. All counties funded congregate meals under 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 80 years old, female (63%), has limitations with 1+ ADLs (64%) and 3+ IADLs (70%), is cognitively impaired and at risk of malnutrition (74%), and is* economically needy (51%). 8 counties funded group respite.

Home-delivered meals is a service that provides a meal (typically lunch), with one-third of the recommended daily dietary allowance, to a home-bound older adult. *The average client is 80 years old, female (69%), has limitations with 1+ ADLs (59%) and 3+ IADLs (77%), is economically needy (56%), is at high risk of malnutrition (65%), and lives alone (46%).* 96 counties funded 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 80 years old, female (58%), and has limitations with 1+ ADLs (79%) and 1+ IADLs (73%).* One county funded home health under the HCCBG.

Housing and home improvement is a service that assists older adults obtain or maintain 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 (74%), economically needy (79%), has limitations with 2+ ADLs (52%) and 2+ IADLs (71%), and is at risk of malnutrition (83%).* 44% live alone. 36 counties funded 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 (78%), lives alone (56%), has limitations with 3+ IADLs (63%), and is at risk of malnutrition (81%).* 25% are cognitively impaired, and 45% are economically needy. 77 counties funded 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 (75%), has limitations with 2+ ADLS (64%) and 3+ IADLs (78%), and is at risk of malnutrition (86%).* 35% are cognitively impaired, 41% live alone, and 42% are economically needy. 88 counties funded 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 (67%), has limitations with 3+ ADLS (58%) and 3+ IADLs (87%), and is at high risk of malnutrition (52%).* 34% are cognitively impaired and 38% are economically needy. 50 counties funded 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 help in performing family functioning skills. *The average client is 74 years old, female (64%), has limitations in 1+ ADLs (57%) and in 3+ IADLs (79%), is cognitively impaired (100%), and is at risk of malnutrition (62%).* One county funded 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 80 years old, female (68%), has limitations in 1+ ADLs (65%) and in 3+ IADLs (67%), is cognitively impaired (56%), is at risk of malnutrition (60%), and is economically needy (*69%). One county funded this service under the HCCBG.

The Senior Companion program offers a part-time stipended volunteer opportunity for low-income persons 60+ years of age 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 (91%), economically needy (56%), and lives alone (73%).* 7 counties funded 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 77 years old, female (79%), economically needy (55%), lives alone (54%), has limitations in 1+ IADLs (61%), and is at risk of malnutrition (55%).* 95 counties funded this program under the HCCBG.

Medical transportation is a service that provides travel to medical appointments. *The average client is 78 years old, female (75%), economically needy (55%), lives alone (54%), has limitations in 1+ ADLs (58%) and 1+ IADLs (78%), and is at risk of malnutrition (58%).* 51 counties funded 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. One county funded this service under the HCCB. 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 funded 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 obtain other appropriate and needed services. 37 counties funded this service under the HCCBG.

Mental Health Counseling is a service that incorporates care consultation, evaluation, and outpatient treatment to older adults with mental health problems. No counties funded 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; the provision of opportunities for older adults to become more involved in the community; the prevention of loneliness and premature institutionalization; and the promotion of personal independence and wellness. 53 counties funded the operation of senior centers under the HCCBG.

Volunteer Program Development supports the development and operation of a systematic program for volunteer participation. These volunteers, encompassing all ages, provide opportunities for older adults to perform community services for other older adults. 7 counties funded 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
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]

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES

PROJECT C.A.R.E:
"Caregiver Alternatives to Running on Empty"

SUMMARY:

The NC Alzheimer's Demonstration Program, Project C.A.R.E: "Caregiver Alternatives to Running on Empty", uses a consumer-directed, family consultant model to provide comprehensive respite support to dementia caregivers. The goal of the program is to increase access, choice, use, and quality of respite care to underserved rural and minority communities. Through the integration of dementia-specific services, Project C.A.R.E. intends to create a seamless, coordinated delivery system that is responsive to the needs, values, and preferences of Alzheimer's families.

Project C.A.R.E. is administered by the Division of Aging and Adult Services and receives technical assistance from the Duke Family Support Program. Operating within the community-based contexts of the Alzheimer's Association and County Department of Social Services, Project C.A.R.E. Family Consultants visit the homes of referred Alzheimer's caregivers in crises. The Consultants offer timely, individualized guidance, counseling, support, advocacy, coaching and education for family caregivers. Their aim is to match families with the most appropriate and preferred local respite and community services tailored to the unique context of care and family needs. Through Project C.A.R.E., dementia caregivers may spend up to $2000 a year toward respite services. Families are able to choose among a full continuum of consumer-directed care options, including adult day services, group respite, private or agency in-home care, and overnight residential respite. There are three pilot sites set up to serve the following ten counties: Charlotte (Mecklenburg County), Winston-Salem (Forsyth, Surry, and Stokes); and Asheville (Polk, Henderson, Transylvania, Rutherford, Madison, and McDowell).

NATIONAL RECOGNITION:

- 2004 Geriatric Best Practice Award: *"Developing Quality Caregiver Support and Respite Programs"* – Southeast Regional Geriatric Best Practices Initiative
- 2005 National Innovative Program Clearinghouse Award – National Alzheimer's Association
- 2005 National Best Practice Model for *"Implementing Systems and Sustained Change in Long-Term Care"* – US Administration on Aging Alzheimer's Disease Demonstration Grants to States (ADDGS) Program and RTI International
- 2005 National Conference of State Legislators – featured by the National Alzheimer's Association as a national model for home and community-based care coordination

OBJECTIVES:

- Provide dementia-specific counseling, information, problem-solving, capacity-building, and appropriate respite care support to family caregivers who are not receiving services due to geographical factors, economic, racial, or cultural isolation from information sources, or gaps in available local resources;
- Strengthen the linkages between the Alzheimer's Association, Family Caregiver Support Program and the community-care system through information sharing, formalizing service agreements and increasing the availability of quality respite;
- Provide dementia-specific education, training, and resources to community-based direct care providers, family caregivers, faith-based organizations, and other aging and adult services providers;
- Link dementia families to supplemental education programs and supportive resources available in the community, including Aging and Disability Resource Centers, caregiver skills training, and faith-based volunteer networks.

OUTCOMES:

- Families are more informed about the value and availability of respite and how to use respite services effectively to preserve family care capacity;
- Families experience greater self-efficacy and control regarding service selection and utilization;
- Increased use of dementia-specific respite care services by low-income rural and minority families;
- Expanded availability of dementia-specific training, education, and resources.

COST OF TEN COUNTY DEMONSTRATION:

- Total federal funding - $933,450 (July 2004 – June 2007) - Title IV OAA funds
- Total budget: 1st year (25% match) - $414,867; 2nd year (35% match) - $478,692
- Funds for direct respite services (minimum 50%): 1st year - $241,370; 2nd year - $258,908
- Flexible annual spending cap for respite care: $2,000 per family
- Respite services include - purchase approximately 2 days per week of adult day services, 2 times a week of in-home personal care, or 7 days of overnight respite per year per (i.e. *if* a family chooses to spread respite care evenly over one year).

PROGRAM MANAGEMENT & KEY PARTNERS:

- **NC Division of Aging and Adult Services (DAAS) Project Director** – Karisa Derence (existing position; 60% of salary used as in-kind match)
- **Western Carolina Alzheimer's Association Chapter** - 2 Family Consultants (full time) for nine counties; *currently funded through private foundation grants
- **Mecklenburg County Department of Social Services** – 1 Family Consultant (part time); *now a county funded position
- **Duke Aging Center Family Support Program** - provides technical assistance and training support to Project C.A.R.E. Family Consultants, Family Caregiver Support Program Resource Specialists, provider agencies, referral sources and client families; *funded through existing DAAS Alzheimer's Support Program contract
- **Four Area Agencies on Aging (Regions B, C, I, and F)** - Family Caregiver Resource Specialists assist with training and volunteer programs, assessments of needs, and building an inventory of resources; *funded through NC Family Caregiver Support Program

October 2005

Alzheimer's Disease Demonstration Grants to States Program: North Carolina's Project C.A.R.E. – Caregiver Alternatives to Running on Empty

"Implementing Systems and Sustained Change in Long-Term Care" Executive Summary

Prepared for

Lori Stalbaum, M.S.W.
Administration on Aging
1 Massachusetts Avenue, NW
Washington, DC 20001

Prepared by

David Brown, M.A.
Kristin Siebenaler, M.P.A.
Joshua Wiener, Ph.D.
RTI International
1615 M Street, NW, Suite 740
Washington, DC 20036

RTI Project Number 09351.000.008

ALZHEIMER'S DISEASE DEMONSTRATION GRANTS TO STATES PROGRAM OF NORTH CAROLINA – PROJECT C.A.R.E.

David Brown, M.A.
Kristin Siebenaler, M.P.A.
Joshua Wiener, Ph.D.

AOA Project Officer: Lori Stalbaum, M.S.W.

RTI International*

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*RTI International is a trade name of Research Triangle Institute.

EXECUTIVE SUMMARY

The Alzheimer's Disease Demonstration Grant to North Carolina is a partnership among the Division of Aging and Adult Services in the North Carolina Department of Health and Human Services, the Duke University Center for Aging Family Support Program, the Western Carolina Chapter of the Alzheimer's Association, the Mecklenburg County Department of Social Services, and the Area Agencies on Aging for Regions B, C, F and I.

The grant funds Project C.A.R.E. (Caregiver Alternatives to Running on Empty), which has created a community-based, family-centered service system that provides direct access to dementia-specific respite care and connects families to other long-term care services. Project C.A.R.E. targets an underserved rural, minority and low-income elderly population. It demonstrates that both public and private entities can deliver dementia-specific respite services, allowing communities to administer the program in a way that is best-suited to local circumstances and needs.

Project C.A.R.E. offers families a personalized approach to respite care. Through Family Consultants, families are offered in-home assessment and care planning, a simplified determination of eligibility, a wide degree of flexibility and choice in the use of respite funding, ongoing case management, and education and training for caregivers and respite providers. Family Consultants also serve as a link for families to other long-term care resources. Family Consultants develop networks of provider, governmental, and volunteer agencies to bring quality dementia-specific respite services to caregivers.

To achieve systems change, Project C.A.R.E.: has used a number of strategies:

- *Integrated the needs of family caregivers into public programs and long-term care planning.* Through cooperation in strategic planning and collaboration with other state programs serving caregivers at the state level and the work of the Family Consultant in building networks of agencies and providers at the local level, Project C.A.R.E. has helped create a state long-term care system that recognizes the needs and preferences of the caregiver as well as the person with dementia.

- *Explored the efficacy of varying administrative sponsorship.* Project C.A.R.E. has demonstrated its effectiveness in two different administrative settings: under the guidance of an Alzheimer's Association Chapter, and as part of a unified county social services agency.

- *Increased access and availability of a comprehensive range and type of dementia-specific respite services by using the Family Consultant model.* Under Project C.A.R.E., the Family Consultant develops agency partnerships, recruits and trains service providers, publicizes the availability of caregiver services, conducts in-home assessments, facilitates the connection between the caregiver and respite care options and providers, and provides continuing support to both caregiver and provider.

- *Offered consumer choice and consumer-directed respite care.* Project C.A.R.E. provides flexibility in meeting the caregiver's needs through individualized attention and multiple options in the type, scheduling, and staffing of respite services.

- *Conducted outreach to low income, rural, and minority families.* Project C.A.R.E. targets underserved rural, minority and low-income elderly populations. By developing personal contacts and building bridges to the faith-based community, Family Consultants have helped overcome the cultural and geographical isolation facing dementia caregivers in rural mountainous areas and urban minority communities.

- *Connected families with information and services.* Project C.A.R.E. is bringing the expertise of the Alzheimer's Association and other proven resources into the community arena, educating both caregivers and providers to techniques which produce a higher quality of life for both client and caregiver. The network development work of the Project C.A.R.E. Family Consultants also puts them and the project in a unique position to link caregivers to a wide range of long term care services and supports.

- *Leveraged ADDGS funds for sustainability.* The grant partners are making a diligent effort to identify resources to sustain the Project C.A.R.E., seeking private foundations funding, collaborations with other long-term care grants, and making plans to approach State legislative staff with evidence of the project's effectiveness. In the Mecklenburg County site Project C.A.R.E. has demonstrated its value to a local agency which is willing to support the Family Consultant function and be an advocate for county-level respite funding.

Through this Alzheimer's Disease Demonstration Grant, Project C.A.R.E. is a replicable model for bringing dementia-specific respite services and resources to family caregivers of persons with Alzheimer's disease and other dementias, with the flexibility to meet the needs of caregivers in different economic, cultural, and geographic settings.

Project C.A.R.E: "Caregiver Alternatives to Running on Empty"

Lessons for the Future

2005

Duke Aging Center Family Support Program

Executive Summary

Caregiver Alternatives to Running on Empty (Project C.A.R.E.) is a partnership between the North Carolina Division of Aging and Adult Services (NC-DAAS), the Mecklenburg County Department of Social Services (DSS) and the Alzheimer's Association, Western Carolina Chapter. The program is funded through the Administration on Aging Alzheimer's Demonstration Grant to States Program and receives technical assistance from the Duke Aging Center Family Support Program. Project C.A.R.E. provides caregiver-focused respite, education and support services for family caregivers of adults with dementia. Over 441 families received much needed respite care during the first three years of the program (July 2001- July 2004.)

The lessons learned from this program fall into two major categories – system lessons and client/family-focused lessons. One primary system lesson is the successful base of dementia-specific respite services in both an Alzheimer's Association and a DSS (with direct links to Alzheimer's Association expertise and resources). The success of both service delivery models suggests that different regions can tailor the program to their own strengths. A corollary to this system lesson and to the success of both service delivery models is the pivotal role of the family consultant. Well-developed community collaborations promote partnerships that integrate public and private resources. In addition, the program has demonstrated the feasibility and appropriateness of a system offering dementia-specific respite care to previously underserved areas and to previously inadequately served families.

Three client/family-focused lessons emerged from the project. First, consumer-directed respite services offer families preferred control over the services they receive. Second, respite for Alzheimer's families must offer in-home and day program options with flexible frequency and duration to meet family-specific needs and preferences. Finally, respite care can and should serve as a portal to other services, information, and resources for families who may be unaware of education, counseling, and other service options.

A Portal for Long-Term Care Services

Perhaps one of the most important benefits of Project C.A.R.E. is as a portal for multiple caregiver and dementia-specific services. The availability of immediate, individualized help and funding attracts families who potentially could benefit the most and who tend to fall through the cracks of traditional long-term care, aging and social service systems.

The lack of traditional eligibility limits or barriers results in serving families who would not know how to get help any other way. Offering a specific subsidized service attracts families who might be unlikely to respond to an offer for "free" or "volunteer" services and who otherwise might not call an Alzheimer's Association chapter or an.Alzheimer's national contact center for information, education or support.

Project C.A.R.E. becomes a point of entry in a "no wrong door" service system and has succeeded in attaining "outreach" goals that traditional aging services and the Alzheimer's Association have considered relatively hard to achieve. As a portal, Project C.A.R.E. links families to dementia-specific resources as well. For example, education and referral is provided to the Alzheimer Association's programs. Because the family consultant may provide counseling and information to families who choose not to enroll in Project C.A.R.E., the "portal" services of the family consultant were extended to 380 additional families.

Project C.A.R.E. has also become a "portal" to Alzheimer's Association support groups. Once families have established respite help, they are often more willing to connect with peers, hear stories and create family-specific support systems. Support group participation reinforces appropriate service use and provides access to consumer information about the quality of services. The family consultant may help translate the "culture of the service bureaucracy or support groups," which can be perceived as "foreign" to specific ethnic or regional cultures.

Future

The implementation of dementia-specific caregiver support needs more than a one-time infusion of legislated funding. System change and infrastructure building take time. Ongoing funding is needed. Project C.A.R.E. has proven its feasibility and value-added benefits and its lessons can inform other community-based long-term care programs. Although there is still a need for well-designed trials documenting benefits of quality dementia-specific respite services[1], the NC Project C.A.R.E. experience provides a foundation for future outcomes-based studies.

In 2003, NC-DHHS implemented a Communications and Coordination Initiative to support consumer-directed coordination of local long-term care service systems. Core service evaluation tools have been developed, including a tool evaluating the availability, adequacy, accessibility, efficiency, equity and quality of respite care for older adults. Project C.A.R.E. already meets each of these new state core service criteria.

The national Alzheimer's Association 2004 National Public Policy Program to Conquer Alzheimer's Disease, "From Hopeless to Hopeful" urges expansion of the AoA ADDGS to all fifty states. The July, 2004 reauthorization of Project C.A.R.E. as a system change grant has helped expand Project C.A.R.E. services offered through the Western Alzheimer's Association to four additional rural counties. In the U.S. Congress, Senators Mikulski and Bond have proposed increasing funding for the AoA's National Family Caregiver Support Program and the Alzheimer's Demonstration from $12 to $25 million. The AoA is collaborating with the national Alzheimer's Association by funding both the Eldercare Locator and the Alzheimer's Association National Contact Center. NC is strategically placed to become a national leader in creating a dementia-capable range of caregiver and care-receiver long-term care services. Through the continued success of the Project C.A.R.E. initiative, we are well on our way.

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[1] Lee H & Cameron M. Respite Care for People with Dementia and Their Carers. Cochrane Database of Systematic Reviews. (2): CD004396. 2004.

Partial Report of Public Expenditures for North Carolina's Older Adults

The attached report provides state summary data provided by the Divisions of Aging and Adult Services; Medical Assistance; Mental Health/Developmental Disabilities/Substance Abuse Services; Services for the Blind; Social Services; and Vocational Rehabilitation. Information was not yet available from all agencies for State Fiscal Year 2004-2005 (ending June 30, 2005); nor for all services (e.g., energy assistance under Social Services, health support and individual/family adjustment under Services for the Blind).

To assist with examining and comparing the service expenditures, each of the various services have been assigned to one of six major service categories:

Code	Description of Categories
1	Adult Care Homes—Includes Special Assistance payments for residents of adult care homes; Medicaid expenditures for personal care services (PCS-basic and enhanced), care management and screening, and transportation.
2	Economic Support—Programs and services that provide an indirect financial support, without which a cash outlay by the recipient would be required.
3	Hospitals, Physicians and Other Health Care—Services that provide a variety of health care to recipients outside their home.
4	Home Health and In-Home Care—Services that provide health and related care to recipients in their home.
5	Institutional Care—Services provided to residents of nursing homes and mental health facilities.
6	Social Support—Services that provide social and/or other support to recipients inside or outside their home.

Reported expenditures generally represent the federal, state, and minimum local share for services provided to individuals age 60 and older. Total expenditures listed under the Division of Aging and Adult Services also include consumer contributions. Several other noteworthy observations about the data include:

- The expenditures reported by Social Services for Special Assistance (SA) covers payments for those in adult care homes and for SA in-home services.
- All reported client counts under the Division of Aging and Adult Services (DAAS) are unduplicated except for Family Caregiver Support—Information. Reported expenditures for DAAS nutrition services include USDA reimbursement.

December 20, 2005

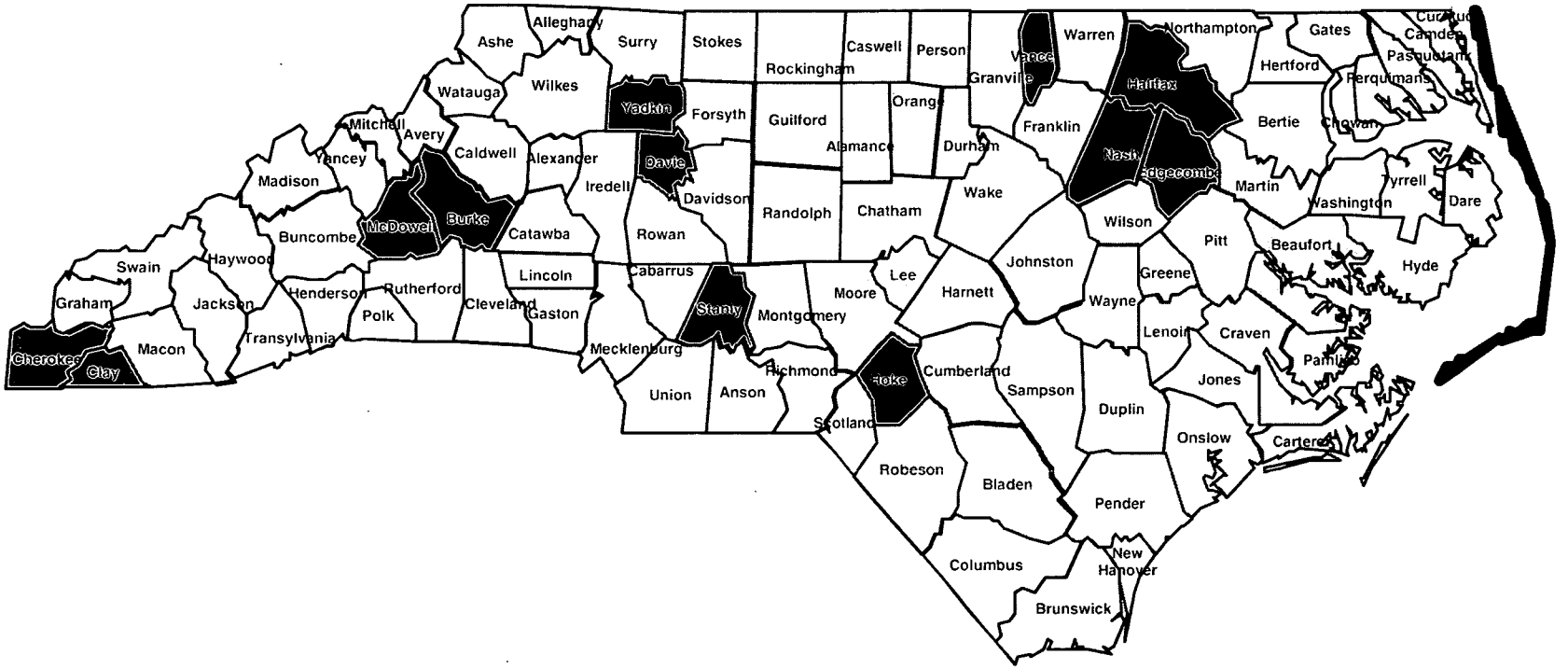
Expenditures by Funding Source, Service and Service Category for Clients 60+ Years of Age: SFY 2004-2005

	Category	Clients	Expenditures
Funding Source: Division of Aging and Adult Services			
Adult Day Care	4	543	$1,686,750
Adult Day Health	4	515	$1,552,845
Care Management	6	230	$895,194
Congregate Nutrition	6	26918	$10,266,466
Family Caregiver Support-Access	6	1565	$441,039
Family Caregiver Support-Counseling/Support groups/Training	6	1271	$436,908
Family Caregiver Support-Information	6	10026	$1,036,083
Family Caregiver Support-Respite Care	6	1691	$1,499,074
Family Caregiver Support-Supplemental Services	6	698	$253,108
Group Respite	6	70	$83,337
Health Promotion/Disease Prevention	3		$508,687
Health Screening	3		$20,683
Home Delivered Meals	4	19655	$11,375,762
Home Health	4	33	$30,424
Housing & Home Improvement	6	1226	$974,274
In Home Aide Level 1	4	3817	$5,164,808
In Home Aide Level 2	4	3868	$9,514,215
In Home Aide Level 3	4	1035	$3,059,438
In Home Aide Level 4	4	14	$39,499
Information & Case Assistance	6		$1,749,061
Institutional Respite	6	75	$244,529
Legal	6		$421,307
Medication Management	3		$180,803
Senior Center	6		$4,558,642
Senior Companion	4	70	$137,880
Transportation, General	6	10751	$5,263,061
Transportation, Medical	3	3819	$1,011,144
Volunteer Program Development	6		$145,767
		Total	*$62,550,788*

	Category	Clients	Expenditures
Funding Source: Division of Medical Assistance			
ACH-PCS Basic/Enhanced	1	17730	$93,911,187
ACH-Transportation	1	17558	$2,770,245
CAP/AIDS	4	7	$75,727
CAP/CHOICE	4	2	$10,915
CAP/DA	4	10637	$174,870,704
CAP/MR	4	238	$10,214,160
Clinics	3	35530	$25,217,792
Dental	3	41376	$13,118,945
Health Check/EPSDT	3	9	$64
HMO	2	9046	$1,495,984
Home Health	4	72856	$49,841,426
Hospice	4	3509	$32,088,284
ICF-MRC	5	468	$46,088,017
Inpatient Hospital	3	21657	$77,073,259
Inpatient Mental Hospital	5	206	$5,921,711
LAB&XRAY/Physicians	3	171260	$86,192,821
Medicare Part A&B Premiums	2	191003	$195,408,939
Nursing Homes	5	38742	$978,036,097
Other Care	3	64711	$10,991,686
Other Practitioners	3	60235	$3,031,936
Outpatient Hospital	3	94824	$51,865,678
Prescribed Drugs	3	168098	$594,582,261
Regular Personal Care (PCS)	4	30476	$174,826,388
		Total	*$2,627,634,225*
Funding Source: Division of Mental Health/Developmental Disabilities/Substance Abuse Services			
Alcohol Rehabilitation Centers	5	29	$227,962
Developmental Disabilities	3	847	$4,927,242
Mental Health	3	17866	$3,262,482
Mental Retardation Centers	5	642	$54,392,530
Psychiatric Hospitals	5	1370	$83,314,260
Substance Abuse	3	2189	$718,388
		Total	*$146,842,864*

	Category	Clients	Expenditures
Funding Source: Division of Services for the Blind			
Adjustment Services for the Blind and Visually Impaired	6		$199,852
Health Support	3		
Independent Living Rehabilitation Program	3	994	$354,490
Individual and Family Adjustment	6		
In-Home Services Level I (Home Management)	4		$469,906
Medical Eye Care Program	3	392	$305,760
Special Assistance for the Blind	1	44	$21,596
		Total	*$1,351,604*
Funding Source: Division of Social Services			
Adult Care Home Case Mgt./Screening	1	4843	$2,365,453
Adult Day Care	4	702	$1,914,732
Adult Day Health	4	347	$1,134,176
Adult Placement	6	622	$147,821
Adult Protective Services	6	5411	$2,783,919
At-Risk Case Management	6	2134	$1,225,703
Energy Assistance	2		
Food Stamps	2	78442	$54,229,182
Guardianship Services	6	1800	$1,433,533
Housing & Home Improvement	6	185	$5,808
In-Home Aide Services	4	5902	$5,400,721
Meals - Home and Congregate	4	1087	$110,022
Other Services	6	10328	$11,002,324
Special Assistance	1	18660	$81,333,151
Transportation	6	5954	$1,176,286
		Total	*$164,262,831*
Funding Source: Division of Vocational Rehabilitation			
Independent Living	3	1521	$3,049,156
Vocational Rehabilitation	6	734	$1,626,425
		Total	*$4,675,581*

Special Assistance In-Home Participating Counties



Original SA/IH Counties (eff. 9/14/2000)
Additional SA/IH Counties (eff. 10/1/2003)
Additional SA/IH Counties (eff. 12/7/2004)
Additional SA/IH Counties (eff. 11/1/2005)

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — December 20, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Charlene Carey	N.C. Right to Life
Kimberly Hill	Lt. Gov. Office
Jerry Cooper	DCALA
GEOFF SANTOLIQUIDO	NC DIV. OF AGING & ADULT SERVICES
Suzanne Merrill	NC Division of Aging & Adult Services
Jim Edgerton	AHEC
Leslee Breen	NC Division of Aging & Adult Services
Mary Anne Salmon	CARES, Jordan Institute for Families UNC Chapel Hill School of Social Work
Dennis W. Streets	NC Division of Aging and Adult Services
Steve Freedman	NC Division of Aging/Adult Services
Roger Bone	Bone & Assoc

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — December 20, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Diana D. Hatch	AARP
Richard C Hatch	AARP/NC Coalition on Aging
Jean Reaves	NCADSA NCCOA
Tracy Hardesty	Fred Bartlett
Rebecca Troutman	NCACC
DAVID BARNES	Poyner + Spruill
Polly Williams	NC Justice Center / Triangle OWL
Abby Emanuelson	NMSS
Rodney E. Ellis	Rodney E. Ellis & Assoc

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — December 20, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Teresa Johnson	5220 Beckwyth Drive, Fuquay Varina NC 27526 NC Adult Day Services Association
Bill Wilson	AARP NC
Mary Bethel	AARP NC
TRACY COLVARD	Division of Medical Assistance
Darlene Creech	Division of Medical Assistance
Lynne Perrin	Div. of Medical Assistance
Christian Coffey	Div. of Medical Assistance
Marjorie Morris	Division of Medical Assistance
Debbie Pittard	Division of Medical Assistance
Nancy Winter	John Locke Foundation
Karen Gottovi	DAAS

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — December 20, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
W Potter Jr	NCDTA – NCDS

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

December 21, 2005

MEMORANDUM

TO: Members - NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the **NC Study Commission on Aging:**

DATE: Wednesday, January 4, 2006

TIME: 10:00 a.m.

LOCATION: Room 643
Legislative Office Building
Raleigh, NC

An optional tour of the Total Life Center on Departure Drive in Raleigh has been arranged for Commission Members at 1:15 p.m. This adult day care center is a combination center offering both a social and health model. It is anticipated that travel time will take approximately 15 minutes and the tour will last 30 minutes.

We will have a handout with directions at the meeting.

Please advise Dee Hodge, Commission Assistant, at (919) 733-5955 or email dannellyla@ncleg.net if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, January 4, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions
Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Approval of Minutes from Prior Meetings

III. Medicaid Institutional Bias Report (S.L. 2004-124, Sec. 10.23)
Larry Nason, Division of Medical Assistance, Department of Health and Human Services
Lisa Alecxih, Vice President, The Lewin Group

IV. Adult Day Services *

- **Overview**
  Shannon Crane, Division of Aging and Adult Services, DHHS
- **NC Adult Day Care Training Project (S.L. 2004-124, Sec. 10.21)**
  Nancy Cox, Partners in Caregiving: The Adult Day Services Program, Wake Forest University School of Medicine

V. Choices and Creativity
Florence Gray Soltys (Commission Member), School of Social Work, UNC-CH

VI. Update on Medicare Part D Impact on CAP/DA
Carol Shaw, Fiscal Research Division, NCGA

VII. Next Meeting:
January 18, 2005 at 10:00 a.m. in Room 643

*** 1:15 p.m. Adult Day Care Tour –**

A tour of the Total Life Center on Departure Drive in Raleigh has been arranged for Commission Members at 1:15 p.m. This adult day care center is a combination center offering both a social and health model. It is anticipated that travel time will take approximately 15 minutes and the tour will last 30 minutes.

North Carolina Study Commission on Aging

MINUTES
Wednesday, January 4, 2006
10:00 AM
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Wednesday, January 4, 2006, at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were: Senator Charlie Dannelly, Co-Chair; Rep. Beverly Earle, Co-Chair; Senators Austin Allran, Stan Bingham, Julia Boseman, and Vernon Malone; Representatives Alice Bordsen, Debbie Clary, Bob England, and Jennifer Weiss; Ms. Judy Pelt, Ms. Linda Howard, and Ms. Florence Soltys.

Senator Charlie Dannelly presided. He called the meeting to order and the Commission approved the minutes from the meetings held on November 2 and November 16, 2005. Senator Dannelly then told members that we would follow the agenda. However, later during the meeting he informed members that Item VI on the agenda – Update on Medicare Part D Impact on CAP/DA – would not be discussed today.

PRESENTATIONS

Medicaid Institutional Bias Report

Mr. Larry Nason of the Facility and Community Care Section of the NC Department of Health and Human Services, Division of Medical Assistance gave a brief overview of the Medicaid Institutional Bias Study goals. He told members that the 2003-2004 North Carolina General Assembly mandated a study of Medicaid institutional bias (S.L. 2004-124, Sec. 10.3) for the purpose of identifying any bias that favors support for individuals in institutional settings over support for individuals living at home. The study was to include a report and recommendations for alleviating those biases. The Lewin Group was awarded the contract to conduct the study in January of 2005 and the work began in February 2005.

Mr. Nason then introduced Ms. Lisa Alecxih, Vice President of The Lewin Group and manager for this project. Ms. Alecxih presented the results of the study to the Commission. She stated that the study focused on Medicaid Long Term Care programs for older adults and adults with physical disabilities. Individuals with MRDD were not

included. Ms. Alecxih reviewed the methods used in conducting the study, gave a report on the breakdown of expenditures and recipients of NC Medicaid LTC expenditures for older adults and people with physical disabilities before itemizing the biases found during the study. Please see Attachment I for more information.

Ms. Alecxih told members that the study looked at four major areas in terms of Medicaid: benefits; availability and accessibility; cost containment; and provider regulation and oversight of quality review. There were several areas where no institutional bias was found. These are listed on Attachment I, page 6. The report includes ten identified instances of bias. Ms. Alecxih reviewed each and explained the recommended action to rectify them. Each bias is listed below along with the recommended action.

1. The Federal provision to reimburse Medicare Part D prescription drug co-pays for Nursing Facility (NF) residents, but not for Home and Community Based Services (HCBS) waiver participants. This creates a bias because the Medicare drug payments are no longer part of the spend down for persons in (HCBS). They still have to pay the co-pay and persons in nursing facilities do not. Recommendation – Advocate for change in the federal legislation or provide coverage for Medicare Part D co-payments for CAP/DA participants through state funding.
2. The lack of a simplified access and consistent support coordination system. Recommendation – 1) Improve outreach and consider expanding the program currently administered in Forsyth and Surry Counties called Aging and Disability Resource Centers. This program is being implemented nearly nationwide through a grant program sponsored by the Administration on Aging and the Centers for Medicare and Medicaid Services. 2) The possibility of going to a regional basis for working with lead agencies for the CAP/DA Program. 3) Reinstitute training that had been going on at lead agencies.
3. The medically needy provision leaves little for persons to pay for living expenses in the community while nursing facilities provide room and board. Recommendation – Increase the medically needy (MN) income standard from the current monthly standard of $242 to a level at least the MN national average of $416 for a single individual.
4. The differences in spousal impoverishment rules regarding income can create hardships for families if a spouse prefers HCBS to NF care. When the person qualifying for the care has a higher income than the person who does not qualify, the person must spend down if they are above 100% of the poverty criteria for eligibility. That reduces the amount of resources to remain in the community for both. In a nursing facility, the spouse in the community is guaranteed up to 150% of the poverty level. Recommendation - Align the spousal impoverishment income rules for LTC beneficiaries in all settings.
5. The application of federal waiver cost neutrality requirement. NC applies the federal waiver cost neutrality requirement in such a way that limits people who have expenses higher than the nursing facility level of care. Recommendation – Develop a mechanism to allow for high cost individuals to have the opportunity to receive care in the community.

6. Enrollment caps on CAP/DA, which is a way of limiting the number of people who can access care in the community. Recommendation – Monitor the use of newly available slots and provide funding for CAP/DA as needed.
7. No differentiation of need on the CAP/DA wait lists due to the first come first served basis for gaining services. Also, the variation between the county lead agencies on how they screen and maintain the wait lists. Recommendation – Create a priority list for waiver admission for persons at risk of institutionalization or who are institutionalized.
8. Inconsistency in the use of the waiver services and the way they are allocated across the counties. Individuals may wait for waiver services in one county while other counties have unused waiver slots. Recommendation – Explore the possibility of more active statewide management of waiver slots and waiting lists.
9. The lack of coordinated efforts to assure quality in the community. There are very clear Federal and State regulations and requirements as it relates to nursing facility care and oversight. It is less clear on the HCBS side. Recommendation – Help alleviate the problem by focusing attention on quality monitoring.
10. The prior approval process for some of the community services is a potential bias in terms of the extent it causes delay in getting needed services. Recommendation – Develop simpler mechanisms for individuals to increase services when needed.

Sen. Allran stated that he would like to see the effect on the state budget the recommended changes would make. He also asked if we made the changes and ended up with biases in favor of home care, what effect would that have on the budget and would that be desirable for the people effected? Ms. Alecxih stated that the Lewin Group plans to do budget estimates but they need to go through a prioritization process first. On the bias in favor of home care, she stated that most surveys of people indicate they would prefer to stay in their home. She feels it would be a legislative decision as to whether or not it is biased too far one way or the other.

Rep. Weiss stated that Ms. Alecxih mentioned some biases that were not on the list presented today. Ms. Alecxih stated that the full report is under review and will be released when the review process is over. Rep. Weiss stated that she is troubled by the fact that a number of the biases violate the Olmstead Act and the ADA. She asked Ms. Alecxih to explain the impact. Ms. Alecxih told commission members that aside from the original court decision, there has not been much court precedent. It is a matter of opinion, but the areas that they looked at seem to favor institutional care over home and community based care. Rep. Weiss further stated that she would like to see the Commission look at the recommendations and come up with recommendations to ensure that people who want to stay at home have that option.

Rep. England asked Ms. Alecxih when she plans to have the numbers for the ten specific items and if it will be before the short session in May. Ms. Alecxih stated that it will definitely be before May but she is not sure if they will be doing all ten of them, they will ask for prioritization.

Ms. Soltys asked Ms. Alecxih to give a rundown of the numbers of counties that have waiting lists and how many have empty slots. Ms. Alecxih stated that she would have to defer that question because she does not have that particular report with her.

Sen. Bingham asked for a listing of states and their medically needy income standards. He also asked what impact that would have on a fiscal note if we changed to the national average. Ms. Alecxih stated that she can provide the state listing but did not bring it today. Regarding the fiscal impact, she does not have that yet.

Senator Malone wanted to know if it was possible to generate statistics on the numbers of people affected. Ms. Alecxih said that she could provide that.

Rep. Bordsen asked if there is a way to quantify the dollars that are not spent in the community when someone is institutionalized. Ms. Alecxih stated that it would be difficult.

Rep. Clary stated that she would like to see DHHS come back in a future meeting regarding prioritizing slots across the counties and other items that won't require legislative action. The chair stated that staff is taking notes.

Adult Day Services

Ms. Shannon Crane with the DHHS Division of Aging and Adult Services told Commission members that Adult Day Care is a provision of services during the day for older adults who cannot live independently at home. The goal is to prevent institutionalization. There are two different types of day care. One is the social model for people who cannot remain independent at home and don't have health problems (Dementia and Alzheimer's, etc. individuals). The other is the health model that has a nurse onsite for a minimum of four hours per day. In North Carolina, there are 50 day care programs with the social model, 54 combination programs and 3 that are adult day health only. That totals 107 adult day care programs in 58 counties. Ms. Crane stated that the legislature approved a $5 rate increase in adult day care taking the rate form $23.07 to $28.07 per day. The health model went from $30 to $35 per day. She thanked the Commission for initiating the $250,000 for the NC Adult Day Care Training Project. She told Commission members that there are still challenges with adult day care. Accessible and affordable transportation is one of the major issues. Sprinkler systems are now required in adult day cares. This has proven a problem in centers that are already open and want to expand. Ms. Crane stated that reimbursement levels continue to be well below the cost of operating a day care program. It is very difficult for centers to recruit and hire quality staff and the day care transportation reimbursement rate is $1.50 per one-way trip. She asked the Commission to consider increasing reimbursement rates.

Ms. Nancy Cox, Director of Partners in Caregiving: The Adult Day Services Program at Wake Forest University School of Medicine was the next presenter. She told members that she would be presenting the final report of the NC Adult Day Services Project. She provided members with a copy of her presentation and a copy of the full report minus the

attachments. (See Attachments II and III) Ms. Cox told Commission members that because of a concern that 30 Adult Day Programs have closed in NC over a five year period, a special provision was included in the 2004 state budget bill for a national adult day services resource center to study the current method of reimbursement for adult day programs and provide training and consultation (S.L. 2004-124, Sec. 10.21). DHHS assigned the special provision responsibility to the Division of Aging and Adult Services. The Division contracted with Partners in Caregiving to carry out the study. Please see Attachment II for a detailed outline of Ms. Cox's presentation.

Choices and Creativity

Ms. Florence Gray Soltys, Commission Member and Clinical Associate Professor, UNC-CH School of Social Work was the last presenter. Ms. Soltys told Commission members that she coordinates a home visiting program that consists of physicians, nurses, social workers, occupational therapists and physical therapists that make home visits. She furnished members with a handout outlining her presentation. (See Attachment IV) Ms. Soltys referenced her handout and in doing so told Commission members that it was incorrect in stating that the CAP program has a waiting list in all counties. She stated that she found out today that statement is not true. She recommended that: 1) case managers tell all clients eligible for CAP that Adult Day Health (ADH) is an option (where available); 2) education be provided to case managers as to what ADH provides; 3) payment from the CAP budget cover the true cost of the service. The current $38.50 is inadequate and the community must raise the money to meet the deficit.

Rep. Clary asked if the CAP managers have something in writing that they give to the caregiver and the participant. Ms. Soltys stated that they sit down with them and develop a plan of care. A copy is left with the family.

Sen. Allran asked Ms. Soltys to elaborate on the fact that a CAP/DA visit by a nurse is $100 regardless of the length of visit. Ms. Soltys stated that is the reimbursement of nurses on a monthly basis. They are to visit once a month to supervise the CNA in the home. There is no mandate as to how long the nurse stays when he/she visits.

Senator Bingham asked Ms. Soltys to give an overview of how she came up with the estimate of $100/day savings if the switch is made to day health. She stated that the figure would come from not having to pay a case manager as much and not paying a CNA $14.40/hr. Instead they would be paying the day health rate.

Senator Allran asked if the views Ms. Soltys expressed were widely shared by other people. She stated that it certainly expresses the views of lots of people in Orange County. She said that the CAP/DA program should be incorporated into the Adult Day Health Services because a nurse would be present a minimum of 20 hours per week, monitoring the individual, giving the medications and knowing when a person needs additional care, etc.

Sen. Dannelly asked Ms. Cox a question regarding Item V Collaborative Relationships, #6 - Promote Small Business Development Resources. He wanted to know whom that was for. Ms. Cox stated that is for the Division on Aging and the NC Adult Day Services Association to promote, through their networks, the existence of resources for adult day programs. There are small business development resources in this state that adult day services can tap into for free counseling and workshops.

At this point, Senator Dannelly thanked all the presenters, etc. He also reminded members to be on time for the adult day care tour at 1:15 p.m.

The meeting adjourned at 12:02 p.m.

After the meeting, Commission members attended a tour at 1:15p.m. of the Total Life Center located at 5124 Departure Drive, Raleigh, NC. The center is a combination center offering both a social and health model.

Charlie S. Dannelly

Senator Charlie Dannelly, Co-Chair
Presiding

Beverly Earle

Rep. Beverly Earle, Co-Chair

Dee Hodge

Dee Hodge
Commission Assistant

North Carolina Institutional Bias Study

Lisa Alecxih, Vice President

Presentation to the Study Commission

January 4, 2006

The Lewin Group

Overview

- Study Goals
- North Carolina Long Term Care
- Findings

Study Goals

- In 2004, HB 1414 DHHS to commission a study of whether an institutional bias exists in Medicaid-financed LTC services.
- "Institutional bias" refers to the policies and practices within Medicaid that make it easier for a beneficiary to access institutional care than services in home and community-based settings.
- Also asked to provide recommendations to alleviate identified biases.
- Focused on Medicaid LTC programs for older adults and adults with physical disabilities.

Study Motivation

- Increasing Medicaid long term care spending
  - In SFY2005, spending in institutions and home and community-based settings constituted one-third of the Medicaid budget.
- Increasing numbers of older adults and persons with disabilities contributing to increased demand for and spending on LTC.
- In response to the Olmstead decision, North Carolina, like other states, has actively focused on providing care for persons requiring LTC services and supports in the least restrictive setting possible.

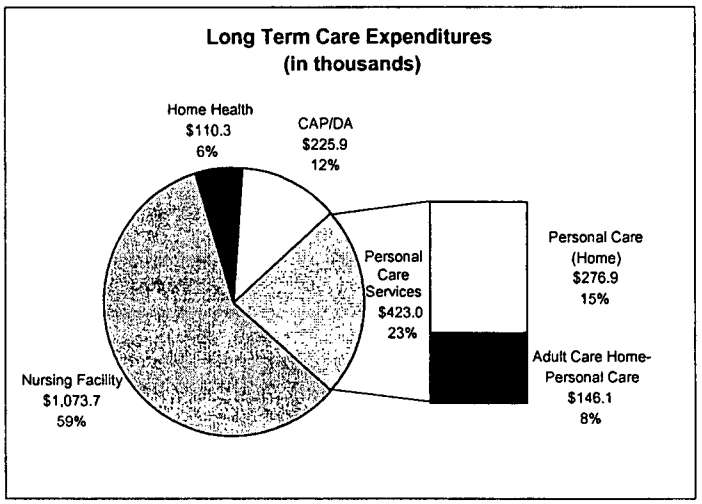
Methods

- Desk review of pertinent policies governing North Carolina's Medicaid LTC benefits including:
  - the North Carolina Administrative Code,
  - the Medicaid State Plan,
  - the CAP/DA Waiver,
  - provider education materials, and
  - utilization review contractor policies and procedures.
- In-person interviews with key NC informants in April 2005, as well as telephone follow-up.
- Interviews with staff in Florida and Georgia, as well as review of administrative policies.
- DMA provided data for the Medicaid long term care services examined for analysis.

North Carolina LTC Services

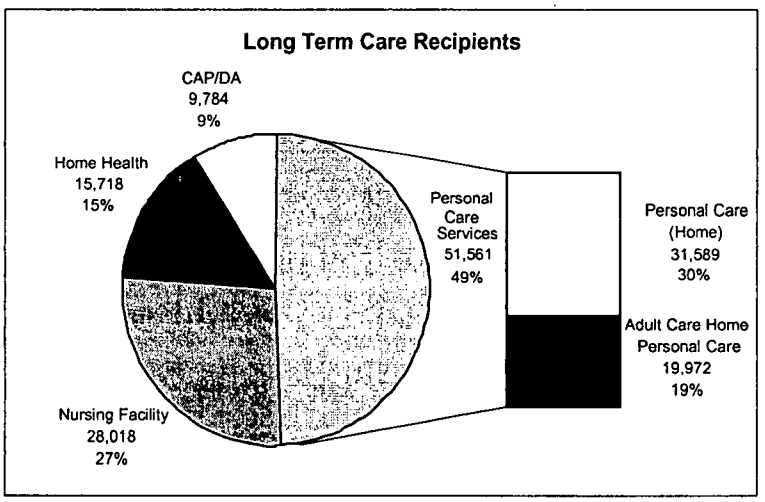
- Mandatory Services
  - Nursing Facility
  - Home Health
- Optional State Plan Services
  - Personal Care Services
    - In Home
    - Adult Care Home
  - Private Duty Nursing
  - Hospice
- Waiver Services
  - Community Alternatives Program for Disabled Adults (CAP/DA)

NC Medicaid LTC Expenditures for Older Adults and People with Physical Disabilities, 2005



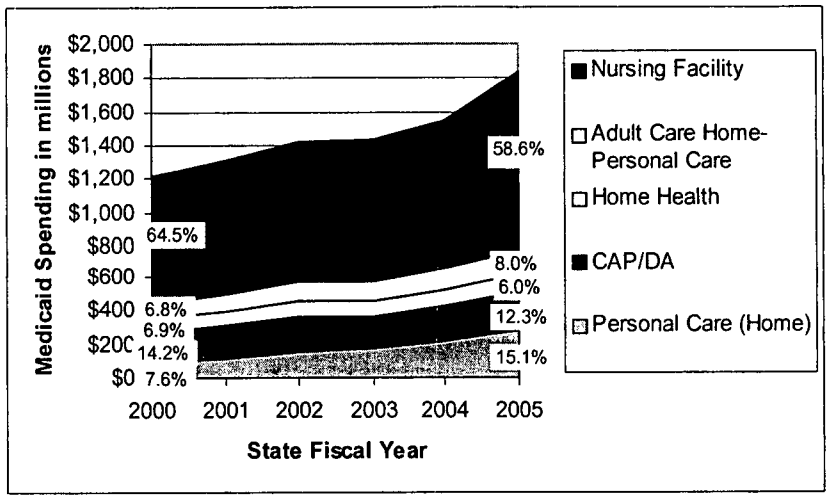
Source: Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005.

NC Medicaid LTC Recipients for Older Adults and People with Physical Disabilities, 2005



Source: Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005.

Growth in North Carolina Medicaid LTC Expenditures, 2000-2005



Source: Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005.

Findings

Areas Where No Bias Found

- Functional Eligibility for Medicaid Long Term Care Services
- Provider capacity appears adequate in HCBS
- Certificate of Need program appropriately limits provider supply
- Long term care payment rates
- Facility Licensing
- Personnel Licensing and Staffing Requirements

Medicaid Long Term Care Benefits

Bias #	Identified Bias	Recommended Action	Legislation required?	Violation of ADA-Olmstead?
1.	Federal provision to reimburse Medicare Part D prescription drug copays for NF residents, but not for HCBS waiver participants.	Advocate for change in federal legislation or provide coverage for Part D copayments for CAP/DA participants through state funds.	Appropriate funding.	Yes. Providing better coverage in nursing facilities for Medicare prescription drug benefits may prevent an institutionalize d person from leaving a nursing home.

Accessing Long Term Care

Bias #	Identified Bias	Recommended Action	Legislation required?	Violation of ADA-Olmstead?
2.	Lack of simplified access and consistent support coordination system.	Study ways to improve efficiency and effectiveness of case management.	No change in policy.	No.

Eligibility for Long Term Care: Financial

Bias #	Identified Bias	Recommended Action	Legislation required?	Violation of ADA-Olmstead?
3.	Medically needy (MN) provision leaves little for persons to pay for living expenses in the community, while NFs provide room and board.	Increase MN income standard from the current monthly standard of $242 to a level at least the national MN average ($416 for single individual).	Amend the Medicaid State Plan. This change would require legislation.	Yes. MN requirements may prevent a NF resident from leaving a nursing home because he/she would not have enough income to cover living expenses.

Eligibility for Long Term Care: Financial

Bias #	Identified Bias	Recommended Action	Legislation required?	Violation of ADA-Olmstead?
4.	Differences in spousal impoverishment rules can create hardships for families if a spouse prefers HCBS over NF care.	Align spousal impoverishment income rules for LTC beneficiaries in all settings.	Amend the Medicaid State Plan. This change would require legislation.	No.

CAP/DA Cost Containment Policies

Bias #	Identified Bias	Recommended Action	Legislation required?	Violation of ADA-Olmstead?
5.	Application of federal waiver cost neutrality requirement.	Develop mechanism to allow for high cost individuals to have the opportunity to receive care in the community.	Change CAP Medicaid eligibility guidelines in CAP/DA Manual and other program instructions. This change may or may not require legislation.	Yes. Individual based waiver spending caps limit access to community based care for those who would prefer to stay in the community but have intense/ expensive care needs.

CAP/DA Cost Containment Policies

Bias #	Identified Bias	Recommended Action	Legislation required?	Violation of ADA-Olmstead?
6.	Enrollment caps on CAP/DA limit the number of people who can access care in the community.	Monitor the use of newly available slots and provide funding for CAP/DA as needed.	Additional funding/ slots would require legislation.	Yes. Olmstead requires that the State demonstrate that it has a "waiting list that move[s] at a reasonable pace."

CAP/DA Cost Containment Policies

Bias #	Identified Bias	Recommended Action	Legislation required?	Violation of ADA-Olmstead?
7.	No differentiation of need on the CAP/DA wait lists.	Create a priority list for waiver admission for persons at risk of institutionalization or who are institutionalized.	No change in policy.	Yes. For people wishing to leave institutions, a waiting list without priority of need could violate Olmstead.

CAP/DA Cost Containment Policies

Bias #	Identified Bias	Recommended Action	Legislation required?	Violation of ADA-Olmstead?
8.	Individuals may wait for waiver services in one county while other counties have unused waiver slots.	Explore possibility of more active statewide management of waiver slots and waiting list.	No change in policy.	Yes. For people wishing to leave institutions, being placed on a waiting list when waiver slots are available could violate Olmstead.

Provider Regulation and Oversight

Bias #	Identified Bias	Recommended Action	Legislation required?	Violation of ADA-Olmstead?
9.	Lack of coordinated effort to assure quality in the community	North Carolina Medicaid can help alleviate the problem by focusing attention on quality monitoring.	This change may or may not require legislation.	No.

Provider Regulation and Oversight

Bias #	Identified Bias	Recommended Action	Legislation required?	Violation of ADA-Olmstead?
10.	Prior Approval process delays appropriate care in the community	Develop simpler mechanisms for individuals to increase services when needed, especially on a temporary basis.	This change would require legislation.	No.

Conclusions

- Some instances of Medicaid bias in North Carolina's LTC system found.
- Overall, policies and practices appear to support individual choice between institutional and home and community-based setting.
- While the national proportion of Medicaid HCBS spending of total long term care spending for older adults and adults with physical disabilities was 25% in FY 2004, NC moved from 35.5% to 41.4% between SFY2000 and 2005.
- Although not within the Medicaid purview, affordable, accessible, individual housing options impact the ability of individuals to choose HCBS.

North Carolina Adult Day Services Project

October 2004 – December 2005

Nancy Cox, MSW
Partners in Caregiving

Special Provision
[Section 10.21(a) S.L. 2004-124]

For … a national adult day services resource center to study the current method of reimbursement for adult day services … *and* … provide training and consultation for adult day programs.

DHHS Assigned Responsibility to DAAS

↓

DAAS Contracted with Partners in Caregiving

Partners in Caregiving

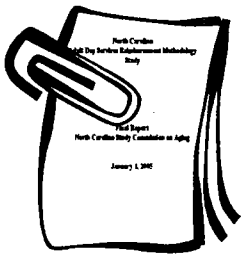
- A National Adult Day Services Resource Center
- Research and Training/ Technical Assistance Since 1988
- Department of Psychiatry, WFU School of Medicine

Reimbursement Methodology Study

Reimbursement Methodology Study

- Study Current Method of Reimbursement for Adult Day Services
- Focus on Two Funding Sources Through DAAS
  - Home and Community Care Block Grant (HCCBG)
  - State Adult Day Care Fund (SADCF)

Reimbursement Study Report



6 Recommendations
for
Systems Change

FY '05 - '06 Recommendations

1. Establish a Formal Cost Analysis Reporting System
2. Delete the SADCF Rate Per Month Formula
3. Make the HCCBG Reimbursable Unit "a Day" vs. a "6-Hour Day"
4. Create a Task Force for a Consistent HCCBG and SADCF Absentee Policy

FY '06 - '07 Recommendations

5. Allow for Negotiated Rates for HCCBG
6. Discuss Feasibility of SADCF Negotiated Rates with Social Services Commission

Reimbursement Report
Future Study Recommendations

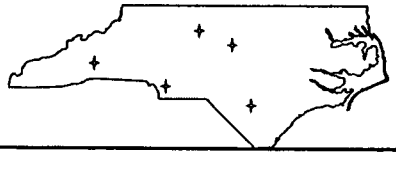
Transportation

Community Alternatives Program for Disabled Adults (CAP-DA)

Training & Technical Assistance

Training Overview

- 5 One-Day Regional Training Sessions for Certified Adult Day Programs
- January through March 2005
- Winston-Salem, Raleigh, Charlotte, Elizabethtown, Hendersonville



Training Invitations

Sent to:

- 106 Certified Adult Day Programs
- 56 Potential Start-Up Programs
- 104 County DSS Adult Day Care Coordinators
- 95 County Health Department Adult Day Health Specialists

Training Invitations

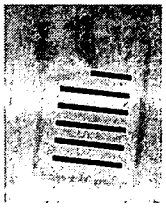
Also Sent to:

- 17 Area Agencies on Aging
- 12 Regional DAAS Adult Program Representatives
- Social Services Commission
- Study Commission on Aging
- 45 State Adult Day Services Associations Across the Country

Training Scholarship

➔ $250 Scholarship Available for
  - Certified Adult Day Programs
  - Travel or Per Diem Coverage

Adult Day Services Profile



- Used to Determine Programs At Risk Of Closing
- Ticket to Attend the Training

Training Session Content

Revolved Around Predictors of Success:

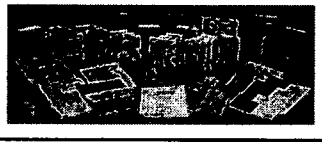
- Marketing
- Financing

- Programming

Training Products

11 Products Were Part of the Training Package

- Seven Marketing Manuals
- Four Programming Training Manuals/Products



Marketing Manuals

- Marketing Adult Day Programs: *Targeting Caregivers to Reach Participants*
- Marketing Adult Day Services to Businesses and Working Caregivers
- Referral Source Marketing for Adult Day Programs
- Special Marketing Issues for Adult Day Programs: *Product Line Marketing, Marketing Within Larger Organizations, Rural Challenges & Opportunities*

Marketing Manuals

- Marketing Tool Kit for Adult Day Programs: *Computer Templates to Create Effective Marketing Materials*
- From the First Call Through the First Days: *A Step-by-Step Guide for Adult Day Centers on Converting Inquiries Into Enrollments*
- New Customers for Adult Day Centers: *Results of a Focus Group on Serving New and Expanded Populations*

Programming Training Products

- Now What? A Handbook of Activities for Adult Day Programs
- Respite Report Collection (2 Volumes)
- Alzheimer's Disease Training DVD
- Program Development Assessment Tool

Additional One-Day Training Session for Monitors

- March 2005: Wilmington
- Part of Annual DAAS Adult Day Care Coordinator Training
- Attended by 30% of County DSS Agencies and 7% County Health Departments
- Focus on Marketing and Financing

Part of One Day Training Package

Comparison of
Standards for Certification
to
Best Practices/Predictors of Success

5 Regional Training Results

- *Completed the Profile*
  94 of 106 Certified Adult Day Programs (89%)
- *Attended a Training*
  88 of the 94 Programs (94%)
- *Requested the $250 Scholarship*
  76 of the 88 Programs (86%)
- *Total Number of Adult Day Program Staff and Board Members Trained:* 138

Other Attendees

- ☑ 8 Start-Up Programs: 6 NC, 1 TN, 1 NY
- ☑ 21% County DSS Agencies
- ☑ 8% County Health Departments
- ☑ 47% Area Agencies on Aging
- ☑ 1 Social Services Commissioner
- ☑ NC Small Business Center Network
- ☑ National Easter Seals
- ☑ Georgia Adult Day Care Association
- ☑ Florida Adult Day Care Association

Additional Training Benefits

- Enhanced Technical Assistance
  - Via Phone or E-Mail as a Part of Training Package for Certified Programs
  - 10 of 88 Programs (11%) Took Advantage Receiving Individual Technical Assistance
    - Strategic Planning
    - Marketing
    - Funding/Financial Management Issues

Training Evaluations

Extremely Positive

Feedback ...

- From Programs ... Want More Training On a Regular Basis to Keep Focused & On Track
- From Monitors ... Training Provided A Wealth of Information To Assist in Providing Technical Assistance at the Local Level

Adult Day Services Profile

- Used to Determine To What Extent A Program Is At Risk of Closing
- Completed By 89% Of All Certified Programs
- The Entire Training Content Revolved Around The Profile

Profile Scale

On Scale of 0-44, Programs Could Be In The:

- Safety Zone: No Risk of Closing
- Warning Zone: Danger Ahead
- Danger Zone: At Risk of Closing

Profile Scores

87 Profiles Were Complete Enough To Be Scored:

- 48 Programs (55%) In The Safety Zone
- 26 Programs (30%) In The Warning Zone
- 13 Programs (15%) In The Danger Zone: At Risk of Closing

Data Analysis

Danger Zone Program Operations

- 69% Social Model Programs
- 54% in Rural Areas
- Only Open 8 Hours Per Day
- Maximum Capacity of Only 18
- Average Daily Attendance of Only 8
- Utilization Rate of Only 43%

Marketing Characteristics

- Only 15% Have a Marketing Plan
- None Have a Monthly Newsletter
- Less Than Half Have Target Marketing Materials

Financial Characteristics

- Only 3 Operating Revenue Streams
- 62% Rely on SADCF Dollars
- Only 6% of Revenue Is Private Pay

Financial Characteristics

- 85% Charge Less Than Unit Cost

  Average Unit Cost: $46/day

  Top Private Pay Fee Charged: $25/day

  Charging $21/day Less Than Cost

Financial Characteristics

- 69% Have a Year-End Deficit
- Deficit Average of -$26,631
- 85% of Programs Without Reserve Funds
- Only 15% With Surplus: Average +$674

Other Characteristics

- Only 15% Have a Strategic Plan
- Only 38% Are Members of the North Carolina Adult Day Services Association

Program Characteristics

- 100% of Adult Day Care Homes
- 27% of Social Model Programs
- Only 2% of Combination Programs

State Association Affiliation

- 68% of Members: Safety Zone
- 8% of Members: Danger Zone

Partners in Caregiving Affiliation

- 10 PIC sites: 100% Safety Zone
- 18 Limited Technical Assistance Sites:
  - 11 (61%) Safety Zone
  - 2 (11%) Danger Zone

Technical Assistance Site Visits

Site Visit Overview

- One-on-One Site Visits
- Purpose To:
  - –As sess Strengths and Weaknesses
  - –Provid e Recommendations for Financial Viability

Site Visit Results

- 22 Site Visits
- April Through June 2005
- Site Visits To:
  - 11 Programs: Danger Zone
  - 10 Programs: Warning Zone
  - 1 Program: Safety Zone

Site Visit Results

- 11 Danger Zone:
  - 4 Adult Day Care Homes
  - 7 Social Model Programs
- 10 Warning Zone:
  - 6 Social Model Programs
  - 4 Combination Programs
- 1 Safety Zone:
  - Combination Model Program

Site Visit Reports

- 9-12 Page Document
- 7-17 Strengths Per Program
- 16-24 Recommendations Per Program:
  - Marketing
  - Financing
  - Programming

Overall Strengths

- Located in Under Served Counties
- Well-Respected: Positive Public Image
- Have Market Appeal: Quality Staff and Programming
- Provide Transportation
- Have Diversified Revenue Streams
- Have Some Marketing Materials in Place

Bottom Line: Poised for Program Growth

Overall Weaknesses

- Lack Board Involvement
- No Strategic Plan
- Certification Not Conducive to Financial Viability
- Program Size Too Small
- Programs Under-Utilized

Financial Weaknesses

- $ Hours of Operation Not Conducive to Working Caregivers
- $ No Extra Fee Charged for Providing Transportation
- $ Private Pay Fees Less Than Unit Cost
- $ Private Pay Revenue Below Average
- $ Heavy Reliance on HCCBG and SADCF Dollars
- $ Budgets Do Not Reflect True Expenses

Marketing Weaknesses

- No Marketing Plans
- No Target Marketing to Formal Referral Sources
- Poorly Done Marketing Materials
- Inquiries Not Being Converted Into Enrollments
- No Referral Source Tracking System
- Monthly Newsletters Virtually Nonexistent

System for Sustainability

Recommendations to Support and Sustain Adult Day Services

Areas Researched And Analyzed

- Reimbursement Methodology Study
- Analysis of Training Sessions, Profile Data, and Site Visit Recommendations
- Consultation with DAAS
- Consultation with NCADSA
- Role of Other State Resources

System Changes are Needed

15 Recommendations in 7 Areas

I. Strategic Plan
II. Public Awareness
III. Technical Assistance
IV. Monitoring
V. Collaborative Relationships
VI. Funding/Fiscal Impact
VII. Predictors of Success

I – Strategic Plan

1. Creation of an Advisory Group by NCADSA to Develop a Comprehensive, Integrated Strategic Plan

II – Public Awareness

2. Creation of a Brochure and Display Board by DAAS
3. Creation of a Statewide Public Awareness Campaign by DAAS

III – Technical Assistance

4. Expanded Technical Assistance By DAAS
   a. Three Fact Sheets
      i. State Departments that Interface with Adult Day Programs
      ii. Requirements/Process to Convert to a Combination Program
      iii. Negotiating and Developing HCCBG and SADCF Vendor Agreements

III – Technical Assistance
(Continued)

4. Expanded Technical Assistance By DAAS
   b. An Adult Day Services List Serv
   c. Quarterly Web-Based Newsletter
   d. Partnership with Area Agencies on Aging

IV – Monitoring

5. Independent Study of Current Monitoring System

V – Collaborative Relationships

6. Promote Small Business Development Resources
   a. Service Core of Retired Executives (SCORE)
   b. Small Business Center Network
   c. Small Business and Technology Development Center

V – Collaborative Relationships
(Continued)

7. Piggyback NCADSA Training with SCORE Workshop
8. Develop Educational Opportunities Through AHEC

VI – Funding/Fiscal Impact

9. Annual Funding Workshop by DAAS
10. Sufficient Lead Time to Implement Revised Rules/Standards
11. Continued Advocacy by DAAS With Department of Insurance

VI – Funding/Fiscal Impact
(Continued)

12. Increase Capacity Limits of Adult Day Care Homes and Adult Day Health Homes
13. Explore Feasibility of Negotiated Hourly Rates for HCCBG and the SADCF

VII – Predictors of Success

14. Mandatory Adult Day Program Director Management Training

VII – Predictors of Success
(Continued)

15. Training/Technical Assistance Follow-Up, Management Training Curriculum Development, Development of a Systems Change Package for Grant Funding

Estimated $200,000
Appropriation for FY 06-07

ATTACHMENT III

North Carolina Adult Day Services Project
October 2004 – November 2005

Final Report
North Carolina Study Commission on Aging
January 2006

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

NORTH CAROLINA ADULT DAY SERVICES PROJECT

Because of a concern that 30 adult day programs closed in North Carolina over a five-year period, the following Special Provision was included in the State budget bill, approved in July of 2004 (Section 10.21(a) 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 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 specified in the Special Provision. Partners in Caregiving: The Adult Day Services Program, a national adult day services resource center in the Department of Psychiatry and Behavioral Medicine at the Wake Forest University School of Medicine (Winston-Salem, NC), was chosen as the consultant.

Partners in Caregiving began contract activities in October of 2004, with an overall contract period of October 4, 2004 through December 31, 2005. In accordance with the Special Provision, the adult day services project focused on two major areas: 1) a reimbursement methodology study; and, 2) training and technical assistance.

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 while. Although some programs would close, others would open. In many cases, the programs that closed later reopened under the auspices of a new organization. However, during the latter part of 2002, several programs closed and have not reopened. Also, several of these programs 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 107 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 services 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, in equilibrium, or that 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 the need is being met. [Note: This is a conservative estimate because adult day programs also serve a younger population with chronic conditions.] 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, twenty-three percent (23%) are physically disabled but cognitively intact (such as stroke, multiple sclerosis, and Parkinson's disease), and fourteen percent (14%) have a chronic mental illness. Forty-three percent (43%) of individuals enrolled in an adult day

program need assistance with toileting, thirty-seven percent (37%) with walking, and twenty-four percent (24%) with eating.

The national study showed that most people attending an adult day program live with an adult child (35%) – the number one caregiver – or a spouse (20%) – the number two caregiver. Of the top three categories of caregivers, the number three caregiver is a residential facility (e.g., group home, assisted living facility, and long-term care facility). Adults, living in a residential setting, are coming out during the day to attend an adult day program.

The average length of stay in an adult 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.

REIMBURSEMENT METHODOLOGY STUDY

In accordance with the Special Provision, the first major area of concentration was to "study the current method of reimbursement for adult day services."

There are three funding sources for adult day services administered through the Department of Health and Human Services: Home and Community Care Block Grant (HCCBG), 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.

To support and sustain adult day services in North Carolina, various reimbursement methodology changes need to be made to determine reasonable reimbursement rates, to allow for negotiated rates with consideration of cost, and to ease administration. The final report of the **North Carolina Adult Day Services Reimbursement Methodology Study** is a separate document that was presented to the North Carolina Study Commission on Aging at its January 20, 2005 meeting. The following changes to the HCCBG and SADCF systems were recommended in the 24-page study report:

Fiscal Year 05-06

Cost Analysis System

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.

Current Rate per Month for SADCF

Recommendation:
The formula for the rate per month (i.e., monthly maximums) for the SADCF should be deleted from the rules.

HCCBG Reimbursable Service Unit

Recommendation:
To ease administration and provide consistency among funding streams, the 6-hour stipulation for 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.

HCCBG and SADCF Absentee Policy

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.

Fiscal Year 06-07

Home and Community Care Block Grant (HCCBG)

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.

State Adult Day Care Fund (SADCF)

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.

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 (DMA), a separate division within the Department of Health and Human Services. As noted in the study, 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.

TRAINING/TECHNICAL ASSISTANCE

In accordance with the Special Provision, the second major area of concentration was to "provide training and consultation to adult day services providers and State and county adult day services consultants."

TRAINING

Training Overview

To support and sustain adult day services in North Carolina, comprehensive statewide training was provided to certified adult day programs, Division of Aging and Adult Services (DAAS) staff, and county Department of Social Services (DSS) adult day care coordinators. [Note: Adult day programs, certified as adult day care and/or day health are monitored monthly by Adult Day Care Coordinators at the local level.]

Five one-day regional training sessions took place across the state (Winston-Salem, Raleigh, Charlotte, Elizabethtown, and Hendersonville) from January through March 2005 specifically for all **certified adult day programs** and DAAS staff. Invitations to attend were also sent to: 56 potential start-up adult day programs (on a DAAS call-in list), 104 county DSS adult day care coordinators, 95 county Health Department adult day health specialists (who monitor quarterly adult day programs certified as day health), 17 Area Agencies on Aging, 12 regional DAAS Adult Program Representatives, the Social Services Commission, and the Study Commission on Aging. A promotional flyer was also sent to adult day programs in other states via the 45 state adult day services associations.

The overall goal of the training was to reach as many certified adult day programs as possible, to expose them to predictors of success for financial viability and the value of being part of a state association network. Because some certified adult day programs might need resources to help offset the cost of travel or per diem coverage to attend the training, a $250 scholarship was available to any certified program. Refer to Attachment A that includes the training session cover memo, flyer, registration form, and scholarship application sent to all certified adult day programs.

Also sent to all certified programs was an Adult Day Services Profile (Attachment B), developed to determine to what extent a program is at risk of closing, if at all. Completing and returning the profile was their ticket to attend one of the training sessions.

Training session content revolved around predictors of success from a marketing, financing, and programming perspective (as determined by Partners in Caregiving research over a 15-year period). Refer to Attachment C for the complete agenda.

As part of the training package, each certified program (by attending a training) had access to individualized technical assistance (via telephone or e-mail) through June 2005. And, by attending a training, each certified program received the following training products developed by Partners in Caregiving:

- ***Marketing Adult Day Programs: Targeting Caregivers to Reach Participants***

  An 83-page manual designed to help adult day programs enroll more participants by targeting caregivers. This manual provides the basic concepts of marketing as they apply to adult day programs, and gives detailed strategies on how to reach each caregiver market segment: Information Seekers, Respite Seekers, and Care Seekers.

- ***Marketing Adult Day Services to Businesses and Working Caregivers***

  A 58-page manual that provides detailed strategies on how to: reach working caregivers; decide on which products to offer; develop promotional materials targeted to working caregivers; market to businesses; and, make that first contact with businesses, including presentation tips.

- ***Referral Source Marketing for Adult Day Programs***

  One of the most effective ways to market adult day programs is by marketing to referral sources. This 89-page manual helps programs: understand and identify their best referral streams; follow the critical steps in referral source marketing; and, track important marketing data.

- ***Special Marketing Issues for Adult Day Programs: Product Line Marketing, Marketing Within Larger Organizations, Rural Challenges & Opportunities***

  This 84-page manual focuses on three marketing issues: product lines, being part of a larger organization, and rural challenges. **Product line marketing** discusses: organizing services to effectively market to caregivers and referral sources; bundling and unbundling core and ancillary products; packaging and pricing; and, using product line marketing to generate referrals, increase enrollments, and develop revenue. **Marketing within larger organizations** discusses: the unique marketing implications of being part of a larger organization; techniques to capture opportunities (and negate risks); and, marketing ideas internally to get the respect you deserve, resources you want, and the participants you need. **Rural challenges and opportunities** discusses: nine critical marketing issues confronted by rural adult day programs; and, strategies to successfully respond to these rural-specific problems.

- ***Marketing Tool Kit for Adult Day Programs: Computer Templates to Create Effective Marketing Materials***

  This 97-page guidebook and accompanying diskette with computer templates (in Microsoft Word and Microsoft Publisher formats) provides adult day programs with an easy way to create effective marketing materials: caregiver and referral source brochures and flyers, newsletter, satisfaction surveys and more. Each template is based on proven marketing strategies and techniques specific to adult day programs. Included are recommendations and production tips to take the materials provided, make only minor changes specific to the program, and quickly and easily put the materials to use – today and on any budget.

- ***From the First Call Through the First Days: A Step-by-Step Guide for Adult Day Centers on Converting Inquiries into Enrollments***

  This 126-page manual is a step-by-step guide for adult day program staff on the successful conversion of the first time telephone caller to an enrolled participant. The guide focuses on the 5 steps of the inquiry-to-enrollment conversion process:

  Step One – The First Call: converting the call to a first visit
  Step Two – Following-Up the First Call: focusing efforts on caregivers who did not commit to a visit
  Step Three – The First Visit: selling benefits, overcoming objections, helping caregivers make the choice
  Step Four – Converting the First Participant Visit into a Long-Term Enrollment: guidelines for the first visit through the first two weeks
  Step Five – Customer Satisfaction: turning the first day into many, many more

- ***New Customers for Adult Day Centers: Results of a Focus Group on Serving New and Expanded Populations***

  This 34-page report focuses on the opportunities, risks, and special challenges of moving beyond serving only the frail elderly. For adult day programs interested in serving new and expanded populations, this reports helps: decide if this approach is right for the program; develop strategies to initiate this development option; and, expand efforts that have already begun. The report provides ideas on how to make the decision to expand work, and shares what others have learned.

- ***Now What? A Handbook of Activities for Adult Day Programs***

  Packed full of dementia programming ideas, this 166-page handbook is designed to serve as a resource guide for adult day program staff, as well as caregivers, and to share a variety of activities that have worked well over time with dementia participants. The 87 activities featured are divided into nine sections: arts and crafts; cooking and recipes; games; holidays and special events; intergenerational; music and movement; outings; personal care; and, socializing/sensory awareness. Photographs accompany most activities, all of which specify group size, materials and supplies needed, length of time, staffing requirements, estimated cost, method and therapeutic value. The handbook also includes sample activity calendars and assessment forms, and an activity resource list.

- ***Respite Report Collection and Respite Report Collection II***

  Nine years of *Respite Report* (the Partners in Caregiving national adult day services newsletter) are bound and subject-indexed to make it easy to learn about successful adult day programs across the country. This two-volume collection includes articles on: programming and activities; staffing considerations; using volunteers and students; caregiver support; transportation; environmental design; marketing, promotion and media relations; fund raising; financial self-sufficiency; strategic planning and much more.

All certified programs (attending a training) also received ***Accepting the Challenge***, an educational training DVD developed by the Eastern North Carolina Chapter of the Alzheimer's Association (Raleigh, NC). Through interactive classroom lecture and demonstration, to on-site interactions with Alzheimer's patients, the DVD is designed to help family caregivers and health care professionals provide the best possible care for people with dementia.

All certified programs (attending a training) also received ***Adult Day Services – Program Development Assessment*** developed by Creative Consulting for Adult Day Centers (Fuquay-Varina, NC). The purpose of this assessment tool is to help adult day centers: 1) identify operational areas of strength and those that need improvement; 2) compare present to potential programming and operations management; 3) measure changes in the culture of the program over time; and, 4) identify and develop a list of priority actions for improving the program.

A **one-day training session** was also conducted at the end of March for all adult day program monitors: **county Department of Social Services adult day care coordinators** and the **county Health Department adult day health specialists**. This training was piggybacked to the annual training for monitors sponsored by DAAS. Training session content revolved around predictors

of success from a marketing and financing perspective (as determined by Partners in Caregiving research over a 15-year period). Refer to Attachment D for the complete agenda. As part of the training package, each adult day care coordinator and adult day health specialist (attending the training) received a ***Comparison of NC Adult Day Care and Day Health Services Standards for Certification to Best Practices/ Predictors of Success***, prepared by Creative Consulting for Adult Day Centers and Partners in Caregiving.

Training Results

Regarding the five regional training sessions, for certified adult day programs and DAAS staff, the response from certified programs was outstanding! A total of 94 (out of 106) certified programs participated in this project, by completing and submitting the Adult Day Services Profile – their ticket to the training. An 89% participation rate is incredible!

Of the 94 programs, 88 actually followed through by attending one of the training sessions, with 76 of the 88 (86%) requesting the $250 scholarship to help defray costs associated with attending the training. Overall, a total of 138 adult day program staff and Board members (representing the 88 certified programs) were trained. DAAS was represented at each training session by an Adult Day Care Consultant.

Of the other groups invited to attend one of the five training sessions, participation was as follows: 8 start-up adult day programs (6 from North Carolina, 1 from Tennessee and 1 from New York), 31 representatives from 21 of the county DSS offices (21%), 10 representatives from 8 of the county Health Department offices (8%), 11 representatives from 8 Area Agencies on Aging (47%), 0 regional DAAS Adult Program Representatives, one Social Services Commissioner, and no representation from the Study Commission on Aging. As a result of the involvement of the Social Services Commissioner, the executive director of the North Carolina Small Business Center Network presented at the training session in Raleigh. Representation from other states also included: National Easter Seals (Chicago, IL), the Georgia Adult Day Care Association, and the Florida Adult Day Care Association, all of whom are interested in the replication of the North Carolina Adult Day Services Project within their national or State network.

Each certified adult day program (by attending the training) had access to individualized technical assistance from the trainers (via telephone or e-mail) through June 2005. Only 10 of the 88 certified programs (11%) took advantage of this training package component. Follow-up technical assistance (11 sessions totaling 6 hours) was provided in regard to strategic planning, marketing, and funding/financial management issues. The small percentage of programs taking advantage of the follow-up technical assistance was no surprise. Once adult day program directors get back to work, they become caught up in the day-to-day operations of the program, with time being an elusive commodity. Technical assistance research conducted by Partners in Caregiving has shown that the most effective form of follow-up technical assistance is through a structured system, such as a mentoring program, in which monthly telephone consultation is scheduled.

Regarding the one-day training session, specifically for county adult day program monitors (piggybacked to the DAAS annual training workshop), 30 of the 100 county DSS offices were represented (30%). And, 7 of the 95 county Health Department offices were represented (7%).

Training Evaluations
Overall, the training session evaluations were extremely positive. Certified adult day programs would like to see more of the same type of training, on a regular basis, to keep directors/ programs focused and on track. Some believe the training should be required. For the monitors, the training provided a wealth of information to assist them in providing technical assistance to adult day programs at the local level. The evaluation summaries for each training session are provided in Attachment E.

ADULT DAY SERVICES PROFILE

Overview
As previously discussed, an Adult Day Services Profile (Attachment B), was developed to determine to what extent an adult day program is at risk of closing, if at all. This at-risk assessment tool was sent to all certified adult day programs. Completing and returning the profile was their ticket to attend one of the training sessions. As previously noted, 94 of the 106 certified programs completed the profile (89% participation).

The Adult Day Services Profile was not a meaningless piece of paper that programs were asked to fill out. All questions asked were crucial questions for sustainability, and were classified as either a risk indicator or critical risk indicator. The training content of the five regional training sessions revolved entirely around the profile. All certified programs received their completed profile back, at the beginning of the training session, to refer to during the course of the day. In this way, each program could see (in black and white) their individual strengths and weaknesses, pinpointing the areas they need to work on for financial viability. This type of technical assistance made the training individualized for each program.

Profile Scoring
Since the training session theme was *Adult Day Programs: Road to Success*, the scoring of the profile revolved around zones: **Safety Zone: No Risk of Closing**; **Warning Zone: Danger Ahead**; and, **Danger Zone: At Risk of Closing**. In scoring the profile, the total points any certified program could receive was 44 points. The lower the score the better the program, the less at-risk of closing.

As previously noted, questions asked on the profile were classified as either a risk indicator or critical risk indicator. Risk indicators earned a program one point, while critical risk indicators earned a program two points. The breakdown is as follows:

Program Structure (8 points):
Open less than 5 years: *2 points*
Certified as a social model program: *2 points*
Housed in a senior center, long term care facility or church: *1 point*
Population base insufficient to support an adult day program (based on the National Study of Adult Day Services): *2 points*
# of adult day programs in the county exceeds the need (based on the National Study): *1 point*

Operation and Utilization (6 points):

Open less than 5 days per week: *1 point*
Open less than 10 hours per day (state average): *2 points*
Maximum capacity of less than 30 (state average): *2 points*
Utilization rate (i.e., average daily attendance ÷ capacity) < 66% (national average): *1 point*

Center Services (2 points):

Does not provide transportation: *2 points*
or Provides transportation for no extra fee: *1 point*

Staffing (2 points):

Overstaffed (i.e., staff to participant ratio < 1:4) + a deficit: *2 points*

Participant Profile (6 points):

Age requirement to attend program is age 60+: *1 point*
Does not know conversion ratio (i.e., % of inquiries converting into enrollments), or conversion ratio is < 34% (national average): *2 points*
Does not know length of stay (i.e., how long participants are enrolled), or length of stay is < 24 months (national average): *2 points*
Does not know top three reasons for discharge, or placement in a residential setting (0.5 pt.) or death (0.5 pt) are not the #1 or #2 reasons for discharge: *1 point*

Financial Information (14 points)

< 3 operating revenue streams: *2 points*
Private pay revenue < 35% of total operating revenue (national average): *1 point*
Financial performance (i.e., % of expenses paid for by operating revenue) < 85% (national average): *1 point*
Program has a deficit and have been open > 5 years: *2 points*
Quarterly cash flow problems (1 pt.) or monthly cash flow problems: *2 points*
Reserve funds: 4-6 months (1 pt.), 1-3 months (1.5 pts.) or no reserve funds: *2 points*
Top private pay fee < unit cost: *2 points*
Private pay fee has been in effect > 3 years: *2 points*

Marketing (3 points):

No written marketing plan: *1 point*
No monthly newsletter: *1 point*
No caregiver or referral source brochure (0.5 pt.) and/or no yellow page ad (0.5 pt.): *1 point*

Strategic Plan (2 points):

Does not have a strategic plan (or does not know): *2 points*

State Involvement (1 point):

Program is not a member of the North Carolina Adult Day Services Association: *1 point*

The At Risk Scale (i.e., the range of points for each zone) was determined by first calculating the average score (19) and then calculating the standard deviation (6). As a result, the Safety Zone was 0 - 19 points, the Warning Zone was 19.5 - 25.5 points, and the Danger Zone was 26 - 44 points.

Of the 94 profiles, 87 were complete enough to be able to be scored. Of the 87 certified adult day programs, 48 (55%) scored in the Safety Zone: No Risk of Closing, 26 (30%) scored in the Warning Zone: Danger Ahead, and 13 (15%) scored in the Danger Zone: At Risk of Closing. At the end of the training session, each certified program received their risk score. The next step, for those programs in the Danger Zone, would be a one-on-one technical assistance site visit to discuss their strengths/accomplishments, in addition to weaknesses/overall concerns, with specific recommendations for program growth.

Data Reporting

The Adult Day Services Profile provides an incredible amount of information never before collected in North Carolina (or any other State). Comparisons of certified adult day programs are made in relation to the following areas:

Program structure: years in operation, certification type, affiliation, tax status

Location: urban/rural, state regions

Operations: number of days open per year, hours of operation, capacity, average daily attendance, utilization

Transportation

Staffing

Marketing: age eligibility, type of building, conversion ratio, length of stay, marketing plan, monthly newsletter, target marketing materials

Financial information: number/types of operating revenue streams, private pay revenue, unit cost, private pay fee, financial performance, surplus/deficit, cash flow, reserve funds

Strategic plan

State association membership

Affiliation with Partners in Caregiving (prior to this project)

At risk scores

Based on the above categories, a total of 33 charts comparing the certified adult day programs is Attachment F.

Data Analysis

Analysis of the Adult Day Services Profile data also provides a wealth of information, not only for North Carolina but the adult day services industry as a whole.

In summary, **adult day programs in North Carolina** have been open on average 12 years, with 58% certified as combination programs, 39% social model programs, and 3% adult day care homes. The majority are free standing (63%), non-profit (78%) organizations, located in urban areas (66%). The largest concentration of adult day programs is in the western part of the State (46%), with 39% in the central region and 15% in the eastern region.

From an operational perspective, on average, programs are open 248 days per year, 10 hours per day, with the majority (76%) serving people age 18 and older. The average maximum capacity of an adult day program (i.e., the number of people who can be served on any given day) is 29, with an average daily attendance of 19, resulting in an average utilization rate of 64% (i.e., programs are not full). And, on average, participants are enrolled in a program for 28 months.

From a marketing perspective, only 40% of programs have a marketing plan, and only 25% publish a monthly newsletter. From a financial perspective, programs have, on average, 5 operating revenue streams, with the top 3 operating revenue streams being private pay/out-of-pocket payments, HCCBG, and SADCF (in that order). Also, from a financial perspective, 67% of adult day programs are charging less than unit cost. On average, unit cost is $50 per day, while the top private pay fee is only $40 per day – a $10 differential! Consequently, 52% of programs have a year-end deficit, which is, on average, $22,761, with 51% of programs having no reserve funds. For the 37% that do have a surplus at the end of the year, it is, on average, $32,975. Only 46% of adult day programs have a strategic plan. But, the majority (76%) are members of the North Carolina Adult Day Services Association.

Regarding their risk of closing, as previously noted, 55% of adult day programs are in the Safety Zone: No Risk of Closing, 30% are in the Warning Zone, and 15% are in the Danger Zone: At Risk of Closing.

For those **adult day programs in the Safety Zone**, it is evident as to why. Regarding certification type, 79% are combination model programs, with 73% located in urban areas. From an operational perspective, these programs are open 10 hours per day, with an average maximum capacity of 36 and an average daily attendance of 25, resulting in an average utilization rate of 72%. From a marketing perspective: 58% have a written marketing plan; 40% have a monthly newsletter; 83% have a caregiver brochure; 77% have an ad (under adult day care) in the yellow pages; and, 69% have a web site.

From a financial perspective, adult day programs in the Safety Zone have, on average, 7 operating revenue streams, with 98% bringing in private pay dollars. Private pay/out-of-pocket payments account for 24% of their total operating revenue. The majority (65%) are charging less than unit cost. On average, unit cost is $50 per day, while the top private pay fee is $44 per day – a $6 differential. Less than half (48%) of the programs have a year-end deficit, which is, on average, $17,275, with 30% of programs having no reserve funds. For the 44% that do have a surplus at the end of the year, it is, on average, $42,673. Sixty-three percent (63%) of adult day

programs in the Safety Zone have a strategic plan, and 79% are members of the North Carolina Adult Day Services Association.

For those **adult day programs in the Danger Zone**, it is evident as to why. Regarding certification type, 69% are social model programs, with 54% located in rural areas. From an operational perspective, these programs are open only 8 hours per day, with an average maximum capacity of only 18 and an average daily attendance of only 8, resulting in an average utilization rate of only 43%. From a marketing perspective: only 15% have a written marketing plan; 0% have a monthly newsletter; 46% have a caregiver brochure; 31% have an ad (under adult day care) in the yellow pages; and, 23% have a web site.

From a financial perspective, adult day programs in the Danger Zone have, on average, only 3 operating revenue streams, with 62% relying on SADCF dollars. Private pay/out-of pocket payments account for only 6% of their total operating revenue. The majority (85%) are charging less than unit cost. On average, unit cost is $46 per day, while the top private pay fee is only $25 per day – a $21 differential!! Consequently, 69% of the programs have a year-end deficit, which is, on average, $26,631, with 85% of programs having no reserve funds. For the 15% that do have a surplus at the end of the year, it is, on average, only $674. Only 15% of adult day programs in the Danger Zone have a strategic plan, and only 38% are members of the North Carolina Adult Day Services Association.

Overall, 100% of the adult day care homes are in the Danger Zone: At Risk of Closing, compared to 27% of the social model programs, and only 2% of the combination programs. Only 8% of state association members are in the Danger Zone, compared to 68% in the Safety Zone and 24% in the Warning Zone.

Regarding affiliation with Partners in Caregiving (prior to this project), all 10 of the North Carolina Partners in Caregiving sites (100%) are in the Safety Zone. These programs received technical assistance from Partners in Caregiving for 3-4 years, through its national Robert Wood Johnson Foundation adult day services demonstration and replication programs. Of the 18 North Carolina adult day programs receiving limited technical assistance (i.e., 12 months or less) from Partners in Caregiving (either on a fee-for-service basis, or as part of the State technical assistance project for 23 start-up programs), 11 (61%) are in the Safety Zone, 5 in the Warning Zone, and 2 in the Danger Zone. For a more detailed analysis of all categories refer to Attachment G.

TECHNICAL ASSISTANCE SITE VISITS

Overview

Adult day programs in the Danger Zone: At Risk of Closing and some in the Warning Zone received a one-on-one technical assistance site visit to discuss their strengths and weaknesses, in addition to recommendations for program growth. The director of Partners in Caregiving (PIC) conducted each site visit, with assistance from two other experienced adult day program directors, who have been involved with PIC, living and breathing the predictors of success: Suzi Kennedy, Executive Director, Life Enrichment Center, Shelby, NC (a PIC demonstration site)

and Teresa Johnson, Executive Director, North Carolina Adult Day Services Association (when she was with the Total Life Centers, Resources for Seniors, Raleigh, NC as a replication site). The site visit agenda is Attachment H.

Site Visit Results

A total of 22 site visits were conducted from the end of April 2005 through the end of June 2005. Of the 22 site visits, 11 certified adult day programs were in the Danger Zone: At Risk of Closing, 10 programs were in the Warning Zone, and 1 program was in the Safety Zone.

Although there were 13 adult day programs in the Danger Zone, identified as at risk of closing, site visits were conducted with only 11 of these programs. The reasons two programs at risk of closing did not receive a site visit are as follows: one program declined the invitation, and the other program was not known to be at risk of closing (at the time the site visits were conducted) due to an incomplete profile that could not be scored. Of the 11 programs receiving a site visit, 4 are adult day care homes (3 social and 1 health), and 7 are social model programs.

The budget allowed for up to 40 site visits to adult day programs at risk of closing. Since there were not nearly that many, site visits were also conducted with 10 programs at the high end of the Warning Zone (i.e., a score of 24 or above). Of these 10 programs, 6 are social model programs and 4 are combination programs.

At the request of DAAS, 1 site visit was conducted with a combination program in the Safety Zone. During the project, this particular program was informed by United Way that they would be cutting a significant amount of their funds, which in their mind was going to put them at risk of closing. In discussing the situation with the program, the decision was made to do a site visit.

Once the site visits were completed, each adult day program received a follow-up, written report, outlining their strengths/accomplishments, in addition to weaknesses/overall concerns, with specific recommendations to help improve financial viability. Each site visit report was a 9 to 12-page document, outlining (on average) 12 strengths/accomplishments per program (ranging from a low of 7 to a high of 17) and, on average, 20 concerns/recommendations per program (ranging from a low of 16 to a high of 24). To help keep the program open, recommendations revolved around marketing, financing, and programming.

Overall, 100% of the adult day programs receiving a site visit are in under served counties, with a population base that can support program growth. For the majority of programs, their strengths lie in the fact that they are established, well-respected programs in the community, with a positive public image. From a private pay perspective, their programs have market appeal, with quality staff and quality programming evident. From a service perspective, transportation is provided. From a financial perspective, there are diversified revenue streams. And, from a marketing perspective, some marketing materials are in place. 100% of these programs are poised for program growth.

For the majority of adult day programs receiving a site visit, their weaknesses lie in the fact that involvement of their Board of Directors is sorely lacking, with no strategic plan in place. Program certification is not conducive to financial viability (i.e., they are adult day care homes or

social model programs). The programs are too small (i.e., their capacity is not conducive to financial viability), and they are underutilized (i.e., they are not full). Also, from a financial perspective, hours of operation are not conducive to working caregivers, transportation is provided but for no extra fee, private pay fees are less than unit cost, private pay revenue is below average, programs are relying too heavily on HCCBG and SADCF dollars, and budgets do not reflect true expenses. From a marketing perspective, there are no marketing plans, target marketing is not being done, marketing materials are poorly done, inquiries are not converting into enrollments, referral source tracking systems are not in place, and monthly newsletters are virtually nonexistent. A summary chart of the strengths/accomplishments and areas of concern/ recommendations can be found in Attachment I.

SYSTEM FOR SUSTAINABILITY

The final component of the North Carolina Adult Day Services Project is to make recommendations for a System for Sustainability for adult day programs in North Carolina. In preparation for making recommendations, several steps were taken and various areas researched and/or analyzed. These include the following:

1. Review of the North Carolina Adult Day Services Reimbursement Methodology Study recommendations.

2. Analysis of the regional adult day services training workshop evaluations, the adult day services profile data, and the technical assistance site visit recommendations.

3. Consultation with the Division of Aging and Adult Services (DAAS) to explore ways the State can better support adult day programs.

4. Consultation with the North Carolina Adult Day Services Association to explore ways the association can better support adult day programs.

5. Examination of the role community college small business centers, area health education centers, or other State resources can play in supporting adult day programs.

6. Exploration of the creation of a statewide marketing plan, including a State public awareness campaign.

7. Investigation of the creation of an Adult Day Services Training Institute, incorporating a mentoring program.

As a result of these examinations, it is clear that changes need to be made to the system in order to support and sustain adult day services in North Carolina. Such changes, aimed to improve the financial viability of adult day programs, result in the following recommendations for a System for Sustainability:

STRATEGIC PLAN

Issue:
The funding and regulating of adult day programs is through an extremely complicated and fragmented system. Within the Department of Health and Human Services, adult day programs work with five separate divisions: aging and adult services, medical assistance, mental health/developmental disabilities/substance abuse services, public health (regarding the USDA Child and Adult Care Food Program), and social services. Adult day programs also work with the Division of Environmental Health in the Department of Environment and Natural Resources, the Department of Insurance, the Department of Transportation, and the Division of Veterans Affairs in the Department of Administration (which includes 15 District Veterans Service Offices). For many adult day programs, this is overwhelming, resulting in ignorance as to available funding and program requirements and guidelines. Support and sustainability of adult day programs will not occur until all players are around the table to address ways to create a seamless system, educate providers, and acknowledge the need for capacity-building based on an increase in demand. Such increased demand is inevitable due to a projected increase in the disabled elderly population, and the fact that many adult day programs now serve a younger population with chronic conditions.

RECOMMENDATION #1:
To support and sustain adult day services, and to plan for industry growth, the North Carolina Adult Day Services Association should create an Advisory Group (made up of key individuals from the various State departments) to move toward the development of a comprehensive, integrated strategic plan, including a statewide marketing plan.

Cost:
Costs to DAAS would be none. However, there would be costs for the Association to carryout this recommendation.

The Advisory Group to be created should be staffed by a professional facilitator(s) trained in the Breakthrough Series. The Institute for Healthcare Improvement (Boston, MA) developed this program to bring together groups of health care organizations that share a commitment to make major, rapid changes that will produce breakthrough results: lower cost and better outcomes at the same time. It is a collaborative model focusing on collaborative goals to effect systems change. The ultimate goal is to achieve breakthrough improvement by creating and implementing a strategic plan to support and sustain adult day services in North Carolina.

The Institute for Healthcare Improvement offers an annual Breakthrough Series College – a 3-day training session on all aspects of the Breakthrough Series methodology. The cost is $4,795 per person. If an organization would like to train a team, the cost would be $4,795 for one person, and up to two additional people at $4,000 each. College enrollment also includes a one-year membership to the Breakthrough Series College Network. Via the network, technical assistance is provided through monthly conference calls and an e-mail listserv, plus access to the College Extranet. The Breakthrough Series training, and the facilitation of the Advisory Group, may be a likely candidate for grant funds through the federal government, or local, state or national foundations.

PUBLIC AWARENESS

Issue:
Similar to most adult day programs across the country, those in North Carolina are underutilized, having more certified space than participants. A logical predictor of financial success is to keep the program full. There is, however, a lack of public awareness as to the existence of adult day programs – the purpose and the value for care recipients and their families.

RECOMMENDATION #2:
To increase overall visibility and public awareness, DAAS should create a generic adult day services brochure (similar to the one for senior centers) and information for the DAAS display board used at State and public functions.

Cost:
DAAS would need to determine total cost, and whether it can be absorbed into the current DAAS budget, or if additional funds would be required.

RECOMMENDATION #3:
In partnership with the DHHS Division of Public Affairs, the Agency for Public Telecommunications (APT) (in the Department of Administration), and the North Carolina Adult Day Services Association, DAAS should develop and implement a statewide adult day services public awareness campaign.

Cost:
To increase citizen access to government and services, APT offers live prime-time cable programs, video/audio/multimedia production, media buying/placement and more. However, since the annual APT appropriation does not fully cover the cost of staffing, equipping, and operating their production facility, all clients must pay to cover the cost of their projects. Once the components and cost of a public awareness campaign are determined, an appropriation to DAAS would be needed to fund the implementation of the campaign. Or, the public awareness campaign may be a likely candidate for grant funds through the federal government or local, state or national foundations.

TECHNICAL ASSISTANCE

Background Information:
At the State level, a responsibility of the DAAS Adult Day Care Consultants is to provide written, verbal, and on-site technical assistance to adult day programs.

RECOMMENDATION #4:
To help support and sustain adult day programs, DAAS should expand its technical assistance as follows:

1. Develop, disseminate (to all certified adult day programs), and post on the DAAS web site the following **fact sheets** for adult day programs:

   a. Information on how the five divisions within DHHS and three other State departments interface with adult day programs. This would provide education and information in response to the complicated and fragmented system of the regulation and funding of adult day services

   b. Information detailing the requirements and process for a program to convert from an adult day care only certification to one that combines adult day care and adult day health. Financial viability of adult day programs improves when a program makes this conversion, so a fact sheet of necessary steps would greatly assist programs in making this transition.

   c. Instructions on negotiating and developing vendor agreements with the local Department of Social Services for State Adult Day Care Funds and with the community advisory board for Home and Community Care Block Grant Funds. This information will assist programs in diversifying their revenue streams, another essential component of achieving financial viability.

2. Create an **adult day services list serv** for the primary purposes of networking, technical assistance, and informal mentoring. The list serv could be developed through the DAAS formal relationship with the Institute on Aging, and should include all certified adult day programs, Adult Day Care Coordinators, Adult Day Health Specialists, regional Adult Program Representatives, Area Agencies on Aging representatives, the North Carolina Adult Day Services Association executive director, and appropriate DAAS staff. DAAS should also promote the list serv to the other divisions within DHHS and the other State departments that work with adult day programs.

3. Create a **quarterly web-based newsletter** for adult day programs, similar to the DAAS web-based newsletter "At a Glance". The primary purpose of the newsletter would be to provide enhanced technical assistance, and up-to-date State and Federal information to adult day programs.

4. For enhanced technical assistance for adult day program service improvement on a regional basis, DAAS should encourage the development of a **partnership between the Area**

Agencies on Aging and adult day programs in their regions. Area Agencies on Aging have expertise in training/education, technical assistance, and monitoring that would prove beneficial to adult day programs.

Cost:
These recommendations can be implemented by current DAAS staff and are, therefore, DAAS budget neutral.

MONITORING

Background Information:
All certified adult day programs are monitored monthly by Adult Day Care Coordinators at the county level (through the County Department of Social Services). Further monitoring is conducted by county Adult Day Health Specialists (through the County Health Department) for programs with a day health component.

Issue:
Inconsistency and lack of uniformity regarding the interpretation of the North Carolina Adult Day Care and Adult Day Health Care Standards for Certification, by the monitors at the county level, was a major topic of discussion during the regional training sessions and site visits. Stories of adult day program practices being acceptable by a monitor in one county but not another were frequent. Furthermore, a practice that may have been acceptable by a monitor one year was not always acceptable by that same monitor the next year, even though the standards had not changed. Although DAAS sponsors an annual training workshop for monitors to discuss interpretation of the standards, attendance is not required. Only 32% of all monitors attended this training in 2005.

Monitoring for compliance is an important function in relation to all operational aspects of adult day programs, especially since these programs are required to meet the standards for certification. Consistent interpretation among counties is essential to ensure a uniform, basic competency of adult day services across the State.

In addition to the DAAS goal of standards to establish policies and procedures that will contribute to good programs, standards should also improve services, and not merely identify shortcomings. Thus, an additional role of the monitors at the local level to monitoring for compliance should also be the provision of technical assistance. Partners in Caregiving research has shown that well-designed technical assistance to effect change contributes to the sustainability of adult day programs.

RECOMMENDATION #5:
For service improvement and consistent/uniform interpretation of standards across counties, DAAS should contract with an independent consultant to study the current adult day program monitoring system. The study should look at the history of the county monitoring system, including how the existing system was created and why, how it currently operates, and how the system can be improved.

The study should also look at the development of a standard monitoring curriculum (including a technical assistance module) with the intent of improving consistency from county to county. The curriculum should address the various needs of all monitors, regardless of their longevity in the position: the desire to learn, problem solve, share best practices, and experience peer interaction and support. Experienced monitors interacting with new monitors provide an extremely valuable form of mentoring/technical assistance.

To be convenient and accessible to all monitors, the study should look at a variety of training methods such as: regional training sessions in the field on an annual basis; distance learning via videoconferencing through the area health education centers (AHEC); and, an on-line seminar (i.e., webinar). A determination should be made as to the most effective and efficient way to provide the training.

Cost:
An appropriation to DAAS would be needed to fund such a study. Funds would also be needed for the development of a standard curriculum. The monitoring system study and curriculum development may, however, be a likely candidate for grant funds through the federal government or local, state or national foundations.

COLLABORATIVE RELATIONSHIPS

Issue:
Most adult day programs are mission-based, non-profit organizations. Unfortunately, although they are a small business, they do not operate like one. Collaborative relationships and networking can contribute to the financial viability of adult day programs.

Background Information:
There are several free or low-cost organizations offering assistance useful in helping adult day programs become more business minded. The following are three of these with expanded presence throughout North Carolina:

The **Service Corp of Retired Executives** (SCORE) is a nonprofit association dedicated to entrepreneur education and the formation, growth and success of small businesses nationwide. As a resource partner with the US Small Business Administration, its mission is to help develop and improve small businesses by offering free, confidential individualized counseling, and low-cost workshops and seminars on how to start, operate, buy and sell a business. In addition to the SCORE CyberChapter for e-mail counseling, there are 13 SCORE chapters in North Carolina for counseling and workshops/seminars. These chapters are located throughout the State, specifically in Asheboro, Asheville, Chapel Hill, Charlotte, Durham, Greensboro, High Point, Kill Devil Hills, New Bern, Raleigh, Southern Pines, Hendersonville, and Wilmington.

The **North Carolina Small Business Center Network** (SBCN) is comprised of 58 Small Business Centers located at the community colleges across the State. The SBCN mission is to increase the success rate and the number of viable small businesses in North Carolina by providing high quality, readily accessible assistance to prospective and existing small business owners and their employees. Each community-based Small Business Center includes a resource library, and offers free, confidential counseling and low-cost workshops and seminars (such as how to start a business, how to write a business plan, financing a business, and marketing for success).

The **North Carolina Small Business and Technology Development Center** (SBTDC) is a business development service of the University of North Carolina, operated in partnership with the US Small Business Administration. The SBTDC helps those interested in starting a business and small business owners meet the challenges of today's business environment, manage an ever-changing world, and plan for the future of their business. The SBTDC does this by providing on-line publications, and educational services and management counseling to small and mid-sized businesses in all 100 North Carolina counties. Most services are free of charge through 17 offices across the State – each affiliated with a college or university.

RECOMMENDATION #6:
DAAS and the North Carolina Adult Day Services Association should promote these small business development resources, on an ongoing basis, on their web sites, including a direct link to SCORE (www.score.org), the Small Business Center Network

(www.ncccs.cc.nc.us/Business_and_Industry/sbcnmainpage.htm), and the Small Business and Technology Development Center (www.sbtdc.org).

Cost:
DAAS budget neutral.

RECOMMENDATION #7:
The North Carolina Adult Day Services Association should piggyback its "Opening an Adult Day Center" workshop and/or its "Keep Your Center Open" workshop with the "How to Start and Maintain a Small Business" workshop sponsored by SCORE chapters across the State. The industry-specific training provided by the Association, combined with the small business offering, would provide a well-rounded, complete training package.

Cost:
None to DAAS.

RECOMMENDATION #8:
For other educational opportunities for adult day programs, DAAS should distribute the list of all certified adult day programs (and the contact information for the North Carolina Adult Day Services Association) to the nine area health education centers (AHEC) to add adult day programs to their mailing lists. The development of a collaborative relationship between AHEC, DAAS, and the North Carolina Adult Day Services Association would ensure that AHEC educational opportunities are responsive to the specific needs of the adult day services industry.

Cost:
DAAS budget neutral.

FUNDING/FISCAL IMPACT

Issue:
Inconsistency and lack of uniformity at the county level regarding Home and Community Care Block Grant (HCCBG) and State Adult Day Care Fund (SADCF) reimbursement guidelines, was another major topic of discussion during the regional training sessions and site visits. For example, reimbursement is based on enrollment versus attendance in some counties, but in other counties, reimbursement is based solely on attendance.

RECOMMENDATION #9:
For consistency and uniformity across counties, DAAS should offer an annual funding workshop for adult day programs receiving HCCBG and SADCF funds, and for individuals administering these funds at the county level. To be convenient and accessible, DAAS should conduct the annual training in the field on a regional basis, or use distance learning such as videoconferencing through AHEC or the creation of an on-line seminar (i.e., webinar).

Cost:
To be cost effective, DAAS should piggyback this annual funding workshop with the annual monitoring workshop.

Issue:
Any changes to administrative rules or standards affecting adult day programs may necessitate extensive training and outreach to programs, adult day care coordinators, adult day health specialists, and other affected parties. Any changes to administrative rules or standards may also have a fiscal impact on adult day programs.

RECOMMENDATION #10:
Prior to implementation, all revised administrative rules or standards should provide sufficient lead time for potential budgetary preparation and/or training and outreach.

Cost:
DAAS budget neutral.

Issue:
Adult Day Services Profile data revealed those scoring in the Danger Zone have an average capacity of only 18 participants (i.e., being able to serve only 18 people on any given day). Adult day programs in the Warning Zone have an average capacity of 22 participants. Research conducted by Partners in Caregiving has shown financial viability for adult day programs across the country equates to serving 40-50 people per day in non-profit programs, and 60-70 people per day in for-profit programs.

Since the participant capacity of a program is based on the amount of program space, the majority of adult day programs would need to relocate in order to be more financially viable. However, all adult day programs certified after January 1, 2003 must comply with the Department of Insurance regulations necessitating programs to have a sprinkler system in place (NC State Building Code, Volume 1-C). Programs certified prior to that date were grandfathered

in. Relocation, however, to expand the program, requires compliance with this regulation. If another, affordable location does not have a sprinkler system already installed, compliance with this regulation is cost-prohibitive. Consequently, relocation for program expansion, with the goal of increasing participant capacity to ensure financial viability, may not be possible.

RECOMMENDATION #11:
To help improve adult day program financial viability, DAAS should continue to advocate with the Department of Insurance for a possible compromise on this regulation so that a sprinkler system is not required or is only required after a certain capacity.

Cost:
DAAS budget neutral.

Issue:
According to the standards for certification, adult day care homes are limited to serving a maximum of six adults in a single family dwelling, and adult day health homes are limited to serving a maximum of five. The Adult Day Services Profile data shows that 100% of the homes are in the Danger Zone: At Risk of Closing. As noted above, financial viability equates to a capacity of serving considerably more people per day than the number allowable in adult day care or day health homes.

RECOMMENDATION #12:
To help improve the financial viability of adult day care homes and adult day health homes, DAAS should consider revising the standards to allow more individuals to be served in single family dwellings, as long as the square footage requirement per participant can be met.

RECOMMENDATION #13:
In addition to the HCCBG and SADCF negotiated rate recommendations in the Reimbursement Methodology Study, DAAS should also explore the feasibility of a negotiated hourly rate (as opposed to a negotiated daily rate) for both HCCBG and the SADCF. A negotiated hourly rate establishes a consistent measure for consumers, funders, and reporting purposes at the State and Federal level.

Cost:
As discussed in the Reimbursement Methodology Study, a cost analysis study by DAAS would need to be conducted as to the impact of negotiated rates on service delivery. This could be done by DAAS staff and, therefore, would be budget neutral.

PREDICTORS OF SUCCESS

Issue:
To keep the doors open, financial viability of adult day programs revolves around predictors of success from a marketing, financing, and programming perspective – not only learning the information but also applying it! In addition, repetition is the key, with people needing people for ongoing technical assistance.

RECOMMENDATION #14:
DAAS should amend the requirements for program directors of adult day programs to include successful completion of adult day services management training. Such requirement should also apply to current adult day program directors; however, they should be given the option of testing out of the required training. Training should be documented and included as a part of the required employee file.

Cost:
The curriculum could be developed by the North Carolina Adult Day Services Association, in conjunction with Partners in Caregiving, and approved by DAAS. The Association and Partners in Caregiving would need to solicit grant funds to cover the cost of curriculum development. This recommendation would be budget neutral for DAAS.

Once a curriculum is developed and approved, DAAS would then approve interested and qualified organizations to conduct the training, but with no funds from DAAS to do so. The approved organizations would provide the training on a fee-for-service basis, and conduct the training annually (or more frequently depending on demand).

Note:
If this recommendation is implemented, North Carolina would be only the second State in the country to do so. DAAS should contact the Illinois Department on Aging and the Illinois Adult Day Services Association regarding their rationale for mandating such a requirement, and how the system works.

RECOMMENDATION #15:
As previously discussed, 94 of 106 certified adult day programs participated in this project. Of the 22 programs receiving a technical assistance site visit, 11 were identified as at-risk of closing, 10 (out of a total of 30) in the warning zone, and one in the safety zone. Partners in Caregiving research has demonstrated the necessity of follow-up technical assistance (1-3 years) for programs to become financially viable. Most programs need to be guided through recommendations for program growth connected to the predictors of success. To maximize on the training of adult day programs and on-site technical assistance provided to the 22 programs, follow-up site visits, mentoring, and project analysis needs to occur. Analysis would include a post Adult Day Services Profile sent to the 94 programs participating in the project to assess the impact of the training. Analysis would also include whether or not the site visit recommendations were implemented and what impact they had on program growth. The follow-up project analysis data could then serve as the basis for future projects to support and sustain adult day programs in North Carolina.

Cost:
To implement this post adult day services training and technical assistance analysis, to develop a curriculum for mandatory adult day program director management training (Recommendation #14), and to develop a systems change package for federal and/or foundation grant funds, focusing on a strategic plan, a public awareness campaign, and a monitoring system study (Recommendation #1, #3, and #5), an estimated $200,000 appropriation to DAAS would be needed for contractual arrangements with Partners in Caregiving.

FINAL COMMENTS

Because the Special Provision funds were a major investment (no other State has funded such an endeavor), the priority now is to develop a System for Sustainability so that these funds are not just a one-shot deal. Building on the Reimbursement Methodology Study and the training and technical assistance that took place, these recommendations form the basis for a System for Sustainability to support and sustain adult day services in North Carolina.

Choices and Creativity

Community Alternatives Program – (CAP)

- Implemented in 1984 as a Medicaid Waiver Program to give those at risk for institutional placement, the choice and support to remain at home.
- The current budget per month per participant is:
  a. Skilled - $3,487.00
  b. Intermediate - $2,680.00
- Services are an in-home aide supervised by a monthly visit from a nurse. This is intermittent care not 24 hours.
- Durable medical equipment

Community Alternatives Program-CAP (Cont'd)

- Must have a caregiver to assume primary responsibility.
- Assessments are done by the lead agency assigned in each county (usually DSS) but some are contracted out.
- Case Management is a part of the model.
- Individuals are referred to the program by their physicians through the use of an FL2.
- A very popular program with waiting lists in all 100 counties.

Adult Day Health Program

- Both social and health models exist with social being the most common.
- A health model must have a nurse present 20 hours per week. Many have full time nurses.
- Most have community boards (non-profit) which governs the policies and fundraiser.
- The individual may attend 1 – 5 days (usual hours 7:30 a.m. – 5:30 p.m.).
- The current average cost for Adult Day Health Programs is approximately $65.00 per day. The social model is less.

Adult Day Health Program- (Cont'd)

- We lack adequate facilities in many areas of the state. Funding is an issue – Medicare does not pay for this care. Many long-term care insurance programs pay but usually private pay or donations or grants provide the funding.
- Activities may include exercise, crafts, reminiscence, guests/volunteers to share, music, lunch, a couple of snacks and rest time.
- The participants may suffer from physical ailments like Stroke, Parkinson's Disease, Diabetes, etc or suffer from depression or dementia.

Considerations:

- That Adult Day Health Programs be a choice for all CAP Clients by educating the case manager about day health programs.
- A nurse is available 20 hours per week making the medical coverage much more complete. Healthcare can be more carefully monitored.
- Many participants are depressed, movement into group activities, sharing meals (lunch and snacks), and social interaction can help to reduce the feeling of isolation and improve feelings of well-being.
- Transportation to the Day Health Center is covered by Medicaid Medical Transportation.

Considerations: (Cont'd)

- Families or primary caregiver would need to be an active part and committed to the plan
- Currently, CAP reimburse the day health program $38.75 per day which does not come near the per day costs. This means the community must work to meet the deficit through grants and fund raising.
- Day health reimbursement has not been increased. Although the nurse, certified nursing assistant, and others have received increases. The cost of day health is approximately one-third that of respite in-home. CAP-DA in home aides are reimbursed at $14.40 per hour. CAP-DA Case Management is reimbursed at $55.28 per hour and a Skilled Nursing visit to the client's home is $101.41 per visit

The Following Would Be The Results of Greater Day Health Usage:

- Savings from over $100.00 per day.
- Better maintenance and monitoring of health condition as to medications and other day to day changes because of the nurse's presence.
- Depression would be reduced.
- Less trips to the emergency room because of better maintenance savings dollars.
- More individuals could be served with the savings.

The Following Would Be The Results of Greater Day Health Usage:

- Day Health Care needs to be increased and better supported as the population ages and becomes more frail as we live longer.
- The state is moving to develop three PACE Programs, which are Medicaid and Medicare Waiver Programs. In order, to have these programs, Adult Day Health must be provided as a part of the plans for the elders.
- Given the above information and the potential cost savings to the state, I respectfully request (1) that the CAP Program more fully incorporate Day Health within the care plan and (2) that the reimbursement be raised to cover the actual costs thus reducing costs and allowing for serving more clients.

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — January 4, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Evelyn Hammond	EHOR
Mary Edwards	Div. of Aging and Adult Services
Glenda Arts	Division of Aging and Adult Services
Bill Wilson	AARP
[illegible]	OSBM
Abby Emanuelson	National MS Society
Mary B. [illegible]	AARP - NC
Daphne Lyon	OSBM
Tracy Colvard	DMA
Darlene Creech	DMA
Lea P. Slaton	DAAS

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — January 4, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ann Umstead	Adult Center for Enrichment Greensboro NC 27401
Teresa Johnson	NC Adult Day Services Association Fuquay-Varina NC 27526
Michael Boles	Resources for Seniors, Inc. Raleigh, NC 27609
Polly Williams	NC Justice Center / Triangle Older Women's League
Ninian Beall	Vance Co. Office on Aging Henderson, NC.
Richard C Hatch	AARP / NC Coalition on Aging
Rosanne Bragg-Cook	NCAOA / Franklin Co Dept of Aging
GEOFF SANTOLIQUIDO	NC DAAS
Suzanne Merrill	NC DAAS
Nancy Winter	JLF
Candice Wilson	NASW-NC

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — January 4, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Barnes	Poyner & Spruill
Karen Gottovi	DAAS
Larry Nason	DMA
Lisa Alecxih	The Lewin Group
Jean Reaves	NCCOA NCAPSA
Shannon Crane	NC Division of Aging & Adult Services
Nancy Cof	WFU School of Medicine
Jerry Cooper	NCAIA
Aggy Flannery	NCHCFA
[illegible]	[illegible] Assoc
Len Walker	NCALTCF

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — 1/4/06

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dennis Streets	NC Division of Aging and Adult Services
Mary Cyrus	" "
Jim Edgerton	DHHC
Allen Dobson	DHHS/DMA
Mark Benton	" "
Charlene Carey	N.C. Right to Life
Johnny Wilson	Bar & Assoc
Doris Hovington	NCADSA

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

January 5, 2006

MEMORANDUM

TO: Members - NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the **NC Study Commission on Aging:**

DATE: **Wednesday, January 18, 2006**

TIME: **10:00 a.m.**

LOCATION: **Room 643**
Legislative Office Building

Please advise Dee Hodge, Commission Assistant, at (919) 733-5955 or email dannellyla@ncleg.net if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, January 18, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Adult Care Homes

Bob Fitzgerald and Barbara Ryan, Division of Facility Services, DHHS

III. Adult Care Home Cost Model

Andrea Russo, Fiscal Research Division, NCGA

IV. Report on the Expansion of the Health Care Personnel Registry

(S.L. 2005-276, Sec. 10.40A (q))
Jesse Goodman, Division of Facility Services, DHHS

V. Next Meeting:

February 1, 2006 at 10:00 a.m. in Room 643

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES
JANUARY 18, 2006
10:00 AM
ROOM 643

The North Carolina Study Commission on Aging was called to order by Representative Beverly Earle at 10:10 am. Representative Earle introduced staff members and asked if any of the members had any remarks.

The following members were present: **Representative Beverly, Cochair, Representative Debbie Clary, Representative Alice Bordsen, Representative Bob England, Representative Jennifer Weiss, Ms. Florence Gray Soltys, Mr. Sam Marsh, Four Senators, Jackie Sheppard and three staff members: Theresa Matula, Ben Popkin and Shawn Parker.**

Mr. Bob Fitzgerald and Barbara Ryan, Division of Facility Services, DHHS presented to the commission **Adult Care Homes**. They discussed in details about the licensure program. The definition of a nursing home is a home for chronic or convalescent patients. A nursing home provides care for persons who have remedial ailments or other ailments for which medical and nursing care are indicated. Nursing care is their primary need, but they will require continuing medical supervision. The key focus is round the clock nursing services needed. (See Handout) There was an adult care home cost modeling committee formed in October 2002. The purpose of the report was to develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to ensure that resident care needs are met. Recommendations were presented to the commission for future legislation. (See Attachment).

Andrea Russo, Fiscal Research Division, presented Adult Care Home Cost Modeling Report to the commission. Cost Model is needed to develop a cost model from data gathered from selected cost effective and efficiently run facilities, which met, establish criteria determined by the committee. Other recommendations were made to the commission. (See Handout)

Report of the Findings and Recommendations of the Adult Care Home Cost Modeling Committee. The Mission is "To develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to ensure that resident care needs are met." Once a decision is made to implement this methodology, a representative group of

individuals will be formed to address implementation schedules, appropriate notification, training and policy development. There are 9 recommendations listed below:

1. Adopt the cost model methodology and change existing APA rules and legislation to accept the cost model approach and seek appropriations to fully fund the new approach.
2. Reassess the cost model every 3 years for proper reimbursement.
3. As part of routine cost modeling and rate setting, study feasibility of allocating costs more appropriately between SA and PCS.
4. Improve the Screening and Assessment Processes to Promote Appropriate Placement and Quality of Care of ACH residents.
5. Ensure that any Division of Facility Services (DFS) regulatory changes with the potential to impact rates are reflected in the cost model.
6. Monitoring & Performance Expectations – DFS, DHHS Office of the Controller, and DHHS Office on Internal Audit.
7. Reimbursement modeling should account for resident mix and facility size.
8. Develop similar modeling for Family Care Homes and Mental Health Group Homes.
9. Implement an income disregard policy to prevent disenfranchisement of ACH residents from financial eligibility for SA and Medicaid.

Report on the Expansion of the Health Care Personnel Registry by Jesse Goodman, Division of Facility Services, DHHS. The Health Care Personnel Registry Section was created in 1996 as a result of legislative action by the North Carolina General Assembly and reorganization within the Division of Facility Services. At that time the responsibilities of the Section were expanded, from having limited regulatory authority for monitoring nurse aides working in nursing homes to include other unlicensed health care personnel working in other types of licensed health care facilities. In 1998 and again in 1999, legislative action broadened the scope of responsibility for the Division and expanded facility reporting requirements.

The commission members then asked questions.

The meeting was adjourned.

Representative Beverly Earle, Presiding Chair
Senator Charlie Dannelly, Co-Chair

Ann Raeford, Commission Assistant

Attachments

Attachment I	Agenda
Attachment II	Adult Care Licensure Program
Attachment III	Adult Care Home Cost Modeling Report

Attachment IV	Report of the Findings and Recommendations of the Adult Care Home Cost Modeling Committee
Attachment V	Report to the Legislative Study Commission on Aging on the Expansion of the Health Care Personnel Registry
Attachment VI	Visitors Registration

ADULT CARE LICENSURE PROGRAM
JANUARY 18, 2006

DEFINITIONS:

Nursing Home: A nursing home is a home for chronic or convalescent patients. A nursing home provides care for persons who have remedial ailments or other ailments, for which medical and nursing care are indicated... Nursing care is their primary need, but they will require continuing medical supervision. G.S. 131E-101 (6)

KEY FOCUS: Round the clock nursing services needed

Combination Home: Licensed nursing home that has an adult care unit (beds) within the nursing home.

KEY FOCUS: The Adult Care Unit can decide to meet either nursing home rules or adult care rules. These units are licensed under the Nursing Home license

Multiunit housing: An assisted living residence in which room and board charges are separate from personal care services and charges. Management has a financial interest, affiliation or formal agreement making personal care services accessible and available through at least one home care or hospice agency. The resident contracts for personal care services with a licensed home care agency or hospice agency of their choice. The residents cannot require 24-hour supervision.

This category of housing is not licensed by the Division of Facility Services. Multiunit housing residences are required to register with the Division and provide a disclosure statement that is part of the resident's annual rental contract.

KEY FOCUS: Room and board does not include 24-hour supervision and resident independently contracts for additional services

Adult Care Home: An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. G.S. 131D-2(a)(1b)

KEY FOCUS: Services include Room and Board; personal care services (ambulation, toileting, bathing, eating, medication administration) and /or supervision

ADULT CARE HOME LICENSURE CATEGORIES:

BY BED SIZE:

Adult Care Home: 7 beds or more
Family Care Home: 2 to 6 beds

BY POPULATION SERVED:

Adult Care Home for the Elderly: Adult Care homes that provide services encompassed in adult care homes but serve only the elderly. Elderly is defined as age 55 or over OR any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia needing adult care services.
New license category created with SB572 approved May 2005.

BY SERVICES:

Special care units: Special care unit for residents with Alzheimer's Disease or related disorders
Special care unit for persons with mental health disability
An advertised or promoted service that provides an environment, staffing, and provision of services to meet the needs of a specific population. There are additional licensure requirements.

ADULT CARE INVENTORY

Facility Type	Total Facilities Licensed in NC	Total Bed Capacity	Special Care Unit	Special Care Unit Bed Capacity	Annual License Fee	Inspections/Monitoring	
						State	County
Adult Care Homes	642	36246	96	2256	$350.00 (base) + 12.50 per bed	Annual Surveys Revisit as Needed	Routine Monitoring Complaint Investigations
Family Care Home	699	3869	0	0	$250.00	Annual Surveys Revisit as Needed	Routine Monitoring Complaint Investigations
Multi-Unit Housing	24	1766	0	0	0		

Data gathered from
2005 License Renewal applications

Services Provided

- **Room and Board** including at least three meals plus three snacks provided per day
- **Personal Care Services** including: Eating; Toileting; Ambulation/Location; Bathing; Dressing; Grooming/Hygiene; Transferring; and other personal care needs residents may be unable to attend to for themselves
- **Health Care**: Implement physician orders; ensure medication administered as orderly; and ensure referral and follow-up to meet the routine and acute health care needs
- **Activities**: Offer at least 14 hours a week of planned group activities of interest to the residents including at least one community outing per month
- **Other Services:** Transportation; Laundry; Personal Fund Management if requested
- **Supervision:** Provided as assessed to meet Resident's needs

Services Provided in Special Care Units

In addition to meeting Basic Services, residents in Special Care Units are provided:
Dedicated Environment that is safe, secure, promotes mobility and minimal use of restraints
Greater supervision as a result of lower staff to resident ratios

Population by Diagnosis

ADULT CARE HOME DATA									
AGE	Total Residents (1)	MI	% of Total Residents with MI	MR/DD	% of Total Residents with MR/DD	ALZ/DEM	% of Total Residents with ALZ/DEM	Total Adult Care Bed Count	Total Adult Care Facilities
18-24	101	59	58.4%	28	27.7%	1	1.0%		
25-34	392	252	64.3%	75	19.1%	4	1.0%		
35-49	1857	1168	62.9%	307	16.5%	55	3.0%		
50-64	3517	1638	46.6%	567	16.1%	397	11.3%		
65-74	3721	950	25.5%	326	8.8%	1048	28.2%		
75-84	7435	652	8.8%	166	2.2%	3200	43.0%		
85+	7808	287	3.7%	79	1.0%	3381	43.3%		
ALL	24831	5006	20.2%	1548	6.2%	8086	32.6%	36246	642

(1) Total number of all residents in all Adult Care Homes in North Carolina

All residents are not identified by primary diagnosis. Data obtained from 2005 license renewals.

Population By Diagnosis (continued)

FAMILY CARE HOME DATA									
AGE	Total Residents (2)	MI	% of Total Residents with MI	MR/DD	% of Total Residents with MR/DD	ALZ/DEM	% of Total Residents with ALZ/DEM	Total Family Care Bed Count	Total Family Care Facilities
18-24	58	36	62.1%	22	37.9%	0	0.0%		
25-34	172	87	50.6%	53	30.8%	0	0.0%		
35-49	659	434	65.9%	144	21.9%	6	0.9%		
50-64	728	381	52.3%	166	22.8%	30	4.1%		
65-74	392	141	36.0%	66	16.8%	43	11.0%		
75-84	333	52	15.6%	26	7.8%	122	36.6%		
85+	236	14	5.9%	9	3.8%	104	44.1%		
ALL	2578	1145	44.4%	486	18.9%	305	11.8%	3669	699

(2)Total number of all residents in all Family Care Homes in North Carolina

All residents are not identified by primary diagnosis.

Data obtained from 2005 License Renewals

Funding Stream

Funding for the resident's room and board services is equally shared by State and County special assistance funds and is an entitlement for indigent residents. The rate is set by the General Assembly. The maximum monthly rate is $1,118. Room and board for residence in Special Care Unit is $1,515. Personal care services are paid by Medicaid funds. Basic Personal care services daily rate is $17.33 for homes with two-thirty beds and $18.98 for homes with 31 or more beds. There is additional payment for resident assessed enhanced services needs in the areas of eating ($10.69), toileting ($3.82), and ambulation ($2.73). These needs are evaluated and case managed by county staff.
Private pay rates are set by the facility and are not regulated.

Senate Bill 622 Highlights

A Six Month Initial License Issued To New Facilities

- This provides for a license to be issued with the onsite inspection scheduled after residents admitted and care can be observed.

Annual Inspection Of All Licensed Facilities And A Physical Plant And A Life Safety Survey Conducted Every Other Year

- Ensures each home will be visited and inspected for rule compliance by the State agency. These inspections offer provider interaction with State licensing agency and training opportunities with county DSS staff. To be implemented by July 1, 2007.

Mandatory Training For County DSS Adult Home Specialists And Their Supervisors

- This provides an opportunity to promote counties' consistency in the survey process and rule application and compliance decisions.

Mandatory Transmission Of DSS Reports To The State Agency

- Ensures that the licensing agency is aware of county monitoring results and provides centralized public access to information.

Annual County Oversight Of Monitoring Performance

- Provides a forum for evaluating county DSS performance with identified opportunities for improved performance.

Mandatory Posting Of The Division's Complaint Number

- Provides consumers easy access to report complaints to the State agency.

Monetary Penalty For Falsification Of Ownership Data On Licensure Application

- Facilitates accurate and complete disclosure to ensure licensure decisions made as specified in statute and rule.

Increase In Licensure And Penalty Fees

- Supports funding for regulatory activity and promotes compliance.

Function Change In Penalty Review Committee Process

- Provides for quality assurance review of agency's actions

Adult Care Home Cost Modeling Report

Fiscal Research Division

NC General Assembly

January 18, 2006

Background/Purpose

- Adult Care Home Cost Modeling Committee formed in October, 2002.
- Final report completed December, 2004.
- Purpose of report was to "develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to ensure that resident care needs are met."

Adult Care Home Cost Modeling Report

- Research
  - Capital cost reporting
  - Special Assistance (SA) payment for Adult Care Home (ACH) room and board costs
- Resident assessment and screening
- Cost model
- Recommendations

Research

- Researched different methods of reimbursing for capital costs.
  - Proposed using a fair rental value of a facility as reimbursable cost.
- Researched policy issues impacting the SA payment for ACH room and board costs.

Resident Assessment and Screening

- An assessment of the residents in the model facilities was completed as a part of the committee work.
- DMA used an existing contract with Myers & Stauffer, LLC, a firm with expertise in the Minimum Data Set (MDS) assessment tool and the Resource Utilization Grouper (RUG) scoring system.

Resident Assessment and Screening (cont.)

- MDS is a resident assessment instrument used nationally by all Medicare-certified nursing facilities.
- The RUG system uses information from the MDS to categorize residents into one of 34 categories based on the intensity of medical conditions and needs.

Resident Assessment and Screening (cont.)

- DMA entered into a contract with the Association of Home and Hospice Care of NC for the services of nurse assessors located throughout the state to perform the assessments.
- Nurse assessors completed the MDS assessment and Myers & Stauffer, LLC analyzed the data.

Resident Assessment and Screening (cont.)

- Results of assessment
  - ACH population looked similar to the nursing facility population in most MDS categories.
  - Special Care Unit (SCU) population demonstrates more memory issues and a higher level of behavior problems.
  - Overall, nursing home residents are more dependent for help with activities of daily living than are adult care home residents.

Cost Model

- Cost model – wanted to develop a cost model from data gathered from selected cost effective and efficiently run facilities which met establish criteria determined by the committee.
- 23 facilities selected (9 with SCUs).

Cost Model (cont.)

- Facilities submitted 2002 cost report data
- Also submitted information on additional needs to meet residents' care needs and costs for full-time staff added after cost report completed.
- Committee used cost report data to estimate FTEs needed for Adult Care Home-Personal Care Services (ACH-PCS) and to determine Special Assistance related costs.

Cost Model (cont.)

- Based on the cost modeling analysis, rates and hours of PCS were proposed:

	Proposed non-SCU	**Proposed SCU**	***04-05 Rate***
SA	$1,124	$1,515	*$1,084*
ACH-PCS	2.31 hours/day	4.07 hours/day	*1.1 hours/day*

Recommendations

1. Adopt the cost model methodology, change rules and legislation to accept the cost model approach, and seek appropriations to fully fund new approach.
   - Costs to fund model are listed in Attachment 6.
   - Cost to State: $55.1 million
   - Total cost: $189.8 million

Recommendations

2. Reassess the cost model every 3 years for proper reimbursement.

3. As part of routine cost modeling and rate setting, study feasibility of allocating costs more appropriately between SA and PCS.

Recommendations

4. Improve the screening and assessment processes to promote appropriate placement and quality of care of ACH residents.
   - Cost estimates of automated screening/admission tool that combines assessment and care planning based on medical, mental health, and functional needs listed in Attachment 7 (page 40 of report).

Recommendations

5. Ensure that any DFS regulatory changes with potential to impact rates are reflected in the cost model.
6. Monitoring and performance expectations – DFS, DHHS Office of the Controller, and DHHS Office of Internal Audit.
   - Once recommendations are implemented, performance expectations will be developed.

Recommendations

7. Reimbursement modeling should account for resident mix and facility size.
   - Special Care Unit (SCU) versus non-SCU facility
     - Costs combined in Attachment 6 of report.
   - Long term, reimbursement should be matched to the resident's needs.

Recommendations

8. Develop similar modeling for Family Care Homes and Mental Health Group Homes.
9. Implement an income disregard policy to prevent disenfranchisement of ACH residents from financial eligibility for SA and Medicaid.
   - Attachment 6 of report includes a "worst-case scenario" cost estimate for this.

S.L. 2005-276 (SB 622)

- Funded increased PCS hours for residents of SCUs (1.1 hours/day to 4.07 hours/day).
- Funded increased SA rate for residents of SCUs ($1,084/month to $1,515/month).
- Increased SA rate ($1,084/month to $1,118/month).
- Subject to CMS approval, allowed the Department to disregard a limited amount of income if the Department shifts costs to PCS from SA.

Questions?

Andrea Russo
Fiscal Research Division
733-4910
andrear@ncleg.net

Report

Of the

Findings and Recommendations

Of the

Adult Care Home Cost Modeling Committee

Mission:
To develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to ensure that resident care needs are met.

December 17, 2004

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Addenda
1. Capital Cost Component Report
2. Final Assessments Report from M&S

List of Acronyms

ACH – Adult Care Home
ADL – Activities of Daily Living
APA – Administrative Procedures Act
CFR – Code of Federal Regulations
CMS – Centers for Medicare and Medicaid Services
COLA – Cost of Living Adjustment
CPI – Consumer Price Index
DFS – Division of Facility Services
DHHS – Department of Health and Human Services
DAAS – Division of Aging and Adult Services
DOL – U.S. Department of Labor
DSS – Division of Social Services
EIS – Eligibility Information System
FCH – Family Care Home
FL-2 – Level of Care Designation Form
FRV – Fair Rental Value
FTE – Full Time Equivalent Staff
HAL – Homes for the Aged
HML – Homes for the Mentally Ill
IPD – Implicit Price Deflator
MDS – Minimum Data Set
MMIS – Medicaid Management Information System
NF – Nursing Facility
OSBM – North Carolina Office of State Budget and Management
PCS – Personnel Care Service
RN – Registered Nurse
RUG – Resource Utilization Grouper
SA – State and County Special Assistance
SCU – Special Care Unit
SMM – State Medicaid Manual
SSA – Social Security Administration
SSI – Supplemental Security Income

Executive Summary

In October 2002, DHHS Deputy Secretary Lanier Cansler announced the formation of an Adult Care Home Cost Modeling Committee (hereinafter referred to as the Committee) to study "the development of a consistent costing methodology" to establish rates for State and County Special Assistance (SA) and Medicaid Personal Care Services (PCS) which fund the care of approximately 70% of the residents in North Carolina's Adult Care Homes (ACHs). (See Attachment 1 announcing formation of the Committee and Attachment 2 for a list of Members of the Committee.) At that meeting, the Deputy Secretary explained that he frequently heard complaints from providers about staffing needs beyond their ability to pay and beyond regulatory requirements, that reimbursement was insufficient to maintain a reliable workforce to meet resident care needs, and about unfairness in determining the capital cost component of the rate. He also heard complaints from advocates and the general public about failure to properly care for residents. Deputy Secretary Cansler's intent in forming the Committee was to develop an improved methodology for establishing an accurate and fair reimbursement rate that is based upon the substantiated care needs of the existing residents and a standardized quality of care.

The Committee agreed to the following mission: **To develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to ensure that resident care needs are met.** The Committee did not start with any preconceived target rate; rather, it started with gathering appropriate cost information from the provider community and identifying demographic and medical care needs of the population served. Excellent discussion occurred on the array of issues surrounding the continuum of care for North Carolina residents in these facilities: appropriate staffing to meet resident care needs, staffing required by licensure, determining resident mix and how that impacts cost of care, processes used to track and report costs, the cost of meeting regulatory requirements, appropriate reimbursement for the capital cost component of facilities, and whether North Carolina's Medicaid State Plan provides the flexibility of process and definitions utilized by other states, among other issues. From these discussions a matrix of both long term and short term actions was developed. (See Attachment 3 for the final version.)

In North Carolina, Homes for the Aged Licensed (HALs) are licensed as either ACHs and have 7 or more beds or as Family Care Homes (FCHs) and are licensed for 2 to 6 beds. In response to a growing number of facilities advertising special care for persons with Alzheimer's Disease or other related forms of dementia, the State established an "Alzheimer's Special Care Unit" (SCU) designation which applies to either stand alone facilities or separate units within the ACH spectrum. For purposes of this study, the Committee focused only on HALs of thirty or more beds, with and without SCUs and those that were SCU only. (Note: Due to the limited number of facilities with SCU beds, some facilities had as few as 24 beds.)

The methodology utilized by the Committee consisted of deciding upon the model approach and developing the model, gathering and analyzing cost/rate information, creating a new method for determining capital costs, assessing resident care needs, and extensive research of Federal and other state approaches to providing care to this population. All this was done under one condition--that no one currently receiving State and County Special Assistance (SA) would be disenfranchised from appropriate SA and Medicaid coverage as a result of our recommendations. Over the long term, this methodology allows for future rate setting that can be updated for inflation, for changes in facility and care standards and periodically adjusted to reflect resident

populations and staffing requirements. The ultimate goal of such a process is to develop an operational environment that produces higher standards of care for ACH residents.

Adopting the cost model approach recommended by the ACH Cost Model Committee will result in allocating more hours to appropriately address client care needs and increasing salaries and benefits to ensure a stable and competent workforce. The Committee discovered that while NC had based its PCS reimbursement on 1.1 hours per resident per day, in fact, resident assessments, when compared to national studies, indicate a need for 2.31 hours for basic ACH residents and 4.07 hours for SCU residents. Additionally, North Carolina salaries and benefits are currently below national averages. Most alarming is that many fragile older residents are being housed with younger and stronger, often mentally ill, residents. Making these changes will change the current daily rate for basic PCS in HALs and in SCUs, which is $18.57* (based on the current 1.1 hours per resident per day) to $41.26 for residents in HALs (based on the recommended 2.31 hours per resident per day) and $72.69 for residents in SCUs (based on the recommended 4.07 hours per resident per day). (*This is actually weighted average for the 1-30 bed category and the 31+ bed category.)

North Carolina's system of long term care has consistently been noted to be a fragmented "patchwork" of programs and very confusing to consumers seeking long term assistance and support. The 2001 NC Institute of Medicine's Task Force on Long Term Care made a number of recommendations involving the creation of a uniform system of entry into long term care. The Division of Aging and Adult Services (DAAS) has received a Federal grant to work on a pilot project to design and implement a community-based information and assistance program for the elderly and the disabled. DAAS has looked to DMA to ensure that a pilot chronic care management component is developed as part of the overall design.

Should the State decide to (1) increase the public financing for ACH services to more accurately reflect the cost of care; (2) create different rates to acknowledge the higher cost of care and staffing needs of SCUs; and (3) make sure that persons with mental health needs get the appropriate treatment services upon admission and following placement, then there needs to be good screening, assessment and client tracking systems developed for ACHs. These management systems would include the following:

1. An improved pre-admission approval system with mental health screening;
2. A prior approval system for SCUs;
3. Medicaid criteria for placement purposes;
4. Use of more sophisticated and automated assessment and care planning tools to help facility staff manage their residents; and
5. Utilization management and quality assurance programs to assist the State in monitoring care, services and placement.

Numerous recommendations have been identified as a result of the Committee's work. Legislation, IT systems, rules and processes must be adjusted or developed. Implementation will not be easy or inexpensive, but the methodology provides a firm foundation for future rate setting. As stated above, based on resident care needs identified through the resident assessments conducted, staffing levels must be increased. The Medicaid PCS cost of implementation will be $188,854,207 ($120,167,932, Federal; $50,152,255, State; and $18,534,020, county). The detail breakout to implement the 2.31 and 4.07 PCS hours per day for all HAL and SCU Medicaid ACH-PCS is:

- ACH-PCS for HAL Facilities (2.31hr/day) equals $180,096,959
- ACH-PCS for SCU Facilities (4.07hr/day) equals $8,757,248

For SA there will be an additional $9,980,260, evenly split between State and county funds, to raise the existing rate to $1124. There will be cost associated with the proposed adoption of an income disregard payment to avoid disenfranchising current SA recipients in the amount of $22,660,113 ($14,411,910, Federal; $6,335,278, State; and $1,912,925, county). See Attachment 6 for a full breakout of these costs. As yet undetermined expenditures will also be required to implement systems changes for the income disregard. Additionally, the recommendations surrounding the screening and assessment processes to ensure residents are placed in the appropriate long-term care setting according to their care needs will cost an estimated $850,000 in developmental costs and $1,344,000 in annual operations. See Attachment 7 for a full breakout of the costs associated with screening and assessments.

Along with these recommendations for increased assessments, salaries and benefits for ACH workers, and increased hours of care for residents, the Committee recognized the need for verification that the increased rate is directed toward quality improvements in resident care. This will be closely watched through routine monitoring and random audits. Additionally, DHHS has included in its expansion budget request additional resources to expand expectations from county Adult Home Specialists for improved inspection and oversight. This is the first time in many years the Department has addressed cost reimbursement in such a thorough and systemic way. The Committee acknowledges that whatever the rate methodology or reimbursement amount, the General Assembly has the final decision on setting the rate. We believe adopting the suggested rate setting model will provide members of the General Assembly, the public, residents and providers, a clearer understanding of the costs of care and a balanced mechanism for determining rates. Very likely the General Assembly will find this package difficult to finance immediately, however recommendations are closely linked and must have coordinated implementation to succeed.

Subsequent to the completion of the draft report, it was reviewed by representatives of the North Carolina County Commissioners Association and the North Carolina Association of Directors of Social Services. Both organizations agreed with the focus on resident care and in general support the recommendations of the report. Indeed one reviewer commented, "The challenge from our perspective seems to be making sure that additional funding is channeled into direct care and services for residents. This study seems to be a first step in that direction." As expected, there is concern over the increased funding required at the county level.

Representatives from several advocacy groups also reviewed the report and support the cost model approach as a systemic way to determine rates based on resident care. All reviewers recognize, as does the Department, that there will be challenges in implementing the recommendations. Some of these challenges are appropriate training for providers on the assessment process, determining the best entity to perform such assessments, development of performance expectations and frequency of application of the inflation factor. These and other implementation details will be resolved by a representative group of individuals at the time the approach is approved.

Developing the Model

Because of the desire of the ACH Cost Modeling Committee to develop a rate that provides more standardized quality to these facilities, it was agreed to develop the cost model from data gathered from selected cost effective and efficiently run facilities which met established criteria determined by the Committee rather than on the basis of all facilities. Since industry representatives frequently commented that the cost report format did not properly reflect the true cost of meeting the care needs of residents as opposed to the regulatory requirements, the format was modified to allow providers to justify increases for staff, benefits or other support line items necessary to meet both regulatory requirements and the care needs of residents with the intent that this would provide valuable comparative staffing and cost data later. A separate subcommittee was established to address the perceived inequities of the capital cost component of the cost reports.

Letters were sent to identified facilities explaining the cost model concept and asking for participation. Training was provided to the selected model facilities in three locations around the state (Hickory, Raleigh and Greenville) to explain the revised cost report format and how it would be used and to answer questions about terminology and definitions. Although the training was provided in April 2003, the Committee was still waiting for some revised cost reports from selected facilities in January 2004. Once the completed, revised reports were received, the staff of the DHHS Controller's Office clarified information to ensure completeness.

During the development of the modeling process and selection of facilities to use in the model, extensive research was conducted of Medicaid State Plans in other states, different methods of costing the capital component and resident assessments were performed. These efforts are discussed in the following sections: Rate Setting and Fiscal Impact, the Capital Cost Component, Resident Assessments and Research.

Rate Setting & Fiscal Impact

Selection of Facilities for the Model
The first step in developing the cost model consisted of identifying representative facilities to participate in the study. Two types of HAL licensed homes were originally targeted: (1) facilities that are entirely SCUs or that have SCUs, and (2) those without SCUs. With the assumption that different sized facilities would have diverse levels of staffing requirements as well as varying levels of costs, the modeled facilities were grouped according to the number of licensed beds. See Selected Information for HAL Model Facilities and Selected Information for SCU Model Facilities at Attachments 4-1 and 4-2, respectively.

The following criteria were applied to select facilities for the modeling process:

- Appropriate geographical and urban rural representation
- Mixture of both private pay and public funding
- Occupancy rate at a minimum of 80%
-
- Include Special Care Units (SCUs) within facilities and those that are stand-alone facilities
- Representation from the following size categories: 31-60 beds , 61-90 beds, and 91+ beds
- Must have been in business for at least one year
- Minimum of 3 facilities per group (therefore 5 were identified to allow for refusals to participate or other probabilities of non-participation)
- No disproportionately high indirect cost ratios compared to direct costs
- No history of penalties and fines
- Those facilities that met the above criteria, were reviewed by industry representatives, the local Departments of Social Services, and the Friends of Residents in Long Term Care as efficient and respected facilities with a good reputation for serving residents

Analyzing the Cost Information
Once the cost reports were received from the model facilities, the painstaking process of analyzing the information started. The cost model began with the existing cost report of each facility and then incorporated the flexibility to address cost needs that are not adequately compensated in rates that are based solely on historical costs adjusted for inflation. One of several needs that industry representatives cited which impacts the care that residents receive is the inability of the facility to fund benefits for full time staff at the existing reimbursement rates. Lack of benefits creates employee turnover and negatively impacts the quality of care provided to the residents. Therefore, the facilities were given the opportunity to add costs for "additional needs" identified at their facility and explain how these additional needs were important for the care of their residents.

The format of the cost report classifies expenditures into specific categories: SA, PCS, Administrative, Medical Transportation, Mental Health Services and Non-Reimbursable Costs. Rates for SA and PCS are based upon the following cost components:

SA

- Housekeeping and Laundry
- Dietary
- Recreational Activities
- Property Ownership and Use
- Operations and Maintenance

PCS

- Personal Care Services
- Health Services
- Initial Orientation/Aide Training

Costs excluded from the analysis are Non-Reimbursable, Mental Health Services and Medical Transportation since these costs are not related to SA or PCS. Medical transportation is reimbursed by Medicaid in a separate process, and Administrative costs were allocated across all cost components above.

The 2002 cost report format and data formed the basis for the modeling exercises. Following are the assumptions and methodologies used in compiling the cost model:

- Assumed the costs in the 2002 cost reports reflected staffing in compliance with North Carolina licensing and operating requirements.
- Additional needs for providing adequate services to meet the unique care needs of the population were identified by the facilities and added to the 2002 base.
- Added costs for current full-time staff in cases where staff had been added subsequent to the submission of the cost report.
- Facilities were asked to separate hours reported on their original cost report into regular and overtime hours so that an appropriate adjustment could be made for the additional cost of overtime.
- PCS FTEs were calculated as follows:
  1. First Line Supervisors – staffing requirements per 10A NCAC 13F.0605
  2. Medication Aides – 37 minutes per resident per day. (Source: An analysis conducted by Jan Brickley, a DFS pharmacist, in 1999, to determine additional work effort required by medication administration rules made effective in 2000.)
  3. Resident Aides – Myers & Stauffer RUG analysis (described later in this report).
  4. Registered Nurses – 1.15 hours per resident per month needing RN services. (Source: Information provided by the NC Assisted Living Association based on Licensed Health Professional Support requirements for RN competency for certain tasks in 10A NCAC 13F.
  5. Median hourly wage rates established by the U.S. Department of Labor (USDOL) for North Carolina were used to calculate salaries by job classification for full-time FTEs. These wage rates were inflated annually based upon inflation factors provided by the N.C. Office of State Budget and Management (OSBM). Casual labor costs were also inflated by these percentages.
- Benefits were calculated on the 2003-04 average benefit rate of $2.44 per hour for each full-time position identified by the facility. Inflation factors provided by OSBM were applied annually. The benefit rate is based on the employer costs for

employee compensation for paid leave, insurance, retirement and savings. (Source: DOL, Bureau of Labor Statistics.)

- Payroll taxes were calculated on total salaries which are based on the inflated hourly wage and include additional FTEs identified by the facilities and Myers & Stauffer's staffing recommendations in the PCS cost center.
- Non-labor expenses were based on reporting year 2002, and have been inflated by applying the annual Gross National Product Price Deflator provided by OSBM.
- A capital cost adjustment of $11.16 was included in the SA rate and was calculated as an average of the 2002 and 2003 capital adjustments of $13.58 and $8.74 per month, respectively. No inflation factor was applied.
- Non labor costs were inflated to reflect projected costs for SFY 2005-06.

To arrive at the PCS FTEs described above, the committee reviewed Myers & Stauffer's analysis of the resident assessments to gain insight into the mix and to understand the resident care needs in ACHs. (See the following section on Resident Assessments.)

Establishing the Rates

Once all components of the cost report were analyzed and combined, the SA and PCS rates were reviewed. Although rates did vary between the different size categories of the non-SCU ACHs, setting separate rates by facility size is not allowable based on current APA rules and payment structures. As such, only one rate was determined for the non-SCU facilities.

The proposed SA rate for the non-SCU adult care homes based on the cost modeling exercise was calculated to be $1,124 per month for 2005-06 compared to the recently established rate of $1,084 per month (effective 10-1-04). The cost model for the SCUs yielded a rate of $1,515 per month versus the $1,084 SA rate in effect. SCUs typically have a lower number of SA residents, thus the financial impact is not excessive. The higher SCU rate was expected since the maintenance and level of care of the SCU residents are more extensive than the non-SCU residents. This finding was supported by information gathered on residents' needs using an assessment process that served as a key component to the ACH cost modeling and is described in more detail later in this report. (See Attachment 5-1 and 5-2 for Rate Proposal for Non-SCU Facilities and for Rate Proposal for All SCU Facilities, respectively.)

The SA rate under the cost model yields a forecasted increase of nearly $10M in SA payments in fiscal year 2005-06 from fiscal year 2004-05. This cost represents an increase in the SA payments to current SA recipients and an average increase of 19 new SA eligibles per month in non-SCU facilities. Only 5 new eligibles per month are projected for SCU facilities from among the currently eligible group. The PCS cost of implementation will be $188,829,187 ($120,152,012, Federal; $50,145,611, State; and $18,531,564, county).

Capital Cost Reporting

Capital costs are typically defined as depreciation, amortization, lease, and mortgage interest expenses, but may include other related expenses such as property taxes and property insurance. Capital costs can also include rent paid to another facility owner. Traditionally, North Carolina has reimbursed facilities using a single state-wide rate based on facility cost reports, as reported in various "cost centers". Historically the "capital cost center" did not recognize cost of capital, differences of ownership structure, whether facilities were owned or leased, geographic cost-of-living differences, and existing tax laws. The ACH Cost Modeling Committee recognized the need to address capital assets in a more thorough manner and formed a Capital Cost Modeling Subcommittee led by the DHHS Internal Auditor. The objectives of the Subcommittee were to develop a methodology based on the need to administer an equitable return on facility investment, minimize administrative costs associated with capital reimbursement, and to standardize the rate setting process so that it would be more easily understood and evenly applied.

The Subcommittee contacted Myers & Stauffer, LLC, to find out more about approaches used by other states. Fortuitously, in 1998, Myers & Stauffer, LLC, developed a report for the State of Washington comparing property payments for nursing facilities. Generally, states use one of four methodologies to reimburse capital costs: (1) flat rate, (2) cost based, (3) fair rental, or (4) blended. Each of these methodologies has unique advantages and disadvantages which are more fully described in Attachment 6, Adult Care Home, Capital Cost Reimbursement Study, Position Paper, dated May 2004. The Subcommittee weighed and considered each of the four alternative approaches in order to develop a recommendation for the full committee. Using the Myers & Stauffer, LLC, study and adapting the historical information contained within NC's cost reports, the Subcommittee recommended a fair rental value (FRV) approach to capital reimbursement. This approach treats capital components from a rental vantage point similar to renting other lodging, a hospital bed or office space. Under this concept, government is not interested and does not become involved in real property management issues/costs such as mortgage interest, capitalization policies (depreciation), leasing, repairs and renovations and a host of other ownership issues. The FRV concept merely looks at the value of the space from a rental perspective.

In essence, the variation of the FRV approach chosen utilizes the adjusted county tax appraisals for the various facilities and applies a rental factor. The Subcommittee selected 2001 as a hold harmless base year and then calculated the facility FRVs for the following two years and applied an Implicit Price Deflator IPD (which adjusts for inflation). For 2002, this process resulted in increased Special Assistance monthly costs/rates of $14 (from $1183 to $1197 per bed). For 2003, the Special Assistance monthly cost/rates would have increased by $9 (from $1,188 to $1,197 per bed). These resulting increases are currently small due to the low inflation rates which have been experienced over the last few years. As inflation increases, the limiting IPD factor would also increase, providing a greater increase in allowable costs.

Resident Assessments Process

The Need for Resident Assessments

Over the course of the last several years, the resident "mix" in ACHs has changed. Some of this change may be due, in part, to the US Supreme Court Olmstead ruling of 1999 and subsequent state planning efforts to divert or transition residents away from state psychiatric hospitals towards the least restrictive appropriate level of care, which has in turn increased the mentally ill population in ACHs. Younger persons with varying forms of mental illness are being placed in facilities with older, more physically frail populations. Increasing populations of residents with greater health care needs and with a diagnosis of mental illness have resulted in the promulgation of rules over the past several years addressing medication administration, staff training, resident assessments and care plans, and licensed health professional support. The mix of frail elderly with younger, mentally ill residents is of growing concern considering minimum staffing requirements and the lack of mental health resources in many areas of the State to provide needed services to mentally ill residents.

Other forces that may be impacting the overall composition of the population dependent on public funds and living in adult care homes include: (1) the increase in the availability of newer Assisted Living facilities which offer more options to the private pay resident and those elders able to make choices about living options, and (2) the SA In-Home Program, operated through local departments of social services, which allows persons who "qualify" for placement in an ACH to live in their private residences. The Committee felt that the combination of these and other factors had resulted in an ACH population with many chronic medical conditions, high levels of mental health needs, and heavy Activities of Daily Living (ADL) needs which together make the population much more dependent on personal care assistance. Yet, industry representatives informed the Committee that regulatory staffing requirements have not changed to reflect the care needs of the population. For these reasons, from early in the deliberations of the Committee, the need for a comprehensive assessment of the resident population was identified.

The current placement process for persons dependent on public funding entering ACHs and the ongoing assessment process of ACH residents are:

> *A person's attending physician must complete and sign a one-page FL-2 form that includes the current and recommended level of care, the diagnosis of the client and any other pertinent information about the client, including items such as functionality and medications. Within 72 hours of admission, the facility conducts an initial assessment of the resident using the Resident Register, an informational form required in rule as part of the admissions process. Another assessment is conducted within 30 days of admission and annually thereafter using the DMA 3050-R or an equivalent. In almost every case, all of the assessments tools are completed manually by the physician or the facility staff.*
> (NOTE: An electronic FL-2e is currently available through ProviderLink, Inc. and is being used primarily for prior approval of nursing facility admissions.)

None of the above mentioned forms are considered a comprehensive assessment instrument nor is the information on the ACH resident recorded in a format that would support data collection or a statewide comparative analysis among the ACH population and populations in other long-term care settings.

To assist in the resident assessments and analysis of the assessment data in a timely manner for the work of the Committee, the Division of Medical Assistance used an existing contract with the consulting firm of Myers & Stauffer, LLC. This firm is known for its expertise in the Minimum Data Set (MDS) assessment tool and the Resource Utilization Grouper (RUG) scoring system. The study was approached in two phases to provide the Committee with assurance that the data collected would produce the outcomes necessary for good decision making. One of the major components of the work performed by Myers & Stauffer, LLC, was a statistical comparison of the ACHs using the same methodology as other national studies to determine staffing needs.

The Assessment Process

The MDS is a **well-researched resident assessment instrument** used nationally by all Medicare certified nursing facilities, and this instrument was determined by the Committee to be the best option available for gathering information on the care needs of the ACH residents. Closely associated with the MDS is the Resource Utilization Grouper (RUG) resident classification system. The RUG system uses information from the MDS to categorize residents into one of 34 different groups based on the intensity of medical conditions/needs, including cognitive impairments and functional limitations as measured by the ability to perform ADLs. ADL needs are a critical component to calculating overall resident needs and are important in determining the outcome of the RUG analysis and staffing requirements. The RUG analysis was performed using the same methodology used in a nursing facility time study conducted from 1995-97 by CMS, and this analysis informed the Committee of the quantity and levels of staffing time required to meet the unique care needs of the residents. (NOTE: A modified MDS 2.0 version was completed by contract nurses during the assessment process. The RUG analysis was performed using RUG-III 34 classification system, Version 5.12.) Once the decisions were made on the assessment instrument and the methodology for analysis of the data, the next step was to determine who would perform the assessments. The Division of Medical Assistance entered into a contract with the Association of Home and Hospice Care of NC for the services of nurse assessors located throughout the State. These nurse assessors were employees of local home health agencies. The contract nurses went on-site to the ACHs selected for the study and completed the MDS on all the residents in the facility (Medicaid and private pay). Although the contract nurses were required to be proficient with the MDS, Myers & Stauffer, LLC, provided "refresher" training via teleconferencing.

All of the facilities participating in the cost modeling received materials in advance to explain the purpose of the study and to provide names of contact persons should there be questions. In addition, the facilities were provided with a copy of the MDS guidelines. The nurse assessors used observation, medical or other resident charts, talked with the facility staff and gathered resident input to complete the MDS. Once the nurse assessors completed the MDS assessments on the residents in the selected facilities, the forms were mailed to Myers & Stauffer, L~~LC, for~~ data entry and RUG analysis. The analysis would produce a comparison of resident profiles between ACH and nursing facilities on available data elements, including:

- RUG distribution (by group and score)
- Cognitive Performance Scale scores
- ADL scores
- Payer source breakdown
- Selected conditions or "outliers"
- Demographics of population

In order to accommodate review and decision making by the ACH Cost Modeling Committee, the assessments were performed in two phases, the first for non-SCU facilities and the second for SCU facilities and MHLs. Actual on-site visits by the contract nurse assessors started June 20, 2003.

Phase I:

- August 2003 – Myers & Stauffer, LLC, completed an analysis on four ACH facilities which included 215 assessments. After review of the analysis, the Committee decided to add a fifth facility to address the concern that the first four facilities did not adequately reflect a population with mental health needs. In December 2003, the fifth facility analysis was completed, increasing the total number of assessments to 270.
- December 2003 – Assessments were completed on a total of 549 ACH residents in nine facilities, bringing the total number of assessments to 819.
- January 2004 – A report was submitted by Myers & Stauffer, LLC, for review by the ACH Cost Modeling Committee.

Phase II:

May 10, 2004 – Myers & Stauffer, LLC, completed the final report adding the Phase II resident assessments that included 11 ACH special care units (SCU) and 8 mental health group home facilities to the Phase I resident assessments. The total assessments for ACH residents now reached 1,137 and 28 mental health residents.

Myers & Stauffer, LLC, issued a final detailed report to the Committee on May 10, 2004. The complete, final report, which provides details on the findings of the MDS results and the RUG analyses, is attached to this report.

Highlights of the MDS Resident Assessment Report

The Adult Care Home population looks similar to the nursing facility population in most of the MDS categories. The SCU population that represents residents with Alzheimer's or related dementia demonstrates more memory issues and a higher level of behavior problems, requiring cueing and supervision. Overall, in the ADLs, the nursing facility population was far more dependent than any of the ACH population. However, the ACH SCU population reported a heightened need for assistance in dressing, toilet use, personal hygiene and bathing--all ADL needs.

The RUG scores reflected the wide range of residents needs. Most of the residents (51%) clustered at the lowest RUG category, Reduced Physical Functioning. The overall results in RUG scores for the 1,137 residents were:

- Reduced Physical Function — 582 residents (51%)
- Impaired Cognition — 397 residents (35%)
- Clinically Complex — 110 residents (9.6%)
- Behavior Problems — 32 residents (2.8%)
- Special Care — 10 residents (<1%)
- Extensive Services — 5 residents (<1%)
- Special Rehabilitation — 1 resident (<1%)

For the Mental Health Group Homes, of the 28 residents assessed:

- Impaired Cognition — 16 residents (64%)

- Special Care 5 residents (20%)
- Special Rehabilitation 1 resident (4%)
- Reduced Physical Function 6 residents (12%)

Improved Screening and Resident Assessment Program Needed

As noted above, entry to an ACH is based on the recommendation of a physician and the physician's signature on a completed, one-page, FL-2 form that documents the overall health care needs/medical conditions and ADL needs of the individual. Once a physician signs the FL-2, the form is sent to the local DSS for determination of placement and eligibility for SA and Medicaid. Although Medicaid heavily funds care needs of residents in ACHs, it does not control the admission process, and there is no Medicaid admissions criteria with which to inform physicians regarding level of care and personal care needs. In addition, there is no formal screening to identify persons with mental health needs or whether they are receiving mental health treatment. Since concerns with quality of care often focus on the issue of mental health services to ACH residents, it is critical that the State make sure that persons with mental health needs are identified and followed by the appropriate health care professionals. (NOTE: The MDS resident assessments performed as part of this study reflect similar data gleaned from a recent Mental Health Screening Project conducted by First Health, Inc. for DHHS. This project clearly shows a high level of ACH residents with behavior and mental health problems. The Mental Health Screening Project indicated that over 40% of the ACH residents included in the sample had mental health problems that required some level of intervention and treatment services.)

Adult care homes serve as a major component of North Carolina's long-term care delivery system, and it is time for the State to move aggressively to implement improved management tools and systems to respond to the growing needs of the adult care home population and to bring more accountability to the program. See Attachment 7 for a list of program enhancements and estimated costs.

Research

Background
The public funding for ACH residents comes primarily from two sources. The first source is from the State and County Special Assistance Program (SA) which is 50% State funds and 50% County funds and is the payment for room and board. The second source of funding is Medicaid. In 1995, Medicaid funds began reimbursing the ACHs for Personal Care Services (PCS). Personal Care Services include "enhanced" personal care services, which provide an additional payment to the ACH. Enhanced PCS must be prior approved by a local agency case manager using Medicaid criteria for residents needing more extensive care. Early discussions in the Committee focused on the Medicaid definitions of PCS, Enhanced PCS, and how PCS provided in the community differ from PCS provided in the ACH setting. Research indicated that expenses covered under the SA rate for room and board in North Carolina were not comparable with what is covered in other states. This led early in the life of the Committee to shifting Initial Orientation/Aide Training and Health Services from the SA rate to the PCS rate. While this shift more appropriately allowed for an increase in Federal Medicaid funds and a decrease of State and county funds, it also became apparent early in our deliberations that shifting costs created the potential for making residents currently in HALs ineligible for SA assistance. (NOTE: The eligibility standard equates to the SA payment level.)The Committee immediately adopted the position to protect this population and ensure that no one was disenfranchised by attempts to better define rates and allocate costs more appropriately between State and Federal dollars.

Policy issues impacting the SA payment for ACH room and board costs were researched for consideration by the Committee and the Department. For purposes of this report, the research is broken into five major issues which are presented below.

Issue 1: Mandatory Minimum State Supplement and Passalong
In 1995, the Congress approved annual cost of living adjustments (COLAs), based on the increase in the Consumer Price Index (CPI), to the Supplemental Security Income (SSI) standard payment amount. In 1977, the Congress mandated that states passalong COLAs to SSI and Social Security beneficiaries receiving mandatory and optional State supplemental payments, and to maintain either a minimum level of payment, or the level of State expenditures under the State's SA Program. In the context of the SA Program, level of payment means an income level or standard representing the approved ACH room and board rate plus a personal needs allowance for the individual's personal needs. Net income is subtracted from the income level to compute the amount of the SA payment for an ACH resident.

Written agreements were required between the states and the Social Security Administration (SSA) as assurance of compliance with these conditions. States' submit an annual compliance report indicating the method by which it complies, i.e., minimum level of payment or total expenditures. North Carolina traditionally uses the minimum level of payment method for compliance but has relied on verbal interpretations from SSA staff on the level of payment it must maintain to meet compliance. Major objectives for the research were:

- Determine what conditions the state must meet to comply with statutory and regulatory requirements for State supplemental payments, and

- Validate that NC is in compliance with the Social Security Act and regulations mandating a minimum level of payment and passalong of COLAs to SSI/State supplement recipients.

Research steps to address the stated objectives included:

- Review of pertinent sections of the Social Security Act and Federal regulations.
- Application of regulations at 20 CFR 416.2096 - .2098 to identify the specific time periods and rules for testing the State's supplemental level of payment.
- Charting by year beginning in 1994 through January 2003 (updated January 2004), the amounts of the SSI benefit rate, annual COLAs, combined SSI and State supplement payment level, maximum State supplement and increases in the State supplement.
- Using the charted amounts and the time periods and rules required by regulation to calculate the minimum level of payment for NC.

Conclusion, Issue 1
The research concluded that North Carolina is in compliance with the mandate for a minimum level of payment and passalong of COLAs. The current $1,084 ACH level of payment exceeds the minimum by over $300. Compliance testing validated the following:

- For the period 7/77 - 3/83, the State's supplemental payment must at least equal the maximum supplemental payment in 12/76, which was $164.20.

  During this period, NC's supplement ranged from $170.60 to $205.70. Annual increases in the amount of supplement equaled or exceeded the amount of the COLAs.

- For the period 4/83 - 1/2004, the combined SSI and State supplemental payment cannot be reduced below the combined level in effect in 3/83 plus subsequent SSI COLAs.

  The combined level in effect in 3/83 was $520.00. Subsequent SSI COLAs through 1/2004 total $279.10. The combined level for 3/83 plus subsequent COLAS equals a minimum level of payment of $799.10 for calendar year 2004.

Issue 2: Options to Prevent Disenfranchisement of Eligible Residents and Protect Medicaid Coverage
The transfers of staff costs for provision of personal assistance to ACH residents and of medically related supply and training costs from the room and board SA rate to the Medicaid PCS rate caused a concurrent decrease in the SA level of payment. In 1995, the SA level of payment was reduced by $173.00. When medical supplies and aide training costs were shifted in October 2002, the level of payment decreased by $51. With each payment level reduction, some SA recipients would have lost financial eligibility for State supplement and automatic eligibility for Medicaid coverage. The General Assembly authorized continued SA payment to these disenfranchised recipients using the SA payment level prior to the cost shift, allowing them to also qualify for Medicaid services.

The search for options to prevent disenfranchisement from the SA Program or the loss of automatic Medicaid coverage was begun soon after formation of the Committee and continued throughout the course of the Committee's work. Research efforts followed up comparisons with other state SA programs referenced in the 2002 Clifton Gunderson study, NC Special Assistance

Rate Methodology and reports that other states had limited the amount of their state supplements and maximized Federal Medicaid funding. The major research objectives were to:

- Gain an understanding of program policies used by other states to provide Medicaid coverage to residents of facilities similar to NC ACH facilities.
- Determine how and by what authority other states provide Medicaid coverage to non-SSI recipients living in residential care facilities,
- Explore methods used by other states to limit their state supplements and maximize federal Medicaid funding, and
- Propose alternatives that would reduce or eliminate disenfranchisement of SA eligibles and protect automatic Medicaid coverage in the event further realignment of costs from SA to Medicaid becomes feasible.

Research of the objectives was approached in several steps. Pertinent sections of the Social Security Act (Titles XVI (SSI) and XIX (Medicaid)) were searched for state latitude in design of their optional SA Programs or the possibility for differing interpretations. Research also involved a reading of the now repealed controlling statute and regulations for administration of pre-SSI State administered assistance programs. From this study, the concept of a Standard of Need and a separate lower Standard of Payment (ratable reduction of need standard used in the Temporary Assistance for Needy Families (TANF) program) was extracted and developed as an alternative for consideration. Conceptually, a non-SSI resident with income below a standard of need meets the income eligibility test and qualifies for automatic Medicaid coverage, however the amount of his state supplement would be determined by the lower standard of payment.

State Medicaid Plans and amendments posted on the CMS website were accessed to learn whether optional coverage groups and financial criteria applied by other states addressed a similar issue. The search included states referenced in the Gunderson Study, states similar in size to NC, states generally considered to be progressive in their Medicaid coverage of needy individuals, and states represented on the Eligibility Technical Advisory Group (E-TAG, a joint State-CMS workgroup). Where available, online administrative rules and policy manuals or handbooks used in the selected states were accessed to research policies for Medicaid coverage of non-SSI recipients living in licensed residential care facilities.

A copy of each state's current approved State Medicaid Plan for optional categorically needy groups and the financial eligibility section of the plans was obtained. This information was used to (1) compile a chart comparing the options for coverage and financial eligibility of the selected states and (2) search for specific regulatory authority supporting the state's interpretations and application of policies.

Following study of written materials, telephone contacts were made with the selected states to discuss program policies providing Medicaid coverage for individuals living in residential care. Discussions centered on non-SSI recipients who do not qualify for a state supplement to pay for room and board.

Brief descriptions of Section 1915(c) waivers posted on the CMS website were accessed and reviewed. Over half the states have approved or pending waivers describing provision of "adult residential care, assisted living, foster care, residential care services", etc. to aged/disabled individuals. Under 1915(c) waivers, non-traditional Medicaid services may be provided in home and community-based living situations to individuals who require the level of care provided in a

medical institution, i.e. a nursing facility or hospital. Use of 1915(c) waivers for their residential care population was discussed with states during the phone contacts. The Standard of Need/Standard of Payment concept was developed and augmented with three case profiles and Medicaid expenditure data for SA residents and for nursing facility (NF) residents. The case profiles represented actual SA Program applicants whose income exceeded the SA payment level by a few dollars and described the effect denial of a state supplement and Medicaid had on their decisions for care. The paper was shared in a face-to-face discussion with CMS officials to obtain feedback and guidance for a solution that provides appropriate levels of care and is less costly to all funding partners than forced admissions to nursing facilities.

Drawing on the policies, administrative rules and State Medicaid Plans of other states and NC General Statutes, options for a $5 minimum guaranteed payment and an income disregard applicable to non-SSI recipients who would otherwise not qualify for a state supplement were developed for consideration. Under the guaranteed minimum payment option, an SA payment of $5 would be issued to non-SSI residents with incomes up to the SA level of payment in effect prior to a reduction related to cost shifting from the room and board cost centers to Medicaid PCS. Receipt of the minimum payment would protect their Medicaid coverage. Under the income disregard option, individuals with income greater than the current SA level of payment would have a limited amount of income disregarded to be used for a specific purpose, making the person eligible for a $1 SA payment.

Conclusions, Issue 2

1. An all inclusive rate, referenced in the Gunderson Study, but not a recommended approach, is best used to gain insight about how regulations have been applied in one state to coordinate non-medical residential care room and board payments with Medicaid PCS payments. Stated simply, survey data and pricing models are applied to establish daily payment rates. Arrayed by 3 geographic areas of the state, the rates include room and board costs and 4 care levels. The state's Medicaid system applies the care level and rate data, subtracts the costs paid by the resident, and reimburses the difference to the licensed residential care facility. SSI recipients use their income to pay only their room and board costs (valued at less than the SSI standard payment). Non-SSI recipients pay room and board costs, and contribute any remaining income to the care cost.

2. Per Diem rates used by another state referenced in the Gunderson Study are not a feasible alternative for NC. A per diem rate for room and board and a per diem rate for medical and remedial care costs are established for each licensed residential facility in the Gunderson study state (400 +), not to exceed a statewide capped rate. Application of this model would be too labor intensive and burdensome to be economical if applied to the 5,000+ licensed facilities in NC. However, this state's policies were instructive for allocation of at least a share of housekeeping, dietary, and laundry service staff costs as reimbursable Medicaid PCS. These services traditionally were considered part of the "room and board" cost, however Medicaid PCS task definitions include light housekeeping, meal preparation and laundry services when authorized for a recipient in his place of residence.

3. Valuable insights were gained about the use of SSI living arrangements and state licensing standards to establish different income standards for State supplemental assistance. Many states have separate SA payment levels for licensed residential care facilities, using licensing criteria to differentiate for type of care/living arrangement or size of facility. This model could have potential in NC, but requires significant staffing and time to develop and implement.

4. CMS disagreed with the Standard of Need/Standard of Payment concept. While they accepted that current Federal laws and regulations have unintended consequences, they interpret the controlling Federal regulation at 42 CFR 435.232 literally. In their view, individuals must have less income than the level of payment or income standard used to determine eligibility and amount of payment, and must actually receive a supplemental payment. CMS recommended protection of Medicaid for non-SSI residents in ACHs through either a 1915(c) waiver or Section 1115 demonstration waiver. CMS staff was noncommittal about NC's chances for getting a Section 1115 waiver approved.

5. The comparison of State Medicaid Plans indicated much similarity in coverage of optional groups of eligibles and financial eligibility. It did not however reveal specific regulatory authority for other States' policies. For instance, a footnoted statement on the bottom of the State Medicaid Plan Attachment (the suggestion of a CMS Regional Office staff member many years ago) was cited as the authority by one state. In another state, administrative rules were adopted based on options allowed by Federal regulations, though no specific Federal regulation was cited. In still another state, the staff knowledgeable about 'Income Standards for Medicaid Only' individuals living in residential care had recently retired. Thus, clear authority to give Medicaid coverage without receipt of a state supplemental payment or waiver authority appears to be ambiguous.

6. The Committee and the Department determined that there are significant drawbacks to either an 1115 or 1915(c) waiver. A Section 1115 demonstration waiver requires lengthy development and approval processes, ongoing evaluations and Federal budget neutrality. Under a Section 1915(c) waiver, the target population must meet the state's criteria for institutional care, i.e. nursing facility or hospital. NC General Statutes, which prohibit ACH facilities from admitting residents who require nursing level of care, would need to be amended.

   - A state's medical need criteria for institutional care may include functional or cognitive limitations as well as the need for medical care. Thus, the ACH resident population could be split between 'waiver' and 'non-waiver'. In addition, PCS for ACH residents eligible under a 1915(c) waiver would have to be defined differently in scope or level of service provision than for non-waiver ACH residents.
   - A primary benefit of a 1915(c) waiver is the option to use 300% of the standard SSI payment as the income threshold for eligibility and to set a different threshold for protection of income to meet the costs for room and board and personal needs. This would allow Medicaid for waiver eligibles with gross monthly income up to $1,692.
   - Neither State nor facility resources are adequate at this time to study how a waiver could be structured, nor to develop the policies, licensing standards or an assessment instrument and process to make the pursuit of waivers a viable alternative.

Issue 3: Definitions Associated with Room and Board and Personal Care

Discussion of research findings associated with State supplemental payments for room and board costs and Medicaid PCS prompted questions from the Committee about the Federal definitions for these terms. The major objectives of the research of definitions of terms were to:

- Determine whether there is a specific or universal definition of room and board under federal laws or regulations governing public assistance programs with Federal oversight and/or financial participation,
- Determine whether there is commonality of the definition of room and board among assistance programs, or states,
- Verify the CMS definition of PCS, and
- Determine what criteria are required by the Internal Revenue Service (IRS) to claim PCS costs as a medical expense deduction for income tax purposes.

Research for definitions used or accepted by CMS and other Federal agencies involved an extensive search of Federal statutes and regulations governing public assistance programs and their administration by states and local governments. In addition, the U.S. DHHS Departmental Appeals Board decisions for over a decade were reviewed to ascertain whether the disputes involved a definition of room and board. Administrative policies for cost allocation and reporting associated with public assistance programs and guidance and interpretations issued in the State Medicaid Manual were reviewed. The online glossary at the CMS website was queried for definitions of "room", "board" and "room and board".

Conclusions, Issue 3

There is no statutory definition for the terms "room," "board," or "room and board" and no specific commonly applied written interpretation among the various assistance programs or states administering the programs with the exception of Section 1915(c) waivers. In the context of waivers, and pursuant to 42 CFR 441.310, the term "board" means 3 meals a day or any other full nutritional regimen. Statute and regulations relating to TANF, Foster Care Maintenance, Foster Care Independence, and SSI generally describe these assistance payments as including food, shelter, utilities, household goods, clothing, etc., without defining the terms. The Departmental Appeals Board cases did not involve a definition of room and board.

The CMS State Medicaid Manual (SMM), Section 4480, describes PCS as a range of human assistance to enable persons with disabilities and chronic conditions of all ages to accomplish tasks that they would normally do for themselves if they did not have a disability. Within this general description, states have latitude to define the scope of PCS services included in their State Medicaid Plan, however services must be provided by a qualified provider who is not a member of the individual's family. The SMM references the Federal Medicaid Program definition of family as "legally responsible relatives". It was concluded that NC's scope of services and delivery meets the limited specifications of 42 CFR 440.167 and the SMM guidance.

According to IRS Publication 502 (for tax year 2002), privately paid costs for "qualified long term care services" may be claimed as a medical expenses in figuring the allowable tax deduction. Qualified long term care services must be prescribed by a licensed health care practitioner to a chronically ill individual who is unable for 90 days or more to perform at least 2 activities of daily living without substantial assistance from another individual due to loss of functional capacity and/or requiring substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Issue 4: Conversion from Cost Reporting to a Prospective Payment System

NC currently requires that certain ACH facilities file cost reports on an annual basis. Cost report data is used to set the allowable room and board rate for residents receiving a state supplement to

their own income and to cost settle overpayment of PCS to private facilities. The major objectives of research were to:

- Determine whether other states may have changed from cost reporting to a prospective payment system for provision of PCS in licensed residential care facilities, and
- Explore how the change was explained or justified in the states' Medicaid plan amendment.

Research of Medicaid PCS reimbursement methodologies and a change in methodologies was approached by searching the online Medicaid State Plans at the CMS website. Medicaid Plan Attachment 3.1-A describing "other medical care and remedial care services" covered by selected states was searched to identify whether PCS is a State Plan Service. Attachment 4.19-B, which describes the State's reimbursement methods, was reviewed for the States covering PCS as a Medicaid Plan service to determine whether cost reporting and settlement or a prospective payment system process is used. Additionally, State Plan amendments to Attachment 4.19-B on the CMS State Medicaid Plan page were searched to determine whether any had changed from cost reporting/settlement to a prospective payment system. If the State's Attachment 4.19-B was not specific about reporting and settlement vs. prospective payment system, reimbursement, information was sought via the State's Medicaid website and administrative rules. Due to constraints of time and locating the most knowledgeable state official, phone contacts with the states were not attempted.

Conclusions, Issue 4

The reimbursement methodologies described in the state plans reviewed are worded very generally referencing terms such as, the lower of billed amount or Title XIX maximum charges, hourly unit rate, and upper limit. The state plans did not specify a cost settlement process, nor did they specify a prospective payment system. States' plan amendments during the past two to three years did not indicate any changes in reimbursement methodology for Medicaid PCS. Methods for reimbursement could not be found on the states' websites or administrative rules. The specificity with which NC describes its reimbursement methods in NC Administrative Code and the State Medicaid Plan is unmatched by other states and probably not required.

Issue 5: State Designed SA Program in Lieu of Federally Prescribed Program

No Federal funds are received to support the cash assistance payments for the costs of room and board in a licensed ACH facility. Yet, Federal laws and regulations of the federally prescribed but optional State Supplemental Assistance Program limit the State's flexibility to make SA Program changes that are beneficial to NC taxpayers without jeopardizing Medicaid coverage for ACH residents. This caused the Committee to question the ability of the State to cease providing the federally prescribed optional SA Program and use existing State and local funds to create a State designed optional State supplement with entitlement to Medicaid.

The major objectives of the research effort were to determine whether NC could cease operating the current optional SA Program without penalty, design its own State Supplemental Assistance Program for ACH residents using current State and local funds, and provide automatic entitlement to Medicaid for the State SA Program recipients.

Public Law 93-66 and Section 1618(a) of the Social Security Act were used to answer the question. P.L. 93-66 authorized states to give individuals who applied for SSI and/or Supplemental Assistance after January 1, 1994, access to Medicaid on the same basis as

mandatory state supplement recipients. Section 1618(a) requires states' to sign agreements with the Social Security Administration in which the state agreed to continue to make supplemental payments at levels not lower than the payment level of March 1983, plus all subsequent cost of living adjustments.

Conclusions, Issue 5

The State would jeopardize receipt of federal financial participation in its Medicaid expenditures if the mandated agreement signed with SSA pursuant to Section 1618(a) is broken and the State ceases to operate its optional SA Program under federally prescribed conditions.

Non-SSI SA recipients are automatically entitled to Medicaid only if their gross income does not exceed $1,692. Medicaid is an automatic entitlement without a separate application for cash assistance recipients, otherwise, individuals must file a separate application and be determined eligible.

Recommendations

The mission of the Adult Care Home Cost Modeling Committee—To develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to meet resident care needs—requires the coordinated implementation of the following recommendations. While it is recognized that full implementation of these recommendations is subject to availability of funds, rules and legislative changes, and CMS approval, it is also apparent that implementation of only one or two would undermine the achievement of the desired outcomes: improved resident care through assessments and the creation of a more stable ACH workforce and a reimbursement rate that drives those outcomes. Once a decision is made to implement this methodology, a representative group of individuals will be formed to address implementation schedules, appropriate notification, training and policy development.

1. **Adopt the cost model methodology and change existing APA rules and legislation to accept the cost model approach and seek appropriations to fully fund the new approach.** This approach means that direct and indirect cost percentiles would be eliminated along with cost settlement.

2. **Reassess the cost model every 3 years for proper reimbursement.** To ensure that ACHs are reimbursed at levels reflective of the existing cost of living increases and current market rates and regulatory changes, the process for reassessment should be conducted on a routine basis. During the off years from cost modeling, cost reports will still be submitted in order to gather data from facilities to be used for statistical and trend identification purposes.

3. **As part of routine cost modeling and rate setting, study feasibility of allocating costs more appropriately between SA and PCS.**

4. **Improve the Screening and Assessment Processes to Promote Appropriate Placement and Quality of Care of ACH residents.** Concerns about resident safety and quality of care continue to underscore the need for improvements in the State's screening and assessment processes for ACHs. DMA should take the lead in this by working with other DHHS divisions and building on the experience from nursing facility prior approval programs (including PASARR), the CAP/DA automated assessment program, the SA In-Home Program automated assessment, and the electronic FL-2e systems.

5. **Ensure that any Division of Facility Services (DFS) regulatory changes with the potential to impact rates are reflected in the cost model.** As the regulatory authority for ACHs, DFS performs initial licensure surveys and inspections of problem facilities and creates rules for ACHs. In this capacity, DFS has the potential to impact the cost of operations within an ACH. Adapting the cost modeling methodology will require that proposed regulatory changes are "run through the model" so that the fiscal impact can be determined and presented the DHHS Rate Setting Review Board prior to implementation.

6. **Monitoring & Performance Expectations—DFS, DHHS Office of the Controller, and DHHS Office of Internal Audit**—Continued ongoing monitoring by DFS to ensure

that ACH facilities are providing care according to written performance expectations; by the Rate Setting Section of the DHHS Office of the Controller to ensure that ACHs are utilizing the increased funding to benefit direct care salaries; and random audits by the DHHS Office of Internal Audit to verify the rate increases are reflected in the direct care component of cost reports. Once these recommendations are fully implemented, performance expectations will be developed.

7. **Reimbursement modeling should account for resident mix and facility size.** Facilities are reimbursed a single SA rate for residents regardless of special needs or size of the facility. The reimbursement model should differentiate between the traditional ACH resident and those in SCUs to reflect the higher staffing need of SCUs. In addition, to the extent that this can be accomplished, the reimbursement system should reflect the different costs associated with types of facilities based on population served and the staffing levels required. Over the longer term, the reimbursement should be matched to the resident's needs. As the adult care homes become proficient in the use of assessments and automation, reimbursement systems can become more sophisticated and similar to case mix systems used in nursing facilities. Such changes will require rules and legislative modifications.

8. **Develop similar modeling for Family Care Homes and Mental Health Group Homes.** The rate paid to Family Care Homes is to be "based on market rate data." It is obvious from the results of the modeling conducted for ACHs that a similar process needs to be followed for other categories of facilities.

9. **Implement an income disregard policy to prevent disenfranchisement of ACH residents from financial eligibility for SA and Medicaid.** As cost modeling is performed, evaluate potential for shifting costs for housekeeping, dietary and laundry services directly related to resident personal care needs to Medicaid. Implementing an SA Income Disregard will require the following steps and could become effective, subsequent to approval by the General Assembly and CMS, within one year, preferably in October when any new SA rate is routinely implemented. The SA Income Disregard will allow a disregard of income in determining SA eligibility. The amount of the disregard, which will be up to the amount of reduction in the SA payment level as a result of shifting costs for Medicaid covered services from SA to the Medicaid program, will be used by the SA recipient to pay for a portion of the costs of the PCS services covered by Medicaid. This Income Disregard will prevent ACH residents from losing their current SA eligibility due to further cost shifts from SA to Medicaid.

   a. Obtain departmental approval of the <u>EIS (Eligibility Information System) "Track Record."</u>

   b. Submit EIS "Track Record" change request to the Division of Information Resource Management (DIRM) so that priority can be assigned and resources allocated. For a change in a case to be effective in EIS for a specific month, the data must be entered in EIS during the previous month.

   c. Prepare legislation to authorize the SA income disregard and its application to the cost of PCS provided to SA recipients by the ACH.

d. Submit Medicaid State Plan amendment to CMS for approval. (This will require 2 year fiscal estimate.)

e. The Division of Medical Assistance (DMA) and Electronic Data Systems (EDS) staff must determine process for manually reducing payment to ACHs for PCS provided to SA recipients with the income disregard and whether it will require any Medicaid Management Information System (MMIS) changes
Any necessary MMIS changes must be in production by whatever target date claims from ACHs for PCS provided will be received.

f. Prepare SA Manual revisions. Counties must have the policy in-hand no less than thirty days prior to implementation. An earlier date for manual revisions is desirable to support training.

g. Conduct training of county staff in new SA income disregard policy. Conduct training sixty days prior to implementation of the new income disregard policy.

Recommended ACH Program Enhancements
(Estimated 30 Month Work Plan)

ACH Enhancement	Tasks and Estimated Target Date for Completion	Comments
Mental Health Screening Program for Medicaid/SA recipients	• Design a process for screening residents for mental health needs prior to admission by March, 2005 • Identify resources/funds for screening program by September, 2005 • If determined that this is the best option, develop RFP and award contract for implementing a mental health screening program by March, 2006	Report due from First Health on the Mental Health Screening Project no later than July 31, 2004. RFP development and contract award process is taking approx. 6 months.
Assessment and care planning instrument for Medicaid and SA recipients residing in ACH's.	• Develop and finalize a new assessment and care planning tool by June, 2005 • Run pilot test of the paper tool from July, 2005 through Sept., 2005 with selected facilities • Determine/allocate resources needed to implement assessment and care planning system (state resources and provider resources) by Sept., 2005 • If determined that this is the best option, develop RFP for a contractor to design an interactive web site to allow ACH providers to access the tool and submit resident information into a searchable database. RFP developed by December, 2005 • Contract could possibly be awarded by Feb., 2006 • Contractor will require 6 months to design system – Aug, 2006 • If above schedule is achievable, conduct Statewide training by Dec., 2006 and quarterly in regions thereafter • Statewide implementation by April, 2007	Tool should be based on the MDS (Minimum Data Set)
Medical and Functional Criteria (level of care) for New Admissions to ACH's	• Draft of Medical and Functional Criteria by April, 2005 • Finalize Medical Criteria and review as medical policy by July, 2005 • Post medical policy for public review by Aug., 2005	Consider separate criteria for the different types of facilities (particularly family care homes). Must be coordinated with DFS rules.
New Screening/Admission Tool Reflecting the ACH level of care criteria	• Develop prior approval screening tool (revised FL2/FL2e) to be used with the medical criteria for admission to an ACH by March, 2005 • Statewide training on new screening tool and new criteria Aug-Oct. 2005 • Develop with automation capability and link to new MMIS prior approval system – To be determined	This tool could use a scoring system of ADL's to determine if the person meets minimum criteria for admission. The approving authority will need to know the criteria for admission and apply consistently to all Medicaid admissions. Process for admission would be coordinated with Mental Health Screening Program. DMA is currently testing the automated FL2e – and a scoring system for ADL needs. Screening tool development and implementation need to be considered in the context of other long term care

		options.
Utilization Management and Quality Assurance Program to have some assurance that persons are placed appropriately in the ACH and that services are being provided based on individual care needs.	• Design utilization management and quality assurance program by June 2006 • Develop RFP to contract for a new utilization management and quality assurance program by November, 2006 • Develop standards and protocols and report requirements for a UM program by November, 2006 • Target date for implementation of UM and QA program for ACH's: July, 2007	Ideally, the utilization management and quality assurance program would be operated by the same entity that designs and operates the assessment system and searchable database. The UM program should only be implemented after the statewide implementation of the new assessment tool. A UM and QA program will consist of multiple levels of review and monitoring. State level support systems will need to be developed and well planned.

Prepared by:
Division of Medical Assistance
October 19, 2004

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

Lanier M. Cansler, Deputy Secretary

MEMORANDUM

TO: Adult Care Home Cost Modeling Committee Members

FROM: Lanier M. Cansler

DATE: October 22, 2002

SUBJECT: Adult Care Cost Modeling Committee

As you are aware, the Department currently performs rate setting for the payment of State County Special Assistance (SCSA), Medicaid Personal Care Services (PCS) and Medical Transportation. Separate rate setting methodologies are employed by the Department in establishing the rates for all three types of service. In an effort to ensure that we are adequately addressing the cost of providing services to our clients who reside in domiciliary type facilities (inclusive of Family Care Homes, Homes for the Aged, Mental Health Facility, Nursing Homes and Mental Health Facilities) we are establishing a committee to consider the potential for development of a consistent costing methodology that could be utilized across each of the three programs considering the full cost of operating these type facilities in a consistent and defensible manner.

I have asked Sandra Trivett and Gary Fuquay to co-chair a committee made up of staff from Division of Social Services, Division of Medical Assistance, Division of Facility Services, Office of Policy and Planning, Controller's Office, Office of Internal Audit, Office of Long Term Care and Adult Care industry representatives. You have been selected by your director to serve on the committee. Sandra and Gary will notify you of the first meeting of the committee.

CC: Lynda McDaniel
Jim Bernstein
Pheon Beal
Nina Yeager
Bob Fitzgerald

Committee Members:
Lou Wilson
Jerry Cooper
Craig Souza
Gary Fuquay
Dan Stewart
Sandra Trivett
Alene Goolsby
John Tanner
Suzanne Merrill
Lynne Perrin
Dave Mosley
Jim Panton
Curtis Crouch
Pat Jeter
Doug Barrick
Jim Upchurch

Members (UPDATE AFTER MEETING WITH ADVOCATE GROUPS)

Adult Care Home Cost Modeling Committee

Gary Fuquay, Co-Chair, Director, DHHS, Division of Medical Assistance

Sandra Trivett, Co-Chair, DHHS Office of Policy and Planning

Doug Barrick, DHHS, Division of Facility Services

Paul Cole, DHHS Office of the Controller

Jerry Cooper, Executive Director, NC Assisted Living Association

Curtis Crouch, DHHS, Office of the Controller

Jeanne Duncan, North Carolina Support Providers Council

Stacy Flannery, North Carolina Health Care Facilities Association

Jackie Franklin, DHHS, Division of Medical Assistance

Alene Goolsby, research consultant, formerly with the Division of Medical Assistance

Bruce Habeck, DHHS Division of Medical Assistance

Lisa Haire, DHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Pat Jeter, DHHS, Division of Medical Assistance

Deborah Landry, DHHS Division of Budget & Analysis

Lynda McDaniel, DHHS, Assistant Secretary for Family Services and Long Term Care, *since retired*

Suzanne Merrill, DHHS, Division of Aging and Adult Services

June Montgomery, DHHS, Office of the Controller

Jim Panton, DHHS, Division of Medical Assistance, *since retired*

Lloyd Pattison, DHHS, Division of Medical Assistance

Lynne Perrin, DHHS, Division of Medical Assistance

Dave Peterson, formerly with the DHHS, Division of Mental Health *(now with Wake County)*

Barbara Ryan, DHHS, Division of Facility Services

Jackie Sheppard, DHHS, Assistant Secretary for Family Services and Long Term Care

Joe Slaton, DHHS Division of Budget & Analysis

Phillip Tarte, DHHS Office of Policy and Planning

Dan Stewart, DHHS Internal Auditor

John Tanner, DHHS, Division of Social Services, *since retired*

Jim Upchurch, DHHS, Division of Facility Services, *since retired*

*Andy Wilson,*DHHS, Division of Medical Assistance

Lou Wilson, Executive Director, NC Association, Long Term Care Facilities

May 24, 2004

Adult Care Cost Modeling
Short and Long Term Approach

PURPOSE STATEMENT: Develop a comprehensive rate setting methodology for Adult Care that encompasses all funding streams provided by DHHS.

Short Term Goals	Actions/Notes	Contact(s)	Finish Date
1. Based upon the current regulatory staffing requirements:			
a. Select a representative sample of at least 3 facilities having clients receiving SA that are considered by DHHS and the industry to be quality providers with efficient operations. (Determine facility sample by geographic orientation, size of facility, Mental Health licensed, SCU's, HAL, SA/Private pay mix, 80% occupancy and other criteria as appropriate.	a. Facilities were selected, solicited, trained and submitted cost reports as requested		9/04
b. Perform an acuity analysis of the clients in the sample.	b. Assessments were completed by RN's in a contract with Home and Hospice Association – in two phases. Myers & Stauffer conducted the analysis of information and prepared final report in May		8/03
2. Based on cost reports and the current staffing requirements:			
a. Perform a staffing analysis of time and effort taken to provide appropriate levels of care to the population in the selected facilities using the RUGS criteria.	a. Industry provided their requirements to care for the client base. Based on their information, the current regulations, and the acuity of clients, M&S completed a staffing analysis for facilities.	Curtis Crouch	5/04
b. Develop a staffing model from the above analysis. (Actual needs gathered from industry input would need to be used for three areas in which standard staffing requirements/overall costs do not exist: Housekeeping, Food Service/Dietary and Medication Administration.)	b. A subgroup convened to discuss and clarify the different FTE's (Nurses, NA's and CNA's) performing most tasks in ACH's and how to adjust for the fact that M&S comparison data was based on RN level of care. The subgroup included: Lynne Perrin, Lou Wilson, Jerry Cooper, and Curtis Crouch. They met Monday, April 19, 2004, to address this issue and reported their results to the committee in late April.	Lynne Perrin	4/04

Short Term Goals	Actions/Notes	Contact(s)	Finish Date
3. Identify any changes needed to the current cost reporting format for Adult Care Homes.	Adopt the cost model methodology but continue to require HAL facilities to submit portions of the existing cost reports to obtain statistical information	Curtis Crouch	9/04
4. Coverage Changes			
a. Work with Myers & Stauffer in coordination with DHHS divisions to research additional direct costs (i.e. Health Services) to be covered by Medicaid for services provided in Adult Care Home other than the current PCS and Medical Transportation.	a. Identified items for possible cost shifting. Have not gone further due to disenfranchising issues.	a. Committee	8/04
b. Review service definitions to understand differences between PCS provided in a facility compared to PCS provided in a private home. (Approval from CMS for service definition changes)	b. Complete	b. Lynne Perrin	4/03
c. Determine the fiscal impact on SA rates changes.	c. Alene Goolsby and Jackie Franklin Both provided information for this population. Curtis Crouch and Hank Bowers brought estimates to the August and September meetings.	c. Curtis Crouch and Hank Bowers	8/04
d. Determine if SA rate changes cause disenfranchisement for existing and future eligibles..	d. Alene Goolsby has provided the group with much research. Goal of Cost Modeling Committee is to ensure disenfranchisement does not occur. A subgroup will develop an action plan for future eligibles.	d. Alene Goolsby, Suzanne Merrill and Andy Wilson	9/04
5. Begin discussion of how DHHS plans to address capital assets as a component of cost reimbursement. Explore options that will provide an equitable approach to reimbursing owners for cost of facilities while recognizing associated mortgage costs and/or owner investment.	Internal Audit coordinated this effort. The information for all model facilities was entered into a cost report for discussion at a late April meeting. Historical data was gathered from samples of the 3 facility sizes for comparison to the new suggestions being proposed. The information was presented to the full committee in May.	Dan Stewart	5/04
6. Discuss elimination of current reimbursement methodology to a Prospective payment system.	DHHS ready to proceed when assessment tool is in place. Industry asked for delay in implementation until final results of staffing analysis and other recommendations are made.	Committee	9/04

Long Term	Actions/Notes	Contact	Finish Date
1. Based on resident assessments of all clients residing in Adult Care Facilities, remodel to accommodate the staffing needs for each designated level of care/licensed type facility.	Study completed and results presented by M&S on May 13.	Lynne Perrin	5/04
2. Continue regular review of changes in definitions and rates by DMA.	On-going DMA rate setting.	Pat Jeter	ongoing

ADULT CARE COST MODELING

SELECTED INFORMATION ON HAL MODEL FACILITIES

FACILITY	LOCATION	NUMBER OF BEDS	NUMBER OF AVAILABLE DAYS	OCCUPANCY PERCENT	SA PERCENT	TOTAL FTEs BEFORE MODELING	TOTAL FTEs AFTER MODELING	INCREASE IN DIRECT & PCS FTEs	INCREASE IN INDIRECT FTEs
31 - 60 Beds									
The Little Flower	Mecklenburg	49	16,790	99.20%	14.55%	19.98	35.57	14.56	0.90
Burnette's Retirement Village	Franklin	60	21,900	88.48%	91.56%	23.76	32.72	8.96	0.00
Country Club Prime Time	Wake	60	21,900	82.00%	99.98%	25.12	35.87	7.85	1.75
McDowell Assisted Living	McDowell	54	19,710	100.00%	88.52%	22.93	34.52	10.05	1.40
The Canterbury House	Person	60	21,900	79.97%	58.94%	23.19	35.58	9.69	1.68
61 - 90 Beds									
Union Park	Union	87	28,047	89.90%	54.03%	30.67	46.81	14.14	1.02
Meadows of Laurinburg	Scotland	80	29,440	91.28%	91.13%	36.98	47.11	9.45	0.51
Homeplace	Durham	71	25,915	90.90%	81.66%	29.00	40.92	9.93	1.05
Reynolda Park	Forsyth	72	22,052	93.66%	49.95%	25.02	41.04	13.67	0.40
Davie Place	Davie	69	25,185	76.06%	86.00%	24.97	35.14	10.17	0.00
91+ Beds									
First Assembly	Cabarrus	180	65,700	81.89%	78.63%	60.27	83.84	20.57	0.00
Greensboro Place	Guilford	93	33,580	94.10%	59.91%	34.79	52.90	16.32	1.16
Meadows of Mount Olive	Wayne	104	38,272	89.57%	77.36%	42.88	55.16	11.71	0.57
Meadows of Greenbrier	Robeson	104	38,272	80.92%	88.42%	42.23	55.95	13.04	0.19

ADULT CARE COST MODELING

SELECTED INFORMATION ON SCU MODEL FACILITIES

FACILITY	LOCATION	NUMBER OF BEDS	NUMBER OF AVAILABLE DAYS	OCCUPANCY PERCENT	SA PERCENT	TOTAL FTEs BEFORE MODELING	TOTAL FTEs AFTER MODELING	INCREASE IN DIRECT & PCS FTEs	INCREASE IN INDIRECT FTEs
Twelve Oaks	Surry	43	15,695	97.35%	57.32%	33.23	34.71	0.87	0.56
Greensboro Place	Guilford	25	8,395	95.81%	24.32%	18.14	38.09	18.90	0.65
DP @ Concord Place	Cabarrus	25	9,125	83.73%	44.08%	15.07	25.15	8.68	0.50
Carillon Assisted Living	Gaston	24	8,760	86.53%	6.03%	8.43	23.00	14.57	0.00
Carolina House of Smithfield	Johnston	24	7,968	95.61%	28.55%	14.62	25.46	9.36	0.65
DP @ High Point Place	Guilford	65	23,508	75.27%	34.81%	35.62	39.27	1.65	1.00
DP @ Statesville Place	Iredell	40	14,600	95.29%	21.87%	28.52	38.61	7.50	1.61
Gastonia Village	Gaston	48	16,790	82.25%	65.00%	16.31	40.50	21.59	1.60
DP @ Burlington Manor	Alamance	52	18,980	95.74%	36.97%	32.85	42.29	7.24	1.50

ACH Cost Modeling - Rate Proposal for all Selected Non-SCU HAL Licensed Facilities

	SA Direct Costs						
	Housekeeping & Laundry	Dietary	Recreational Activities	**Total**	**Resident Days**	**Direct per Resident Day**	**Direct per Resident Month**
Burnette's Retirement Village	$105,506	$163,044	$14,508	**$283,058**	**19,372**	**$14.61**	**$444.44**
McDowell Assisted Living	$100,901	$169,297	$43,802	**$314,000**	**19,710**	**$15.93**	**$484.57**
The Little Flower	$66,780	$165,171	$111,135	**$343,086**	**16,655**	**$20.60**	**$626.57**
The Canterbury House	$60,551	$150,479	$47,678	**$258,707**	**17,513**	**$14.77**	**$449.32**
Country Club Prime Time	$69,569	$160,988	$47,186	**$277,743**	**17,958**	**$15.47**	**$470.43**
Meadows of Laurinburg	$75,824	$212,537	$25,636	**$313,998**	**26,872**	**$11.68**	**$355.42**
Reynolda Park	$63,323	$233,318	$68,579	**$365,220**	**20,654**	**$17.68**	**$537.85**
Union Park	$67,640	$246,086	$66,275	**$380,001**	**25,215**	**$15.07**	**$458.39**
Davie Place	$47,482	$108,722	$39,980	**$196,185**	**22,697**	**$8.64**	**$262.91**
Homeplace	$77,128	$261,241	$41,001	**$379,371**	**23,556**	**$16.11**	**$489.86**
Greensboro Place	$76,647	$265,349	$74,001	**$415,997**	**31,599**	**$13.16**	**$400.43**
Meadows of Greenbrier	$97,034	$261,405	$25,989	**$384,428**	**30,972**	**$12.41**	**$377.54**
First Assembly	$228,149	$785,230	$48,226	**$1,061,605**	**53,805**	**$19.73**	**$600.14**
Meadows of Mount Olive	$98,489	$261,364	$28,120	**$387,973**	**34,280**	**$11.32**	**$344.25**
Total	**$1,235,024**	**$3,444,232**	**$682,116**	**$5,361,371**	**360,858**	**$14.86**	**$451.91**

ACH Cost Modeling - Rate Proposal for all Selected Non-SCU HAL Licensed Facilities

	SA Indirect Costs						
	Property Ownership and Use	Operations and Maintenance	Administration Allocation	**Total**	**Resident Days**	**Indirect per Resident Day**	**Indirect per Resident Month**
Burnette's Retirement Village	$196,970	$95,475	$64,463	**$356,908**	**19,372**	**$18.42**	**$560.39**
McDowell Assisted Living	$118,790	$55,321	$132,746	**$306,857**	**19,710**	**$15.57**	**$473.54**
The Little Flower	$181,068	$78,440	$80,848	**$340,356**	**16,655**	**$20.44**	**$621.59**
The Canterbury House	$285,667	$82,843	$82,650	**$451,160**	**17,513**	**$25.76**	**$783.58**
Country Club Prime Time	$185,562	$80,263	$82,586	**$348,411**	**17,958**	**$19.40**	**$590.13**
Meadows of Laurinburg	$463,260	$98,205	$127,261	**$688,726**	**26,872**	**$25.63**	**$779.57**
Reynolda Park	$363,224	$103,530	$168,617	**$635,372**	**20,654**	**$30.76**	**$935.70**
Union Park	$465,304	$122,735	$187,456	**$775,496**	**25,215**	**$30.76**	**$935.47**
Davie Place	$355,555	$82,925	$90,666	**$529,145**	**22,697**	**$23.31**	**$709.12**
Homeplace	$268,864	$119,433	$126,455	**$514,752**	**23,556**	**$21.85**	**$664.67**
Greensboro Place	$497,122	$133,816	$180,228	**$811,166**	**31,599**	**$25.67**	**$780.81**
Meadows of Greenbrier	$439,588	$91,746	$113,668	**$645,002**	**30,972**	**$20.83**	**$633.44**
First Assembly	$478,173	$266,666	$102,735	**$847,574**	**53,805**	**$15.75**	**$479.14**
Meadows of Mount Olive	$328,760	$138,795	$122,425	**$589,980**	**34,280**	**$17.21**	**$523.49**
Total	**$4,627,907**	**$1,550,193**	**$1,662,805**	**$7,840,904**	**360,858**	**$21.73**	**$660.91**

SA Totals	**$36.59**	**$1,112.82**
Capital Cost Adjustment		**$11.16**
SA Total		**$1,123.98**

ACH Cost Modeling – Rate Proposal for All SCU Bed Facilities Combined

	SA Direct Costs						
	Housekeeping & Laundry	Dietary	Recreational Activities	Total	Resident Days	Direct per Resident Day	Direct per Resident Month
Carolina House of Smithfield	43,402	123,948	75,035	**$242,384**	**7,618**	**$31.82**	**$967.78**
Concord Place & Discovery Prog	56,256	100,963	65,642	**$222,861**	**7,640**	**$29.17**	**$887.26**
Twelve Oaks	59,351	88,242	31,176	**$178,769**	**15,279**	**$11.70**	**$355.89**
Greensboro Place (SAL)	67,742	92,216	66,261	**$226,220**	**8,043**	**$28.13**	**$855.51**
Carillon Assisted Living of Crame	53,267	65,192	15,259	**$133,719**	**7,580**	**$17.64**	**$536.58**
Gastonia Village (SAL)	102,089	187,455	89,180	**$378,724**	**13,810**	**$27.42**	**$834.14**
DP @ High Point Place (SAL)	73,983	210,565	67,057	**$351,605**	**17,694**	**$19.87**	**$604.42**
DP @ Burlington Manor (SAL)	86,848	188,787	65,018	**$340,653**	**18,172**	**$18.75**	**$570.19**
DP @ Statesville Place (SAL)	83,486	191,579	67,602	**$342,667**	**13,912**	**$24.63**	**$749.19**
Total	**626,424**	**1,248,947**	**542,229**	**2,417,601**	**109,748**	**$22.03**	**$670.04**

	SA Indirect Costs						
	Property Ownership and Use	Operations and Maintenance	Administration Allocation	Total	Resident Days	Indirect per Resident Day	Indirect per Resident Month
Carolina House of Smithfield	110,110	52,582	60,632	**$223,324**	**7,618**	**$29.32**	**$891.68**
Concord Place & Discovery Prog	115,916	47,916	39,310	**$203,143**	**7,640**	**$26.59**	**$808.76**
Twelve Oaks	215,804	62,634	32,665	**$311,103**	**15,279**	**$20.36**	**$619.33**
Greensboro Place (SAL)	109,020	41,418	30,521	**$180,959**	**8,043**	**$22.50**	**$684.34**
Carillon Assisted Living of Crame	59,905	32,824	46,657	**$139,386**	**7,580**	**$18.39**	**$559.32**
Gastonia Village (SAL)	216,128	87,425	148,322	**$451,875**	**13,810**	**$32.72**	**$995.26**
DP @ High Point Place (SAL)	342,914	99,271	173,190	**$615,375**	**17,694**	**$34.78**	**$1,057.85**
DP @ Burlington Manor (SAL)	226,487	97,348	113,609	**$437,444**	**18,172**	**$24.07**	**$732.20**
DP @ Statesville Place (SAL)	220,474	85,613	140,959	**$447,046**	**13,912**	**$32.13**	**$977.40**
Total	**1,616,758**	**607,031**	**785,866**	**3,009,655**	**109,748**	**$27.42**	**$834.13**
						$49.45	**$1,504.16**
				Capital Cost Adjustment			**$11.16**
				SA Totals			**$1,515.32**

Adult Care Home Cost Modeling Committee
Summary of Funding Requirements

	Total	Federal	State	County
SCSA	$9,980,260.00	$0.00	$4,990,130.00	$4,990,130.00
PCS	$188,854,207.00	$120,167,932.00	$50,152,255.00	$18,534,020.00
Breakout: HAL	$180,096,959.00	$114,595,695.00	$47,826,674.00	$17,674,590.00
SCU	$8,757,248.00	$5,572,237.00	$2,325,581.00	$859,430.00
Administration	$1,318,322.00	$674,039.00	$644,283.00	$0.00
Income Disregard	$22,660,113.00	$14,411,910.00	$6,335,278.00	$1,912,925.00
Total	$222,812,902.00	$135,253,881.00	$62,121,946.00	$25,437,075.00

Enhancements to Adult Care Home Services
Estimated Costs

Program Enhancement	Developmental Costs/Year 1	Ongoing Operations	Based on:
Automated Screening/Admission Tool that combines assessment and care planning based on medical, mental health, and functional needs			
Automated Assessment Instrument	$ 100,000.00	$ -	Estimate based on AQUIP costs
Systems Development/Testing/Modifications, etc. **(1)**	$ 550,000.00	$ -	Estimate based on AQUIP costs
Systems Maintenance/Enhancements/Modifications	$ -	$ 250,000.00	Estimate based on AQUIP costs
Quarterly Agency/Provider Training	$ -	$ 48,000.00	$12,000 per quarterly session
DMA Staff	$ 200,000.00	$ 200,000.00	Two consultants, one support, fringe, computers, etc.
Prior Approval System with Automated FL2	$ -	$ 168,000.00	6,000 prior approvals by fiscal agent at $28.00
Contract Mental Health Screenings/Level I	$ -	$ 168,000.00	6000 evaluations at $28.00
Contract Mental Health Scrrenings /Level II	$ -	$ 270,000.00	1000 evaluations at $270.00
Contracted QA/UR Reviews	$ -	$ 240,000.00	$20,000 per month X 12 months
TOTAL	**$ 850,000.00**	**$ 1,344,000.00**	

Notes:

(1) Includes systems development, DMA staff training, in-house testing pilot project with selected agencies, and final modifications after pilot progam.

(2) Significant savings could be realized by contracting with one organization for all assessments and reviews.

North Carolina Department of Health and Human Services

Adult Care Home Capital Cost Reimbursement Study Position Paper May 2004

Adult Care Cost Modeling Committee
Prepared by the Office of the Internal Auditor

Overall Objective of Capital Cost Component Reimbursement

The purpose of this document is to summarize and present alternative methodologies available in the determination and treatment of the Facility Capital
Component of an Adult Care Home Cost Model to achieve the following objectives.

- **Equitable Return on Investment.** The primary objective is to provide a recommendation for the most equitable and feasible alternative. This includes an equitable and fair return to each facility owner, without regard to the capital structure of that owner's business and without affecting the owner's normal business decisions regarding depreciation, rent, improvements and/or repairs.
- **Minimize Costs.** Secondary to this process is that the methodology should seek to minimize the administrative costs associated with capital reimbursement.
- **Process Simplification.** A third objective is the simplification of the process in order to facilitate a better understanding of the program by the public, the legislature, facility owners and investors.

Background and Challenges

Although the objective of the Capital Cost Modeling Subcommittee is to analyze and identify an equitable and feasible capital reimbursement alternative, there are hurdles to overcome since considerations regarding the capital cost component can be complex. For example, considerations involve issues such as:

- Historical (Actual) Construction Cost
- Depreciation methods
- Financing/mortgage Costs
- Major Repairs/Renovations and Capitalization Policies
- Equipment – Fixed versus Moveable
- Geographical Considerations versus "One size fits all"
- Metropolitan vs. Rural Construction Costs
- Metropolitan vs. Rural Land Costs

- Leased or Rented Facilities
- Disposal Gains/Losses
- Excess Bed Capacity
- Facility Size
- Fair Market Rental Value considerations
- Property Taxes
- Insurance

There are several challenges relating to capital costs:

- Facility administrative time and costs involved in capturing, compiling and reporting the cost data
- State administrative time and costs involved in analyzing and auditing the data reported
- Issues pertaining to equitable reimbursements

Historically, these factors have resulted in increased administrative burdens, primarily accounting considerations for both the provider and the State program administrators. Because of these burdens and other considerations, a number of other States have considered alternatives. As noted in the following report section, an increasing number of States are trending to a form of fair rental reimbursement for facility reimbursement. Fair rental has the advantage of being equitable and can be simpler to administer than flat rate or cost-based systems.

Capital Environment in Other States

A Study produced by Myers & Stauffer, LC in 1998 for the State of Washington, Department of Social and Health Services addressed the issue of ***Medicaid Property Payment Study – Comparison of Property Payment Systems in Other States***. While this study addressed Medicaid nursing facility property reimbursement methodologies, the issue regarding capital facility reimbursement is equally relevant to the adult care home industry. Thus, the Washington Study provides valuable insights into various methodologies in reimbursing facilities for the capital component.

The firm of Myers & Stauffer, LC researched and prepared a comparative review of practices in other states and found a great deal of variation in how States reimburse capital costs. The study points out that because of the relative fixed nature of capital costs, these capital costs are more often segregated from normal operating expenses and reimbursed separately. Capital costs are typically defined as depreciation, amortization, lease, mortgage interest expenses, but may include other related expenses such as property taxes and property insurance. Capital costs can also be rent paid to another facility owner. Clouding these different forms of capital costs are transactions/expenses with related parties. For example, the rent/lease or mortgage interest expense may be paid to an affiliated organization (i.e. common ownership interest), and may not be an "arm's length" transaction. Thus, costs incurred and reported may not be the same as a similar transaction conducted by unrelated parties.

The Myers & Stauffer Study broadly separates methodologies into four categories:

1) Flat Rate
2) Cost Based
3) Fair Rental
4) Blended

There are advantages and disadvantages to each of the four categories as enumerated below.

Capital Cost Reimbursement Alternatives - Pros and Cons

Methodology	Advantages	Disadvantages
Flat rate	• Administrative ease • Least opportunity to manipulate costs	• Disincentive for new facility investment • Disincentive for maintenance of existing facilities
Cost based	• Relatively easy to administer • More closely related to provider's actual costs • Easy to understand and communicate	• Require accurate cost data • Encourage manipulation of costs
Fair Rental	• Reward for long term program participation • Recognize owner's equity • Opportunity for capital accumulation to fund improvements • Less subject to manipulation	• Can be administratively cumbersome for property evaluations • Need for periodic appraisal updates
Blended	• Has the advantages of both the cost based and fair rental methodologies, i.e. ease of administration, recognizes owner's equity, etc.	• Has both the disadvantages of cost based and fair rental systems, i.e. can be administratively cumbersome, requires periodic evaluations, subject to manipulation, etc.

Capital Cost Reimbursement Alternatives - pros and cons

Historical Facility Reimbursement in North Carolina

Adult Care Homes have historically been reimbursed on a single state-wide rate. The basis for the rate has been audited cost reports filed by the various facilities. Pre-defined cost report templates with cost centers are completed, audited and submitted to the DHHS Controller's Office. The cost information is entered into a DHHS database, costs are consolidated, sorted (arrayed) by Direct Costs and Indirect Costs. (The Indirect Cost component contains administrative and capital costs.)

The State's formula for computing a state-wide rate has typically been to select the 75th percentile for Direct Costs and 60th percentile for Indirect Costs. The sum of these two percentiles is included in the data provided to the N.C. General Assembly for funding consideration.

Shortcomings. There are a number of shortcomings in the current system such as the following:

- **Cost of Capital.** There is no recognition of the cost of capital. For example, mortgage interest is recognized as operating costs for a facility that is built and financed 100%. On the other hand, an identical facility that is built with an owner's capital (neither borrowings nor mortgage interest) does not reflect any mortgage interest expense. Thus, there is no recognition of owner equity in the present system. There can be a dramatic difference in operating costs for the two otherwise identical facilities.
- **Ownership changes** produce disparities. For example, two identical facilities are built. One is sold ten years later at 250% of the original construction costs. The operating costs (depreciation and mortgage expense) for the new owners is much greater than the facility that was not sold—even though the facilities are physically and operationally identical.
- **Capitalization Policies.** State and Federal tax rules regarding capitalization policies influence decisions on whether to expense or capitalize major repairs or leasehold improvements.
- **Geographical Differences.** Currently, there is no recognition for geographical cost-of-living disparities. For example, a facility in the city of Charlotte receives the same

reimbursement as a facility in Chowan County which has a much lower labor rate that factors into both capital and operational costs.

These are some of the inequities produced by the current system. However, a couple of the main issues are that the current cost reimbursement process does not recognize owner's equity and facility capital costs are subject to wide fluctuations.

Cost Analogy

The fair price for a bed in an Adult Care Home is conceptually not that different from the fair price for a bed in a motel or other lodging establishment. The person renting the bed does not generally consider the costs that have been incurred by the developer/ builder/ owner of the motel. Likewise, the renter is not interested in how much, if any, mortgage interest is being incurred for the property or the cost of repairs for the past year. Instead, the "renter" is looking for a "fair price" considering the location and quality of services offered.

Fair rental reimbursement systems similarly do not consider historical costs, mortgage interest or other cost accounting data. Instead, a fair rental reimbursement system bases the capital payment to the owner upon the fair market rental value of the property. Each state that utilizes a fair rental value for facility capital reimbursement has introduced "twists" pertinent to their special situation. Thus, there is not any particular methodology that can be found in multiple States—only variations of the fair rental value approach.

Overview of Proposal

Underlying the current proposal are the previously stated objectives: namely, an equitable system of capital reimbursement that is simple and economical to administer. The category that best meets this objective is the Fair Rental Value which more and more States are gravitating toward. While the broad recommendation is to utilize a Fair Rental Value, there is within this category a great deal of diversity. Of the five States utilizing a version of Fair Rental Value, the Texas model showed the most promise as meeting other objectives such as being economical and simple to administer.

Texas computes a flat rate rental value per bed based upon the most recent local county property tax assessment. This is much cheaper than other States (in fact, no costs) that require certified real estate

appraisals that are subject to debate/appeal and other costly administrative issues. These outside independent appraisals often only serve to take money away from services and the facility owner. Texas applies a limitation of the 80th percentile or the prior years allowable fee adjusted for inflation. The rental factor utilized by Texas is a flat 14% and includes real estate taxes, insurance and moveable equipment along with other capital components.

North Carolina's Proposed Approach

A system similar to the approach taken by Texas is recommended for North Carolina.

- **Fair Rental Value.** The facility owner's capital costs would be paid based upon a "fair investment return" on the property's "assessed value" as determined by an independent party, e.g. the county tax assessor. In North Carolina, real property values are generally assessed every eight years for county tax purposes. Since property values can change dramatically in an eight-year period, there is an inherent need to adjust county tax valuations during the intervening years. Fortunately, the North Carolina Department of Revenue reviews prior year real property sales data annually for each of the State's 100 counties and compares the sales data to county assessed values for the same properties. Thus, the State is able to estimate with a high degree of confidence the current fair market value of property in each county based upon the statistical analysis. Real property assessment adjustments can easily be made during the intervening years between official assessment years with the aid of the North Carolina Department of Revenue statistics. The County assessed property value and the Department of Revenue data are both free (economical) and simple to administer which meets our objectives. An example of the adjustments for a sample facility in our sample is shown below.

Example of Real Estate Assessment Adjustment

	2003	2002	2001
County Assessed Value	252,800	252,800	252,800
NCDOR Adjustment factor	0.8060	0.8319	0.8477
Adjusted Assessed Value	313,648	303,883	298,219

- **Facility Type.** The adult care home payment rate is a single state-wide rate, as required by Federal regulations. We would therefore propose that payment rates continue to be established based upon a specified percentile ranking for non-capital costs.

- **Fair Rate of Return** – Texas employs a 14% fixed rate of return. While we were initially pessimistic about using a flat rate, our review indicates that North Carolina's computed rate is in line with Texas' rate. North Carolina's computed rate (12.6%) for 2001 is actually lower than Texas; however, Texas' rate also includes property taxes, insurance and movable equipment which is not a part of our recommended proposal as noted below. Other states use various ways of computing "fair investment return value" using a published rate, such as government investment yields plus an adjustment factor.

- **Capital Items.** The proposal substitutes a fair rental value (FRV) for the following cost items: depreciation, mortgage interest, building repairs and maintenance, and rent.

- **Excluded Capital Related Costs**

  We excluded costs which have a greater degree of variability, e.g. mobile/movable equipment, property taxes, insurance, etc. which can be considered either as capital costs or with other administrative costs separate from the major capital component. We see little value to including taxes, insurance or movable equipment in the fair rental value since they are not included in the county assessed value of real property and do not impact an "equity position" of assessed real property value.

Sample Study and Results

Methodology

In order to determine the impact that a proposal like this would have, we statistically selected a random sample from those adult care home facilities who had submitted cost reports for each of the three calendar years 2001, 2002 and 2003. Capital costs were obtained from the DHHS Controller's Office database. The primary capital cost components (depreciation, mortgage interest, leasehold improvements, building repairs and maintenance, and rent) were extracted. Assessed property values were obtained from either the tax notices submitted by the facility property managers or the county tax assessor's office (or their web site).

Approach Taken

In order to determine a fair rental rate, we:

- Statistically selected facilities from all except the small size (1-30) categories. (Smaller facilities were excluded since accurate cost data was not available for some of them. Facilities that did not have cost data for all three years were also excluded.)

- Obtained assessed real property values for the years 2001, 2002, 2003.

- Established 2001 as a "hold harmless" base year. The fair rental factor was set to equal the amount of actual costs reported by the facilities for 2001.

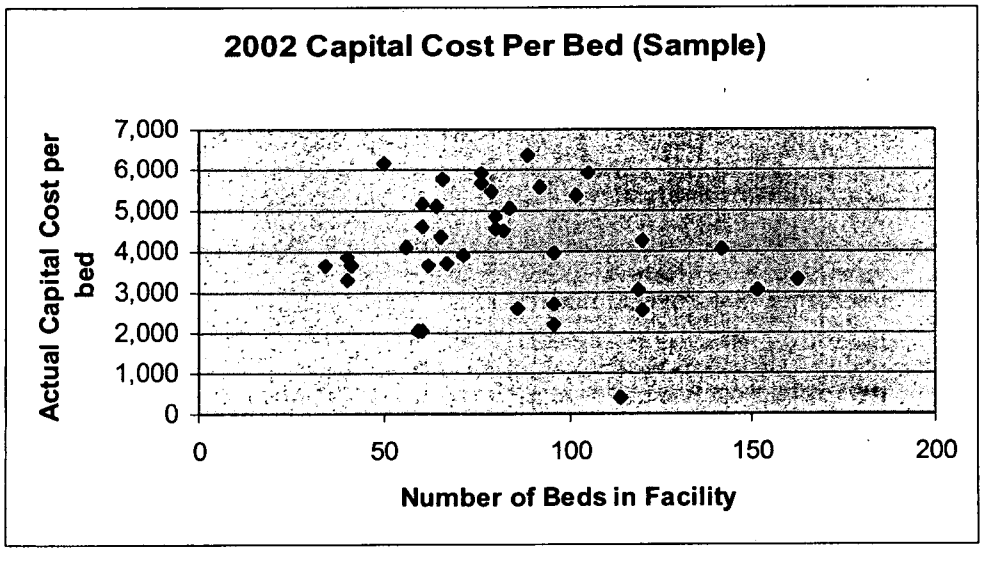
- Used the same rental rate developed in the base year 2001 to compute a fair rental value per bed for the next two years, 2002 and 2003.

- Totaled the actual capital costs reported to the Controller's Office on the Adult Care Home Cost Reports.

We then tabulated the total assessed tax values for 2001 and compared that value with the reported actual capital costs for 2001. From this number, we computed a fair value rental rate whereby, overall, the owners would have the same amount of capital costs from the fair rental value as from those costs reported to the Controller's Office.

We then compared the fair rental values per bed in 2002 and 2003 with the actual costs reported by the facilities to determine how much effect the proposed change in capital reimbursement methodology had on capital costs reimbursement.

The actual capital cost per bed varied significantly within the sample, from a low of $398 per bed in Oakhurst in Greensboro (114 licensed beds) to a high of $6,154 per bed for Autumn Winds of Bryson City (50 licensed beds).



Fair Rental Value Results

The year 2001 was established as a "hold harmless" base year in which the rental factor was set to equal the actual reported capital costs for the facilities in our sample.

Year	Adjusted Assessed Value	12.6% Fair Rental Rate	Actual Costs Reported	Difference	Rental Difference As a % of Actual
2001*	86,777,324	10,918,371	10,918,371	0	
2002	87,512,381	11,026,560	10,440,838	585,722	5.61%
2003	91,347,578	11,509,795	10,515,205	994,590	9.46%
* Base year of Study					

- As shown in the above table, application of the fair rental value for the 38 facilities in our sample resulted in an additional cost amount of $585,722 being included as equity cost in the year 2002 and an additional cost amount of $994,590 being reported in the year 2003 subject to inflation limitations more fully described below.

Fair Rental Value Limitations

In Texas, the current year fair rental value/fee is compared to the previous years allowable rental value/fee as adjusted for inflation based on the Implicit Price Deflator for Personal Consumption Expenditures. The lesser of the two is used as the basis for the allowable fair rental value increase. The Implicit Price Deflator is a better gauge for inflation since:

> *The IPD measures the prices of a much wider group of goods and services than the CPI. For example, the IPD includes all consumption of health care rather than just out of pocket expenses and consumer purchased insurance measured in the CPI. The IPD is based on current economic conditions and consumer expenditures, tastes and preferences. It is frequently used to adjust state economic and revenue data. The state expenditure limit is based on the IPD as well as inflation adjustments in the state's biennial budget.* [State of Washington Department of Finance]

> *Although it is up a bit recently,* ***the Fed's preferred measure of inflation -- the personal consumption expenditure price index****, excluding food and energy costs -- was a mere 1.4% higher in March than a year ago, well within the 1%-to-2% comfort range of many central bankers.* [BusinessWeek Online May 24, 2004]

Likewise in North Carolina, it would be prudent to place a cap on the amount of rental value increase in any given year. Application of the IPD would be as follows.

Computation of Additional Cost/Bed	2002		2003	
FRV limited to Implicit Price Deflato	**FRV**	**Deflator**	**FRV**	**Deflator**
Additional Capital -Fair Rental Value	5.61%	3.79%	9.47%	2.44%
Weighted Capital Costs in State Rate	0.3029	0.3029	0.3029	0.3029
Fair Rental Value Adjustment %	1.70%	1.15%	2.87%	0.74%
State Reimbursement Rate	$1,183.00	$1,183.00	$1,183.00	$1,183.00
FRV Effect on **Monthly** Reimburseme	$20.10	$13.58	$33.93	$8.74
FRV or Deflator Limit **Annualized per Bed**	N/A	$162.97	N/A	$104.92

Category	Cost Reports Weighted	Reimburse. pro-rated
Labor Related Costs	31.65%	$374.42
Other Costs	38.06%	$450.25
Capital Costs	30.29%	$358.33
Total	100.00%	$1,183.00

- **From a percentage view**, the limiting factor is the lower of the fair rental value increase (5.61%) or the Implicit Price Deflator (3.79%) for 2002.. For 2003, the limiting factor is the lower of the fair rental value increase (9.47%) or the Implicit Price Deflator (2.44%).
- **From a fiscal impact standpoint**, the additional average cost increment/ reimbursement using the fair rental values (FRV) instead of actual capital costs reported would result in an additional $162.97 annually per bed for 2002 and $104.92 per bed for 2003.
- **On a monthly basis**, application of the proposed methodology would have increased Special Assistance monthly cost/rates by $14 from $1,183 to $1,197 per bed in 2002. For 2003, the Special Assistance monthly cost/rates would have increased by $9 from $1,188 to $1,197 per bed. These resulting increases are currently small due to the low inflation rates which have been experienced over the last few years. As inflation increases, the limiting IPD factor would also increase, providing a greater increase in allowable cost.

Conclusion

This report achieves its objectives in regard to providing a more equitable calculation of capital facility reimbursement than the current system based on historical costs. The methodology suggested is also economical to calculate and easy to administer. It also removes conflict of interest situations where facilities are sold to related parties. Further, it makes the State indifferent to management decisions such as capitalization policies, repairs that are expensed versus capitalized, etc.

While refinements can be and should be made to the proposed model, this report provides insight (3 years of data) into the potential impact of implementing this type of model. Thus, the proposed model appears to be a viable candidate for implementation.

Schedule 1

Implicit Price Deflator
Personal Consumption Expenditures

Background

The Bureau of Economic Analysis, U.S. Department of Commerce, publishes numerous statistics, one of which is the Price Index for Personal Consumption Expenditures. From the price index published, an implicit price deflator (IPD) may be derived for any time period. The price deflator is the measure of inflation between two points in time for the index being measured, in this case the personal consumption expenditure.

Obtaining the information

Step 1 – go to the Bureau of Economic Analysis web page main statistics page at http://www.fedstats.gov/key_stats/BEAkey.html.

On this page, select the Nation Income and Product Accounts (NIPA) which is located at http://www.bea.gov/bea/dn1.htm

Select the interactive NIPA tables.

Go to "List of all NIPA Tables"

Select Table 2.3.4 Table 2.3.4. Price Indexes for Personal Consumption Expenditures by Major Type of Product (A) (Q)

Select the date range and whether the information should be displayed annually or quarterly. For example, selecting annual for the last three years yields the following table of information:

Table 2.3.4. Price Indexes for Personal Consumption
Expenditures by Major Type of Product
[Index numbers, 2000=100]
Bureau of Economic Analysis
Downloaded on 5/18/04 At 11:23:26 AM Published date
is 4/30/04

Line		2000	2001	2002	2003
1	Personal consumption expenditures	100	102.039	103.429	105.325
2	Durable goods	100	98.086	95.208	91.682
3	Motor vehicles and parts	100	100.375	98.766	95.992
4	Furniture and household equipment	100	94.139	88.778	83.538
5	Other	100	100.348	99.531	97.905
6	Nondurable goods	100	101.53	102.075	104.179
7	Food	100	102.944	104.942	106.966
8	Clothing and shoes	100	98.02	95.405	93.047
9	Gasoline, fuel oil, and other energy goods	100	96.767	90.53	105.687
10	Gasoline and oil	100	96.337	90.415	105.259
11	Fuel oil and coal	100	101.695	91.778	110.164
12	Other	100	102.75	104.986	105.136
13	Services	100	103.168	105.946	109.007
14	**Housing**	**100**	**103.85**	**107.786**	**110.411**
15	Household operation	100	104.405	103.49	107.497
16	Electricity and gas	100	110.652	104.857	113.155
17	Other household operation	100	100.827	102.715	104.193
18	Transportation	100	101.543	102.826	105.558
19	Medical care	100	103.643	106.241	109.444
20	Recreation	100	103.422	106.476	109.658
21	Other	100	101.831	105.419	108.455
	Addenda:				
22	Energy goods and services\1\	100	102.655	96.601	108.888
23	Personal consumption expenditures excluding food and energy	100	101.85	103.581	104.84

The results of the data can be summarized as follows:

Year	Current Index	Prior Yr Index	Divide Indexes	Deflator
2003	110.411	107.786	1.024	2.44%
2002	107.786	103.850	1.038	3.79%
2001	103.850	100.000	1.039	3.85%
2000	100.000			

The MDS Assessment Study, which is quite lengthy, is available only in hard copy. Please call the Office of Policy and Planning, 919-733-1665, for a copy.

New Version of Attachment 6 (Page 39 of Adult Care Home Cost Modeling Committee Report)

Cost to Fully Implement the Adult Care Home Cost Model Summary of Funding Requirements				
	Total	Federal	State	County
SCSA**	$9,980,260.00	$0.00	$4,990,130.00	$4,990,130.00
PCS**	$188,854,207.00	$120,167,932.00	$50,152,255.00	$18,534,020.00
Breakout: HAL	$180,096,959.00	$114,595,695.00	$47,826,674.00	$17,674,590.00
SCU	$8,757,248.00	$5,572,237.00	$2,325,581.00	$859,430.00
Total	$198,834,467.00	$120,167,932.00	$55,142,385.00	$23,524,150.00

NOTE: The success of the Cost Model Approach is dependent upon new program efforts to enhance resident assessments. This will require systems and staffing costs outlined in Attachment 7 which follows.

** **SCSA** dollar figures represents the cost of increasing staff salaries and benefits to the national average based on those necessary for our current clients, which equates to the SA rate raising to $1124 from $1084 per month for Non-SCU clients and to $1515 from $1084 per month for SCU clients.

** **PCS** dollar figure represents the additional cost to the state for its currents clients if we fully fund the needed PCS hours identified with the study of the clients in the homes. Currently the state only pays for 1.1 hours of personal care services to the clients per day. The study by Meyers & Stauffer indicated that the average clients in a non-SCU bed requires 2.31 hours of personal care services per day and a SCU bed client requires 4.07 hours of personal care services per day.

Cost to Implement an Income Disregard				
	Total	Federal	State	County
Income Disregard**	$22,660,113.00	$14,411,910.00	$6,335,278.00	$1,912,925.00

** **Income Disregard** dollar figures represent projected PCS cost for maintaining SA and ACH PCS eligibility for residents if costs are shifted from SA to ACH PCS independent of implementation of the Cost Model Approach. An income disregard will prevent disenfranchisement of SA residents and residents who would have been eligible for SA and ACH PCS except when a reduction in the SA rate due to a shift of costs to ACH PCS.

REPORT TO THE LEGISLATIVE STUDY COMMISSION ON AGING ON THE EXPANSION OF THE HEALTH CARE PERSONNEL REGISTRY

North Carolina Department of Health and Human Services
Division of Facility Services
Health Care Personnel Registry Section

November 18, 2005

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November 18, 2005

TO THE MEMBERS OF THE LEGISLATIVE STUDY COMMISSION ON AGING

The North Carolina Department of Health and Human Services, Division of Facility Services, Health Care Personnel Registry Section submits to you for your consideration its study report pursuant to Session Law 2005-276 Section 10.40A.(q).

Respectfully Submitted,

Jesse S. Goodman, Chief
Health Care Personnel Registry Section

North Carolina Department of Health and Human Services
Division of Facility Services
Health Care Personnel Registry Section

Section Overview

The Health Care Personnel Registry Section was created in 1996 as a result of legislative action by the North Carolina General Assembly and reorganization within the Division of Facility Services. At that time the responsibilities of the Section were expanded, from having limited regulatory authority for monitoring nurse aides working in nursing homes to include other unlicensed health care personnel working in other types of licensed health care facilities. In 1998 and again in 1999, legislative action broadened the scope of responsibility for the Division and expanded facility reporting requirements.

It is the purpose of the Section to review and determine federal and state compliance of all nurse aide training and competency evaluation programs offered in the state. To improve the quality of care provided the elderly and chronically ill, the Section spearheaded an initiative to develop a competency-based nurse aide training curriculum. The effort was accomplished working in partnership with representatives from the private sector as well as representatives of other state agencies and professional associations. This curriculum is available to all health care providers and serves to facilitate and ensure uniformity and consistency in the training of nurse aides. The North Carolina Community College System Office has adopted this curriculum for use throughout its system in both continuing education and college credit programs.

The Section is also responsible for the investigation of all allegations of resident abuse or neglect, misappropriation of resident or facility property, fraud against a resident or facility and diversion of resident or facility drugs when these acts occur in nursing homes, hospitals, home care agencies, hospices, nursing pools, adult care homes, family care homes, state-operated hospitals, and residential facilities and hospitals for the mentally ill, developmentally disabled and substance abusers, by unlicensed assistive personnel (nurse aides) or unlicensed health care personnel (nurse aides, in-home aides, in-home personal care aides, adult care home personal care aides or their supervisors). Further, the Section is responsible for taking administrative action, within the scope of its regulatory authority, against such individuals when it finds one of these acts has occurred.

Tracking and public awareness of unlicensed assistive personnel and unlicensed health care personnel remains a primary mission for the Section. The Section is responsible for providing a registry of all nurse aides who have met federal and state training and competency requirements to perform Nurse Aide I tasks. Additionally, it maintains a listing of unlicensed assistive personnel and unlicensed health care personnel who are being investigated for or have been found to have caused harm to a resident or a facility. These listings are contained on the Nurse Aide I Registry and the Health Care Personnel Registry and may be used by an employer for the purpose of screening prospective applicants for employment or reviewing the employment status of a current employee. Almost all licensed health care facilities are now required to access the Health Care Personnel Registry prior to employing unlicensed assistive and unlicensed health care personnel.

Information from both the Nurse Aide Registry and the Health Care Personnel Registry is made available to the general public and all health care providers via Internet access at www.ncnar.org and through a 24-hour telephone voice response system at (919) 715-0562. Additionally, the Section provides on-line assistance five days a week during normal business hours as a public service to employers and the general public for inquiries pertaining to the eligibility of an aide to practice in a health care setting in North Carolina.

Response to Legislative Request

The General Assembly enacted as part of Senate Bill 622, S.L. 2055-276 the following provision.

SECTION 10.40A.(q) 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, including unlicensed health care settings, that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

In response to the directive the Department initiated a study to determine if any additional health care facilities and health care personnel should be included in the Health Care Personnel Registry. A study group was appointed representing the following: State agencies and provider associations representing nursing homes, hospitals, home care agencies, mental health/developmental disability/substance abuse providers, adult care and assisted living facilities.
This group met over the course of three months and developed the following recommendations and offer them to the Legislative Study Commission on Aging for its consideration.

Recommendation 1.

The Health Care Personnel Registry should be expanded to include all unlicensed staff of health care facilities, as defined in G.S. 131E-256, which have access to residents or clients and or their property.

Rationale: Health care facilities, as defined in G.S. 131E-256, employ a substantial number of unlicensed staff, including housekeeping, dietary and administrative staff that may have direct contact or access to residents/clients and/or their property. These staff provide important services in the settings they work and while we all believe that the majority of these staff provide excellent support to residents and clients the Health Care Personnel Registry has received reports from time to time alleging abuse, neglect or misappropriation of property involving persons employed in these positions. These reports have not been able to be acted on by the Health Care Personnel Registry because the employment categories fall outside of the statutory authority of the program. This has and continues to cause frustration and concern at all levels because these individuals may move from employer to employer without any record of these past actions. It is the purpose of this recommendation to address this concern and provide additional safety to residents and clients served by these providers.

Recommendation 2.

The Health Care Personnel Registry should be expanded to include the following health care facilities; Licensable facilities as defined in G.S. 122C-3(14)b which includes all MH/DD/SAS day treatment programs, agencies and/or community service providers as defined in 10 NCAC 27G.0602(10), which includes unlicensed MH/DD/SAS community based service providers and multiunit assisted housing with services as defined in G.S. 131D-2(7a).

Rationale: As in Recommendation 1 there are health care service providers who are not within the legislative authority of the Health Care Personnel Registry and therefore when allegations are reported from these providers the Registry staff has not authority to investigate these situations. This has and continues to cause frustration and concern at all levels because individuals who were employed by the service providers and let go because of these actions may move from employer to employer without any record of these past actions. Therefore, as in Recommendation 1, it is the purpose of this recommendation to address this concern and provide additional safety to residents and clients served by these providers.

Recommendation 3.

Health Care Facilities as defined in G.S. 131E-256(b) shall not employ any person who has a substantiated finding on the Health Care Personnel Registry.

Rationale: One of the natural outgrowths of the establishment of the Health Care Personnel Registry in 1996 has been the practice of providers to not hire persons who have substantiated findings listed on the Registry. A further outgrowth has been the establishment of regulations by the state licensing agencies for nursing homes, adult care homes, mental health group homes and home care agencies to prohibit the hiring of persons with substantiated findings listed on the Registry. The members of the study group felt strongly that as this is required by most licensing agencies and it is in fact a common practice by most service providers that all providers should be held to the same standard.

Fiscal Impact

As with all expansions the cost of doing business will increase if the recommendations outline above are enacted by the General Assembly. This cost will be in the form of additional staff resources that will be necessary to process the increased number of allegation reports and investigators needed to screen, investigate and defend recommended substantiations before Administrative Law Judges when appealed by the accused staff. However, it is extremely important to discuss before considering the impact of these recommendations the current status of the Health Care Personnel Registry program. As pointed out in the overview of the program the Registry Section has experienced several legislative expansions since 1996. The last major expansion occurred in 1999 with the addition of MH/DD/SAS facilities. Over the past five years the number of allegations reported to the Section has increased by 280% (1760 in 2000 to 6681 in 2005) with a 62% increase in cases needing investigations for the same time period. The Section has had no increase in staff resources to address this growth resulting in a steady increase in the time from receipt of allegations to completion of investigations. It is therefore projected that an additional 18 investigator positions, three regional supervisor/investigator positions and six administrative support positions, at a project cost of $1.7 million, will be required to; first address the program's growth over the past five years and second, to meet the demand that will be created by the above recommendations.

HCPR Expansion Study Committee Members

Polly Welch, North Carolina Health Care Facilities Association

Lou Wilson, North Carolina Association-Long Term Care Facilities

Jerry Cooper, North Carolina Assisted Living Facilities Association

Kathie Smith, North Carolina Association for Home Care and Hospice

Linda Horton, North Carolina Hospital Association

Peyton Maynard, Developmental Disabilities Facilities Association

Robert Hedrick, Community Support Providers Council

Jeff Horton, Chief, Licensure and Certification Section, Division of Facility Services

Stephanie Alexander, Chief, Mental Health Licensure Section, Division of Facility Services

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

Barbara Ryan, Chief, Adult Care Licensure Section, Division of Facility Services

Jesse Goodman, Chief, Health Care Personnel Registry Section, Division of Facility Services

DRAFT

G.S. 131E-256 reads as rewritten:

§ 131E-256. Health Care Personnel Registry.
(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:
(1) Been subject to findings by the Department of:
a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services defined by G.S. 131E-201 are being provided.
b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
c. Misappropriation of the property of a health care facility.
d. Diversion of drugs belonging to a health care facility or to a patient or client.
e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.
(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.
The Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.
(a1) The Department shall include in the registry a brief statement of any individual disputing the finding entered against the individual in the health care personnel registry pursuant to subdivision (1) of subsection (a) of this section.
(b) For the purpose of this section, the following are considered to be "health care facilities":
(1) Adult Care Homes as defined in G.S. 131D-2.
(2) Hospitals as defined in G.S. 131E-76.
(3) Home Care Agencies as defined in G.S. 131E-136.
(4) Nursing Pools as defined by G.S. 131E-154.2.
(5) Hospices as defined by G.S. 131E-201.
(6) Nursing Facilities as defined by G.S. 131E-255.
(7) Licensable facilities as defined in G.S. 122C-3(14)b.
(~~7~~ 8) State-Operated Facilities as defined in G.S. 122C-3(14)f.
(~~8~~ 9) Residential Facilities as defined in G.S. 122C-3(14)e.
(~~9~~10) 24-Hour Facilities as defined in G.S. 122C-3(14)g.
(11) Multiunit Assisted Housing with Services as defined in G.S. 131D-2(7a)

(12) Agencies and/or community service providers as defined in 10 NCAC 27G.0602(10), not already defined above.
(13) Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program as provided for in G.S. 143B-181.1(a)(11).
(c) For the purpose of this section, the following are considered to be "health care personnel":
~~(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.~~
~~(2) A nurse aide.~~
~~(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.~~
~~(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.~~
(1) Any unlicensed staff of a health care facility as defined in this section that has direct access to residents, clients or their property.
(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Health Care Personnel Registry.
(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.
(~~d2~~)(e) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.
(f) Health Care Facilities as defined in this section shall not employ any person who has a substantiated finding on the Health Care Personnel Registry.
(~~e~~) (g)The Department shall provide an employer or potential employer of any person listed on the Health Care Personnel Registry information concerning the nature of the finding or allegation and the status of the investigation.
(~~f~~)(h) No person shall be liable for providing any information for the health care

personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

~~(g)~~ (i)Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

~~(h)~~ (j)The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

~~(i)~~ (k)In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel to petition the Department to have his or her name removed from the registry upon a determination that:

(1) The employment and personal history of the nurse aid does not reflect a pattern of abusive behavior or neglect;

(2) The neglect involved in the original finding was a singular occurrence; and

(3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section. (1995 (Reg. Sess., 1996), c. 713, s. 3(b); 1998-212, s. 12.16E; 1999-159, s. 1; 2000-55, s. 1; 2004-203, ss. 52(a), (b), (c).)

Health Care Personnel Registry Report

S.L. 2005-276, Section 10.40A (q)

SECTION 10.40A.(q) 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, including unlicensed health care settings, that should be contained in the Health Care Personnel Registry and listed in G.S. 131E-256. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by December 1, 2005.

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — January 18, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Charlene Carey	N.C. Right to Life
[illegible]	Bom & Asso.
[illegible]	FP
[illegible]	HHS
Jennifer [illegible]	NASW, NC
Canaan Wilson	NASW - NC
[illegible]	Bom & Assoc -

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — January 18, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joyce Cherry, RN	Roanoke Valley Adult Day Ctr.
Jean Reaves, Dr	Roanoke Valley Adult Day Ctr.
Barbara Ryan	Division Facility Services
Bob Fitzgerald	DHHS / DFS
Jeff Horton	DHHS / DFS
Jesse Goodman	DHHS / DFS
Wayne Williams	OSBM
Kari Boursness	OSBM
Richard Hatch	AARP / NC Coalition on Aging
Polly Williams	NC Justice Center / Triangle OWL
Roxanne Bragg-Cash	NCAOA Franklin Co Dept of Aging

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — January 18, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Abby C Emanuelson	Nat'l MS Society
[illegible]	NCATCF
Jenny Cogan	NCALA
Evelyn Hawsmone	DHSR
Mary Edwards	DAAS
Sharon Walker	DAAS
John Motyc	GOV OFFICE
DAVID BARNES	Poyner + Spruill
Jim Edgerton	AHIC
Karen Gottovi	Div Aging + Adult Services
[illegible]	NBO

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

January 23, 2006

MEMORANDUM

TO: Members - NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the **NC Study Commission on Aging:**

DATE: **Wednesday, February 1, 2006**

TIME: **10:00 a.m.**

LOCATION: **Room 643**
Legislative Office Building

Please advise Dee Hodge, Commission Assistant, at (919) 733-5955 or email dannellyla@ncleg.net if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, February 1, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Update on PCS Restructuring

Sherry Thomas, Association for Home and Hospice Care

III. Home Health TeleHealth

Sherry Thomas, Association for Home and Hospice Care

IV. Report on Issues Related to Mentally Ill Residents of Long-Term Care Facilities (S.L. 2004-124, Section 10.2(a))

Jackie Sheppard, Emily Saunders, Julie Budzinski, and Bonnie Morrell, DHHS

V. Next Meeting:

- **February 15, 2006 at 10:00 a.m. in Room 643**

Upcoming Public Hearings:

(Additional information and directions will be forthcoming)

- **February 21, 2006 from 10:30 a.m. – 12:30 p.m.**
  Martin Community College, Williamston, NC
- **February 28, 2006 from 10:30 a.m. – 12:30 p.m.**
  The Foundation at Isothermal Community College, Spindale, NC

North Carolina Study Commission on Aging

MINUTES
Wednesday, February 1, 2006
10:00 AM
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Wednesday, February 1, 2006, at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were: Senator Charlie Dannelly, Co-Chair; Senators Austin Allran, Stan Bingham, and Vernon Malone; Representatives Alice Bordsen, Bob England, and Jennifer Weiss; Mr. Brad Allen, Mr. Sam Marsh, Ms. Judy Pelt, and Ms. Florence Soltys. Mr. Jackie Sheppard, Ex-Officio Member was also present.

Senator Charlie Dannelly presided. He called the meeting to order and made a few introductions prior to the presentations.

PRESENTATIONS

Update on PCS Restructuring

Ms. Sherry Thomas, Senior Vice President of the Association for Home and Hospice Care of North Carolina was the first presenter. She furnished Commission members with the following handouts: Power Point Presentation on Personal Care Services (PCS) Restructuring (Attachment 1) and PCS Physician Authorization for Certification and Treatment (PACT) Form (Attachment 2). Ms. Thomas told Commission members that PCS were restructured to make sure the right patients were receiving the right services. She also stated that controlled access with stricter criteria on the front end of the program was necessary so the program would be available only to those who really need it.

Following are new policy requirements for In-Home Personal Care Services:

- The patient must have two Activities of Daily Living (ADL) deficits that require hands on assistance to qualify for In-Home PCS and the need for PCS must be clearly linked to a patient's medical condition.
- The new assessment form is mandatory statewide (Attachment 2). The RN who conducts the assessment clearly states on the form why the patient needs the services and why the patient is eligible for services.

- Division of Medical Assistance (DMA) time guidance must be assigned to in-home aide tasks. For example, completely bathing a patient allows no more than 30 minutes.
- Home management tasks can not exceed the time budgeted for personal care.
- Prior approval is required for up to 20 hours of PCS/month under PCS Plus
- 4 ADL impairments requiring extensive assistance or 3 ADL impairments and specified physical limitations may qualify for PCS Plus.
- Direct solicitation by the PCS provider agencies is prohibited.

Rep. Weiss asked if there will be monitoring of those persons who have been receiving these services switching to Adult care homes. Ms. Karen Gottovi stated that as of 1/13/06, 9868 people were waiting for services. Of that total, 1546 are waiting for home management and 2112 are waiting for In-Home PCS. There are other levels of PCS that have waiting lists as well.

Rep. England asked if someone could go back and look at those individuals who have been removed from the program because they did not meet the new criteria. He wants to know what happens to them and why they were there until the new criteria removed them. Ms. Thomas stated that instead of continued hour reductions in the program, the new criterion allows those who are the sickest to continue to stay at home. She is not sure what happens to those who can't get into the program, them unless they can be tracked through another service.

Ms. Soltys asked how often the aides go to the home and what type of supervision there is over the agencies that provide the aides. The DSS workers are on a regular survey cycle and the Careline and the hotline continue. The DMA has a new UR/QA program where staff will go into the field to make sure the services are being delivered appropriately. The RN supervision takes place every 90 days.

Home Health TeleHealth

Ms. Sherry Thomas also gave Commission members a brief presentation on telehomecare. This is a system that utilizes telecommunications to deliver healthcare services that are typically provided to patients in the home, such as vital sign monitoring, patient education, and assistance with following their care plans. The data is collected and transmitted using the patient's home telephone line. Please see Attachment 3 for a more thorough description of this service.

Ms. Thomas stated that the Association for Home & Hospice Care of NC encourages the Commission to support legislation to implement telehomecare in NC's Medicaid home health program to assist in controlling health care costs and to improve patient outcomes.

Report on Issues Related to Mentally Ill Residents of Long-Term Care Facilities

Mr. Jackie Sheppard, Assistant Secretary for Long-Term Care and Family Services with the NC Department of Health and Human Services (DHHS) gave the next presentation.

He furnished Commission members with a copy of the authorization directing DHHS to conduct a study of issues related to mentally ill individuals residing in long-term care facilities (Attachment 4). He also furnished members with a copy of the Final Report and Recommendations (Attachment 5). Following are recommendations which are discussed in detail within the report.

- Expansion of mental health specialty teams to provide training and technical assistance to long term care facilities.
- Design and implementation of an automated screening, assessment and care planning system to be used prior to admission to long term care services.
- Conduct a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness.
- Strengthen the training curriculum in all law enforcement training programs to improve law enforcement response in long term care settings.
- Further evaluation of a number of statutes and rules to provide appropriate guidance to long term care facility operators according to the needs and characteristics of residents served.

At the conclusion of his presentation, Mr. Sheppard introduced Ms. Emily Saunders with the Adult Care Licensure Section of the Division of Facility Services, Ms. Julie Budzinski with the Division of Medical Assistance and Ms. Bonnie Morrell with the Division of Mental Health. These persons fielded questions from members. Senator Dannelly ultimately asked members to give their thoughts and recommendations to staff relative to the report.

The meeting adjourned at 11:35am.

Charlie S. Dannelly

Senator Charlie Dannelly, Co-Chair
Presiding

Beverly Earle

Rep. Beverly Earle, Co-Chair

Dee Hodge

Dee Hodge
Commission Assistant

Personal Care Services **

Sherry Thomas, BSN, MPH
Senior Vice President

Association for Home &
Hospice Care of North Carolina

February 1, 2006

1

Why Did PCS Restructure ?

- Established in the 80's with few changes since except for hour reductions
- Restructured to make sure serving the right patients with the right amount of services
- To regain confidence with the NC Legislators - if service hours continue to be cut, then the frailest patients suffer. Better to control access with tighter criteria than create a situation where the most frail patients cannot get the hours needed to meet their care needs and stay at home.

2

What is In-Home PCS ?

Medicaid Personal Care Services (PCS) covers the services of an in-home aide in the patient's private residence to assist with the patient's personal care needs which are directly linked to a medical condition.

Patients must have a minimum of ***two*** Activities of Daily Living (ADL) deficits identified through a mandated, standardized RN assessment and services must be authorized by the attending physician.

3

PCS Mandated RN Assessment Form – Physician Authorization for Certification and Treatment (PACT)

- The new PCS RN Assessment form (PACT) is mandatory
- Documentation on the PCS PACT form serves as the basis for determining whether or not the patient qualifies or continues to qualify for PCS and must paint a clear picture of the patient's functioning in each activity of daily living, the related need for assistance and the expected duration of the need.
- The RN assessor certifies by signature on the PCS PACT Form that he/she completed the in-home assessment, determined the need for PCS, and developed the plan of care.
- All RNs who complete a PCS assessment must be certified through State approved curriculum and testing – 800 RNs to-date.

4

PCS Personal Care Criteria

- PCS is authorized by the patient's primary physician
- In-home PCS services are provided in the patient's private residence. In-home PCS is not covered when the patient is in a nursing home, group home, adult care home, hospital or at school.
- The patient must have 2 ADL deficits which require hands on assistance by an in-home aide (Unlike adult care home PCS, supervision and prompting in the task does not meet the criteria for in-home PCS services)

5

Activities of Daily Living (ADLs) Based on the KATZ scale

- Bathing
- Dressing
- Toileting
- Bowel/Bladder incontinence
- Transferring/ambulation
- Feeding

6

ADL Needs are Scored Based on the Nursing Home MDS Definitions

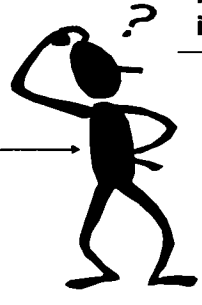
- INDEPENDENT: No help needed or oversight needed. Does not meet in-home PCS Criteria
- SUPERVISION: Oversight, encouragement, or cueing needed. Does not meet in-home PCS Criteria
- LIMITED ASSISTANCE: Individual highly involved in activity; receives help in guided maneuvering of limbs or other non-weight bearing assistance. - Would get less hours of aide care
- EXTENSIVE ASSISTANCE: While individual performs part of activity, help of the following is needed: weight-bearing support OR substantial or consistent hands-on assistance with eating, toileting, bathing, dressing, personal hygiene, or self-monitoring of meds.
- FULL DEPENDENCE: Full performance of activity by another.

7

ADL deficits clearly related to medical condition - for example:

Medical Condition

Congestive Heart Failure



Resulting in..

Identified Need

Debilitation with Severe shortness of Breath = Unmet Needs of Bathing & Dressing = **PCS eligibility**

8

PCS criteria –other

- PCS services cannot be in excess of the patient's identified needs nor are they primarily intended for the convenience of the patient, the patient's caretaker or the provider
- Without PCS, the patient's medical condition would deteriorate
- Pregnant patients have additional conditions for coverage and require prior approval
- PCS for infants and children must not replace parental responsibilities or normal age appropriate tasks that a child would require – but rather be linked to a medical condition.

9

PCS Service Limitations

- No more than 3 ½ hours per day
- No more than 60 hours per month
- In assigning time to in-home aide tasks, the agency uses the new DMA time guidance. For example – completely bathing a patient allows no more than 30 minutes.
- No separate reimbursement rate for the RN assessment or required RN supervision

10

Home Management Tasks Criteria

- The only home management tasks allowed are listed on the covered tasks in the DMA policy. These tasks must be related and incidental to the patient's personal care needs as indicated on the PCS assessment form. Home management tasks can not exceed the time budgeted for personal care
- Home management tasks cannot be completed for others living in the household
- The aide is expected when possible to complete multiple tasks simultaneously

11

PCS Plus

- PCS-Plus is for patients who have a qualifying medical condition and personal care needs that exceed the service limit for regular PCS.
- Up to an additional 20 hours of PCS a month are available through the PCS-Plus program (with Prior Approval) from DMA staff.
- Specific criteria – 4 ADL impairments requiring extensive assistance or 3 ADL impairments and specified physical limitations

12

Physician Responsibilities

- Referral authorization- the physician must order the RN assessment.
- The physician authorizes the start of PCS services or continuation of services- with a verbal order or signed order.

13

When Services Are Not Covered

- PCS is not covered when the patient's primary need is housekeeping or/or homemaking. Home Management tasks completed for other residents of the household (even if elderly or frail) are not covered by PCS.
- Medicare or Medicaid Hospice patients may not receive in-home PCS
- A patient may not receive PCS and another substantially equivalent federal or state funded service on the same day.

14

When Services Are Not Covered

- PCS covered transportation is only for essential shopping/errands such as picking up prescriptions, food items and/or paying essential bills that cannot be paid through the mail.
- Companion/sitter services, continuous monitoring and ongoing supervision is not covered.

15

Direct Patient Solicitation Prohibited in Policy

- Direct solicitation by the PCS provider to patients or their representatives is prohibited
  Direct solicitation by the PCS provider agencies or agency representatives to patients and/or their representatives for PCS services is prohibited.

  Examples are :Provider going door to door or having agency representatives in the patient areas in MD offices

16

New Utilization Review/Quality Assurance Program

- UR/QA provides a prospective review for PCS
- Until now PCS reviews were post payment reviews by Program Integrity - Pay & Chase.
- QA establishes measurable benchmarks for quality services and communicates quality standards in a measurable format. *If you measure it ,it will improve.*
- DMA's UR/QA program will be both record review and on-site review (need to ensure resources are allocated for this) to prevent problems with services from occurring. Program Integrity will continue as usual.

17

So What is Different in PCS ?

- Stricter, measurable and specific ADL criteria for eligibility
- Mandated Assessment tool – PCS PACT documents criteria clearly for surveyors, agency staff, etc.
- Time and task- definitions and guidance in both personal care and then links home management to personal care needs and medical conditions
- RN training requirements- web based certification
- RN supervision standards and frequency aligned with DFS
- Solicitation Prohibited
- UR/QA program – upfront reviews measure quality and appropriate utlization.

18

Companion Legislation

- Medical Care Commission –

New Home Care Licensure Rules

- Limited geographic service area
- DFS required training for licensure
- If substantiated findings on HCPR prohibited from hiring
- And, DFS required training prior to home care licensure

19

More rules coming....

- New Director qualifications
- New aide qualifications

20

What is Expected?

- New PCS policy was effective 11/01/2005
- About 20,000 patients must be reassessed by end of March
- All nurses must be certified by end of January
- Agency UR/QA must start by the end of January – DMA performing reviews in February

21

Already We Know....

- Based on DMA data available for November (which was the first month under the new PCS Policies) we see a significant downward trend in the number of patients served compared to the period of July 2005 through October, 2005.
- For the period of July 2005 through October 2005 the average number of monthly patients served was 36,700. For the month of November the number of patients served declined by 1752 patients. This equates to a monthly reduction in PCS cost of $1,278,960.
- Under the stricter criteria, we expect the downward trend to continue and project that the new stricter criteria will reduce the average monthly patients by 15 to 20%.

22

Bears Watching...

- What happens to patients who cannot enter the program due to stricter criteria? Will they go where criteria is less strict or deteriorate without services?
- Will the current in-home aide rate cover the costs of the aides, administrative overhead, RN assessment/supervision and new UR/QA requirements?
- Will only the larger agencies with higher volumes of patients survive?

23

Questions??

24

PERSONAL CARE SERVICES (PCS)
PHYSICIAN AUTHORIZATION FOR CERTIFICATION AND TREATMENT (PACT) FORM

Referral Date:_____ Date Initial Assessment Completed:_____ Date Last Reassessment Completed:_____

Provider Name:_____ PCS Provider #:_____ Provider Phone #:_____

Provider Address:_____

PATIENT INFORMATION

1. PATIENT FIRST & LAST NAME:_____
2. MEDICAID ID # (MID):_____ 3. SOCIAL SECURITY# _____
4. PATIENT ADDRESS:_____
5. PATIENT PHONE:_____ 6. SEX: ☐Male ☐Female 7. DATE OF BIRTH (mm/dd/yy):_____
8. PATIENT LIVES: *Check all that apply* ☐Alone ☐w/Spouse ☐w/Adult Child(ren) ☐w/Parent(s) ☐w/others
9. CONTACT PERSON'S NAME:_____ RELATIONSHIP TO PATIENT:_____
   ADDRESS:_____ PHONE: (H)_____ (W)_____
10. ATTENDING PHYSICIAN'S NAME:_____ PHONE:_____
    ADDRESS:_____
11. DATE OF MOST RECENT EXAM (mm/dd/yy):_____ 12. Vital Signs @ Assessment: B/P____ T____ P____ R____ Wt____ Ht____
13. REASON FOR REFERRAL:_____ Referral Source:_____
14. DIAGNOSIS (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? ☐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:

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 using the scores below. Check the applicable boxes. Indicate the days when assistance is needed in the blank beside a task. M=Mon T=Tues W=Wed Th=Thurs F=Fri S=Sat Sun=Sunday

A. ADL Self-Performance Scores

0. INDEPENDENT: No help needed or oversight needed.
1. SUPERVISION: Oversight, encouragement, or cueing needed.
2. LIMITED ASSISTANCE: Individual highly involved in activity; receives hands-on help in *guided maneuvering of limbs with eating, toileting, bathing, dressing, personal hygiene self monitoring of meds and / or* other non-weight bearing assistance.
3. EXTENSIVE ASSISTANCE: While individual performs part of activity, substantial or consistent hands-on assistance *with eating, toileting, bathing, dressing, personal hygiene, self-monitoring of meds and /* or weight bearing assistance is needed.
4. FULL DEPENDENCE: Full performance of activity by another.

B. ADL Support Provided Scores

0. No set-up or physical help needed 1.Set-up help only 2.One person physical assist 3.Two+ persons assist and/or one person assist w/assistive equipment

			A. ADL Self-Performance	B. ADL Support Provided	Place a check in the box if assistance is needed
19.	**Ambulation:**	Note assistive equipment patient is to use while ambulating: ☐Cane ☐ Quad cane ☐Walker ☐ Bed/chair bound ☐other _____			
20.	**Non-ambulatory/ Transfer:**	Moving to and between surfaces: bed, chair, wheelchair, standing position. Note assistive equipment patient is to use during transfer: ☐ Manual wheelchair ☐ Electric wheelchair ☐Hoyer lift ☐Transfer Board ☐Trapeze Bar ☐ other _____ Note self sufficiency once transferred _____			
21.	**Nutrition:**	*Check assistance needed with taking in food by any method.* ☐Oral ☐Parenteral ☐ Tube_____ ☐Feed patient ☐Set-up only Dietary Restrictions_____ Supplements_____ Diet Ordered_____ Meal Prep: ☐ 1 meal_____ ☐ 2meals_____ Kitchen cleanup (cleaning table, stove, washing dishes, putting away items used, sweeping)_____			
22.	**Respiration:**	☐Normal ☐Dyspneic with minimal exertion ☐Tracheostomy ☐Mechanical Oxygen: ☐Continuous ☐Intermittent ☐Nebulizer Treatments _____ A. Dust_____ B. Vacuum_____ C. Mop_____ D. Sweep_____			
23.	**Endurance:**	☐Pt. is never short of breath (SOB) ☐Pt. is SOB when walking more than 20 feet or climbing stairs ☐Patient is SOB when walking less than 20 feet and or dressing self or using commode. ☐Pt is SOB w/minimal exertion (i.e. eating, talking, performing ADLs, agitation) ☐Pt is SOB at rest ☐Pt has generalized weakness A. Change bed linens_____ B. Make bed_____ C. Grocery shop_____ D. Pick-up medicine_____ E. Pay utility bills _____ F. Take out garbage_____ ☐Check smoke alarm: _____			
24.	**Skin:**	☐Normal ☐Dry, cracked or bleeding areas ☐Pressure areas ☐Decubiti A. Diabetic foot care required?: ☐Yes ☐No Freq:_____ B. Nail Care?: ☐Yes ☐No Freq:_____			
25.	**Bathing:**	A. Taking full body bath_____ B. Shower_____ C. Sponge bath_____ D. Shampooing hair_____ E. Clean bathroom after bathing_____ ☐ Transferring in and out of tub and shower *Devices needed:* ☐ Shower bench ☐ Bath Safety Bars ☐Detachable shower head			
26.	**Personal hygiene:**	☐Combing hair ☐Brushing teeth ☐Cleaning dentures ☐Washing/drying face and hands and perineum A. Braiding or setting hair_____ B. Shaving_____			
27.	**Dressing:**	☐Laying out clothes ☐Retrieving clothes from closet ☐Putting clothes on and taking clothes off ☐Donning/removing TED Hose ☐ Donning/removing prosthesis A. ROM_____ B. 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 ☐Ileostomy ☐Indwelling catheter ☐Condom Catheter ☐Occasional incontinence (less than daily) ☐Daily incontinence ☐Incontinence during the day and night *Devices/supplies needed:* ☐ Bed/chair bound ☐ Bedside commode ☐ Elevated Toilet Seat ☐ Bedpan ☐Urinal ☐Pads ☐Diapers ☐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/supplies needed:* ☐Bedside Commode ☐ Elevated Toilet Seat ☐Bedpan ☐ Pads ☐ Diapers ☐Enemas_____ ☐Bowel Program_____			
30.	**Self-monitoring:**	Self-monitoring of: ☐ Pre-poured medications ☐ Blood Sugars: Notify MD if BS is above_____ or below_____ BP: Notify MD if BP is > _____ or < _____ ☐ 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:** *7-day look-back*	Location of pain_____ Severity of Pain: *Rate 0 – 10: 0=no pain and 10=worst pain* _____ Pain frequency: ☐No pain ☐Pain < daily ☐Pain > daily Pain control: ☐No pain ☐Pain improved with medication ☐No pain relief or improvement w/medication
32.	**Cognitive Skills for Daily Decision Mkg:**	☐Independent (decisions consistent/reasonable) ☐Modified independence (some difficulty in new situations only) ☐Moderately impaired (decisions poor, cues/supervision required) ☐Severely impaired (never/rarely makes decision) ☐Patient requires step-by-step verbal prompting ☐MR/DD _____ (level)
33.	**Behavior:**	☐Cooperative ☐Passive ☐Physically abusive ☐Verbally abusive ☐Wanders ☐Injures self/others/property ☐Non-responsive
34.	**Vision:**	☐Adequate for daily activities ☐Limited (sees large objects) ☐Very limited (blind) *Client uses:* ☐Glasses ☐Contacts
35.	**Hearing:**	☐Adequate for daily activities ☐Hears loud sounds/voices ☐Very limited (deaf) *Client uses:* ☐Hearing aids
36.	**Speech:**	☐Normal ☐Slurred ☐Weak ☐Other impediment: specify_____ Primary Language(s)Spoken_____
37.	**Communication Method:**	☐Speech ☐Gestures ☐Writing ☐Assistive Device: specify type _____ ☐ Client unable to write; have client make mark here: _____ Nurse's initials: _____

38. ☐ Additional time needed. Document here information specific to client needs for other covered home management tasks AND exceptions requiring additional time over identified time guidance:

39. Patient's perception of what he/she thinks their needs are:

40. Please check if any of the following apply to this patient:
- ☐ Presence of continuous and/or substantial pain interfering with individual's activity or movement
- ☐ Dyspneic 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

41. Has the patient executed an advance directive (living will or durable power of attorney)? ☐No ☐Yes If yes, specify location of original doc.: _____

42. 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

43. 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 O_2 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: _____

44. Are there sources (family, friends, programs, or agencies) available to meet the above needs at the time that services have been requested? ☐Yes ☐No

NURSE ASSESSOR CERTIFICATION

I certify that I, and no one else, have completed the above in-home assessment of the patient's condition. Falsification: an individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and will be referred to the NC Board of Nursing for investigation.

☐ 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.

☐ I have determined that the patient does not meet the criteria for personal care services.

_____ _____ _____

PRINT RN NAME RN SIGNATURE Date Signed: Time in /out of home

PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:

PLAN OF CARE

45. 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 15 minute increments or in hours) required for each day.

Category #	Category Name	Category #	Category Name
19	Ambulation	27	Dressing
20	Non-ambulatory/Transfer	28	Bladder
21	Nutrition	29	Bowel
22, 23	Respiration	30	Self-monitoring
23	Endurance	30	Medication Assistance
24	Skin	31	Pain
25	Bathing	32	Cognitive Skills for Daily Decision-making
26	Personal hygiene	33	Behavior

Day of the Week	Task(s) To Be Accomplished Specify the category # and the amount of time required for each task (i.e. # 19: 15 minutes)	Total Time per Day *(in 15 min increments or in hours)*
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

46. **Goals/Objectives:** The need for PCS is expected to ☐change OR ☐end on ____/____/____. If no change is expected, state why:

_____

47. Has a **verbal order** been obtained to **assess the patient** and determine eligibility for PCS per DMA Guidelines? ☐Yes Date:_____

48. Specify the date that a verbal order was obtained to **start PCS**:_____ Who conveyed/obtained this verbal order?_____

PHYSICIAN CERTIFICATION

I certify that I am the patient's primary 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. Falsification: an individual who certifies a false statement in this plan may be subject to investigation for Medicaid fraud and will be referred to the North Carolina Board of Medicine.

ATTENDING PHYSICIAN'S SIGNATURE _____ DATE_____

Association for Home & Hospice Care of North Carolina

ATTACHMENT 3

TELEHOMECARE

Sherry Thomas, BSN, MPH

Imagine that you are an 82 year old patient with congestive heart failure due to coronary artery disease. (CHF is a condition in which the heart cannot pump enough blood to the body's other organs. The failing heart is not able to work efficiently and as blood out of the heart slows, blood returning to the heart backs up causing congestion in the tissues and fluid collects in the lungs.) On bad days you are so short of breath that you find it extremely difficult to walk the length of your living room and your feet are so swollen you cannot get your bedroom shoes on. Over the past year you have had four hospitalizations and two trips to the emergency room when you have felt so starved for air that you felt you were dying. On your last trip there, your physician ordered home health nursing and telehomecare.

Now, along with your nurse and physician, you take an active part in monitoring your condition. In the morning, you go to a monitor on your kitchen table – stick your arm through an attached sleeve for blood pressure monitoring; step on a digital scale for your weight; and, put your finger in a pulse oximeter to meaure your oxygen saturation. The machine asks you questions that include how you slept – did you need two pillows to help you breathe better? – is your swelling more than yesterday? And three times a day, because you are a little forgetful, the machine tells you to take your medications.

Your daily recordings are sent over the telephone line to your home health nurse's monitoring station where she can see trends in your CHF status. Because your weight is up today above the individualized parameter that your physician set, the machine alerts the nurse that you need specific attention first. Now, instead of a last minute panicked ER visit, the nurse calls you at home before your condition deteriorates. Following physician orders, she advices you to take an extra fluid pill and to re-monitor in one hour. If needed, she will make a home visit for a more thorough assessment. Because you are now better recognizing symptoms of your CHF and able to reach your home health nurse twenty-four hours a day, you have greater peace of mind.

- ⇒ Telehomecare utilizes telecommunications to deliver healthcare services that are typically provided to patients in the home, such as vital sign monitoring, patient education, and assistance with helping patients follow their care plans. Some of these services can now be delivered more frequently and patient data transmitted more regularly by using the ordinary household telephone or telephone line. Includes simple-to-use devices, such as telecommunications-ready glucometers (measures blood sugar) or peak flow meters (a peak glow meter is a portable, inexpensive, hand-held device used to measure how air flows from your lungs in one "fast blast." In other words, the meter measures your ability to push air out of your lungs - useful for patient with asthma).
- ⇒ Telemonitoring equipment can vary from a single, automated phone call transmitted three times a day to remind an elderly patient to take a certain number of particular pills, for instance, or a full-scale workstation with which a patient with a number of health problems and his clinician can televisit to substitute for regular in-person visits.
- ⇒ Costs of home telehealthcare equipment have an large price spread, depending on the varied capabilities that each product offers. Telehealth services can range from an automated phone call (at a cost of 33 cents) which can assist a patient with medication compliance, to more than $25,000 for a single telehealth workstation that can practically replicate the numerous services available on a fully-equipped hospital floor. And there is wide variability in pricing of the range of equipment in between those two extremes, from telecommunications-ready blood pressure cuffs or glucometers that may cost less than $100 each, to more modest workstations that only attempt to make electronic or automate the conventional nursing visits (using a simple video camera for the nurse to see the patient, and including a few of the most needed vital sign monitoring devices attachments).
- ⇒ Particularly beneficial to patients living with chronic diseases, such as diabetes, congestive heart failure, and asthma.
- ⇒ Daily documentation of patient information using telehealth technology allows the care provider to track health patterns over time and detect deviations in patient data that may indicate a decline in health before it becomes acute. A telehealth system can provide alerts that are activated when patient-specific baselines exceed a given parameter - weight, for instance. This is practically impossible in the traditional care delivery model.

Can Telehealth Lower Healthcare Costs & Improve Patient Outcomes?

- ⇒ 45% of the American population is affected by one or more chronic illnesses consuming approximately 78% of all healthcare spending in the United States-*more than $1 trillion annually*. Telehealth is an important part of an effective disease management model whose aim is helping patients better self-manage their conditions through guidance, education and improved patient/clinician communication. *Karen Utterback, RN, MSN, Vice President of Clinical Strategy for the McKesson Corporation*
- ⇒ Cardiovascular Disease (CVD) is one of NC's leading chronic illnesses. CVD hospitalizations, emergency room visits and deaths are even more prevalent among blacks, the under served and rural residents. Approximately five million Americans suffer from CHF and 500,000 new cases diagnosed each year. CHF currently accounts for 875,000 hospitalizations and, for geriatric patients, it is the most common diagnosis requiring hospitalization. Health care expenditures are estimated in the billions. Patients with CHF have high incidences of emergency department utilization, as well as hospital re-admissions. *Craig Lehmann PhD CC (NRCC) FACB and Jean Marie Giacini BS, in the May/June, 2004 issue of Home Health Care Technology Report*
- ⇒ 28% of elderly patient admissions to the hospital are due to medication noncompliance or adverse drug events. The U.S. Food and Drug Administration (FDA) estimates the costs of drug related hospital admissions of elderly patients at $20 billion annually. The FDA says that medication errors cause approximately one death per day.
- ⇒ In a July/August 2005 article in the Remington Report, Will Telemonitoring Play a Significant Role in Disease Management and Pay for Performance, Barbara Rosenblum, the President of Strategic Healthcare Programs (SHP), reported that in 2001, the average charges for hospital DRG 127 (Heart Failure) were $13,405. (http://hcup.ahrq.gove/HCUPnet.asp). Of the 743 patients in the SHP database with CHF, the hospitalization rate was 6.9% vs. 10.2% for the non-monitored comparative group. Rosenblum goes on to say that ...If the 734 patients had been hospitalized at 10.2% (the non-monitored rate), there would have been 75 hospitalizations. At 6.9% there were only 51. Therefore, this sample resulted in a projected $321,730 in hospitalization savings.
- ⇒ Karen Utterback goes on to say in her January/February, 2005 article Supporting a New Model of Care with Telehealth Technology that ... In a study conducted by Mercy Healthcare Sacramento, they found that CHF patients using telehealth with extensive disease management programs experienced a 73% reduction in hospitalization and ER visits and an 80% reduction in total bed-days as compared to standard care (Mercy Healthcare, 2001).
- ⇒ Jude Lauffer, RN,C Disease Management Specialist with Gateway Health Plan whose company is managing Pennsylvania Medicaid patients reports that Gateway has a cardiac disease management program utilizing home health agencies to provide telehealth services. To qualify for monitoring, patients need to have greater than 1 hospital admit in a 12 month period for CHF. Medicaid reimburses a daily per diem to have the monitor in the home and the results followed by home health. They reimburse for skilled visits as needed in addition to the daily per diem. For the forty-four patients in the project demonstration they have achieved a twenty-seven percent reduction in hospital admissions.
- ⇒ Members of our Association utilizing telehealth have reported improvement in both emergent care outcomes and acute care hospitalization outcomes.
- ⇒ Scott County, Tennessee, Telemedicine Program with the assistance of the University of Tennessee Medical Center Telemedicine Network reduced total costs of care for patients admitted with CHF. Days of hospitalization during a 12-month period were evaluated for the 34 participants and compared with a national benchmark for CHF patients without telehealth. The participants averaged 1.26 days per year hospitalized for CHF admitting diagnosis compared with 6.2 for the national data. When the cost of providing the telehealth care was added to the estimated cost of hospital days for the participants, their total cost of care was 53% of the estimated cost of hospital days based on the national data for CHF patients not having home telehealth (Burgiss, Dimmick, & Robbins, 2001).

Reimbursement for Telehealth

- ⇒ 10 states allow for telemedicine reimbursement under Medicaid, as of mid-1998. Reimbursement charges and allowances vary from state to state, because states set their own rates. There is no standard fee for telemedicine reimbursement paid nationwide; but the states which allow it will reimburse under the home care benefit if a provider can establish and document the cost savings of using telemedicine. South Carolina Medicaid is considering a project demonstration this year.

⇒ Some commercial insurers and a growing number of managed care organizations (MCOs) have also been, like Medicaid payers, relatively more welcoming to the newer technology. A number of larger MCOs will also reimburse for telehealth, on a case- by-case basis.

⇒ Blue Cross Blue Shield of South Carolina is beginning a large telehomecare project.

eral Initiatives

CMS has contracted with the Quality Improvement Organizations (QIOs) to work with a subset of home health agencies to implement telehomecare. The overarching goal of the introduction of home telehealth is to aid in the reduction of acute care hospitalization rates through the application of home telehealth technology as a practice tool. The primary objectives of home telehealth are to: 1. Decrease acute hospitalizations 2. Reduce unscheduled nursing visits 3. Identify and manage early exacerbation/decompensation of the patient's condition.

The Carolina Centers for Medical Excellence is working with North Carolina agencies to develop methods to incorporate telephone monitoring and the use of telemonitors into their operations to achieve this goal. Currently in NC we have 13 certified home health agencies incorporating telehomecare into their Medicare home health services.

In Summary

By compelling patients to answer detailed questions not only about their vital sign readings, but about their symptoms and knowledge of their diagnosis, providers make patients active participants in their own care. Educating patients about their diagnosis and providing detailed, interactive information helps them modify behaviors and improve medication compliance. It also helps patients avoid acute episodes with doctor and hospital visits, which are very costly physically, emotionally, and financially. Additionally, going through the motions of answering questions on a daily basis gives patients the comfort of knowing they are being looked after and helps reduce feelings of isolation, which can negatively impact their well-being.

Recommendation

The Association for Home & Hospice Care of North Carolina encourages this committee to support lation to implement telehomecare in NC's Medicaid home health program to assist in controlling th care costs and to improve patient outcomes.

For more information please contact Jim Edgerton at 919-848-3450

Issues Related to Mentally Ill Residents of Long-Term Care Facilities

S.L. 2004-124, Section 10.2(a)

(House Bill 1414, Section 10.2(a))

STUDY ISSUES RELATED TO MENTALLY ILL RESIDENTS OF LONG-TERM CARE FACILITIES

SECTION 10.2.(a) 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 residents' 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.

(7) Identifying specific problems that exist due to mixing aging and mentally ill populations.

SECTION 10.2.(b) 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.

Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities

General Assembly of NC Session 2004
House Bill 1414 Section 10.2(a) & (b)

Prepared For: The North Carolina Study Commission on Aging
December 1, 2005.

Final Report and Recommendations

I. Summary of Recommendations

Over the past year, the NC Department of Health and Human Services has worked closely with a Study Group, comprised of long term care provider associations, advocacy organizations and state government staff, convened in response to the Special Provision at Section 10.2(a) & (b) of HB 1414. The following report represents the Department's effort to summarize the work of the Study Group and prioritize their recommendations to support ongoing efforts within the Department to improve both long term care services and support persons with mental illness with appropriate treatment and services.

The Department is making the following recommendations, discussed in detail within the report as indicated:

- Expansion of mental health specialty teams to provide training and technical assistance to long term care facilities. (page 12)
- Design and implementation of an automated screening, assessment and care planning system to be used prior to admission to long term care services.(page 13)
- Conducting a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness. (page 14)
- Strengthening training curriculums in all law enforcement training programs to improve law enforcement response in long term care settings. (page 15)
- Further evaluation of a number of statutes and rules to provide appropriate guidance to long term care facility operators according to the needs and characteristics of residents served.(page 10-11)

II. Introduction

On February 10, 2004, the North Carolina Study Commission on Aging heard presentations regarding people with mental illness who live in long-term care facilities.

The Commission considered many questions regarding this issue, including:

- Are adult care homes appropriate housing options for persons with mental illness?
- Is staffing and training at both nursing facilities and adult care homes adequate to meet the needs of diverse population groups?
- Do existing laws and rules provide the best guidance to those who operate these facilities?

- Does mixing younger people with mental illness with the frail elderly in adult care homes and nursing facilities compromise the health and safety of residents?

To address these issues, the Commission recommended that the General Assembly require the Department of Health and Human Services (DHHS) to work with long-term care providers and advocates to study these and other related issues.

During its 2004 session, the legislature approved House Bill 1414, which included the Special Provision at 10.2(b) directing the Department of Health and Human Services to convene a Study Group to provide recommendations on the following study areas:

1. Do current State statues and Departmental rules adequately address the populations served by long-term care facilities?
2. Would the development of separate licensure categories for adult care homes and nursing facilities improve care for the various populations served in those facilities?
3. Are adult care home rules easy to understand, attainable under current staffing patterns and include appropriate guidance to facility operators to best serve the needs of their residents?
4. Do these rules support residents' freedom of choice, as well as their autonomy, dignity, and independence?
5. What is the most effective way to identify mentally ill individuals that have mental health treatment needs?
6. Can the criteria for admission of mentally ill individuals to long-term care facilities be improved to ensure that the health and safety of all residents are safeguarded?
7. What changes need to be made to improve the quality of care for mentally ill individuals in adult care homes and nursing facilities? What is the potential cost associated with implementing these recommendations?
8. What specific problems exist as a result of mixing aging and mentally ill populations?

DHHS was also asked to include in this report how it defines "mentally ill" for purposes of this study.

For purposes of this study, the definition of mental illness is drawn directly from General Statute 122C-3(21):

> Mental illness means an illness which so lessens the capacity of the individual to use self control, judgment and discretion in the conduct of his affairs and social relations so as to make it necessary or advisable to be under treatment, care, supervision, guidance or control.

This is a functional definition that can include a broad spectrum of conditions including serious depression, schizophrenia, bipolar disorder and other psychiatric diagnoses where functioning can be improved or restored with appropriate medication and rehabilitative treatment. Dementia also meets this functional definition and is a progressive brain dysfunction that leads to a gradually increasing restriction of daily activities. The most well known type of dementia is Alzheimer's disease.

Developing the Study

NC DHHS Assistant Secretary for Long Term Care Jackie Sheppard convened the Study Group in December, 2004. The Study Group met for ten sessions and included representation of long term care provider associations, advocacy organizations and state government staff. A number of committees were formed to address particular study issues, some of which joined with existing DHHS committees to build on existing discussions and Department efforts. (See Attachment A: Study Group Members, Meetings and Subcommittees)

The Study Group reached agreement on statements of consensus (Attachment B: Consensus Statements) and presented a draft report to the Department in September 2005. The draft report included lengthy discussion of the issues and a number of recommendations.

This report represents the Department's effort to summarize the work of the Study Group and prioritize their recommendations to support ongoing efforts within the Department to improve both long term care services and support persons with mental illness with appropriate treatment and services.

III. Scope and Context of the Report

The issue of serving the mental health needs of long term care residents is not new and pre-dates the current re-design of the publicly funded MH/DD/SAS system. In fact, state agencies and long-term health care providers have been engaged in a discussion of how best to provide this care for a decade or more.

Long term care facilities as referenced in the Special Provision include adult care homes and nursing facilities. The two are designed to meet different needs and operate under different statutes and rules. A nursing facility provides care for persons who have ailments for which medical and nursing care is indicated, but are not sick enough to require general hospital care. Nursing care is their primary need, but they also require continuing medical supervision.

An adult care home is a facility which provides residential care for older adults or adults with disabilities whose principal need is a home with the shelter and personal care their age or disability requires. Medical care in an adult care home is usually occasional, incidental, and/or short term intermittent, but includes the supervised administration of medication.

While neither of these types of care is designed to provide for the mental health needs of their residents, many residents of both adult care homes and nursing homes have mental health issues.

While comparing results from different population studies is complicated by the difference in parameters and indicators used, a report commissioned by the Department in 2004 found that over 40% of the adult care home population carried an active diagnosis of mental illness.

(Adult Care Home Mental Health Needs Assessment Report of Findings, First Health, July 15, 2004).

A limited sample study of nursing facility residents done as part of the Adult Care Cost Modeling Report found a similar percentage, 41.8%, to have a psychiatric or mood disorder diagnosis (Myers and Stauffer 2003). Comprehensive national studies indicate that as high as 80% of nursing facility residents have diagnosable psychiatric disorders, with dementia being the most prevalent condition. (Mental Health Services in Nursing Homes: Models of Mental Health Services in Nursing Homes: A Review of the Literature Psychiatric Services, November 1, 2002)

When the locus of care for persons with mental illness first shifted from the large state hospitals to the community decades ago, there were few residential options available to persons with mental illness, and many adult care homes stepped forward to fill that gap, providing shelter for those who had none.

North Carolina's current mental health reform effort is designed to improve the state's capacity to meet the needs of persons with mental illness according to evidence based practices, but many with mental illnesses continue to live in long term care settings because there are not yet more appropriate alternatives available to them in their communities.

As a result, long term care facilities have been an unavoidable choice for many individuals with mental illness, despite the fact that these facilities are not designed to provide psychiatric treatment or the rehabilitative services to allow persons with mental illnesses, particularly younger adults, to achieve a greater measure of independence.

Members of the committee agreed that without a large investment of new resources into community-based services, people facing the challenge of mental illness are likely to continue to be served in adult care homes and nursing facilities.

The Department has taken steps in addressing some of the challenges posed by this issue. Since 2001, for example, the Department has been engaged in a Department-wide effort to improve the quality of long term care services as outlined in the Institute of Medicine's Long Term Care Plan for NC. While the resources to implement the full range of changes suggested by the report have not been available, the Department has implemented a number of the recommendations and other initiatives in an ongoing effort to improve long term care services for all residents.

The NC DHHS Division of Medical Assistance has also undertaken population studies to assess the needs, both physical and behavioral, of current long term care populations and is moving forward with an automated screening and assessment tool that will be used for Medicaid providers and recipients needing long term care services. Further information on this effort is included in Recommendation B.

In addition, the NC DHHS Division of MH/DD/SAS has funded 21 geriatric mental health specialty teams. These teams provide training and case consultation to adult care homes and nursing facilities to help staff understand and manage some of the challenging behaviors of older adults.

The Division is also piloting a specialized long term geriatric behavioral unit for nursing facility residents and a Special Care Unit in an adult care home. These pilots are designed to serve persons who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents. Expanding both of these initiatives are included in Recommendations A and C.

The NC DHHS Division of Aging and Adult Services is also involved in a wide variety of initiatives targeted at improving the long term care delivery system, including:

- Implementing the Aging and Disability Resource Center Grant to create a coordinated system of information and access for all persons seeking long-term support.
- Convening a multidisciplinary taskforce called SAFE-in-Long Term Care composed of individuals in the fields of law enforcement, long term care, advocacy and state government to raise awareness regarding appropriate responses to crimes occurring in long term care settings.
- Initiating the Quality Improvement Consultation Program for Adult Care Homes as directed by recently passed legislation "to promote better care and improve quality of life in a safe environment for residents in adult care homes through consultation and assistance with adult care home providers."

In addition, the Department has implemented North Carolina's response to the 1999 US Supreme Court's Olmstead decision by coordinating Department wide efforts to reduce reliance of institutional care by addressing a variety of system issues including transportation, strengthening the direct care work force and expanding the availability and improved access to affordable community housing.

IV. Summary of Study Group Discussions

The Study Group's discussions covered a gamut of issues and concerns raised in the Special Provision that can be captured under four themes:

- Health and safety
- Screening and disclosure
- Training of staff, and
- Services to residents with mental illness.

A. Health and Safety

While many persons with a diagnosis of mental illness reside in long term care settings without difficulties, others, because of the nature of their illness, inadequate treatment, or lack of expertise among facility staff, can exhibit behaviors that can impact other residents and/or pose a potential safety risk to staff and residents.

Licensed skilled nursing facilities in NC are well-equipped to care for the frail older adult, medically complex residents that they serve. Many of these residents have age-related dementia or Alzheimer's disease, and some have mental illness that is effectively managed.

However, industry representatives report that these facilities are increasingly struggling with safety issues related to a growing number of residents with challenging behaviors that have an impact on the safety of residents in the facilities.

In adult care homes some older adult residents and their significant others cite concerns about the safety and the vulnerability of other older adults due to reports of behavior problems such as verbal/physical/sexual abuse by some younger residents. The facilities, however, have found that the needed services and alternative placements to address these unexpected acute challenging behaviors are not widely available or accessible.

While there is currently no comprehensive information available as to the scope and breadth of these problems, the NC DHHS Long Term Care Ombudsman Program receives and investigates complaints made by or on behalf of long term care residents. The Ombudsman Program is an advocacy program, not a regulatory agency. In the course of their work, the program's staff have reviewed situations in which persons exhibit aggressive behaviors, engage in illicit drug use and/or alcohol abuse that negatively impact the health and safety of other residents. The Ombudsman staff also report concerns that the needs of persons with mental illness are not always being met. These reports include the inappropriate use of infringement of the patient rights as a behavior modification tool and even reports by some residents with mental illness that their health concerns are often disregarded and not reported to health professionals.

It was also noted that law enforcement must be called by the facility when the safety of residents or staff are in danger. Complaints received by the Ombudsman Program indicate law enforcement officials can be hesitant to arrest or detain residents who commit criminal acts. The law enforcement response is complicated by the need to carefully assess and differentiate between a criminal act and psychosis requiring treatment. (See Attachment C: 2005 Regional Program Survey by the Long Term Care Ombudsman Program)

B. Screening and Disclosure

Members of the Study Group agreed that a good screening mechanism is a critical component to appropriate placement but that current tools are either inadequate or not used appropriately. They agreed that while a framework for this approach is already established through assessment and care planning requirements, the critical component of screening persons for appropriate placement within a continuum of long-term care is missing. The Study Group felt that this is the area in greatest need of attention from a regulatory standpoint. Such a tool would allow for the adequate evaluation by the facility of the needs of the potential resident and the determination by the facility of its ability and resources to meet those needs.

The Study Group also felt that disclosure by facilities of what services can and cannot be provided and disclosure by referral sources of resident history, condition and needs are not adequately addressed in statute or rule. In addition, facilities report that some residents who were initially admitted were later found to have persistent behaviors that pose a potential threat to themselves or other residents. In many cases these individuals have not responded to interventions and services that are available to the facility, yet do not meet the statutory criteria for involuntary commitment to a psychiatric hospital.

1. Nursing facilities Currently, nursing facilities are subject to stringent Federal regulations related to Medicare and Medicaid. All nursing facility residents are subject to the Pre-admission Screening and Annual Resident Review regulations, commonly called the PASARR. The PASARR Program was established by Congress to ensure that every individual seeking admission to a Medicaid certified nursing facility (NF) is properly assessed to determine if he/she requires nursing facility care and if he/she has a major mental illness (MI), mental retardation (MR) or a related condition (RC) that requires specialized services.

Every new admission to a certified nursing facility, regardless of payment source, is subject to a Level I screening prior to admission, with the exception of individuals readmitted after treatment in a hospital unless there has been a significant change in status. After receiving the Level I screen, if individuals are suspected of having either mental illness or mental retardation or a related condition, a Level II evaluation must be completed with the recipient by a qualified professional to assess whether nursing facility services and specialized services are needed. Recommendations based on the Level II evaluations are forwarded to the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services for final determination of services and placement for the individual. All persons identified as MI or MR/RC by this process receive an annual resident review designed to assess their care needs or whenever there is a significant change in the resident's condition. It should be noted that PASARR does not include screening and evaluation for nursing facility residents who have dementia and who may have significant challenging behaviors.

The PASARR process is not without some flaws for persons with psychiatric illness, however, particularly in the admission screening process. For example, the PASARR by regulation excludes screening for dementia. Dementia and certain related challenging behaviors can pose immense concerns for Nursing facilities and the residents for whom they care. Also, at the time of the PASARR screening, behaviors may not always be evident. Current or long–term residents may develop dementia and related behavior issues that are not related to the primary reason for admission to the nursing facility. A limited number of nursing facilities have the ability to deal with ambulatory residents with more challenging behaviors, such as a person who roams and rummages in other resident rooms. Although this person is not violent, he/she is at risk of being injured by other residents who react strongly to having someone handling his/her possessions. Additionally, over time, a resident may develop a new psychiatric illness and /or develop behavior/symptoms related to another diagnosis. Facility operators also stated that often there is an inability to get appropriate services for these long-term residents who develop new psychiatric disorders, and once these problems manifest there are limited discharge/care and/or treatment opportunities available.

2. Adult Care Homes Similarly for persons entering an adult care home, the facility will review the FL2 (the current screening tool) and if the home feels it can meet the needs of the individual and has a vacancy the person is admitted. Study Group members agreed that in some instances the FL2 does not include all the information it could/should contain in order for the adult care home to make a sound admission decision. The home may decide to meet the potential resident before deciding whether they can meet the individual's needs, however, it may be days before the symptoms of the illness manifest. The home then cannot meet the needs of the resident, is not trained in handling those specific behaviors and/or has no place to refer the resident or get support. They have now accepted a resident with no viable options available for assistance. This resident may even be a danger to himself or others.

Additionally, as the resident "ages in place" exacerbation of old conditions may develop, as well as new conditions.

A program similar to PASARR for adult care homes is not currently available. Study Group members indicated that this inconsistency in systems has been used by referring agencies or doctors to by-pass the assurances required by nursing facilities, by placing the resident in an adult care home who only have exclusionary criteria rather than defined admission criteria. As a result, the adult care home has no way of knowing that a person should have received such a screening, and subsequently the resident may not receive services or needed support from trained staff. The true picture of resident needs may only come to light after they are placed and the challenging behaviors emerge.

C. Training of Staff

Typically, mental health crisis situations are unpredictable, although at times there is evidence of a person's escalating behaviors. Members of the Study Group were in agreement that presently there is not enough trained staff, particularly nursing assistants, personal care and medication aides, to care for residents with mental illness. Training is most important for monitoring behavior changes and responding with appropriate interventions when dealing with challenging behaviors exhibited by some residents with mental illness. An understanding of mental illness and how it impacts behavior can result in more effective interventions and prevention of crisis situations.

The current training requirements for direct care staff, including aides and supervisors, in adult care homes are focused primarily on personal care with little emphasis on training related to the additional skills that are needed to care for residents who also have cognitive impairment and/or mental illness. It was also noted that instructors, who provide the training that is currently required, usually do not have the experience and/or education that is directly related to the care of residents who have cognitive impairment and/or mental illness. Likewise, nursing facility direct care staff, while highly trained to manage clinical issues of facility residents, do not receive training specific to managing and de-escalating challenging behaviors.

Nursing assistants, personal care and medication aides in adult care homes often have not had the training needed for appropriate interaction with residents based on their particular mental illness, and specifically to administer and/or monitor the side effects of psychotropic medications. When there is a need for facility staff to be involved in implementing an appropriate behavior plans, this does not routinely occur because the plans are not developed and agreed upon with participation by the resident and approval by the attending physician or supervision of a qualified mental health professional.

D. Services to residents with mental illness

The Local Management Entities (LMEs) for the public mental health, developmental disabilities and substance abuse system of services have responsibility for access to the available services by providing screening, triage, and referral to appropriate provider agencies. LME's also have a responsibility to assure crisis services. These responsibilities include responding to the needs of their communities including the needs of residents in long

term care facilities. The types of mental health services that are often needed by some residents in long term care settings includes: evaluation and assessment of residents who are exhibiting behaviors that appear to be related to mental illness; development of person centered plans that include consideration of each individual's needs for a wide range of services or supports; and provision of ongoing treatment and rehabilitative services, and cooperation and support for others who are providing service and support for the individual.

The Study Group found that statute and rules related to both adult care homes and nursing facilities do not address coordination or linkages to these resources that would provide a more systematic and operational framework for meeting the needs of residents who require additional services.

Long term care providers report that greater involvement of mental health professionals is needed to do evaluations; to assist in the development of care plans; to provide treatment for some residents; and to provide consultation, training, and support for facility staff who are caring for residents with challenging behaviors related to cognitive impairment or mental illness. They also report that access to psychiatric consultation, evaluations, and treatment is difficult particularly if it is not provided on site and that the availability of gero-specialists, social workers, psychologists and psychiatrists is extremely limited.

Other concerns raised related to activities that are offered for older adults frequently do not meet the diverse needs of younger residents, and are often not an integral part of the personal care plan. It was also noted that there are not alternative residential options for providing stabilization of acute behavior that becomes problematic in the nursing facility or adult care home but does not meet the criteria for involuntary commitment to a psychiatric hospital.

Finally, the Study Group agreed that at the current time, the availability of mental health resources, the capacity to perform timely and thorough evaluations, development of person centered plans, and access to the broad array of services and supports needed for persons with mental illness varies greatly across the state. Poor coordination, unavailable transportation to rehabilitation activities, and few on-site mental health services were identified as additional barriers to assure the provision and coordination of needed services in many areas.

V. Rules and Statute Review

A. Discussion

Subcommittee members were asked to complete charts to gauge opinion on whether the statutes and rules adequately address the population served in adult care homes. The results collected served as a basis for discussion of the issues by a majority of subcommittee members and the Adult Care Home Mental Health Workgroup.

Statutes and rules governing adult care homes do not make direct references to the specific populations served such as persons with mental illness, those who are medically frail and those of advanced age. Addressing the needs of these populations is encompassed, in part at least, in the context of an array of care and services mandated by statute and promulgated in rule, and in the requirements for admission, assessment, care planning and training.

Addressing specific populations and their particular needs in law and rule has a number of pitfalls, not the least of which is the inevitable failure to take into account the wide range of persons being served and their wide range of needs. In addition, singling out one group of residents should not be done at the expense of another group who may have some of the same needs but also a number of other specialized needs as well. Rules would inevitably become more complex and extensive without necessarily promoting attention to the particular needs of individual residents. The primary concern should be one of adequately addressing needs of individuals rather than generically addressing populations.

Subcommittee members felt that well-designed screening, assessment and care planning instruments would better accomplish the intention of the current adult care admission rule:

> "Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted to an adult care home when, in the opinion of the resident, physician, family or social worker, and the administrator, the services and accommodations of the home will meet his particular needs." (Rules 10A NCAC 13F and 13G .0701 Admission of Residents.)

There was no clear indication from results of Subcommittee discussions that adult care home rules were not understandable and not supportive of residents' freedom or the autonomy, dignity and independence philosophy of assisted living. Based on the Adult Care Home Cost Modeling Report (December, 2004), current staffing patterns are insufficient to meet all the requirements in rule. Again, the Subcommittee felt that the combination of improved screening and disclosure would help assure appropriate admission of residents so that facilities are able to meet residents' needs, make residents and their responsible persons aware when residency in a facility will no longer be viable, and protect the health and safety of all residents in the home.

A number of rules and statutes were identified as needing further evaluation and attention in relation to providing appropriate guidance to facility operators according to needs and characteristics of residents served. These are listed in detail below:

B. Recommendations: NC General Statutes 131D and 131E

The Department of Health and Human Services recommends to the NC General Assembly the following:

1. Assure definitions of abuse, neglect and exploitation are consistent with definitions of these terms in other statutes that impact adult care homes or types of residents in these homes.(GS131D-2(a))
2. Qualify "provide services" as "services established by rule" to provide greater clarity and avoid the possible misconception that these facilities provide any and all services "to assure quality of life...." etc. Coordination of services provided by community resources needs to be addressed since facilities cannot be expected to

be providers of all services that may be needed. Additional funds would be needed to implement this coordination. (GS131D-4.1)

3. Evaluate current staffing requirements that are based on requiring specific amounts of staff time per resident in relation to a more "outcome" orientation to staffing which would focus greater attention on whether the needs of residents are being met rather than number of staff present. (GS131D-4.3)

4. Address coordination of services to take into account services needed that the facility cannot directly provide (see #2 above). (GS131D-4.4)

5. Establish a mandate for screening of potential adult care home residents. Additional funds would be necessary for the development and implementation of this screening.(GS131D-4.5)

6. Establish a mandate for:
   - full disclosure in writing by all facilities to residents and their responsible persons such as required of special care units in 131D-8; and
   - full disclosure of information about potential residents to the facility so that facilities are fully aware of the resident's history and care needs in order to make informed decisions about admitting residents. (GS131D-2)

The study group also discussed the possibility of suggesting that there be exceptions to a Resident's and Patient's Bill of Rights in situations where they may make implementation of specific behavior plans difficult. However, deleting any of these Rights would risk changing the nature and character of these facilities. Rights may now be restricted in accordance with approved plans of care. If the deletion of Rights are necessary in order to provide appropriate treatment to a particular individual in an adult care home or nursing home, that individual would likely be more appropriately placed in a licensed mental health facility.

C. Recommendations: Administrative Rules for Adult Care Homes of Seven or More Beds (10A NCAC 13F) and Family Care Homes (10A NCAC 13G)

The Department of Health and Human Services recommends that the NC Medical Care Commission:

1. Strengthen training on caring for residents with cognitive impairments and/or mental health needs. Training should include specific methods for de-escalation of challenging behaviors and the implementation of appropriate behavior plans for residents with challenging behaviors. Training by qualified instructors is critical to enabling staff to meet resident needs. Additional training of staff upon employment and on an annual basis needs to be considered. This would require additional funds for trainers and staff time for training, including staff coverage while staff is being trained. Any mandatory requirements for additional training should be conditioned upon the availability of necessary resources. The use of mental health specialty teams like the geriatric specialty teams should be explored. (10A NCAC 13F and 13G .0501-.0502: Personal Care Training)

2. Evaluate the feasibility of a more outcome-based orientation to staffing and explore outcome-based measures. Staffing ratios are not directly related to residents receiving appropriate care and services and reliance on this kind of staffing requirement may even have a negative impact on care. Greater attention should be given to assuring staffing to meet the needs of residents. Increased funds will be needed to increase staff time. Thorough screening, assessment and care planning processes are critical to the effectiveness of an outcome-oriented approach. (10A NCAC 13F .0604-.0605: Staffing)

3. Require that admission of residents be dependent on facility review and evaluation of the results of a pre-admission screening process and all other information regarding the resident's mental and physical condition, needs and history provided to the facility. (10A NCAC 13F and 13G .0701: Admission of Residents)

4. Require that the examination of a resident who has been an inpatient of a psychiatric facility within 12 months prior to admission and does not have a current plan for psychiatric care be examined by a mental health professional. The allowance of 30 days for the examination should be considered for possible reduction. (10A NCAC 13F .0703(e) and 13G .0702(e):TB Test and Medical Examination)

5. Include requirements regarding facility disclosure to residents and responsible persons here or in a separate rule. (10A NCAC 13F and 13G .0704:Resident Contract)

VI. Recommendations for improving the quality of care for persons with mental illness in long term care facilities

A. The Department of Health and Human Services recommends the expansion of mental health specialty teams to provide training and technical assistance to long term care facilities.

The Department and the Study Group believe that the quality of care for persons with mental illness in long term care facilities can be supported and improved by making it possible for facility staff to have access to training, technical assistance, case consultation, and assistance with referrals to mental health treatment services. A geriatric mental health specialty team model has been a successful strategy to address needs of both long term care staff and residents with mental illness. However, current funding has been made available to fund only 21 such teams and the staffing qualifications and focus of these teams are on the specific needs and issues of older (age 60 and over) long term care residents. The current small number of these teams makes it impossible for them to meet the needs of all long-term care facilities for this kind of consultation and training.

Mental health specialty team staff with the training, experience, and skills would be needed to help long term care staff address the challenging behaviors of younger residents in long term care are also needed. For example, 5,867 or 24% of all adult care home residents are under

the age of 65, However 3,117 or 62% of adult care home residents under age 65 have a mental health diagnosis.[1]

In order to increase the availability of mental health specialty teams to address behavioral issues presented by long term care residents of all ages, proposed initial steps are:

1. To add 12 additional geriatric mental health specialty staff to existing teams. These staff would supplement the capacity of current teams that are serving areas with large number of long term care facilities. These staff will be qualified mental health professionals who have experience working with older adults with mental illness. These staff will focus on training, consultation and support to facilities for residents 60 and older who may present behavioral challenges that are related to dementia or other mental health diagnoses. The cost per staff is approximately $65,000 per year for staff, travel, and training materials.

2. To add 25 qualified mental health specialty staff that are mental health clinicians who have training and experience about the needs of younger individuals who have major mental illness some of whom may exhibit behaviors that are not consistent with the expectations of staff and other residents in long term care settings. These staff will focus on training, consultation and support to facilities for residents under the age of 60 years old. The cost of one person would be approximately $65,000 per year for staff, travel, and training materials.

Currently the cost of a two person Geriatric Mental Health Specialty Team is $130,000 per year or $65,000 to cover the costs of each team member. This includes staff salaries and benefits, transportation/travel costs associated with travel to long term care facilities throughout the geographic area served, and a small amount of money for training materials and supplies used when providing training to long term care facility staff.

The cost of implementing this recommendation to fund a total of 37 additional team members would be approximately $2,405,000 per year. Additional background information, data about the number, type and location of long term care facilities that was used to develop the proposed action steps is included in Attachment E.

B. The Department of Health and Human Services requests support of the design and implementation of an automated screening system to be used prior to admission to a nursing facility, adult care home, or other home and community based services; and the design and implementation of an automated assessment and care planning system to be used once the setting of care is determined.

The Department is currently working on an integrated, web-based system that will streamline the screening and assessment processes for Medicaid providers and recipients needing long term care services. The overall design of the new system will include among other things, the capacity to identify persons with mental illness, substance abuse and/or mental retardation prior to admission to a nursing facility, an adult care home or before receiving other home and community services. The Division of Medical Assistance will work with the

[1] 2005 Adult care home population census information from the NC Division of Facility Services

Division of MH/DD/SAS to see that the design complements the diagnostic assessment process underway for persons who meet the DMH/DD/SA target population criteria.

The new process will meet the requirements of the federally mandated Pre-Admission and Annual Resident Review (PASARR) program. If the mental health portion of the screening identifies the need for a more thorough mental health evaluation, then a qualified mental health professional should perform the evaluation and determine needed mental health services or supports. Overall, the new automated screening and assessment system should promote one's independence, self-management of health, and be formed around person-centered planning concepts.

The detailed work plan for the integrated access and management system for Medicaid will be available December 2005. The estimated resources required to implement the system will be determined through a formal bid process, but it is estimated to cost $1 million for design and development and $2.3 million for annual operating costs. At this time it is anticipated that current expenditures will be redirected to support this system. The need for additional resources, primarily for ongoing operations and training to implement the new system are estimated at $248,000 per year.

C. The Department of Health and Human Services requests $620,000 for a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness.

The Department believes that there is a need to increase choice and treatment options for people with mental illness of all ages, particularly those who would benefit from more than the residential care and personal assistance than adult care homes are designed and funded to provide - and those with both medical and behavioral issues that nursing facilities are not equipped to manage. Improved screening and background disclosure of residents will inevitably result in persons being found inappropriate for either adult care or a nursing facility. Without alternative settings to meet these needs the state will remain dependent upon more costly care in the State psychiatric hospitals.

At this time the Department does not support creating a separate licensure category for adult care homes that serve persons with mental illness. On October 1, 2005 the General Assembly ratified SB 572 - An Act To Create A Licensure Category For Assisted Living Communities That Serve Only Frail Older Adults (see Attachment D). Assisted Living Communities that wish to serve only the frail elder population are now able to acquire a license that designates them as communities that serve only the frail elder population. While facilities wishing to serve only a population of persons with mental illness do not have that option as either an adult care home or nursing facility, they can apply for license as a mental health facility.

The Department believes that attention and resources must be devoted to creating a range of housing and treatment options that meet the needs of persons with mental illness that are consistent with evidenced based treatments. As a first step, a study should be undertaken to quantify the need, in terms of projected numbers to be served and the types and designs of alternative residential and treatment settings. The scope of this study would include a review of models used in other states, applicable Federal and State policies and regulations,

potential funding sources, and development of cost estimates to develop a continuum of residential services, including, but not limited to:

- Community based residential options for providing stabilization of acute behavior that does not meet the criteria for involuntary commitment to a psychiatric hospital, including facilities that can provide both the nursing care and the psychiatric stabilization and treatment that are needed before return to a nursing facility is considered, as well as facilities that can provide both the personal care and psychiatric stabilization and treatment that are needed before return to an adult-care home is considered.
- Long term acute care hospitals specializing in the care of older people who have both medical and acute behavioral or psychiatric care needs or "swing beds" designed specifically for people with nursing care needs and acute behavioral or psychiatric care needs. The average length of stay of a long-term acute hospital is approximately 28 days. This length of stay would lend itself to the observation, stabilization, and intervention time necessary to return the older adult to the nursing facility
- Specialized long term geriatric behavioral units for nursing facility residents who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents. A single pilot of this model has recently begun operations.
- Specialized long term geriatric behavioral units for adult-care home residents who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents, including a review of the current ACH- 12 bed special MH unit rules (10A NCAC 13F Section .1400) to determine if there needs to be any changes in staffing requirements and other areas
- Community based supportive housing, housing with supportive services, for adults with mental illness in their communities.

D. The Department of Health and Human Services supports strengthening training curriculums in all law enforcement training programs to improve law enforcement response in long term care settings.

The Department will work with key officials in the Training and Standards Division of the Department of Justice in order to promote the use of N.C. Intervention Training and to facilitate the development of new mental health training curricula for law enforcement officers. The new curriculum should include identification of major mental illnesses, action steps for crisis response by law enforcement officers and alternatives to involuntary commitments. Officers at every level should be afforded access to available and newly developed training modules addressing their response to individuals with mental illness.

With appropriate and adequate training, law enforcement officers can develop skills to address the safety issues confronting staff and residents while de-escalating the situation. This training is highly encouraged for "first responders." Facilities are encouraged to have a "crisis plan" in place in order to avoid unnecessary demands on emergency hospital resources.

These efforts will build upon the Division of Aging and Adult Services' multidisciplinary taskforce called SAFE-in-Long Term Care. S.A.F.E. is an acronym that stands for Strategic Alliances For Elders in Long Term Care. SAFE is composed of individuals in the fields of law

enforcement, long term care, advocacy and state government. This taskforce was convened to raise awareness regarding appropriate responses to crimes occurring in long term care settings and ensuring that justice is served. SAFE seeks to eliminate this lack of knowledge and awareness about these crimes by providing education and training to the general public and especially those professionals who have an obligation to protect society's most vulnerable from harm.

VII. Attachments

A Study Group Members, Meetings and Subcommittees
B Consensus Statements
C 2005 Regional Program Survey by the Long Term Care Ombudsman Program
D Session Law 2005-66
E Detail for Expanding Mental Health Specialty Teams in LTC settings

Attachment A: Study Group Members, Meetings and Subcommittees

The following persons and agencies were active participants in the Study Group on Long-Term Care Facilities Serving Persons with Mental Illness

Name	Organization
Dr. Ann Louise Barrick	John Umstead Hospital
Doug Barrick	Division of Facility Services
Mary Bethel	Division of Aging and Adult Services
Julia Bick	Office of the Secretary
Debbie Brantley	Division of Aging and Adult Services
Julie Budzinski	Division of Medical Assistance
Sally Cameron	NC Psychological Association and Coalition for Persons Disabled by Mental Illness
Laura Clark, Ph. D.	John Umstead Hospital
Carol Duncan Clayton	NC Council of Community Programs
Jerry Cooper	NC Assisted Living Association
Michiele Elliott	Division of Facility Services / Adult Care
Bob Fitzgerald	Division of Facility Services
Stacy Flannery	NC Health Care Facilities Association
Karen McLeod	County DSS Directors Association
Karen Gottovi	Division of Aging and Adult Services
Dick Hatch	NC Coalition on Aging
Robin Huffman	NC Psychiatric Association
Ann Johnson	Governor's Advisory Council on Aging
Pam Kilpatrick	Dept. of Health and Human Services
Kathryn Lanier	Division of Aging and Adult Services
Bonnie Morell	Division of MH/DD/SAS
Jill Passmore	Friends of Residents in Long-Term Care
Lynne Perrin	Division of Medical Assistance
Gwen Phillips	Adult Foster Care Association
Barbara Ryan	Division of Facility Services
Kim Schmidt	NC Mental Health Consumers Organization
Jackie Sheppard	Dept. of Health and Human Services
Benjamin Staples	NAMI - NC
Sam Teruel-Velez	Division of Vocational Rehabilitation
Sandra Trivett	Office of Policy and Planning
Polly Welsh	NC Health Care Facilities Association
Sharon Wilder	Division of Aging – State LTC Ombudsman
Belinda Wilson	NC Association of Long Term Care
Lou Wilson	NC Association of Long Term Care
Maggie McGlynn	Facilitation provided by McGlynn Associates, Inc.

The Study Group met on the following dates for 2-4 hours each:

December 16, 2004	June 27, 2005
January 24, 2005	July 25, 2005
February 28th, 2005	August 22, 2005
March 28, 2005	September 12, 2005
May 25, 2005	September 26, 2005

The following Committees were formed or members joined in existing committees to review specific areas. Group members and meeting dates are also shown.

Committee	***Meeting Date(s)***
Guiding Principles *Sally Cameron, Julia Bick, Jill Passmore, Polly Welsh, Belinda Wilson, Lou Wilson, Bonnie Morrell, Barbara Ryan, Michielle Elliott, Ann-Louise Barrick, Robin Huffman, Carolyn Duncan Clayton, Laura Clark*	4/14 and 5/12 2005 as well as e-mails
Mixed Population *Jill Passmore, Gwen Phillips, Sharon Wilder, Karen McLeod, Belinda Wilson, Lou Wilson, Sally Cameron, Ann Louis Barrick, Laura Clark, Julia Bick, Carol Duncan Clayton, Michiele Elliott, Robin Huffman and Sam Teruel-Velez.*	Work done via e-mail and phone calls.
Assessment Workgroup and Admissions/Prescreening *Lynne Perrin, Lou Wilson, Jerry Cooper, Bonnie Morell, Julie Budzinski, Robin Huffman, Ann Louise Barrick, Laura Clark, Belinda Wilson, Benjamin Staples, Stacy Flannery, and Sandra Trivett. Others included: Kevin Gwynn, Scott Little, Kathie Smith, , Carol Duncan Clayton, Jean Reaves, Sandy Gegax, Leslie Meilhon, Geoff Santoloquido, Nancy Warren, Kathryn Lanier, Charles Williams, Suzanne Merrill, Ellen Walls, Libby Kinsey, Bruce Habeck, Vicki Hewitt, Pat Jeter, Carolyn Wiser and Carol Robertson.*	12/29 2004 and 1/6, 2/24, 3/3, 4/5, 4/15, 4/18, 5/5, 6/9, 8/15 and 8/16 2005 as well as e-mails
Rules and Statutes *Barbara Ryan, Sally Cameron, Doug Barrick, Lou Wilson, Carol Duncan Clayton, Julie Budzinski, Julia Bick, Sharon Wilder and existing members*	6/6 2005 as well as e-mails
Nursing facilities *Bonnie Morell, Stacy Flannery, Polly Welsh, Lynne Perrin, Julie Budzinski, Margaret Comin, Benjamin Staples and Carol Robertson.*	8/9 2005 as well as e-mails

Attachment B: CONSENSUS STATEMENTS

Both long- and short-term strategies need to be developed to address the range of issues raised by the study bill.

This subject is not an either/or situation in terms of the residential settings – all settings are viable.

There is a current situation that must be addressed with resources and attention to improve quality of life for persons with mental illness in adult care homes.

Attention and direct resources must be devoted to creating a range of residential options for persons with mental illness in the community.

People who are mentally ill should be treated as they would if they lived in any other setting. They should:

- make their own choices with regard to living arrangements
- receive the services and supports they need to live successfully in the setting of their choice

Prior to placement in any community setting, an initial screening would be done to promote health and safety.

There would be an evaluation of those presently living in community residential settings.

There is a need to quantify the actual capacity and the desired capacity for the continuum of care as a part of moving the system forward.

Attachment C

Regional Program Survey by the Long Term Care Ombudsman Program:
Data compilation for 2003 and 2004 investigated complaints related to residents diagnosed with mental illness.

Jan-05

Adult Care Home Residents	**2003**	**2004**
Total Clients under 60	186	229
Total Clients with hx MI, MR, SA	165	199
Total Clients with Criminal hx	14	21
No. Complaints from family, residents, legal rep.		
Violent Behaviors /assaults in facility	27	40
Threatening(verbal or physical) behaviors toward staff/residents	31	53
Inappropriate Sexual Behaviors	9	23
Not receiving mental health services	14	25
Not receiving medications as ordered/timely	53	44
Not taking medications ordered	24	22
Inappropriate transfers or discharges	54	67
Elopements/wandering	8	8
Inappropriate attempts to commit resident	6	11
Criminal activities within or without facility	28	26
Complaints from providers		
Violent Behaviors /assaults in facility	34	
Threatening(verbal or physical) behaviors toward staff/residents	25	56
Inappropriate Sexual Behaviors	11	18
Not receiving mental health services	13	30
Not receiving medications as ordered/timely	7	13
Not taking medications ordered	21	32
Inappropriate transfers or discharges	6	23
Elopements/wandering	10	7
Inappropriate attempts to commit resident	3	10
Criminal activities within or without facility	1	0
Client/caller referrals		
Local Mental Health Agency	103	100
Governors Advocacy Council for Persons w/Disabilities	55	44
ARC of N. C.	6	8
DFS/DSS	1831	1231
Mental Health Geriatric Teams	8	23
State Mental Health Consumer Advocate	2	1

Attachment C

Technical Assistance Provided

Technical Assistance provided: facility staff	271	251
Technical Assistance provided: residents/families	795	777
Support Sessions for Residents' Councils re: MI,MR,SA	26	29
Specialized Training: Facility Staff	55	62
Specialized Training: Community Groups	22	20
Systemic Advocacy Hours	997	1135

Top Four Advocacy Issues:

Threatening(verbal or physical) behaviors toward staff/residents
Transfers/Discharges
Staff Training and Education
Appropriate Mental Health Services

Attachment D

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005 SESSION LAW 2005-66 SENATE BILL 572

AN ACT to create a licensure category for assisted living communities that serve only elderly adults.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2(a)(1d) reads as rewritten:

"' 131D-2. Licensing of adult care homes for the aged and disabled.

(a) The following definitions will apply in the interpretation of this section:

1d) "Assisted living residence" means any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice agencies. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living residences are to be distinguished from nursing homes subject to provisions of G.S. 131E-102. Effective ~~October 1, 1995,~~ October 1, 2005, there are two types of assisted living residences: adult care homes and ~~group homes for developmentally disabled adults.~~ adult care homes that serve only elderly persons. As used in this section, "elderly person" means:

a. Any person who has attained the age of 55 years or older and requires assistance with activities of daily living, housing, and services, or

b. Any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia who requires assistance with activities of daily living, housing, and services provided by a licensed Alzheimer's and dementia care unit.

Effective July 1, 1996, there is a third type, multiunit assisted housing with services."

SECTION 2. The Medical Care Commission shall adopt rules to implement this act.

SECTION 3. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 18th day of May, 2005.

Attachment E

Detail for Expanding Mental Health Specialty Teams in LTC settings

Background regarding Geriatric Mental Health Specialty Teams

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 has allocated State and Mental Health Block Grant funding to support 21 community-based Geriatric Mental Health Specialty Teams. Nine of the teams serve multiple mh/dd/sa catchment areas. These teams are available to provide support, training, and consultation to long term care facilities and other organizations throughout the State.

Geriatric Mental Health Specialty 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:

- providing holistic support services and technical assistance to nursing homes, adult care homes, caregivers and other agencies that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization, and
- assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals; and

This is to be accomplished by providing support, training and consultation to the staff serving the identified individuals and developing linkages with community providers serving older individuals.

Each team consists of a registered nurse and a masters prepared therapist. The teams operate on an itinerant basis and thus provide the majority of services to the staff 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.

Geriatric Mental Health Specialty Team Focus on Older Adults [1]

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;

[1] Individuals younger than 60 years of age may be served if their needs require the expertise of a geriatric specialist.

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.

Geriatric Mental Health Specialty Team Activities

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:

- train facility staff, caregivers and other agencies on topics such as recognizing symptoms of mental illness, behavioral interventions, communication issues, and medication issues;
- provide resource information and identify ongoing training resources for staff and caregivers;
- provide individual case consultation to staff of long term care facilities or caregiver regarding behaviors that may result in hospitalization or a need for more intensive services;
- provide consultative support to staff or caregiver in the transition of individuals from a State hospital to a long term care facility or other community setting;
- provide consultation to staff or caregiver in identifying and addressing issues that may threaten successful community placement;
- provide training to staff or caregiver on the development and implementation of intervention plans as needed;
- establish linkages with community providers serving the geriatric population for the purpose of increasing community opportunities for the gero-psychiatric population;
- 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; and
- provide crisis-oriented support, either face-to-face or via telephone to the agency staff or caregiver during normal business hours.

Need for Increased Capacity.

The number of Geriatric Mental Health Specialty Teams needs to be increased. Mental Health Specialty Teams are also needed to provide training and technical assistance to Long Term Care facilities regarding younger residents.

There are a total of 87,147 licensed long term care beds in 1,672 facilities that are licensed as either family care homes, adult care homes, or nursing facilities.[2] Table I below shows the distribution by type of facility.

Table I. Number of Long Term Care Facilities and Number of Beds

Type of Long Term Care Facilities	# of Facilities	# of Beds	Location
Family Care Homes	644	3,633	In 77 of 100 counties
Adult Care Homes	636	35,955	In 91 of 100 counties
Adult Care Home beds in Nursing Facilities		5,248	Co-located with some nursing facilities
Nursing Facilities	392	42,311	In 98 of 100 counties
	1,672	87,147	

Currently 18,964 (76%) residents of Adult Care Homes are 65 or older and 5,867 (24 %) residents are 64 or younger based on the 2005 facility population census. The age distribution in Family Care is composed of 961 (37%) residents who are 65 or older and 1,617 (63%) who are 64 or younger. Tables II and III [3] below show the age distribution in these two types of facilities by age and disability groups.

Residents in nursing facilities are predominantly older adults who have medical problems and many of whom have Alzheimer's disease or dementia. However some of the younger nursing facility residents may also exhibit behaviors that require mental health consultations.

Table II. Adult Care Home 2005 License Renewal Data

Age	*Total residents*	% of total in age group	*# with mental illness*	% of age group	*# with MR/DD*	% of age group	*# with Alz/Dem*	% of age group Alz/Dem
18-24	101	0%	59	58%	28	28%	1	1%
25-34	392	2%	252	64%	75	19%	4	1%
35-49	1,857	7%	1,168	63%	307	17%	55	3%
50-64	3,517	14%	1,638	47%	567	16%	397	11%
65-74	3,721	15%	950	26%	326	9%	1,048	28%
75-84	7,435	30%	652	9%	166	2%	3,200	43%
85+	7,808	31%	287	4%	79	1%	3,381	43%
Total	24,831		5,006		1,548		8,086	

[2] North Carolina Division of Facility Services: Licensed Facilities as of 10/31/0533
[3] North Carolina Division of Facility Services: Data from 2005 License Renewals

Table III. Family Care Homes 2005 License Renewal Data

Age	*Total residents*	% of total age group	*# with mental illness*	% of age group	*# with MR/DD*	% of age group	*# with Alz/Dem*	% of age group Alz/Dem
18-24	58	2%	36	62%	22	38%	0	0%
25-34	172	7%	87	51%	53	31%	0	0%
35-49	659	26%	434	66%	144	22%	6	1%
50-64	728	28%	381	52%	166	23%	30	4%
65-74	392	15%	141	36%	66	17%	43	11%
75-84	333	13%	52	16%	26	8%	122	37%
85+	236	9%	14	6%	9	4%	104	44%
Total	2,578		1,145		486		305	

Given the large number of long term care residents and facilities, 12 additional geriatric mental health specialty staff and 25 qualified mental health specialty staff to provide training and consultation should be added to existing teams in order to have at least one team member per approximately 25 long term care facilities.

Currently the cost of a two person Geriatric Mental Health Specialty Team is $130,000 per year or $65,000 to cover the costs of each team member. This includes staff salaries and benefits, transportation/travel costs associated with travel to long term care facilities throughout the geographic area served, and a small amount of money for training materials and supplies used when providing training to long term care facility staff.

The cost of implementing this recommendation to fund a total of 37 additional team members would be approximately $2,405,000 per year.

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — 2-1-06

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Edwards	DAAS
Sandra Truett	DHHS / Pol. & Planning
Geoff Sanzaiquido	DAAS
Dennis Streets	DAAS
Mary Bather	AARP-NC
Yoko Crume	DAAS
Jean Reaves	NCADSA NCCOA
Polly Williams	NC Justice Center / Triangle OWL
Lynn Bonner	NAO
DAVID BARNE	Pognant Spill
Abby C. Emanuelson	NMSS

VISITOR REGISTRATION SHEET

NC Study Commission on Aging 2-1-06

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jack Cozort	NC AHHC
Karen Gottovi	NC Div. Aging & Adult Svcs
[illegible]	[illegible]
[illegible]	NCARTCF
Richard Hatch	AARP/NCCOA
Wayne Williams	OSBM
Kari Bargess	OSBM
Sally Cameron	NC [illegible]
Charlene Carey	NC Right to Life
[illegible]	Raleigh [illegible]
Jerry Cooper	NCALA

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — 2-1-06

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Emily H. Saunders	NC Division of Facility Services
Julia Bick	NC DHHS - Office of the Secretary
Jim Rose	Assoc. for Home Care + Hospice
Sherry Thomas	" " " "
Jim Edgerton	" " " "
Kathryn Lanier	NC Div of Aging & Adult Services
Sharon Walker	NC Div of Aging + Adult Services
Bonnie Morell	NC Div of Aging [illegible]
Julie Budzynski	Div. Medical Asst.
Tracy Colvard	" "
Lea P. Slaton	DAAS

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — 2/1/06

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tom Taaffe	RMBHS

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

February 3, 2006

MEMORANDUM

TO: Members - NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the **NC Study Commission on Aging:**

DAY: **Wednesday** **TIME: 10:00 A.M.**

DATE: **February 15, 2006**

LOCATION: **Room 643**
Legislative Office Building

Please advise Dee Hodge, Commission Assistant, at (919) 733-5955 or email dannellyla@ncleg.net if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, February 15, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions
Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. NC NOVA (New Organizational Vision Award)
Susan Harmuth, NC NOVA Project Coordinator

III. Update on Criminal Record Background Checks for LTC
Melynda Swindells and Kathy Shepherd, Division of Child Development, DHHS

IV. Housing for Older Adults
Andrea Russo

V. Pain Management in Older Adults
Laura Hanson, MD, Division of Geriatrics, UNC

VI Upcoming Meeting/Public Hearings:

Public Hearings

- **February 21, 2006 from 10:30 a.m. – 12:30 p.m.**
  Martin Community College, Williamston, NC
- **February 28, 2006 from 10:30 a.m. – 12:30 p.m.**
  The Foundation at Isothermal Community College, Spindale, NC

Meeting

March 15, 2006 at 10:00 a.m. in Room 643

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES
FEBRUARY 15, 2006
10:00 AM
ROOM 415

Representative Beverly Earle called the meeting to order at 10:10 am. No remarks were give by Senator Charlie Dannelly, Co-Chair. The following members were present:

Representative Beverly Earle, Chair
Representative Alice Bordsen
Representative Bob England
Representative Jennifer Weiss
Brad Allen
Sam Marsh

Four Senators were present.

Following the agenda, the first presenter was Ms. Susan Harmuth, NC NOVA Project Coordinator. **North Carolina New Organizational Vision Award**. Direct Care jobs are among the fastest growing jobs in NC. It is also among the occupations with the largest job growth between 2004 and 2014. She stated that direct care workers have many names but several most commonly used job titles are nurse aides, in-home aides/home health aides and personal care aides and attendants. North Carolina's role is to develop special licensure program to integrate policy and practice.

Providers need a reliable supply of quality direct care workers to meet current and future demand for long-term care and the relationship between worker and care recipient is key to consumers. NOVA is in direct partnership with:

- ✓ **NC Assisted Living Association**
- ✓ **NC Association of Non-Profit Homes for the Aging**
- ✓ **NC Friends of Residents in Long-Term Care**
- ✓ **NC Health Care Facilities Association**
- ✓ **NC Dept of Health and Human Services**
- ✓ **NC Institute on Aging, UNC-Chapel Hill**
- ✓ **NC Foundation for Advanced Health Programs**

North Carolina has high turnover of direct care workers with average annual rates in 2004. NC NOVA expectations and criteria address workplace factors shown to have an impact on direct care workforce turnover. The expected benefit to workers is to improve workplace environment, job skills and job satisfaction, opportunities for personal and professional growth and improved staff relationships and communication. (See Attachment II and III)

Update on Criminal Record Background Checks for LTC

Presenters: Melynda Swindells and Kathy Shepherd, Division of Child Development, DHHS. The department hired new employees to begin the new program. They explained the turn around time from the old system to the new one. It went from a turn around time from 2 to 3 months to 7 days. From 30 days to 12 days. 80% of the criminal checks come back with no records. 20% had hits on a national level. They also hire 62% with a record. Checks are done by fingerprints.

Andrea Russo, Research Division presented to the commission an update on **Housing For the Older Adults**. Some of the members wanted to know what is considered affordable housing. Affordable housing is housing that cost no more that 30% of a household's monthly income and people are generally referring to housing affordable to low-income households. They are many different agencies that provide affordable housing. Housing and home improvement assist older adults with obtaining or retaining adequate housing and basic furnishings. They are funded through the Home and Community Care Block Grant. There are an estimated 4,000 elderly households assisted by state agencies with comprehensive rehabilitation or repairs/modifications/weatherization in a year. About 800 elderly apartments financed in a year. The commission asked questions.

Pain Management in Older Adults

Laura Hanson, MD, Division of Geriatrics, UNC

Dr. Hanson began by explaining the definition of Pain. Pain is and unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is what the person in pain says it is. Suffering is pain experience modified by psychological adaptations, experience of other physical symptoms, and broader spiritual or social concerns. The objective is to discuss pain prevalence in geriatric populations, to discuss unique barriers to pain treatment for older patients and to discuss strategies to support access to pain management. The commission members asked questions.

Representative Earle informed the commission members of the up coming public hearings:

February 21, 200 form 10:30 am to 12:30 pm in Martin Community College, Williamston, North Carolina.

February 28, 2006 from 10:30 am – 12:30 pm at The Foundation at Isothermal Community College, Spindale, North Carolina.

The meeting was adjourned.

Representative Beverly Earle, Presiding Chair
Senator Charlie Dannelly, Chair

Ann Raeford, Commission Assistant

Attachments

Attachment I	Agenda
Attachment II	NC NOVA
Attachment III	Housing Options for Seniors
Attachment IV	NC Housing Finance Agency
Attachment V	Community Assistance
Attachment VI	Pain Management for Geriatric Patients
Attachment VII	Visitors Registration

Housing Options for Seniors

Fiscal Research Division
North Carolina General Assembly
February 15, 2006

Why are we talking about housing?

- Safe, affordable housing was mentioned as an issue facing older adults by organizations representing older adults at the Aging Study Commission Meeting on Nov. 16, 2005.
- According to HUD's special tabulations of 2000 Census data:
  - 41% of elderly renter households had a housing problem
    - 40% were cost-burdened
    - 20% were severely cost-burdened
  - 23% of elderly home-owning households had a housing problem
    - 22.5% were cost burdened
    - 10% were severely cost-burdened
  - It is important to note that this data does not capture housing condition problems very well.

What is affordable housing?

- Housing that costs no more than 30% of a household's monthly income.
- Affordable housing means different things to different households.
- Affordable doesn't necessarily mean "safe".
- What was once affordable may not continue to be as a person ages.
- When "affordable housing" is mentioned, people are generally referring to housing affordable to low-income households.
- This still presents a wide range of what is "affordable".
  - A person on SSI can't afford more than $170 per month for housing costs, while someone at the upper end of what is considered low-income could afford almost $1,000 per month.

Who provides affordable housing?

- Private market
- Housing authorities
- Nonprofit developers
- For-profit developers
- Local government
- **State government**
- Federal government

What housing services does government provide?

- Rental housing
  - Financing for new apartment complexes
  - Vouchers to rent existing apartments
  - Funding to rehabilitate older apartments
- Owner-occupied housing
  - First-time homebuyer programs
  - Funding for rehabilitation,
  - Funding for weatherization, urgent repair, home modification

NC State Agencies Working on Housing for the Elderly

- DHHS, Office of Economic Opportunity (OEO)
- DHHS, Division of Aging and Adult Services (DAAS)
- Dept. of Commerce, Division of Community Assistance (DCA)
- N.C. Housing Finance Agency (NCHFA)

Office of Economic Opportunity

North Carolina Weatherization Assistance Program

- Helps low-income citizens save energy and reduce expenses through the installation of energy conservation materials, the implementation of energy efficiency measures in their homes, and energy education.
- Funds provided through the U.S. Dept. of Energy, the federal Low Income Home Energy Assistance Program, and Petroleum Violation Escrow funds.
- Funds are subgranted to community organizations.

Heating and Air Repair and Replacement Program (HARRP)

- Works in concert with Weatherization program to repair and/or replace inefficient heating and air systems
- Funds provided through the Low Income Home Energy Assistance Program

OEO (cont.)

- In SFY 04-05, 1,869 elderly households received assistance through the Weatherization Assistance Program.
  - Of those elderly households, 661 also received assistance through HARRP
- The average cost of assistance was:
  - $2,447 for Weatherization
  - $1,753 for HARRP

Division of Aging and Adult Services

Housing and Home Improvement

- Assists older adults with obtaining or retaining adequate housing and basic furnishings. Types of assistance include:
  - providing information housing options;
  - helping to improve landlord/tenant relations;
  - identifying substandard housing;
  - securing correction of housing code violations;
  - assisting with finding and relocating to alternative housing;
  - 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.
- Funded through the Home and Community Care Block Grant

DAAS (cont.)

- In SFY 04-05, 1,226 seniors were served with $965,573 in HCCBG funding.
- 36 counties chose to use their HCCBG funding for this activity.
- In those counties, 719 people are on waiting lists.

Dept. of Commerce, Div. of Community Assistance (DCA)

- DCA receives their funding for housing programs from the federal Community Development Block Grant program (CDBG) administered by HUD
- 3 of their CDBG-funded programs served elderly households in 2004.

DCA (cont.)

1. **Concentrated Needs**: funds local governments to strengthen neighborhoods through improvements, preservation, or development.
2. **Scattered Site Housing**: grants to county governments on a rotating basis to address the most critical housing needs of very low-income families throughout the county. Funds are for rehabilitation or relocation.
3. **Infrastructure Hook-Up Program**: enables eligible local governments with existing public water and/or sewer lines to "hook-up" low and moderate income households to non-CDBG funded lines.

DCA (cont.)

- In 2004, 385 elderly households were assisted by these programs with $13,550,040.

NC Housing Finance Agency

Urgent Repair Program

- Provides grants for emergency home repairs for elderly homeowners and other homeowners with special needs (with income restrictions).
- Funds may also be used for accessibility modifications
- NCHFA awards funds to nonprofit organizations, local governments, and regional councils for this program.
- Program is financed through the NC Housing Trust Fund and other agency resources.

NCHFA (cont.)

Urgent Repair Program (cont.)

- In 2005, 542 elderly homeowners received assistance through this program.
- A total of $1,171,812 in state Housing Trust Fund financing was used to provide these services ($336,592 in other Agency resources was also used).
- Average cost of $3,359 per household.

NCHFA (cont.)

Urgent Repair Program (cont.)

- In the recent 2006 cycle, the Agency awarded $2,120,000 in funds to nonprofits and local governments to provide repairs/modifications in 636 homes in 36 counties.
  - It is estimated that 450 of these homes will be owned by elderly households.
- The maximum assistance per unit for this program is $5,000.

NCHFA (cont.)

Single Family Rehabilitation Program (SFR)

- Goal: to make a long-term positive impact on the state's stock of standard affordable housing by encouraging the comprehensive rehabilitation of existing, moderately deteriorated, single-family housing units owned and occupied by lower-income elderly or disabled homeowners.
- Financing made available to nonprofit organizations, local governments, and regional counties on a rotating schedule by county.
- Program is funded through the federal HOME Investment Partnership Program (HOME).

NCHFA (cont.)

Single Family Rehabilitation Program (cont.)

- SFR was recently reopened after extensive program evaluation.
- In the recent 2006 cycle, 21 projects were awarded $6,797,000 in HOME funding to provide comprehensive rehabilitation to 196 homes in 21 counties.
- Only elderly and disabled households will be eligible for this assistance.
- It is estimated that about 100 of the households assisted will be elderly.
- The maximum assistance is $40,000 or $40 per square foot in the form of a 0% interest loan forgiven at $3,000 per year.
- It is the intention of the Agency to provide funding to the 98 non-entitlement counties over the next 4 years on a rotating basis.

NCHFA (cont.)

Rental Housing Production Program

- NCHFA provides financing for the development of affordable apartments.
- Financing includes federal and state housing tax credits, and below-market-rate loans through the Rental Production Program
  - The Rental Production Program is funded through the HOME program, the state Housing Trust Fund, and state-provided HOME match.

NCHFA (cont.)

Rental Housing Production Program

- In 2005, 12 applications to build elderly apartment complexes received financing.
- Total of 812 units
- $48 million (estimated) in federal housing tax credit equity will be generated
- $9 million in state housing tax credits
- $720,000 in loans from state Housing Trust Fund
- $3.5 million in loans from HOME program

Summary of Households Assisted

- Estimated 4,000 elderly households assisted by state agencies with comprehensive rehabilitation or repairs/modifications/weatherization in a year.
  - Majority of households above were assisted with repairs/ modifications/ weatherization.
- About 800 elderly apartments financed in a year.

Questions?

Andrea Russo
Fiscal Research Division
733-4910
andrear@ncleg.net

North Carolina Division of Aging and Adult Services

Housing and Home Improvement is a service that 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.

Housing and Home Improvement		
ALEXANDER	ALEXANDER COUNTY DSS 604 7TH ST, SW TAYLORSVILLE, NC 28681-2413	KAREN HOYLE Phone - 828-632-1080 khoyle@co.alexander.nc.us
BLADEN	BLADEN CO DIVISION ON AGING PO BOX 520 ELIZABETHTOWN, NC 28337	JOAN ALLEN Phone - 910-862-6930 FAX - 910-862-6913 doa@bladenco.org
BRUNSWICK	BRUNSWICK SENIOR RESOURCES PO BOX 89 BOLIVIA, NC 28422	JIM RUSSELL Phone - 910-253-2199 FAX - 910-253-4561
BUNCOMBE	MOUNTAIN HOUSING OPPORTUNITY PO BOX 2278 ASHEVILLE, NC 28802-	LLOYD FREEL Phone - 828-254-4030 FAX - 828-2540120 lloyd@mtnhousing.org
BURKE	FOOTHILLS SERVICE PROJECT PO BOX 10 HILDEBRAN, NC 28637-	REV R.L. ICARD Phone - 828-397-2484 icardfsp@conninc.com
CABARRUS	CABARRUS CO DEPT OF COMMERCE PO BOX 707 CONCORD, NC 28026-	KELLY SIFFORD Phone - 704-920-2142 FAX - 704-920-2144
CALDWELL	FOOTHILLS SERVICE PROJECT PO BOX 10 HILDEBRAN, NC 28637-	REV R.L. ICARD Phone - 828-397-2484 icardfsp@conninc.com

CHEROKEE	J ROBERT PENLAND SENIOR CENTER 69 ALPINE STREET MURPHY, NC 28906	WESLEY ODOM Phone - 828-837-2467 FAX - 828-837-1938 cando117@hotmail.com
CHOWAN	CHOWAN COUNTY DSS PO BOX 296 EDENTON, NC 27932	SHERRY JORDAN Phone - 252-482-7717
CLEVELAND	CLEVELAND CO COUNCIL ON AGING 100 T. R. Harris Drive SHELBY, NC 28150	ELIZABETH SHIPLEY Phone - 704-482-3488 FAX - 704-481-1608 coa@agingcouncil.org
COLUMBUS	COLUMBUS CO DEPT OF AGING 827 WASHINGTON STREET WHITEVILLE, NC 28472	ED WORLEY Phone - 910-640-6602 FAX - 910-640-6646
CUMBERLAND	CCCCOA INC 339 DEVERS STREET FAYETTEVILLE, NC 28303	MARSHALL LANTER Phone - 910-484-0111 FAX - 910-484-0627
CURRITUCK	CURRITUCK COUNTY DSS PO BOX 99 CURRITUCK, NC 27929-	CARLA MEBANE Phone - 252-231-3083
DUPLIN	DUPLIN CO SERVICES FOR AGED PO BOX 928 KENANSVILLE, NC 28349-0928	WALTER BROWN Phone - 910-296-2140 duplinage@duplinnet.com
FORSYTH	SHEPHERD CENTER OF GREATER WS 1700 EBERT ST WINSTON-SALEM, NC 27103-	SAM MATTHEWS Phone - 336-748-0217 FAX - 336-748-0522 shepcntr@bellsouth.net
GATES	ALBEMARLE COMMISSION PO BOX 646 HERTFORD, NC 27944	DARLENE HARRELL Phone - 252-426-5753
GRANVILLE	GRANVILLE CO SENIOR SERVICES	KATHY MAY Phone - 919-693-1930

	120 ORANGE ST OXFORD, NC 27565	FAX - 919-693-2147 seniorcenter100@hotmail.com
HALIFAX	CHOANOKE AREA DEVELOPMENT ASSN PO BOX 530 RICH SQUARE, NC 27869-	SALLIE SURFACE Phone - 252-539-4155
HARNETT	HARNETT CO DEPARTMENT OF AGING 309 CORNELIUS HARNETT BLVD LILLINGTON, NC 27546	MAY MARSHBANKS Phone - 910-893-7578 FAX - 910-814-2564
HAYWOOD	HAYWOOD CO COUNCIL ON AGING 81 Elmwood Way WAYNESVILLE, NC 28786	DENISE MATHIS Phone - 828-452-2370 FAX - 828-452-6761
HENDERSON	HOUSING ASSISTANCE CORPORATION PO BOX 2057 HENDERSONVILLE, NC 28793-	KEN PERKINS Phone - 828-692-4744 FAX - 828-692-3009
HYDE	HYDE COUNTY DSS PO BOX 220 SWAN QUARTER, NC 27885	TONI MARSHALL Phone - 252-926-3371
JACKSON	JACKSON CO DEPT ON AGING PO BOX 596 SYLVA, NC 28779-0596	HELEN BRYSON Phone - 828-586-8562 FAX - 828-586-1120 helenbryson@mchsi.com
LEE	LEE COUNTY SENIOR SERVICES 1615 S THIRD STREET SANFORD, NC 27330	DEBBIE DAVIDSON Phone - 919-776-0501 FAX - 919-774-7593 enrichment.center@leecountync.com
LINCOLN	LINCOLN CO SENIOR SERVICES DPT P O BOX 939 LINCOLNTON, NC 28093-	ERMA DEEN HOYLE Phone - 704 732-9053 FAX - 704 732-9060

NORTHAMPTON	CHOANOKE AREA DEVELOPMENT ASSN PO BOX 530 RICH SQUARE, NC 27869-	SALLIE SURFACE Phone - 252-539-4155
PAMLICO	PAMLICO SENIOR SERVICES PO BOX 184 ALLIANCE, NC 28509-	LINDA POTTER Phone - 252-745-7196 FAX - 252-745-3144 pcss@cconect.net
PASQUOTANK	ALBEMARLE COMMISSION PO BOX 646 HERTFORD, NC 27944	DARLENE HARRELL Phone - 252-426-5753
PERQUIMANS	ALBEMARLE COMMISSION PO BOX 646 HERTFORD, NC 27944	DARLENE HARRELL Phone - 252-426-5753
RANDOLPH	REGIONAL CONSOLIDATED SERVICES 221 S FAYETTEVILLE STREET ASHEBORO, NC 27204-1883	TERI MABRY Phone - 336-629-5141 FAX - 336-629-1290 terim@regionalcs.org
ROBESON	ROBESON CO CHURCH & COMM CTR 210 EAST 15TH STREET LUMBERTON, NC 28358-	REV. PAT LYKINS Phone - 910-738-5204 FAX - 910-738-6852 rcccinfo@carolina.net
SAMPSON	SAMPSON COUNTY DEPT ON AGING 371 ROWAN RD CLINTON, NC 28328	LORIE SUTTON Phone - 910-592-4653 FAX - 910-590-2142
SWAIN	EASTERN BAND OF CHEROKEES 133 TSALI MANOR STREET CHEROKEE, NC 28719	DEBI WEST Phone - 828-497-4471 FAX - 828-497-3519 tsaliman@dnet.net
WILKES	BROC ELDERLY NUTRITION	MARY EDNA FAW Phone - 336-667-7174

	PROGRAM 1203 A SCHOOL ST. WILKESBORO, NC 28697-	FAX - 336-667-5920

Community Development Block Grant Program

The North Carolina Department of Commerce oversees the comprehensive community economic development strategies that are carried out by state governmental agencies and its allies. The Department, through the Division of Community Assistance (DCA), administers the North Carolina Small Cities Community Development Block Grant (CDBG) program. Much of the CDBG program is oriented toward the goals contained in the department's strategic plan and the 2001-2005 North Carolina Consolidated Plan which are organized to fulfill the department's mission statement:

To improve the economic well-being and quality of life of all North Carolinians

In 2004, the state received over $50 million in CDBG funds. After allowing for administration and technical assistance, approximately $49 million in funds are available to be awarded for specific program categories. Category awards are funded either through competition or on a non-competitive basis.

All North Carolina small cities are eligible to apply for funds except for 23 entitlement cities that receive funds directly from the U.S. Department of Housing and Urban Development (HUD). North Carolina's entitlement cities are: Asheville, Burlington, Cary, Chapel Hill, Charlotte, Concord, Durham, Fayetteville, Gastonia, Goldsboro, Greensboro, Greenville, Hickory, High Point, Jacksonville, Kannapolis, Lenoir, Morganton, Raleigh, Rocky Mount, Salisbury, Wilmington, and Winston-Salem.

All counties, except for the two HUD-designated urban counties of Wake and Cumberland, are eligible to apply for Small Cities CDBG funds. All municipalities in the two counties are ineligible except for the Town of Holly Springs in Wake County and the Town of Linden in Cumberland County.

Each program category has specific requirements. Please refer to the specific program description for further details. You may also consult with Program Development Staff at 919 733-2850 or TDD 1 800 735-2962.

2005 CDBG Program Categories:

Category	Purpose
Community Revitalization Concentrated Needs Revitalization Strategies	To strengthen neighborhoods and rehabilitate homes of low to moderate income citizens
Scattered Site Housing	To address the most critical housing needs of families

Infrastructure	To provide public water or sewer to correct severe health or environmental problems
Economic Development	To provide grants or loans to local governments for creating and retaining jobs
Housing Development	To support development of single family and rental housing.
Urgent Needs	To help communities recover from disasters that threaten public health and safety where no insufficient or no local/other funds are available
Capacity Building	To help non-profits design and carry out CDBG activities in partnership with units of local government

Additional NC Small Cities CDBG Information:

- CDBG 2004 Investment Plan
- CDBG 2005 Investment Plan
- 2005 Consolidated Plan - Draft
- Citizen Participation Plan
- CDBG Calendar of Events
- Staff Directory
- Directions to the Division of Community Assistance

For additional information, please contact:

Division of Community Assistance
Community Development Block Grant Program
1307 Glenwood Avenue
Suite 250
Raleigh, NC 27605
919 733-2850
919 733-5262 (*fax*)

Last Updated: 02-16-04

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Community Revitalization

Community Revitalization grants are designed to provide funds to local governments to strengthen neighborhoods and rehabilitate homes of low- to moderate-income citizens. Awards are made on a competitive basis. In 2005, Community Revitalization grants will comprise approximately 31% of CDBG funds.

Concentrated Needs

A Concentrated Needs project under the 2005-2006 application may be defined as a project whose purpose is to use CDBG-funded activities to revitalize, through improvements, preservation or development, a residential area (or two residential sub-areas) delineated by a distinct boundary formed from property lines, streets, or natural topographical features. A maximum grant of $700,000 is available in this category. Concentrated Needs applicants may request up to 15% for local option to undertake any eligible activity in the applicant's jurisdiction, except job creation. All non-entitlement local governments are eligible for these funds as long as they are not selected for a Revitalization Strategies (RS) grant. Applications run on a two-year cycle with 2005 grants being awarded to the highest ranked applications submitted in the Fall 2004 competitive round, and 2006 grants being awarded to communities that ranked just behind. In 2005, 16 communities were awarded Concentrated Needs grants.

The 2005-2006 application cycle is closed. The Division of Community Assistance received 93 CDBG Concentrated Needs Applications in December, 2004. To view a distribution map of awards, a list of awards by rank and a list of awards by allocation areas, click on the following links:

- Distribution Map of 2005-2006 Concentrated Needs Awards
- A list of awards by rank
- A list of awards by allocation areas
- Concentrated Needs Application and Guidelines

The following documents are needed to complete the 2005-2006 CN Application:

- The 2005 Special Income Limits document is needed to complete the form, VIII. National Objective Part B-1 Benefit: LMI Levels of Income, on page 93.
- The Ability-To-Pay (ATP) document enables a municipality or county to determine its relative position or ranking among all non-entitlement municipalities or counties as to whether the local government should have resources enabling them to provide local funds for the project. The ATP will not indicate how much money a local government should put in the project. It is only a guide to assist the local government in making a decision about the amount of local funds to commit to the project.

Revitalization Strategies

The RS grant category is designed to aid local governments with long-term, multi-need revitalization efforts in high poverty neighborhoods. This new category provides $350,000 a year for up to five years (for a total of $1.75 million) to complete each project. The communities selected for the 2002-2006 funding cycle are Brevard, Whiteville, Caldwell County, Elizabeth City, Madison County, Hamlet, Roanoke Rapids, Wilson, Hyde County and Sanford. **Communities wishing to pursue a RS grant should already begin to develop strategic plans to address the needs of the neighborhoods for which they seek funding.**

The RS application is being revised. The 2001 Application is available below for information purposes only. No date has been set for future applications.

2001

- Grant Award Results (by Score) for 2002-2006

For additional information, please contact:

Concentrated Needs
Vanessa Tunstall, Senior Development Specialist
vtunstall@ncdca.org
or
Liz Wolfe, Section Chief
lwolfe@ncdca.org
919 733-2850

Revitalization Strategies
Aaron Cain
Program Analyst
919 733-2850
acain@ncdca.org

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NC Department of Commerce | 301 North Wilmington Street, Raleigh, NC 27601 (919) 733-4151 | 4301 Mail Service Center, Raleigh, NC 27699-4301

Scattered Site Rehabilitation

Scattered Site grants are made to approximately 33 county governments on a rotating basis to address the most critical housing needs of very low-income families throughout the county including participating municipalities. County governments receive $400,000 every 3 years with funds targeted to very low-income homeowners for rehabilitation or relocation purposes. Counties must submit a detailed plan that includes input from all interested municipalities within the county describing how funds will be distributed to meet housing needs.

In **2003**, the following counties received Scattered Site Housing grants: Anson, Avery, Brunswick, Caldwell, Carteret, Catawba, Craven, Davidson, Duplin, Edgecombe, Forsyth, Graham, Granville, Greene, Hoke, Iredell, Jackson, Lenoir, Lincoln, McDowell, Moore, Pamlico, Perquimans, Pitt, Randolph, Rutherford, Stanley, Tyrell, Union, Watauga, Wilson, and Yadkin. The towns of Holly Springs and Linden received funds as well.

In **2004**, the following counties are scheduled to receive Scattered Site Housing grants: Alamance, Beaufort, Buncombe, Burke, Cabarrus, Chatham, Cherokee, Chowan, Cleveland, Davie, Guilford, Hertford, Hyde, Johnston, Jones, Macon, Martin, Mecklenburg, Mitchell, Nash, New Hanover, Orange, Pasquotank, Richmond, Robeson, Rockingham, Sampson, Stokes, Swain, Vance, Washington, Wilkes.

In **2005**, the following counties are scheduled to receive Scattered Site Housing grants: Alexander, Ashe, Bertie, Bladen, Camden, Caswell, Clay, Columbus, Currituck, Dare, Durham, Franklin, Gaston, Gates, Halifax, Harnett, Haywood, Henderson, Lee, Madison, Montgomery, North Hampton, Onslow, Pender, Person, Polk, Rowan, Scotland, Surry, Transylvania, Warren, Wayne, Yancey.

2005

- Scattered Site Application and Guidelines

For additional information, please contact:

Iris Payne
Community Development Financial Consultant
(919) 733-2850
ipayne@ncdca.org

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Infrastructure

The purpose of the Infrastructure (IF) category is to improve the quality of life in a residential area (target area project) or in a local government's jurisdiction (area-wide jurisdictional project) by using CDBG funds to eliminate severe water and wastewater (sewer) problems with health and environmental consequences. Activities include the installation of public water or sewer lines, improvements to water or sewer treatment plants that have specific problems such as being under moratoriums or special orders of consent. There are two pools of infrastructure funds available in 2005 with $2.35 million in each pool. One pool of funds is reserved for 21st Century Communities, a designation given to selected economically distressed counties and their municipalities. The counties selected for funding preference in 2004-2005 are Mitchell, Caswell, Northampton-Hertford, Washington and Hoke. The maximum grant in 2005 is $750,000

Applications for the 2005 21st Century Communities Pool will be accepted in an open window cycle until allocated funds are depleted or until December 31, 2005. The window for the 2005 Regular Pool of funds has closed.

Hook-Up Program

The Infrastructure Hook-Up Program is designed to enable eligible local governments with existing public water and/or sewer line(s) to connect or "hook-up" low and moderate-income (LMI) households to non-CDBG funded line(s). CDBG funds may only be used to connect LMI owner-occupied dwellings and LMI tenant-occupied dwellings provided the landlord is also LMI The maximum grant amount is $75,000.

CDBG funds may be used to pay for the following eligible activities in the Infrastructure Hook-Up Program, 1) tap-on or assessment fee to connect to the line, 2) service connection for the private property, 3) use of special equipment such as grinder pumps or vacuum pits to transport residential wastewater to the existing sewer lines, 4) cost to remove septic tanks or cap wells, as required by the health department, 5) repairs to a LMI household's leaking water pipes provided that it is documented that the leaking pipes are a result of connecting to the public water line.

Applications for 2005 were accepted in an open window cycle until allocated funds were depleted. The window for 2005 applications has closed. A local government interested in applying for the Infrastructure Hook-Up Program must call, to see if funds are available and, if they are, to request to be put on the "Prospective Applicant List". If funds are available, the requested amount will be reserved for the potential applicant. A potential applicant will have **90 days from the date of the request** to submit the application; otherwise, the reservation will be rescinded and will become available to another potential applicant.

- 2005 Infrastructure Application Guidelines
- 2005 Infrastructure Hook-Up Application Guidelines

For additional information, please contact:

Vanessa Tunstall
Senior Development Specialist
919 733-2850
vtunstall@ncdca.org

Back

NC Department of Commerce | 301 North Wilmington Street Raleigh, NC 27601 | (919) 733-4151 | 4301 Mail Service Center Raleigh, NC 27699-4301

2013 Mail Service Center
Raleigh, NC 27699
Lawrence D. Wilson, Director

Phone: (919)715-5850
Fax: (919)715-5855

Office of Economic Opportunity

North Carolina Department of Health and Human Services

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY

North Carolina Weatherization Assistance Program

Purpose: The Weatherization Assistance Program is designed to help low-income citizens save energy and reduce expenses through the installation of energy conservation materials, the implementation of energy efficiency measures in their homes and energy education.

Goal: The goal of the program is to create a safe, energy efficient and comfortable home environment for the families served. Priority is placed on providing assistance to the elderly, individuals with disabilities and families with children.

Eligibility: Families with incomes below 150% of poverty or those receiving cash assistance payments under Title IV or XVI of the Social Security Assistance Act are eligible for weatherization services. Over eighty percent of the families served in North Carolina have annual incomes below $15,000. The 3500 families that benefit from the program annually save an average of $218 in energy costs per year throughout the life time of the installed measures.

Program Scope: The North Carolina Weatherization Assistance Program is implemented in all counties in the state through thirty-three (33) subrecipients. Agency staff conduct an energy audit and performs diagnostic testing to determine air infiltration, heat loss, levels of carbon monoxide and identify recommended energy efficiency, safety and health measures. Measures installed may include: air sealing; insulation of attics, walls, and floors; duct sealing and insulation; water heater tank wrap and other general heat waste measures.

Funding: Funding for the $10 million Weatherization Assistance Program is provided through the U.S. Department of Energy, the federal Low Income Home Energy Assistance Program and Petroleum Violation Escrow funds available to the state.

Heating and Air Repair and Replacement Program

Description: The Heating and Air Repair and Replacement Program works in concert with the Weatherization Assistance Program to repair and/or replace inefficient heating and air systems in the homes of low-income families, especially the elderly, individuals with disabilities and families with children.

Attachment IV

Eligibility: Program eligibility is the same as the Weatherization Assistance Program.

Services: All homes that are weatherized receive an energy audit and diagnostic testing to determine levels of carbon monoxide and to identify recommended health, safety and air/heating system energy efficiency measures to be undertaken.

Funding: The N.C. Department of Health and Human Services, through the Low Income Home Energy Assistance Program, provides funding for the $ 2.0 million Heating and Air Repair and Replacement Program. Over 900 low-income families receive services through the program annually.

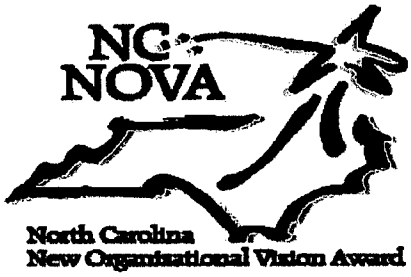
For additional information, contact the Office of Economic Opportunity at 919-715-5850

Listing of Weatherization Assistance Program Subgrantees (Adobe PDF Format)

This page updated on November 16, 2005

Return to OEO Programs

Return to OEO Home Page



NC NOVA PARTNER TEAM

Association for Home and Hospice Care of North Carolina

North Carolina Assisted Living Association

North Carolina Association, Long-Term Care Facilities

North Carolina Association of Non-Profit Homes for the Aging

North Carolina Health Care Facilities Association

Harnett Manor: Direct Care Supervisor representative
Direct Care Worker representative

Direct Care Workers Association of North Carolina

North Carolina Friends of Residents of Long-Term Care

Individual Consumer Representative

North Carolina Institute on Aging, UNC-Chapel Hill

Gerontological Nursing Program, Duke University

The Carolinas Center for Medical Excellence
(previously Medical Review of North Carolina)

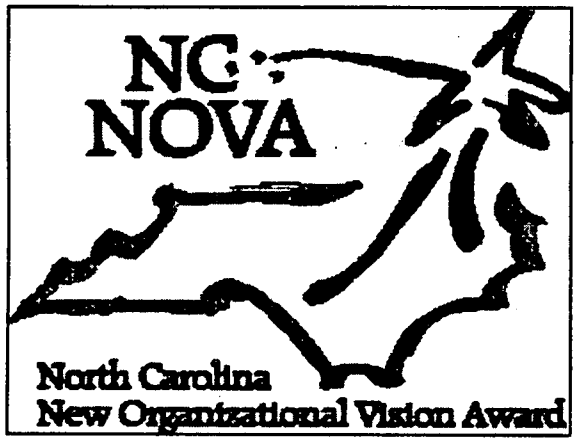
North Carolina Department of Health and Human Services

North Carolina Foundation for Advanced Health Programs

Dear Susan,

I am delighted that you have been given the opportunity to brief the Study Commission on Aging about the activities and efforts of NC Nova. It has been my pleasure and good fortune to have participated in the NC Nova process as a representative of a consumer organization dedicated to improving the services provided to our friends and relatives in long term care facilities. Over many years as staff and Commission member of the Study Commission on Aging I have been distressed that consumer representatives and providers all too often have been in an adversarial relationship about what improvements need to be made in the system to improve care for those residing in long term care. This quite often stymies any positive efforts. No matter our point of view, all agree that the system of long term care depends on the front line providers. For the first time in my experience, NC Nova has been responsible for gathering all the actors together to attack issues related to front line workers and how the system can be stabilized so that turnover and job satisfaction can be improved. We have all worked together to develop demonstration projects that will help the workers and ultimately provide better care for residents in long term care. I hope that the Study Commission continues to monitor the projects because legislation may be needed to implement system wide improvements that will be shown by the various projects.

John Young
Partner Team Member
Friends of Residents in Long Term Care



Who Are Direct Care Workers?

- Go by many names but several most commonly used job titles include:
  - Nurse Aides
  - In-Home Aides/Home Health Aides
  - Personal Care Aides/Attendants
- Folks who provide most of paid hands on care for long term care recipients

Direct Care Worker Growth 2004 -14

- Dire ct care jobs among **fastest growing jobs**
- Dire ct care jobs also among occupations with **largest job growth** between 2004-2014
- NC p rojected to need **30,590** additional direct care workers between 2002-2012
- Vacan cies and growth major issue for many states
- W orkforce development & retention issue

NC NOVA: New Organizational Vision Award

A Voluntary Special Licensing Award for Home Care Agencies, Adult Care Homes & Nursing Facilities

Better Jobs Better Care: A National Initiative

- Research and demonstration project
  - **Improve the recruitment and retention of quality direct care workers**
  - **Improve the quality of long -term care for consumers**
- Funded by: The Robert Wood Johnson Foundation and The Atlantic Philanthropies
- Institute for the Future of Aging Services in Washington is the national program office

North Carolina's Role

- Develop special licensure program to integrate polic y and practice
- NC NOVA consistent with recommendations in IOM reports (LTC Task Force & Nursing Shortage)
- Partner Team began meeting monthly in July 2003 to develop criteria for special licensure award
- Pilot data will be evaluated
  - To refine NC NOVA before statewide launch in 2007
  - To show other states what works in North Carolina
- Support providers to meet NC NOVA through TA/Training

North Carolina's Partner Team

- Association for Home and Hospice Care of North Carolina
- Direct care consumer
- Direct care workers and frontline supervisor
- Direct Care Workers Association of N.C.
- Duke University Gerontological Nursing Program
- Carolinas Center for Medical Excellence
- NC Association, Long Term Care Facilities

North Carolina's Partner Team

- NC Assisted Living Association
- NC Association of Non-Profit Homes for the Aging
- NC Friends of Residents in Long-Term Care
- NC Health Care Facilities Association
- NC Dept. of Health and Human Services
- NC Institute on Aging, UNC-Chapel Hill
- NC Foundation for Advanced Health Programs

NC NOVA: An Overview

- Voluntary, comprehensive "Raise the Bar" organizational culture change program – now being piloted
- Incentive/reward based program for meeting higher standards
- Special/separate license issued for NC NOVAdesignation
- Uniform criteria across long term care settings
- Independent review by Carolinas Center for Medical Excellence

Why NC NOVA is important

- North Carolina has high turnover of direct care workers, with average annual rates in 2004:
  - Adult care homes – 106%
  - Nursing facilities – 107%
  - Home care agencies – 41%
- NC NOVA expectations and criteria address workplace factors shown to have an impact on direct care workforce turnover

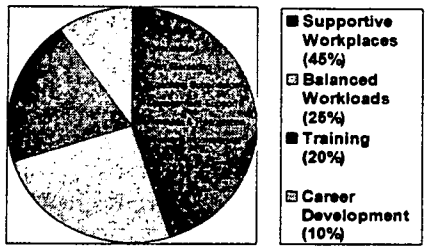
Why NC NOVA is important

- Providers need a reliable supply of quality direct care workers to meet current and future demand for long-term care
- Relationship between worker and care recipient is key to consumers
- Demand for direct care workers is growing

NC NOVA: Program Overview

- Voluntary s et of workplace expectations, criteria and outcomes focusing on direct care workforce in Adult Care Homes, Home Care agencies & Nursing facilities
- Four id entified areas (domains) intended to help providers "raise the bar" to achieve meaningful change in organizational culture
- Requi res employer investment, time, energy, resources

NC NOVA Domains



NC NOVA: Pilot program

- 60 pilot sites – 20 each by type - selected by state associations (more already working on)
- CCME reviews applications, makes site visits and NOVA determinations
- Pilot phase July 2005 – May 2006
- Statewide implementation planned for 2007

NC NOVA: Expected benefit to providers

- Improved retention of quality direct care workers to care for clients/residents
- Improved staff relationships/communications
- Marketing and recruiting boost from NC NOVA designation
- Show impacts with goal of ultimately tying NC NOVA to reimbursement differential
- Feedback thus far from pilots

NC NOVA: Expected benefit to workers

- Improved workplace environment, job skills and job satisfaction
- Opportunities for personal & professional growth
- Improved staff relationships/communication

NC NOVA: Expected benefit to consumers

- More stable, satisfied and quality direct care workforce for consumers and residents
- Stable, quality direct care workforce available in long-term care settings for the future
- Improved care

Partner Team Request

Partner Team requesting your support for legislation to implement NC NOVA statewide in early 2007

Resources

- Paraprofessional Healthcare Institute (www.paraprofessional.org)
- Better Jobs Better Care, national initiative (www.bjbc.org)
- Institute for the Future of Aging Services, national program office (www.futureofaging.org)

NC NOVA: Provider Information Manual

- Go to: www.dhhs.state.nc.us/ltc
  click on: "Workforce Issues," then
  click on: "Initiatives", then
  click on: "BJBC Demonstration"
  click on: NC NOVA Provider Information Manual

North Carolina
New Organizational Vision Award

Pilot Project
Information Manual

Revised
March 2005

This document was developed and published by the North Carolina Foundation for Advanced Health Programs in collaboration with the NC NOVA Partner Team.

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and the NC NOVA Partner Team express their appreciation to

THE PARAPROFESSIONAL HEALTHCARE INSTITUTE

for its technical assistance in developing the domains and criteria

for NC NOVA special licensure designation detailed in this manual.

Funding for this project is provided by

The Robert Wood Johnson Foundation and The Atlantic Philanthropies,

through the Better Jobs Better Care Program.

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SECTION I: PURPOSE

The purpose of this document is to:

- Describe the New Organizational Vision Award (NC NOVA), which is a voluntary, special licensure program for home care agencies, adult care homes and nursing facilities being developed under North Carolina's Better Jobs, Better Care demonstration grant.

- Explain NC NOVA's goal of positively changing workplace culture to improve the recruitment and retention of direct care workers and the program's expectations for doing so.

- Provide background information about eligibility requirements for participation as a pilot site and the criteria for attaining NC NOVA special licensure designation.

- Outline reporting requirements that are specific to participation as a pilot site for purposes of the national Better Jobs Better Care demonstration grant evaluation effort.

- Present a timeline for developing, piloting and fine-tuning the special licensure program that will culminate with its implementation statewide in January 2007.

- Serve as a resource document for NC NOVA pilot sites and other organizations interested in applying for special licensure designation once the program is implemented statewide. (Note: This manual will be updated once any final program revisions are made prior to statewide implementation.)

SECTION II: INTRODUCTION

North Carolina is one of five state-based coalitions that received a Better Jobs Better Care demonstration grant funded jointly by The Robert Wood Johnson Foundation[1] and Atlantic Philanthropies[2]. Started in July 2003, these 42-month demonstration grants are intended to implement changes in policy and practice that will improve the recruitment and retention of high-quality direct care workers to meet the needs of long-term care consumers in both home and community-based settings. The Institute for the Future of Aging Services (IFAS), based in Washington D.C., is the National Program Office for this effort. IFAS contracts with the Paraprofessional Healthcare Institute, based in New York, to provide technical assistance to demonstration grantees.

North Carolina's broad-based coalition, known as the "Partner Team," is made up of consumers, direct care workers and supervisors, long-term care provider-related associations, state regulators, educators and researchers. The coalition's efforts are under the N.C. Foundation for Advanced Health Programs, lead agency for the grant.

The Partner Team was funded to develop, pilot and implement a uniform set of criteria and expectations for statewide use, on a voluntary basis, across home care, adult care homes, and nursing facilities. These expectations and criteria address factors that affect the recruitment, retention and job satisfaction of direct care workers. Providers that are judged to meet the expectations and criteria established under this voluntary, raise-the-bar program will receive a special licensure designation to be known as North Carolina's New Organizational Vision Award. NC NOVA designation will be issued as a separate license document sent to the provider in addition to the provider's regular license. It is the intent that this special designation would be the basis for the provider being eligible

[1] The Robert Wood Johnson Foundation, based in Princeton, N.J., is the nation's largest philanthropy devoted exclusively to health and health care. It concentrates its grant making in four goal areas: to assure that all Americans have access to quality health care at reasonable cost; to improve the quality of care and support for people with chronic health conditions; to promote healthy communities and lifestyles; and to reduce the personal, social and economic harm caused by substance abuse – tobacco, alcohol, and illicit drugs.

[2] The Atlantic Philanthropies work globally to identify and support leaders, institutions, and organizations dedicated to learning, knowledge building, and solving pressing social problems. It has a longstanding interest in aging.

for labor enhancement funding or a reimbursement differential that North Carolina might adopt in the future.

Medical Review of North Carolina, North Carolina's Peer Review Organization, will be the entity responsible for determining whether a pilot-project applicant for NC NOVA meets the expectations and criteria established for receipt of an NC NOVA designation. Once Medical Review of North Carolina determines an applicant does indeed meet the criteria, it will notify the North Carolina Division of Facility Services, which, in turn, will prepare the NC NOVA license award document.

NC NOVA is intended to be a meaningful and voluntary "raise-the-bar" program pertaining to direct care staff recruitment and retention that would apply across long-term-care-related settings. Toward that end, the Partner Team has identified job practices known to contribute to high turnover in the direct care workforce and, by extension, workplace cultures in which turnover is low and job satisfaction high. These practices were grouped into four major areas called "domains." The domains are:

- Supportive Workplaces
- Balanced Workloads
- Training
- Career Opportunities

Within each domain, the Partner Team has outlined expectations that a provider would have to voluntarily meet to achieve special licensure designation. While not highly prescriptive or financially burdensome, the special program will require that providers make an investment of time and resources, and that they change their workplace culture. The Partner Team determined that the domains and related criteria for NC NOVA would be weighted as follows:

- Supportive Workplaces 45%
- Balanced Workloads 25%
- Training 20%
- Career Opportunities 10%

Specific elements and criteria related to these domains are addressed more fully in Section V.

The Partner Team will pilot test NC NOVA requirements and review procedures between July 2005 and August 2006 with applications accepted between July 2005 and May 2006. Sixty provider entities will participate in the pilot phase: 20 home care agencies; 20 adult care homes; and 20 nursing facilities, including some from Continuing Care Retirement Communities. State-level provider associations selected the agencies/facilities that will participate in the pilot, representing their respective long-term care setting. It is expected that the pilots will, on the whole, represent a diverse group of participants in terms of geographic location, size, ownership type, etc.

Once the pilot phase has concluded, the Partner Team will make any final changes needed to NC NOVA in time for full statewide implementation in 2007.

Each pilot site will be paid $2,600 to participate in this workforce initiative, largely in consideration of the employment and termination data for direct care staff that is required as part of the Better Jobs Better Care national evaluation effort. Technical assistance for data collection will be available through the national Better Jobs Better Care evaluation team at Penn State University. Data from the 60 pilot sites will be aggregated, and only statewide data will be reported. No data from any individual pilot site will be available. Appendix 1 details data submission requirements for pilot sites.

Note: Applications, provider-specific notes from on-site visits and any other provider-specific material that Medical Review of North Carolina uses to determine whether a pilot site attains NC NOVA designation will be held in confidence by Medical Review of North Carolina and destroyed after the special licensure decision is made.

To assist pilot sites and/or those that would want to participate once special licensure is implemented statewide, Appendix 2 and Appendix 3 include resource information on research/best practices related to the impact of workplace culture change on recruitment and retention, the stability of an organization's workforce, job performance

and satisfaction. Also included is information about existing training programs, curricula and resources to help organizations plan to meet the expectations and criteria for special licensure.

At the time this document was updated in March 2005, the Partner Team was working on the instruments and procedures that Medical Review of North Carolina would use to assess whether changes in practices and policies undertaken by program participants had actually made a positive impact on workers and, ultimately, consumers. To keep up with the Partner Team's continued work in this and other areas, potential pilot sites should periodically check for updates at

For information about the national Better Jobs Better Care effort, go to www.bjbc.org.

SPECIAL LICENSURE PILOT FRAMEWORK

The 60 organizations expected to participate in the NC NOVA pilot phase will be expected to:

- Attend an orientation meeting. The meeting will include information about time schedules, expectations, application/review procedures, national program evaluation reporting requirements, resources for NC NOVA initiatives, etc.

- Work toward implementing the NC NOVA requirements with the expectation of submitting an application for NC NOVA review **no later than May 2006.** *(The May deadline is included to ensure adequate time for Medical Review of North Carolina to conduct reviews and make NC NOVA determinations by August 2006 and provide the NC NOVA Partner Team enough time to make any changes to the model prior to statewide implementation in 2007.)*

- Provide feedback as requested from the NC NOVA Partner Team

The North Carolina Division of Facility Services will issue a separate, special license in addition to the operating license to a provider that meets the requirements for NC NOVA designation. The special licensure designation will be awarded for two years. Only under certain conditions would the special licensure designation be terminated prior to the two-year award period. (See Section VIII for details on termination.)

STATEWIDE IMPLEMENTATION

During the pilot phase, the Partner Team will make any necessary refinements to the expectations, criteria and processes. Once these refinements are complete, NC NOVA will be open to licensed home care agencies, adult care homes and nursing facilities statewide. It is expected that, at some point in the future, NC NOVA will be used to determine eligibility for any labor enhancement funds that may be approved or for some type of reimbursement differential in recognition of the comprehensive investment employers have made to their direct care workforce through this initiative. The development of the NC NOVA special licensure program and the intent to tie this award to labor enhancement funds or some reimbursement differential are consistent with the workforce recommendations contained in the Institute of Medicine's Long Term Care Task Force report published in 2001. (See http://www.ncmedicaljournal.com/mar-apr-02/ar030204.pdf.)

EXPECTED BENEFITS OF NC NOVA

TO PROVIDERS:

- Improved retention of quality direct care workers to care for clients/residents
- Improve staff relationships and communication
- A marketing and recruiting boost from NC NOVA designation
- Future possibility of ultimately tying special licensure award to increased funding

TO WORKERS:

- Better workplace environment and job satisfaction

- Opportunities for personal and professional growth
- Improved staff relationships/communication

TO CONSUMERS:

- More stable, satisfied and quality direct care workforce for today's clients/residents
- Stable, quality direct care workforce available in long-term care settings for the future
- Recognition of and appreciation for the essential role direct care workers play in the delivery of quality long-term care services

SECTION III: PARTNER TEAM MEMBERS

Kathie Smith	Association for Home and Hospice Care of North Carolina
Sandy Spillman	N.C. Assisted Living Association
Lou Wilson	N.C. Association, Long-Term Care Facilities
Belinda Wilson	N.C. Association, Long-Term Care Facilities
Susan Williamson	N.C. Association Non-Profit Homes for the Aging
Polly Godwin Welsh	N.C. Health Care Facilities Association
Laurie Blanton	Harnett Manor: Direct Care Supervisor
Brenda McLaughlin	Harnett Manor: Direct Care Worker
Margie Barron	South Village, Rocky Mount: Direct Care Worker
Mary Edge	South Village, Rocky Mount: Direct Care Worker
Jan Moxley	Direct Care Workers Association of North Carolina
John Young	N.C. Friends of Residents of Long-Term Care
Pat Capehart	Consumer
Bob Konrad	N.C. Institute on Aging, UN.C.-Chapel Hill
Ellie McConnell	Gerontological Nursing Program, Duke University
Kirsten Corazzini	Gerontological Nursing Program, Duke University
Jill McArdle	Medical Review of North Carolina
Phyllis Daw	N.C. Department of Health and Human Services
Jesse Goodman	N.C. Department of Health and Human Services
Emily Saunders	N.C. Department of Health and Human Services
Hazel Slocumb	N.C. Department of Health and Human Services
Beverly Speroff	N.C. Department of Health and Human Services
Susan Harmuth	N.C. Foundation for Advanced Health Programs
Mike Massoglia	Project Team Facilitator

SECTION IV: PROPOSED TIMETABLE

2003

July	Partner Team begins work under Better Jobs Better Care grant

2004

May	Consensus reached on domains to be part of special licensure and relative weights
August	Consensus reached on eligibility criteria for participation in special licensure program and conditions under which a special license could be revoked. Partner Team also determined that the decision of Medical Review with regard to application and on-site review process for NC NOVA would be final (no appeals)
October	Consensus reached on three of six Supportive Workplace domain elements Measurement subcommittee begins meeting to develop measurement instruments associated with criteria developed by the Partner Team
November	Consensus reached on name and logo for special licensure program (NC NOVA) Consensus reached on final three domain elements for Supportive Workplace domain Measurement subcommittee continues its work Two-day coaching supervision training sessions initiated to support training for potential pilot projects (November 2004 – January 2005)

2005

February	Consensus reached on final three domains for NC NOVA Measurement committee continues to meet PowerPoint presentation developed to support Partner Team members with providing information to respective constituents about NC NOVA

Boilerplate Memorandum of Understanding developed for use with participating pilot sites for NC NOVA by state level provider associations on Partner Team

March — Provider Manual readied for pilot sites

May — Partner Team and several pilot sites meet with representatives from national Better Jobs Better Care program

Orientation meeting conducted for pilot sites

June/July — Penn State provides technical assistance to pilot sites regarding data collection for national program evaluation

Pilot sites begin instituting necessary organizational change initiatives in effort to meet NC NOVA criteria

Additional coaching supervision training sessions conducted in support of pilot sites

Period opens for pilot sites, when ready, to submit application for NC NOVA, and Medical Review of North Carolina will conduct reviews accordingly. The deadline for applications is May 2006.

2006

January — Legislation drafted for statewide implementation of NC NOVA

May — Application period closes for NC NOVA pilot participation.

August — Partner Team begins determination of whether any changes are needed to NC NOVA criteria, procedures, etc., prior to finalizing for statewide implementation.

October — Partner Team makes final changes to NC NOVA program and related materials in preparation for statewide implementation

Begin providing information to state level provider associations, provider organizations, direct care workers, consumer advocacy organizations, policymakers, etc., about special licensure program and statewide implementation plans

2007

January — NC NOVA statewide implementation begins

SECTION V: DOMAINS AND CRITERIA FOR NC NOVA DESIGNATION

The supportive workplaces domain has the following six elements:

Orientation	Management Support
Peer Mentoring	Reward and Recognition
Coaching Supervision	Worker Empowerment

DOMAIN #1: SUPPORTIVE WORKPLACES

Supportive Workplaces Element #1: Orientation

Orientation is a structured, time limited, initial training process by which an employer familiarizes new employees to organizational mission, policies and procedures and the workplace environment.

Recommended Elements for Successful Interventions

A critical piece in supporting new workers entering a workplace is an effective orientation to the job, the organization, and the people. This will vary according to setting, but optimally the following elements should be included:

a. Set a minimal length of time with a defined beginning and end to complete orientation, with defined minimum prescriptive elements based on practice setting. No exceptions.

b. Ensure that orientation includes relationships as well as tasks. Personally introduce new direct care worker to staff and residents/clients (and a peer mentor) with whom they will work.

c. A system in place that demonstrates the peer-mentoring program is fully understood and supported by organizational leadership. All staff are oriented to the mentors role.

d. Based on competency assessment, work experience, readiness and case mix of client population, have an initial schedule for new workers with a gradually increasing load, rather than a full assignment of clients or residents to care for on day one.

e. Evidence that facilities/agencies provide support in understanding/adopting employment rules and practices.

f. Include topics such as communication, teamwork, problem solving skills; use adult learner centered training techniques.

g. Provide information about organizational mission, culture and values.

h. A system in place that provides extra support during the initial probationary period including at a minimum: a structured peer mentoring program (and assigning a single peer mentor to a new employee); a process fostering on-going skills development and skills reinforcement with multiple disciplines and integrating expertise from supervisory staff; on-going access to a peer support group(s); and demonstration that employees are make aware of this system.

Supportive Workplaces Element #2: Peer Mentoring

Recommended Elements for Successful Interventions

Peer mentoring is an extremely effective means for creating a supportive workplace environment for new workers in terms of orientation, and for seasoned workers in terms of a career path opportunity. To succeed as an intervention, Peer Mentoring needs to be a formal program that is clearly thought out and understood by all staff within the organization. Programs are most successful when the following elements are included:

a. Peer mentors have a clearly defined role responsibilities and job description whereby mentors provide one on one support to individually assigned new employees.

b. There is a clear system for mentors to provide support to new employees and manage their assigned caregiving responsibilities. (Caseload reduction or opportunity for increased hours and shift flexibility are three examples). This role is not just an add-on to existing responsibilities – it is a commitment to providing the peer mentor time to carry out mentor responsibilities).

c. There is a fair, consistent criteria based system for selecting peer mentors.

d. There is a system for initial and on-going assignments and on-going evaluation.

e. Peer mentoring is viewed as a career pathway and compensated accordingly.

f. The mentoring program is fully understood and supported by organizational leadership; all staff are oriented to the mentors' role.

g. A system in place that demonstrates that mentors and mentees have a clear understanding of the nature, purpose and length of the mentor/mentee relationship.

h. Peer Mentors must be trained. An effective training program would be interactive and focus on interpersonal communication and problem-solving skills, leadership development and teaching/coaching skills (within applicable scope of practice act requirements). Ongoing support must be provided to mentors, through additional in-services, coaching, or peer support groups.

i. There is a staff person responsible for program oversight and on-going troubleshooting.

j. A peer mentor does not take the place of a supervisor.

k. An ongoing system for evaluating the peer-mentoring program should be in place. The system should incorporate information from both mentors and mentees.

Supportive Workplaces Element #3: Coaching Supervision

Coaching Supervision is an approach to supervision that relies on working with employees in a manner that centers on developing problem solving skills, the ability to think critically, prioritize and communicate effectively.[3]

Recommended Elements for Successful Interventions

A key component of a supportive workplace includes workers who are valued by a coaching approach to supervision that is skillfully applied. Supervision is a skill that can be taught and learned through formal training. Persons charged with supervisory duties need formal training to effectively carry out their supervisory responsibilities. Coaching Supervision training should be available to all senior managers and front line supervisors in the organization. In this way, the coaching approach is inherent throughout the organization.

Having supervisors who have completed training in coaching supervision is critical to creating a workplace where employees feel valued and respected. The attention needed includes adequate supervisory training, a coaching approach to supervision, and organizational structures that make coaching supervision possible. Specific elements are:

a. Supervisory jobs are designed or restructured so that there is time allotted for coaching supervision. Management will need to review job descriptions with the understanding that supervision of workers is a significant task that requires time and training. Job descriptions need to include or reflect adequate time that supervisors need to coach.

b. Personnel Policies, especially policies related to performance improvement and disciplinary action (review in context of definition of coaching), need to reflect a coaching approach to supervision, and need to be effectively communicated and enforced. All staff should be trained in the implementation of these policies.

c. Training in the coaching approach to supervision is essential.
An acceptable, standardized training program would be sanctioned by the NC Department of Health and Human Services and offered by qualified trainers in accordance with trainer requirements established by the NC Department of Health and Human Services. Training would be interactive and include coaching principles, interpersonal communication and problem solving, and opportunity for skill building and practice.

d. Commitment from senior management to a coaching-based model of communication and managing people should be visible throughout the organization. Management must demonstrate their belief in workers' ability to

[3] Paraprofessional Healthcare Institute, "Creating a Culture of Retention: A Coaching Approach to Paraprofessional Supervision", September 2001, p. 5.

succeed and be willing to provide consistent support through effective and respectful supervision.

e. Supervisors implementing the coaching approach should have ongoing support and skill building. This may take the form of additional in-services, one-on-one coaching, and coaching discussion groups.

f. Employees need to be oriented to this supervisory approach and their respective roles with regard to the coaching approach to supervision.

Supportive Workplaces Element #4: Management Support

Recommended Elements for Successful Interventions

Management creates and supports a climate of mutual respect and responsiveness that values front-line caregiving as a shared goal of direct care workers, clinical staff and non-clinical personnel throughout the organization. A commitment by top management goes along with worker empowerment as factors critical to the success of any change initiative.

Some specific elements central to management support are:

a. Clients/residents and their direct care workers are central to decision-making, within the scope of their jobs and caregiving responsibilities.

b. Jobs are designed so that workforce and caregiving practices respect and reinforce the consumer-caregiver relationship. When practical, relationship should precede task; for example, consistent assignment and caregiving practices that promote personal preferences in bathing, meals and other daily routines. But often the need for an immediate response to a consumer—by any staff member, even if the staff member is not able to fully respond to the consumer's request at that moment—will take priority, as in answering a call bell or helping to pour coffee at dinner.

c. Supervisory practices reinforce a supportive environment to overcome obstacles and/or performance issues using such techniques as respectful two-way communication, problem solving and other strategies detailed elsewhere in the section on Coaching Supervision.

d. Management creates systems for ongoing communication within and between departments with the goal of making sure that all workers on all shifts are kept up to date and have a way to comment on issues that arise. Communication on substantive matters is clear and timely.

e. Case management or employee counseling is offered to address logistical and emotional issues such as coordinating access to community services needed to overcome external obstacles such as childcare, transportation, housing, etc. Management offers support groups for employees to address life/work issues—especially in the first 90 days of employment, as part of the orientation and mentoring of new employees.

f. Opportunities are created for managers and line staff from different departments and levels to develop leadership and participation skills, so that a representative group has the capacity to lead a change process.

g. Management gives workers the tools they need to do their jobs. These could range from lifts that help with caregiving responsibilities to mileage allowances in home health that help with employment responsibilities.

h. Management supports professional development and skills building in workers' areas of expertise including financial support for tuition, registration, release time, etc.

Supportive Workplaces Element #5: Worker Empowerment

Recommended Elements for Successful Interventions

Worker empowerment is fundamental to creating a supportive workplace environment. There are many understandings of the term "empowerment" and many ways that direct care workers can be empowered consistent with their experience, insights and expertise. To be effective, they require worker participation in planning and decision-making about day-to-day and long range care practices and work environment. Communication pathways are open, and staff at all levels and in all departments, engage in problem solving around issues that directly affect the care of residents/patients and the work environment. Organization leadership and team members demonstrate their clear conviction of the value of direct care worker experience, insights and expertise in organizational operations including recognition that direct care workers have both direct care and non-direct care responsibilities.

In the workplace, direct-care workers are likely to have the most personal contact with and may be the staff closest to residents/clients. Direct care workers may be in best position to understand how policies affect their ability to establish caring relationships. Involving direct-care workers from the beginning in evaluating current practices and developing new ones helps assure that workers will be able to adapt and integrate the new practices into daily routines.

True empowerment requires that:

- Direct care workers have input into care-planning
- Direct care workers have input into resident/client quality of care and quality assurance/quality improvement processes
- Formal mechanisms exist and are implemented for involving direct care workers in the establishment of consistent care delivery teams and care assignments, to the extent possible and based on worker preferences and the ability of the organization to meet /patient care needs.
  (Note: don't want to preclude floaters—just want to be sure there are formal mechanisms for involvement in assignment and care teams and mechanisms for preventing workers from being assigned in isolation of a routine schedule)
- Direct care workers participate in key committees to evaluate current practice and design alternatives, e.g. Better Life Committee, policy committees, etc.
- Direct care workers have opportunities for flexible scheduling and assignments (e.g. self scheduling, flexible shifts, etc.)
- Direct care workers have a quiet, designated place and the necessary resources (such as a table/desk, chair, pads, pens/pencils, access to charts, time, etc.) at reasonable times to complete non-direct care tasks.

- Clear and timely feedback is provided in response to suggestions/input provided by direct care workers about patient/resident care and work environment.

- Direct care workers must have the information and support they need to function effectively in a participatory setting.

Supportive Workplaces Element #6 Rewards and Recognition

Recommended Elements for Successful Interventions

Reward and recognition are distinct from an organization's regular compensation policies. Rewards, whether monetary or non-monetary, address the needs and interests of the direct care workers themselves. Extrinsic rewards and worker recognition are helpful additions to other daily efforts to acknowledge the value of workers both as individuals and a group. Managers should engage workers in a participatory process to determine what would be valued and meaningful forms of recognition.

When developing reward and recognition programs it is essential to:

- Be fair and equitable in the selection process
- Involve worker participation with guidance from management about what would be feasible, given time and budget constraints
- Be valued and meaningful to direct care workers themselves
- Clearly show link between rewards and behaviors or actions being recognized
- Go beyond basic compensation

Attempts to recognize and reward employees must be culturally sensitive. In today's culturally diverse work environment, managers need to find out from workers what is acceptable.

Some examples of reward and recognition programs might include:

a. Worker appreciation events, where all or selected workers are publicly honored.

b. Daily/weekly/monthly/annual acknowledgement of worker contributions.

c. Financial incentives/bonuses for performance, attendance, recruitment, leadership, etc.

d. Opportunities for personal or professional development.

e. Company-sponsored activities for workers and their families, e.g., boat ride, trip to amusement park, barbeque, etc.

f. Programs that are solely performance based (e.g. such as a lottery or bonus eligible only to persons who had perfect attendance for the month/week, etc.)

DOMAIN 1: SUPPORTIVE WORKPLACES

Criteria for NC NOVA Designation: Orientation

Orientation is a structured, time limited, initial training process by which an employer familiarizes new employees to the workplace environment as well as the organizational mission, policies and procedures.

An orientation program provides essential and enhanced support for all new employees during their initial probationary period.

An effective orientation to the job, the organization, and the people is critical to supporting new employees entering a workplace. This will vary according to setting, but optimally the following elements should be included:

Criteria for NC NOVA Designation: Orientation		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
The program has standardized content, sets minimum number of hours for orientation and relies on training techniques geared to the knowledge level of new employees. The program incorporates principles of adult learning including notions that: • Adults need to be involved in the planning and evaluation of their instruction. • Experience (including mistakes) provides the basis for learning activities. • Adult are most interested in learning subjects that have immediate relevance to their job or personal life. • Adult learning is problem-centered rather than content-oriented.	• Topics and hours of orientation program • Adult learning principles incorporated in teaching methods • Policies & Procedures describing existence of Orientation Program completed probationary period and adjusted as needed • Orientation materials provided to new employees, including designated contact person for questions and/or clarification. • Records that document completion of orientation program • Opportunities for skills reinforcement and	• Workers become better acquainted with organization and organization policies. • Worker skills are strengthened. • Employees are aware of support system(s) • Improved job satisfaction of newer aides because of support system(s) <u>Workers are:</u> • Well-adjusted to structure of organization, its policies and procedures, culture, values and mission • Fully introduced to staff and clients/patients • Welcomed into the team

Criteria for NC NOVA Designation: Orientation		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Orientation content includes, but is not limited to: • Information about the mission and values of the organization. • Tasks as well as relationships with patients/residents and staff • Interpersonal skills training on topics such as communications, teamwork, problem solving. • Employment/administrative rules and practices and practical information such as organizational paperwork, how to find and order supplies, lunch, break and time-off polices and procedures. • Overview and implementation of structured peer mentoring program (and assigning a single peer mentor to a new employee). • A process fostering ongoing skills development and skills reinforcement • Ongoing access to peer support.	additional training, and peer support groups.	• Well acclimated to tasks and roles expected of them on the job <u>Workers receive:</u> • Identified peer mentor and ongoing support as needed following initial probationary period • Timely feedback on performance and development. • Validation for achievement of significant milestone

Criteria for NC NOVA Designation: Orientation		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Based on competency assessment, work experience, readiness and case mix of client population, have an initial schedule for new workers with a gradually increasing load, rather than a full assignment of clients/residents to care for on day one.	• Policies & Procedures call for assignment of graduated caseload for new workers over first 3-7 days. • Records documenting new worker's assignments and caseload during orientation period. • On-site observation	New workers assigned work at a pace they can keep up with.
Peer mentoring program in place, which orients new employees, reinforces skills, and provides support. (See Peer Mentoring element for details of peer mentoring role.)		Peer mentoring program initiated during orientation.

DOMAIN 1: SUPPORTIVE WORKPLACES

Criteria for NC NOVA Designation: Peer Mentoring

Peer Mentoring is an extremely effective means for creating a supportive workplace environment—for new workers in terms of orientation, and for seasoned workers in terms of a career path opportunity. To succeed as an intervention, Peer Mentoring needs to be a formal program that is clearly thought out to meet the needs of the LTC organization and understood by all staff. Programs are most successful when the following elements are included:

Criteria for NC NOVA Designation: Peer Mentoring		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Peer mentors have a clearly defined role that spells out responsibilities, job description and what their organization wants them to do; namely, give one-on-one support—not supervision—to individually assigned new employees, in particular, and other employees in general.	Peer Mentor job description • Clear role • One-on-one mentoring Job descriptions of new hires There is a plan such that new employees do not receive a full caseload until having successfully completed the orientation/mentoring process. The supervisor, in conjunction with the mentor and worker, will make this determination.	Peer Mentors have a clear role, which is understood by all facility staff. • On site interviews with mentors, new workers, managers, other workers • List of new hires and Peer Mentors assigned to them • Schedule of Peer Mentors and new hire interactions.
There is a clear system for mentors to provide support to new employees and to carry out their own, new and existing caregiving responsibilities, if any. This role is not just an add-on to existing responsibilities; the role is management's commitment to providing the mentor time to carry out mentoring responsibilities.	Description of system for mentoring and carrying out care assignments that could include: • Caseload reduction • Opportunity for increased hours • Shift flexibility • Plan for mentoring new (and others as needed)	Mentors can manage their mentoring responsibilities and care assignments. • Individual interviews with mentors, co-workers, and managers Ask for examples Will need to look at how the day or week is spent.

Criteria for NC NOVA Designation: Peer Mentoring		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
There is a fair, consistent criteria-based system for selecting, not appointing, peer mentors.	Description of selection system and criteria and documentation, including: • Application process • Schedule of interviews • Log of applicants	The mentor selection system is viewed as fair and objective. • Individual interviews with mentors, co-workers, and managers Documented description of applicants
Peer Mentors must be trained. An effective training program would be interactive, and focus on interpersonal communication and problem-solving skills, leadership development and teaching/coaching skills (within applicable scope of practice act requirements). Ongoing support must be provided to mentors, through additional in-services, coaching, or peer support groups.	Description of training program and curriculum • Attendance lists • Detailed curriculum • Include in-services and ongoing support	Mentors are effectively trained and prepared for their role. On-site interviews with mentors, mentees, co-workers and mangers.
An adequate number of mentors is available on each shift (if applicable) as a resource for all workers, not only new hires.	Description of the process for assigning mentors, including how the number needed was derived • Mentor available all shifts (if applicable) • Submit information about how determine the number of mentors needed	The mentor-mentee assignment process is understood and viewed as fair. • On-site interviews with mentors, mentees, co-workers and mangers.
There is an ongoing system for evaluating both the peer mentoring program and the mentors themselves. The system should incorporate information from mentors. mentees, managers and consumers.	Description and evidence of evaluation system • Feedback forms • Sample evaluations • Questions include time allocation and value of program • Report of changes made	The mentor program is regularly evaluated and changes made where needed. On-site interviews with mentors, mentees, co-workers and managers

Criteria for NC NOVA Designation: Peer Mentoring		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Peer Mentoring is viewed as a career pathway and compensated accordingly	Evidence of additional compensation for mentors and amount. (Range of options: hourly increase, bonus, stipend) Evidence of how this position fits into a larger career lattice within the organization, if applicable	Workers view mentoring a career pathway. On-site interviews with mentors, mentees, co-workers and mangers.
There is a designated staff person responsible for program oversight and on-going troubleshooting.	Identification and job description of staff person • Resume and qualifications for the job • Sample of activities in the job of PM oversight	The Mentor program is effectively managed. • On-site interviews with Mentor Liaison, mentors and mentees. • Seek out examples of troubleshooting.

DOMAIN 1: SUPPORTIVE WORKPLACES

Criteria for NC NOVA Designation: Coaching Supervision

Coaching Supervision is an approach to supervision that relies on working with employees in a manner that centers on developing problem solving skills; the ability to think critically, prioritize and communicate effectively.[4]

Preparing supervisors to use effective, respectful, team-building methods for leadership and management is a key element of a supportive workplace where employees feel valued and respected. Supervision is a skill that can be taught and learned through formal training. Employees charged with supervisory duties need formal training to effectively carry out their duties. Training in "Coaching Supervision" should be available to all senior managers and front-line supervisors so the coaching approach is inherent throughout the organization.

Criteria for NC NOVA Designation: Coaching Supervision		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Management and supervisory staff receive training in coaching supervision approach. *Note: Front-line supervisors include persons charged with the functional role of assigning job duties and/or direct supervision of frontline workers.* *(Workers supervised by front-line supervisors include direct care staff as well as housekeeping staff, nutritional services staff,*	• Written policies and procedures underscore the organization's commitment to coaching supervision and specify the senior managers and supervisory staff required to receive coaching supervision training. • An operational plan to train front-line supervisors, management/leadership staff so that: o 50 percent of existing staff, including the administrator and director or nursing, complete DHHS-approved training within four months	• Commitment from senior management and supervisors to provide the time and resources to support a coaching-based approach to communication and managing people. • Direct care workers show evidence of problem-solving skills. • Evidence of effective communication skills throughout the organization. • The climate is open to change and problem-solving rather than "this is how we do it."

[4] Paraprofessional Healthcare Institute, "Creating a Culture of Retention: A Coaching Approach to Paraprofessional Supervision", September 2001, p. 5.

Criteria for NC NOVA Designation: Coaching Supervision		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
social services/activity staff in the organization as appropriate. *Front-line supervisors (for purposes of coaching supervision training)do not include irregular PRN staff.*	of the organization's application for special licensure designation o an additional 30 percent complete their training within the next four months o 100 percent of new hires (in front-line supervisory, management and leadership positions) complete DHHS-approved training within six months of their employment • Organizational training records indicating who was trained, when and where. • Plan and documentation of periodic refresher training/support on coaching supervision techniques.	• Organization sustains its coaching supervision program to continually improve supervisors' skills.
Training in the coaching approach to supervision is completed through a program and trainer approved by NC DHHS.	• DHHS-approved training program used. • Certificates of completion of DHHS-approved program maintained in appropriate staff files.	Through interviews show that • Employees are comfortable sharing opinions and ideas about work-related problems or issues with supervisors, managers and co-workers • Supervisors perceive that they have gained work time because workers are able to solve most work

Criteria for NC NOVA Designation: Coaching Supervision		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
		related problems independently
Supervisory jobs and responsibilities are designed or restructured to include an expectation that coaching supervision techniques are used.	• Written job descriptions for supervisors that emphasize coaching supervision role and incorporate coaching philosophy and goals. • Written job descriptions show allocation or reallocation of assignments and responsibilities in order to emphasize coaching role.	• Improvement in supervisory relationships with fewer formal write-ups for disciplinary action of workers.
Coaching approach to supervision is reflected in key management and personnel practices and policies, especially those relating to performance improvement and discipline action.	• All staff are trained in the implementation of policies relating to performance improvement and disciplinary action using a coaching approach • Except in cases of abuse, neglect or endangerment of clients, residents and/or staff, formal disciplinary actions and annual evaluations of workers are conducted face-to-face by, or with, input from the supervisor bringing the action.	• Employees have knowledge of performance expectations and a clear sense of accountability.
All employees are oriented to coaching supervisory approach and their respective roles with regard to the coaching approach to supervision.	Description of orientation program, including an explanation of coaching supervision approach and related policies and procedures.	Employees understand coaching supervisory approach and their roles in process.

DOMAIN 1: SUPPORTIVE WORKPLACES

Criteria for NC NOVA Designation: Management Support

Management creates and supports a climate of mutual respect and responsiveness that values front-line caregiving as a shared goal of direct care workers, clinical staff and non-clinical personnel throughout the organization. A commitment by top management supports all the other domains and is essential to the success of any change initiative.

Criteria for NC NOVA Designation: Management Support		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Management creates, develops and supports participatory and collaborative systems for ongoing communication within and between departments with the goal of making sure that all workers on all shifts are kept up to date and have a way to comment on issues that arise. Clear and timely feedback is provided in response to day-to-day communication from direct care workers about patient/resident care and work environment.	Organizational communications plan and practice, including: • Description of communication systems and tools • How management communicates with staff • How departments communicate with one another • How input is solicited from and feedback provided to direct care workers • Description of process for communication between shifts and shift report • How change is communicated • Description of process for worker input in communication Direct observation important here	Workers are informed and have the opportunity to provide input on matters that affect their ability to do their jobs. They are actively engaged in organizational initiatives or changes • On-site interviews with workers and managers: o "Do you have the information needed to do your job? o "Can you provide input in response to information you receive? o Examples your input is listened to?"

Criteria for NC NOVA Designation: Management Support		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Case management or employee counseling is offered to address logistical and emotional issues such as coordinating access to community services needed to overcome obstacles such as childcare, transportation, housing, etc. Management offers support groups for employees to address life/work issues—especially in the first 90 days of employment, as part of the orientation and mentoring of new employees.	Description of case management or counseling supports • Program is offered • Information on how it is used and evaluated • Support groups are offered, linked to orientation • Describe support group structure and process • Describe specific supports for new employees, addressing work-life issues • Structures in place? When and how long?	Workers are supported in addressing logistical and emotional barriers to work. On-site interviews
Opportunities are created for managers and line staff from different departments and levels to develop leadership and participation skills, so that a representative group has the capacity to lead a change process.	Development of "natural" leadership at all levels • Describe process and mechanisms for leadership development • Is there training for leadership? • Do staff get paid leave time? Established leadership group responsible for change process • Committee description, minutes, direct care workers' part. • What is the committee charged with? • How often do they meet? • What authority do they have? What is outcome of decisions or recommendations?	Workers at all levels participate actively in leading change process. • On-site Interviews with workers and managers • On-site observation of key committee meetings: o "Are direct care workers present? o Do they contribute to the discussion? o Do others facilitate their contribution"?

DOMAIN 1: SUPPORTIVE WORKPLACES

Criteria for NC NOVA Designation: Rewards & Recognition

Rewards and recognition are distinct from regular compensation policies. Rewards, whether monetary or non-monetary, address the needs and interests of the direct-care workers themselves. Extrinsic rewards and worker recognition are helpful additions to other daily efforts to acknowledge the value of workers both as individuals and as a group. Managers should engage workers in a participatory process to determine what would be valued, meaningful and culturally sensitive forms of recognition.

Criteria for NC NOVA Designation: Rewards & Recognition		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
A cross-section of workers is involved in participatory processes that solicit their ideas about what actions and behaviors should be recognized and what rewards would be meaningful.	Description of how the rewards are developed, including information about how: • Workers input is solicited (e.g., through focus group, worker committee). • Worker input is incorporated	• Workers are valued, formally recognized members of the organization who are involved in creating a positive work culture. • Rewards are implemented and workers participate • Workers receive recognition of their impact on the team and on their clients / residents.
Management is clear about what would be feasible, given time and budget constraints.	• Evidence of management input regarding constraints for the design of the overall rewards and recognition program. • Details of the program are shared with all employees when approved, modified or updated	• Workers' loyalty to organization increases. • Workers' trust in management increases.

Criteria for NC NOVA Designation: Rewards & Recognition		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Rewards are distinct from an organization's regular compensation policies and could include: • Worker appreciation events where all or selected workers are publicly honored • Daily, weekly, monthly, annual acknowledgement of worker contributions • Financial incentives/bonuses for performance, attendance, recruitment or leadership, etc., or other programs that are solely performance-based such as a lottery or bonus eligible for staff with perfect attendance, etc. • Company-sponsored activities for workers and their families	Examination of progression in wage scale or worker wage and benefits over time.	Through interviews find that: • Workers' job appreciation has increased • Workers can articulate that the rewards/recognition program for is distinct from their regular evaluation/wage increases • Workers are aware of opportunities to earn increased income and for what purposes. • The broader reward structure helps make positions more attractive to workers
Efforts to recognize and reward employees are culturally sensitive.	Description of how worker cultural sensitivity was considered in the program design. (e.g., through focus group, worker committee), and how worker input was incorporated.	• Workers feel valued in ways that are acceptable to them.

DOMAIN 1: SUPPORTIVE WORKPLACES

Criteria for NC NOVA Designation: Worker Empowerment

Worker empowerment is fundamental to creating a supportive workplace environment. To be effective, it requires formal, well-understood mechanisms for worker participation in planning and decision-making about day-to-day and long range care practices and work environment.

Criteria for NC NOVA Designation: Worker Empowerment		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Input from direct care workers influences the ongoing process of individualized care planning	Care Planning Program Description, including orientation procedures that cover the agency's philosophy and methodology regarding the care planning process. Description of licensed personnel's role and responsibility in soliciting input and providing feedback from direct care workers re: care plans. Description of direct care workers' role and responsibility in contributing to ongoing care planning. Sample care plan, with the recipient's name removed, that exemplifies direct care workers' involvement	Workers' perspectives are consistently included and valued in the care planning process. • On-site observation • Interviews with managers • Interviews with workers: Are you involved in care planning for the people you care for? Can you give an example of how an idea or comment from you was made part of the plan? Is action taken in response to your reporting a consumer's need? If action is not taken based on your comment or idea, are you given feedback in a timely manner?

Criteria for NC NOVA Designation: Worker Empowerment		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Care delivery assignments are consistently based on worker and client preferences, worker competencies and care needs of the clients.	Policies and Procedures regarding care assignment, including descriptions of: • How care assignments are made and how effectiveness is evaluated. • How consumer and worker preferences are managed.	• Interview with workers and clients: Do you believe your needs and preferences are taken into consideration when the assignments are made? • Interview with manager Tell me how needs and preferences of the direct care workers and clients influence your assignment of care
Direct care workers have a quiet, designated place, designated times and the necessary resources to complete non-direct care tasks	Descriptions of accommodations and resources (such as table/desk, chair, pads, pens/pencils, access to charts, time, etc.) over and above a break room	Workers are satisfied with the space and resources for non-direct care tasks. • On-site evaluation • Interviews

Direct care workers and staff have avenues of input into agency decision-making	Committee descriptions, minutes, attendance and other examples of input that address such questions as:
	• What are committees charged with?
	• How often do they meet?
	• What are their roles and responsibilities?
	• What is the outcome of committee decisions or recommendations?
	• How many direct care workers are active committee members?
	• How often do workers seek input from their peers to bring to the committee meetings?
		Workers' input on committees is valued.
		
		• Interviews to elicit workers' perceptions of their input and value
		• Interviews with workers and managers
		• On-site observation of committee meetings:
		  ○ Are direct care workers present?
		  ○ Do they contribute to the discussion?
		  ○ Do others facilitate their contribution?

Criteria for NC NOVA Designation: Worker Empowerment		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Direct care workers have input into residential/client quality of care and quality assurance/quality improvement processes	Description of QA/QI policies and processes that include descriptions of the process and how input is solicited	Workers understand the QA/QI process and their input is valued. • Interviews to elicit workers' perceptions of value and knowledge • Interviews with workers and managers to identify specific examples of "input" listened to
Direct care workers have the information and support they need to function effectively in a participatory setting	Description of training and/or orientation process for direct care workers' roles on committees or teams addressing such questions as: • How are direct care workers prepared for participation? • What support to managers and peers provide? • Is there any peer-to-peer communication among workers and shifts? • How often are staff meetings held? • Can workers call a meeting if they see the need to do so?	Workers have the skills and confidence to voice opinions, knowledge and ideas. • Interviews to elicit workers' feelings of confidence and knowledge • Interviews with workers and managers

DOMAIN #2: TRAINING

Training is the ongoing process of instruction that enables workers to maintain and advance the skills they need to perform their jobs safely and effectively. Training and orientation are distinct but sometimes overlapping processes. Unlike orientation, training does not have a fixed duration; rather, it is a continuous undertaking that builds upon workers' demonstrated skills and strengthens their ability to thrive in a positive, problem-solving environment.

In direct care settings, effective training should be characterized by:

- An emphasis on strengthening the person-centered services and care respectful relationships, compassion and humanity that underlie the mission and values of the agency, facility or institution.

- Respect for the diverse backgrounds, training levels and learning styles of individual workers and research showing that adults are motivated more by "real-world problems" that build on real-life experiences and situations.

- Linkages with quality improvement initiatives and topics generated with input from front-line caregivers as well as the insights of administrators, whose broader view of the environment can help them identify emerging trends and needs.

- Involvement of experts outside of agency or facility, when necessary, because, not all agency or facility trainers will have expertise in each aspect of clinical care in which direct care workers must acquire proficiency.

Training initiatives targeted to direct care workers would be expected to include the following elements:

1. Ongoing training integrated into workplace management and conducted according to a written plan that covers specific skills and attitudes and dedicates time in which workers are relieved of their customary responsibilities to attend training.

2. Basic and advanced competencies for workers are identified and their core knowledge assessed for providing care to the target population of the agency, facility or institution. This needs assessment should address such issues as scope of care provided, case mix of people seen and the availability of clinically trained supervisors or consultants.

3. Routine availability of training on core values and customer service as well as knowledge and skills needed to perform in the organization.

4. Training modules focus on both high-volume, high-risk situations such as the process of dying and palliative care; effective techniques for caring for people with cognitive impairment; handling family member dissatisfaction about how care is scheduled; techniques for coaching and mentoring; infection control; CPR;

preventing behavioral disturbances in people with dementia; as well as low-volume but high-risk situations such as colostomy care or dealing with a new type of equipment such as a new tube-feeding set-up.

5. Clinical skills training includes both simulated and live practice opportunities with a knowledgeable and skilled practitioner who supervises learning from the introduction of the content, through practice in a simplified environment to demonstration/return-demonstration at the bedside or chair-side.

6. Preceptors or mentors who help translate new knowledge into daily care routines.

7. Staff learning accomplishments accompanied by visible recognition and reward.

Criteria for NC NOVA Designation: Training

Training is the ongoing process of instruction that enables workers to maintain and advance the skills they need to perform their jobs safely and effectively. Training and orientation are distinct but sometimes overlapping processes. Unlike orientation, training does not have a fixed duration; rather, it is a continuous undertaking that builds upon workers' demonstrated skills and strengthens their ability to thrive in a positive, problem-solving environment.

In direct-care settings, effective training is characterized by:

- Emphasis on person-centered services in all trainings involving client/customer service.

- Attention to encouraging the development of respectful relationships between the customer and the worker, strengthening the compassion and humanity underlying the mission and values of the agency, facility or institution.

- Respect for the diverse backgrounds, training levels and learning styles of individual workers. Research shows adults tend to be motivated more by "real-world problems" that build on real-life experiences and situations, for example, and some are "visual" learners while others are "auditory" learners.

- Linkages with quality-improvement initiatives and topics generated with input from front-line caregivers as well as the insights of administrators, whose broader view of the environment can help identify emerging trends and needs.

- Involvement of experts outside of agency or facility, when indicated, because not all agency or facility trainers will have expertise in each aspect of clinical care in which direct care workers must acquire proficiency.

- Recognition of the need for diversity in the methods and perspectives required to best assist direct-care workers in meeting the clinical and relational skill requirements of their positions.

Training initiatives targeted to direct-care workers under NC NOVA are expected to exceed minimum licensing requirements pertaining to continuing education for staff. Instruction provided as part of the organization's ongoing training for direct care workers assumes that it takes place while workers are on paid status and should include the following elements:

Criteria for NC NOVA Designation: Training		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
A formal training needs assessment is conducted at least annually at the agency, facility or institution and reviewed with employees. The assessment includes: • Identification of basic and advanced competencies that workers need including specific skill sets and attitudes • Assessment of workers' core knowledge regarding the provision of care/services to organization's target population • Needs assessment of such areas as scope of care provided, case mix of people seen and availability of clinically trained supervisors or consultants. Input from employees at all levels of organization using as collaborative and comprehensive methods as possible and reflecting individually identified training needs.	• Policies & Procedures regarding training needs assessment (process, content, timeline). • Reports on results of training needs assessment that include observations, assessment, description of methodology and people involved in doing the assessment and a plan of action for formal implementation. For instance, direct care workers are asked to submit individual training needs/preferences which are then reviewed and obviously incorporated into the training plan developed; or a list of potential training topics is provided from which direct care workers can identify individual needs and also add other content.	Through interviews with senior management determine that: • Assessment of training needs is a regular part of organization's activities • Assessment yields useful information about ongoing training needs as conditions at facility, agency, or institution change. • Service delivery meets needs of target population. Through interviews with direct care workers and review of documents related to assessment and training, determine that workers had direct input and that training conducted corresponds to identified needs.
Ongoing training plan for the organization is created that reflects the findings from the needs assessment.	A copy of the training plan which includes but is not limited to: timeline, content areas, and processes.	Through interviews with senior management and workers determine that: • A clear, plan is established annually with priorities that relate to the needs assessment. • Training seamlessly integrated into operation of the organization

Criteria for NC NOVA Designation: Training		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Routine training is available on: • Organizational core values • Customer service • Knowledge and skills needed to perform *satisfactorily* in the organization. • Use and maintenance of necessary equipment and supplies.	• Policies & Procedures regarding organization's training programs. • Material detailing trainings offered (timelines, content/ curriculum/, list of participants). • Instruction manuals for equipment.	Through interviews with management and workers determine that: • An ongoing training program is in place. • An established core set of skills and expectations is continually reinforced.
Training content includes situations workers commonly experience involving a high degree of skill and precision to master because of the risk involved with them.	Training modules include: • Process of dying and palliative care • Effective techniques for caring for people with cognitive impairment • HIPAA • Addressing family concerns • Coaching and mentoring techniques • Infection control • CPR • Managing behavioral disturbances in people with dementia.	Through interviews with workers determine that: • Training modules address highest-risk situations, both those that arise frequently and those that occur less frequently • The needs they identify are considered when their training plans are developed
Training modules cover situations workers deal with infrequently but still require a high degree of skill to master because of the risk involved.	Examples of training modules might include: • Colostomy care • Dealing with new type of equipment such as tube-feeding set-up.	Through interviews with workers determine they are prepared because they have the skills and ability to serve the clients they are assigned to work with
Clinical skills training includes both simulated and live practice opportunities with knowledgeable and skilled practitioner with evidence of at least some formal training in adult education. This practitioner is responsible for supervising learning from	Review written training materials and curricula for clinical skills training.	Clinical training is effective because it: • Is conducted through both simulation and live practice. • Incorporates proven methods aimed for adult learners

Criteria for NC NOVA Designation: Training		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
content introduction through practice in a simplified environment (using a demonstration /return-demonstration methodology) at bedside or chair side.		
When appropriate, someone with expertise—preceptor, supervisor or co-worker—is identified and available to help workers integrate their new skills and knowledge into daily care routines.	Documentation of experts	Through interviews determine that staff know who these experts are and how to get their help as needed.
Workers schedules/hours are considered when scheduling trainings, and the training is in a convenient location.	Documentation of location/timing.	Through interviews with workers determine that: they are able and willing to attend training because times and locations are convenient
Workers are relieved of their customary responsibilities to attend training, and coverage is obtained to ensure continuity in care.	Review Personnel / Policy Manual.	Through interviews with workers determine that they have a greater incentive to attend training knowing they are relieved of customary responsibilities and that care will be provided to client/consumer. Through interviews with management determine that it can explain how training is conducted to relieve workers of duties.
Staff learning accomplishments are accompanied by visible recognition and reward. (See page 22 for more discussion on this point.)	Documentation to support that each training will have a specifically designated way of rewarding staff either through recognition in the form of a certificate or plaque or through financial rewards.	Through interviews with training managers and workers determine that: • Training and learning are encouraged for all workers through recognition and reward. • Organization communicates to staff that it values "progress" through learning and training.

DOMAIN #3: BALANCED WORKLOADS

Balanced workloads result from ongoing cooperation between management and direct care workers. The process is designed to provide the right level of staffing and resources necessary given an ever-changing case-mix needs of the facility or agency.

Because each direct care setting is unique, with needs that can change in significant ways on a daily basis, flexibility in scheduling and assignments—rotating assignments to avoid burn-out, for example, or distributing workloads on a case-mix basis—might be the most important principle underlying the goal of balanced workloads.

Other principles that underlie balanced direct care workloads include:

- Ongoing review of the population that the direct care staff/care team serve and the reasonableness of the assigned workload and expectations for productivity based on patient acuity, the intensity of care needed and competency of available staff.

- Input from direct care workers on the care team and the creation of a written, widely understood mechanism for identifying and making adjustments to staff/team assignments as frequently as conditions warrant.

- Consideration of special needs such as dementia and the inclusion of staff training to meet those needs as part of any approved plan for safe and balanced workloads.

- Extensive back-up planning thoughtfully created and widely communicated to staff, with float pool, on-call list and overtime provisions to ensure necessary coverage for holidays, adverse weather and other staffing contingencies.

- Giving employees time to perform their tasks and establishing mechanisms both to track, measure and correct excessive overtime and to detect worker burnout.

- Training staff members to use and maintain necessary equipment, which is strategically located and kept in good working order with sufficient supplies.

Examples that demonstrate balanced workloads in direct care settings include:

1. Direct care staff self-schedule work shifts, both under normal conditions and when responding to unanticipated changes in staffing or care demands consistent with employee staffing needs.

2. There are internal temporary, float pools, on-call schedules, temp lists or similar devices available to reduce reliance on contract workers to meet staffing demands.

3. Direct care staff has a system to identify warning signs of worker burnout and rotate worker/care team assignments to make needed and timely adjustments.

4. Home care agencies offer alternative for some staff to ensure full-time work. There are financial or scheduling incentives to work less desirable or harder to fill shifts or assignments and these incentives are assumed to be above any applicable wage and hour requirements.

5. In residential settings there are pay differentials for working on a hall or team that is short-staffed.

6. Workers have input into their work schedule based on their work availability and preferences.

7. The agency has implemented a process to ensure clients have realistic expectations of direct care worker assignments.

8. Productivity standards and maximum patient visit thresholds are developed to ensure safe, effective and quality care, taking into consideration acuity, assigned tasks and travel considerations.

Criteria for NC NOVA Designation: Balanced Workloads

Balanced workloads result from ongoing cooperation between management and direct-care workers. Because each direct-care setting is unique, with *client-based* needs that can change in significant ways on a daily basis, flexibility in scheduling and assignment is designed to provide the right level of staffing and resources necessary given an ever-changing client and case-mix needs and the need to build relationships between workers and consumers. Having balanced workloads also assumes an appropriate level of qualified staff, equipment and supplies.

Examples that demonstrate balanced workloads in direct care settings include:

Criteria for NC NOVA Designation: Balanced Workloads		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Workers have meaningful input into their work schedule based on their work availability and preferences.	• On-site observations of scheduling operations. • Process to determine worker availability. Examples could include: o Survey o Charts o Written requests	Through interviews with workers determine that: • Their stated preferences and availability are taken into account by schedulers. • They are less like to call off/out based on scheduling conflicts if they have input into their own schedules.
Ongoing review of client / resident population *with* direct care staff/care team to assess reasonableness of assigned clients / residents and expectations for productivity based on client / resident acuity, intensity of care needed and competency of available staff.	• Documentation that those responsible for scheduling understand that they should incorporate the strengths, training and preferences of staff into their scheduling practices. • Equipment and supplies are strategically located / readily available with equipment in good working order and ample supplies.	Through interviews with supervisors, schedulers and workers determine that care team and workers are continuously involved in fine-tuning workload and assignments in order to create balanced workloads.
Extensive back-up staffing plan exists and is communicated to staff to ensure coverage for holidays, adverse weather, and other contingencies. Organizations utilize internal back-up systems before relying	• Existence of internal temporary float pools, on-call schedules and/or temp lists. • Review relevant Policies and Procedures for getting into float pools to	Through interviews with supervisors and workers regarding how back-up staffing plan works (in particular, whether workers know how to "join" and what benefits are involved with

Criteria for NC NOVA Designation: Balanced Workloads		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
on contract workers	work overtime, if desired.	being in the on-call pool) determine that: • The organization is not heavily reliant on contract workers who are costly to the organization and disrupt continuity of care for the clients/residents. • Care teams, workers, and client/patients can count on reliable back-up staffing plans to meet expected and unexpected contingencies. • Higher wages earned by workers who wish to work additional shifts. Direct care staff is satisfied with the number of hours worked.
"Early-warning system" in place to detect and correct worker burnout and unwanted or excessive overtime.	• Written material describing "early-warning system." • Written records detailing rotations of worker/care team assignments in response to early detection.	Organization continuously monitors overtime and other potential indicators of worker burnout to detect and correct overburdening of workforce.
Financial and/or scheduling incentives exist to reward workers for helping out in unexpected emergencies or staff shortages and/or harder-to-fill shifts or assignments.	• Documented assessment of organization's staffing patterns, which identifies systemically difficult to fill shifts/hours/locations. • Review Personnel Manual for written policies regarding incentives. For example, pay differentials exist in residential settings for working on a short-staffed hall or team.	Interview direct care staff to determine that workers are compensated for working unexpected emergencies or staff shortages and/or harder to fill shifts or assignments.

DOMAIN #4: CAREER DEVELOPMENT

Recommended Elements for Successful Interventions

Opportunities for career advancement are an important ingredient of better jobs that can help to stabilize the workforce. A good, employer-based career development program is open, equitable and accessible to all employees, including clinical, administrative and paraprofessional. Employees know that there are opportunities for increased compensation in the form of extra pay, benefits or other workplace inducements for those who acquire additional skills or take on added responsibilities within the organization to promote improved quality of care.

A career development system should incorporate what are widely regarded as fundamental practices of human resources management, at least including:

- Written personnel policies discussed at orientation and available to all employees.
- Regular performance reviews that include both written and face-to-face assessments of an employee's strengths, weaknesses and opportunities for advancement with an associated professional development plan that is revised as needed to reflect opportunities for advancement opportunities within the organization and/or the profession and beyond.
- A structured, incremental system that categorizes direct care job titles, descriptions, qualifications, responsibilities and pay ranges. Personnel policies should also address the minimum and maximum incremental wage increases for an employee moving from one job category to another.
- The posting of internal job vacancies and a formal application and selection process for employees who want to fill them.
- Opportunities for continuing education and management support through reimbursement of tuition and/or registration fees, release time, etc.
- Career paths within unlicensed category for direct care workers.

Some examples of career development initiatives that could apply to direct care workplaces include:

1. Having peer mentors/unlicensed persons who will be orienting new staff involved in the pre-employment interview process.
2. Rewarding seniority and expertise with more control and choice over work scheduling, shifts and assignments.

3. Implementing a "Win-A-Step-Up" type model that provides financial incentives for direct care workers who complete certain additional job-related training.

4. Incorporating into the organization's career advancement pathways any new state-recognized direct care job categories such as medication aide and/or geriatric nurse aide and their associated job descriptions and wage scales.

5. Including job categories and wage differentials for peer mentors.

6. An internally developed set of unlicensed direct care job categories that represent a career ladder or lattice with corresponding reward within these unlicensed job categories.

Criteria for NC NOVA Designation: Career Development

Opportunities for career development and advancement are an important ingredient of better jobs that can help to stabilize the workforce.

A good, employer-based career development system (CDS) is open, equitable and accessible to all employees, including clinical, administrative and paraprofessional staff members. It is a structured, incremental system that incorporates what are widely regarded as fundamental practices of human resources management and categorizes direct-care job titles, descriptions, qualifications, responsibilities and pay ranges. With it are personnel policies stating minimum and maximum incremental wage increases for an employee moving from one job category to another. Employees know that there are opportunities for increased compensation in the form of extra pay, benefits or other workplace inducements for those who acquire additional skills or take on added responsibilities within the organization to promote improved quality of care.

Some examples of career development initiatives applicable to direct-care workplaces may include, but are not limited to, career ladders and lattices, rewarding excellence in care, and policies for promoting from within.

Criteria for NC NOVA Designation: Career Development		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
There is a CDS in place that incorporates into the organization's career pathways new state-recognized direct-care job categories as appropriate and their associated job descriptions and wage scales	• Policies & Procedures relating to CDS and other job-related materials are posted at the organization. • A list of individuals promoted and/or interviews conducted under the CDS.	Through on-site interviews with workers determine that: • They perceive the CDS to have meaningful career steps accompanied by increased compensation and responsibility. • They receive feedback on and are encouraged to take advantage of specific career development opportunities open and appropriate to them.

Criteria for NC NOVA Designation: Career Development		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
Develop internal set of unlicensed direct-care job categories (such as peer mentors, senior aides, family liaisons) that represent a career ladder or lattice with corresponding reward within categories.	Policies & Procedures relating to CDS and other job-related materials posted at organization.	Through on-site interviews with workers determine that: • They understand the career ladder for unlicensed positions. • They see opportunity to advance within the sector rather than only outside of the sector. • Workers in different steps in fact have functional differences in their jobs.
Regular performance reviews that include both written and face-to-face assessments of employee's strengths, weaknesses and opportunities for advancement with associated professional development plan revised as needed to reflect advancement opportunities within organization and/or profession and beyond.	Sample of personnel records, with names blocked out, containing performance reviews	Through interviews with employees determine: • Their awareness of CDS and the extent to which it and employees' professional development plans are addressed at performance reviews. • Workers are recognized for their contributions, skills and talents • Workers are given the opportunity to improve themselves.
Opportunities for continuing education with management support.	Policies & Procedures relating to CDS that are posted and could include: • Reimbursement of tuition and/or registration fees • Granting of release time • Implementation of a "Win-A-Step-Up" model with financial incentives to direct-care workers who complete additional job-related training.	Through interviews with workers determine: • Their knowledge of opportunities for continuing education. • Barriers to furthering workers' education are eliminated or lessened.
The posting of internal job vacancies and a formal application and selection process for employees who	Policies and procedures relating to CDS and other job-related materials posted at	Through interviews with workers determine: • Their knowledge of

Criteria for NC NOVA Designation: Career Development		
Activity	**Expected Evidence of Structure and Process**	**Outcome**
want to fill them.	the organization.	opportunities for continuing education • The selection process is seen as fair, and equal opportunity for participation exists

SECTION VI: NC NOVA APPLICATION AND REVIEW PROCESS

Medical Review of North Carolina (MRNC) is the entity that will be managing the application, review and determination process for the NC NOVA special licensure pilot project. Pilot projects will need to contact MRNC to obtain an NC NOVA application. Contact information for MRNC is included at the end of this section.

The application and review process will be comprised of the following components:

8. Once the applicant submits a completed application to MRNC, NC NOVA trained MRNC staff will conduct a pre-site visit desk review of the application and evidence submitted by the pilot applicant for NC NOVA designation;

9. After the initial desk review is completed, MRNC will conduct a conference call with the applicant to clarify any questions MRNC has pertaining to the application;

10. Once it is determined that the application information is complete, MRNC will schedule the on-site visit;

11. Trained MRNC staff will conduct an on-site review. The purpose of the on-site review is to confirm that application information and evidence submitted in/with the application is evident in the daily operations of the applicant. The on-site review will include interviews with administrative, supervisory, direct care staff and others as appropriate.

    Note: It is important that the applicant help all staff within the organization understand that NC NOVA is not a regulatory survey. This is a "raise-the-bar" program to recognize and honor organizations that meet NC NOVA criteria. Staff should have a clear understanding of the goals of NC NOVA as well as the application, review, and determination process so they will be comfortable speaking with on-site reviewers

12. MRNC will conduct a post on-site review to compile all information and determine whether the applicant has met the requirements for NC NOVA special licensure designation.

13. MRNC will notify the applicant by letter as to whether or not they have met the criteria for NC NOVA special licensure designation. For each organization determined to meet the criteria, MRNC will notify the Division of Facility Services that an NC NOVA special licensure award needs to be sent to the applicant. The Division of Facility Services will be responsible for preparing and sending the special license to the successful applicant within a specified period of time. In cases where the applicant was determined not to meet the criteria, MRNC will provide a brief summary to the applicant identifying areas that need additional attention. The decision of MRNC is final. Entities that do not meet the criteria for NC NOVA special licensure designation may re-apply when ready for reconsideration.

14. The Division of Facility Services will mail an NC NOVA special license to each awardee following notification by MRNC.

15. Once MRNC makes a determination as to whether an applicant has or has not met the criteria for NC NOVA, all provider specific information collected through the application, on-site review, and post-review determination process will be destroyed.

Contact Information for Medical Review of North Carolina:

Medical Review of North Carolina
100 Regency Forest Dr.
Suite 200
Cary, NC 27511-9227
Attn: NC NOVA

Or via email at: NC_Nova@mrnc.org

SECTION VII: ELIGIBILITY CRITERIA TO APPLY FOR SPECIAL LICENSURE

NC NOVA special licensure designation is a **voluntary** program for home care agencies, adult care homes and nursing facilities.

State provider associations represented on the Partner Team are responsible for selecting agencies to participate in the pilot phase. Agencies/facilities selected to participate in the pilot must have a license in good standing (no provisional status).

Pilot sites must maintain their license/certification in good standing throughout the application, desk review and on-site review to be eligible to receive a NC NOVA special licensure designation.

Pilot sites determined to meet NC NOVA criteria will be issued a special licensure certificate. Because this is a voluntary program, all pilots (and future applicants once the program is implemented statewide) must agree to abide by the decision of Medical Review of North Carolina regarding whether or not the agency/facility met the criteria for NC NOVA designation as a result of the desk and on-site review process.

In the unlikely event a pilot site is decertified by Medicare and Medicaid or has its license revoked or licensure status changed to "provisional" at any point during the application and review process, the pilot will need to contact Medical Review of North Carolina to have its special licensure application/review put on hold until such time full license/certification is reinstated. The application/review process can resume once full license/certification is reinstated.

Applications, notes from on-site visits and any other material that Medical Review of North Carolina uses to determine whether a pilot site attains NC NOVA designation will be destroyed after the special licensure decision is made.

SECTION VIII: CONDITIONS FOR TERMINATING SPECIAL LICENSURE

Once a pilot site is awarded the NC NOVA designation, the designation remains in effect for two years. The only mandatory condition for which the Division of Facility Services would terminate special licensure designation prior to the end of the two-year award period is in the event that license or certification status negatively changes (i.e., license revoked or changed to provisional status; or decertified by Medicare and Medicaid).

In the event there is a change of ownership during the special licensure award period, the new licensee may seek to maintain the special licensure designation for the duration of the award period by requesting an expedited review through Medical Review of North Carolina. The purpose of the expedited review will be to ensure that the new licensee continues to meet the criteria for special licensure. The Partner Team will more fully develop the process for expedited review at a later date.

Appendix 1: Data Submission Requirements

OVERVIEW

Pilot providers will designate an individual to serve as a data liaison with the National Better Jobs Better Care evaluation team (Penn State University) to coordinate efforts to ensure the following:

- Needed technical assistance from Penn State is arranged/obtained
- All required evaluation data are submitted accurately and in a timely manner pertaining to all routine and quarterly data submission requirements which will include, at a minimum:
    - Submission of employee (direct care workers) hiring and termination data (some data submitted consistent with the provider's payroll cycle). Once the first listing of workers is submitted, only new additions/terminations will need to be reflected on subsequent forms.
    - Submission of quarterly data including: direct care worker employment status (full-time, part-time & hours of employment); number of job openings, direct care wages by person, use of temp agency direct care staff, and health insurance coverage).

    For both categories of data above, a simple web-based format for submission of this data will be provided by Penn State University. In the event the provider does not have computer capacity to complete this data, a hard copy format will be made available. Penn State will provide technical assistance to each pilot site. In addition, Penn State will provide summary data to each pilot on turnover data, etc. for the specific use of the pilot site if they so desire.

- Before and after surveys completed by direct care staff and manager of clinical services (e.g. Director of Nursing in a nursing facility). These surveys address information about job characteristics, job satisfaction, impact of culture change initiatives to compare changes at beginning of demonstration and end.

- Participate in any telephone interviews set up through the national program evaluation office.

  It is important to note that none of the data collected by Penn State for purposes of the national Better Jobs Better Care evaluation will be pilot site specific. The smallest unit of data that will be reflected in any evaluation data/reports they produce for the national program will be aggregate state data.

Data specifically related to NC NOVA: provider may also be requested to submit

- Additional information that the Partner Team may request for use by the Partner Team to make any necessary revisions to NC NOVA program, if any.

  Note: All application, on-site review materials and interview information submitted to or collected by Medical Review of North Carolina for the purpose of determining whether an applicant has met the criteria for NC NOVA will remain confidential. The only provider specific information that will be provided to the Partner Team, Division of Facility Services, or public is a list of pilot organizations that received an NC NOVA award. All specific information submitted by the provider will be destroyed upon notification of the provider as to whether they will receive an NOVA award, or not, based on their application and review process. For the benefit of individual providers, Medical Review of North Carolina will NC NOVA applicants a brief synopsis of applicant strengths and any areas that need additional attention for purposes of meeting NC NOVA criteria.

- Agree to abide by the findings of Medical Review of North Carolina regarding whether criteria for receipt of an NC NOVA award has been met.

- In the event the provider decides to not complete implementation efforts in readiness of submitting an NC NOVA application, the provider agrees to continue submitting routine and quarterly data required of all pilot projects throughout the pilot period (July 2005 through December 2006).

Appendix 2: State-Approved Coaching Supervision Trainers

Trainers – Coaching Supervision	Telephone Number	Email Address
Dottie Bement	910-944-9665 (h) 910-695-3965 (w)	bementd@sandhills.edu
Diana Bond	919-350-5920/8547	dbond@wakemed.org
Trent Cockerham	336-679-8852	Trent.cockerham@triadgroupinc.com
Tony Garcia	336-243-2500	TGRN@triad.rr.com
Therese Gilmore	910-326-1068	trgilmore@ec.rr.com
Jodi Hernandez	919-733-0440 (w-Ral.) 336-357-2700 (w – Lex.)	Jodi.hernandez@ncmail.net
Carla Hutcherson	252-535-2072 252-578-5295 (cell)	lucasgrl@3rddoor.com
Rose Ludd	336-421-3717	luddr@bellsouth.net
Leigh-Anne Royster	919-563-6514	lean@email.unc.edu
Kathie Smith	919-848-3450	kathiesmith@homeandhospicecare.org
Teepa Snow	919-832-3732	tsnow@alznc.org
Sandy Spillman	336-724-1000, ext 108 (w) 336-813-1240 (cell)	sandydss@aol.com
Pat Strickland	828-694-1761 (w) 828-693-8548 (h) 828-777-9121 (cell)	pats@blueridge.edu
Donna White	919-733-0440, ext. 232	Donna.white@ncmail.net
Allyson Woodside	910-257-0246	allykatzen@yahoo.com

Appendix 3: Resource Documents

Making Workforce Development Part of the Debate

"Why Workforce Development Should Be Part of the Long-Term Care Quality Debate" (Stone, Dawson, Harahan; October 2003).

Available online via
http://www.paraprofessional.org/publications/LTC_Quality_Debate_Paper.pdf

Recent Findings on Frontline LTC Workers

"Recent Findings on Frontline Long-Term Care Workers: A Research Synthesis 1999-2003," (authored by staff with the Institute for the Future of Aging Services and published by the DHHS's Office of Disability, Aging and Long-Term Care Policy), May 2004.

Available online via:
http://www.directcareclearinghouse.org/download/research%20synthesis.pdf

Creating a Culture of Retention

"Creating a Culture of Retention: A Coaching Approach to Paraprofessional Supervision" (Paraprofessional Healthcare Institute)

Also available online via:
http://www.paraprofessional.org/publications/PHICoaching.pdf

Peer Mentoring in LTC

Introducing Peer Mentoring in Long-Term Care Settings. This is one of a series of occasional papers produced by the Paraprofessional Healthcare Institute. (May 2003).

Available online via:
http://www.directcareclearinghouse.org/download/WorkforceStrategies2.pdf

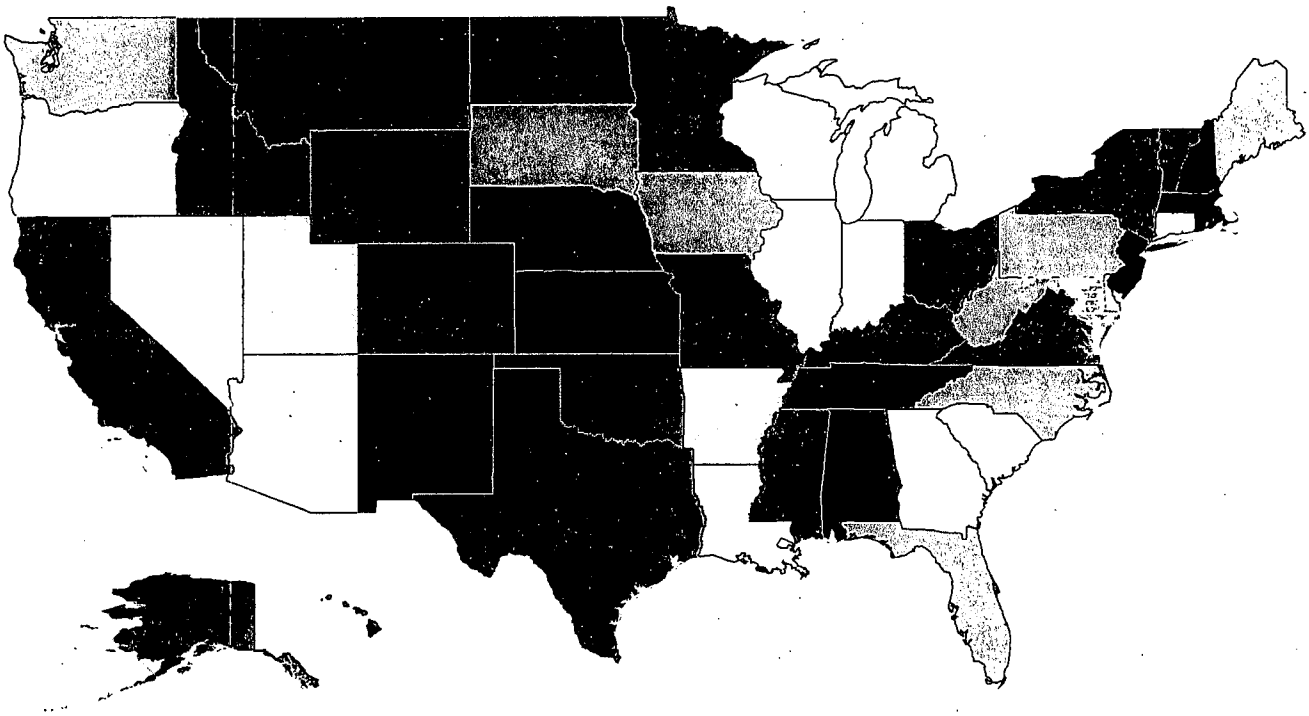
Training for Recruitment and Retention

"The Role of Training in Improving the Recruitment and Retention of Direct-Care Workers in Long-Term Care. One in a series of occasional papers (Workforce Strategies No. 3) produced by The Paraprofessional Healthcare Institute (January 2005).

MAKING THE GRADE: HOW DO THE STATES RATE?

Grades for 2003

Figure 1:
States' grades for 2003 are presented in Figure 1 and Table 5.



A	B+	B	C+	C	D+	D	F
None	Alabama	Florida	Arkansas	Alaska	Arizona	New Hampshire	None
	Kansas	Iowa	Maryland	California	Connecticut	New Jersey	
	Nebraska	Maine	Michigan	Colorado	Delaware	Rhode Island	
	Massachusetts	North Carolina	Nevada	Idaho	Dist. of Columbia		
	New Mexico	Pennsylvania	Oregon	Kentucky	Georgia		
		South Dakota	South Carolina	Minnesota	Hawaii		
		Washington	Utah	Mississippi	Illinois		
		West Virginia	Wisconsin	Missouri	Indiana		
				Montana	Louisiana		
				New York			
				North Dakota			
				Ohio			
				Oklahoma			
				Tennessee			
				Texas			
				Vermont			
				Virginia			
				Wyoming			

NORTH CAROLINA

POLICIES EVALUATED

Statutes

UNIFORM CONTROLLED SUBSTANCES ACT
Chapter 90. Medicine and Allied Occupations; Article 5. North Carolina Controlled Substances Act

MEDICAL PRACTICE ACT (*No provisions found*)
Chapter 90. Medicine and Allied Occupations; Article 1. Practice of Medicine

PHARMACY PRACTICE ACT (*No provisions found*)
Chapter 90. Medicine and Allied Occupations
Article 4. Pharmacy
Article 4A. North Carolina Pharmacy Practice Act

INTRACTABLE PAIN TREATMENT ACT
No policy found

Regulations

CONTROLLED SUBSTANCES REGULATIONS (*No provisions found*)
Chapter 45. North Carolina Drug Commission

MEDICAL BOARD REGULATIONS (*No provisions found*)
Title 21. Occupational Licensing Boards; Chapter 32. Board of Medical Examiners

PHARMACY BOARD REGULATIONS (*No provisions found*)
Title 21. Occupational Licensing Boards; Chapter 46. Board of Pharmacy

Other Governmental Policies

MEDICAL BOARD POLICY STATEMENT
North Carolina Board of Medical Examiners. "Management of Chronic Non-Malignant Pain." *Forum.* No 4, December 1996. Adopted: September 13, 1996.

JOINT BOARD POLICY STATEMENT
North Carolina Medical, Nursing, and Pharmacy Boards. "Joint Statement on Pain Management in End-of-Life Care." Adopted: October 21, 1999.

MEDICAL BOARD POLICY STATEMENT
North Carolina Board of Medical Examiners. "End-of-Life Responsibilities and Palliative Care." Adopted: October 21, 1999.

NORTH CAROLINA

PROVISIONS THAT MAY ENHANCE PAIN MANAGEMENT

	1	2	3	4	5	6	7	8
Criteria	**Controlled substances are necessary for public health**	**Pain management is part of medical practice**	**Opioids are part of professional practice**	**Encourages pain management**	**Addresses fear of regulatory scrutiny**	**Prescription amount alone does not determine legitimacy**	**Physical dependence or analgesic tolerance are not confused with "addiction"**	**Other provisions that may enhance pain management**
STATUTES								
Controlled Substances Act[1]								
Medical Practice Act[1]								
Pharmacy Practice Act[1]								
Intractable Pain Treatment Act[2]								
REGULATIONS								
Controlled Substances[1]								
Medical Board[1]								
Pharmacy Board[1]								
OTHER GOVERNMENTAL POLICIES								
Medical Board Statement on Chronic Pain			●		●	●		
Joint Board Policy Statement				●	●			●
Medical Board Statement on Palliative Care				●	●			

Note: A dot indicates that one or more provisions were identified
[1] No provisions were found in this policy
[2] No policy found

NORTH CAROLINA

PROVISIONS THAT MAY IMPEDE PAIN MANAGEMENT

	9	10	11	12	13	14	15	16	17
Criteria	**Opioids are a last resort**	**Implies opioids are not part of professional practice**	**Perpetuates belief that opioids hasten death**	**Physical dependence or analgesic tolerance confused with "addiction"**	**Medical decisions are restricted**	**Length of prescription validity is restricted**	**Practitioners are subject to additional prescription requirements**	**Other provisions that may impede pain management**	**Provisions that are ambiguous**
STATUTES									
Controlled Substances Act				•					
Medical Practice Act[1]									
Pharmacy Practice Act[1]									
Intractable Pain Treatment Act[2]									
REGULATIONS									
Controlled Substances[1]									
Medical Board[1]									
Pharmacy Board[1]									
OTHER GOVERNMENTAL POLICIES									
Medical Board Statement on Chronic Pain[1]									
Joint Board Policy Statement[1]									
Medical Board Statement on Palliative Care[1]									

Note: A dot indicates that one or more provisions were identified
[1] No provisions were found in this policy
[2] No policy found

STATUTES

Controlled Substances Act

N.C. Gen. Stat. § 90-87

§ 90-87. Definitions

.
.
.

(13) "Drug dependent person" means a person who is using a controlled substance and who is in a state of psychic or physical dependence, or both, arising from use of that controlled substance on a continuous basis. Drug dependence is characterized by behavioral and other responses which include a strong compulsion to take the substance on a continuous basis in order to experience its psychic effects, or to avoid the discomfort of its absence.

.
.
.

CRITERION 12: [-]
Physical dependence or analgesic tolerance confused with "addiction"

OTHER GOVERNMENTAL POLICIES

Medical Board Policy Statement

MANAGEMENT OF CHRONIC NON-MALIGNANT PAIN

It has become increasingly apparent to physicians and their patients that the use of effective pain management has not kept pace with other advances in medical practice. There are several factors that have contributed to this. These include a history of relatively low priority given pain management in our health care system, the incomplete integration of current knowledge in medical education and clinical practice, a sparsity of practitioners specifically trained in pain management, and the fear of legal consequences when controlled substances are used--fear shared by physician and patient.

There are three general categories of pain.

Acute Pain is associated with surgery, trauma and acute illness. It has received its share of attention by physicians, its treatment by various means is widely accepted by patients, and it has been addressed in guidelines issued by the Agency for Health Care Policy and Research of the U.S. Department of Health and Human Services.

Cancer Pain has been receiving greater attention and more enlightened treatment by physicians and patients, particularly since development of the hospice movement. It has also been addressed in AHCPR guidelines.

Chronic Non-Malignant Pain is often difficult to diagnose, often intractable, and often under treated. It is the management of chronic non-malignant pain on which the North Carolina Medical Board wishes to focus attention in this position statement.

The North Carolina Medical Board recognizes that many strategies exist for treating chronic non-malignant pain. Because such pain may have many causes and perpetuating factors, treatment will vary from behavioral and rehabilitation approaches to the use of a number of medications, including opioids. Specialty groups in the field point out that most chronic non-malignant pain is best managed in a coordinated way, using a number of strategies in concert. Inadequate management of such pain is not uncommon, however, despite the availability of safe and effective treatments.

The Board is aware that some physicians avoid prescribing controlled substances such as opioids in treating chronic non-malignant pain. While it does not suggest those physicians abandon their reservations or professional judgement about using opioids in such situations, neither does the Board wish to be an obstacle to proper and effective management of chronic pain by physicians. It should be understood that the Board recognizes opioids can be an appropriate treatment for chronic pain.

CRITERION 3: [+]
Opioids are part of professional practice

(CONTINUED ON NEXT PAGE)

OTHER GOVERNMENTAL POLICIES

Medical Board Policy Statement

It is the position of the North Carolina Medical Board that effective management of chronic pain should include:

- thorough documentation of all aspects of the patient's assessment and care;
- a thorough history and physical examination, including a drug and pain history;
- appropriate studies;
- a working diagnosis and treatment plan;
- a rationale for the treatment selected;
- education of the patient;
- clear understanding by the patient and physician of methods and goals of treatment;
- a specific follow-up protocol, which must be adhered to;
- regular assessment of treatment efficacy;
- consultation with a specialist in pain medicine, when warranted; and
- use of a multidisciplinary approach, when indicated.

The Board expects physicians using controlled substances in the management of chronic pain to be familiar with conditions such as:

- physical dependence;
- respiratory depression and other side effects;
- tolerance;
- addiction; and
- pseudo addiction.

There is an abundance of literature available on these topics and on the effective management of pain. The physician's knowledge should be regularly updated in these areas.

No physician need fear reprisals from the Board for appropriately prescribing, as described above, even large amounts of controlled substances indefinitely for chronic non-malignant pain.

Nothing in this statement should be construed as advocating the imprudent use of controlled substances .

CRITERION 5: [+]
Addresses fear of regulatory scrutiny

CRITERION 6: [+]
Prescription amount alone does not determine legitimacy

OTHER GOVERNMENTAL POLICIES

Joint Board Policy Statement

JOINT STATEMENT ON PAIN MANAGEMENT
IN END-OF-LIFE CARE

Through dialogue with members of the healthcare community and consumers, a number of perceived regulatory barriers to adequate pain management in end-of-life care have been expressed to the Boards of Medicine, Nursing, and Pharmacy. The following statement attempts to address these misperceptions by outlining practice expectations for physicians and other health care professionals authorized to prescribe medications, as well as nurses and pharmacists involved in this aspect of end-of-life care. The statement is based on:

> the legal scope of practice for each of these licensed health professionals;
>
> professional collaboration and communication among health professionals providing palliative care; and
>
> a standard of care that assures on-going pain assessment, a therapeutic plan for pain management interventions; and evidence of adequate symptom management for the dying patient.

CRITERION 4: *Encourages pain management* [+]

It is the position of all three Boards that patients and their families should be assured of competent, comprehensive palliative care at the end of their lives. Physicians, nurses and pharmacists should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided.

Because of the overwhelming concern of patients about pain relief, the physician needs to give special attention to the effective assessment of pain. It is particularly important that the physician frankly but sensitively discuss with the patient and the family their concerns and choices at the end of life. As part of this discussion, the physician should make clear that, in some end of life care situations, there are inherent risks associated with effective pain relief. *The Medical Board will assume opioid use in such patients is appropriate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan.* Because the Board is aware of the inherent risks associated with effective pain relief in such situations, it will not interpret their occurrence as subject to discipline by the Board.

CRITERION 5: *Addresses fear of regulatory scrutiny* [+]

With regard to pharmacy practice, North Carolina has no quantity restrictions on dispensing controlled substances including those in Schedule II. This is significant when utilizing the federal rule that allows the partial filling of Schedule II prescriptions for up to 60 days. In these situations it would minimize expenses and unnecessary waste of drugs if the prescriber would note on the prescription that the patient is terminally ill and specify the largest anticipated quantity that could be needed for the next two months. The pharmacist could then dispense smaller quantities of the prescription to meet the patient's needs up to the total quantity authorized. Government-approved labeling for dosage level and frequency can be useful as guidance for patient care. Health professionals may, on occasion, determine that higher levels are justified in specific cases. However, these occasions would be exceptions to general practice and would need to be properly documented to establish informed consent of the patient and family.

(CONTINUED ON NEXT PAGE)

OTHER GOVERNMENTAL POLICIES

Joint Board Policy Statement

(CONTINUED)

Federal and state rules also allow the fax transmittal of an original prescription for Schedule II drugs for hospice patients. If the prescriber notes the hospice status of the patient on the faxed document, it serves as the original. Pharmacy rules also allow the emergency refilling of prescriptions in Schedules III, IV, and V. While this does not apply to Schedule II drugs, it can be useful in situations where the patient is using drugs such as Vicodin for pain or Xanax for anxiety.

The nurse is often the health professional most involved in on-going pain assessment, implementing the prescribed pain management plan, evaluating the patient's response to such interventions and adjusting medication levels based on patient status. In order to achieve adequate pain management, the prescription must provide dosage ranges and frequency parameters within which the nurse may adjust (titrate) medication in order to achieve adequate pain control. Consistent with the licensee's scope of practice, the RN or LPN is accountable for implementing the pain management plan utilizing his/her knowledge base and documented assessment of the patient's needs. *The nurse has the authority to adjust medication levels within the dosage and frequency ranges stipulated by the prescriber and according to the agency's established protocols.* However, the nurse does not have the authority to change the medical pain management plan. When adequate pain management is not achieved under the currently prescribed treatment plan, the nurse is responsible for reporting such findings to the prescriber and documenting this communication. Only the physician or other health professional with authority to prescribe may change the medical pain management plan.

Communication and collaboration between members of the healthcare team, and the patient and family are essential in achieving adequate pain management in end-of-life care. Within this interdisciplinary framework for end of life care, effective pain management should include:

thorough documentation of all aspects of the patient's assessment and care;

a working diagnosis and therapeutic treatment plan including pharmacologic and non-pharmacologic interventions;

regular and documented evaluation of response to the interventions and, as appropriate, revisions to the treatment plan;

evidence of communication among care providers;

education of the patient and family; and

a clear understanding by the patient, the family and healthcare team of the treatment goals.

It is important to remind health professionals that licensing boards hold each licensee accountable for providing safe, effective care. Exercising this standard of care requires the application of knowledge, skills, as well as ethical principles focused on optimum patient care while taking all appropriate measures to relieve suffering. The healthcare team should give primary importance to the expressed desires of the patient tempered by the judgement and legal responsibilities of each licensed health professional as to what is in the patient's best interest.

CRITERION 8: [+]
Other provisions that may enhance pain management

Comment: This provision informs practitioners about acceptable practices under Federal and state policies, which may enhance pain management.

CRITERION 8: [+]
Other provisions that may enhance pain management

Comment: This provision recognizes the need for increased communication between healthcare practitioners..

OTHER GOVERNMENTAL POLICIES

Medical Board Policy Statement

END-OF-LIFE RESPONSIBILITIES AND PALLIATIVE CARE

Assuring Patients

Death is part of life. When appropriate processes have determined that the use of life-sustaining or invasive interventions will only prolong the dying process, it is incumbent on physicians to accept death "not as a failure, but the natural culmination of our lives."*

CRITERION 4: ***Encourages pain management*** [+]

It is the position of the North Carolina Medical Board that patients and their families should be assured of competent, comprehensive palliative care at the end of their lives. Physicians should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided.

Palliative Care

There is no one definition of palliative care, but the Board accepts that found in the *Oxford Textbook of Palliative Medicine*: "The study and management of patients with active, progressive, far advanced disease for whom the prognosis is limited and the focus of care is the quality of life." This is not intended to exclude remissions and requires that the management of patients be comprehensive, embracing the efforts of medical clinicians and of those who provide psychosocial services, spiritual support, and hospice care.

A physician who provides palliative care, encompassing the full range of comfort care, should assess his or her patient's physical, psychological, and spiritual conditions. Because of the overwhelming concern of patients about pain relief, special attention should be given the effective assessment of pain. It is particularly important that the physician frankly but sensitively discuss with the patient and the family their concerns and choices at the end of life. As part of this discussion, the physician should make clear that, in some cases, there are inherent risks associated with effective pain relief in such situations.

Opioid Use

The Board will assume opioid use in such patients is appropriate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan. (See the Board's position statement on the Management of Chronic Non-Malignant Pain for an outline of what the Board expects of physicians in the management of pain.) Because the Board is aware of the inherent risks associated with effective pain relief in such situations, it will not interpret their occurrence as subject to discipline by the Board.

CRITERION 5: ***Addresses fear of regulatory scrutiny*** [+]

Selected Guides

To assist physicians in meeting these responsibilities, the Board recommends *Cancer Pain Relief: With a Guide to Opioid Availability*, 2nd ed (1996), *Cancer Pain Relief and Palliative Care* (1990), *Cancer Pain Relief and Palliative Care in Children* (1999), and *Symptom Relief in Terminal Illness* (1998), (World Health Organization, Geneva); *Management of Cancer Pain* (1994), (Agency for Health Care Policy and Research, Rockville, MD); *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain*, 4th Edition (1999) (American Pain Society, Glenview, IL); *Hospice Care: A Physician's Guide* (1998) (Hospice for the Carolinas, Raleigh); and the *Oxford Textbook of Palliative Medicine* (1993) (Oxford Medical, Oxford).

Pain Management for Geriatric Patients

Laura Hanson MD, MPH
Pain and Symptom Care Program
Division of Geriatrics, UNC School of Medicine

Objectives

- To discuss pain prevalence in geriatric populations
- To discuss unique barriers to pain treatment for older patients
- To discuss strategies to support access to pain management

Pain and suffering

- Pain= "an unpleasant sensory and emotional experience associated with actual or potential tissue damage." International Association for the Study of Pain, 1980
- Pain is what the person in pain says it is
- Suffering=pain experience modified by psychological adaptations, experience of other physical symptoms, and broader spiritual or social concerns

Pain is common for older patients

- 40-80% of NH residents have pain
  - 14.7% have daily moderate to severe pain
- 29% of NH residents with advanced cancer have daily pain
  - 26% of them receive no pain medication

Ferrell BA JAGS 38:409
Bernabei JAMA 279:1877

Pain is undertreated

- Bereaved family members believe pain was undertreated
  - Less if in hospice (18%)
  - More if in home health (43%) or nursing home (32%)
- 41% of cancer patients undertreated
  - Primary risk factor age > 70

Hanson JAGS 45:1339
Teno JAMA 291:88
Cleeland NEJM 330:592

Barriers – patient / family attitudes

- Pain is normal when you're old
- Value stoicism, "being strong"
- Fear of addiction
- Problems communicating pain
  - unable to talk
  - confusion / dementia

Goth FM JAGS 49:188
AGS Panel JAGS 50:S205

Barriers – provider attitudes

- Pain is normal when you're old
- Older patients feel less pain
- Legal risks of using opioids
  - $15 million damages for failure to treat NH resident's pain with opioids
  - NC Boards all endorse right to effective pain control
- Failure to recognize chronic persistent pain
- Older patients can't tolerate pain medications

Acute Behaviors

Patients with acute (new) pain may be:

- Crying
- Guarding
- Grimacing and moaning
- High BP, pulse
- Restless or extremely still

Persistent pain behaviors

Patients with persistent pain:

- may not express pain by telling you
- express pain with depressed mood, withdrawal
- have no abnormal vital signs
- come to expect and endure pain

Assess – verbal, dementia

- 67-83% of residents with dementia are able to use at least one scale
  - Present Pain Intensity
- Words are easier than numbers
- Ask in the present – "Are you in pain now?"
- Ask several ways – "discomfort"
- Give time to respond

Ferrell BA JPSM 10:591
Herr KA Clin J Pain 14:29
Krulewitch H JAGS 48:1607

Assess non-verbal

- Use changes in behavior -- "just not herself"
  - more passive, withdrawn, not eating, OR
  - more agitated, aggressive, restless
  - Hurley observational scale (DS-DAT), PAINAD
- Observe behaviors during personal care
  - breakthrough or incident pain

Hurley AC Res Nurs Health 15:369
Buffum MD JAGS 52:1093

Pain Treatment

BEFORE medication

- Baseline mental status exam
- Know concurrent chronic illnesses
  - hepatic function
  - renal function
  - hydration status

Morphine pharmacology

- Peak effect slightly higher
  - Use slightly lower dose
- Half-life longer
  - Increase interval

BUT, every elder is an individual . . .

Opioid side effects

- Side effects that improve on stable dose
  - Sedation, confusion
  - Respiratory depression
  - Nausea
- Side effects that persist but are treatable
  - Constipation
- Side effect that require med change
  - neurotoxicity

Opioids and delirium

- Dementia risk factor for delirium
- Higher doses associated with <u>less</u> confusion
- Opioids cause delirium; however, so can untreated pain

Morrison RS J Geron 58A:76

Non-medication Treatments

Use for <u>every</u> elder in pain

- Music
- Soft lighting, decreased noise, OR added distractions
- Massage
- Warm or cold packs
- Repositioning, exercise
- Emotional and spiritual support

Medication for Persistent Pain

Medication choice based on mechanism, severity, toxicity

- <u>scheduled, not PRN</u>
- long-acting + breakthrough agent
- provide breakthrough pain treatment
- order bowel regimen with every opioid

Combining medications at low doses can increase effect with fewer side effects

Educate patients and families

Address fears about opioids:

- Addiction to pain medicine is rare
- Patients develop tolerance to sedation, nausea in a few days to weeks
- Constipation is monitored and treated
- Morphine does not cause death

Communication tips

- Discuss care plan with patient, family
- Consultant pharmacists
- Communicate pain care plan to other involved health care providers – consulting MDs, nursing aides, nurses

Carolinas Center for Medical Excellence – NHQI

CMS "Quality Measure" - Pain

- "% of all NH residents with daily moderate pain OR with horrible / excruciating pain at any frequency"
- target population to review care plan for pain assessment and treatment
- assists NHs to improve quality of pain management

Palliative Care

Comprehensive interdisciplinary care to improve quality of life for persons with incurable illnesses and their families

- Advance care planning
- Symptom control
- Spiritual care, bereavement support

Expanding on Hospice

Hospice

- < 6 months prognosis
- Palliation only
- Sites home / NH

Palliative Care Services

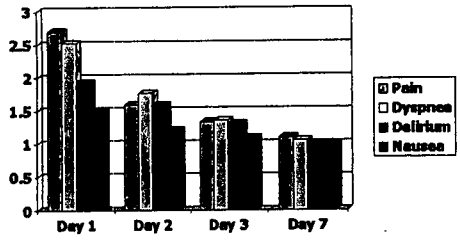
- Not limited to last 6 months of life
- May be combined with curative, disease-specific treatments
- Sites hospital, NH

UNC Pain and Symptom Care Program

Advanced practice nurse + MD with expertise and certification in pain and symptom management

- University HealthSystems Constortium Better Performer
- Rapid growth in demand for services

UNC PSCP Symptom Scores



Policy implications

- NC has a Grade "B" from the UWisc. Pain and Policy Studies Group
- Professional board policy statements
  - NCMB Chronic Non-malignant Pain 1996
  - Joint Boards Pain in EOL 1999
  - NCMB EOL and Palliative Care 1999

WILLIAMSTON PUBLIC HEARING

Date: February 21, 2006

Time: 10:30 am - 12:30 pm

Place: Martin Community College
Building 2 - Auditorium
1161 Kehukee Park Road
Williamston, NC

Directions from the Legislative complex are attached.

Hotel Suggestion: Holiday Inn Williamston
1764 US Hwy 17/64
Williamston, NC
Reservations – 1-800-315-2621
Front Desk – 252-792-9003

Check-in time: 3:00 pm
Check-out time: 11:00 am

LOCATED AT INTERSECTION OF HIGHWAY ALT 64, 17 AND 13. FROM NORTH AND WEST TAKE EXIT 514 TO HWY 17 SOUTH. FROM EAST TURN LEFT ON ALT 64.

Directions from the hotel to Martin Community College are attached.

2006
Study Commission on Aging
Public Hearings

DATE:	February 21, 2006	February 28, 2006
LOCATION:	Williamston, NC	Spindale, NC
SITE:	Martin Community College Auditorium- Bldg. 2 1161 Kehukee Park Rd. Williamston, NC 27892	The Foundation at Isothermal Community College 286 ICC Loop Rd. Spindale, NC 28160
TIME:	10:30 am –12:30	10:30 am –12:30
LOCAL AAA CONTACT:	Cynthia Davis Mid East Commission PO Box 1787 Washington, NC 27889 (252)-974-1835 FAX (252) 948-1884	Laura Lynch Isothermal Planning and Development Commission PO Box 841 Rutherfordton, NC 28139 (828) 287-2281 ext. 1232 FAX (828) 287-2736
LOCAL MEDIA CONTACTS:	Generating List (see handout)	Generating List (see handout)
DATE PRESS RELEASES SENT:	2/03/06	2/03/06
AREA GA MEMBERS:	Host County: Sen. Jenkins, Rep. Warren Area: Senators Basnight, Holloman Representatives Hunter, McLawhorn, Williams.	Host County: Sen. Dalton, Rep. England Area: Senators Apodaca, Jacumin, Presnell Representatives Clary, Gillespie, Moore.
OTHER INFORMATION:	Lunch invite after meeting (AAA)	Dinner Monday night
HOTELS	Fairfield Inn and Suites by Marriott 1071 Cantle Ct. Williamston, NC 27892 Hampton Inn 1099 Hampton Ct. Williamston, NC 27892	Holiday Inn Express 200 HOLIDAY INN DRIVE FOREST CITY, NC 28043 (Open ?) Jameson Inn Forest City

North Carolina
Study Commission On Aging

PRESS RELEASE February 2006

COMMISSION TO HOLD PUBLIC HEARING IN WILLIAMSTON, 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. The event will take place on **Tuesday February 21, 2006 from 10:30 a.m. until 12:30 p.m. at Martin Community College,** Building 2 Auditorium, Williamston, NC.

The Commission Co-chairs, Representative Beverly Earle and Senator Charlie Dannelly 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.

For more information, contact Cynthia Davis, Mid-East Commission Area Agency on Aging (252) 974-1835, or Shawn Parker, Study Commission on Aging, (919) 733-2578.

North Carolina
Study Commission On Aging

PRESS RELEASE February 2006

COMMISSION TO HOLD PUBLIC HEARING IN SPINDALE, 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. The event will take place on **Tuesday February 28, 2006 from 10:30 a.m. until 12:30 p.m. at The Foundation Conference Center, Isothermal Community College, 286 ICC Loop Rd. Spindale, NC**.

The Commission Co-chairs, Representative Beverly Earle and Senator Charlie Dannelly 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.

For more information, contact Laura Lynch, Isothermal Planning and Development Commission, (828) 287-2735 ext.1232 or Shawn Parker, Study Commission on Aging, (919) 733-2578.

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — February 15, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bill Bowers	AstraZeneca
Patricia A. Yancey	FRLTC
Mary Beth	AARP-NC
Lara Hanson	UNC — guest speaker
[illegible]	Bone + Assoc.
Juanne Stevens	NCMA
Susan Harmuth	NC Foundation for Advanced Health Programs
Johnny Tillett	Bone/Hanson

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — February 15, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Melynda Swindells	DHHS Criminal Record Check Unit
Katherine Shepherd	DHHS | Division of Child Dev.
Polly Welsh	NCHCFA
Jill McArdle	The Carolinas Center for Medical Excellence
Kathie Smith	Assn Home and Hospice Care of NC
Susan Williamson	NC Assoc of Non Profit Homes for Aging
Sandy Spillman	North Carolina Assisted Living Assn.
Hazel Slocumb	NC DHHS / DFS
Don St. Onge	DHHS / Budget + Analysis
Mary Jane McCracken	The Carolinas Ctr. for Med. Excellence
Roxanne Ray-Cash	NC AOA, Forsyth Co Dept of Aging

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — February 15, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Edwards	DAAS
Jean Beaves	NCCOA NCADSA
Jan Moxley	DHHS / Office of Long Term Care
Karen Bottori	Div. of Aging & Adult Svcs.
BOB KUCAB	NCHFA
Rob Kindseatter	DHHS Div. of Child Dev.
Richard C Hatch	AARP / NC Coalition on Aging
Polly Williams	NC Justice Center / Triangle OWL
Mike Massoglia	NCFAHS
NANCY EVANS	DAAS
Kain Barsness	OSBM
Andy Silver	Carolinas Center for Medical Excellence

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — February 15, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeff Horton	DHHS DFS
Wayne Wallace	OSBM
Evelyn Hawkins	EHGR
Becki Gray	Civitas Institute
Jim Edgerton	DHHC
Charlene Carey	NC Right to Life
Jennifer Pulliam	NASW-NC
Nina Hightower	NASW-NC
Bill Wilson	AARP NC
Jim Bon	Bon & Assoc
BRIAN SHANK	ASTRA ZENECA

February 7, 2006

MEMORANDUM

TO: Members, **NC Study Commission on Aging**

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: **Public Hearings**

The NC Study Commission on Aging will be conducting two spring public hearings:

DAY: **Tuesday** **TIME:** **10:30am - 12:30pm**

DATE: **February 21, 2006**

LOCATION: **Martin Community College**
Building 2 – Auditorium
1161 Kehukee Park Road
Williamston, NC

DAY: **Tuesday** **TIME:** **10:30am - 12:30pm**

DATE: **February 28, 2006**

LOCATION: **Isothermal Community College**
The Foundation
286 ICC Loop Road
Spindale, NC

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

North Carolina Study Commission on Aging

Tuesday, February 21, 2006
10:30 AM
Martin Community College
Williamston, NC

The North Carolina Study Commission on Aging held a public hearing on Tuesday, February 21, 2006, at 10:30 am at the Martin Community College in Williamston. The hearing was very well attended and there were many presenters. The following are issues that were discussed most often.

- The fact that Medicare Part D is confusing
- Nutrition & outreach funding
- Home & Community Care Block Grants
- NC Senior Games funding
- NC Senior Centers funding
- Adult Day Care funding
- Transportation

Attached are handouts that were furnished by some of the public speakers.

The hearing ended at 12:30 pm.

--Thank you and the General Assembly for your support of the NC Senior Games program.

---PICTURES---

As a year round program promoting health and wellness for NC residents 55 years of age and better,

it is one of the few programs in our state whose focus is on the prevention of health problems in our

senior population. It encourages seniors to engage in activities that help them become healthier

while having fun in the process. As the senior population continues to grow in our country, ways to

reduce health care costs become more and more important. The Senior Games program serves

over 60,000 participants in North Carolina's 100 counties with the same amount of money needed

to care for just 3 residents in a skilled nursing facility each year. We are helping to keep health

care costs lower with health promotions, education, and recreation opportunities for seniors in

communities and senior centers statewide. Healthy lifestyles go a long way in minimizing medical

problems of the aging. Prevention is less expensive than treatment and is much more fun.

–The North Carolina Senior Games is the most comprehensive program of its kind in the country

including not only sports and physical activities, but also a walking program and many areas of the

arts. Our goal is to keep seniors healthy, both mentally and physically.

–We also encourage young people to become involved with family members who are participants

as volunteers and spectators. We want them to learn at an early age that healthy lifestyles pay off

Pictures

–Thank you for the special funding we received. This has helped us provide for more participation

among low income seniors and allowed of the increase awareness of the program in rural areas and

among the diverse groups in our state.

–Thank you for believing in Senior Games, for supporting it, and for helping us promote health and

wellness for our North Carolina seniors.

Judith Moss
NC Senior Games

Sorry my printer went berserk!

NORTH CAROLINA STUDY COMMISSION ON AGING
WILLIAMSTON, NC PUBLIC HEARING
FEBRUARY 21, 2005

My name is Jean Reaves and I am here today to accomplish several things. First I would like to stress to you the uniqueness of Aging in Rural Eastern North Carolina. Second, I would like to share with you the uniqueness of Adult Day Services and ask that you assist in allowing this service to be given an equitable ranking in North Carolina. And thirdly, I hope to challenge you as the aging leaders of our state who have the power to affect policy.

Here in Rural Eastern North Carolina the challenges of meeting the needs of our booming aging population needs to be addressed as a current economic issue, health care issue, work force issue, veterans issue and should be a topic of almost every planning and budget discussion over the next 20 years. In North Carolina we are very much a part of the world-wide longevity revolution. We have enhanced life expectancy over the past century by a healthier, more productive 26.4 years. However here in rural North Carolina we also need to look at some startling numbers that address the existence of some real disparities.

1. African Americans and other minority groups have a significantly lower life expectancy.
2. African American seniors have almost a 3-1 higher poverty rate than White seniors.
3. Women age 65 and older are almost twice as likely to be poor than men.
4. The coastal plains region of North Carolina, labeled by some as the Buckle of the Stroke Belt, has the fourth highest stroke rate in the nation.

Over and over again we hear our seniors speak of the desire to remain in their own home and be allowed to age in place. The reality is that half of NC's seniors live in rural areas which leaves them facing a long list of challenges---isolation, lagging infrastructure, sparse resources, and weak economic competitiveness. We must put the appropriate focus on this booming aging population because it is the right thing to do but it is also because it we, you and I are part of these baby boomers and we are the available and growing natural resource.

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 education and social programs to healthy seniors. These small businesses include personal care service providers and meals on wheels programs. Finally this new and under recognized aging industry also includes the all encompassing and therapeutic alternative to full residential placement through North Carolina's 82 adult day centers. Adult Day Services in North Carolina has a remarkable safety record. Adult Day Services in North Carolina provides meals and medication management on a daily basis to its participants. Adult Day Services in North Carolina provides a therapeutic alternative which breaks the isolation and offers caregiver respite in an one size fits all package while still recognizing person centered programming at its finest.

As Home Health Reform moves forward North Carolina will see a potential of 17% of seniors currently receiving home health services no longer eligible for services in their homes. Adult Day Centers provide many of those services in a congregate cost effective package by assisting with toileting schedules, providing at least two meals per day and often even provide bathing for their participants. As Mental Health Reform moves into its next several phases in North Carolina adult day centers are already providing quality day programming and independent life skills programming for both the adult DD population and many mentally ill adults. Yes adult day centers are serving the Alzheimer's patients but they are also providing a much needed stable and consistent environment for others who struggle with depression, organic brain disease, and many other mental health diagnosis. What then is the problem. Why on December 1, 2005 did another adult day center close its doors just 50 miles from this very location?

Adult Day Centers are a very real part of the continuum of long term care. Yet they have historically, in North Carolina, received very low reimbursement for what is known to be a quality service. Adult Day Services Assoc therefore request fair and equitable reimbursement rates under the CAP-DA program. Many other services within CAP-DA have received regular rate adjustments. CAP Adult Day Health has not had a rate increase since the late 1990's. The study commission recently received information about the plight of North Carolina's under paid and under appreciated direct care staff. Adult day centers have dedicated direct care staff who were totally excluded from this study. We provide a positive, cost effective, safe alternative but yet adult day center staff are under paid and have little or no benefits due to the overall nature of doing business with minimal reimbursements. Adult Day Services Assoc requests the opportunity to fulfill the recommendations of the Systems for Sustainability presented to you in December 2005 and therefore secure the future of a viable service within the North Carolina. A service that has a proven record of quality and choice for both its participants and for the family caregivers who selflessly give of themselves. Those who make the choice to use adult day services should also have the opportunity of a LTC insurance tax credit. We often speak of personal responsibility, partnerships that responsibly fund needed services and yet we have been unable to commit to something as sensible as a tax credit for those citizens who take the responsible step and purchase LTC insurance.

Finally as you drove to this meeting today maybe you were fortunate enough to arrive in Williamston on the new and efficient 64 by-pass. Many of you however drove on two lane roads with poor or non-existent shoulders. You drove for many miles and saw a few scattered houses maybe a country store popped up or even a gas station. You probably did pass a school somewhere along your trip and were comforted with the sight of the occasional county church building. Those of us who live in rural eastern North Carolina know the reality of limited transportation resources. Even yesterday when the TV was showing salt brime spread on I-40 and Capital Blvd none of us saw such trucks on our rural roads. All I can ask as you return to Raleigh this afternoon that you realize that nothing happens in rural Eastern North Carolina if you don't first address the reality of rural transportation. Adult Day Services Assoc requests that you address the overall need for reasonable and adequate transportation systems that address the needs of North Carolina seniors and the service providers who work tirelessly to effectively to meet those needs.

I will close by again thanking you for this opportunity to address you this morning and leave you with this final thought:

I opened by sharing some startling demographics of aging in rural North Carolina and specifically in rural Eastern North Carolina. I will close by stressing that the pubic and private sectors share in the responsibility for helping vulnerable seniors and their families. And even though it is a fact that 1/3 of older North Carolinians are considered poor, even though it is a fact that the well-being of seniors varies greatly by race, class and other factors, it is also fact that healthy and successful aging requires a combination of commitment on the part of individuals, government and society. As leaders in our state I ask that you help us to package that commitment to the benefit of the citizens of our great state.

Thank you

Grace Martin Harwell Senior Center
310 W. Main Street
Washington, NC 27889
Importance of the Senior Center to Its Community
Examples

1. A gentleman in his 70's walked with me every Friday morning in our walking program, he walked with me on Friday. On Wednesday, he attended a club meeting at our center. He couldn t get warm. On Thursday, he had trouble breathing. On Friday I visited him in the hospital . He hugged my neck and said he would be ready to walk with me on the next Friday. He passed away on Thursday and was buried on Saturday. Last Friday, his wife showed up to walk and was greeted by her peers with encouraging words and hugs. They all walked and talked of how wonderful it was to be active right up to your last day on earth.

2. Mary called the center one day and explained that she lived alone with her pets and had no family in the area. Could she talk to us daily just so someone realize something was wrong if she did not call? We talked to her for years, allowing her the independence she struggled to have. She fell down the stairs one day and dragged herself to the phone and called the senior center. She said there is a lot of blood a lot! We called 911 and met the parametics at her home and called her daughter in Charlotte. She had lost an excessive amount of blood. When her daughter scolded her for not calling 911, she said, "but I don t know anyone at 911. I called my friends at the senior center. I knew they would take care of me." She had never even been to the senior center.

Grace Martin Harwell Senior Center
Washington, NC 27889
January 2006 Senior Center Usage
Unduplicated Persons Served

140	Club Meetings
84	Fitness Room
80	Exercise Class
46	Crafts
4	Computers
9	Card & Board Games
28	Bingo
105	Senior Dance
41	Walking Program
7	Billiards Tournament
20	Weight Management Program

* We hosted community programs including BC Arts Council/Church Women United/AARP/Choral Society/BC Human Services CoAlition/Friends of the Library

Our Senior Center is a community serving its surrounding community.
Thank you for your support.
It is appreciated.
It is not misused or abused.
We do not take it for granted.
Carolyne Everett
Grace Martin Harwell Senior Center
Washington, NC

Introduction: Tara Chamblee, Assistant Administrative Secretary, Hertford County Office of Aging - Representing the Office of Aging and our Director, Linda Blackburn who could not be here today.

Hertford County recognizes many of the same issues faced by those in our surrounding Region and State.

Specifically in Hertford County we face issues with our congregate nutrition programs and Respite programs. While we are a rural county in eastern North Carolina and have issues surrounding transportation, many of our older adults can't access our congregation nutrition sites. Currently we are at the maximum number we can serve given our current funding. As you all know, participation in congregate nutrition programs offers the older adult much more than a well balanced meal for the day. This participation decreases the opportunity for the older adult to isolate with their own homes, fellowship with other people of their own age and the opportunity to remain active and involved.

Respite services, to non medicaid eligible older adults and their caregivers in our county is an unmet need based on the number requesting these services. Unfortunately we do not have the funding to provide these services to the total need in the county and many of our older adults may die before their caregivers receive this much needed service.

The Home and Community Care Block grant funding is crucial to our being able to delivery the quality of service that we now provide, and we hope that the importance of this funding - and any increases that can be obtained - will continue to be a high priority item. We appreciate the support and funding from our state, federal and Area Agency on Aging currently received. However, our older adult population is growing rapidly and baby boomers are sitting on the sidelines - soon to enter senior services. We need to be prepared to offer the highest quality services available and those that represent the needs of this population group.

Thank you for the opportunity to speak before you and thank you for all that you do.

AARP North Carolina
2006 Legislative Agenda

State Legislative Priority Issues:

- **Encourage citizens to take responsibility for their long term care by reinstating the tax credit for the purchase of long-term care insurance.**
- **Increase funding for the Home and Community Care Block Grant so as to reduce the waiting list for home and community based services which allow persons to stay in their homes.**
- **Reduce the property tax burden on limited-income older and disabled adults by increasing homestead property relief.**
- **Increase funding for the NC Housing Trust Fund to provide more housing for limited income families.**
- **Preserve Medicaid eligibility and services for older and disabled adults in North Carolina.**

Additional State Legislative Issues:

Health and Long Term Care

- Oppose legislation that will make it harder for low-income older and disabled adults to qualify for Medicaid long-term care services including home and community based services (e.g., punitive Medicaid lien and property transfer provisions).
- Take steps to eliminate institutional biases identified in the study reported to the Study Commission on Aging.
- Increase the Medicaid medically needy income standard from the current level of $242 per month. For states which offer the Medicaid medically needy program, the national average income level is $416.20.
- Take steps to implement the recommendations in the report on issues related to persons with mental illness in long-term care facilities.
- Increase funds to adult care homes, nursing homes and home care providers to improve the salaries and benefits of direct care workers (pass-through).

Livable Communities

- Improve the rights of people purchasing and living in manufactured housing.
- Expand transportation options and services for seniors.

Prescription Drugs

- Support measures that will strengthen education and outreach services to Medicare eligible individuals about the new Medicare Part D Prescription Drug Program.
- Provide a State wrap-around program to assist low-income individuals who do not qualify for the full "extra help" subsidy assistance under the Medicare Prescription Drug Program.
- Support legislation to provide greater disclosure and regulation of pharmacy benefits managers.

Economic Security

- Protect retirees and workers from erosions to their existing pension plans.
- Support consumer protections by opposing unreasonable banking fees and predatory and payday lending practices, and supporting legislation to prevent identity theft and consumer scams.

Lobbying Reform

- Lobbyists should provide full and timely disclosure of lobbying activities and expenditures.
- Require lobbying standards that protect against real and perceived conflicts of interest (e.g., revolving door practices) by lawmakers, their staffs, and lobbyists.
- Provide appropriate mechanisms to enforce lobbying requirements and limitations on gifts that lawmakers and their staffs may accept from lobbyists.
- Provide adequate funding to state agencies to enforce lobbying laws and regulations.

Federal Legislative Issues:

Social Security

- Enhance the solvency of the Social Security System by permitting the system to invest part of the trust fund so that it earns higher returns than offered by Treasury bonds.
- Raise the cap on the amount of wages taxed to support Social Security so that the same share of the nation's wages is taxed as in the past. This would raise the cap from $90,000 to approximately $140,000.
- Make Social Security a truly universal system by including all newly-hired state and local government workers in the Social Security System.

Prescription Drugs

- Allow for the safe importation of prescription drugs from outside the country to reduce these costs to the consumer.
- Lower drug costs by negotiating bulk drug purchasing agreements.

Comments by: Cynthia L Davis, AAA Director
Mid-East Commission Area Agency on Aging

Thank you NC Study Commission on Aging – We appreciate your efforts in holding a public hearing in Williamston - Region Q. The following are areas I ask the Study Commission to consider in their report to the General Assembly -

- **Support legislation to increase Home and Community Care Block Grant Funding.** Home and community-based services help impaired older adults stay in their homes. Some key services include home-delivered meals, adult day care/day health care, in-home aide, and respite care for family caregivers. With the approaching Baby Boomer generation, there will be an increase in the demand for services. There are far too many older adults on the waiting list statewide today. Statewide, the waiting list is just under 10,000 – in this region, the waiting list is just under 800. Note that many seniors who are in need, never make it to the waiting list – there may be no HDM routes to put them on a waiting list for, or the list is several years long and putting someone on the list just doesn't make sense to the senior or caregiver. Additional HCCBG money could increase the number of adults served and who could remain at home.

- **Support legislation to increase state funding for administrative support for Area Agencies on Aging.** In June 2001, there was $1,000,000+ available in AAA administrative support funds. In the 2002 – 2003 year only a little over $400,000 was available which meant that each region had been reduced in funding from $57,900 to $27,777. Currently each region still receives $27,777. These funds support varied personnel and AAA activities - Aging Program Specialists, Long-term Care Ombudsmen, and Information & Referral Specialists. More money should be provided so the AAAs can adequately perform our responsibilities.

- **Restore the North Carolina income tax credit for long-term care insurance that expired.** 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 that assist with the cost of in-home and nursing home care. The legislation had a sunset provision that stipulated that the credit expired for taxable years beginning on or after January 1, 2004. This credit can no longer be taken.

- **Support increased funding for Senior Games.** Senior Games is an investment in health and well- being. It keeps our seniors moving in the right direction. Region Q took a 50% reduction in 3D Health Promotion money last year because of the funding formula revision yet; every county in this region knew the value of Senior Games and took money from their HCCBG allocation to contribute towards the reduction so the program could continue at the same level. Our seniors should not have to choose between wellness and in-home care – there should be adequate money - we should not have to take from one vital component to give to another vital component.

- **Senior Center development, construction, and outreach are most important and should receive adequate funding.** Senior Centers are focal points in our counties. One of our counties has been struggling to build a senior center. There

should be a way to help them obtain their dream of a center. Our other senior centers are struggling in day-to-day operations. There should be more money to help them operate. Senior Centers are a vital point of what is happening in our counties. With Medicare Part D, where do seniors go?.....to senior centers. It is a blessing and a curse – a blessing in that we are reaching people we would not necessarily see, and a curse in that we are not staffed to handle to volume we are experiencing. We need to be able to handle the Part D-ers, as well as the impending Baby Boomers who are coming to see us at Senior Centers. Adequate funding would help our centers address the community needs.

- **Assure affordability of prescription drugs**. As you know, Senior Care ended and I will not go through the Medicare Part D horror stories we hear throughout the state today but, there are numerous seniors who are 60-65 who aren't Medicare eligible and those who are eligible, well.....the donut hole may await them. There is still a huge problem with seniors affording their prescriptions. We must have something in place that takes care of the "not-Medicare Part-D eligible" as well as the "donut hole-ers".

- **Support funding for the NC Housing Trust Fund.** This is a vital source of support for independent housing with services. We must continue to support the creation of affordable housing with supportive service – not one without the other – only one with the other. Seniors need choices for decent and affordable housing – especially in rural areas.

Thank you for the opportunity to express some of the needs of seniors in our region. We appreciate what you are doing to help.

Name Alice Little

Adress 1066 Worthville Rd. Lot 5

City Asheboro Zip 27317

Phone 336-495-0962

Randleman Randolph Co. Senior Center

1) Why the Senior Center matters to me.

It is a place to go and meet people, and have fun. It gets me out of the house. I get depressed at home, I live by myself.

2) How the State of North Carolina can help make my Senior Center better.

More funding for trips, and activitys, things to do to keep us active, like dancing. Better & cheaper health care for us that are to young for medicare and to old for medicaid.

3) What other issue is important to me.

better health care, more cost cuts, better programs ~~programs~~ for low income familys & seniors

Williamson

Keep your mind Occupid

to Keep your bones healthy - ~~ex~~ movement, movem

Jan. start Senior games
Training to play in April-May
State games Oct.
National ..

Name Harvey Lee Davis

Adress 717 FRANKS ST

City ASHEBORO, NC Zip 27203

Phone 1-336-625-4848

SALT BOX ASHEBORO NC Senior Center

1) Why the Senior Center matters to me.

Meeting friend
some where to Have fun
and find out how the
other one is getting along

2) How the State of North Carolina can help make my Senior Center better.

for having more speeker about
thang what is going on in the State
and Goverment more transpation for
~~Senior~~ Senior and better pay

3) What other issue is important to me.

Help the one that carry food
from the center and the one
that is serving in the center
more and better food better
pay for the wokers

Name Margie McDowell

Adress 3826 Camp Navaho Rd.

City Randleman NC Zip 27317

Phone 336-4950723

Randolph, ~~Randleman~~ Senior Center

1) Why the Senior Center matters to me.

a place to go meet people - help one little worst off than I am - and it just lots of fun -

2) How the State of North Carolina can help make my Senior Center better.

have more fun - help for trips more stuff to do. like Dining, really need. more too do,

3) What other issue is important to me.

better heath - cut cost on Medic

Name Vera Chisem

Adress 5545 Walking St Dr

City Trinity N.C. Zip 27370

Phone 861 6256

Archdale N.C Senior Center

1) Why the Senior Center matters to me.

2) How the State of North Carolina can help make my Senior Center better.

By learning How to Crocete
And learned How to A.

3) What other issue is important to me.

PUBLIC HEARING
NC Study Commission on Aging
February 21, 2006, 10:30 A.M
Martin Co. Community College

NAME	ORGANIZATION OR AFFILIATION	CHECK ONE SPEAKER	CHECK ONE OBSERVER
Gordon Campbell	Down East Senior Games	✓	
Carolyne Everett	Grace Martin Harwell Senior Center	✓	
Alice Ballance	Kiddie World	✓	
Thelma Spivey	Kiddie World		✓
Patricia Rowell	Archdale Sr. Citizen	✓	
not speaking JACK PILKINGTON	N.C. SENIOR GAMES		✓
Clinton C. Jones	Senior Legislature	✓	
CYnthia Davis	Mid-East Commission	✓	
Carolyn Tulghum	NC Senior Games Pitt Greenville	✓	
Earnestine Haseling	NC Senior Games	✓	
Joan Windley	Beaufort Co. DSS Aging + Nutrition		✓
ARTHUR DAIL	MID EAST ADV COUN		✓

PUBLIC HEARING
NC Study Commission on Aging
February 21, 2006, 10:30 A.M
Martin Co. Community College

NAME	ORGANIZATION OR AFFILIATION	CHECK ONE SPEAKER	OBSERVER
O L Thompson	Down East Senior Games		✓
R. A. Moon	"		✓
Ernest L. Pitt	"		✓
✓ Jean Reaves	NC Adult Day Services Assoc Roanoke Valley Adult Day Ctr	✓	
✓ Stella Bicks	Roanoke Valley Adult Day Ctr.	✓	
✓ DElores A Peterson		✓	
✓ Roger Edwards	Roanoke Valley Adult Day Ctr	✓	
✓ Judith Moss	Down East Senior Games	✓	
Molly Long			✓
Brad Pate	STUDY COMMISSION		✓
✓ Jesse Partee	DOWN EAST SENIOR GAMES	✓	
Mary Moore	United Hospice		✓

PUBLIC HEARING
NC Study Commission on Aging
February 21, 2006, 10:30 A.M
Martin Co. Community College

NAME	ORGANIZATION OR AFFILIATION	CHECK ONE SPEAKER	CHECK ONE OBSERVER
Mary Jones	E.L. Roberson Center		✓
Maggie Murray	" " " "		✓
Harry Ballard	" " " "		✓
Alberta Pettway	" " " "		✓
Laura Fuller	Albermarle	✓	
Gordon Campbell	" "	✓	
Judy Moss	DESG (Down East Senior Games)	✓	
Shirley Mays	" "		✓
Robert Young	North Carolina Senate		
Beverly Earle	NC House		
Julie Sheppard	NCDHHS		
Shawn Parker	NCGA		

PUBLIC HEARING
NC Study Commission on Aging
February 21, 2006, 10:30 A.M
Martin Co. Community College

NAME	ORGANIZATION OR AFFILIATION	CHECK ONE SPEAKER	CHECK ONE OBSERVER
Venita Thompson	Bertie Co on Aging		✓
Janis Saputo	Pitt County Council on Aging	✓	

PUBLIC HEARING
NC Study Commission on Aging
February 21, 2006, 10:30 A.M
Martin Co. Community College

NAME	ORGANIZATION OR AFFILIATION	CHECK ONE SPEAKER	CHECK ONE OBSERVER
Bill Miller	Adult Day Care	✓	

PUBLIC HEARING
NC Study Commission on Aging
February 21, 2006, 10:30 A.M
Martin Co. Community College

NAME	ORGANIZATION OR AFFILIATION	CHECK SPEAKER	ONE OBSERVER
Vicki Paul			✓
Lee Riddick	Gov advisory Council/Region	Senior	

PUBLIC HEARING
NC Study Commission on Aging
February 21, 2006, 10:30 A.M
Martin Co. Community College

NAME	ORGANIZATION OR AFFILIATION	CHECK ONE SPEAKER	CHECK ONE OBSERVER
Bob Jackson	AARP	✓	
Charles S Sutton	MidEast		✓

PUBLIC HEARING
NC Study Commission on Aging
February 21, 2006, 10:30 A.M
Martin Co. Community College

NAME	ORGANIZATION OR AFFILIATION	CHECK SPEAKER	ONE OBSERVER
Lynne Raisor	AAA Region R		✓
Pat Finn	Albermale Region		✓
Harvey Davis	Senior Ashboro		✓
Alice Little	Randleman Senior		✓
Margie McDowell	Randleman "		✓
Cynthia Davis		✓	
Clinton C. Jones	Sr. Tarheel Legisl.	✓	
Patricia Rowell	Archdale Sr. Citizen	✓	
Lindsay Brown			✓
Ernestine Coble	Randleman	✓	
Johnny Johnston JR			✓
Vera Chisem	Archadale Senior		✓

PUBLIC HEARING
NC Study Commission on Aging
February 21, 2006, 10:30 A.M
Martin Co. Community College

NAME	ORGANIZATION OR AFFILIATION	CHECK ONE SPEAKER	CHECK ONE OBSERVER
Sam Marsh	Board Commission on Aging		✓
Kristen Bond	Agera Care Hospice		✓
Marsha Anderson	Martin Co DOA		✓
WC Moses			✓
Pat Rowell	Archdale Senior Center	✓	
Olga Jone	Tar Heel Senior		✓
Allen Winstead	Randolph Senior Adults		✓

PUBLIC HEARING
NC Study Commission on Aging
February 21, 2006, 10:30 A.M
Martin Co. Community College

NAME	ORGANIZATION OR AFFILIATION	CHECK ONE SPEAKER	CHECK ONE OBSERVER
✓ Tara Chamblee	HCOA	✓	
Orlanda Reed	HCOA		✓
Lynda Whitehead-Taylor	Legal Aid of N.C.		✓
Archie J. Brakebill	Beaufort County Midcoast C.O.A.		✓
✓ Jessie McDonald	Senior Games	✓	
Helen Sommerkamp	Senior Gov Leg Legislature		✓
Helen Newsome	Martin Dept of Aging		✓
✓ Helen Walter	N.C. Senior Games	✓	
Ben Popkin	NC General Assembly		✓
Judy Pelt	Aging Commission Member		
✓ Alice Keene	Pitt County Community Schools & Recreation	✓	

February 7, 2006

MEMORANDUM

TO: Members, **NC Study Commission on Aging**

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: **Public Hearings**

The NC Study Commission on Aging will be conducting two spring public hearings:

DAY: **Tuesday** **TIME:** **10:30am - 12:30pm**

DATE: **February 21, 2006**

LOCATION: **Martin Community College**
Building 2 – Auditorium
1161 Kehukee Park Road
Williamston, NC

DAY: **Tuesday** **TIME:** **10:30am - 12:30pm**

DATE: **February 28, 2006**

LOCATION: **Isothermal Community College**
The Foundation
286 ICC Loop Road
Spindale, NC

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

NORTH CAROLINA STUDY COMMISSION ON AGING

AGENDA

MONDAY, FEBRUARY 28, 2006
SPINDALE, NORTH CAROLINA

ISOTHERMAL COMMUNITY COLLEGE

OPENING REMARKS
REPRESENTATIVE BEVERLY EARLE

INTRODUCTION OF MEMBERS

PUBLIC MEMBERS SPEAK

NEXT MEETING MARCH 15, 2006

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES
FEBRUARY 28, 2006
10:00 AM
SPINDALE, NORTH CAROLINA

PUBLIC HEARING

The North Carolina Study Commission on Aging, Public Hearing was held in Spindale, North Carolina. The hearing was called to order by Representative Beverly Earle at 10:45 am. It was held at the Isothermal Community College in Rutherford County. Members of the Commission were asked to introduced themselves. Senator Dannelly, Chair, also gave remarks.
The following members were present:

Representative Beverly Earle, Chair
Representative Debbie Clary
Representative Alice Bordsen
Representative Bob England
Regina Duffy Fisher
Brad Allen
Shawn Parker, Staff

Three Senators were also present.

The public was asked to speak at this time.

Speakers

Dorothy Crawford – Macon County
Services Provided With Home and Community Care Block Grant Funds – The program need to be expanded to serve more seniors. There are 10,000 people on the waiting list for different types of services across the state. The state will not be ready for the baby boomers
Lonnie Proctor – Cleveland County
Senior Games – Senior games help us to stay healthy. It is a method of prevention. It is cheaper to keep us healthy, than going to the emergency room.
Michelle Templin – Family Caregiver Resource Specialist – Area Agency on Aging
Caregivers are an invisible population, they are not recognized as valuable members of our society.
Martha Sacks
Please provide more in-home care
Matt McKeithan – Hair Haven Nursing and Assisted Living Facility – Owner

Stated concerns for adequate housing for senior adults and their access to services.

Vince West
Senior Games – Continue to provide funds to the Senior Games

Kimberly Cole
Life Care offers adults a place to go during the daytime for medical monitoring, nutritional meals and creative activities.

Fred Halleger
Senior Games – Continue to fund the games.

Gerry Lacombach – Rutherford County
The Senior Center is an excellent investment in maintaining good health longer.

Lisa Abernathy – Senior Center Dirctor of the Neal Senior Center in Cleveland County
Senior Centers need more funding.

Scott Brackett
Please help with my Medicaid Part D.

Paulette Horne – Shelby, North Carolina
Need funds for Outreach Area Senior housing. Need more Meals On Wheels.

Tom Ensley - Cleveland County
Social Services – Need more funds for Outreach, Senior Housing and Nutrition Program.

Pat Morgan
Need more skilled nurses. Need more quality caregivers, need at least 6 weeks of more training.

John Highfield – Senior-Friendly Mecklenburg
To foster a senior-friendly community that values dignity and independence for all older adults. To engage the community in crating a dynamic plan that enhances the quality of life for older adults by focusing resources on their needs.

Nancy Clark
Would like to submit a list of recommendations to the commission. Will present at next meeting.

Debbie Lee – Ombudsman with Centralina Area Agency on Aging
Seniors will double in 2030. Let us continue to work to revitalize the Guardianship program in North Carolina.

Representative Earle thanked everyone for coming, with a special thanks to Senator Dalton for coming.

Beverly Earle

Representative Beverly Earle, Presiding Chair
Senator Charlie Dannelly

Ann Raeford

Ann Raeford, Commission Assistant

Attachments

Attachment I	Agenda
Attachment II	Remarks for Public
Attachment III	Visitors Registration

NC Study Commission On Aging
Public Hearing,
Tuesday February 28, 2006
Spindale, NC

Thank you for the opportunity to speak briefly concerning the value of services provided with Home and Community Care Block Grant (HCCBG) funds.

I am Dorothy Rose Crawford from Macon County, an AARP volunteer. What I say today is AARP's position as well as NC Senior Tar Heel Legislature position but I am not speaking as a spokesperson for STHL, only as a member and former Speaker, a retired Social Services Director and as a aging person of the fastest segment of aging, those over the age of 85.

As you are aware these HCCBG funds are administered by the Division of Aging and Adult Services to help provide services to older adults (60 years of age and older to allow individuals to remain in their homes or community. State funds are combined with federal Older American Act funds and required local match to make up the Block Grant funding.

As you have heard many times from all reliable scientific surveys individuals want to remain in their own homes and with adequate in-home services a large percentage can. Key services provided with Home and Community Care Block Grant funds are home delivered meals, adult day care or adult health care, respite care for family caregivers, home repairs, transportation. Each county decides which services to fund in what amount based on its county's identified needs.

Those in particular need of service are the over 125,000 older adults age 85 and older and those who are disabled. A quarter of persons age 65 and older living in communities have 2 or more physical or mental conditions that make it difficult for them to do such activities as walking, dressing and bathing. Without question there is an increasing meed for services, but the state is losing ground in its effort to help frail older people in the community. Not even considering the baby boomer who are rapidly approaching the need for these services. Baby boomers expect immediate service. There are nearly 10,000 people in NC on waiting list for these services and the real number unknown as only about half of providers report waiting list information. Almost all who receive these services are non-medicaid eligible. So many of these people are just over the medicaid eligible level. As stated there is an increased need for services but the state is losing ground in its effort to help frail older people. State funding is almost 2% less now than it was in FY 2000-01. During the last four years there has been a decline in the number of persons served and the number of services provided through Home and Community Care Block Grant funds. As a result more expensive services such as institutional placements increase. One measure that could help with payment in the future is to reinstate the long term care insurance tax credit which expired on December 31, 2003. Bills are still pending in the NC House and Senate. Long term care insurance policies are designed to assist a person in maintaining his or her level of functioning. Long term care services may include but are not limited to help with daily activities at home, respite care, home health care, adult day care and care in a nursing home. Insurance can help now and greatly in the future.

Caregivers can and do provide lots of care, but family caregivers need relief at times to continue giving care. Just a little respite can mean stability for the total family. Adult Day care services makes it possible for a number of people to remain at home or in relatives home with this service during the day. Aides or homemaker service makes it possible for couples to be some what independent if there is help with shopping, light household chores, help bathing, or dressing. These services pay off financially as well as they give the individuals helped a quality of life.

We, of the aging community, and advocates for the aging and disabled ask for your help by increasing funding for home and community based services for older adults by increasing the Home and Community Care Block Grant so that services may be available to our citizens who need them and as is the practice in Macon county payment for the service be on a sliding fee basis.

Thank you for the opportunity to speak today.

Dorothy Rose Crawford

Dorothy Rose Crawford
North Carolina AARP Advocacy Council Member
can work and keep

Region C Family Caregiver Program
Cleveland, McDowell, Polk and Rutherford Counties
2-28-2006

Our region has done an exceptional job with the funding for the Family Caregiver Program since its inception in 2001.

As you well know that caregivers are an invisible population, they are not recognized as valuable members of our society. Considering that 80% of all care to older adults is provided in the home, I'd say that they are a significant part of our healthcare system and are a major resource in North Carolina.
Medicaid pays an average of $20,000 for Assisted Living facilities and an average of $49,000 for Skilled Nursing care. With the Family Caregiver Program we spend an average of $1600.00 a year to give respite care so that the caregiver can take a break. The sad thing here is that we are not even able to serve 10% of this population with our funding.

Yes you might ask how this cuts down on cost for the state; well here are the stats from the American Medical Association. The majority of caregivers provide help with household chores, transportation, and personal care; however, 37% provide more medically necessary treatments such as giving medicines, injections, and other medical treatment[1] . The longer we are able to help a caregiver keep a loved one at home the longer we postpone paying the enormous cost of Nursing or Rest Home facilities. However, our system has neglected the needs of caregivers for so long that they care for as long as they can, wear out or worse – then their loved one gets placed.
<u>If we do not take care of the caregiver before burn out, then what happens is they end up being placed and for most low income seniors that means eating up more Medicaid dollars.</u>

We are thankful for all funding that helps us serve the care giving population; I feel that we need additional funding to expand the services to this population. I have caregivers within this region that have bankrupted themselves, dove into their children's college savings plans, and retirement to care for a loved one. We should be doing more to provide the help these caregivers need so that they still have a future to look forward to.

One more thing you may not realize is that due to all the job loss in our area; this has impacted other funding sources that people once turned to for help. We don't have as many people with jobs to contribute to United Ways, Hospices and other goodwill agencies. This in turn places the burden back on us.

Respectfully
Michelle D. Templin
Family Caregiver Resource Specialist
Area Agency on Aging

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[1] <u>Health Risk of Caregiving</u> American Medical Association, www.ama-assn.org/ama/pub/printcat/8802.html

Thank you for allowing me to address you today. My name is Mack McKeithan and I am the owner of Fair Haven Home, in Forest City. Our facility has 30 skilled nursing beds and 37 assisted living beds. I am also the developer of Eastwood Village Retirement Community which consists of 33 individually owned homes adjacent to Fair Haven. I have over 30 years experience in long-term care.

What I would like to address today is my concern for adequate housing for senior adults and their access to services. Even though I own a nursing home I am concerned about the increased costs as the baby-boom generation begins to enter the system. I hope North Carolina can explore using some Medicaid Money to begin to provide some services in a congregate setting. In-home services work well on a limited basis. It doesn't take much thought to recognize it takes time for a nurse to travel from one home to another and someone is paying for that time. The same idea applies to any in-home service. However, I also feel there are a good number of residents in assisted living and nursing homes that could have their needs met more efficiently.

I have designed a 30 unit apartment complex complete with a doctor's office, pharmacy services, post office, bank, exercise area, a large dining area and other amenities to help keep people independent with the help of some services. The services would include one meal a day, maid service, weekly nursing oversight of medications and health, on site physician services, activities and transportation. This is the type of development many affluent people can now get at a continuing care retirement community. With the use of tax credits and section 8 housing I feel it can be made available to the lower income elderly with some assistance of Medicaid dollars. I estimate it will cost around $400/month to provide these services as opposed to around $1,700/month for the costs in assisted living and $4,000 in skilled nursing. My staff has estimated that as much as 20% of our current population of residents could live independently if they had the services I described available. I also want to make this type of community available to the private pay renter as well as lower income. The private pay renter will also help absorb part of the extra costs of services.

I hired a consultant and last August we made the rounds in Raleigh and visited with the North Carolina Housing Finance Agency, Community of Affordable Housing Equity Corporation and the Community Investment Corporation. All of the groups were very receptive and said this was the type of development they would like to fund. However, when it came time to mix in the private pay renters they felt we would have problems. The problem came because the private pay market would have to absorb the costs for all of the services. If it were possible to have some Medicaid funds diverted to this type of project then the idea may be workable.

Because we already have the nursing, activity and dietary staff available, I feel we can develop this concept with a minimum of costs.

I am enclosing a copy of my plans with this speech and I hope North Carolina will look at new ways to provide services to the elderly and save some Medicaid money in the process.

RUTHERFORD

LIFE SERVICES

CARE
START
SKILLS
ABILITIES
CHALLENGE

You and your loved one both deserve to have the most fulfilling life possible and the LIFECare program for adults can help.

This unique program gives two people their lives back. Families and caregivers are given the opportunity to go to work, run errands, or take a break. Participants are given the opportunity to enjoy a welcoming, stimulating environment with social interaction and interesting activities. LIFECare also gives everyone peace of mind in knowing loved ones are being cared for by a competent medically-trained staff.

What is LIFECare?

LIFECare offers adults a place to go during the daytime for medical monitoring, nutritional meals and creative activities. Participants can come every day, every morning, or even one afternoon a week.

The center is licensed by the North Carolina Division of Aging and is a member of the North Carolina Adult Day Services Association.

LIFECare is a division of Rutherford LIFEServices, who has been providing services to help people meet their full potential for 35 years.

CARE THAT LEADS TO A HIGHER QUALITY

CARE THAT LEADS TO A BETTER LIFE

Who is eligible?

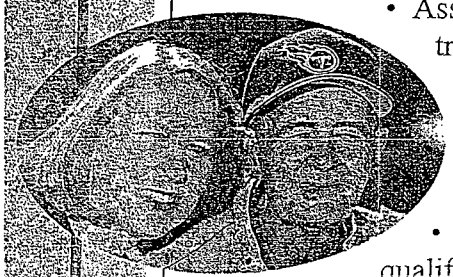
- Adults ages 18 years or older who need supervision and care during the day.
- Adults who need medical and/or nutritional monitoring or assistance with the activities of daily living.
- Adults who need to be administered medication, special foods, or other medical treatments.
- Ambulatory or non-ambulatory individuals.

What are the hours of operation?

- Monday - Friday, 7:30 a.m. - 5:30 p.m.

What services are provided?

- Monitoring of vital signs.
- Administering of medication.
- Assistance with personal care (help with using the rest room, grooming, etc...) Showers are also available.
- Planned activities such as crafts, music, fitness, movies and other outings, seasonal celebrations and gardening.
- Breakfast, lunch and afternoon snacks. (Special attention is given to dietary needs.)
- A courtyard with a flowing pond and raised flower beds.
- Assistance with arranging transportation with Rutherford County Transit.



Who is on staff?

- LIFECare employs qualified, licensed caregivers and nurses who provide assistance and medical monitoring.

RUTHERFORD LIFE SERVICES
CARE START SKILLS ABILITIES CHALLENGE

We are so thankful that Mom is a participant in the LIFECare program. She thinks and expresses herself more clearly than she did six months ago. She's happier, too! Our hearts rejoice every time we think about her involvement in the day care. And while Mom is busy being treated like a queen, Dad is able to rest and regroup at home so he can continue caring for her during the demanding evening hours. We truly appreciate your sacrifice and, deep inside, I know Mom does, too! Thank you.

~ Cheryl Tomblin

What are methods of payment?

- Private pay charges based on the level of care fee structure. (An assessment tool is used to determine the level of care required.)
- Medicaid covers those who qualify through the Community Alternative Program (CAP).
- Qualifying veterans are covered through a contract with the Veterans Administration.
- Financial assistance may be available and evaluated as needed by our outreach coordinator.

How do you enroll?

- Anyone interested in enrolling in LIFECare should call (828) 288-1697 or (828) 286-4352. After an initial interview and assessment of their needs, each participant can spend a trial half day (up to four hours) at the center at no charge. This trial session is used to help the participant become adjusted to their new surroundings and to determine the level of care needed. Following this, the caregiver, participant and staff will meet to discuss the level of care, the cost of service, the beginning date and assistance with arranging transportation.

Rutherford LIFECare
859 Thunder Road
Spindale, NC 28160
(828) 288-1697 or (828) 286-4352
www.rutherfordlifeservices.com

I appreciate this opportunity to report to the Study Commission on Aging what I observe going on in Rutherford County to help our Senior citizens.

I serve the people of this county in the following ways:

- As a volunteer at the Senior Center
- As a Senior Games Ambassador
- As a person who represents the Senior population on the Rutherford County Board of Parks, Recreation and the Arts

The Rutherford County Senior Center is well-managed, but the Center is outgrowing its facility. The meals-on-wheels program needs to be expanded; more community-based centers need to be developed to deliver meals to people who are located farther from the present center. The activities provided help us to retain our connectivity with other people for a longer period of our senior life – thus by keeping our interests going, we keep ourselves going longer and need less in the way of nursing home assistance and in-home care. **The Senior Center is an excellent investment in maintaining good health longer**.

The local Senior Games provide an outlet to stimulate us to more healthful and active participation in life. It is true that even though it is "healthful" it is also just plain fun for us to compete against each other each year…especially since it requires that we "practice" for the games all year round. However, with rising entry costs and people on fixed incomes, many of us can no longer participate. **We need to raise funds to provide for those who can no longer pay their own way.**

On the Board of Parks, Recreation, and the Arts much work is being done to improve the recreation facilities in the county to make all parks and recreation areas more accessible to both Senior and Handicapped Citizens. Seniors especially need more places where they can safely walk. **This means that more sidewalks and safe trails need to be provided. Some seniors can no longer drive, so parks and walking areas need to be distributed to every area of the county to make them available to those who cannot drive to get to them.**

Because we live in Rutherford County which has the dubious pleasure of the highest unemployment rate of any of the 100 North Carolina counties, funding for all of our efforts is forever a problem. We are doing everything we can on our own. However, we note that many of our newest residents are retirees so our needs continue to grow. **What I ask of you is that you support our efforts with funding when you are back in Raleigh. Whenever funds that were promised from Raleigh but are at the last minute withheld from us…when this happens, we are in dire straits. Please help us with steady funding that we can use to continue the useful programs that we work on here.**

Submitted by:
Gerry Luckenbach
Tuesday, February 21, 2006

Mister/Madame Chairman and Honorable members of this commission, my name is Lisa Abernethy. I serve as the Senior Center Director of the Neal Senior Center in Cleveland County. It is indeed an honor and privilege to have this moment of your valuable time to share with you the current and upcoming needs, concerns and issues facing not only our Senior Center but in all probability others across the state. Thank you very much for this opportunity to speak to you in reference to Senior Center Operations.

First, and foremost, in Cleveland County we are very grateful for any and all funds we have received. Those funds have helped:

- The Senior Center serve an average of 550 seniors on a monthly basis which equates to around 6,600 seniors annually.
- The Senior Center provide a safe and welcoming environment where seniors lives are improved through:
  1. Socialization, whether it be through the classes, programs, activities or special events we offer on a daily, weekly, monthly or yearly basis. It is a basic human need to have contact with other humans. Older humans need such contact as much or more than babies or young children; or
  2. Health awareness and prevention classes and seminars as well as the availability of fitness equipment and exercise opportunities. Almost 500 seniors are served annually through 4 Health Care Fairs held throughout the county. Senior Games also offers a year round program of healthy living; or
  3. Volunteerism. Through the Senior Center older adults have the opportunity to give back to their community and in Cleveland County we are dependent upon the 600 or so senior volunteers to keep most if not all of our programs, classes, activities, etc. running.

These activities and opportunities help seniors be the best they can be by helping them stay active mentally and physically. For example, statistics show that mental health affects physical health and seniors who are active in their local centers suffer less depression due to loneliness. Active seniors are more equipped to handle the daily challenges of being older adults.

Unfortunately, five years ago, cuts were made to the Block Grant Funding. Due to those cuts, certain services, programs and even staff had to be trimmed from our operations. On top of the losses in Block Grant Funding, Cleveland County also suffered losses to its economy. Our major industries are gone. Industries, which were once generous with donations that helped, keep our ball rolling. Industries, which have not been replaced in Cleveland County or other rural North Carolina counties.

Add to this the ever-present increase in the cost of living. Yes, it does affect Senior Center operations. Again, for example, the increase in gas prices resulted in an approximate 30% increase in our utilities. So do we freeze participants in the winter and burn them out in the summer to reduce operating costs thereby taking away that nice safe, welcoming environment or do we have to tighten our belts elsewhere and reduce activities, programs and available opportunities? Currently, our operating budget does not come near to meeting the needs of senior adults in Cleveland County. If the budget does not meet current needs, how will we be able to meet the needs of or provide services for a brand new group of adults, those wonderful "baby boomers," hurtling towards senior adulthood? Over the next 22 years, Senior Centers will be facing a crisis. Many, including the Neal Senior Center in Cleveland County are not in the 21st Century technologically. Upgraded computer hardware, networking capabilities and software are and will continue to be an urgent problem for center staffs and participants. A new and larger variety of classes and programs as well as new and different hours of operation will need to be considered. More adequate and appropriate staff will need to be hired by centers. None of this can be done without funding. It is time to take a look at the big picture, many North Carolina counties, especially rural North Carolina counties will experience a tremendous shift in their populations, they will become overwhelmingly senior populations. Who has the framework in place to help seniors stay active mentally and physically? Senior Centers.

Senior Centers were established to provide health awareness, healthy activities and opportunities to learn about and create healthy lifestyles for seniors age 55 and above. By investing in the future of North Carolina's senior centers and her senior adults, the state will reap benefits of:

1. Healthier, vital older adults who are involved in the mainstream of society instead of occupying nursing home beds;
2. Less of a drain on medical resources, just to mention a few.

Isn't it time we started sowing a future to meet the needs of our seniors who have worked hard to create the great state and nation we live in? We will all reap an unbelievable harvest, if we do.

Thank you again for your time.

MADAME CHAIRMAN AND HONORABLE MEMBERS of this commission, my name is Paulette Horne. I serve as the Services Director at The Council on Aging/Neal Center in Cleveland County. We appreciate the privilege of being here to share with you our concerns and issues facing the Senior Center. Thank you very much for this opportunity to speak to you.

As you have already heard from our Senior Center Director, about some of our most pressing concerns; I would like to share some of the issues that are facing the Services Department.

1. OUTREACH
2. SENIOR HOUSING
3. NUTRITION PROGRAM

All of these areas are suffering due to lack of funds. Thank you again for the opportunity to speak to you.

Tom Ensley Cleveland Co. DSS

To speak on Behalf of our Elderly Pop. in Clev. Co.
one of our mission is to protect & serve vulnerable and disabled Adults in Clev. Co. It is for this reason that we come before you this morning.

$122,000

The Cleveland County Department of Social Services meets this mission goal by providing **in-home aide** services to disabled and elderly adults in our Cleveland County. In-Home aide services is just one of the services provided in Cleveland County to serve our older population from Home and Community Care Block Grant; but we consider it a very valuable service. In-Home Aide Services are intended to assist individuals and their families with maintaining the necessary degree of self-sufficiency to enable the adult to safely remain in their own home as long as possible. As you are aware, most of our elderly citizens desire to remain at home. The aim of the service is to prevent deterioration that may ultimately lead to out of home placement and to prevent abuse, neglect or exploitation of a disabled or elderly adult. It is our experience that this service accomplishes its goals for those limited numbers of adults who are able to receive the service.

Target the most needful
No Income
Physical needs first
Financial last

In-Home Aide services is cost effective and provided by paraprofessionals. Examples of tasks may include housekeeping, cooking, shopping, or assistance with personal care.

The eligibility is based on need for the service for all of the following reasons:

1. The adult is unable to carry out one of more tasks essential to the activities of daily living.
2. The adult needs help with these tasks in order to remain in his/her own home.
3. A responsible person is not available to perform these tasks or the primary caregiver needs relief.

Our typical client

The Cleveland County Department of Social Services has a contract with an In-Home Aide Agency appropriately certified and licensed by the State of North Carolina to provide the service. The agency validates that all staff are competent and provides ongoing training and supervision. Necessary steps are taken to determine the presence of any past criminal behavior in order to provide security to the vulnerable adult.

Again, The Program operates from funding from the Home and Community Care Block Grant. The Department of Social Services maintains approximately 24 adults on this program at any given time and has an average of 45 people waiting for the service currently. The Department anticipates utilizing all funds available for this year and has the ability to utilize more if that opportunity presents itself. There has been very little increase in the funding for this service over the last several years and in fact, funding was cut during this current year lowering our clients served from an average of 30 to about 24 adults. Over the years, the in-home aide program has assisted many adults to maintain a good quality of life and an opportunity to remain in their own home. With only a few hours of care each day or each week, some have remained in their own homes for over 10 years with the help of the in-home aide program. Often these same people have little or no family involvement and are living on very limited incomes.

Lastly, the program costs less than out of home placement and enhances an adult's ability to maintain dignity and independence. An in-home aide can serve an adult 5 days per week for 2 hours per day for about ½ of the cost of an adult care home.

$ 26 per day
$ 600
$ 800

It costs less than half of what it costs for Assisted Living 1200 and approximately 1/5 of the cost of Nursing Home 3000+

We would like to take a moment to thank the legislature for continuing funding for the special assistance in-home program. Our agency was fortunate to add one of the first cases in the state to this program and we currently have 45 people being served. This program targets the most needy individuals and allows for funds that normally go to pay for adult care home care in f acilities to be used by the adult to stay at home.

Typical Client

60-70 yr old White or African American female who lives alone.

Limited Income - But not eligible for Medicaid.

May or may not have medicaid.

Very few family contacts.

Her family is usually neighbors or church members or anyone who comes enough to visit her Daily

37

50-60 yrs

in a nursing home

600 3000

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 private, public and non-profit agencies who are developing 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.**

Executive Advisory Board

Jerry Fox, Chair; Ted Rast, Co-Chair; Doug Booth; Carla DuPuy; Ruth M. Easterling; Paul Franz; Dr. E. K. Fretwell, Jr.; Bruce Landgarten; Harvey Gantt; Maryann Gilmore; Gerald Johnson; Peter Keber; Gloria Pace King; Mountain Odom; Mark Peres; Betty Chafin Rash; Donald C. Sanders; Dr. Dena Shenk; Dr. C. Don Steger, Sara Wolf

301 Billingsley Road • Charlotte, North Carolina 28211 • 704-336-4109

http://statusofseniors.charmeck.org

The 2005 Strategic Plan Report Contains Strategies for 7 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. Advocate a more "senior-friendly" Physical Environment
3. Celebrate and Support the role of informal and family Caregivers;
4. Begin a Community Safety campaign in high-density areas focusing on seniors;
5. Advocate coordinated "senior-friendly" options leading to Transportation Independence.
6. Develop an integrated approach for Community Education and Communication with key stakeholders and the general public;
7. Advocate improvements needed in Long Term Care Public Policies;

- NEXT STEPS:
  - Actively pursue the implementation strategies for these recommendations
  - Once these strategies are well underway, develop recommendations and strategies for additional issues in the Charlotte-Mecklenburg Senior-Friendly Matrix

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 pursue a plan that covers all areas in the C-M Senior-Friendly Community Matrix: 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 2000 there were 80,440 age 60+ older adults in Mecklenburg.
- In 1990 the average profile of the 66,617 older adults was a female (60%), age 60 to 74 (43%), and White/Caucasian (81%).

Mecklenburg's Future:

- Experts say a labor shortage is all but inevitable as baby boomers retire.
- The age 60+ Mecklenburg population will triple to 243,619 people by 2030, while the 0-17 age population will not even have doubled by 2030 when it will reach 308,689.
- The older adult population rate of growth currently 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 it will grow to 18.5 % by 2030.
- "The dominant factor for business in the next two decades is not going to be economics or technology; it will be demographics." Peter Drucker: The Future Has Happened Already
- By 2010 there will be 168 million jobs in the U.S. and 158 million workers.

To learn how you can help, contact:
John Highfill at highfjv@co.mecklenburg.nc.us or 704-336-4109.

301 Billingsley Road • Charlotte, North Carolina 28211 • 704-336-4109
http://statusofseniors.charmeck.org

I am Debi Lee, Lead Regional Ombudsman 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 – three 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 --- 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 –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 continue to work 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. Medicare D issues and concerns.
- 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.
- 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.

2) 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.

3) 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 county that received a Long Term Care Planning Grant. Rowan and Cabarrus Counties have begun to work with planning initiative as well. Our Region has had the opportunity to work with them, I want you to know how exciting it has been to see 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. 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.

Debi Lee
Lead Regional Ombudsman
Centralina Area Agency on Aging
P.O. Box 35008
Charlotte, NC 28235
704-348-2727
dlee@centralina.org

FACT SHEET
North Carolina Regional Long Term Care Ombudsman Association
2005 - 2006 Legislative Priorities

State Issues

A Long Term Care **Ombudsman** is an advocate for residents' rights and is responsible for investigating complaints made by, or on behalf of, nursing and adult care home residents. Long Term Care **Ombudsmen** work with residents, family members, concerned citizens, facilities, as well as public and private agencies to enhance the quality of care and quality of life for residents in long term care facilities.

The North Carolina Long Term Care **Ombudsman** Program, as established by the Older American's Act, consists of individuals at the state and local levels. The State Long Term Care **Ombudsman** is located within the North Carolina Division of Aging and Adult Services in Raleigh. Regional Long Term Care **Ombudsmen** are housed in each Area Agency on Aging, located in Lead Regional Organizations. The North Carolina Regional Long Term Care Ombudsman Association is a subcommittee of the North Carolina Association of Area Agencies on Aging.

1. **Support a rate increase for long term care facilities <u>only</u> if the increases are applied to wage/benefit plans for direct care employees.**

Long Term Care/Enhancement Funds bills were introduced in the 2003 –2004 session. The bills addressed Long Term Care Enhancement Funds and were sent to the Appropriations committee where no action was taken. The following is direct language from the Long Term Care/Enhancement Funds Bill.

SECTION 2. Funds appropriated in this act shall be allocated in accordance with the following:

- The amount of the labor enhancement benefit shall be allocated equitably among the various care settings.
- 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.
- 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.
- 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 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 pre-labor enhancement turnover rates and turnover rates at the end of each fiscal year for which labor enhancement funds are received.

2. **Support a bill that would increase Medicaid nursing home residents' personal needs allowance in nursing homes from $30 per month $50 per month.**

Federal law requires a Medicaid personal needs allowance of at least $30 per month. A Medicaid Personal Needs Allowance Increase bill was introduced in the 2004 – 2005 legislative session that would increase the Medicaid personal needs allowance from $30.00 per month to $50 per month for residents in skilled nursing facilities. The bill was referred to Appropriations, where no action was taken. The following information is taken from the bill.

The personal needs allowance of residents in NC nursing homes has not been increased since 1988. $30.00 per month is not sufficient to cover the cost of personal needs of residents. In December 2004, over 25% of states paid $40.00 - $49.00 in Medicaid personal needs allowance for skilled nursing facility residents, and protocols for automatic annual increases in

the personal needs allowance are in place in five states. Furthermore, the Medicaid personal needs allowance paid by the State draws down the federal match to these funds.

3. **Support the need for a minimum standard that requires adult care homes to establish and maintain resident councils/family councils.**

It is important for residents of adult care homes and their families to be aware of their power as consumers. It is also important for facilities to recognize the importance of resident and family input. Disabled adults, who reside in Adult Care Homes, in many cases, have the ability to speak for themselves. Promoting dialogue between consumers and providers makes sense.

Federal Law gives nursing home residents and their families the right to organize and be heard. [Reference 42 CFR section 483.15(c); Public Law 100-203 Social Security Act] The facility is required to listen to resident and/or family group recommendations and grievances. Acting upon these issues does not mean that the facility must accede to all group recommendations, but the facility must seriously consider the group's recommendations and must attempt to accommodate those recommendations, to the extent practicable, in developing and changing facility policies affecting resident care and life in the facility. The facility must communicate its decisions to the resident and/or family group. **Should the same not be the case for adult home residents who are more capable of self- advocacy?**

Resident Councils and Family Councils are defined as groups that meet regularly to:

- Discuss and offer suggestions about facility policies and procedures affecting resident's care, treatment, and quality of life;
- Support each other;
- Plan resident and family activities;
- Participate in educational activities; or
- Address general concerns

Proposed Legislation:

A. Adult Care Homes with 12 or more residents shall offer residents the opportunity to organize and participate in resident groups in the facility.
B. The resident's family has the right to meet in the facility with the families of other residents in the facility;
C. The facility must provide a resident or family group, if one exists, with private space;
D. Staff or visitors may attend meetings at the group's invitation;
E. The facility must provide a designated staff person responsible for providing assistance and must respond to written requests that result from group meetings.
F. When a resident and/or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility

4. **Support the N.C. Study Commission on Aging to study the mentally ill residents in long term care facilities.**

Study of Mentally Ill LTC Residents Issues was introduced as a bill in the 2003-2004 session. The Aging Study Commission is working on the report and final recommendations for October 2005. The following are some of the categories studied.

*"**SECTION 10.2(a)** 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 residents' 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.*
7. *Identifying specific problems that exist due to mixing of aging and mentally ill populations."*

FACT SHEET
North Carolina Regional Long Term Care Ombudsman Association
2005 – 2006 Legislative Priorities

Federal Issues

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1. **Support the need to increase the minimum number of direct care nursing staff in Nursing Facilities to the following ratios:**
   Minimum Level Direct Care Staff (RN, LPN, or CNA)

Dayshift	I FTE for each 5 residents	
Evening Shift	I FTE for each 10 residents	
Night Shift	I FTE for each 15 residents	(*FTE - Full Time Equivalent)

   Minimum Licensed nurses (RN and LPNs) providing direct care, treatments and medications, planning, coordination and supervision at the unit level:

Dayshift	I FTE for each 15 residents	
Evening Shift	I FTE for each 20 residents	
Night Shift	I FTE for each 30 residents	(*FTE - Full Time Equivalent)

   The National Citizens Coalition for Nursing Home Reform (NCCNHR) Staffing Standards.
   In 1998, NCCNHR members voted to support these minimum nurse-staffing ratios developed in consultation with long-term care experts over a period of years. Since then, these standards have been used, as intended, as "a model framework for state and federal action", introduced in several congressional bills, and used as a basis for debate in a number of state legislatures that have enacted state staffing standards.

2. **Support the Reauthorization of the Older American Act that extends current provisions for Long Term Care Ombudsman programs and requires that any changes related to the Ombudsman Program enhance program effectiveness. Support the need to increase appropriations for Ombudsman Programs under title VII.**
   This item is a priority issue for both the National Citizens Coalition for Nursing Home Reform (NCCNHR) and the National Association of State Ombudsman Programs (NASOP).

3. **Support the continued development and funding of the National Elder Abuse Center. Elder Justice Act of 2005** On February 10, 2003, Sen. John Breaux (D-La.), Ranking Member, Senate Special Committee on Aging, and Sen. Orrin Hatch (R-Utah), Chairman of the Senate Judiciary Committee, introduced the Elder Justice Act of 2003 - S. 333. The bill before the Senate is an important step towards ensuring the safety of vulnerable elders. If passed, the new law among other things would:

   - Establish dual Offices of Elder Justice in the US Department of Health and Human Services/Administration on Aging and US Department of Justice to coordinate elder abuse prevention efforts nationally.
   - Require an FBI criminal background check of long-term care nursing aides and better training for workers in the detection of elder abuse.
   - Establish an Office of Adult Protective Services within the US Department of Health and Human Services, Administration for Children and Families.
   - Enhance law enforcement response to elder abuse.

4. Support the effort to ensure maximum consistency in enforcement of the National Nursing Home Reform Law. (OBRA 87)

On July 9, Senate Finance Committee Chairman Charles Grassley of Iowa sent a letter to CMS Administrator Mark McClellan on the results of interviews between his staff and approximately 20 state surveyors, who charged that their hands were tied in agencies that required them to overlook or downgrade deficiencies. Grassley conducted the interviews after years of hearings and government reports showing that some of the inconsistency in the survey process appears to be related to differences in the way states cite and code deficiencies and to political pressure in some states to cite harmful deficiencies at a non-harm level. [Grassley's letter is posted on the NCCNHR website under "Washington Update". [www.nursinghomeaction.org]

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — February 28, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Coenner	Macon County
Edwina Hawkins	Macon County
Frank Hawkins	Macon County
George Hardy	Macon County
Raymond Romero	Macon County
John [illegible]	Macon County
Lucas Cole	Rutherfordton
Laura Lewis	Area Agency on Aging
Diane Padgett	"
Teala McDowell	Cleveland Co. Dept Social Services
Regina Fisher	Mecklenburg Co.

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — February 28, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Edwards	DAAS
John L Crawford	Macon County
Elizabeth McBride	Macon County
Donald McBride	"
Mary West	"
J Hall	Polk Cty
Jan Simpson	Area Agency on Agency
Jim Freeman	Polk County - Tryon
Pam Doty	The Meeting Place - Polk County
Marlin Mueller	Macon County Sr. Games
Ronald Mueller	Macon County Sr. Games

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — February 28, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sandra MCGRAFF	Community Clinic of Rutherford Co.
Marion Mechaloo	Area Agency on Aging
Angela Williams	Wilkes Senior Center
Pat Morgan	Citizen
Carolyn Atchley	Dept. of Aging / Sr. Center Rutherford County
Pam Bunn	Daily Courier / Oak Street, Forest City
Danielle Lowell	" "
Teresa Holbrooks	Macon Co. Rec. Park
Seth Adams	" "
Esther Street	Swain County Comb.
Allen Street	" " "

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — February 28, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Phyllis Wilson	
Ray Wilson	
Fay Hassell	United Ways of Ford Co
Lucy Kennedy	Life Enrichment Center of Clev. City
B. Brock	WIC
Cindy Kincaid	Area Agency on Aging, Centralina
Lisa Bradley	Haywood Co DSS
Misti Carver	Haywood Co. DSS
Tammy S. Campa	

2005 Status of Seniors Initiative

Strategic Planning Report

Status of Seniors Initiative

Senior-Friendly
Mecklenburg

October, 2005

Older Americans... a new and different generation!

Implementation Strategies

Visit us at http://statusofseniors.charmeck.org

County Manager's Office

On behalf of the Board of County Commissioners and my Executive Team, I want to thank everyone involved in the Status of Seniors Initiative 2005 Strategic Planning Report. The study is a positive reminder of the vast resource Mecklenburg County has in its aging population. While some will dwell on our need for additional services to care of our older citizens, many of us see a healthy and intelligent core of new community volunteers who have time to make a real difference in the lives of the people of Mecklenburg County. We look forward to making Mecklenburg County "Senior Friendly." *Harry L. Jones, Sr. County Manager*

Mecklenburg Board of County Commissioners

H. Parks Helms (Chairman, At-Large)
Phone: 704-372-4884
Email: PHelms@helmshenderson.com

Wilhelmenia Rembert (Vice-Chairman, At-Large) Phone: 704-336-2641
Email: wirembert04@bellsouth.net

Jennifer Roberts (At-Large)
Phone: 704-336-2574
Robertjw@co.mecklenburg.nc.us

Jim Puckett (District 1)
Phone: 704-363-1379
Email: jhpucket@bellsouth.net

Norman A. Mitchell, Sr. (District 2)
Phone: 704-399-3061
Email: normanam@aol.com

Valerie Woodard (District 3)
Phone: 704-537-8958
Email: 2woodard@bellsouth.net

Dumont Clarke (District 4)
Phone: 704-331-1051
Email: dumontclarke@mvalaw.com

J. Daniel Bishop (District 5)
Phone: 704-716-1202
Email: dan@votedanbishop.com

Bill James (District 6)
Phone: 704-336-2573
Email: Wjames@carolina.rr.com

Contact the Manager's Office at 704-336-2472 or visit the Manager's web site at www.charmeck.org

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

February 16, 2006

MEMORANDUM

TO: Members - NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be **two** meetings of the NC Study Commission on Aging in March:

DAY: **Wednesday** **TIME: 10:00 A.M.**

DATES: **March 15, 2006** **AND** **March 29, 2006**

LOCATION: **Room 643**
Legislative Office Building

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, March 15, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions
Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Approve Minutes
(Meetings: 12/20/05, 1/4/06, 1/18/06, 2/1/06, 2/15/06)

III. Letters to the Commission from Adult Day Care Participants and Families
Theresa Matula, Commission Staff, Research Division, NCGA

IV. Summary of Public Hearing Comments
Shawn Parker, Commission Staff, Research Division, NCGA

V. Draft Letter on Federal Funding for Training in Geriatrics and Gerontology
Ben Popkin, Commission Staff, Research Division, NCGA

VI. Update on Medicare Part D
Carol Shaw, Fiscal Research Division, NCGA
Mike James, Person Street Pharmacy

VII. Criminal Record Background Checks for LTC: Input from Employers
Jim Edgerton, Association for Home and Hospice Care
Stacy Flannery, NC Health Care Facilities Association
Jerry Cooper, NC Assisted Living Association

VIII. Overview of Fines and Penalties in LTC Facilities
Jeff Horton, Division of Facility Services, DHHS

IX. Next Meeting:
March 29, 2006 at 10:00 a.m. in Room 643

North Carolina Study Commission on Aging

MINUTES
Wednesday, March 15, 2006
10:00 AM
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Wednesday, March 15, 2006, at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were: Senator Charlie Dannelly, Co-Chair; Rep. Beverly Earle, Co-Chair; Senators Austin Allran, and Vernon Malone; Representatives Alice Bordsen, Bob England, and Jennifer Weiss; Mr. Brad Allen, Ms. Linda Howard, Mr. Sam Marsh, and Ms. Judy Pelt. Mr. Jackie Sheppard, Ex-Officio Member, was also present.

Senator Charlie Dannelly presided. He called the meeting to order and made a few introductions prior to the presentations.

First on the agenda was approval of minutes from meetings held on 12/20/05, 1/4/06, 1/18/06, 2/1/06, and 2/15/06. The minutes were approved as written.

PRESENTATIONS

Letters to the Commission from Adult Day Care Participants and Families

Ms. Theresa Matula, Commission Staff, gave Commission members a brief overview of the 54 letters received from persons associated with the Loving Touch Adult Day/Health Care Center in Charlotte. She furnished each member with a sample copy asking for additional financial assistance for Adult Day Care facilities. (Attachment I)

Summary of Public Hearing Comments

Mr. Shawn Parker, Commission Staff, gave a short presentation and furnished handouts on the two public hearings which were conducted recently. (Attachment II) Following are the issues mentioned with the greatest frequency.

- Support for Senior Games
- Preserve and Expand Home and Community Care Block Grants
- Preserve and Expand Senior Center Funding
- Support for In-Home and Community-Based Services

Draft Letter on Federal Funding for Training in Geriatrics and Gerontology

Mr. Ben Popkin, Commission Staff, presented Commission members with a copy of the draft letter proposed to be sent to members of the NC Congressional Delegation. (See Attachment III) He told Commission members that the draft was prepared with the assistance of Dr. Laura Hanson who is a UNC Physician affiliated with the Geriatrics Program. The letter is intended to raise attention to the fact that funding for geriatrics education was eliminated in the last budget. Members were given a chance to review the draft and agreed that it should be sent to the Congressional Delegation. It was suggested that the letter reflect that those being copied are actually members of the Commission on Aging and agree to its content.

Update on Medicare Part D

Ms. Carol Shaw, Fiscal Research Division, NCGA, was the next presenter. She gave a presentation on the impact of Medicare Part D on the budget for the NC Medicaid Program. She furnished Commission members with a handout entitled Impact of the Medicare Part D Program on the NC Medicaid Program, Revised Estimates (Attachment IV). She focused on the additional savings that the state would realize because of the Medicare Part D Program taking over the cost of prescription drugs for duel eligibles (persons eligible for both Medicare and Medicaid). The Medicare Modernization Act requires a payment from the state to support the Medicare Part D Program. This is known as the "clawback". The clawback is designed to be 90% of estimated state savings for 2006 and it will decline 1.67 percentage points until reaching 75% of estimated state savings in 2015. The Fiscal Research Division estimates a total savings of $35,378,760 for fiscal year 2005-06 of which counties must contribute $5,306,814 and a savings of $98,826,090 for fiscal year 2006-07 of which counties must contribute $14,823,914. Please see Attachment IV for the formula and other pertinent information.

Ms. Shaw also gave a presentation on Supplementing Medicare Part D Coverage: How are States Responding? (See Attachment V) Following is a list of what states are doing.

- Providing funds to enhance or supplement Medicare Part D for selected residents
- Redirecting state-funded pharmaceutical program services to populations not covered by Medicare
- Reducing or eliminating benefits previously included in state pharmaceutical assistance programs that will now be covered by Medicare Part D
- Terminating state-funded programs

Please see Attachment VI for details of states providing additional subsidized "wrap around" benefits to Medicare enrollees in 2006 and Attachment VII for 2007 Medicare Part D Transitional and Emergency Coverage by state. Ms. Shaw told Commission members that NC terminated its prescription drug coverage for dual eligibles for claims after December 31, 2005 because of Medicare Part D.

Mr. Mike James representing the Person Street Pharmacy was the next presenter. Mr. James told Commission members that there have been a lot of problems with Medicare Part D. Pharmacists are seeing clients who can not get their medicine because they have

joined a plan that does not cover the medicine they need. Pharmacies are lucky to get $1.50 gross margin on prescriptions filled. Mr. James asked the commission to contact the congressional delegation and tell them that something needs to be done because rural pharmacies will be going out of business if they don't get better reimbursement rates.

Mr. Bill Rustin, President of the Association of Community Pharmacists spoke next. Mr. Rustin told Commission members that independent and chain pharmacies are losing ± $5 on every prescription filled under Medicare Part D. The average community pharmacy is underwriting and subsidizing the entire Medicare Program because the reimbursements are so low. In rural counties with only two pharmacies, if one pharmacy closes due to loss, the other may have to do the same. The NC Board of Pharmacy is doing all it can to alert Congress to the problems and hope that the NCGA will aid in that effort.

Mr. Andy Ellen, Vice President and General Council of the NC Retail Merchants Association was the next presenter. Please see Attachment VIII, page 4 for a copy of his presentation. He said he hopes the Commission will help 1) continue to talk with the congressional delegation abut the importance of adequately reimbursing the pharmacies, 2) look at how the formularies are set up and how the pharmacy benefit managers have an impact in the program 3) talk to the House and Senate leadership and work with Medicaid and DHHS on ways to adequately reimburse pharmacies and make sure that network is there and 4) go home and talk to pharmacists about the problems they are having and see if they have suggestions.

Criminal Record Background Checks for LTC: Input from Employers

Ms. Stacey Flannery, Director of Legislative Affairs with the NC Health Care Facilities Association was next. She told Commission members that every unlicensed person working in a facility has to have a NC background check. Non-5 year residents who are considered direct-care employees and non-5 year residents who are considered direct access workers are required to be fingerprinted and have a national background check. Most providers feel the background checks are efficient. Providers prefer to make their own hiring decisions indicating they would not want DHHS to make a final determination of employability. However, providers also commonly do not hire individuals with a finding on the national criminal history check. (See Attachment IX)

Mr. Jerry Cooper with the NC Assisted Living Association spoke next. He told Commission members that background checks go directly to DHHS and the facility is notified if there is a hit. All background checks are done initially through the SBI. The majority of the providers also use a private contractor. This allows the facility to input information and get real time data online while the applicant is present. They are also able to get DMV records as well. In terms of persons who have lived in NC less than five years, they have to go through the criminal records unit. It does require fingerprints. Very few persons are being hired who have lived in NC less than five years. If a hit is found while doing the check, that person is usually terminated. All new administrators must have a criminal background check including fingerprints. Checks on about 297

people have been run resulting in only one hit. Employers rely heavily on the Health Care Personnel Registry and the NC Assisted Living Association supports expansion.

Overview of Fines and Penalties in Long Term Care Facilities

Mr. Jeff Horton with the DHHS Division of Facility Services was the next presenter. He talked about Adult Care Homes. Examples of fines and penalties assessed in Adult Care Homes include elopements, poor medication management, lack of coordination of services, lack of response when laboratory results are received, appointments and supervision problems. A "Type A" fine is assessed when there has been a death, serious physical harm or substantial risk of death or serious physical harm. A "Type B" fine is assessed when there is no substantial risk of death or serious physical harm. A Type B fine is only assessed when the facility is given a chance to correct a problem and on a follow-up visit the problem is not corrected. The fine accrues on a daily basis. There were 76 Type A violations assessed in 2005 and 22 Type B. Forty-three percent of the Type A violations are still outstanding and 17 have been appealed. 2005 outstanding penalties for Adult Care Homes total $104,720.00. Rep. Earle asked for information in writing to include the name of the facility, owner, outstanding fines and penalties. She also asked for the reason and stage of the appeals.

If a home has an outstanding penalty and it is time for license renewal, the license it not renewed. Mr. Horton told commission members that in the past owners who were fined would pass ownership to other persons in order to circumvent the fines. Now, the owners are not allowed to transfer ownership without first paying the fines. Training sessions are not required in lieu of fines and penalties. The average amount of time to collect a fine is about a year.

Ms. Beverly Speroff, Chief of the Nursing Home Licensure and Certification Section of the Division of Facility Services gave a presentation on nursing facilities. Please see Attachment X for terms relative to the Federal enforcement process. Ms. Speroff told Commission members that they conduct routine inspections and complaint based inspections. If the facility in not in compliance, they note a deficiency. An enforcement grid is used to assess the seriousness and scope of the deficiency.

Rep. Earle asked for a listing of facilities under the assisted living category.

The meeting adjourned at 12:35 p.m.

Charlie S. Dannelly

Senator Charlie Dannelly, Co-Chair
Presiding

Beverly Earle

Rep. Beverly Earle, Co-Chair

Dee Hodge

Dee Hodge, Commission Assistant

The Study Commission on Aging received 55 letters similar to the one below. Each letter was individually signed by either a Participant and Caregiver, Staff Member, or Concerned Citizen.

To: North Carolina Commission on Aging

From: Participants and Caregivers of Loving Touch Adult Day/Health Care Center, Inc.

Date: February 21, 2006

Loving Touch Adult Day/Health Care Center is a program to provide therapeutic resources to the participants. It's a Loving, Safe and Clean place to interact with others. Participants enjoy coming to the Day Care while their family members are at work or taking care of personal needs. The participants are giving the opportunity to engage in a variety of social activities while interaction with others their own age. Participants are able to go on therapeutic outings such as Restaurants and the Public Library. The Center provides outside Speakers who visit once a month to provide educational information and materials to the participants. Please give our Adult Day Care facilities more financial assistance. This will enable us to continue and allow others to attend. This helps us to be healthier during our senior/disabled years.

HANNAH B BROWN
Participant

Ricky D Bank
Caregiver

Maria Reiser - PO Box 620551, Charlotte, NC 28262
(704) 688-7296, (800) 745-0402
MariaReiser@MaryKay.com

RECEIVED
MAR 10 2006
RESEARCH DIVISION

March 7, 2006

NC Legislative Office Building
Attention: Theresa Matula, Research Division
300 N. Salisbury Street
Suite 545
Raleigh, NC 27603

Ms. Matula,

My mother, Vicenta Garcia, has truly enjoyed and benefited from the Adult Day Care at Luz Nacientead.

Up to the time that Vicenta joined the Day Care she had not much to look forward too after the loss of her husband in June of 2005. After starting to attend she comes home regularly excited and full of great stories about her day and the activities that she was involved in. Whether its an art project, an English lesson, a movie and discussion or a trip to the Charlotte Senior Center, she always comes home with a positive attitude and full of joy.

On the days that my mom attends she gets up early and is prepared to for her transport at least 45 minutes before it arrives. Such is not the case on the days that she stays at home. She usually sleeps late and is not motivated during the day.

The Adult Day Care has been a great benefit to my mom and is something that she looks forward too on a regular basis.

Maria Reiser

ATTACHMENT II

Williamston, NC
February 21, 2006

Spindale, NC
February 28, 2006

NC Study Commission On Aging Public Hearings 2006

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)

2006 Public Hearings

Date	Location	Number of Speakers
February 21, 2006	Williamston, NC	26
February 28, 2006	Spindale, NC	17

The issues mentioned with the greatest frequency were:

- **Support for Senior Games**
- **Preserve and Expand Home and Community Care Block Grant (HCCBG)**
- **Preserve and Expand Senior Center Funding**
- **Support for In-Home and Community-Based Services**

NC Study Commission on Aging - 2006 Public Hearings
Frequency of Issues Expressed by Speakers

	WILLIAMSTON	SPINDALE	TOTAL
HOME-BASED SUPPORT SERVICES /ADULT DAY			
Increase HCC Block Grant - increase funding; expand coverage to nutrition programs, transportation, in-home aid services, home repair	6	4	10
Additional Funds For Home Based Services - general	5	4	9
Adult Day/Adult Day Health Care – increase funding, increase availability, allow rehabilitation services	6	2	8
Transportation Services – increase availability, increase funding, increase reimbursement	4	2	6
Home Delivered Meals	1	3	4
Respite Care – increase availability, decrease waiting lists	2	1	3
State/County Special Assistance (SA) in Home Project- preserve and expand support	0	3	3
Institutional Bias concerns	1	1	2
PROGRAM SUPPORT			
Senior Games	11	4	15
Senior Centers	5	5	10
Area Agency on Aging- restore professional staff funding	1	3	4
Adult Protective Services	2	1	3
CAP-DA-support Community Alternatives for Disabled Adults	1	1	2

	WILLIAMSTON	SPINDALE	TOTAL
ADULT CARE HOMES/NURSING HOMES			
Insufficient Staffing Levels – salary, benefits, training/career levels, quality and ratios	0	2	2
Increase Inspections, Stiffer fines, Stricter Enforcement	0	2	2
Concerns of combining Elderly/Mental Health Populations	0	1	1
MEDICAL CARE/INSURANCE/ PRESCRIPTION DRUGS			
Medicare Part D Concerns	4	1	5
Re-enact Long Term Care Insurance Tax Credit	3	1	4
Raise Medically Needy Income Limit	1	1	2
Prescription Drug Education – proper use, dose, effect	0	1	1
Prescription Drug Assistance	1	0	1
HOUSING AND ENVIRONMENT			
Create Safe and Affordable Housing for Seniors	2	2	4
Support for NC Housing Trust Fund	2	1	3
Property Tax Relief	1	1	2
Improve Air and Water Quality	0	1	1
Mixed Use Housing	0	1	1
OTHER			
Issues Related to Grandparent with Custody of Minors	1	2	3
Totals	60	51	111

Prepared by Aging Commission Staff

ATTACHMENT III

DRAFT North Carolina Study Commission On Aging

Legislative Building 16 West Jones Street Raleigh, NC 27601

March 15, 2006

The Honorable XX
U.S. House of Representatives
Washington, DC 20515

Dear Senator XX:

On behalf of the North Carolina Study Commission on Aging, we ask for your support to renew funding to the HRSA-Bureau of Health Professions geriatrics programs, previously funded under Title VII of the Public Health Service Act. **Reinstating the funding that was eliminated for Title VII training of Geriatrics Health Professionals in the FY 2006 budget, and providing at least $302 million for training of all health professionals with a specific allocation of $36 million in support of geriatrics will help ensure that North Carolina continues to offer accessible, quality healthcare to the older adult population.**

In late 2005, the President and Congress eliminated all funding for Title VII training of Geriatrics Health Professionals. All health profession training programs in North Carolina were affected, losing approximately $3 million in total funding that would have provided training for geriatrics health professionals from multiple disciplines (clinical medicine, nursing, social work and physical and occupational therapy). Additionally the last federal budget, eliminated funds for the Carolina Geriatrics Education Center – an interdisciplinary training center – and for Geriatrics Academic Career Awards which train future physician leaders in Geriatric Medicine, seriously damaging health professionals' ability to meet these growing demands. There are forty-seven GECs across the United States; each GEC works in their state and in their communities to meet the needs of their health care professionals and of their citizens. Together GECs have trained over 450,000 health care professionals to better diagnose, treat, and prevent diseases and other health concerns unique to older adults.

The Carolina Geriatrics Education Center is part of the National Association of Geriatric Education Centers (NAGEC) and provides training in geriatrics to health care professionals of multiple disciplines across the state of North Carolina. Members of the consortium include the Program on Aging (UNC School of Medicine, Chapel Hill), five Area Health Education Centers (AHECs) – Area L AHEC, Mountain AHEC, Charlotte AHEC, Eastern AHEC, and Wake AHEC, – and the Rural Health Group, Inc., Jackson, NC. In the fiscal year 2003-2004, the CGEC consortium trained over one thousand North Carolina health care professionals from twenty-two disciplines. For many of these professionals who work in medically underserved areas of our state, this is the only source of training and it is critical to their continuing ability to meet the growing needs of our older adults.

Your support for funding is critical as it provides the health care workforce training required to meet the demands of the growing older adult population. According to the North Carolina Department of Health and Human Services, Division of Aging and Adult Services, the percentage of North Carolinians age 65 and older will increase by 6% over the next 25 years, with the population of older adults reaching approximately 2.2 million in our State. North Carolina, like the nation, has a profound shortage of physicians, nurses, social workers and other health care professionals with training in care of the aging patient. Eliminating Title VII funding has greatly diminished geriatrics training for these providers who are already in short supply, and the quality of health care and the lives of our seniors will suffer for it. As such, the North Carolina Study Commission on Aging respectfully requests that the funding that was eliminated in the FY 2006 budget be reinstated in the House Labor, Health and Human Services and Education Appropriations bill for FY 2007, and that at least $302 million is provided for the training of all health professionals with a specific allocation of $36 million in support of geriatrics.

Sincerely,

Senator Charlie S. Dannelly
Co-Chair

Representative Beverly M. Earle
Co-Chair

c: Senator Austin Allran
Representative Alice Bordsen
Representative Jennifer Weiss
Ms. Linda Howard

Senator Stan Bingham
Representative Debbie Clary
Mr. Brad Allen
Ms. Florence Gray Soltys
Ms. Judy Pelt

Senator Vernon Malone
Representative Bob England
Ms. Regina Buffy Fisher
Mr. Sam Marsh

Impact of the Medicare Part D Program on the NC Medicaid Program

Revised Estimates

Fiscal Research Division

March 15, 2006

What is Impact of the Medicare Part D Program on the NC Medicaid Program?

- The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) created a new Medicare Part D prescription drug benefit effective January 1, 2006.
- Medicare Part D is available for all Medicare recipients including persons eligible for both Medicare and Medicaid – commonly called dual eligibles.
- Previously, state Medicaid programs paid for outpatient prescription drug coverage for dual eligibles.

What is Impact of the Medicare Part D Program on the NC Medicaid Program?

- Effective January 1, 2006, state Medicaid programs cannot request federal matching funds for outpatient prescription drug claims because the Medicare Part D Program be paying for these benefits.
- In expectation that states would enjoy a fiscal windfall from the federal government's assumption of what has been shared Medicaid costs, the MMA requires a state payment to the federal government supporting the Medicare Part D program.
- This payment to federal government is called the phased down state contribution by the federal government, but it is popularly known as the "clawback".

How Does the Clawback Work?

- The state clawback is a monthly payment from the states to the federal government to reduce net Medicare Part D costs.
- To ensure that states make the monthly payments, the MMA requires that states pay interest on any unpaid amount of the monthly clawback.
- Any unpaid amount plus interest will be offset against the federal matching Medicaid payments that states otherwise receive during the quarter in which the clawback payment is due.
- Each payment is made after the cost is accrued, so the first payment was due February 1, 2006.

How Does the Clawback Work?

- The clawback is designed to be 90% of estimated state savings for 2006, and it will decline 1.67 percentage points until reaching 75% of estimated state savings in 2015.
- The Congressional Budget Office estimates that the clawback from all states will total $6 Billion for 2006 and $9 Billion for 2007.
- These clawback payments mark a significant change in the federal-state fiscal relationship because the federal Medicare program finances a significant portion of the new drug benefit using state funds.

The Clawback Formula Revised 2/8/06

The monthly state clawback for 2006 is determined using the following formula:

Monthly State Clawback Payment	=	Per Capita Medicaid Expenditures for Drugs for Dual Eligibles (Based on 2003 expenditures and inflated 22.4% to reflect growth in national per capita prescription drug spending.)	X	Full Dual Eligibles Enrolled in a Medicare Part D Each Month	X	Phased Down Percentage (90% for 2006)

North Carolina's Clawback for 2006 Revised by CMS 2/8/06

2003 Baseline Total Per Capita Drug Expenditures for NC Dual Eligibles	$214.69
2006 Total Per Capita Drug Expenditures for NC (Baseline times 22.4%)	$262.78
2006 NC Per Capita Drug Cost (Jan. – Sept.)	$95.23
2006 NC Per Capita Drug Cost (Oct – Dec.)	$93.23
2006 Clawback Percentage	90%
Final 2006 NC Per Capita Clawback (Jan. – Sept.)	$86.38
Final 2006 NC Per Capita Clawback (Oct – Dec.)	$83.94

North Carolina's Clawback for 2006 Revised 2/8/06

North Carolina's monthly clawback payment will be $18.6 million

Estimated Monthly Clawback Payment For NC	=	Monthly Per Capita Medicaid Expenditures for Drugs for Dual Eligibles	X	Monthly Full Dual Eligibles (Based on October 2005 Dual Eligibles)	X	Phased Down Percentage
$18.6 Million		**$95.23**		**216,600**		**90%**

North Carolina's Clawback for 2006 Revised 2/8/06

State Fiscal Year	Annual Clawback Payment
2005-06 (Five Months)	$93.5 Million
2006-07 (Twelve Months)	$222 Million

Note: The clawback payment for SFY 2006-07 is estimated because NC's 2007 per capita clawback will not be issued by the federal government until October 2006. The annual clawback estimate for SFY 2006-07 uses NC's 2006 per capita clawback to calculate the twelve month impact.

Will Medicare Part D Reduce the NC Medicaid Budget?

YES!

The Fiscal Research Division estimates that the annual cost of the Medicare Part D clawback during the 2005-07 biennium will be less than the annual cost of outpatient prescription drugs for dual eligibles based on a 15.3% annual growth rate for outpatient prescription drug costs.

How Much will NC Save? Revised 2/8/06

	2005-06	2006-07
Estimated State Cost for Outpatient Prescription Drugs for Dual Eligibles	$128,930,459	$320,791,197
Estimated Clawback Payment	$93,551,700	$221,965,107
Estimated Total Savings for NC	**$35,378,760**	**$98,826,090**
State Share of Savings	**$30,071,946**	**$84,002,176**
County Share of Savings	**$5,306,814**	**$14,823,914**

Note: Section 10.11(b) of the 2005 Budget Bill requires counties to pay 15% of the federal Medicare Part D clawback payments required under the Medicare Modernization Act of 2003.

Impact of Revised Medicare Part D Clawback Payments

- **Additional Budget Savings in FY 2005-06**:
  - Enacted budget assumes $11 million in savings related to the implementation of Medicare Part D.
  - FRD estimates indicate that additional savings **(up to $20 million)** may occur.
- **Additional Budget Savings in FY 2006-07**:
  - Enacted budget assumes $22 million in savings related to the implementation of Medicare Part D.
  - FRD estimates indicate that additional savings **(up to $62 million**) will be available.

Supplementing Medicare Part D Coverage:
How Are States Responding?

Fiscal Research Division

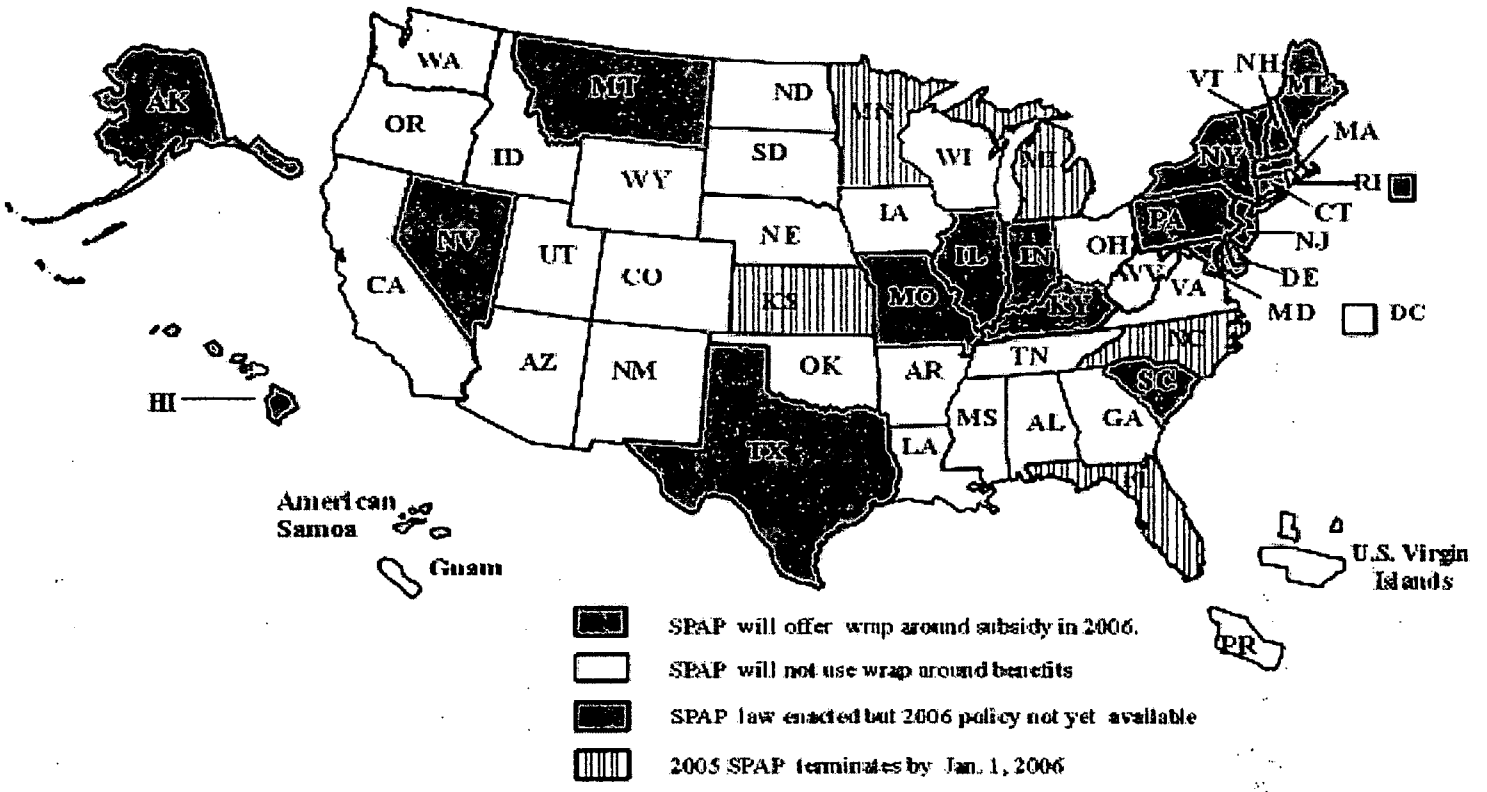
March 15, 2006

Supplementing Medicare Part D Coverage: How are States Responding?

- Providing state funds to enhance or supplement Medicare part D prescription drug coverage for selected state residents, a strategy called "wrap-around" benefits.
- Redirecting some state-funded pharmaceutical program services to populations not covered by Medicare.
- Reducing or eliminating benefits previously included in state pharmaceutical assistance programs (SPAP) that will now be covered by Medicare Part D.
- Terminating state-funded program.

Map of State Pharmaceutical Assistance Programs (SPAPs)

States with Laws or Programs to Wrap Around or Coordinate SPAP and Medicare Part D Benefits



© Compiled by NCSL; updated 12/30/2005. Includes new programs in AK, HI, KY, MT & NH not operational until 1/06 or later. For details regarding content and status, consult NCSL reports online at: www.ncsl.org/programs/health/drugdisc05.htm

Supplementing Medicare Part D Coverage: Wrap Around and Coordinated Benefits

- Use state resources to pay part or all of the $250 annual deductible for selected Medicare beneficiaries.
- Use state resources to pay part or all of the Part D monthly premium for selected Medicare beneficiaries.
- Use state resources to pay part of the patient co-payments or coinsurance for selected Medicare beneficiaries.
- Use state resources to pay part of or the entire coverage gap (doughnut hole) from $2,250 to $5,100 for selected Medicare beneficiaries.

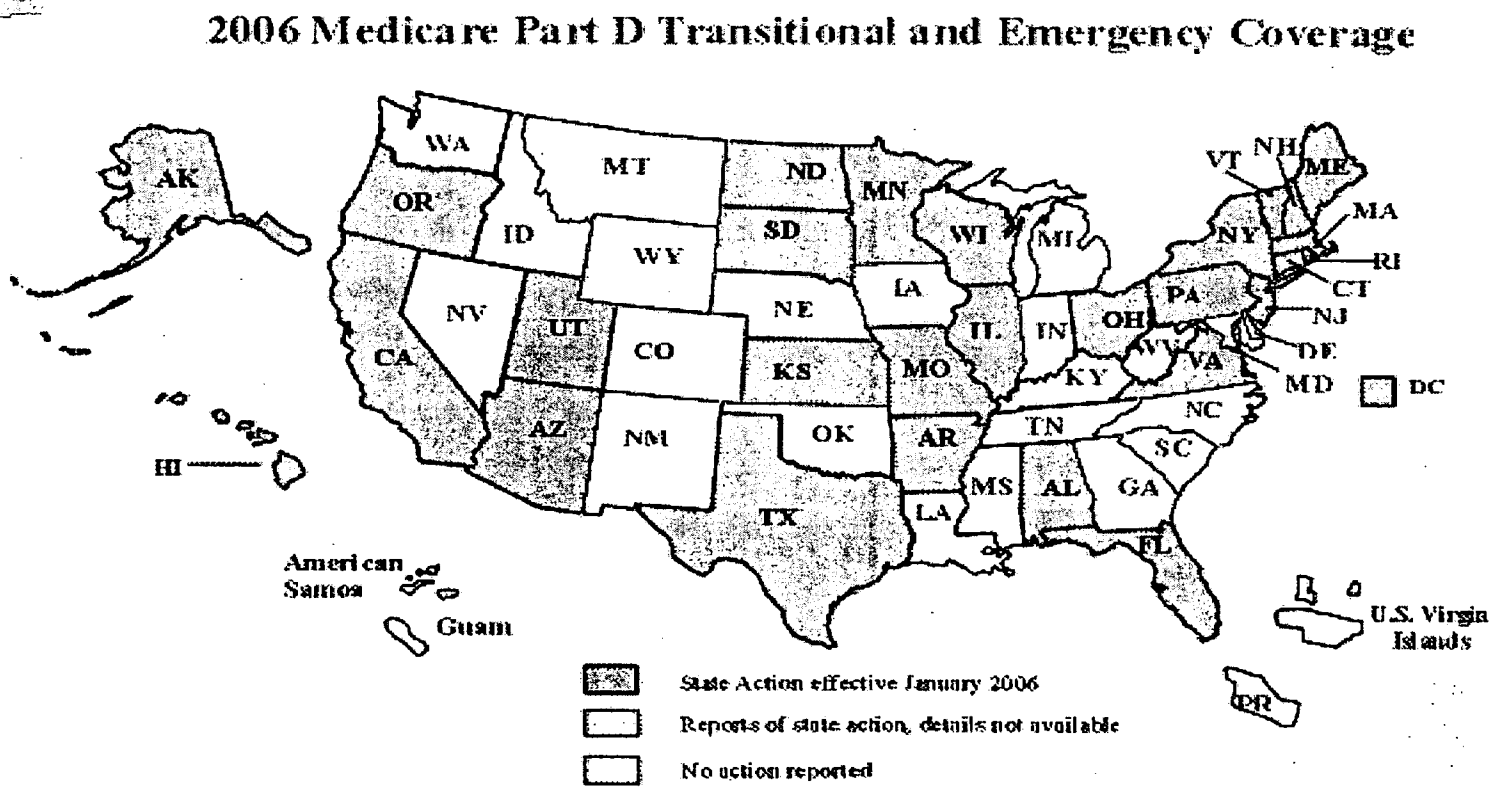
Supplementing Medicare Part D Coverage: Wrap Around and Coordinated Benefits

- Cover pharmaceutical products excluded from coverage by Medicare Part D or not included in formularies of individual Part D plans.
- Require enrollment in Part D as a condition of receiving state benefits, or authorize voluntary automatic enrollment into locally available Part D plans.
- Medicare Part D Wrap Around Coverage.xls

Medicare Part D Coverage: States' Response to Start-Up Problems

- In response to start-up problems with Medicare Part D coverage, many states are offering temporary prescription drug coverage for dual eligibles and other Medicare enrollees.
- In most states, emergency transition or "gap coverage" is being provided when dual eligibles are denied service at pharmacies due to record-keeping flaws or other eligibility process issues.
- Some states enacted laws if their legislature was in session, while other states used executive authority. 27 states and the District of Columbia have responded.
- Medicare Part D Transitional and Emergency Coverage.xls

Map of States Providing Emergency Coverage



© Compiled by NCSL; updated 1/27/2006. For details regarding content and status, consult NCSL report online at: www.ncsl.org/programs/health/partdpatch.htm

Medicare Part D Coverage: CMS's Response to Start-Up Problems

On January 24th, CMS announced the establishment of a demonstration reimbursement plan for states to fully reimbursed their efforts to help Medicare dual eligibles have continued access to drugs during their transition to Medicare Part D.

Medicare Part D Coverage: CMS's Response to Start-Up Problems

- Key features of the demonstration plan include:
  - **State Reimbursement**: States meeting the conditions of the waiver will have their full drug benefit costs reimbursed through CMS assurance of payment reconciliation with the prescription drug plans and Medicare payment of any net drug cost differential after reconciliation. CMS will also provide funding for administrative costs incurred by states.
  - **Payer of Last Resort**: States will use payment approaches that support pharmacist efforts to primarily bill the Medicare Part D plan, and that promote the use of Medicare point-of-sale billing, before relying on state payment.

Medicare Part D Coverage: CMS's Response to Start-Up Problems

- Key features of the demonstration plan include:
  - **End Date**: Temporary demonstration program would have an anticipated end date of February 15, 2006. Secretary may provide a short-term extension of the demonstration program.
  - **Retroactive Effective Date**: The demonstration is retroactive to the first date the state paid claims.

Medicare Part D Coverage: North Carolina's Response

- North Carolina's Senior Care Program ended December 31, 2005 because the Medicare Part D Program began on January 1, 2006.
- The NC Medicaid Program discontinued providing prescription drug coverage for dual eligibles on December 31, 2005 as required under federal law.
- So far, NC has not initiated emergency transition or "gap coverage" because NC pharmacies have not denied services to dual eligibles when there have been record-keeping flaws or other eligibility process issues.

ATTACHME

STATES PROVIDING ADDITIONAL SUBSIDIZED "WRAP AROUND" BENEFITS TO MEDICARE ENROLLEES IN 2006

STATE	Maximum Income (% of '06 Federal Poverty)	Premium Assistance	Deductible Assistance	Copayment Assistance	Coverage Gap (>$2,250) Assistance	Moderate Income Asssitance (Above 250% FPL)	Persons with Disabilities under age 65
Alaska	175%	Yes	Yes		3	No	No
Connecticut	218.30%	Yes	Yes 1	Yes 1	Yes 100%	No	Yes
Delaware	200%	Yes	Yes	No	Yes	No	Yes
Hawaii	150%	Yes 2	Yes 2	Yes	Yes 2	No	Yes
Illinois	216.50%	Yes	Yes	Yes 1	Yes	No	Yes
Indiana	150%	Yes 4	Yes 4	Yes 4	No	No	No
Kentucky	150%	Yes 3	Yes 3	Yes 3	Yes 3	No	Yes 3
Maine	185%	Yes	Yes	Yes 1	Yes	No	Yes
Maryland	300%	Yes >$10	Yes 100%	Yes 3	Yes 3	Yes 300%	Yes
Massachusetts	500%	Yes	Yes	Yes	Yes	Yes 500%	Yes 188%
Missouri	150% 4	Yes	Yes	Yes			Yes
Montana	200%	Yes	Yes	No	No	No	Yes
Nevada	236.40%	Yes	3	No	Yes	No	Yes
New Hampshire	150%	Yes 2	Yes 2	Yes 2	Yes 2	No	Yes
New Jersey	316.20%	Yes	Yes	Yes	Yes	Yes 316%	Yes
New York	357.10%	No	Yes	Yes 1	Yes	Yes 357%	No
Pennsylvania	240%	Yes	Yes	Yes 1	Yes	No	No
Rhode Island	392%	4	4	4	4	Yes 392%	No
South Carolina	200%	No	No		Yes	No	No
Vermont	225%	Yes 1	Yes	3	3	No	Yes
Wisconsin	240%	No	No		6	No	No

This table does not include Medicaid program benefits.

1 – State can or will pay the portion that is higher than the standard state copayment or premium.

2 – Applies primarily to non-dual-eligible enrollees up to 150% of FPL, or duals between 135% and 150%.

3 – May be authorized in statute, but not currently established as a benefit.

4 - Under review or not yet determined.

5- Approved by CMS in MA, 8/29/05.

6 - Because of its 1115 Pharmacy Plus waiver, valid through 2007, WI does not describe its benefit as a wrap around. Enrollees over 200% FPL may be able to obtain benefits for expenses above $2,250.

2007 Medicare Part D Transiitonal and Emergency Coverage

ATTACHMENT VII

State	Coverage	Explanation / legal authority / dates
Alabama	Loans to pharmacies	State will loan pharmacies funds to cover the costs of the prescriptions until the Medicare payment can be adjudicated. (1)
Alaska	Dual-eligibles	State covers one 30-day transitional supply. Terminates on 3/31/06. (2)
Arizona	Dual-eligibles	State covering people that have had organ transplants, have life threatening conditions or haven't been assigned to a Part D Plan.
Arkansas	Dual-eligibles	Executive authority declared public health emergency.
California	Dual-eligibles	Executive authority allows state to cover prescriptions when Medicare payment cannot be adjudicated, from 1/12/06 to 1/17/06. 2006 law, AB 132, appropriates $150 million for use through 2/11/06; signed by governor 1/20/06.
Connecticut	Dual-eligibles and ConnPACE (SPAP) enrollees	State covers prescriptions when Medicare payment cannot be adjudicated. 2005 law, SB 2500. (2)
Florida	Dual-eligibles	State covers prescriptions when Medicare payment cannot be adjudicated. Began 1/26/06, after federal reimbursement was announced.
Hawaii	Dual-eligibles	State covers prescriptions when Medicare payment cannot be adjudicated.(2)
Illinois	Dual-eligibles and Illinois Cares Rx (SPAP) enrollees	Executive authority allows state to cover Part D approved prescriptions when Medicare payment cannot be adjudicated. (2)
Kansas	Dual-eligibles	State covers Part D approved prescriptions when Medicare payment cannot be adjudicated. Terminates on 2/1/06. (1),(2)
Maine	Dual-eligibles and SPAP enrollees	State covers copayments above those set by CMS. Began 1/3/06. (2)
Massachusetts	Dual-eligibles	2005 law allows state to cover non-Part D out-patient prescriptions and cover excess copayment. Chapter 175 of 2005 signed 12/30/05. Began 1/7/06. (2)
Minnesota	Dual-eligibles	State covers prescriptions when Medicare payment cannot be adjudicated.(2)
Missouri	Dual-eligibles	State covers prescriptions when Medicare payment cannot be adjudicated. Began 1/17/06.(2)
New Hampshire	Dual-eligibles	State covers prescriptions when Medicare payment cannot be adjudicated from 1/10/06 until 3/1/06. Law enacted 1/10/06 and appropriated $500,000. (2)
New Jersey	Dual-eligibles	State covers prescriptions when Medicare payment cannot be adjudicated (1)
New York	Dual-eligibles	Governor: allows administrative edit. 2006 legislation, A 9462, would pay pharmacists, retroactive from 1/1/06 until "no longer necessary." (Passed Assembly & sent; sent to Governor 1/26/06)
North Dakota	Dual-eligibles and Part D enrollees	State covers prescriptions when Medicare payment cannot be adjudicated or when Medicare enrollee has not received their plan information between 1/6/06 and 1/23/06. State may provide additional help on a case-by-case basis until 2/15/06. 2005 law HB 1465, signed 4/25/05.
Ohio	Dual-eligibles	Executive action allows state to pay excess copays from Part D plans from 1/13/06 until 1/31/06. (2)
Oregon	Dual-eligibles	State covers prescription costs when Medicare payment cannot be adjudicated. (2)
Pennsylvania	Dual-eligibles	Executive action allows state Medicaid to pay the excess copay, the amount individuals are inappropriately charged over the low-income subsidy level. State expects to spend no more than $2 million during January and expects to be reimbursed by CMS and the plans for the costs. (2)
Rhode Island	Dual-eligibles	Executive action allows pharmacies to bill state if claim cannot be adjudicated with Medicare from 1/11/06 until 1/31/06. (2)
South Dakota	Dual-eligibles	Executive action allows for a 30-day prescription from 1/9/06 until 1/27/06. (2)

2007 Medicare Part D Transiitonal and Emergency Coverage

State	Coverage	Explanation / legal authority / dates
Texas	Dual-eligibles	Executive action announced 1/25/06 authorizes Texas Health and Human Services Commission to cover Part D approved prescriptions when Medicare payment cannot be adjudicated. Established after federal reimbursement was announced. State website
Utah	Dual-eligibles	Executive action allows for state to pay for 30 days supplies. See story online.
Vermont	Dual-eligibles and SPAP enrollees	2006 emergency law; covering all uncovered charges for enrollees until 3/1/06 or "until federal operational problems cease." (H 582) signed 1/10/06. Date extended to 3/1/06 on 2/1/06. See story online.
Wisconsin	Dual-eligibles	Executive action allows state to cover prescription costs when Medicare payment cannot be adjudicated. Began 1/13/06. Press release online.
District of Columbia	Dual-eligibles	State covers prescription costs when billing Medicare PDP is unsuccessful. Began 1/18/06, will terminate after 90 days. (2)
	Total = 27 states + D.C.	

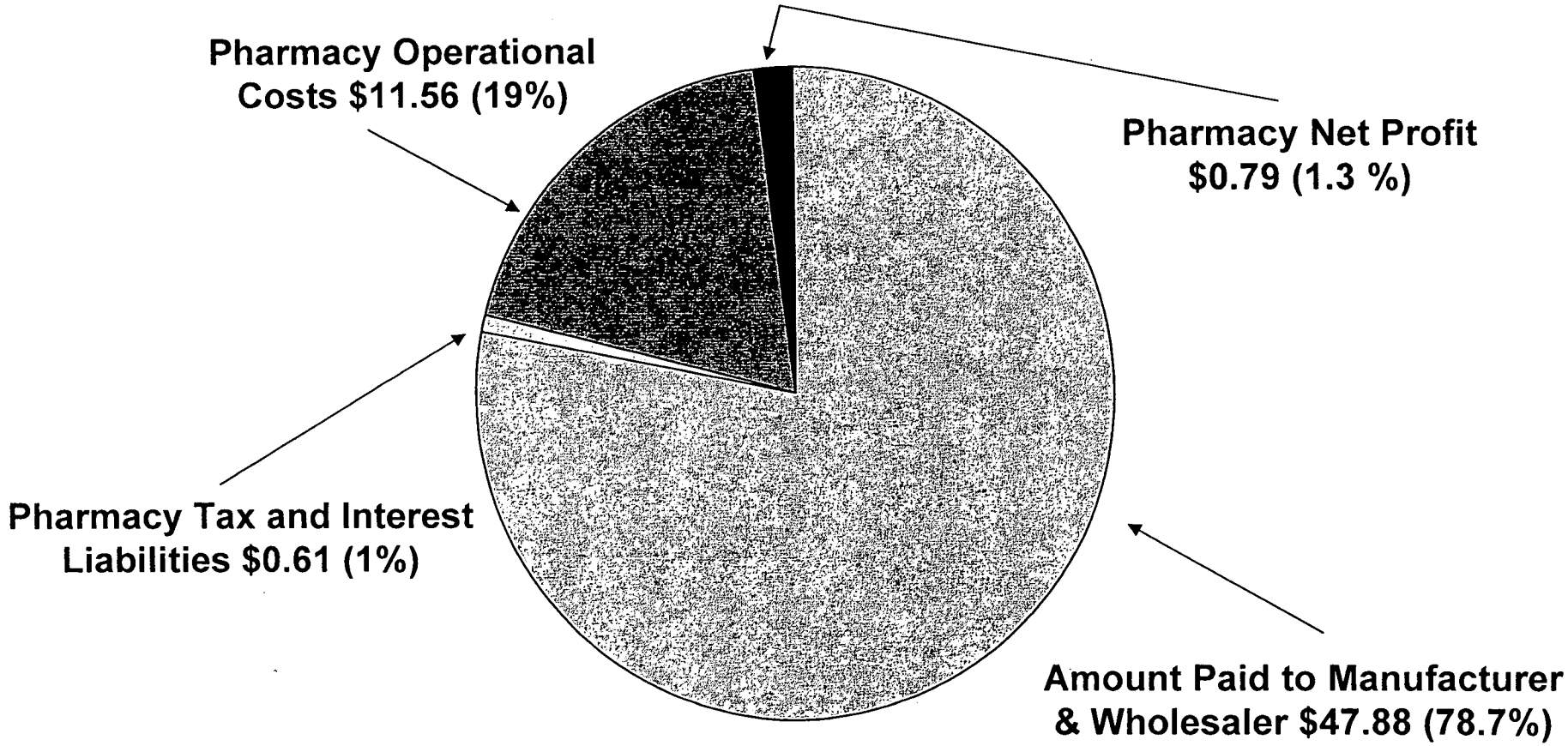
Sources: NCSL survey and state research, January 2006.

(1) - National Association of State Medicaid Directors (NASMD) www.nasmd.org

(2) - National Legislative Association on Prescription Drug Prices (NLARx) www.nlarx.org

The information listed is the best known and available from multiple sources as of the date noted. It is designed as a tracking report, subject to regular additions. Disclaimer: This report includes brief summaries of state actions and is not intended as an offer of consumer benefits. States may have additional terms and conditions not described in this summary. Please use the links included in the table above for further information. Also see State Pharmaceutical Assistance Programs in 2006: Helping to Make Medicare Part D Easier and More Affordable.

Retail Rx Cost Components
National Medicaid Average: $60.84
Prescription Breakdown



SOURCES: NACDS Economics Department; CMS Drug Utilization Data, Fortune Magazine "Fortune 500" Compilation

MEDIALERT

The North Carolina Board of Pharmacy
6015 Farrington Road, Suite 201
Chapel Hill, NC 27517

Board Members
Betty H. Dennis, President, Carrboro
Rebecca W. Chater, Asheville
Wallace E. Nelson, Edenton
L. Stan Haywood, Asheboro
Robert L. Crocker, Farmville
J. Parker, Chesson, Jr., Durham

Contact
David R. Work, Executive Director
919/246-0079; 919/219-6561 [cell]
E-Mail: drw@ncbop.org

FOR IMMEDIATE RELEASE

Proposed Medicaid Cuts Hit Rural Counties Hard

Staff of the North Carolina Board of Pharmacy has polled most of the retail pharmacies in over 40 rural counties North Carolina. The proposed Medicaid cuts would have an extreme effect on this area where pharmacies are utely dependent on Medicaid payments to maintain cash flow and keep their doors open. Stores with 30 to 35% of their prescription volume in Medicaid prescriptions have a situation where Medicaid accounts for over 50% of their dollar volume.

Pharmacy Board staff calculations from confidential data submitted show that the following counties will be most severely affected by the proposed cuts: Avery, Bertie, Caswell, Cherokee, Graham, Hoke, Jones, Northhampton, Pamlico, Perquimans and Washington. It is entirely possible that no retail pharmacies in these counties would survive the cuts proposed in Washington for Medicaid.

Other counties which would have substantial impact from the proposal are: Alleghany, Anson, Ashe, Bladen, Currituck, Edgecombe, Granville, Greene, Hertford, Macon, Mitchell, Scotland, Swain and Transylvania. One or two pharmacies may be able to survive but they would need to serve the entire county.

This would deal a devastating blow to pharmaceutical services in these rural areas. Once the detrimental effect of these cuts hits the economies of these communities there will be a dearth of pharmaceutical services for years to come. As we have seen in New Orleans, it can be very difficult to replace the infrastructure once the damage is done. Few pharmacists, if any, would be willing to risk capital going into these areas after all the pharmacies have discontinued business.

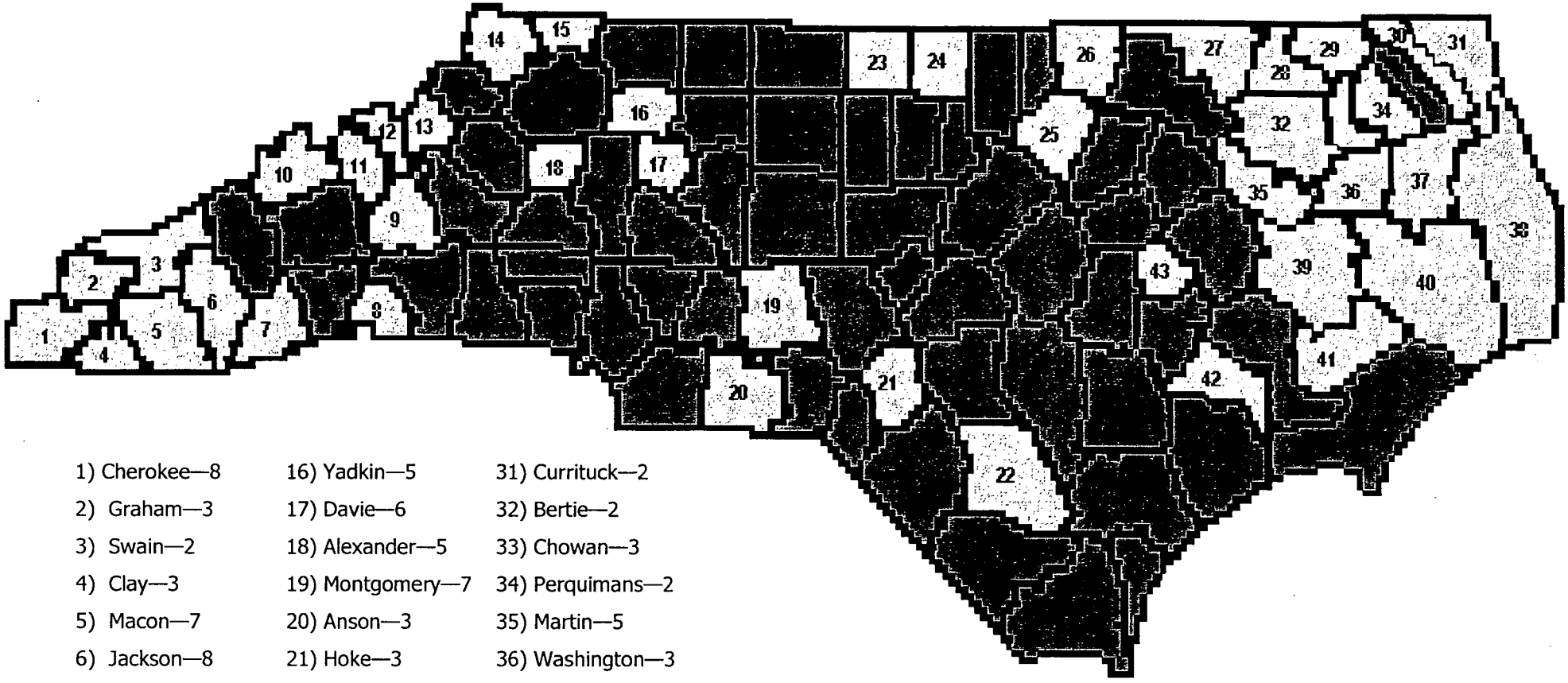
When 50% of Medicaid recipients are children, the use of mail order pharmacy is just not an option. A child with n ear infection should not have to wait for the U.S. mail to get their antibiotic.

Medicaid cannot meet the needs of the poor without access to pharmaceutical goods and services. Cutting benefits too far could do irreparable damage.

December 22, 2005

KEY

There are 43 Counties which Currently have 9 or Less Pharmacies



1) Cherokee—8
2) Graham—3
3) Swain—2
4) Clay—3
5) Macon—7
6) Jackson—8
7) Transylvania—7
8) Polk—4
9) McDowell—6
10) Madison—8
11) Yancey—2
12) Mitchell—6
13) Avery—5
14) Ashe—5
15) Alleghany—3
16) Yadkin—5
17) Davie—6
18) Alexander—5
19) Montgomery—7
20) Anson—3
21) Hoke—3
22) Bladen—8
23) Caswell—3
24) Person—6
25) Franklin—4
26) Warren—4
27) Northampton—2
28) Hertford—5
29) Gates—1
30) Camden—0
31) Currituck—2
32) Bertie—2
33) Chowan—3
34) Perquimans—2
35) Martin—5
36) Washington—3
37) Tyrrell—1
38) Dare—9
39) Beaufort—9
40) Hyde—1
41) Pamlico—2
42) Jones—2
43) Greene—1

Comments to the
NC Study Commission on Aging
March 15, 2006
Andy Ellen
General Counsel
North Carolina Retail Merchants Association

We constantly see articles about jobs being lost in textiles and manufacturing in North Carolina. You see the headlines, "Textile Plant Closes – 200 Jobs Lost." I equate the effect of Medicare Part D on community pharmacy to the effect China has had on these important sectors. Community pharmacy employs 80,000 people in North Carolina and many of those jobs are in danger of being lost. I usually talk about North Carolina having the largest shortage of pharmacists in the country. After Medicare Part D this may no longer be a problem. The difference is that the jobs losses will be spread throughout the state rather than in one city or town. The other difference is these jobs losses affect the public, health and welfare of all of North Carolina citizens.

When the Medicare Part D prescription drug coverage became effective on January 1, 2006, trouble began for community pharmacies. I use the term community pharmacies – because Medicare Part D has dramatically affected both independent pharmacies and chain pharmacies. When senior citizens showed up in community pharmacies on January 1, 2006 confused and bewildered, pharmacists were there to ease their fears, walk people through the enrollment process, wait on the phone for hours on-end only to be hung up, dispense drugs to seniors that have been long-term customers on the hope that they would be paid and now wait for the payment.

The question is will North Carolina seniors, or any North Carolina citizen have a community pharmacy to get their medicine filled in or will they end up waiting for the Postman to bring their medicine? If you read CMS's materials, Medicare Part D has been a smooth transition and it is only getting better. I can tell you that it is not getting better for pharmacies throughout the country. Here are some headlines:

Wisconsin
Druggists borrowing money as a stop-gap – They're hoping for reimbursement when Part D mix-ups end

New Jersey

Medicare Plan: What a Headache
Borrowing money because they have not been paid

Pharmacists says Medicare changes are a tough pill to swallow

Rhode Island

Pharmacists say not getting paid for filling prescriptions

Massachusetts

Local pharmacist describes Medicare drug coverage woes

Michigan

Medicare Part D a mess, local pharmacist says

Medicare Woes for Pharmacies

Mike and Bill have laid out the reasons why independent pharmacies are getting crushed financially by Medicare Part D. Let me say that chain pharmacies are undergoing the same financial crisis. The average pharmacy maintains $300,000 in prescription drug inventory. Extrapolate inventory costs for a small chain like Kerr Drug headquartered here in Raleigh over 100 stores totaling $30 million, add in all of the pharmacists' salaries, utility bills, employee benefits etc. and then imagine that instead of getting paid every ten days for filling a prescription that you are now getting paid every 30 days. To top it off imagine that the reimbursement you are receiving barely covers your product cost. You are sending merchandise out the door and senior citizens and the sick are getting the prescriptions they need but you're not getting paid for it. Your employees still expect to be paid and you must pay your wholesaler within 15 days for the prescription that just went out the door. Now let's extrapolate these costs over CVS or Eckerd with 250 plus stores in North Carolina and then all over the country and you see why they are in trouble as well.

The problem is that there is currently no light at the end of the tunnel. If I am a community pharmacist or even a major chain, I cannot say to myself "Well, if I can get to April or May things are going to get better." Under the current plan things are not going to get better. I am still getting paid every 30 days rather than every ten days and the reimbursement I am receiving does not cover my cost. All I am doing is getting further into debt.

There is a public health concern because if a pharmacy closes the pharmacy is not coming back. You can see from the map that you have before you, that there is a perfect storm coming and it could put North Carolina in a crisis mode.

You can look at what the North Carolina Board of Pharmacy has said about access and how proposed reimbursement cuts could cripple access to prescription drugs in North Carolina. As I see it, you have three paths pharmacies will go down:

Recently, Dr. David Work of the North Carolina Board of Pharmacy told of two community pharmacies located in a
mountain county. Both stores had over 70% of their business come from Medicaid and much of this business was now being switched to Medicare. Both pharmacists were concerned that they would close their doors and if this was the case, citizens would be forced to drive an hour and a half over mountain roads to Virginia to get their prescriptions filled and this scenario was contingent on the Virginia pharmacies remaining open.

In so many of these communities, pharmacies serve as the sole health care provider. The pharmacist is the only health care provider that you generally do not need an appointment to see or an additional co-payment. It is vitally important that the drug distribution network is maintained for all of our citizens. If you think back just three or four months ago when Katrina hit, FEMA had truckloads of prescription drugs sent in to Louisiana and Mississippi to serve those affected by Katrina. Those drugs are still in the warehouse because FEMA could not figure out how to distribute drugs to the neediest of patients. Instead, community pharmacies worked day and day to make sure people had their medicine. The House and Senate recently named disaster preparedness committee will hopefully make this an issue of discussion.

What can this committee do? The pharmacy industry is not looking for a handout or a bailout. What we are looking for is reasonable solutions to a terrible problem.

1) Support North Carolina Medicaid continuing to work with community pharmacy on innovative ways to improve patient health and ensure access to prescription drugs.
2) Encourage House and Senate leaders and the Governor's Office to sit down with community pharmacy representatives to work out solutions on how to ensure this stable distribution channel for prescription drugs remains in place.
3) When you go home this weekend, stop by and talk with your community pharmacist about the problems they are having with Medicare Part D. Better yet, talk with the senior citizens in your area about where they would get access to prescription drugs.

Criminal Background Checks in NC's Skilled Nursing Facilities

North Carolina
Health Care Facilities Association
March 15, 2006

131E-265

- Original legislation enacted in 1996
- Supported industry request for requirement to conduct criminal background checks prior to employment

Current NCGS 131E-265

- ALL unlicensed applicants for employment
- Three categories:
  - All unlicensed (State check)
  - Non-5 year resident, direct-care (Public Law 105-277)
  - Non-5 year resident, direct-access (SB 41)

NC State Background Check

- SBI or private vendor
- Fingerprints are not required

Public Law 105-277

Non-5 Year Resident, Direct-Care Applicant

- "Direct patient care" is interpreted by the SBI to mean any care delivered directly a patient that relates to that patient's physical, medical or dietary well-being. Employees providing direct patient include nurse aides and may include dietary, therapy, and housekeeping workers, or other unlicensed staff that engage in hands-on care activities.
- Fingerprints are required and must be submitted to the SBI, which in turn submits directly to the FBI.
- SBI receives information from FBI and forwards results of the state and national check directly to the facility.

Senate Bill 41

Non-5 Year Resident, Direct Access Applicant

- "Direct-access employee" is interpreted by the SBI to mean an unlicensed employee that does not meet the "direct care" definition but has unsupervised access to a patient. Most employees that are direct care would fit this definition.
- Fingerprints are required and must be submitted to the SBI, which in turn submits directly to the FBI.
- The SBI receives the information from the FBI and forwards to the DHHS Criminal Records Unit (the federal law will not allow the facilities to receive records for non-direct care employees).

Senate Bill 41

Non-5 Year Resident, Direct Access Applicant

- CRU staff send the results of the state check to the facility, and will notify the facility if there are findings in the national check that may have some bearing on the applicant's fitness to work in a skilled facility, including the state where the violation occurred. Facilities will then have the option of pursuing additional criminal history information from that state's public records.

SB 41 Process

Provider Response to Simple Survey

- A majority of the providers that responded reported that very few or a minimal number of their applicants met the criteria for the SB 41 process
- Most respondents believe process is efficient
- Most respondents agree they are notified of findings in a timely manner

SB 41 Process

Provider Response to Simple Survey

- Most respondents feel the DHHS CRU is responsive to questions/problems
- A clear majority of respondents indicated they do not commonly hire individuals with a finding on the national criminal history provided through the SB 41 process
- Most respondents prefer to make their own hiring decisions, indicating they would not want the DHHS CRU to make a final determination of employability

Liberty Nursing & Rehab Center of Mecklenburg
3700 Shamrock Drive
Charlotte, North Carolina
Synopsis of the January 2006 Incident

- On January 23, 2006, the facility discovered a resident was missing.

- On January 24, 2006, the facility administrator reported an elopement of a resident to the Division of Facility Services via a letter. The DFS Complaint Intake Unit called the facility to find out more information. The administrator described facility wide searches, police involvement and media involvement.

- On January 26 and January 30- 31, 2006, DFS Nursing Home Licensure & Certification Section staff conducted a complaint survey. This survey found one deficiency at the immediate jeopardy level. The deficient practice was described as: "Based on observations, medical record review, staff and family interviews, the facility failed to ensure the proper supervision of a resident who had Alzheimer's disease, failed to adequately conduct a thorough search when this resident was discovered to be missing, and failed to keep residents on the unit protected by assuring that access to unsafe areas could not be obtained by the residents".

- On February 7, 2006, the Centers for Medicare and Medicaid Services imposed a civil money penalty in the amount of $10,000.00 per day effective January 23, 2006, which continued until the jeopardy was removed or the facility was terminated. Denial of payment for new admissions was effective February 9, 2006, if the facility was still out of compliance on that date. The Medicare provider agreement terminated on February 23, 2006, if the immediate jeopardy to resident's health and safety was not removed by that date.

- On February 14, 2006, CMS accepted the facility's credible allegation of compliance.

- On February 20, 2006, state surveyors conducted the revisit and found that the facility corrected the problem on the date (February 11, 2006) they alleged it was corrected.

- On February 22, 2006, CMS notified the facility that Liberty Nursing and Rehab, of Mecklenburg County was in substantial compliance with the Medicare requirements for participation for Skilled Nursing Facilities, effective February 11, 2006. CMS canceled the denial of payment for new admissions which was in effect from February 9, 2006 through February 10, 2006 and termination action.

Overview of the Federal Enforcement Process in Nursing Facilities

- **Deficiency** means a skilled nursing facility's or nursing facility's failure to meet a participation requirement specified in the Act or in 42 CFR Part 483 Subpart B.

- An **enforcement grid** is used to assess the seriousness and scope of deficiencies. See handout.

- Deficiencies assessed on the grid from B-L require an **acceptable plan of correction**.

- Facilities may be given an **opportunity to correct** their deficiencies before remedies are imposed when they do not meet the criteria for no opportunity to correct.

- Facilities will be given **no opportunity to correct** deficiencies before remedies are imposed when they meet the criteria.

- **Category 1** remedies include directed inservice training, directed plan of correction and state monitoring

- **Category 2** remedies include denial of payment for new admissions, denial of payment for all individuals and civil money penalties: $50 - $3,000/day $1,000 - $10,000/instance

- **Category 3** remedies include temporary management, termination and civil money penalties: $3050 - $10,000/day or $1,000 - $10,000/instance

- **Mandatory Remedies** include **denial of payment for new admissions** which is imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying deficiencies and **termination**, if the facility does not achieve substantial compliance within 6 months of the date of the survey that found it to be of it to be out of compliance.

- **Revisits** are conducted to determine whether substantial compliance has been achieved.

- **Informal Dispute Resolution** is a process that gives providers one opportunity to refute cited deficiencies after any survey.

- **Nurse Aide Training and Competency Evaluation Programs** are lost when certain criteria are met.

- **Appeal Waiver** - A facility may waive the right to a hearing in writing within 60 calendar days from the date of the notice of imposition of the civil money penalty and reduce the civil money penalty amount by 35 percent.

- Before collecting a civil money penalty, CMS is required to conduct a **hearing** for a facility that properly requests one.
- The regional office has the authority to **settle** cases at any time prior to a final administrative decision when it imposed the civil money penalty.

Immediate jeopardy to resident health or safety	J PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	K PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	L PoC Required: Cat. 3 Optional: Cat. 2 Optional: Cat. 1
Actual harm that is not immediate	G PoC Required* Cat. 2 Optional: Cat. 1	H PoC Required* Cat. 2 Optional: Cat. 1	I PoC Required* Cat. 2 Optional: Cat. 1 Optional: Temporary Mgmt.
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required* Cat. 1 Optional: Cat. 2	E PoC Required* Cat. 1 Optional: Cat. 2	F PoC Required* Cat. 2 Optional: Cat. 1
No actual harm with potential for minimal harm	A No PoC No remedies Commitment to Correct Not on CMS-52567	B PoC	C PoC
	Isolated	Pattern	Widespread

Substandard quality of care is any deficiency in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25, Quality of Care, that constitutes immediate jeopardy to resident health or safety; or, a pattern of or widespread actual harm that is not immediate jeopardy; or, a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Substantial compliance

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — March 15, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ramu Carpenter	
Teresa Johnson	NC Adult Day Services Assn
Rosanne Briggs-Cash	NCAOA, Franklin Co Dept of Aging
Jean Beaver	NC ADSA NCCOA
Kay, Ray & Dakota Murray	nurse & Loyola New Orleans MSN student
Jeff Horton	DHHS DFS
Beverly Sperioff	DHHS DFS
Barbara Ryan	DHHS DFI
Michele Elliott	DHHS DFS
Polly Williams	NC Justice Center / Triangle OWL
Mary Bethea	AARP-NC
Bill Wilson	AARP NC

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — March 15, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Glenda Artis	Division of Aging and Adult Services
Mary Edwards	DAAS
Andrea Schwarz	UNC
John Bowdrich	AstraZeneca
Dick Hatch	AARP/NC Coalition on Aging
Diane D. Hatch	AARP
Jobey Tate	Bone/Assoc.
Larry Nam	DMA
Evelyn Hawthorne	EHGR
Jerry Cooper	NCARA
Joanne Stevens	NCNA

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — March 15, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Abby Emanuelson	NMSS
Dennis Streets	NC Div. of Aging and Adult Services
Sharon Wilder	NC Div. of Aging + Adult Services
Charlene Carey	NC Right to Life

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

February 16, 2006

MEMORANDUM

TO: Members - NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be **two** meetings of the NC Study Commission on Aging in March:

DAY: **Wednesday** **TIME: 10:00 A.M.**

DATES: **March 15, 2006** **AND** **March 29, 2006**

LOCATION: **Room 643**
Legislative Office Building

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, March 29, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Long-Term Care Ombudsman

Dennis Streets, Director, Division of Aging and Adult Services, DHHS
Sharon Wilder, State Long Term Care Ombudsman

III. Final Report on the Medicaid Institutional Bias Study

~~*Lisa Alecxih, Vice President, The Lewin Group*~~

Last minute cancellation by the Lewin Group due to a missed flight. Larry Nason and representatives from DHHS will review The Lewin Group's report.

IV. Remarks from DHHS and Responses to Previous Commission Questions on the Medicaid Institutional Bias Study

Larry Nason, Charlotte Gibbons, and Tracy Colvard, Division of Medical Assistance, DHHS

V. Next Meeting:
April 4, 2006 at 10:00 a.m. in Room 643

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES
MARCH 29, 2006
10:00 AM
ROOM 643

The meeting was called to order by Representative Beverly Earle at 10:05 am in Room 643 of the Legislative Office Building. She thanked everyone for coming. The following members were present:

Representative Beverly Earle, Chair
Representative Alice Bordsen
Representative Jennifer Weiss
Ms. Florence Soltys
Mr. Brad Allen
Theresa Matula, Staff
Mr. Jackie Sheppard, Ex-Officio
Representative Debbie Clary
Representative Bob England
Ms. Linda Howard
Ms. Regina Fisher
Ms. Judy Pelt
Ben Popkins, Staff
Three Senators

The first presenter for the meeting was Mr. Dennis Streets, Director, Division of Aging and Adult Services, DHHS and Ms. Sharon Wilder, State Long Term Care Ombudsman. Mr. Streets presentation was on The Long Term Care Ombudsman Program. This program was organized to advocate and direct services or on behalf or residents in nursing facilities and adult care homes to help protect their health, safety, welfare, and rights. It requires the Office of State Long Term Care Ombudsman to perform the functions and duties mandated by the Older Americans Act of 1965. The Ombudsman Program is also required to provide technical support for the development of resident and family councils to protect the well being and rights of residents, to promote community involvement with long term care residents and facilities, provide information to the general public on long term care issues, work with long term care providers to resolve issues of common concern and assist long term care providers with staff training. They are also required to train and provide technical assistance to community advisory committee. They collect and report data regarding the number of complaints handled and other program activities, coordinate activities for elder abuse awareness, education, and prevention and provide information to public agencies,

legislators, and others on problems impacting the rights of residents as well as make recommendations for resolution of issues identified.
(See Attachment II & III)

Due to a last minute cancellation by the Lewin Group due to a missed flight, Mr Larry Nason, Charlotte Gibbons and Tracy Colvard, Division of Medical Assistance, and representatives from DHHS had to review the Lewin Group's report. During their introduction they spoke of the goal of this study. It was to determine whether an institutional bias exists in North Carolina's Medicaid financed LTC services and, if so, what steps should be taken to ameliorate any bias. Lewin reviewed policies and related administrative practices that may generate a bias for the use of institutional services over home and community based services. Lewin also conducted interviews with key informants such as state staff, providers, and consumers. The interviews assessed the application of policies in practice and operational implications that may also contribute to or ameliorate an institutional bias. They focused on four areas:

- Medicaid long term care benefits
- Long term care availability and accessibility
- Cost containment practices
- Long term care provider regulation and oversight

In the report the Lewin examined the policies and related administrative practices that may generate a bias for the use of institutional services over home and community based services, and addressed potential federal, state, and local policy changes that may be necessary to alleviate and identified bias.

Discussion and Questioned were addressed at this time.

The meeting was adjourned.

Representative Beverly Earle, Presiding

Ann Raeford, Committee Assistant

Attachments

Attachment I	Agenda
Attachment II	The Long Term Care Ombudsman Program NC Division of Aging and Adult Services
Attachment III	North Carolina Institutional Bias Study Combined Report

North Carolina Division of Aging and Adult Services

Long Term Care Ombudsman Program:
An Overview

1

The Long Term Care Ombudsman Program N. C. Division of Aging and Adult Services

Mandated by federal law—Older Americans Act (PL 106-501, Section 704) and state law (GS 143B-181.15 -.25) to provide:

- advocacy and direct services to or on behalf of **residents** in nursing facilities and adult care homes to help protect their health, safety, welfare, and rights.

N.C. Division of Aging and Adult Services 2

North Carolina General Statute 143B-181.17

- Requires the Office of State Long Term Care Ombudsman to perform the functions and duties mandated by the Older Americans Act of 1965, as amended.
- State Statute incorporates the federal mandates and includes additional responsibilities.

N.C. Division of Aging and Adult Services 3

The Long Term Care Ombudsman Program is required to:

1. Receive and attempt to resolve complaints made by or on behalf of residents in long term care facilities;
2. Ensure that residents have regular and timely access to the services provided through the Program and that the residents and complainants receive timely responses from Program's representatives;
3. Represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

The Ombudsman Program is also is required to:

4. Provide technical support for the development of resident and family councils to protect the well-being and rights of residents;
5. Promote community involvement with long term care residents and facilities;
6. Provide information to the general public on long term care issues;
7. Work with long term care providers to resolve issues of common concern;
8. Assist long term care providers with staff training (particularly on Residents' Rights);

And furthermore is required to:

9. Train and provide technical assistance to community advisory committees;
10. Collect and report data regarding the number of complaints handled and other program activities;
11. Coordinate activities for elder abuse awareness, education, and prevention; and
12. Provide information to public agencies, legislators, and others on problems impacting the rights of residents as well as make recommendations for resolution of issues identified.

Overview of Program's Staff Capacity

- The Program includes:
  - Three (3) full-time staff in the Division of Aging and Adult Services and,
  - **27.6** full-time equivalents (FTE) Regional Long Term Care Ombudsmen positions.
- This FTE number translates to **25** full-time regional ombudsmen and **4** part-time regional ombudsmen located in the **17** area agencies on aging across the state.
- There are **89,056** licensed long term care beds in North Carolina.
- Which means there is **one** Regional Ombudsman for every **3,227** licensed beds. (89,056 divided by 27.6)

N.C. Division of Aging and Adult Services 7

Long Term Care Ombudsman Program Services Overview

2004	2005	
3,460	2,972	Complaints processed by the LTC Ombudsman Program
1,228	1,343	Number of persons filing complaints
8,528	8,968	Resident visits made by Regional Ombudsmen
394	555	Facility Licensure Surveys attended
166	136	Resident Council meetings attended
134	96	Family Council Meetings attended
15,409	16,385	Individuals provided Technical Assistance
5,250	5,446	Consultations provided to LTC providers
543	501	Training Sessions provided LTC staff
532	776	Community Education Sessions completed
3,375	3,325	Training hours for CAC members/New Ombudsmen

N.C. Division of Aging and Adult Services 8

Factors affecting Ombudsman Program Services:

- Personnel turnover in several regions left vacancies for extended periods of time in late 2004.
- Major drop in # of complaints in 2005 is directly linked to one program where a Regional Ombudsman was on Medical Leave for six months.
- Complaints filed with the Program have become more time consuming and complex. (Examples: representing complainants with guardians, assisting residents with transfer/discharge hearings, and rights restrictions imposed by facilities).
- The transition of a younger population into adult care homes, many of whom have persistent mental illnesses. Both the residents and providers call the Regional Ombudsman with complaints about care issues, unavailable services, and rights violations—many times the residents are calling repetitively.
- Involvement in the Medicare Part D education process and enrollment problems.
- Involvement in other DHHS-related activities (e.g., nursing home transition).
- The recent fuel shortage reduced Ombudsman ability to travel for several months.

N.C. Division of Aging and Adult Services 9

II

Reports of the National and NC Institutes of Medicine

- The National Institute of Medicine recommended in its 1995 report that the Long Term Care Ombudsman Program be funded at a level that would permit ombudsmen to adequately perform all of their functions. It recommended that **one full-time equivalent paid ombudsman per every 2000 beds** be used as a base line indicator of performance.
- North Carolina currently has 1 FTE for every 3,227 beds and would need an additional 16.5 regional ombudsman positions to reach the IoM benchmark.

"The availability of long-term care Ombudsmen and community advisory committee volunteers with appropriate training across the state varies from county-to-county, yet the service provided by the long-term care Ombudsmen has been considered valuable by both clients and families and by providers of care."—*2001 NC Institute of Medicine Long-Term Care Plan for NC*

[1] Uhrich-Wahlberg, J., Pendley, J.C. and Eaton, C.L., Billiers An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act, Washington, D. C.: IOM 1995

Why the Long Term Care Ombudsman Program Is Important

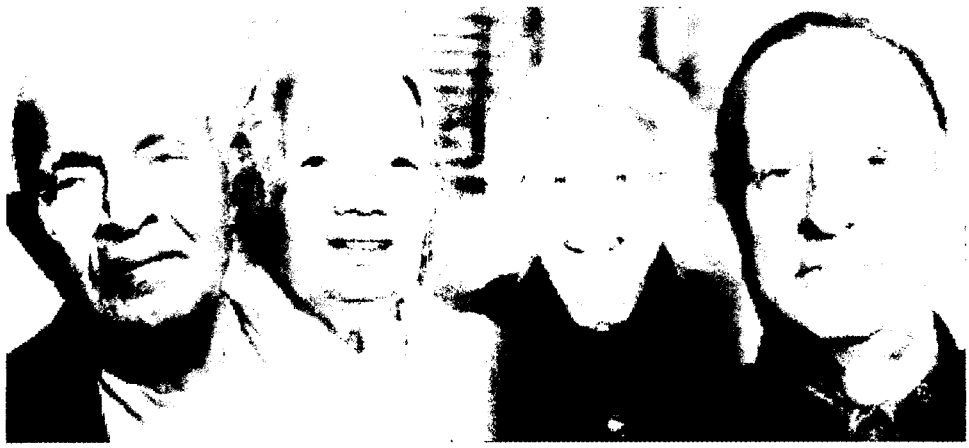
- Empowers residents and their families to exercise their right to receive quality care and services.
- Supports long term care residents by responding directly to them, giving accurate information about their rights, the regulations governing their care, and providing the presence of an Ombudsman to guide residents in negotiating the long term care system.
- Provides direct services to residents, such as offering interventions to resolve complaints at the facility level. The Program uses mediation techniques, negotiation skills, and persuasion to resolve grievances and effect change for residents.

Program Results

ese are real ple who have needs. Don't gorize them nd put them in a slot. Even those who are confused will feel left out and not cared about. We can't think that they have reached a point and don't matter anymore."—a 51 year old resident

- Over 75% of total complaints are resolved or partially resolved locally without referring to a regulatory agency. This alone saves the State and taxpayers the expense of formal complaint investigations and follow up by the licensure agencies.
- Provides consumer education on a variety of long term care issues, such as options for choosing a facility, payment sources, Residents' Rights, elder abuse prevention, types of legal authority, information about dementia and related behaviors, and problem solving skills.
- Addresses systemic problems that affect residents' quality of life negatively as the "voice" of the resident.

North Carolina State Long Term Care Ombudsman Program



2004 Annual Report

Promoting quality of life
and quality of care
for long term care residents.

- Draft Report -
For Study Commission
on Aging Members

The LEWIN GROUP

North Carolina Institutional Bias Study Combined Report

DRAFT

Prepared for:

North Carolina Department of Health and Human Services

March 27, 2006

M E M O R A N D U M

TO: Theresa Matula
Legislative Analyst
Research Division
North Carolina General Assembly

FROM: Mark T. Benton
Senior Deputy Director/Chief Operating Officer
North Carolina Division of Medical Assistance

SUBJ: Request for Additional Information by the Study Commission on Aging

DATE: February 9, 2006

In response to your e-mail of January 9, 2006, the following information is provided.

Bullet #1: Regarding Bias 1

The Medicare program will reimburse Part D prescription drug co-payments for nursing facility residents, however, CAP/DA participants who also meet the nursing facility level of care will have to pay their own co-payments.

Information Requested: What is the number of people affected and what is the funding estimate to address the issue of Part D co-payments for CAP/DA participants.

Answer: The estimated cost to cover Part D co-payments for CAP/DA dually eligible recipients is $2,388,636. If The Lewin Group recommendation is implemented, these co-payments would be picked up by the state.

This estimate is based on SFY 2005 prescriptions billed (796,212) to Medicaid multiplied by the current co-payment of $3.00. During SFY 2005 there were 11,547 dually eligible CAP/DA recipients. The estimate does not account for any changes in medication utilization or any change in the co-payment. While the new NC Leads Medicaid management information system will be able to access different funding sources, i.e., state funds, the current MMIS does not have this capability. Therefore, a state funded program for reimbursing pharmacies for co-payments would require development of a payment mechanism that would take into consideration the current Point of Sale system for reimbursing pharmacies and MMIS data.

Contact Person: This information was provided by Darlene Creech of the Facility and Community Care Section of the Division of Medical Assistance. Her e-mail address is Darlene.Creech@ncmail.net

Bullet #2: Regarding Bias 3:

Medical needy requirements are inconsistent across settings. Medical needy requirements leave little money for persons to pay for living expenses if they prefer to remain the community, while institutions provide room and board.

Information Requested: Provide a breakdown by state of the amount of medically needy standard for all 50 states.

Answer: Data provided in Exhibit 1 below.

Exhibit 1: Individual Medicaid Medically Needy Limits by State, 2002

State	Medically Needy Limits - Individual	Notes
Louisiana	$100.00	
Arkansas	$108.33	
Florida	$180.00	
West Virginia	$200.00	
Kentucky	$217.00	
Tennessee	$241.00	
North Carolina	$242.00	
Illinois	$283.00	
Maine	$315.00	
Virginia	$345.12	
Maryland	$350.00	
New Jersey	$367.00	
Utah	$382.00	
Nebraska	$392.00	
Michigan	$408.00	**Average**
Hawaii	$418.00	**$416**
Pennsylvania	$425.00	
Kansas	$475.00	
Minnesota	$482.00	
Iowa	$483.00	
North Dakota	$500.00	
Massachusetts	$522.00	
Montana	$525.00	
New Hampshire	$566.00	
Washington	$571.00	
Connecticut	$476.19	**Regions B&C**
Wisconsin	$591.67	**Region A $574.86**
California	$600.00	

New York	$642.00	
Rhode Island	$650.00	
Vermont	$825.00	
Alabama	n/a	
Alaska	n/a	
Arizona	n/a	
Colorado	n/a	
Delaware	n/a	
District of Columbia	n/a	
Georgia	n/a	
Idaho	n/a	
Indiana	n/a	
Mississippi	n/a	
Missouri	n/a	
Nevada	n/a	
New Mexico	n/a	
Ohio	n/a	
Oklahoma	n/a	
Oregon	n/a	
South Carolina	n/a	
South Dakota	n/a	
Texas	n/a	
Wyoming	n/a	
Average	**$415.56**	

Notes:

n/a -- State does not have a Medicaid Medically Needy program and is not included in the calculation.
Source: American Public Human Services Association (APHSA), Center for Workers with Disabilities website (http://www.aphsa.org/disabilities/center_initiatives/abd.htm). Data were collected in 2002.
Note: Connecticut uses a different MNIL for different regions of the state. For this calculation, we used the amount used in Regions B (Hartford) and C (New Haven). Region A is Fairfield. (2004 MNIL rates are close to the $476 used above and can be found at http://www.cga.ct.gov/ph/medicaid/mmcc/HUSKY/HUSKYProgramChanges200403.htm)

Contact Person: This information was provided by Lisa Alecxih of The Lewin Group. Her e-mail address is lisa.alecxih@lewin.com

Bullet #3: Regarding Bias 4

Spousal impoverishment provisions are inconsistent across settings. Differences in spousal impoverishment rules can create hardships for families if a spouse prefers home or community-based care over institutional care.

Information Requested: What specifically is needed from a legislative standpoint to align spousal impoverishment income rules?

Answer: This question was addressed by the DMA Eligibility Section as follows.

The state determines eligibility for Community Alternative Program for Disabled Adults (CAP/DA) recipients by the rules covered under the home and community-based waiver group under 42 CFR 435.217. NC determines eligibility for the CAP waiver groups under the rules applying to institutional groups, but chose not to apply post-eligibility treatment of income rules to those individuals. Applicants must meet the financial eligibility requirements for the categorical needy and the medically needy groups as specified in Medicaid Eligibility Requirements for Private Living Arrangements (PLA) budgeting. PLA budgeting does not include spousal protection for income.

Long term care (LTC) budgeting is covered under 42 CFR 435.725, and allows post-eligibility treatment of income by a standard formula to calculate the basic spousal allowance. Long term care budgeting is a two step process. Once financial eligibility is determined to exist (Step 1), the individual's share of cost is determined (Step 2). This is called a patient monthly liability (PML). In determining the PML, the recipient is only allowed $30 for a personal needs allowance. All other income must be used by the recipient for his PML. During this step of budgeting, LTC budgeting allows post-eligibility treatment of the spouses income using a standard formula to calculate the basic spousal allowance. An allowance can be deducted from the institutionalized spouse's income if the community spouse's income is less than 150% of the poverty level ($1,197 per month). This is called spousal income protection. Spousal income protection was enacted to avoid causing a community spouse financial hardship when the institutionalized spouse is permanently absent from the home, allowing the community spouse to maintain his/her standard of living. After the community spouse's income allowance is deducted from countable income, the institutionalized spouse receives a $30 a month personal needs allowance deduction. The remainder is the institutionalized spouse's PML and the amount he/she is responsible for paying to the facility each month.

We do not have the history on why the Division decided against LTC budgeting for CAP/DA recipients. However, we believe the decision was made because recipients without a community spouse would only have $30 a month income remaining, (personal needs allowance). Since CAP/DA recipients remain at home and are solely responsible for expenses, this method of budgeting would prevent a single CAP recipient from participating in the CAP/DA program.

Due to federal regulations, the Home and Community Based Waiver would have to be amended and approved by CMS in order to align CAP and LTC spousal impoverishment rules.

Contact Person: This information was provided by Charlotte Gibbons of the DMA Eligibility Section. Her e-mail address is charlotte.gibbons@ncmail.net

Bullet #4: Regarding Bias 5

The application of federal cost neutrality requirement in North Carolina creates an institutional bias. The individual budget cap placed on CAP/DA participants excludes high cost individuals from receiving care in the community.

Information Requested: Is legislation required to address the federal cost neutrality requirement, as it is applied to the CAP/DA Program?

Answer: Yes, legislation is required at the federal level. Federal regulations currently require that the State give assurances to CMS that:

- ...the recipient, but for the provision of waiver services (Note: Such as CAP/DA), would otherwise be institutionalized in a hospital, nursing facility, or ICF?MR {42 CFR 441.302(1)(c)(ii)}.

- ...the average per capita fiscal year expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made in the fiscal year for the level of care provided in a hospital, nursing facility, or ICF/MR {42 CFR 441.302(2)(e)}.

- ...the agency's actual total expenditures for home and community-based and other Medicaid services under the waiver and its claim for federal financial participation in expenditures for the services provided to recipients under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals, absent the waiver, in a hospital, nursing facility, or ICF/MR {42 CFR 441.302(2)(f)}.

The Lewin Group is recommending that the state change the way it meets this requirement. Currently the state (along with other measures) caps the individual monthly cost limit for each participant in CAP/DA as one way to assure compliance. According to the The Lewin Group report, this practice results in individuals with the most intense needs (and, therefore, the most expensive to serve) being excluded from home and community-based services. They recommend that the individual limit should be changed to an average cost per individual based on the expected expenditures for nursing facility care for the year. Based on historical data, this would increase the monthly limit per individual. Higher cost individuals being served in the community would be balanced with others with lower expenses, keeping the state below the overall average expenditure limit, but allowing the state to serve individuals with more acute needs. In addition, the state would be able to grant exceptions on a case-by-case basis, according to defined criteria, while still keeping the overall spending within the defined limits (see pages 30-32 in the Institutional Bias Report).

This and other options to improve the effectiveness of the CAP/DA program and ensure that the neediest individuals are served by the program are under active consideration by the Facility and Community Care Section of DMA. Several issues are relevant to implementing this change. The Division would need:

- More and better data to estimate the costs associated with serving individuals in the CAP/DA program with higher acuity levels and to assure compliance with the federal cost neutrality requirements cited above;

- To implement a more rigorous assessment for CAP/DA participation and assess all individuals before being placed on a waiting list; and
- To wait until the new Medicaid Management Information System (MMIS) is implemented and tested before changes in reimbursement could be implemented.

The Facility and Community Care Section is currently developing a uniform screening program and automated program intake system that will address many of these issues and make these types of program changes administratively manageable.

A change in the way the state meets these federal requirements would require a waiver amendment, or a change in the waiver renewal application and approval from CMS.

Contact Person: This information was researched by Larry Nason of the Facility and Community Care Section of the Division of Medical Assistance. His e-mail address is Larry.Nason@ncmail.net

#5: Regarding Bias 6

Enrollment caps (in the CAP/DA program) limit the number of people who can access care in the community.

Information Requested: A breakdown of CAP/DA slot assignments and usage and a breakdown of the waiting list for CAP/DA by county.. Does the waiting list move at a reasonable pace?

Answer: There are 13,200 CAP/DA slots allocated as indicated in Exhibit 2 below. Currently, there are 1900 vacant slots as of 12/31/05. Slots were allocated in July 2004 based on recommendations by the N.C. Institute of Medicine in a study entitled "Community Alternatives Program for Disabled Adults (CAP/DA): 2003." Each county received slots relative to its share of the statewide total of Medicaid aged, blind and disabled recipients ages 18 and older.

As of 1/31/06, there were a total of 8,196 individuals on the counties' waiting lists for CAP/DA slots. See Exhibit 3 below for numbers of individuals waiting per county. The counties vary in how they process waiting lists. Some counties have the resources to apply rigorous screening criteria so that individuals are quickly assessed for eligibility for Medicaid and the CAP/DA program. Other counties place individuals on the waiting list without performing such screens. It is important to note that counties do not receive administrative funds for managing waiting lists. An FL-2 approved at the nursing facility level of care is required before local case managers can bill Medicaid for any services. (An FL-2 is Medicaid's prior approval form for long term care services)

Counties also vary in how individuals fill slots once they are on the waiting list. The majority of counties exercise a "first come, first served" methodology. Length of time that one stays on a waiting list varies from county to county since each county determines the resources and staff that are allocated to the CAP/DA program.

Exhibit 2: Final Allocation of CAP/DA Slots for SFY 04-05

Alamance	113
Alexander	104
Alleghany	73
Anson	91
Ashe	187
Avery	213
Beaufort	135
Bertie	201
Bladen	164
Brunswick	70
Buncombe	289
Burke	285
Cabarrus	293
Caldwell	214
Camden	15
Carteret	119
Caswell	54
Catawba	183
Chatham	61
Cherokee	161
Chowan	60
Clay	56
Cleveland	162
Columbus	236
Craven	156
Cumberland	304
Currituck	26
Dare	16
Davidson	123
Davie	103
Duplin	140
Durham	163
Edgecombe	119
Forsyth	202
Franklin	118
Gaston	165
Gates	48
Graham	122
Granville	77
Greene	41
Guilford	376
Halifax	147
Harnett	123
Haywood	166
Henderson	80

Hertford	158
Hoke	104
Hyde	27
Iredell	209
Jackson	95
Johnston	86
Jones	51
Lee	120
Lenoir	106
Lincoln	133
Macon	79
Madison	39
Martin	71
McDowell	68
Mecklenberg	548
Mitchell	101
Montgomery	37
Moore	108
Nash	123
New Hanover	150
Northampton	88
Onslow	165
Orange	86
Pamlico	54
Pasquotank	82
Pender	138
Perquimans	34
Person	52
Pitt	141
Polk	60
Randolph	166
Richmond	89
Robeson	493
Rockingham	381
Rowan	202
Rutherford	112
Sampson	69
Scotland	153
Stanly	94
Stokes	90
Surry	161
Swain	78
Transylvania	45
Tyrrell	12

Union	95
Vance	58
Wake	420
Warren	33
Washington	73
Watauga	78
Wayne	40

Wilkes	208
Wilson	183
Yadkin	107
Yancey	93
Total	**3,200**

Exhibit 3: CAP/DA Waiting Lists

	Number on Waiting List		Number on Waiting List
Alamance	83	**Johnston**	43
Alexander	54	**Jones**	30
Alleghany	25	**Lee**	50
Anson	27	**Lenoir**	104
Ashe	16	**Lincoln**	33
Avery	49	**Macon**	61
Beaufort	168	**Madison**	67
Bertie	114	**Martin**	167
Bladen	128	**McDowell**	46
Brunswick	67	**Mecklenberg**	312
Buncombe	178	**Mitchell**	212
Burke	36	**Montgomery**	65
Cabarrus	0	**Moore**	56
Caldwell	95	**Nash**	63
Camden	3	**New Hanover**	41
Carteret	123	**Northampton**	150
Caswell	58	**Onslow**	84
Catawba	39	**Orange**	20
Chatham	22	**Pamlico**	14
Cherokee	28	**Pasquotank**	23
Chowan	6	**Pender**	46
Clay	5	**Perquimans**	4
Cleveland	65	**Person**	40
Columbus	260	**Pitt**	278
Craven	123	**Polk**	3
Cumberland	167	**Randolph**	27
Currituck	2	**Richmond**	127
Dare	2	**Robeson**	1,110
Davidson	27	**Rockingham**	0
Davie	0	**Rowan**	25
Duplin	11	**Rutherford**	23
Durham	35	**Sampson**	134
Edgecombe	292	**Scotland**	173
Forsyth	75	**Stanly**	85
Franklin	65	**Stokes**	121

Gaston	85	**Surry**	172
Gates	7	**Swain**	21
Graham	20	**Transylvania**	3
Granville	83	**Tyrrell**	21
Greene	82	**Union**	58
Guilford	90	**Vance**	118
Halifax	201	**Wake**	221
Harnett	88	**Warren**	81
Haywood	19	**Washington**	2
Henderson	4	**Watauga**	0
Hertford	101	**Wayne**	31
Hoke	52	**Wilkes**	30
Hyde	5	**Wilson**	40
Iredell	201	**Yadkin**	64
Jackson	0	**Yancey**	11
Total			**8,196**

Contact Person: This information was provided by Darlene Creech of the Facility and Community Care Section of the Division of Medical Assistance. Her e-mail address is Darlene.Creech@ncmail.net

#6: Regarding Bias 7

There is no differentiation of need on the CAP/DA wait list.

Information Requested: In response to Bias 7, should North Carolina prioritize the CAP/DA waiting list based on risk to institutionalization and can this be done?

Answer: In order to prioritize CAP/DA waiting lists based on risk of institutionalization, it would be necessary for all 8,196 individuals to be prior approved for nursing facility level of care. As indicated above, counties do not receive reimbursement for case management activities related to arranging for FL-2 completion and submission. Once basic eligibility is established (nursing facility level of care is met), additional assessment activities would be necessary to determine relative risks among all those qualifying for nursing facility level of care.

Several Division of Medical Assistance initiatives will address certain aspects of this issue. A uniform screening/assessment tool and the related automated business processes are currently being designed. This completed project will facilitate a central point of entry for all individuals in need of Medicaid long term care. Screening, medical eligibility, level of care, and prior approval will all be determined using an automated interface. This process would facilitate an "upfront" determination of long term care needs and the best options for meeting those needs.

Additionally, the CAP/DA clinical coverage policy is currently being amended to prohibit certain individuals from being placed on waiting lists including:

- CAP/DA clients transferring from other counties;
- Individuals transferring from other waiver programs (CAP/C and CAP/AIDS);
- Individuals being discharged from hospitals or nursing facilities; and
- Individuals transferring from Medicaid's Private Duty Nursing services.

Additional waiting list standards are also being considered.

Contact Person: This information was provided by Darlene Creech of the Facility and Community Care Section of the Division of Medical Assistance. Her e-mail address is Darlene.Creech@ncmail.net

#7: Regarding Bias 8

There is an inconsistent allocation of CAP/DA slots. Individuals may wait for waiver services in one county while other counties have unused waiver slots.

Information Requested: In regard to Bias 8, can these slots be moved easily when not being utilized?

Answer: The Division of Medical Assistance is reluctant to realign unused slots. Considerable time and effort was expended by the Slot Allocation Workgroup in 2003 - 2004 to arrive at the Medicaid population-based method of slot allocation. This workgroup, formed as a result of the Institute of Medicine's study cited above, considered many aspects of the issue including local governance, equitable distribution and ease of administration. At the time of allocation, there was recognition that there would likely be an 18-24 month time frame necessary for all counties to effectively fill their slots and arrive at a desirable slot utilization level. This time frame has not yet been reached.

Additional program management activities are also being implemented which impact recipients' entry to and discharge from the CAP/DA program, and therefore affect slot utilization. The State is monitoring closely the medical eligibility of the 11,000+ individuals currently enrolled in CAP/DA. Efforts are focused on assuring that participants effectively meet the program criteria and receive services commensurate with their needs. Therefore, State and local staff is actively evaluating program data that only recently became available with the implementation of an automated assessment, quality and utilization tool in 2005. It is desirable to complete this evaluation process and make final CAP/DA coverage policy changes before considering substantive changes to the slot allocation process.

Contact Person: This information was provided by Darlene Creech of the Facility and Community Care Section of the Division of Medical Assistance. Her e-mail address is Darlene.Creech@ncmail.net

Summary of Biases and Recommendations

Bias Number	Identified Bias	Type	Recommended Action	Would legislative policy change be required?	Cost Estimate[1]
Medicaid Long Term Care Benefits					
1.	Federal provision to reimburse Medicare Part D prescription drug copays for nursing facility residents, but not for home and community-based waiver participants.	Federal Policy	Advocate for a change in federal legislation or provide coverage for Part D copayments for CAP/DA participants through state funds.	General Assembly would need to appropriate funding.	$2.4 million *(DMA estimate)*
Availability and Accessibility					
2.	Lack of simplified access and consistent support coordination system	State Administration/ Local Operation	Study ways to improve efficiency and effectiveness of case management.	No change in policy	$30,000-$50,000
3.	Medically needy requirements leave little money for persons to pay for living expenses if they prefer to remain in the community, while institutions provide room and board.	State Policy	Increase medically needy income standard from the current monthly standard of $242 to a level at least the national medically needy average ($416 for single individual).	Amend the Medicaid State Plan. This change would require state legislation to change the medically needy limit and appropriate funds to cover the increased costs.	$52-$55 million
4.	Differences in spousal impoverishment rules can create hardships for families if a spouse prefers home or community-based care over institutional care.	State Policy	Align spousal impoverishment income rules for LTC beneficiaries in all settings.	Amend the Medicaid State Plan. This change would require state legislation to appropriate funds to cover the increased costs.	$113,000

[1] The Lewin Group's contract included estimating the cost of three recommendations. DMA prioritized the recommendations for the cost estimates.

Bias Number	Identified Bias	Type	Recommended Action	Would legislative policy change be required?	Cost Estimate[1]
Cost Containment					
5.	Application of federal waiver cost neutrality requirement.	State Administration	Develop mechanism to allow for high cost individuals to have the opportunity to receive care in the community, either through exceptions to the budget cap or a new system of approval perhaps based on the CAP/C program. This may require additional coordination across counties/lead agencies.	Change CAP Medicaid eligibility guidelines in CAP/DA Manual and other program instructions. This change may or may not require state legislation.	Not estimated
6.	Enrollment caps limit number of people who can access care in the community.	State Policy	Develop a financing mechanism that allows flexibility to increase CAP/DA slots.	Change budget structure for Medicaid LTC. This change would require state legislation to increase the enrollment caps and funds to cover the increased costs, as well as federal approval.	Not estimated

Bias Number	Identified Bias	Type	Recommended Action	Would legislative policy change be required?	Cost Estimate[1]
7.	No differentiation of need on the CAP/DA wait lists.	State Administration/ Local Operation	Create a priority list for waiver admission for persons at risk of institutionalization or who are institutionalized	No change in policy. This could require state legislation for the appropriation of funds to cover the activities to prioritize the wait lists. However, better targeting of individuals who might otherwise be institutionalized could save on NF costs.	Not estimated
Provider Regulation and Oversight					
8.	Individuals may wait for waiver services in one county while other counties have unused waiver slots.	State Administration	Explore possibility of more active statewide management of waiver slots and waiting list.	No change in policy This could require state legislation to appropriate funds to cover the activities to monitor wait lists.	Not estimated
9.	Lack of coordinated effort to assure quality in the community	State Administration/ Local Operation	North Carolina Medicaid can help alleviate the problem by focusing attention on quality monitoring.	This change may or may not require state legislation to change the state's authority and appropriate funds to cover greater quality oversight.	Not estimated
10.	Prior Approval process delays appropriate care in the community	State Policy	Develop simpler mechanisms for individuals to increase services when needed, especially on a temporary basis.	This change would require state legislation to change the prior approval process and appropriate funds to cover the potential increase in service use.	Not estimated

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

March 29, 2006

The Honorable Beverly Earle, Co-Chair
North Carolina Aging Study Commission
NC House of Representatives
634 Legislative Office Building
Raleigh, NC 27603

The Honorable Charlie Dannelly, Co-Chair
North Carolina Aging Study Commission
NC Senate
2010 Legislative Building
Raleigh, NC 27601

Dear Rep. Earle and Senator Dannelly:

Since the inception of the Institute of the Medicine's Long Term Care Plan in 2001 and prior to the requirement for the institutional bias study, the Department has been proactively addressing issues affecting individuals who need long term services and supports. The Department's vision of Long Term Services and Support is: "People of all ages and their families live in inclusive, responsive communities where they have choices and control over their long term services and supports." We have learned from our Departmental grant initiatives, including our work with consumers, that when care needs are identified early and needed services are available, people are able to stay in the settings of their choice longer.

I am pleased that the Lewin Report found no bias in the areas of functional eligibility for Medicaid long term care services, provider capacity in home and community based services, certificate of need program, long term care payment rates, facility licensing and personnel licensing and staffing requirements.

While the report identified a number of areas where additional work is needed, we are currently addressing some of the issues as follows:

- NC Care Link project is developing a statewide and centralized information and referral infrastructure that enables consumers and their families to locate up-to-date services and supports information via a web-based data repository. By using issues-based searches and consumer decision making tools, consumers will be able to locate resources to use within their local communities.

- The Division of Medical Assistance is developing an automated screening and assessment system. This web-based system will identify the appropriate level of care and functionality for prior approval across the continuum of long term services and supports.

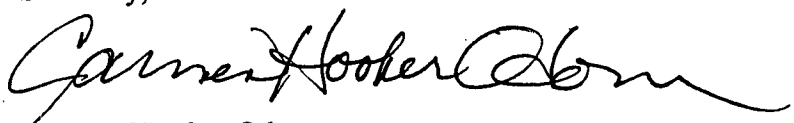
- The Division of Facility Services is in the process of conducting routine annual inspections of adult care homes and inspects home care agencies every three years to assure quality in the community.

- The Division of Aging and Adult Services is overseeing Aging and Disability Resource pilot projects in Surry and Forsyth counties. They are demonstrating a coordinated system of information on and access to long term supports and services.

In addition to the initiatives cited above, the Department will be exploring the increased flexibility afforded under the deficit reduction act as it pertains to cash and counseling, money follows the person and flexibility around the home and community-based services.

We are always open to hearing the perspectives of others, and we look forward to further studying the implications of this report in greater depth.

Sincerely,



Carmen Hooker Odom

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Aging N. C. Study — 3/29/06

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Mary Anne Cox	"
Anne McKune	UNC Chapel Hill - School of Social Work
Bridget Mahoney	UNC - CH SSW
Rachel Joseph	"
Gail Kenny	Meredith College
Joanne Caye	UNC - Chapel Hill - Sch of Social Work
Maura Nsonwu	Joint Master of Social Work Program Greensboro
Zaconiia Titus	UNC - Chapel Hill School of Social Work
Amy Stone	Appalachian State Univ. School of SW
Tzu Han Huang	UNC - Chapel Hill - Sch of Social Work
Laura Teeter	" "
Kimberly Arrington	Joint Master of Social Work Program - Greensboro
Sarah Bix	Joint Master of Social Work - A&T, UNCG
Shannon Buckalew	Joint Master of Social Work - NC A&T, UNCG
Danielle Farr	Joint Master of Social Work - NC A&T, UNCG
Carla Holloman	Joint Master of Social Work - NCA&T/UNCG
Jennifer Sullivan	NASW. NC
Rob Fuller	App. State - School of SW
Jennifer Johnson	Appalachian State - School of SW.
Erick Echeverria	UNC Charlotte BSW
Charles Apple	UNCC BSW
Jami Malcolm	UNCC BSW
Stacy Flannery	NCHCFA
Jessica Brinkley	Joint Master of Social Work NC A&T; UNCG (UNISW?)
Keka Grady	JMSW

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Nicky Stubbs	Meredith College
Brittany manner	meredith college
Nichole Jordan	Meredith College
Serena Faison	East Carolina University
Mary Ann Johnson	East Carolina University
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North Carolina Study Commission on Aging — March 29, 2006

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Kathie Smith	AHHC of NC
Polly Welsh	NCHCFA
Sandra Trivett	NC-DHHS
Richard Hatch	AARP / NC Coalition on Aging
Glenda Arms	Division of Aging and Adult Services
Mary Jo Littlewood	Division of Aging and Adult Services
Suzie Williamson	NCANPHA
Abby C. Emanuelson	NASS
Bill Wilson	AARPNC
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North Carolina Study Commission on Aging — March 29, 2006

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Sharon Wilder	" "
Julia Brown	" "
Iris Gerosty	820 Ascot Lane Raleigh 27615
Emily Saunders	" " "
Mary Edwards	" " "
Debbie Brantley	" " "
Joanne Stevens	NCNA + nurses
Marjorie Morris	Division of Medical Assistance (DMA)
Darlene Creech	" " " "
Jerry Colvard	" " " "

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North Carolina Study Commission on Aging — March 29, 2006

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Adrian Wilson	NC State
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Amy Phillips	Campbell Univ.
Kellie Reed Ashcraft	Appalachian State Univ. Soc Wk Prog.
Leslie Skinner	NCSU
Lura Hampton	NCSU

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Adrienne Turner	JMSW - student (UNCG+A&T)
Annie Felterman	JMSW student (A+T, UNCG)
Liz McGhee	JMSW student (UNCG + A+T)
Danielle Brown	BSW Student UNC-Charlotte
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A Suzanne Boyd, PhD	UNC Charlotte - Dept of Social Work
Marcia A Shoke, PhD	"
Jean Reaves	NCADSA NCCOA

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NC Commission on Aging

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Lauren McCullough	University of NC @ Wilmington
Sarah Cox	UNCW - Student
Amy Melton	NCSU.
Ashley Manning	NCSU
Nina Lightower	BSW Student - Meredith College
Kathy Moraschi	Student BSW Meredith College
Marcy Adams	JMSW student - UNCG & A&T

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North Carolina Study Commission on Aging — March 29, 2006

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Shawna Morrison-Flood	UNCG + A+T State University
Kathryn DeSimone	Meredith College
Deborah Chase	Meredith College

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North Carolina Study Commission on Aging — March 29, 2006

Name of Committee — **Date**

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Larry Nason	Divison of Medical Assistance
Mary Bethel	AARP-NC
[illegible]	Bonc & Asso.
[illegible]	DMA
[illegible]	NASW
Maggie Simpson	NASW
Leah Reaves	UNC Wilmington
Jodi Martin	NASW
Jacqueline Gray	NASW
Lisa Byrd	Campbell University
Laura Wooten	Campbell University

VISITOR REGISTRATION SHEET

Aging N.C Study — 3/29/06

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brandi Creech	Appalachian State
Fumie Kishiwada	Appalachian State University
Jessica Soule	UNC Chapel Hill
Jasmine Stinson	Appalachian State
Rebekah East	Appalachian State
Patricia Wiley	UNCC - BSW Student [illegible]
Tameka Norwood	UNC Chapel Hill MSW Student
Carina Vinzant	UNC-Charlotte
Jodie Massey	UNC Charlotte
Sonya Muhammad	UNC-Charlotte
Alex Swain	Campbell University

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — March 29, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Vanessa Vazquez	Campbell University
Mary Arant	Campbell University
Linda Hernandez	Campbell University
Nikisha McNeill	Campbell University
Brooke Wargin	Campbell University
Billy Boyce	Campbell University
Marcia Smith-Fischer	UNC-Greensboro
Heather Tinsley	UNC-Wilmington
Amanda Eribsen	UNC-Wilmington
Michael Taylor (13 yrs.)	Wilm
Barbara Nowakowski	UNCW - Wilm

March 20, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice Correction in Day of the Week

There will be two meetings of the NC Study Commission on Aging.

DAY:	Wednesday & Tuesday	TIME:	10:00 A.M.
DATES:	March 29, 2006 (Wednesday)		
	AND		
	April 4, 2006 (Tuesday)		
LOCATION:	Room 643		
	Legislative Office Building		

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Tuesday, April 4, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions
Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Revisions to Draft Letter on Federal Funding for Training in Geriatrics and Gerontology
Ben Popkin, Staff, Research Division, NCGA

III. Slots in the Community Alternatives Program for Disabled Adults (CAP/DA)
Tracy Colvard, Division of Medical Assistance, DHHS

IV. Presentation of Draft Recommendations
Theresa Matula, Staff, Research Division, NCGA

V. Consideration of Recommendations and Directions to Staff Regarding Report Preparation

VI. Next Meeting:
Early May – Date to Be Announced

North Carolina Study Commission on Aging

MINUTES
Wednesday, April 4, 2006
10:00 AM
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Wednesday, April 4, 2006, at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were: Rep. Beverly Earle, Co-Chair; Senators Austin Allran, Stan Bingham and Vernon Malone; Representatives Alice Bordsen, and Jennifer Weiss; Mr. Brad Allen, Ms. Linda Howard, Ms. Judy Pelt and Ms. Florence Gray Soltys. Mr. Jackie Sheppard, Ex-Officio Member, was also present.

Rep. Beverly Earle presided.

PRESENTATIONS

Revisions to Draft Letter on Federal Funding for Training in Geriatrics and Gerontology

Mr. Ben Popkin, Aging Commission Staff, Research Division, NCGA, was the first presenter. He reviewed the revised draft letter on Federal funding for geriatric and gerontology. The committee voted unanimously to send the letter the NC Congressional delegation. (Attachment I)

Slots in the Community Alternatives Program for Disabled Adults (CAP/DA)

Tracy Colvard with the DHHS Division of Medical Assistance gave the next presentation on CAP/DA. He gave a quick review of the program. Please see Attachment II for a copy of his presentation slides. Mr. Colvard told Commission members that CAP/DA slots range from 12 in Tyrell County to 548 in Mecklenburg County. There are currently 1570 vacant slots out of 13, 200. A slot Allocation workgroup was formed to establish a county base allocation of slots and distribute new slots based on percentage of the Medicaid aged, blind, and disabled recipients over 18 years of age.

Mr. Colvard told Commission members that they will be creating service packages to meet recipient needs because there are recipients of CAP/DA who may only need telephone alert. Because of cases such as this, they will implement planned management

activities such as creating a streamlined entry into long term care or uniformed screening. This uniform screening to firmly define the medical necessity criteria will be in place by January 2007. They will also reimburse services based on acuity, not predetermined budget limits. Hopefully this part will be in place by 2008.

Questions were asked relative to persons being on CAP/DA when they only need telephone alert. Why is this happening and what type of training is being done to do prevent it? Mr. Colvard stated that physicians are putting on the FL-2's whatever they are told to by families. However, now that they are reviewing the program, they will attempt to get appropriate services to fit a client's needs.

Mr. Colvard told Commission members that the reason there are waiting lists in some counties and empty slots in others is partly due to county infrastructure. Some counties don't want to increase their program or staffing needs to handle more slots. He also stated that there is no prescreening prior to being put on the waiting list. Commission members were given a copy of Final Allocation of CAP/DA Slots for 2004-05 (Attachment III). Mr. Colvard agreed to furnish members with the written formula used to determine how slots are allocated to the various counties.

Mr. Jackie Sheppard, Ex Officio Member, told the Commission that DHHS will make another presentation to report exactly where they are at implementing the new policies.

Presentation of Draft Recommendations

Ms. Theresa Matula, Commission Staff, presented the proposed recommendations to Commission members next. She reviewed each recommendation along with background information. There were twelve recommendations and each was approved unanimously by Commission members. Recommendation 8 was changed to include "substantial infractions". Please see Attachment IV. Following is a brief reference for each recommendation.

1. Increase Adult Day Care Reimbursement Rates
2. Increase CAP Awareness of Adults Day Health Options and Update
3. Health Care Personnel Registry
4. Telemonitoring Evaluation
5. LTC Ombusdman
6. NC NOVA Special Licensure Designation
7. Housing
8. Posting of Fines and Penalties for LTC Facilities
9. LTC Insurance Tax Credit
10. Medicaid Institutional Bias – CAP/DA Slots
11. Medicaid Institutional Bias – Recommendations to Address Biases
12. Additional Funds for Home and Community Care Block Grant

The meeting adjourned at 12:04 p.m.

Beverly Earle

Representative Beverly Earle
Co-Chair

Dee Hodge

Dee Hodge
Commission Assistant

ATTACHMENT I

DRAFT North Carolina Study Commission On Aging

Legislative Building 16 West Jones Street Raleigh, NC 27601

April 4, 2006

The Honorable XX
U.S. House of Representatives
Washington, DC 20515

Dear Representative XX:

On behalf of the North Carolina Study Commission on Aging, we ask for your support for reinstating funding for Title VII Geriatrics Health Professionals training as provided for by the Specter/Harkin amendment to the 2007 Labor, Health and Human Services and Education appropriations bill. The Specter/Harkin amendment to the Senate Budget Resolution, passed by the Senate on March 13, restored funding for Title VII training of Geriatrics Health Professionals to FY 2005 levels. Restoring the funding that was eliminated for Title VII training of Geriatrics Health Professionals in the FY 2006 budget will help ensure that North Carolina continues to offer accessible, quality healthcare to the older adult population.

Elimination of Title VII funding in the FY 2006 federal budget removed approximately $3 million in total federal funding that would have provided training for geriatrics health professionals from multiple disciplines (clinical medicine, nursing, social work and physical and occupational therapy). Cuts to the FY 2006 federal budget eliminated funds for the Carolina Geriatrics Education Center – which trains health professionals, faculty, students and practitioners in techniques of diagnosis, disease prevention, and treatment of older adults – and for Geriatrics Academic Career Awards – which train future physician leaders in Geriatric Medicine.

The Carolina Geriatrics Education Center is part of the National Association of Geriatric Education Centers (NAGEC) and provides training in geriatrics to health care professionals of multiple disciplines across the state of North Carolina. Members of the consortium include the Program on Aging (UNC School of Medicine, Chapel Hill), five Area Health Education Centers (AHECs) – Area L AHEC, Mountain AHEC, Charlotte AHEC, Eastern AHEC, and Wake AHEC, – and the Rural Health Group, Inc., Jackson, NC. In the fiscal year 2003-2004, the CGEC consortium trained over one thousand North Carolina health care professionals from twenty-two disciplines. For many of these professionals who work in medically underserved areas of our state, this is the only source of training and it is critical to their continuing ability to meet the growing needs of our older adults.

Your support for the Specter/Harkin amendment provisions of the FY 2007 federal budget is critical as it provides the health care workforce training required to meet the demands of the growing older adult population. North Carolina, like the nation, has a profound shortage of physicians, nurses, social workers and other health care professionals with training in care of the aging patient. Eliminating Title VII funding has greatly diminished geriatrics training for these providers who are already in short supply, and the quality of health care and the lives of our seniors will suffer for it. As such, the North Carolina Study Commission on Aging respectfully requests that the members of the United State House of Representatives support the reinstatement of Title VII funding for the training of geriatrics health professionals by supporting the Specter/Harkin amendment provisions to the House Labor, Health and Human Services and Education Appropriations bill for FY 2007.

Sincerely,

Senator Charlie S. Dannelly
Co-Chair

Representative Beverly M. Earle
Co-Chair

c: Senator Austin Allran
Representative Alice Bordsen
Representative Jennifer Weiss
Ms. Linda Howard

Senator Stan Bingham
Representative Debbie Clary
Mr. Brad Allen
Ms. Florence Gray Soltys
Ms. Judy Pelt

Senator Vernon Malone
Representative Bob England
Ms. Regina Buffy Fisher
Mr. Sam Marsh

Community Alternatives Program for Disabled Adults:
Slot Allocation & Related Issues

Presented by:
Tracy Colvard, CAP/DA and PCS Manager
NC Division of Medical Assistance
April 4, 2006

Quick Review – CAP/DA Program

- Home and Community Based Waiver Program implemented in 1982
- Nursing facility level of care and at risk for being institutionalized within 30 days
- Health, safety and well-being maintained at home within a capped budget limit
- Require case management
- Administered locally by lead agency designated by the county commissioners

2

CAP/DA Services

- Adult Day Health
- In-Home Aide – 90% of Budget
- Waiver Supplies
- Home Mobility Aids
- Preparation and Delivery of Meals
- Respite Care
- Telephone Alert
- Case Management

3

Waiver Highlights

- Optional services that states may offer
- States "waive" certain statutory requirements to offer services to specified target groups
- Must demonstrate "cost neutrality"
- States determine number of waiver participants based on available resources
- "Slots" help manage participants and related expenses

CAP/DA Slot History

- Historically slot allocations depended on county utilization patterns
- Freeze in program enrollment October 2001 – July 2002 resulted in a reduction of 2,200 CAP/DA participants – from 10,230 to 8,049.
- $28 million budget increase in 2004-2005 SFY provided 2,500 new slots - total number of CAP/DA slots statewide became 13,200.
- County slot allocation ranges from 12 in Tyrrell to 548 in Mecklenburg.

Slot Utilization

- Of the13,200 CAP/DA slots, 88% are filled (1570 vacant slots)
- Average county slot utilization = 86%
- Range of county slot utilization = 33% - 104%

Slot Allocation Workgroup

- Institute of Medicine 2003 study - develop methodology to more equitably distribute services across the state.
- Slot Allocation Workgroup adopted a methodology in 2004 that:
  - Established a county base allocation correcting previous inequities, and
  - Distributed new slots based on percentage of the Medicaid aged, blind, and disabled recipients ≥ 18 years old in each county.
- Workgroup left door open to reallocate slots if counties did not utilize them.

Slot Allocation

- Counties received new slot allocations in July 2004 – some of the new slots were refused (119), which were reallocated among the remaining counties.
- County commissioners were encouraged by DHHS to provide all necessary resources to rebuild local CAP/DA programs - replace staff lost during the freeze and add new staff to manage the increased slots.

Slots and Waiting Lists

- Most counties fill slots by taking the individual at the top of the waiting list (first come- first served). Exception: individuals admitted to nursing facilities on or before June 1, 2004 have priority status.
- Counties determine own waiting list policies.
- Approximately 8,200 individuals on waiting lists statewide.
- Counties do not receive funds to administer waiting lists – an approved FL-2 required before services can be billed

CAP/DA Monitoring Activities

- Change in section management in 2004 – implementation of AQUIP (Automated Quality and Utilization Improvement Program) - automated assessment and plan of care tool
- Reliable data from this system is becoming available.
- AQUIP applies Resource Utilization Group (RUG) III to each CAP/DA assessment.
- RUG-III - a "grouper" that classifies recipients by their acuity level.

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RUG-III Grouper

RUG-III grouper aggregates acuity into seven major categories:

- Special Rehabilitation
- Extensive Services
- Special Care
- Clinically Complex
- Impaired Cognition
- Behavior Problems
- Reduced Physical Functions

Acuity levels are higher in top groups and lower in bottom groups.

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CAP/DA RUG Analysis

- 11% of CAP/DA recipients MAY not meet nursing facility level of care.

RUG Category	CAP/DA	Nursing Facility
Rehabilitation	1%	9%
Extensive Serv.	2%	2%
Special Care	9%	9%
Clinically Complex	23%	26%
Impaired Cognition	11%	11%
Behavior Problems	1%	1%
Reduced Physical Functions	53%	42%

12

2 years worth of data

CAP/DA RUG Analysis

- Are evaluating 1100+ CAP/DA recipients for medical necessity
- At conclusion CAP/DA participants will more closely reflect a population that meets the eligibility criteria.
- Reviews will be ongoing (monthly basis) to reinforce the eligibility parameters and waiver requirements.

13

CAP/DA Management Activities

- Amend and promulgate CAP/DA policy.
- Clarify and reinforce with lead agencies CAP/DA program eligibility and nursing facility level of care requirements.
- Take appropriate action for current participants who don't meet medical necessity.
- Continually assure CAP/DA recipients meet program requirements.
- Integrate CAP/DA program needs into other home and community services management initiatives

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Summary

- Focus on care management not slot management.
- Implement planned management activities:
  - Create a streamlined entry into long term care (uniform screening)
  - Create service packages to meet recipient needs without waiver restraints (Deficit Reduction Act)
  - Reimburse services based on acuity not on pre-determined budget limits (case mix reimbursement)

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Exhibit 2: Final Allocation of CAP/DA Slots for SFY 04-05

ATTACHMENT III

Alamance	113
Alexander	104
Alleghany	73
Anson	91
Ashe	187
Avery	213
Beaufort	135
Bertie	201
Bladen	164
Brunswick	70
Buncombe	289
Burke	285
Cabarrus	293
Caldwell	214
Camden	15
Carteret	119
Caswell	54
Catawba	183
Chatham	61
Cherokee	161
Chowan	60
Clay	56
Cleveland	162
Columbus	236
Craven	156
Cumberland	304
Currituck	26
Dare	16
Davidson	123
Davie	103
Duplin	140
Durham	163
Edgecombe	119
Forsyth	202
Franklin	118
Gaston	165
Gates	48
Graham	122
Granville	77
Greene	41
Guilford	376
Halifax	147
Harnett	123
Haywood	166
Henderson	80
Hertford	158
Hoke	104
Hyde	27
Iredell	209
Jackson	95
Johnston	86

Jones	51
Lee	120
Lenoir	106
Lincoln	133
Macon	79
Madison	39
Martin	71
McDowell	68
Mecklenberg	548
Mitchell	101
Montgomery	37
Moore	108
Nash	123
New Hanover	150
Northampton	88
Onslow	165
Orange	86
Pamlico	54
Pasquotank	82
Pender	138
Perquimans	34
Person	52
Pitt	141
Polk	60
Randolph	166
Richmond	89
Robeson	493
Rockingham	381
Rowan	202
Rutherford	112
Sampson	69
Scotland	153
Stanly	94
Stokes	90
Surry	161
Swain	78
Transylvania	45
Tyrrell	12
Union	95
Vance	58
Wake	420
Warren	33
Washington	73
Watauga	78
Wayne	40
Wilkes	208
Wilson	183
Yadkin	107
Yancey	93
Total	13,200

Study Commission on Aging
DRAFT Recommendations - Overview

4/4/06

Recommendation 1: Increase Adult Day Care Reimbursement Rates

The Study Commission on Aging recommends that the General Assembly appropriate funds to the Adult Day Care Fund and to the Home and Community Care Block Grant for a $5.00 per day rate increase for adult day care and adult day health care.

Recommendation 2: Increase CAP Awareness of Adult Day Health Options and Update

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Aging and Adult Services, and the Division of Medical Assistance, to provide education, and training if necessary, to ensure that case managers with the Community Alternatives Program (CAP) are aware of Adult Day Health Services and that this option is being considered in all situations appropriate for the client. The Department shall report by July 30, 2006, to the Study Commission on Aging on these efforts, and shall also provide a status report on changes implemented as a result of the Adult Day Services Study.

Recommendation 3: Health Care Personnel Registry

The Study Commission on Aging recommends that the General Assembly enact legislation and appropriate funding for staff support to expand the Health Care Personnel Registry to include unlicensed staff that have access to residents or clients and or their property and are employed in health care facilities as defined in G.S. 131E-256; and expand the definition of health care facilities to include all MH/DD/SAS day treatment programs, agencies and/or community service providers as defined in 10NCAN27G.0602(10), which includes unlicensed MH/DD/SAS community based services providers and multiunit assisted housing with services as defined in G.S. 131D-2(7a); and prohibit health care facilities defined under G.S. 131E-256 from hiring any person who has a substantiated finding on the Health Care Personnel Registry.

Recommendation 4: Telemonitoring Evaluation

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Medical Assistance, to evaluate the use telemonitoring equipment as a tool to improve the health of home-based individuals through increased monitoring and responsiveness resulting in increased stabilization rates and decreased hospitalization rates, the evaluation must include a representative number of older adults. The Department shall report to the Commission on the cost effectiveness of telemonitoring and the benefits to individuals and healthcare providers by August 1, 2007.

Recommendation 5: LTC Ombudsman

The Study Commission on Aging recommends that the General Assembly appropriate funding for 10 Long Term Care Ombudsman positions and related travel expenses.

Recommendation 6: NC NOVA Special Licensure Designation

The Study Commission on Aging recommends that the General Assembly enact legislation implementing the North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation in which long-term care providers may participate on a voluntary basis in an effort to improve recruitment, retention, development, and job satisfaction of the direct care workforce, and improve the care provided to long-term care clients, residents, and patients.

Recommendation 7: Housing

The Study Commission on Aging recommends that the General Assembly appropriate an additional $10 million dollars for the Housing Trust Fund with $4 million of the total amount going to the Urgent Repair Program to provide grants for emergency home repairs for elderly homeowners and other homeowners with special needs.

Recommendation 8: Posting of Fines and Penalties for LTC Facilities

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services direct the Division of Facility Services to post the fines and penalties assessed to long-term care facilities.

Recommendation 9: LTC Insurance Tax Credit

The Study Commission on Aging recommends that the General Assembly enact House Bill 118 or Senate Bill 37 Reenact Long-Term Care Insurance Tax Credit.

Recommendation 10: Medicaid Institutional Bias – CAP/DA Slots

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to review the CAP/DA program including slot distribution and re-distribution to ensure that the CAP/DA waiting list is managed as efficiently as possible, identification and alleviation of identified biases, implementation of a uniform screening/assessment tool, and other strategies to ensure maximum operational efficiency and effectiveness for those individuals qualifying for CAP/DA services, and to make an interim report to the Study Commission on Aging by August 30, 2006 and a final report by August 30, 2007.

Recommendation 11: Medicaid Institutional Bias – Recommendations to Address Biases

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to work with providers and advocates of home and community based services to review the North Carolina Institutional Bias Study Report prepared by The Lewin Group and to make recommendations on ways to address the biases identified in the report and to report to the Study Commission on Aging by October 15, 2006.

Recommendation 12: Additional Funds for Home and Community Care Block Grant

The Study Commission on Aging recommends that the General Assembly appropriate an additional $5 million in funding for the Home and Community Care Block Grant (HCCBG).

Study Commission on Aging
DRAFT Recommendations - Background

4/4/06

Recommendation 1: Increase Adult Day Care Reimbursement Rates

The Study Commission on Aging recommends that the General Assembly appropriate funds to the Adult Day Care Fund and to the Home and Community Care Block Grant for a $5.00 per day rate increase for adult day care and adult day health care.

Background 1:

On 1/4/06, the Commission heard presentations on Adult Day Services. The presentation included general information on both the social model and the health model as well a final report on the NC Adult Day Services Project. The Commission also toured the Total Life Center in Raleigh, which is a combination center offering both a social and health model.

There are 107 total Adult Day Care and Adult Day Health Care programs located in 58 counties. Of the 107 total programs: there are 50 Adult Day Care programs, 54 Adult Day Care/Adult Day Health combination programs and 3 Adult Day Health only programs. The current average cost for providing services in an Adult Day Care facility is $46.00 per day, the current reimbursement rate is $28.07. The reimbursement is $17.93 less than the average cost per day of providing services. The current average cost for providing services in an Adult Day Health Care facility is $53.00 per day, the current reimbursement rate is $35.00. The reimbursement is $18.00 less than the average cost per day of providing services.

According to Fiscal staff estimates, the cost estimate for a $5.00 per day rate increase is $1,043,750 in State funding.

Recommendation 2: Increase CAP Awareness of Adult Day Health Options and Update

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Aging and Adult Services, and the Division of Medical Assistance, to provide education, and training if necessary, to ensure that case managers with the Community Alternatives Program (CAP) are aware of Adult Day Health Services and that this option is being considered in all situations appropriate for the client. The Department shall report by July 30, 2006, to the Study Commission on Aging on these efforts, and shall also provide a status report on changes implemented as a result of the Adult Day Services Study.

Background 2:

On 1/4/06, the Commission heard presentations on Adult Day Services, including the health model. The Commission also heard a presentation on this date regarding the health services provided to CAP/DA participants as compared to health services provided at an adult day health care program.

The presentation on 1/4/06 included a report with recommendations which resulted from the study authorized by S.L. 2004-124, Sec. 10.21. The Division of Aging and Adult Services has begun work on some of the recommendations contained in the report. The above action will allow the Commission to monitor progress on report recommendations and track the status of adult day and adult day health programs.

Recommendation 3: Health Care Personnel Registry

Recommendation 3a:

The Study Commission on Aging recommends that the General Assembly enact legislation and appropriate funding for staff support to expand the Health Care Personnel Registry to include unlicensed staff that have access to residents or clients and or their property and are employed in health care facilities as defined in G.S. 131E-256; and

Recommendation 3b:

expand the definition of health care facilities to include all MH/DD/SAS day treatment programs, agencies and/or community service providers as defined in 10NCAN27G.0602(10), which includes unlicensed MH/DD/SAS community based services providers and multiunit assisted housing with services as defined in G.S. 131D-2(7a); and

Recommendation 3c:

prohibit health care facilities defined under G.S. 131E-256 from hiring any person who has a substantiated finding on the Health Care Personnel Registry.

Background 3:

On 1/18/06, the Commission heard a report in response to S.L. 2005-276, Section 10.40A(q). This legislation was based on a recommendation contained in the Commission's report to the 2005 General Assembly which stated, "The North Carolina Study Commission on Aging 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."

The Department presented to the Commission a report that included the following three recommendations:

1. The Health Care Personnel Registry should be expanded to include all unlicensed staff of health care facilities, as defined in G.S. 131E-256, which have access to residents or clients and or their property.
2. The Health Care Personnel Registry should be expanded to include the following health care facilities: Licensable facilities as defined in G.S. 122C-3(14)b which includes all MH/DD/SAS day treatment programs, agencies and/or community service providers as defined in 10 NCAC 27G.0602(10), which includes unlicensed MH/DD/SAS community based service providers and multiunit assisted housing with services as defined in G.S. 131D-2(7a).
3. Health Care Facilities as defined in G. S. 131E-256(b) shall not employ any person who has a substantiated finding on the Health Care Personnel Registry.

The Department estimates that they will need additional staff resources to process the increased number of allegation reports as a result of the expansion, and to manage expansions over the last five years. (The Department reports that in the last five years, allegations have increased 280% and there has been a 62% increase in cases needing investigations.) The Department estimates that it will need $1.7 million for: 18 investigator positions, 3 regional supervisor/investigator positions, and 6 administrative support positions.

Recommendation 4: Telemonitoring Evaluation

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Medical Assistance, to evaluate the use telemonitoring equipment as a tool to improve the health of home-based individuals through increased monitoring and responsiveness resulting in increased stabilization rates and decreased hospitalization rates, the evaluation must include a representative number of older adults. The Department shall report to the Commission on the cost effectiveness of telemonitoring and the benefits to individuals and healthcare providers by August 1, 2007.

Background 4:

On 2/1/06, the Study Commission on Aging heard a presentation on Home Health Telehealth. Telemonitoring equipment is capable of monitoring and conveying vital signs, providing patient education, and assisting individuals with medication compliance. A telemonitoring program could allow more frequent tracking of an individual's health status with a goal improved care through more immediate provider intervention, increased stabilization, and reduced hospitalization. The presentation was made by a representative from the Association of Home and Hospice Care of North Carolina and the Commission was asked to support legislation to implement telehome care in NC's Medicaid home health program to assist in controlling health care costs and to improve patient outcomes.

Recommendation 5: LTC Ombudsman

The Study Commission on Aging recommends that the General Assembly appropriate funding for 10 Long Term Care Ombudsman positions and related travel expenses.

Background 5:

During the 3/29/06 meeting, the Department provided budget information for the SFY 05-06 regional Long Term Care Ombudsman Program, full time equivalent (FTE) data, and cost estimates to align the program with national standards for long term care ombudsman coverage.

- Current Regional Ombudsman Funding:

Federal	State*	Local	Total
$1,509,512	$407,071	$212,952	$2,129,535

*State funding including state matching funds and $318,275 in recurring state appropriations.

- Currently, 27.6 long term care ombudsman FTEs serve 89,056 beds. This is a ratio of 1 to approximately 3,227 beds. The national standard is based on the 1995 report of the United States Institute on Medicine which recommends one (1) ombudsman for every 2,000 long term care beds.
- An additional 16.5 FTEs would be required to meet the benchmark of one (1) FTE per 2,000 beds. However, the estimated occupancy rate in 2004 for nursing facilities was 89.4% and was 79% for adult care homes and the estimate on the total number of occupied beds is 75,467. Therefore, one (1) FTE per 2,000 occupied beds would require 37.73 Long-Tem Care Ombudsman FTEs. There are currently 27.6 FTEs. Therefore, there need to be 10.13 additional FTEs in order to meet a one (1) FTE per 2,000 "occupied" beds benchmark.
- The Division of Aging and Adult Services estimates that $492,136 is the cost for salary, benefits, and travel for 10 FTEs. The average hiring rate based on information reported by the area agencies on aging equates to the hiring rate for a grade 70 state position.

Recommendation 6: NC NOVA Special Licensure Designation

The Study Commission on Aging recommends that the General Assembly enact legislation implementing the North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation in which long-term care providers may participate on a voluntary basis in an effort to improve recruitment, retention, development, and job satisfaction of the direct care workforce, and improve the care provided to long-term care clients, residents, and patients.

Background 6:

On 2/15/06, the Commission heard a presentation on the NC NOVA project. The presentation pointed out that NC has high turnover rates for direct care workers, with average annual rates in 2004 as follows: 106% in adult care homes, 107% in nursing homes, and 41% in home care agencies. The presentation also provided that direct care jobs are among the occupations with the largest projected job growth - it is anticipated that NC will need 30,590 additional direct care workers from 2002 to 2012.

The NC NOVA project is a voluntary special licensing award for home care agencies, adult care homes, and nursing homes. It has been funded thus far by The Robert Wood Johnson Foundation and The Atlantic Philanthropies. The Institute of the Future of Aging Services in Washington is the national program office. The focus of NC NOVA is workforce development and retention for direct care workers. Direct care workers include nurse aides, in-home aides/home health aides, and personal care aides/attendants. As of November 2004, the median hourly wage for the three major job categories is as follows:

Home Health Aides:	$8.22	(median hourly wage)
Nurse Aides, Orderlies, Attendants:	$9.59	(median hourly wage)
Personal and Home Care Aides:	$8.06	(median hourly wage)
	$8.83	(weighted median hourly wage across categories)

The weighted median hourly wage across the same three categories for 2004 was $8.83, and for 2003 it was: $8.67

The NC NOVA project is an incentive/reward based program with uniform criteria across long-term care settings. NC NOVA is currently being piloted in 60 sites: 20 adult care homes, 20 nursing homes, and 20 home health agencies. The pilot phase lasts from July 2005 until May 2006. Review will be conducted by the Carolinas Center for Medical Excellence and a special license is issued for entities obtaining the NC NOVA designation. It is anticipated that NC NOVA will benefit providers, workers and consumers. Legislation is needed to allow statewide implementation in early 2007. State funds are not needed as the grant contains sufficient funds for operation in FY 2006-2007.

Recommendation 7: Housing

The Study Commission on Aging recommends that the General Assembly appropriate an additional $10 million dollars for the Housing Trust Fund with $4 million of the total amount going to the Urgent Repair Program to provide grants for emergency home repairs for elderly homeowners and other homeowners with special needs.

Background 7:

On 2/15/06, the Commission heard a presentation on housing. The presentation provided that according to HUD's special tabulations of 2000 Census data: 41% of elderly renter households had a housing problem (40% were cost-burdened, 20% were severely cost-burdened), and 23% of elderly home-owning households had a housing problem (22.5% were cost-burdened, 10% were severely cost-burdened.) The Commission received information on a number of housing programs, one of which was the Urgent Repair Program.

The Urgent Repair Program provides grants for emergency home repairs for elderly homeowners and other homeowners with special needs (with income restrictions). Funds may also be used for accessibility modifications. The Program is financed through the NC Housing Trust Fund and other agencies. The North Carolina Housing Finance Agency awards funds to nonprofit organizations, local governments and regional councils for the Urgent Repair Program. In 2005, 543 elderly homeowners received assistance through the program and the average cost per household was $3,359.

Recommendation 8: Posting of Fines and Penalties for LTC Facilities

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services direct the Division of Facility Services to post the fines and penalties assessed to long-term care facilities.

Background 8:

On 3/15/06, the Commission heard a presentation on fines and penalties in long-term care facilities presented by the Division of Facility Services, DHHS. The Commission learned that fines and penalties assessed to long-term care facilities are not currently posted in a location accessible to the public.

The Department has indicated that they are researching a way to post penalties for the public's use on the Department's website.

Recommendation 9: LTC Insurance Tax Credit

The Study Commission on Aging recommends that the General Assembly enact House Bill 118 or Senate Bill 37 Reenact Long-Term Care Insurance Tax Credit.

Background 9:

The Commission recommended the Long-Term Care Insurance Tax Credit in 1997 and 1998. G.S. 105-151.28 Credit for premiums paid on long-term care insurance was enacted in 1998. 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. In 2003 and 2004, the Commission recommended repealing the sunset.

The Commission's report to the 2005 General Assembly, the North Carolina Study Commission on Aging recommended that the General Assembly re-enact the Long-Term Care Insurance Tax Credit. As a result, House Bill 118 Reenact Long-Term Care Insurance Tax Credit was introduced in the House and referred to the House Committee on Finance on 2/9/05. Senate Bill 37 Reenact Long-Term Care Insurance Tax Credit was introduced in the Senate and referred to the Senate Committee on Finance on 2/3/05.

Recommendation 10: Medicaid Institutional Bias – CAP/DA Slots

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to review the CAP/DA program including slot distribution and re-distribution to ensure that the CAP/DA waiting list is managed as efficiently as possible, identification and alleviation of identified biases, implementation of a uniform screening/assessment tool, and other strategies to ensure maximum operational efficiency and effectiveness for those individuals qualifying for CAP/DA services, and to make an interim report to the Study Commission on Aging by August 30, 2006 and a final report by August 30, 2007.

Background 10:

On 1/4/06 and on 3/29/06, the Commission heard presentations on the Medicaid institutional Bias Study. This study was mandated by Section 10.3 of S.L. 2004-124 for the purpose of identifying any bias that favors support for individuals in institutional settings over support for individuals living at home. During these two meetings, the Commission had a number of questions concerning CAP/DA slots and the waiting list for slots. Based on information shared by the Department, there are 13,200 CAP/DA slots for SFY 04-05. There is a waiting list of 8,196 individuals that need a CAP/DA slot.

Bias #6 contained in The Lewin Group's report stated that, "Enrollment caps (in CAP/DA) limit the number of people who can access care in the community." Bias # 7 stated that, "There is no differentiation of need on the CAP/DA wait list." Bias #8 provided that, "There is an inconsistent allocation of CAP/DA slots. Individuals may wait for waiver services in one county while other counties have unused waiver slots.

The Commission wondered whether there was a way to prioritize the wait list based on risk of institutionalization. The Division of Medical Assistance indicated that a uniform screening/assessment tool and the related automated business processes are currently being designed. The Division anticipates that upon completion, this will create a central point of entry for all individuals in need of Medicaid long term care. It is also anticipated that the process would facilitate an "upfront" determination of long term care needs and the best options for meeting those needs. Further, the Division indicates that the CAP/DA clinical coverage policy is currently being amended to prohibit certain individuals from being placed on waiting lists including:

- CAP-DA Clients transferring from other counties;
- Individuals transferring from other waiver programs (CAP/C and CAP/AIDS);
- Individuals being discharged from hospitals or nursing facilities; and
- And Individuals transferring from Medicaid's Private Duty Nursing services.

Commission requested a subsequent presentation on slot allocation and related issues during the meeting on April 4, 2006.

Recommendation 11: Medicaid Institutional Bias – Recommendations to Address Biases

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to work with providers and advocates of home and community based services to review the North Carolina Institutional Bias Study Report prepared by The Lewin Group and to make recommendations on ways to address the biases identified in the report and to report to the Study Commission on Aging by October 15, 2006.

Background 11:
On 1/4/06 and on 3/29/06, the Commission heard presentations on the Medicaid Institutional Bias Study. This study was mandated by Section 10.3 of S.L. 2004-124 for the purpose of identifying any bias that favors support for individuals in institutional settings over support for individuals living at home. In response to The Lewin Group's report, in a letter dated 3/29/06, Secretary Hooker Odom indicated that the Department was in the process of addressing a number of areas where additional work is needed. The Commission is interested in exploring The Lewin Group's report and possible solutions further and believes it would be productive for the Department to work with providers during the legislative session and report to the Commission next interim.

Recommendation 12: Additional Funds for Home and Community Care Block Grant

The Study Commission on Aging recommends that the General Assembly appropriate an additional $5 million in funding for the Home and Community Care Block Grant (HCCBG).

Background 12:
Preserve and expand the Home and Community Care Block Grant (HCCBG) was one of the most frequently mentioned issues during the public hearings conducted by the Commission. Preserve and Expand Senior Center Funding and Support for In-Home and Community Based Services are two other areas mentioned with great frequency, and both are eligible for funding under the HCCBG.

The HCCBG, established by G.S.143B-181.1(a)(11), is the consolidation of 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 includes federal funds, State funds, local funds, and a consumer contribution component. It gives counties greater discretion, flexibility and authority in determining services, service levels and service providers; and streamlines and simplifies the administration of services.

With input from older adults, County Commissioners approve an annual funding plan that defines services to be provided, the funding levels for these services, and the community service agencies to provide these services. Counties can select from among 18 eligible services including: 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, Institutional Respite Care, Mental Health Counseling, Senior Center Operations, Senior Companion, Skilled Home (Health) Care, Transportation, and Volunteer Program Development. Counties make the decision on which services to provide, however congregate nutrition and home-delivered meals are provided in almost every county under the HCCBG.

Any person age 60 and older is eligible for services under the HCCBG. Although, 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).

The focus of the HCCBG is to support the frail elderly in their preference to be cared for at home; improve and maintain the physical and mental health of older adults; assist older adults and their caregivers with accessing services and information; provide relief to family caregivers so that they can continue their caregiving; and allow older adults to remain actively engaged with their communities.

According to Fiscal staff, in 2003, $1,000,000 was cut from the HCCBG. In 2004, $800,000 was appropriated for HCCBG - $460,000 of which was to increase by $5, the daily Adult Day Care and Adult Day Health Care funded by the HCCBG and $340,000 remaining for the rest of HCCBG.

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — April 4, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Teresa Johnson	NC Adult Day Services Association
Dennis Streets	NC Div. of Aging + Adult Services
Mary Edwards	NC DAAS
Bill Wilson	AARP NC
Sandra Truvett	DHHS — OPP
JESSE GOODMAN	DHHS - DFS
TRACY COLVARD	DHHS- DMA
Susan Aamuth	NC NOVA
Darlene Creech	NC DMA - DHHS
Lynne Perrin	" " "
Jim Edgerton	AHHC

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — April 4, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Polly Williams	NC Justice Center / Triangle Older Women's League
Stacy Flannery	NCHCFA
Wellie Brantley	DAAS - DHHS
Dick Hatch	AARP / NC Coalition on Aging
Kari Barsness	OSBM
Johny Fitts	Fitts Hall
Evelyn Hawthorne	NCHCFA
Abby Emanuelson	NMSS
Ted Bone	Bone & Assoc.
Joanne Stevens	nursing NCNA
Roger Bone	Bone & Assoc.

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — April 4, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Boardish	AstraZeneca

North Carolina Study Commission On Aging

Legislative Building 16 West Jones Street Raleigh, NC 27601

August 30. 2006

MEMORANDUM

TO: **Members, NC Study Commission on Aging**

FROM: **Senator Charlie Dannelly, Co-Chair**
Representative Beverly Earle, Co-Chair

SUBJECT: **Meeting Notice**

There will be a meeting of the NC Study Commission on Aging:

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

DATE: **September 12, 2006**

LOCATION: **Room 643**
Legislative Office Building

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Tuesday, September 12, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Overview of 2006 Legislation Related to Aging

Shawn Parker, Commission Staff, Research Division, NCGA

Overview of 2006 Budget Items Related to Aging

Carol Shaw, Commission Staff, Fiscal Research Division, NCGA

III. Status of 2006 Study Commission Recommendations

Theresa Matula, Commission Staff, Research Division, NCGA

IV. Tentative Meeting Dates

Theresa Matula, Commission Staff, Research Division, NCGA

V. Next Meeting:

September 27, 2005 at 10:00 a.m. in Room 643

North Carolina Study Commission on Aging

MINUTES
Tuesday, September 12, 2006
10:00 AM
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Tuesday, September 12, 2006, at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were: Senator Charlie Dannelly, Co-Chair, Rep. Beverly Earle, Co-Chair; Senators Austin Allran, Stan Bingham, and Katie Dorsett; Representatives Alice Bordsen, Debbie Clary, Bob England, and Jennifer Weiss; Mr. Sam Marsh, Ms. Judy Pelt and Ms. Linda Howard. Mr. Jackie Sheppard, Ex-Officio Member, was also present.

Senator Charlie Dannelly presided. He welcomed the members and introduced Senator Katie Dorsett as the replacement for Senator Julia Boseman. Each member then introduced themselves to Sen. Dorsett.

PRESENTATIONS

Overview of 2006 Legislation Related to Aging

Mr. Shawn Parker, Aging Commission Staff, NCGA Research Division, was the first presenter. He provided members with a handout entitled Summary of Substantive Legislation Related to Aging. (Attachment 1) Following is a brief list of legislation discussed.

- S.L. 2066-66, Sec. 10.1 amends S.L. 2005-276, Section 10.40A(p), to require the progress report on the Quality Home Improvement Consultation Program on or before January 1, 2007.
- S.L. 2006-66, Sec. 10.5 repeals GS 108A-5B and enacts GS 108A-58.1 to update provisions on ineligibility for Medicaid assistance based on transfer of assets for less than fair market value.
- S.L. 2006-66, Sec. 10.7A expands the scope of the Community Care of NC care management model.
- S.L. 2006, Sec. 10.9 revises the implementation date of the Health Coverage for Workers with Disabilities Act to become effective July 1, 2007.

- S.L. 2006-66, Sec. 10.9D directs DHHS to study issues relating to the provision of pharmacy services to Medicaid recipients enrolled in Medicare Part D and to develop strategies to assist pharmacists to provide services to the population.
- S.L. 2006-66, Sec. 10.10 directs DHHS to develop a NC Long-Term Care Partnership Program to reduce future Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid.
- S.L. 2006-66, Sec. 10.30 requires that the independent and supportive living apartments for persons with disabilities must be affordable to persons with incomes at the Supplemental Security Income level.
- S.L. 2006-156 allows DHHS to use funds appropriated for the 2006-07 fiscal year to increase the maximum number of assignments to the special assistance in-home program to 1500 persons.
- S.L. 2006-179 increases from Class 1 to Class A1 the penalty for committing assault or battery upon a handicapped person.
- S.L. 2006-197 directs the Justus-Warren Heart Disease and Stroke Prevention Task Force to establish and maintain a Stroke Advisory Council.

Mr. Parker told Commission members that there were also a number of studies established.

- The Legislative Research Commission my study issues related to the regulation of pharmacy benefit management.
- The Joint Legislative Health Care Oversight Committee is allowed to study issues related to geriatric care providers, the feasibility of establishing a prescription drug cost management office, rural health care access and needs, the state fair Housing Act and to study no-fault compensation for injuries to elderly and disabled persons.

Overview of 2006 Budget Items Related to Aging

Ms. Carol Shaw, Commission Staff, NCGA Fiscal Research Division, gave a presentation on budget items. She furnished members with a handout entitled Budget Actions Affecting Older Adults – FY 2006-07 and gave details on each figure and which department each affects. (Attachment 2)

Ms. Shaw stated that there was over $10 million appropriated for housing for disabled persons and funding for the Housing Trust Fund was increased by $5 million. Both of these items were left off the list and could potentially affect the elderly.

Representative Earle asked for a breakdown of the $12 million for inflationary increases for Medicaid providers. Ms. Shaw stated that the Division of Medical Assistance is to report to the commission in November or December. She also stated that she would get the breakdown of what the money in items 7 & 8 will be used specifically for. See Attachment 2, Items 7 & 8.

Senator Allran asked if the $5 increase in adult day care rates would cover the full cost. Ms. Theresa Matula stated that the increase will not cover the actual costs but it will help.

Status of 2006 Study Commission Recommendations

Ms. Theresa Matula, Commission Staff, NCGA Research Division, furnished members with a handout entitled 2006 Recommendation Status Report. Please see Attachment 3 for a listing of 12 recommendations and the result achieved during the 2006 Session of the NCGA. Ms. Matula told Commission members that 8 out of 12 recommendations were enacted.

Senator Bingham asked about the status of the telemonitoring pilot program. Ms. Matula stated that implementation is not required until October 1, 2006. The commission is scheduled to receive a report in August of 2007. Mr. Jim Edgerton with the Association of Home & Hospice Care told Commission members that the program has been done in other states and is being done for private insurers. He stated that Baptist Hospital did a study last year of 33 chronically ill patients who were placed on the system. Admissions were reduced by 30% and the length of stay in the hospital reduced by 60%. Mr. Edgerton further stated that DHHS Medicaid Division has formed a task force to study the issue.

Tentative Meeting Dates

Ms. Matula continued by handing out a list of potential future meeting dates for the Commission. She informed members that the November 29th date may be shifted or eliminated. (Attachment 4)

Ms. Matula also mentioned the letter from the Co-Chairs to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Services Co-Chairs relative to renewing the effort of focusing on the mentally ill in long term care facilities. The letter mentioned working together on this and other issues. (Attachment 5) Rep. Earle mentioned that there may be a subcommittee formed of Mental Health Oversight members and 4 members from the Aging Commission.

The meeting adjourned at 11:15am.

Charlie S. Dannelly

Senator Charlie Dannelly, Co-Chair
Presiding

Beverly Earle

Rep. Beverly Earle, Co-Chair

Dee Hodge

Dee Hodge
Commission Assistant

ATTACHMENT 1

Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2006 Session

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

Enacted Legislation

Change Progress Report Date: Quality Improvement Consultation Program for Adult Care Homes

S.L. 2006-66, Sec. 10.1 (SB 1741, Sec. 10.1), amends S.L. 2005-276, Section 10.40A(p), to require the progress report on the Quality Home Improvement Consultation Program on or before January 1, 2007, (previously April 1, 2006). The report must be submitted to the Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and to the House of Representatives Subcommittee on Health and Human Services, and must address the following topics:

- Principles and philosophies that are resident-centered and promote independence, dignity, and choice for residents;
- Approaches to develop continuous quality improvement with a focus on resident satisfaction and optimal outcomes;
- Dissemination of best practice models that have been used successfully elsewhere;
- A determination of the availability of standardized instruments, and their use to the extent possible, to assess and measure adult care home performance according to quality of life indicators;
- Utilization of quality improvement plans for adult care homes that identify and resolve issues that adversely affect quality of care and services to residents. The plans include agreed upon time frames for completion of improvements and identification of needed resources;
- Training required to equip county departments of social services' staff to implement the Program;
- A distinction of roles between the regulatory role of the Department's Division of Facility Services and the quality improvement consultation and monitoring responsibilities of the county departments of social services; and
- Identification of staffing and other resources needed to implement the Program.

Transfer of Assets Rewrite

S.L. 2006-66, Sec. 10.5 (SB 1741, Sec. 10.5)Repeals GS 108A-58 and enacts GS 108A-58.1 to update provisions on ineligibility for Medicaid assistance based on transfer of assets for less than fair market value. Incorporates provisions provided by federal law. Allows waiver of penalty if Department determines it would impose an undue hardship.

Pilot Projects to Control Cost and Improve Quality of Care for Aged, Blind, and Disabled Medicaid Recipients

S.L. 2006-66, Sec. 10.7A (SB 1741, Sec. 10.7A) expands the scope of the Community Care of NC care management model, to provide that the initiatives may include pilot projects to control costs and improve care for the aged, blind, and disabled recipients of Medicaid. Also amends section 10.14 of SL 2005-276 to authorize use of funds for grants through the Office of Rural Health and Community Care for cost containment programs

Extend Effective Date on Changes to Liens on Real Property for Purposes of Estate Recovery Under Medicaid

S.L. 2006-66, Sec. 10.9 (SB 1741, Sec. 10.9) revises the implementation date of the Health Coverage for Workers with Disabilities Act, which was created by Section 10.18 of S.L. 2005-276. The section of the act calling for its implementation will now become effective on July 1, 2007.

DHHS to Study Strategies to Offset the Cost to Pharmacists of Providing Service to Medicaid Recipients Enrolled in Medicare Part D

S.L. 2006-66, Sec. 10.9D (SB 1741, Sec. 10.9D) directs the Department of Health and Human Services to study issues relating to the provision of pharmacy services to Medicaid recipients enrolled in Medicare Part D and to develop strategies to assist pharmacists to provide services to this population. Specific items to be addressed include the special circumstances of pharmacists providing services to long-term care facilities and the impact of the Deficit Reduction Act of 2005 on the payment for generic drugs under Medicaid. Findings and recommended strategies will be reported not later than April 1, 2007 to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

Private-Public Long-Term Care Partnership Program

S.L. 2006-66, Sec. 10.10 (SB 1741, Sec. 10.10), directs the Department of Health and Human Services to develop a North Carolina Long-Term Care Partnership Program in an effort to reduce future Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid. The Department must structure the program in accordance with federal laws and guidelines for qualified State long-term care partnerships. Prior to submitting the Program for federal approval of the State Plan amendment, the Department must submit the proposed Program 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. The Program is prohibited from becoming effective until it is reviewed in accordance with this section.

Independent-And Supportive-Living Apartments Initiative

S.L. 2006-66, Sec. 10.30 (SB 1741, Sec. 10.30), requires that the independent and supportive living apartments for persons with disabilities constructed from funds appropriated in this act must be affordable to persons with incomes at the Supplemental Security Income level. The section further provides that if the North Carolina Housing Finance Agency is able to finance the apartments for less than the amount appropriated, any remaining funds, as well as any interest earned on the amount appropriated, may be used to finance additional apartments, group homes, and transitional housing for individuals with disabilities.

Special Assistance In-Home Assignments

S.L. 2006-156 (HB 2576) allows the Department of Health and Human Services to use funds appropriated for the 2006-2007 fiscal year to increase the maximum number of assignments to the special assistance in-home program to 1,500 persons.

Assault Handicapped/Increase Penalty

S.L. 2006-179 (SB 488) increases from Class 1 to Class A1 the penalty for committing assault or battery upon a handicapped person. The range of punishment for a Class 1 misdemeanor is a minimum of 1-45 days of community service with a maximum of up to 120 days active, depending on the person's prior record. The range of punishment for a Class A1 misdemeanor is 1-150 days, with the possibility of an active sentence even if the person has no prior convictions.

This act becomes effective December 1, 2006, and applies to offenses committed on or after that date.*

Stroke Advisory Council

S.L. 2006-197 (HB 1860) directs the Justus-Warren Heart Disease and Stroke Prevention Task Force to establish and maintain a Stoke Advisory Council. The Council will advise the Task Force regarding the development of a statewide system of stroke care.

Studies

Legislative Research Commission

Pharmacy Benefits Manager

The Legislative Research Commission may study issues regarding the regulation of pharmacy benefit management.

Joint Legislative Health Care Oversight Committee

Geriatric Care Providers

The Joint Legislative Health Care Oversight Committee to study the methods of increasing the number of geriatric care providers in the State.

Prescription Drug Cost Management Office

The Committee may study the feasibility of establishing an Office for Prescription Drug Cost Management ("Office") in the Department of Administration or other appropriate State agency to manage the cost of prescription drugs incurred by State agencies and programs that cover or provide prescription drugs. The responsibilities of the Office shall include negotiating prescription drug price discounts with participating pharmaceutical manufacturers and pharmacists for prescription drugs paid for, in whole or in part, with State funds.

Rural Health Care Access and Needs

The Committee may study, in consultation with the Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development, the health care needs in rural areas of the State and other health professional shortage areas of the State without inpatient services and with a high percentage of uninsured residents

State Fair Housing Act Study

The North Carolina Human Relations Commission is required to study whether the State Fair Housing Act should be amended to make it an unlawful discriminatory housing practice to refuse to enter into a residential real estate transaction with a person based upon the fact that the person receives public assistance due to age or physical or mental disability. The Commission shall report its findings and recommendations to the 2007 General Assembly upon its convening.

Study No-Fault Compensation for Injuries to Elderly and Disabled Persons

The Commissioner of Insurance, the North Carolina Industrial Commission and the Department of Health and Human Services may jointly study the utility, efficacy, and advisability of creating a system of no-fault compensation, with such compensation based on scheduled amounts and subject to limits on total compensation paid, for injuries resulting from regular and ordinary course of care provided at nursing homes, homes for the elderly, other long-term care facilities, and assisted living facilities. If the study is conducted, the findings and recommendations must be presented to the 2007 General Assembly upon its convening.

Study Commission on Aging Recommendations

NC NOVA-Special Voluntary Licensure Designation

S.L. 2006-104 (SB 1277) establishes the North Carolina New Organizational Vision Award (NC NOVA). NC NOVA is a voluntary special licensure designation that will be rewarded to adult care homes, home care agencies, and nursing homes that have been determined through written and on-site review, by an independent review organization, to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff, and the care provided to long-term care clients and residents. The NC NOVA program will be implemented by the Department of Health and Human Services.

Adult Day Awareness/Status of Study Recommendations

S.L. 2006-108 (SB 1278) directs the Department of Health and Human Services to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health programs, and requires the Department to make a status report on the Partners in Caregiving study recommendations. The Department is required to report on the status of its activities under this act to the North Carolina Study Commission on Aging not later than July 30, 2006.

Pilot Program to Evaluate Telemonitoring in Equipment in Home Care Services

S.L. 2006-66, Sec. 10.9C (SB 1741, Sec. 10.9C), authorizes the Department of Health and Human Services, Division of Medical Assistance to implement a pilot program to evaluate the use of telemonitoring equipment. The evaluation will include a representative number of older adults and shall focus on whether or not the use of this equipment results in decreased hospital rates and increased stabilization rates for home-based individuals. The section requires the Department to report its findings to the Study Commission on Aging, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division by July 1, 2007.

Note: Also see the summary in this Chapter of S.L. 2006-194 (SB 1280) DHHS Evaluate Telemonitoring/Home Care Licenses.

CAP/DA Review and Report

S.L. 2006-109 (SB 1276) requires the Department of Health and Human Services to review and report on the Community Alternatives Program for Disabled Adults (CAP/DA) in response to the institutional bias report. The report must include actions taken and planned by the Department in response to each bias identified in the institutional bias study. The inclusion of the following information is also required in the report:

Information on the utilization of CAP/DA slots, including a history of slots used per year over the last 10 years and the anticipated need during the next 10 years.

A description of the CAP/DA slot allocation formula; and a breakdown of slots by county, including the reallocation of any unused slots.

Strategies to ensure that the CAP/DA waiting list is managed as efficiently as possible, including consideration of whether there should be an expiration date tied to unused slots so that they may be reallocated in a timely manner to areas with waiting lists.

Implementation of a uniform screening/assessment tool and other strategies to ensure maximum operation efficiency and effectiveness for those individuals qualifying for CAP/DA services. This should include information on whether the lists should be prioritized by risk of institutionalization.

The Department must submit an interim report to the NC Study Commission on Aging on or before August 30, 2006, and a final report on or before August 30, 2007.

Review of NC Institutional Bias Report

S.L. 2006-110 (SB 1279) directs the Department of Health and Human Services to collaborate with providers and advocates of home and community-based services to make recommendations addressing the biases identified in the institutional bias report prepared by The Lewin Group. (Institutional bias refers to the policies and practices within Medicaid that make it easier for a beneficiary to access institutional care than services in home and community based settings.)

The Department is required to report its findings and recommendations to the NC Study Commission on Aging on or before October 15, 2006.

DHHS Evaluate Telemonitoring/Home Care Licenses

S.L. 2006-194 (SB 1280) requires the Department of Health and Human Services, Division of Medical Assistance to evaluate the use of telemonitoring equipment for home and community-based recipients by establishing a pilot program to be implemented by October 1, 2006. The Division of Aging will determine an appropriate remuneration to home care agencies participating in the pilot. The evaluation will include a representative number of older adults and shall focus on whether or not the use of this equipment results in decreased hospital rates and increased stabilization rates for home and community-based recipients and requires the Department to report its findings to the Study Commission on Aging by August 1, 2007.

This act also implements a one-year moratorium, beginning January 1, 2007, on the licensing of new home care agencies offering in home aide services. However, the moratorium does not prevent the Department from issuing licenses to certified home health agencies or to agencies that need a new license for an existing home care agency being acquired.

Note: Also see the summary in this Chapter of S.L. 2006-66, Sec. 10.9C (SB 1741, Sec. 10.9C), DHHS Pilot Program to Evaluate Telemonitoring in Equipment in Home Care Services.

Long Term Care Quality Improvement Program/Long Term Care Ombudsman Positions

S.L. 2006-221, Sec. 13B (SB 198, Sec. 13B) clarifies that of the funds appropriated to the Department of Health and Human Services for Long Term Care Quality Improvement must be allocated to the Area Agencies on Aging to support eight regional long term care ombudsman positions including benefits and travel and $100,000 for a contract for the Quality Improvement Program authorized in S.L. 2005-276, Section 10.40A(p). This section clarifies that the long term care ombudsman positions are not State positions.

** Trina Griffin contributed to the summary of SB 488*

ATTACHMENT 2

Budget Actions Affecting Older Adults
FY 2006-07

Division of Aging and Adult Services	FY 2006-07
1. **Home and Community Care Block Grant** Provides increased recurring funding for the Home and Community Care Block Grant.	$4,000,000
2. **Long-Term Care Quality Improvement** Provides recurring funding for eight long-term care ombudsman positions and $1000,000 for a contract for the Quality Improvement Program authorized in Section 10.40A(p) of S.L. 2005-276.	$492,136
3. **Adult Day Care Rates** Provides recurring funding to increase the daily rates adult day care and adult day Health care programs by $5.	$1,043,750
Division of Social Services	
4. **State/County Special Assistance Rate Adjustment** Provides recurring funding to increase in the State/County Special Assistance monthly rate from $1,118per month to $1,148 per month effective January 1, 2007.	$2,400,000
5. **Food Banks** Provides nonrecurring funding to be equally distributed to the regional network of food banks in North Carolina.	$750,000
Division of Medical Assistance	
6. **Inflationary Increases for Medicaid Providers** Provides funding for inflationary increases for Medicaid providers effective January 1, 2007. Skilled nursing facilities and in-home service providers are also eligible for inflationary increases.	$12,000,000
7. **Reimbursement Rates for Skilled Nursing Facilities** Provides funding to adjust case-mix reimbursement rates for skilled nursing facilities effective January 1, 2007.	$1,500,000
8. **Rate Adjustment for In-Home Services** Provides funding for rate increases for home-health and personal care service providers effective January 1, 2007.	$1,500,000

2006 Recommendation Status Report

North Carolina Study Commission on Aging
Recommendations
to the
2005 North Carolina General Assembly, 2006 Regular Session

Prepared by Staff for the
North Carolina Study Commission on Aging

September 12, 2005

2006 RECOMMENDATION STATUS REPORT

RECOMMENDATION	RESULT
Recommendation 1: Increase Adult Day Care Reimbursement Rates The Study Commission on Aging recommends that the General Assembly appropriate funds to the Adult Day Care Fund and to the Home and Community Care Block Grant for a $5.00 per day rate increase for adult day care and adult day health care.	In response to this recommendation, SB 1270 and HB 2058 were introduced and both were referred to House and Senate Appropriations Committees. • The General Assembly provided $1,043,750 in recurring funding for an increase in the daily rates for adult day care and adult day health care programs by $5.00. Of the total funds, $556,556 was allocated to the State Adult Day Care Fund and $487,194 was allocated to the Home and Community Care Block Grant Program.
Recommendation 2: Increase CAP Awareness of Adult Day Health Options and Update The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Aging and Adult Services, and the Division of Medical Assistance, to provide education, and training if necessary, to ensure that case managers with the Community Alternatives Program (CAP) are aware of Adult Day Health Services and that this option is being considered in all situations appropriate for the client. The Department shall report by July 30, 2006, to the Study Commission on Aging on these efforts, and shall also provide a status report on changes implemented as a result of the Adult Day Services Study.	In response to this recommendation, SB 1278 and HB 2054 were introduced. • Senate Bill 1278 was enacted and S.L. 2006-108 directs the Department of Health and Human Services to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health programs, and requires the Department to make a status report on the Partners in Caregiving study recommendations. The Department is required to report on the status of its activities under this act to the North Carolina Study Commission on Aging not later than July 30, 2006. The act became effective July 13, 2006.
Recommendation 3: Health Care Personnel Registry The Study Commission on Aging recommends that the General Assembly enact legislation and appropriate funding for staff support to expand the Health Care Personnel Registry to include unlicensed staff that have access to residents or clients and or their property and are employed in health care facilities as defined in G.S. 131E-256; and expand the definition of health care facilities to include all MH/DD/SAS day treatment programs, agencies and/or community service providers as defined in 10A NCAC 27G.0602(10)(b), which includes unlicensed MH/DD/SAS community based services providers and multiunit assisted housing with services as defined in G.S. 131D-2(7a); and prohibit health care facilities defined under G.S. 131E-256 from hiring any person who has a substantiated finding on the Health Care Personnel Registry.	In response to this recommendation, SB 1275 and HB 2050 were introduced. • SB 1275 was referred to the Senate Committee on Health Care. In the Senate Committee on Health care, a committee substitute for SB 1275 was adopted and once reported in, the bill referred to the Senate Committee on Appropriations/Base Budget. • HB 2050 received a favorable report in the House Committee on Aging and was referred to the House Committee on Appropriations.

RECOMMENDATION	RESULT
Recommendation 4: Telemonitoring Evaluation The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Medical Assistance, to evaluate the use of telemonitoring equipment as a tool to improve the health of home-based individuals through increased monitoring and responsiveness resulting in increased stabilization rates and decreased hospitalization rates, the evaluation must include a representative number of older adults. The Department shall report to the Commission on the cost effectiveness of telemonitoring and the benefits to individuals and healthcare providers by August 1, 2007.	In response to this recommendation, SB 1280 and HB 2053 were introduced. • S.L. 2006-66, Sec. 10.9C (SB 1741, Sec. 10.9C), *allows* the Department of Health and Human Services, Division of Medical Assistance to implement a pilot program to evaluate the use of telemonitoring equipment in home care services and community-based long-term care services. The program must include a representative number of older adults and must evaluate the use of telemonitoring equipment as a tool to improve the health of home care clients and community-based long-term care clients through increased monitoring and responsiveness, and resulting in increased stabilization rates. The section requires the Department to report on the implementation of the pilot program and its findings on the cost-effectiveness of telemonitoring and the benefits to individuals and health care providers. The report must be made to the Study Commission on Aging, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division by July 1, 2007. This section became effective July 1, 2006. • Additionally, Senate Bill 1280 was enacted and varies from the above provision. S.L. 2006-194 *requires* the Department of Health and Human Services, Division of Medical Assistance, to implement a pilot program to evaluate the use of telemonitoring equipment in home and community based services and requires the Division to determine *remuneration* to home care agencies and other providers for participation. The program must include a representative number of older adults, be implemented by October 1, 2006, and evaluate the use of telemonitoring equipment as a tool to improve the health of home and community based recipients through increased monitoring and responsiveness, and resulting in increased stabilization rates and decreased hospitalization rates. The Department shall report to the Study Commission on Aging by August 1, 2007 and the report must include findings and recommendation on the cost-effectiveness of telemonitoring and the benefits to individuals and health care providers. The act also implements a one-year moratorium, beginning January 1, 2007, on the licensing of new home care agencies offering in-home aide services. However, the moratorium does not prevent the Department from issuing licenses to certified home health agencies or to agencies that need a new license for an existing home care agency being acquired. This act became effective August 3, 2006.

RECOMMENDATION	RESULT
Recommendation 5: LTC Ombudsman The Study Commission on Aging recommends that the General Assembly appropriate funding for 10 Long Term Care Ombudsman positions and related travel expenses.	In response to this recommendation SB 1271 and HB 2057 were introduced. • SB 1271 was referred to the Senate Committee on Appropriations/Base Budget. • HB 2057 was referred to the House Committee on Appropriations. • The General Assembly provided $492,136 in recurring funding for eight long-term care ombudsman positions including benefits and travel and $100,000 for a contract for the Quality Improvement Program authorized in Section 10.40A(p) of S.L. 2005-276. Additionally, S.L. 2006-221, Sec. 13B (SB 198, Sec. 13B) clarifies that of the funds appropriated to the Department of Health and Human Services for Long Term Care Quality Improvement must be allocated to the Area Agencies on Aging to support eight regional long term care ombudsman positions including benefits and travel and $100,000 for a contract for the Quality Improvement Program authorized in S.L. 2005-276, Section 10.40A(p). This section also clarifies that the long term care ombudsman positions are not State positions.
Recommendation 6: NC NOVA Special Licensure Designation The Study Commission on Aging recommends that the General Assembly enact legislation implementing the North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation in which long-term care providers may participate on a voluntary basis in an effort to improve recruitment, retention, development, and job satisfaction of the direct care workforce, and improve the care provided to long-term care clients, residents, and patients.	In response to this recommendation, SB 1277 and HB 2055 were introduced. • SB 1277 was enacted and S.L. 2006-104 establishes the North Carolina New Organizational Vision Award (NC NOVA). NC NOVA is a voluntary special licensure designation that will be rewarded to adult care homes, home care agencies, and nursing homes that have been determined through written and on-site review, by an independent review organization, to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff, and the care provided to long-term care clients and residents. The NC NOVA program will be implemented by the Department of Health and Human Services. This act becomes effective January 1, 2007.

RECOMMENDATION	RESULT
Recommendation 7: Housing The Study Commission on Aging recommends that the General Assembly appropriate an additional $10 million dollars for the Housing Trust Fund with $4 million of the total amount going to the Urgent Repair Program to provide grants for emergency home repairs for elderly homeowners and other homeowners with special needs.	In response to this recommendation, SB 1272 and HB 2051 were introduced. • SB 1272 was referred to the Senate Committee on Appropriations/Base Budget. • HB 2051 was referred to the House Committee on Appropriations.
Recommendation 8: Posting of Fines and Penalties for LTC Facilities The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Facility Services to post by October 15, 2006, the substantiated infractions, fines, and penalties assessed to long-term care facilities.	In response to this recommendation, SB 1274 and HB 2059 were introduced. • SB 1274 was referred to the Senate Committee on Health Care. • HB 2059 received a favorable report in the House Committee on Aging, passed 2nd and 3rd reading in the House and was sent to the Senate where it was referred to the Senate Committee on Health Care. *Note: The Division of Facility Services has indicated that they plan have fines and penalties posted online by October 1, 2006 and they plan to update them monthly.*
Recommendation 9: LTC Insurance Tax Credit The Study Commission on Aging recommends that the General Assembly enact House Bill 118 or Senate Bill 37 Reenact Long-Term Care Insurance Tax Credit.	HB 118 was referred to the House Committee on Finance and SB 37 was referred to the Senate Committee on Finance.

RECOMMENDATION	RESULT
<u>Recommendation 10:</u> Medicaid Institutional Bias – CAP/DA Slots The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to review the CAP/DA program including slot distribution and re-distribution to ensure that the CAP/DA waiting list is managed as efficiently as possible, identification and alleviation of identified biases, implementation of a uniform screening/assessment tool, and other strategies to ensure maximum operational efficiency and effectiveness for those individuals qualifying for CAP/DA services, and to make an interim report to the Study Commission on Aging by August 30, 2006 and a final report by August 30, 2007.	In response to this recommendation, SB 1276 and HB 2055 were introduced. • SB 1276 was enacted and S.L. 2006-109 requires the Department of Health and Human Services to review and report on the Community Alternatives Program for Disabled Adults (CAP/DA) in response to the institutional bias report. The report must include actions taken and planned by the Department in response to each bias identified in the institutional bias study. The inclusion of the following information is also required in the report: ➢ Information on the utilization of CAP/DA slots, including a history of slots used per year over the last 10 years and the anticipated need during the next 10 years. ➢ A description of the CAP/DA slot allocation formula; and a breakdown of slots by county, including the reallocation of any unused slots. ➢ Strategies to ensure that the CAP/DA waiting list is managed as efficiently as possible, including consideration of whether there should be an expiration date tied to unused slots so that they may be reallocated in a timely manner to areas with waiting lists. ➢ Implementation of a uniform screening/assessment tool and other strategies to ensure maximum operation efficiency and effectiveness for those individuals qualifying for CAP/DA services. This should include information on whether the lists should be prioritized by risk of institutionalization. The Department must submit an interim report to the NC Study Commission on Aging on or before August 30, 2006, and a final report on or before August 30, 2007. The act became effective July 13, 2006. *Note: The Department has requested an extension on the interim reporting date to November 1, 2006.*

RECOMMENDATION	RESULT
<u>Recommendation 11:</u> Medicaid Institutional Bias – Recommendations to Address Biases The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to work with providers and advocates of home and community based services to review the North Carolina Institutional Bias Study Report prepared by The Lewin Group and to make recommendations on ways to address the biases identified in the report and to report to the Study Commission on Aging by October 15, 2006.	In response to this recommendation, SB 1279 and HB 2052 were introduced. • SB 1279 was enacted and S.L. 2006-110 directs the Department of Health and Human Services to collaborate with providers and advocates of home and community-based services to make recommendations addressing the biases identified in the institutional bias report prepared by The Lewin Group. (Institutional bias refers to the policies and practices within Medicaid that make it easier for a beneficiary to access institutional care than services in home and community based settings.) The Department is required to report its findings and recommendations to the NC Study Commission on Aging on or before October 15, 2006. This act became effective July 13, 2006.
<u>Recommendation 12:</u> Additional Funds for Home and Community Care Block Grant The Study Commission on Aging recommends that the General Assembly appropriate an additional $5 million in funding for the Home and Community Care Block Grant (HCCBG).	In response to this recommendation, SB 1273 and HB 2056 were introduced. • SB 1273 was referred to the Senate Committee on Appropriations/Base Budget. • HB 2056 was referred to the House Committee on Appropriations. • The General Assembly provided $4,000,000 in recurring funding for the Home and Community Care Block Grant.

"Tentative" Meeting Dates for the Study Commission on Aging

Please note the following are tentative dates, Commission members will continue to receive meeting notices announcing each meeting.

Tuesday, September 12, 2006	Meeting
Wednesday, September 27, 2006	Meeting
Tuesday, October 3, 2006	Public Hearing (Burlington)
Wednesday, October 11, 2006	Meeting
Tuesday, October 17, 2006	Public Hearing (Charlotte)
Wednesday, October 25, 2006	Meeting
Wednesday, November 15, 2006	Meeting
Wednesday, November 29, 2006	Meeting
Wednesday, December 13, 2006	Meeting
Wednesday, January 3, 2007	Meeting
Tuesday, January 9, 2007	Meeting
Tuesday, January 23, 2007	Meeting

North Carolina Study Commission On Aging

ATTACHMENT 5

Legislative Building 16 West Jones Street Raleigh, NC 27601

August 29, 2006

Representative Verla C. Insko
Co-Chair, Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, and Substance Abuse Services
Legislative Building
16 West Jones Street
Raleigh, NC 27601

Senator Martin L. Nesbitt
Co-Chair, Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, and Substance Abuse Services
Legislative Office Building
300 N. Salisbury Street
Raleigh, NC 27603

Dear Verla and Martin:

As the Co-Chairs of the North Carolina Study Commission on Aging, we are writing to ask the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services for assistance in addressing issues related to serving mentally ill individuals residing in long-term care (LTC) facilities. Perhaps if your Committee and our Commission bring a renewed focus to researching these issues this interim we can develop solutions to better serve these residents.

The Study Commission on Aging has been looking into this issue over the last few years and we are committed to addressing it again this interim. During our second meeting this interim, the Study Commission on Aging plans to focus on Geriatric Mental Health Specialty Teams; the Department's progress toward an automated screening, assessment and care planning system; and perhaps other recommendations mentioned in the report resulting from S.L. 2004-124, Section 10.2.

One issue that may need further exploration is long-term care licensing categories. Session Law 2005-66 created a new adult care home licensure category for those facilities that serve individuals 55 years of age or older, and any adult with a primary diagnosis of Alzheimer's disease or other form of dementia. Perhaps the State needs to determine whether is possible for one facility to meet the needs of mentally ill individuals under the age of 55 residing in long-term care facilities, mentally ill individuals 55 years of age and older that reside in these facilities, and long-term care residents that suffer from dementia and Alzheimer's. Page 14 of the report for S.L. 2004-124, Section 10.2 indicated that, "At this time the Department does not support creating a separate licensure category for adult care homes that serve persons with mental illness." However, it may be that the range of knowledge and care required by this variety of residents, in addition to the other residents typically found in a long-term care facility, presents a scope broader than the training typically found in long-term care providers and staff. If so, we wonder whether there is a way to achieve greater efficiency and effectiveness through some type of

coordination of those residents that present similar care needs and that utilize similar services. Somewhat related to this idea of specialized care, the Study Commission on Aging plans to take a look at the current role of Special Care Units. However, it might be helpful for the State to examine how other states combine populations in long-term care facilities.

Additionally, page 8 of the report from S.L. 2004-124, Section 10.2 mentions that responsibilities of Local Management Entities (LMEs) include "responding to the needs of their communities including the needs of residents in long term care facilities." The structure of the mental health system, types and locations of providers, and the role of the LME, are not areas with which the Commission is a whole is knowledgeable. However, we wonder whether there is a way to strengthen the link between the mental health system and those residents in long-term care facilities.

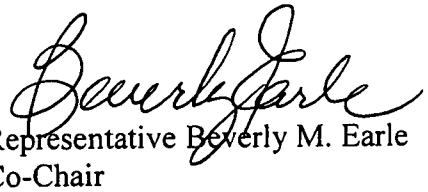
In summary, we are requesting that the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, join the Study Commission on Aging's renewed focus and study of issues related to mentally ill residents in long-term care facilities. Perhaps both your Committee and our Commission could even consider some joint recommendations to the General Assembly. As a starting point, perhaps elements of these joint recommendations might include the following requests:

- An examination of whether other states combine young mentally ill individuals with residents 55 years of age and older in long-term care facilities, and an exploration of whether the State should have several types of long-term care facilities to best serve individuals; and
- an examination of whether there is a way to strengthen identification, care coordination, and accountability between the mental health system and those individuals residing in long-term care facilities in need of mental health services.

We appreciate your Committee's efforts thus far in improving the lives of mentally ill residents in North Carolina. We hope that you might join us this interim in an exploration of the best ways to serve mentally ill individuals residing in long-term care facilities.

Sincerely,

Senator Charlie S. Dannelly
Co-Chair



Representative Beverly M. Earle
Co-Chair

c: Senator Austin Allran
Senator Stan Bingham
Senator Vernon Malone
Representative Alice Bordsen
Representative Debbie Clary
Representative Bob England
Representative Jennifer Weiss
Mr. Brad Allen
Ms. Linda Howard
Ms. Regina Duffy Fisher
Ms. Florence Gray Soltys
Mr. Sam Marsh
Ms. Judy Pelt

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — September 12, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Edwards	DAAS
Roxane Begg-Cook	NCAOA
Lynette Tolson	HHS
Jim Edgerton	AHEC
Pat Blackwell	Bone & Associates
Stacy Flannery	NCHCFA
Jenny Cooper	NC ALA
Mary Bethea	AARP-NC
Joann Stevens	MSIC
Carolyn [illegible]	NCOA
Charlene Carey	NC Right to Life

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — September 12, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Mitchell	Novartis
Bill Wilson	AARP
Frank Gray	NCANB

September 13, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the NC Study Commission on Aging:

DAY: Wednesday **TIME:** 10:00 A.M.

DATE: September 27, 2006

LOCATION: Room 643
Legislative Office Building

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, September 27, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Current LTC Facility Screening and Assessment

Lynne Perrin, Division of Medical Assistance, DHHS

Future LTC Facility Screening and Assessment

Lynne Perrin, Division of Medical Assistance, DHHS

III. Geriatric Mental Health Specialty Teams

Bonnie Morell, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS

Case Studies - Geriatric Mental Health Specialty Teams

Barbara Warren, Geriatric Mental Health Specialty Team Member

IV. DHHS Recommendation for a Study of Residential Choices and Treatment Options for Individuals with Mental Illness

Jackie Sheppard, Assistant Secretary, Long-Term Care and Family Services, DHHS

V. Meeting Adjourned

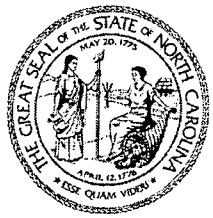
Public Hearings:

Burlington - Tuesday, October 3, 2006
10:00 a.m. until 12:00 p.m.
John Robert Kernodle Senior Activities Center
1535 South Mebane Street in Burlington, NC.

Charlotte - Tuesday, October 17, 2006
10:30 a.m. until 12:30 p.m.
Shamrock Senior Center
3925 Willard Farrow Drive in Charlotte, NC.

Next Meeting:

October 11, 2006 at 10:00 a.m. in Room 544



DRAFT

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES
SEPTEMBER 27, 2006
10: AM
ROOM 634

The North Carolina Study Commission on Aging opened by Representative Beverly Earle at 10:10 am in Room 634 of the Legislative Office Building. Senator Charlie Dannelly declined remarks. The following members were present:

Rep. Beverly Earle, Co-Chair
Rep. Alice Bordsen
Rep. Jennifer Weiss
Rep. Bob England
Rep. Debbie Clary
Theresa Matula, Staff
Two Senators
Ms. Regina Fisher
Mr. Jackie Sheppard, Ex-Officio
Ms. Linda Howard
Ms. Florence Soltys
Shawn Parker, Staff

The first presenter was Ms Lynne Perrin, Division of Medical Assistance, DHHS. The topic of her handout was "Screening and Assessment Processes: Nursing Facilities and Adult Care Homes". She began by giving a little background and history of the screenings. The initial placement recommendation comes from the attending physician. This procedure is done with assessing the medical conditions, diagnosis, functional capacities, behaviors and medications. Then it is signed by the physician. Nursing facilities uses two screening tools

- FL@ for NF Level of Care – Medical and functional information
- PASARR Screen – mental information

The level of care is determined by Medicaid fiscal agent nurses and medical director based on DMA policies and medical criteria and the medical/health information from the physician. And FL2 goes to EDS fir final determination as to NF level of care.

Adult care homes screening and assessments are done as a level of care recommendation from the physician. The FL2 signed by physician goes to the adult care home and county dss for placement decision, and a facility and individual determine whether the admission occurs. State policy for adult care homes assessments are to be completed within 72 hours of admission. The goal for the uniform screening program is to ensure timely, appropriate placement of Medicaid recipients in the right service or setting of care. (See Attachment II)

The next presenter was Ms. Bonnie Morrell, Division of Mental Health, Developmental Disabilities, and Substance Abuse. There were twenty geriatric mental health specialty teams that were started in FY 02-03. The start up fund was from the mental health trust fund. Ongoing funds were transferred from the state psychiatric hospitals as number of geriatric beds was reduced and people returned to communities. The purpose of this specialty team was to assist with the discharge and planning for older adults returning to the community from the state hospitals, and to help with their needs for treatment. The geriatric mental health specialty team has made a positive difference with the older adults. (See Attachment III)

Ms. Barbara Warren, Geriatric Mental Health Specialty Team Member presented to the committee case studies. She focused on demographic and epidemiological data.
Demographic data:

- The number of Americans aged 65 and older increased tenfold during the twentieth century
- Substantial increases also occurred in the group of people aged 85 and older

Epidemiological data:

- Grief, mourning an bereavement issues
- High incidence of suicide
- Five percent of older adults are receiving nursing home care at any given time
- Thirty-five percent will require LTC at some time during their lives

Geriatric Specialty Teams are grant-funded. There are twenty one teams across the state of North Carolina. Their mission is to optimize the mental health and wellness of individuals over age 60 through the provision of education for caregivers, the linkage with integrative community programs and to connect with excellent support services. Some other services the specialty team offer is to assist caregivers of adults over age 60 with mental illness, who reside in their own homes through client and caregiver education and linkage with community resources and community services. (See Attachment IV)

The Department of Health and Human Services gave recommendations for a study of residential choices and treatment options for individuals with mental illness. To review the entire report see the attachment entitled: **"An Act To Provide Support and Training for Long-Term Care Providers Caring for Residents with Mental Illnesses: Geriatric Mental Health Specialty Teams".**

It was announced that the next meeting would be on October 3, 2006, and the meeting was adjourned.

Beverly Earle

Representative Beverly Earle, Co-Chair, Presiding

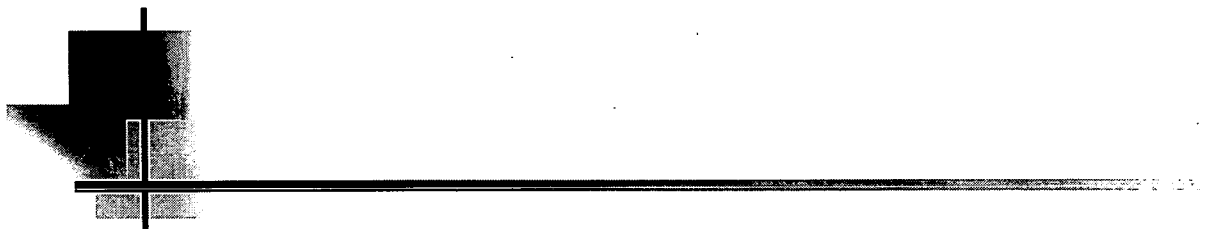
Ann Raeford

Ann Raeford, Committee Assistant

Attachments

Attachment I	Agenda
Attachment II	Screening and Assessment Processes
Attachment III	Geriatric Mental Health Specialty Teams
Attachment IV	Geriatric Specialty Team Case Studies
Attachment V	Final Report Geriatric Mental Health Specialty Teams

Screening and Assessment Processes: Nursing Facilities and Adult Care Homes



Legislative Study Commission on Aging

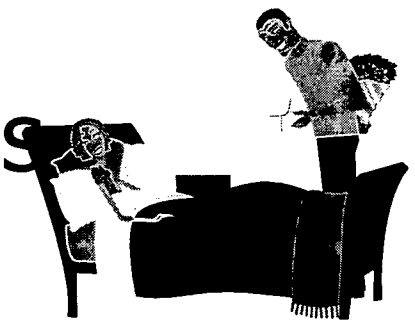
Presented By:
Lynne Perrin
Division of Medical Assistance
Department of Health and Human Services
September 27, 2006

Current Screening Process for NF's and ACH's

- Initial Placement Recommendation comes from the attending physician
- Completion of the FL2
  - Medical conditions
  - Diagnosis
  - Functional Capacities
  - Behaviors
  - Medications
- Signed by a physician

Nursing Facility Admission Process

Uses Two Screening Tools



- ***FL2*** for NF Level of Care Determination –Medical and Functional information
- ***PASARR*** Screen – mental health information

NF Level of Care

- Level of care determinations made by Medicaid fiscal agent (EDS) nurses and medical director based on DMA policies and medical criteria and the medical/health information from the physician
- FL2 goes to EDS for final determination as to NF level of care

Pre-Admission Screening and Annual Resident Review – PASARR

- No one can be admitted to a Nursing Facility without PASARR
- Federal requirement to screen for mental illness or mental retardation prior to nursing facility admission
- If MR or MI are found in the Level 1 screen, then a Level 2 evaluation is performed by a qualified mental health professional

PASARR

- If the Level 2 PASARR evaluation confirms that MI and/or MR is present, then a recommendation for specialized services is sent to DMH/DD/SAS for a final determination as to placement and services.
- Annual reviews are performed by mental health professionals on those identified through the Level 2 evaluation.

PASARR

- DMA contracts with EDS to operate the PASARR program and DMH/DD/SAS makes final placement determination for those with MI and MR.
- Prior to December 2005, DMA contracted with two separate contractors for NF admissions.

Nursing Facility Assessment Process

- Driven by Federal regulations
- Comprehensive assessment tool – RAI/MDS completed by the NF staff within 14 days of admission
- Quarterly reviews and full assessments annually
- Used to create plan of care and establish level of acuity and resource needs
- Forms the basis for case mix reimbursement system

– highly sophisticated
– computerized data

NF-MDS coordinators

DFS – reviews
DMA-MDS Validation Program

Adult Care Homes Screening and Assessment

Adult Care Homes Screening Process

- Level of care recommendation from the physician
- FL2 signed by physician goes to the adult care home and county dss for placement decision
- Facility and individual determine whether the admission occurs

Assessment Process for ACH

- State policy for ACH assessments to be completed within 72 hours of admission
- Tool is 3050-R completed by the ACH staff
- Reviewed and signed by the attending physician

Forces for Change

- State long term care plan calls for creation of a uniform portal of entry and screening for long term care services
- Separate screening processes and requirements exist for individual programs even though the basic elements of each screening process are essentially the same.
- Separate and inconsistent screening is inefficient, contributes to inappropriate level of care decisions and ultimately leads to inappropriate utilization.

Forces for Change

- Responsibility for screening is assumed by multiple organizations, public and private, as well as individual health professionals throughout the state.

- Up until December 1, 2005, two different private organizations evaluated requests for nursing home admission for compliance with the requirements of the federally mandated PASARR program.

Uniform Screening Program-

Replaces Eight Separate Processes

- Nursing Facility Care;
- Adult Care Homes/Personal Care Services;
- Community Alternatives Program for Disabled Adults (CAP/DA);
- Community Alternatives Program for Disabled Adults (CAP/CHOICE) Choice Program;
- Community Alternatives Program for Children (CAP/C);
- Private Duty Nursing;
- Personal Care Services (PCS); and
- Personal Care Services Plus (an enhanced PCS program)

Uniform Screening Program

- Contract awarded to EDS to design and implement the Uniform Screening Program
- Rapid development and testing
- Implementation statewide by September 2007

Uniform Screening Program

- Fully automated using Web portal technology
- Systems logic will apply Medicaid medical criteria to information on the individual screened
- Design is based on a business process model that will simplify the request for Medicaid services by referring agencies, streamline processing, speed up determinations and permit on-line status tracking of all requests for service.

Uniform Screening Program

Goal -

To ensure timely, appropriate placement of Medicaid recipients in the right service or setting of care.

Uniform Screening Program

Objectives to be achieved through the uniform screening program include the following:

- Reduce inappropriate placements;
- Reduce paperwork of referring agencies;

Uniform Screening Program

- Provide a clearer picture of the applicant's needs to providers to whom the applicant shall be referred;
- Provide recipients a clearer set of service options responsive to their current needs and to encourage choice;

Uniform Screening Program

- Reduce the costs of screening through streamlined processes, procedures, automation, consolidation of screening responsibilities and attendant staffing reductions; and
- Foster the creation of a more coherent, comprehensive system of long term care services.

Future Adult Care Home Assessment System

- DMA is encouraged that a new, automated assessment program will be developed and tested over the coming months within adult care homes
- CMS approved NC for a Systems Change Transformation Grant
- Adult care home assessments are included in this grant

Adult Care Home Assessment System

- Comprehensive assessment tool with triggers to identify service needs and support the creating of plans of care
- Will denote risk areas where further evaluation is needed
- Web-based system that will include outcomes tracking and monitoring of care

North Carolina Study Commission on Aging

Geriatric Mental Health Specialty Teams

September 27, 2006

Mental Health Specialty Teams Background

- Twenty Geriatric MH Specialty Teams were started in FY 02-03
- Startup funding was from MH Trust Fund.
- Ongoing funds were transferred from State psychiatric hospitals as number of geriatric beds was reduced and people returned to communities.

Purpose of Initial Teams

- Established to assist with successful reintegration of older adults into community from State hospitals and
- To increase the capacity of long term care facilities and caregivers to help address issues so that older adults could live successfully in the community.

Location and Staff

- Initially each team had at least two staff a nurse and a master's level mental health clinician with experience working with older adults
- Teams served multiple counties

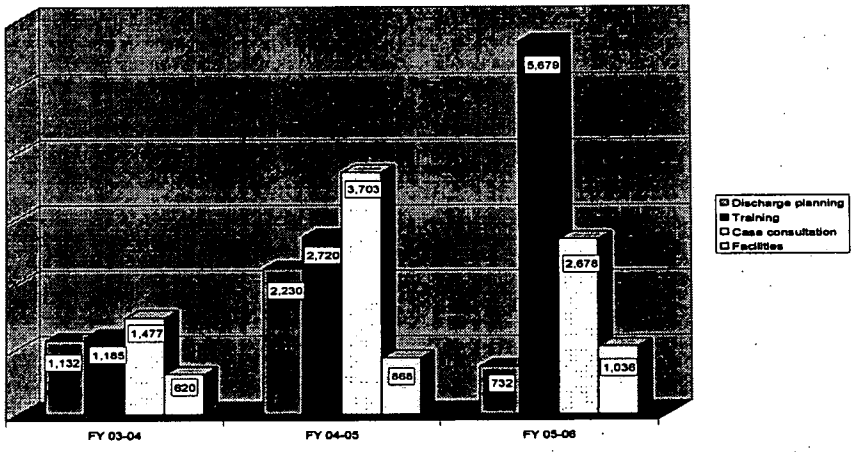
What Did Teams Do

- Assisted with discharge planning for older adults returning to the community from State psychiatric hospitals
- Linked older adults with needed MH treatment services.
- Provided training and consultation to caregivers including staff of adult care homes, nursing facilities, and other caregivers.

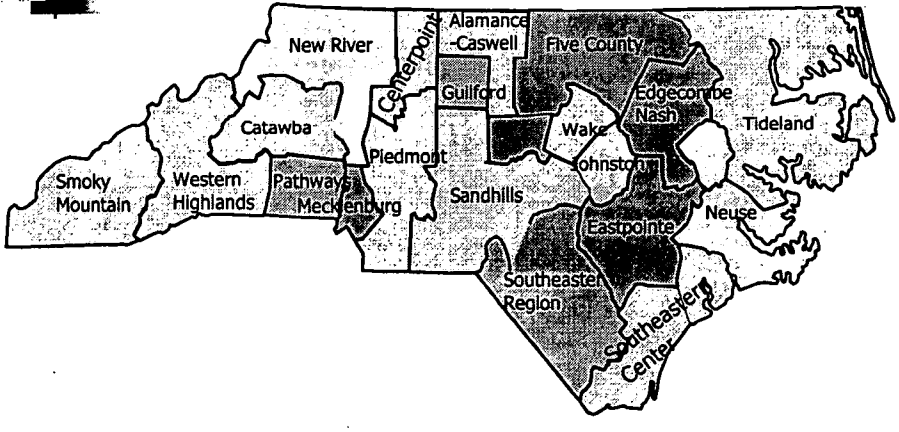
Changes in FY 05-06

- Funding for these teams was increased by 20% to enable them to focus on providing additional training and consultation to long term care facilities.
- This was done in response to SL 2004-144 *An Act to Provide Support and Training for Long-term Care Providers Caring for Residents with Mental Illness.*

What Have Teams Done?



Where Are Teams Located



Change in team responsibilities and capacity

- As of January 2007, funding is being made available for teams to add an additional position to focus on needs related to younger adults in long term care.
- Name of teams will change to Mental Health Specialty Teams

Mental Health Specialty Teams

- The addition of a position focused on younger adults is based on one of the recommendations that were developed in response to a special provision 2004 Session HB 1414 Section 10.2 to *Study Issues Related to Mentally Ill Residents of Long-Term Care Facilities*

Teams make a difference

- The Geriatric MH Specialty Teams have made a positive difference
- Barbara Warren who is with the team from New River is here today to give you some real life examples about the work her team is doing and how it has improved the lives of older adults in long term care.

Teams are just one of the strategies to improve services

- The work of these teams, even with the addition of a position to focus on issues related to younger residents is only one of several strategies to address the needs of people who exhibit difficult behaviors related to a serious mental illness.

1 Focus on Aging: The Role of The Geriatric Specialty Team

Presented by:
Barbara Ellen Warren MSW, LCSW
Clinical Therapist/Team Leader
Geriatric Specialty Team

2 New River BHC/Crossroads GST Team Members:

- **Barbara E. Warren, MSW, LCSW**
- **Katy Wilson, RN**
- **ASU Interns (Intermittent Basis)**
  - **Presently: Rhonda Shepherd, BSW Intern**

3 The Need for Geriatric Specialists

- **Demographic Data**
- **Epidemiological Data**

4 Focus on Aging – Demographic Data:

- **"The number of Americans aged 65 and older increased tenfold during the twentieth century..." ***
  - ***from 3.1 million in 1900 to 35 million in 2000 (from 4% of the US population to 12.4%)***

* According to the National Center for Health Statistics [NCHS], as cited by Richardson & Barusch (2006) in Gerontological Practice for the Twenty-first Century: A Social Work Perspective.

5 Focus on Aging – Demographic Data:

- **"Substantial increases also occurred in the group of people aged 85 and older..." ***
  - ***from 122,000 individuals in 1900 to 4.2 million individuals in 2000***

* According to the National Center for Health Statistics [NCHS], as cited by Richardson & Barusch (2006) in Gerontological

Practice for the Twenty-first Century: A Social Work Perspective (p.4).

6 Focus on Aging:
Epidemiological Data

- **Grief, Mourning & Bereavement Issues**
- **High incidence of suicide**
  (40 per 100,000 of the population)*
- **Five percent of older adults are receiving nursing home care at any given time.***
- **Thirty-five percent will require LTC at some time during their lives.***

* Kaplan, H & Sadock, B. (1998) Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry. Baltimore: Lippincott Williams & Wilkins

7 Focus on Aging: Overarching Needs

- **Confront ageism**
- **Distinguish between medical and psychiatric illness**
- **De-stigmatize mental illness**
- **Embrace prevention**
- **Obtain appropriate early intervention**
- **Improve health and overall quality of life for older adults**

8 Definition of Health:
World Health Organization

"Health is a state of complete physical, mental and social well-being
and not merely the absence of disease or infirmity."

** Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.*

9

Geriatric Specialty Teams

10 Geriatric Specialty Teams

- **Teams are grant-funded.**
- **The grant for our local team was awarded to New River Behavioral Healthcare, covers eight counties, and included the "Crossroads & New River areas."**
- **There are 21 teams across the state of North Carolina.**

11 Our GST Service Area:

- **All New River and Crossroads counties:**

- Wilkes
- Watauga
- Alleghany
- Avery
- Ashe
- Surry
- Yadkin
- Iredell

12 GST Development:

- **Geriatric Specialty Teams were developed by the State of NC:**
  - to assist with de-institutionalization (including transition of individuals over age 60 from state hospitals into the community setting)
  - to promote the mental health and wellness of individuals over age 60 (keep them out of state hospitals, enhance their quality of life and allow them to live in the least restrictive setting) >

13 Mission Statement

- **To optimize the mental health and wellness of individuals over age 60 ... through :**
  - the provision of education for caregivers
  - linkage with integrative community programs
  - connection with excellent support services

14 Provision of Education:

- Caregiver & LTC staff training on topics such as: recognizing symptoms of mental illness (early intervention), communication issues, stress management, medication side-effects, and client empowerment
- Provision of resource information for LTC staff or family caregivers
- Enhancing communication between state hospitals and LTC staff during placement

15 Linkage with Holistic Care:

- Assisting discharge planners as they transition clients from state hospitals to the community by recommending housing arrangements that best meet client needs
- Helping new caregivers design intervention plans that promote wellness
- Consultation with caregivers (may include medication review & recommendations by GST registered nurse, in collaboration with client's pharmacist, physician, and/or psychiatrist)
- Referral to specialized community support groups and/or outpatient treatment programs

16 Connection with Support Services:

- **Client/caregiver linkage with community support groups, services, clubs, and alliances, to enhance direct community involvement**
  - Examples: NAMI, Senior companions, In-Home care programs, Hospice,

Senior centers, meal programs, social clubs, rehabilitation programs

17 ## Description of Other Services:

Geriatric Specialty Teams also assist caregivers of adults over age 60, with mental illness, who reside in their own homes through:

- **Client & caregiver education**
- **Linkage with community resources and community services**

18 ## Services are provided…

- **Primarily through *education* -- many problems that occur in LTC (or in the home) are due to lack of caregiver training and education with regard to mental illness)**
- **Sometimes, through *consultation* with staff/caregivers (to improve care & quality of life for specific individuals) >**

19 ## Presentations

- **Our team currently provides more than 24 different programs free of charge.**
- **Each class carries CEU credit from the Division of Facility Services.**
- **Most classes are done in about an hour (for "front-line" caregivers).**
- **Courses are offered on-site for the convenience of caregivers. >**

20 ## Some Current Topics Offered:

- **Overview of Mental Illness (Focusing on Older Adults)**
- **Hands on with Alzheimer's Disease**
- **Paranoia, Suspiciousness, & Accusations**
- **Recognizing Medication Side Effects I & II**
- **Dealing with Difficult Behavior I & II**
- **Helping Caregivers Cope with Grief**
- **Stress Management for Caregivers**
- **Assessing Mental Status / Involuntary Commitment**
- **Late Life Depression**
- **Resident Rights: Improving Quality of Life in LTC**
- **Dealing with Dementia: Accepting the Challenge (1 – 4)**
- **Bipolar Disorder**
- **Schizophrenia**
- **Diabetes and Mental Illness**

21 ## The Geriatric Specialty Team

- **Offers classes at:**
  - **Long Term Care Centers**
  - **Senior Centers**
  - **Private Residences**
  - **Agencies on Aging**
  - **Conferences on Aging**

-Shelters (for staff) - ex: Oasis, Hospitality House

(Cont...) →

Insert:

Letter from Villages of Wilkes

- Hospice and Home Care Agencies
- Extension Centers
- Community Action Committees, etc.

22 ☐ For more information:

- **Contact us at:**
  - New River Behavioral HealthCare North Wilkesboro, NC
  - (336) 667-5151 Ext. 178 or Ext. 130
  - (336) 927-9265 Cell Phone
- Or e-mail: warrenb@newriver.org (Barbara)

PER GAIL – NR

- NOT DIVESTING
- W/STILL BE A PUBLIC AUTHORITY BECAUSE OF AN
- INTER-COUNTY AGREEMENT

→ 160A

Final 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 30, 2005

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

Final Report on Geriatric Mental Health Specialty Teams

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 final report provides a summary of the Division's efforts to meet the requirements described within S.B. 1148.

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 21 community-based Geriatric Mental Health Specialty Teams. Nine of the teams serve multiple counties. These teams are available to provide support, training, and consultation to long term care facilities and other organizations throughout the State. In as much as the creation of the specialty teams represented a new approach to serving elderly persons with mental illness, the Division has standardized 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, caregivers and other agencies 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 support, training and consultation to the staff serving the identified individuals and developing linkages with community providers serving older individuals.

Each team consists of a registered nurse and a masters prepared therapist. The teams operate on an itinerant basis and thus provide the majority of services to the staff 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 or caregiver in the transition of individuals from a State hospital to a long term care facility or other community setting;
- provide consultation to staff or caregiver in identifying and addressing issues that may threaten successful community placement;
- provide crisis-oriented support, either face-to-face or via telephone to the agency staff or caregiver during normal business hours;
- provide individual case consultation to staff of long term care facilities or caregiver regarding behaviors that may result in hospitalization or a need for more intensive services;
- provide training to staff or caregiver on the development and implementation of intervention plans as needed;
- train facility staff, caregivers and other agencies 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 and caregiver.

* 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.

As a means of monitoring the activities of the Geriatric Teams, each team is required to submit to the Division a quarterly activity report.

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 hours of individual case consultations with facility staff; 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.

During fiscal year 2004-2005 the Geriatric Specialty Teams provided a total of 2,230 hours of hospital discharge planning; 2,720 hours of training to staff of long term care facilities; 3,703 hours of individual case consultations with facility staff; 7,721 hours of technical assistance and program development and 4,271 hours of community development and education. These services were provided to 209 nursing facilities; 356 adult care homes; 220 human service agencies; 56 local hospitals and 27 private medical facilities. This increased level of services reflects the fact that the teams have become better known in their communities resulting in more requests for their services from long term care facilities and agencies that serve older adults.

As the purpose of the teams is to support the staff providing services to the individuals residing in the long term care facility or family home, the Geriatric Specialty Teams do not track the number of individuals served. The teams do track the hours spent training staff and the hours spent providing case consultation to staff regarding a specific individual the staff is serving. Beginning in SFY2006, the teams will be tracking both the hours spent in case consultations and the number of individuals for which consultation is provided.

The Geriatric Specialty Teams and LME staff meet on a quarterly basis in each region with a representative from the Division. The focus of these meetings has been to discuss the purpose of the teams in order to ensure team consistency throughout the state. The meetings also have offered an opportunity for training on topics pertinent to the participants. The team members use this meeting to share ideas on needed training for team members and to discuss success stories and barriers.

A survey of 37 team members was conducted in FY 04-05 to obtain information about the experience and training the team members have had regarding working with older persons with mental illnesses. All 37 team members had at least 3 years experience and appropriate training to work with this population. Of the 37 team members who were surveyed, 31 had over 5 years experience and 15 of these had over 15 years experience.

In FY 05-06, all of the Geriatric Specialty Team funding has been allocated to the LMEs on a recurring basis with reimbursement based on expenditures. The actual expenditures are currently being tracked and will be available for FY 05-06.

Standardization Activities

The Department was required by SB 1148 to develop and implement a standardized screening and referral process for the Geriatric Specialty Teams which addressed issues of service orders and authorization. The Division assessed the operation of the Geriatric Specialty Teams and reviewed service provision and funding needs. Funds were identified in SFY 04-05 and allocated in SFY 05-06 from within Mental Health Block Grant resources available to the Division to fully support each approved position for the Geriatric Specialty Teams. As a result, the need for a screening and referral process, forms, service orders or authorizations that had been needed to provide billable services have been eliminated. In the event that an individual residing at a long term care facility or family home requires mental health service, the Geriatric Specialty Team will make the referral to the appropriate LME.

Geriatric Specialty Team Study Committee

SB 1148 called 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 was formed. The committee first convened on October 28, 2004. Study committee members included representatives of the following interests: nursing homes, adult care homes, area programs, persons with mental illness, Division of Aging and Adult Services, Friends of Residents in Long Term Care and the Division of MHDDSAS. Through this study, consideration was 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.

At its initial meeting, the study committee agreed that a review of demographic and service information was necessary before meaningful study or recommendations could be achieved. Specifically, the committee requested the following data:

1) a roster of Geriatric Mental Health Specialty Team service areas including the number of people served and the facilities served by type (nursing home, family care home, or adult care home);
2) a list of Local Management Entities including phone numbers and a contact persons;
3) a summary of long term care facility information including number of facilities and number of beds by type and by county;
4) a summary of mental health diagnostic information from the adult care home licensure renewal applications; and
5) a summary of completed Geriatric Specialty Team Non-Unit Cost Reimbursement (Non-UCR) Activity Reports.

In addition, the study committee requested qualitative information about the work and challenges of the Geriatric Mental Health Specialty Teams.

In response, DMHDDSAS staff presented the requested service and demographic data during the November 29, 2004 Study Committee meeting. Also, representatives from three Geriatric Mental Health Specialty Teams serving both urban and rural geographic areas gave a presentation on the operations of their teams, including challenges as well as successes.

After reviewing and discussing the data and considering the information provided by the Geriatric Specialty Team members, the study committee made the following recommendations:

1. The mission of the Geriatric Mental Health Specialty Teams should remain unchanged as originally established with their specific focus on improving care for older adults with mental illness who are being reintegrated into the community when they are discharged from State psychiatric hospitals and on providing training and technical assistance to nursing homes, adult care homes, caregivers and other agencies that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization.

2. The Geriatric Mental Health Specialty Teams should continue to operate and be administered through their Local Management Entities as originally established.

3. Each Team should be fully funded with 100% non-UCR funds. The rationale for such funding took into consideration that teams were funded at 80% requiring them to supplement funding through billable direct client services. Often the provision of direct client billable services reduced team availability to provide community capacity building activities such as education, training and technical assistance. As a result, beginning with FY 05-06, the teams are funded at 100%. The teams no longer need or are required to provide direct client services.

4. The study committee was concerned about the inappropriate placement of some mentally ill persons under the age of 60 in long term care facilities. The committee, therefore, recommended continued study and consideration of creating Long Term Care Mental Health Specialty Teams for non-geriatric persons as part of the requirements of HB 1414 Section 10.2. (a) "Study Issues Related to Mentally Ill Residents of Long-Term Care facilities." The HB 1414 study committee recommended a pre-admission screening and assessment that will have the capacity to identify whether individuals are appropriate for a long term care setting. In addition, that committee recommended that potential funding for the development of long term care specialty teams be explored. The purpose of those teams would be to provide training and technical assistance to facilities that serve younger adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization.

Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities
General Assembly of NC Session 2004
House Bill 1414 Section 10.2(a) & (b)

Prepared For: The North Carolina Study Commission on Aging
December 1, 2005.

Final Report and Recommendations

I. Summary of Recommendations

Over the past year, the NC Department of Health and Human Services has worked closely with a Study Group, comprised of long term care provider associations, advocacy organizations and state government staff, convened in response to the Special Provision at Section 10.2(a) & (b) of HB 1414. The following report represents the Department's effort to summarize the work of the Study Group and prioritize their recommendations to support ongoing efforts within the Department to improve both long term care services and support persons with mental illness with appropriate treatment and services.

The Department is making the following recommendations, discussed in detail within the report as indicated:

- Expansion of mental health specialty teams to provide training and technical assistance to long term care facilities. (page 12)
- Design and implementation of an automated screening, assessment and care planning system to be used prior to admission to long term care services.(page 13)
- Conducting a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness. (page 14)
- Strengthening training curriculums in all law enforcement training programs to improve law enforcement response in long term care settings. (page 15)
- Further evaluation of a number of statutes and rules to provide appropriate guidance to long term care facility operators according to the needs and characteristics of residents served.(page 10-11)

II. Introduction

On February 10, 2004, the North Carolina Study Commission on Aging heard presentations regarding people with mental illness who live in long-term care facilities.

The Commission considered many questions regarding this issue, including:

- Are adult care homes appropriate housing options for persons with mental illness?
- Is staffing and training at both nursing facilities and adult care homes adequate to meet the needs of diverse population groups?
- Do existing laws and rules provide the best guidance to those who operate these facilities?

- Does mixing younger people with mental illness with the frail elderly in adult care homes and nursing facilities compromise the health and safety of residents?

To address these issues, the Commission recommended that the General Assembly require the Department of Health and Human Services (DHHS) to work with long-term care providers and advocates to study these and other related issues.

During its 2004 session, the legislature approved House Bill 1414, which included the Special Provision at 10.2(b) directing the Department of Health and Human Services to convene a Study Group to provide recommendations on the following study areas:

1. Do current State statues and Departmental rules adequately address the populations served by long-term care facilities?
2. Would the development of separate licensure categories for adult care homes and nursing facilities improve care for the various populations served in those facilities?
3. Are adult care home rules easy to understand, attainable under current staffing patterns and include appropriate guidance to facility operators to best serve the needs of their residents?
4. Do these rules support residents' freedom of choice, as well as their autonomy, dignity, and independence?
5. What is the most effective way to identify mentally ill individuals that have mental health treatment needs?
6. Can the criteria for admission of mentally ill individuals to long-term care facilities be improved to ensure that the health and safety of all residents are safeguarded?
7. What changes need to be made to improve the quality of care for mentally ill individuals in adult care homes and nursing facilities? What is the potential cost associated with implementing these recommendations?
8. What specific problems exist as a result of mixing aging and mentally ill populations?

DHHS was also asked to include in this report how it defines "mentally ill" for purposes of this study.

For purposes of this study, the definition of mental illness is drawn directly from General Statute 122C-3(21):

> Mental illness means an illness which so lessens the capacity of the individual to use self control, judgment and discretion in the conduct of his affairs and social relations so as to make it necessary or advisable to be under treatment, care, supervision, guidance or control.

This is a functional definition that can include a broad spectrum of conditions including serious depression, schizophrenia, bipolar disorder and other psychiatric diagnoses where functioning can be improved or restored with appropriate medication and rehabilitative treatment. Dementia also meets this functional definition and is a progressive brain dysfunction that leads to a gradually increasing restriction of daily activities. The most well known type of dementia is Alzheimer's disease.

Developing the Study

NC DHHS Assistant Secretary for Long Term Care Jackie Sheppard convened the Study Group in December, 2004. The Study Group met for ten sessions and included representation of long term care provider associations, advocacy organizations and state government staff. A number of committees were formed to address particular study issues, some of which joined with existing DHHS committees to build on existing discussions and Department efforts. (See Attachment A: Study Group Members, Meetings and Subcommittees)

The Study Group reached agreement on statements of consensus (Attachment B: Consensus Statements) and presented a draft report to the Department in September 2005. The draft report included lengthy discussion of the issues and a number of recommendations.

This report represents the Department's effort to summarize the work of the Study Group and prioritize their recommendations to support ongoing efforts within the Department to improve both long term care services and support persons with mental illness with appropriate treatment and services.

III. Scope and Context of the Report

The issue of serving the mental health needs of long term care residents is not new and pre-dates the current re-design of the publicly funded MH/DD/SAS system. In fact, state agencies and long-term health care providers have been engaged in a discussion of how best to provide this care for a decade or more.

Long term care facilities as referenced in the Special Provision include adult care homes and nursing facilities. The two are designed to meet different needs and operate under different statutes and rules. A nursing facility provides care for persons who have ailments for which medical and nursing care is indicated, but are not sick enough to require general hospital care. Nursing care is their primary need, but they also require continuing medical supervision.

An adult care home is a facility which provides residential care for older adults or adults with disabilities whose principal need is a home with the shelter and personal care their age or disability requires. Medical care in an adult care home is usually occasional, incidental, and/or short term intermittent, but includes the supervised administration of medication.

While neither of these types of care is designed to provide for the mental health needs of their residents, many residents of both adult care homes and nursing homes have mental health issues.

While comparing results from different population studies is complicated by the difference in parameters and indicators used, a report commissioned by the Department in 2004 found that over 40% of the adult care home population carried an active diagnosis of mental illness. (Adult Care Home Mental Health Needs Assessment Report of Findings, First Health, July 15, 2004).

A limited sample study of nursing facility residents done as part of the Adult Care Cost Modeling Report found a similar percentage, 41.8%, to have a psychiatric or mood disorder diagnosis (Myers and Stauffer 2003). Comprehensive national studies indicate that as high as 80% of nursing facility residents have diagnosable psychiatric disorders, with dementia being the most prevalent condition. (Mental Health Services in Nursing Homes: Models of Mental Health Services in Nursing Homes: A Review of the Literature Psychiatric Services, November 1, 2002)

When the locus of care for persons with mental illness first shifted from the large state hospitals to the community decades ago, there were few residential options available to persons with mental illness, and many adult care homes stepped forward to fill that gap, providing shelter for those who had none.

North Carolina's current mental health reform effort is designed to improve the state's capacity to meet the needs of persons with mental illness according to evidence based practices, but many with mental illnesses continue to live in long term care settings because there are not yet more appropriate alternatives available to them in their communities.

As a result, long term care facilities have been an unavoidable choice for many individuals with mental illness, despite the fact that these facilities are not designed to provide psychiatric treatment or the rehabilitative services to allow persons with mental illnesses, particularly younger adults, to achieve a greater measure of independence.

Members of the committee agreed that without a large investment of new resources into community-based services, people facing the challenge of mental illness are likely to continue to be served in adult care homes and nursing facilities.

The Department has taken steps in addressing some of the challenges posed by this issue. Since 2001, for example, the Department has been engaged in a Department-wide effort to improve the quality of long term care services as outlined in the Institute of Medicine's Long Term Care Plan for NC. While the resources to implement the full range of changes suggested by the report have not been available, the Department has implemented a number of the recommendations and other initiatives in an ongoing effort to improve long term care services for all residents.

The NC DHHS Division of Medical Assistance has also undertaken population studies to assess the needs, both physical and behavioral, of current long term care populations and is moving forward with an automated screening and assessment tool that will be used for Medicaid providers and recipients needing long term care services. Further information on this effort is included in Recommendation B.

In addition, the NC DHHS Division of MH/DD/SAS has funded 21 geriatric mental health specialty teams. These teams provide training and case consultation to adult care homes and nursing facilities to help staff understand and manage some of the challenging behaviors of older adults.

The Division is also piloting a specialized long term geriatric behavioral unit for nursing facility residents and a Special Care Unit in an adult care home. These pilots are designed to serve persons who exhibit persistent behaviors that pose potential danger to the individual and/or to

other residents. Expanding both of these initiatives are included in Recommendations A and C.

The NC DHHS Division of Aging and Adult Services is also involved in a wide variety of initiatives targeted at improving the long term care delivery system, including:

- Implementing the Aging and Disability Resource Center Grant to create a coordinated system of information and access for all persons seeking long-term support.
- Convening a multidisciplinary taskforce called SAFE-in-Long Term Care composed of individuals in the fields of law enforcement, long term care, advocacy and state government to raise awareness regarding appropriate responses to crimes occurring in long term care settings.
- Initiating the Quality Improvement Consultation Program for Adult Care Homes as directed by recently passed legislation "to promote better care and improve quality of life in a safe environment for residents in adult care homes through consultation and assistance with adult care home providers."

In addition, the Department has implemented North Carolina's response to the 1999 US Supreme Court's Olmstead decision by coordinating Department wide efforts to reduce reliance of institutional care by addressing a variety of system issues including transportation, strengthening the direct care work force and expanding the availability and improved access to affordable community housing.

IV. Summary of Study Group Discussions

The Study Group's discussions covered a gamut of issues and concerns raised in the Special Provision that can be captured under four themes:

- Health and safety
- Screening and disclosure
- Training of staff, and
- Services to residents with mental illness.

A. Health and Safety

While many persons with a diagnosis of mental illness reside in long term care settings without difficulties, others, because of the nature of their illness, inadequate treatment, or lack of expertise among facility staff, can exhibit behaviors that can impact other residents and/or pose a potential safety risk to staff and residents.

Licensed skilled nursing facilities in NC are well-equipped to care for the frail older adult, medically complex residents that they serve. Many of these residents have age-related dementia or Alzheimer's disease, and some have mental illness that is effectively managed. However, industry representatives report that these facilities are increasingly struggling with safety issues related to a growing number of residents with challenging behaviors that have an impact on the safety of residents in the facilities.

In adult care homes some older adult residents and their significant others cite concerns about the safety and the vulnerability of other older adults due to reports of behavior problems such as verbal/physical/sexual abuse by some younger residents. The facilities, however, have found that the needed services and alternative placements to address these unexpected acute challenging behaviors are not widely available or accessible.

While there is currently no comprehensive information available as to the scope and breadth of these problems, the NC DHHS Long Term Care Ombudsman Program receives and investigates complaints made by or on behalf of long term care residents. The Ombudsman Program is an advocacy program, not a regulatory agency. In the course of their work, the program's staff have reviewed situations in which persons exhibit aggressive behaviors, engage in illicit drug use and/or alcohol abuse that negatively impact the health and safety of other residents. The Ombudsman staff also report concerns that the needs of persons with mental illness are not always being met. These reports include the inappropriate use of infringement of the patient rights as a behavior modification tool and even reports by some residents with mental illness that their health concerns are often disregarded and not reported to health professionals.

It was also noted that law enforcement must be called by the facility when the safety of residents or staff are in danger. Complaints received by the Ombudsman Program indicate law enforcement officials can be hesitant to arrest or detain residents who commit criminal acts. The law enforcement response is complicated by the need to carefully assess and differentiate between a criminal act and psychosis requiring treatment. (See Attachment C: 2005 Regional Program Survey by the Long Term Care Ombudsman Program)

B. Screening and Disclosure

Members of the Study Group agreed that a good screening mechanism is a critical component to appropriate placement but that current tools are either inadequate or not used appropriately. They agreed that while a framework for this approach is already established through assessment and care planning requirements, the critical component of screening persons for appropriate placement within a continuum of long-term care is missing. The Study Group felt that this is the area in greatest need of attention from a regulatory standpoint. Such a tool would allow for the adequate evaluation by the facility of the needs of the potential resident and the determination by the facility of its ability and resources to meet those needs.

The Study Group also felt that disclosure by facilities of what services can and cannot be provided and disclosure by referral sources of resident history, condition and needs are not adequately addressed in statute or rule. In addition, facilities report that some residents who were initially admitted were later found to have persistent behaviors that pose a potential threat to themselves or other residents. In many cases these individuals have not responded to interventions and services that are available to the facility, yet do not meet the statutory criteria for involuntary commitment to a psychiatric hospital.

1. Nursing facilities Currently, nursing facilities are subject to stringent Federal regulations related to Medicare and Medicaid. All nursing facility residents are subject to the Pre-

admission Screening and Annual Resident Review regulations, commonly called the PASARR. The PASARR Program was established by Congress to ensure that every individual seeking admission to a Medicaid certified nursing facility (NF) is properly assessed to determine if he/she requires nursing facility care and if he/she has a major mental illness (MI), mental retardation (MR) or a related condition (RC) that requires specialized services.

Every new admission to a certified nursing facility, regardless of payment source, is subject to a Level I screening prior to admission, with the exception of individuals readmitted after treatment in a hospital unless there has been a significant change in status. After receiving the Level I screen, if individuals are suspected of having either mental illness or mental retardation or a related condition, a Level II evaluation must be completed with the recipient by a qualified professional to assess whether nursing facility services and specialized services are needed. Recommendations based on the Level II evaluations are forwarded to the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services for final determination of services and placement for the individual. All persons identified as MI or MR/RC by this process receive an annual resident review designed to assess their care needs or whenever there is a significant change in the resident's condition. It should be noted that PASARR does not include screening and evaluation for nursing facility residents who have dementia and who may have significant challenging behaviors.

The PASARR process is not without some flaws for persons with psychiatric illness, however, particularly in the admission screening process. For example, the PASARR by regulation excludes screening for dementia. Dementia and certain related challenging behaviors can pose immense concerns for Nursing facilities and the residents for whom they care. Also, at the time of the PASARR screening, behaviors may not always be evident. Current or long-term residents may develop dementia and related behavior issues that are not related to the primary reason for admission to the nursing facility. A limited number of nursing facilities have the ability to deal with ambulatory residents with more challenging behaviors, such as a person who roams and rummages in other resident rooms. Although this person is not violent, he/she is at risk of being injured by other residents who react strongly to having someone handling his/her possessions. Additionally, over time, a resident may develop a new psychiatric illness and /or develop behavior/symptoms related to another diagnosis. Facility operators also stated that often there is an inability to get appropriate services for these long-term residents who develop new psychiatric disorders, and once these problems manifest there are limited discharge/care and/or treatment opportunities available.

2. Adult Care Homes Similarly for persons entering an adult care home, the facility will review the FL2 (the current screening tool) and if the home feels it can meet the needs of the individual and has a vacancy the person is admitted. Study Group members agreed that in some instances the FL2 does not include all the information it could/should contain in order for the adult care home to make a sound admission decision. The home may decide to meet the potential resident before deciding whether they can meet the individual's needs, however, it may be days before the symptoms of the illness manifest. The home then cannot meet the needs of the resident, is not trained in handling those specific behaviors and/or has no place to refer the resident or get support. They have now accepted a resident with no viable options available for assistance. This resident may even be a danger to himself or others. Additionally, as the resident "ages in place" exacerbation of old conditions may develop, as well as new conditions.

A program similar to PASARR for adult care homes is not currently available. Study Group members indicated that this inconsistency in systems has been used by referring agencies or doctors to by-pass the assurances required by nursing facilities, by placing the resident in an adult care home who only have exclusionary criteria rather than defined admission criteria. As a result, the adult care home has no way of knowing that a person should have received such a screening, and subsequently the resident may not receive services or needed support from trained staff. The true picture of resident needs may only come to light after they are placed and the challenging behaviors emerge.

C. Training of Staff

Typically, mental health crisis situations are unpredictable, although at times there is evidence of a person's escalating behaviors. Members of the Study Group were in agreement that presently there is not enough trained staff, particularly nursing assistants, personal care and medication aides, to care for residents with mental illness. Training is most important for monitoring behavior changes and responding with appropriate interventions when dealing with challenging behaviors exhibited by some residents with mental illness. An understanding of mental illness and how it impacts behavior can result in more effective interventions and prevention of crisis situations.

The current training requirements for direct care staff, including aides and supervisors, in adult care homes are focused primarily on personal care with little emphasis on training related to the additional skills that are needed to care for residents who also have cognitive impairment and/or mental illness. It was also noted that instructors, who provide the training that is currently required, usually do not have the experience and/or education that is directly related to the care of residents who have cognitive impairment and/or mental illness. Likewise, nursing facility direct care staff, while highly trained to manage clinical issues of facility residents, do not receive training specific to managing and de-escalating challenging behaviors.

Nursing assistants, personal care and medication aides in adult care homes often have not had the training needed for appropriate interaction with residents based on their particular mental illness, and specifically to administer and/or monitor the side effects of psychotropic medications. When there is a need for facility staff to be involved in implementing an appropriate behavior plans, this does not routinely occur because the plans are not developed and agreed upon with participation by the resident and approval by the attending physician or supervision of a qualified mental health professional.

D. Services to residents with mental illness

The Local Management Entities (LMEs) for the public mental health, developmental disabilities and substance abuse system of services have responsibility for access to the available services by providing screening, triage, and referral to appropriate provider agencies. LME's also have a responsibility to assure crisis services. These responsibilities include responding to the needs of their communities including the needs of residents in long term care facilities. The types of mental health services that are often needed by some residents in long term care settings includes: evaluation and assessment of residents who are exhibiting behaviors that appear to be related to mental illness; development of person

centered plans that include consideration of each individual's needs for a wide range of services or supports; and provision of ongoing treatment and rehabilitative services, and cooperation and support for others who are providing service and support for the individual.

The Study Group found that statute and rules related to both adult care homes and nursing facilities do not address coordination or linkages to these resources that would provide a more systematic and operational framework for meeting the needs of residents who require additional services.

Long term care providers report that greater involvement of mental health professionals is needed to do evaluations; to assist in the development of care plans; to provide treatment for some residents; and to provide consultation, training, and support for facility staff who are caring for residents with challenging behaviors related to cognitive impairment or mental illness. They also report that access to psychiatric consultation, evaluations, and treatment is difficult particularly if it is not provided on site and that the availability of gero-specialists, social workers, psychologists and psychiatrists is extremely limited.

Other concerns raised related to activities that are offered for older adults frequently do not meet the diverse needs of younger residents, and are often not an integral part of the personal care plan. It was also noted that there are not alternative residential options for providing stabilization of acute behavior that becomes problematic in the nursing facility or adult care home but does not meet the criteria for involuntary commitment to a psychiatric hospital.

Finally, the Study Group agreed that at the current time, the availability of mental health resources, the capacity to perform timely and thorough evaluations, development of person centered plans, and access to the broad array of services and supports needed for persons with mental illness varies greatly across the state. Poor coordination, unavailable transportation to rehabilitation activities, and few on-site mental health services were identified as additional barriers to assure the provision and coordination of needed services in many areas.

V. Rules and Statute Review

A. Discussion

Subcommittee members were asked to complete charts to gauge opinion on whether the statutes and rules adequately address the population served in adult care homes. The results collected served as a basis for discussion of the issues by a majority of subcommittee members and the Adult Care Home Mental Health Workgroup.

Statutes and rules governing adult care homes do not make direct references to the specific populations served such as persons with mental illness, those who are medically frail and those of advanced age. Addressing the needs of these populations is encompassed, in part at least, in the context of an array of care and services mandated by statute and promulgated in rule, and in the requirements for admission, assessment, care planning and training.

Addressing specific populations and their particular needs in law and rule has a number of pitfalls, not the least of which is the inevitable failure to take into account the wide range of

persons being served and their wide range of needs. In addition, singling out one group of residents should not be done at the expense of another group who may have some of the same needs but also a number of other specialized needs as well. Rules would inevitably become more complex and extensive without necessarily promoting attention to the particular needs of individual residents. The primary concern should be one of adequately addressing needs of individuals rather than generically addressing populations.

Subcommittee members felt that well-designed screening, assessment and care planning instruments would better accomplish the intention of the current adult care admission rule:

> "Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted to an adult care home when, in the opinion of the resident, physician, family or social worker, and the administrator, the services and accommodations of the home will meet his particular needs." (Rules 10A NCAC 13F and 13G .0701 Admission of Residents.)

There was no clear indication from results of Subcommittee discussions that adult care home rules were not understandable and not supportive of residents' freedom or the autonomy, dignity and independence philosophy of assisted living. Based on the Adult Care Home Cost Modeling Report (December, 2004), current staffing patterns are insufficient to meet all the requirements in rule. Again, the Subcommittee felt that the combination of improved screening and disclosure would help assure appropriate admission of residents so that facilities are able to meet residents' needs, make residents and their responsible persons aware when residency in a facility will no longer be viable, and protect the health and safety of all residents in the home.

A number of rules and statutes were identified as needing further evaluation and attention in relation to providing appropriate guidance to facility operators according to needs and characteristics of residents served. These are listed in detail below:

B. Recommendations: NC General Statutes 131D and 131E

The Department of Health and Human Services recommends to the NC General Assembly the following:

1. Assure definitions of abuse, neglect and exploitation are consistent with definitions of these terms in other statutes that impact adult care homes or types of residents in these homes.(GS131D-2(a))
2. Qualify "provide services" as "services established by rule" to provide greater clarity and avoid the possible misconception that these facilities provide any and all services "to assure quality of life...." etc. Coordination of services provided by community resources needs to be addressed since facilities cannot be expected to be providers of all services that may be needed. Additional funds would be needed to implement this coordination. (GS131D-4.1)
3. Evaluate current staffing requirements that are based on requiring specific amounts of staff time per resident in relation to a more "outcome" orientation to staffing which

would focus greater attention on whether the needs of residents are being met rather than number of staff present. (GS131D-4.3)

4. Address coordination of services to take into account services needed that the facility cannot directly provide (see #2 above). (GS131D-4.4)
5. Establish a mandate for screening of potential adult care home residents. Additional funds would be necessary for the development and implementation of this screening.(GS131D-4.5)
6. Establish a mandate for:
   - full disclosure in writing by all facilities to residents and their responsible persons such as required of special care units in 131D-8; and
   - full disclosure of information about potential residents to the facility so that facilities are fully aware of the resident's history and care needs in order to make informed decisions about admitting residents. (GS131D-2)

The study group also discussed the possibility of suggesting that there be exceptions to a Resident's and Patient's Bill of Rights in situations where they may make implementation of specific behavior plans difficult. However, deleting any of these Rights would risk changing the nature and character of these facilities. Rights may now be restricted in accordance with approved plans of care. If the deletion of Rights are necessary in order to provide appropriate treatment to a particular individual in an adult care home or nursing home, that individual would likely be more appropriately placed in a licensed mental health facility.

C. Recommendations: Administrative Rules for Adult Care Homes of Seven or More Beds (10A NCAC 13F) and Family Care Homes (10A NCAC 13G)

The Department of Health and Human Services recommends that the NC Medical Care Commission:

1. Strengthen training on caring for residents with cognitive impairments and/or mental health needs. Training should include specific methods for de-escalation of challenging behaviors and the implementation of appropriate behavior plans for residents with challenging behaviors. Training by qualified instructors is critical to enabling staff to meet resident needs. Additional training of staff upon employment and on an annual basis needs to be considered. This would require additional funds for trainers and staff time for training, including staff coverage while staff is being trained. Any mandatory requirements for additional training should be conditioned upon the availability of necessary resources. The use of mental health specialty teams like the geriatric specialty teams should be explored. (10A NCAC 13F and 13G .0501-.0502: Personal Care Training)
2. Evaluate the feasibility of a more outcome-based orientation to staffing and explore outcome-based measures. Staffing ratios are not directly related to residents receiving appropriate care and services and reliance on this kind of staffing requirement may even have a negative impact on care. Greater attention should be given to assuring staffing to meet the needs of residents. Increased funds will be needed to increase staff time. Thorough screening, assessment and care planning processes are critical to the effectiveness of an outcome-oriented approach. (10A NCAC 13F .0604-.0605: Staffing)

3. Require that admission of residents be dependent on facility review and evaluation of the results of a pre-admission screening process and all other information regarding the resident's mental and physical condition, needs and history provided to the facility. (10A NCAC 13F and 13G .0701: Admission of Residents)
4. Require that the examination of a resident who has been an inpatient of a psychiatric facility within 12 months prior to admission and does not have a current plan for psychiatric care be examined by a mental health professional. The allowance of 30 days for the examination should be considered for possible reduction. (10A NCAC 13F .0703(e) and 13G .0702(e):TB Test and Medical Examination)
5. Include requirements regarding facility disclosure to residents and responsible persons here or in a separate rule. (10A NCAC 13F and 13G .0704:Resident Contract)

VI. Recommendations for improving the quality of care for persons with mental illness in long term care facilities

A. The Department of Health and Human Services recommends the expansion of mental health specialty teams to provide training and technical assistance to long term care facilities.

The Department and the Study Group believe that the quality of care for persons with mental illness in long term care facilities can be supported and improved by making it possible for facility staff to have access to training, technical assistance, case consultation, and assistance with referrals to mental health treatment services. A geriatric mental health specialty team model has been a successful strategy to address needs of both long term care staff and residents with mental illness. However, current funding has been made available to fund only 21 such teams and the staffing qualifications and focus of these teams are on the specific needs and issues of older (age 60 and over) long term care residents. The current small number of these teams makes it impossible for them to meet the needs of all long-term care facilities for this kind of consultation and training.

Mental health specialty team staff with the training, experience, and skills would be needed to help long term care staff address the challenging behaviors of younger residents in long term care are also needed. For example, 5,867 or 24% of all adult care home residents are under the age of 65, However 3,117 or 62% of adult care home residents under age 65 have a mental health diagnosis.[1]

In order to increase the availability of mental health specialty teams to address behavioral issues presented by long term care residents of all ages, proposed initial steps are:

1. To add 12 additional geriatric mental health specialty staff to existing teams. These staff would supplement the capacity of current teams that are serving areas with large number of long term care facilities. These staff will be qualified mental health professionals who have experience working with older adults with mental illness. These staff will focus on training, consultation and support to facilities for residents 60 and older who may present behavioral challenges that are related to

[1] 2005 Adult care home population census information from the NC Division of Facility Services

dementia or other mental health diagnoses. The cost per staff is approximately $65,000 per year for staff, travel, and training materials.

2. To add 25 qualified mental health specialty staff that are mental health clinicians who have training and experience about the needs of younger individuals who have major mental illness some of whom may exhibit behaviors that are not consistent with the expectations of staff and other residents in long term care settings. These staff will focus on training, consultation and support to facilities for residents under the age of 60 years old. The cost of one person would be approximately $65,000 per year for staff, travel, and training materials.

Currently the cost of a two person Geriatric Mental Health Specialty Team is $130,000 per year or $65,000 to cover the costs of each team member. This includes staff salaries and benefits, transportation/travel costs associated with travel to long term care facilities throughout the geographic area served, and a small amount of money for training materials and supplies used when providing training to long term care facility staff.

The cost of implementing this recommendation to fund a total of 37 additional team members would be approximately $2,405,000 per year. Additional background information, data about the number, type and location of long term care facilities that was used to develop the proposed action steps is included in Attachment E.

B. The Department of Health and Human Services requests support of the design and implementation of an automated screening system to be used prior to admission to a nursing facility, adult care home, or other home and community based services; and the design and implementation of an automated assessment and care planning system to be used once the setting of care is determined.

The Department is currently working on an integrated, web-based system that will streamline the screening and assessment processes for Medicaid providers and recipients needing long term care services. The overall design of the new system will include among other things, the capacity to identify persons with mental illness, substance abuse and/or mental retardation prior to admission to a nursing facility, an adult care home or before receiving other home and community services. The Division of Medical Assistance will work with the Division of MH/DD/SAS to see that the design complements the diagnostic assessment process underway for persons who meet the DMH/DD/SA target population criteria.

The new process will meet the requirements of the federally mandated Pre-Admission and Annual Resident Review (PASARR) program. If the mental health portion of the screening identifies the need for a more thorough mental health evaluation, then a qualified mental health professional should perform the evaluation and determine needed mental health services or supports. Overall, the new automated screening and assessment system should promote one's independence, self-management of health, and be formed around person-centered planning concepts.

The detailed work plan for the integrated access and management system for Medicaid will be available December 2005. The estimated resources required to implement the system will be determined through a formal bid process, but it is estimated to cost $1 million for design and development and $2.3 million for annual operating costs. At this time it is anticipated that

current expenditures will be redirected to support this system. The need for additional resources, primarily for ongoing operations and training to implement the new system are estimated at $248,000 per year.

C. The Department of Health and Human Services requests $620,000 for a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness.

The Department believes that there is a need to increase choice and treatment options for people with mental illness of all ages, particularly those who would benefit from more than the residential care and personal assistance than adult care homes are designed and funded to provide - and those with both medical and behavioral issues that nursing facilities are not equipped to manage. Improved screening and background disclosure of residents will inevitably result in persons being found inappropriate for either adult care or a nursing facility. Without alternative settings to meet these needs the state will remain dependent upon more costly care in the State psychiatric hospitals.

At this time the Department does not support creating a separate licensure category for adult care homes that serve persons with mental illness. On October 1, 2005 the General Assembly ratified SB 572 - An Act To Create A Licensure Category For Assisted Living Communities That Serve Only Frail Older Adults (see Attachment D). Assisted Living Communities that wish to serve only the frail elder population are now able to acquire a license that designates them as communities that serve only the frail elder population. While facilities wishing to serve only a population of persons with mental illness do not have that option as either an adult care home or nursing facility, they can apply for license as a mental health facility.

The Department believes that attention and resources must be devoted to creating a range of housing and treatment options that meet the needs of persons with mental illness that are consistent with evidenced based treatments. As a first step, a study should be undertaken to quantify the need, in terms of projected numbers to be served and the types and designs of alternative residential and treatment settings. The scope of this study would include a review of models used in other states, applicable Federal and State policies and regulations, potential funding sources, and development of cost estimates to develop a continuum of residential services, including, but not limited to:

- Community based residential options for providing stabilization of acute behavior that does not meet the criteria for involuntary commitment to a psychiatric hospital, including facilities that can provide both the nursing care and the psychiatric stabilization and treatment that are needed before return to a nursing facility is considered, as well as facilities that can provide both the personal care and psychiatric stabilization and treatment that are needed before return to an adult-care home is considered.
- Long term acute care hospitals specializing in the care of older people who have both medical and acute behavioral or psychiatric care needs or "swing beds" designed specifically for people with nursing care needs and acute behavioral or psychiatric care needs. The average length of stay of a long-term acute hospital is approximately 28

days. This length of stay would lend itself to the observation, stabilization, and intervention time necessary to return the older adult to the nursing facility

- Specialized long term geriatric behavioral units for nursing facility residents who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents. A single pilot of this model has recently begun operations.
- Specialized long term geriatric behavioral units for adult-care home residents who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents, including a review of the current ACH- 12 bed special MH unit rules (10A NCAC 13F Section .1400) to determine if there needs to be any changes in staffing requirements and other areas
- Community based supportive housing, housing with supportive services, for adults with mental illness in their communities.

D. The Department of Health and Human Services supports strengthening training curriculums in all law enforcement training programs to improve law enforcement response in long term care settings.

The Department will work with key officials in the Training and Standards Division of the Department of Justice in order to promote the use of N.C. Intervention Training and to facilitate the development of new mental health training curricula for law enforcement officers. The new curriculum should include identification of major mental illnesses, action steps for crisis response by law enforcement officers and alternatives to involuntary commitments. Officers at every level should be afforded access to available and newly developed training modules addressing their response to individuals with mental illness.

With appropriate and adequate training, law enforcement officers can develop skills to address the safety issues confronting staff and residents while de-escalating the situation. This training is highly encouraged for "first responders." Facilities are encouraged to have a "crisis plan" in place in order to avoid unnecessary demands on emergency hospital resources.

These efforts will build upon the Division of Aging and Adult Services' multidisciplinary taskforce called SAFE-in-Long Term Care. S.A.F.E. is an acronym that stands for Strategic Alliances For Elders in Long Term Care. SAFE is composed of individuals in the fields of law enforcement, long term care, advocacy and state government. This taskforce was convened to raise awareness regarding appropriate responses to crimes occurring in long term care settings and ensuring that justice is served. SAFE seeks to eliminate this lack of knowledge and awareness about these crimes by providing education and training to the general public and especially those professionals who have an obligation to protect society's most vulnerable from harm.

VII. Attachments

A Study Group Members, Meetings and Subcommittees
B Consensus Statements
C 2005 Regional Program Survey by the Long Term Care Ombudsman Program
D Session Law 2005-66
E Detail for Expanding Mental Health Specialty Teams in LTC settings

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — Sept. 27, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara E Warren, MSW LCSW	Geriatric Specialty Team (Team Leader) Crossroads / New River Areas
Polly Williams	NC Justice Center
Jerry Cooper	NCALA
Dennis Streets	NC DHHS - DAAS
Bill Lamb	UNC-CH
Lou Wilson	NCALTCF
Kari Barsness	DSBM
Wayne Wilber	OSBM
Eric Frazier	Charlotte Observer
Evelyn Hammond	EHOR
Lorna Bizzell	NCAOA / Franklin Co Dept of Aging

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — Sept. 27, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Eleanor Helms	Consumer Advocate 1161 N Blount Raleigh
Lynda Zoch	HHS
Roger Bone	Bone & Assoc
Lou Wilson	NCALTCF
Terry Stoops	NCFB
Stacy Flannery	NCHCFA
Patrick Bifolchi	ALLEY ASSOCIATES, INC.

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — Sept. 27, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Edwards	Div. of Aging & Adult Services
David Kerley	Intern Div. of Aging & Adult Svcs.
Mary Bethel	AARP-NC
Jeff Horton	DHHS-DFS
Jim Edgerton	AHHC
J. Gregory Wallace	Elder Law Section, NCBA
Lori Walston	DHHS - Public Affairs
Jim Jones	DHHS - Public Affairs
Dick Hatch	AARP / N Coalition on Aging
Becki Gray	Cecil G. Sheps Institute

September 20, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Public Hearings

The NC Study Commission on Aging will be conducting two public hearings:

DAY:	Tuesday	TIME:	10:00am - 12:00pm
DATE:	October 3, 2006		
LOCATION:	John Robert Kernodle Senior Activities Center 1535 South Mebane Street Burlington, North Carolina		

DAY:	Tuesday	TIME:	10:30am - 12:30pm
DATE:	October 17, 2006		
LOCATION:	Shamrock Senior Center 3925 Willard Farrow Drive Charlotte, North Carolina		

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

The John Robert Kernodle Senior Activities Center
Public Hearing
October 3, 2006
10:00 am – 12:00 am

North Carolina Study Commission on Aging

Opening Remarks
Representative Beverly Earle
Senator Charlie Dannelly

Open to Public

NORTH CAROLINA STUDY COMMISSION ON AGING

Minutes
October 3, 2006
10:00 am – 12:00 pm

PUBLIC HEARING

The North Carolina Study Commission on Aging, Public Hearing was held in Burlington, NC at The John Robert Kernodle Senior Activities Center. The hearing was called to order by Representative Beverly Earle at 10:15 am. Representative Earle thanked the public and commission members for attending. The following members were present:

Representative Beverly Earle, Chair
Representative Debbie Clary
Representative Alice Bordsen
Shawn Parker, Staff
Senator Charlie Dannelly, Chair
Mr. Brad Allen
Ms. Regina Fisher
Representative Bob England
Theresa Matula, Staff
Three other Senators were also present.

The public was asked to speak for no more than three minutes.

Speakers

Jane Smith – Alamance County
Senior Adult Activities/Community Center Supervisor for the Burlington Recreation & Parks Department. On behalf of the senior adults in our county I want to welcome you and I encourage you all to support the programs that will benefit our seniors so that they can have the best quality of life through senior center activities and senior games.

Emily Downs – Nurse
Home care is an economical choice for our state. A vast majority of individuals do not need around the clock care to stay home. The can live comfortably with intermittent assistance. An improved system to meet the needs of seniors into the future would include many more programs such as Project Care to help families who are already working hard to keep a loved one home and in his or her community and increased state funding for care that can help our seniors who want to live for as long as possible at home.

Wilhelmenia Pledger – Family Consultant/Casemanager Alzheimer's Association
My purpose for coming today is to ask for your support in maintaining funding and also expand Project CARE statewide, Caregivers Alternative to Running on Empty, a successful respite program that is being utilized in 10 of our western counties.

Blair Barton-Percival – Community Based Program Manager Area Agency on Aging
I would like to bring to your attention the fact that Area Agencies on Aging have been cut $570,000 in administrative support since 2003. These funds help us help older adults and Their caregivers and are greatly needed. Please consider restoring these funds and help us stay on the cutting edge of services and programs.

Pat & Bill Stevens
We are here today to ask the Commission on Aging to vote for continuing to support the NC Senior Games program which is so vital to our aging population.

Susan Sellers – Director of the Hamlet Senior Center
I would like for you to study, examine, and make recommendation to the General Assembly and the Governor is to increase Senior Center allocations. Senior center improve the quality and delivery of care for our older adults in North Carolina.

Beatrice Jefferson – Northampton county
Senior center are important. They provide nutrition, socialization, educational, recreational, and many other activities.

Viola Reddick – Hamlet Senior Center
I am her today to request that you increase funds for senior centers and senior games because I believe you can't have one without the other.

Sabrena Lea – LTC Program Manager & Senior Regional Ombudsman
I stand before you to bring to your attention three issues. Passage of legislation to issue that residents in adult care homes have a residents council forum to promote self-advocacy, to increase wages for direct care workers by providing rate increase for long term care facilities to be utilized as pass through, and to ensure that adult care homes be required to maintain adequate heating and cooling systems to promote resident health and safety.

Agnes Moore – Nash County Resident
Please continue funding for the senior centers and senior games. They offer a wide range of social and economic opportunities and supports for all citizens.

Jamie Wilson, Nash County Senior Center Coordinator
I encourage you to visit your local senior center. You may be surprised at what you see. You will not just see bingo. You will see creative programs that are ever changing with the needs and desire of the people we serve. We are proud of the senior centers of North Carolina. We hope you are as well, and will recommend an increase in Senior Center General Purpose Funding.

Stacie Nelson – Aging Services Director
Our mission is to provide a statewide organization for senior center professionals to advocate for senior centers network and collaborate on common issues, share

information, co-market initiative, and provide for additional staff training and development.

Mary Bethal – Associate State Director for Advocacy for AARP of North Carolina
I would like to bring before you four issues that are a great concern for our state. Support efforts to increase choices and options for long term care, the need to strengthen disaster planning for special need populations, including older adults and support for a state prescription drug assistance program.

Brenda Porter, Program Director Alamance ElderCare, Inc.
Given the way the system works, there is such a disincentive to live at home. More emphasis and dollars ned to go toward community based services versus institutional placement. Most older adults live in the community, not in facilities.

Dick Hatch, Chair of the AARP of North Carolina
We are asking the commission to again recommend re-enactment of the North Carolina income tax credit for premiums paid for long term care insurance that expired in 2004.

At this time, Rep. Earle asked if there were any other speakers. This concluded our public hearing. She thanked everyone for coming, and informed them that all their recommendations would be taken very serious.

The hearing was adjourned.

Beverly Earle

Representative Beverly Earle, Chair

Ann Raeford

Ann Raeford, Committee Assistant

Attachments

Attachment I	Agenda
Attachment II	Written Remarks
Attachment III	Visitors Registration

Jane Smith Senior Adult Activities/ Community Center Supervisor for the Burlington Recreation & Parks Department
My office is in this building & day in & day out I know the how important activities are to our older adults.

On behalf of the senior adults in our county I want to welcome you and I encourage you all to support the programs that will benefit our seniors so that they can have the best quality of life through senior center activities & senior games.

I came to talk to you today in praise of a specific grant called Project Care through the Alzheimer's Association. I want to let you know how much seniors in our community have benefited from this grant. I also want to tell you that the grant may end but the need for these types of alternatives for care will not end-they will only grow.

Project Care has been a valuable resource to seniors in Forsyth County for ~~over~~ 6 years now. Specifically, it provides respite for caregivers of individuals who are 60years of age or older. It also provided respite for caregivers who them selves were over the age of 60who might be the primary caregiver for a grandchild, for example.

We all know the senior population is growing…the problem is there is a large group of seniors who do not qualify for Medicaid, who do not have long term care insurance, and yet are not wealthy. These are the individuals who rely on home care funding such as Project Care.

These individuals may have worked entire lifetimes paying major medical insurance, never realizing they needed Long Term Care Insurance to cover their personal care and activities of daily living-the very tasks most needed to keep our aging population at home where they want to be. These individuals need alternatives for care. Project care is one such alternative and we need more.

Thousands of hours of home care/respite care have been paid for through Project Care. I think the community of Forsyth County is a better place to live because of it. These caregivers who work alongside us everyday need a break so badly. And a seemingly small break or respite can do so much good. One caregiver had not been to the mall in years, nor even out to dinner with a friend, before Project Care-she had not been away from her mother long enough to do the activities most people take for granted.

In my line of work-overseeing a large home care office in Winston-Salem, I see this ever-growing need everyday regarding home care and seniors: More and more seniors will "fall through the cracks" when it comes to declining health and home care options. ~~as the elderly population escalates~~. They need more education regarding Long term care options and more resources so that they can live at home-where they want to be- with their friends and families close by.

I want to leave you with this: Home care is an economical choice for our state: a vast majority of individuals do not need around-the-clock care to stay home. They can live comfortably with intermittent assistance. An improved system to meet the needs of seniors into the future would include many more programs (such as Project Care) to help families who are already working hard to keep a loved one home and in his/her community and increased state funding for care that can help our seniors who want to live for as long as possible AT HOME. Thank you,

Emily Downs
w/ Bayada Nurses
336-723-1000

Statement Before the North Carolina Study Commission on Aging

Date: October 3rd 2006
By: Wilhelmenia Pledger, Family Consultant/ Casemanager WC Alzheimer's Association
Subject: Project C.A.R.E. Respite Program

Good morning my name is Wilhelmenia Pledger. I am the Family Consultant and Casemanager at the Alzheimer's Association Western Carolina Chapter in the Triad Area, which serves families living in the 49 western counties of North Carolina. My purpose for coming today is to ask for your support in maintaining funding and also expand **Project C.A.R.E** statewide, *" Caregivers Alternative to Running on Empty"*, a successful respite program that is being utilized in 10 of our western counties. This is the 6th year for this program and **Project C.A.R.E.** has brought critical respite support to over 1000 low income, rural and minority families, who are caring for someone with Alzheimer's or various other types of Dementia. **Project C.A.R.E.** is an Alzheimer's Demonstration Program, which is currently funded by the Federal Administration on Aging. Key partners include the North Carolina Aging and Adult Services, the Duke Aging Center Program and the NC Family Caregiver Support Program. This program also works closely with other local and regional community resource agencies.

As a Family Consultant with **Project C.A.R.E.**, for Forsyth, Stokes and Surry Counties, it is a pleasure to be associated with a program that does so much in the community for families who would otherwise be alone as they face the challenge of Alzheimer's. The **Project C.A.R.**E. design is very personal, bringing a Consultant into the home to discuss and help solve problems firsthand and to encourage isolated families to accept the help that is available. One result is the quick response of the Consultant in arranging services for the families; this allows them to utilize either the in-home services, adult day services or the short-term residential care. Dementia caregivers get the break and the rest they need and they are able to keep their loved ones home longer. This makes **Project C.A.R.E.** cost effective and gives a boost to local economy as it builds strong community networks and partnerships.

Alzheimer's is called the "caregivers disease" because of the all too common deterioration of health that results from intense and long-term physical, financial and emotional stress. There are no "typical" families each challenge is different as they go through the caregiving process. Yet the responses of families, after experiencing the assistance of **Project C.A.R.E.** are a testimonial to the effectiveness of our work. Numerous letters from caregivers and provider agencies were sent to our Association to support and attest to how **Project C.A.R.E.** "Help! I just feel overwhelmed", or " I have encountered an enormous responsibility that I wasn't ready for." There is an increasing amount of desperate desire for continuation of this program from the many families affected by Alzheimer's disease. Again, we are here to bring awareness and encourage your continued support.

Awards and honors include the Southeast Regional Geriatric Best Practice Award and the Alzheimer's Association National Program Clearinghouse award. We are further honored to have presented at the 2005 National State Legislatures Meeting, as a model for grassroots systems change. . If the intent of this commission is to find and highlight programs that work, and that address the needs of a growing constituency in an efficient and cost-effective way, than I think **Project C.A.R.E.** is an appropriate choice. I will be happy to answer questions and provide further information about **Project C.A.R.E.** Again, thank you for your time.

Blair Barton-Percival
Piedmont Triad Council of Governments
Area Agency on Aging
October 3, 2006

NC Study Commission on Aging Presentation

My name is Blair Barton-Percival, Community Based Program Manager with the Piedmont Triad Council of Governments Area Agency on Aging, also known as Region G. Region G is a seven county region which includes Alamance, Caswell, Davidson, Guilford, Montgomery, Randolph and Rockingham counties. I would like to take a moment and welcome you to our region and thank you for taking the time to conduct these hearings in Burlington and Charlotte. I would also like to thank you for the increase in Home and Community Care Block Grant (HCCBG) funding and the additional Ombudsman positions this year.

I know you are well versed in issues affecting older adults and their caregivers, so I will quickly review a couple of items and then share with you some innovative program concepts I hope you will find interesting. To begin, you may know that 85% of care to older adults is provided by family and friends in the home. Home and Community Based Care is the first choice of the majority of people. As an Area Agency on Aging we support the agencies that support and assist caregivers. Research conducted on community based programs has consistently shown to provide home and community based services at a cost effective rate. There is a place for institutional care and facilities on the continuum of care, however, today I want to discuss home and community based care.

Blair Barton-Percival
Piedmont Triad Council of Governments
Area Agency on Aging
October 3, 2006

If caregivers were paid for the community and home based assistance they freely provide to family, friends, and neighbors, the health care system would have to pay about 200 billion dollars annually to keep them on the job. Funders and policy makers realized this when they created the National Family Caregiver Support Program (NFCSP) in order to aid those individuals who are providing informal and unpaid assistance to adults who are 60+. There have been original programs developed right here in North Carolina, such as Groceries on Wheels (right here in Alamance County). This program aids caregivers in their responsibilities to their loved ones by having volunteers grocery shop for caregivers, removing one responsibility of the caregiver. This interaction with the volunteer also provides a new social contact which can be extremely valuable in combating isolation. The Alamance County Meals on Wheels (MOW) program was only the second MOW in the nation to implement this new service.

Area Agencies on Aging in the search for creative programs targeting caregivers have forged great new partnerships and collaborations. For instance, libraries across North Carolina have become active in engaging older adults with services and claiming a chair at the aging table. Librarians are discussing outreach methods with aging professionals in order to conduct programs to reach older adults and their caregivers and providing their facilities to conduct trainings, seminars and support groups. North Carolina Cooperative Extensions are offering cutting edge and ground-breaking trainings tailored to Grandparents Raising Grandchildren, also known as Kinship Care.

Cooperative Extension teamed-up with the 4H Club and is offering intergenerational programming with mentoring, education, and fun incorporated into one opportunity!

Other innovative programs and services available include Grandparents Raising Grandchildren Support Groups. There are Lunch n' Learns, Trainings, and Support Networks already available, however, adoption and legal services for Grandparents Raising their Grandchildren or Kinship Care is desired and needed. In this region we will be funding an attorney with NC Legal Services to help provide legal services to Kinship Caregivers allowing Grandparents to enroll their grandkids in schools, make health care decisions and receive financial assistance in a more formal manner.

The Senior Friendly Livable Community Initiative led by the Division of Aging and Adult Services (DAAS) has expanded many horizons and brought together human services and private industry. Area Agencies on Aging lead aging advocates to engage city planners, law enforcement, employers, and industry in initiatives at the local level and provide the tools and information for successful planning.

An area that needs greater support is Health Care and Health Promotion. Eligible adults using Medicare Part D must have a wraparound program in NC. Area Agencies on Aging and the entire Aging Network worked diligently to educate and inform older adults and their caregivers about Medicare Part D, but it is evident there is more work to be

done. North Carolinians need a statewide program to help fill in the Medicare gaps that will leave so many without their essential medications.

I have mentioned volunteers a couple of times in my short presentation and as we all know volunteers are the backbone of human services. Area Agencies rely heavily on volunteers to sit on committees, participate in seminars, share opinions and suggestions, distribute information, educate the public, and advocate continuously. Our job is to support those volunteers and keep the information and training available. However, this endeavor and all those I have already mentioned take time, energy and manpower. I would like to bring to your attention the fact that Area Agencies on Aging have been cut $570,000 in administrative support since 2003. These funds help us help older adults and their caregivers and are greatly needed. Please consider restoring these funds and help us stay on the cutting edge of services and programs.

SPEECH TO THE
NORTH CAROLINA COMMITTEE ON AGING
(by Pat & Bill Stevens)

October 3, 2006
Kernodle Center – Burlington, NC

Thank you for inviting us to speak today. Bill and I have been involved in NC Senior Games for 17 years. We have competed on the local, state, and national levels; and this year we have been the Alamance/Burlington Ambassadors.

We have enjoyed representing and speaking about NC Senior Games. The opportunities it offers for keeping fit, making friends, volunteering, and enjoying competition are endless and so beneficial.

Senior Games has motivated us to keep in shape: Bill, playing basketball; and me, swimming the backstroke. We are former badminton players, too. In 2005, after a bout with Lymphoma, I needed physical therapy to regain strength and balance. I couldn't wait to get back in the pool to do water exercises and swimming!! Senior Games competition was also one of my motivations to get back in shape and I was able to compete locally, and then last Saturday at Raleigh, in the 100-yard backstroke. Adlib: Nat'l Level Basketball Team - 2nd Badminton - Silver

Besides sports, many seniors compete in Silver Arts. I hope you have seen the beautiful handicrafts, paintings, photography and wood carvings created by our seniors. And let's not forget the seniors in the Performing Arts. We have so many talented people in North Carolina.

We are here today to ask the Commission on Aging Co-Chairs, Representative Beverly Earle & Senator Charlie Dannelly, to vote for continuing to support the NC Senior Games program which is so vital to our aging population.

THANK YOU.

(Bill and Pat Stevens)

Good morning...my name is Susan Sellers. I am the Director of the Hamlet Senior Center, to which I have held the one and only full-time position for 22 years. My only staff positions has been volunteers and Title V employees provided through our local Council of Governments, which their greater part of salary is paid by the agency and our city government matches a small percentage.

I feel I can stand before you this morning and represent a large portion of senior centers in our state, because as far as staffing goes, our centers face the same worry.

My issues, which I would like for you to study, examine, and make recommendation to the General Assembly and the Governor is to increase Senior Center Allocations. There is NO other way, than without increased allocations can senior centers improve the quality and delivery of care for our older adults in North Carolina than by addressing the issue of Senior Center Allocations.

At one time, our local government considered closing our senior center due to lack of state and other resources. And, without increased allocations, I continue to remain a one-person operation. Therefore our delivery of services remains a minimal. Our adult population suffers due to the lack of funding and services.

For years, the General Assembly has allocated the same dollars $1,365,316 for 163 senior centers across North Carolina. The Division of Aging and Adult Services (or DAAS) annually appropriates these funds into "shares" by Area Agencies on Aging to senior centers. These shares are divided equally, however, as more centers are being built or certified, more centers are receiving less and less.

DAAS has been a national leader in strengthening Senior Centers through its voluntary certification of Centers of Excellence and Merit initiative, which began in 1998.

Currently the State has 38 centers of Excellence. I am to say, the Hamlet Senior Center is a center of Excellence, but not without sacrifice from my advisory board, volunteers, my family and many man-hours to become so. Still, with all that, I still can only deliver minimal services and struggle with limited resources. I also struggle with adjusting to a future of serving today's seniors and aging boomers, with very limited resources. The effect of Medicare Part D information and counseling assistance is still taking a significant toll on many of the centers. While tying certification centers to improve their quality, it has also strained the availability of funds for all centers. An increasing number of centers, certified and non-certified, has been an additional pressure on State support.

With the increased third share for centers of Excellence, this would not make allowance to hire a part-time position at $5.15 per hour, 20 hours per week and paying their social security.

Increased funding for centers should be an incentive that would stimulate directors to become certified. However, if the level of funding for certified centers continues to decrease significantly, what reward and incentive will directors go out of their way to deliver their services?

Thank you

NOTES

Hello, my name is Beatrice Jefferson from Northampton County. I am here to say how important Senior Centers are. Our center, JW Faison Sr. center provides nutrition, socialization, educational, recreational and many other activities. We can go to the center and be active and involved. Many of the seniors who come to our center would have no where else to go for these activities. Please consider additional funds to continue these valuable community resources. Thank you.

Good morning, I thank you for allowing me to speak, I have pins from our Sr games our 2006 Logo

My name is Viola Reddick, I am a participant of the Hamlet Senior Center Richmond Co, and I serve on the center's Advisory Board.

I am here today to request that you increase funds for senior centers and Senior Games because I believe you can't have one without the other.

In June, our senior center received the Center of Excellence award. However, prior to that, we had to make changes in order to meet standards set by the Division of Aging and Adult Services. One of these changes was to expand our center's building by 240 additional square feet. We did so with General Purpose funds and expanded the combined meeting room/billiards room/library/craft room/computer room/lecture room.

However, I feel the room, which needs to be considered now is our multi-purpose room. This room is used for a congregate nutrition site, however, activities are scheduled around the lunch program, these activities are i.e. exercise, line dancing, chair volleyball, table tennis, large social gatherings, quilting, etc. In truth, I really feel a larger room is really needed to run programming at the same time.

Funds, which senior centers receive now would not cover expenses for such construction and funds could not be "rolled over" to the following budget year either. An increase in senior centers shares is needed to meet the growing needs for the future programming and delivery of services through senior centers to stay caught up with the times!

Susan Sellers is the Director of the Hamlet Senior Center. Senior Games of Richmond County is coordinated through the Senior Center. Susan Sellers is our Local Senior Games Coordinator, Events Director, and Souvenirs Chairman. She believes in the benefits of Senior Games that she has coordinated this program for now 17 years.

This is why, I ask for more funds for senior centers. Hiring full-time staff would make the life of one-person operations better!

This is why I say, I can't request allocations for one without the other because both programs mean the very life to me!

Personal life experience...why and how you became involved in center and senior games!

Miss husband passed 26 yrs ago with no family in N.C. I needed a family. I found that at the Sr center. I met cousins, sister & Bro every day some where. It has added years to my life from the activities & fellowship

I am 80 years young. Senior Games helps me to keep my heart into staying young through the Fun, Fitness, Fellowship, Friends, and the Senior Games Family!

I have been a participant of Senior Games for 14 **years.**
I have been a participant of State Finals for 9 **years.**
I have been a participant of National for 1 **years.**

Last year in Pittsburg, Won 3rd place, Shuffleboard, Real Proud of me my medal in Richmond CO

Please keep North Carolina Senior Games alive by continuing funding the best ever Senior Olympic program in the nation serving 60, 000 participants in all 100 counties!

We are just recycled Seniors ten years

To: **The Honorable Members of the North Carolina Study Commission on Aging**

From: **Sabrena Lea**
Long Term Care Program Manager & Senior Regional Ombudsman
Piedmont Triad Council of Governments
2216 West Meadowview Rd Suite 201
Greensboro, NC 27407
336-294-4950 ext. 332

October 3, 2006

RE: **Comments for Public Hearing in Burlington, NC**

Please allow me this opportunity express my appreciation on behalf of Piedmont Triad Council of Governments Area Agency on Aging and aging service providers from across this region for your efforts and advocacy for programs and services to meet the needs of older adults across our state. Thank you for advocacy that led to the allocation of increase funding for the Home and Community Care Block Grant, adult day services rate increases, and funding for eight new regional ombudsman positions. Be assured that the allocation of these funds will translate into the improvement of programs and services for older adults and enhance the quality of life in North Carolina.

This morning I stand before you on behalf of the nearly 12,000 citizens in this seven county region, and over 88,000 older and disabled adults living in licensed long-term care facilities to bring your attention to three important issues.

1. **Passage of legislation to issue that residents in adult care homes have a resident's council forum to promote self- advocacy.** Disabled adults, who reside in Adult Care Homes, in many cases, have the ability to speak for themselves. It is important for residents of adult care homes and their families to be aware of their power as consumers. It is also important for facilities to recognize the importance of resident and family input. Promoting dialogue between consumers and providers makes sense.

   Federal Law gives nursing home residents and their families the right to organize and be heard. [Reference 42 CFR section 483.15(c); Public Law 100-203 Social Security Act] The facility is required to listen to resident and/or family group recommendations and grievances. Acting upon these issues does not mean that the facility must accede to all group recommendations, but the facility must seriously consider the group's recommendations and must attempt to accommodate those recommendations, to the extent practicable, in developing and changing facility policies affecting resident care and life in the facility. The facility must communicate its decisions to the resident and/or family group. **Should the same not be the case for adult home residents who are more capable of self- advocacy?**

2. **Passage of legislation to increase wages for direct care workers by providing rate increase for long-term care facilities to be utilized as pass-through.** High staff turnover in long-term care facilities jeopardizes the well-being of vulnerable residents. Poor care cost more. Equitable pay for the

valuable work done by direct care workers could reduce staff turnover, which would help to improve the overall quality of patient care.

SB 205 and HB 308 (2003-2004 Session) Both bills addressed Long-Term Care Enhancement Funds and were sent to the Appropriations committee where no action was taken. The following is direct language from SB 205.

SECTION 2. Funds appropriated in this act shall be allocated in accordance with the following:

- The amount of the labor enhancement benefit shall be allocated equitably among the various care settings.
- 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.
- 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.
- 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 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 pre-labor enhancement turnover rates and turnover rates at the end of each fiscal year for which labor enhancement funds are received.

3. **Passage of legislation to ensure that adult care homes be required to maintain adequate heating and cooling systems to promote resident health and safety**. Current adult care home regulation does not require facilities to have air conditioning. Consequently during the summer months when the external temperature rises to 85 degrees, frail older adults are place at risk for heat related illness. It is estimated that in as many as 100 adult care homes across this state that currently do not have any cooling systems. External temperatures of 85 degrees can produce internal heat indexes of over 100 degrees. According to the national weather service, elderly persons, small children, chronic invalids, those on certain medications or drugs (especially tranquilizers and anticholinergics), and alcohol problems are particularly susceptible to heat reactions at these temperatures, especially during heat waves in areas where moderate climate usually prevails. Current regulations only require the facility to provide fans when the internal temperature reaches 80 degrees. In most case when the internal temperature reaches 80 degrees, a fan would only at best move the hot around. It seems only reasonable that a facility licensed to care for disabled adults who are more susceptible to heat related illness, in a state that regularly has numerous days during the summer months when the temperature exceeds 80 degrees, be required to maintain a physical environment conducive to the health and safety of its residents.

Study Commission on Aging

Burlington, NC

October 3, 2006

Agnes Moore, Nash County Resident

The North Carolina Division of Aging and Adult Services has made Livable and Senior Friendly Communities one of its top initiatives. Its vision is a senior-friendly community offers wide range of social and economic opportunities and supports for all citizens, including seniors; values seniors' contributions to the community; promotes positive intergenerational relations; considers the needs and interests of seniors in physical and community planning; respects and supports seniors' desire and efforts to live independently; and, acknowledging the primary role that families, friends and neighbors play in the lives of older adults, enhances their capacity for caring.

In 2002 Nash County had 14,665 people 60 years old or older. In 2000 29% of the county population were Baby Boomers, which will increase the need for more services and senior-friendly communities. You can see our need for senior-friendly communities is imperative. Nash County Office on Aging has started a Senior-Friendly Business Program. Evaluations have been done on four businesses. There is a need to continue this program. Programs such as this need to be funded. Funding would enable us to begin to build senior-friendly communities across the state. We need to promote these programs, which will improve the lives of all people. We need to begin now.

Nash County Senior-Friendly Business Certification Program materials can be found at www.aging.co.nash.nc.us

Study Commission on Aging

Burlington, NC

October 3, 2006

Jamie Wilson, Nash County Senior Center Coordinator

In 1998 the North Carolina Division of Aging and Adult Services developed the Senior Center Certification Process, also known as Senior Center Operations and Program Evaluation. This is an in depth process that that once completed results in an award of Senior Center of Merit or Senior Center of Excellence. Of the 163 senior centers in North Carolina, 7 are Centers of Merit and 35 are Centers of Excellence. This process, along with the Ann Johnson Institute for Senior Center Management has made North Carolina a national leader in strengthening senior centers and has enhanced the overall professionalism and quality of service provided by senior centers.

While North Carolina is leading the way in improving senior centers, funding has not increased. Senior centers are being held to higher standards with the same amount or sometimes reduced funding. Increased shares of Senior Center General Purpose funding is an incentive for becoming a certified center. Non-certified centers receive 1 share, Centers of Merit receive 2 shares and Centers of Excellence receive 3 shares of General Purpose funding. As North Carolina continues to improve the quality of senior centers through the certification process, the "General Purpose Pie" continues to be cut in more slices, reducing the amount of funding each center receives. In FY 2004-05 a Center of Excellence received $17,740. In FY 2005-06 a Center of Excellence received $16,361. This year a Center of Excellence will receive $15,367.

It is imperative that the General Assembly increase this funding source in order that senior centers across North Carolina will have the means to uphold their level of services in a field that will become very challenging over the next few years. The first of the Baby Boomers are now 60 years old and eligible for services through the Older Americans Act. Senior centers need to be equipped with the resources to properly serve this group. Centers depend on General Purpose money to maintain safe, user-friendly buildings, to supply programs, to enhance services and many times to pay the salary of a greatly needed staff person.

I encourage you to visit your local senior center. You may be surprised at what you see. You will not just see bingo; you will see creative programs that are ever changing with the needs and desires of the people we serve. You will see a fixture of the community; a place where regardless of your race or socio-economic background, you have friends. You will see a focal point for aging services, a place that your community needs.

We are proud of the senior centers of North Carolina. We hope you are as well, and will recommend an increase in Senior Center General Purpose Funding.

NC Senior Center Alliance

Officers:

Stacie Nelson, Chair
Nash County Senior Center

Calvin Vaughn, Vice Chair
Roy B. Culler Senior Center

Myra Green, Secretary
Shamrock Senior Center

Rick Eldridge, NISC State Delegate
Rufty-Homes Senior Center

Subcommittee Chairs:

Mike Murphy,
Training/Mentoring
Cabarrus County Senior Center

Patsy Wilson,
Membership/Communication
Rutherford County Senior Center

Patrick Woods,
Advocacy
Franklinton Senior Center

Henry Sizemore,
Special Projects
Sammy Williams Center for Active Living

October 3, 2006

My Name is Stacie Nelson and I am the Aging Services Director for Nash County. I would like to share with you that senior centers across our state are organizing in new and exciting ways. At the annual North Carolina Association on Aging conference in April 2006 the first steering committee of the North Carolina Senior Center Alliance was assembled and I currently serve as Chair for this Alliance. The Senior Center Alliance is a subsection of the North Carolina Association on Aging and exists for the following purpose:

To provide a statewide organization for senior center professionals to advocate for senior centers, network and collaborate on common issues, share information, co-market initiatives, and provide for additional staff training and development.

Today I am here to advocate for Senior Centers. I would like to express the pride I have working in a North Carolina Senior Center. Our Division of Aging and Adult Services has done a phenomenal job implementing model programs that make our state a leader in the aging field. These programs give each and every employee working in aging services a vision and goals to improve service delivery. I am proud to work in a state that has a unique closeness among aging professionals with a shared ambition and desire to effectively touch the lives of those who need us most.
I would ask that the Study Commission on Aging to make Senior Center General Purpose funding a priority issue. As it is today, the more centers that raise their level of performance to the Center of Merit and Center of Excellence status the less there will be available in General Purpose dollars for their efforts. Centers such as the Nash County Senior Center are using those funds to pay salaries. Salaries for positions that are necessary to continue to expand service delivery for programs such as enrolling Medicare beneficiaries in a Medicare Part D Plan. Senior Centers play a vital role in their communities stepping up the plate to assist when there are no other available resources. We are all being reminded often these days of the changes in our population. By the year 2030 the number of individuals over the age of 65 will out number those under the age of 18. We must take action to prepare to care for this growing population. I ask myself often and would like to ask you; how are our focal points for aging services, our senior centers, going to continue to provide quality services to a growing population if our funding continues to decrease?
Thank you very much for this opportunity to stand before you today.

Sincerely,

Stacie Nelson

103 NORTH ALSTON STREET, NASHVILLE, NC 27856

Senior Employment Program 10/03/06

The Senior Employment Program opened a door of opportunity for me that would not have been there other wise.

Through that program I applied and was hired for a part time job at the Nash Senior Center in Nashville.

I received on the job training and multiple computer courses at the community college. After working at the center for over a year---I was hired for a permanent part time position. I couldn't have been more excited.

My job at the Nash Senior Center keeps me active, independent and gives me an opportunity to do something that is genuinely needed. Part of my job duties is installing Hastens Systems, which is a type of life line call system for people with serious health problems.

The Senior Employment Program has helped many a senior feel good about themselves and has proven that seniors still have great valve in the market place.

Amy T. Farmer
Nash Senior Center
Nashville, N.C. 27856

Testimony by Karen Gottovi
Study Commission on Aging Public Hearing
October 3, 2006

I am Karen Gottovi, a member of the Advocacy Council for AARP North Carolina. I retired as Director of the N.C. Division of Aging and Adult Services at the end of this past February. I am pleased to have this opportunity today to share with you a few brief comments on several needs of our State's older adult population.

My former staff at the Division of Aging and Adult Services tell me that the waiting list for the **Home and Community Care Block Grant** has grown to 10,600. It is estimated that the $4 million which was appropriated in the last legislative session – which several of you worked very hard to get in the budget – will take care of about 3000 people. More funding is needed for this program which helps to keep older adults in their homes.

If older adults are to stay in their communities, they must have safe, affordable and accessible housing. Many older adults in our state who do own their homes often have difficulty paying for needed repairs to keep their homes habitable. We are lucky in our state to have the Housing Trust Fund which was created in 1987 to provide "bricks and mortar" to help finance affordable housing construction and renovation. This last legislative session a small amount of non-recurring funding was appropriated for the **Housing Trust Fund**. AARP North Carolina encourages you to support additional recurring funding for the Trust Fund.

Speaking of housing, we have many older adults with limited income in North Carolina who can not afford to pay their property tax. In many parts of our State, tax rates are going up by leaps and bounds and older and disabled adults, particularly those on fixed incomes, find themselves house rich and cash poor. In the last legislative session, several bills were introduced to reduce the property tax burden on limited income older and disabled adults by **increasing homestead property tax relief**. We encourage you to again support, as you have several times in the past, help for older and disabled adults with their property tax burden.

A final issue I would like to touch on is that of the **medically needy income standard for aged, blind, and disabled adults** under Medicaid. The medically needy income limit in our State is $242 per month, an amount which anyone would be hard pressed to live on. This income level has not been increased in over 30 years and is several hundred dollars less than the average income level for the other states in the country that offer the medically needy program. Because this limit is so low, there are many older and disabled adults in our state with incomes just over the poverty level who can not get help with their medical bills through the Medicaid program. This limit needs to be raised.

I want to close by adding my thanks to the Study Commission for your good work and your advocacy on behalf of our State's older citizens.

Testimony by Mary Bethel
Study Commission on Aging Public Hearing
October 3, 2006

My name is Mary Bethel and I am Associate State Director for Advocacy for AARP of North Carolina. Prior to coming to work for AARP one year ago today, I worked for almost 29 years with the N.C. Division of Aging and Adult Services. Thank you for allowing me to make a few comments today to the Commission. I would like to share with you, in the next few minutes, several issues which AARP North Carolina believes are key issues facing older adults in our great State.

AARP North Carolina, like many other aging advocacy groups in our State, **support efforts to increase choices and options for long term care.** The Commission has advocated for a number of programs and services in the last several years that have expanded the range and scope of options that older and disabled adults have for their care in the long term. We salute you for this and ask that you continue to work for the following:

- **Increased funding for the Home and Community Care Block Grant**
- **Expansion of the Special Assistance/In-Home Program**
- **Strengthening of the Community Alternatives Program for Disabled Adults (CAP/DA)**
- **Increased funding for the Housing Trust Fund for construction and renovation of housing for older adults**
- **Alleviation of institutional bias in public programs**
- **Viable solutions to the housing of persons with mental illness**

- **Support for a well trained and qualified workforce in the home as well as in long-term care facilities**
- **Support for family caregivers**

A second issue I wish to raise is that of the **need to strengthen disaster planning for special need populations, including older adults.** Our State has had our share of hurricanes and ice storms in recent years so we are no stranger to dealing with natural disasters. How older adults fair in a disaster varies greatly from one county to another depending in large measure on whether the county has a valid and functional plan for addressing the needs of special population groups. Unfortunately, if our State was faced with events such as a major category 4 or 5 hurricane which required wholesale evacuation of a large area or a pandemic flu epidemic, few counties in the state would be able to meet the needs of frail older adults in the community or those living in long-term care facilities. It is my understanding that in the next few weeks, under executive order from the Governor, a Council is being established to look at disaster preparedness for the disabled and the elderly. The work of this Council needs to be followed closely and AARP North Carolina encourages the Study Commission to be an advocate for legislative recommendations coming from the Council.

A third issue that I bring to you today is the need for **support for a state prescription drug assistance program.** In January of this year, as you are aware, the federal Medicare Part D Prescription Drug Program began and Senior Care, our state prescription drug assistance program for older adults with incomes at or below 250% of the federal poverty level, ended. North Carolina is the only state in the country that did not continue a State

Prescription Assistance Program that had helped seniors with incomes above 135% of the federal poverty level. Under Medicare Part D, persons with incomes up to 150% of the federal poverty level and limited assets can receive some federal assistance with their out-of-pocket costs, however, there are many older and disabled adults enrolled in Medicare Part D prescription drug plans who don't qualify for the federal assistance and need help paying their out-of-pocket costs for prescription drugs. Last year a loosely formed coalition of 43 agencies and groups in the state concerned about prescription drug access advocated for legislation to establish a state prescription drug "wraparound" assistance program which would serve all Medicare beneficiaries who have incomes at or below 200% of the federal poverty level and assets of no more than $20,000 (single) or $30,000 (couple) but who are not eligible for the full low-income subsidy under Medicare. This coalition met again last week and affirmed continuing support for a state "wraparound" program. AARP North Carolina is a member of this coalition and we ask the Study Commission for your support of this need.

A fourth issue that AARP North Carolina brings to you as a concern is that of the **need to expand dental care services for special need populations in our state,** including persons who are residing in nursing homes and adult care homes and persons with dementia. At this time only two programs exist in North Carolina which provide dental care services to special population groups. These programs employ dental practitioners trained to work with persons with special needs and provide services on-site at care facilities or other locations which can accommodate the persons with special needs. Another speaker will address this issue further so I will not comment

any more on this except to say that addressing the dental care needs of some of our State's most vulnerable citizens is a long term problem for which a solution is needed.

In closing, on behalf of AARP North Carolina, thank you for your work to find solutions to the problems facing our State's older residents. We are indeed fortunate to have a body like the Commission as a visible and effective advocate for seniors.

NC Study Commission on Aging
October 3, 2006

Aging and caregiving are the two things that almost all of us have in common.

- Given the way the system works, there is such a disincentive to live at home. More emphasis and dollars need to go toward community based services versus institutional placement. Most older adults live in the community, not in facilities.

- Older Americans are such a diverse group. In planning and allocation of funding, we should always consider that individuals 60+ present a wide, wide range of needs, interests and resources. We are serving the spectrum - from the very well senior to the frail, at-risk senior.

- Our state's LTC plan recommends several various core services to be available in every county. Community based "access" type services, which include Information and Assistance and Care Management services, are listed as two of these important core services. Increased funding emphasis should be given to Information and Assistance and Care Management services. These services, which are often time intensive by their very nature, are provided to individuals across the spectrum who have wide ranging needs and resources and are facing various life situations. Information and Assistance and Care Management are critical to persons finding and obtaining services they need; and, helping families develop and implement a plan to keep a frail loved one at home versus seeking institutional placement.

  Information and Assistance and Care Management services need to be available in sufficient numbers to meet both the current and growing need for them. These services are provided across the spectrum – from the very well to the at-risk. Having sufficient numbers of Care Managers on staff is integral to providing these services. These are important services that save the system money by focusing on identification of needs of elders and their caregivers, employing collaboration and problem solving techniques to locate, obtain and coordinate services; and, providing multidimensional assessment of needs, development, coordination and monitoring of detailed care plans to enable frail older persons to remain living at home versus seeking placement.

Brenda Porter, Program Director
Alamance ElderCare, Inc.
(336) 538-8080

STATEMENT BY RICHARD C. HATCH, CHAIR OF AARP-NC CAPITAL LEGISLATIVE TEAM AT PUBLIC HEARING OF NC STUDY COMMINSSION ON AGING BURLINGTON, NC OCTOBER 3, 2006

Thank you Mr. Chairman and members of the Commission. I am Dick Hatch, chair of AARP North Carolina's Capital Legislative Team. AARP-North Carolina is asking the Study Commission on Aging to again recommend re-enactment of the North Carolina income tax credit for premiums paid for long-term care insurance that expired in 2004.

In May of this year, AARP North Carolina conducted a statewide poll of citizens aged 50 and over in our state. Nearly six in ten supported a state tax credit for those who purchase long-term care insurance – even if it meant that other taxes would have to increase or some services would have to be reduced.

In addition to AARP, a long-term care insurance tax credit has been supported by the Governor's Advisory Council on Aging, The Senior Tar Heel Legislature, and the NC Coalition on Aging.

In 2004, the last year for which we have data, over 30 states offered a long-term care tax credit or deduction that was as good or better than the federal tax deduction.

The benefits of long-term care insurance extend far beyond the policyholders. The Health Insurance Association of America, in a 2002 study found that long-term care insurance helped in the many ways, I will mention just a few.

- Disabled older adults were more able to remain in their homes, and delay or avoid using institutional services.
- Long-term care insurance policyholders were 66% less likely to have to spend their assets to pay for nursing home care to the point of impoverishment and Medicaid eligibility.
- Long-term care insurance will reduce state and federal Medicaid expenditures and federal Medicare home health expenditures. Medicaid savings were projected to total about $5,000 per policy holder.

A state income tax credit for premiums paid for long-term care insurance will benefit middle-class taxpayers the most. The wealthy don't need insurance to pay for long-term care costs, and even if they did buy long-term care insurance, they are likely to claim the cost of premiums as an itemized deduction on their federal income tax return, making them ineligible for a state income tax credit Many very low income taxpayers will have their long-term care expenses paid by Medicaid, so they don't need insurance. The tax credit we seek will benefit state taxpayers who didn't itemize and took the standard deduction on their federal income taxes—that's the middle-class taxpayer.

Thank you Madam Chairman and Commission members.

Testimony by Diana Hatch

Study Commission on Aging Public Hearing

October 3, 2006

I am Diana (Dee) Hatch, AARP North Carolina State President. With more than 1 million members in North Carolina, we are the largest membership organization for people 50 and older in our state. I am pleased to have this opportunity to speak with you briefly today about several issues of importance to our older adults and their families. I also sincerely want to thank each of you for your advocacy on behalf of aging issues in the last legislative session. Due to your efforts, this was one of the most successful sessions in recent memory.

On behalf of AARP North Carolina, I ask for your support for **increased funding for the Home and Community Care Block Grant**. My husband and I deliver meals to the homebound through the Meals on Wheels Program in our county. We get to see first hand the importance that lunch-time meal plays in helping older and disabled adults stay in their homes. According to the Division of Aging and Adult Services, there are currently 3,400 older adults on the waiting list for home delivered meals. Data from the Division also shows that the mean age of meal recipients is 80, 63% are widowed, and 90% percent of those who get meals are at moderate to high risk of malnutrition. Home delivered meals are just one of the many home and community based services that help older adults stay in their community. AARP joins numerous other groups in our state in asking that you support increased funding to help reduce the waiting list for meals as well as other services.

I also want to ask that you look at ways to better **support our family caregivers**. Family caregivers provide 80% of the care to older and disabled adults and are the backbone of our long term care system. It is estimated that the value of

(over)

family caregiving in North Carolina is $7.5 billion. In our state, more than 1.6 million people 18+ care for someone over age 60. Almost half provide care to someone with dementia.

Everyday we hear stories about caregivers and the challenges they face such as giving up paid employment, and in many cases health insurance benefits, in order to stay at home and care for an older or disabled family member. Increasingly more attention is also focusing on the physical and emotional toll that the caregiving role has on caregivers, particularly those who provide care for a long period of time. AARP North Carolina would like to encourage the Study Commission on Aging to examine the challenges faced by family caregivers and to identify steps, such as expanding respite care and authorizing paid family leave and tax breaks for caregivers. These initiatives will help to provide better support for those who care for members of their family. It is imperative that we support our families. Not only is it the right thing to do, it is also important from a financial standpoint because our public system can not afford the cost of institutional care for the coming large influx of older and disabled adults.

Thank you again for giving me the opportunity to address you and for the steps you have already taken to help the older citizens in our state.

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — 10-3-06

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Judy Whitfield	Kernodle Senior Activities Center
Chatki Brown	Kernodle Senior activities Center
Ruby Johnson	K.S. Center
Harold Johnson	JRK. Center
Jane Smith	Kernodle Sr Center Box 1358 Burlington NC 27216
Mike Holp	K.S. Center
Betty Baughn	K.S center
Reva R. Terrell	KS Center
Klaus Wirbelauer	KS Center, Burlington, N.C. 27215
Pam Kelly	Asheville Parks & Recreation
Amy Lickman	Asheville Parks & Recreation

VISITOR REGISTRATION SHEET

N.C. STUDY COMM. ON AGING — 10-03-06

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Viola Reddick	Hamlet Sr. Center 102 Veterans Dr. Hamlet
Susan Sellers	Hamlet Senior Center 102 Veterans Dr. Hamlet, 28345
Melody Wiggins	City of Graham Recreation & Parks PO Drawer 357, Graham, NC 27253
Penelope Butler	501 Carr St. Mebane, NC 27302
Faye Ingleman	PO Box 1011 Haw River, NC 27258
Dona Bowland	2239 Rockland Dr Burlington NC 27215
Mary Jarrett	Alamance Eldercare PO Box 2021 ARMC Burlington, NC 27217
Mary Bethea	AARP - NC 225 Hillsborough St. - Suite xxx Raleigh NC 27603
Karen Bottoni	AARP Advocacy Council 609 Leonidas Ct Raleigh, NC 27604
Beverly Shue	1711 Hanford Hills Rd Graham NC 27253
Dawn Baughman	1711 Hanford Hills Rd. Graham NC 27253

VISITOR REGISTRATION SHEET

N.C. Study Commission on Aging 10-3-06

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pat Dixon	205 Cobb Street, Gibsonville, NC 27249
Debbie Porch	546 Rockwood Drive, Graham, NC 27253
Kathryn Porter	Friendship Adult Day Services, Inc. P.O. Box 3303 Burlington NC 27216
Carolyn Biggerstaff	Share-A-Home of Guilford County Inc. 1808 Bailitt St. Greensboro, NC 27403
Dennis Williams	Alamance County Transportation Authority PO Box 2746 Burlington, N.C. 27216
Roosevelt Brinkley	4140 W. Gustard Rd Nashville N.C
Jamie Wilson	Nash County Senior Center 103 N. Alston St. Nashville NC 27856
Dorothy Johnson	P.O. Box 744 Nashville, NC. 27856
Yvonne C. Moore	3629 Pleasant Grove Ch Rd. Nashville, N.C. 27856
Stacie Nelson	Nash County Aging Dept. 103 North Alston St Nashville, NC 27856
Jeanine Gangloff	HOPE ministry of Eastern Alamance PO Box 849 Haw River, NC 27258

VISITOR REGISTRATION SHEET

N.C. STUDY COMM. ON AGING 10-3-06

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jenise H. Davis	ADULT SERVICES PROGRAM MANAGER GUILFORD COUNTY- DSS. 1203 MAPLE ST GREENSBORO, NC 27402
Stephen M. ROSS	MAYOR (City of BURLINGTON) 425 S. Lexington Ave, Burlington N.C. 27215
ELLEN TAYLOR ATKINS	TRIAD RETIREMENT LIVING ASSOC. C/O SENIOR CARE CONCEPTS PO BOX 4548 GREENSBORO, NC 27404
Emma Ray	Senior Tar Heel Legislator Guilford Ct. 336 707 9102
BLAIR BARTON-PERCIVAL	PTCOG AAA 2216 W. Meadowview Rd Greensboro, NC
JOE CONNOLLY	LAND-of-Sky Regional Council, AAA 25 Heritage DR Asheville, NC 28806

VISITOR REGISTRATION SHEET

N.C. Study Commission on Aging 10-3-06

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY
NATALIE LING	HOPE MINISTRY of EASTERN NA. @ ST ANDREW'S Episcopal Church Hoke River
Elizabeth Daniel	632 Wendy DR, Graham NC 27253 Chm Alm County Com on Aging
Amy FARMER	NASH Senior Center - Nashville, NC
Agnes Moore	Nash Senior Center - Nashville NC
Lisa Miller	Kernersville Senior Enrichment Center
Deanna Cole	Kernersville Senior Enrichment Center
Patricia Drewry	Kernersville Senior Enrichment Center
KEN DREWRY	KERNERSVILLE SENIOR Enrichment Center
Bill J. Cole	Kernersville Sr. Enrichment Cnt.
LUELLEN KAIGHN	NAMI, CFAC CASWELL, Rockingham, Alleghany
SABRENA LEA	PTCOG/AAA Greensboro, NC
Renée Griffin	Senior Resources of Guilford
FINLEY GRAVES	SENIOR BURLINGTON NC
Kellie Retiever	Geriatric Specialty Team - Therapeutic Alternatives
Eileen McGuinness-Vaillancourt	Alzheimer's Association 1315 Ashleybrook La W.-S. 27103
Wilhelmenia Pledger	Alzheimer's Association 1315 Ashleybrook Lane W-S NC 27103
Willie Pledger	161 Northoaks Dr. W-S NC 27105
VALERIA JACKSON	660 SINK AVE. W-S NC 27127
Betty A. Alexander	3055 Draper Court, W.S, NC 27105
HENRY TRIPP	P.O. Box 683 - Pleasant Garden, NC 27313
Lorrie Roth	Health Force 2302 W. Meadowview Rd GSO 27407
Emily Downs	Barnes & Noble 2.00 Cloverdale Blvd Suite 150 W-S 27103
Larissa Ferretti	Elon University, NC
Ruby M. Lockerman	Cumberland Co. DSS
JEAN M CHRISTO	Touched By Angels Home Health Care
Betsy Lee	Access Dental Care
HENRY THIEL	ALA. Co ADVISORY COMM. SENIOR

VISITOR REGISTRATION SHEET

NC Study Commission on Aging 10-3-06

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY
BILL STEVENS	ALAMANCE-BURLINGTON SENIOR GAMES
Pat Stevens	" " " "
Dick Hatch	AARP-NC
Diane D. Hatch	AARP-NC
Jennifer Ellis	Guilford County Community Advisory Committee
Shirley Preiss	concern for adult day care.
KAREN WEBB	AHA-CASW. Rockingham Local Management Entity

October 3, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be two meetings of the NC Study Commission on Aging during October.

DAY:	Wednesday	TIME:	10:00 AM
DATE:	October 11, 2006		
LOCATION:	[redacted] Legislative Office Building		

DAY:	Wednesday	TIME:	10:00 AM
DATE:	October 25, 2006		
LOCATION:	Room 643 Legislative Office Building		

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, October 11, 2006
10:00 a.m.
Legislative Office Building
Room 544

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Special Care Units

- **Special Care Units - Defined**
  Doug Barrick, Division of Facility Services, DHHS
- **Special Care Units – Reimbursement Changes (State/County Special Assistance & PCS)**
  Carol Shaw, Commission Staff, Fiscal Research Division, NCGA

III. Report: Adult Day Awareness/Status Study Recommendations

(S.L. 2006-108)
Shannon Crane, Adult Day Care/Day Health Specialist, Division of Aging and Adult Services, DHHS

IV. Report: Adult Protective Services Task Force Colloboration

(S.L. 2005-23)
Suzanne Merrill, Adult Services Section Chief, NC Division of Aging and Adult Services
Nancy Warren, Adult Services Program Administrator, NC Division of Aging and Adult Services
John Eller, Director of the Services for Adults Division, Mecklenburg County DSS
Jan Elliott, Director of the Scotland County DSS

V. Meeting Adjourned

Public Hearing:

Charlotte - Tuesday, October 17, 2006
10:30 a.m. until 12:30 p.m.
Shamrock Senior Center
3925 Willard Farrow Drive in Charlotte, NC

Next Meeting: October 25, 2006 at 10:00 a.m. in Room 643

Additional Information:

Medication Management 101
Auditorium of Sheraton Imperial Hotel
(Same location as N.C. Conference on Aging)
October 24, 2006 12:00 pm to 4:00 pm

North Carolina Conference on Aging
Sheraton Imperial Hotel and Convention Center
Research Triange Park, NC
October 25-27, 2006

North Carolina Study Commission on Aging

MINUTES
Wednesday, October 11, 2006
10:00 AM
Room 544, Legislative Office Building

The North Carolina Study Commission on Aging met on Wednesday, October 11, 2006, at 10:00 A.M. in Room 544 of the Legislative Office Building. Members present were: Senator Charlie Dannelly, Co-Chair, Rep. Beverly Earle, Co-Chair; Senators Austin Allran, Stan Bingham, and Katie Dorsett; Representatives Debbie Clary, Bob England, and Jennifer Weiss; Mr. Brad Allen, Ms. Judy Pelt and Ms. Florence Soltys.

Representative Earle presided.

PRESENTATIONS

Special Care Units

Mr. Doug Barrick with the Division of Facility Services Adult Care Licensure Section of DHHS was the first presenter. He furnished Commission members with a handout entitled Adult Care Home Alzheimer's Special Care Units (SCU). (Attachment 1) He stated that special care units are defined as any section, wing or hallway within an adult care home separated by closed doors from the rest of the home, or a program provided by an adult care home that is designated or advertised especially for the care of residents with Alzheimer's Disease or related disorders. Mr. Barrick then discussed the specific requirements in more detail. See Attachment 1.

Senator Bingham asked if waiting lists exist for the SCUs. Mr. Jerry Cooper with the NC Assisted Living Association told Commission members that a survey was conducted and it was determined that most SCUs operate at 93-94% occupancy. He added that in smaller areas (Smithfield, Wake Forest, Gastonia, etc.) waiting lists exist for both private and Medicaid consumers. The waiting lists usually include 8-10 beds in existing SCUs.

Rep. Weiss asked staff for a report on how the staffing ratios and recommendations for SCUs in North Carolina compare to those in other states.

Rep. England asked if there is any information on how many people would qualify statewide. Mr. Cooper stated that number would be difficult to compute. He added that

not all Alzheimer's patients require placement in SCUs. Alzheimer's and related dementia account for the majority and is the fastest growing diagnosis for the 85+ age group. Mr. Cooper added that mental illnesses in SCUs have not been tracked. There are individuals who have mental issues but the primary issue is Alzheimer's and dementia.

Ms. Carol Shaw, Commission Staff, NCGA Fiscal Research Division, was the next presenter. She furnished commission members with a brief presentation and handout entitled Recent Changes in Reimbursement for Special Care Units (Attachment 2). She furnished members with background information on how that NC came to change reimbursement rates. She stated that in October of 2002, DHHS established an Adult Care Home Cost Modeling Committee which met for two years. The report from the committee recommended that reimbursement modeling should account for resident mix and facility size. Also, the committee concluded that reimbursement models should differentiate between the traditional adult care home resident and those in SCUs to reflect the higher staffing need of SCUs. Rates should also reflect the different costs associated with types of facilities based on populations served and the staffing levels required. Ms. Shaw concluded with most recent changes stating that during the 2006 Session the NCGA increased the State/County Special Assistance (SC/SA) rate for non-SCU resident to $1,148/month and appropriated $2.4 million to fund the increase. The SC/SA rate for SCU residents was not increased and remains at $1,515/month. In September 2006, 530 individuals were receiving SA-SCU payments. SCU payments currently comprise just over 2% of all SA payments and just over 3% of all expenditures for SA. In October 2006, the Division of Medical Assistance began paying for 4.07 hours of ACH PCS for residents of SCUs that have been prior approved to receive a higher level of services. DMA has received 189 prior authorization requests for services in SCUs. 131 requests for services have been approved and 58 requests have been denied. Please see Attachment 2 for further details.

Rep. Weiss also asked if there is a requirement that persons who work at SCUs get paid more money. Ms. Shaw stated that there is not. Mr. Barrick stated that the rules do not address staff wages at all. Ms. Lou Wilson with the NC Long Term Care Association added that in the Adult Care Home PCS Program facilities cannot make a profit on personal care monies from Medicaid. All monies must be used for personal care which means it must be passed through for aides, supervisors, or to the staff that relates to personal care. The department determines if a small amount can be used for administration. If the facility does not use the money, it is required to pay it back to Medicaid every year.

Ms. Soltys asked who does the assessments, what the training beyond the FL-2 is, how many medical personnel come in and what the training of the social worker is. Ms. Shaw stated that social workers determine that the person meets financial requirements and the paperwork is done. They rely on the FL-2 that is filled out by the physician's office. The FL-2 tells whether the person has Alzheimer's or dementia. The facility does the assessment and it is submitted to Raleigh and reviewed by a nurse. On the Medicaid side, clinical nurses do the assessment.

Ms. Soltys stated that she works in the Geriatric Evaluation Unit at UNC and she feels the committee needs to know that persons from SCUs are being brought to appointments and dropped off. No one comes with them to explain why they are there and patients cannot tell providers why they are there. Ms. Barbara Ryan with the Division of Facility Services stated that type of situation needs to be addressed as a complaint because that is inappropriate.

Report: Adult Day Awareness/Status of Study Recommendations

Ms. Shannon Crane, Adult Day Care Consultant with the DHHS Division of Aging was the next presenter. She furnished members with a folder labeled Adult Day Awareness/Status of Study Recommendation (Attachment 3). Ms. Crane told Commission members that the report was authorized by SB 1278 and HB 2054 which stated that DHHS Division of Aging and Adult Services and the Division of Medical Assistance shall provide education and training, if necessary, to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health services and report on the status of the Partners in Caregiving Study recommendations. Ms. Crane stated that the Division of Aging and Adult Services (DAAS) and CAP met in early June of 2006. Following are the issues that have already been implemented.

- General information sheet generated for CAP case managers and consultants and posted on the website
- Special CAP section of DAAS website developed
- CAP notification of new adult day health programs system
- Notice to adult day health programs were mailed and included information on the CAP case manager(s), encouraged programs to provide brochures and other information to individuals and encouraged adult day health program directors and/or their board members to join the CAP advisory meeting in their area

Further initiatives in progress include:

- DMA-CAP plans to contact representatives of the Office of Research Demonstrations and Rural Health Development to discuss educating the Community Care Networks
- A presentation by DAAS Adult Day Services staff will be included as a part of the day set aside for CAP Case managers at the next Association of Home and Hospice Care Conference
- DMA-CAP tracking of the effectiveness of this awareness campaign through both numbers enrolled in and expenditures to adult day health programs.

Ms. Crane reviewed other initiatives and recommendations. Please see Attachment 3 for further details.

Rep. Clary asked Ms. Crane if she felt licensure of adult day health care would help gain access to Medicaid. Ms. Crane stated that she certainly supports Medicaid paying for adult day care and adult day health services. She stated that the change to licensure would make a big difference, however. One program the state is considering is an

overnight respite care. Currently, overnight respite would require the facility to be licensed.

Report: Adult Protective Services Task Force Collaboration

Ms. Suzanne Merrill, Adult Services Section Chief, NC Division of Aging and Adult Services, was the next presenter. Members were furnished copies of the Adult Protective Services Task Force Report to the Commission. (Attachment 4) Ms. Merrill stated that the report was prepared in response to Session Law 2005-23. This law directed the APS Task Force to collaborate with stakeholders and others interested in improving APS and report those finding to this Commission and the House Study Committee on Guardianship Laws. After collaborating, reviewing feedback and researching other states' APS laws and policies, recommendations were developed to strengthen NC's APS Program. Ms. Warren stated that NC's APS Law has not been meaningfully updated since 1975. The task force created The APS Clearinghouse Model: NC's System of Protection.

Next, Ms. Nancy Warren, Adult Services Program Administrator with the NC Division of Aging and Adult Services reviewed the core recommendations from the APS Task Force. Please see Attachment 5, pages 3-6 for a complete listing. Ms. Warren added that the total proposed APS Clearinghouse Budget to implement statewide is $15,212,202.

Mr. John Eller, Director, Mecklenburg County DSS Services for Adults Division, spoke briefly on the importance of implementing the changes recommended.

Ms. Jan Elliott, Director of the Scotland County DSS, told Commission members that the NC Association of County Directors of Social Services Board endorsed the APS Clearinghouse Model in September of 2006. She stated that implementation of the model requires adequate funding and the directors support a Pilot as the first step which allows for phased in, fine tuning and funding processes to take place over several years.

Ms. Soltys asked if someone could compare the Child Protective Services and the number of clients per individual and the training required with that of Adult Protective Services. Ms. Elliott answered that comparisons were made and APS is much more on par now than ever before.

Rep Weiss asked about the number of persons that will need to be case workers. She stated that there is a program to train CPS workers and give them scholarships through the schools of social work. She asked if this type of initiative was being considered in terms of APS workers. Mr. Eller stated that they realize that something needs to be done to make sure that the staff is competent. He added that discussions have taken place to look at the Child Welfare Collaborative Model as it relates to adults.

Rep. Clary asked if the APS workers are currently being paid by the county and the state. Ms. Elliott stated that currently they use the social services block grant money which is 75% federal dollars and 25% county dollars. They are also using the APS funds already

appropriated from the state. Counties must pick up additional costs if the resources aren't available.

Ms. Judy Pelt, Commission Member and member of the APS Task Force, stated that it is important that the commission consider supporting the pilot.

The meeting adjourned at 12:25pm.

Beverly Earle

Rep. Beverly Earle, Co-Chair
Presiding

Charlie A. Dannelly

Senator Charlie Dannelly, Co-Chair

Dee Hodge

Dee Hodge
Commission Assistant

ADULT CARE HOME ALZHEIMER'S SPECIAL CARE UNITS

SATUTORY AUTHORITY: G.S. 131D-4.6 Licensure of Special Care Units
G.S. 131D-8 Disclosure Information Required

DEFINITIONS:

Special Care Units for Persons with Alzheimer's Disease or Related Disorders: Any section, wing or hallway within an adult care home separated by closed doors from the rest of the home, or a program provided by an adult care home, that is designated or advertised especially for the special care of residents with Alzheimer's Disease or related disorders.

Related Disorders: Dementing or memory impairing conditions characterized by irreversible memory dysfunction (Examples – multi-infarct dementia, Parkinson's Disease, Huntington's Disease).

LICENSURE:

Construction: Approval by DFS Construction Section of plans for new or renovated construction.

Disclosure Statement: Approval by Adult Care Licensure Section of disclosure statement to be provided to family members or responsible party seeking admission of person to special care unit.

Licensure Change Application (if facility is currently licensed)**:** Submission to to Adult Care Licensure Section with policies and procedures for operation.

Issuance of License: Once DFS has approved the completed construction/renovation project, disclosure statement and other application materials, a license with special care unit designation and indication of number of special care unit beds is issued.

REQUIREMENTS:

Rules 10A NCAC 13F .1301-.1310 – effective December 1, 1999.

- Physical Environment – separated from rest of facility by closed doors which may be locked using special locking devices as defined by State

Building Code; located so staff and visitors do not have to pass through unit to reach other building areas; living and dining space, staff work area, nourishment station (for snacks), and medication and resident record storage, toilet and hand lavatory per 5 residents and shower for bathing within unit; direct access from facility to secured outside area; avoidance or minimization of distracting mechanical noises.

- Policies and Procedures – admission/discharge, assessment/care planning, safety measures, staffing, staff training, activity plans, family involvement.
- Admission – physician diagnosis on FL-2 of Alzheimer's or related disorder; pre-admission screening by facility; disclosure statement.
- Resident Profile - developed within 30 days of admission and quarterly thereafter; serves as basis for care planning.
- Staffing – to meet needs of residents but never less than 1/8 on 1st and 2nd shifts plus 1 hour for each additional resident and 1/10 on 3rd shift plus .8 hours for each additional resident; care coordinator 8 hours/day five days/week (may be counted in required staffing for units of 15 or fewer residents).
- Staff Training – 20 hours of dementia specific training for administrator prior to operation; 6 hours of staff orientation on nature/needs of residents within first week of employment; 20 hours of dementia specific training within 6 months of employment; 12 hours of continuing education annually with 6 of those hours dementia specific.

STATISTICS

103 Alzheimer's Special Care Units statewide.
2933 Alzheimer's Special Care Unit beds statewide.
16 facilities designated entirely as Alzheimer's Special Care Units, largest being 65 beds.
Average size unit – 28 beds
Largest unit within a licensed facility – 62 beds; smallest – 10 beds.

Recent Changes in Reimbursement for Special Care Units

- In October 2002, the Department of Health and Human Services established an Adult Care Home Cost Modeling Committee. Membership on the committee included departmental representatives from all programs affecting adult care homes, long-term care industry representatives, and long-term care advocates.

- The Committee had the following mission: **To develop a consistent and defensible costing methodology that considers the full cost of operating Adult Care Home facilities to ensure that resident care needs are met.**

- The Committee issued its final report in December 2004 which included the following recommendation: **Reimbursement modeling should account for resident mix and facility size.** The Committee recommended that the reimbursement model should differentiate between the traditional adult care home resident and those in Special Care Units (SCUs) to reflect the higher staffing need of SCUs. The Committee also recommended that the reimbursement system should reflect the different costs associated with types of facilities based on population served and the staffing levels required.

- At the time of the report (December 2004), the State/County Special Assistance (SC/SA) rate for all residents was $1,084 per month, and Medicaid paid for 1.01 hour per day of basic Adult Care Home Personal Care Services (ACH PCS). The Committee used the new cost model to recommend the following new rates for SC/SA and ACH PCS for the traditional ACH resident and those in SCUs:
  - SC/SA Rate for Non-SCU Resident -- $1,124 per month
  - SC/SA Rate for SCU Resident -- $1,515 per month
  - ACH PSC Rate for Non-SCU Resident – 2.31 hours per day
  - ACH PCS Rate for SCU Resident – 4.07 hours per day

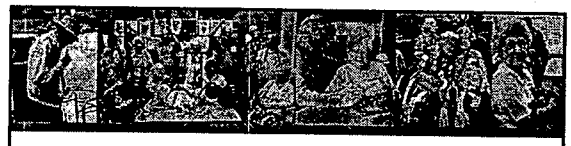
- During the 2005 Session, the North Carolina General Assembly enacted several recommendations from the Committee:
  - Increased SA Rate for Non-SCU residents to $1,118 per month effective October 1, 2005 and appropriated $3.1 million to fund the increase.
  - Increased SA Rate for SCU residents to $1,515 per month effective October 1, 2005 and appropriated $380,000 to fund the increase.
  - Increased the number of ACH PCS hours for SCU residents to 4.07 hours per day effective October 1, 2006 and appropriated $1.7 million to fund the increase in the number of hours.

Recent Changes in Reimbursement for Special Care Units

- During the 2006 Session, The North Carolina General Assembly increased the SC/SA rate for non-SCU residents to $1,148 per month and appropriated $2.4 million to fund the increase. The SC/SA rate for SCU residents was not increased and remains at $1,515 per month.

- In September 2006, 530 individuals are receiving SA-SCU payments. SCU payments currently comprise just over 2% of all SA payments and just over 3% of all expenditures for SA.

- In October 2006, the Division of Medical Assistance began paying for 4.07 hours of ACH PCS for residents of SCUs that have been prior approved to receive the higher level of services. DMA has received 189 prior authorization requests for services in SCUs. 131 requests for services have been approved and 58 requests have been denied.



Adult Day Awareness/ Status of Study Recommendations

Pursuant to S.B. 1278 and H.B. 2054

Shannon Crane, MA
Division of Aging & Adult Services (DAAS)

1

S.B. 1278 and H.B. 2054

- ☑ *... shall provide education, and training if necessary, to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health services*
- ☑ *... shall report on the status of the Partners in Caregiving Study recommendations*

2

Overview

- CAP Awareness Initiatives
- Improved Day Services Program Initiatives
  - Administrative Rule Changes
  - Works in Progress
  - Completed Tasks
- Initiatives Beyond DAAS
  - NC Adult Day Services Initiatives
  - Initiatives Dependent on Funding

3

Community Alternative Program Initiatives

1. General Information Sheet for CAP Case Managers Distributed & Posted
2. Special Section on DAAS Website Developed
3. CAP Notification of New Adult Day Health Programs
4. Notice to Adult Day Health Programs Sent
5. Additional Initiatives in Progress

4

Improved Program Initiatives

Administrative Rule Recommendations

#2A Deletion of Formula for Monthly Reimbursement Rate

#10B Time Allowance for Rule Implementation

#12B Increase in Day Home Capacity Limits

5

Improved Program Initiatives

Works In Progress

#1A Establishment of Formal Reporting System

#4A Consensus on Absentee Policy

#5-6A Reimbursement through Negotiated Rates

#5B Review of Current Monitoring System

#13B Consideration of Hourly Rate for Reimbursement

6

Improved Program Initiatives

Completed Tasks

#3A HCCBG Definition of Reimbursable Unit

#2B Adult Day Services Brochure

#4B Expansion of DAAS Technical Assistance

#6B Promotion of Small Business Resources

7

Improved Program Initiatives

Completed Tasks, cont'd.

#8B Increased AHEC Communications

#9B Annual Funding Workshop

#11B Advocacy with DOI - Sprinkler System

8

Initiatives Beyond DAAS

North Carolina Adult Day Services Association Initiatives

#1B Establishment of Strategic Plan and Statewide Marketing Plan

#7B Offering of Industry Specific Training

9

Initiatives Beyond DAAS

Initiatives Dependent on Funding

#3B Statewide Adult Day Services Public Awareness Campaign

#14B Development of Management Training for Adult Day Service Program Directors

#15B Follow-up Technical Assistance

10

Background Information

At the recommendation of the Study Commission on Aging, the Adult Day Awareness/Status of Study Recommendation directed the Department of Health and Human Services to assure awareness of adult day health services and to provide a status report on changes implemented as a result of the Adult Day Services Study. Specifically, the General Assembly of North Carolina enacted:

> Section 1.(a) The Department of Health and Human Services, Division of Aging and Adult Services and the Division of Medical Assistance, shall provide education, and training if necessary, to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health services and that this option is being considered in all situations appropriate for the client.
>
> Section 1.(b) The Department of Health and Human Services, Division of Aging and Adult Services, shall report on the status of the Partners in Caregiving Study recommendations.
>
> Section 1.(c) The Department shall report the status of its activities under this section to the North Carolina Study Commission on Aging not later than July 30, 2006.

CAP Awareness Initiatives

- DAAS & CAP Meeting in early June

  1. General information sheet for CAP case managers and consultants distributed and posted [attachment B]
  2. Special CAP section of DAAS website developed
  3. CAP notification of new adult day health programs system devised [when new program is certified, CAP notified and information sent to CAP listserv
  4. Notice to adult day health programs mailed

     Included Information on the CAP case manager(s)

     Encouraged programs to provide brochures and other information to these individuals

     Encouraged adult day health program directors and/or their board members to join the CAP advisory meetings in their area
  5. Further initiatives in progress

     DMA-CAP has plans to contact representatives of the Office of Research, Demonstrations and Rural Health Development to discuss educating the Community Care Networks (the Medicaid managed care networks)

     A presentation by DAAS Adult Day Services staff will be included as a part of the day set aside for CAP Case managers at the next Association of Home and Hospice Care conference

     DMA-CAP is tracking the effectiveness of this awareness campaign through both numbers enrolled in and expenditures to adult day health programs

Improved Program Initiatives - Administrative Rule Recommendations

#2-A Deletion of Formula for Monthly Reimbursement Rate

The formula for the rate per month (i.e., monthly maximums) for the SADCF should be deleted from the administrative rules.

Action:

The adult day care and day health care rules have been revised and this recommended change is included. The process of changing APA [Administrative Procedures Act] rules has been initiated with an anticipated effective date of July 1, 2007. Counties currently interpret the monthly maximum differently; some reimburse the total monthly maximum amount every month, regardless of the number of days in that month, others only reimburse the daily maximum for the number of days of service. The elimination of the monthly maximum will help assure consistency in reimbursement from county to county.

#10-B Time Allowance for Rule Implementation

Prior to implementation, all revised administrative rules or standards should provide sufficient lead time for potential budgetary preparation and/or training and outreach.

Action:

Rule changes not made through legislative mandate will be delayed from 3 to 6 months in order for adequate training and lead time.

#12-B Increase in Day Home Capacity Limits

To help improve the financial viability of adult day care homes and adult day health homes, DAAS should consider revising the standards to allow more individuals to be served in single family dwellings, as long as the square footage requirement per participant can be met.

Action:

The building code sets a limit of 16 for residential occupancy for adult day care homes and adult day health homes. The adult day care rules have been revised to reflect this maximum and the process of changing APA [Administrative Procedures Act] rules has been initiated with an anticipated effective date of July 1, 2007.

Improved Program Initiatives - Works In Progress

#1-A Establishment of Formal Reporting System

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.

Action:

The Division of Aging and Adult Services [DAAS] recognizes the need to emphasize uniformity in the determining actual provider daily care costs. The challenge continues to be developing financial technical assistance and formats that can address the needs of providers with a wide

range of managerial experience and capacity. Responses from providers on the 2004 cost analysis/ budgeting tool indicate that revisions are necessary for the tool to be fully accepted and useful to all providers. DAAS has refined the provider cost analysis/budgeting tool and has plans to pilot it between now and July, 2007. Use of this tool will be covered during regional training on new adult day service rules in early 2007 and a cost analysis session will be integrated into the yearly Adult Day Services training workshop. The cost analysis/budgeting tool or an approved equivalent will be required as part of the existing annual recertification materials beginning July 1, 2007. The Division will then begin to compile and analyze adult day services daily care cost data most likely on a biannual basis.

#4-A Consensus on Absentee Policy

DAAS needs to develop a task force to address the HCCBG and SADCF absentee policy differences and arrive at consensus in the development of a consistent absentee policy and interpretation.

Action:

The Division held an ad-hoc committee meeting with six adult day service providers, two Area Agency on Aging Directors, two county Department of Social Services (DSS) Adult Day Care Coordinators and two Adult Program Representatives (APR's) and a consensus on this policy was reached. DAAS plans to send an Administrative Letter notifying providers and fund managers of this decision by the end of October.

#5-6A Reimbursement Through Negotiated Rates

#5-A: 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.

#6-A: 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:

As per Partners in Caregiving note on this recommendation, a cost analysis study by DAAS would need to be conducted as to the impact of negotiated rates on service delivery. This is not feasible without having a cost analysis tool [recommendation #1-A]. There is concern that negotiated rates may have a negative impact on the number of people served. The current reimbursement rate for adult day care is comparable to other HCCBG services in terms of ratio of average actual cost to reimbursement.

The reimbursement study recommendations were presented to the Social Services Commission in early 2005 and this recommendation was among them. Therefore, discussions have been initiated. Further action, however, is not recommended prior to knowing the full effect such a change would have on service delivery and whether implementation of this suggestion would decrease the number of individuals served or adversely affect the current reimbursed rate for day care services. These types of questions cannot be addressed prior to having sufficient experience with a cost analysis tool.

#5B Review of Current Monitoring System

For service improvement and consistent/uniform interpretation of standards across counties, DAAS should contract with an independent consultant to study the current adult day program

monitoring system. The study should look at the history of the county monitoring system, including how the existing system was created and why, how it currently operates, and how the system can be improved.

The study should also look at the development of a standard monitoring curriculum (including a technical assistance module) with the intent of improving consistency from county to county. The curriculum should address the various needs of all monitors, regardless of their longevity in the position: the desire to learn, problem solve, share best practices, and experience peer interaction and support. Experienced monitors interacting with new monitors provide an extremely valuable form of mentoring/technical assistance.

To be convenient and accessible to all monitors, the study should look at a variety of training methods such as: regional training sessions in the field on an annual basis; distance learning via videoconferencing through the area health education centers (AHEC); and, an on-line seminar (i.e., webinar). A determination should be made as to the most effective and efficient way to provide the training.

Action:
Since there is insufficient funding to contract with an independent consultant, DAAS modified its May 2006 Adult Day Services Training Workshop to focus specifically on the monitoring tools. The workshop paired experienced monitors and day care providers with newer ones in order to facilitate mentoring and technical assistance. DAAS has also developed a risk-based monitoring system in order to be responsive to well-developed programs consistently in compliance with day care regulations and target those with major compliance issues. This system is scheduled to be implemented along with other adult day care rule changes currently being moved through the APA process. Frequently asked questions regarding adult day services administrative rule interpretations have also been compiled and posted on the DAAS website in order to facilitate uniform interpretation across counties:
[http://www.dhhs.state.nc.us/aging/adcpolicy.htm].

#13B Consideration of Hourly Rate for Reimbursement
In addition to the HCCBG and SADCF negotiated rate recommendations in the Reimbursement Methodology Study, DAAS should also explore the feasibility of a negotiated hourly rate (as opposed to a negotiated daily rate) for both HCCBG and the SADCF. A negotiated hourly rate establishes a consistent measure for consumers, funders, and reporting purposes at the State and Federal level.

Action:
As discussed in the Reimbursement Methodology Study [Recommendation 5 and 6-A], this area needs further research and study after the development of a cost analysis tool [Recommendation 1-A]. However, DAAS will conduct a survey to understand concerns that adult day service providers have regarding a move towards an hourly rate. During earlier discussions with day programs, there was significant resistance to this change due to a perceived increase in administrative work and decrease in overall reimbursement amounts. A better understanding of these concerns is needed.

#3A HCCBG Definition of Reimbursable Unit

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 Community Alternatives Program/Disabled Adults, 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:

In the HCCBG manual, the unit of service for adult day care and adult day health care is already defined as "1 day." The confusion was due to the parenthesis after this definition, which references a 6-hour minimum. Responsibility for administering HCCBG adult day care funds rests with the Area Agency on Aging [AAA] Directors. Policy interpretation guidelines have been sent to the AAA Directors regarding this reference. Specifically, it has been made clear that the 6-hour reference to a unit of service is interpreted by the Division as an operational definition for day service programs [must be open a minimum of 6 hours], not as the definition of what constitutes one day for a specific participant. This information has also been posted on the adult day services section of the Division website in a new area titled "Policy Interpretations and Frequently Asked Questions," http://www.dhhs.state.nc.us/aging/adcpolicy.htm.

#2B Adult Day Services Brochure

To increase overall visibility and public awareness, DAAS should create a generic adult day services brochure (similar to the one for senior centers) and information for the DAAS display board used at State and public functions.

Action:

DAAS has drafted a generic adult day services brochure and information about adult day services is now available as a part of the DAAS exhibit at State and public functions.

#4B Expansion of DAAS Technical Assistance

To help support and sustain adult day programs, DAAS should expand its technical assistance as follows:

1. Develop, disseminate (to all certified adult day programs), and post on the DAAS web site the following **fact sheets** for adult day programs:
   a. Information on how the five divisions within DHHS (i.e. Divisions of Aging and Adult Services, Medical Assistance, Public Health, Mental Health, Social Services, and Developmental Disabilities and Substance Abuse Services) and three other State departments (i.e. Departments of Insurance, Veteran Affairs, and Environment and Natural Resources) interface with adult day programs. This would provide education and information in response to the complicated and fragmented system of the regulation and funding of adult day services.
   b. Information detailing the requirements and process for a program to convert from an adult day care only certification to one that combines adult day care and adult day health. Financial viability of adult day programs improves when a program makes this conversion, so a fact sheet of necessary steps would greatly assist programs in making this transition.

c. Instructions on negotiating and developing vendor agreements with the local Department of Social Services for State Adult Day Care Funds and with the community advisory board [sic*] for Home and Community Care Block Grant Funds. This information will assist programs in diversifying their revenue streams, another essential component of achieving financial viability.

2. Create an **adult day services list serve** for the primary purposes of networking, technical assistance, and informal mentoring. The list serve could be developed through the DAAS formal relationship with the Institute on Aging, and should include all certified adult day programs, Adult Day Care Coordinators, Adult Day Health Specialists, regional Adult Program Representatives, Area Agencies on Aging representatives, the North Carolina Adult Day Services Association executive director, and appropriate DAAS staff. DAAS should also promote the list serve to the other divisions within DHHS and the other State departments that work with adult day programs.
3. Create a **quarterly web-based newsletter** for adult day programs, similar to the DAAS web-based newsletter "At a Glance". The primary purpose of the newsletter would be to provide enhanced technical assistance, and up-to-date State and Federal information to adult day programs.
4. For enhanced technical assistance for adult day program service improvement on a regional basis, DAAS should encourage the development of a partnership between the Area Agencies on Aging and adult day programs in their regions. Area Agencies on Aging have expertise in training/education, technical assistance, and monitoring that would prove beneficial to adult day programs.

Action:

1. DAAS staff has developed the first two fact sheets and posted these on our website [http://www.dhhs.state.nc.us/aging/adcresources.htm]. The third fact sheet is no longer applicable, as vending agreements have been replaced by contracts. However, a funding fact sheet has been developed and a workshop on contract negotiations was added to the annual Adult Day Services training. The developed fact sheets are posted on the Division website under "Additional Resources," http://www.dhhs.state.nc.us/aging/adcresources.htm. (*Community advisory boards do not negotiate or administer HCCBG funding.)
2. A list serve has been created for ease in disseminating education and information relevant to day programs. Other divisions within DHHS and other State departments that work with adult day programs have been invited to join the list serve.
3. A section of the DAAS website now includes up-to-date information about what is happening in adult day care on a state and federal level and provides additional information of assistance to day service program operators.
4. DAAS includes Area Agencies on Aging on all correspondence and communications sent to adult day programs and encourages them to continue their partnerships with day care programs.

#6B Promotion of Small Business Resources

DAAS and the North Carolina Adult Day Services Association should promote these small business development resources, on an ongoing basis, on their web sites, including a direct link to SCORE (www.score.org), the Small Business Center Network (www.ncccs.cc.nc.us/Business_and_Industry/sbcnmainpage.htm), and the Small Business and Technology Development Center (www.sbtdc.org).

Action:
DAAS included information about these organizations in a resource notebook distributed at the annual Adult Day Services Workshop and has posted them on the DAAS website [http://www.dhhs.state.nc.us/aging/adcresources.htm]. A notice about these resources has also been sent to the listserv. Furthermore, NCADSA includes links to these resources, and others, on their website (http://www.ncadsa.org/).

#8B Increased AHEC Communications
For other educational opportunities for adult day programs, DAAS should distribute the list of all certified adult day programs (and the contact information for the North Carolina Adult Day Services Association) to the nine area health education centers (AHEC) to add adult day programs to their mailing lists. The development of a collaborative relationship between AHEC, DAAS, and the North Carolina Adult Day Services Association would ensure that AHEC educational opportunities are responsive to the specific needs of the adult day services industry.

Action:
DAAS contacted staff of central AHEC and received an updated list of aging contacts for each of the nine area AHEC centers. These individuals were contacted about adult day services, provided a list of certified programs, solicited for input in ways we can better work together and added to the adult day services listserv. Information materials regarding the services of AHEC and their programs were also distributed at the annual Adult Day Services Workshop and a link to AHEC has been added to the DAAS website, http://www.dhhs.state.nc.us/aging/adcresources.htm.

#9B Annual Funding Workshop
For consistency and uniformity across counties, DAAS should offer an annual funding workshop for adult day programs receiving HCCBG and SADCF funds, and for individuals administering these funds at the county level. To be convenient and accessible, DAAS should conduct the annual training in the field on a regional basis, or use distance learning such as videoconferencing through AHEC or the creation of an on-line seminar (i.e., webinar).

Action:
The annual Adult Day Services Workshop included a session on funding. This workshop will be expanded in FY 2006-07. A fact sheet regarding potential funding sources has also been posted to our web page on Adult Day Care (see Attachment C).

#11B Advocacy with Department of Insurance - Sprinkler System
To help improve adult day program financial viability, DAAS should continue to advocate with the Department of Insurance for a possible compromise on this regulation so that a sprinkler system is not required or is only required after a certain capacity.

Action:
DAAS continues to educate the Department of Insurance and the Building Code Council about the adverse effect that the sprinkler rule has had on adult day service programs. DAAS staff will also continue to assist the NCADSA in their advocacy efforts with the Building Code Council.

Improved Program Initiatives - Initiatives Beyond DAAS
North Carolina Adult Day Services Association Initiatives

#1B Establishment of Strategic Plan and Statewide Marketing Plan
To support and sustain adult day services, and to plan for industry growth, the North Carolina Adult Day Services Association (NCADSA) should create an Advisory Group (made up of key individuals from the various State departments) to move toward the development of a comprehensive, integrated strategic plan, including a statewide marketing plan.

Action:
The NC Adult Day Services Association is expanding its capability to secure resources to support and sustain adult day programs through a new 501(c)3 organization, the Adult Day Services Resource Center of North Carolina, Inc. The mission of the new organization is an extension of NCADSA's mission to promote the availability, accessibility, quality and cost-effectiveness of adult day services in NC. By procuring additional resources, Adult Day Services Resource Center of North Carolina will work to achieve this goal as it fosters and advances quality adult day services through education, partnerships and collaborations for the benefit of providers, consumers and their caregivers.

#7B Offering of Industry Specific Training
The North Carolina Adult Day Services Association should piggyback its "Opening an Adult Day Center" workshop and/or its "Keep Your Center Open" workshop with the "How to Start and Maintain a Small Business" workshop sponsored by SCORE chapters across the State. The industry-specific training provided by the Association, combined with the small business offering, would provide a well-rounded, complete training package.

Action:
The North Carolina Adult Day Services Association (NCADSA) has already begun strengthening the relationship between adult day programs, SCORE and the Small Business Center Network. NCADSA offered a workshop in August in Winston-Salem, NC, targeted for persons interested in Opening an Adult Day Program. Although there was not enough interest to hold the workshop, the contacts have been made to offer a similar class in the future. NASDA included a session on how to write/revise a business plan at their recent conference, held at the end of September, 2006. Given the multiple SCORE chapters and their diverse services and schedules, the Association is distributing information about all the SCORE chapters in North Carolina to current and potential providers through written information and links on the association's website.

Improved Program Initiatives - Initiatives Beyond DAAS
Initiatives Dependant on Funding

#3B Statewide Adult Day Services Public Awareness Campaign
In partnership with the DHHS Division of Public Affairs, the Agency for Public Telecommunications (APT) (in the Department of Administration), and the North Carolina Adult Day Services Association, DAAS should develop and implement a statewide adult day services public awareness campaign.

Action:
DAAS currently promotes National Adult Day Service week through the Department's Office of Public Affairs and will continue to do as much as possible to raise statewide awareness of the benefits of adult day services. This will include partnership with NCADSA in seeking grant funds for prime-time cable programs, video/audio/multimedia production, and media buying/placement.

#14B Development of Management Training for Adult Day Service Program Directors
DAAS should amend the requirements for program directors of adult day programs to include successful completion of adult day services management training. Such requirement should also apply to current adult day program directors; however, they should be given the option of testing out of the required training. Training should be documented and included as a part of the required employee file.

Action:
Legislative action would be needed to fund curriculum development.

#15B Follow-up Technical Assistance
As previously discussed, 94 of 106 certified adult day programs participated in this project. Of the 22 programs receiving a technical assistance site visit, 11 were identified as at-risk of closing, 10 (out of a total of 30) in the warning zone, and one in the safety zone. Partners in Caregiving research has demonstrated the necessity of follow-up technical assistance (1-3 years) for programs to become financially viable. Most programs need to be guided through recommendations for program growth connected to the predictors of success. To maximize on the training of adult day programs and on-site technical assistance provided to the 22 programs, follow-up site visits, mentoring, and project analysis needs to occur. Analysis would include a post Adult Day Services Profile sent to the 94 programs participating in the project to assess the impact of the training. Analysis would also include whether or not the site visit recommendations were implemented and what impact they had on program growth. The follow-up project analysis data could then serve as the basis for future projects to support and sustain adult day programs in North Carolina.

Action:
Legislative action would be needed to fund this recommendation.

Fact Sheet on Adult Day Care Services Interaction –Working with Government Agencies

Division of Aging and Adult Services
http://www.ncdhhs.gov/aging

- certifies and recertifies all adult day care and day health programs under General Statute 131-D6;
- provides technical assistance and consultation to local department of social service who monitor the programs;
- provides administrative oversight for the Home and Community Care Block and the State Adult Day Care Fund.

Division of Public Health
http://www.ncpublichealth.com/

- provides technical assistance to the Division of Aging and Adult Services on public health matters, and the development and implementation of standards, policies and procedures for certification and monitoring of adult day health services;
- provides ongoing health related consultation and technical assistance to staff of the local health departments who are designated to carry out the direct responsibility for annual review and monitoring visits to the programs.

Division of Mental Health, Developmental Disabilities, and Substance Abuse
http://www.ncdhhs.gov/mhddsas/

- serves as a potential funding source for adult day service providers serving clients with mental health and/or developmental disabilities;
- provides further information through the utilization of local management entities (LME) http://www.ncdhhs.gov/mhddsas/lmedirectory.htm

Division of Medical Assistance (DMA)
http://www.ncdhhs.gov/dma

- serves as a potential funding source for adult day service providers with a health component serving clients receiving Community Alternative Program (CAP) services (CAP-DA, CAP-MR/DD, CAP-HIV);
- enrolls providers through county lead agencies http://www.ncdhhs.gov/dma/CAPContactList.pdf.

Division of Social Services
http://www.ncdhhs.gov/dss/

- provides technical assistance and consultation to local county departments of social services on contracts for the State Adult Day Care Fund;
- contracts with adult day service providers to provide adult day services and receive reimbursement through the State Adult Day Care Fund.

Department of Insurance –Office of State Fire Marshal
http://www.ncdoi.com/

- consults and provides technical assistance to local building and fire inspectors on the NC Building Code.

Department of Environmental Health and Natural Resources
http://www.deh.enr.state.nc.us/

- conducts annual sanitation inspections and provides consultation and technical assistance through the local health departments.

Department of Veterans Affairs
http://www.doa.state.nc.us/vets/va.htm

- serves as a potential funding source for adult day service providers with a health component;
- contracts with adult day service programs to provide health services through contracting officer at the Veterans Administration Hospital in Asheville: 828-299-2532.

Steps for Adult Day Health Conversion for an Existing Adult Day Care Center

Adult Day Care Programs that wish to convert to an adult day care and adult day health combination or adult day health only program should consider the additional costs and certification requirements. Please note that the process of converting to add the health component requires a new certification, thus all of the required materials and steps for initial certification will be have to be completed.

- Contact Glenda Artis at the Division of Aging & Adult Services, 919-733-0440, as well as the local Department of Social Services Adult Day Care Coordinator in your county regarding your plans. The coordinator will also need to contact the local health department regarding your request to add adult day health to your program. A nurse (RN) from the health department will share certification and monitoring responsibilities with the adult day care coordinator.

- Check with your local zoning board to determine if there are any concerns about the program changing its status by providing health services. The local zoning ordinance will affect whether there is the need for an additional zoning variance or if there are restrictions on providing day health services at the programs' present location.

- Contact building, fire, and sanitation inspectors to determine if any changes are needed in order to meet code with regard to the additional space requirements.

- Consider the possibility your program will need to make physical changes to the building in order to accommodate additional space and square footage requirements per certification. For example, programs with a day health component are required to have a separate treatment room and a minimum of one office. Programs serving more than 12 participants must also have a separate male and female bathroom.

- Review any additional staffing needs. Having a day health component requires programs to have a health care coordinator and a substitute for the health care coordinator. Furthermore, staff members who will be providing personal care are required to have additional training. The staff to participant ratio will change from 1 staff per 8 participants to 1 staff per 6 participants. Since staff needs are changing significantly, programs should consider the additional costs that this may entail.

- Remember the conversion is treated as an initial certification. Program policies, the organizational chart, budget, floor plan, and other items will generally need modification to accommodate the addition of the day health service.

If you have further questions about adult day health conversion process, please contact the Division of Aging and Adult Services at 919-733-0440

Adult Day Awareness/Status of Study Recommendation

Pursuant to S.B. 1278 and H.B. 2054

Report
To
The North Carolina Study Commission on Aging

October 2006

Prepared by
North Carolina Department of Health and Human Services
Division of Aging and Adult Services

Background Information

At the recommendation of the Study Commission on Aging, the Adult Day Awareness/Status of Study Recommendation directed the Department of Health and Human Services to assure awareness of adult day health services and to provide a status report on changes implemented as a result of the Adult Day Services Study. Specifically, the General Assembly of North Carolina enacted:

> Section 1.(a) The Department of Health and Human Services, Division of Aging and Adult Services and the Division of Medical Assistance, shall provide education, and training if necessary, to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health services and that this option is being considered in all situations appropriate for the client.
>
> Section 1.(b) The Department of Health and Human Services, Division of Aging and Adult Services, shall report on the status of the Partners in Caregiving Study recommendations.
>
> Section 1.(c) The Department shall report the status of its activities under this section to the North Carolina Study Commission on Aging not later than July 30, 2006.

The following report has been prepared in response to this legislation.

Section 1.(a): Adult Day Awareness

Appropriate staff members of the Division of Aging and Adult Services (DAAS) and the Division of Medical Assistance (DMA) met on June 14, 2006 in response to Section 1.(a) of S.B. 1278 and H.B. 2054.

The CAP program is for individuals who are nursing home eligible and adult day health services are a part of the overall 'menu' of services available for these individuals. There are 58 programs offering adult day health care in the State, located in 37 counties (see Attachment A).

The following action steps were agreed upon and initiated by DAAS and DMA:

1. An information sheet about Adult Day Services for CAP case managers and consultants was developed by DAAS and DMA (see Attachment B);
2. DAAS will utilize their website for keeping CAP case managers informed about the program through posting the information sheet, sending reminders to the CAP case manager listserv, and keeping the adult day services on-line list of providers updated;
3. DAAS will notify DMA when a new adult day health program is certified and DMA will ensure this information is communicated to the CAP case managers in that service area;
4. DAAS will mail to the existing adult day health programs information on the CAP case manager(s) in their area and encourage programs to provide brochures and other information to these individuals for distribution to CAP client families;

5. DAAS will encourage adult day health program directors and/or their board members to join the CAP advisory meetings in their area;
6. DMA-CAP will contact representatives of the Office of Research, Demonstrations and Rural Health Development to discuss educating the Community Care Networks (the Medicaid managed care networks) since this office is responsible for expanding the scope of the Community Care Networks to include the Aged, Blind, and Disabled, and CAP-DA clients;
7. DMA-CAP will include a presentation by DAAS Adult Day Services staff as a part of the day set aside for CAP case managers at the next Association of Home and Hospice Care conference and have information available regarding adult day health services at future meetings;
8. DMA-CAP will track effectiveness of this awareness campaign through both numbers enrolled in and expenditures to adult day health programs.

Section 1.(b): Status of Study

A. REIMBURSEMENT METHODOLOGY STUDY RECOMMENDATIONS

COST ANALYSIS SYSTEM

Recommendation #1-A:
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.

Action:
The Division of Aging and Adult Services [DAAS] recognizes the need to emphasize uniformity in the determining actual provider daily care costs. The challenge continues to be developing financial technical assistance and formats that can address the needs of providers with a wide range of managerial experience and capacity. Responses from providers on the 2004 cost analysis/ budgeting tool indicate that revisions are necessary for the tool to be fully accepted and useful to all providers. DAAS has refined the provider cost analysis/budgeting tool and has plans to pilot it between now and July, 2007. Use of this tool will be covered during regional training on new adult day service rules in early 2007 and a cost analysis session will be integrated into the yearly Adult Day Services training workshop. The cost analysis/budgeting tool or an approved equivalent will be required as part of the existing annual recertification materials beginning July 1, 2007. The Division will then begin to compile and analyze adult day services daily care cost data most likely on a biannual basis.

CURRENT RATE PER MONTH FOR STATE ADULT DAY CARE FUND (SADCF)

Recommendation #2-A:
The formula for the rate per month (i.e., monthly maximums) for the SADCF should be deleted from the administrative rules.

Action:
The adult day care and day health care rules have been revised and this recommended change is included. The process of changing APA [Administrative Procedures Act] rules has been initiated with an anticipated effective date of July 1, 2007. Counties currently interpret the monthly maximum differently; some reimburse the total monthly maximum amount every month, regardless of the number of days in that month, others only reimburse the daily maximum for the number of days of service. The elimination of the monthly maximum will help assure consistency in reimbursement from county to county.

HOME AND COMMUNITY CARE BLOCK GRANT REIMBURSABLE SERVICE UNIT (HCCBG)

Recommendation #3-A:
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 Community Alternatives Program/Disabled Adults, 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:
In the HCCBG manual, the unit of service for adult day care and adult day health care is already defined as "1 day." The confusion was due to the parenthesis after this definition, which references a 6-hour minimum. Responsibility for administering HCCBG adult day care funds rests with the Area Agency on Aging [AAA] Directors. Policy interpretation guidelines have been sent to the AAA Directors regarding this reference. Specifically, it has been made clear that the 6-hour reference to a unit of service is interpreted by the Division as an operational definition for day service programs [must be open a minimum of 6 hours], not as the definition of what constitutes one day for a specific participant. This information has also been posted on the adult day services section of the Division website in a new area titled "Policy Interpretations and Frequently Asked Questions," http://www.dhhs.state.nc.us/aging/adcpolicy.htm.

HCCBG AND SADCF ABSENTEE POLICY

Recommendation #4-A:
DAAS needs to develop a task force to address the HCCBG and SADCF absentee policy differences and arrive at consensus in the development of a consistent absentee policy and interpretation.

Action:
The Division held an ad-hoc committee meeting with six adult day service providers, two Area Agency on Aging Directors, two county Department of Social Services (DSS) Adult Day Care Coordinators and two Adult Program Representatives (APR's) and a consensus on this policy was reached. DAAS plans to send an Administrative Letter notifying providers and fund managers of this decision by the end of October.

Recommendations #5-A & 6-A:

#5-A: 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.

#6-A: 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:
As per Partners in Caregiving note on this recommendation, a cost analysis study by DAAS would need to be conducted as to the impact of negotiated rates on service delivery. This is not feasible without having a cost analysis tool [recommendation #1-A]. There is concern that negotiated rates may have a negative impact on the number of people served. The current reimbursement rate for adult day care is comparable to other HCCBG services in terms of ratio of average actual cost to reimbursement.

The reimbursement study recommendations were presented to the Social Services Commission in early 2005 and this recommendation was among them. Therefore, discussions have been initiated. Further action, however, is not recommended prior to knowing the full effect such a change would have on service delivery and whether implementation of this suggestion would decrease the number of individuals served or adversely affect the current reimbursed rate for day care services. These types of questions cannot be addressed prior to having sufficient experience with a cost analysis tool.

B. SYSTEM FOR SUSTAINABILITY RECOMMENDATIONS

STRATEGIC PLAN

Recommendation #1-B:
To support and sustain adult day services, and to plan for industry growth, the North Carolina Adult Day Services Association (NCADSA) should create an Advisory Group (made up of key individuals from the various State departments) to move toward the development of a comprehensive, integrated strategic plan, including a statewide marketing plan.

Action:
The NC Adult Day Services Association is expanding its capability to secure resources to support and sustain adult day programs through a new 501(c)3 organization, the Adult Day Services Resource Center of North Carolina, Inc. The mission of the new organization is an extension of NCADSA's mission to promote the availability, accessibility, quality and cost-effectiveness of adult day services in NC. By procuring additional resources, Adult Day Services Resource Center of North Carolina will work to achieve this goal as it fosters and advances quality adult day services through education, partnerships and collaborations for the benefit of providers, consumers and their caregivers.

PUBLIC AWARENESS

Recommendation #2-B

To increase overall visibility and public awareness, DAAS should create a generic adult day services brochure (similar to the one for senior centers) and information for the DAAS display board used at State and public functions.

Action:

DAAS has drafted a generic adult day services brochure and information about adult day services is now available as a part of the DAAS exhibit at State and public functions.

Recommendation #3-B:

In partnership with the DHHS Division of Public Affairs, the Agency for Public Telecommunications (APT) (in the Department of Administration), and the North Carolina Adult Day Services Association, DAAS should develop and implement a statewide adult day services public awareness campaign.

Action:

DAAS currently promotes National Adult Day Service week through the Department's Office of Public Affairs and will continue to do as much as possible to raise statewide awareness of the benefits of adult day services. This will include partnership with NCADSA in seeking grant funds for prime-time cable programs, video/audio/multimedia production, and media buying/placement.

TECHNICAL ASSISTANCE

Recommendation #4-B:

To help support and sustain adult day programs, DAAS should expand its technical assistance as follows:

1. Develop, disseminate (to all certified adult day programs), and post on the DAAS web site the following **fact sheets** for adult day programs:
   a. Information on how the five divisions within DHHS (i.e. Divisions of Aging and Adult Services, Medical Assistance, Public Health, Mental Health, Social Services, and Developmental Disabilities and Substance Abuse Services) and three other State departments (i.e. Departments of Insurance, Veteran Affairs, and Environment and Natural Resources) interface with adult day programs. This would provide education and information in response to the complicated and fragmented system of the regulation and funding of adult day services.
   b. Information detailing the requirements and process for a program to convert from an adult day care only certification to one that combines adult day care and adult day health. Financial viability of adult day programs improves when a program makes this conversion, so a fact sheet of necessary steps would greatly assist programs in making this transition.
   c. Instructions on negotiating and developing vendor agreements with the local Department of Social Services for State Adult Day Care Funds and with the community advisory board [sic*] for Home and Community Care Block Grant Funds. This information will assist programs in diversifying their revenue streams, another essential component of achieving financial viability.

2. Create an **adult day services list serve** for the primary purposes of networking, technical assistance, and informal mentoring. The list serve could be developed through the DAAS formal relationship with the Institute on Aging, and should include all certified adult day programs, Adult Day Care Coordinators, Adult Day Health Specialists, regional Adult Program Representatives, Area Agencies on Aging representatives, the North Carolina Adult Day Services Association executive director, and appropriate DAAS staff. DAAS should also promote the list serve to the other divisions within DHHS and the other State departments that work with adult day programs.
3. Create a **quarterly web-based newsletter** for adult day programs, similar to the DAAS web-based newsletter "At a Glance". The primary purpose of the newsletter would be to provide enhanced technical assistance, and up-to-date State and Federal information to adult day programs.
4. For enhanced technical assistance for adult day program service improvement on a regional basis, DAAS should encourage the development of a partnership between the Area Agencies on Aging and adult day programs in their regions. Area Agencies on Aging have expertise in training/education, technical assistance, and monitoring that would prove beneficial to adult day programs.

Action:

1. DAAS staff has developed the first two fact sheets and posted these on our website [http://www.dhhs.state.nc.us/aging/adcresources.htm]. The third fact sheet is no longer applicable, as vending agreements have been replaced by contracts. However, a funding fact sheet has been developed and a workshop on contract negotiations was added to the annual Adult Day Services training. The developed fact sheets are posted on the Division website under "Additional Resources," http://www.dhhs.state.nc.us/aging/adcresources.htm. (*Community advisory boards do not negotiate or administer HCCBG funding.)
2. A list serve has been created for ease in disseminating education and information relevant to day programs. Other divisions within DHHS and other State departments that work with adult day programs have been invited to join the list serve.
3. A section of the DAAS website now includes up-to-date information about what is happening in adult day care on a state and federal level and provides additional information of assistance to day service program operators.
4. DAAS includes Area Agencies on Aging on all correspondence and communications sent to adult day programs and encourages them to continue their partnerships with day care programs.

MONITORING

Recommendation #5-B:

For service improvement and consistent/uniform interpretation of standards across counties, DAAS should contract with an independent consultant to study the current adult day program monitoring system. The study should look at the history of the county monitoring system, including how the existing system was created and why, how it currently operates, and how the system can be improved.

The study should also look at the development of a standard monitoring curriculum (including a technical assistance module) with the intent of improving consistency from county to county. The curriculum should address the various needs of all monitors, regardless of their longevity in the position: the desire to learn, problem solve, share best practices, and experience peer

interaction and support. Experienced monitors interacting with new monitors provide an extremely valuable form of mentoring/technical assistance.

To be convenient and accessible to all monitors, the study should look at a variety of training methods such as: regional training sessions in the field on an annual basis; distance learning via videoconferencing through the area health education centers (AHEC); and, an on-line seminar (i.e., webinar). A determination should be made as to the most effective and efficient way to provide the training.

Action:
Since there is insufficient funding to contract with an independent consultant, DAAS modified its May 2006 Adult Day Services Training Workshop to focus specifically on the monitoring tools. The workshop paired experienced monitors and day care providers with newer ones in order to facilitate mentoring and technical assistance. DAAS has also developed a risk-based monitoring system in order to be responsive to well-developed programs consistently in compliance with day care regulations and target those with major compliance issues. This system is scheduled to be implemented along with other adult day care rule changes currently being moved through the APA process. Frequently asked questions regarding adult day services administrative rule interpretations have also been compiled and posted on the DAAS website in order to facilitate uniform interpretation across counties:
[http://www.dhhs.state.nc.us/aging/adcpolicy.htm].

COLLABORATIVE RELATIONSHIPS

Recommendation #6-B:
DAAS and the North Carolina Adult Day Services Association should promote these small business development resources, on an ongoing basis, on their web sites, including a direct link to SCORE (www.score.org), the Small Business Center Network (www.ncccs.cc.nc.us/Business_and_Industry/sbcnmainpage.htm), and the Small Business and Technology Development Center (www.sbtdc.org).

Action:
DAAS included information about these organizations in a resource notebook distributed at the annual Adult Day Services Workshop and has posted them on the DAAS website [http://www.dhhs.state.nc.us/aging/adcresources.htm]. A notice about these resources has also been sent to the listserv. Furthermore, NCADSA includes links to these resources, and others, on their website (http://www.ncadsa.org/).

Recommendation #7-B:
The North Carolina Adult Day Services Association should piggyback its "Opening an Adult Day Center" workshop and/or its "Keep Your Center Open" workshop with the "How to Start and Maintain a Small Business" workshop sponsored by SCORE chapters across the State. The industry-specific training provided by the Association, combined with the small business offering, would provide a well-rounded, complete training package.

Action:
The North Carolina Adult Day Services Association (NCADSA) has already begun strengthening the relationship between adult day programs, SCORE and the Small Business Center Network. NCADSA offered a workshop in August in Winston-Salem, NC, targeted for

persons interested in Opening an Adult Day Program. Although there was not enough interest to hold the workshop, the contacts have been made to offer a similar class in the future. NASDA included a session on how to write/revise a business plan at their recent conference, held at the end of September, 2006. Given the multiple SCORE chapters and their diverse services and schedules, the Association is distributing information about all the SCORE chapters in North Carolina to current and potential providers through written information and links on the association's website.

Recommendation #8-B:
For other educational opportunities for adult day programs, DAAS should distribute the list of all certified adult day programs (and the contact information for the North Carolina Adult Day Services Association) to the nine area health education centers (AHEC) to add adult day programs to their mailing lists. The development of a collaborative relationship between AHEC, DAAS, and the North Carolina Adult Day Services Association would ensure that AHEC educational opportunities are responsive to the specific needs of the adult day services industry.

Action:
DAAS contacted staff of central AHEC and received an updated list of aging contacts for each of the nine area AHEC centers. These individuals were contacted about adult day services, provided a list of certified programs, solicited for input in ways we can better work together and added to the adult day services listserv. Information materials regarding the services of AHEC and their programs were also distributed at the annual Adult Day Services Workshop and a link to AHEC has been added to the DAAS website, http://www.dhhs.state.nc.us/aging/adcresources.htm.

FUNDING/FISCAL IMPACT

Recommendation #9-B:
For consistency and uniformity across counties, DAAS should offer an annual funding workshop for adult day programs receiving HCCBG and SADCF funds, and for individuals administering these funds at the county level. To be convenient and accessible, DAAS should conduct the annual training in the field on a regional basis, or use distance learning such as videoconferencing through AHEC or the creation of an on-line seminar (i.e., webinar).

Action:
The annual Adult Day Services Workshop included a session on funding. This workshop will be expanded in FY 2006-07. A fact sheet regarding potential funding sources has also been posted to our web page on Adult Day Care (see Attachment C).

Recommendation #10-B:
Prior to implementation, all revised administrative rules or standards should provide sufficient lead time for potential budgetary preparation and/or training and outreach.

Action:
Rule changes not made through legislative mandate will be delayed from 3 to 6 months in order for adequate training and lead time.

Recommendation #11-B:
To help improve adult day program financial viability, DAAS should continue to advocate with the Department of Insurance for a possible compromise on this regulation so that a sprinkler

system is not required or is only required after a certain capacity.

Action:
DAAS continues to educate the Department of Insurance and the Building Code Council about the adverse effect that the sprinkler rule has had on adult day service programs. DAAS staff will also continue to assist the NCADSA in their advocacy efforts with the Building Code Council.

Recommendation #12-B
To help improve the financial viability of adult day care homes and adult day health homes, DAAS should consider revising the standards to allow more individuals to be served in single family dwellings, as long as the square footage requirement per participant can be met.

Action:
The building code sets a limit of 16 for residential occupancy for adult day care homes and adult day health homes. The adult day care rules have been revised to reflect this maximum and the process of changing APA [Administrative Procedures Act] rules has been initiated with an anticipated effective date of July 1, 2007.

Recommendation #13-B
In addition to the HCCBG and SADCF negotiated rate recommendations in the Reimbursement Methodology Study, DAAS should also explore the feasibility of a negotiated hourly rate (as opposed to a negotiated daily rate) for both HCCBG and the SADCF. A negotiated hourly rate establishes a consistent measure for consumers, funders, and reporting purposes at the State and Federal level.

Action:
As discussed in the Reimbursement Methodology Study [Recommendation 5 and 6-A], this area needs further research and study after the development of a cost analysis tool [Recommendation 1-A]. However, DAAS will conduct a survey to understand concerns that adult day service providers have regarding a move towards an hourly rate. During earlier discussions with day programs, there was significant resistance to this change due to a perceived increase in administrative work and decrease in overall reimbursement amounts. A better understanding of these concerns is needed.

PREDICTORS OF SUCCESS

Recommendation #14-B:
DAAS should amend the requirements for program directors of adult day programs to include successful completion of adult day services management training. Such requirement should also apply to current adult day program directors; however, they should be given the option of testing out of the required training. Training should be documented and included as a part of the required employee file.

Action:
Legislative action would be needed to fund curriculum development.

Recommendation #15-B:
As previously discussed, 94 of 106 certified adult day programs participated in this project. Of the 22 programs receiving a technical assistance site visit, 11 were identified as at-risk of

closing, 10 (out of a total of 30) in the warning zone, and one in the safety zone. Partners in Caregiving research has demonstrated the necessity of follow-up technical assistance (1-3 years) for programs to become financially viable. Most programs need to be guided through recommendations for program growth connected to the predictors of success. To maximize on the training of adult day programs and on-site technical assistance provided to the 22 programs, follow-up site visits, mentoring, and project analysis needs to occur. Analysis would include a post Adult Day Services Profile sent to the 94 programs participating in the project to assess the impact of the training. Analysis would also include whether or not the site visit recommendations were implemented and what impact they had on program growth. The follow-up project analysis data could then serve as the basis for future projects to support and sustain adult day programs in North Carolina.

Action:
Legislative action would be needed to fund this recommendation.

Attachment A

North Carolina Programs Offering Adult Day Health Services
58 Programs Located in 37 Counties

	County	Name of Program	City	Capacity	Type of Program
1	Alexander	Adult Life Programs, Inc.-Taylorsville	Alexander	24	ADC/ADH
2	Ashe	Generations Adult Day Health Care	West Jefferson	40	ADC/ADH
3	Buncombe	Mountain Care	Asheville	66	ADC/ADH
4	Burke	Quaker Meadows Generations, Adult Service Center	Morganton	32	ADC/ADH
5	Cabarrus	Coltrane L.I.F.E. Center, Inc.	Concord	94	ADC/ADH, ALZ
6	Carteret	Newport Developmental Center	Newport	6	ADH, DD
7	Chowan	Chowan Life Center	Elizabeth City	40	ADC/ADH
8	Cleveland	Life Enrichment Center of Cleveland County, Inc.	Shelby	50	ADC/ADH
9	Cleveland	Life Enrichment Center of Cleveland County, Inc.	Kings Mountain	100	ADC/ADH
10	Cumberland	Bethel Adult Day Health Care Center	Fayetteville	28	ADC/ADH
11	Cumberland	Cape Fear Adult Day Health Center	Fayetteville	29	ADC/ADH

12	Cumberland	Southern Hospitality Adult Day Care Center	Fayetteville	10	ADC/ADH
13	Davidson	The Life Center of Davidson County, Inc.	Lexington	65	ADC/ADH
14	Duplin	Duplin Adult Day Services	Wallace	10	ADC/ADH
15	Durham	Community Life Adult Day Health Care Ctr.	Durham	50	ADC/ADH
16	Edgecombe	Adult Day Health Activity Center, Inc.	Rocky Mount	52	ADC/ADH, ALZ, DD
17	Forsyth	Elizabeth and Tab Williams Adult Day Center of Senior Services, Inc.	Winston-Salem	95	ADC/ADH
18	Forsyth	Mount Zion Senior Enrichment Adult Day Care/Day Health Center	Winston-Salem	40	ADC/ADH
19	Franklin	Franklin County Adult Day Program	Louisburg	24	ADC/ADH
20	Granville	Harold Sherman Adult Day Center	Oxford	26	ADC/ADH
21	Guilford	Adult Center for Enrichment at Caldwell House	Greensboro	16	ADC/ADH
22	Guilford	Adult Center for Enrichment at Washington Square	Greensboro	29	ADC/ADH
23	Guilford	Emmanuel Senior Enrichment Center	High Point	40	ADC/ADH

24	Guilford	After Gateway, Inc.	Greensboro	12	ADH, DD
25	Guilford	ACE at River Landing	Greensboro	21	ADC/ADH
26	Halifax	Roanoke Valley Adult Day Care Center	Weldon	48	ADC/ADH
27	Henderson	Pardee Adult Day Services	Flat Rock	50	ADC/ADH
28	Iredell	Life Span, Inc. Enrichment Center-Troutman	Barium Springs	45	ADC/ADH, DD
29	Lenoir	Day Break Adult Day Services	Kinston	20	ADC/ADH
30	Madison	Madison County Adult Day and Health Care Center	Marshall	10	ADC/ADH
31	Mecklenburg	Adult Care and Share Center, Inc.	Charlotte	36	ADC/ADH
32	Mecklenburg	Blessed Assurance Adult Day and Health Care	Matthews	40	ADC/ADH
33	Mecklenburg	Mt. Olive Adult Day Care Home	Charlotte	10	ADC/ADH
34	Mecklenburg	New Friends Adult Day Care/Day Health	Charlotte	67	ADC/ADH, ALZ
35	Mecklenburg	Pritchard - PALS	Charlotte	48	ADC/ADH
36	Mecklenburg	Samaritan Adult Day Health	Charlotte	5	ADH home
37	Mecklenburg	University Adult Care Center, Inc.	Charlotte	61	ADC/ADH
38	Mecklenburg	Loving Care Adult Day Care/Day Health	Charlotte	50	ADC/ADH

39	Mecklenburg	Loving Touch Adult Day Health Care Center, Inc.	Charlotte	30	ADC/ADH
40	Nash	The Wright's Center	Rocky Mount	42	ADC/ADH
41	New Hanover	Elderhaus at the Lake	Wilmington	72	ADC/ADH
42	New Hanover	Coastal Adult Day Care, Inc-Day Care/Day Health Program	Wilmington	35	ADC/ADH
43	Orange	Central Orange Adult Day Health Center	Hillsborough	10	ADC/ADH
44	Pasquotank	Day Break Adult Day / Health Care Center	Elizabeth City	30	ADC/ADH
45	Person	Generations Adult Day Services	Roxboro	20	ADC/ADH
46	Pitt	Creative Living Center	Greenville	24	ADC/ADH
47	Rowan	Abundant Living Adult Day Care, Inc.- Haven House	Salisbury	16	ADC/ADH
48	Rutherford	Rutherford LIFECare	Spindale	29	ADC/ADH
49	Sampson	Sampson County Adult Day Health Care Center	Clinton	42	ADC/ADH
50	Scotland	Scotland County Adult Day Services	Laurinburg	30	ADC/ADH
51	Transylvania	K.O.A.L.A. Adult Day Care/Day Health	Brevard	45	ADC/ADH
52	Wake	Resources For Seniors Total Life Center - Departure Dr.	Raleigh	91	ADC/ADH

53	Wake	Resources For Seniors Total Life Center - Eastern Wake	Wendell	25	ADC/ADH
54	Wake	Cary Total Life Center at Bond Park	Cary	29	ADC/ADH
55	Wake	Southeastern Wake Adult Care Center	Raleigh	40	ADC/ADH
56	Wake	Family Circle Elder Care	Garner	10	ADC/ADH
57	Watauga	The Adult Day Care Center at Blowing Rock Hospital	Blowing Rock	10	ADC/ADH
58	Yancey	W.A.M.Y. Community Action, Inc. Adult Day and Health Care Ctr. of Yancey Co.	Burnsville	15	ADC/ADH ALZ/DD

Program Type:

ADC/ADH	*Combination Adult Day Care and Adult Day Health Care Center*
ADH	*Adult Day Health Care Center*
ADH Home	*Adult Day Health Care Program Located in a Single Family Dwelling*
ALZ	*Alzheimer's Special Care Services*
DD	*Developmental Disabilities Special Care Services*

Attachment B

Consider Adult Day Health Services For Your CAP Clients

> *John comes to our adult day and health care program one day a week. He is confined to a wheelchair and can only stand with the assistance of a hydraulic lift. This is his one outing each week. The rest of his life is spent sitting on the porch. He is parked there in the morning and gets no socialization unless someone on the street stops to talk with him. John cannot speak above a slight whisper, so we know there are few who stop to talk. The smile on his face when he is with us is the picture of gratitude and joy.*
>
> *J. Small, Director*

Adult Day Health Services (S5102)

Adult Day Health Services is care for the client in a certified Adult Day Health Care facility. This type of care is for aged, disabled, and handicapped adults who need a structured day program of activities and services with nursing supervision. This organized program, offered in a community group setting, supports the adult's independence and promotes social, physical, and emotional well-being. Services include health services and a variety of program activities designed to meet the individual needs and interests of the clients, and referral to and assistance in using appropriate community resources. Food and food services include a nutritional meal and snacks as appropriate to the program.

Although the service is not to be provided at the same time of day that a client receives In-Home Aide Services, Respite, or one of the regular Medicaid services that works directly with the client (such as Personal Care Services), it can work in conjunction with many of these services. Many CAP clients have an In-Home Aide who can assist them in getting up, dressed and to the program.

Here's what CAP clients have to say about their participation in adult day health services:

- *This is the best place in the world, and the people who take care of us -- I love you all.*
- *I have made some wonderful friends attending this program and I love coming every day.*
- *We are like one big happy family and I enjoy my time here.*
- *I thank God for this place because I don't know what I would do all day long if I had to stay home.*
- *We are blest to have such a wonderful place to come to with such loving people taking care of us all.*
- *This place is a life saver. I don't know what we would do without it.*

The North Carolina Division of Aging and Adult Services certifies these programs and keeps an updated list on our website. Although a program may not be available in your county, it is possible to send a client to a program in another county that may be near the client's home. The updated list of programs can be accessed through http://www.dhhs.state.nc.us/aging/adcsvc.htm or by calling Shannon Crane at 919-733-0440 ext. 210.

Attachment C

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 & COMMUNITY CARE BLOCK GRANT (HCCBG)

- Older American Act funding and other state and local funds are combined into this block grant to support home and community-based services;
- Funding can be used only for participants age 60 and older;
- Administered through the Area Agencies on Aging (AAA);
- Contact the AAA in your region to find out the lead agency for HCCBG in your county.

NORTH CAROLINA STATE ADULT DAY CARE FUND

- Funds allocated to counties by the North Carolina Division of Aging & Adult Services;
- Administered via a vendor agreement through county Departments of Social Services to purchase Adult Day Services for eligible participants;
- Contact your local Department of Social Services for more information.

STATE COUNTY SPECIAL ASSISTANCE IN-HOME PROGRAM

- Eighty-seven county Departments of Social Services participate in the SA/In-Home Program;
- Program recipients receive a cash benefit that is used for a variety of supports – all of which are basic needs for people living at home;
- Adult day services may be purchased by SA/In-Home Program recipients with the monthly benefit payment;
- 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 pmts are based on individual enrollee eligibility as determined by USDA guidelines;
- Administered by the North Carolina Division of Women's and Children's Health;
- Contact NC Division of Public Health, Special Nutrition Programs Unit at 919-707-5799.

PRIVATE PAY/OUT OF POCKET PAYMENTS

- Set the top fee equal to or greater than the cost of the 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 potentially 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 to find out the local CAP coordinator in your region.

VETERANS ADMINISTRATION (VA)

- Eligibility only for certified Adult Day Programs with the Day HEALTH component;
- Administered through area Veterans Administration Hospitals and/or outpatient clinics;
- Contracted reimbursement for qualifying veterans;
- Contact your area VA for more information.

UNITED WAY

- Contact the local agency for specific requirements for obtaining funds and/or becoming a member agency.

MEDICARE PART B *(does not cover daily care)*

- May cover the cost of the following services provided in the day care environment:
  - Out-patient or partial hospitalization mental health services by licensed clinic social workers or psychologists for assessment and psychotherapeutic treatment;
  - Out-patient restorative and functional maintenance rehabilitation by licensed physical therapists, occupational therapists, and/or speech therapists or approved personnel;
  - Psychiatrist and physician visits.

TITLE V (SR. 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 adult day services that are not-for-profit;
- Administered by various agencies - contact your regional AAA for more information.

GRANTS AND FOUNDATION FUNDING

- Start up, operating, capital and special projects funding may be obtained through grants and foundation 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;
- Look for a local foundation center or library with 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 (www.hud.gov).

AREA MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE PROGRAMS (MH/DD/SA)

- Adult Day programs can possibly contract with Area MH/DD/SA Programs who reimburse for adult day services for the MR/DD population;
- Some Area Programs are especially interested in adult day health services;
- See http://www.dhhs.state.nc.us/mhddsas/lmedirectory.htm for local listings.

CITY/COUNTY GENERAL FUNDS

- Many localities use discretionary money to fund human service agencies;
- Call your local government office for more information.

CHURCHES/CIVIC ORGANIZATIONS

- These organizations may offer sponsorship, space or scholarships for clients.

FAMILY CAREGIVER SUPPORT PROGRAM

- New program with the 2000 reauthorization of the Older Americans Act allocated through DAAS to the Area Agencies on Aging;
- Limited funds for various family caregiver support services including respite services;
- Adult day respite services may be available based on AAA and county planning decisions;

- Eligibility includes family caregiver providing regular care for someone age sixty or older with at least two impairments in activities of daily living;
- Services are sub-contracted through the Area Agencies on Aging; Contact the Area Agency on Aging Family Caregiver Resource Specialist: http://www.dhhs.state.nc.us/aging/fcaregr/fcjobs.htm

North Carolina Division of Aging
Adult Day Services Daily Cost Computation Worksheet C:732Aadsdailyrate.xls
Provider:
County:
Current Budget Period: July 1, 2006 through June 30, 2007 or _____

Do not include any client transportation costs such as drivers, fuel, vehicle maintenance, etc.

Projected Line Item Expense	Grand Total	Adult Day Care	Adult Day Health Care
Staff Salary	//////////////	//////////////	//////////////
	0		
	0		
	0		
	0		
A. Subtotal, Staff Salary	0	**0**	**0**
Fringe Benefits	//////////////	//////////////	//////////////
1) FICA	0		
2) Health Ins.	0		
3) Retirement	0		
4) Unemployment Insurance	0		
5) Worker's Compensation	0		
6) Long Term Disability	0		
7) Dental Insurance	0		
8) Life Insurance	0		
9) Other	0		
B. Subtotal, Fringe Benefits	0	**0**	**0**
Staff Travel	//////////////	//////////////	//////////////
1) Lodging and Meals	0		
2) Mileage Reimbursement	0		
3) Commercial Transportation	0		
4) Other Travel Cost:	0		
C. Subtotal, Staff Travel	0	**0**	**0**
Other Operating Expenses	//////////////	//////////////	//////////////
1) Rent	0		
2) Telephone	0		
3) Postage/Shipping	0		
4) Printing/Publications	0		
5) Copying	0		
6) Equipment Rental	0		
7) Equipment Purchase/Depreciation	0		
8) Equipment Maintenance	0		
9) Contracted Labor	0		
10) Activity/Program Supplies	0		
11) Office Supplies	0		
12) Conference Registration	0		
13) Auto Liability Insurance	0		
14) Client Meals	0		
15) Advertising	0		
16) Employee Recruitment	0		
17) Other:	0		
18) Other:	0		
D. Subtotal, Other Operating Expenses	**0**	**0**	**0**
E. Grand Total, Expenses	**0**	**0**	**0**
F. Total Projected Service Days	//////////////		
G. Projected Average Daily Participation	//////////////		
H. Daily Cost Per Client (E divided by F, divided by G)	//////////////	**#DIV/0!**	**#DIV/0!**

North Carolina Division of Aging
Adult Day Services Client Transportation Worksheet C:732Aadsdailyrate.xls
Provider:
County:
Current Budget Period July 1, 2006 through June 30, 2007 or _____

	Grand Total	Adult Day Care	Adult Day Health Care
A. Total Projected Client Transportation Costs			
B. Total Projected Service Days	//////////////		
C. Average Daily Participation Utilizing Transportation	//////////////		
D. Average Daily Cost of Round Trip Per Client*	//////////////	**#DIV/0!**	**#DIV/0!**

*** A divided by B, divided by C**

North Carolina Division of Aging and Adult Services Adult Day Services Projected Revenues

Adult Day Services Program:_____
County:
Budget Period: through

Projected Revenues	Grand Total	Adult Day Care	Adult Day Health Care
A. Fed/State Funding From the Division of Aging and Adult Services	//////////	//////////	//////////
Home and Community Care Block Grant (HCCBG)	0		
State Adult Day Care Fund (SADCF)	0		
Family Caregiver Support	0		
Total Fed/State Funding Through Division of Aging and Adult Services	**0**	**0**	**0**
B. Required Minimum Match (Cash or In-Kind) Paid by Center or County	//////////	//////////	//////////
1) HCCBG (10%)	0	0	0
2) SSBG (12.5%)	0	0	0
No local match required for Family Caregiver Support Program	//////////	//////////	//////////
Total Required Minimum Match	**0**	**0**	**0**
C. Total Fed/State Funding and Required Minimum Match	**0**	**0**	**0**
D. Local Cash, Non-Match	//////////	//////////	//////////
1) fundraising Events	0		
2) Donations, Memorials, Etc.	0		
3) Grants/Foundations	0		
4)	0		
5)	0		
Total Local Cash, Non-Match	**0**	**0**	**0**
E. Other Revenues Non-Match	//////////	//////////	//////////
1) Private Pay Daily Care	0		
2) Private Pay Transportation	0		
3) Medicaid CAP-DA	0		
4) Medicaid CAP-DD	0		
5) Medicaid CAP-HIV	0		
6) NC Sales Tax Refund	0		
7)	0		
Total Other Revenues Non-Match	**0**	**0**	**0**
F. Client Cost Sharing	**0**		
Total Projected Revenues	**0**	**0**	**0**

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North Carolina Division of Aging and Adult Services

Adult Day Care

POLICY INTERPRETATIONS AND FREQUENTLY ASKED QUESTIONS

This section of our web page has been created in an effort to better communicate adult day care/day health policy interpretations and answer frequently asked questions. Additional information will be forthcoming so please check back often.

1. Adult Day Care Enrollment Fees
2. First Aid/CPR Training
3. Transportation
4. HCCBG Unit of Service

Policy Interpretation Frequently Asked Questions

Additional Resources

CAP Case Managers Information

County List of Certified Adult Day Care Programs

Standards

Sanitation Rules

Home and Community Care Block Grant Adult Day Care Service Providers

Adult Day Care Forms

Adult Day Health Care

▸ **Proposed** Administrative Rules

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North Carolina Division of Aging and Adult Services

Additional Resources

1. North Carolina Adult Day Service Association
2. SCORE
3. Small Business Center Network
4. North Carolina Small Business and Technology Development Center
5. Funding Fact Sheet
6. North Carolina Area Health Education Centers
7. Study Commission on Aging Report - Updated October 2006
8. Adult Day Care Services Interaction
9. Steps for Adult Day Health Conversion

Policy Interpretation Frequently Asked Questions

Additional Resources

CAP Case Managers Information

County List of Certified Adult Day Care

Programs

Standards

Sanitation Rules

Home and Community Care Block Grant

Adult Day Care Service Providers

Adult Day Care Forms

Adult Day Health Care

▸ **Proposed** Administrative Rules

ATTACHMENT 4

Adult Protective Services Task Force

Report to
North Carolina Study Commission on Aging
and
House Study Committee on State Guardianship Laws
Pursuant to Session Law 2005-23

Responding Today…
Preparing for
Tomorrow

Prepared by:
North Carolina Department of Health and Human Services
Division of Aging and Adult Services

The APS Clearinghouse Model: NC's System of Protection

Presentation to the North Carolina Study Commission on Aging

Presented By:
North Carolina Department of Health & Huma n Services
Division of Aging and Adult Services
October 11, 2006

Adult Protective Services Task Force Report and Collaborative Efforts

- Report prepared in response to Session Law 2005-23
- SL 2005-23 directed the APS Task Force to collaborate with stakeholders and others interested in improving Adult Protective Services, and to report those findings to the Study Commission on Aging and the House Study Committee on Guardianship Laws
- Collaboration with stakeholders in state and county government, the court system, legal professionals, numerous consumer advocacy organizations, support groups, trade associations, and other entities interested in vulnerable and elder adults (see list of the stakeholders in report)

Adult Protective Services Task Force Report and Collaborative Efforts

- Obtained considerable feedback and input from stakeholders via written comments, numerous presentations by Division staff to stakeholder groups, and ongoing dialogue with stakeholders
- Careful and thorough review of stakeholder feedback by Task Force as recommendations were formulated
- Extensive research of other States' APS laws and policies plus a thorough review of elder abuse literature helped shape Task Force recommendations
- Report contains important recommendations to strengthen NC's Adult Protective Services Program

Protecting Vulnerable and Elder Adults A Time for Change, A Need to Act

- Aging of NC's population; dramatic changes in demographics
- Increasing numbers of informal caregivers dealing with complex care needs can lead to caregiver stress and burn out
- Increased emphasis on community-based treatment for vulnerable and elder adults with chronic mental illness, mental retardation, and substance abuse

Protecting Vulnerable and Elder Adults
A Time for Change, A Need to Act

- Increased incidence of financial exploitation and violence against vulnerable and elder adults
- NC's Adult Protective Services (APS) law is 30 years old and has not been meaningfully updated since its creation in 1975
- Federal funding is stagnant; no infusion of state funds for APS since 2000, which has limited expansion of the APS workforce

Response to A Time for Change, A Need to Act

- Creation of the NC APS Task Force
  - A collaborative effort between the Division of Aging and Adult Services (DAAS) and the NC Association of County Directors of Social Services.
  - Task Force composition: county DSS directors, assistant directors, supervisors and social workers; staff from DAAS; representatives from the Attorney General's Office

Response to A Time for Change, A Need to Act

- Culmination of Task Force's work and collaboration with stake holders and other interested parties is:

The APS Clearinghouse Model: NC's System of Protection

The APS Clearinghouse Model: NC's System of Protection

- "Clearinghouse" concept came from discussion with a key stakeholder
- Grows out of recognition that NC's APS Program must be comprehensive and prepared to respond to all instances of mistreatment, not just those adults defined in current law as "disabled adults."

The APS Clearinghouse Mo del: NC's System of Protection

The Clearinghouse Model accomplishes this broader mission by:

- Changing the emphasis of APS to an array of protective services interventions vs. a narrow problem-solving focus
- Enabling county DSSs to offer services voluntarily to new populations of adults not served under the current law
  - Vulnerable adults 18 years of age and older with a physical or mental impairment who have been abused, neglected, or exploited

The APS Clearinghouse Mo del: NC's System of Protection

- Elder adults 60 years of age and older with no impairment who have been abused, neglected, or exploited
- Vulnerable and elder adults at substantial risk of abuse, neglect, or exploitation

- Ensuring additional rights and protections for vulnerable and elder adults

The APS Clearinghouse Mo del: NC's System of Protection

- Establishing mandatory competency-based training requirements for APS social workers and supervisors in county DSSs
- Establishing mandatory staffing requirements and caseload standards in county DSSs
- Enhancing the APS data collection system
- Increasing public awareness of adult mistreatment

Core Recommendations and Findings of North Carolina's APS Task Force

Core Recommendation 1

Clarify and strengthen North Carolina General Statute 108A Protection of the Abused, Neglected or Exploited Disabled Adult Act and North Carolina Administrative Code 10NCAC 71A

- Current law and policy are restrictive; require involuntary evaluations and allow only one method of intervention

Core Recommendations and Findings of North Carolina's APS Task Force

APS Clearinghouse Model is Composed of Three Components

- **APS Information & Referral** - Provides information about and referral to services and resources with adult's consent.
- **APS Outreach** - Provides casework services as needed to vulnerable and elder adults with consent.
- **APS Intervention** - Is the provision of emergency or essential services to vulnerable adults. May be provided with adults consent or by court order when the vulnerable adult lacks ability to consent.

Core Recommendations and Findings of North Carolina's APS Task Force

- **The definition of '<u>vulnerable adult</u>' is based on the adult's functional strengths and limitations; not on a diagnosis**
- **Age 60 and older is recognized as the definition for elder adults who have been or are at substantial risk of being abused, neglected or exploited**

Core Recommendations and Findings of North Carolina's APS Task Force

Why Age 60?

- **Affords the same opportunity to be free from abuse, neglect, or exploitation afforded to vulnerable adults and adults at substantial risk**
- **Other NC general statutes use age for purposes of definition: criminal exploitation statute, a licensure category for assisted living communities, and Mental Health Geriatric Specialty Teams**
- **Other State's APS laws recognize age as a criteria for APS**
- **Older Americans Act uses age 60 for services and funding**
- **Some recognition in elder abuse literature that age can produce changes making adults less able to protect themselves.**

Core Recommendations and Findings of North Carolina's APS Task Force

- **APS is defined primarily as a voluntary intervention provided to vulnerable and elder adults with consent of the adult**
- **"Substantial Risk" has been added to the law to support the provision of services to vulnerable and elder adults at risk of abuse, neglect or exploitation.**

Core Recommendations and Findings of North Carolina's APS Task Force

Core Recommendation 2

Provide adequate funding for the 100 county departments of social services to hire additional staff to carry out the APS Clearinghouse Model

- Currently 150.96 SW FTEs carrying out all APS requirements
- County departments of social services need 212 additional FTEs SW positions to carry out all requirements under the APS Clearinghouse Model

Core Recommendations and Findings of North Carolina's APS Task Force

Core Recommendation 3

Provide staff in the Division of Aging and Adult Services (DAAS) to support county DSSs to implement the APS Clearinghouse Model

- DAAS has 1.75 FTE positions supporting county DSSs
- 5.0 FTEs are needed in DAAS to implement the APS Clearinghouse Model statewide (see recommendation 9 for staff needed for the pilot)
- .28 FTE of an attorney position is needed in the Attorney General's Office to provide legal consultation

Core Recommendations and Findings of North Carolina's APS Task Force

Core Recommendation 4

Establish a mandatory competency-based training and continuing education program for APS social workers and supervisors in county DSSs

- No mandatory training requirements now-wide variation in level of expertise and practice at the local level.
- A mandatory competency-based program of pre-service, basic, advanced and specialized trainings, and continuing education for APS social workers and supervisors assures a competent, well trained work force

Core Recommendations and Findings of North Carolina's APS Task Force

Core Recommendation 5

Provide funding to county departments of social services for the provision of essential services for vulnerable adults who have beenabused, neglected or exploited, or who are at substantial risk of abuse, neglect, or exploitation.

- Funding is needed to pay for essential services to protect vulnerable adults who have been abused, neglected or exploited or who are at substantial risk of abuse, neglect or exploitation and are unable to pay for these services.

Core Recommendations and Findings of North Carolina's APS Task Force

Core Recommendation 6

Establish a caseload standard based on an in depth job analysis of the time and tasks associated with implementation of APS Clearinghouse Model

- A standard of 12 concurrent APS cases and an APS supervisor/worker ratio not exceeding an average of one FTE supervisory position to five APS social work positions are needed to assure adequate resources to implement NC's system of protection and to deliver quality social work services

Core Recommendations and Findings of North Carolina's APS Task Force

Core Recommendation 7

Enhance technology and data colection systems to strengthen accountability and support implementation of the APS Clearinghouse Model pilot and statewide implementation

Core Recommendations and Findings of North Carolina's APS Task Force

Core Recommendation 8

Develop and implement a statewide public awareness and education campaign to raise community understanding about the abuse, neglect and exploitation of vulnerable and elder adults

Core Recommendations and Findings of North Carolina's APS Task Force

Core Recommendation 9

Develop and implement a 12 month pilot of the APS Clearinghouse Model

- Provide funding for staff in county departments of social services to carry out the pilot based on workload standards described in Recommendation 6
- Provide funding for 3 of 5 staff positions in DAAS to plan and conduct the pilot

Core Recommendations and Findings of North Carolina's APS Task Force

Total Proposed APS Clearinghouse Budget to Implement Statewide	$ 15,212,202

$1,822,085 Total Budget to Pilot Clearinghouse Model	27.103 Total FTE's
$1,617,308 County Staff	24.103 County Staff
$179,027 DAAS Staff	3.0 DAAS Staff
$18,000 Public Education	
$6,750 Essential Services	

APS Clearinghouse Model Will:

- Increase our ability to reach out to citizens to offer voluntary services
- Enable us to respond to high risk situations before harm occurs and provide the opportunity to assist older adults who are victimized, but not incapacitated
- Allow APS to intervene before the adult's health deteriorates to life-threatening levels
- Allow APS to provide information and services to a greater number of adults

Support For APS Clearinghouse Model

North Carolina Association of County Directors of Social Services Board Endorsed Clearinghouse Model in September 2006

- Able to Reach More Adults Earlier
- Reflects Good Practice
- Requires Adequate Funding
- Support Pilot as First Step

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — October 11, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Edwards	Div of Aging + Adult Services
Anna Kumar	Visitor
Glenda Arts	Div of Aging & Adult Services
Shannon [illegible]	" "
Barbara Pope	Division of Facility Services
Dennis Streets	Division of Aging + Adult Services
John Eller	Mecklenburg Co. Social Services
Steve Freedman	Division of Aging & Adult Services
GEOFF SANTOLIQUIDO	DIV. OF AGING & ADULT SERVICES
[illegible]	DFS
Hugh B. [illegible] II	NCALTF

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — October 11, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCALTCF
Cathy Garner	NCALTCF
Kari Barsness	OSBM
Wayne Wallace	OSBM
Gregory Wallace	NCBA Elder Law Section
Jim Edgar	AHHC
Quinn C. Hatch	AARP
Mary Bethel	AARP
Dick Hatch	AARP/NC Coalition on Aging
Evelyn Standhome	NCAHA
Sarah Lugar	DAAS

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — October 11, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Roxanne Briggs-Cash	NCAOA, Franklin Co Dept of Aging

September 20, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Public Hearings

The NC Study Commission on Aging will be conducting two public hearings:

DAY:	Tuesday	TIME:	10:00am - 12:00pm
DATE:	October 3, 2006		
LOCATION:	John Robert Kernodle Senior Activities Center 1535 South Mebane Street Burlington, North Carolina		

DAY:	Tuesday	TIME:	10:30am - 12:30pm
DATE:	October 17, 2006		
LOCATION:	Shamrock Senior Center 3925 Willard Farrow Drive Charlotte, North Carolina		

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

North Carolina Study Commission on Aging

Tuesday, October 17, 2006
10:30 AM
Shamrock Senior Center
Charlotte, NC

The North Carolina Study Commission on Aging held a public hearing on Tuesday, October 17, 2006, at 10:30 am at the Shamrock Senior Center in Charlotte. The hearing was very well attended and there were many presenters. The following are issues that were discussed most frequently.

- Increase funding/continue support for Senior Centers
- Increase funding/continue support for Senior Games
- Increase/continue funding for Alzheimer's and Project C.A.R.E.
- Increase funding for Home and Community Care Block Grants
- Resolve Issues related to Mentally Ill in LTC facilities
- Increase funding/support for senior friendly housing

Attached are handouts that were furnished by some of the public speakers.

The hearing ended at approximately 12:30 pm.

North Carolina Study Commission on Aging
Public Hearing, Charlotte, North Carolina
October 17, 2006

My name is Joe Connolly, Director for the Area Agency on Aging (AAA) at the Land-of-Sky Regional Council, serving Transylvania, Madison, Henderson and Buncombe Counties. I am here today as a representative of our state-wide organization, the North Carolina Association of Area Agencies on Aging.

I would like to begin my comments this morning by thanking you for coming here to Charlotte for this public hearing and, equally importantly, thanking you for your work over the years on issues of concern to older adults. In particular, I would like to express my appreciation for your support in the last legislative session that led to increases in funding for the Home and Community Care Block Grant, additional funding for the Ombudsman program, and increases in the reimbursement rate for Adult Day Centers.

The legislative agenda for the North Carolina Association of Area Agencies on Aging this year includes the following priority items for which the AAA Directors would like to specifically request your support:

- Increase Home and Community Care Block Grant Funding

Although a significant funding increase was received as a result of legislative action in the last session, additional funding support is still need to more fully address the needs of older adults. As you know, these services help 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. The N.C Division of Aging and Adult Services reports that there are 10,150 older adults on the waiting list statewide as of June 2006. It is estimated by the Division of Aging and Adult Services that it would take $14million to address this need.

- Support Legislation to implement the recommendations of the Adult Protective Services Task Force

The recommendations will include many items such as funding for additional APS positions needed initially to implement a pilot to demonstrate the APS Clearinghouse Model and then to implement the Clearinghouse Model statewide.

- Support a rate increase for long term care facilities only if the increases are applied to wage/benefit plans for direct care employees.

High staff turnover rates in long term care facilities jeopardize the well-being of vulnerable residents. Equitable pay for the valuable work done by direct care workers could reduce staff turnover and help to assure that quality, trained staff are retained at facilities.

However, the main agenda item that I would like to discuss this morning is to ask for your support for legislation to increase state funding by $570,000 for operating and administrative support to the Area Agencies on Aging. These funds were reduced during the 2003 session of the General Assembly.

As of June 30, 2001 there was $1,042,200 available in AAA administrative support funds to support the expenses of the 17 Area agencies on Aging across the state. By fiscal year 2003 year only $472,200 was available which meant that each region had been reduced in funding from $57,900 to $27,777. Currently each region still receives $27,777.

These funds support varied personnel and AAA activities. Staff members supported with these funds include AAA Directors, Aging Program Coordinators, Long-term Care Ombudsmen and Information & Referral Specialists. Area Agencies administer 23 million dollars in services funding; provide leadership and support to enroll North Carolinians in the Medicare Part D program; provide technical assistance, administrative support and in many instances travel funds to support the work of the Senior Tar Heel Legislature; plus the AAAs are key players in a new Division of Aging and Adult Services initiative regarding planning for the "boomer" population.

Under the guidance of the North Carolina Division of Aging and Adult Services, your Area Agencies on Aging are taking a leadership role, working together with our county governments, service providers and older adults themselves, in planning for the significant growth in our population of older adults. We will be leading a more comprehensive planning process that will help our communities identify, assess and respond to the needs and interests of a very diverse population of older adults, our rapidly aging boomer population and family caregivers.

A quick look at some demographic trends will help point out the need for this planning process. For example, our 4 county region of Transylvania, Madison, Henderson and Buncombe Counties is looking at a both an increase, and significant shifts, in our overall population. (Please see the attached graph charts for more information).

In less than twenty-five years, the overall population in our 4 county region is projected to increase by approximately 37% from just over 350,000 people to over 480,000. However, the growth in the older adult segment of our population is the key factor in this projected growth. In the same time period, our over 60 population is projected to increase by over 85% from 79,000 to almost 146,000.

And our population make-up will also change significantly. By 2030, the older adult segment of our region's population will increase from it current 22% to 30%. In Transylvania County, older adults are projected to comprise over 40% of the population base.

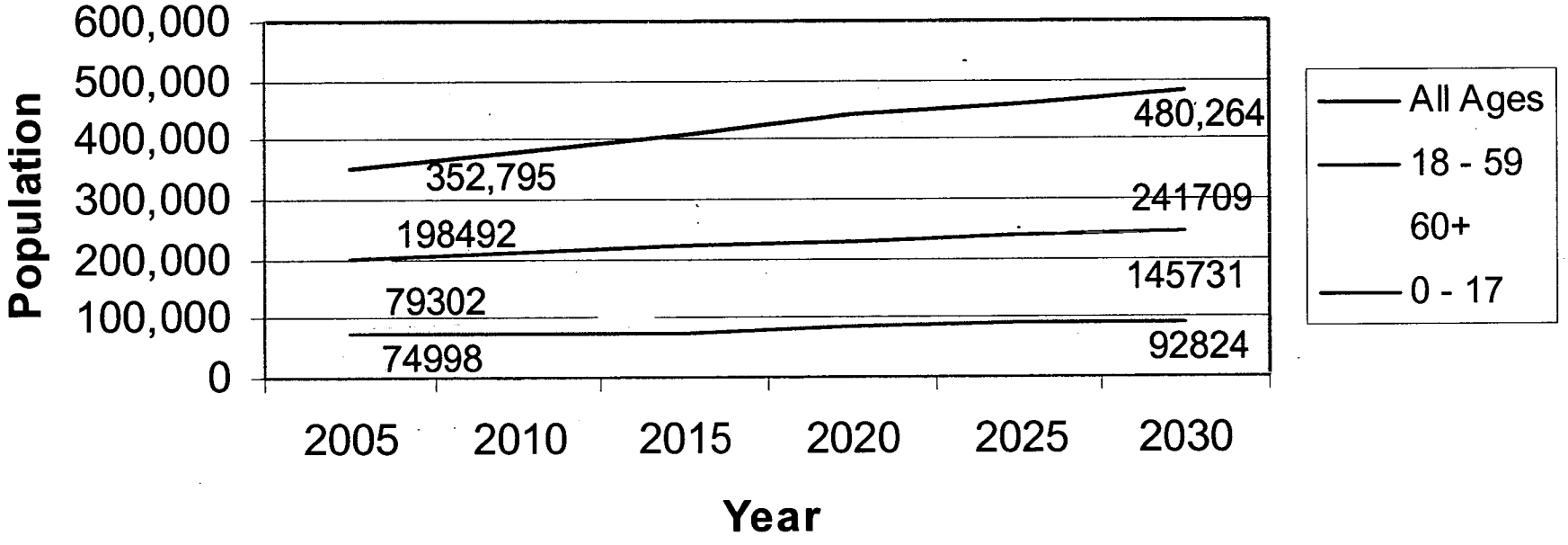
Similar demographic changes are happening in counties all across the state.

The 17 Area Agencies on Aging need this requested increase in funding to build the planning capacity and infrastructure at the local level. It will be a critical support in helping us more fully engage our communities in preparing for this coming shift in our population base and in building a planning process that is designed to promote independence, dignity and choice for older adults.

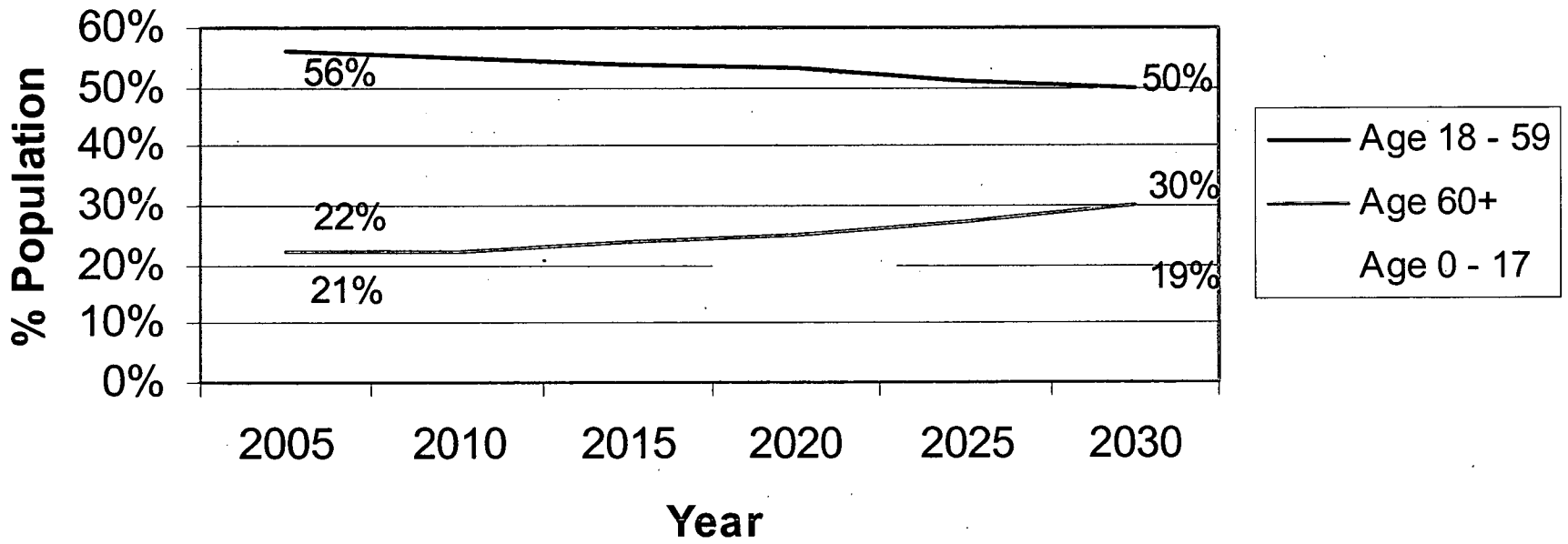
Respectfully submitted,

Joe Connolly
Director, Area Agency on Aging
Land-of-Sky Regional Council
25 Heritage Drive
Asheville, NC 28806

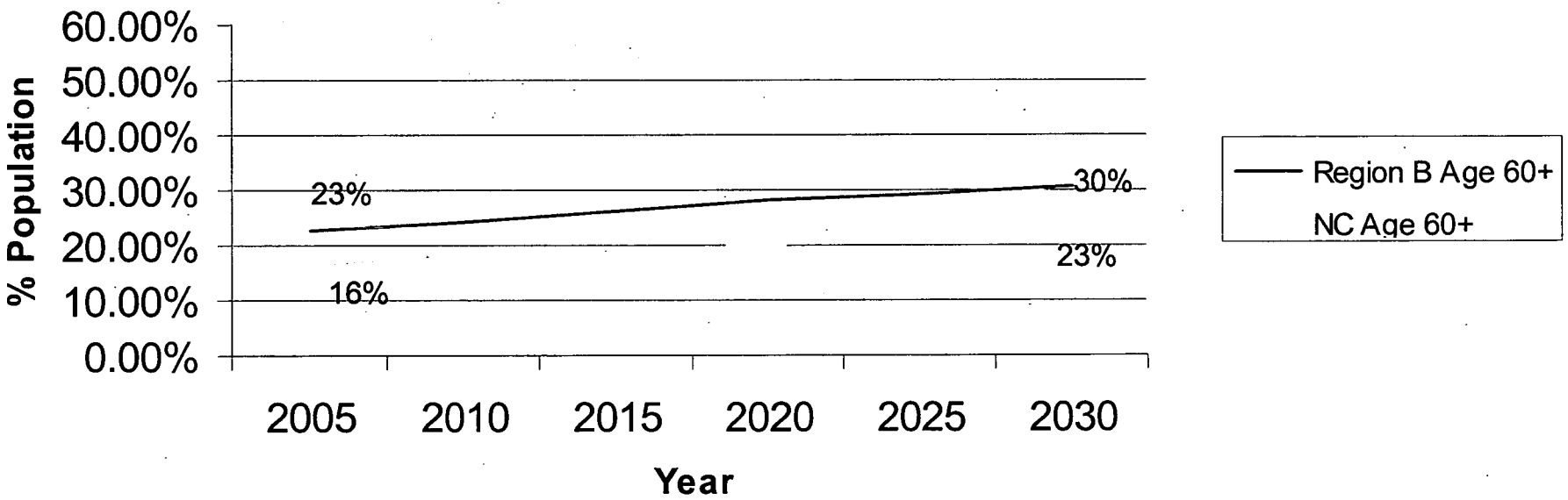
Projected Population Growth by Age Group in Region B
(Buncombe, Henderson, Madison & Transylvania)
(2005 - 2030)



Projected Shifts in Age Group Populations in Region B (Buncombe, Henderson, Madison & Transylvania) (2005 - 2030)



Projected Change Among Older Age Groups (60+):
Region B (Buncombe, Henderson, Madison & Transylvania) vs. NC



Statement for the North Carolina Study Commission on Aging

10-18-06, Charlotte, NC

Teresa Hoover, Program Associate, Alzheimer's Association–Western Carolina Chapter

Alzheimer's Disease, Dementia and the Alzheimer's Association

Good morning and thank you for allowing me to speak to you today about a subject of great importance to all of us – Alzheimer's disease, dementia and the work of the Alzheimer's Association. My name is Teresa Hoover and I am a Program Associate with the Western Carolina Chapter of the Association.

Alzheimer's is a progressive brain disorder and is the most common form of dementia. It is a disease that destroys the brain resulting in memory loss, impaired ability to learn, reason, communicate or carry out daily activities. It is not a normal part of the aging process but most commonly affects individuals over sixty-five. The likelihood of developing Alzheimer's approximately doubles every five years after age sixty-five and by age eighty-five reaches nearly fifty percent.

Often described as "the long goodbye", Alzheimer's disease is now the fourth leading cause of death among adults. One of ten families is directly affected and family and friends care for seven out of ten Alzheimer's patients. It is estimated there are 4 1/2 million people with Alzheimer's across the nation and almost 150 thousand in North Carolina. By 2030, without medical advances, Alzheimer's is expected to increase by three hundred percent – to over 14 million people in the US.

The Alzheimer's Association is the largest national voluntary health organization dedicated to eliminating Alzheimer's disease by advancing research while ensuring adequate care and services for individuals with the disease, their families and their caregivers. It is a network of chapters across the country and the premier source of information and support for the millions of Americans with Alzheimer's disease.

The Western Carolina Chapter serves the 49 western most counties in the state of North Carolina. We cover this very large territory with 4 offices – Charlotte, Hickory, Winston-Salem and Asheville. Our staff is small but extremely dedicated to providing support to families throughout this region through a broad range of services. Our services include:

- A 24 hour, 7 days per week Helpline to respond to questions and needs of family members, community and professional caregivers and people with dementia
- Support Groups: the Association trains facilitators and establish support groups for caregivers and early stage groups for the person and their care partners
- The Association's Safe Return® Program is the only nationwide program that assists safe and timely return of individuals with Alzheimer's disease or related dementia who wander and become lost. Safe Return provides family support, as well as education to the community and professionals on wandering awareness and safety.
- Care Consultation is a service designed to assist the person with the disease and/or their families and/or professional caregivers in planning for and dealing with all aspects of the disease.
- Disease-specific and community resource information is disseminated through our newsletter, brochures, and web sites
- Education is crucial for early detection of Alzheimer's, for anyone caring for a person with dementia and to increase community awareness. The Alzheimer's Association provides education

for people with dementia and their families, the community and professionals through presentations, facility-based in-services, health fairs, community awareness talks, activity programming training, and annual conferences.

As the largest private, nonprofit funder of Alzheimer's disease research, the Association has awarded more than $185 million in research grants since 1982 and is committed to both supporting and participating in research. We also advocate at the federal level for increased spending for current and future efforts to find a cure, prevention and treatment.

And there is hope. With accelerated research efforts there is now a greater understanding of the disease processes at work in the Alzheimer's brain. Experts now see the potential for promising new generations of treatments to *prevent*, slow, or even reverse damage to nerve cells. Many disease modifying medications are currently being studied and tested and offer great promise. Ongoing research will soon clarify the role of cardiovascular factors and other risk factors that individuals may influence through lifestyle. And a strategy to delay the onset of Alzheimer's by five years could halve the number of affected individuals over the next 50 years.

The state of North Carolina has a rapidly growing senior population and thus the potential for thousands more individuals and families coping with Alzheimer's and related dementias. It is our hope that the Western Carolina Chapter, with sufficient help and support, will continue to grow in order to meet the ever-increasing needs of citizens throughout our service area.

Thank you for your attention. I will be glad to answer questions as time permits today or you can contact our office.

For more information please contact the Alzheimer's Association-Western Carolina Chapter at 800-888-6671 or 704-532-7390)

Statement for the North Carolina Study Commission on Aging:

10-17-06, Charlotte, NC

Beth Croom, Executive Director, Alzheimer's Association – Western Carolina Chapter

NC Project C.A.R.E: "Caregiver Alternatives to Running on Empty"

Good morning. My name is Beth Croom, Executive Director of the Alzheimer's Association – Western Carolina Chapter. My purpose for coming today is to request your support in our efforts to secure permanent state funding for **Project C.A.R.E**-- moving toward our ultimate goal of statewide expansion. **Project C.A.R.E.** - "**C**aregiver **A**lternatives to **R**unning on **E**mpty" – is now in its 6th year, serves 10 counties and has provided critical respite care and support to over 1500 low-income, rural and minority families who care at home for a loved one with Alzheimer's disease or other dementias.

The demonstration program, currently funded by the U.S. Administration on Aging, is a partnership between the NC Division of Adult and Aging Services, Duke Family Support Program, Mecklenburg County DSS and our Chapter office. **Project C.A.R.E.** works closely with the NC Family Caregiver Support Program as well as many other state and community programs.

The respite care services, accessed and funded through **Project C.A.R.E.**, are provided families through local provider agencies, including adult day services, in-home care, group respite and residential facilities. **Project C.A.R.E.** is cost effective by making use of existing community programs and services, delaying or preventing institutional placement, and working to improve the health and well-being of the caregiver. The program also boosts local economies by increasing business for providers, creating jobs for direct care workers and building strong "dementia capable" community networks and partnerships.

As the Director of the Western Carolina Chapter, it is a pleasure to be associated with a program that does so much good in the community, for families who would otherwise be alone as they face the challenge of Alzheimer's. The **Project C.A.R.E.** design, a *nationally recognized best practice model*, is very personal, bringing a Family Consultant into the home to provide individualized training, counseling, and care consultation—and to encourage isolated families to accept the help that is available. The timely arrangement of funding allows families on fixed incomes immediate access to a wide range of respite options and other community programs, such as the expertise and services of the Alzheimer's Association. Dementia caregivers get the break and support they desperately need and are able to keep their loved one at home longer.

The responses of family caregivers, after experiencing the relief and support provided by **Project C.A.R.E.**, are testimonial to the effectiveness of our work. Numerous letters from client families and local partners attest to the success of **Project C.A.R.E.** and how much

the program has impacted individual lives and the community as a whole. There is widespread support on a local, state, and national level for **Project C.A.R.E.** to continue.

Federal funding for the 10 counties served by this program will end next June 2007. An annual allocation of state funds to support **Project C.A.R.E.** will not only secure the existing program sites, it will open up opportunities for new federal grants that will expand this program into additional counties. The services of **Project C.A.R.E.** need to be available across the state so that all families caring for someone with Alzheimer's can receive the help and support they critically need to continue providing care at home for as long as possible.

If the intent of this commission is to find and highlight programs that work, and that address the needs of a growing constituency in an effective and efficient way, then **Project C.A.R.E.** is the appropriate choice.

I will be happy to answer questions and provide further information* about **Project C.A.R.E.** Again, thank you for your time.

[*For more information, please contact Len Erker, Director of Respite and Mountain Area Policy, Asheville Area Office at (828) 254-7363 or len.erker@alz.org, and/or Karisa Derence, State Project Director, NC DAAS at (919) 733-0440 ext#220 or karisa.derence@ncmail.net]

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 private, public and non-profit agencies who are developing 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.**

Executive Advisory Board

Jerry Fox, Chair; Ted Rast, Co-Chair; Doug Booth; Carla DuPuy; Ruth M. Easterling; Paul Franz; Dr. E. K. Fretwell, Jr.; Bruce Landgarten; Harvey Gantt; Maryann Gilmore; Gerald Johnson; Peter Keber; Gloria Pace King; Fountain Odom; Mark Peres; Betty Chafin Rash; Donald C. Sanders; Dr. Dena Shenk; Dr. C. Don Steger, Sara Wolf

301 Billingsley Road • Charlotte, North Carolina 28211 • 704-336-4109

http://statusofseniors.charmeck.org

The 2005 Strategic Plan Report Contains Strategies for 7 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. Advocate a more "senior-friendly" Physical Environment
3. Celebrate and Support the role of informal and family Caregivers;
4. Begin a Community Safety campaign in high-density areas focusing on seniors;
5. Advocate coordinated "senior-friendly" options leading to Transportation Independence.
6. Develop an integrated approach for Community Education and Communication with key stakeholders and the general public;
7. Advocate improvements needed in Long Term Care Public Policies;

- NEXT STEPS:
  - Actively pursue the implementation strategies for these recommendations
  - Once these strategies are well underway, develop recommendations and strategies for additional issues in the Charlotte-Mecklenburg Senior-Friendly Matrix

The Scope of the Process

- The collaborative partnership seeks to involve broad groups of consumers, providers, businesses, 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 pursue a plan that covers all areas in the C-M Senior-Friendly Community Matrix: 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 **in**:

- 2000 there were 80,440 age 60+ older adults in Mecklenburg.
- 1990 the average profile of the 66,617 older adults was a female (60%), age 60 to 74 (43%), and White/Caucasian (81%).

Mecklenburg's **Future**:

- "The dominant factor for business in the next two decades is not going to be economics or technology; it will be demographics." Peter Drucker: The Future Has Happened Already
- By 2010 there will be 168 million jobs in the U.S. and 158 million workers.
- The age 60+ Mecklenburg population will triple to 243,619 people by 2030, while the 0-17 age population will not even have doubled by 2030 when it will reach 308,689.
- The older adult population rate of growth currently 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 it will grow to 18.5 % by 2030.

To learn how you can help, contact:
John Highfill at highfjv@co.mecklenburg.nc.us or 704-336-4109.

301 Billingsley Road • Charlotte, North Carolina 28211 • 704-336-4109
http://statusofseniors.charmeck.org

Interim HEALTHCARE®

Stephen M. Smith, M.P.H
President

October 17, 2006

Dear Senator Dannelly and Representative Earle
and Members of the North Carolina Study Commission on Aging,

Thank you for this opportunity for providing input on the future of services to our aging population. I am a home care provider soon beginning my twenty-fifth year in the industry. I am a past-president of the Association for Home and Hospice Care of North Carolina (AHHC) and fully support their statement being submitted to you today by Jim Edgerton. The following comments are mine individually, and I strongly encourage the Study Commission to recommend the adoption of:

- Rate increases for Medicaid Home Care Services. The AHHC statement provides the rationale, but I will add that operating costs in nearly all categories have risen, and in particular in the area of all lines of insurances.

- With AHHC and other associations who represent the long-term care industry, study the workforce supply issues of health caregivers, especially in the area of Nurse Aides. As of recently, there were 304,370 Nurse Aides on the mandatory State Registry. However, only 110,007 , or slightly over 36% were categorized as " active". This equates to a serious workforce issue for the long-term care industry. From our experience, many of the inactive Nurse Aides are employed in other service sector jobs with better pay and benefits, that the current rate of $ 14.40 permits home care agencies to offer them. I do not support a wage pass-through, but rather to allow market forces to dictate. Agencies that do not compensate their Nurse Aides appropriately will not be competitive.

- Continue the moratorium set to begin on January 1, 2007 through 2008. This will allow the appropriate DHHS divisions to survey all new agencies that have not been surveyed within the past three years, or possibly ever. Serious sanctions, including license revocation, should be considered for those home care agencies who are seriously out-of-compliance. The State currently have nearly 1,000 Medicaid PCS providers, many who are small and lack critical mass. Many of these operators have no prior experience, are not members of the home care association , do not attend state-sponsored training and hence are essentially disconnected from the industry and their obligations.

- With the rising costs of transportation, encourage the use of public transportation and car-pooling among health caregivers. This will require the cooperation of non-skilled level home care clients and the state enforcement agencies. Currently, if a Nurse Aide deviates more than 15 minutes from their assigned schedule by clock time, it is considered a " deviation" and must be documented by the supervisory RN. This can take up a significant amount of time over the course of a week or month, and is essentially a " paper-shuffle". With the shortage of both RN's and Nurse Aides , and the increasing transportation costs, this rule needs to be relaxed. Use of public transportation or car pooling by caregivers may create reasonable deviations from time-to-time by the caregiver. The total time worked is what should be important in non-skilled care, not the exact time they arrive and leave.

- If I can be of service to you, please feel free to contact me.

Sincerely,

Stephen M. Smith

305 LIBERTY STREET. P.O. BOX 2249, WHITEVILLE, NC 28472-7249
• TELEPHONE: (910) 642-2106, ext. 226 • FAX (910) 641-0674 • EMAIL: stevesmith@interimec.com
WEB: www.interimec.com

My name is Fred Weber.

I am a member of the Charlotte –Mecklenburg Senior Games & Silver Arts board of directors, and a North Carolina Ambassador for the games.

At the age of 62, I was considerably overweight, an alcohol abuser, and a smoker.

I am now 68, and -- thanks to Senior Games -- I am in very good condition, free of the habits that threatened my health, and looking forward to my next competition.

Last June, I helped represent Mecklenburg County as one of the 14,000 plus seniors who met in Pittsburgh, Pennsylvania to compete at the National Games.

Along with more than 60,000 other North Carolinians, I exemplify what can be accomplished when a community invests in the health of its senior population.

Senior Games is a low-cost endeavor that has an obvious, beneficial impact on our aging citizenry.

I am here to acknowledge what you have already done, and to encourage your continued support of Senior Games.

Thank you.

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Bill Wilson
AARP North Carolina
Study Commission on Aging – Charlotte Public Hearing
October 17, 2006

Good morning, my name is Bill Wilson. I am Associate State Director for Advocacy for AARP North Carolina. Thank you for the opportunity to speak to you today. I would like to share with you just a few of the issues AARP believes are important to older adults in North Carolina.

The North Carolina General Assembly passed legislation in 1998 allowing individuals who purchased long-term care insurance to claim a state income tax credit effective beginning with the 1999 tax year. The credit was 15% of the premium paid, not to exceed $350. The legislation had a sunset provision that ended the credit after the 2003 tax year. In 2004, over 30 states offered a long term care tax credit or tax deduction that was as good as or better than the federal tax credit. In the last General Assembly session, six different House bills were introduced to re-enact the tax credit and a majority of House members co-sponsored at least one of these bills.

The tax credit offers several benefits beyond the tax credit itself. Many of the insurance policies provide coverage for home and community based services in addition to institutional based services; helping people to stay in their home and communities. According to estimates by the Health Insurance Association of America, long term care insurance reduces state and federal Medicaid expenditures by $5,000 per policy holder and federal Medicare home health expenditures by $1,600 per policy holder.

This past May, AARP conducted a statewide poll of adults 50 and over. Nearly six in ten supported a state tax credit for purchasers of long term care insurance – even if it meant other taxes would need to be increased or other services reduced. We think it is time to re-enact this credit.

AARP also supports reducing the property tax burden on limited income older adults and people with disabilities by the relief provided through the Homestead Exemption. Legislation introduced in the 2005-06 General Assembly saw different approaches to property tax relief.

The current law excludes $20,000 or 50% of the appraised property value, whichever is greater, to qualified individuals. The income limit for eligibility is currently $19,700 and is indexed to Social Security. AARP supports increasing the income level to $25,000 with continued Social Security indexing. AARP hears about this issue from older adults living in urban areas where property values have soared from inflation, and from more rural older adults whose property is being encroached by new development. AARP polling of the 50 plus population showed that 70% support this – even if they were not eligible for the relief.

While this may be the most straight-forward approach to property tax relief, AARP also supports legislation to allow low income older adults and people with disabilities to defer property taxes until the property is transferred or sold, and legislation to provide a state tax credit equal to 50% of the property taxes paid for individuals just above the current income eligibility limit for the homestead exemption.

Finally, I want to mention our support for the NC Housing Trust Fund. One of the recommendations of this Study Commission last year was to provide $10 million to the Trust Fund. Four million was to be earmarked for the Urgent Repair Program to make homes habitable so residents can remain in their homes. Repair and renovation funds are an important part of allowing low-income older adults and people with disabilities to remain in their homes.

AARP North Carolina appreciates the work and leadership of the Study Commission's members in addressing critical aging issues. We need only look at progress in this year's short session to see the imprint of the Commission's work on older adults in our State. Additional funding for Home and Community Care Block Grants, Long Term Care Quality Improvements, Adult Day Care Rates, Mental Health, State and County Special Assistance Rates, In-Home Services Rates, Medicaid Provider Reimbursements, and the list goes on.

I have provided you with a copy of AARP North Carolina's 2007 Legislative Agenda, and for the record, we would like all these issues noted in our support to the Commission. Thank you for the opportunity to speak to you today.

AARP North Carolina

The power to make it better.™

2007-08 Legislative Agenda

Accessible and Affordable Health Care

- Establish a state prescription drug wrap-around benefit for low-income Medicare eligible individuals
- Take steps to reduce the number of uninsured (implement the recommendations of the Institute of Medicine report including establishing a high risk pool)
- Establish mental health parity
- Preserve Medicaid eligibility and services for older and disabled adults
- Address the high cost of prescription drugs and expand options for obtaining prescription medication
- Expand dental care services for older and disabled adults, including special need populations (e.g., nursing home and adult care home residents, persons with dementia)

Expand Options and Choices for Long Term Care

- Increase funding for the Home and Community Care Block Grant
- Re-enact the long term care insurance tax credit
- Increase funding for the Housing Trust Fund
- Expand transportation options and services
- Expand health promotion and disease prevention programs
- Increase the medically needy income standard from the current level of $242 per month
- Address policies which make it harder for low-income older and disabled adults to qualify for Medicaid long term care services (e.g., punitive Medicaid lien)
- Strengthen the senior center network
- Reduce the property tax burden on limited-income older and disabled adults by increasing homestead property tax relief
- Expand the Special Assistance/In-Home Program
- Strengthen the Community Alternatives Program for Disabled Adults
- Take steps to alleviate institutional bias (policies and practices which direct people to placement in a long term care facility versus obtaining care in their home and community)
- Increase funding for adult day services

Enhance Long Term Care Quality and Safety

- Address issues related to the appropriate placement of individuals with mental illness
- Support direct care worker recruitment and retention
- Strengthen the penalty/penalty review process
- Support efforts to empower residents, to the extent possible, to make decisions regarding their care
- Strengthen the health care personnel registry
- Increase the personal needs allowance from $30 to $60
- Establish a provider tracking data base
- Support NC NOVA, a voluntary licensure program which focuses on recruitment and retention of direct care workers
- Establish a star rating system for long term care facilities
- Examine the assisted living category of multi-unit assisted housing with services and take steps to help ensure that only persons appropriate for this housing option are provided services in these facilities

Support Families and Vulnerable Older and Disabled Adults

- Expand programs and services for family caregivers
- Expand programs and services for grandparents and other kinship relatives raising minor children
- Strengthen elder abuse and guardianship laws
- Strengthen disaster planning for special need populations including older and disabled adults
- Strengthen consumer protections in areas such as payday lending and identity theft

Expand Lobbying, Ethics, and Campaign Finance Reform

- Expand public campaign financing to Council of State races
- Expand the gift ban
- Strengthen the independent ethics commission
- Restrict lobbyists from raising money for elected officials
- Establish a pilot program for public financing of State House and Senate races
- Authorize public campaign financing for local government races
- Create an independent, bipartisan redistricting commission

NC Study Commission on Aging
Talking Points
October 17, 2006

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 as well as teaching and assisting them to 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 include 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

- The Aging Study Commission has been a strong supporter and policy maker for Home Care in North Carolina and we thank you for your support. In the past two years the Aging Study Commission has sponsored legislation that implemented quality improvements such as quality assurance/utilization review, staffing qualifications, additional state survey staff, etc. You have been a strong supporter of increased funding for Home Care programs.

- In SFY 2006-2007, home care providers will serve approximately 300,000 patients and families and employ more than 65,000 North Carolina citizens which include 9000 nurses, 3000 therapists, and 43,000 in-home aides.

- 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.

- Medicare provides nearly 2/3 of skilled home health services whereas Medicaid, private insurance, priv pay, and indigent funds pay for the remaining 1/3.

- Home Care Services Medicaid rates have been frozen for the past two years while inflation increases in health care cost have averaged approximately 4% per year. This year the Legislature only provided enough funds for a 1% rate increase that will become effective January 1, 2007.

Recommendations

- In the 2007 Legislative Session the General Assembly 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 to cover increased cost of services and inflation increases in SFYs 2007-2008 and 2008-2009. The increased cost is due to new regulations related to new utilization review and quality assurance requirements of agencies providing services through PCS program. These new requirements will take considerable registered nurse time.

- The Institutional Bias Report sanctioned two years ago by the Aging Study Commission identified 10 institutional biases that limit the availability and accessibility for in-home services. Legislation was passed in 2006 that directs the Department to collaborate with providers and advocates of home and community-based long-term care services to make recommendations on ways to address the biases identified in the report. This collaboration process has not started. Some of the recommendations in the report such increasing the medically needy income standard to the national average and the alignment of spousal impoverishment income rules for LTC beneficiaries in all settings should be funded through a phase in plan for the 2007-2009 biennium.

- 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.

- Provide funding for the UNC Institute on Aging to implement the Win A Step Up program (WASU) in home care. This program which is currently being implemented in Skilled Nursing Facilities is based on the T.E.A.C.H. model for child care which provides quality education and retention incentives to staff.

- Home Care Services should be the last priority for budget reductions.

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 Coz Legislative Consultant Association for Home & Hospice Care of North Carolina

3101 Industrial Dr. Suite 204
Raleigh, NC 27609 (919) 848-3450

The Arc
Rowan County
1918 West Innes Street
Salisbury, NC 28144
(704) 637-1521

The Arc of Rowan advocates for people with mental retardation and related developmental disabilities in Rowan County.

Not unique to Rowan County are many issue rated to our "graying" population. People with disabilities are living longer and are living with elderly parents. Many times the person with the disability out lives their parents.

Everyone has their own set of circumstances but this is common situation:

When a person lives in a group home they must attend the local vocational workshop during the day. No matter how old (70's and 80's included) they must go to work every day, all day to keep their group home placement. Once unable to work all day (with out regard to choice) the aging person must then move into a rest home.

Affordable **Day Programs** are needed for **all** people aging. This will allow **aging-in-place.**

Jane Jackman
Executive Director
The Arc of Rowan

Testimony by Max Melton
Study Commission on Aging Public Hearing
October 17, 2006
Shamrock Senior Center - Charlotte, North Carolina

I am Max Melton, a member of the Advocacy Council for AARP North Carolina and serve as an alternate from Union County to the North Carolina Senior Tar Heel Legislature. I also serve as vice chair of the Board of Directors for HealthQuest, a free pharmacy for seniors and handicapped who cannot pay for their prescription drugs. By year end 2006, HealthQuest will disperse approximately 45,000 prescriptions with a retail value of more than 4.5 million dollars. We serve approximately 1,000 clients per month from Union and Anson Counties.

The reason I am here today is to seek your support for a state drug assistance program. As you know, when the Federal Medicare Part D Prescription Drug Program began in January of this year, our <u>state</u> prescription drug assistance program for older adults know as Senior Care, ended. There are many older adults enrolled in Medicare Part D who don't qualify for federal assistance and need help.

Let me give you an example. We had several in our program at HealthQuest who were slightly over the 150% poverty level. The drug companies said we would have to stop serving them and they should sign up for Medicare Part D. Some did and have now gone into that familiar "donut hole" and have come back to HealthQuest for help. If the drug companies say no and we do not have samples on hand, the client will again have to make some hard choices.

A. Cut back on food to pay for medication.

B. Cut back on medication and take only what they can afford. (pill splitting)

C. Stop taking some of the more expensive medications (which is usually the one they need the most).

Now if that is happening in Union County where we have a free pharmacy, think about what is happening in counties across North Carolina where there is no free pharmacy help.

Even with the new program beginning in 2007 where 24 million dollars taken from the national tobacco settlement to help seniors with income of less than $17,150 (single) or $23,100 (couples), most will not be able to pay for all needed medication. According to the news article 50,000 North Carolina seniors are expected to take advantage of the program which would pay $18 per month or $216 for the year.

This program will certainly help, but in most cases it will not nearly meet the need while in the "donut hole" and are left to pay 100% of their medications. AARP, along with 43 other agencies and groups in the state are asking for the legislature to establish a state prescription drug "wrap around" assistance program which would serve all Medicare beneficiaries who have income at or below 200% of the federal poverty level, but are not eligible for the full low-income subsidy under Medicare.

While I am speaking, I want to say "thank you" for the four million which was appropriated in the last year's budget and added to the Home and Community Care Block Grant. However, more funding is needed for this program which helps keep older adults in their homes. I deliver meals to the homebound through the Meals on Wheels Program in Union County. I get to see first hand what we are doing to help older and disabled adults stay in their homes. According to the Division of Aging

and Adult Services, there are still several thousand on the waiting list for meals and other services.

In closing, I want to say thank you for all you are doing to meet the needs of seniors and disabled in North Carolina. Your job is not easy.

BUNCOMBE COUNTY AD-HOC COMMITTEE
Impact of younger mentally ill population living in Adult Care Homes

Background:

The primary intent of adult care homes is to provide a supportive environment for the elderly or physically disabled population, who need help with personal care but do not require the skilled services of a 24 hour nurse. However, these homes in our community are often now filled with younger, mentally ill individuals with a very different and complex set of social and medication needs.

Recently, local law enforcement officials requested a meeting with Buncombe County Department of Social Services (DSS) regarding their increasing number of calls to Adult Care Homes (ACH). Under the leadership of DSS staff, an ad-hoc committee of local organizations that serve residents of ACH was formed. Organizations participating included the Area Agency on Aging, Buncombe County Sheriff's Department, Buncombe County Department of Social Services, Buncombe County ACH Advisory Committee, Black Mountain Police Department, ACH owners and operators, New Vistas, and the Mental Health Geriatric Specialty Team.

Impact on local resources:

The **Long Term Care Ombudsman Program** is funded through the Older Americans Act and therefore is designed to serve individuals age 60 and over. Staff report that the overwhelming majority of complaints concerning care received by the Ombudsman serving Buncombe County are from residents younger then 60 years of age. For example, in a recent six month period, thirty-two out of forty complaints, or 80%, were from residents younger than 60.

The **Buncombe County Sheriff's Department** (BCSD) responded to a total of 129 calls from just two ACH facilities in the period from April through December, 2005. Most were calls involving adults with Serious and Persistent Mental Illness (SPMI), in which no crime had been committed. The **Asheville Police Department** responded to 163 calls to 20 facilities in the city limits of Asheville in 2005. The **Black Mountain Police Department** has 3 documented felony cases involving ACH ranging from employee theft of medication, embezzlement of resident funds and sexual assault.

In addition, the BCSD must respond and serve involuntary commitments on the SPMI. In the calendar year beginning January 1, 2005, through December 31, 2005, the BCSD provided **transportation for 1137 subjects under commitment** to various facilities throughout the state. In the provision of these services the County used 3,372 personnel hours from the Patrol Division at an estimated entry-level salary cost of $51,120, plus an additional expense of $6,483.08 in fuel costs. Medicaid does not reimburse local law enforcement for expenses related to commitment transports.

Buncombe County Department of Social Services reports an ongoing **rise** in violent incidents involving SPMI in ACH each calendar year.

The **Geriatric Specialty Team**, contracted for mental health service through Western Highlands, recently provided 2 in-service trainings focusing on aggression and de-escalation at one of the adult care homes referred to in the above section by the Sheriff's Department.

Recommendations:

Mandated **training** for all staff in facilities to manage SPMI in order to minimize inappropriate calls to local law enforcement and local ombudsmen. Optimally, each facility should develop an **Intervention Program** to address concerns in-house before utilizing outside sources.

Require **Supervisor-In-Charge** to have specialized training in de-escalation skills to respond at all times to SPMI residents and to provide in-house training to other staff.

Many of the concerns raised above are addressed in the final report of the **"Study of Issues Related to Persons with Mental Illness in Long Term Care Facilities."** Our committee would urge that these proposed recommendations be adopted to strengthen the safety and well-being of all residents in long-term care facilities, with the following exception:

This committee would like to see **separate facilities for the younger SPMI and older, disabled adults for the following reasons:**

- Though violent acts perpetrated by younger, mentally ill residents against elderly or physically disabled residents are rare, when they do occur they can have serious, even fatal consequences for the victims
- Mixing younger mentally ill residents with elderly and physically disabled residents is a disservice to younger residents. The rules Adult Care Homes operate under are targeted to elderly and physically disabled residents, and day-to-day operations at the homes including food service and activity programs are geared to an elderly, physically disabled population.
- Mixing younger mentally ill residents with elderly and physically disabled residents presents Adult Care Home staff, who already experience high burnout and high job turnover, with a very difficult work environment. A leading Adult Care Home industry trade group leader was recently quoted in the Charlotte Observer as saying "it's hard to train staff to meet the needs of a 35-year-old mentally ill man and a frail 85-year-old woman".
- If facilities specialized in the populations they treat, those that serve the elderly could continue training staff in delivering hands-on care such as bathing and grooming. Those that would choose to serve the younger, mentally ill population could concentrate on training staff to provide behavioral interventions and diversionary activities. This should then result in decreased demands on law enforcement and ombudsman time.
- It is increasingly evident that mixed populations in Adult Care Homes serves neither the residents, the facility staff or the community well.

David H. Reece

Charles Lee made presentation

883-C Washington Street, Raleigh, NC 27605 email: friends@forltc.org
(919) 782-1530 or toll-free (888) 411-7571 website: www.forltc.org

TO: Members of the Study Commission on Aging
Co-chairperson, Senator Charlie Dannelly
Co-chairperson, Representative Beverly Earle

FROM: Bill Lamb, Past President
Friends of Residents in Long Term Care Board of Directors

DATE: October 17, 2006

The members of Friends of Residents in Long Term Care express our appreciation to the Study Commission on Aging for your work over the years to improve the lives of frail and disabled elderly persons in our state. Because the organization advocates on behalf of residents in long term care facilities, the following recommendations are offered for your consideration, review, action and/or follow-up pertaining to measures for improving conditions in North Carolina's long term care facilities.

I. PENALTY REVIEW COMMITTEE – Review changes made to the Penalty Review Committee during the 2005 Session (Section 10.40A.(a.) of the 2005 Appropriations Act - SB 622) and make recommendations to restore the Committee's authority to meet monthly to review penalties. Having the committee meet more often will provide sunshine on the penalty process and will give residents and/or family members a forum for commenting on penalties.

II. PLAN FOR STAR-RATING SYSTEM FOR ADULT CARE HOMES – Continue supporting the development of a Star-rating System for Adult Care Homes.

In the 2005 budget bill **(Section 10.41 of the 2005 Appropriations Act - SB 622),** the General Assembly directed the Department of Health and Human Services to develop a plan to improve the quality of care in adult care homes by implementing a star-rating system. In 2007, DHHS is required to report on the status and details of the plan, including a recommended time line for implementation. **Once developed, such a system could provide valuable information about the best facilities and give consumers some guidance for selecting an adult care home. In the future, hopefully decisions made by the General Assembly to provide additional funding for adult care homes will be based on the star-rating system.**

III. MIXED POPULATIONS – Recommend measures that will meet the needs of medically diverse populations by ensuring individuals are placed in appropriate settings, appropriate groupings, or provided specialized services. Recommend thorough assessments and appropriate reimbursement levels. Assessments should provide that --

- 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, an adult care home or nursing home should serve that person.
- To meet the needs of aggressive persons or sexual offenders, a Pre-Admission Screening and Resident Review (PASARR)-type evaluation should be conducted to determine how best to meet the needs of such individuals.

IV. POSTING OF FINES ON THE INTERNET – Review the Division of Facility Services' recent posting of fines on the Internet to determine whether or not the posting provides consumers with information that is user friendly, easy to understand, and timely.

V. PROVIDER TRACKING DATABASE SYSTEM – Request a progress report on the proposal for planning, developing, and implementing a provider tracking database system. Included in the Department of Health and Human Services (DHHS) 2005 budget to the General Assembly was a request for $800,000 in non-recurring funds to be used to develop a provider-tracking database to monitor the performance and provide effective oversight of all provider facilities serving vulnerable populations. The database would have allowed clients and families to more readily obtain information about the track record of long term care facilities. The request was included in the Senate's version of the budget bill **(Section 10.10 A. of the 2005 Appropriations Act - SB 622).** Funding for the data base was not included in the final budget; however, **a special provision was included directing the Department of Health and Human Services to develop a proposal for planning, developing, and implementing a provider tracking database system.** DHHS was directed to submit the proposal and other required documentation to the Office of State Budget and Management and to the Office of Information Technology Services for review and approval. If approved, DHHS was directed to then submit the proposal and documentation to the General Assembly for review no later than May 1, 2006. The General Assembly was to have determined whether and to what extent funds should be appropriated to implement the system. No funds were appropriated during the 2006 Session, and the status of the tracking system is unknown.

VI. COMPLAINT INTAKE UNIT – Ask for a progress report on how the expanded Complaint Intake Unit has affected the handling of complaints and whether the expansion of staff has resulted in complaints being investigated in a more timely and aggressive manner.

In the 2005 budget, the General Assembly appropriated recurring and non-recurring funds to expand the Division of Facility Services' (DFS) Complaint Intake Unit by 3.5 positions. The purpose of the expansion was to provide sufficient staff to respond to the anticipated increase in complaint call volume generated by the posting of a toll-free complaint number in all residential facilities monitored by DFS. The expansion would also support a new automated call directory system.

VII. STAFFING – Recommend funding to provide adequate pay and benefits for direct care staff to increase retention and improve quality of care. Improve staff working conditions by limiting the number of consecutive hours that can be worked by registered and licensed nurses, medication technicians, and certified nursing aides/assistants. Require adequate staff training based on the needs of individual residents.

VIII. ENFORCEMENT/MONITORING – Keep monitoring of adult care homes at the local level. Recommend funding for a contingency fund so that the temporary management law can be used at any point during which a facility may be at risk of losing certification, license to operate, or its federal funding. **Amend GS 131E-230 to allow the Attorney General, Governor's Advocacy Council for Persons with Disabilities, and residents of the facilities to petition the courts to invoke the temporary management process when warranted.** Require the Division of Facility Services to deny a license to homes that are part of chains with persistent problems of noncompliance and inadequate care.

Thank you.

Cc: Patricia Yancey, Governmental Relations Consultant
Friends of Residents in Long Term Care

Good Morning,

My name is Patrick Barlow and I am the business partner that Debra just spoke about. We have been trying to keep up with all the media horror stories about rest homes that have recently been published. We have heard that the problem is mentally ill are housed in rest homes when rest homes were intended for the elderly. We have heard that the solution is to increase fines and penalties, convict rest home owners & workers, and to shut down the homes.

I would like to help you get a better idea of what happens daily in a rest home. Let's pretend that your home is a rest home and I bring 20 elderly, sound minded clients to your home. I tell you that you don't have to worry about housekeeping, laundry, food, or transportation. All of that will be taken care of for you. All you have to do is:

Get your 20 clients up, bath them, shave them, & help them dress

Assist them with brushing their teeth, washing their hands, and combing their hair

Assist them with clipping their nails and skin care

Assist everyone to the dining room and feed clients that need assistance

Assist anyone that needs help with going to the bathroom or with walking

Anyone that has a diaper, you must get changed in a timely manner

Document everything you do for every client (this is how the state can tell if you are doing a good job)

Oh, I forgot, you must also give everyone their medications and write down every individual pill that you give out.

If there are any accidents, you must complete all required paperwork

If the fire alarms sounds, you must get everyone out safely and complete the necessary paperwork

You must provide everyone with at least 2 hours each day of activities, help them use the phone, and help them with their money.

BUT,
THE MOST IMPORTANT THING YOU HAVE TO DO IS MAKE SURE YOU KNOW WHERE ALL 20 ARE EVERY MINUTE OF EVERY DAY.

Now, let's say that you helped Ms. Jones with a bath. Ms. Jones tells you see is going to watch TV. You decide to help Ms. Johnson with her bath. You are in the bathroom with Ms. Johnson and Ms. Jones is on her way to watch TV. On her way to the TV room, Ms. Jones sees a field of flowers across the street and decides she wants to give you some flowers because you have been so kind to her. She starts out across the street, looks both ways, and sees no cars. She steps into the highway but did not hear the car that was speeding down the road. Keep in mind that Ms. Jones is not mentally ill and does not have Dementia or Alzheimers. She just wanted to do a good deed.

First of all, you will be in trouble because Ms. Jones did not complete the appropriate paperwork for leaving your yard. You were responsible for making sure she did that. What did you do wrong? Should you receive a fine, a conviction, maybe go to prison? How could you have handled things differently to avoid such a tragic accident? Your name will be plastered across the headlines of every local newspaper. The regulators will come & investigate and, many, many, times put the blame on you. Again, what did you do wrong?

This is not a let's pretend story. It is what is expected in rest homes in NC. The staffing ratio in rest homes is <u>one to 20.</u> One person can not care for 20 people. And to make matters worse, you will be paid $6.50 to $7.00/hour for this responsibility of working in a rest home.

Rest Homes are like everything else, in the fact that, there are good homes and not-so

good homes. If you operate a good rest home in this state, you do it in spite of the state, certainly not with their help. The regulations and reimbursement rates are designed to save money for the state, not to provide quality care for the disabled or elderly. Rest home regulations "set rest homes up to fail" no matter what type of population they serve. The problems in rest homes are not because they house mentally ill clients.
As long as rest home regulations and reimbursement rates stay the same, there will continue to be tragedies in rest homes. The only reason Debra and I have been successful is because of the dedication we have to our clients.

Keep in mind that rest homes owners and operators do not make the regulations, they follow the regulations the state has outlined for them. When this system fails, the state refuses to take the responsibility.

Comments for the Study Commission on Aging, October 17, 2006

I am Laura Wasson, Adult Social Work Services Manager representing the Mecklenburg County Department of Social Services. I would like to tell you from an agency perspective how invaluable Project CARE services are to the customers we serve, and how much of a need we still have in the community.

Research shows caregivers need breaks and time for themselves to maintain their physical and mental health. They may suffer both physically and emotionally from the stress of caregiving. Our community must support caregivers so they can continue providing the needed support for their loved ones.

We have been fortunate to have the benefit of offering respite services through Project CARE to the citizens of Mecklenburg County for 5 years. During this time, we have seen quite an increase in the need for this service. This year alone, we have filled the 39 slots we had available for the year in just *six weeks*.

Studies have shown that the cost of allowing someone to age in place at home is far less expensive and much preferred over placement in a facility. The current $2000 allowed to each eligible family for respite services allows caregivers a bit of a break to be able to tend to their own personal needs and the assurance of knowing that their loved one is being taken care of.

We hear regularly from caregivers who say without these services, they wouldn't have the strength or emotional energy to continue providing care. Many have accessed Project CARE on more than one occasion as a person diagnosed with Alzheimer's/Dementia can suffer from the disease for many years. We must take care of those who care for others, so they may continue caring.

As the population ages and the rise in diagnosed Alzheimer's/Dementia occurs, Project CARE services needs to continue to be an option. If new funds aren't allocated for Project CARE, many families will go without services, continue to suffer burnout, and will potentially be unable to continue caring for their loved ones at home.

Thank you.

CHARLOTTE-MECKLENBURG COUNCIL ON AGING
STUDY COMMISSION ON AGING – STATEMENT
October 17, 2006 – Shamrock Senior Center

As we have seen with recent nationwide natural disasters, such as hurricanes, flooding and snow/ice storms, as well as with terrorist or man-made disasters, it's evident that communities, facilities and businesses need to be prepared for large-scale emergencies.

The death toll of Hurricane Katrina was in the thousands, with many residents and facilities unable to evacuate for a variety of reasons, including one particular facility in Baton Rouge, Louisiana. Thirty-five patients of St. Rita's Nursing Home in St. Bernard Parish died due to drowning as Hurricane Katrina hit Louisiana. The deaths of this particular nursing home, along with deaths that occurred at other health facilities, could have been prevented, as patients should have been evacuated.

As outlined in the Social Security Act, all Medicaid and Medicare long-term care facilities are required to have written plans in place to address all types of emergencies or disasters. These facilities are also required to provide adequate staff training on the protocols delineated in the plans.

Long-term care facilities have large numbers of older adults all living in one area, all with different medical, physical and nutritional needs. If an emergency occurs, the diverse needs of all residents must be addressed accurately and appropriately. The safety and well being of residents is the sole concern of long term care facility administrators and staff. This is why it is important for facilities to have comprehensive, "all-hazard" plans in place, in order to successfully execute disaster protocols, whether evacuating the facility or not.

As older adults are likely to have more physical limitations, pre-existing medical conditions and lower levels of sensory awareness, long-term care facilities have a lot to account for when planning for their emergency management strategies. Facilities may need resources and collaborations with vendors outside of their own capabilities in order to implement and execute successful disaster plans. The cooperation and attention from outside agencies should be identified, in order to provide facilities with these needed resources.

The Charlotte-Mecklenburg Council on Aging would like to ask for your support in ensuring that all long-term care facilities in Mecklenburg County, as well as in the state of North Carolina, have sufficient written plans in place to address all types of emergencies and disasters, as well as adequate staff training and preparation to carry out these emergency plans.

Marie Shook, Executive Director, mashook@charmeckcoa.org
Kellie Visker, Office Manager, kvisker@charmeckcoa.org

Please visit our website! www.charmeckcoa.org

Charlotte-Mecklenburg Council on Aging
Public Policy Platform
2006-2007

The aging baby boomers are the largest generation in our country's history.
In 2000 there were 80,440 age 60+ older adults in Mecklenburg County.
By 2030 that population will triple to 243,619.

Source: US Census 2000
Mecklenburg Status of Seniors Report, 2005

To prepare for the future health and safety needs of Mecklenburg County's aging population, every policy maker should know . . .

Who comprises the aging population in Mecklenburg County?

- Forty-five percent of seniors in Mecklenburg County live on $20,000 a year or less and spend more than 30 percent of their income on housing.
  - Of those earning less than $20,000, 35% stated that they felt "down" or depressed or hopeless
  - Twelve percent of low-income residents report poor health compared to 3% of respondents with higher incomes
- Forty-three percent of older adults in Mecklenburg County can be defined as "at risk" or "frail" due to their difficulty performing one or more basic tasks of daily living
- According to the UNCC Boomer's Study (2005), projections of older adults who are severely impaired will reach 130,000. It is further projected that 69,000 of these older adults will be living in the community or in another assisted-living type arrangement.

What will be the impact of the shifting aging population?

- According to the NC Division of Aging, one half of caregivers in Mecklenburg County experience caregiver burden (71% partners, 60% parents, 56% spouses and 50% children).
  - With the large numbers of baby boomers reaching retirement age, and the population of those age 65 plus projected to triple over the next 20-30 years, more community residents are likely to experience this type of burden – due to more older adults needing care
- According to the Status of Seniors Initiative (SOSI) and the University of North Carolina at Charlotte Master of Public Administration project (UNCC MPA), 19% of the total population surveyed in Mecklenburg County has a family member or friend over 60 who is receiving care
  - With the population of those 65 plus expected to nearly triple, the numbers of those receiving care is likely to increase
- According to the SOSI, 39% of caregivers indicated that they have had difficulty finding out about services
  - These types of services will need to be evaluated and changes may need to be implemented in order to make caregiver services accessible and familiar

What are the needs of Older Adults now and in the near future?

- Forty-six percent of seniors reported not receiving the help they needed with activities of daily living, for example walking or bathing
- 80% of all care received by older adults is provided by family and friends. Stresses of eldercare affect employee productivity. A 2004 AARP survey reports of working caregivers:
    - 56% say they are less productive at work.
    - 51% say they had to take time off during the work day for eldercare.
    - 30% say they are absent for full days to deal with eldercare matters.
    - 6% of working caregivers had to give up work entirely.
    - Nationally, lost productivity costs businesses $11.4 to $29 billion annually due to replacement costs for employees who quit due to caregiver responsibilities, absenteeism, workday disruptions, and costs associated with supervision of employed caregivers.
- Thirty-two percent of caregivers in Mecklenburg County, age 65 plus, have reported not knowing where to call for assistance
- According to the SOSI and the UNCC MPA project, nearly 85% of caregivers in Mecklenburg County reported caregiver services as essential or critical
    - These types are services will need to be evaluated and possibly restructured to meet the needs of an aging Mecklenburg population
- Eighty-six percent of seniors report taking prescribed medications, and 40% reported having made a decision not to purchase prescriptions at least once.
    - Sixteen percent reported having gone without other essentials such as rent, food or utilities in order to purchase needed medications
- According to the UNCC Boomer's Study, participant's expressed significant concerns about the ease of mobility and availability of transportation in the Charlotte-Mecklenburg area (2005)

The Charlotte-Mecklenburg Council on Aging urges policy makers to enhance the quality of life for the aging population in Mecklenburg County by:

Maintaining and expanding services and support for the aging population

- **support a study on the impact of higher property taxes on seniors**
- start a process for creation of an acute care geriatric psychiatric in-hospital unit
- Recreation
- Wellness / Prevention

Providing improved infrastructure for a senior-friendly community

- more compact, walk-able mixed-used neighborhoods
- more coordination of transit services for seniors
- more public education about all transit services available to seniors
- support the establishment of a Transportation Education & Advocacy Taskforce for seniors

Ensuring access to safe and affordable living options

- safer and better designed neighborhoods
- more housing options and more affordable housing
- senior friendly interior design in all new housing and co-use of facilities

Encouraging the business community to take an active leadership role in developing solutions to address the impact of eldercare on their employees

- Support the recommendations from Status of Seniors Initiatives program
- Chamber of Commerce place senior issues on their agenda

The mission of the **Charlotte-Mecklenburg Council on Aging** is to address, advocate, and support the rights and needs of older adults on issues that affect them.

Charlotte-Mecklenburg Council on Aging
2225 Tyvola Road
Charlotte, North Carolina 28210

704.527.8807
www.charmeckcoa.org

NC Study Commission on Aging:

October 17, 2006

Financial Exploitation of Older Adults

The problem of financial exploitation of the elderly is not new. The number of older adults that fall prey to various scams and schemes makes headlines almost weekly and is well documented by the State Attorney General's Office. For the past several years, the Mecklenburg County Elder Abuse Task Force has been focused on the problems associated with financial exploitation of the elderly. Of particular concern to our group is the growing problem of the misuse of Power of Attorney. In Mecklenburg County alone, Adult Protective Services has compiled statistics that demonstrate that thousands of dollars are being taken by the attorney- in- fact appointed in the Power of Attorney. This position of trust is often violated and the adult victim has little recourse. Once the Power of Attorney is in place, the person appointed as attorney- in- fact can easily misuse the principal's assets. This problem is compounded further by the fact that many of our elderly citizens are completely unaware that their money is being taken. Many times the older adult experiences cognitive decline which further contributes to the ease with which money is misused. In one year alone in Mecklenburg County, Adult Protective Services cases revealed losses in excess of $700,000.00. This is money that could have benefited the older adult and could have been used to provide for their care. Unfortunately, these losses not only affect the adult victim, but they directly impact the taxpayers of North Carolina. According to State Medicaid Policy, if the adult is a victim of exploitation, no sanctions are imposed. Thus Medicaid dollars begin paying the cost of care since the adult's assets were exploited. It should be noted that in almost all of these cases, no criminal or civil action is taken to punish the offender or recover the assets. The Mecklenburg County Elder Abuse Task Force has recommended that statistics should be tracked state wide to raise awareness of the huge fiscal impact this problem creates. We believe this issue warrants immediate attention at the State level as it represents a growing threat to our older citizens and it has significant consequences for the State Medicaid budget.

Wayne Mullis, MSW
Social Services Manager
Adult Social Work Services
Mecklenburg County Department of Social Services

Centralina
Council of Governments

Gayla S. Woody

Aging Program Administrator
Centralina Council of Governments
Area Agency on Aging
Charlotte, North Carolina

BEFORE THE

NC Study Commission on Aging

"Planning for the Baby Boomers"

October 17, 2006
10:00 a.m.
Charlotte, NC

CENTRALINA
Area Agency on Aging

Centralina Area Agency on Aging
Midtown Plaza Building - 1300 Baxter Street, Suite 450
PO Box 35008, Charlotte, North Carolina 28235
Phone: 704-372-2416 Fax: 704-347-4710
www.centralina.org

Good morning distinguished members of the Committee. Thank you so much for this opportunity to talk with you about how my community is preparing for the demographic changes facing the nation and specifically North Carolina. My name is Gayla Woody and I am the Program Administrator of the Centralina Area Agency on Aging (AAA). My region covers nine counties in North Carolina: Anson, Cabarrus, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly and Union counties. Our region is the largest region in the state and includes Charlotte, the largest city.

While the counties in my agency's planning and service area (PSA) range from a large, metropolitan area to a very small rural region, they share at least one characteristic. The aging of our nation's adults — in particular the demographic cohort known as "baby boomers" and the fastest growing population in the country, those 85 years and older — will present tremendous challenges and opportunities for all of these communities.

With the first wave of boomers turning 60 this year, and thus becoming eligible for Older Americans Act (OAA) services, we cannot afford to sit still and wait. To ensure that America's communities are prepared to meet the needs of today's and tomorrow's older adults, preparation and planning must start now.

The Aging of America

The rise in the number of aging citizens will impact the social, physical and fiscal fabric of our nation's cities and counties, dramatically affecting local aging, health and human services; emergency preparedness; land use, housing and transportation; public safety, workforce and economic development; recreation, education/lifelong learning; and volunteerism/civic engagement policies and programs.

An organized, informed and thoughtful community planning process to prepare for the aging of this nation's population is needed at every level. Preparedness is not just for disasters and emergencies, but should be used to help a community adapt to changing demographic needs. "Livable communities for all ages" refers to places where citizens

can grow up and grow old with maximum independence, safety and well-being. Although there is much that individuals can and should do to maximize their independence as they age, public policy makers must make critical decisions relating to housing opportunities, transportation systems, and land use regulations, for example, that affect the ability of an older adult to live at home and in their community.

One Approach: Mecklenburg County's *Status of Seniors Initiative*

I am proud to report that Mecklenburg County (which includes the City of Charlotte) has refused to wait and see. We know we cannot afford to: currently there are almost 90,000 people over the age of 60 in the county and there will be approximately one-quarter of a million people over 60 by the year 2030. That's almost a tripling of our elderly population in fewer than 25 years.

In order to begin evaluating what this change will mean and to plan accordingly, the Mecklenburg County Commissioners convened a group to examine the issue and called the project "The Status of Seniors Initiative" (SOSI). This planning project was actually part of the Planning Project that the NC General Assembly Study Commission on Aging awarded Mecklenburg and New Hanover County about four years ago. Representatives from the hospitals, home care agencies, social service organizations, housing authority, transportation services, health department, the United Way and others were included in the initiative. The collaboration also included the Charlotte Chamber of Commerce, local attorneys, and representatives from colleges and universities, the real estate industry and others. As the director of the area agency on aging, I am a member of the project's executive steering committee.

After four years of data gathering, research, analysis and strategic planning, SOSI has completed three reports looking at the impact of baby boomers on our community and has identified seven recommendations to begin making changes. Our motto is "A Senior Friendly Mecklenburg" and our vision is a "senior-friendly community that values dignity

and independence for all older adults." (These reports and recommendations can be found online at http://statusofseniors.charmeck.org.)

To provide you with a sense of how we approached the demographic challenges, here are the categories we explored first:

1) *Need for Information.* How does our community ensure that older adults, baby boomers, caregivers and others can get information about aging issues, services or where to go for assistance?
2) *Caregivers.* One-third of current older adults believe they will be a caregiver in the next five years. Estimates of lost worker hours and income and the resulting reduced pension benefits are as high as $11.6 billion dollars. How will our community provide the support caregivers need in order to continue to function?
3) *Physical Environments.* Will our community physically provide the opportunities for older adults and baby boomers to remain independent? We asked questions like: Is there enough time to cross the street before the light changes? Are the street signs actually large enough to read? Are the sidewalks wide enough for wheelchairs? Are there safe places to walk? And do we have adequate and appropriate housing?
4) *Transportation.* Will we have enough support for those who can no longer drive? Will our community have adequate and varied resources to accommodate the transportation needs of older adults?
5) *A Focal Point Organization for Aging.* Our community has a fragmented service delivery system which sometimes makes it very difficult to get information and services on aging in just one place. We think the boomers will expect more and thus demand changes. Can we develop a uniform and seamless system for all people, regardless of income status?
6) *Safety & Security.* We found that most older adults perceive safety as an important issue, regardless of the actual incidence of crime against older adults in their community. So how can our community communicate a

safer, more secure environment for seniors? What can we do to help both reduce actual crime against older adults and to reduce citizens' fears?

7) *Public Policy.* One of the guiding principles of SOSI is that our community have a structure in place to allow those that wish to "age in place" to have the supports they need. We need to rebalance our system to provide more options than just institutional care.

With these goals in mind, several projects are already underway.

1) In partnership with the Charlotte Police Department, we have implemented a training program for new police officers called "First Responders." This training teaches law enforcement about the unique needs of older adults and how to recognize signs of abuse, neglect or exploitation.
2) In partnership with the Chamber of Commerce and a local Builders Association, a meeting was held with over 200 real estate and building professionals to talk about the SOSI report and its recommendations. The Charlotte Planning Commission Director and a representative from the Metropolitan Planning Organization talked about some of their initiatives in response to the report.
3) The community college and the local Council on Aging are co-hosting a conference entitled "Can Businesses Boom as Boomers Retire?"
4) Our local government television channel ran a 30-minute program about the SOSI report and what we can expect from the aging of the boomers. There have been newspaper articles, as well as presentations to the County Commissioners, the City of Charlotte, the Chamber, the United Way, AARP chapters, and countless others. A very important part of the work is educating the public about what this means to our community.

It has been quite an adventure over the last four years as our Mecklenburg community has pulled together to begin preparing for the future. It is important to note that other than a "will" and committed volunteers, we have very little in the "way" of funds. I am very proud to say that the Mecklenburg County Commissioners this past year provided

some financial support to move their recommendations forward. Progress has been much slower than if we had had even one staff member dedicated solely to this project. Yet it has been so exciting to see the large number of people involved with SOSI, including many "non-traditional" stakeholders who aren't normally identified as part of the aging community.

Scaled to Fit: Rowan County's LIFE

Rowan is also one of the counties in my AAA's PSA. In 2003, I began to work with a group called Rowan LIFE ("Life Improvement for Everyone") that included the local senior center (Rufty Holmes Senior Center) and the county's senior services department, all of which recognized that the community was in need of more planning for the future. Although a much smaller and more rural area, Rowan County shared several common denominators with Mecklenburg County, including:

- Recognition that the boomers would significantly increase the number of older persons in the community;
- Interest in Rowan County becoming a more senior-friendly community;
- A broad collaboration with many "non-traditional" stakeholders;
- Very little funding to support the initiative; and
- Committed volunteers.

Rowan LIFE has completed their first report and has identified five initiatives on which they are currently working. As Rowan LIFE completed their report, the local United Way was developing their community needs assessment. United Way decided to include the Rowan LIFE report for their section on aging. In addition, United Way's collaboration with the project has also resulted in the community getting a 211 county-wide information and assistance system established.

It is so exciting to see that the planning Rowan and Mecklenburg Counties have done has positioned them to leverage grants and other funding to achieve their goals. For example, in Rowan County, a uniform and seamless service delivery system is a major

goal. Because of the collaborative work we have done with Rowan LIFE, this community is positioned to receive a State Rural Health grant of several hundred thousand dollars to help make changes to their service delivery system.

Another part of the grant that Rowan County applied for is about helping older adults with chronic illnesses manage their conditions for improved quality of life. One part of that management will include health promotion and disease prevention activities. Currently, Rowan County uses Older Americans Act Title III D funds for a very exciting evidence-based walking program our region calls "Walk Around the World." Participants in the program take a simple pre-test to determine baseline capacity, then maintain a regular walking schedule and record the actual number of steps taken. After six months, a post-test determines the individual's increased capacity. Working together, this community is making strides in helping people stay healthy.

With the burgeoning of the boomers into the elderly population, it is absolutely critical that we increase funding for and emphasis on health promotion programs. We will never have enough money to take care of everyone, but teaching and supporting people to live healthier lifestyles will improve quality of life and will be the only way our service delivery systems will be able to continue to offer service supports to the most frail and needy elders.

Small Steps: Early Responses to Boomers

I would like to mention a couple of other programs that have been initiated in my PSA in preparation for the boomers. One of my smallest counties, Lincoln County, was the only county in North Carolina that did not have a congregate meal program where older adults could gather in a public place for meals and socialization. Since the late 1980s, I had been encouraging Lincoln County to begin a meal program. About two years ago, while meeting with the local service providers, I again asked the question about the congregate program. The service provider responded: "You know, I don't think baby boomers are going to be interested in a congregate program; I wouldn't. So why would I

go to the effort of starting a program that is going to die?" I responded: "Ok, we're boomers sitting around this table, so what kind of meal program would we be interested in?"

Out of this conversation about the preferences of baby boomers, the "Restaurant Voucher Program" was born. The program provides a variety of opportunities for participants to attend programs on healthy living, where they receive meal vouchers to use in participating local restaurants. Boomers like to have choices so the program includes several restaurants. Boomers may not want to come to a congregate meal at a certain pre-determined time, but they will go to the participating restaurant for lunch or dinner during the restaurant's more open hours. The program also allows multi-generational families to go out together and the participant can still use their voucher (vs. congregate meal programs that are limited to eligible older adults). This program has very good partnerships with the local restaurants, most of which see it as a community service.

One of our other small counties, Cabarrus, has a pilot program for consumer-directed care. Again, for boomers, choice is a very important word. The Cabarrus County consumer-directed care program allows eligible participants to directly contract with providers and thus customize any services to their individual needs. While not workable for every consumer, this approach to offering services and supports is becoming popular and may be one of many ways to prepare the long-term care infrastructure for the future. For example, a boomer is caring for an older parent in her home, which does not contain a washer or dryer. The parent's medical condition is increasing the need for frequent laundering, so the caregiver asks a AAA for respite care so she can go to the Laundromat, or the services of an in-home aide to do the laundry. But consumer-directed care could allow for the purchase of a washer and dryer for the home, eliminating the need for respite or chore services, which over the long run are more expensive than the two appliances.

What We Still Need to Do and Why

As the Centralina Area Agency on Aging director, I have invested a lot of time in supporting Mecklenburg and Rowan counties' community planning efforts. I believe that AAAs can offer tremendous technical assistance to local community planning entities to help them define their mission, determine their process and gather critical information. Unfortunately, I have only had the staff resources and time to support two of the nine counties in our PSA.

In the late 90's NC General Assembly awarded $50,000 to each Area Agency on Aging for their planning efforts. The next year these funds were cut almost in half. Some of the other counties in my region have expressed interest in starting similar planning processes, but with my agency's regular responsibilities under the Older Americans Act and the recent demands that Medicare Part D enrollment counseling and assistance has placed on my agency, I simply do not have enough staff time to provide this level of support for all nine counties.

There are three specific things I would ask the Study Commission to consider:

1) I would urge NC General Assembly to at a minimum replace the $50,000 and consider increasing the funds to support AAAs to expand this community planning role. In the long run, this is the most cost-effective and rational way to brace ourselves for the boomers and their effect on our nation.

2) Many thanks for the additional $4 million in Home and Community Care Block Grant Funds this year. It has made a tremendous difference in our region. However, it still is not enough to erase our waiting lists or to position our programs to meet the demands of the burgeoning Baby Boomer population.

3) Provide support to the Aging Network for implementation of the NCRX. We are thrilled about this new program. The Aging Network is recognized across the country as being at the grassroots level to support older adults and soon to be older adults as they

try to determine the best Prescription Drug Plan. We have found that good counseling is essential for most, no matter how well educated. North Carolina is very fortunate to have the NCRX program. We can make the best use of our funds in North Carolina if we can help our older adults make the best decisions regarding Medicare Part D. Having staff at the grassroots level that are trained and trusted by the older adults is the most cost effective and efficient.

In conclusion, the boomers will change the way we do business. In North Carolina and in my region, we have also recognized that as an aging network, we must collaborate and work with many "non-traditional" players. Aging impacts all parts of life — our environment, our workforce, our caregivers, our health, our service delivery system and our leisure — just to name a few. It is critical that we educate our communities about what this change will mean and aggressively plan to meet the challenges it will bring with it.

Thank you for the opportunity to speak before you today. I would be pleased to answer any questions you have today or in the future.

North Carolina Laws Pertaining to Financial Exploitation (as of March, 2005)

14-32.3(c)	Exploitation
14-90	Embezzlement
14-100	Obtaining Property by False Pretenses
14-100.1	Using Fraudulent ID
14-101	Obtaining Signatures by False Pretenses
14-119	Forgery of Notes, Checks, Securities
14-120	Uttering Forged Paper or Instrument
14-122	Forgery of Deeds, Wills, Other Instruments
14-168.1	Conversion by Bailee, Lessee, Tenant or POA

POWER OF ATTORNEY — NORTH CAROLINA Chapter 32A Form 55-832
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STATE OF NORTH CAROLINA

COUNTY OF MECKLENBURG

NOTICE: The powers granted by this document are broad and sweeping. They are defined in Chapter 32A of the North Carolina General Statutes which expressly permits the use of any other or different form of Power of Attorney desired by the parties concerned.

Recording: Time, Book and Page

Mail after recording to

This instrument prepared by [redacted]

Brief Description for the index

North Carolina Statutory Short Form Power of Attorney

THIS POWER OF ATTORNEY made this [redacted] day of [redacted], 19[redacted], by and between:

PRINCIPAL	ATTORNEY-IN-FACT	ALTERNATE ATTORNEY-IN-FACT
[redacted]	[redacted]	

Enter in appropriate block for each party: name, address, county and state.

Know all men by these presents, that I, the above named principal, hereby make, constitute, and appoint the above named as my true and lawful attorney-in-fact for me and in my name, place, and stead, giving unto said attorney-in-fact full power to act in my name, place and stead in any way which I myself could do if I were personally present with respect to the following matters as each of them is defined in Chapter 32A of the North Carolina General Statutes to the extent that I am permitted by law to act through an agent:

(Initial the line opposite any one or more of the subdivisions as to which the principal desires to give the agent authority and strike through those subdivisions remaining to which the principal does not give the agent authority.)

USE BLACK INK ONLY

(1) Real Property Transactions
(2) Personal Property Transactions
(3) Bond, Share and Commodity Transactions
(4) Banking Transactions
(5) Safe Deposits
(6) Business Operating Transactions
(7) Insurance Transactions
(8) Estate Transactions
(9) Personal Relationships and Affairs
(10) Tax, Social Security and Unemployment
(11) Benefits from Military Service
~~(12) The principal also desires to give the agent the following additional authority:~~

(with full power of substitution and revocation), hereby ratifying and affirming that which the attorney-in-fact (or the substitute) shall lawfully do or cause to be done by said attorney-in-fact (or the substitute lawfully designated by virtue of the power herein conferred upon said attorney-in-fact).

(Initial the line opposite any one or more of the subdivisions as to which the principal desires to give the agent authority and strike through those subdivisions remaining to which the principal does not give the agent authority.)

This Power of Attorney shall be a Durable Power of Attorney and shall not be affected by my subsequent incapacity or mental incompetence.

~~This Power of Attorney terminates on _____, 19____.~~

This Power of Attorney shall become effective date hereof

Should my first named attorney-in-fact be unable to perform all the matters and things herein set out to be done and performed and if I have appointed an alternate attorney-in-fact hereinabove, then and in that event the alternate attorney-in-fact hereinabove designated shall be my true and lawful attorney-in-fact to do and perform in my name and in my stead all matters and things herein authorized to be done and performed by my attorney-in-fact with all the powers and authority herein given.

My attorney-in-fact shall keep full and accurate records of all transactions for me as my agent, of all my property and the disposition thereof, and shall render to me, if competent, or to my nearest living relative if I shall be incompetent or incapacitated, at least annually, inventories and accounts of all transactions of my attorney-in-fact done in my behalf; and to the extent that I am able to do so, I hereby relieve my attorney-in-fact of the responsibility and duty of filing any reports with the court.

IN WITNESS WHEREOF, the principal has hereunto set his hand and seal the day and year above written.

Signature: _____ (Seal)

[redacted]

The Need for Increased Support for Oral Care in Nursing Home Populations

Ford T. Grant, DMD
Director, Carolinas Mobile Dentistry

The importance of ~~maintaining~~ Maintaining good oral health through a lifetime has been clearly demonstrated in recent scientific studies connecting oral disease/neglect with systemic disease. No population suffers more than disabled older adults.

Established connections include:

- Heart Attack
- Coronary Artery Disease
- Stroke
- Diabetes
- Aspiration Pneumonia
- Wound Healing
- Nutrition

supporting references available on request

Quality of life issues are more difficult to measure, but are clearly affected by oral health.

More recently, a connection between bone drugs (bisphosphonates like Fosamax and Boniva) and necrosis of the jaw has been reported. Recommendations for persons on these medications are to maintain meticulous oral hygiene for the remainder of their lives. These drugs are commonly used in the elderly.

On-site oral care of this population is feasible and has been demonstrated by Carolinas Mobile Dentistry and Access Dental Care. These programs are under funded and struggle to find new dentists to care for this population. support these programs specifully

special Care Dentistry Act

Clinical Education programs in Geriatric Dentistry need funding to train the next generation of Special Care Dentists.

Changes in Medicaid funding must occur to support these efforts and should look at procedures that are ~~essential in~~ unique to the elderly population. (i.e.: root canal therapy vs. extraction in patients on bone medications.)

New regulations and Policies sometimes erect unintended barriers to care and should be reviewed to determine if this is happening. An "Access impact statement."

Oral Health of Vulnerable Older Adults in North Carolina
October 17, 2006

We, as a society, are beginning to understand the importance of good oral health and its impact on systemic health and well-being. Good oral health is crucial in the elderly. The rapid growth of our aging populations have forced professional and consumer groups to start the search for quality, comprehensive, cost-effective oral health services that focus on the elderly. Residents of long-term care facilities are often denied access to quality oral care due to barriers created by disability, dementia, financing, and transportation. Comprehensive on-site dental care programs in North Carolina have demonstrated that these barriers can be overcome. Support for these programs is growing:

- Dentists are acutely aware of the oral health needs for the aging and disabled. This year, the American Dental Association plans to release a position paper calling for action on special care dentistry issues including education and adequate financing of dental care.
- Special Care Dentistry Act (US House of Representative Bill #4624) mandates that dental services for "blind, aging, and disabled" adults be funded at a 90% federal and 10% state allocation. It is receiving bipartisan support, has solid documentation showing that the vulnerable populations incur fewer, less costly medical expenses when oral health is managed.
- The North Carolina Dental Society and North Carolina Council on Developmental Disabilities have committed significant resources to support a better system of care for special care populations.
- Many aging advocacy organizations have placed oral health as a priority.

North Carolina is only one of two states with a special care delivery model combining the best of a private/public partnerships, public because it is non-profit and able to utilize grant funding and contributions for start-up costs and private because its sustainability is based on meeting operating expenses through fee-for-service reimbursement. Carolinas HealthCare System initiated this model in 1997. Carolinas Mobile Dentistry, based in Charlotte, worked together with other state organizations to share their experience in on-site dental care delivery and Access Dental Care (Greensboro) was created. Together, these two organizations serve 70 long-term care facilities in 11 North Carolina piedmont counties and both programs have a waiting list of facilities requesting services. Local dental practitioners support this model because they need a referral source for their patients and have seen the quality of care these programs offer. Other communities statewide want programs and several have begun planning and fundraising.

This model:

- Depends on production for sustaining funding, but special care patients require additional time and expertise for delivery of services so production requires more time per service than does the standard private practice.
- Maintains a patient load of approximately 80% Medicaid patients, a percentage many times that of a private practice. Medicaid reimburses a special care practice at a rate that is below cost.
- Seeks not only to provide dental services but also to **advance education**, health services **research** and **policy objectives** for special care dentistry.

North Carolina leads the way in provision of oral health care to its frail elderly and disabled populations, but its non-profit special care providers must have additional operating support if they are to continue serving a predominantly indigent population. Additional support for these two programs and a future statewide expansion will create a viable special care dental system that benefits everyone and assures the training of future special care providers, creates a profession of special care dentistry that has reasonable working parameters and provides access to care for a population that currently has no alternative.

Proposal

Additional funding of $1000/day/delivery unit (dentist, hygienist, and assistants) is needed. This will supplement existing revenue based on private pay patients, Medicaid patients and a retainer fee paid by facilities served (approximately $6/licensed bed/month).

This supplemental fee will:

- Create competitive salaries and working hours for special care practitioners.
- Provide a training pipeline for future special care practitioners.
- Create stable, sustainable programs that can provide care and advance its staff training, community education, and research goals. No other agency or institution can do this as well as these specialty non-profits.
- More equitably compensate these non-profits for providing care to indigent patients.
- Allow replacement of older equipment/delivery systems that initially were purchased with private foundation funds.

Detailed financial data is available to support the requested funds.

Consequences of no funding increase with result in:

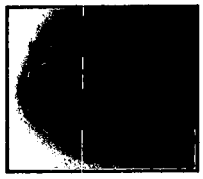
- Selective treatment of special care populations. Medicaid funded patients will be dropped and the easiest-to-care for patients will be selected.
- Loss of Special Care Dentist as they return to the private sector.
- Loss of the only referral source for private practitioners.
- Limited availability of services.
- Under-treatment for North Carolina's fastest growing population.

HR4624, "THE SPECIAL CARE DENTISTRY ACT:"

An opportunity to save health costs and improve oral health for America's most vulnerable citizens

The State of Oral Health for America's Most Vulnerable Citizens is Deplorable

Charles is infected. He is aged, disabled and like 1,300 other patients in a Louisiana geriatric dental practice who have active oral abscesses, he has no access to the extractions he needs. Medicaid in Louisiana does not provide extractions for adults and, like 46 other states, Medicaid fails to provide adequate oral health services to its aged, blind, and disabled population.



Harold is a mentally retarded, adult on Medicaid. He has abscesses, infected gums, loose teeth, and cavities. Medicaid will not pay to remove his infections.

America's most vulnerable citizens are experiencing needless pain and suffering as a result of untreated dental disease.

Sarah is autistic. She was admitted to a locked psychiatric facility at the cost of $150,000 per year. Luckily she lives in California where there are adult dental benefits for aged, blind, and disabled adults. Once Sarah's dental problems were recognized and treated, she stopped acting out and she was able to return to her community living facility.

These special populations have:

- **more cavities**
- **more dental infections and**
- **more dental abscesses than the general population**

There are Large Health Disparities

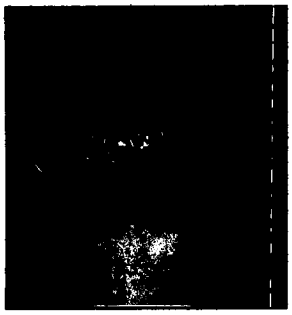
The 2000 Report of the Surgeon General on Oral Health in America and many other reports have found that the elderly population, people with mental retardation and those with other disabilities have more dental disease, more missing teeth, and more difficulty obtaining dental care than other members of the general population.[1]

Almost two thirds of community-based residential facilities report having inadequate access to dental care.[2,3,4] In our elderly population an estimated 70 percent of the nation's two million plus nursing home population has dental problems including dentures that don't fit, loss of some or all of their teeth, and most significantly, poor oral hygiene.[5]

The Current System Ignores the Needs of these Special Populations

Dental services are currently classified as "optional services" for adults under the Medicaid program. Currently the majority of states do not provide dental benefits for adults or limit services to emergency care only.[6] Thus most adult Medicaid beneficiaries do not have dental benefits.

Our "aged, blind, and disabled" populations are disproportionately impacted by this restriction in Medicaid coverage. They can get into far worse trouble and require much more expensive treatment when dental disease progresses. These vulnerable people often require greater time and expertise to treat and may require expensive medical care such as sedation or general anesthesia in order to receive dental treatment.



The Consequences of Oral Health Disparities

These major oral health disparities result in significant avoidable costs. There is mounting evidence that poor oral health leads to serious systemic diseases including poor birth outcomes, cardiovascular diseases, pneumonia, and other general health problems which result in billions of dollars in preventable health care expenditures annually.[7,8] In Maryland, when adult dental benefits were eliminated in 1993 there was a 12% increase in visits to the hospital emergency department for people with dental problems – a very expensive way to provide treatment for dental problems![9]

HR4624, "The Special Care Dentistry Act"

The Social Security Act uses the terms "Aged, Blind and Disabled" to identify vulnerable adults and children. The Special Care Dentistry Act extends required Medicaid dental benefits beyond children to include these vulnerable adults in every state. It does not require coverage for all adult populations.

"The Special Care Dentistry Act" addresses these disparities and reduces avoidable general health care costs.

It does this by:

- expanding federally required Medicaid coverage to include the nation's "Aged, Blind and Disabled"
- supporting states by increasing federal funding for Medicaid oral health services by creating a 90/10 federal/state match
- and providing additional support for other medically necessary services such as transportation.

Without this legislation, we will not be able to stop the spread of age discrimination and oral/medical neglect as states cut Medicaid funding for our most vulnerable adults. An increase in the federal match to 90/10 will help the states meet this important new requirement and also strengthen present day federal support for children's oral health services.

Cost Benefit Analysis

"The Special Care Dentistry Act" will save billions in current unnecessary and preventable general health expenditures caused by the consequences of oral neglect.

Providing early identification and treatment of dental disease for these vulnerable populations will cost less than .5% of the total Medicaid expenditures nationally.

The bill assures that people of all ages who are "aged, blind, and disabled" will have access to critical oral health care services. By providing this coverage, widespread infection, suffering and neglect currently experienced by this country's most vulnerable citizens can be minimized and overall health care expenditures reduced.

For more information...

Special Care DENTISTRY ASSOCIATION

Academy of Dentistry for Persons with Disabilities
American Association of Hospital Dentists
American Society for Geriatric Dentistry

401 N. Michigan Avenue
Chicago, Illinois 60611

Phone: (312)527-6764
Email: SCD@SCDonline.org

Web Site: http://www.SCDonline.org

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Prepared by Gregory Folse, DDS, Paul Glassman DDS, MA, MBA, Michael Helgeson, DDS. January 2005.

FRIENDS OF RESIDENTS IN LONG TERM CARE

883-C Washington Street, Raleigh, NC 27605 email: friends@forltc.org
(919) 782-1530 or toll-free (888) 411-7571 website: www.forltc.org

TO: Members of the Study Commission on Aging
Co-chairperson, Senator Charlie Dannelly
Co-chairperson, Representative Beverly Earle

FROM: Bill Lamb, Past President
Friends of Residents in Long Term Care Board of Directors

DATE: October 17, 2006

The members of Friends of Residents in Long Term Care express our appreciation to the Study Commission on Aging for your work over the years to improve the lives of frail and disabled elderly persons in our state. Because the organization advocates on behalf of residents in long term care facilities, the following recommendations are offered for your consideration, review, action and/or follow-up pertaining to measures for improving conditions in North Carolina's long term care facilities.

I. PENALTY REVIEW COMMITTEE – Review changes made to the Penalty Review Committee during the 2005 Session (Section 10.40A.(a.) of the 2005 Appropriations Act - SB 622) and make recommendations to restore the Committee's authority to meet monthly to review penalties. Having the committee meet more often will provide sunshine on the penalty process and will give residents and/or family members a forum for commenting on penalties.

II. PLAN FOR STAR-RATING SYSTEM FOR ADULT CARE HOMES – Continue supporting the development of a Star-rating System for Adult Care Homes.

In the 2005 budget bill **(Section 10.41 of the 2005 Appropriations Act - SB 622),** the General Assembly directed the Department of Health and Human Services to develop a plan to improve the quality of care in adult care homes by implementing a star-rating system. In 2007, DHHS is required to report on the status and details of the plan, including a recommended time line for implementation. **Once developed, such a system could provide valuable information about the best facilities and give consumers some guidance for selecting an adult care home. In the future, hopefully decisions made by the General Assembly to provide additional funding for adult care homes will be based on the star-rating system.**

III. MIXED POPULATIONS – Recommend measures that will meet the needs of medically diverse populations by ensuring individuals are placed in appropriate settings, appropriate groupings, or provided specialized services. Recommend thorough assessments and appropriate reimbursement levels. Assessments should provide that –

- 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, an adult care home or nursing home should serve that person.
- To meet the needs of aggressive persons or sexual offenders, a Pre-Admission Screening and Resident Review (PASARR)-type evaluation should be conducted to determine how best to meet the needs of such individuals.

IV. POSTING OF FINES ON THE INTERNET -- Review the Division of Facility Services' recent posting of fines on the Internet to determine whether or not the posting provides consumers with information that is user friendly, easy to understand, and timely.

V. PROVIDER TRACKING DATABASE SYSTEM -- Request a progress report on the proposal for planning, developing, and implementing a provider tracking database system. Included in the Department of Health and Human Services (DHHS) 2005 budget to the General Assembly was a request for $800,000 in non-recurring funds to be used to develop a provider-tracking database to monitor the performance and provide effective oversight of all provider facilities serving vulnerable populations. The database would have allowed clients and families to more readily obtain information about the track record of long term care facilities. The request was included in the Senate's version of the budget bill **(Section 10.10 A. of the 2005 Appropriations Act - SB 622).** Funding for the data base was not included in the final budget; however, **a special provision was included directing the Department of Health and Human Services to develop a proposal for planning, developing, and implementing a provider tracking database system.** DHHS was directed to submit the proposal and other required documentation to the Office of State Budget and Management and to the Office of Information Technology Services for review and approval. If approved, DHHS was directed to then submit the proposal and documentation to the General Assembly for review no later than May 1, 2006. The General Assembly was to have determined whether and to what extent funds should be appropriated to implement the system. No funds were appropriated during the 2006 Session, and the status of the tracking system is unknown.

VI. COMPLAINT INTAKE UNIT -- Ask for a progress report on how the expanded Complaint Intake Unit has affected the handling of complaints and whether the expansion of staff has resulted in complaints being investigated in a more timely and aggressive manner.

In the 2005 budget, the General Assembly appropriated recurring and non-recurring funds to expand the Division of Facility Services' (DFS) Complaint Intake Unit by 3.5 positions. The purpose of the expansion was to provide sufficient staff to respond to the anticipated increase in complaint call volume generated by the posting of a toll-free complaint number in all residential facilities monitored by DFS. The expansion would also support a new automated call directory system.

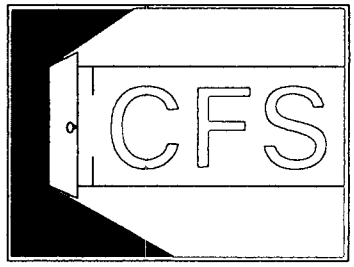
VII. STAFFING -- Recommend funding to provide adequate pay and benefits for direct care staff to increase retention and improve quality of care. Improve staff working conditions by limiting the number of consecutive hours that can be worked by registered and licensed nurses, medication technicians, and certified nursing aides/assistants. Require adequate staff training based on the needs of individual residents.

VIII. ENFORCEMENT/MONITORING -- Keep monitoring of adult care homes at the local level. Recommend funding for a contingency fund so that the temporary management law can be used at any point during which a facility may be at risk of losing certification, license to operate, or its federal funding. **Amend GS 131E-230 to allow the Attorney General, Governor's Advocacy Council for Persons with Disabilities, and residents of the facilities to petition the courts to invoke the temporary management process when warranted.** Require the Division of Facility Services to deny a license to homes that are part of chains with persistent problems of noncompliance and inadequate care.

Thank you.

Cc: Patricia Yancey, Governmental Relations Consultant
Friends of Residents in Long Term Care

Adults with Mental Illness in Residential Facilities:
Facing the Challenges and Finding Solutions.

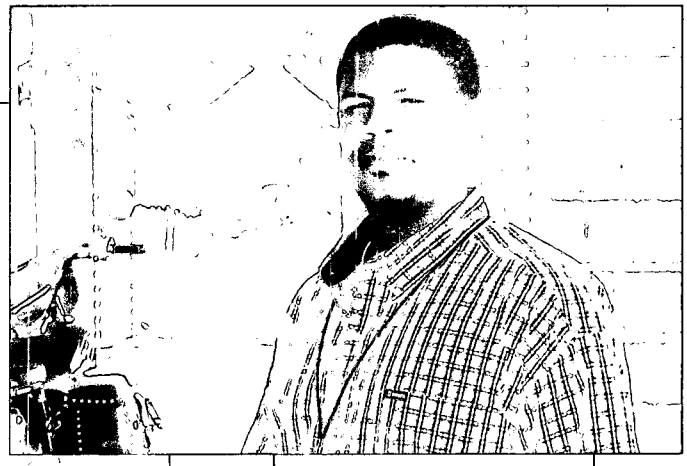


Cleveland Family Services, Inc
PO Box 262
Shelby, NC 28151
Office: (704)482-6634
Fax: (704)482-6653

An Overview of the History and Needs of Consumers, the Current Gaps in Services, and the Immediate and Long-Term Options to Improve the Lives of Individuals Residing in Facilities.

Prepared by the CFS Management Team
October 16, 2006

Cassandra Bell-Gash
Owner and Executive
Director of CFS



Opening the door to a brighter future!

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UNITED STATES CONSTITUTION
Amendment XIV
Section 1.

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges of immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the law.

Introduction

Cleveland Family Services, Inc. is a faith based human services agency which provides services to individuals with mental illness, developmental disabilities, and substance abuse issues. Cleveland Family Services is a corporation in the state of North Carolina endorsed by Pathways LME to provide Community Support for adults and children, Targeted Case Management and Diagnostic Assessment. Specifically, for the dialogue of adults with mental illness residing in long term facilities we reference the enhanced benefit Community Support.

Community Support consists of mental health and substance abuse rehabilitation services and supports necessary to assist the person in achieving and maintaining rehabilitative, sobriety, and recovery goals. The service is designed to meet the mental health/substance abuse treatment, financial, social, and other treatment support needs of the recipient. ***The service is also designed to assist the recipient in acquiring mental health/substance abuse recovery skills necessary to successfully address his/her educational, vocational, and housing needs.*** **The service activities of Community Support consist of a variety of interventions; identification and intervention to address barriers that impede the development of skills necessary for independent functioning in the community; family psychoeducation development and revision of the recipient's Person Centered Plan; and one-on-one interventions with the community to develop interpersonal and community coping skills, including adaptation in the home, school and work environments; therapeutic mentoring; symptom monitoring; monitoring medications; and self management of symptoms. Community Support includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. Community Support workers also inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services.**

Cleveland Family Services, Inc. will provide individuals with opportunities to establish and incorporate best practices for growth and development. It is the philosophy of this program to promote community empowerment and to ensure that all individuals have access to resources that will improve their overall health. Thus, the below listed entrance criteria for the enhanced benefit of Community Support is a resource that this agency advocates for a realistic implementation of services to individuals residing in long term care facilities.

Entrance Criteria

The recipient is eligible for this service when:

A. there are two(2) identified needs in the appropriate documented life domains
AND

B. there is an Axis I or II diagnosis, present other than a sole diagnosis of Development Disability
AND/OR

C. ASAM (American Society for Addiction Medicine) criteria are met
AND

D. the recipient is experiencing difficulties in at least one of the following areas:
    1. is at risk for institutionalization, or hospitalization or is placed outside the natural living environment.
    2. is receiving or needs crisis intervention services
    3. has unmet identified needs for services from multiple agencies
    4. needs advocacy and service coordination to direct service provision from multiple agencies
    5. DSS has substantiated abuse, neglect, or has established dependency as defined by DSS criteria
    6. recipient exhibits intense, verbal and limited physical aggression due to symptoms associated with diagnosis that is sufficient to create functional problems in the home, community, school, job, etc
    7. functional problems that may result in the recipient's inability to access clinic-based services in a timely or helpful manner
    8. is in active recovery from substance abuse/dependency and is need of continuing relapse prevention support

A BRIEF HISTORY OF TREATMENT OF THE MENTALLY ILL in AMERICA

Timeline:

*1700-1800- ***"Distraction"*** signified a state of mental agitation and excitement short of complete madness.

*1773- The first hospitals established to protect citizens from the threat to social order posed by ***"lunatics"***. The first American Hospital devoted entirely to confinement and care of mental patients opens.

*1800-1900- Mental Illness was called ***"demonic possession", "madness", "lunacy"***

*Early 1800- Institutions increased control of the insane through confinement, which was paralleled by growing confidence in science's ability to ***"cure"*** insanity through aggressive medical treatment.

*1857- The first federally funded mental hospital- ***Government Hospital for the Insane in Washington, DC.***

*1880- Asylum critics joined together to found an organization dedicated to reforming mental health care, ***the National Association for the Protection of the Insane and the Prevention of Insanity. (NAPIPI)***

*1890's- Americans began making new contributions in research and scientific psychiatry.

*1910- The first use of a drug, salversan, which had terrible side affects,but killed the spirochete responsible for syphilis, which helped the victims of the tertiary stage of syphilitic infection. This was the first time a drug was proven to ***"cure"*** a mental illness

*WWI- A split occurs between psychological and bio-medical approaches to the treatment of the mentally ill. Most public mental hospitals offered only custodial care, characterized by monotony and anonymity and complaints of patient abuse.

*1932- The American Medical Association published the first American Classification of Disease,***The Standard Classified Nomenclature of Disease** ,including a list of mental disorders complied by the American Psychiatric Association.

*1990-2000- State Hospitals down-size or close.

*1999- Supreme Court decision ***Olmstead vs. L.C.***

Gaps in Services

Residential options are **extremely limited** for mentally ill consumers who require placements with 24 hour supervision. Many adults are faced with this daunting problem immediately following one (or more) hospitalization(s) for severe psychiatric symptoms of a diagnosis that has resulted in a decrease in functioning for the adult consumer; a strain in or loss of family/community supports; a loss of employment and financial crisis, all the while facing the prospect of dealing with a lifelong diagnosis. Most of these consumers are consumed with the trauma of the loss of their independence and struggling to process the overwhelming changes in their lives as residential options are quickly being reviewed prior to discharge.

A quick review of the NC Division of Facility Services Mental Health Facility Listing will evidence the extremely limited opportunity for 27G.5600A Supervised Living MI Adult beds in each county. There are Supervised Living DD Adult options and many MH Child Residential treatment beds listed, but very few Adult MI beds. (An astute reader will immediately wonder what happens to all of the children in residential level III or IV as they turn 18?)

It soon becomes evident that any mentally ill adult, requiring 24 hour supervision at the time of discharge from a psychiatric unit, usually **only** has the option of a domiciliary care (rest home) placement. This is not a new problem; this has been the frequent and **lone placement solution** for **many years**. Rest home staff are not specially trained in caring for the mentally ill individual. Their care and mandated service is basically custodial in nature; meals, administering medication, providing transportation to medical appointments and minimal, often age inappropriate activities, and limited staffing ratios for supervision. They have no specific training for monitoring the psychotropic medications mentally ill adults are prescribed. Mentally ill residents' symptoms and behaviors are often confusing and daunting for the RH staff to manage.

Mentally ill adults in rest home placement can easily "slip through the cracks", by being placed in a facility far from their home county and not reentering into mental health treatment in the new county. Mental Health reform has increased the chance of this occurring, by the increase in the complexity of multiple service providers, gaps in available services that vary from county to county and a decrease in LME staff to track consumer movement and continuity of care.

This all results in the consumer often times have a "placement" and an MD continuing their medications, but, no qualified Mental Health Professional assisting the consumer in treatment planning and accessing Mental Health services. Any rehabilitative treatment which would help the consumer stabilize mental health symptoms, explore vocational options, increase social interaction, increase activity level and community integration, and possibly later facilitate a move to a lesser level of care or eventually independent living , **never** occurs. They remain in the rest home placement until their behaviors warrant a 30 day discharge and placement to another RH facility or their symptoms exacerbate and warrant another psychiatric hospitalization.

Current Options

The current options for addressing the residential needs of adults with mental illness are clearly limited. There have long been challenges in providing the needed treatment to this population in a manner which protects their civil rights. In the absence of the leveling of facilities and a resulting higher reimbursement rate for higher acuity level, there are **already existing periodic services** which are making a **positive impact** on the lives of individuals with mental illness who reside in residential facilities.

Community Support, a **Medicaid-billable service**, is one such option for residents with Medicaid who meet eligibility requirements. While this is a relatively new service (implemented on 3/20/06), many **positive outcomes** for consumers have already been documented. The use of this service in facility settings has not been done on a large scale, however in the facilities where Cleveland Family Services has offered this service, facility administrators have reported an immediate **decrease in behavioral incidents** and early data suggests a decrease in decompensation resulting in psychiatric hospitalization as well. Not surprisingly, consumers report **higher consumer satisfaction** and seem to have greater hope for the future as a result of the skill-building activities which increase levels of independence and functioning ability and the increased involvement in their communities.

The reason for the quick, positive results is easy to see. Generally speaking, the most needy consumers in a facility are the first to be referred for screening/assessment to determine if they meet eligibility requirements. These residents often require more attention of facility staff, and consequently, other residents receive less attention. With an already challenging 1:20 staff to resident ratio, even a small number of actively psychotic residents in a facility create an overwhelming burden. When these most needy consumers begin to receive **individualized services which address their treatment needs**, the

benefits to the individual are obvious. The benefits to the other facility residents are also significant as the facility staff are not overwhelmed by too high an acuity of need.

The first option then is not to simply remove "problem" residents who have mental illness. The first option must be to provide for the treatment needs of individuals so that they can succeed in the least restrictive environment possible. In addition to being the right thing to do, this would appear to be much more cost effective than other more radical plans.

Many professionals in the system are still not aware that **Community Support can be delivered in a residential facility setting.** Because the service is relatively new, considerable education is needed to let all stakeholders know about these resources. Cleveland Family Services has offered to provide technical assistance and training to residential facilities and other service providers in an effort to make known strategies which have proven effective in addressing the complex issues at hand.

Long Term Strategies

The positive outcomes produced by Community Support is an encouragement in light of the daunting challenges of ensuring appropriate residential options for individuals with mental illness which include the necessary treatment components to foster success. Long term strategies must include the following if we are to protect the rights of **all** of our citizens and strengthen our service delivery system:

- **Education of the public**
- **Enhanced training of Residential Facility staff**
- **Interdisciplinary treatment approaches**
- **Service provider collaboration**
- **Improved tracking of consumer movement/continuity of care**
- **Increased sophistication of advocacy efforts**
- **Education of consumers in self-advocacy**
- **Investigation of leveling of residential facilities**
- **Implementation of lower staff ratios in facilities serving higher acuity consumers**
- **Allocation of funding for alternative housing solutions for consumers who have the capacity for independent living with rehabilitative efforts**
- **Residents of Rest Home Facilities who meet the criteria for Nursing Home level of care need to be expediently assessed and placed appropriately**

Much more can be discussed as we examine the challenges presented by the residential needs of our citizens with mental illness. We have merely scratched the surface of this complex issue. It is **our hope that this public discussion will bring action** in the near future which will protect the rights of all Carolinians.

A Guardianship Perspective:

My name is Thomas Gray and I have worked in this field for over 20 years. I have worked with the Department of Social Services in both Gaston and Mecklenburg Counties with Adult Placement, Protective Services, Guardianship, and Facility Monitoring for 12 years. During the last 8 years, I have worked with Mental Health in both Case Management and Guardianship capacities, advocating for client's needs and services.

Historically, rest home staffing ratios have always been around 1 staff to 20 or more residents. In my history, I have noticed that the population in rest homes is a mixture of both mentally ill consumers and the elderly. This mix is not something that just occurred in the last few years.

Many of the 67 rest homes I have worked with across the state have done a tremendous job working with the mixture of both populations. I have placed numerous consumers with Debra Kirby's facilities, for example. She and her staff have worked with me to accept very challenging consumers with no other options. These rest homes have provided a safe, secure, and stable environment for the consumers.

While these rest homes have provided a safe and stable environment, many of these consumers need additional supports. As stated earlier with the staffing ratios, 1 staff to 20 residents is simply not sufficient for the high intensity care many of these consumers require. Supports that the facilities offer, such as medication management and group or individual therapy, are needed, but often not enough to address their mental illness.

As a guardian, with a case load of over 60 individuals with chronic and persistent mental illness, I have researched quality facilities. My primary objective, of course, being the safety of the consumer. While I have found many facilities, such as

Debra Kirby's that provide tremendous care, I have also found rest homes that did not.

In 2005, I went to Cleveland Family Services, and asked the owner, Cassandra Bell-Gash, if she could provide individualized services to some of my consumers that were in facilities. She immediately responded with and emphatic "yes", when she realized how remote the facilities were and how limited the resources were for the consumers. The question was never how inadequate services were in the facility, but what additional services would provide continuity of care for the consumer and a person centered approach to the consumer's overall needs. I was thrilled to know that I would have a provider in the facility, assisting my consumers with individualized care, specific and measurable goals being addressed, and added supports for the actual facility.

This service, in my role as a guardian, has changed the face of rest home living for mentally ill residents/consumers. The consumer/resident now has safe, secure, and stable environment, from the facility and staff. In addition, the consumer now has added supports for reaching obtainable goals, increased socialization, and individualized care. The staff at the facilities have additional supports, such as emergency services, if a crisis were to occur, the ratio of 1:20 becomes less intense, and there are more members of a "team" to facilitate care for each resident.

Thomas Gray, BA, QMHP, QDDP
Program Coordinator
Cleveland Family Services
704.297.5990

The Family Without Hope

As a qualified mental health professional with over 30 years of Human Service experience, it has been my privilege to serve the Adult Mental Health population of North Carolina.

It has been my observation that Cleveland Family Services, through community support services, has dramatically increased the quality of life for mentally ill people.

There are some folks we reach, others we do not. With those, that we do not reach, we are proud to say we plant faith seeds of hope, through community support interventions, that will grow into the lives of the mentally ill citizens.

A 37 year old Caucasian woman, brown hair, hazel eyes, who has experienced the death of her brother, due to community violence, and another brother engaged in criminal behavior, has reviewed our services for over 2 years. She has a mental health diagnosis of paranoid schizophrenia, lives at home with her aged parents, who also have multiple health problems. Both parents have had heart surgery and with the mothers additional diabetes , this client lives with minimal hope for a quality of life. The aunt, who is a psychiatric nurse in a local Cleveland County Hospital is presently seeking guardianship for the client.

The aunt who is currently working full time as a psychiatric nurse, wants to have her placed in an assisted living home with continued community support services from Cleveland Family Services.

The client as a complicated mental illness. She has grandiose delusions, anger, and paranoid schizophrenia. This makes it impossible for her to remain at home. She must have community support services to keep her safe. Cleveland Family Services honors her right to live a safe and dignified life by her continual rehabilitation of daily

living skills. Cleveland Family Services has provided support and respite care for the family through Community Support professionals. Community Support Services has advocated for the aunt to be named guardian, and continue to provide resources through community mental health services.

It is my professional belief that Cleveland Family Services has offered hope to this family. She would have had to be placed in a state facility for the rest of her life, had we not successfully intervened.

Rita Conte, BS, QMHP
Cleveland Family Services

Close To Home

I have worked in Mental Health for years; however, I have been dealing with Mental Illness for a life time or at least most of my brother's life time. At age 16 he began to exhibit signs of schizophrenia. He was 21 before he was diagnosed. My family spent those years watching as his behavior went from odd to bizarre. We were ignorant about mental illness and did not know what to do to help him. The only thing we could do was love him and be there for him. After a hospital stay and lots of education for the whole family my brother and our family are able to deal with his illness.

He once told me that schizophrenia was like sitting in a room with ten radios on ten different channels and no way to turn them off. One says stalk that girl, the next kill her, the next cut her up, God screams it's a sin, and the voice of our mother saying don't forget to eat your vegetables. The noise at times is deafening. There are times when dying even begins to look good. But no matter how bad things were he still had family who loved him even when he pushed them to their limits.

Imagine how it must be for the schizophrenics who have little or no natural supports who in addition to the voices find themselves needing to live in a facility surrounded by the cacophony created by communal living.

82.6% of the consumers that Cleveland Family Services serves are in some type of alternative living arrangement, from family care homes to assisted living. We provide services in 19 different homes throughout the Piedmont and Western North Carolina. 31% of these consumers suffer from some form of schizophrenia. These homes provide a good home, a roof over their heads, good food everyday, but home owners and mental health providers alike, need more funding, good programs, and governmental supports. These consumers deserve the same quality of life that my brother has been able to enjoy. Limited resources and little of no natural supports should not be a barrier to a life worth living.

I urge advocates, lobbyist, and politicians on both sides of the isle to remember when mental health issues are discussed the statistics are not just numbers or dollar signs but are consumers who are slowly losing their voice. Please do not allow mentally ill consumers to go to a facility in a remote town in the mountains and be forgotten. They need everyone's support.

Submitted by
Karen Carpenter
Service Management Coordinator
Cleveland Family Services

Facility/Collaterals Testimonials

Betty Boles-Vanover, Resident Care Coordinator for Canterbury Hills, Candler North Carolina a ninety-nine bed facility stated "I have seen a real change in our residents since they started Community Support with Cleveland Family Services. We have residents who have not left the facility in a year now out enjoying the community. The behaviors have decreased and moral has increased. It makes it easier for the staff to work their eight hours. Even attention seeking trips to the hospital have dropped."

Georgette Ormsby, Owner of Haven-n-Hills, Bostic, North Carolina; Walden's Pond, Cherryville, North Carolina and St Marks, Cherryville, North Carolina stated "I can't believe the difference in the quality of life my residents have since they started Community Support with Cleveland Family Services. They now have something to look forward to. The behavior issues have decreased. The residents are managing their own money better. It is just wonderful to see the huge difference the service makes."

Joy Williams, Owner of Joyful Home I Ellenboro, North Carolina and Joyful Home II, Forest City, North Carolina stated "The services my residents get make the difference between night and day. I have one resident whose hours have been cut since Value Options and all the positives we saw are slipping away, he has had three missing person reports filed and is at risk now of involuntary commitment. The residents who get services are wonderful limited behavior problems. I have one resident who has no one but the home care staff and her Community Support staff. She lives for her time in the community."

I have been working in the mental health system in North Carolina for 12 years. While always pleased about how exceptionally well the State covers mental health services for children, I had no idea how sparse the services are for chronically mentally ill adults. I was aware that the de-institutionalization movement had moved many of the mentally ill into group homes in their home communities, but had no awareness that this movement was accompanied by little to no supportive services to insure that the residents of these homes were actually **integrated** into their home communities, rather than just **institutionalized** in a group home.

Community Support services are a vehicle to potentially move these individuals into lower levels of care, increase their independence and integrate them into our community in a meaningful way. Clients that I have contact with are excited at the prospect of increasing their independence and enjoying the community that they are supposed to be part of.

Thank you for your consideration and continued support of these often ignored citizens.

Sincerely,

Martha V. Perry, Ph.D

Martha V. Perry, Ph.D
Licensed Psychologist

Olmstead Ruling

"Even though the U.S. Supreme Court is the nation's highest court, it is only once in a great while that it has the opportunity to make a decision that directly affects millions of Americans. Some decisions are so important that they become household names, like the 1954 *Brown v. Board of Education* decision. In that case, the court rejected the idea of "separate but equal" schools for racial minorities and ordered the states to integrate their public schools."

"Olmstead is also a case about integration and some people have referred to it as the *Brown v. Board of Education* of disability rights movement. In this landmark decision, the Court ruled that, when appropriate, states must provide services to people with disabilities in the community rather than in institutions."

Referenced:

- **UPenn Collaborative On Community Integration , August 4, 2006**

Civil Rights Overview

"A civil right is an enforceable right or privilege, which if interfered with by another gives rise to an action for injury. Examples of civil rights are freedom of speech, press, assembly, the right to vote, freedom from involuntary servitude, and the right to equality in public places. Discrimination occurs when the civil rights of an individual are denied or interfered with because of their membership in a particular group or class. Statues have been enacted to prevent discrimination based on a person's race, sex, religion, age, previous condition of servitude, physical limitation, national origin in some instances sexual preference."

"The judiciary, most notable the Supreme Court, plays a crucial role in interpreting the extent of the civil rights. A single Supreme Court ruling can change the very nature of a right throughout the entire country. Supreme Court decisions can also affect the manner in which Congress enacts civil rights legislation, as occurred with the Civil Rights Act of 1964. The federal courts were/are crucial in mandating and supervising school desegregation programs and other programs established to rectify state or local discrimination."

Referenced

- **The United States Constitution (http://www.law.cornell.edu/consitution.overview)**
- **Chapter 21 (Civil Rights) of Title 42 of The United States Code, October 16, 2006**

Resource Guide/References:

** Cornell Law School - LII (Legal Information Institute) , 10/16/2006 - Civil Rights: An Overview*

** UPenn Collaborative on Community Integration, 8/4/2006 - "What is Olmstead and how does it affect me?"*

** North Carolina Mental Health/Developmental Disabilities/Substance Abuse Service Definitions, service definitions.*

** Civil Rights, The United States Constitution*

** Americans with Disabilities Act*

** Olmstead Ruling, 1999*

Opening the door to a brighter future!

The following Information has been submitted by the Leadership Team and Employees of Cleveland Family Services.

Cassandra Bell-Gash.....Owner/Executive Director

Banzen Warren.....Operations Coordinator

Tom Gray.....Program Coordinator

Chelsea Greene.....Independent Consultant

Carla Bradshaw.....Quality Assurance/Quality Improvement

Laura Blanton.....Service Management Clinical Supervisor

Rita Conte`.....Qualified Mental Health Professional

Nichole Russell.....Service Management Specialist

Karen Carpenter.....Service Management Coordinator

For more information please contact one of the following sites:

Cleveland Family Services
Administrative Offices
1105-2 E. Dixon Blvd.
Shelby, NC 28150

Main Number 704-482-6634
800 # 888-239-3449
Fax 704-482-6653

Cleveland Family Services
Clinical Office Shelby
400 Royster Ave. Suite 3
Shelby, NC 28150

Main Number 704-471-2128
Fax # 704-471-0989

Cleveland Family Services
Clinical Office Ashville
305 Stoneridge Blvd.
Asheville, NC 28804

Main Number 828-658-1270
800# 877-207-1200
Fax # 828-685-1277
PVT Fax # 828-658-4339

October 2005

Alzheimer's Disease Demonstration Grants to States Program: North Carolina's Project C.A.R.E. – Caregiver Alternatives to Running on Empty

"Implementing Systems and Sustained Change in Long-Term Care" Executive Summary

Prepared for

Lori Stalbaum, M.S.W.
Administration on Aging
1 Massachusetts Avenue, NW
Washington, DC 20001

Prepared by

David Brown, M.A.
Kristin Siebenaler, M.P.A.
Joshua Wiener, Ph.D.
RTI International
1615 M Street, NW, Suite 740
Washington, DC 20036

RTI Project Number 09351.000.008

ALZHEIMER'S DISEASE DEMONSTRATION GRANTS TO STATES PROGRAM OF NORTH CAROLINA – PROJECT C.A.R.E.

David Brown, M.A.
Kristin Siebenaler, M.P.A.
Joshua Wiener, Ph.D.

AOA Project Officer: Lori Stalbaum, M.S.W.

RTI International*

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*RTI International is a trade name of Research Triangle Institute.

EXECUTIVE SUMMARY

The Alzheimer's Disease Demonstration Grant to North Carolina is a partnership among the Division of Aging and Adult Services in the North Carolina Department of Health and Human Services, the Duke University Center for Aging Family Support Program, the Western Carolina Chapter of the Alzheimer's Association, the Mecklenburg County Department of Social Services, and the Area Agencies on Aging for Regions B, C, F and I.

The grant funds Project C.A.R.E. (Caregiver Alternatives to Running on Empty), which has created a community-based, family-centered service system that provides direct access to dementia-specific respite care and connects families to other long-term care services. Project C.A.R.E. targets an underserved rural, minority and low-income elderly population. It demonstrates that both public and private entities can deliver dementia-specific respite services, allowing communities to administer the program in a way that is best-suited to local circumstances and needs.

Project C.A.R.E. offers families a personalized approach to respite care. Through Family Consultants, families are offered in-home assessment and care planning, a simplified determination of eligibility, a wide degree of flexibility and choice in the use of respite funding, ongoing case management, and education and training for caregivers and respite providers. Family Consultants also serve as a link for families to other long-term care resources. Family Consultants develop networks of provider, governmental, and volunteer agencies to bring quality dementia-specific respite services to caregivers.

To achieve systems change, Project C.A.R.E.: has used a number of strategies:

- *Integrated the needs of family caregivers into public programs and long-term care planning.* Through cooperation in strategic planning and collaboration with other state programs serving caregivers at the state level and the work of the Family Consultant in building networks of agencies and providers at the local level, Project C.A.R.E. has helped create a state long-term care system that recognizes the needs and preferences of the caregiver as well as the person with dementia.

- *Explored the efficacy of varying administrative sponsorship.* Project C.A.R.E. has demonstrated its effectiveness in two different administrative settings: under the guidance of an Alzheimer's Association Chapter, and as part of a unified county social services agency.

- *Increased access and availability of a comprehensive range and type of dementia-specific respite services by using the Family Consultant model.* Under Project C.A.R.E., the Family Consultant develops agency partnerships, recruits and trains service providers, publicizes the availability of caregiver services, conducts in-home assessments, facilitates the connection between the caregiver and respite care options and providers, and provides continuing support to both caregiver and provider.

- *Offered consumer choice and consumer-directed respite care.* Project C.A.R.E. provides flexibility in meeting the caregiver's needs through individualized attention and multiple options in the type, scheduling, and staffing of respite services.

- *Conducted outreach to low income, rural, and minority families.* Project C.A.R.E. targets underserved rural, minority and low-income elderly populations. By developing personal contacts and building bridges to the faith-based community, Family Consultants have helped overcome the cultural and geographical isolation facing dementia caregivers in rural mountainous areas and urban minority communities.

- *Connected families with information and services.* Project C.A.R.E. is bringing the expertise of the Alzheimer's Association and other proven resources into the community arena, educating both caregivers and providers to techniques which produce a higher quality of life for both client and caregiver. The network development work of the Project C.A.R.E. Family Consultants also puts them and the project in a unique position to link caregivers to a wide range of long term care services and supports.

- *Leveraged ADDGS funds for sustainability.* The grant partners are making a diligent effort to identify resources to sustain the Project C.A.R.E., seeking private foundations funding, collaborations with other long-term care grants, and making plans to approach State legislative staff with evidence of the project's effectiveness. In the Mecklenburg County site Project C.A.R.E. has demonstrated its value to a local agency which is willing to support the Family Consultant function and be an advocate for county-level respite funding.

Through this Alzheimer's Disease Demonstration Grant, Project C.A.R.E. is a replicable model for bringing dementia-specific respite services and resources to family caregivers of persons with Alzheimer's disease and other dementias, with the flexibility to meet the needs of caregivers in different economic, cultural, and geographic settings.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES

PROJECT C.A.R.E:
"Caregiver Alternatives to Running on Empty"

SUMMARY:

The NC Alzheimer's Demonstration Program, Project C.A.R.E: "Caregiver Alternatives to Running on Empty", uses a consumer-directed, family consultant model to provide comprehensive respite support to dementia caregivers. The goal of the program is to increase access, choice, use, and quality of respite care to underserved rural and minority communities. Through the integration of dementia-specific services, Project C.A.R.E. intends to create a seamless, coordinated delivery system that is responsive to the needs, values, and preferences of Alzheimer's families.

Project C.A.R.E. is administered by the Division of Aging and Adult Services and receives technical assistance from the Duke Family Support Program. Operating within the community-based contexts of the Alzheimer's Association and County Department of Social Services, Project C.A.R.E. Family Consultants visit the homes of referred Alzheimer's caregivers in crises. The Consultants offer timely, individualized guidance, counseling, support, advocacy and education for family caregivers. Their aim is to match families with the most appropriate and preferred local respite and community services tailored to the unique context of care and family needs. Through Project C.A.R.E., dementia caregivers may spend up to $2000 a year toward respite services. Families are able to choose among a full continuum of consumer-directed care options, including adult day services, group respite, private or agency in-home care, and overnight residential respite. There are three pilot sites set up to serve the following ten counties: Charlotte (Mecklenburg County), Winston-Salem (Forsyth, Surry, and Stokes); and Asheville (Polk, Henderson, Transylvania, Rutherford, Madison, and McDowell).

NATIONAL RECOGNITION:

- **2004 Geriatric Best Practice Award:** *"Developing Quality Caregiver Support and Respite Programs"* – Southeast Regional Geriatric Best Practices Initiative
- **2005 National Innovative Program Clearinghouse Award** – National Alzheimer's Association
- **2005 National Best Practice Model** for *"Implementing Systems and Sustained Change in Long-Term Care"* – US Administration on Aging Alzheimer's Disease Demonstration Grants to States (ADDGS) Program and RTI International
- **2005 National Conference of State Legislators** – featured by the National Alzheimer's Association as a national model for home and community-based care coordination

OBJECTIVES:

- Provide dementia-specific counseling, information, care consultation, capacity-building, and appropriate respite support to family caregivers who are not receiving services due to geographical factors, economic, racial, or cultural isolation, or gaps in available local resources;
- Strengthen the linkages between the Alzheimer's Association, Family Caregiver Support Program and the community-care system through information sharing, formalizing service agreements and increasing the availability of quality respite;
- Provide dementia-specific education, training, and resources to community-based direct care providers, volunteers, faith-based organizations, and other aging and adult services providers;
- Link dementia families to supplemental education programs and supportive resources available in the community, including Aging and Disability Resource Centers, caregiver skills training, and faith-based volunteer networks.

OUTCOMES:

- Families are more informed about the value and availability of respite and how to use respite services effectively to preserve family care capacity;
- Families experience greater self-efficacy and control regarding service selection and utilization;
- Increased use of dementia-specific respite care services by low-income rural and minority families;
- Expanded availability of dementia-specific training, education, and resources.

COST OF DEMONSTRATION:

- Total federal funding - $933,450 (July 2004 – June 2007) - Title IV OAA funds
- Total budget: 1st year (25% match) - $414,867; 2nd year (35% match) - $478,692; 3rd year (45% match) - $545,454
- Funds for direct respite services (minimum 50%): 1st year - $241,370; 2nd year - $258,908; $3rd year - $276,098
- Flexible annual spending cap for respite care: $2,000 per family
- Respite services include - purchase approximately 2 days per week of adult day services, 2 times a week of in-home personal care, or 7 days of overnight respite per year per family (*Note: *if* a family chooses to spread respite care evenly over one year).

PROGRAM MANAGEMENT:

- **NC Division of Aging and Adult Services (DAAS) Project Director** – Karisa Derence (existing position; 60% of salary used as in-kind match)
- **Western Carolina Alzheimer's Association Chapter** - 2 Family Consultants + 1 Family Consultant Supervisor/Outreach Specialist for nine counties; *currently funded through federal funds and private foundation grants
- **Mecklenburg County Department of Social Services** – 1 Family Consultant (part-time); *now a county funded position
- **Duke Aging Center Family Support Program** - provides technical assistance and training support to Project C.A.R.E. Family Consultants, Family Caregiver Support Program Resource Specialists, provider agencies, referral sources and client families; *funded through existing DAAS Alzheimer's Support Program contract
- **Four Area Agencies on Aging (Regions B, C, I, and F)** - Family Caregiver Resource Specialists assist with training and volunteer programs, assessments of needs, and building an inventory of resources; *funded through NC Family Caregiver Support Program

**For more information, please contact Karisa Derence at (919) 733-0440 or karisa.derence@ncmail.net*

Alzheimer's disease growth: U.S. will see average 44 percent increase in Alzheimer's disease by 2025

The United States will see a 44 percent increase in individuals with Alzheimer's disease by 2025, with the Western and Southeastern states to be hit the hardest. The study, "State-Specific Projections Through 2025 of Alzheimer Disease Prevalence," published in the May 11 issue of *Neurology*, reinforces findings from previous studies showing that the United States will face a devastating blow from Alzheimer's disease unless science finds a way to slow the progression of the disease or prevent it.

According to U.S. Census data, the size of the older population (65 and older) will double over the next 25 years, growing to 70 million by 2030 when the youngest of the post-World War II baby boomers will be more than 65 years old. Because age is a known risk factor for Alzheimer's, the United States could realize a 70 percent increase in the prevalence of Alzheimer's disease, with an estimated 7.7 million people affected.

Alzheimer's disease poses perhaps the greatest threat to our healthcare system – but it doesn't have to be that way. With proper funding, the Alzheimer's Association goal of delaying the disabling symptoms and eventually preventing Alzheimer's appears to be a feasible scientific objective that the research community can achieve in the next decade.

As the world leader in Alzheimer research and support, the Alzheimer's Association can provide experts to answer questions about the potential growth of Alzheimer's disease. Experts can also discuss the progress that has been made in the past 15 years through the combined efforts of the National Institute on Aging, the Alzheimer's Disease Centers, universities and pharmaceutical companies in understanding how the brain changes as we age.

Highlights from the study on state-by-state projections

The greatest increase in cases of Alzheimer's disease will occur in the Western region of the country. Six states in the West will see their total number of cases of Alzheimer's disease at least double between 2000 and 2025. This is due to low total population sizes and the high growth of the older population overall.

- Utah – 127 percent increase
- Alaska – 126 percent increase
- Colorado – 124 percent increase
- Wyoming – 114 percent increase
- Nevada – 100 percent increase
- Idaho – 100 percent increase

The three largest states in the country will continue to have the greatest total number of cases and will also experience significant growth rates.

- Texas – 74 percent increase
- Florida – 64 percent increase
- California – 50 percent increase

Only two states and the District of Columbia will not see an increase in prevalence of Alzheimer's disease. This is due in part to the slower growth rates of the older population in these areas.

- District of Columbia
- Pennsylvania
- Rhode Island

Contact Center **1.800.272.3900**
TDD Access **1.312.335.8882**
Web site **www.alz.org**
e-mail **info@alz.org**
Fact sheet prepared **June 7, 2004**

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State-by-state growth of Alzheimer's disease (2000 – 2025)

State	Total 2000	Total 2025	% Increase
Alabama	84,000	110,000	31%
Alaska	3,400	7,700	126%
Arizona	78,000	130,000	67%
Arkansas	56,000	76,000	36%
California	440,000	660,000	50%
Colorado	49,000	110,000	124%
Connecticut	68,000	76,000	12%
Delaware	12,000	16,000	33%
District of Columbia	10,000	10,000	0%
Florida	360,000	590,000	64%
Georgia	110,000	160,000	45%
Hawaii	23,000	34,000	48%
Idaho	19,000	38,000	100%
Illinois	210,000	239,000	14%
Indiana	100,000	130,000	30%
Iowa	65,000	77,000	18%
Kansas	50,000	62,000	24%
Kentucky	74,000	97,000	31%
Louisiana	73,000	100,000	37%
Maine	25,000	28,000	12%
Maryland	78,000	100,000	28%
Massachusetts	120,000	140,000	17%
Michigan	170,000	190,000	12%
Minnesota	88,000	110,000	25%
Mississippi	51,000	65,000	27%
Missouri	110,000	130,000	18%
Montana	16,000	29,000	81%
Nebraska	33,000	44,000	33%
Nevada	21,000	42,000	100%
New Hampshire	19,000	26,000	37%

State	Total 2000	Total 2025	% Increase
New Jersey	150,000	170,000	13%
New Mexico	27,000	43,000	59%
New York	330,000	350,000	6%
North Carolina	130,000	211,000	62%
North Dakota	16,000	20,000	25%
Ohio	200,000	250,000	25%
Oklahoma	62,000	96,000	55%
Oregon	57,000	110,000	93%
Pennsylvania	280,000	280,000	0%
Rhode Island	24,000	24,000	0%
South Carolina	67,000	100,000	49%
South Dakota	17,000	21,000	24%
Tennessee	100,000	140,000	40%
Texas	270,000	470,000	74%
Utah	22,000	50,000	127%
Vermont	10,000	13,000	30%
Virginia	100,000	160,000	60%
Washington	83,000	150,000	81%
West Virginia	40,000	50,000	25%
Wisconsin	100,000	130,000	30%
Wyoming	7,000	15,000	114%

For more information, please visit www.alz.org or call 1.800.272.3900.

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Estimated Prevalence* of Alzheimer's Disease Using 2000 Census Figures

Alamance	2,535
Alexander	497
Alleghany	279
Anson	517
Ashe	612
Avery	355
Buncombe	4,513
Burke	1,580
Cabarrus	2,047
Caldwell	1,327
Caswell	396
Catawba	2,258
Cherokee	641
Clay	279
Cleveland	1,744
Davidson	2,417
Davie	651
Forsyth	5,205
Gaston	3,079
Graham	223
Guilford	6,766
Haywood	1,352
Henderson	2,704
Iredell	1,977
Jackson	578
Lincoln	928
Macon	891
Madison	453
McDowell	790
Mecklenburg	8,043
Mitchell	382
Montgomery	499
Moore	2,183
Polk	691
Randolph	2,062
Richmond	824
Rockingham	1,867
Rowan	2,574
Rutherford	1,410
Stanly	1,100
Stokes	705
Surry	1,524
Swain	271
Transylvania	963
Union	1,380
Watauga	622
Wilkes	1,207
Yadkin	675
Yancey	444

49 county total.....77,023

*The formula for calculating these estimates is based on a 1990 study by Denis Evans et al, from the Millbank Quarterly, as applied to U.S. Census data for 2000. The Evans study shows that Alzheimer's Disease afflicts 47.2% of those over age 85, 18.7% of those 75 to 84 and 3% of those 65 to 74. All other figures from the U.S. Bureau of the Census 2000 findings.

January 2006

Alzheimer's Disease Demonstration Grants to States Program: North Carolina

Final Report

Prepared for

Lori Stalbaum, M.S.W.
Administration on Aging
1 Massachusetts Avenue, NW
Washington, DC 20001

Prepared by

David Brown, M.A.
Kristin Siebenaler, M.P.A.
Joshua M. Wiener, Ph.D.
RTI International
1615 M Street, NW, Suite 740
Washington, DC 20036

RTI Project Number 0209351.000.008

ALZHEIMER'S DISEASE DEMONSTRATION GRANTS TO STATES PROGRAM: NORTH CAROLINA

David Brown, M.A.
Kristin Siebenaler, M.P.A.
Joshua M. Wiener, Ph.D.

AOA Project Officer: Lori Stalbaum, M.S.W.

RTI International*

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To achieve systems change, Project C.A.R.E. has used a number of strategies:

- Integrating the needs of family caregivers into public programs and long-term care planning. Through cooperation in strategic planning and collaboration with other state programs serving caregivers at the state level and the work of the Family Consultant in building networks of providers at the local level, Project C.A.R.E. has helped create a state long-term care system that recognizes the caregiver's needs and preferences as well as those of the person with dementia.

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- Leveraging Alzheimer's Disease Demonstration Grants to States (ADDGS) funds for sustainability. The Grant partners are making a diligent effort to identify resources to sustain Project C.A.R.E. by seeking private foundation funding, collaborating with other long-term care grants, and making plans to approach state legislative staff with evidence of the project's effectiveness. In the Mecklenburg County site, Project C.A.R.E. demonstrated its value to a local agency that is willing to support the Family Consultant function and be an advocate for county-level respite funding.

Project C.A.R.E. is a replicable model for state and local governments to consider. Through this Alzheimer's Disease Demonstration Grant, Project C.A.R.E. has brought dementia-specific respite services and resources to family caregivers of persons with Alzheimer's disease and other dementias, with the flexibility to meet the needs of caregivers in different economic, cultural, and geographic settings.

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INTRODUCTION: OVERVIEW OF ADDGS PROGRAM AND CASE STUDIES

Alzheimer's disease is a devastating degenerative disease that causes memory loss, challenging behavior problems, and severe functional limitations. A person with late-stage Alzheimer's disease requires constant supervision, support, and hands-on care. While many persons with Alzheimer's disease are admitted to nursing homes, the majority of people with the disease live in the community, where their families provide most of the care.

To improve services to persons with Alzheimer's disease, Congress established the Alzheimer's Disease Demonstration Grants to States (ADDGS) program, which is administered by the U.S. Administration on Aging. The program's mission is to "expand the availability of diagnostic and support services for persons with Alzheimer's disease, their families, and their caregivers, as well as to improve the responsiveness of the home and community-based care system to persons with dementia. The program focuses on serving hard to reach and underserved people with Alzheimer's disease or related disorders (ADRDs)" (U.S. Administration on Aging, no date).

This paper discusses one of five case studies conducted by the ADDGS National Resource Center in 2005 on the activities of selected state programs. The goals of the case studies are to:

- Document "promising practices."
- Identify policy issues relevant to providing services to people with Alzheimer's disease and their families.
- Identify strategies for accomplishing program goals.
- Identify implementation barriers and ways of overcoming them.
- Assess how selected sites are addressing the goals of the ADDGS program.

One of the themes of the case studies is how grantees achieve *systems change* and *sustained change*, which are two of the key priorities of the U.S. Administration on Aging for current and future grantees under the ADDGS program. At its core, these systems and sustained change case studies are about how grantees seek to change the "care environment" for people with Alzheimer's disease and their families. To improve the care environment, it is necessary that:

- The needed services exist and are maintained over time.
- Eligibility criteria for the services include people with dementia and their families.
- People with dementia or their families know that services exist, understand how the services would benefit them, and know how to locate and arrange the services or are effectively assisted with these functions (e.g., through care consultation and information and referral systems and by knowledgeable health, social service, and long-term care providers).

- Service providers are trained and knowledgeable about Alzheimer's disease and dementia care.
- The quality of the services is high enough that people with dementia and their families will accept and benefit from them.
- Funding is available for the services.

In these case studies, systems change refers to activities that result in ongoing modification in state or local government or provider practices, policies, financing, and delivery of services for people with Alzheimer's disease and their families. In Maine, for example, the model respite care program established with ADDGS funds and administered by the Area Agencies on Aging was incorporated into the state home- and community-based care system by making respite care a covered service in Medicaid and state-funded programs.

Although often hard to document, an important component of systems change is altering the "ongoing way of doing business" among providers or government officials in ways that take into account the needs of persons with Alzheimer's disease and their families. An example would be how the North Carolina Grantee established informal relationships among providers and state officials. At the local level, Family Consultants have developed and trained informal networks of providers to meet caregiver needs. At the state level, the grant leadership is working with officials from a range of departments to coordinate efforts and to develop joint policies to address caregiver concerns. Moreover, some Grant activities are supportive of and consistent with overall state efforts at systems change, but they may not alter the financing and delivery system.

Sustained change, on the other hand, refers to whether the activities funded by the project will continue after the grant ends. An example of sustained change is the continued support by Tulsa Community College (TCC) of the ADDGS-initiated Geriatric Technician training program. Sustained change can be achieved through systems change or through obtaining other sources of funding. All systems change is sustained change, but not all sustained change is systems change. Some activities are geared to particular activities or service areas by providers and do not change the overall financing and delivery system within the state.

To illuminate the issues involving systems and sustained change, Maine, North Carolina, and Oklahoma were selected for case studies.[1] North Carolina was selected for this case study because of its initiatives to create a community-based, family-centered service system that provides access to dementia-specific respite care and long-term care services. As part of the Grant, North Carolina is targeting an underserved rural, minority, and low-income elderly population.

[1] The theme of the other case studies is the use of evidence-based practices. ADDGS programs in California and Colorado were selected to illustrate those issues.

The overall goal of Project C.A.R.E. is to improve the quality and choice of and access to respite services for families in the community caring for individuals with Alzheimer's disease or related dementia. **Exhibit 1** lists the specific goals of Project C.A.R.E.

Exhibit 1. Principal Components of North Carolina's ADDGS Grant

- Integrating the needs of the family dementia caregiver into Division of Aging and Adult Services long-term care service programs and state long-term care planning.
- Exploring the efficacy of varying administrative sponsorship.
- Increasing access and availability of a comprehensive range of dementia-specific respite services by using the Family Consultant model.
- Offering consumer choice, consumer-directed respite care, and a flexible dementia caregiver program.
- Conducting outreach to rural, minority, and low-income families with dementia-specific respite care.
- Connecting families with dementia-specific training, providing informational and educational materials, and serving as a portal for families to access community resources, information, and other long-term care service options.
- Leveraging ADDGS funds to sustain the program after Grant funding ends.

Information for this case study was gathered by reviewing administrative files at the U.S. Administration on Aging and Web sites and by conducting an in-person site visit in July 2005 in Raleigh, Durham, Winston-Salem, and Charlotte, North Carolina. As part of the site visit, RTI staff interviewed Project C.A.R.E. staff at the state and local levels, state aging officials, research experts, grant partner (e.g., Area Agencies on Aging and hospice) staff, respite providers, and advocacy group representatives.

The principal findings from the North Carolina case study are listed in **Exhibit 2**.

Exhibit 2. Principal Findings from the North Carolina Case Study

- The Grant has integrated the needs of family dementia caregivers into public programs and long-term care planning. This has been accomplished through cooperative strategic planning at the state level and through the Family Consultants' efforts to build networks of agencies and providers at the local level.
- The efficacy of Project C.A.R.E. has been validated in two different settings: as a direct service of the Alzheimer's Association and as a part of a unified county social services agency.
- Project C.A.R.E. has raised the profile of the Western Carolina Alzheimer's Association Chapter and made the needs of Alzheimer's disease caregivers visible to policymakers at the state and local level in North Carolina.
- The North Carolina project has increased access and availability of a comprehensive range of dementia-specific respite services. The project has used the Family Consultant model to develop agency partnerships, recruit and train service providers, publicize the availability of caregiver services, conduct in-home assessments, facilitate the connection between the caregiver and respite care options and providers, and provide continuing case coordination.
- The Grant has expanded consumer choice and consumer-directed respite care. It has offered individualized attention and specific consumer-directed options in scheduling and staffing of respite services. At the state level, Project C.A.R.E. has worked with other agencies and grants to expand consumer-directed service options.
- Project C.A.R.E. has targeted rural, minority, and low-income families using personal contacts with organizations, including faith-based organizations, and individuals to overcome the cultural and geographical isolation facing rural mountainous communities and urban minority communities.
- The North Carolina project has connected families and providers with information and services to produce a higher quality of life for persons with Alzheimer's disease and their caregivers. It has connected caregivers to a range of other services offered by faith-based organizations, volunteer groups, social service and public safety agencies, and service groups.
- Project C.A.R.E. has leveraged ADDGS funds for sustainability through resources from private foundations and other long-term care grants and by approaching the state legislature. At the Mecklenburg County site, the program has demonstrated its value to a local agency that now includes the Family Consultant's responsibilities among its permanent functions.

BACKGROUND ON NORTH CAROLINA AND ADDGS GRANTEE

The North Carolina Division of Aging and Adult Services (the Division), part of the North Carolina Department of Health and Human Services, administers state and federal programs for older adults in North Carolina and the state's social service programs for both older and disabled adults and their families. The Division is the designated State Unit on Aging, responsible for the state aging plan and partnering with Area Agencies on Aging and county Departments of Aging to implement the plan. The Division oversees the social service programs provided by the state's 100 county departments of social services. These programs include case management, home and community-based services, institutional placement services, the State Adult Protective Services program, and guardianship services.

North Carolina began to provide support for caregivers of older adults with Alzheimer's disease in 1984 with a state legislative appropriation, totaling $200,000 annually, to create an Alzheimer's Support Program. The Division implements this program through a contractual arrangement with the state's two Alzheimer's Association chapters (the Western Carolina Chapter and the Eastern North Carolina Chapter), which each receive $75,000 annually. The Division has a technical support contract for the program with the Duke University Center for Aging Support Program, which receives $50,000 annually.

North Carolina also provides services to individuals with Alzheimer's disease through a county-based system. Each county receives funding from the State Home and Community Care Block Grant program, which consolidates funds from both state and Older American Act funds. The Division of Medical Assistance within the North Carolina Department of Health and Human Services operates a Medicaid home and community-based services waiver program, the Community Alternatives Program for Disabled Adults, which offers an array of services, including adult day services. Divisional staff report that funding for this service is limited, waiting lists for in-home services are long, and the state has the most restrictive income and resource limitations in the United States. As a result, access is limited to the very poor, those with no savings, and those with little or no Social Security work history.

North Carolina has received three ADDGS Grants. The state received its first ADDGS Grant in 1993 and used those funds through June 2000 to develop state group respite standards and to establish a community-based group respite program. With that funding, the state created group respite services using existing senior centers as locations to reach people in rural and underserved areas. In 2001, a second ADDGS Grant allowed the state to introduce the first pilot version of Project C.A.R.E. The current Project C.A.R.E. Grant builds on that grant. It offers families an individualized approach to respite care with in-home assessment and care planning, some respite funding with a wide degree of flexibility and choice, and education and training for caregivers.

The key elements of Project C.A.R.E. are the:

- Use of a Family Consultant model.
- Delivery of dementia-specific respite care using both public and private entities.

The Family Consultant is trained in dementia caregiving issues and supported by dementia and social work experts. The Family Consultant conducts outreach to the community through presentations and visits to support groups, health fairs, and educational events and to individuals through in-home assessments. In the home, the Family Consultant directly assists family caregivers through counseling and assessing the caregiver's needs, advising the caregiver about options for support, bringing the caregiver into contact with appropriate service providers, and monitoring the quality of respite care. The Family Consultant also administers the funds the project provides to families for respite care.

The Family Consultant develops dementia-specific respite care by working with private service providers, public service organizations, faith-based groups, and governmental agencies to promote the development of dementia-specific care support. The Family Consultant makes potential providers aware of the demand for their services. The Family Consultant organizes respite care training opportunities in cooperation with Alzheimer's Association staff. By developing a pool of potential new consumers, the Family Consultant gives providers an incentive to train their workers on the needs of dementia caregivers.

Project C.A.R.E. is now based in three sites in North Carolina, compared to two sites under the previous Project C.A.R.E. ADDGS Grant from 2001 to 2004. Two of the sites continue from the previous grant project: a site based in Asheville serves six isolated rural western counties (an increase of two counties from the previous project grant) and a site based in Winston-Salem serves urban Forsyth County and two adjacent rural counties (an increase of one rural county from the previous project grant). The third site, based in Charlotte, was a comparison site under the previous project grant and now provides full Project C.A.R.E. services to urban Mecklenburg County. The Western Carolina Alzheimer's Association Chapter employs the Family Consultants for the Asheville and Winston-Salem sites, while the Mecklenburg County Department of Social Services provides the Family Consultant in that site, with support from the local office of the Alzheimer's Chapter.

The primary partners for both the current and earlier Project C.A.R.E. grant are the following:

The Western Carolina Chapter of the Alzheimer's Association, (the Chapter), which has been in operation for 22 years and now covers 49 of the state's 100 counties. The Chapter serves as an advocate for individuals with dementia and provides information, education, and training to family and professional caregivers. The Chapter employs and supports two full-time Family Consultants, one based in Asheville and the other based in Winston-Salem. The Chapter office in Charlotte also supports the Mecklenburg County Department of Social Services Family Consultant in implementing Project C.A.R.E. in that county.

The Mecklenburg County Department of Social Services, whose Services for Adults Division is responsible for providing human services, transportation, senior nutrition, adult social work, and Medicaid services to adult county residents. The Department is active in outreach to older adults through its centralized county information and assistance program, "Just 1 Call," and the Status of Seniors Initiative, a community-wide strategic planning process seeking to create a "senior-friendly" community. The Department also is responsible for local administration of the National Family Caregiver Support Program in the county under the oversight of the local Area

Agency on Aging. The Department employs the Project C.A.R.E. Family Consultant for the county who also works as a Family Caregiver Support Specialist. The Family Consultant concentrates on community outreach and caregiver education and is a program mentor to social workers in the Department's Services for Adults Division.

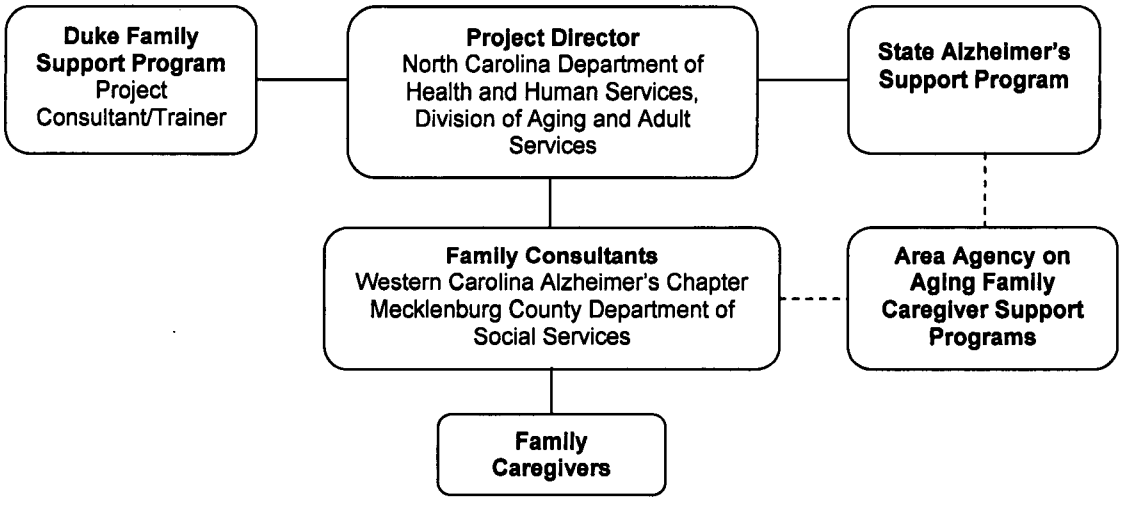
The Duke University Center for Aging Family Support Program, which has been providing dementia-specific training and technical assistance for the state since 1984. In addition to Project C.A.R.E., the Duke University program works with the National Family Caregiver Support Program and the State Alzheimer's Support Program. The Center provides training and technical assistance and assists in developing and reviewing grant-generated educational and policy products.

The State Alzheimer's Support Program, which provides funding to the state's two Alzheimer's Association chapters for services to Alzheimer's families, and to the Duke University Center for Aging Support Program for technical support of their efforts. The program collaborates with Project C.A.R.E. at the state level in support of Alzheimer's services.

The Area Agencies on Aging for Regions B, C, F, and I, which administer Older American Act services in the counties being served by Project C.A.R.E. The Family Caregiver Support Program is assisting the Project C.A.R.E. Family Consultants with outreach, assessment, community training and volunteer initiatives, and development of an inventory of resources. The Family Caregiver Resource Specialists also are identifying and referring families in need of dementia-specific respite care to Project C.A.R.E.

The organizational relationships among the partners are depicted in **Exhibit 3**. (Solid lines show a formal reporting relationship and dotted lines an informal consultative relationship.)

Exhibit 3. Project C.A.R.E. Key Partners



GRANT STRATEGIES AND ACTIVITIES TO ACHIEVE SYSTEMS AND SUSTAINED CHANGE

The Grant has used a variety of strategies and activities to achieve systems and sustained change for people with dementia. These strategies are described below.

Integrating the Needs of Dementia Family Caregivers into Public Programs and Long-Term Care Planning

State officials report that Project C.A.R.E. is increasing awareness and knowledge about caregiver needs and preferences within the North Carolina Department of Health and Human Services. Working with the Long Term Care Cabinet, the U.S. Administration on Aging-funded National Family Caregiver Support Program, and the state-funded Alzheimer's Support Program, Project C.A.R.E. is helping to change state long-term care services to incorporate the needs and preferences of the family caregiver in addition to those of the person with disabilities.

The State Long Term Care Cabinet, sponsored by the Office of Long-Term Care, includes the Directors of Divisions and Offices of the Department of Health and Human Services with responsibility for long-term care services. Through its representatives on the Cabinet, Project C.A.R.E. is part of the planning process for the Department of Health and Human Services that addresses special long-term care issues that cut across departmental divisions and offices and makes recommendations to the Secretary of Health and Human Services. Project C.A.R.E. staff participate on and make presentations to workgroups of the Cabinet in support of services to dementia caregivers.

Project C.A.R.E. works with the National Family Caregiver Support Program at the state and local levels. At the state level, leaders of the two programs jointly plan to meet caregiver needs and maintain legislative support for caregiver services. At the local level, the Family Consultants work in close cooperation with regional and county Family Caregiver Program Resource Specialists. The North Carolina Family Caregiver Support Program does not have a dementia-specific component, and the two programs provide referrals to each other, linking dementia caregivers to Project C.A.R.E. and giving the Family Consultants a source of support for nondementia caregivers they encounter. The North Carolina Family Caregiver Support Program provided almost $90,000 for fiscal years 2002-2004 to Project C.A.R.E. for respite services in rural mountain counties. The two programs also conduct joint provider training.

Project C.A.R.E. is also particularly involved with the state-funded Alzheimer's Support Program. The funding for the Alzheimer's Support Program is counted as part of the state matching funding for the ADDGS Grant. This circumstance protected the program in 2002, when the state legislature considered ending the program as a cost-cutting measure. Because doing so would have ended Project C.A.R.E. as well, the Division and the Alzheimer's Association chapters were able to convince the legislature to maintain the program.

Exploring the Efficacy of Varying Administrative Sponsorship

Project C.A.R.E. is piloting two service models that differ by type of organization administering the project. One method uses a private entity, the Western Carolina Chapter of the Alzheimer's Association, and the other method uses a public entity, the Mecklenburg County

Department of Social Services. Both methods have been successful at bringing the Alzheimer's Association resources to underserved populations and at tailoring the project to regional strengths and needs (Martin et al., 2005).

Western Carolina Chapter

As implemented by the Chapter, Project C.A.R.E. provides a direct link between dementia caregivers and the expertise of the Alzheimer's Association. The Chapter administers Project C.A.R.E. through two full-time Family Consultants working out of area offices in Asheville and Winston-Salem. **Appendix 1** illustrates the service areas of these two offices in North Carolina. As Chapter employees, the Family Consultants spread an awareness of the Chapter's range of activities to the public and to the network of government and provider agencies serving dementia caregivers. Within this cooperative framework, the Chapter is able to provide outreach, education, and training to the cooperating agencies, enhancing their knowledge of dementia and dementia caretaking issues.

The implementation of Project C.A.R.E. through the Western Carolina Chapter has changed the role of the Chapter in serving dementia caregivers and persons with Alzheimer's disease. Prior to the 2001 Grant project, the Chapter (then divided into two chapters, the Western North Carolina Chapter based in Asheville and the Carolina Piedmont Chapter based in Charlotte) had ceased offering any in-home services and had become primarily a provider of educational and outreach programs. The Asheville-based predecessor chapter had provided a one-time grant of $500 for respite to families who requested it, but neither of the predecessor chapters was coordinating services to families by the time they merged in 2001. Now, however, the Western Carolina Chapter is a central agency in the coordination of local dementia caregiver services in both regions.

Project C.A.R.E. has enhanced the relationships between the Chapter and its partners in the Grant and the national Alzheimer's Association. The Division also has developed a much closer relationship with the Chapter, and both organizations express increased satisfaction with their working relationship. The Chapter has also gained a close relationship with the Area Agencies on Aging in the Project C.A.R.E. service area and with the Mecklenburg County Department of Social Services (Charlotte headquarters) in providing expertise on Alzheimer's disease and related disorders. The national Alzheimer's Association policy office has expressed interest in Project C.A.R.E., and the Chapter was honored at the national Alzheimer's Association 2005 Dementia Care Conference with a National Program Clearinghouse Award. The Chapter has built productive relationships with community service providers, who are increasingly participating in Chapter workshops and classes and hosting support groups and other activities.

Mecklenburg County Department of Social Services

In Mecklenburg County, the Family Consultant funding and function reside with the Department of Social Services, a comprehensive social service agency for the county. Also in Mecklenburg County, the National Family Caregiver Support Program is administered by county-level staff in consultation with the Regional Family Caregiver Resource Specialist at the Area Agency on Aging. Thus, in Mecklenburg County, the regular Home and Community Care

Block Grant program, the National Family Caregiver Support Program, and Project C.A.R.E. all operate within the same agency. The Charlotte office of the Western Carolina Alzheimer's Association Chapter supports Project C.A.R.E. by providing dementia expertise, education materials, and training for the Family Consultant and other involved agency staff members.

Under the 2001 ADDGS Grant, a case manager in Mecklenburg County provided counseling, needs assessment, and respite services, including funds for dementia respite, but without a dementia focus as a comparison to the work being done in the other service areas of Project C.A.R.E. Mecklenburg County was designated a regular service area of the project under the current Grant, and the Department expanded the role of Project C.A.R.E. by assigning its 20 social workers in the Department's Services for Adults Division to conduct in-home visits to connect caregivers to Project C.A.R.E. and other resources as part of their case management duties. Supported by training from the Chapter and directed on the Project C.A.R.E. approach by the Family Consultant, each staff member implements Project C.A.R.E. with dementia caregivers they encounter in their duties. Intake staff screen applicants for service for potential eligibility for Project C.A.R.E. as a part of the standardized departmental assessment used in their initial contacts with clients. The Family Consultant, who is phasing out of direct service, is increasing outreach activities, both in identifying and referring families for services and in making educational presentations to the general community.

Project C.A.R.E. has been beneficial to the Department of Social Services by providing additional training and resources. The Department has also sent representatives to Alzheimer's conferences both in Charlotte and at Duke University. The Grant funding has also helped the departmental staff extend services by providing additional funding for services to dementia caregivers. Home and Community Care Block Grant program funding for adult services in the county last year was fully committed a month and a half after the beginning of the fiscal year; the availability of Project C.A.R.E. respite funds for dementia caregivers provided an ongoing source of support for this population. Project C.A.R.E. funding and the Family Caregiver Support Program are among the few sources of support that the department has to offer to caregivers after Home and Community Block Grant funds are depleted.

In the Mecklenburg County site, the Charlotte office of the Western Carolina Alzheimer's Association Chapter acts in a consulting role to the Family Consultant and the Department of Social Services. Instead of linking to a network of agencies, the Chapter is forging links with a Department that brings all those agency functions together in one organization. In this setting, the Chapter has the opportunity to support the Department's organizational effort to reach dementia caregivers by providing expertise and educational resources to Department staff.

Increasing Access to a Comprehensive Range of Respite Services Using the Family Consultant Model

The Family Consultant increases access to dementia-specific respite services for dementia caregivers in five ways:

- Personalized assessment.

- Simplified eligibility.
- Financial support.
- Ongoing case management.
- Provider development.

The in-home assessment is a key element in this process, giving the Family Consultant the opportunity to become intimately aware of the caregiver's situation and needs. By being present in the home, the Family Consultant can gain the trust of the caregiver, provide the caregiver with the opportunity to discuss needs in a secure setting, and observe the interactions of the caregiver with the person with dementia and other family members. With this level of knowledge, the Family Consultant is able to guide the caregiver to the respite services that best respond to those needs.

Coupled with the personalized approach of the in-home assessment is the Project C.A.R.E. structural orientation toward ease of eligibility determination and initiation of services. There is no means test for Project C.A.R.E., which spares the caregiver a potentially lengthy application. Eligible families are those in which:

- An individual has been diagnosed with Alzheimer's disease or a related dementia.
- The individual with dementia resides in a county served by the program.
- The individual is not receiving Medicaid Community Alternative Program services.

Once an eligible individual is identified, the Family Consultant can offer funding that the caregiver may use to purchase respite services. Caregivers are eligible to receive an annual stipend for respite from the grant, once up to $2,500 per year but now reduced to $1,800 in the Asheville and Winston-Salem areas and $2,000 in Mecklenburg County. The amount was reduced to provide funding to more families. This funding, which is paid directly to the vendor of the caregiver's choice, gives the family the opportunity to use respite care and become familiar with the local respite provider network. There is no co-pay requirement for families, although they are given the opportunity to voluntarily contribute to Project C.A.R.E. based on a sliding scale formula.

Family Consultants report that the project is not able to provide funding to every family it serves at the time of initial assessment. In the Asheville and Winston-Salem areas, there has been a waiting list of up to 190 families. Those Family Consultants report, however, that families generally wait no more than 3 months to receive funding, and that families receive counseling, consultation, training, and other support services even when respite funds are not available. The Mecklenburg County Family Consultant also reports that families may experience a delay in receiving Project C.A.R.E. respite support until additional funding comes at the beginning of a fiscal year. The average length of Project C.A.R.E. service use is approximately 8 to 10 months with one-third of client families re-enrolling annually. The caseload turnover is about two-thirds

annually, most often due to the client becoming eligible for Medicaid waiver support, passing away, or entering a nursing home.

The Family Consultant provides an ongoing case management/care planning function for the caregiver. The Family Consultant establishes a continuing relationship with the caregiver, monitoring the family situation and assessing whether the services in place are continuing to meet the caregiver's needs as the family situation changes. The Family Consultant maintains an ongoing relationship with the provider agencies serving the families and is available to assist if issues concerning quality or appropriateness of care. The Family Consultant also links families to other resources, such as Powerful Tools for Caregiving self-care classes, local support teams, Faith In Action groups, and the Alzheimer's Association's Safe Return program.

Finally, the Family Consultant encourages local respite care providers to expand their capacity and expertise. The Family Consultant provides referrals for service to qualified agencies, and the respite funding is an important source of income for these providers. Typically, these service providers assess many families with a need for respite care but no means to pay for it, while the provider has excess capacity but no way to subsidize the respite need. Project C.A.R.E. subsidies bridge the gap, enabling the agencies to serve the families. One technique for encouraging caregivers and clients to try respite care is a program called "Memory Camp," provided by Project C.A.R.E. funds. Working with cooperating adult day services providers, the Family Consultant can give free 3-day passes to family caregivers that allow them to bring their family members with dementia to the adult day services center. Often when families try these "Memory Camps" they find that both they and their family member with dementia enjoy the experience and are willing to accept the Project C.A.R.E. respite support.

Offering Consumer Choice and Consumer-Directed Respite Care

The introduction of consumer choice and consumer-directed services to support dementia caregivers is an important feature of the current Project C.A.R.E. Grant project. At the local level, family caregivers have the choice of using Grant respite funding to select in-home, overnight respite, and congregate care (adult day services and group respite). In the four rural counties added to Project C.A.R.E.'s service area under the current Grant, families have a consumer-directed option of hiring respite workers directly rather than using agency-directed services. Families have flexibility in scheduling, including the ability to use care sporadically rather than at a regular established time and the ability to schedule care in the evenings and on weekends rather than during standard business hours. Family caregivers also have the ability to budget the Project C.A.R.E. respite funding across the entire year rather than on a weekly or monthly basis. The Family Consultants work with providers regarding service issues if a family is not satisfied and connect families with other providers if needed.

The option of hiring a worker privately, introduced in anticipation of a lack of service providers in some rural areas, has been used only occasionally thus far. Grant staff members believe that this may be because families are concerned about the absence of liability protection for privately hired support or because this approach is less needed as service providers have expanded services.

Incorporating Project C.A.R.E.'s flexibility into the Mecklenburg County Department of Social Services setting accustomed to tightly regulated programs has been a challenge. The County Department overcame the barrier of managing funds in a flexible manner through the practical step of having staff from the departmental accounting department meet with State Division of Aging and Adult Services finance staff. Armed with a technical understanding of the issues and appropriate accounting procedures relating to flexible funding under the Grant, the County Department accounting staff was able to smoothly integrate project finances into the Departmental system. Now that the County Department has seen how this flexibility works in practice, it has extended it to some degree into its own social service programs.

Project C.A.R.E. also works to promote consumer direction at the state level in collaboration with a number of other grant efforts in the state. State staff believe that input from Project C.A.R.E. is helping state officials evaluate options for increasing consumer choice and consumer-directed care. In particular, Project C.A.R.E. is working with the Office of Long-Term Care, grantee for a U.S. Centers for Medicare & Medicaid Services-funded Real Choice Systems Change grant and grantee with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services for the North Carolina Community-Integrated Personal Assistance Services and Supports (CPASS) Initiative. This project is focusing on creating state regulations supportive of consumer direction, joint development of resource materials, and direct care workforce recruitment and retention. Leaders of both CPASS and the consumer-directed component of the Real Choice Systems Change grant also cooperate regularly with the Project C.A.R.E. grant leadership by sharing information, training, and educational materials.

Project C.A.R.E. is also promoting consumer direction through contacts with other grants and groups. Project C.A.R.E. is working with leaders of the Aging and Disability Resource Center (ADRC), a grant project jointly funded by the U.S. Centers for Medicare & Medicaid Services and the U.S. Administration on Aging. The ADRC will provide a central source for aging and disability information, and Project C.A.R.E. will provide training for staff and volunteers on dementia-specific respite and caregiving information. The state Direct Care Workers Association, developed by the Real Choice Grant, keeps its membership aware of the Project C.A.R.E. effort to introduce consumer choice and works with Project C.A.R.E. leadership to increase the training and education opportunities for direct service workers. At the time of the site visit, the state had submitted a Real Choice Systems Transformation grant application, which would facilitate increased cooperation between all the grantees in their local efforts.

Providing Outreach to Rural, Minority, and Low-Income Families

The Project C.A.R.E. sites specifically target three underserved populations: the low-income, mostly Caucasian, rural, population of the mountain counties; the low-income, minority population of two urban areas (Mecklenburg County [Charlotte] and Forsyth County [Winston-Salem]); and the low-income, mostly Caucasian, rural, population near the North Carolina-Virginia border (Surry and Stokes counties). While different in many ways, these populations share a common characteristic—insular communities that are economically, culturally, or geographically isolated and lack access to dementia-specific respite care and other caregiver services.

In establishing the trust level that makes it possible for Family Consultants to work with this population, the Family Consultants begin by establishing relationships with trusted community institutions. In Winston-Salem, for instance, the Family Consultant made a connection with a ministerial roundtable within the African American community, presenting an overview of Alzheimer's disease, its impact on the African American community, and available care and support. In response, the roundtable members publicized Project C.A.R.E. in their congregations and arranged for the Family Consultant to speak to the congregations before Sunday services, and they also publicized the project to women's fellowship and missionary groups. In the mountainous counties around Asheville, the faith community has also been helpful in reaching this population. For example, the Family Consultant there is working with a large congregation through its 40 deacons. After a presentation about Alzheimer's disease and Project C.A.R.E., the deacons, each of whom was responsible for church members in a geographic area, publicized the project and encouraged congregational caregivers to seek support through Project C.A.R.E. Because of the level of service Family Consultants provide, they have gained acceptance in the targeted communities through word-of-mouth endorsement.

The outreach situation for Stokes and Surry counties is complicated by the fact that these predominately white and rural counties are part of the same site as the adjoining urban and largely African American Forsyth County. Under the first Project C.A.R.E. from 2001 to 2004, the Family Consultant had been doing outreach only in Forsyth County. The Family Consultant therefore had to develop a different approach to reaching families in these two rural counties. Working with the Family Caregiver Resource Specialist from the Area Agency on Aging, the Family Consultant introduced Project C.A.R.E. through a presentation at Stokes County's primary senior center. With this introduction, the Family Consultant has been able to contact and support families in the county. Outreach in adjoining Surry County began in July 2005 with the Family Consultant approaching community leaders and service providers to develop outreach methods suited to the population. This Family Consultant also has successfully pursued media exposure. In Winston-Salem, connections with the ministerial roundtable resulted in the Family Consultant appearing on a minister's radio show on two consecutive days, resulting in numerous inquiries. The Family Consultant also appeared in a local access television show, and contact information for Project C.A.R.E. has been displayed by the station in its announcement line.

Connecting Families with Information and Services

Project C.A.R.E. uses its close relationship with the Alzheimer's Association and the Duke Family Support Program to make dementia-specific resources available to both caregivers and provider agencies. Family Consultants educate caregivers on an in-person basis through the in-home assessment process.

Working in cooperation with Alzheimer's Association staff, the Family Consultants offer group educational sessions for caregivers, provider agencies, and volunteers. These sessions include training on the nature of Alzheimer's disease and related disorders, communication skills for working with people with these diseases, techniques for managing behavioral issues that often accompany the disease, and techniques for providing personal care. For providers, other sessions cover practical issues in dementia care, such as making referrals, assessing family needs, selecting appropriate respite services, and procuring payment for services from state and county programs and agencies. This training has the potential to help caregivers better manage

interactions with their family member with dementia, contributing to reduced stress and a higher quality of life. The training also is designed to improve the quality of care offered by provider agencies to persons with dementia, making respite a more acceptable option for caregivers.

The Family Consultants also cooperate with representatives of other programs serving caregivers, most notably Family Caregiver Resource Specialists from the Area Agencies on Aging, in conducting joint training presentations. In addition to conducting general presentations for caregiving families and respite providers about their programs, their joint efforts include the presentation of the Mather LifeWays training course "Powerful Tools for Caregiving," which teaches caregiver skills and addresses issues such as self-care, stress management, and coping skills.

The Duke Family Support Program has also been an important source of educational information for Project C.A.R.E., producing a number of publications and other printed materials in cooperation with the grants the Family Consultants make available to caregivers. These publications are listed in **Exhibit 4**.

Exhibit 4. Publications for Project C.A.R.E. from the Duke Family Support Program

- "You Are One of Us," a guide to helping faith-based congregations connect with Alzheimer's families (Gwyther, 1995).
- Visiting tips and a sample letter that families could adapt to send to their congregation friends explaining that a family member has Alzheimer's disease.
- A guide for caregivers in dealing with feelings of anger, "Pressure Points—Alzheimer's and Anger" (Ballard, Gwyther, and Toal, 2000).
- A pamphlet titled "Wait a Minute—When Anger Gets Too Much." Based on "Pressure Points" and developed in cooperation with the Winston-Salem-based Family Consultant, it offers simple straightforward advice. The flyer was printed on waterproof stock to make it sturdy and encourage caregivers to keep it handy on the counter or on the refrigerator door to guide them in emergencies.
- "Working with Family Caregivers of People with Memory Disorders," a North Carolina information and assistance toolkit for training county aging providers to work with family dementia caregivers (Gwyther and Ballard, 2002).

Project C.A.R.E. also serves as a portal for families to access locally based community resources, information, and other long-term care services. Family Consultants connect families to local services such as hospice and volunteer service groups. Family Consultants particularly reported working closely with local hospice organizations that often become involved with caregiver families experiencing end-stage Alzheimer's disease. With their common interest in the support of caregivers, the two programs cooperate so that families have the advantage of both resources. One particularly valuable hospice service is professional counseling for caregivers. Family Consultants also work with other kinds of volunteer groups such as faith communities, which provide housing modifications and repairs, food, and temporary funding for utilities. An important partner in Charlotte is Love, Inc., a faith-based organization with a membership of 160

congregations from 23 denominations and 1,500 to 2,000 volunteers. The organization provides services such as ramps for houses and operates an Adopt an Elder program that links volunteers with older persons to help with household chores.

The Family Consultants also have developed ties with public service agencies in the counties, for instance, publicizing such benefits as free cooling fans when these are made available by local senior services agencies or consulting with the local police. Family Consultants also help families to access benefits such as the $1,200 per year benefit for prescription medications available to elderly families from the state tobacco settlement fund. Many dementia medications are quite expensive, making this a very valuable service.

Appendixes 2 and 3 contain tables of the services the Grants have provided, including gender and race, for the prior Grant and for the first year of the current Grant, respectively.

Leveraging ADDGS Funds for Sustained Change

A key issue for Project C.A.R.E. is how to continue and expand funding. The Division is very interested in piloting Project C.A.R.E. in select eastern North Carolina counties to demonstrate its applicability statewide. In addition to maintaining the current models of Project C.A.R.E., the Division wants to demonstrate a third service administrative structure in which the Family Consultant would be based in a different community-based organization such as an Area Agency on Aging. The Duke Family Support Program asserts that North Carolina is strategically placed to create a seamless, coordinated dementia-capable system of family-centered, caregiver-focused long-term care services that can be replicated in other states (Martin et al., 2005).

The placement of the Family Consultant within the Department of Social Services in Mecklenburg County has potential for sustaining a higher level of service to dementia caregivers than existed prior to Project C.A.R.E. The Family Consultant is a regular employee of the Department of Social Services, reserving Project C.A.R.E. grant funding exclusively for dementia-specific respite care. Additionally, training by the Charlotte Chapter of the Alzheimer's Association and Duke Family Support Program is given to adult services and intake staff members in the Department, disseminating the knowledge throughout the organization and further enhancing the Department's organizational competency in dementia caregiving issues. Although the Department may not be able to provide the same level of dementia-specific respite funding in the absence of grant support, the intake referral process and institutional knowledge of the issues would still provide dementia caregivers with a higher level of service than existed prior to Project C.A.R.E.

In the other two project sites, where the Family Consultant is an employee of the Alzheimer's Association Chapter, it is less clear that the Family Consultant function could be maintained in the absence of ADDGS funding. The Chapter primarily depends on grants from the state and federal government and private contributions to fund its budget. The Chapter has had some success in securing foundation support to pay the salaries of the Family Consultant. They have received grants from the Kate B. Reynolds Foundation for $150,000 for fiscal years 2004-2006 and the Sisters of Mercy for $92,000 in fiscal years 2005 and 2006. Without additional funding, Chapter officials are uncertain of their ability to continue the respite service component of Project C.A.R.E. at the conclusion of the current Grant.

The Division is working in cooperation with the Western Carolina Alzheimer's Association Chapter to develop a strategy for continuing the project, and divisional and grant leaders foresee four possible approaches:

- Applying for support from private foundations to expand Project C.A.R.E. to eastern North Carolina. Divisional and grant leaders agree that this may prove useful but that ongoing continuation will require a steady stream of governmental funding.

- Approaching the legislature for budgetary appropriations for dementia-specific respite services by the counties. The state already supports respite care under the Home and Community Care Block Grant, but there is no separate appropriation for dementia-specific respite services under this block grant program. A drawback to this approach is that, even if there were a separate appropriation, county-level appropriations would require the Alzheimer's Association chapters to advocate in each county for dementia-specific respite services be one of the funded block grant services and to become an approved provider of those services. In the case of the Western Carolina Chapter, a county-based program would involve them in 49 sets of negotiations with separate and uniquely organized county governments. Another approach under discussion would include future dementia caregiver support as a separate program associated with the National Family Caregiver Support Program and funded jointly by the state. Division leaders have not yet developed a proposal detailing how this could be structured.

- Collaborating with the State's Real Choice Systems Change Grant to expand Project C.A.R.E. to eastern North Carolina. Division staff members and leaders of the grant have informally discussed using some of the grant funding for this purpose.

- Supporting the development of federal legislation to give states continuation funds through the ADDGS program. Under that circumstance, Divisional leaders indicated they would seek to leverage those funds to gain state funding to continue Project C.A.R.E. in the western part of the state and to expand to the eastern part of the state.

In support of these sustainability strategies, the Grantee is working to conduct research and evaluation activities for the Grant, using Division resources and relationships with local universities. A recent article in the *North Carolina Medical Journal* describes Project C.A.R.E. and discusses its role in providing dementia-specific respite (Derence, 2005). Two postdoctoral fellows and their advisors at the University of North Carolina's Institute on Aging are exploring future directions for Project C.A.R.E., which include the possible expansion of the program to the eastern part of the state. The Division is providing a small stipend of $2,500 from grant funds to support this study, the results of which will be submitted to the *Journal of Applied Gerontology*, a publication that is widely read in the southeastern policy and practice community. The Duke Family Support Program and the Division prepared a policy paper that describes the Project C.A.R.E. delivery of dementia-specific respite services and discusses lessons learned through the previous grant (Martin et al., 2005). The Division also has a contractual arrangement with the Center for Aging Research and Education Support at the University of North Carolina to examine selected programs and is considering having the Center conduct a formal evaluation of the current Project C.A.R.E. Grant in its third year.

CONCLUSION

Project C.A.R.E. offers families a personalized approach to respite care based on an in-home assessment and care planning, a wide degree of flexibility and choice in using respite funding, and dementia-specific education and training for caregivers. In both public and private administrative settings, Family Consultants have successfully brought personalized and flexible supports and resources to caregivers. They have developed networks of provider agencies to provide quality dementia-specific respite services, as well as networks of governmental and volunteer agencies to jointly serve dementia caregivers. Family Consultants have also provided a connection for caregivers to other community resources.

To achieve systems change, Project C.A.R.E. used a number of strategies:

- Integrating the needs of family dementia caregivers into public programs and long-term care planning. Through Project C.A.R.E., North Carolina has made a commitment to providing integrated services to dementia caregivers, moving forward the Division's belief that serving family caregivers as well as persons with disabilities is appropriate and feasible. Both in terms of cooperation in strategic planning at the state level and in the role of the Family Consultant in building networks of agencies and providers at the local level, Project C.A.R.E. brings together all available resources to make them available to the caregiver in a single package.

- Exploring the efficacy of varying administrative sponsorship. Project C.A.R.E. has demonstrated its effectiveness in two different settings. Under the guidance of the Alzheimer's Association, Project C.A.R.E. demonstrated the ability of the Family Consultant to coordinate with both local and regional groups to organize and deliver care to Alzheimer's caregivers. As a part of a unified county social services agency, Project C.A.R.E. demonstrated that it can harness the resources of a public agency and integrate the dementia caregiver support in the operations of a county social services agency, connecting Alzheimer's caregivers to a wide array of services while maintaining the flexibility that makes it effective.

  At an institutional level, Project C.A.R.E. raised the profile of the Alzheimer's Association Chapter and made the needs of Alzheimer's disease caregivers visible to policy makers at the state and local levels in North Carolina. The Division, the Area Agencies on Aging, and county and city governments have raised the priority of the needs of Alzheimer's disease caregivers and rely on the Alzheimer's Association Chapter for guidance in matters related to Alzheimer's disease.

- Increasing access and availability of a comprehensive range and type of dementia-specific respite services by using the Family Consultant model. Access is one of the key goals of Project C.A.R.E. and is expressed in the range of the Family Consultant functions: developing agency partnerships to offer a range of dementia-specific respite services, recruiting and training service providers to provide quality respite care, publicizing the availability of other caregiver services, conducting in-home assessments with the caregiver, facilitating the connection between the caregiver and

respite care options and providers, and continuing a case coordination relationship with both caregiver and provider to monitor the caregiver's satisfaction with services.

- Offering consumer choice and consumer-directed respite care. Project C.A.R.E. is committed to flexibility in meeting the caregiver's needs, both in terms of the individualized attention provided by the in-home assessment and the respite options available for the caregiver. The current grant extends this commitment with specific consumer-directed elements in the new service areas, granting caregivers multiple options in scheduling and staffing of respite services. At the state level, Project C.A.R.E. works with other agencies and grants to expand consumer-directed services.

- Outreach to rural, minority, and low-income families. The data in the appendices illustrate the effectiveness of Project C.A.R.E. in the intensive and time-consuming effort of targeting underserved populations. By making personal contacts with the organizations and individuals in these communities, the Family Consultants have taken the resources of the Alzheimer's Association and the project to individuals who would otherwise not have known about them. Family Consultants have helped overcome some of the cultural and geographical isolation facing rural mountainous communities and urban minority communities.

- Connecting families with information and services. The network development work of the Project C.A.R.E. Family Consultants also puts them and the project in a unique position to link caregivers to a wide range of long-term care services and supports beyond the Grant resources. Faith-based organizations, volunteer groups, social service and public safety agencies, and service groups all provide services that can be of value to Alzheimer's caregivers. The Family Consultant is able to make caregivers aware of these services and to make the contacts needed to bring the services to the caregivers. Project C.A.R.E. has demonstrated that it can transfer the expertise of the Alzheimer's Association into the community arena, educating both caregivers and providers on techniques that produce a higher quality of life for both the person with Alzheimer's disease and the caregiver. The project also incorporates other useful techniques into its training and resource offerings, including the "Powerful Tools" training.

- Leveraging ADDGS funds for sustainability. While it is difficult in the state's economic climate to introduce and sustain new governmental programs, the Division and the Chapter have made a diligent effort to identify resources to sustain Project C.A.R.E. Efforts are being made to engage private foundations in this need, to collaborate with other long-term care grants, and to approach state legislative staff with evidence of the project's effectiveness. The Mecklenburg County site also provides a potential template for sustainability; the program has demonstrated its value to a local agency that is willing to support the Family Consultant function and be an advocate for county-level respite funding.

Project C.A.R.E. has piloted replicable methods for delivering dementia-specific respite services and a model for bringing caregiver resources to family caregivers of persons with Alzheimer's disease and other dementias. The project has incorporated flexibility in developing and delivering resources to meet the needs of caregivers in different economic, cultural, and geographic settings.

REFERENCES

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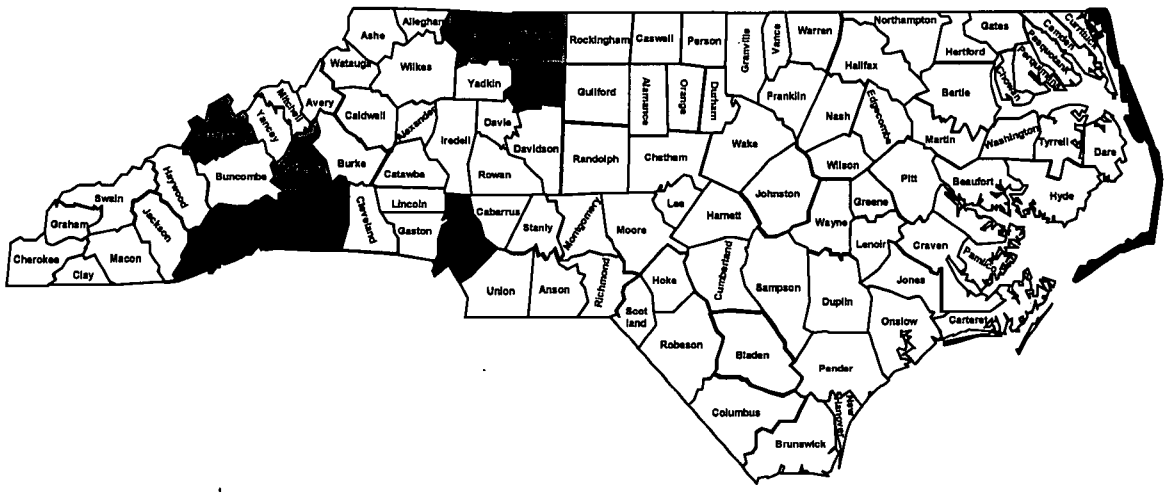
APPENDICES

APPENDIX 1

Project C.A.R.E. Site Map



The counties colored purple were included in the first Project C.A.R.E. grant from 2001-2004.
The counties colored green were added for the current Project C.A.R.E. grant, 2004-2007.

APPENDIX 2. Project C.A.R.E. Enrollment and Utilization, July 2001-June 2004

PROJECT C.A.R.E. DATA: 10/01 – 7/04	Four-County Region	Forsyth County	Totals
Enrollments			
Year 1	**86**	**70**	**156**
Families "rolled over" from Year 1 to Year 2	52	50	**102**
New families enrolled Year 2	15	23	**38**
Year 2 Total	**67**	**73**	**140**
Families "rolled over" from Year 2 to Year 3	30	28	**58**
New families enrolled Year 3	47	53	**100**
Year 3 Total	**77**	**81**	**158**
Total nonduplicated enrollment	148	146	**294**
(Families "rolled over" from Year 1 to Year 3)	2	6	**8**
Nonenrolled			
Consultation, referral, information	160	83	**243**
Provider Agencies (by Type)			
In-home providers	24	18	**42**
Adult day providers	4	2	**6**
Overnight providers	7	3	**10**
Total provider agencies used	**35**	**23**	**58**
Service Use (Year 1+ Year 2+ Year 3)			
Families receiving in-home service	89	64	**153**
Families receiving adult day service	45	63	**108**
Families receiving residential overnight	5	7	**12**
No agency selected at this time	9	12	**21**
Totals	**148**	**146**	**294**
Client Gender			
Male	63	42	**105**
Female	85	104	**189**
Totals	**148**	**146**	**294**
Client Race			
African American	12	96	**108**
White	136	49	**185**
Native American	0	1	**1**
Totals	**148**	**146**	**294**

Note: From 2001–2004, the Mecklenburg County site was a "control" site for Project C.A.R.E. While funding was provided for dementia respite, the funding was administered through the county Department of Social Services without a dementia awareness focus. During 2001–2004, a total of 144 families received Project C.A.R.E. funding for respite services. In Mecklenburg County, 74 percent of client families selected adult day services and 26 percent used in-home aide services. None of the clients chose residential respite care.

APPENDIX 3. Project C.A.R.E. Enrollment and Utilization, July 2004-June 2005

PROJECT C.A.R.E. DATA SUMMARY

Annual Report for 7/1/04 and 6/30/05

Project C.A.R.E. Service Areas	Six-County Region	Forsyth & Stokes Counties	Mecklenburg County	Totals
Number of families enrolled in Project C.A.R.E.	110	65	44	219
Nonenrolled (consultation, referral, information)	112	126	55	293
Number of Provider Agencies Used (by Type)				
In-home providers	16	18	6	40
Adult day providers	3	2	12	17
Overnight providers	3	4	0	7
Private-pay services	4	0	0	4
Total	**26**	**24**	**18**	**68**
Choice of Respite Type				
Families receiving in-home service	67	28	13	108
Families receiving adult day service	32	25	32	89
Families receiving residential overnight	2	1	0	3
Families receiving private-pay services	3	0	0	3
Families not choosing	6	11	0	17
Total	**110**	**65**	**45**	**220**
Client Gender (Person with Dementia)				
Male	52	18	15	85
Female	58	47	29	134
Total	**110**	**65**	**44**	**219**
Client Race				
African American	9	35	34	78
White	101	29	10	140
Native American	0	1	0	1
Total	**110**	**65**	**44**	**219**
Caregiver Gender				
Male	20	16	6	42
Female	90	49	38	177
Total	**110**	**65**	**44**	**219**

PROJECT C.A.R.E. - CLIENT DATA
July 1, 2001 - June 30, 2006

TOTAL YEARLY FUNDING FOR PROJECT C.A.R.E. RESPITE SERVICE				
	Asheville Area	Winston-Salem Area	Charlotte Area	Totals
Y1 2001-2002 *(Family Limit $2500)*	$91,700	$91,700	$50,000	**$233,400**
Y2 2002-2003 *(Family Limit $2500)*	$105,775	$105,775	$57,680	**$269,230**
Y3 2003-2004 *(Family Limit $2000)*	$106,000	$106,000	$57,680	**$269,680**
Y4 2004-2005 *(Family Limit $1800)*	$94,600	$94,600	$50,000	**$239,200**
Y5 2005-2006 *(Family Limit $1800)*	$94,600	$94,600	$50,000	**$239,200**
Y6 2006-2007 (Family Limit $2000)				
Total Project C.A.R.E. Funding	**$492,675**	**$492,675**	**$265,360**	**$1,250,710**
Additional Y1-Y5 Region B & C Funding for Asheville	$115,164	$0	0	**$115,164**
Total All Funding Sources	**$607,839**	**$492,675**	**$265,360**	**$1,365,874**

ENROLLMENT				
First 3-Year Cycle 7/1/01-6/30/04	**Asheville Area**	**Winston-Salem Area**	**Charlotte Area**	**Totals**
Total Families Served Year 1	**86**	**70**	**31**	**187**
Families Re-Enrolled from Y1 to Y2	52	50	27	**129**
New Families Enrolled Y2	15	23	20	**58**
*** Total Families Served Year 2**	**67**	**73**	**47**	**187**
Families Re-Enrolled from Y2 to Y3	30	28	12	**70**
New Families Enrolled Y3	47	53	54	**154**
Total Families Served Year 3	**77**	**81**	**66**	**224**
Total NEW Families Enrolled Y1+Y2+Y3	**148**	**146**	**105**	**399**
*** Total Families Served Y1+Y2+Y3**	**230**	**224**	**144**	**598**
Second 3-Year Cycle 7/1/04-4/30/06	**Asheville Area**	**Winston-Salem Area**	**Charlotte Area**	**Totals**
Families Re-Enrolled from Y3 to Y4	40	39	10	**89**
New Families Enrolled Y4	48	31	34	**113**
Total Families Served Y4	**88**	**70**	**44**	**202**
Families Re-Enrolled from Y4 to Y5	52	35	7	**94**
New Families Enrolled Y5	64	30	37	**131**
Total Families Served Y5	**116**	**65**	**44**	**225**
Families Re-Enrolled from Y5 to Y6				
New Families Enrolled Y6				
Total Families Served Y6				
Total NEW Families Enrolled Y4+Y5	**112**	**61**	**71**	**244**
Total Families Served Y4+Y5	**204**	**135**	**88**	**427**
Total NEW Families Enrolled Y1 through Y5	**260**	**207**	**176**	**643**
*** Total Families Served Y1 through Y5**	**434**	**359**	**232**	**1025**
** Includes re-enrolled + newly enrolled families*				

NON-ENROLLED FAMILIES (Information, consultation, referral only)				
	Asheville Area	Winston-Salem Area	Charlotte Area	Totals
First 3 Year Cycle (Y1+Y2+Y3)	160	83	41	284
Y4 +Y5	205	201	63	469
Totals	**365**	**284**	**104**	**753**

TOTAL DIFFERENT PROVIDER AGENCIES UTILIZED (Y1-Y5)				
	Asheville Area	Winston-Salem Area	Charlotte Area	Total
In-Home	28	20	8	56
Adult Day	5	3	10	18
Overnight (24 hour)	12	4	2	18
Totals	**45**	**27**	**20**	**92**

CAREGIVER CHOICE OF RESPITE				
Asheville Area				
	In-Home	Adult Day	Overnite	Total
Y1+Y2+Y3	89	45	5	139
Y4+Y5	144	71	5	220
Total	**233**	**116**	**10**	**359**
Winston-Salem Area				
	In-Home	Adult Day	Overnite	Total
Y1+Y2+Y3	64	63	7	134
Y4+Y5	57	75	3	135
Total	**121**	**138**	**10**	**269**

Charlotte Area				
	In-Home	Adult Day	Overnite	Total
Y1+Y2+Y3	38	106	2	146
Y4+Y5	23	65	3	91
Total	**61**	**171**	**5**	**237**

CLIENT GENDER (Person with dementia)				
	Asheville Area	Winston Salem Area	Charlotte Area	Total
Male (Y1+Y2+Y3)	63	42	52	157
Female (Y1+Y2+Y3)	85	104	92	281
Male (Y4+Y5)	114	29	28	171
Female (Y4+Y5)	122	91	60	273
Total	**384**	**266**	**232**	**882**

CLIENT RACE				
	Asheville Area	Winston Salem Area	Charlotte Area	Total
African American (Y1+Y2+Y3)	12	96	98	206
White (Y1+Y2+Y3)	136	49	46	231
Native American (Y1+Y2+Y3)	0	1	0	1
African American (Y4+Y5)	9	56	52	117
White (Y4+Y5)	226	63	33	322
Native American (Y4+Y5)	1	1	3	5
Total	**384**	**266**	**232**	**882**

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Health & Wellness, Lifelong Learning, Civic & Social Engagement

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Phone: 704-216-7714 Fax: 704-633-8517 Email: office@ruftyholmes.org

October 17, 2006

Members of the NC Study Commission on Aging,

As the Executive Director of Rufty-Holmes Senior Center in Rowan County, I serve on the Steering Committee for the newly formed North Carolina Senior Center Alliance as the state delegate to the National Institute of Senior Centers. Being involved nationally and statewide with senior centers, as well as having worked in a senior center for nineteen years, I see first hand the important role centers play in the aging network.

The North Carolina Division of Aging has made strengthening senior centers a high priority in its state aging plan. This has been done in recognition of the fact that senior centers serve as focal points for aging services in our local communities. Senior centers are the infrastructure that provides for the delivery of aging services on the local level. Funds for aging programs coming from the state and federal level are administered for the most part through senior centers in our counties.

Most funding received for local aging services goes into direct services to clients, and that it should. However, we need to recognize that in order to effectively deliver these services, and assist local clients, the infrastructure has to exist and perform adequately. Senior Centers are called upon often to deliver services without adequate administrative support. A good case in point is assisting clients with Medicare Part D enrollments, but this is not the only example.

The NC General Assembly provides a Senior Center General Purpose Grant to assist centers across the state with its "infrastructure" needs. Unfortunately, the amount of funding has not increased proportionate to the number of centers being developed across the state. This results in all centers receiving less funding, rather than more, as time goes on.

In FY 2004-05 a Center of Excellence received $17,740. In FY 2005-06 that same Center of Excellence only received $16,361, and this year saw that reduced to $15,367.

We are trying to strengthen senior centers and need to reward excellence in service delivery. We need additional dollars allocated to this grant each year. As the baby boomers swell the number of persons in our older adult age group, senior centers will be greatly overburdened.

We need to develop the infrastructure and capacity now for senior centers to meet today's and tomorrow's challenges. I hope you will consider making this a priority of the Study Commission's work.

Sincerely,

Rick Eldridge, Executive Director
Rufty-Holmes Senior Center

Austin Courier

OCTOBER

VISITOR REGISTRATION SHEET

N.C. STUDY COMMISSION ON AGING 10-17-06

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY
Bill + Betty Babb	Citizens
Betty Cuevas	"
Mike Murphy	Cabarrus County Dept. of Aging
Billy Hall	Cabarrus County Dept of Aging
Wanda + Frank Whitley	Cabarrus Co. Dept of Aging
Laura Blanton	Cleveland Family Services
Maryan Gilmore	Senior Directions (Monthly Newspaper)
Thomas Gray	Cleveland Family Services
Banzen Warren	Cleveland Family Services
Cola Bradshaw	Cleveland Family Services
Karen Carpenter	Cleveland Family Services
Cassandra Bell-Cash	Cleveland Family Services
TED DMIN	CABARRUS CO. COUNCIL ON AGING
Fred Weber	Char-Meck Senior Games
Evelyn Newman	COA
Sheneka Clark	Willow Ridge Assisted Living
Anthony Stevenson	Willow Ridge Assisted Living
Tammie Shutters	Americas Living Centers
Mark Lee	Friends of Residents
Bill Candle	Cabarrus County Senior Games
Mary Candle	Cabarrus County Senior Games
Susan McCracken	Lincoln Co DSS
Dean Bethea	" "
Hilary Kayler	Area Agency on Aging
Irene Beck	
[illegible]	Carolinas Mobile Dentistry
Alan Bethea	Lincoln County [illegible]

VISITOR REGISTRATION SHEET

N.C. STUDY COMMISSION ON AGING 10-17-06

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY
Becky Wiemhoff	Stanly Co. Senior Services Aging Advisory Com.
Janice Abernathy	Stanly Co. ~~[illegible]~~ Tar Heel Legislature
[illegible]	Centralina Area Agency on Aging
[illegible]	The Arc/Rowan
Kathryn Falbo-Woodson	Mental Health Assoc. of Central Carolinas
Kate Ahdieh	Sardis Oaks
Carla Scott	East Towne Assisted Living
Bill Wilson	AARP NC
Darlyne Menscer, MD	Eastland FP — Carolinas Healthcare System
Leslie Pack	Carolinas Medical Center
Sindy McCrystle APRN	Eastland Family Practice (Div. of Medical Educ Geriatrics Carolinas Healthcare System)
Christina Bowen, MD	Carolinas Med Center — Resident Family Med.
Blanche Penn	Winners PLUS Agency Inc.
Lucy Bush Carter	Friendship Trays, Inc.
Tammy Johnson	Winners Plus Agency Inc.
Paul Babinski	LIBERTY HEALTHCARE / CHF Mecklenburg Council on Aging
Ronda Deitch	AARP North Carolina

VISITOR REGISTRATION SHEET

N.C. STUDY COMMISSION ON AGING 10-17-06

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY
Lou Wilson	NCALTCF
Carol Lewis	
Barbara Lawrence	
Irene Eck	
Robert Johnson	
Robert J. Baker Sr	Yancey County Senior Center
Debra Kirby	McAlpine Adult Care
Patrick Barlow	" " "
Pat White	
Felicia Thompkins	American Living Centers
GINA HOFERT	UNC CHARLOTTE / Charlotte Senior Center @ Shamrock

October 3, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be two meetings of the NC Study Commission on Aging during October.

DAY:	Wednesday	TIME:	10:00 AM
DATE:	October 11, 2006		
LOCATION:	[redacted] Legislative Office Building		

DAY:	Wednesday	TIME:	10:00 AM
DATE:	October 25, 2006		
LOCATION:	Room 643 Legislative Office Building		

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, October 25, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Summary: Public Hearing Comments

Theresa Matula, Staff, Research Division, NCGA

III. Dental Care for Older Adults

Dr. Bill Milner, Access Dental Care

IV. Penalty Review Committee

- **2005 Changes** (S.L. 2005-276, Section 10.40A (l))
- **Recommendations**

Barbara Ryan, Division of Facility Services, DHHS

V. Status Report: Online Posting of Fines and Penalties

Barbara Ryan, Division of Facility Services, DHHS

VI. Meeting Adjourned

Next Meeting:
November 15, 2006 at 10:00 a.m. in Room 544

Additional Information:
North Carolina Conference on Aging
Sheraton Imperial Hotel and Convention Center
Research Triange Park, NC
October 25-27, 2006

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES
OCTOBER 25, 2006
ROOM 643
10:00 AM

The meeting was opened by Representative Beverly Earle at 10:10 am of the Legislative Office Building in Room 643. Representative Earle gave opening remarks and asked if her Co-Chair had any remarks at this time. He declined. The following members were present:

Representative Beverly Earle, Chair
Representative Bob England
Sam Marsh
Representative Debbie Clary
Linda Howard

Four Senators were present.

The meeting begin with a presentation from Ms. Theresa Matula, Research Division on the Public Hearings. She began with background information stating that 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 and are augmented by new problems. The issues mention with the greatest frequency were:

- Increase funding and continue to support for senior centers (23)
- Increase and continue support for senior games (11)
- Increase and continue funding for Alzheimers and Project C.A.R.E.
- Increase funding for home and community care block grant (7)
- Resolve issues related to mentally ill in long term care facilities (6)
- Increase funding support for senior friendly housing (6)

The next presenter was Mr. Bill Milner, and Dr. Ford Grant, Access Dental Care. He stated that North Carolina needs a comprehensive approach to provide special care dental services to its frail elderly and developmentally disabled populations. Over 200,000 North Carolinians live in skilled nursing facilities, group homes or are homebound. They include all age groups and have a variety of complicated intellectual and physical disabilities, such as profound retardation, autism, cerebral palsy, dementia, heart attack, cerebral vascular disorders (stroke), head injuries, multiple sclerosis and muscular dystrophy.

H.R. 4624 "Special Care Dentistry Act of 2005"

The purpose is to reduce the growth of Medicaid and Medicare expenditures by providing medically necessary coverage for effective and affordable special care dentistry services for the nation's most vulnerable children, adults and elders. And to reduce pain, suffering and a reduction in general health for Medicaid's most vulnerable enrollees, by providing services to reduce infections of the teeth, gums and bloodstream that contribute to costly and life threatening conditions including heart disease, stroke, diabetes, dementia and pneumonia.

Penalty Review Committee

Barbara Ryan, Division of Facility Services, DHHS
It is stated that the Secretary shall establish a penalty review committee within the Department, which shall review administrative penalties assessed pursuant to this section and pursuant to G.S. 131E-129. (See Attachment IV)

Status Report Online Posting of Fines and Penalties
Ms. Barbara Ryan, Division of Facility Services, DHHS gave a brief discussion on how to access penalties and fines online. North Carolina's Adult Care Home Fines and Nursing Home Inspection Information is part of DHHS's ongoing effort to provide information to citizens and family members faced with difficult health care decisions. A list of adult care homes or nursing homes can be obtained on the home page of this web site http:facility-services.state.nc.us—Dirctory of Regulated Facilities. This listings allow you to search for adult care homes or nursing homes in North Carolina by county. There are necessary regulatory delays between when an adult care home or nursing home is inspected and when fines or findings from the inspection will appear on this web site. Therefore, when visiting an adult care home or nursing home, we encourage you to request copies of more recent inspection results. For both adult care homes and nursing homes, months will typically pass between inspections and much could change for the better or worse in a facility between inspections. Therefore, it is advised that you inspect the facility yourself before making such an important decision.

There was a question and answer session at this time. Questions were asked by the committee members and answered by staff.

The meeting was adjourned.

Beverly Earle

Representative Beverly Earle, Chair

Ann Raeford

Ann Raeford, Committee Assistant

Attachments

Attachment I	Agenda
Attachment II	Summary of Public Hearings
Attachment III	North Carolina Special Care Populations
Attachment IV	Visitor's Registration Sheet

Burlington, NC
October 3, 2006

Charlotte, NC
October 17, 2006

NC Study Commission On Aging Public Hearings Fall 2006

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)

Fall 2006 Public Hearings

Date	Location	Number of Speakers
October 3, 2006	Burlington, NC	40
October 17, 2006	Charlotte, NC	33

The issues mentioned with the greatest frequency were:

- **Increase Funding/Continue Support for Senior Centers (23)**
- **Increase/Continue Support for Senior Games (11)**
- **Increase /Continue Funding for Alzheimers and Project C.A.R.E. (10)**
- **Increase Funding for Home and Community Care Block Grant (7)**
- **Resolve Issues Related to Mentally Ill in LTC Facilities (6)**
- **Increase Funding/Support for Senior Friendly Housing (6)**

NC Study Commission on Aging – Fall 2006 Public Hearings
Frequency of Issues Expressed by Speakers

	BURLINGTON	CHARLOTTE	TOTAL
PROGRAM SUPPORT			
Increase Funding for Home and Community Care Block Grant	5	2	7
Increase Funding for Home & Community Based Services	1		1
Increase Funding for Home Care		1	1
Increase Funding for Transportation Services	1	1	2
Increase Funding/Continue Support for Senior Centers	16	7	23
Support for Congregate and Home Delivered Meals for Seniors		1	1
Increase/Continue Support for Senior Games	9	2	11
Increase Medically Needy Income Limit	1		1
Increase Funding for Area Agency on Aging	2	2	4
Increase Funding /Expand Dental Care for Special Needs Population	2	1	3
Support for State/County Special Assistance (SA) In -Home	1		1
Eliminate Institutional Bias	1	1	2
Expand Win-A-Step Up to Home Care		1	1
Support for Community Alternatives Program for Disabled Adults (CAP/DA)	1	1	2
Decrease Social Worker Case Load	1		1
Increase Funding/Support for Senior Adult Planning	1	2	3
Strengthen Disaster Planning/Emergency Preparedness	1	1	2
Increase Support for Family Caregivers	2		2
Increase/Continue Funding for Alzheimers and Project C.A.R.E.	6	4	10
HOUSING/TAXES			
Increase Funding/Support for Senior Friendly Housing	4	2	6
Support/ Increase Funding for NC Housing Trust Fund	2	1	3
Property Tax Relief/ Support for Homestead Exemption	1	1	2
Support Impact Fees	1		1

	BURLINGTON	CHARLOTTE	TOTAL
LONG-TERM CARE FACILITIES			
Require Increase in Nursing Hours of Care in Nursing Homes		1	1
Resolve Issues Related to Mentally Ill in LTC Facilities	3	3	6
Increase Funding/Support for Mentally Ill in LTC Facilities		4	4
Require Adequate Heating and Cooling Regulation in LTC Facilities	1		1
Increase Wages/ Support for Direct Care Workers	2		2
Provide Background Checks on Facility Administrators	1		1
Implement Star Rating System for Adult Care Homes		1	1
Support Resident Councils for Adult Care Homes	1		1
MEDICAL CARE/INSURANCE/ PRESCRIPTION DRUGS			
Support for Prescription Drug Assistance Program	1	2	3
Restore Long Term Care Insurance Tax Credit	2	1	3
Increase MDs that Accept Medicaid		1	1
Raise Medically Needy Income Limit	1	1	2
Establish Medical Malpractice Limits	1		1
Support for National and State Health Care System		1	1
OTHER			
Auto Insurance Discounts for Seniors Taking Driving Safety		1	1
Concern Regarding Financial Exploitation of Older Adults		2	2
Support for Victim Legal Assistance		1	1
Support for Judicial System Reform		1	1
Concern for Immigration Issues		1	1
Concern for Disabled Child Outliving Parent Caregiver		1	1
Totals	72	53	125

Prepared by Aging Commission Staff

North Carolina's Special Care Populations

Who Are They?

North Carolina needs a comprehensive approach to provide special care dental services to its frail elderly and developmentally disabled populations. Over 200,000 North Carolinians live in skilled nursing facilities, group homes or are homebound. They include all age groups and have a variety of complicated intellectual and physical disabilities, such as profound retardation, autism, cerebral palsy, dementia, heart attack, cerebral vascular disorders (stroke), head injuries, multiple sclerosis and muscular dystrophy.

What Are The Problems?

1. No Access for the Frail Elderly and Disabled. The traditional dental practice does not work for them. Transportation issues to and from facilities and lack of wheel-chair-accessible operatory space keeps many frail elderly and disabled patients out of the dental chair. Because many of these individuals cannot travel to a dental office without the aid of an ambulance, they have no access to regular dental services.
2. No Access for the Intellectually Disabled. Deinstitutionalization of the mentally disabled has placed those with major intellectual disabilities – the profoundly retarded and the mentally disabled -- in communities without dental care services.
3. No Professional Training. Most communities have no dental care services for these individuals because dentists have not been trained to manage behaviors common to intellectually disabled citizens or those with no muscle control. The practice of "Special Care Dentistry" requires expertise beyond anything now taught at the UNC School of Dentistry or any dental hygiene program. It is teachable, but the continuing education for interested community practitioners is limited.
4. A Costly Public Health Issue. Because of lack of available care, many elderly individuals, who took care of their dental health as long as they were able, are forced to live with the gross oral infections that develop when their dental care ceases. These infections result in expensive medical care for illnesses such as aspiration pneumonia, uncontrolled diabetes, wound healing, stroke and heart disease.
5. Existing Service Models Stretched to Breaking Point. North Carolina has two organizations that have successfully delivered dental care to nursing home residents, group home residents and community dwelling individuals. But these organizations need expanded state reimbursement for this care if they are to continue. Their business model currently uses foundation start-up monies, revenue from private/Medicaid fees and facility retainers for sustaining funding.

H.R. 4624 "Special Care Dentistry Act of 2005"

Purpose

- To reduce the growth of Medicaid and Medicare expenditures by providing medically necessary coverage for effective and affordable special care dentistry services for the nation's most vulnerable children, adults and elders.

- To reduce pain, suffering and a reduction in general health for Medicaid's most vulnerable enrollees, by providing services to reduce infections of the teeth, gums and bloodstream that contribute to costly and life-threatening conditions including heart disease, stroke, diabetes, dementia and pneumonia.

Summary

- Provides targeted coverage for special care dentistry services that will help reduce unnecessary Medicaid expenditures for medical conditions that are common among children and adults with special healthcare needs.

- Targets Medicaid coverage to the most vulnerable enrollees using the existing EPSDT program to target needy children, and existing Social Security categories of "Aged, Blind or Disabled" to target adults with special needs.

- Permits flexibility for states allowing them to either make provision for special care dentistry coverage through a state's existing EPSDT program or by creating a separate program for Aged, Blind or Disabled Adults.

- Recognizes that special care dentistry services targeted for Medicaid eligible children and "Aged, Blind or Disabled Adults" are necessary to stop the spread of preventable infections and are medically necessary.

- Provides improved financial support to states by increasing the federal share of the Medicaid cost (FMAP) to 90 % federal and 10 % state .

- Provides better access to privately funded healthcare options for nursing home residents by strengthening and clarifying provisions of the Applied Income laws (PETI Provisions).

Special Care Dentistry Delivers a Formula for Change:
A Model Has Been Developed but Must Be Implemented Statewide

William E. Milner, DDS, MPH

The Reality of Now

Not-so-pretty scenarios are being played out daily in our communities:

- The benefit of a lifetime of dental care rapidly disappears for patients who cannot access a local dentist's office. Longtime dental patients are frequently turned away from practices because of complicating medical conditions, limited mobility, or change in financial status. Lack of on-site care in skilled nursing facilities, group homes, or home health programs forces them to receive only emergency care at best. A lifelong routine of regular checkups and preventive and restorative care is forced to come to an end.
- Unable to clean their own mouths, these compromised residents depend on the facilities or home caretakers for daily preventive care. Almost universally, caretakers shy away from cleaning mouths; they will take care of every other part of the body, but avoid the mouth out of fear that they will hurt the resident or that they will be bitten. What results is a filthy mouth with rapidly progressing root decay and gum disease. It gets worse for the typical dementia, head trauma, or non-communicative stroke patient who cannot say he or she hurts.
- After a few months of little or no oral healthcare, residents are in a constant state of oral infection, a dangerous condition with spin-off effects. Oral bacteria and debris can be aspirated into the lungs, which causes aspiration pneumonia and necessitates costly treatment and trips to the hospital. Diabetics have trouble controlling their disease because of this constant source of infection. Oral bacteria can also enter the blood stream, landing on heart valves and causing infection.
- Families are frustrated with the lack of availability of basic dental care. Caretakers are willing to drive anywhere for help, but help doesn't exist. Those with autism, cerebral palsy, muscular dystrophy, and a dizzying variety of syndromes are left without the hope of care.

Talk to a facility director of nursing, a health coordinator for group homes, or any family member providing care for a home health patient, and you will hear the same scenarios confirmed. Fragile, disabled, dependent North Carolinians deserve better. Luckily a solution is at hand. North Carolina has a tested and proven model of care, the established networks to create a statewide system, and the political will to provide quality, consistent care to its most vulnerable populations.

Four major areas must be considered from a public policy perspective to change this situation.

Table 1.
North Carolina's Rapidly Growing Senior Population

NC ranks 10th among states in the number of persons age 65+.
By 2020, the population 65+ will have grown 71% from the 2000 baseline.
By 2030, there will be 2.2 million 65+ (17.8% of the population).
In 2000, 219,068 persons with disabilities received Medicaid.
Total Nursing Home Residents – 47,336 in over 400 facilities.
Total Group Home Residents (mental/physical disabilities) – 4,520.
Total Home Based Residents (mental/physical disabilities) – 5,364.

A Different Dental Practice and a Provider with a Mission

A new type of dental practice is emerging because of the huge growth in numbers of the older population. To accommodate this demographic and health status shift in the population, the North Carolina Dental Society has initiated a new service area—Special Care Dentistry.

What is it? Special Care Dentistry serves those living in nursing homes, assisted living facilities, group homes, or the community at-large—patients who have intellectual and/or physical disabilities and are medically compromised. There are a few special care practices in the state. This infant area of expertise needs the support of North Carolina's dental care proponents and special care interest organizations in order to expand to serve the state's entire special care population.

William E. Milner, DDS, MPH, is President of Access Dental Care. He can be reached at bmilner@accessdentalcare.org or 2275 Vanstory Street, Suite 102, Greensboro, NC 27403. Telephone: 336-292-5029.

There are two major similarities between a traditional dental practice and a practice dedicated to special care.

- The treatment philosophy is the same. No matter what the disability, all patients deserve the same quality of care that any of us within the community receives.
- The other similarity involves how care is provided. Special Care Dentistry involves the complete dental team—dentist, dental hygienist, dental assistant, and office support staff.

But to be successful, the practice of Special Care Dentistry, whether on a full-time or part-time basis, requires a completely different practice organization.

- For instance, it requires an expanded practice location. Although Special Care Dentistry can be delivered in the fixed-office setting, most special care patients either cannot be easily moved to an office or exhibit behaviors that cannot be managed in a waiting room. Because of this, most patient care takes place at a facility, community center, or in the hospital operating room. Local private practitioners working in a limited number of facilities can provide emergency care and some clinical services, but they cannot provide comprehensive services for the entire special care community.
- It requires different equipment. Equipment needs to be mobile because it needs to go into a variety of settings, such as a long-term care facility, community center, or home. Residents who are sick or who have trache tubes or cumbersome geri-chairs cannot be transported outside to a "Winnebago style" van for care, especially in the middle of winter.
- It requires different reimbursement rates. Because 80% of special care patients depend on Medicaid to pay for their dental care, and Medicaid reimburses at approximately 62% of cost, a special care practice cannot serve the entire community with comprehensive, quality care, and be fiscally sustainable based solely on fee-for-service reimbursement.
- It requires a different legal structure. The most workable structure to emerge is the nonprofit practice. Nonprofit status allows the funding of start-up costs through grants and provides tax deductibility for contributions that help offset the cost of providing care to most patients at Medicaid rates.

Beyond the changes in practice organization and reimbursement, it requires a provider with a specific set of dental and interpersonal skills.

- It requires a different mindset. Direct patient care for special care patients requires more time per patient. It requires special training, flexibility, creativity, and a dedication to serve these difficult patients. In addition, this type of practice is more physically demanding than the traditional practice, both because of moving portable equipment into and out of facilities on a daily basis and treating patients who may be combative.
- It requires extensive communication about care because more individuals are involved in treating or approving treatment plans for the patient. The dental provider in a nursing home works with facility and hospital administrators, physicians, directors of nursing, charge nurses, social workers, other ancillary providers, a variety of responsible parties, those responsible for the daily oral hygiene of the patient, state facility surveyors, and the patient. Communication with these team members adds extra time to the process.
- It requires attention to detail. The nursing home chart is huge compared to the typical dental chart. Twenty percent of special care patients require conscious sedation for treatment. Conscious sedation monitoring by nurses and the dental team greatly extends treatment time. The long list of drugs these patients are taking requires a specialized knowledge of pharmacology. Treatment forms include a variety of permission requirements for guardian, power of attorney, and healthcare power of attorney.

Formula for Change: Expand the Number of Comprehensive, On-Site Programs

Making excuses for intermittent, less than comprehensive care is unacceptable and degrading to special care patients. To serve the special needs populations, dentistry must expand the recruitment efforts and the number of training opportunities for special care dental providers who will serve all patients, no matter their reimbursement source, location, type of dental care needed, or disability.

The nonprofit practice is the most workable model to date. It is a model that can be expanded to accept special needs patient referrals from local practitioners; serve the rapid influx of retirees to North Carolina; relieve the gap in service to those deinstitutionalized by North Carolina's mental health hospital system; and support special care patients, families, local healthcare providers, and organizations representing the special needs patients.

Access Dental Care mobile equipment and truck.

Changes Require a New Breed of Community Practitioner

The growth of this special needs population requires a dental team with special training. Until recently, the few practitioners providing comprehensive special care worked at the University of North Carolina at Chapel Hill (UNC-Chapel Hill) School of Dentistry, in a limited number of hospital dentistry programs, in the state mental retardation hospital system, or in a local private pediatric practice. A few private practice dentists go to a limited number of nursing facilities on their "day off;" most work with few dental staff and carry basic portable equipment. Unfortunately, none of these is sufficient for today's special care dental treatment needs.

The UNC-Chapel Hill School of Dentistry is, first and foremost, a teaching center, not an access to care facility. Its staff's expertise has made it the default special care referral source over the years for local practitioners. The special care population has grown so rapidly and is so difficult to transport that the school cannot continue to provide statewide access to care. To complicate matters, the School of Dentistry has experienced decreases in public funding, limiting its ability to start new teaching programs targeting special care populations. This means that neither dental school students nor faculty members have the opportunity to learn how to treat special needs populations in the community setting. If dental students are not introduced early in the education process to delivering care in community on-site programs, we lose the opportunity to put future practitioners into the special care professional pipeline.

State mental hospital dental staff experience on-the-job training because they handle North Carolina's toughest cognitively disabled patients daily. But, a few years ago, North Carolina decided to initiate a program of de-institutionalization, placing many of these severely and profoundly handicapped residents back into community group homes. Now group home programs are desperately seeking local dental care for these residents, arguably the most difficult to treat in dentistry. Communities without special care providers have no resources to call on.

Some larger hospitals have dentists on staff and/or graduate training programs that care for special care residents, primarily in the operating room setting. These dental teams are also responsible for in-house physician referrals, preparing patients for surgery, and providing oral care to support cancer therapy. To this point, they are at capacity providing in-house care and have not been able to expand to on-site community programs.

There are some dentists providing limited care to long-term care residents. Because of the extreme shortage of comprehensive special care programs, facilities contract with these providers knowing that many of their residents will not get the care they need. Mass examinations are followed by some extractions and denture work. Treatment plans for the remaining residents are provided, and the facility is required to find a dentist willing to provide care. This is a dead-end referral because most local dentists are not trained to deal with these patients.

Some local dentists will continue to treat some special care patients. Pediatric dentists still care for children with disabilities, but their practice volumes have forced them to restrict the number of older special care patients they see. General practitioners have an important role in caring for early dementia patients and the manageable chronically ill.

Special Care Dental Programs

North Carolina's Special Care Dentistry programs emerged in the late 1990s and have created a sample framework for a statewide system.

- In the mid-1980s, The North Carolina Dental Society created a special care committee to address the treatment needs of patients and education needs of providers.
- In 1997, this committee supported the development of Carolinas Mobile Dentistry (CMD) at Carolinas HealthCare System, Charlotte. It began service to nursing homes in the Charlotte area. CMD covers 1,800 beds.
- In 2000, the North Carolina Dental Society initiated Access Dental Care. This Greensboro non-profit assisted Wake Forest University Baptist Medical Center (WFUBMC) in creating their Special Needs/Portable Dentistry program in 2002. It also teamed with Healthy Cabarrus, Kannapolis to start a branch of Access Dental Care in a four-county region around Concord/Kannapolis. Access Dental Care has now absorbed the WFUBMC program to serve 4,000 beds and plans an expansion of service to the Triangle region.
- By 2006, the Carolinas Mobile Dentistry and Access Dental Care programs will cover over 7,000 beds.

Table 2.
Access Dental Care Five-Year Summary

Totals from August, 2000 – July, 2005*
Clinical
• 3702 Total Patients in the Practice
• 19,505 Total Patient Visits
• 32,116 Patient Services Provided
Financial
• $2,815,966 billed with an average gross of $98 per patient.
• $1,908,824 paid to date
• Over $903,000 in uncompensated care provided. This amounts to almost two years of net revenue. (80% of our patients are Medicaid beneficiaries)
• 162 Operating Room Patients (MR/DD patients-Medicaid) with an average gross of $1350 per patient.

*Figures do not include the newly acquired WFUMBC program.

Formula for Change: Special Care Professional Education

A new model of care requires a new program of education for dental providers. At this point, North Carolina does not have a program that trains special care providers. Short student rotations and courses at the UNC-Chapel Hill School of Dentistry provide exposure to the special care patient, but do not provide the formal training necessary to enter an active practice. A post-graduate residency would allow dentists and hygienists to gain across-the-board dental skills provided in fixed, mobile, and hospital settings. Education for current local practitioners interested in Special Care Dentistry can be supplied by mini-residencies, regular continuing education, and on-site practical experiences.

Residents and their families are asking legitimate questions about the lack of daily oral care. Facility administrators and directors of nursing must finally make oral health and daily oral hygiene a priority. When this happens, special care dental staff can train the facilities' admitting nurses and education coordinators, who can, in turn, maintain a consistent teaching and monitoring process of direct care staff. Charge nurses and nursing aides must understand the ramifications of not providing daily oral hygiene and be held accountable. Failure to do this will, at some time in the future, put the facility at risk (e.g., families will take legal action).

There are a few existing education programs that need to continue. North Carolina Division of Facility Services surveyors, those in charge of ensuring that federal and state Medicaid funds are spent wisely, receive regular training. This training should to be expanded to include other long-term care advocacy groups. Future facility administrators are provided oral health programming information during the North Carolina School of Public Health Administrator in Training course. Every future administrator knows what a comprehensive dental program looks like. University interdisciplinary training should continue giving various future healthcare providers an understanding of oral health issues.

Funding that Matches the Practice

As it is currently structured, Medicaid reimbursement does not address the unique practice nature of special care dental services. Many services required by these patients are not even deemed eligible for reimbursement. Right now, 75-80% of skilled nursing home residents and almost all group home residents depend on Medicaid to reimburse their medical and dental providers.

To correct this inequity and to draw more practitioners into special care practice, higher reimbursement rates must be implemented, taking the following factors into account for special care patients.

- Special care patients take longer to treat. Their behavior must be handled before their dental needs can be treated. All of this requires working with the gamut of care givers and responsible parties. This takes more time that is not reimbursed and allows fewer patients to be treated in a day. (Access Dental Care currently averages 15 patients per day) For example, the autistic patient requires a special treatment regime and environment. It takes many appointments to gain the patient's trust, none of which are reimbursable. The treatment setting must be quiet, consistent, and supportive of parents.
- Patients with special care needs require more expertise to treat. Each new employee, dentist, or auxiliary must spend six months to one year learning to care for these individuals. None of this training experience is reimbursable to organizations.
- On-site programs require travel time and expenses, none of which is reimbursed. Access Dental Care fuel costs have doubled in the past five years. Each team spends approximately two hours each day going to a facility, setting up the dental equipment, breaking down the dental equipment, and returning to the administrative office.
- Communication with responsible parties takes time and is not reimbursed.

Public funding of dental services for the truly needy and vulnerable populations continues to be a problem. Historically dentistry has received 1-2% of total Medicaid funding, and now, in North Carolina, Dental Medicaid rates reimburse at 62 cents on the 2001 dollar. A lawsuit several years ago increased Medicaid rates by 12%, but inflation has now neutralized these gains with no sign of significant increases in the future. Although the overall population is increasing dramatically, the relative numbers of the special needs population are small, and what might seem to be a large increase in reimbursement rates would actually result in a relatively small increase in overall expenditures.

Formula for Change: Innovative Funding of Special Care Dentistry

Existing special care programs have been created through "grassroots" community efforts, with initial funding from grant support. Generous seed money from several North Carolina foundations is the reason for Special Care Dentistry's successful programming to date. Medicaid's inclusion of adult services has given providers the chance to deliver comprehensive care. There is ample financial data to craft an expanded list of reimbursable services for Special Care Dentistry. It should include funding for education priorities, public policy initiatives, program development, and fair fee-for-service reimbursement.

Public Policy Initiatives

Starting a new field of service delivery involves creating a new structure of practice. Old rules must be reviewed, present practices changed to improve service, and future programs created to deal with a changing population. Special care providers are currently treating patients five to six days a week plus trying to develop awareness of special needs in education, research, local program building, and public policy development. It is an overwhelming

task. This core of individuals has the expertise to manage this change process, but they need the time. Unfortunately, the present organizations operate on such a thin profit margin, any time spent not treating patients puts them at financial risk. The following action areas need to be implemented.

- Provide support for long-term care provider organizations to establish consistent, quality Special Care Dentistry services.
- Work with communities wanting their own special care dental program. Several North Carolina communities are requesting help, but there is no time available to help them develop a program.
- Create health services research projects that support the development of community programs and ensure the quality of care provided.
- Review North Carolina's existing dental practice laws to allow for the more efficient practice of Special Care Dentistry.

Our Next Step

Many North Carolina foundations, the North Carolina Dental Society, long-term care organizations, individual nursing/group homes, and responsible parties of the mentally and physically disabled have "put their money where their mouths are." North Carolina's long-term care organizations understand the need for change and are asking special care dental providers what they can do to help create a statewide system. Dentistry has developed a successful model for providing care, but now needs the support of other organizations that will benefit from these changes. It is time to agree on a workable business/policy plan and make sure that specific changes are made. North Carolina's future long-term care residents deserve a better quality of life—one that puts the mouth back into the body. **NCMedJ**

Formula for Change: A Special Care Dentistry Center

Fund a North Carolina Special Care Dentistry Center to coordinate the activities mentioned in this commentary. A part-time dentist, a hygienist, and an office assistant can bring together the necessary parties to do the job right. Funding must be sustainable, giving this group the chance to work on the necessary issues and not spend all their time raising money.

For More Information:

To learn more about Access Dental Care and Carolinas Mobile Dentistry, visit their Web pages:

Access Dental Care
www.accessdentalcare.org

Carolinas Mobile Dentistry
www.carolinas.org/services/seniorcare/mobiledentistry.cfm

Caregivers Don't Need To Do This Alone!

- Significant increase in the number of persons providing care to a friend or family member age 60 or older from 2000 to 2003
- Over 25% of adult North Carolinians now provide care to an older friend or relative
- Almost half of those receiving care are reported to have memory loss or dementia

Many people need the support of others who are in similar situations or perhaps the support of a professional. They may need education on caregiving issues. Caregivers may need respite or a "time-out" from their caregiving duties. Seeking information on what services are available and assistance to help connect with these services can be an important first step.

North Carolina Family Caregiver Support Program
http://www.dhhs.state.nc.us/aging

§ 131D-34. Penalties; remedies.

(h) The Secretary shall establish a penalty review committee within the Department, which shall ~~meet at least semiannually to review violations and penalties imposed by the Adult Care Licensure Section; provide a forum for residents, guardians or families of residents, local department of social services, and providers; and make recommendations to the Department for changes in policy, training, or rules as a result of its review and publish a report~~ review administrative penalties assessed pursuant to this section and pursuant to G.S.131E-129 as follows:

(1) The Secretary shall administer the work of the Committee and provide public notice of its meetings via website and to the following parties involved in the penalties the Committee will be reviewing:

a. The licensed provider ~~and~~ who, upon receipt of notice of a scheduled PRC meeting, shall post notice of the scheduled PRC meeting in a conspicuous place available to residents, family members and the public.

b. The local department of social services that is responsible for oversight of the facility involved;

~~c. The residents affected; and~~

~~d. The families or guardians of the residents affected.~~

(2) The Secretary shall ensure that the Nursing Home/Adult Care Home Penalty Review Committee established by this subsection is comprised of nine members. At least one member shall be appointed from each of the following categories:

a. A licensed pharmacist;

b. A registered nurse experienced in long term care;

c. A representative of a nursing home;

d. A representative of an adult care home; and

e. Two public members. One shall be a "near" relative of a nursing home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. One shall be a "near" relative of a rest home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. For purposes of this subdivision, a "near" relative is a spouse, sibling, parent, child, grandparent, or grandchild.

(3) Neither the pharmacist, nurse, nor public members appointed under this subsection nor any member of their immediate families shall be employed by or own any interest in a nursing home or adult care home.

(4) ~~Repealed by Session Laws 2005-276, s. 10.40A(l), effective July 1, 2005.~~ Prior to serving on the committee, each member shall complete a training program by the Department of Health and Human Services that covers standards of care and applicable

State and federal laws and regulations governing facilities licensed under Chapter 131D and Chapter 131E of the General Statutes.

~~(4a) The Department of Health and Human Services shall notify families or guardians of affected residents of the right to request a penalty review committee review of the Department's penalty decision before the decision becomes final. Within 60 days of receipt of a request from a family member or guardian for review of the Department's penalty decision, the penalty review committee shall meet to conduct the review and shall inform the family member or guardian of the results of the review.~~

(5) Each member of the Committee shall serve a term of two years. The initial terms of the members shall commence on August 3, 1989. The Secretary shall fill all vacancies. Unexcused absences from three consecutive meetings constitute resignation from the Committee.

(6) The Committee shall be cochaired by:

a. One member of the Department outside of the Division of Facility Services; and

b. One member who is not affiliated with the Department.

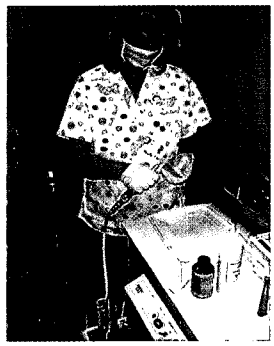
(i) The clear proceeds of civil penalties provided for in this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. (1987, c. 600, s. 3; 1989, c. 556, s. 1; 1991, c. 66, s. 1; c. 572, s. 3; 1993, c. 390, s. 4; 1993 (Reg. Sess., 1994), c. 698, s. 1; 1995, c. 535, s. 16; 1995 (Reg. Sess., 1996), c. 602, s. 1; 1997-431, s. 1; 1997-443, s. 11A.118(a); 1998-215, s. 78(a); 2005-276, s. 10.40A(l).)

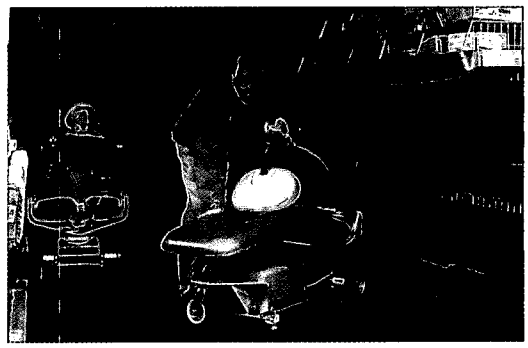
access

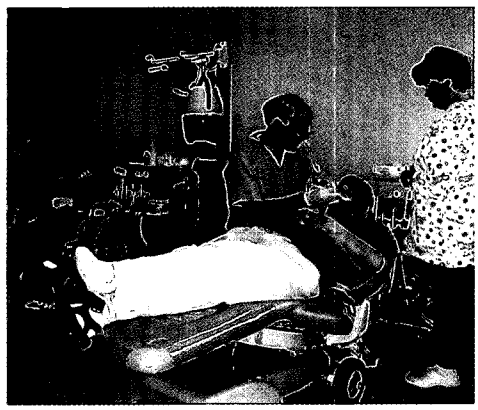
DENTAL CARE

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

Access Dental Care
Totals from August, 2000 – July, 2006

Clinical

- 5181 Total Patients Served
- 1500 MR/DD Patients Served
- 2599 Active Patients Total
- 25,691 Total Patient Visits
- 42,280 Patient Services
  1. 66% Diagnostic/Preventive
     19,859 Diagnostic (exams, x-rays)
     8,446 Preventive (cleanings, fluoride treatment, education, sealants)
  2. 13% Restorative (5,213 fillings)
  3. <1% Endodontic (80 root canals)
  4. 2% Periodontic (1,187 treatments - gum)
  5. 5% Removable Prosthetic (2,151 denture procedures - dentures, partials, relines, repairs)
  6. <1% Fixed Prosthetic (150 crown/bridge procedures)
  7. 13% Oral Surgery (5,194 extractions)

Financial

- $3,610,612 Billed
- $2,370,923 Paid to date
- Average of $95.00 per appointment
- Over $1,239,000 in uncompensated care provided. This amounts to almost two years of production. (85% of our patients are Medicaid)
- 190 Operating Room Patients (MR/DD patients-Medicaid)

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North Carolina Department of
Environment and Natural Resources

ENFORCEMENT

Departmental Enforcement
Enforcement Assessment 2000
Penalty Policy for Self-Reported Violations
DENR Compliance Report 2000
DENR Compliance Report 2001
DENR Compliance Report 2002
DENR Compliance Report 2003
DENR Compliance Report 2004
DENR Compliance Report 2005
Flowcharts
NCAWWA PowerPoint Presentation 08/20/2003

Air
Civil penalty assessments
Special Orders by Consent
Stage I vapor recovery compliance
Smoking vehicle complaint form
Vehicle inspection and maintenance program

Coast/Fisheries
List of CAMA violators
Bycatch Reduction Devices
Polluted Area Proclamations
Fisheries Proclamations

Land Resources
Enforcement Actions - Mining, Sedimentation Pollution Control, Dam Safety
Report a possible violation to the Sedimentatior Pollution Control Act

Waste Management
Underground storage tank civil penalties
Hazardous waste civil penalties
Solid waste civil penalties
Inactive Hazardous Sites

Water
Water Quality Enforcement Actions

NCDENR, 1601 Mail Service Center, Raleigh, NC 27699-1601 919-733-4984 Fax 919-715-3060

Division of Air Quality Civil Penalty Assessments: 09/01/2006 to 09/30/2006

County	Case Number	Violator	Violation	NOV Date	Date Assessed	Penalty Amount	Invest Cost	Total Amount Due
Alamance	2006-167	Riley Paving, Inc.	Permit A.11 Permit A.9	06/01/2006	09/21/2006	$ 1,000	$ 270	$ 1,270
Beaufort	2006-179	Williams Tree and Landscaping	2D .1900 Open Burning	05/11/2006	09/21/2006	$ 2,250	$ 192	$ 2,442
Cherokee	2006-163	Dick Higdon	2D .1900 Open Burning	05/02/2006	09/21/2006	$ 3,000	$ 175	$ 3,175
Craven	2006-160	Robert Evans	2D .1900 Open Burning	04/27/2006	09/15/2006	$ 750	$ 163	$ 913
Cumberland	2006-156	Young's Auto Repair & Body Shop	2D .1900 Open Burning	04/12/2006	09/15/2006	$ 2,000	$ 206	$ 2,206
Cumberland	2006-158	Dwight Davis	2D .1900 Open Burning	05/03/2006	09/08/2006	$ 1,000	$ 198	$ 1,198
Currituck	2006-196	Martin Beickert	2D .1900 Open Burning	06/29/2006	09/22/2006	$ 250	$ 230	$ 480
Davie	2006-154	Funder America, Inc	2D .0521 Control of Visible Emissions	04/28/2006	09/08/2006	$ 4,000	$ 276	$ 4,276
Guilford	2006-146	Piedmont Hardwood Dry Kiln Company	2D .0521 Control of Visible Emissions	04/19/2006	09/08/2006	$ 6,000	$ 250	$ 6,250
Guilford	2006-147	Hickory Printing Group, Inc.	NC General Statutes NCGS 143-215.108 Control of sources of air pollution; permits required.	04/25/2006	09/08/2006	$ 1,500	$ 244	$ 1,744
Harnett	2006-138	Clark Langdon	2D .1900 Open Burning	04/12/2006	09/08/2006	$ 1,125	$ 422	$ 1,547
Harnett	2006-139	Ricky and Janice Byrd	2D .1900 Open Burning	04/12/2006	09/15/2006	$ 250	$ 250	$ 500
Harnett	2006-157	Roger Elliott, Jr.	2D .1900 Open Burning	04/12/2006	09/15/2006	$ 2,000	$ 261	$ 2,261
Henderson	2006-172	James Whitaker	2D .1900 Open Burning	06/07/2006	09/21/2006	$ 2,000	$ 195	$ 2,195
Henderson	2006-173	Larry Sweezy and Rita Sweezy	2D .1900 Open Burning	06/07/2006	09/21/2006	$ 750	$ 195	$ 945
Johnston	2006-165	Jerry G Williams and Sons Inc	2D .0521 Control of Visible Emissions Permit A. 10 Permit A.11, A.12, A.13	01/17/2006	09/08/2006	$ 3,500	$ 263	$ 3,763
Macon	2006-174	Sid Burrell d/b/a S & T Construction	2D .1900 Open Burning	04/27/2006	09/21/2006	$ 1,000	$ 247	$ 1,247
Montgomery	2006-128	Capel, Inc.	2Q .0315 Synthetic Minor Facilities	04/04/2006	09/22/2006	$ 500	$ 212	$ 712
Moore	2006-250	Town of Carthage	2D .1900 Open Burning	08/24/2006	09/22/2006	$ 6,000	$ 256	$ 6,256
Moore	2006-251	Ronnie Gray	2D .1900 Open Burning	08/24/2006	09/22/2006	$ 1,500	$ 256	$ 1,756
Moore	2006-252	C & L Grading, Inc.	2D .1900 Open Burning	08/24/2006	09/22/2006	$ 1,500	$ 256	$ 1,756
Onslow	2006-149	C Ray Peele Construction	2D .1900 Open Burning	05/04/2006	09/15/2006	$ 1,500	$ 279	$ 1,779
Pamlico	2006-161	Sarah Fodrey	2D .1900 Open Burning	04/07/2006	09/21/2006	$ 2,250	$ 304	$ 2,554
Pender	2006-151	Walter Lee Costin	2D .1900 Open Burning	05/11/2006	09/08/2006	$ 1,125	$ 228	$ 1,353
Union	2006-169	Union County Customs	2D .1900 Open Burning	04/07/2006	09/22/2006	$ 1,500	$ 202	$ 1,702
Union	2006-183	Davis Steel & Iron Co., Inc.	2D .1900 Open Burning	06/14/2006	09/22/2006	$ 3,000	$ 234	$ 3,234
Union	2006-186	AEP Industries, Inc.	Late Report (excluding ACC)	06/20/2006	09/22/2006	$ 1,000	$ 179	$ 1,179
Wake	2006-050	T R Vernal Paving, Inc.	Late Report (excluding ACC) Permit A.10.b and A.11.b Permit A.15 Permit A.7.a.ii Permit A.7.c.iii	02/02/2006	09/22/2006	$ 2,500	$ 324	$ 2,824

North Carolina Department of Environment and Natural Resources

DIVISION OF WASTE MANAGEMENT

Educating today for a cleaner tomorrow

Environmental Fines -- Underground Storage Tank (UST) Section (Division of Waste Management)

Civil Penalties Assessed During the Month of June 2006

Responsible Party	Facility Name	Violation(s)	Penalty Amount	Date Assessed
Cliff Saint Barnes 209 McKinney Rd. W. Marion, NC McDowell Co.	CJ's Riverside Food Mart] 1247 Hwy. 70 W. Marion, NC McDowell Co.	Violation of 15A NCAC 2N .0304 by failing to provide secondary containment or enhanced leak detection for five UST systems located between 100 and 500 feet of a public water supply well, violation of 15A NCAC 2N .0502 by failing to conduct a valid method of leak detection for three pressurized piping systems, and violation of 15A NCAC 2N .0505 by failing to conduct an annual test of the operation of three automatic line leak detectors.	$5,961.83	6/29/06

Return to NOV-UST page

North Carolina Department of Environment and Natural Resources

Division of Waste Management

Hazardous Waste Section - Civil Penalty Assessments, October 2006

Name	Violation	Penalty Amount	Date Issued
Carolina Analytical Services, LLC 7570 NC Hwy. 902 Bear Creek, NC 27207 NCP 011 706 003 Chatham County	Carolina Analytical Services, LLC: • offered hazardous waste to and shipped hazardous waste by a transporter that had not received an EPA identification number; and • offered hazardous waste to and disposed of hazardous waste at a facility that had not received an EPA identification number and was not permitted as a hazardous waste treatment, storage, or disposal facility;	$11,000	10/19/06

Questions or comments? Email: lebeed.kady@ncmail.net

Return to Civil Penalties Assessment List

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North Carolina Department of
Environment and Natural Resources

Sediment Pollution Control Violations

Civil Penalties for Violations of Sedimentation Pollution Control Act of 1973 (SPCA)

August 1, 2006 through August 31, 2006

Case Number	Person Assessed	County	Amount Assessed
06-012	N. Brunswick -Sanitary District	Brunswick	$76,680.00
06-014	Carolina Investment	Onslow	$20,540.00
06-019	Breakaway Land-Company, Inc.	Madison	$3,200.00
06-028	Crestwood Homes, LLC	Iredell	$2,550.00
06-029	Gabriel Retirement -Services, LLC	Forsyth	$8,845.00
06-030	Lake Hickory -Developers, LLC	Alexander	$43,310.00
06-031	Ashcroft Business -	Rockingham	$5,940.00
06-032	Cabarrus County	Cabarrus	$5,000.00
06-033	Casewell Health -Holdings, LLC	Caswell	$3,200.00

DWQ September 2006 Assessments

Case Number	Owner - Facility	Permit Number	County	Region	As Built Flow MGD	Report Month	Penalty Assessment Approved	Penalty Amount	Enforcement Costs	Total Penalties	Total Cases in Previous 12 Months
LR-2006-0033	Buncombe Properties - Eden's Glen Mobile Village WWTP	NC0068152	Buncombe	Asheville	0.015	7-2006	09/27/06	500.00	100.00	600.00	0
LV-2006-0333	NC Four C's, LLC - High Vista Falls WWTS	WQ0015929	Henderson	Asheville		4-2006	09/01/06	500.00	56.16	556.16	1
LV-2006-0335	Town of Lake Lure - Lake Lure WWTP	NC0025381	Rutherford	Asheville	0.995	2-2006	09/05/06	250.00	126.82	376.82	0
LV-2006-0336	Town of Rosman - Rosman WWTP	NC0021946	Transylvania	Asheville	0.09	3-2006	09/06/06	250.00	126.82	376.82	0
LV-2006-0361	Lake Toxaway Co - Lake Toxaway Co-Golf Course	WQ0000731	Transylvania	Asheville		6-2006	09/25/06	250.00	79.61	329.61	0
RV-2006-0003	Gordon Patrizio - Gordon Patrizio	NC0085448	Buncombe	Asheville	0.00036		09/11/06	500.00		500.00	0
RV-2006-0004	Thomas Drolen - Thomas Drolen	NC0085341	Buncombe	Asheville	0.	8-2001	09/13/06	500.00		500.00	0
RV-2006-0005	Charles Binkelman - Binkelman residence	NC0085456	Buncombe	Asheville	0.0004	8-2001	09/13/06	500.00		500.00	0
RV-2006-0006	John M Pruett - Pruett residence	NC0085464	Buncombe	Asheville	0.00036	8-2001	09/13/06	500.00		500.00	0
SP-2006-0014	Town of Rutherfordton - Rutherfordton WWTP	NC0025909	Rutherford	Asheville	1.	4-2006	09/08/06	1,000.00		1,000.00	9
LV-2006-0337	Town of White Lake - White Lake WWTP	NC0023353	Bladen	Fayetteville	0.8	6-2006	09/11/06	250.00	76.62	326.62	1
LV-2006-0338	Town of St Pauls - St. Pauls WWTP	NC0020095	Robeson	Fayetteville	0.5	6-2006	09/11/06	1,000.00	76.62	1,076.62	3
LV-2006-0339	Robeson County Water Department - Raemon Well WTP	NC0086894	Robeson	Fayetteville	0.	6-2006	09/11/06	350.00	76.62	426.62	0
LV-2006-0344	Town of Rowland - Rowland WWTP	NC0069612	Robeson	Fayetteville	0.387	6-2006	09/05/06	250.00	76.62	326.62	1
LV-2006-0345	Town of Star - Star WWTP	NC0058548	Montgomery	Fayetteville	0.6	6-2006	09/05/06	1,250.00	193.14	1,443.14	10
PC-2006-0037	Primrose Villa Inc - Primrose Villa Incorporated-Retiremt	WQ0010938	Harnett	Fayetteville			09/13/06	10,000.00	483.78	10,483.78	0
PC-2006-0040	Value Place LLC - Value Place Hotel-Walter Reed Road	NCR000137	Cumberland	Fayetteville			09/27/06	600.00	70.41	670.41	0
LR-2006-0029	RDH Tire & Retread - RDH Tire & Retread	NC0075523	Rowan	Mooresville	0.	6-2006	09/06/06	500.00	100.00	600.00	0
LV-2006-0356	Ridge Community Sewer Association - Ridge Community WWTP	NC0069175	Gaston	Mooresville	0.01	5-2006	09/13/06	945.00	80.15	1,025.15	5
LV-2006-0370	City of Claremont - McLin Creek WWTP	NC0081370	Catawba	Mooresville	0.3	6-2006	09/29/06	1,000.00	80.15	1,080.15	2
DV-2006-0009	City of Durham - Durham Collection System	WQCS00005	Durham	Raleigh	40.		09/12/06	32,000.00	1,431.14	33,431.14	0
LR-2006-0030	Nash/Rocky Mount Schools - Southern Nash High School	NC0037915	Nash	Raleigh	0.015	7-2006	09/26/06	8,000.00	100.00	8,100.00	4
LV-2006-0127	Town of Scotland Neck - Scotland Neck WWTP	NC0023337	Halifax	Raleigh	0.675	12-2005	09/11/06	2,175.00	148.89	2,323.89	0
LV-2006-0315	Halifax County Schools - Bakers Elementary School WWTP	NC0038636	Halifax	Raleigh	0.0073	5-2006	09/12/06	250.00	49.07	299.07	1
LV-2006-0317	Town of Pinetops - Pinetops WWTP	NC0020435	Edgecombe	Raleigh	0.3	10-2005	09/01/06	250.00	47.79	297.79	1
LV-2006-0332	Trails Property Owners Assoc - Trails WWTP	NC0042285	Orange	Raleigh	0.04	6-2006	09/07/06	405.00	44.49	449.49	5
LV-2006-0350	Wake County - Mount Auburn Training Center	NC0049034	Wake	Raleigh	0.0024	4-2006	09/12/06	250.00	53.07	303.07	2
LV-2006-0351	Pope Industrial Park II Ltd Partnership - Pope Industrial Park	NC0060526	Wake	Raleigh	0.008	4-2006	09/12/06	812.50	53.07	865.57	7
PC-2006-0033	Aqua North Carolina Inc - Governors Club	WQ0000088	Chatham	Raleigh	0.1725	3-2006	09/08/06	300.00	58.91	358.91	0
PC-2006-0038	Lee's Long Term Care Facility - Lee's Long Term Care Facility	WQ0015393	Wake	Raleigh	0.00455		09/27/06	350.00	95.48	445.48	0
SP-2006-0004	Town of Scotland Neck - Scotland Neck WWTP	NC0023337	Halifax	Raleigh	0.675		09/08/06	15,128.85	506.78	15,635.63	0
CV-2006-0016	Town of Edenton - Wharf Landing Sewer Extension	WQ0024686	Chowan	Washington			09/12/06	1,279.70	.00	1,279.70	0
LV-2006-0357	Town of River Bend - River Bend WWTP	NC0030406	Craven	Washington	0.33	9-2005	09/18/06	1,000.00	34.00	1,034.00	0

DWQ September 2006 Assessments

Case Number	Owner - Facility	Permit Number	County	Region	As Built Flow MGD	Report Month	Penalty Assessment Approved	Penalty Amount	Enforcement Costs	Total Penalties	Total Cases in Previous 12 Months
LV-2006-0358	Town of River Bend - River Bend WWTP	NC0030406	Craven	Washington	0.33	10-2005	09/18/06	1,250.00	34.00	1,284.00	0
LV-2006-0340	Brunswick County - Carolina Shores WWTF	NC0044873	Brunswick	Wilmington	0.53	2-2006	09/05/06	1,500.00	61.24	1,561.24	4
LV-2006-0341	Town of Lake Waccamaw - Lake Waccamaw WWTP	NC0021881	Columbus	Wilmington	0.4	2-2006	09/05/06	250.00	61.24	311.24	0
LV-2006-0342	City of Whiteville - Whitemarsh WWTP	NC0021920	Columbus	Wilmington	3.	2-2006	09/05/06	1,000.00	61.24	1,061.24	4
LV-2006-0343	Scientific Water & Sewerage Corporation - Lauradale WWTP	NC0036226	Onslow	Wilmington	0.4	2-2006	09/05/06	500.00	61.24	561.24	1
LM-2006-0045	Tweetsie Railroad - Tweetsie Railroad	NC0032131	Watauga	Winston-Salem	0.07	6-2006	09/21/06	500.00	104.00	604.00	0
LV-2006-0346	Hilltop Living Center - Hilltop Living Center	NC0059536	Davidson	Winston-Salem	0.003	6-2006	09/08/06	250.00	117.20	367.20	4
LV-2006-0347	Head Mobile Home Park - Head Mobile Home Park	NC0057223	Forsyth	Winston-Salem	0.0016	5-2006	09/06/06	100.00	94.00	194.00	3
LV-2006-0348	High Point Healthcare, Inc. - High Point Healthcare	NC0046035	Forsyth	Winston-Salem	0.01	5-2006	09/06/06	200.00	94.00	294.00	0
LV-2006-0354	Town of Yanceyville - Yanceyville WWTP	NC0040011	Caswell	Winston-Salem	0.45	6-2006	09/12/06	500.00	93.35	593.35	1
LV-2006-0362	Aqua North Carolina Inc - Greystone Subdivision WWTP	NC0078115	Forsyth	Winston-Salem	0.032	6-2006	09/25/06	250.00	96.00	346.00	1
PC-2006-0039	County Of Rockingham - Rockingham Water and Sewer Highway 220	NCR000069	Rockingham	Winston-Salem			09/21/06	1,500.00	95.00	1,595.00	0
Total Cases:	45										

CAMA Rules & Policies :: Enforcement

CAMA permits are intended to protect the environment, public-trust rights and the economy of the North Carolina coast. To ensure that Coastal Resources Commission regulations are followed, Coastal Management employs a number of compliance tools. For example, DCM staff monitor projects that have received major or general permits to make sure they are being carried out correctly. Staff also conduct routine aerial surveillance to look for unpermitted activity.

The division's most critical compliance tool is enforcement. Someone is determined to be in violation when they begin development in an Area of Environmental Concern (AEC) without a valid CAMA permit or if any of their CAMA-permitted work does not comply with the issued permit. Once a violation has occurred, Coastal Management staff can issue a violation notice, halt development in progress, require restoration of the site and assess a penalty for the violation.

In dealing with violations, Coastal Management's first priority is to seek resource recovery through prompt, voluntary restoration of the damaged area. The division's enforcement authority allows the division to require restoration for activity that could not be permitted, and to assess civil penalties of up to $2,500 per day for unpermitted work. The division issues about 150 violation notices each year; most penalties assessed are between $150 and $500. Fines collected are deposited into the state's General Fund and are turned over to local school boards as required by law.

If you suspect a CAMA violation has occurred, contact the Coastal Management office nearest you. Office numbers are available on the "Contact DCM" link at the top of this page.

Want to know more about enforcement? Check out the Enforcement FAQs and the Enforcement Process Flowchart (in PDF format).

CAMA violation notices: August 2006

The Division of Coastal Management issued the following violation notices during August. Penalties are not assessed at the time the violation notices are issued; they are assessed later.

Elizabeth City District:

Harold Capps, Currituck County, unauthorized major development by engaging in land disturbing activity within 75' of normal water level including filling of Section 404 Wetlands within the Estuarine Shoreline Area of Environmental Concern adjacent to Currituck Sound.

Estate of John Dusewicz (c/o Leeann Kirkley) and David Neal (contrator), Dare County, unauthorized minor development by constructing a swimming pool with deck, hot tub, and gravel parking area within the Ocean Erodible Area of Environmental Concern adjacent to the Atlantic Ocean.

Reed Meredith, Dare County, unauthorized major development by relocating a floating dock system and the unauthorized construction of jet ski ramps within the Estuarine Waters, Estuarine Shoreline, and Public Trust Area Areas of Environmental Concern in and adjacent to Roanoke Sound.

Morehead City District:

Glovers Creek Development LLC (c/o John Fulcher), Carteret County, violation of terms and conditions of CAMA Minor Permit no. 334-06 by exceeding the authorized area permitted for land disturbing activity within the Estuarine Shoreline Area of Environmental Concern adjacent to Core Sound.

Charles Mason Sr., Carteret County, unauthorized major development by replacing a bulkhead in the man-made canal system contiguous with Core Sound within the Estuarine Waters and Estuarine Shoreline Areas of Environmental Concern.

Sandy Point Homeowners Association (c/o Eugene August), Carteret County, unauthorized major development and violation of the State's dredge and fill law by excavating Coastal Wetlands within the Estuarine Shoreline Area of Environmental Concern adjacent to the Neuse River.

Washington District:

Amy Johnson, Hyde County, unauthorized major development and violation of the State dredge and fill law by filling and grading Coastal Wetlands adjacent to the Pamlico Sound.

Wilmington District:

IOM Developers (c/o Freddie Stancil) and A.D. Register (contractor), Onslow County, unauthorized major development by constructing a pier with a T-head platform within the Estuarine Waters and Public Trust Area Areas of Environmental Concern in Chadwick Bay.

Forest by the Sea Homeowners Association (c/o Loretta Whelan), New Hanover County, violation of terms and conditions of State Permit No. 56-79 by failing to install a permanent pump-out sewage disposal facility at the authorized marina in accordance with permit conditions and terms.

Dockside Marina (c/o James Bain), New Hanover County, violation of terms and conditions of State Permit No. 20-89 by failing to install a permanent pump-out sewage disposal facility at the authorized marina in accordance with permit conditions and terms.

Pender Marina Holdings, Harbour Village Marina Inc. (c/o Rick Turner) and Bernard O. Medina (contractor), Pender County, unauthorized minor development by constructing a nonwater dependent concrete sidewalk and pads within the Estuarine Shoreline Area of Environmental Concern buffer.

Creekside Yacht Club Inc. (c/o Tommy Vann), New Hanover County, violation of terms and conditions of State Permit No. 178-85 by failing to install a permanent pump-out sewage disposal facility at the authorized marina in accordance with permit conditions and terms.

Joseph Johnson III, New Hanover County, unauthorized minor development by constructing a concrete driveway within the Estuarine Shoreline Area of Environmental Concern adjacent to Middle Sound.

Crockers Landing (c/o Terry Wilder), New Hanover County, violation of terms and conditions of State Permit No. 123-85 by failing to install a permanent pump-out sewage disposal facility at the authorized marina in accordance with permit conditions and terms.

Waterfront Villas and Yacht Club (c/o Stewart Pittman), New Hanover County, violation of terms and conditions of State Permit No. 168-96 by failing to install a permanent pump-out sewage disposal facility at the authorized marina in accordance with permit conditions and terms.

Bridge Tender Marina (c/o Johnnie Baker), New Hanover County, violation of terms and conditions of State Permit No. 127-89 by failing to install a permanent pump-out sewage disposal facility at the authorized marina in accordance with permit conditions and terms.

The Tides Homeowners Association, New Hanover County, violation of terms and conditions of State Permit No. 30-91 by failing to install a permanent pump-out sewage disposal facility at the authorized marina in accordance with permit conditions and terms.

Dolphin Bay Homeowners Association (c/o Michael Ayers), New Hanover County, violation of terms and conditions of State Permit No. 61-91 by failing to install a permanent pump-out sewage disposal facility at the authorized marina in accordance with permit conditions and terms.

Gray Gables (c/o Dean Hardison), New Hanover County, violation of terms and conditions of State Permit No. 90-84 by failing to install a permanent pump-out sewage disposal facility at the authorized marina in accordance with permit conditions and terms.

Pleasure Island Marina (c/o Steve MacCurry), New Hanover County, violation of terms and conditions of State Permit No. 17-97 by failing to install a permanent pump-out sewage disposal facility at the authorized marina in accordance with permit conditions and terms.

Charles DeVane and Charlie Perry (contractor), Brunswick County, unauthorized major development by constructing a pier and L-head platform within the Estuarine Waters and Public Trust Area Areas of Environmental Concern adjacent to the Atlantic Intracoastal Waterway.

Kent Warlick, Pender County, unauthorized major development by constructing a boathouse, personal watercraft docks, and floating docks within the Estuarine Waters and Public Trust Area Areas of Environmental Concern in the NE Cape Fear River.

2006 reports
2005 reports
2004 reports
2003 reports
2002 reports
2001 reports

Last Modified: October 03, 2006

NCDENR . Division of Coastal Management . 1638 Mail Service Center . Raleigh, NC 27699-1638 .
919-733-2293 . 1-888-4RCOAST . E-mail Us

Candlelight Reflections

to honor, hope and remember

November is **National Alzheimer's Disease Awareness Month** and **National Family Caregiver Month**

Candlelight Reflections will honor all those who have been or are currently affected by Alzheimer's disease and related disorders as well as all family caregivers. From all across North Carolina, people are joining to participate in and/or host local Candlelight Reflections on November 1st.

Families provide at least 80% of all long term care—an enormous contribution to the long term care system. In North Carolina, 1.7 million adults are caring for an older person—more than 28% of the adult population. Over 40% of North Carolina caregivers take care of someone with a memory disorder like Alzheimer's disease. Their "caregiving career" will last an average of 8 years but may be as long as 20.

One in ten Americans say that they have a family member with Alzheimer's and one in three know someone with the disease. Alzheimer's disease is now the fifth leading cause of death in the United States following heart disease, cancer, cerebrovascular disease, and chronic lower respiratory diseases.

In North Carolina alone, an estimated 132,000 have the disease. Over the next 20 years, this number is expected to increase to 253,000 residents. More than 70% of people with Alzheimer's disease live at home and are cared for by family and friends.

Please join us on November 1st through Candlelight Reflections. Our hope is that the flame of each candle will enlighten our communities and state leaders as to the growing numbers of those living with Alzheimer's and the critical need to support all family caregivers.

Contact:

- Eastern North Carolina Chapter: **(919) 832-3732** or **www.alznc.org**
- Western Carolina Chapter: **(704) 532-7392** or **www.alz-nc.org**
- Duke Bryan Alzheimer's Disease Research Center (ADRC) African-American Community Outreach Program (AACOP): **866-444-2372**
- A list of local Area Agency on Aging Family Caregiver Resource Specialists can be found at **www.dhhs.state.nc.us/aging/fcaregr/fcjobs.htm**
- or call the NC Division of Aging and Adult Services at **(919) 733-3983.**

alzheimer's association®
nc family caregiver support program

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2005

H
2

HOUSE BILL 2059*
Committee Substitute Favorable 6/7/06

Short Title:	LTC Fines Posted on Internet.	(Public)
Sponsors:		
Referred to:		

May 18, 2006

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, TO POST THE FINES AND PENALTIES ASSESSED TO LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Facility Services, shall establish and maintain a list of fines and penalties imposed on nursing homes licensed pursuant to Article 6 of Chapter 131E of the General Statutes, and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes, along with a record of fines or payments made pursuant to settlement agreements and the dates such payments were made. The list shall be accessible on the Internet and implemented not later than October 15, 2006. The Department shall report on the implementation of the list to the North Carolina Study Commission on Aging not later than November 1, 2006.

SECTION 2. This act is effective when it becomes law.

This document (also available in PDF and RTF formats) is not an official document.
Please read the NCGA Web Site disclaimer for more information.

Home Page, Division of Facility Services - Netscape

File Edit View Go Bookmarks Tools Window Help

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

Home Netscape Search

Netscape Enter Search Terms Form Fill Clear Browser History News Email Weather

North Carolina
Department of Health and Human Services

The Division of Facility Services (DFS) regulates medical, mental health and group care facilities, emergency medical services, and local jails. We ensure that people are safe, and that the care in these facilities is adequate. We make certain that medical facilities are built only when there is a need for them.

Department of Health and Human Services	North Carolina Home Page	New Adult Care Home Fines and Nursing Home Inspection Information	New Filing a Complaint Against Healthcare Facilities/Homes	EMS Kids Page

What We Do
Section Descriptions and Contact Information

What's New?
The Latest News in the Division

Directory of Regulated Facilities
Reports of Facilities and Services (PDF)

Regulated Facilities Listing
List of Facilities and Services (ASCII Text)

For Citizens
Helpful Information About Facilities and Services

For Providers
Helpful Information for Providers

Request Form
Request More Information

Forms and Applications
On-Line Forms and Applications

start statutory recommend... Intro for Barbara R... Home Page, Division... 6:59 AM

Division of Facility Services Long Term Care Fines and Survey Findings

NOTES: Click here to view facility fine information Penalties Imposed Since January 2006.

Introduction

North Carolina's Adult Care Home Fines and Nursing Home Inspection Information is part of DHHS's ongoing effort to provide information to citizens and family members faced with difficult health care decisions. A listing of adult care homes or nursing homes can be obtained on the home page of this web site http://facility-services.state.nc.us -- Directory of Regulated Facilities. The listings allow you to search for adult care homes or nursing homes in North Carolina by county.

Difference in Adult Care Homes from Nursing Homes

The primary difference between adult care homes and nursing homes is as follows:

"Adult Care Homes" provide care and assistance to people with problems carrying out activities of daily living and supervision to people with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated, trained staff. Smaller adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

"Nursing Homes"are for people who need chronic or rehabilitative care, who, on admission are not acutely ill and who do not usually require special facilities such as an operating room, X ray facilities, laboratory facilities, and obstetrical facilities. A "nursing home" provides care for people who have remedial ailments or other ailments, for which medical and nursing care are indicated; who, however, are not sick enough to require general hospital care. Nursing care is their primary need, but they will require continuing medical supervision.

Information on This Site

There are necessary regulatory delays between when an adult care home or nursing home is inspected and when fines or findings from the inspection will appear on this web site. Therefore, when visiting an adult care home or nursing home, we encourage you to request copies of more recent inspection results.

Every effort is made to ensure accuracy of the information on this web site; however, corrections, comments, and suggestions are welcome and can be made by e-mailing: WebMaster.DFS@ncmail.net.

Inspections

The goal of inspections is to assess how well the adult care home or nursing home complies with applicable laws and regulations affecting the quality of care provided. Inspections are typically conducted on an annual basis and when the State receives (hyperlink to complaint line info) complaints. All inspections are unannounced. Inspections conducted on an annual basis typically last one to four days. Complaint inspections may last one or more days depending

upon the number of allegations and what inspectors find during the course of the inspection.

Regarding adult care home inspections, one possible result of an inspection is the imposition of fines due to "Type A" violation, which is defined as a condition or conditions that have resulted in death or serious physical harm to a resident or are likely to result in death or serious physical harm. The range for a "Type A" violation is $500.00 to $10,000 for each Type A Violation in homes licensed for six or fewer beds and $1,000 to $20,000 for each Type A Violation in facilities licensed for seven or more beds.

Another sanction that could result in the imposition of fines would be due to a "Type B" violation, which is an identified condition which impacts the quality of care of the residents in the adult care home but has not been corrected by the facility after the State has allowed the facility a reasonable period of time to correct. The range for a "Type B" violation is up to $400.00 for each day that the deficiency continues beyond the date specified for correction without just reason for such failure. Please note that adult care homes have the right to appeal the imposition of fines by filing an appeal with the North Carolina Office of Administrative Hearings. If a fine is appealed, it may go to hearing or a settlement may be reached between the State and the facility.

Regarding nursing home inspections, some nursing homes are state-licensed, but not Medicare/Medicaid certified. Of the 436 nursing homes in North Carolina, 15 are not Medicare/Medicaid certified. These "licensed only" homes that have had a state fine imposed (Type A or Type B violation) will be posted on this website. The Centers for Medicare and Medicaid Services has the authority to impose civil money penalties in nursing homes participating in the Medicare and Medicaid programs. The fines for these facilities can be obtained through a freedom of information request at Freedom of Information Act Request Form [PDF, 42KB]. The Nursing Home Inspection Information can be accessed at Centers for Medicare and Medicaid Services web site with instructions on how to scroll down and click on "Compare Nursing Homes in Your Area."

For both adult care homes and nursing homes, months will typically pass between inspections and much could change for the better or worse in a facility between inspections. Therefore, it is advised that you inspect the facility yourself before making such an important decision.

NOTES: To view the rule that was cited and resulted in the imposition of the fine or penalty, CLICK on the BLUE text under "Reason for Issuance"

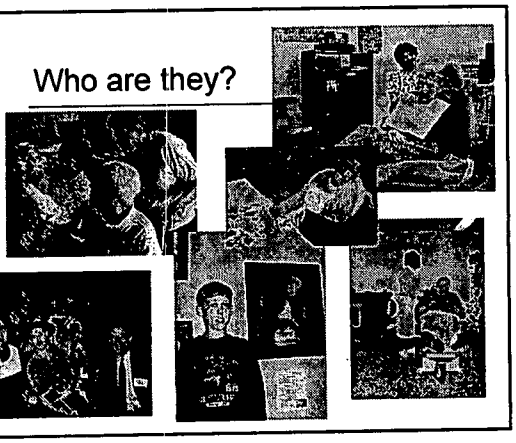
COUNTY	FACILITY NAME	LICENSE NUMBER	PENALTY ISSUED DATE	PENALTY AMOUNT	REASON FOR ISSUANCE	CURRENT DISPOSITION	Amount Paid	DATE OF PAYMENT
Cleveland	Brooks Family Care Home	FCL-023-024	09/14/2006	$2,340.00	10A NCAC 13G .1002 Medication Orders; 13G .1004 Medication Administration			
Cleveland	Openview Retirement Center	HAL-023-004	01/23/2006	$2,000.00	10A NCAC 13F .0307 Fire Alarm System; 13F .0901(b) Personal Care and Supervision; 13F .1212(a) Reporting of Accidents and Incidents; 13F .0407(a) Other Staff Qualifications	Paid	$2,000.00	03/28/2006
Craven	Homeplace of Newbern	HAL-025-014	01/12/2006	$2,000.00	10A NCAC 13F .0305 Physical Environment; 13F .1304 Special Care Unit Bldg. Requirements; GS 131D-21 (2) Declaration of Residents' Rights	Paid	$2,000.00	02/02/2006
Cumberland	Forest Hills Rest Home	HAL-026-003	01/23/2006	$2,700.00	10A NCAC 13F .1004 Medication Administration GS 131D-21 (2) Declaration of Residents' Rights	Paid	$2,700.00	03/29/2006
Cumberland	Forest Hills Rest Home	HAL-026-003	01/23/2006	$3,000.00	10A NCAC 13F .1004 Medication Administration GS 131D-21 (2) Declaration of Residents' Rights	Paid	$3,000.00	03/29/2006
Duplin	Golden Care	HAL-031-003	09/14/2006	$2,960.00	10A NCAC 13F .0407(a)(5) Other Staff Qualifications; 13F .0507 Training on Cardio-Pulmonary Resuscitation GS 131D-21(2) Declaration of Residents' Rights			
Franklin	Alston Family Care Home	FCL-035-008	07/14/2006	$2,040.00	10A NCAC 13G .0405 Test For Tuberculosis GS 131D-21 (2) Declaration of Residents' Rights	Paid	$2,040.00	09/18/2006
Graham	R&M Family Care Home	FCL-038-004	01/12/2006	$1,000.00	10A NCAC 13G .0801 (c)(d) Resident Assessment; 13G .1002(a) Medication Orders; 13G .1004(a) Medication Administration; GS 131D-21(2) Declaration of Residents' Rights	Paid	$1,000.00	03/24/2006
Guilford	Friendship Care	HAL-041-002	08/22/2006	$3,920.00	10A NCAC 13F .0703 Tuberculosis Test, Medical Examination and Immunizations; 13F .1004 Medication Administration; GS 131D-21 (2) Declaration of Residents' Rights			
Guilford	Friendship Care Assisted Living	HAL-041-002	07/14/2006	$12,000.00	10A NCAC 13F .0909 Resident Rights GS 131D-21 (2)(4) Declaration of Residents' Rights			
Guilford	Piedmont Christian Home	HAL-041-010	09/06/2006	$12,000.00	10A NCAC 13F .0901(b) Personal Care and Supervision; 13F .0902(b) Health Care; 13F .0909 Residents Rights GS 131D-21 Declaration of Residents' Rights			

COUNTY	FACILITY NAME	LICENSE NUMBER	PENALTY ISSUED DATE	PENALTY AMOUNT	PENALTY TYPE	REASON FOR PENALTY ISSUANCE		CURRENT STATUS	Amount Paid	DATE OF PAYMENT
						RULE CITED	NATURE OF VIOLATION			
Alamance	L M & S Adult Care NO 2	FCL-001-063	07/14/2006	$1,350.00	Not corrected Type B	10A NCAC 13G .0406 Other Staff Qualifications	Criminal background checks for4 staff members were not done before hiring	Partial pmt.	$500.00	09/14/2006
Brunswick	Eldo Family Care Home #1	FCL-010-002	04/07/2006	$500.00	Type A	10A NCAC 13G .0601 Management and Other Staff	Nine (three that lived in the facility and 6 from another facility) residents were left unattended and unsupervised by staff	Paid	$500.00	06/08/2006
Buncombe	Dominion Falls Family Care Home	FCL-011-139	04/06/2006	$500.00	Not corrected Type A	10A NCAC 13G .0909 Resident Rights; 13G .0601 Management and Other Staff; GS 131D-21 Declaration of Residents' Rights	Staff left two residents alone and unsupervised			
Buncombe	Marjorie McCune Memorial Ctr.	HAL-011-011	01/23/2006	$3,000.00	Type A	10A NCAC 13F .0909 Resident Rights; 13F .0902 Health Care; GS 131D-21(2)(4) Declaration of Residents' Rights	Resident receiving Coumadin did not have lab work performed as ordered	Paid	$3,000.00	06/19/2006
Buncombe	Marjorie McCune Memorial Ctr.	HAL-011-011	04/10/2006	$900.00	Not corrected Type A	10A NCAC 13F .0902 Health Care; 13F .0909 Residents Rights; GS 131D-21 Declaration of Residents' Rights	Resident receiving Coumadin did not have lab work performed as ordered	Paid	$900.00	06/30/2006
Buncombe	Richmond Hill Rest Home #3	HAL-011-190	07/14/2006	Staff Training	Type A	10A NCAC 13F .0601 Management of Facilities with a Capacity or Census of Seven to Thirty Residents; 13F .0909 Residents Rights; GS 131D-21 (4) Declaration of Residents' Rights	Staff left residents alone and unsupervised to attend meeting.			
Buncombe	Richmond Hill Rest Home #4	HAL-011-189	06/02/2006	$1,000.00	Type A	10A NCAC 13F .0902 Health Care (a)(b)(c); 13F .0909 Residents' Rights; GS 131D-21 (2) Declaration of Residents' Rights	Resident receiving Coumadin did not have lab work performed as ordered	Paid	$1,000.00	07/21/2006
Burke	Longview Assisted Living	HAL-012-022	01/23/2006	$1,350.00	Not corrected Type B	10A NCAC 13F .1001 Medication Administration Policies and Procedures; 13F .1004(a) Medication Administration; GS 131D-21 (2) Declaration of Residents' Rights	Residents did not receive medications as ordered			
Cabarrus	Concord House	HAL-013-031	06/02/2006	$3,420.00	Not corrected Type B	10A NCAC 13F .1004(e) Medication Administration; GS 131D-21 (2) Declaration of Residents' Rights				
Cabarrus	Concord House	HAL-013-031	09/14/2006	$12,000.00	Type A	10A NCAC 13F .1004 Medication Administration; GS 131D-21 Declaration of Residents' Rights		Appealed		
Caswell	Jones Family Care #4	FCL-017-030	01/26/2006	$1,000.00	Type A	10A NCAC 13G .0901(b) Personal Care and Supervision; GS 131D-21 Declaration of Residents' Rights	Resident locked out of facility and left unsupervised until staff returned.	Paid	$1,000.00	03/08/2006

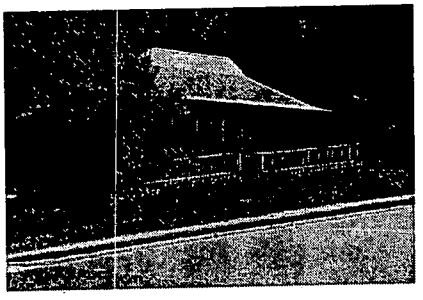
Serving North Carolina's Special Care Populations

North Carolina Study Commission on Aging
October 25, 2006
Dr. Bill Milner
Dr. Ford Grant

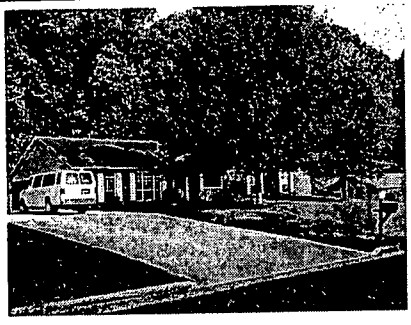
Who are they?



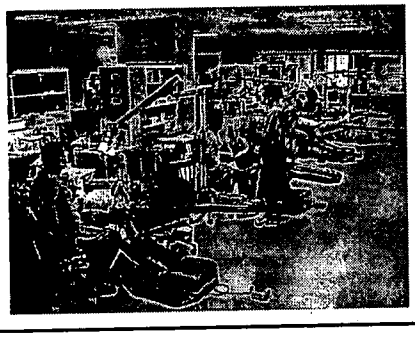
No Access for the Frail Elderly and Disabled



No Access for the Intellectually Disabled



No Professional Training



A Costly Public Health Issue

Existing Service Models Stretched to Breaking Point

Can We Build It?

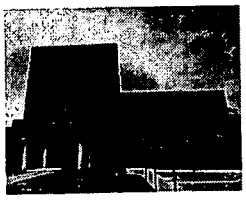
- Support and expand comprehensive, quality programs.
- Coordinate services using the existing network.
- Train a statewide workforce of medical and dental providers.

If We Build It, What Is The Cost?

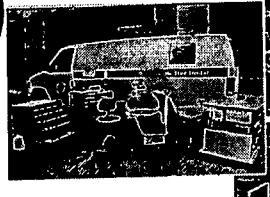
If We Build It, What Is The Cost?		$1,000,000
Total served	8,000 beds	
Current Service Support	Funding of non-profits - Carolinas Health Care/Carolinas Mobile Dentistry, Charlotte and Access Dental Care, Greensboro. (6,000 beds/15 Piedmont counties)	$800,000
Program Expansion	Add an additional service region (2,000 beds/Triangle, Asheville or Greenville)	$200,000

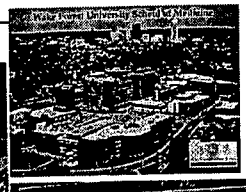
Who Provides Services Now?

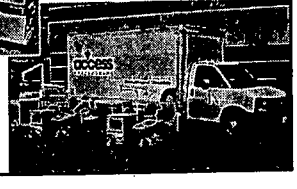
State/County Funded Programs



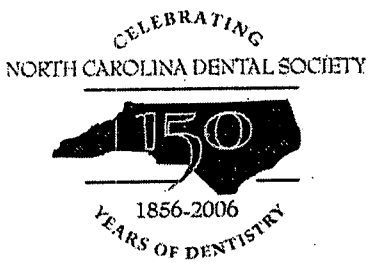
Non-Profits







Private Sector



Who Supports This Because They Are Aware of the Need?

- North Carolina Dental Society
- North Carolina Council on Developmental Disabilities
- North Carolina AARP
- North Carolina Arc
- North Carolina AHEC
- Access Dental Care
- Carolinas Health Care – Carolinas Mobile Dentistry

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — October 25, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
William L. Warren	Division of Facility Services, DHHS
Bob Fitzgerald	"
Barbara Ryan	"
Becki Gray	Civitas Institute
Joanne Stern	nursing
[illegible]	NCAHC / FIS
Evelyn Hawthorne	EHGR
Jean Reaves	NC Coalition on Aging
Bill Rusoni	[illegible]
Thomas R. Konrad	Friends of Residents of LTC
Lynette Zeb	HHS

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — October 25, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lao Rubsnt	CSPC
Jim Elgin	DHHC
Hugh Wilson	NCHA
Dana Simpson	Smith Anderson
Mike James	DCP
Stephen Morris	ACP
[illegible]	HHS
Bill Walker	AARP
Patrick T. Biffle	Alley Associates, Inc.

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — October 25, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Payne + Spruill
Diane Cox	DHHS
Polly Williams	Friends of Residents in Long Term Care/Justice Center
Mary Bethel	AARP-NC
Abby Emanuelson	NMSS-NC
Roger Bone	Bone & Assoc
Lee Hilson	NCCUCF
[illegible]	[illegible]
DR. FORD T. Grant	Carolinas Mobile Dentistry Charlotte, NC
Sam Smith	WCSP
Dr. Bill Milner	NC Dental Society

VISITOR REGISTRATION SHEET

N.C. STUDY COMMISSION ON AGING — 10-25-06

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
LOUISE E. BROWN	149 SPRING GARDEN CIR. HIGH POINT NC 27260
Danny R. Bowland	2239 Rocklane Dr., Burlington, N.C. 27215
Rebecca Bayse	JW Faison Senior Center Po Box 634 Jackson, NC 27845
Beatrice Jefferson	Jackson, N.C. 27845 P.O. Box 3649
Lois Farmer	1904 Morningside Dr Apt E Burlington, N.C. 27217
Holly Long	1272 Holmes Lane Mebane, NC 27302
SUSAN Clark	1272 Holmes Lane, Mebane, NC 27302
Sue Lamm-Gurley	1515 McCuiston Dr. Burlington, NC 27215
W. Ad Pauline Thornton	4270 Euliss Rd. Burlington, NC 27215
Bill Carothers	1528 S. Mebane St. #1103k Burlington N.C. 27215
Norman Melton	NAMI & Board LME 6219 Mt. Herman Rock Creek Rd ~~Snow Camp, N.C. 27349~~

VISITOR REGISTRATION SHEET

N.C. STUDY COMM. ON AGING — 10-25-80

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Anne Arnett	Hospice of Wake County
Linda Marsh	Hospice of Wake County Horizons Home & Palliative Care.
Rosa L. Flowe	2513 Hyde St Burlington, NC 27217
Rose Vincent	2317 Morningside Dr Burlington NC 27217
Gayle Alexander	1880 Brookwood Ave #120 Burlington, NC 27215
Helen Brennan	ARMC - Geriatric Development P.O. Box 202, Burlington, NC 27215
Frances Gerringer	4307 N NC 87 Elon NC 27244
HULON GERRINGER	4307 N. N.C. 87 ELON, N.C. 27244
Sister Inez D. Cavin	Sr. Legislative Advocate Alz. Co. Planning Com Service for Elderly 211 Banks St, Graham, N.C. 27253
Sandi Throckmorton	Alamance-Caswell-Rockingham LME & Gibsonville Senior Ctr 400 Steele St, GBV 27249
Myrtle Robinson	Hospice & Palliative Care of Greensboro 2500 Summit Ave G'boro, NC 27405
Terri Prots	Moore County Dept. of Aging & Senior Enrichment Center PO Box 487/302 Monroe St. Carthage, NC 28327
Jill Sherman	Moore County Dept. of Aging & Sr. Enrichment Ctr. P.O. Box 487, Carthage, NC 28327

VISITOR REGISTRATION SHEET

N.C. STUDY COMM. ON AGING — 10-25-00

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DEE BLACK	ASHEVILLE PARKS + RECREATION
Margaret Kelly	North Carolina Area Agencies on Aging
Diane Robinson	104 Meadowood Dr. Burlington, NC 27215
Barbara Pagliari	Alamance ARMC P.O. Box 202, Burlington, NC 27217
Brenda Porter	Alamance Elder Care PO Box 202 Burlington, NC 27216
Kathleen Vaughn	Alamance Co. DSS
Susan York	Alamance Co DSS 319 N Graham Hopedale Rd Burlington NC 27217
Hilari Boykin	Nash Senior Center Nashville, NC
Kristy Boykin	Nash Senior Center Nashville, NC
John Boykin	Nash Senior Center Nashville, NC
Cathy Green	Transition Coordinator Nash Rocky Mount Schools

October 30, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the NC Study Commission on Aging:

DAY: Wednesday **TIME:** 10:00 A.M.

DATE: November 15, 2006

LOCATION: [redacted]
Legislative Office Building

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, November 15, 2006
10:00 a.m.
Legislative Office Building
Room 544

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Information to Share: (5 minutes alloted)

- **2005 NC Oral Health Summit Access to Dental Care Report**
- **NC Rx Program**

Theresa Matula, Commission Staff, Research Division, NCGA

III. CAP/DA Report (S.L. 2006-109) (20 minutes alloted)

Tracy Colvard, Division of Medical Assistance, DHHS

IV. Status Report: Special Assistance In-Home Slots (15 minutes alloted)

Geoff Santoliquido, Division of Aging and Adult Services, DHHS

V. Securing Wheelchairs in Vans (20 minutes alloted)

Dr. Robert Sullivan

VI. Liability Insurance for LTC Facilities (20 minutes alloted)

Jeff Weber, Attorney, Anderson Weber & Henry

Bill Hale, Department of Insurance

VII. Registered Sex Offenders Residing in LTC Facilities (20 minutes alloted)

Jeff Weber, Attorney, Anderson Weber & Henry

Summary of GAO Report - LTC Facilities:Information on Residents Who Are Sex Offenders or Are Paroled for Other Crimes

Ben Popkin, Commission Staff, Research Division, NCGA

VIII. Meeting Adjourned

Next Meeting:
December 13, 2006 at 10:00 a.m. in Room 643

North Carolina Study Commission on Aging

MINUTES
Wednesday, November 15, 2006
10:00 AM
Room 544, Legislative Office Building

The North Carolina Study Commission on Aging met on Wednesday, November 15, 2006, at 10:00 A.M. in Room 544 of the Legislative Office Building. Members present were: Senator Charlie Dannelly, Co-Chair, Rep. Beverly Earle, Co-Chair; Representatives Bob England and Jennifer Weiss; Mr. Brad Allen, Mr. Sam Marsh, Ms. Judy Pelt and Ms. Linda Howard. Mr. Jackie Sheppard, Ex-Officio Member, was also present.

Representative Earle called the meeting to order. She presided until Senator Dannelly arrived.

PRESENTATIONS

Information to Share: 2005 NC Oral Health Summit Access to Dental Care Report and NC Rx Program

Ms. Theresa Matula, Commission Staff, NCGA Research Division, was the first presenter. Ms. Matula reminded Commission members that at the last meeting one of the questions raised was where the shortages of dentists are. She furnished members with a copy of the NC Oral Health Summit Access to Dental Care Summit Proceedings and Action Plan along with a four page excerpt derived from the complete report. (Attachment 1) The excerpt included a map of NC which identified where the dentists are distributed throughout NC. Also included are recommendations relevant to the older adult population and the mention of Mobile Dental Units from the report included.

Ms. Matula also mentioned that NC has just begun a new senior prescription drug assistance program. Formerly known as Senior Care, it is now called NC Rx. She furnished members with a handout of information and an application packet. (Attachment 2) Applicants must apply before December 31st in order to be eligible to receive benefits during 2007. It will assist enrollees with $18.00 toward their portion of Medicare Part D premiums.

CAP/DA REPORT (S.L. 2006-109)

Tracy Colvard, CAP/DA and PCS Manager with the DHHS Division of Medical Assistance was the next presenter. He stated that his presentation involved the CAP/DA interim report which was submitted to the Commission on November 1, 2006. (Attachment 3) It covered slot issues; waiting list issues and assurance that appropriate clients are being served. He discussed the following report requirements and where the department is with each one.

1. Information on the utilization of CAP/DA slots including the history of slots used over the past 10 years and anticipated need for slots during the next 10 years.
2. A description of the current CAP/DA slot allocation formula and county specific slot information.
3. Information on strategies to ensure that the CAP/DA waiting list is managed as efficiently as possible.
4. Implementation of a uniform screening/assessment toll and other strategies to ensure maximum operation efficiency and effectiveness for those individuals qualifying for CAP/DA services.

At this point, Senator Dannelly took over presiding the meeting. He called for questions and there was a lot of discussion relative to slot allocations and the efficient use of them. Mr. Colvard gave the following responses. Not all counties use all of their slots and they are not reallocated to accommodate other counties. Presently, every penny of the CAP/DA budget is being used. He agreed that there are too many slots for the actual budget and explained that the slots are for one person at one time, a tracking mechanism. The budget for each slot is different based on the service need. Rep. Earle asked Mr. Colvard to furnish the breakdown of slots, counties, and monies utilized. Mr. Colvard stated there are 13,200 slots statewide of which probably 11,200 or 11,500 are being used. (Attachment 3, page 9) He added that apparently there were miscalculations when the slots were given out because the budget is at maximum use. Rep. Earle added that if more money needs to be appropriated, the NCGA needs to know that.

Rep. Weiss asked what is being done to make sure the resources are being utilized intelligently. She said there doesn't seem to be any auditing or evaluation of whether the services that are being provided are appropriate for each person's needs. Mr. Colvard stated that they use the case mix methodology. Based on a person's need, an appropriate budget is assigned in order to avoid someone who doesn't need the services getting services they don't need. Rep. Weiss added that there needs to be better management of the use of how the resources within a slot are allocated. If the monitoring was done more efficiently, the slots could be filled.

Ms. Judy Pelt added that the reimbursements are there for the actual services provided through Medicaid. The administrative cost of the case management position is reimbursed very poorly and there are a lot of county and local administrative dollars involved. One reason there are a lot of vacant positions is because the case management piece is not funded.

Status Report: Special Assistance In-Home Slots

Mr. Geoff Santoliquido, with the DHHS Division of Aging and Adult Services spoke next. Mr. Santoliquido told commission members that an expansion of the Special Assistance In-Home (SA/IH) Slots became possible with the passage of House Bill 2576. The number of slots increased from 1000 to 1500. Prior to the expansion, 72 counties were offering SA/IH. Every County Department of Social Services was notified of the new slots. An Aging Planning Bulletin was developed to help counties get stakeholders energized about the program. (Attachment 4) The response was tremendous and all of the requests were not able to be fulfilled. Fifty-four of the 72 participating counties requested an additional 479 slots. Fifteen of the nonparticipating counties requested 139 slots. Individual counties were contacted and counter proposals presented because they were not able to grant all requests. The 500 slots were distributed appropriately. (Attachment 5) Mr. Santoliquido also furnished a map of NC which showed SA/IH participating counties and the dates they began their programs. (Attachment 6) He stated that the counties that provide the case management component of the SA/IH Program are using a program called At-Risk Case Management which is funded by Medicaid. There is no state funding provided to match the federal funding. This means that the county match requirement is about 36% and the federal government provides the balance. That is a challenge to the counties not participating.

Mr. Santoliquido also furnished commission members with a copy of the brochure counties are using in the communities entitled "An Alternative to Adult Care Living for Eligible Adults". (Attachment 7) The other handout entitled SA In-Home Client Count, 2004-Present was also furnished. (Attachment 8) This handout showed a significant growth curve in clients served.

Securing Wheelchairs in Vans

Dr. Robert Sullivan, a retired physician, gave the next presentation. He told Commission members that he is currently working with Community Care NC and the Division of Facility Services. He stated that he was seeking the assistance of the Commission in protecting the health and safety of NC citizens who are seated in wheelchairs while being transported in vans. Persons are being injured while being transported but there are no statistical records of these incidences because they occur when no accident is involved.

Dr. Sullivan stated that legislation is needed that clarifies the appropriate chair to use when transporting someone in a van, the tie-down system that should be used, and the passenger restraint system that should be provided. He asked for support from the Commission and sponsorship for legislation that will not require state funding and that will facilitate safety for citizens. He furnished a brochure entitled Securing Wheelchairs in Vans. (Attachment 9) This brochure included a summary of the solutions, key elements to incorporate into legislation, letters of support, reports from incident investigations, and a "Ride Safe" article from the University of Michigan.

Registered Sex Offenders Residing in LTC Facilities

Mr. Jeff Weber, Attorney with Anderson Weber & Henry gave a presentation on sex offenders in LTC facilities. He furnished for the record a 2005 Report from A Perfect Cause, America's Disability & Elder Rights Advocates on Predators in America's Nursing Homes and a 2004-2006 report on ongoing Investigations. (Attachments 10 & 11)

Mr. Weber also furnished, for the record, copies of the United States Government Accountability Office Report to Congressional Requesters - Long-Term Care Facilities: Information on Residents Who Are Registered Sex Offenders or Are Paroled for Other Crimes. (Attachment 12) Mr. Weber stated he would furnish more copies later, if necessary.

Liability Insurance for LTC Facilities

Mr. Weber stated that through discussions with NC long term care leaders, insurance companies and brokers, defense and plaintiff's lawyers and various legislators, following are reasons to consider liability insurance for LTC facilities.

- To have minimal professional liability insurance coverage
- To recognize a minimal threshold of financial responsibility
- To screen those who have nothing to offer clients
- To screen the thinly capitalized multiple tier investor
- To lower the cost of litigation
- To allow access to justice for victims and their families
- To encourage long term care facilities to do the right thing
- To ultimately lower the cost of health care

Mr. Sam Marsh stated that he would like to add that there needs to be a cap on the liability awards. Virginia has a cap and that has helped keep premiums down.

Mr. Bill Hale, Special Counsel with the NC Department of Insurance furnished Commission members with a list of NC General Statutes requiring liability insurance. (Attachment 13) There are two types of requirements. One type is where a specific amount is required by statute. The other type is where an agency or board of commission has delegated the authority to set the amount required. Mr. Hale stated that he is not advocating either one.

Summary of GAO Report – LTC Facilities: Information on Residents Who Are Sex Offenders or Are Paroled for Other Crimes

Mr. Ben Popkin, Commission Staff, NCGA Research Division, spoke next. See Attachment 12 for the report. The GAO was asked to look at three specific issues – 1) the prevalence of sex offenders living in LTC facilities and the extent of any abuses that they may have caused, 2) the legal requirement for notifying facilities when sex offenders are residents and 3) the extent to which facilities have different supervision and

separation requirements for offenders as opposed to other residents. Mr. Popkin stated that the FBI's National Sex Offender Registry was used to take a look at the current state of affairs. They found that there were approximately 700 registered sex offenders currently living in nursing homes or intermediate care facilities for people with mental retardation. Approximately 3% of nursing homes and 0.7% of ICFs-MR housed at least 1 identified sex offender during 2005. The GAO concluded that they could not determine any risk that the sex offenders posed on other residents because offender status was not tracked with abuses reported. Facility administrators expressed a great concern over the risk to residents posed by cognitively impaired or mentally ill residents as opposed to the registered sex offenders. Federal law requires state law enforcement agencies to release relevant information about registered sex offenders when necessary to protect the public, but how states do so is at the state's discretion. Mr. Popkin stated that LTC facilities contacted do not routinely impose different supervision or separation requirements on residents who are offenders based solely on their prior convictions. Instead, facilities base such decisions on the demonstrated behaviors of residents.

Mr. Popkin added that the GAO further recommended that the FBI assess the current completeness of the NSOR and evaluate more options to make it more comprehensive. See Attachment 14.

Mr. Popkin added that he would look into whether facilities could share information with staff and others about residents who were known offenders in light of the Privacy Rule issued under HIPPA.

The meeting adjourned at 11:55am.

Charlie S. Dannelly

Senator Charlie Dannelly, Co-Chair
Presiding

Beverly Earle

Rep. Beverly Earle, Co-Chair

Dee Hodge

Dee Hodge
Commission Assistant

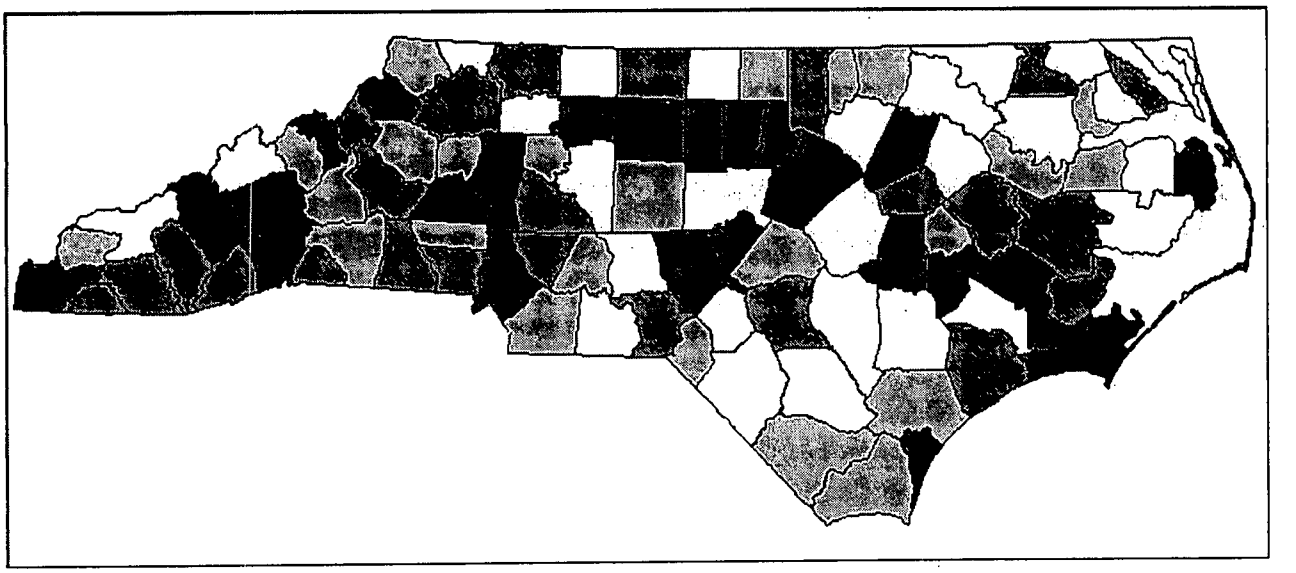
2005 North Carolina Oral Health Summit Access to Dental Care Summit Proceedings and Action Plan

Selected Excerpts

(Content has been reformatted)

Excerpts from pages 15-26 pertaining to Increasing the Overall Supply of Dentist and Dental Hygienists in the State with a Particular focus on Efforts to Recruit Dental Professionals to Underserved Areas and to Treat Underserved Populations.

Map 1. Dentists per 10,000 Population, North Carolina, 2003.



Dentists per 10,000 Population (# of Counties)	
3.70 to 10.77	(24)
2.67 to 3.69	(24)
1.94 to 2.66	(24)
0.01 to 1.93	(24)
No Active Dentists	(4)

One of the major concerns addressed in the 1999 NC IOM Dental Care Access Report was the limited supply of dental professionals in North Carolina.

- In 1999, the dentist-to-population ratio was 4.0 dentists per 10,000 people, and the dental hygienist-to-population ratio was 4.6 per 10,000.
- In 2004, the supply of dental professionals in North Carolina was still grim, with a dentist-to-population ratio of only 4.1 dentists per 10,000 people. This rate placed North Carolina 47th out of the 50 states, well below the national average of 5.8 dentists per 10,000 people.
- Even more staggering is the unequal distribution of dentists across counties. Four of North Carolina's 100 counties, all in the eastern part of the state, have no practicing

dentists, and only eight counties have a dentist-to-population ratio equal to or greater than the national average (See Map 1).

- Seventy-nine counties qualify as federally designated dental health professional shortage areas, meaning that they have a full-time-equivalent dentist to population ratio of at least 1:5,000, or between 1:4,000 and 1:5,000 with unusually high needs for dental services or insufficient capacity of existing dental providers.
- This shortage and the uneven distribution of dental professionals in North Carolina are major barriers to accessing dental care in the state.

Dental hygienists also play a vital role in providing dental care services.

- Fortunately, the number of dental hygienists increased 18% from SFY 1999 to SFY 2003, and the ratio of hygienists-to-population increased 6%, to 4.8 per 10,000 people. As a result, North Carolina experienced a 5% increase in the ratio of dental hygienists-to-dentists over the same period.
- Nonetheless, this ratio remains very low, particularly considering the number of dental health professional shortage areas in North Carolina.

2005 Proposed Action Plan:
The University of North Carolina System should make it a priority to expand the number of dental students trained in North Carolina. The goal of this initiative should be to increase the number of dentists who practice in underserved areas of the state and who agree to treat Medicaid and other underserved populations.

2005 Proposed Action Plan:
The Office of Research, Demonstrations and Rural Health Development should continue its work to expand the number of dental safety net programs and recruit dental professionals to serve low-income underserved populations and in dental underserved areas of North Carolina. To this end, it should work with the NC DHHS Oral Health Section to secure funding for these efforts. (Related to 1999 Task Force Recommendation #4)

2005 Proposed Action Plan:
The NC Dental Society should seek private funding from its members and private philanthropies to support the work of the NC Dental Care Foundation for the purpose of assuring access to needed preventive and primary dental care services in underserved communities and for underserved populations in our state. (Related to 1999 Task Force Recommendation #5)

2005 Proposed Action Plan:
The NC health professional loan repayment program should implement a requirement for individuals who have completed their dental or dental hygiene education and obtained a license to practice to report every six months (during the period of obligated practice) on the place of practice and volume of patients served. (Related to 1999 Task Force Recommendation #8)

2005 Proposed Action Plan:
The Board of Governors' should vote to carry a requirement of service in underserved areas upon graduation for individuals in the Scholarship Program. In addition, the Board of Governors' should consider reallocating funds currently used to support special arrangements with Meharry Medical College and Morehouse School of Medicine for the admission of North Carolina minority and dental students and applying those funds to scholarship support at North Carolina's own academic institutions. (Related to 1999 Task Force Recommendation #9)

Excerpts from pages 33-38 pertaining to Training Dental Professionals to Treat Special Needs Patients and Designing Programs to Expand Access to Dental Services

2005 Proposed Action Plan:
a) The UNC-CH School of Dentistry, the NC AHEC system, and the NC Community Colleges that offer educational programs for dentists, dental hygienists, and dental assistants should intensify and strengthen special-care education programs to train professionals on child management skills and how to provide quality oral health services to residents and patients in group homes, long-term care facilities, home health, and hospice settings.
b) The Division of Medical Assistance should enhance the Medicaid reimbursement for patients with disabilities or behavioral problems that require additional time to treat. (Related to 1999 Task Force Recommendation #20)

Dental services to institutional and other difficult-to-serve populations

Since the release of the NC Institute of Medicine's report on Dental Care Access in April, 1999, there have been a number of agencies that have established programs to provide dental services to institutional and other difficult-to-serve populations (see sidebar for examples). Mobile dental care programs have been helpful in reaching special needs patients who face obstacles that keep them from getting to the dentist's office; however, these dental vans are not available in all parts of the state. Additional work is needed to ensure that these programs are available statewide.

Currently, the Sheps Center at UNC-Chapel Hill has funding from the NC Council on Developmental Disabilities to conduct a three-year demonstration project aimed at improving the quality of medical care for adults with development disabilities. Although not currently in the scope of this funding, the Sheps Center would like to extend the project's focus to dental care. Care coordination for people with disabilities in the program is provided by care managers through Local Management Entities (LMEs) or through Community Care of North Carolina (CCNC). These staff could help train caregivers on how to improve oral hygiene in the home environment.

Brief History of Dental Services Study

1998

NC General Assembly asked the NC Department of Health and Human Services (DHHS) to study and recommend strategies to increase access to dental services for Medicaid recipients.

1999

The NC IOM Task Force on Dental Care Access released its report to the NC General Assembly and the NC DHHS in April 1999. It consisted of 23 recommendations, which focused on:

1) Increasing dental participation in the Medicaid program;

2) Increasing the overall supply of dentists and dental hygienists in the state with a particular focus on efforts to recruit dental professionals to practice in underserved areas and to treat underserved populations;

3) Increasing the number of pediatric dentists practicing in North Carolina and expanding the provision of preventive dental services to young children;

4) Training dental professionals to treat special needs patients and designing programs to expand access to dental services; and

5) Educating Medicaid recipients about the importance of ongoing dental care, and developing programs to remove non-financial barriers to the use of dental services.

2003

The NC IOM convened a one-day meeting in 2003 to review progress on these recommendations.

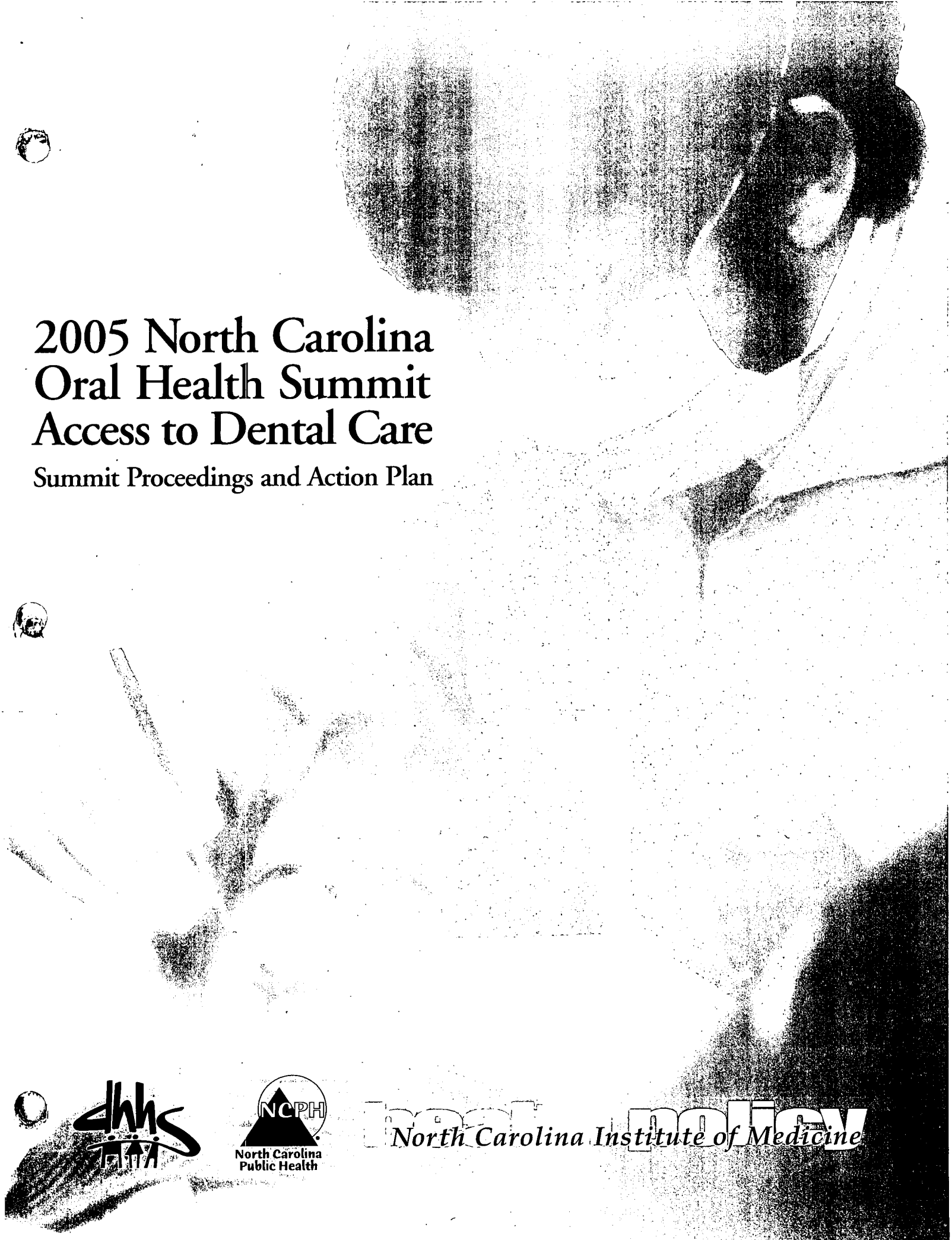
In July 2003, the Oral Health Section of the NC Division of Public Health, a division of the NC Department of Health and Human Services, obtained funding from the Association of State and Territorial Dental Directors and the National Governors Association to convene an NC Oral Health Summit. The purpose of the Summit was to review the 1999 NC IOM Task Force report for progress made since 2003.

2005

The NC Oral Health Summit was held on April 8, 2005, and included 63 participants. Six of the original 22 members of the NC IOM Task Force were among the participants. The resulting document was designed to be a "genesis for a new *action plan*, which if implemented, will help ensure access to dental care for more of the underserved North Carolinians across the state."

2005 North Carolina Oral Health Summit Access to Dental Care

Summit Proceedings and Action Plan



dhhs

NCPH
North Carolina Public Health

North Carolina Institute of Medicine

NCRx

- NCRx is open to North Carolina seniors with incomes below 175% of the federal poverty guidelines -- $17,150 for individuals and $23,100 for married couples, and assets of $20,000 or less for individuals and $30,000 or less for married couples (not including a home, car and $1500 per person to cover burial expenses).

- NCRx will assist both new and existing eligible Part D enrollees by paying $18 per month towards the premiums for participating plans. The enrollee will be responsible for any difference between the NCRx subsidy and their plan's total monthly premium. NCRx is now in the process of contracting with all interested Medicare Prescription Drug Plans serving North Carolina. A list of plans that agree to accept payment from NCRx will soon be available on their website (www.ncrx.gov) and through the NCRx Call Center at 1-888-488-NCRX (6279).

- Funding for NCRx is being provided by the North Carolina Health and Wellness Trust Fund.

- For Information about NCRx, Medicare Prescription Drug Coverage or Extra Help, call NCRx at 1-888-488-NCRX (6279) or check the following resources:

  North Carolina Seniors Health Insurance Information Program
  1-800-443-9354 www.ncshiip.com

  Medicare
  1-800-633-4227 www.medicare.gov

Frequently Asked Questions for NCRx

WHAT IS NCRx?

NCRx is Governor Easley's new prescription drug assistance plan to help low-income seniors participate in the federal Medicare Part D prescription drug program. NCRx will be available to low-income seniors who meet the eligibility requirements. NCRx will pay up to $18 toward monthly premiums for participating Medicare Prescription Drug Plans.

WHO IS ELIGIBLE FOR NCRX?

You are eligible for NCRx if you meet all of the following criteria:

- North Carolina Resident
- Medicare Beneficiary
- Age 65 or older
- Income at or below $17,150 for individuals and $23,100 for married couples
- Combined savings, investments and real estate (other than your home, car, and $1500 per person to cover burial expenses) of $20,000 or less for individuals and $30,000 or less for a married couples
- Enrolled or will enroll in a Medicare Prescription Drug Plan that participates with NCRx
- No other form of drug coverage that is as good or better than Medicare Part D
- Not eligible for the full federal "Extra Help" subsidy for Medicare Part D

HOW DO I APPLY FOR NCRX?

You may call to request an application 1-888-488-NCRX (6279). You may also request that an application be mailed to you at our web site, www.ncrx.gov.

CAN I ENROLL AT ANY TIME?

You must apply before December 31, 2006 to be eligible for NCRx benefits for 2007.

HOW DOES NCRx WORK?

Once your application to NCRx has been approved and you are enrolled in a participating Medicare Prescription Drug Plan, NCRx will pay $18 of your monthly premium.

For example, if the Medicare Prescription Drug Plan you choose costs $30 per month, NCRx will pay $18 per month. You will pay the remaining $12 per month. If the plan you choose costs less than $18, NCRx will pay the full monthly premium.

WHICH MEDICARE PRESCRIPTION DRUG PLANS PARTICIPATE WITH NCRx?

Any Medicare Prescription Drug Plan that will accept payment from NCRx can participate. The names of participating plans will soon be available at this website (www.ncrx.gov) or by calling NCRx at 1-888-488-NCRX (6279).

WHAT IF I AM ALREADY ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN?

If you are already enrolled in Medicare Part D, and you meet the NCRx eligibility requirements, you can still apply for NCRx. If your Medicare Prescription Drug Plan participates in NCRx, then NCRx will subsidize $18 of your premium. The names of participating plans will soon be available on the website (www.ncrx.gov) or by calling NCRx at 1-888-488-NCRX (6279).

WHAT IF I AM NOT ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN?

If you are not enrolled in a Medicare Prescription Drug Plan, and you meet the NCRx eligibility requirements, you should apply for NCRx. If your application is approved, you must then enroll in a Medicare Prescription Drug Plan prior to December 31, 2006. For assistance in choosing a plan that meets your needs you can call NCRx at 1-888-488-NCRX (6279).

WHAT IF MY INCOME IS LESS THAN $14,700 FOR AN INDIVIDUAL OR $19,800 FOR MARRIED COUPLES?

If your income is less than $14,700 for an individual or $19,800 for married couples, and your combined savings, investments and real estate (not including your home, car, or a $1500 burial allowance) are less than $10,000 for an individual and $20,000 for a married couple, you may be eligible for greater federal assistance with your drug plan costs – enough to cover all of your drug costs except for small co-payments.

To apply for this federal benefit, you must complete and submit an "Extra Help" application, available at www.medicare.gov, your local senior service center or social security office. You may also get a federal Extra Help application from NCRx by calling 1-888-488-NCRX (6279). If your income and resources meet the Extra Help guidelines you should apply for Extra Help right away. If you are eligible for federal Extra Help, in most cases you cannot also receive premium assistance from NCRx.

ATTACHMENT 3

Community Alternatives Program for Disabled Adults: Issues Identified in the Medicaid Institutional Bias Study

Interim Report to the North Carolina Study Commission on Aging
November 1, 2006

North Carolina Department of Health and Human Services
Division of Medical Assistance

Community Alternatives Program for Disabilities Adults: Issues Identified in the Medicaid Institutional Bias Study

November 1, 2006

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Aging Planning Bulletin for Local Planning Commissions
Number 1

SA In-Home Option

The 2006 North Carolina General Assembly affirmed its support of the State/County Special Assistance (SA) In-Home Option by increasing the statewide number of participants from 1,000 to 1,500, effective July 1, 2006. The SA In-Home Program for Adults (SA/IH) provides a cash supplement to help low-income individuals who are at risk of entering an Adult Care Home (ACH), and would like to remain at home. Thus, SA/IH provides an alternative to ACH placement for individuals who can live at home safely with additional supportive services and discretionary income.

The SA In-Home Program helps with living expenses such as food, shelter, clothing, and other daily necessities. The checks are sent monthly to eligible individuals living in a private living arrangement. The amount of the check is based on income and need and follows a comprehensive services assessment conducted by a case management of the county DSS.

The services assessment is needed to determine whether an applicant/recipient can remain safely at home, and what support services and additional income are needed to assure the applicant's needs are met. The case manager's role is essential in helping the clients remain at home. All SA/IH recipients receive ongoing case management. The case manager establishes the amount of the SA/In-Home payment, works with the client and client's family to determine how the payments are used, and monitors to assure that the payments are used as intended.

Urgency: (High)

As of the beginning of August 2006, 72 counties are offering SA/IH. Each participating county has a limited number of slots. With the recent expansion of the available slots by 500, the Division of Aging and Adult Services has notified each county DSS that it can join the program or increase its number of slots. **The county DSS must respond by September 1, 2006.**

Relevance:

For Consumers (High)

- People who receive Special Assistance at home rate their quality of life significantly higher in terms of feelings/emotions, physical and social environment, and community access.
- They also believe they have more control over their lives.

Mr. R, of Cleveland County, suffers from multiple health problems that are debilitating, including cancer. A friend assists with his care. Mr. R values being as independent as possible and wants to avoid out of home placement. He uses the SA In-Home funds for assistance with his care, and utility bills as well as special food for his recommended dietary needs. Without the SA In-Home assistance, Mr. R's needs could not be met and out of home placement would be necessary.

For County Government (High)

- County government is responsible for half of the cost of Special Assistance, with the State responsible for the other half. The experience of the program since it started in 1999 has shown substantial cost savings. In June 2006, the average monthly SA/IH payment was $340 while the average monthly SA/ACH payment was $460.
- The total overall cost of serving SA/IH recipients during fiscal year 2004-05 was 29.6% less than the overall cost for SA/ACH recipients.
- One financial issue for some counties is that they have to provide a 36.37% match for the Medicaid case management service that is necessary for SA/IH.

For Local Service Providers (Moderate)

- The County Department of Social Services has responsibility for this program.
- The SA/IH program can serve as an option for CAP-DA clients whose condition improves—making them not eligible for this more extensive care.
- The SA/IH program can be an option for HCCBG clients whose condition worsens.
- Local home and community care providers are likely to get referrals as SA/IH clients can choose among services that will help them best.

Questions for Local Planning Team:

- Does your county offer this option? If not, why?

- If your county has this option, how well is it working? Consider the number of available slots filled? What has been the experience of those in the program? How aware are possible referral sources?

Best Practices:

- As of August 1st, Graham County has more clients using the SA In-Home Option (30) than it supports in adult care homes (14).
- Hertford County has kept its 15 slots filled for 6 consecutive months; Lee and Dare counties have had all of their 12 slots filled for 4 consecutive months.

Contact and Resource Information:

Local: Your County Department of Social Services Director or Adult Services Supervisor

State: Geoff Santoliquido or Brenda Porter, at 919-733-3818; geoff.santoliquido@ncmail.net or Brenda.porter@ncmail.net

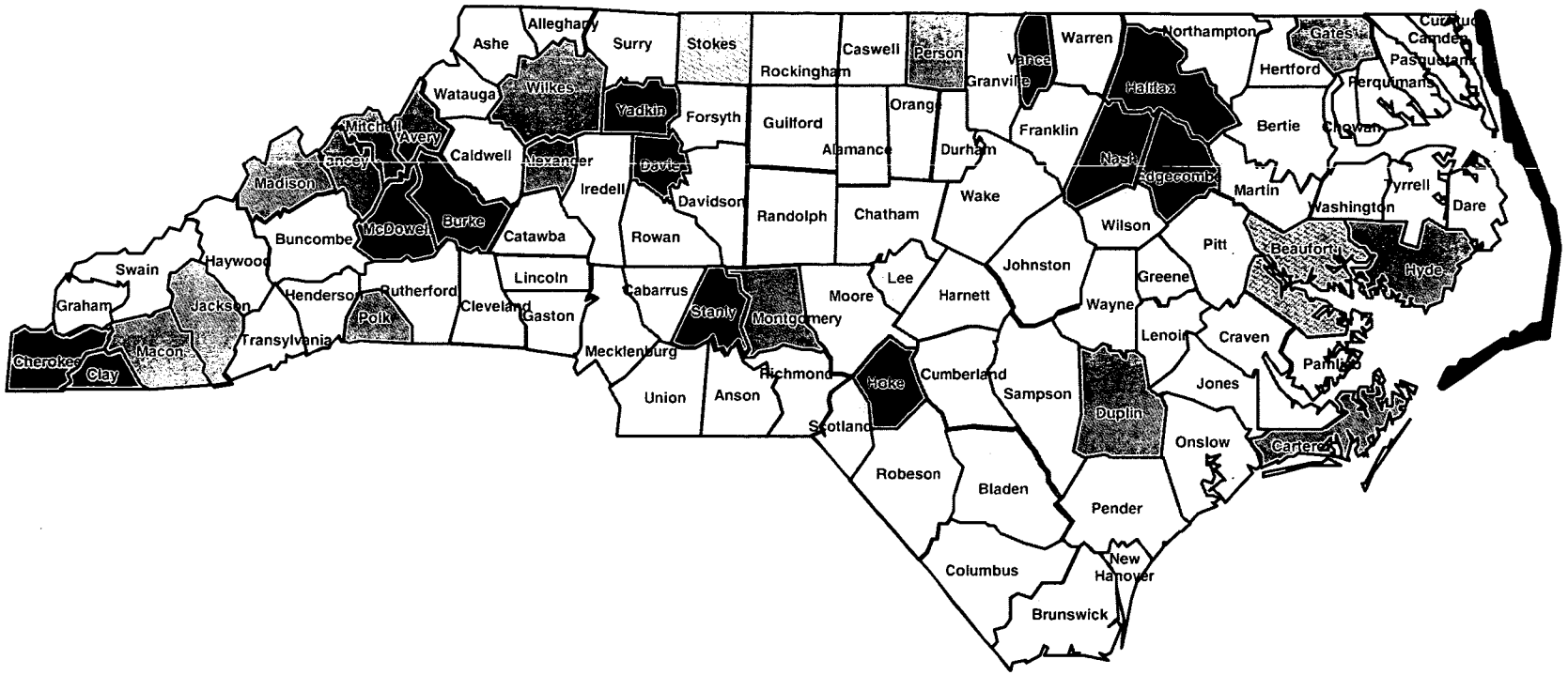
http://www.dhhs.state.nc.us/aging/adultsvcs/afs_sa_inhome.htm

http://www.dhhs.state.nc.us/aging/adultsvcs/SAInHomeFinalReport2006.pdf

September 2006 SA/In-Home Expansion
Distribution of 500 awarded slots

Slots awarded to pre-expansion Counties (395 slots awarded to 54 counties)						Slots awarded to new Counties (105 slots awarded to 15 counties)	
County	# Slots awarded	New Total # Slots	County	# Slots awarded	New Total # Slots	County	# Slots awarded
Alamance	2	8	Lee	4	16	Alexander	10
Ashe	18	25	Lincoln	6	17	Avery	3
Beaufort	2	7	Martin	2	10	Carteret	20
Bladen	5	11	McDowell	10	13	Duplin	8
Buncombe	4	26	Mecklenburg	4	28	Gates	3
Cabarrus	23	65	Moore	4	14	Hyde	3
Caldwell	4	15	Nash	10	19	Jackson	4
Catawba	5	15	New Hanover	10	23	Macon	4
Chatham	14	24	Onslow	4	13	Madison	3
Cleveland	4	51	Orange	3	9	Mitchell	3
Columbus	2	10	Pamlico	3	5	Montgomery	26
urrituck	4	8	Pasquotank	8	30	Person	7
are	5	17	Pender	4	9	Polk	4
Davidson	5	14	Pitt	3	16	Wilkes	5
Durham	30	56	Randolph	6	20	Yancey	2
Forsyth	12	41	Robeson	15	46		
Franklin	7	17	Rowan	15	30		
Gaston	5	29	Rutherford	3	10		
Graham	24	54	Stanly	3	6		
Guilford	12	62	Stokes	8	18		
Halifax	16	25	Surry	2	9		
Harnett	10	30	Swain	1	7		
Haywood	8	26	Vance	8	15		
Henderson	5	34	Wake	5	30		
Hertford	8	23	Watauga	4	9		
Iredell	5	19	Wilson	3	22		
Johnston	4	25	Yadkin	4	9		

Special Assistance In-Home Participating Counties



Original SA/IH Counties (eff. 9/14/2000)
Additional SA/IH Counties (eff. 10/1/2003)
Additional SA/IH Counties (eff. 12/7/2004)
Additional SA/IH Counties (eff. 11/1/2005)
Additional SA/IH Counties (eff. 9/8/2006)

SA In-Home Program Participating Counties (87 counties)

Alamance
Alexander*
Ashe
Avery*
Beaufort
Bertie
Bladen
Buncombe
Burke
Cabarrus
Caldwell
Carteret*
Caswell
Catawba
Chatham
Cherokee
Clay
Cleveland
Columbus
Craven
Cumberland
Currituck
Dare
Davidson
Davie
Duplin*
Durham
Edgecombe
Forsyth
Franklin
Gaston
Gates*
Graham
Guilford
Halifax
Harnett
Haywood
Henderson
Hertford
Hoke
Hyde*
Iredell
Jackson*
Johnston
Lee
Lenoir
Lincoln
Macon*
Madison*
Martin
McDowell
Mecklenburg
Mitchell*
Montgomery*
Moore
Nash
New Hanover
Northampton
Onslow
Orange
Pamlico
Pasquotank
Pender
Person*
Pitt
Polk*
Randolph
Robeson
Rockingham
Rowan
Rutherford
Sampson
Scotland
Stanly
Stokes
Surry
Swain
Transylvania
Union
Vance
Wake
Watauga
Wayne
Wilkes*
Wilson
Yadkin
Yancey*

* County entered Program in September 2006

How [illegible]here can I apply?

Apply for the Special Assistance In-Home Program at your county department of social services. You may send someone to represent you. Please bring the following items, if you have them, when you apply at the county department of social services:

- Income information that includes recent pay stubs, Social Security, SSI, or Veteran's Administration (VA) award letters;
- Savings and checking account information that includes passbooks, checkbooks, bank statements, etc;
- Information on assets such as property, stocks, bonds, IRAs, annuities, and trust funds owned by you and or your spouse;
- Social Security card or other verification of Social Security number;
- Proof of age (birth certificate or other); and
- Insurance

After all of your information is provided, expect the application process to take up to 45 days for aged individuals and 60 days for disabled individuals. Processing time varies depending on how long it takes to verify an applicant's information.

What is the penalty for fraud?

Fraud is committed when an applicant, recipient or someone acting on behalf of an applicant or recipient knowingly gives incorrect or misleading information to get public assistance. Recipients must report any change in their financial situation that may affect their eligibility within five days of the change. The penalty for fraud is repayment of the money and can include a fine, imprisonment, and/or termination from the program.

Division of Aging and Adult Services
N.C. Department of Health and Human Services
693 Palmer Drive, Raleigh, NC
Mailing address: 2101 Mail Service Center
Raleigh, NC 27699-2101

The NC DHHS is an equal opportunity provider and employer.

DSS-8166a (11/06)
Division of Aging and Adult Services

An Alternative To Adult Care Living For Eligible Adults

The State/County Special Assistance In-Home Program For Adults

Do you need rest home care but want to remain living at home? Do you now live in an adult care home, such as a rest home or a mental health group home, but want to return home? Need help paying for this care? Read further to see if you are eligible for the Special Assistance In-Home Program.

Due to increased funding by the General Assembly in the 2006 session, the number of counties now providing this service has grown to 87 out of 100 counties in North Carolina.

Can I get help paying my expenses at home?

For older or disabled adults who need adult home care but want to remain living at home, the State/County Special Assistance In-Home Program helps with living expenses such as food, shelter, clothing and other daily necessities. The checks are sent monthly to eligible individuals living in a private living arrangement.

Am I eligible?

Low income people are potentially eligible if they are 65 or older, or if they are disabled according to Social Security guidelines and between the ages of 18 and 65.

All applicants must:

- Need adult care home level of care as verified by a doctor but desire to live in a private living setting
- Be a U.S. citizens or qualified alien
- Meet income and asset requirements
- Qualify for Medicaid separately
- Be a resident of NC, living in a participating county
- Meet all other Special Assistance eligibility requirements

What are the income and asset requirements?

Special Assistance in an adult care home is available to applicants with a monthly income of $1,163.49 or less and who have savings and assets worth less than $2,000.

Examples of countable income include wages, retirement benefits, Supplemental Security Income (SSI) and Veteran's benefits. Examples of assets that are counted are property, cash, savings, checking accounts, stocks, bonds, annuities, some IRAs, and the cash value of life insurance policies. Some assets that are not coun[illegible]re a home used as a primary residence, personal belongings, life insurance with a cash value of $1,500 or less, burial plots and burial insurance. One essential vehicle is excluded as a resource if it is the primary mode of transportation.

How do I qualify for Medicaid?

Eligibility for Medicaid for the Special Assistance In-Home Program is <u>not</u> automatic as it is for Special Assistance in adult care homes. Recipients in private living arrangements must be determined eligible for Medicaid separately. If an applicant for the In-Home Program is not already receiving Medicaid, they must apply for it and be found eligible.

Medicaid income and asset limits:

	Individual	Couple
Income	$ 817	$ 1,100
Assets	$ 2,000	$ 3,000

How much will my Special Assistance check be?

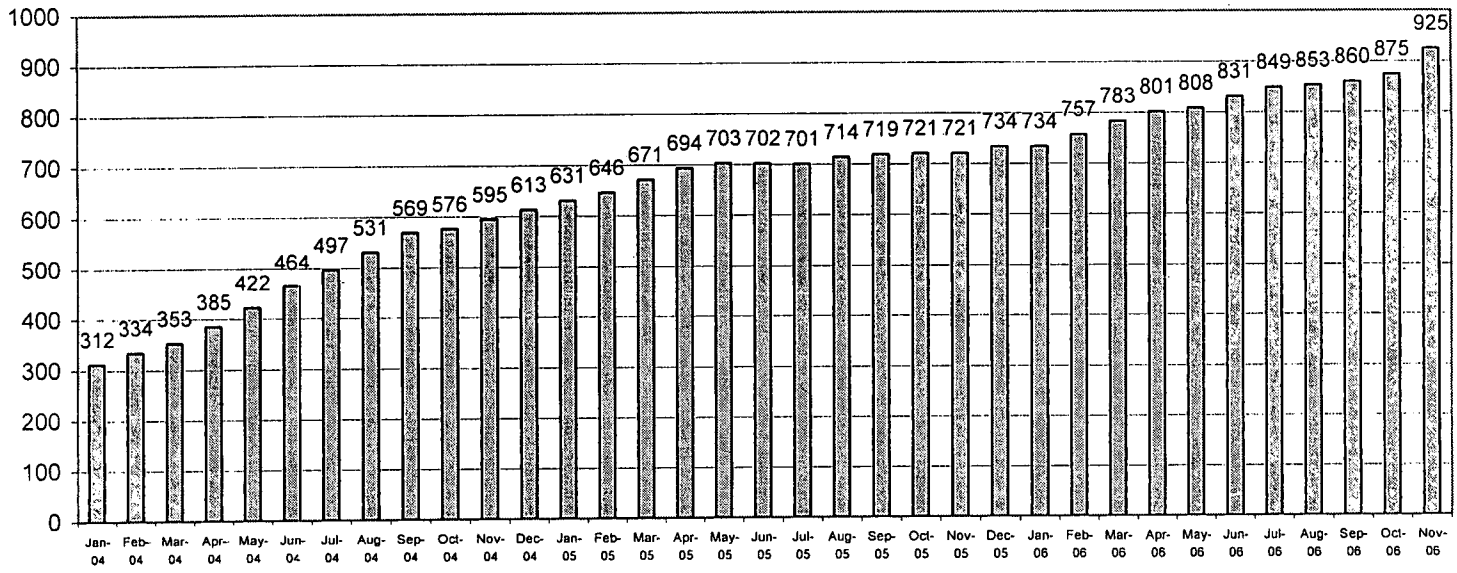
The maximum amount a Special Assistance recipient can receive in aid is set by the General Assembly. The maximum amount of an individual's check is determined by taking the maximum rate, subtracting the individual's total monthly countable income, then multiplying by 75%.

$1,164	Maximum Rate (Maintenance Amount)
- (varies)	Total countable monthly income
= $	Multiply by 0.75
= $	Maximum SA Payment Amount

<u>Note</u>: The actual payment amount may be less than the maximum SA Payment Amount if it is appropriate, depending upon the assessment and service plan completed by an Adult Services case manager.

Each individual is entitled to $20 income exclusion, as well as $46 in personal needs allowance. For most kinds of earned income, there is an initial $65 exclusion and ½ of the remainder of their income is counted.

SA In-Home Client Count, 2004 - Present



2004	Client Count	Percentage increase from prior month	2005	Client Count	Percentage increase from prior month	2006	Client Count	Percentage increase from prior month
January	312		January	631	3%	January	734	0%
February	334	7%	February	646	2%	February	757	3%
March	353	6%	March	671	4%	March	783	3%
April	385	9%	April	694	3%	April	801	2%
May	422	10%	May	703	1%	May	808	1%
June	464	10%	June	702	0%	June	831	3%
July	497	7%	July	701	0%	July	849	2%
August	531	7%	August	714	2%	August	853	0%
September	569	7%	September	719	1%	September	860	1%
October	576	1%	October	721	0%	October	875	2%
November	595	3%	November	721	0%	November	925	6%
December	613	3%	December	734	2%			

Attachment 9

North Carolina Study Commission on Aging

Wednesday, November 15, 2006

Securing Wheelchairs in Vans

Dr. Robert Sullivan

Contents:

1. Executive Summary
2. Key elements to incorporate in legislation
3. Letters of support
4. Reports from Incident Investigations
5. *Ride Safe* article from the University of Michigan

Robert J. Sullivan Jr. MD MPH
Box 10245
Raleigh, NC 27605
(919) 968-0224

1

Executive Summary

Wheelchair Transportation Safety Restraints

North Carolina Study Commission on Aging
Robert J. Sullivan Jr. MD MPH
November 15, 2006

The transportation of passengers seated in wheelchairs within motor vehicles is a new experience. The Americans with Disabilities Act in 1990 required municipal buses to offer accommodations. The availability of electric lifts and hand controls encouraged van adaptations for commercial operators and recently for personal use. Certified passenger restraint systems are mandated for adults and children seated in those vans. There is no law regulating restraint systems for persons seated in wheelchairs.

Vehicular trauma is a regrettably frequent event for persons transported in wheelchairs. The majority of incidents occur during ordinary driving maneuvers without a collision. Statistical tabulations omit the events since police are rarely summoned. The injured are driven for medical care by the vehicle operator.

In North Carolina, the Division of Facilities Services tabulates incident reports filed by Nursing Homes. This source of information yields valuable insights about hazards associated with van transportation.

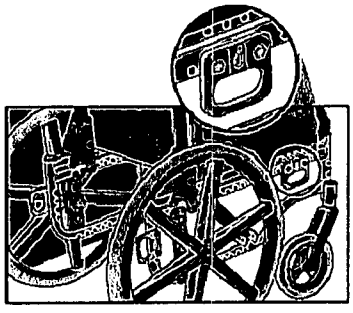
1) Problems occur despite well-intentioned efforts to secure the chairs and apply restraints
2) Van operators lack knowledge about three crucial areas
   - Wheelchairs must be specifically designed for use in vehicles.
   - Restraint systems must be properly attached to the chair.
   - Restraint systems must be properly applied to the passenger seated in the chair.
3) The situation resembles that of Child Safety Restraints.

A solution is available from research by the University of Michigan Traffic Research Institute (*UMTRI*)

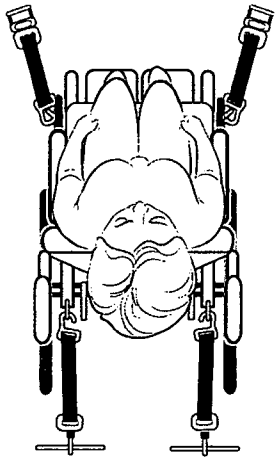
1) Whenever possible, transfer the rider to a seat and use the seatbelt.
2) If transfer to a seat is not possible, use a wheelchair and tiedown system that protects the occupant.
   a. Use a *Transit Wheelchair* (WC/19 compliant) with securement points for tiedown straps, arm rests that permit the lap belt to cross the pelvis and a shoulder strap to cross the chest.
   b. Secure the wheelchair to the vehicle with four tiedown straps positioned as shown below.
   c. Apply both lap and shoulder belts to the rider. The seatbelt must fit snugly cross the pelvis and be anchored at a 45° angle on each side. The shoulder strap must be in contact with the middle of the chest and shoulder and it must avoid contact with the neck.

Legislation is required to assure wide dissemination of this information to van modification shops and compliance with these simple requirements by van transportation operators.

WC/19 Wheelchair



Four Tiedowns



Lap and Shoulder Belt

2

Key elements to incorporate in legislation

Wheelchair Transportation Safety Restraints

Key elements to consider for incorporation in legislation
November 15, 2006

The following draft recommendations are abstracted from
Ride Safe: Information to help you travel more safely in motor vehicles while seated in your wheelchair.
Published by the Rehabilitation Engineering Research Center on Wheelchair Transportation Safety, University of Michigan Health System, University of Michigan Transportation Research Institute, 2005. (http://www.travelsafer.org)

The purpose of this legislation is to enhance safety for individuals with disabilities that require transportation in vans while seated in wheelchairs.

1. When traveling in motor vehicles, whenever possible wheelchair users shall transfer to a seat installed by the vehicle manufacturer and use the vehicle seatbelt system that complies with federal safety standards. If transfer is not feasible, and transportation must be accomplished while seated in a wheelchair, the requirements in Sections 2-10 shall be met.
2. The wheelchairs used for transportation shall be designed and tested for use as a seat in a motor vehicle as described in the ANSI/RESNA WC19 standards.
3. The WC19 wheelchair shall be secured within the vehicle using a Wheelchair Tiedown and Occupant Restraint System (WTORS) that has been crash tested and labeled as complying with SAE J2249 as described in Sections 3.1 -3.3.
    - 3.1 The rider shall be positioned facing forward in the vehicle.
    - 3.2 If a docking device is not used, then four tiedown straps shall be secured to the WC19 wheelchair at welded junctions on the frame designated for strap attachment and tightened to remove all slack.
        - 3.2.1 Tiedowns shall not be attached to adjustable, movable or removable parts of the wheelchair such as armrests, footrests or wheels.
        - 3.2.2 The securement points shall be as close to the seat surface as possible to provide greater wheelchair stability during travel.
        - 3.2.3 Rear securement points should be high enough to result in angles of the rear tiedown straps to equal between 30 and 45 degrees to the horizontal.
        - 3.2.4 Floor anchor points for rear tiedown straps shall be located directly behind the rear securement points on the wheelchair.
        - 3.2.5 Floor anchor point for front tiedown straps shall be spaced wider than the wheelchair to increase lateral stability during travel.
    - 3.3. An acceptable alternative to the use of a four-point tiedown is a docking device that engages hardware on the WC19 wheelchair frame and locks it to the vehicle body.
        - 3.3.1 Clamp-type securement devices that engage wheels on the chair are not acceptable since they do not provide effective securement.

4. In addition to securing the wheelchair to the vehicle body, the occupant must also be restrained with a crash-tested lap and shoulder belt system attached to the vehicle body.
    - 4.1 The lap belt shall be placed low across the front of the pelvis near the upper thighs and not over the abdomen.
    - 4.2 The ends of the lap belt shall be form an angle of between 45 and 75 degrees to the horizontal when viewed from the side to assure the occupant will remain within the wheelchair during quick vehicle maneuvers.
    - 4.3 The diagonal shoulder belt shall cross the middle of the shoulder and center of the chest and be connected to the lap belt near the hip of the wheelchair rider.
    - 4.4 The upper anchor point or D-ring guide shall be located so that the belt remains in good contact with the shoulder and chest without contacting the neck while traveling.
    - 4.5 The belt system may be secured to WC19 wheelchairs that are equipped with crash-tested lap belt anchor systems that comply with ANSI/RESNA WC19 standards.
    - 4.6 The belt system may be secured directly to the vehicle frame provided the attachment points for the lap belt form an angle of between 45 and 75 degrees to the horizontal when viewed from the side and the diagonal shoulder belt crosses the middle of the shoulder and center of the chest and is connected to the lap belt near the hip of the wheelchair rider
5. The wheelchair backrest shall recline no more than 30 degrees for ordinary use. Where greater than 30 degrees of backrest recline is required, the shoulder belt anchor point shall be moved rearward and down to maintain contact of the diagonal belt with the riders shoulder and chest.
6. Hard trays shall be removed or covered with dense padding to reduce the chance of rider injury from contact with the tray.
7. A properly positioned headrest shall be provided to protect the neck from rear impact.
8. The space occupied by the wheelchair rider shall be free from loose objects and equipment that could break loose and cause injury in a crash.

3
Letters of Support

THE UNIVERSITY OF NORTH CAROLINA
HIGHWAY SAFETY
RESEARCH CENTER

730 Martin Luther King Jr Blvd • Suite 300 • Campus Box 3430 • Chapel Hill, NC 27599-3430 • Phone: 919-962-2203 • Fax: 919-962-8710

October 30, 2006

Robert J. Sullivan Jr. MD MPH
Medical Advisor
Nursing Home Licensure and Certification Section
Division of Facility Services
NC Department of Health and Human Services
Box 10245
Raleigh, NC 27605

Dear Dr. Sullivan,

As a highway safety and occupant restraint researcher and educator, I appreciate and share your concern regarding injuries to individuals being transported in vehicles while seated in wheelchairs that have been documented by the Nursing Home Licensure and Certification Section. It is well known that protecting wheelchair occupants in motor vehicles is a difficult task to accomplish and your case-investigation reports underscore the vital importance of this issue.

I believe there is much that can be done to protect the vulnerable wheelchair-bound population, young and old alike. Based on work done at the University of Michigan Transportation Research Institute, the use of ANSI/RESNA WC19 compliant transit wheelchairs that are secured within a vehicle using a Wheelchair Tiedown and Occupant Restraint System compliant with SAE J2249 standards would make a tremendous difference.

The UNC Highway Safety Research Center would be pleased to work with you and the NC Legislature and other interested individuals and agencies to draft a law or develop regulations that specifies what qualifies as an acceptable vehicle restraint system for wheelchair occupants. The State of North Carolina has experienced remarkable reductions in deaths and injuries to motor vehicle occupants due to the passage of safety belt and child safety restraint laws. I anticipate that similar benefits will occur for persons of all ages who must travel in vehicles while seated in wheelchairs if requirements that wheelchair tiedowns and occupant restraint systems be compliant with SAE J2249 standards are enacted.

Thank you for taking the leadership in this important area of transportation safety.

Sincerely,

William L. Hall
Manager, Occupant Protection Program

NCHCFA
North Carolina Health Care Facilities Association
5109 Bur Oak Circle, Raleigh, NC 27612 • (919) 782-3827 • Fax (919) 787-8418
e-mail: nchcfa@nchcfa.org • website: www.nchcfa.org

October 18, 2006

Robert J. Sullivan Jr. MD MPH
Medical Director
Community Care of North Carolina
Box 10245
Raleigh, NC 27605

Dear Dr. Sullivan

As you are aware, at our meeting in Myrtle Beach in August 2006 our organization distributed copies of the *Ride Safe* article from the University of Michigan Transportation Research Institute. It is with the knowledge and support from members of the North Carolina Health Care Facilities Association that I write to endorse your efforts to secure legislation that will enact standards for passenger restraint installation and application for wheelchair occupants. We understand that the proposed legislation will specify use of ANSI/RESNA WC19 compliant transit wheelchairs secured within the vehicle using a Wheelchair Tiedown and Occupant Restraint System compliant with SAE J2249 standards.

We anticipate the enactment of legal requirements for tiedown strength, number and location will simply result in the delivery of an improved vehicle to our member facilities at a cost comparable to current procedures used. We already conduct ongoing education sessions to train staff in proper restraint application techniques, thus a shift to accommodate new requirements will involve a trivial effort. Our members understand that the specification of WC19 compliant wheelchairs will involve some added expense. However, the chairs differ only slightly in design and cost from existing equipment, and each facility will need to purchase only two or three chairs to satisfy new legal requirements. Our members believe the enhanced safety afforded by WC19 wheelchairs is well worth that investment. In fact, the information provided in the *Ride Safe* document was sufficiently convincing that many of our member facilities have set out to meet the proposed requirements regardless of legislative mandate.

Please let me know if there are ways that the NCHCFA can be helpful in advancing proposed legislation regarding restraint systems for wheelchair occupants during vehicle transportation. Thank you for bringing this important issue to our attention, and providing such a simple and efficient solution.

Polly G. Welsh

Sincerely,
Polly Godwin Welsh,
Director of Regulatory Systems and Quality Initiatives
North Carolina Health Care Facilities Association.

AARP North Carolina

October 12, 2006

Robert J. Sullivan Jr., MD MPH
Medical Advisor
Nursing Home Licensure and Certification Section
N.C. Division of Facility Services
2701 Mail Service Center
Raleigh, N.C. 27699-2701

Dear Dr. Sullivan:

Thank you for sharing information with our office regarding the problems that exist in regard to injury and death associated with transportation by wheelchair in motor vehicles. As the materials you sent to us document, many of the accidents involving persons in wheelchairs who are riding in vans could be prevented if persons were properly secured.

We thank you for bringing this issue to our attention and for your efforts to educate others in our State about this problem. We are pleased to support your efforts to seek legislation defining criteria pertaining to wheelchair transportation safety restraints.

Sincerely,

Robert N. Jackson
State Director
AARP North Carolina
225 Hillsborough Street
Suite 440
Raleigh, N.C. 27603
(919)508-0265

North Carolina Coalition on Aging

Jean Reaves, President
P. O. Box 12762
Raleigh, NC 27605-2762

Phone 252-536-2273
Fax 252-536-5119

October 10, 2006

Robert J. Sullivan Jr. MD MPH
Medical Director
Community Care of North Carolina
Box 10245
Raleigh NC 27605

Dear Dr. Sullivan

It was a pleasure to welcome you to our meeting on September 22 at the NC State University Club. Your presentation regarding restraint systems for wheelchair occupants was amazing. The fact that so many of our members rose to express support of your efforts and to report on injuries experienced by family members and friends was enlightening. We clearly need to take action to protect our older citizens.

I am sending this letter to document the unanimous vote of support passed by members of our organization for your efforts to secure legislation that will improve safety for everyone who is transported within a vehicle using a wheelchair. From your talk, and the informative handout, our organization understands that the law you are proposing will require the use of ANSI/RESNA WC19 compliant transit wheelchairs and that they will be required to be secured within the vehicle using a Wheelchair Tiedown and Occupant Restraint System compliant with SAE J2249 standards. It seems so simple; I really do not know why this has not been done before.

Thank you for giving us the opportunity to join you in this important effort to bring the safety of those transported in wheelchairs up to the standards we have enacted for child safety. Please let our organization know how we can help our legislators understand the support that exists for the enactment of laws governing this area.

Sincerely,

Jean Reaves
President, NC Coalition on Aging

North Carolina Department of Health and Human Services
Governor's Advisory Council on Aging

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Ann B Johnson
Chair

October 11, 2006

Robert J. Sullivan Jr. MD, MPH
Medical Director
Community Care of North Carolina
Box 10245
Raleigh NC 27605

Dear Dr. Sullivan

It was a pleasure to have you join us at the September 19, 2006 meeting of the Governor's Advisory Council on Aging. Your presentation about inadequate restraint systems for wheelchair occupants being transported in vans and busses was an eye opener. It was particularly alarming to hear our Council members volunteer stories from their own experience about injury and death related to this very issue.

This letter is sent to confirm that by unanimous vote, the Governor's Advisory Council on Aging agreed to send a letter of endorsement for your effort to secure legislation regulating the installation and application of occupant safety restraint systems for wheelchairs. The Council expects that the proposed legislation will include language that requires the use of ANSI/RESNA WC19 compliant transit wheelchairs that are secured within the vehicle using a Wheelchair Tiedown and Occupant Restraint System compliant with SAE J2249 standards.

The Council anticipates that the passage of a law to enhance the safety for wheelchair occupants will have the same beneficial effect as laws enacted for the transportation of children. Please keep the Council informed of your efforts and let us know how our members can prove helpful in securing passage of this legislation.

Sincerely,

Ann B. Johnson by me

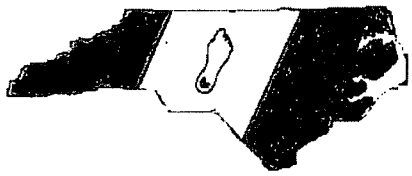
Ann B. Johnson

ABJ:me

cc: Carmen Hooker Odom
Jackie Sheppard
Dennis Streets

2101 Mail Service Center ¦ Raleigh, North Carolina 27699-2101 ¦ (919) 733-3983
State Courier No. 56-20-02 ¦ Fax No. (919) 733-0443

North Carolina



Senior Tar Heel Legislature

Officers:

Speaker
Rev. Lamar L. Moore
(Davidson County)
6340 NC HWY 47
Lexington, N.C. 27292

Speaker Pro Tempore
Dr. Delilah B. Blanks
(Bladen County)
1369 Bowen-Blanks Road
Riegelwood, N.C. 28456

Deputy Speaker Pro Tempore
Edwin S. Deaver
(Cumberland County)
P.O. Box 127
Hope Mills, N.C. 28348

Secretary
Betty Hunt
(Randolph County)
1206 Ben Lambeth Road
Asheboro, N.C. 27205

October 11, 2006

Robert J. Sullivan Jr. MD. MPH
Medical Director
Community Care of North Carolina
Box 10245
Raleigh NC 27605

Dear Dr. Sullivan,

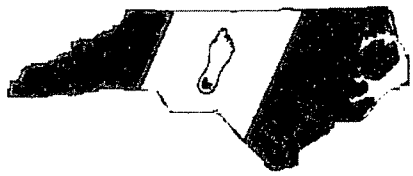
Thank you for your presentation on Wheelchair Vehicle Transportation Safety at our meeting at the Brownstone Hotel on October 3, 2006. Our group was unaware of the magnitude of the problem associated with inadequate restraint systems for wheelchair occupants traveling in vans and busses. I was deeply impressed by spontaneous reports from our delegates during the discussion following your talk in which they personally described injuries experienced by family and friends traveling in wheelchairs.

This letter is sent to confirm that a motion of endorsement passed today by unanimous vote of the Senior Tar Heel Legislature for your effort to secure legislation regulating the installation and application of wheelchair-occupant safety restraints. We understand that the proposed law will require the use of ANSI RESNA WC19 compliant transit wheelchairs to be secured within vehicles using a Wheelchair Tiedown and Occupant Restraint System compliant with SAE J2249 standards.

It is our belief that the legislation you are seeking is particularly relevant and appropriate in light of the documented reduction in traffic injuries that followed enactment of laws regarding childhood restraint systems. There is no reason that adults should be denied similar protection.

2101 Mail Service Center • Raleigh, NC 27699-2101 • Phone No. (919)733-3983 • Fax No. (919)733-0443

North Carolina



Senior Tar Heel Legislature

Thank you again for your presentation. The offers from our membership to lobby legislative staff and representatives to encourage passage are worth noting and I hope you will accept those offers.

Sincerely yours,

Lamar Moore by me

Lamar L. Moore
Speaker

Cc: Dennis Streets
Mary Edwards

2101 Mail Service Center • Raleigh, NC 27699-2101 • Phone No. (919)733-3983 • Fax No. (919)733-0443

4

Reports from Incident Investigations

North Carolina Division of Facility Services
Nursing Home Licensure and Certification Section

Excerpts from typical Incident Investigations during the past year.
August, 2006

1. Picked up the patient from Dialysis going back to facility. The patient had slightly slid down stopped at light started to go. Pt slid down in wheelchair. Resident fell out of the wheelchair, fractured a leg and expired in the hospital. The driver admitted only three of the four wheels on the wheelchair had been secured. I could not find anything wrong with the van or the belt on the van (which held the resident in place).

2. Resident out of facility at appointment in the facility van when car in front of van stopped suddenly and resident slid out of wheelchair. Resident skin tear to the right arm and later complained of shoulder pain. Resident slipped under the belt (which was the shoulder harness) and fell to the floor. Each of the four wheels on the wheelchair was secured by tightening and retightening a strap attaching the wheels to the floor by metal bands that slipped into metal grooves. Next, a shoulder harness, bolted to the top of the van above the side windows, was put through the armrests in front of the wheelchair and then attached to a metal groove in front of the left front wheel of the wheelchair with the wheelchair facing toward the front of the van. This belt was similar to the shoulder harness in personal vehicles except there was no lap belt attached to the shoulder harness and the wheelchair did not have a lap belt.

3. Resident sustained a fall from the wheelchair in the facility van. The resident was transported from the hospital to the facility for admission. The resident sustained bruises to the left hand and elbow area, a bruise on the posterior shoulder blade, 4 bruises with hematoma on the posterior mid back left of the midline and a bruise on the right hand near the thumb. The transport driver had to slam on the brakes when a vehicle in front of the van "stopped short." Resident 1, who was seated in a wheelchair behind the driver and passenger seats, slid out of the wheelchair and landed to the right of the wheelchair on the van floor. Resident 2, who was seated in a wheelchair behind Resident # 1, slid out of the wheelchair and fell partially on top of Resident # 1 with his head resting on her chest. Due to complaints of shoulder and back pain, Resident # 1 was taken to the Emergency Department (ED) for evaluation by the Emergency Medical Transport. The driver was terminated due to failure to fasten seatbelts on 2 residents in the wheelchair van resulting in residents sliding out of chairs in van resulting in bruises and abrasions.

4. A review of the facility incident log for 4/21/06 revealed that Resident # 2 sustained a fall from the wheelchair in the facility van during transport. A review of the Nurses Notes for 4/21/06 2:15 PM revealed "Resident fell out of wheelchair on transportation van when driver slammed on brakes to keep from hitting a car. Res (resident) sustained two open areas on R (right) knee.

5. "Received call that resident on way to Doctor's office. During transport, resident was in wheelchair and driver had to stop abruptly. Resident fell out of wheelchair and landed on floor of van. Resident has deformed 3rd finger of right hand with swelling, bleeding across back of hand. Has abrasions on both knees, small abrasion on R shoulder. A review of the facility Occurrence Report dated 7/3/06 revealed, "Resident stated he was riding the facility van and a police car pulled in front of them. Bruises on knees, right

index finger edema with open area." A review of the van driver's written statement dated 7/3/06 revealed, "I was taking Resident # 1 to a doctor's appointment at approximately 2 PM. The van was on ___ Street at the intersection of ____ and ____ Street when a police car ran a stop sign. The police car had its lights on so I had to come to a complete stop and Resident # 1 fell out of the wheelchair. The wheelchair was secured to the floor. During an interview with Resident # 1 on 7/6/06 at 2:05 PM, Resident # 1 stated, "I had a doctor's appointment and we left around 2:00 PM. I was in a wheelchair. The driver used the lift to get the wheelchair in the van and put it beside the driver, looking out the big window. About 5 minutes later, the wheelchair slid to the left against the door. The driver had locked only one side of the wheelchair, and put only one strap on the right rear wheel. There was no seatbelt on the wheelchair. When I slid, the driver reached back and locked the other side of the wheelchair and said, 'It's okay.' Two or three minutes later, a cop pulled out in front and she hit the brakes. I fell forward and to the left, the wheelchair landed on top of me. Resident # 1 was the last transport on 7/3/06, and we initiated self-release seatbelts to be used on the wheelchairs on 7/4/06 before the first van transport. From now on, we will turn the wheelchairs so that they will be facing backward, so if there is a sudden stop, they will not go forward. In an interview with the Administrator on 7/7/06 at 11:00 AM, he stated, "Usually we have 1-2 staff transporting, depending on the resident and the situation. The wheelchairs are secured in the vans. If a resident was at risk for falls, or unable to sit safely without a seatbelt on the wheelchair in the facility, they would be transported with a seatbelt on the wheelchair in the van. If a resident didn't already need a seatbelt on the wheelchair, they would not be transported with one. Seatbelts have now been initiated for all residents on the vans, and new ones have been ordered.

6. Nurse # 3 had documented that at 12:45 PM the lady doing the transportation had returned with Resident #1 and reported he had a skin tear on his right hand when she hit a bump in van # 1. The exact description of the event included, "The lady driving the facility bus had said the bus ran into a bump and Resident was jolted and in the process cut his right hand." The resident stated, "I got pinned against the door. She pulled off the road and put on her brakes. As I recall, I was facing the side door. I couldn't move. My right leg was screwed up. It bruised it. The only cut was on my hand." At 9:20 AM on 7/22/05 an interview was conducted with the Director of Maintenance/Transportation who revealed, "I just found out a little while ago when they were talking about Resident #1 falling out of the chair. The chair was stationary. I understand the chair was strapped down, but I don't know about him being strapped in. We have a lap or seat belt in the other one (van # 2). The van (# 1) didn't have a wheelchair lap belt. You can get the tie down straps from any auto store." "One of the latches was broken a week or so ago. I always put the tie downs through the spokes and made sure they are tied down good." There was straps that I strapped the large wheels and I strapped the front wheels, too. I locked the wheels to the chair. I was pulling onto the main road after the appointment and was turning left. I heard him yell. He tilted over. He fell out of the chair. He was on his knees. He was in front of the entryway door. It banged his knee. His hand was hurt. There was a skin tear. He didn't have any bruises." The interview continued, "I think it was the way I turned. It was a sharp left turn. I looked and it was okay. You don't have long to get out of there. Traffic was coming. I had difficulty snapping the seat belt and when it didn't fasten, I just laid it across his lap. I put on the brakes and got off the road. I had trouble

with it (the tie down) tightening. The hook at the bottom may have come out on one side and let the chair go.

7. The facility failed to ensure that a resident in a geri-chair being transported in a van was secured properly with a seat belt resulting in the resident sliding out of the chair and sustaining injuries when the van stopped suddenly Interview with Resident revealed she recently had an accident where she "slid" out of the geri-chair while riding in the van to go to a physician's appointment. "The van stopped all of a sudden and I just slid right on down and out. I fell on my knees and broke a little bone there. I wasn't strapped in, people are just careless. The chair didn't turn over, it was strapped." A car pulled out in front of the van, causing the van to have to brake suddenly. The resident slid out of the geri-chair onto the floor between the geri-chair and the van front seat. The geri-chair did not turn over or tilt. The resident stated to the driver that she hit her head. A hematoma was noted to the back of the head, there was a skin tear to the right calf, a laceration to the right 4th toe and the right 3rd toenail was "pulled loose". There was moderate bleeding noted. X-rays taken at the emergency department were all negative except for a fracture of the proximal (part closest to the center of the body) right fibula (bone in lower leg). The driver stated that to her knowledge there had never been a van seat belt attached to the van floor, just whatever seatbelt was on the individual wheelchairs and geri-chairs. The driver stated "I never thought about it (a van seatbelt securing the resident). I always made sure the chairs were tied down tight.

8. Record review revealed an "Incident/Accident Report" dated 12/13/2004 at 8:15 PM, which documented the resident was "in van with seatbelt on returning to facility and when driver was turning into parking lot, the patient fell onto the floor in the van. Patient with two bruises on left the cheek and one bruise on the left neck." An interview with Resident #18 on 12/15/2004 at 12:35 PM indicated she fell out of her seat in the facility van when the driver was making a turn. During the same interview the resident indicated she was wearing a seatbelt and the driver was not turning fast. An interview with resident #18 at 3:45 PM on 12/15/2004 indicated that she had her seatbelt on, but the driver placed the seatbelt underneath her arm. Also during the same interview the resident revealed that her seatbelt was not tight enough. "It was very loose." In an interview and demonstration of the transport van's seatbelt use by the Activity Department when the incident occurred on 12/15/2004 at 4:00 PM, the Activity Director told the story of what happen on the day of the incident/accident on 12/13/2004, when she was transporting residents back from the Christmas Lighting. The Activity Director revealed she put Resident #18 in a vinyl individual seat and lock the seatbelt. When the driver (Activity Director) went to make a sharp turn the resident slid out of her seat onto the floor with her seatbelt in place. She then immediately stops the van and unhooks the seatbelt from around the resident. A plastic footstool was turn upside down by her seat, so when the resident fell out of her seat she hit her face on the footstool. Also during the same interview the Activity Director indicated the resident had sustained three bruises to the left side of her face. The Activity Director revealed that the Administrator informed her today (12/15/2004) that the resident's seatbelt may not have been pulled tight enough around the resident. "Maybe I didn't pull the seatbelt tight enough." During the demonstration the Activity Director demonstrated how she attached the seatbelt around the resident in the individual seat. During this demonstration it was revealed that the

Activity Director did not know how to adjust and secure the shoulder seatbelt when in use. The Activity Director stated, "I don't see any way to make the seatbelt tighter."

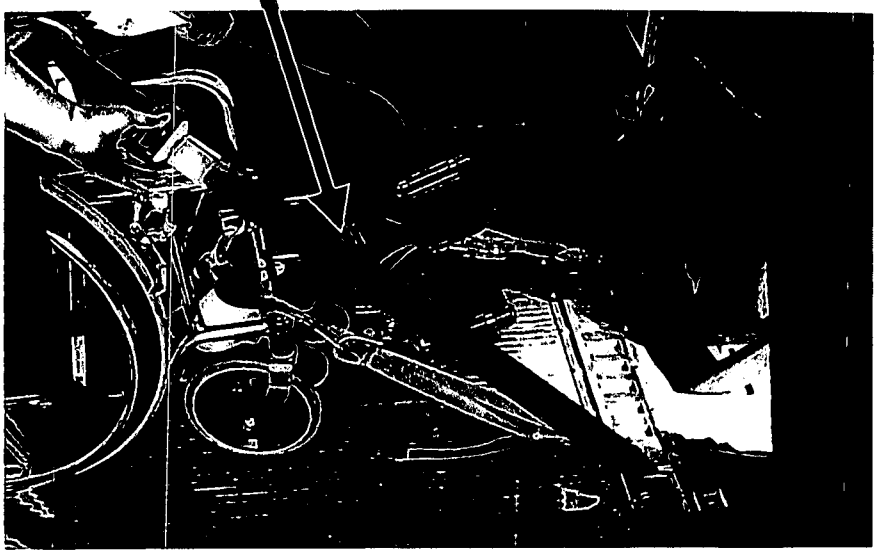
9. The facility failed to ensure that wheelchair dependent residents were appropriately strapped in the facility's van during transport. This involved one of two facility vans which did not have the proper straps to ensure residents were secured in their wheelchairs. Interview with Resident #3 on 1/4/05 at 2:39 PM revealed that wheelchair residents were not always strapped into the wheelchairs during transport. Resident #3 stated that sometimes she rides the van in a regular seat and sometimes she is transported in a wheelchair. Referring to notes she kept, Resident #3 described two instances where residents' wheelchairs were strapped to the floor but the residents were not strapped in their wheelchairs since the grievance was filed. Resident #3 stated that she was on the van during these instances and observed for herself that one resident each trip was not strapped into the van appropriately. The facility had no manufacturer recommendations or instructions available for utilizing the van's specific seat, shoulder and wheelchair safety straps for the wheelchairs during transportation.

10. The facility failed to safely secure 4 residents during transport in the facility van. Resident stated that on 2/26/2004 and 3/01/2004, he could not bend his knee and his outstretched leg would not fit in the transport van. The van's wheel chair securing device places the chair across the width of the van. He stated that his chair was tied with a rope through the back wheels and a staff member sat beside him and held onto the chair. The driver of the facility transport van on 3/08/2004 at 10:30 AM stated the transport van had an attachment plate for one wheel chair. She stated that if she had to transport more than one wheel chair bound resident, she secured the second resident with a rope tied through the spokes of the back wheel and secured to the floor supports of the back seat. A second staff member would ride along during the transport next to the second resident and help hold the wheel chair. She stated the resident secured with the attachment plate was also secured with a seatbelt attached to the van. The second resident who would be secured with a rope would not have access to a seatbelt, but used a wheel chair lap belt.

11. The following photographs were furnished as evidence of compliance with restraint expectations by a facility appealing a citation for endangering resident safety. The citation followed two separate transportation incidents in the past year that did not involve a collision. In the first instance, a resident slid from the chair and suffered severe injury requiring hospitalization. In the second instance, a resident slid from the chair and died an hour later at the hospital. The facility management vigorously defended their actions with proof that van restraints were inspected following each event and certified by the installer (a local Ford dealer) to be functioning properly. Unfortunately, the pictures provide evidence of precisely why the residents slide from the chairs with such ease. (Annotations illustrate errors that do not meet UMTRI recommendations)

Armrests prevent positioning the seatbelt across the pelvis thus allowing the rider to slide under the belt during sudden stops.

The lap belt is secured to the vehicle floor ahead of the rider instead of behind. This permits the entire restraint system (shoulder and lap) to slacken rather than tighten during an accident.



5

Ride Safe

An article by the University of Michigan Transportation Research Institute

Ride Safe

Information to help you travel more safely in motor vehicles while seated in your wheelchair.

Rehabilitation Engineering Research Center on Wheelchair Transportation Safety

University of Michigan Health System

University of Michigan Transportation Research Institute

Initially funded through a grant from the FRIENDS of the University of Michigan Hospitals

2005

When traveling in a motor vehicle, it is generally safest for wheelchair users to transfer to a vehicle seat and use the vehicle seatbelt system or a child safety seat that complies with federal safety standards. The wheelchair should then be stored and secured in the vehicle.

If transferring is not feasible, it is very important to secure the wheelchair to the vehicle facing forward and to use crash-tested seatbelts for the wheelchair-seated rider.

1 START WITH THE RIGHT EQUIPMENT

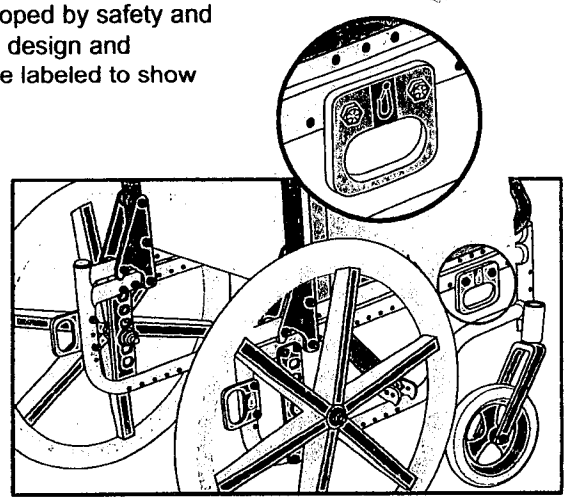
The Wheelchair

WC19 your ticket to ride

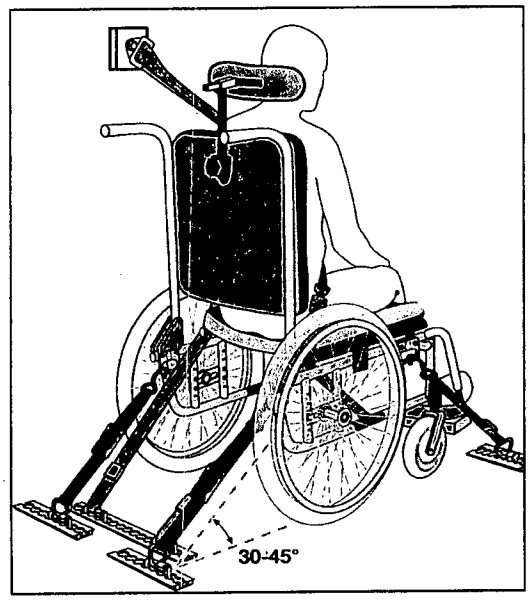
It is best if you have a wheelchair that has been designed and tested for use as a seat in motor vehicles, often referred to as a WC19 wheelchair or a transit wheelchair. These wheelchairs comply with ANSI/RESNA WC19, a voluntary standard developed by safety and rehabilitation experts. Wheelchairs that meet the design and performance requirements of this standard will be labeled to show that they comply with WC19.

Most importantly, a WC19 wheelchair has four, crash-tested securement points where tiedown straps and hooks can be easily attached. These points are clearly marked with a hook symbol.

If a WC19 wheelchair is not available, the next best choice is a wheelchair with an accessible metal frame where tiedown straps and hooks can be attached at frame junctions.



The Wheelchair Tiedown and Occupant Restraint System (WTORS)



It is important to use a complete WTORS to secure the wheelchair and provide the wheelchair occupant with a properly designed and tested seatbelt system.

Always use a WTORS that has been crash tested and labeled as complying with SAE J2249, a voluntary standard developed by safety and rehabilitation experts. The most common type of wheelchair tiedown uses four straps to secure the wheelchair to the vehicle. Although it requires someone other than the wheelchair rider to secure and release the wheelchair, this tiedown can secure a wide range of WC19 and non-WC19 wheelchairs.

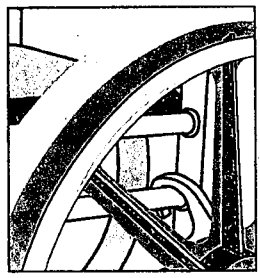
To protect the rider during a crash or sudden braking, and to minimize the likelihood of injury caused by contact with the vehicle, a seatbelt system with both pelvic and upper torso belts must be used.

2 SECURE THE WHEELCHAIR

Four-Point Tiedowns

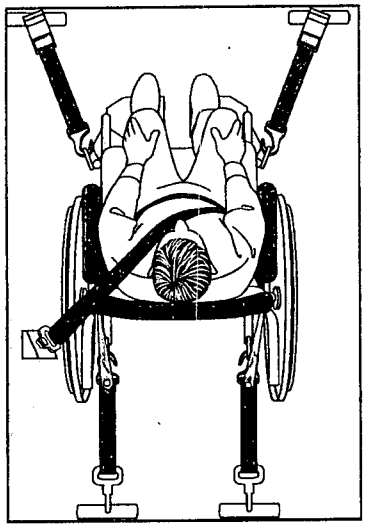
D Always position the wheelchair and rider facing forward in the vehicle.

D When securing a WC19 wheelchair, attach the four tiedown straps to the securement points provided on the wheelchair. Tighten the straps to remove all slack.



D If you do not have a WC19 wheelchair, it is best to attach the tiedown straps to welded junctions of the wheelchair frame or to other structural areas where the frame is fastened together with hardened steel bolts indicated by six raised lines or bumps on the bolt head.

D **Do not attach tiedowns to adjustable, moving, or removable parts of the wheelchair such as armrests, footrests, and wheels.**

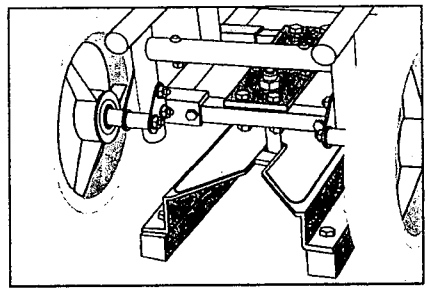


D When securing non-WC19 wheelchairs, choose structural securement points as close to the seat surface as possible to provide greater wheelchair stability during travel. It is best if the rear securement points are high enough to result in angles of the rear tiedown straps between 30 and 45 degrees to the horizontal.

D If you have a non-WC19 wheelchair with a tilt seat, make sure to attach both the front and rear straps to either the seat frame or to the base frame. Mixing wheelchair securement points between the seat and base can result in the tiedown straps becoming slack if the angle of the seat changes during a crash.

D It is best if floor anchor points for rear tiedown straps are located directly behind the rear securement points on the wheelchair. If possible, the front tiedown straps should anchor to the floor at points that are spaced wider than the wheelchair to increase lateral stability during travel.

Other Methods of Wheelchair Securement



D In addition to securing wheelchairs using a four-point tiedown, wheelchairs can also be secured using a docking tiedown device. This method is primarily used in private vehicles since it requires the addition of adaptor hardware to the wheelchair frame that will engage with the docking tiedown device in the vehicle. Docking securement devices allow the wheelchair rider to secure and release the wheelchair without assistance.

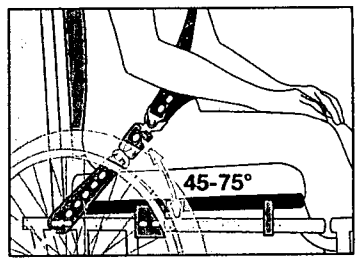
D If you plan to secure your wheelchair with a docking tiedown device, you should check with the WTORS or wheelchair manufacturer to ensure that your wheelchair model has been successfully crash tested with their system.

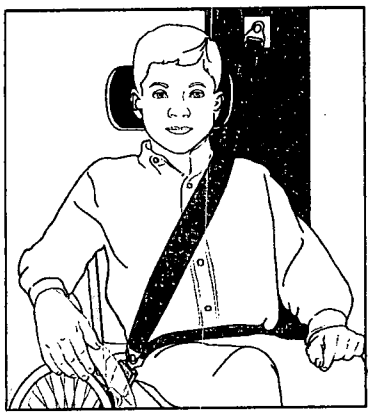
D Clamp-type securement devices are not recommended since they do not provide effective wheelchair securement in frontal crash testing.

3 PROTECT THE WHEELCHAIR RIDER

In addition to securing the wheelchair, **it is very important to provide effective restraint for the wheelchair user with a crash-tested lap and shoulder belt or with a child restraint harness.** Postural support belts attached to the wheelchair are not strong enough to withstand the forces of a crash and are usually not positioned correctly to restrain the occupant safely in a crash.

The lap belt should be placed low across the front of the pelvis near the upper thighs, not high over the abdomen. When possible, the lap belt should be angled between 45 and 75 degrees to the horizontal when viewed from the side. Some wheelchair features, like armrests, can interfere with good belt fit. To avoid placing the lap belt over the armrest and to keep the lap belt low on the pelvis, it may be necessary to insert the belt between the armrest and the seatback, or through an opening under the armrest.





A diagonal shoulder belt should cross the middle of the shoulder and the center of the chest, and should connect to the lap belt near the hip of the wheelchair rider. The upper shoulder-belt anchor point or D-ring guide should be anchored above and behind the top of the occupant's shoulder, so that the belt is in good contact with the shoulder and chest while traveling.

Newer WC19 wheelchairs offer the option of a crash-tested lap belt that is anchored to the wheelchair frame. If the wheelchair has an onboard crash-tested lapbelt, complete the belt system by attaching the lower end of a shoulder belt to the lap belt. Crash-tested wheelchair-anchored lap belts will be labeled to indicate that they comply with with ANSI/RESNA WC19.

Other Important Points

- Read and follow all manufacturers' instructions.
- It is best to ride with the wheelchair backrest positioned at an angle of 30 degrees or less to the vertical. If a greater recline angle is needed, the shoulder belt anchor point should be moved rearward along the vehicle sidewall so the belt maintains contact with the rider's shoulder and chest.

  Maximize the clear space around the rider to reduce the possibility of contact with vehicle components and other passengers in a crash. Cover vehicle components that are close to the rider with dense padding.
- Check WTORS equipment regularly and replace worn or broken components. Keep anchorage track free of dirt and debris.
- If a WTORS and wheelchair have been involved in a vehicle crash, check with the manufacturers to determine if the equipment needs to be repaired or replaced.
- If possible, remove hard trays and secure them elsewhere in the vehicle to reduce the chance of rider injury from contact with the tray. Consider the use of foam trays instead of rigid trays during transit. If it is not possible to remove a hard tray, place dense padding between the rider and the tray and make sure that the tray is securely attached to the wheelchair so it will not break loose and cause injury to other occupants in a crash.
- A properly positioned headrest can help protect the neck in a rear impact.
- If it is necessary to use a head and neck support during travel, soft neck collars are safer than stiff collars or head straps which could cause neck injury in a crash. The soft collar should not be attached to the seating system.
- Secure medical and other equipment to the wheelchair or vehicle to prevent it from breaking loose and causing injuries in a crash.

RESOURCES

Organizations

Rehabilitation Engineering and Research Center on Wheelchair Transportation Safety
www.rercwts.pitt.edu

University of Michigan Transportation Research Institute
www.umtri.umich.edu

University of Pittsburgh
www.wheelchairnet.org

Society of Automotive Engineers
www.sae.org

RESNA Rehabilitation Engineering Society of North America
www.resna.org

National Highway Traffic Safety Administration
www.nhtsa.dot.gov

National Mobility Equipment Dealer's Association
www.nmeda.org

The Association for Driver Rehabilitation Specialists
www.driver-ed.org

A Helpful Publication

School Bus Transportation of Students in Wheelchairs
A manual of procedures and practices used by the Washtenaw Intermediate School District for providing effective wheelchair securement and occupant restraint.

Washtenaw Intermediate School District
734-994-8100
www.wash.k12.mi.us

Wheelchair Manufacturers (Ask for Frames and/or Seating Products that Comply with WC19)

Convaid
www.convaid.com; 800-266-8243

Freedom Designs
www.freedomdesigns.com; 800-331-8551

GOVAN + wheelchair and docking system
www.smd-abitech.com; 204-975-3004

Invacare
www.invacare.com; 800-333-6900

Mulholland Postioning Systems
www.mulhollandinc.com; 800-543-4769

Otto Bock
www.ottobock.com; 800-328-4058

Permobil
www.permobil.com; 800-736-0925

Pride Mobility
www.pridemobility.com; 800-800-8586

Sammons Preston
www.sammonspreston.com; 800-323-5547

Sunrise Medical
www.sunrisemedicalonline.com; 800-333-4000

Wheelchair Seating Manufacturers (Ask for Products that have been Tested to WC19)

Adaptive Engineering Lab
www.aelseating.com; 800-327-6080

Adaptive Equipment Systems
www.aesys.com; 800-237-2370

Wheelchair Tiedown and Occupant Restraint Manufacturers (Ask for Products that Comply with SAE J2249)

Creative Controls
www.creativecontrolsinc.com; 800-539-7237

EZ-Lock
www.ezlock.net; 225-214-4620

Orthosafe
www.orthosafe.com; 609-587-9444

Q'Straint
www.qstraint.com; 800-987-9987

SureLok
www.sure-lok.com; 866-787-3565

GLOSSARY OF TERMS

Anchor point: The location on a vehicle, wheelchair, or wheelchair tiedown where a belt-restraint or wheelchair-tiedown anchorage is attached.

ANSI-RESNA WC19 (officially, SECTION 19 ANSI/RESNA WC/VOL. 1 *Wheelchairs for use in Motor Vehicles*): A voluntary standard for wheelchairs designed for use when traveling facing forward in a motor vehicle. NOTE: ISO 7176/19 is an international transit wheelchair standard that specifies similar design and performance requirements as ANSI/RESNA WC19.

Belt: A length of energy-absorbing webbing material used in occupant restraint systems.

Docking tiedown: A method for securing wheelchairs where portions of the wheelchair frame, or add-on components fastened to the wheelchair frame, engage with a securement device anchored to the vehicle.

Four-point strap-type tiedown: A method for securing a wheelchair where four straps are attached to the wheelchair at four separate securement points and attached to the vehicle at four separate anchor points.

Occupant restraint: A system or device designed to restrain a motor vehicle occupant in a crash by keeping the occupant in the vehicle seat and minimizing contact with the vehicle interior, other occupants, or objects outside the vehicle.

Postural support: A padded component and/or belt used to help maintain a person in a desired position during normal wheelchair use. In general postural supports are <u>not</u> designed to provide effective occupant restraint in a motor vehicle crash.

SAE Recommended Practice J2249 (officially, SAE J2249 *Wheelchair Tiedowns and Occupant Restraints for Use in Motor Vehicles*): A Society of Automotive Engineers Recommended Practice that specifies design and performance requirements for wheelchair tiedown and occupant restraint systems. NOTE: ISO 10542 is an international WTORS standard that specifies comparable design and performance requirements as SAE J2249.

Securement points: Specific structural points on the wheelchair base or seat frame that are designed for attachment of wheelchair tiedowns.

Strap: A length of webbing material used in wheelchair tiedown systems.

WC19 wheelchair: A crash-tested wheelchair with four clearly identified securement points that meets the design and performance requirements of ANSI-RESNA WC19 Wheelchairs Used as Seats in Motor Vehicles, and is sometimes called a transit wheelchair.

Wheelchair tiedown and occupant-restraint system (WTORS): A complete system for use by wheelchair-seated occupants comprised of a system or device for securing the wheelchair and a belt-type restraint system for limiting occupant movement in a motor vehicle crash.

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ATTACHMENT 10

A PERFECT CAUSE

AMERICA'S DISABILITY & ELDER RIGHTS ADVOCATES

Predators in America's Nursing Homes

Registered Sex Offenders Residing in Nursing Homes

2005 Report

Documented & Reported by the Nursing Home Watchdog Group
A Perfect Cause
A 501(c) (3), Not For Profit Corporation

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www.APerfectCause.org --405.228.0513

A PERFECT CAUSE
AMERICA'S DISABILITY & ELDER RIGHTS ADVOCATES

Introduction

It has been a year, since A Perfect Cause released its initial findings regarding Predators in America's Nursing Homes. Unfortunately, the problem of predators residing in long-term care facilities has grown dramatically. Even worse, A Perfect Cause has documented more rapes, assaults, arrests, and even one murder in long-term care facilities committed by residents with criminal records.

Appeals to the President of the United States, most state governors, as well as far too many state legislators and regulatory officials have fallen on deaf ears.

On the positive side, since releasing our findings in July 2004, four U.S. Congressional leaders appealed to the Government Accountability Office (GAO) for an in-depth federal investigation. The appeal by Congressman Henry Waxman, Senator Chuck Grassley, Congresswoman Betty McCollum, and now former Congressman Brad Carson was made in August 2004. The GAO accepted their request, in September 2004. The GAO anticipates completion of its investigation by year's end.

As well, there has been isolated movement in a few states to address the clear and present danger of predators residing in long-term care facilities. Yet other states choose to offer lip service or deny the risks imposed on those who can no longer protect themselves.

Illinois recently passed what appears to be the most forward thinking legislation to address the issue. Oklahoma choose to ignore the offenses uncovered by A Perfect Cause, yet passed legislation requiring law enforcement to notify and post notices if a registered sex offender or violent offender is residing in the nursing home. Unfortunately, the state of Oklahoma continues to ignore risks posed by inmates, parolees, and violent offenders found incompetent to stand trial who are placed into long-term care facilities by state and county agencies. As for the state's violent offender list, only 29 violent offenders are listed and eight of these violent offenders have no known address.

A Perfect Cause also uncovered New Jersey's policy regarding child molesters residing in nursing homes. In New Jersey, Tier 3 (High Risk) and Tier 2 (Moderate Risk) Sex Offenders, who are child molesters, are downgraded to Tier 1 (Low Risk) whenever they are moved into nursing homes. Low Risk sex offenders are not posted on the state's sex offender registry website and only law enforcement officials have access to records for these offenders. The apparent logic is that a child molester is not near their normal prey while living in a nursing home; therefore they do not pose a risk to the and disabled elderly.

A Perfect Cause's 2005 Report, clearly demonstrates the risks of housing criminal offenders with vulnerable adults. The number of registered sex offenders has grown from 380 last July, to 800 that have been located since the group initiated investigations in April 2004. In addition, this report documents over 20 cases of rape, assault, murder, and other crimes committed by criminal offenders while residing in long-term care facilities.

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The Beginning

The Predators in America's Nursing Homes – Registered Sex Offenders Residing In Nursing Homes analysis began with a phone call from Ziva Branstetter, Special Projects Editor of the Tulsa World, in mid-April 2004. Ms. Branstetter was seeking a comment from A Perfect Cause to the Tulsa World's investigative findings, which uncovered violent offenders found incompetent to stand trial, being placed in Oklahoma nursing homes and other long-term care facilities by order of district court judges.

After voicing shock and concern, A Perfect Cause immediately began investigations of its own. During the course of these investigations, other groups of predators were identified as residing in nursing homes and other long-term care facilities.

These groups include:

- Registered Sex Offenders
- Sex Offenders, who are not required to register
- Prison & County Jail Inmates
- Parolees
- Violent Offenders Found Incompetent to Stand Trial (see above)
- Convicted Felons

Many of these predators are warehoused in nursing homes by order or direction of state and county agencies including:

- Department of Human Services
- Department of Corrections
- County Sheriffs
- District Attorneys
- District Court Judges

For the purpose of this analysis, A Perfect Cause chose to identify registered sex offenders, residing in America's nursing homes.

A Perfect Cause began searching online sex offender registries in late April 2004 and concluded its first search on June 16, 2004. Offenders' addresses on these state registry websites were matched against a database of Medicare and / or Medicaid approved nursing homes downloaded from the Medicare.gov website, in late April 2004.

A Perfect Cause has continued to screen sex offender registries, including Massachusetts and California when their registries went online after A Perfect Cause's findings were first posted. The screening process has continued, with the final screens completed in July 2005.

Due to the nature of many of the online registries, A Perfect Cause does not guarantee that each offender is currently residing in the named facility. However, based on the sex offender registry data, each offender is either a current or previous resident of the nursing home facility.

The organization will attempt to identify other predators residing in nursing homes, by submitting more requests to all state governors and the President of the United States for assistance.

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Who Is In Harm's Way?

The number of citizens placed in harm's way, by warehousing predators in nursing homes is significant. Those most at risk include:

- Facilities' residents
- Staff and their children
- Visiting family members and friends, with their children
- Children from civic, church, and school groups - who visit and perform for long-term care residents
- Residents in neighborhoods near these facilities

Predators are often placed in these facilities without the knowledge of the residents, staff, visitors, and neighbors.

Many of these predators have committed crimes of opportunity against the most vulnerable citizens in our society - people with disabilities, the elderly, and children - who are physically incapable of fending off physical assaults, who have difficulty communicating, and who can be intimidated not to report these assaults.

In addition to several cases of murder, rape, and assault of residents by predators residing in nursing homes, two cases document the rape and sexual assault of a Rhode Island assisted living facility's housekeeper and a three-year-old girl who was visiting family in a Texas nursing home.

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What The Study Does Not Include

This study's data does not include violent offenders found incompetent to stand trial, prison and county jail inmates, parolees, violent offenders who have plea bargained release to nursing homes, and convicted felons. However, 22 cited cases of murder, rape, assault, and other offenses committed by residents with criminal histories are documented in this report.

Likely many more predators are residing in nursing homes and other long-term care facilities, than are uncovered in this analysis.

Most states do not list all sex offenders online. Those states with online registries typically post only the highest risk, aggravated, and /or habitual offenders.

Most sex offenders are not required to register unless they have been convicted or released from incarceration, parole, or probation since the 1990's.

Many sex offenders list PO Boxes as their residential addresses, while others have absconded or their whereabouts are unknown to law enforcement, despite requirements for their registration. For example on July 29, 2005; 1,396 out of Oklahoma's 5,194 registered sex offenders are delinquent or are in non-compliance with the state's sex offender registration act.

Many offenders listed addresses with one street number and / or within the same hundred block of a nursing home - these offenders were not included in this analysis. However, A Perfect Cause did confirm three Arkansas offenders residing in nursing homes who listed addresses in the same hundred block of a nursing home.

This analysis does not include sex offenders residing in Assisted Living Facilities, Residential Care Centers, and Intermediate Care Facilities for the Mentally Retarded (ICFMR) - with the exception of Oklahoma and a handful of Illinois facilities warehousing sex offenders.

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Findings

A Perfect Cause has located 800 Registered Sex Offenders living in nursing homes, in 36 states since the group initiated its on-going investigations in April 2004. 795 offenders were residents, while five were employees of long-term care facilities. States with the highest total number of registered sex offenders living in nursing homes are Texas with 124 offenders, Illinois with 121, California with 106, Ohio with 102, and Florida with 58.

637 offenders are currently residing in long-term care facilities. States with the highest number of offenders currently residing in nursing homes are Texas with 100 offenders, California with 95, Ohio with 89, Illinois with 76, Missouri with 38, and Florida with 37. Two offenders were also located as employees in Massachusetts and Virginia facilities.

In July 2004's report, A Perfect Cause located 380 Registered Sex Offenders residing in 289 nursing homes, in 37 states. States with the highest number of registered sex offenders in nursing homes are Texas with 70 offenders, Illinois with 57, Ohio with 39 plus three offenders listing two nursing homes as work addresses, Missouri with 35 offenders, and Florida with 30.

States with No Registered Sex Offenders In Nursing Homes

- ✓ Alabama
- ✓ North Dakota
- ✓ Pennsylvania
- ✓ Wyoming

There is no assurance that these states do not have any registered sex offenders or other criminal offenders residing or working in long-term care facilities. There were no registered sex offenders who were posted on the states' sex offender registry websites with addresses that matched nursing homes.

States Not Included in Study

- ✓ Hawaii
- ✓ Maine
- ✓ Minnesota
- ✓ Nevada
- ✓ Rhode Island
- ✓ South Dakota
- ✓ Vermont
- ✓ Washington
- ✓ West Virginia
- ✓ Wisconsin
- ✓ District of Columbia

These states do not have online sex offender registries or their sex offender registries do not list a complete address for the offender.
Note:

- *MA was not online during initial 2004 data capture*
  - *4 Residents / 1 Employee located in Nov. 2004*
- *CA was not online during initial 2004 data capture –*
  - *66 Residents / 0 Employees located in Dec. 2004*
- *OR is not online - Screened from hardcopy of offender registry*
  - *4 Residents / 0 Employees Located in Mar. 2005*

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Findings

About the Offenders
The natural assumption is – these offenders are so old or disabled they are no longer a threat to others. Data in the study does not support this argument.

2005 – Out of 756 offenders with dates of birth and / or ages posted on the sex offender sites, 341 of the offenders (45.2%) are under 60 years of age. 496 (65.8%) are under 70 years of age. The two youngest offenders living in nursing homes were 19 years of age.

47 out of 49 offenders in their 80's and 90's, were convicted above the age of 59. Ten were convicted in their 80's, with the two oldest being approximately 85 when last convicted.

76.4% of the offenders, out of 305 with ages and dates of conviction listed, were convicted within the past 14 years.

A Perfect Cause has also documented 12 of the inactive offenders (who were previously residing in nursing homes) are currently incarcerated. Six others are listed as absconded or with no known address.

2004 - Of the 346 registered sex offenders with dates of birth and /or ages listed in their profiles, 154 offenders (44.5%) are under 60 years of age. 227 offenders (65.6%) are under 70 years of age.

2004 - Of the six offenders in their 90's, four predators most recent offenses or convictions occurred in their 80's. Three Ohio offenders listed two nursing homes as their places of employment.

2004 -Of the 380-registered sex offenders identified in the analysis, 244 listed age ranges of victims or distinguished if the victims were adults or minors. 25 victims were classified as adults. Two offenders, whose victims were 65 and 77 year old females, reside in Texas nursing homes. One offender in a Florida nursing home's victim is identified as "elder/disabled." Most states did not list the ages of their adult victims.

Recidivism Rates
What is the risk? Recidivism rates are listed below for Oklahoma and California, along with an additional study.

Most of the reported recidivism rates are for relatively short periods of time. It appears that as time progresses, the likelihood to re-offend increases.

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STATISTICS

States with Registered Sex Offenders in Nursing Homes

Listed Alphabetically

State	Residents Total	Residents June 2005	Residents June 2004	Interim	Employees Total	Employees June 2004	Employees June 2005
AK	4	4	3				
AR	3	3	3				
AZ	6	5	2				
CA	106	95	0	66			
CO	2	1	2				
CT	11	10	6				
DE	4	4	2				
FL	58	37	30				
GA	13	12	5				
IA	9	8	3				
ID	5	3	3				
IL	121	76	57				
IN	9	7	6				
KS	12	9	11				
KY	3	3	3				
LA	13	10	10				
MA	5	5	0	4	1		1
MD	4	4	1				
MI	22	17	15				
MO	38	38	35				
MS	3	3	1				
MT	5	3	2				
NC	12	11	9				
NE	5	3	3				
NH	3	2	3				
NJ	2	1	1				
NM	10	10	10				
NY	10	10	3				
OH	102	89	39		3	3	0
OK	38	26	19				
OR	4	4	0	4			
SC	2	2	2				
TN	1	1	0				
TX	124	100	70				
UT	11	7	9				
VA	15	14	12		1		1
Totals	795	637	380	74	5	3	2

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STATISTICS
States with Registered Sex Offenders in Nursing Homes

Ranked By Total Offenders

Residents Rank	State	Total
1	TX	124
2	IL	121
3	CA	106
4	OH	102
5	FL	58
6	MO	38
7	OK	38
8	MI	22
9	VA	15
10	GA	13
11	LA	13
12	KS	12
13	NC	12
14	CT	11
15	UT	11
16	NM	10
17	NY	10
18	IA	9
19	IN	9
20	AZ	6
21	ID	5
22	MA	5
23	MT	5
24	NE	5
25	AK	4
26	DE	4
27	MD	4
28	OR	4
29	AR	3
30	KY	3
31	MS	3
32	NH	3
33	CO	2
34	NJ	2
35	SC	2
36	TN	1
	Totals	795

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STATISTICS

States with Registered Sex Offenders in Nursing Homes

Ranked By Active Offenders

Rank	State	Residents June 2005
1	TX	100
2	CA	95
3	OH	89
4	IL	76
5	MO	38
6	FL	37
7	OK	26
8	MI	17
9	VA	14
10	GA	12
11	NC	11
12	CT	10
13	LA	10
14	NM	10
15	NY	10
16	KS	9
17	IA	8
18	IN	7
19	UT	7
20	MA	5
21	AZ	5
22	AK	4
23	DE	4
24	MD	4
25	OR	4
26	AR	3
27	ID	3
28	KY	3
29	MS	3
30	MT	3
31	NE	3
32	NH	2
33	SC	2
34	CO	1
35	NJ	1
36	TN	1
	Totals	637

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STATISTICS

States with Registered Sex Offenders in Nursing Homes

Ranked By Percentage of Increase

Rank	State	Residents June 2005	June 2004*	%
1	MD	4	1	300%
2	NY	10	3	233%
3	MS	3	1	200%
4	IA	8	3	167%
5	AZ	5	2	150%
6	GA	12	5	140%
7	OH	89	39	128%
8	DE	4	2	100%
9	TN	1	0	100%
10	CT	10	6	67%
11	MA	5	4	25%
12	MT	3	2	50%
13	CA	95	66	44%
14	TX	100	70	43%
15	OK	26	19	37%
16	AK	4	3	33%
17	IL	76	57	33%
18	FL	37	30	23%
19	NC	11	9	22%
20	IN	7	6	17%
21	VA	14	12	17%
22	MI	17	15	13%
23	MO	38	35	9%
24	AR	3	3	0%
25	ID	3	3	0%
26	KY	3	3	0%
27	LA	10	10	0%
28	NE	3	3	0%
29	NJ	1	1	0%
30	NM	10	10	0%
31	OR	4	4	0%
32	SC	2	2	0%
33	KS	9	11	-18%
34	UT	7	9	-22%
35	NH	2	3	-33%
36	CO	1	2	-50%
	Totals	637	454	40%

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STATISTICS
Registered Sex Offender Age Breakdown

Ages	#	%	Teens/50's vs 60's-90's	
Teens	2	0.3%		
20's	25	3.3%		
30's	54	7.2%		
40's	123	16.3%		
50's	137	18.2%	341	45.2%
60's	155	20.6%		
70's	145	19.2%		
80's	98	13.0%		
90's	15	2.0%	413	54.8%
Totals	754	100.0%	754	100.0%

* 754 Out of 800 Records Obtained Documented Ages

Years Since Conviction

Range	#	%	Running Total / %	
0 - 4	41	13.4%	41	13.4%
5 - 9	97	31.8%	138	45.2%
10 - 14	95	31.1%	233	76.4%
15 - 19	41	13.4%	274	89.8%
20 - 29	27	8.9%	301	98.7%
30 - 39	2	0.7%	303	99.3%
40 - 49	1	0.3%	304	99.7%
50 - 59	1	0.3%	305	100.0%
Totals	305	100.0%		

* Only 305 Out of 800 Records Obtained Documented Conviction Dates and Ages

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STATISTICS
Inactive Offenders

Status	#
Incarcerated	12
Absconded / Unk Address	6
Change of Address	66
PO Box / Not Listed	64
Deceased	12
Address Not Disclosed	2
	162

* In-Active Offenders are Offenders Whose Addresses Are No Longer Listed At The Long-Term Care Facility
* Note: Database Tracks Offenders If They Relocate to Other Long-Term Care Facilities When Relocated, Status At The Previous Facility Is Listed As In-Active

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STATISTICS
Offenders in Their 80's & 90's with Age of Last Conviction

Offenders' Ages	Age @ Conviction	Offenders' Ages	Age @ Conviction
80	69	85	71
80	70	85	71
80	71	85	78
80	71	85	78
80	72	85	80
80	72	85	81
80	72	86	44
81	69	86	67
81	69	86	74
81	73	86	76
81	73	86	76
81	76	86	83
81	76	87	70
81	77	87	71
82	56	88	79
82	66	88	79
82	70	89	85
82	72	90	83
83	73	91	74
83	79	91	77
84	70	91	82
84	73	91	83
84	80	91	84
85	65	95	85
85	68		

* 47 of 49 Offenders Convicted Above the Age of 59

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STATISTICS

Formerly in Nursing Homes, Now Incarcerated

#	Offender	Last Long-Term Care Facility Located	City	State	Age
1	JENNINGS, LARRY CHARLES	SIERRA VISTA	HIGHLAND	CA	43
2	WILLIS, CECIL LORENZO	BONIFAY NURSING AND REHAB CENTER	BONIFAY	FL	77
3	BOOTH, DALE E.	SUMNER CARE AND REHAB CENTER	SUMNER	IL	58
4	EVANS, FRANADO R	PERSHING ESTATES	DECATUR	IL	41
5	FOSHEE, SHERRELL E.	CARDINAL HEALTH CARE	ENERGY	IL	74
6	HUNT, MORRIS	EMERALD PARK HEALTH CARE CTR	EVERGREEN PARK	IL	59
7	MOORE, ORLANDO	COUNTRYSIDE HEALTHCARE CENTER	DOLTON	IL	67
8	OLIVER, LARRY	CALIFORNIA GARDENS N & REHAB C	CHICAGO	IL	50
9	WOODRUM, BOBBY	WINSTON MANOR CNV & NURSING	CHICAGO	IL	64
10	McDANIEL, BILLY RAY	GREEN PARK NURSING & REHAB CENTER	TULSA	OK	68
11	MORRIS, JAMES HESTON	PINE HILL NURSING AND REHAB	JEFFERSON	TX	65
12	ORTEGA, GREGORIO JAMES	PALO DURO NURSING AND REHAB	AMARILLO	TX	51

Formerly in Nursing Homes, Location Now Unknown

#	Offender	Last Long-Term Care Facility Located	City	State	Age
1	GRIFFIN, HIAWATHA	SOUTH SHORE NUR & REHAB CENTER	CHICAGO	IL	62
2	POWERS, HAYDEN L	SHARON HEALTH CARE ELMS	PEORIA	IL	66
3	SPURR, JOHN T	EMERALD PARK HEALTH CARE CTR	EVERGREEN PARK	IL	57
4	MAFFETT, DANNY	EDNA LEE'S RESIDENTIAL CARE	VINITA	OK	56
5	WARNER, JOHN JAMES	OAKRIDGE NURSING HOME - ICFMR	WEWOKA	OK	49
6	DAVILA, ANTONIO VILLARREAL	LYNNHAVEN NURSING CENTER	CORPUS CHRISTI	TX	68

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Conventional Wisdom?

Only Old Registered Sex Offenders Live in Nursing Homes

✓ **FALSE**

Based on A Perfect Cause's July 2005 analysis, 45.2% of the 756 offenders with ages listed in sex offender registries are under 60 years of age.

In the group's 2004 analysis, 44.5% of the 346 offenders with listed ages were under 60 years of age.

Two 19-year-old sex offenders have been located as nursing home residents.

See "Registered Sex Offender Age Breakdown" above under STATISTICS

Elderly Sex Offenders Are Not A Threat

✓ **FALSE**

Based on the data analysis, 47 of 49 Registered Sex Offenders, with listed ages and dates of conviction, were convicted above the age of 59.

Ten of the 49 were convicted in their 80's. Two were convicted at 85 years of age.

Two cases cited below, Edwards and King, document two offenders at 83 and 86 years of age respectively who assaulted other nursing home residents.

See "Registered Sex Offender Age Breakdown" above under STATISTICS

Disabled / Infirm Offenders Are Safe

✓ **FALSE**

Four cited cases below dispute this statement.

Miri D. King	Reno, NV	May 2000
Ivey Edwards	Jacksonville, FL	July 2002
Samuel Irving	New York, NY	May 2004
John Enos	Norwood, MA	Feb 2005

Child Molesters Do Not Pose a Threat to Old People

✓ **FALSE**

Three cited cases below dispute this statement.

Miri D. King	Reno, NV	May 2000
Ivey Edwards	Jacksonville, FL	July 2002
John Enos	Norwood, MA	Feb 2005

Its Only Registered Sex Offenders Who Pose a Risk

✓ **FALSE**

Five cited cases below dispute this statement.

Billy Ray McDaniel	Oklahoma City, OK	Sept 2002
Samuel Irving	New York, NY	May 2004
Hedrick (Chgs Dropped)	Oklahoma City, OK	July 2004
Patrick Wilhoite	Richardson, TX	May 2001
Ronald J. Leddy	Central Falls, RI	June 2005

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RECIDIVISM RATES

Webster's Dictionary defines "recidivism" as a tendency to relapse into a previous condition or mode of behavior; esp.: relapse into criminal behavior. This may be thought of as the rate or percentage of offenders who are committed to the custody of the Department of Corrections for another offense within a specified period of time. Different states use different tracking periods varying from 1 to 20 years as reported by the Corrections Yearbook. Oklahoma uses the standard reporting period of three years, as seen below.

Offense Category	# Released	# Returned	% Returned
Unauthorized Use of Motor Vehicle	1522	621	40.8
Burglary II	7397	2890	39.1
Burglary I	821	314	38.3
Larceny	9557	3525	36.9
DUI - 2nd Offense	8891	3212	36.1
Murder I	182	65	35.7
Forgery	2529	882	34.9
Escape	2747	951	34.6
Robbery	3001	1035	34.5
Bogus Check	1341	414	30.9
Weapons	1950	558	28.6
Bribery	7	2	28.6
Possession/Obtaining Drugs	7473	2125	28.4
Assault	3133	848	27.1
Other Non-Violent Crimes	1637	429	26.2
Fraud	1239	307	24.8
Arson	439	106	24.2
Distribution of Drugs	8775	2066	23.5
Embezzlement	804	188	23.4
Other Violent Crimes	1081	234	21.7
Rape	1269	262	20.7
Gambling	20	4	20.0
Manslaughter	846	167	19.7
Kidnapping	162	31	19.1
Murder II	271	51	18.8
Sex Offenses (not including rape)	2143	362	16.9
Drug Trafficking	426	33	7.8
(Unknown Offenses at time of prison release not included)			

Represents Oklahoma offenders released from Jan. 1, 1985 – June 30, 1999.

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California Recidivism Rates w/in 1 & 2 Years for Male Felons Released from Prison for First Time in 2001
By Principal Commitment Offense

Published Mar 2004

Principal Commitment Offense	# Paroled	One Year #	One Year %	Two Years #	Two Years %
Murder First (new law)	-	-	0.0%	-	0.0%
Murder Second (new law)	3	-	0.0%	-	0.0%
Manslaughter	342	85	24.9%	130	38.0%
Vehicular Manslaughter	106	19	17.9%	33	31.1%
Robbery	2,807	1,156	41.2%	1,605	57.2%
Assault/Deadly WP	2,370	959	40.5%	1,281	54.1%
Attempted Murder First	4	1	25.0%	1	25.0%
Attempted Murder Second	193	48	24.9%	74	38.3%
Other Assault/Battery	3,366	1,466	43.6%	1,961	58.3%
Rape	245	72	29.4%	96	39.2%
Lewd Act With Child	978	224	22.9%	301	30.8%
Oral Copulation	100	37	37.0%	51	51.0%
Sodomy	33	6	18.2%	9	27.3%
Sexual Penetration with Object	53	11	20.8%	15	28.3%
Other Sex	864	421	48.7%	526	60.9%
Kidnapping	146	36	24.7%	58	39.7%
Burglary First	1,743	794	45.6%	1,049	60.2%
Burglary Second	2,766	1,410	51.0%	1,799	65.0%
Grand Theft	1,319	587	44.5%	731	55.4%
Petty Theft With Prior	2,651	1,460	55.1%	1,810	68.3%
Receiving Stolen Property	1,394	747	53.6%	927	66.5%
Vehicle Theft	2,253	1,305	57.9%	1,583	70.3%
Forgery/Fraud	925	363	39.2%	488	52.8%
Other Property	240	106	44.2%	132	55.0%
CS Possession	9,672	4,813	49.8%	6,173	63.8%
CS Possession for Sale	5,230	1,643	31.4%	2,263	43.3%
CS Sales	1,954	577	29.5%	774	39.6%
CS Manufacturing	1,270	271	21.3%	411	32.4%
CS Other	249	125	50.2%	159	63.9%
Hashish Possession	26	6	23.1%	11	42.3%
Marijuana Possession for Sale	649	214	33.0%	293	45.2%
Marijuana Sale	298	104	34.9%	142	47.7%
Marijuana Other	85	20	23.5%	30	35.3%
Escape	60	29	48.3%	37	61.7%
Driving Under Influence	1,512	391	25.9%	586	38.8%
Arson	131	48	36.6%	68	51.9%
Possession Weapon	1,861	901	48.4%	1,196	64.3%
Other Offenses	1,374	579	42.1%	776	56.5%
TOTAL	49,272	21,034	42.7%	27,579	56.0%

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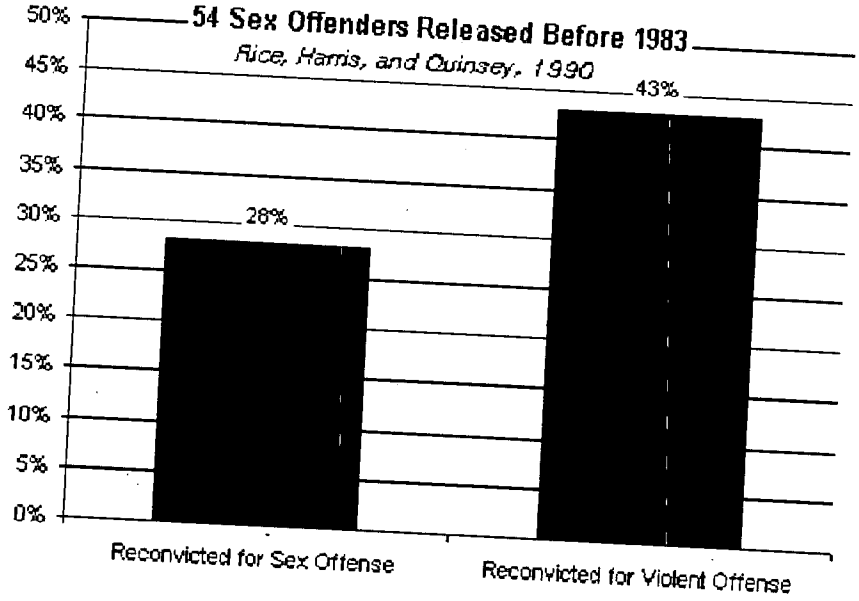
RECIDIVISM RATES

Rapists

There has been considerable research on the recidivism of rapists across various institutional and community-based settings and with varying periods of follow-up. A follow-up study of sex offenders released from a maximum-security psychiatric institution in California found that 10 of the 57 rapists (19 percent) studied were reconvicted of a rape within five years, most of which occurred during the first year of the follow-up period (Sturgeon and Taylor, 1980). These same authors reported that among 68 sex offenders not found to be mentally disordered who were paroled in 1973, 19 (28 percent) were reconvicted for a sex offense within five years.

In a study of 231 sex offenders placed on probation in Philadelphia between 1966 and 1969, 11 percent were rearrested for a sex offense and 57 percent were rearrested for any offense (Romero and Williams, 1985). Rice, Harris, and Quinsey (1990) conducted a more recent study of 54 rapists who were released from prison before 1983. After four years, 28 percent had a reconviction for a sex offense and 43 percent had a conviction for a violent offense.



In their summary of the research on the recidivism of rapists, Quinsey, Lalumiere, Rice, and Harris (1995) noted that the significant variation in recidivism across studies of rapists is likely due to differences in the types of offenders involved (e.g., institutionalized offenders, mentally disordered offenders, or probationers) or in the length of the follow-up period. They further noted that throughout these studies, the proportion of offenders who had a prior sex offense was similar to the proportion that had a subsequent sex offense.

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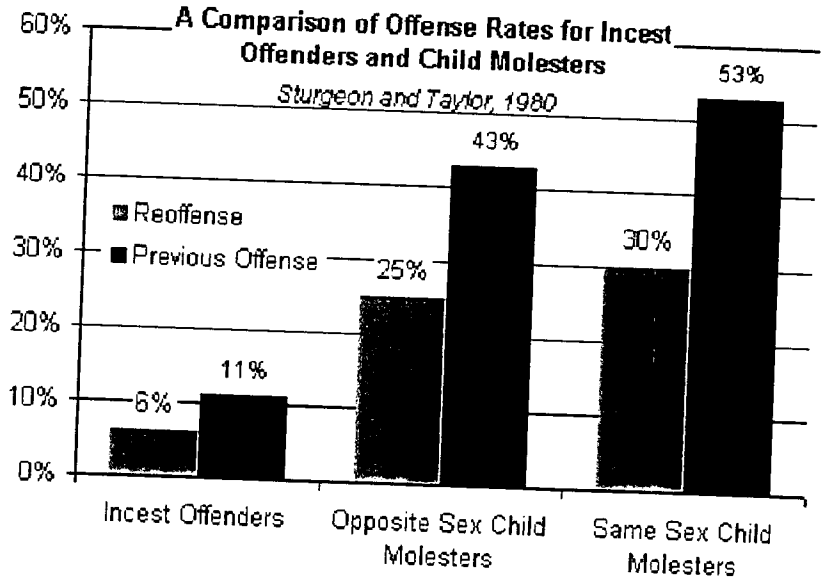
RECIDIVISM RATES

Child Molesters

Studies of the recidivism of child molesters reveal specific patterns of reoffending across victim types and offender characteristics. A study involving mentally disordered sex offenders compared same-sex and opposite-sex child molesters and incest offenders. Results of this five-year follow-up study found that same-sex child molesters had the highest rate of previous sex offenses (53 percent), as well as the highest reconviction rate for sex crimes (30 percent). In comparison, 43 percent of opposite-sex child molesters had prior sex offenses and a reconviction rate for sex crimes of 25 percent, and incest offenders had prior convictions at a rate of 11 percent and a reconviction rate of 6 percent (Sturgeon and Taylor, 1980). Interestingly, the recidivism rate for same-sex child molesters for other crimes against persons was also quite high, with 26 percent having reconvictions for these offenses. Similarly, a number of other studies have found that child molesters have relatively high rates of nonsexual offenses (Quinsey, 1984).



Several studies have involved follow-up of extra-familial child molesters. One such study (Barbaree and Marshall, 1988) included both official and unofficial measures of recidivism (reconviction, new charge, or unofficial record). Using both types of measures, researchers found that 43 percent of these offenders (convicted of sex offenses involving victims under the age of 16 years) sexually reoffended within a four-year follow-up period. In contrast to other studies of child molesters, this study found no difference in recidivism between opposite-sex and same-sex offenders.

In a more recent study (Rice, Quinsey, and Harris, 1991), extra-familial child molesters were followed for an average of six years. During that time, 31 percent had a reconviction for a second sexual offense.

Source: Recidivism of Sex Offenders - Center for Sex Offender Management
Silver Spring, MD 20910
Phone: (301) 589-9383
Internet: www.csom.org

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Cited Cases – Murder, Rapes, Assaults, & Arrests

Florida
Edwards, Ivey
83 Year Old Sex Offender / multiple criminal offenses, including fondling a child
July 2002
Accused of raping a 77-year-old female nursing home resident in Jacksonville, FL
Police & Court Records
http://www.aperfectcause.org/PDF_APC/NV-MirlDKing-06121913.pdf

Illinois
Sharp, Larry
54-Year-Old Convicted Rapist
May 2005
Allegedly groped 77-year-old woman in Homewood, IL nursing home
Chicago Sun Times – May 12, 2005
http://www.aperfectcause.org/artman/publish/article_1122.asp

Kolze, Thomas
61-Year-Old Convicted Child Molester
Late 2003
Reported touched the thighs and arms of an Alzheimer's patient, touched the chest of another woman with dementia.
Chicago Sun Times – April 24, 2005
http://www.aperfectcause.org/artman/publish/article_1077.asp

Wallace, Karey D.
35-Year-Old Sex Offender
Reportedly tried to rob a vide store near the nursing home
Chicago Sun Times – April 24, 2005
http://www.aperfectcause.org/artman/publish/article_1077.asp

Oliver, Larry
50-Year-Old Sex Offender
2004
Arrested for drug possession
Chicago Sun Times – April 24, 2005
http://www.aperfectcause.org/artman/publish/article_1077.asp

Cothrain, James
57-Year-Old
April 2005
Arrested on warrant for obstructing a court order for criminal damage to property
Daily Southdown – April 9, 2005
http://www.aperfectcause.org/artman/publish/article_1059.asp

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Cited Cases – Murder, Rapes, Assaults, & Arrests

Illinois - Continued
Williams, Jerry L.
49-Year-Old
April 2005
Arrested on warrant for violation of conditional release on domestic battery charges
Daily Southdown – April 9, 2005
http://www.aperfectcause.org/artman/publish/article_1059.asp

Young, Maurice
46-Year-Old
April 2005
Arrested on warrant for battery and failing to register as a child sex offender
Daily Southdown – April 9, 2005
http://www.aperfectcause.org/artman/publish/article_1059.asp

Barber, Tyrone
54-Year-Old
April 2005
Arrested for failing to register as a child sex offender
Daily Southdown – April 9, 2005
http://www.aperfectcause.org/artman/publish/article_1059.asp

Louisiana
Sylvester, Robert Jr.
48-Year-Old with Convictions for Armed Robbery and Burglary – On Parole
Booked for the aggravated rape of a mentally handicapped female in her 30's. Both resided in the nursing home.
The Times Picayune – December 2004
http://www.aperfectcause.org/artman/publish/article_790.asp

Massachusetts
Enos, John
68-Year-Old Level 3 (High Risk) Registered Sex Offender
February 2005
Charged with raping is 90-year-old male roommate in a Norwood, MA nursing home
Note: A Perfect Cause located this offender, residing in the nursing home in Nov. 2004
The Boston Globe - February 10, 2005
http://www.aperfectcause.org/artman/publish/article_961.asp
A Perfect Cause – Predators Search System
http://aperfectcause.org/ussolu/offenderdata.asp?s_offender=ENOS%2C+JOHN+A%2E&ussolistDir=&ID=20

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Cited Cases – Murder, Rapes, Assaults, & Arrests

Minnesota
WK
44-Year-Old Level 2 Sex Offender – Admitted to nursing home from, Minnesota Correctional Facility
Charged in 1997 with 1st & 2nd Degree Criminal Sexual Conduct Against A Vulnerable Adult
February 2004
Developed "friendship" with unsuspecting resident, found in resident's room
Press Release – MN Attorney General Mike Hatch - May 26, 2004
http://www.aperfectcause.org/artman/publish/article_24.asp

JA
26-Year-Old Level 2 Sex Offender under Department of Corrections jurisdiction, Pedophile
August 2003
JA's Husky dog put is mouth on the food of other residents
Fall 2003
Fondled private parts of 43-year-old female with mental retardation, borderline intelligence, and schizophrenia. Penetrated female resident's vagina causing bleeding, had sexually explicit photo of same resident.
Note – Nursing home's management thought the relationship was cute.
Press Release – MN Attorney General Mike Hatch - May 26, 2004
http://www.aperfectcause.org/artman/publish/article_24.asp

AS
54-Year-Old Sex Offender - Admitted to nursing home from, Minnesota Correctional Facility
History of oral sex involving a minor
Fondled the breasts of a female resident, who was unable to make informed sexual decisions
Note: Nursing home staff treated this incident as "consensual sex."
Press Release – MN Attorney General Mike Hatch - May 26, 2004
http://www.aperfectcause.org/artman/publish/article_24.asp

Unidentified
Alleged Murderer
Kidnapped a vulnerable female resident from the facility, was missing for four days, left her on the streets. There was no report
Star Tribune – May 27, 2004
http://www.aperfectcause.org/artman/publish/article_25.asp

Nevada
King, Mirl D.
86-Year-Old Convicted Child Molester
May 2000
Reported to have sexually assaulted 2 female residents within a 2 ½ hour period
Police & Court Records
http://www.aperfectcause.org/PDF_APC/NV-MirlDKing-06121913.pdf

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Cited Cases – Murder, Rapes, Assaults, & Arrests

New York
Irving, Samuel
43-Year-Old with Drug, Weapons, and Robbery Convictions – Double Amputee
May 2004
Confessed to raping and beating a 78-year-old invalid in a Brooklyn nursing home where both lived.
New York Daily News – May 9, 2004
http://www.aperfectcause.org/artman/publish/article_18.asp
Later attempted to hire a hit man to "whack" the victim, staffer who caught him, and the prosecutor
New York Post – June 23, 2004
http://www.aperfectcause.org/artman/publish/article_48.asp

Oklahoma
Barefoot, Bryan
31-Year-Old Sex Offender
June 2002 – April 2003
Promiscuous sexual behavior (usually chooses young low functioning females who cannot talk well enough to tell on him. Initiated a group session of sexual interaction with several males and one of the lower functioning females. Takes things that don't belong to him. Bullies those weaker than himself.
Tulsa World – May 9, 2004
http://www.aperfectcause.org/artman/publish/article_16.asp
Police & Court Records
http://www.aperfectcause.org/PDF_APC/OK-BryanEBarefoot-04101970.pdf

McDaniel, Billy Ray
65-Year-Old previously convicted of Unauthorized Use of a Motor Vehicle, Larceny of Merchandise, and Attempted Burglary II
September 2002
Sexually battered an 89-year-old female nursing home resident. 21 days later was interviewed by the police investigator at another nursing home.
Police & Court Records
http://www.aperfectcause.org/PDF_APC/OK-McDanielBillyRay-12011936.pdf
Update
Violated 5 year suspended sentence and sex offender registration requirements, was located by Fox News in Tulsa and A Perfect Cause in an Tulsa nursing home, while he was listed with "no known address" on the Dept. of Corrections Sex Offender Registry website. He is listed as an Aggravated Sex Offender.
FOX 23 News – May 9, 2005
http://www.aperfectcause.org/artman/publish/article_1114.asp
Tulsa World – May 10, 2005
http://www.aperfectcause.org/artman/publish/article_1111.asp

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Cited Cases – Murder, Rapes, Assaults, & Arrests

Oklahoma -Continued
Hedrick, Kenneth Lee – Charges Dropped
40-Year-Old previously convicted of Possession of a Controlled Dangerous Substance (methamphetamine) and Failure to Stop at a Road Block
July 2004
Arrested for raping a 77-year-old female who was also residing in an Oklahoma City nursing home
The Oklahoman – July 22, 2004
http://www.aperfectcause.org/artman/publish/article_74.asp
Police & Court Records
http://www.aperfectcause.org/PDF_APC/OK-HedrickKennethLee-01021964.pdf

Rhode Island
Leddy, Ronald J.
43-Year-Old Criminal History includes convictions for Robbery, Stolen Cars, Possession of a Pistol, Assault with the Intent to Commit a Felony, and Escape.
June 2005
Accused of murder and rape, while residing in an assisted living facility. Murder victim was a 35-year old daughter of a retired police detective. The facility's housekeeper was the rape victim.
The Pawtucket Times – June 11, 2005
http://www.aperfectcause.org/artman/publish/article_1173.asp

Texas
Wilhoite, Patrick
65-Year-Old with previous convictions for Larceny
May 2001
Convicted of sexually molesting a three year girl who was visiting family in the nursing home
KVTV – CBS 11 News – March 2, 2005
http://www.aperfectcause.org/artman/publish/article_1000.asp

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Famous & Infamous Quotes

"This is incomprehensible. How could you put sex offenders in a locked ward with vulnerable adults?" "It defies imagination. I'm absolutely dumbfounded that this could go on in this state and that government agencies were involved."

Minnesota Attorney General Mike Hatch
Star Tribune
May 27, 2004
http://www.aperfectcause.org/artman/publish/article_25.asp

"This was better then just letting them out into the community or having them live under a bridge." 'W.K. was himself a "vulnerable adult" and that "even vulnerable adults have relationships."'

Minnesota Corrections Commissioner Joan Fabian
Star Tribune
May 27, 2004
http://www.aperfectcause.org/artman/publish/article_25.asp

"Elderly sex offenders in nursing homes are a low-risk group. Sex drive declines with age. Though there are exceptions to the rule, men like those in Carlton Manor are not likely to offend again in old age." At least 10 of Carlton Manor's sex offenders are 59 or older.

"I would be more concerned about people who weren't ID'd as sex offenders living next to you than somebody identified living in a secured nursing home."

Dr. Wesley Maram – psychologist - Sex Offender Solutions, in CA
The Columbus Dispatch
July 16, 2004
http://www.aperfectcause.org/artman/publish/article_297.asp

"The guys we have here are well-behaved. The ones who have been in prison are grateful to be here."

Carlton Manor Administrator Drew Vogel
The Columbus Dispatch - July 16, 2004
http://www.aperfectcause.org/artman/publish/article_297.asp

"If they're in a controlled environment, as far as access to the public, it would be better than not."

Fayette County Deputy Sheriff Robert Russell
The Columbus Dispatch - July 16, 2004
http://www.aperfectcause.org/artman/publish/article_297.asp

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Famous & Infamous Quotes

'Would not support a ban on sex offenders being placed in nursing homes because "they are not the only folks who present these problems for us in nursing homes." Crutcher said Alzheimer's patients and other nursing home residents can also become sexually aggressive.'

'Regulations are in place allowing the state to ensure the safety of all residents in nursing homes and other facilities inspected by the department.'

Oklahoma Department of Health, Commissioner Dr. Mike Crutcher
Tulsa World
May 11, 2004
http://www.aperfectcause.org/artman/publish/article_21.asp

'(Oklahoma State Secretary of Health, Terry) Cline and health officials also reviewed nursing home assault records for the past three years and found that no registered sex offenders had committed assaults on fellow residents during that period of time. The assailants were either nursing home employees or more frequently, other residents without criminal records.'

Press Release – Oklahoma Governor Brad Henry – January 27, 2005
http://www.aperfectcause.org/artman/publish/article_936.asp

'Some senators also questioned whether a crime someone committed decades ago should be held against them.'

The Advocate – June 17, 2005
http://www.aperfectcause.org/artman/publish/article_1179.asp

"I think the concerns are somewhat exaggerated. The bill in no way releases anytime a felon or anybody into a nursing home."

"People who are dying from an incurable illness, who are not a danger, who can't commit crimes anymore due to their physical situation, the Post Prison Transfer Board needs to have the ability to put them somewhere, to allow them to be maybe detained somewhere else so that person can get appropriate medical care."

Arkansas State Representative – Will Bond
Arkansas News Bureau – March 5, 2005
http://www.aperfectcause.org/artman/publish/article_1022.asp

"Said... he did not previously see Enos as a threat. "He was bedridden. This is not someone who is going to be roaming around. He's in tough shape and lost part of his foot.

Comments made about John Enos (see Cited Cases – above)
Officer Robert Baker - Norwood, MA Police Department (handles sex registry issues)
The Boston Globe – February 10, 2005
http://www.aperfectcause.org/artman/publish/article_961.asp

"It is inconceivable how anyone would think it is appropriate to place these predators among the most vulnerable adults in our society, our disabled and elderly loved ones, who often cannot physically protect themselves or report what has happened to them."

"When you put predators in with the prey, somebody's going to get bit."

Wes Bledsoe – President, A Perfect Cause

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A Violation of Resident Rights / Regulations

According to the Code of Federal Regulations, Title 42, Subpart B Requirements for Long Term Care Facilities, Part 483.15 Quality of life – A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

(e) Accommodation of needs. A resident has the right to - (1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

(f) Activities. – (1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(h) Environment. The facility must provide - (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible

Warehousing predators in nursing homes appears to violate these regulations.

Does reasonable accommodation include living with predators?

Can these predators endanger the health and safety of other residents?

Are these facilities providing the services that meet the physical, mental, and psychosocial well-being of residents by placing predators in the same facility?

What activities and assessments are provided for offenders to meet their physical, mental, and psychosocial needs?

Is locking a registered sex offender under 60 years of age on the Alzheimer's ward of a nursing home meeting that offender's needs?

Do nursing homes with predators offer safe and homelike environments?

How long would most families choose to live with a violent offender or sex offender in their home?

How many families have locked their doors and used security alarms for years, to keep criminals outside of their homes? Yet, how many long-term care residents are forced to live with criminal offenders, under the same roof, with no locked door between them, simply because they are disabled or elderly and require assistance with their activities of daily living?

Do the disabled and elderly have the right to live in a residence without criminal offenders?

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Proposed Action Steps By Residents and Families

1. Check A Perfect Cause's Predators' Search System

   Residents and families are encouraged to access and check A Perfect Cause's website and Predators Search System at www.APerfectCause.org. We are tracking violent offenders across the nation who are living and working long-term care facilities.

   Due to limited access to information about offenders and residents, A Perfect Cause cannot assure you that all violent offenders and / or nursing homes have been screened.

2. Ask the Long-Term Care Facility's Administrator these Questions
   - Do you have any sex offenders as residents in this facility?
   - Will you allow sex offenders as residents in the future?
   - Do you have any prison inmates or parolees as residents in this facility?
   - Will you allow prison inmates or parolees as residents in the future?
   - Do you have any jail inmates as residents in this facility?
   - Will you allow jail inmates as residents in the future?
   - Do you have any violent offenders found incompetent to stand trial as residents in this facility?
   - Will you allow violent offenders found incompetent to stand trial as residents in the future?
   - Do you have any convicted felons in this facility?
   - Will you allow convicted felons as residents in the future?
   - Do you have any residents who sexually or physically assault other residents in this facility?
   - Will you allow any residents who sexually or physically assault other residents in the facility, in the future?
   - If yes to any of the above, what special training and security have you implemented to care for these offenders and to safeguard other residents?
   - If you do admit them in the future, will you notify residents, families, and visitors?
   - How will you notify residents, families, and visitors?

3. Use Video Monitoring where Applicable

   Many states allow for one party consent video monitoring. If your state allows this type of security, it is your right to use video monitoring with the permission of the resident and / or the resident's legal representative.

   Video monitoring can protect residents, staff, and visitors as a preventive measure.

   It can also document criminal activities, abuse, and neglect allowing the residents' families, staff, regulatory agencies, and law enforcement to effectively and swiftly respond before these actions are repeated.

   Families cannot be present 24 hours a day, seven days a week to monitor their loved ones. Facilities are not adequately staffed to monitor the activities of residents and while many facilities have "lock-down" or "secure" units, residents continue experience rape, assault, neglect, and abuse in America's nursing homes.

4. Move Your Loved One to a Facility Without Violent Offenders

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Proposed Action Steps
For Regulatory Officials and Legislators

1. Immediately conduct public hearings and investigations as into the placement of predators into long-term care facilities by state and county agencies.

2.a. Immediately put an end to the practice of placing any and all of the above offenders into long-term care facilities with non-offenders.

2.b. In the interim, require all state and county agencies who are placing any of the above offenders into long-term care facilities to report such placement to the state regulatory agency.

3. Require long-term care facilities to immediately report all cases of rape, sexual and physical assault to law enforcement and to the state's long-term care regulatory agency.

4. Require the state long-term care regulatory agency to track all incidents of rapes, sexual and physical assaults in long-term care facilities. This includes attaching a copy of law enforcement's incident report to the file.

5. Require the state long-term care regulatory agency to track all assailants who rape, sexually and / or physically assault other residents, staff, and / or visitors. As part of this process, require a national criminal background check on all assailants.

6. Require national criminal background checks on all staff.

7. Require national criminal background checks on all residents. This will screen the offenders from non-offenders. Consider apartment complexes that require not only credit checks, but criminal background checks as well. These complexes wish to keep undesirable tenants out, while protecting the peace and safety of other residents.

Further, these apartment complexes provide a key to their residents, to locks on their doors, and these residents allow whomever they choose to come and go as they please. In a nursing home, the residents do not receive a key. Their doors are open 24 hours a day, seven days a week, to whomever is in the facility.

8. Post visible notices on all entrances of long-term care facilities housing offenders, stating there is a violent offender on the premises.

9. Establish separate long-term care facilities for residents who are violent offenders. Do not mix offenders with non-offenders. Require specialized training and security in these facilities. Offer higher reimbursement rates to operators who wish to contact for this business.

This is also an economical benefit for those facilities housing non-offenders. They will not endure workers compensation claims from staff offended or affected by offenders, as well the facilities will not be sued for failing to protect residents from rapes, sexual and / or physical assaults.

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About A Perfect Cause

A Perfect Cause, is a 501 (c) (3) not-for-profit organization, serving as America's disability and elder rights advocates. The organization's mission is to end needless suffering and preventable deaths, while protecting the rights of people with disabilities and our elders for quality healthcare and long-term care services.

The organization was founded in the spring of 2001, by Wes Bledsoe in honor of his grandmother, Eunice Allen, an Oklahoma City nursing home victim and the thousands of other nursing home victims who needlessly suffer and die from preventable causes, each year.

The organizations key goals are:

- To create Awareness of America's long-term care crisis, of resources for consumers searching for long-term care solutions, and to change our consciousness of how we perceive people with disabilities and our elders.
- To call for Accountability by long-term care owners and operators, governors, legislators, regulatory officials, law enforcement and prosecutors, healthcare providers, residents' families, and concerned citizens.
- To Inform the public about conditions in long-term care facilities so they can make informed consumer choices.
- To Educate consumers about the nursing home environment, preventable causes of death, and other care giving solutions.
- To Intervene on behalf of long-term care residents and families in crisis.

A Perfect Cause's ongoing investigations and analysis of Predators in America's Nursing Homes, is solely funded through private contributions.

To contact A Perfect Cause call 405.228.0513, email info@APerfectCause.org, or visit the A Perfect Cause website at www.APerfectCause.org.

"When You Put Predators In With The Prey, Somebody's Going to Get Bit!"

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ATTACHMENT 11

America's Disability & Elder Rights Advocates

Predators in America's Nursing Homes
Ongoing Investigations and Reports
2004 – 2006

Criminal Acts Committed By Predators While Residing in America's Long-Term Care Facilities

Prepared for:
Senator Charles Grassley
Congressman Henry Waxman
Congressman Ernest Istook

United States Government Accounta

ATTACHMENT 12

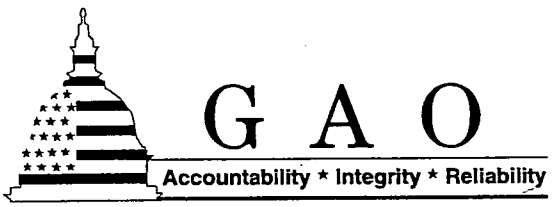
GAO

Report to Congression

March 2006

LONG-TERM CARE FACILITIES

Information on Residents Who Are Registered Sex Offenders or Are Paroled for Other Crimes



GAO-06-326

North Carolina General Statutes Requiring Liability Insurance

§ 20-280. Taxi cab operators

§ 20-281. Rental vehicles

§ 20-309. Motor vehicles

§ 20-359.1. House movers – motor vehicle, CGL, and workers' comp

§ 58-1-36. Warranty companies

§ 62-268. Common carriers

§ 74C-10. Private protective services

§ 74D-9. Alarm systems

§ 74E-3. Company police agencies

§ 74G-3. Campus police agencies

§ 75A-13.3. Personal watercraft rentals

§ 95-111.12. Amusement devices

§ 95-120.1. Passenger tramways

§§ 104E-7 and 104E-10.1. Low-level radioactive waste facilities

§ 106-65.37. Structural pest control

§ 113-35. Pyrotechnics at State parks

§ 115C-238.29F. Charter schools

§ 119-56. Liquefied petroleum gas dealers

§ 130A-255. Mass gatherings

§ 130A-309.23. Used oil transporters.

§ 131E-154.4. Nursing pools

§ 143-215.94H. Petroleum underground storage tank operators

§ 143-215.104F. Dry-cleaning solvent assessment and remediation agreements

§ 143-341. State Games of North Carolina

§ 143-467. Pesticide applicators

§ 148-37. Private confinement facilities for prisoners

§ 153A-250. Ambulance services – city and county franchises

Prepared by:
William K. Hale
Special Counsel
NC Department of Insurance
November 15, 2006

March 2006

GAO
Accountability · Integrity · Reliability

Highlights

Highlights of GAO-06-326, a report to congressional requesters

LONG-TERM CARE FACILITIES

Information on Residents Who Are Registered Sex Offenders or Are Paroled for Other Crimes

Why GAO Did This Study

Approximately 23,000 nursing homes and intermediate care facilities for people with mental retardation (ICF-MR) receive federal Medicare and Medicaid funding. Media reports have cited examples of convicted sex offenders residing in long-term care facilities and, in some cases, allegedly abusing other residents. Given concerns about resident safety, GAO was asked to assess (1) the prevalence of sex offenders and others on parole for non-sex offenses living in long-term care facilities and the extent of any abuse they may have caused, (2) the legal requirements for notifying facilities and others when offenders are residents, and (3) the extent to which facilities have different supervision and separation requirements for offenders. GAO analyzed a national database for sex offenders and analyzed state databases in a sample of eight states for sex offenders and parolees.

What GAO Recommends

GAO recommends that the Federal Bureau of Investigation (FBI) assess the completeness of the National Sex Offender Registry (NSOR), including state submission rates, and evaluate options to increase its comprehensiveness. The Department of Justice (DOJ) commented that these recommendations are unnecessary because of efforts already in place. GAO recognizes these efforts but maintains that the recommendations remain valid.

www.gao.gov/cgi-bin/getrpt?GAO-06-326.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

What GAO Found

By analyzing the FBI's NSOR, which is a compilation of sex offender registries submitted by all states, GAO identified about 700 registered sex offenders living in nursing homes or ICFs-MR during 2005. Most identified sex offenders were male, under age 65, and living in nursing homes, and represented 0.05 percent of the 1.5 million residents of nursing homes and ICFs-MR. About 3 percent of nursing homes and 0.7 percent of ICFs-MR housed at least 1 identified sex offender during 2005. However, these estimates are understated due to data limitations. For example, because of a lack of resources or an inability to comply with certain FBI reporting requirements, states have had varying degrees of difficulty submitting their full state registries to the NSOR. While the FBI does not track NSOR submission rates, GAO compared sex offender registry data from seven of the eight states reviewed to NSOR data and found that the NSOR data included about 57 percent of sex offenders registered in these states, with submission rates ranging from 1 percent to 83 percent. Because a national data source on parolees that included address information was not available, GAO also obtained parolee databases from the eight reviewed states and identified 204 offenders on parole for non-sex offenses living in long-term care facilities. GAO could not determine the overall risk that registered sex offenders and parolees pose to other residents in long-term care facilities because offender status is not tracked with abuse reporting. Facility administrators expressed greater concern over the risk posed by cognitively impaired or mentally ill residents.

Federal law requires state law enforcement agencies to release relevant information about registered sex offenders when necessary to protect the public, but GAO did not identify a similar federal law for the parolee population. States have broad discretion in how to implement the requirement for registered sex offender notification. Therefore, the extent to which states' community notification laws apply to all registered sex offenders or explicitly include long-term care facilities varies. For example, four of the eight states GAO reviewed—California, Illinois, Minnesota, and Oklahoma—had laws that specified long-term care facilities as entities to be notified for at least some registered sex offenders who entered them. However, some facility administrators GAO contacted were uncertain as to whether they could share information with staff and others about residents who were known offenders in light of the Privacy Rule issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Long-term care facilities GAO contacted do not routinely impose different supervision or separation requirements on residents who are offenders based solely on their prior convictions. Instead, these facilities base such decisions on the demonstrated behaviors of residents. Even if long-term care facilities wanted to impose different supervision and separation requirements on offenders, their ability to do so is limited because they are not always aware of residents' prior convictions.

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — November 15, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Darryl S. Chad	R. Chad & Associates
Dennis W. Streets	NC Div. of Aging and Adult Services
Geoff Santoliquido	DAAS
Rebecca Trentman	
BILL HALE	NC DEPT OF INSURANCE
Jean Reaves	NCCOA, NCADSA
Shonda K Corbett	N C C U
Stacy Flannery	NCHCFA
Jeff Hunter	DHHS - DFS
W H Potts Jr	NCDS & NCPDA
Thomas R Konrad	Friends of Residents of LTC

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — November 15, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TRACY COLVARD	DMA
Wendy Alling	DMA
Mary Edwards	DAAS
Suzanne Merrill	DAAS
Bob Jackson	AARP
Michelle Hall	NCGA
Polly Williams	NC Justice Center
Beverly Speroff	DFS
Steve Freedman	DAAS
Lynette Lee	HHS
Abby C. Emanuel	NMSS

November 28, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the NC Study Commission on Aging:

DAY: Wednesday **TIME:** 10:00 A.M.

DATE: December 13, 2006

LOCATION: Room 643
Legislative Office Building

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, December 13, 2006
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Institutional Bias Collaboration Report (S.L. 2006-110)

Dennis Streets, Division of Aging and Adult Services, DHHS
Jackie Sheppard, Office of the Secretary, DHHS

III. Project C.A.R.E.

Karisa Derence, Division of Aging and Adult Services, DHHS

IV. Senior Centers: Operation and Construction Funding

Steve Freedman, Division of Aging and Adult Services, DHHS

V. Approval of Minutes

VI. Meeting Adjourned

Next Meeting:
January 3, 2007 at 9:30 a.m. in Room 643

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES
DECEMBER 13, 2006
ROOM 643
10:00 AM

The meeting was opened by Representative Beverly Earle at 10:10 am in Room 643 of the Legislative Office Building. The following members were present: Representative Beverly Earle, Chair, Representative Debbie Clary, Representative Alice Bordsen, Representative Bob England, Representative Jennifer Weiss, Five Senators, Jackie Sheppard, Ex-Officio, Theresa Matula, Staff, Shawn Parker, Staff and Bern Popkins.

The meeting begin with a presentation from Mr. Dennis Street,, Division of Aging and Adult Services. Handouts were given entitled "North Carolina Bias Study Combined Report" See Attachment II for report. Session Law 2006-110 directed the Department of Health and Human Services to collaborate with providers and advocates of home and community-based services to review and make recommendations addressing the biases identified in the North Carolina Institutional Bias Commission on Aging. It also required the department to submit a final report on its review of the Community Alternative Program for Disabled Adults relative to the Medicaid Institutional Bias Study by August 30, 2007.

Project C.A.R.E.

Karisa Derence, M.A., Alzheimer's Specialist Project C.A.R.E., Director. Caregivers Alternatives to Running on Empty. Family caregivers identify respite temporary relief from caregiving as one of their greatest unmet needs. The most effective respite programs promote flexibility and consumer control, allowing families to get the kind of help they need when they need it. A report states that among family caregivers of people with dementia, approximately one in four provides constant care and average of 47 hours per week often for years on end. Caregivers of people with dementia are particularly vulnerable to severe exhaustion and stress related illness, which place both the caregiver and the person with dementia at risk and are among the most-citied reasons for early institutionalization. Ongoing support groups and continuous availability of

caregiver counseling through-out care for someone with dementia delays nursing home placement by almost a year.

The North Carolina Division of Aging and Adult Services believes that support of family caregivers is an essential investment for the future of North Carolina's long term care system and overall economic well being. The division welcomes the opportunity to put caregivers at the forefront of a statewide focus through the National Family Caregivers Support Program and raise awareness about the diverse needs of caregivers in their day to day lives.

Senior Centers: Operation and Construction Funding

Mr. Steve Freedman, Division of Aging and Adult Services, DHHS, presented to the commission information on Senior Centers. Multipurpose senior center are community facilities with a provision of broad spectrum of services which include, health, socializing, nutrition, education and recreation. They must be open 40 hours per week, must be staffed by a full time, paid Director, must be staffed by adequate number of personnel. Senior centers are designated as community focal points through the Older Americans Act. 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 interest enhance their dignity, support their independence, and encourage their involvement in and with the center and the community.

Some of the services offered at a Senior Center is health and wellness programs, arts and humanities, intergenerational programs, employment assistance, transportation services, volunteer opportunities, educational opportunities, information and referral, financial assistance, meal and nutritional program, community action and social networking opportunities, and leisure travel. Questions were asked at this time, and answered by staff.

We had the approval of the last minutes and the meeting was adjourned.

Beverly Earle

Representative Beverly Earle, Chair

Ann Raeford

Ann Raeford, Committee Assistance

Attachments

Attachment I	Agenda
Attachment II	Project C.A.R.E.
Attachment III	Senior Centers
Attachment IV	Visitor's Registration

North Carolina Senior Centers

What is a Senior Center?

Multipurpose Senior Center (MPSC)

- community facility
- provision of broad spectrum of services
  - Health
  - Social
  - Nutritional
  - Educational
  - Recreational

Multipurpose Senior Center Administrative Requirements

- Must be open 40 hours per week
- Must be staffed by a full time, paid Director
- Must be staffed by adequate number of personnel
  - paid or volunteer
  - capable of implementing programs/services that meet state standards

"Focal Points" on Aging

Senior centers are designated as community focal points through the Older Americans Act

Focal Point Components:

- Facility/space
- Information and referral
- "Co-location" of services
- Service coordination
- Outreach

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."

Services Offered at a Senior Center

- Health and wellness programs
- Arts and humanities
- Intergenerational programs
- Employment assistance
- Transportation services
- Volunteer opportunities

- Educational opportunities
- Information and referral
- Financial assistance
- Meal and nutritional program
- Community action and social networking opportunities
- Leisure travel

Future Programming

- Physical fitness activities

- Internet training

History of Senior Centers

- First senior center opened 60 years ago in New York City under city sponsorship
- Over 15,000 centers nationwide, serving close to 10 million older adults annually
- Many supported by government and local non-profit organizations (i.e., United Way)
- Since 1965 OAA has provided some funding support to 6,000 senior centers through service contracts for program activities

NC-DAAS Senior Center History

- 1975 OAA funding-Title V Senior Center Development
- 1978 OAA-elimination of Title V and consolidation with other Title III services
- General Assembly senior center development funding: 1978,1984,1986,1987,1988,1997-2006
- 1990-Senior Center Operations and Development Standards (construction, renovations)
- 1998-New state level initiative in support of senior centers (model centers and state certification process)

Senior Center Participants

- 60% are age 70+
- 23% are age 80+
- 27% are African Americans
- 8% need help in getting around the center
- 81% of centers serve participants with some form of dementia

Senior Center Capacity Survey

Staffing (number of employees)

-25% have only one employee

-average number of employees=4

Participation

-average attendance=85 people/day

Senior Center Affiliation

- 54%-public (county/city)
- 46%-private, non-profit
- 55%-operated by offices on aging (½ public & ½ private)
- 23%-operated by Parks and Recreation Departments
- 16%-independent (free standing/non affiliation)
- 3%-operated by DSS
- 4%-all others

Budget and Funding Sources

- 92% of centers utilize state funds in their budgets
- Primary funding sources=Home and Community Care Block Grant (HCCBG) and local government
  - HCCBG-primary funder of non-profit Council on Aging and independent centers (state and federal)
  - Local Government-primary revenue source of county government departments on aging and parks and recreation sponsored centers

- State funding (General Purpose and Outreach funds) made up the third largest source of funding for all centers

- Approximately 2/3 of centers charge fees for some programs and ½ offer scholarships to programs that charge fees

Greatest Needs

→ Physical space
→ Computers and computer classes
→ Staff
→ Transportation
→ Salaries

Funding for Senior Centers

The Division of Aging and Adult Services provides funding for senior centers through:

✓ Senior Center Operations [HCCBG-federal (OAA) and state funds]
✓ Senior Center General Purpose (state appropriation)
✓ Senior Center Outreach (state appropriation)

Senior Center Operations

- Allowable HCCBG service
- Funded at the discretion of the counties
- Must operate full time programs and meet state service standards
- FY '06-$2.9 million budget for 65 centers
- Funding represents 5.6% of state's overall HCCBG budget
- Average senior center received $44,358

Senior Center General Purpose

- Initiated in 1997
- Used for any purpose that supports operations or development
- Expenditures included:
  - Equipment purchases/repairs
  - Building maintenance
  - Supplies
  - Administrative costs
  - Activities
  - Construction

- FY '06 appropriation=$1,265,316
- 25% local match (cash or in-kind)
- 161 centers received funding from $5,454 to $16,352 (based on certification)

Senior Center Outreach

- Initiated in1988 as a state appropriation
- Purpose is to reach unserved and under served elderly through statewide outreach of services
- FY '06 appropriation=$100,000 (reduced from $365,000)

- Funding allocated to each of the 17 Area Agencies on Aging to award
  - Each AAA region received $5,882
  - Approximately 89 centers received an average of $1,124
  - 25% local match (cash or in-kind)

Current Funding Support

- Senior Center Operations (HCCBG)=$2.9 million
- Senior Center General Purpose (state)=$1.26 million
- Senior center Outreach (state)=$100,000
- TOTAL=$4,248,557
  - $300,000 decrease in state support over the past 4 years
  - Local match increased from 10-25% for state appropriations

Senior Center Certification Program

Purpose:

- Support senior center development
- Strengthen operations and programming
- Increase state and local support

Incentives and Benefits

- Clients benefit from quality services and programs
- Senior centers and staff receive:
  1. Improves credibility
  2. Creates case for funding
  3. Provides accountability
  4. Enhances professionalism
  5. Measures areas for improvement
  6. Creates strategies for the future

Centers of Merit and Excellence

★ Centers of Merit

Meet all the requirements of the Home and Community Care Block Grant and are providers of very high quality services

★ Centers of Excellence

Provide exemplary services and opportunities to their communities and serve as mentors and models to developing centers

Senior Center Certification

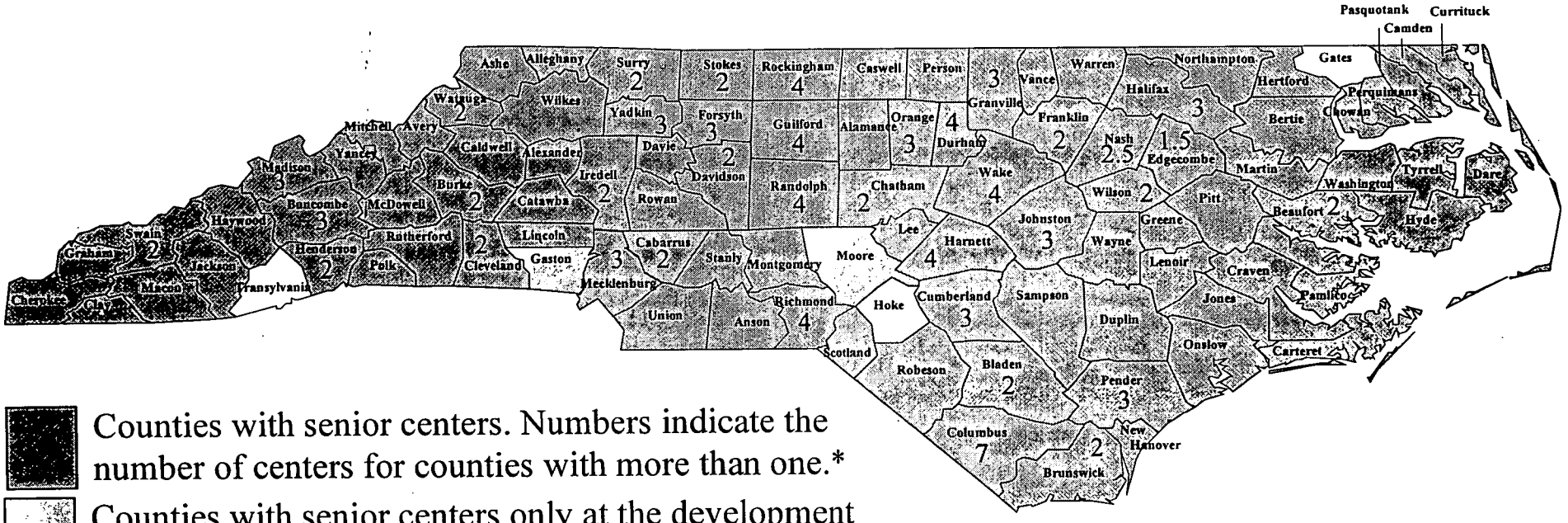
- Initiated certification program in 1999
- 163 recognized senior centers in NC
- 38 Centers of Excellence
- 8 Centers of Merit
- 28% of the state's centers are certified

Certification and General Purpose Funding

- Over past 7 years, certification process has increased the base funding for certified centers
- Funding is used as incentive for centers to make investments and meet requirements

- Appropriation is based on shares
  - Uncertified centers=one share
  - Centers of Merit=two shares
  - Centers of Excellence=three shares
- 2006 Funding
  - Uncertified centers (117)=$5,123
  - Centers of Merit (8)=$10,245
  - Centers of Excellence (38)=$15,368

Counties with One or More Senior Centers

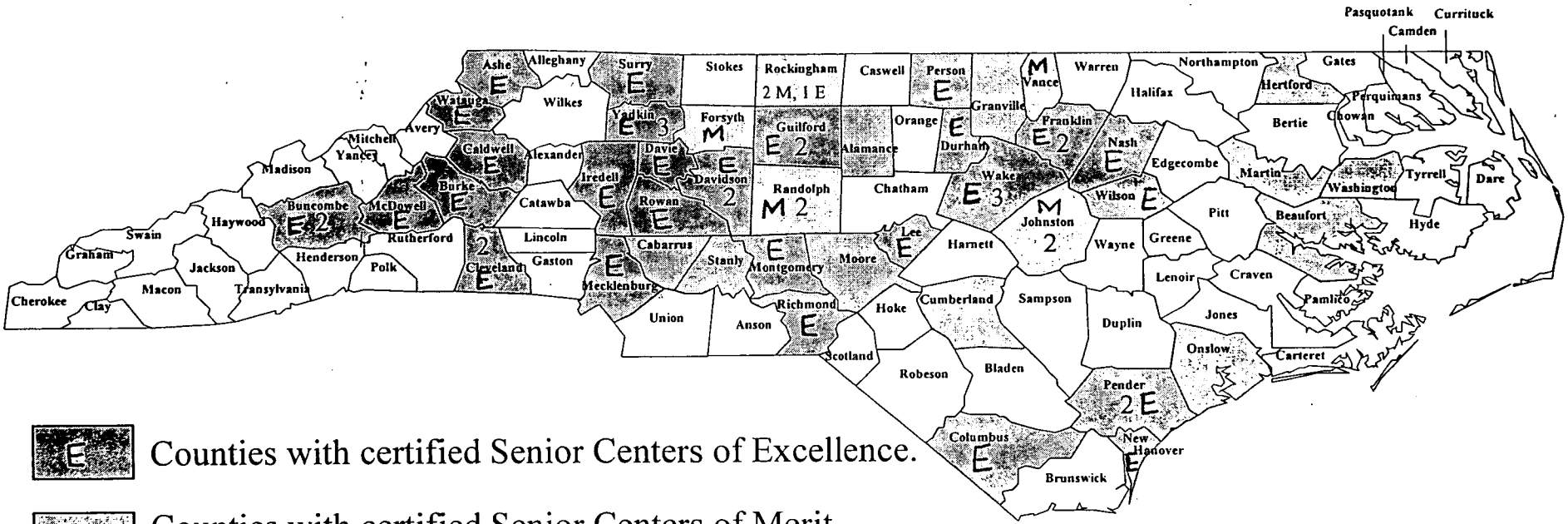


Counties with senior centers. Numbers indicate the number of centers for counties with more than one.*

Counties with senior centers only at the development stage

*The following counties with existing senior centers also have additional centers at the development stage: Mecklenburg, Stokes, Edgecombe, Halifax, and Harnett.

Counties with One or More Certified Senior Centers



Counties with certified Senior Centers of Excellence.

Counties with certified Senior Centers of Merit.

Counties *without* certified centers, that have one or more centers that have applied for certification in 2007*.

Numbers indicate counties with more than one certified center

*This does not include counties that already have certified centers, but have additional centers applying for certification.

The Senior Center Certification Process at a Glance

Purpose

- Improve the quality of senior centers
- Recognize excellence that exists
- Provide a guide for developing activities and services that respond to consumers' wishes

Benefits

To older adults and their families

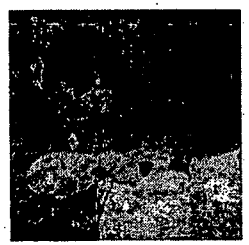
- A voice in program development
- Enhanced performance of center staff
- Greater variety of activities and services

To the community

- Optimum use of resources
- Focal point for community activities
- Prestige of having a certified center

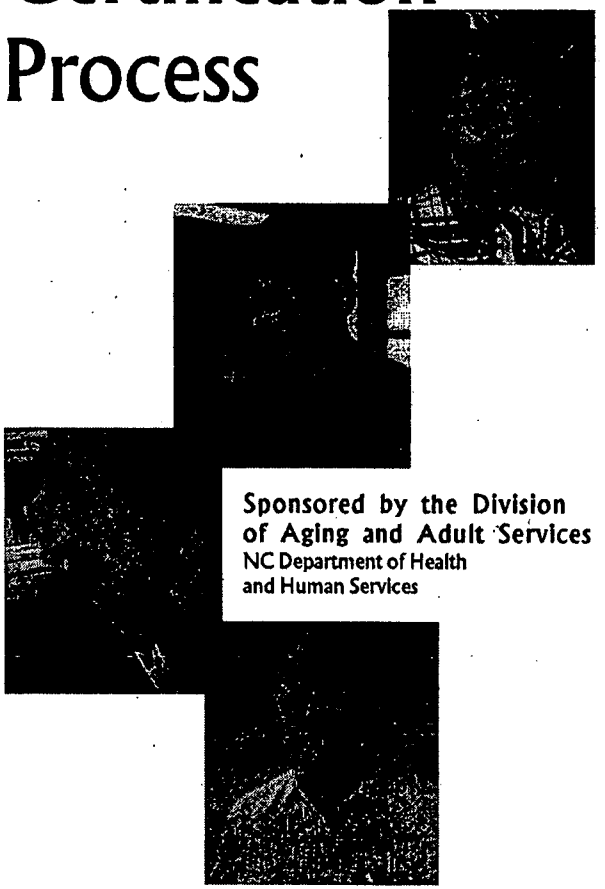
To the center

- Increased consumer satisfaction
- Blueprint for development and measurable outcomes for grant proposals
- Meets Home and Community Care Block Grant standards
- Public recognition
- Potential for drawing state funds



Photos taken at senior centers in Wilmington and Garland, NC.
© 2001, Mary Anne P. Salmon.

North Carolina Senior Center Certification Process



Sponsored by the Division of Aging and Adult Services
NC Department of Health and Human Services

North Carolina Senior Center Certification Process

SENIOR CENTERS can be convenient locations in the community for older adults to gather; participate in recreational, educational, and health-promoting activities; and obtain information about other community programs and services.

Because senior centers in North Carolina are in various stages of development, and because many communities do not yet have them, in fall 1998, the Division of Aging and Adult Services assembled a task force for senior center development, composed of senior center directors, representatives from Area Agencies on Aging, older adults, the division, the NC Institute on Aging, and the Center for Aging Research and Educational Services (CARES). Its charge was to develop a standard for best practice in senior center operations.

Centers of Merit and Centers of Excellence

The task force identified a model with two tiers—the Center of Merit and the Center of Excellence—and best practices for five major operational areas

- outreach and access to services
- programs and activities
- planning, evaluation, and input from older adults
- staffing
- operations and physical plant.

Self-Evaluation and Site Visits

The task force also established a process by which centers could complete a self-evaluation, ask to be reviewed by independent site visitors, and receive

certification at the level of Merit or Excellence from the Division of Aging and Adult Services, based on the recommendation of the site review team. They also negotiated minimum standards for each level of certification.

CENTERS OF MERIT meet all the requirements of the Home and Community Care Block Grant and are providers of very high quality services.

CENTERS OF EXCELLENCE provide exemplary services and opportunities to their communities and serve as mentors and models to developing centers.

Certification is a voluntary process that senior centers can use to be recognized in their communities and across the state. Its purpose is to strengthen the capacity of senior centers by providing a set of measurable indicators of best practice. The self-evaluation tool also provides a framework for planning development and seeking resources from the community, the state, and other sources.

Help for Interested Centers

Steve Freedman, Leslee Breen, and Judy Smith, of the Division of Aging and Adult Services, provide consultation, as do Area Agencies on Aging.

Under contract with the Division, CARES (part of the Jordan Institute for Families, School of Social Work at UNC-Chapel Hill; http://ssw.unc.edu/cares/cares.htm) provides training on the certification process and on using the self-evaluation tool as a blueprint for building capacity and enhancing quality.

Contact

Steve Freedman
Leslee Breen
Judy Smith

Location
N.C. Division of Aging and Adult Services
2101 Mail Service Center
Raleigh, NC 27699-2101

Telephone
(919) 733-733-0440
(Fax) (919) 715-0868

Website
www.dhhs.state.nc.us/aging/

E-mail
Steve.Freedman@ncmail.net
Leslee.Breen@ncmail.net
Judy.Smith@ncmail.net

The Ann Johnson Institute for Senior Center Management is sponsored by the NC Division of Aging and Adult Services to provide ongoing professional development for senior center managers and leaders.

Those completing all six of the two-and-one-half-day modules receive a Certificate in Senior Center Management. Participants may apply for Continuing Education Units.

The institute is named to honor Ann Johnson, resident of North Carolina, nationally recognized advocate for older adults, and champion of senior centers. Through her work on the Governor's Advisory Council on Aging and elsewhere, she assisted the Division of Aging and Adult Services first in establishing a voluntary certification process for centers (1999) and then this institute to continue the professional development of senior center managers (2001). The first cohort of managers to complete all six modules received certificates in March 2004.

The senior center certification process requires continuing professional education for all center personnel as part of the minimum requirements. With two modules offered annually, the institute provides one possible venue for managers wishing to meet this standard.

To learn more about the Ann Johnson Institute, North Carolina's senior center certification process, and where centers are located, visit the NC Division of Aging and Adult Services' website at
http://www.dhhs.state.nc.us/aging/home.htm

The North Carolina Division of
Aging and Adult Services
2101 Mail Service Center
Raleigh, NC 27699-2101
(919) 733-3983
State Courier Number 56-20-02

The Ann Johnson Institute for Senior Center Management

Sponsored by the
Division of Aging
and Adult Services
NC Department of Health and Human Services

The Ann Johnson Institute for Senior Center Management

Module 1
The Empowered Manager
- Leadership styles
- Managing time and meetings
- Developing effective teams
- Your professional image

Module 2
The Art of Supervision and Developing Human Resources
- Building a great place to work
- Recruitment, interviewing, orientation, retention
- Making diversity work
- Cultivating volunteers
- Legal issues
- Motivation
- Delegation

Module 3
Senior Center Operations and Financing
- Fundraising and grantwriting
- Budgets and fiscal management
- Contracts and MOUs
- Standards, regulations, and allowable expenditures
- Reporting and record keeping
- Day-to-day operations

Module 4
Planning, Evaluation, and Governance
- Working with boards and advisory committees
- Ethics
- Navigating change
- Strategic planning
- Outcome-based management evaluation

Module 5
Developing Outstanding Programs
- Customer-driven programming
- Community collaboration
- Targeting diversity and underserved groups
- Policy development
- Great ideas poster session

Module 6
Dynamic Publicity, Marketing, and Communications
- Marketing your senior center
- Public relations, image, and visibility
- Working with the media
- Effective newsletters and publications
- Dynamic verbal and written communications

"The sessions are presented in practical, understandable ways that are immediately usable by any senior center manager."

—A 2004 Graduate

Ann Johnson (center), with the first cohort of graduates, 2004.

"After attending this training, I feel confident that I could manage any organization."

—A Senior Center Director

Ann Johnson

Center for Aging Research and Educational Services

Meet Ann Johnson. She is energetic and well-informed. Community-minded and passionate. And for nearly half of her 83 years, she has channeled her energy to one cause: improving the lives of North Carolina's senior citizens.

Technically Ann Johnson is retired, but don't let this technicality [illegible] you. Since "retirement," Johnson has advocated for older adults in the Senior Tar Heel Legislature and the NC Association of Aging, as well as served as Chair of the Governor's Advisory Council on Aging. She has also been active behind the scenes, working with academics, politicians and fellow senior citizens to identify needs and craft solutions.

In 1967, Johnson began working at Durham's Coordinating Council for Senior Citizens, charged with developing a neighborhood concept of senior centers. Her hard work came to fruition and inspired other communities. Currently, there are 160 senior centers sprinkled throughout North Carolina.

Often, senior citizens are silent sufferers. Many are either not able or are simply too embarrassed to advocate for their own needs. Senior centers were created to fill the gap and keep older adults connected to their communities, to services and to each other.

"Senior centers have become a very important benchmark of community support. They can make a difference in access to services for older adults and their families," Johnson said. "Now it's about time we came to grips with fragmentation."

What is Fragmentation?

While most older adults are healthy, active, and self-sufficient, aging brings a combination of predictable risks: loss of income, the death of a spouse and friends, and chronic medical conditions which can lead to multiple medications. These problems interact with one another. For example, a 75-year-old who has had a knee replacement is less likely than a 45-year-old to live with someone who can help care for them.

Although the needs of older people tend to compound, there is no single service system able to accommodate that fact. The system is fragmented. The services that a person needs may only be available through different organizations, and some may not be available at all depending on a person's income and location.

Many older adult have spoken about the need for "one stop shopping." Others talk about wanting "no wrong door"—an ideal situation where an older person or family member could go to any one of the service organizations he or she needed and be automatically connected to other relevant services.

A multipurpose senior center tries to help older adults deal with fragmentation by providing not only information about the different services available, but helping people get those services. "People usually think of senior centers as willy-nilly for fun and games," Johnson said. "They should be response systems. Senior centers can make a difference in access to services for older adults and their families."

Center for Aging Research and Educational Services

Johnson has not worked alone in her quest to improve the quality and breadth of services offered at senior centers. She found an ally in the Jordan Institute's Center for Aging Research and Educational Services (CARES). Under the direction of Jordan Institute Associate Director and School of Social Work Professor, Gary Nelson, CARES' mission is to support practitioners and policy makers who work with older adults through training, research and technical assistance.

"Senior centers should not be run 'for seniors.' Instead seniors should be fully involved in deciding what the center will offer," said CARES Research Specialist Mary Anne Salmon. "Of course there are standards and professional guidelines that need to be met."

Because senior centers are in various stages of development, the North Carolina Division of Aging assembled a task force to determine guideposts for local centers. "It was an excellent opportunity to set up goals for senior centers," Johnson said. Along with Johnson, CARES was tapped to serve on the task force.

The task force was responsible for developing standards and professional guidelines, as well as designing a process for evaluating and strengthening North Carolina's senior centers. Criteria for two levels of certification emerged: Centers of Merit and Centers of Excellence.

Centers of Merit meet conditions that define an outstanding senior center. Centers of Excellence meet those same criteria and go beyond them, especially in the areas of self-determination, advocacy and quality of life. "The certification tool looks for provision of access to key services, a variety of activities, and clear indication of the meaningful involvement of older adults in planning the center's activities and programs," Salmon said. To date, more than 30 centers have been certified.

Johnson is enthusiastic about the changes that are happening at centers across the state, and optimistic that other centers will follow suit. "This is about a revolution in the way social services are provided," she said. "It depends on collaboration and consumer-directed care." Nelson agrees, "What we are advocating is a dramatic transformation. We are working to forge alliances between senior citizens, practitioners and organizations to streamline service delivery."

On a canary yellow legal pad, Johnson outlined five goals for senior centers of the future: 1) They should be in an identifiable location—that way everyone knows where to go to find answers. 2) They should be a response system—a one-stop shop for services and service referrals. 3) They should have a defined service area—every community in the state should be served. 4) They should have a diverse program of services and activities—such as blood pressure monitoring, Medicare benefits counseling and home health services, as well as art classes, lectures and computer training. 5) They should be a full decision-making partnership with older adults—seniors should be fully involved in what the center offers.

Johnson's vision and voice have made a tremendous impact in North Carolina. "There are few people, like Ann, who have stood so tall and so steadfast for the interests of older North Carolinians," said Nelson. That is why a training program developed by CARES and the Division of Aging for senior center administrators is named The Ann Johnson Institute of Senior Center Management.

"CARES can take no credit for Ann, but she exemplifies what we try to do—providing resources for the people on the front lines working for older adults, and what we hope our support will lead to—productive, empowered, vital older adults," said Salmon.

Project C.A.R.E:

Caregiver Alternatives to Running on Empty

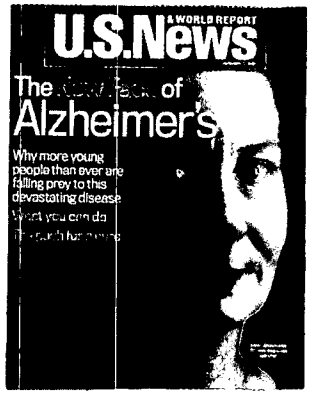
A NATIONAL BEST PRACTICE MODEL

Karisa Derence, MA, Alzheimer's Support Specialist
NC Division of Aging and Adult Services

Len Erker, MA, Director of Respite and Mountain Area Policy, Western Carolina Alzheimer's Association

Dementia and Caregiving

- Most vulnerable caregiver population
- Unique needs and level of care
- Critical public health issue
- Increasing disease prevalence



FOUNDATION:

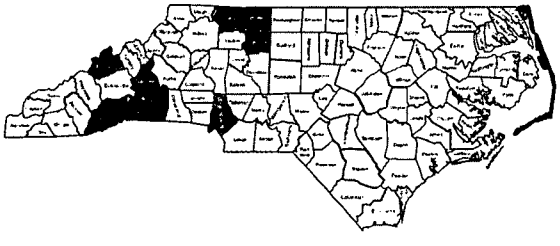
PUBLIC-PRIVATE PARTNERSHIPS

NC ALZHEIMER'S SUPPORT NETWORK

- NC Division of Aging and Adult Services
- Duke Aging Center Family Support Program
- State Alzheimer's Association Chapters

- Mecklenburg County Department of Social Services
- Home and Community-Based Service

PROJECT C.A.R.E. SITES



Key Program Features

- **Dementia-Specific:** responsive to the unique needs of dementia caregivers, provides expertise and understanding
- **Consumer-Directed Services:** annual cap, full continuum of respite care options, flexible frequency & duration
- **Comprehensive Support:** evidence-based intervention, portal, coordinated local services, seamless entry
- **Community Network Building:** dementia-friendly, responsive, mutually beneficial, increases quality of care
- **Cost-Effective:** strengthens family care capacity, preserves caregiver health, prevent/delay institutionalization, utilizes existing providers, boosts local economy

Family Consultant Model

- Quick response
- In-home assessment, individualized care
- Family-centered, holistic approach
- Personal relationship, ongoing support
- Multiple roles based on family needs
- Link to community resources, neutral
- Network building
- Quality control

"Barrier Buster"

- Isolation
- Accessibility
- Crises Intervention
- Caregiver Exhaustion
- Caregiver Guilt
- Privacy/Trust

Project C.A.R.E. Response...

Family Caregiver Crisis

Project C.A.R.E. Intervention

Respite Care Services

Comprehensive Support

Dementia-Friendly Communities

Program Funding

- Federal Alzheimer's Grant + 45% Local Match = $545,454
  - Direct respite services – 51%
  - Administrative Cost – 8.5%
  - Annual Spending Cap – $2000

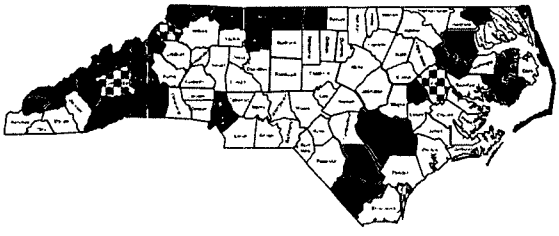
Future Direction

- Current Funding Status
- From Demonstration to Statewide
- Priority: Secure Program Infrastructure and
- National Leader in Dementia Caregiver Support

Grant Opportunities

- Continuation of program contingent upon annual state funding: $500,000
- Pending Expansion Grants:
  - ✓ New Federal Grant – $1 million
  - ✓ Kate B. Reynolds Charitable Trust – $1 million

Project C.A.R.E. Expansion



Mutual State Goals

- ✓ Reaching Underserved Populations/Unmet Needs
- ✓ Strengthening Home and Community-Based Care Network
- ✓ Reducing Medicaid Costs/Rebalancing
- ✓ Providing Appropriate, High-Quality, Cost-Effective Care in the Least Restrictive Setting
- ✓ Investing in Family Caregiving as the Primary Resource for Long Term Care in North Carolina

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES

PROJECT C.A.R.E:
"Caregiver Alternatives to Running on Empty"

SUMMARY:

The NC Alzheimer's Demonstration Program, Project C.A.R.E: "Caregiver Alternatives to Running on Empty", uses a consumer-directed, family consultant model to provide comprehensive respite support to dementia caregivers. The goal of the program is to increase access, choice, use, and quality of respite care to low-income rural and minority communities. Through the integration of dementia-specific services, Project C.A.R.E. intends to create a seamless, coordinated delivery system that is responsive to the needs, values, and preferences of Alzheimer's families.

Project C.A.R.E. is administered by the Division of Aging and Adult Services and receives technical assistance from the Duke Family Support Program. Operating within the community-based contexts of the Alzheimer's Association and County Department of Social Services, Project C.A.R.E. Family Consultants visit the homes of referred Alzheimer's caregivers in crises. The Consultants offer timely, individualized guidance, counseling, support, advocacy and education for family caregivers. Their aim is to match families with the most appropriate and preferred local respite and community services tailored to the unique context of care and family needs. Through Project C.A.R.E., dementia caregivers may spend up to $2000 a year toward respite services. Families are able to choose among a full continuum of consumer-directed care options, including adult day services, group respite, private or agency in-home care, and overnight residential respite. There are three pilot sites set up to serve the following ten counties: Charlotte (Mecklenburg County), Winston-Salem (Forsyth, Surry, and Stokes); and Asheville (Polk, Henderson, Transylvania, Rutherford, Madison, and McDowell).

NATIONAL RECOGNITION:

- **2004 Geriatric Best Practice Award:** *"Developing Quality Caregiver Support and Respite Programs"* – Southeast Regional Geriatric Best Practices Initiative
- **2005 National Innovative Program Clearinghouse Award** – National Alzheimer's Association
- **2005 National Best Practice Model** for *"Implementing Systems and Sustained Change in Long-Term Care"* – US Administration on Aging Alzheimer's Disease Demonstration Grants to States (ADDGS) Program and RTI International
- **2005 National Conference of State Legislators** – featured by the National Alzheimer's Association as a national model for home and community-based care coordination

OBJECTIVES:

- Provide dementia-specific counseling, information, care consultation, capacity-building, and appropriate respite support to family caregivers who are not receiving services due to geographical factors, economic, racial, or cultural isolation, or gaps in available local resources;
- Strengthen the linkages between the Alzheimer's Association, Family Caregiver Support Program and the community-care system through information sharing, formalizing service agreements and increasing the availability of quality respite;
- Provide dementia-specific education, training, and resources to community-based direct care providers, volunteers, faith-based organizations, and other aging and adult services providers;
- Link dementia families to supplemental education programs and supportive resources available in the community, including Aging and Disability Resource Centers, caregiver skills training, Hospice and faith-based volunteer networks.

OUTCOMES:

- Family caregivers are more informed about the value and availability of respite and how to use services effectively to maintain or improve their health while preserving family care capacity;
- Families experience greater self-efficacy and control regarding service selection and utilization;
- Increased use of dementia-specific respite care services by low-income rural and minority families;
- Expanded availability of dementia-specific training, education, and resources in the community.

COST OF DEMONSTRATION:

- Total federal funding - $933,450 (July 2004 – June 2007) - Title IV OAA funds
- Total budget: 1st year (25% match) - $414,867; 2nd year (35% match) - $478,692; 3rd year (45% match) - $545,454
- Funds for direct respite services (minimum 50%): 1st year - $241,370; 2nd year - $258,908; $3rd year - $276,098
- Flexible annual spending cap for respite care: $2,000 per family
- Respite services include - purchase approximately 2 days per week of adult day services, 2 times a week of in-home personal care, or 7 days of overnight respite per year per family (*Note: *if* a family chooses to spread respite care evenly over one year).

PROGRAM MANAGEMENT:

- **NC Division of Aging and Adult Services (DAAS) Project Director** – Karisa Derence (existing position; 60% of salary used as in-kind match)
- **Western Carolina Alzheimer's Association Chapter** - 2 Family Consultants + 1 Family Consultant Supervisor/Outreach Specialist for nine counties; *currently funded through federal funds and private foundation grants
- **Mecklenburg County Department of Social Services** – 1 Family Consultant (part-time); *now a county funded position
- **Duke Aging Center Family Support Program** - provides technical assistance and training support to Project C.A.R.E. Family Consultants, Family Caregiver Support Program Resource Specialists, provider agencies, referral sources and client families; *funded through existing DAAS Alzheimer's Support Program contract
- **Four Area Agencies on Aging (Regions B, C, I, and F)** - Family Caregiver Resource Specialists assist with training and volunteer programs, assessments of needs, and building an inventory of resources; *funded through NC Family Caregiver Support Program

**For more information, please contact Karisa Derence at (919) 733-0440 or karisa.derence@ncmail.net*

PROJECT C.A.R.E. - CLIENT DATA
July 1, 2001 - June 30, 2006

TOTAL YEARLY FUNDING FOR PROJECT C.A.R.E. RESPITE SERVICE				
	Asheville Area	Winston-Salem Area	Charlotte Area	Totals
Y1 2001-2002 *(Family Limit $2500)*	$91,700	$91,700	$50,000	**$233,400**
Y2 2002-2003 *(Family Limit $2500)*	$105,775	$105,775	$57,680	**$269,230**
Y3 2003-2004 *(Family Limit $2000)*	$106,000	$106,000	$57,680	**$269,680**
Y4 2004-2005 *(Family Limit $1800)*	$94,600	$94,600	$50,000	**$239,200**
Y5 2005-2006 *(Family Limit $1800)*	$94,600	$94,600	$50,000	**$239,200**
Y6 2006-2007 (Family Limit $2000)				
Total Project C.A.R.E. Funding	**$492,675**	**$492,675**	**$265,360**	**$1,250,710**
Additional Y1-Y5 Region B & C Funding for Asheville	$115,164	$0	0	**$115,164**
Total All Funding Sources	**$607,839**	**$492,675**	**$265,360**	**$1,365,874**

ENROLLMENT				
First 3-Year Cycle 7/1/01-6/30/04	**Asheville Area**	**Winston-Salem Area**	**Charlotte Area**	**Totals**
Total Families Served Year 1	**86**	**70**	**31**	**187**
Families Re-Enrolled from Y1 to Y2	52	50	27	**129**
New Families Enrolled Y2	15	23	20	**58**
*** Total Families Served Year 2**	**67**	**73**	**47**	**187**
Families Re-Enrolled from Y2 to Y3	30	28	12	**70**
New Families Enrolled Y3	47	53	54	**154**
Total Families Served Year 3	**77**	**81**	**66**	**224**
Total NEW Families Enrolled Y1+Y2+Y3	**148**	**146**	**105**	**399**
*** Total Families Served Y1+Y2+Y3**	**230**	**224**	**144**	**598**
Second 3-Year Cycle 7/1/04-4/30/06	**Asheville Area**	**Winston-Salem Area**	**Charlotte Area**	**Totals**
Families Re-Enrolled from Y3 to Y4	40	39	10	**89**
New Families Enrolled Y4	48	31	34	**113**
Total Families Served Y4	**88**	**70**	**44**	**202**
Families Re-Enrolled from Y4 to Y5	52	35	7	**94**
New Families Enrolled Y5	64	30	37	**131**
Total Families Served Y5	**116**	**65**	**44**	**225**
Families Re-Enrolled from Y5 to Y6				
New Families Enrolled Y6				
Total Families Served Y6				
Total NEW Families Enrolled Y4+Y5	**112**	**61**	**71**	**244**
Total Families Served Y4+Y5	**204**	**135**	**88**	**427**
Total NEW Families Enrolled Y1 through Y5	**260**	**207**	**176**	**643**
*** Total Families Served Y1 through Y5**	**434**	**359**	**232**	**1025**
** Includes re-enrolled + newly enrolled families*				

NON-ENROLLED FAMILIES (Information, consultation, referral only)				
	Asheville Area	Winston-Salem Area	Charlotte Area	Totals
First 3 Year Cycle (Y1+Y2+Y3)	160	83	41	284
Y4 +Y5	205	201	63	469
Totals	**365**	**284**	**104**	**753**

TOTAL DIFFERENT PROVIDER AGENCIES UTILIZED (Y1-Y5)				
	Asheville Area	Winston-Salem Area	Charlotte Area	Total
In-Home	28	20	8	56
Adult Day	5	3	10	18
Overnight (24 hour)	12	4	2	18
Totals	**45**	**27**	**20**	**92**

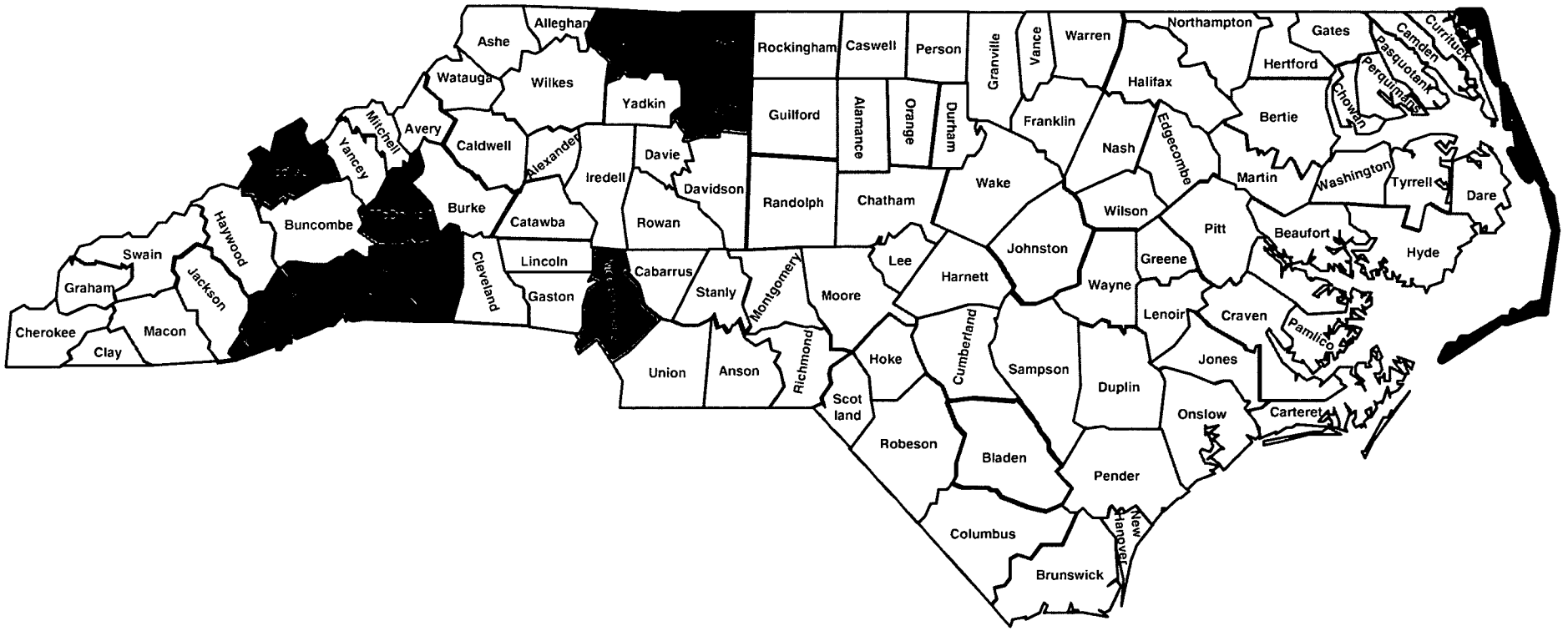
CAREGIVER CHOICE OF RESPITE				
Asheville Area				
	In-Home	Adult Day	Overnite	Total
Y1+Y2+Y3	89	45	5	139
Y4+Y5	144	71	5	220
Total	**233**	**116**	**10**	**359**
Winston-Salem Area				
	In-Home	Adult Day	Overnite	Total
Y1+Y2+Y3	64	63	7	134
Y4+Y5	57	75	3	135
Total	**121**	**138**	**10**	**269**

Charlotte Area				
	In-Home	Adult Day	Overnite	Total
Y1+Y2+Y3	38	106	2	146
Y4+Y5	23	65	3	91
Total	**61**	**171**	**5**	**237**

CLIENT GENDER (Person with dementia)				
	Asheville Area	Winston Salem Area	Charlotte Area	Total
Male (Y1+Y2+Y3)	63	42	52	157
Female (Y1+Y2+Y3)	85	104	92	281
Male (Y4+Y5)	114	29	28	171
Female (Y4+Y5)	122	91	60	273
Total	**384**	**266**	**232**	**882**

CLIENT RACE				
	Asheville Area	Winston Salem Area	Charlotte Area	Total
African American (Y1+Y2+Y3)	12	96	98	206
White (Y1+Y2+Y3)	136	49	46	231
Native American (Y1+Y2+Y3)	0	1	0	1
African American (Y4+Y5)	9	56	52	117
White (Y4+Y5)	226	63	33	322
Native American (Y4+Y5)	1	1	3	5
Total	**384**	**266**	**232**	**882**

Project C.A.R.E. Site Map



NEUROLOGY

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Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease

Mary S. Mittelman, DrPH, William E. Haley, PhD, Olivio J. Clay, MA and David L. Roth, PhD

From the Department of Psychiatry (M.S.M.), New York University School of Medicine, NY; School of Aging Studies (W.E.H.), University of South Florida; and Department of Biostatistics (O.J.C., D.L.R.), University of Alabama at Birmingham.

Address correspondence and reprint requests to Dr. Mary Mittelman, Department of Psychiatry, New York University School of Medicine, 550 First Avenue, New York, NY 10016; e-mail: mary.mittelman@med.nyu.edu

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- All Health Services Research
- Alzheimer's disease

Objective: To determine the effectiveness of a counseling and support intervention for spouse caregivers in delaying time to nursing home placement of patients with Alzheimer disease (AD), and identify the mechanisms through which the intervention accomplished this goal.

Methods: We conducted a randomized controlled trial of an enhanced counseling and support intervention compared to usual care. Participants were a referred volunteer sample of 406 spouse caregivers of community-dwelling patients who had enrolled in the study over a 9.5-year period. The intervention consisted of six sessions of individual and family counseling, support group participation, and continuous availability of ad hoc telephone counseling. Structured questionnaires were administered at baseline and at regular follow-up intervals, every 4 months for the first year and every 6 months thereafter. Cox proportional hazard models were used to test the effects of the intervention on the time

to nursing home placement for the patients after controlling for multiple time-invariant and time-dependent predictors of placement.

Results: Patients whose spouses received the intervention experienced a 28.3% reduction in the rate of nursing home placement compared with usual care controls (hazard ratio = 0.717 after covariate adjustment, $p = 0.025$). The difference in model-predicted median time to placement was 557 days. Improvements in caregivers' satisfaction with social support, response to patient behavior problems, and symptoms of depression collectively accounted for 61.2% of the intervention's beneficial impact on placement.

Conclusion: Greater access to effective programs of counseling and support could yield considerable benefits for caregivers, patients with Alzheimer disease, and society.

Funded by the NIMH (R01 MH 42216) and the NIA (R01 AG14634). Additional funding was provided through the NYU Alzheimer's Disease Center (P30-AG08051). W.E.H. was supported by the Florida AD Research Center (P50-AG025711).

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October 2005

Alzheimer's Disease Demonstration Grants to States Program: North Carolina's Project C.A.R.E. – Caregiver Alternatives to Running on Empty

"Implementing Systems and Sustained Change in Long-Term Care" Executive Summary

Prepared for

Lori Stalbaum, M.S.W.
Administration on Aging
1 Massachusetts Avenue, NW
Washington, DC 20001

Prepared by

David Brown, M.A.
Kristin Siebenaler, M.P.A.
Joshua Wiener, Ph.D.
RTI International
1615 M Street, NW, Suite 740
Washington, DC 20036

RTI Project Number 09351.000.008

ALZHEIMER'S DISEASE DEMONSTRATION GRANTS TO STATES PROGRAM OF NORTH CAROLINA – PROJECT C.A.R.E.

David Brown, M.A.
Kristin Siebenaler, M.P.A.
Joshua Wiener, Ph.D.

AOA Project Officer: Lori Stalbaum, M.S.W.

RTI International*

Contract No. GS-10F-0097L MOBIS
Delivery Order No. HHSP233L00400143U

October 2005

This project was funded by the Administration on Aging under Contract no. GS-10F-0097L MOBIS, Delivery Order No. HHSP233L00400143U. This report is a product of the Alzheimer's Disease Demonstration Grants to States National Resource Center. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Administration on Aging or RTI International. RTI assumes responsibility for the accuracy and completeness of the information contained in this report. The authors would like to thank the ADDGS Grant staff, other state officials, providers, consumers, researchers, educators and others who gave so generously of their time to provide information about Grant activities.

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*RTI International is a trade name of Research Triangle Institute.

EXECUTIVE SUMMARY

The Alzheimer's Disease Demonstration Grant to North Carolina is a partnership among the Division of Aging and Adult Services in the North Carolina Department of Health and Human Services, the Duke University Center for Aging Family Support Program, the Western Carolina Chapter of the Alzheimer's Association, the Mecklenburg County Department of Social Services, and the Area Agencies on Aging for Regions B, C, F and I.

The grant funds Project C.A.R.E. (Caregiver Alternatives to Running on Empty), which has created a community-based, family-centered service system that provides direct access to dementia-specific respite care and connects families to other long-term care services. Project C.A.R.E. targets an underserved rural, minority and low-income elderly population. It demonstrates that both public and private entities can deliver dementia-specific respite services, allowing communities to administer the program in a way that is best-suited to local circumstances and needs.

Project C.A.R.E. offers families a personalized approach to respite care. Through Family Consultants, families are offered in-home assessment and care planning, a simplified determination of eligibility, a wide degree of flexibility and choice in the use of respite funding, ongoing case management, and education and training for caregivers and respite providers. Family Consultants also serve as a link for families to other long-term care resources. Family Consultants develop networks of provider, governmental, and volunteer agencies to bring quality dementia-specific respite services to caregivers.

To achieve systems change, Project C.A.R.E.: has used a number of strategies:

- *Integrated the needs of family caregivers into public programs and long-term care planning.* Through cooperation in strategic planning and collaboration with other state programs serving caregivers at the state level and the work of the Family Consultant in building networks of agencies and providers at the local level, Project C.A.R.E. has helped create a state long-term care system that recognizes the needs and preferences of the caregiver as well as the person with dementia.

- *Explored the efficacy of varying administrative sponsorship.* Project C.A.R.E. has demonstrated its effectiveness in two different administrative settings: under the guidance of an Alzheimer's Association Chapter, and as part of a unified county social services agency.

- *Increased access and availability of a comprehensive range and type of dementia-specific respite services by using the Family Consultant model.* Under Project C.A.R.E., the Family Consultant develops agency partnerships, recruits and trains service providers, publicizes the availability of caregiver services, conducts in-home assessments, facilitates the connection between the caregiver and respite care options and providers, and provides continuing support to both caregiver and provider.

- *Offered consumer choice and consumer-directed respite care.* Project C.A.R.E. provides flexibility in meeting the caregiver's needs through individualized attention and multiple options in the type, scheduling, and staffing of respite services.

- *Conducted outreach to low income, rural, and minority families.* Project C.A.R.E. targets underserved rural, minority and low-income elderly populations. By developing personal contacts and building bridges to the faith-based community, Family Consultants have helped overcome the cultural and geographical isolation facing dementia caregivers in rural mountainous areas and urban minority communities.

- *Connected families with information and services.* Project C.A.R.E. is bringing the expertise of the Alzheimer's Association and other proven resources into the community arena, educating both caregivers and providers to techniques which produce a higher quality of life for both client and caregiver. The network development work of the Project C.A.R.E. Family Consultants also puts them and the project in a unique position to link caregivers to a wide range of long term care services and supports.

- *Leveraged ADDGS funds for sustainability.* The grant partners are making a diligent effort to identify resources to sustain the Project C.A.R.E., seeking private foundations funding, collaborations with other long-term care grants, and making plans to approach State legislative staff with evidence of the project's effectiveness. In the Mecklenburg County site Project C.A.R.E. has demonstrated its value to a local agency which is willing to support the Family Consultant function and be an advocate for county-level respite funding.

Through this Alzheimer's Disease Demonstration Grant, Project C.A.R.E. is a replicable model for bringing dementia-specific respite services and resources to family caregivers of persons with Alzheimer's disease and other dementias, with the flexibility to meet the needs of caregivers in different economic, cultural, and geographic settings.

Date: December 12, 2006

To: Study Commission on Aging

When I moved back to Brevard after 30 years of living away, I anticipated some wonderful years left to spend with my parents. Those dreams did not materialize because within a month my dad had a stroke.

Once involved in the caregiving role for a parent, I quickly realized how difficult and how expensive it is to find good respite care. I was also watching my mother struggle to care for my dad and at the same time, assume all the responsibilities that they had once shared.

I had visions of revamping the system so that assistance would be available for my mother. Eventually, I became more familiar with the day-to-day activities of caregiving and realized that I could not change the illness or prevent my dad from slipping away. What I could do was change my response. I volunteered to become a member of the Senior Tar Heel Legislature to have a voice in changes which affect the senior citizens of North Carolina.

We were blessed with supportive people in the home and community-based care network and their willingness to share information which led us to find Len Erker and Project C.A.R.E. The two years my mother received help from Project C.A.R.E. also gave my sisters and I respite relief indirectly because we knew during those times, our mother was getting a much needed break from her continuous responsibilities.

In addition to the advantages of remaining in the home because it keeps the family together is the savings in money for the family, as well as for the state. My parents worked very hard to save their money so they could be independent when they retired. Health problems alter all of those plans for many senior adults, my parents included.

The cost of respite care is $18 - $20 per hour in this area, which totaled approximately $320 per month to allow my dad to remain at home. This level of respite support was only possible through the help of Project C.A.R.E. The cost in the nursing home was approximately $5300 per month from Medicaid as well as my mother paying $256 of her money for his care. In addition to that, she was required to "spend down" which leaves her vulnerable to requiring government assistance when she becomes unable to stay by herself. Any program that requires less money and still allows the family unit to remain intact must surely be an advantage to the alternative!

I strongly urge you to support an annual appropriation of state funds for Project C.A.R.E.

Delores Stroup
Senior Tarheel
Transylvania County Delegate

Date: December 12, 2006

To: Study Commission on Aging

I am writing to you after having been a caregiver for over five years in hopes that something I say may have an influence on your decision to fund Project C.A.R.E.

My husband, D.S. Winchester, began showing signs of dementia in the late 90's. In January of 2001, my husband had a stroke from which he partially recovered. Then he started having mini-strokes that increased his dementia.

A home health care nurse informed me of the possibility that I might get some respite care assistance through the local Alzheimer's Association in Asheville.

Len Erker came to our home and talked to me about Project C.A.R.E. I enrolled in the program and was allotted an amount of money to pay for someone to care for my husband at home four hours once a week. It was a life saver for me! I was able to go into town (Brevard) to buy groceries and do other errands, attend a Mission Group Meeting with ladies from my church and sometimes I had time to just go into another room in the house by myself and rest.

When my husband completely lost his mobility, I had to admit him to a nursing home which was the hardest decision of my life.

I learned shortly afterwards from Mr. Erker that Cathy Thorpe was going to teach a class for six weeks just for caregivers. I decided to take the class. After the 2nd week, I realized I had depression so I made an appointment with my doctor. He prescribed a medication which has really helped me. Caregiving is a stressful thing! I shall never forget when we watched a film in one of the classes about a lady who was taking care of her husband. She refused help from family, friends, everyone. The picture ended showing the husband being taken to the cemetery to her funeral; the caregiver without help can certainly go first!

My husband died September 4, 2006 in the nursing home at the age of 87. I am 86 and had he lived, we would have celebrated 65 years of marriage in November. Because of the help I received through Project C.A.R.E. and the Alzheimer's Association, I was able to keep him at our home much longer.

It is my prayer that money can be appropriated for Project C.A.R.E. because it is a great help to caregivers like me. Many thanks for the help you gave me!

Julia Winchester

North Carolina Association
LTCF
Long Term Care Facilities

4010 Barrett Drive, Suite 102, Raleigh, NC 27609
Telephone: (919) 787-3560 - Fax: (919) 783-5415
Email: info@ncaltcf.com
Website: http://www.ncaltcf.com

December 13, 2006

To: The Aging Study Commission Members

From: Lou Wilson and Roger Bone

Re: Joint Adult care Home and Mentally Ill Issues

We are very disappointed with the recommendations from the Joint Committee regarding the mentally ill population in adult care homes. While we support the expansion for consumers having options and choice we can no longer continue to ignore more than 8,000 people who are mentally ill and/or developmentally disabled who currently live in adult care homes or the challenges faced by facilities in providing services to the consumers.

A report commissioned by the Department in 2004 found that over 40% of the adult care home population carried an active diagnosis of mental illness. (Adult Care Home Mental Health Needs Assessment Report of Findings, First Health, July 15, 2004).

Adult care homes are part of North Carolina's Home and Community Based Services program. This subject is not an either/or situation in terms of the residential settings – all settings are viable.

People who are mentally ill and live in adult care homes should be treated as they would if they lived in any other setting. Federal law protects their rights to such treatment. They should:

- make their own choices with regard to living arrangements
- receive the services and supports they need to live successfully in the setting of their choice

Therefore, please consider the following recommendations:

1) Staff training-Training is most important for monitoring behavior changes and responding with appropriate interventions when dealing with challenging behaviors exhibited by some residents with mental illness.

The current training requirements for direct care staff, including aides and supervisors, in adult care homes are focused primarily on personal care with little emphasis on training related to the additional skills that are needed to care for residents who also have cognitive impairment and/or mental illness.

-more-

Recommendation: require rules to assure that all direct care staff are trained appropriately to meet the needs of the mentally ill population living in the facilities.

2) Services-The types of mental health services that are often needed by some residents in long term care settings includes: evaluation and assessment of residents who are exhibiting behaviors that appear to be related to mental illness; development of person centered plans that include consideration of each individual's needs for a wide range of services or supports; and provision of ongoing treatment and rehabilitative services, and cooperation and support for others who are providing service and support for the individual.

Recommendation: Changes in the law to assure " Right to Treatment" for mentally ill persons living in adult care homes similar to Article 3- GS 122C (see attachment) which applies only to persons living in Home and Community Based Group Homes.

3) Licensure-

Recommendation: require new rules for any facility who houses more than three mentally ill persons and require the home's license to be designated as a community residential setting and contracts for appropriate mental health services from a mental health professional.

Thank you for your assistance.

Article 3.

Clients' Rights and Advance Instruction.

Part 1. Client's Rights.

§ 122C-51. Declaration of policy on clients' rights.

It is the policy of the State to assure basic human rights to each client of a acility. These rights include the right to dignity, privacy, humane care, and reedom from mental and physical abuse, neglect, and exploitation. Each facility hall assure to each client the right to live as normally as possible while receiving are and treatment.

It is further the policy of this State that each client who is admitted to and is eceiving services from a facility has the right to treatment, including access to nedical care and habilitation, regardless of age or degree of mental illness, levelopmental disabilities, or substance abuse. Each client has the right to an ndividualized written treatment or habilitation plan setting forth a program to naximize the development or restoration of his capabilities. (1973, c. 475, s. 1; c. 436, ss. 1, 8; 1985, c. 589, s. 2; 1989, c. 625, s. 7; 1997-442, s. 1.)

§ 122C-57. Right to treatment and consent to treatment.

(a) Each client who is admitted to and is receiving services from a facility ıas the right to receive age-appropriate treatment for mental health, mental tardation, and substance abuse illness or disability. Each client within 30 days of dmission to a facility shall have an individual written treatment or habilitation lan implemented by the facility. The client and the client's legally responsible erson shall be informed in advance of the potential risks and alleged benefits of he treatment choices.

(b) Each client has the right to be free from unnecessary or excessive ıedication. Medication shall not be used for punishment, discipline, or staff onvenience.

(c) Medication shall be administered in accordance with accepted medical andards and only upon the order of a physician as documented in the client's ecord.

(d) Each voluntarily admitted client, the client's legally responsible person, r a health care agent named pursuant to a valid health care power of attorney has ıe right to consent to or refuse any treatment offered by the facility. Consent may e withdrawn at any time by the person who gave the consent. If treatment is efused, the qualified professional shall determine whether treatment in some other ıodality is possible. If all appropriate treatment modalities are refused, the oluntarily admitted client may be discharged. In an emergency, a voluntarily dmitted client may be administered treatment or medication, other than those pecified in subsection (f) of this section, despite the refusal of the client, the lient's legally responsible person, a health care agent named pursuant to a valid ealth care power of attorney, or the client's refusal expressed in a valid advance ıstruction for mental health treatment. The Commission may adopt rules to rovide a procedure to be followed when a voluntarily admitted client refuses

minor from treatment shall include notice to and consultation with the minor's legally responsible person and in no event shall a minor be discharged from treatment upon the minor's request alone.

(e) In the case of an involuntarily committed client, treatment measures other than those requiring express written consent as specified in subsection (f) of this section may be given despite the refusal of the client, the client's legally responsible person, a health care agent named pursuant to a valid health care power of attorney, or the client's refusal expressed in a valid advance instruction for mental health treatment in the event of an emergency or when consideration of side effects related to the specific treatment measure is given and in the professional judgment, as documented in the client's record, of the treating physician and a second physician, who is either the director of clinical services of the facility, or the director's designee, either:

(1) The client, without the benefit of the specific treatment measure, is incapable of participating in any available treatment plan which will give the client a realistic opportunity of improving the client's condition;

(2) There is, without the benefit of the specific treatment measure, a significant possibility that the client will harm self or others before improvement of the client's condition is realized.

(f) Treatment involving electroshock therapy, the use of experimental drugs or procedures, or surgery other than emergency surgery may not be given without the express and informed written consent of the client, the client's legally responsible person, a health care agent named pursuant to a valid health care power of attorney, or the client's consent expressed in a valid advance instruction for mental health treatment. This consent may be withdrawn at any time by the person who gave the consent. The Commission may adopt rules specifying other therapeutic and diagnostic procedures that require the express and informed written consent of the client, the client's legally responsible person, or a health care agent named pursuant to a valid health care power of attorney. (1973, c. 475, s. 1; c. 1436, ss. 6, 7; 1981, c. 328, ss. 1, 2; 1985, c. 589, s. 2; 1995, c. 336, s. 1; 1997-442, s. 3; 1998-198, s. 5; 1998-217, s. 53(a)(4); 1999-456, s. 4.)

VISITOR REGISTRATION SHEET

North Carolina Study Committee on Aging — Dec. 13, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joann Stevens	nursing
Evelyn Hawthorne	NC-AARP
Mark Hensley	Div. Aging + Adult Services
[illegible]	R. Chad & Assoc.
[illegible]	FRLTC

VISITOR REGISTRATION SHEET

North Carolina Study Committee on Aging — Dec. 13, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bowdish	Astra Zeneca
DONNIE CHARLESTON	NC ACC
Bill Wilson	AARP
TRACY COLVARD	DMA
Lynne Perrin	DMA
[illegible]	Bon: Assn
[illegible]	Bruce [illegible]
Ann C Eller	DHHS
BILL LAMB	FOR_LTC
Teresa + Steven Johnson	NC Adult Day Services Assn
John McKay	GOODMCG

VISITOR REGISTRATION SHEET

North Carolina Study Committee on Aging — Dec. 13, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Abby C. Emanuel	Nat'l MS Society
Annette Jones	HHS
Dick Hatch	AARP / NC Coalition on Aging
Ed Regan	NCRGEA
Larry Nixon	PMA
Ann B. Johnson	Gov. Adv. Council
Stacy Flannery	NCHCFA
S Kam	HHS
Lynn Wilson	NCALTCF
Roger Bone	Bone + Associates.
Sam Watts	NC. Center for Elder Abuse Prevention

VISITOR REGISTRATION SHEET

North Carolina Study Committee on Aging — Dec. 13, 2006

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rick Eldridge	Rufty-Holmes Senior Center 1120 South Boundary Street Salisbury, NC 28144
Margaret Morse	Center for Aging Research & Educational Services School of Social Work, UNC-Chapel Hill CB# 3550 CH NC 27599-3550
Mary Anne P. Salmon	same as Margaret Morse above
Susan Williamson	NCANPHA 3700 National Dr Suite 218 Raleigh NC 27612 swilliamson@NCANPHA.org
Jim Elder	AHIC
Dennis Streets	DHHS - Div of Aging & Adult Services
Theo Friedman	DHHS - DAAS
Leslee Breen	DHHS - DAAS
Stacie Nelson	Nash County Department of Aging / Senior Center
Judy Smith	DHHS - Aging & Adult Services
Mary Edwards	DHHS - DAAS

December 14, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be three meetings of the NC Study Commission on Aging during January.

DAY:	Wednesday	TIME:	9:30 AM
DATE:	January 3, 2007		
LOCATION:	Room 643 Legislative Office Building		

DAY:	Tuesday	TIME:	10:00 AM
DATES:	January 9, 2007 & January 23, 2007		
LOCATION:	Room 643 Legislative Office Building		

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Wednesday, January 3, 2007
9:30 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions
Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Quality Improvement Consultation Program (20 minutes)
Suzanne Merrill and Emily Saunders, Division of Aging and Adult Services, DHHS

III. Star Rating System for Adult Care Homes (20 minutes)
Jeff Horton, Division of Facility Services, DHHS

IV. LTC Partnership Plan (15 minutes)
Angela Floyd, Division of Medical Assistance, DHHS

V. Win-A-Step Up (15 minutes)
Bob Konrad, Cecil G. Sheps Center, UNC

VI. Approaches to Medicaid Services to the Aged, Blind, and Disabled and Long-Term Care Populations (15 minutes)
Laura Hopkins, Vice President of AMERIPLUS, AMERIGROUP Corp.

VII. Report from the Commission on Aging and Mental Health Oversight Subcommittee (20 minutes)

VIII. Approval of Minutes

IX. Meeting Adjourned

Next Meeting:
January 9, 2007 at 10:00 a.m. in Room 643

North Carolina Study Commission on Aging

MINUTES
Wednesday, January 3, 2007
9:30 AM
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Wednesday, January 3, 2007, at 9:30 A.M. in Room 643 of the Legislative Office Building. Members present were: Senator Charlie Dannelly, Co-Chair, Rep. Beverly Earle, Co-Chair; Senators Stan Bingham, Katie Dorsett and Vernon Malone; Representatives Alice Bordsen, Debbie Clary and Jennifer Weiss; Mr. Sam Marsh, Ms. Judy Pelt and Ms. Florence Soltys. Mr. Jackie Sheppard, Ex-Officio Member, was also present.

Senator Dannelly presided.

PRESENTATIONS

Quality Improvement Consultation Program

Ms. Suzanne Merrill with the DHHS Division of Aging and Adult Services was the first presenter. She furnished members with a handout entitled Quality Improvement Consultation Program for Adult Care Homes (Attachment 1). She explained the purpose of the program and the issues it is designed to address. Ms. Merrill told members that the Carolina Center for Medical Excellence was contracted to assist in implementing the Quality Improvement Pilot. Please see Attachment 1 for further details.

Next, Ms. Merrill discussed the composition of the stakeholder task force which met to review, evaluate, research, etc., quality improvement topics. The task force concluded after six meetings that 1) Medication safety would be a priority topic and 2) the program would focus on distinct quality improvement consultation and monitoring roles within Adult Care Homes (ACH). See Attachment 1. Ms. Merrill told members that all county Departments of Social Services were contacted regarding participation in a pilot program. Six counties submitted proposals. She stated that the Division of Aging and Adult Services will select and notify participants by January 12, 2007. The pilot will begin April 2, 2007 and end February 29, 2008.

Next, Ms. Emily Saunders, also with the Division of Aging and Adult Services, discussed the Quality Improvement Pilot Program in more detail. She reviewed the various

forms/tools designed to help ACH providers and consultants determine which areas they will focus on to track quality improvement activities. These tools include:

- Resident Survey: Receiving Medications
- Medication Management Self-Assessment Tool
- Medication Pass Observation Worksheet
- Medication Review Worksheet
- Quality Improvement Action Plan

See Attachment 1 for copies.

Ms. Saunders stated that the Medication Pass Observation Worksheet was the only worksheet to be completed monthly. The others are required to be completed at the beginning and at the end of the program. The outcome is expected to be an increase in resident satisfaction and quality of life and a decrease over time in the 20% deficiency rate in medication management.

After Ms. Saunders' presentation, there was discussion relative to whether residents will be capable of responding to the survey and if family members will participate. Ms. Saunders stated that they focused on the resident when preparing the survey however; there is nothing to say that a family component cannot be addressed. Rep. Clary asked what percentage of clients in adult care homes has dementia and what the value is of having the resident prepare the survey. Mr. Jerry Cooper stated that 60-65% of the clients have some type of cognitive impairment and he hopes they will be able to utilize family members in completion of the surveys. Ms. Saunders added that they will rely on care givers to determine which clients have the ability to complete the survey. There was also concern as to whether the adult care provider can be objective in completing the Medication Pass Observation Worksheet. Ms. Saunders stated that she feels that the ACH will be looking to improve and accurate completion of the form will be in their best interest.

There was discussion regarding the fact that medication safety is the starting point and how/if the other list of topics will be addressed. Ms. Saunders replied that other topics will come on board as the pilot program grows.

The next concern was regarding the composition of the task force and if there was any consideration given to having a family member on the task force. Ms. Merrill stated that inclusion of a family member would have been a good addition to the task force.

Star Rating System for Adult Care Homes

Mr. Jeff Horton with the DHHS Division of Facility Services was the next presenter. He furnished members with a copy of the DHHS Division of Facility Services' Report on the plan for developing a star rating system for Adult Care Homes. See Attachment 2. Mr. Horton stated that an adult care home would be assigned a rating of one to five stars, depending upon points assigned as the result of inspections, administrative actions imposed, active involvement in Department approved quality improvement initiatives, and whether the home had a special licensure designation pursuant to the NC NOVA

program. It is recommended that each ACH's rating be available via the internet on the Division of Facility Services' website. Mr. Horton also discussed a time line for implementation of the system. Not later than June 30, 2007 was recommended for passage of legislation as outlined in Appendix A of Attachment 2. Not later than June 30, 2008 was recommended for staff to be hired to implement the star-rating system. January 1, 2009 was recommended as the date for issuance of star-rating certificates to adult care homes.

Regarding the fiscal impact of the star-rating system, Mr. Horton told commission members that it is estimated that two additional staff will be needed to make enhancements to the current licensing database and coordination of rule development for adoption of rules by the NC Medical Care Commission. These two staff persons would also be responsible for printing and mailing out star-rating certificates and maintenance of the database. Total cost for implementation of the system is estimated to be $150,000 for the first year and $105,000 in recurring funds.

There was discussion regarding the star-rating system and DSS staff being involved in annual inspections because they are already involved with monitoring. Mr. Horton stated that they are starting to include DSS staff in the inspections. It was also suggested that County Advisory Committees be consulted when determining star ratings because they receive complaints about homes.

There was further discussion regarding the incentive for ACHs to get involved with the star-rating system. Mr. Horton stated that the primary reason would be competition. The higher rating will mean a higher quality of care.

LTC Partnership Plan

Ms. Angela Floyd with the DHHS Division of Medical Assistance presented next. She discussed the Long Term Care Insurance Partnership Program (LTCIP) and furnished members with a handout of her power point presentation. See Attachment 3. Ms. Floyd told Commission members that this program provides incentives to ensure against the substantial costs of providing for long-term care needs. She reviewed the general requirements for participation in the program and stated that one of the goals is to reduce Medicaid spending by getting persons to participate and to provide protection of assets. The LTCIP utilizes dollar for dollar asset protection. Ms. Floyd discussed the various agency roles and responsibilities and what the next steps will be in getting the program underway. Please see attachment 3 for further details.

Rep. Weis asked if advocates for senior citizens and persons with disabilities were included as stakeholders. Ms. Floyd stated that advocates will be brought in through the Division of Aging.

Rep. Weiss stated that she would like to know if policy makers should be re-instituting the long term care tax credit. She stated that it would be helpful to know what the fiscal

impact is and questioned if the partnership plan would help low, middle or upper class individuals.

WIN A STEP UP

Mr. Bob Konrad, Researcher with the NC Institute on Aging was the next presenter. He furnished members with a one page handout and a brochure regarding the WIN A STEP UP Program. See Attachment 4. WIN A STEP UP stands for **W**orkforce **I**mprovement for **N**ursing **A**ssistants: **S**upporting **T**raining, **E**ducation, and **P**ayment for **U**pgrading **P**erformance. Mr. Konrad stated that the program enhances care for people living in NC nursing homes by reducing NC's 117% annual nursing home aide turnover rate. The objectives of the program are to upgrade the skill base of nursing assistants, increase their career commitment and job satisfaction, and provide rewards and recognition. Nurse aides complete a 30 hour curriculum, agree to continue working for their employer and are rewarded with a bonus or raise. Frontline supervisors are trained to help improve their style of management and communication with nurse aides.

Mr. Konrad told Commission members that currently the program is funded through civil monetary penalties. That funding is tapering to end in FY2008-09. This particular funding is available for innovative quality improvement programs. The WIN A STEP UP Program is no longer innovative, that's why he is looking to the General Assembly for regular, long term funding.

Approaches to Medicaid Services to the Aged, Blind, and Disabled and Long-Term Care Populations

Ms. Laura Hopkins, Vice President of AMERIPLUS, AMERIGROUP Corp. gave a presentation on AMERIGROUP Community Care. She furnished members with a folder of information on the program. See Attachment 5. Ms. Hopkins stated that the program began in 1994 to bring solutions to the health care needs of low-income families, the disabled and elderly, and uninsured children. It is a fully integrated medical management model integrating physical, behavioral, and social needs. Discussion with NC legislators began in 2005. Ms. Hopkins discussed the four models of care states use to provide access to healthcare for Medicaid SSI recipients. They are: 1) Managed Care, 2) Home and Community-Based Waivers, 3) ASO Program to manage particular aspects of care, and 4) Fee for Service. She discussed briefly the programs underway in Texas, Arizona and Florida. Lastly, Ms. Hopkins talked about the benefits of the Medicaid Managed Care Model. She stated that this approach -

- Reduces emergency room visits, hospital admission, and nursing home placement
- Rebalances service utilization in favor of home and community-based services versus institutional-based care
- Uses traditional providers as the cornerstone of care
- Integrates streamline access to services making it easier for consumers to get timely care and services
- Is a comprehensive care coordination model that is consumer centric

After discussion, it was decided that DHHS would make a presentation at the next meeting on what is being done to implement this program in North Carolina. Rep. Earle asked Mr. Jackie Sheppard to have his staff prepare a report on what is being done in other states as well.

Report from the Commission on Aging and Mental Health Oversight Subcommittee

Mr. Ben Popkin, Commission Staff, Research Division, NCGA gave a brief presentation on the report from the Subcommittee on Mentally Ill Residents in Adult Care Homes. He furnished commission members with a handout of proposed recommendations. Please see Attachment 6 for a list of those recommendations.

A letter from Ms. Lou Wilson and Mr. Roger Bone regarding joint adult care home and mentally ill issues was also passed out to members. See Attachment 7.

Approval of Minutes

At this point, Senator Dannelly asked for a motion to approve the minutes from the meetings on September 12, 2006, October 11, 2006 and November 15, 2006. The minutes were approved unanimously.

The meeting adjourned at 12:10 pm.

Charlie S. Dannelly

Senator Charlie Dannelly, Co-Chair
Presiding

Beverly Earle

Rep. Beverly Earle, Co-Chair

Dee Hodge

Dee Hodge
Commission Assistant

ATTACHMENT 1

QUALITY IMPROVEMENT CONSULTATION PROGRAM FOR ADULT CARE HOMES

SESSION LAW 2005-276 - SECTION 10.40A.(p)

PROGRESS REPORT

TO

NORTH CAROLINA STUDY COMMISSION ON AGING

January 3, 2007

PREPARED BY
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES

I. LEGISLATIVE MANDATE

- **SESSION LAW 2005-276 - SECTION 10.40A.(p) QUALITY IMPROVEMENT (QI) CONSULTATION PROGRAM FOR ADULT CARE HOMES**

- **PURPOSE OF THE QI PROGRAM**

  ▪PROMOTE BETTER CARE

  ▪IMPROVE QUALITY OF LIFE IN A SAFE ENVIROMENT

- **QI PROGRAM IS COMPREHENSIVE AND, AS DIRECTED BY SL 2005-276, ADDRESSES THE FOLLOWING:**

  ▪RESIDENT CENTERED PRINCIPLES AND PHILOSOPHIES

  ▪DIGNITY, CHOICE AND INDEPENDENCE FOR RESIDENTS

  ▪CONTINUOUS QUALITY IMPROVEMENT APPROACH

  ▪DISSEMINATION OF "BEST PRACTICE" MODELS

  ▪UTILIZATION OF STANDARDIZED INSTRUMENTS TO ASSESS AND MEASURE HOMES' PERFORMANCE AND RESIDENT OUTCOMES

  ▪UTILIZATION OF QUALITY IMPROVEMENT PLANS

- TRAINING FOR COUNTY DSS STAFF TO IMPLEMENT QI PROGRAM
- DISTINCTION BETWEEN DIVISION OF FACILITY SERVICES' REGULATORY ROLE AND COUNTY DSS CONSULTATION AND MONITORING ROLES
- IDENTIFICATION OF STAFF AND RESOURCES NEEDED TO IMPLEMENT QI PROGRAM STATEWIDE

- **DIVISION OF AGING AND ADULT SERVICES TO CONDUCT PILOT IN UP TO FOUR COUNTY DSSs**

II. STAKEHOLDER TASK FORCE

- **TASK FORCE COMPOSITION**
  - ADULT AND FAMILY CARE PROVIDERS
  - COUNTY DSS STAFF
  - ADVOCACY ORGANIZATIONS
  - AREA AGENCIES ON AGING
  - HOME CARE AND NURSING HOME PROVIDERS FAMILIAR WITH QI PROGRAMS
  - STAFF WITHIN DHHS INVOLVED IN LICENSURE, REGULATIONS AND OVERSITE OF ADULT AND FAMILY CARE HOMES
  - STAFF FROM THE CAROLINAS CENTER FOR MEDICAL EXCELLENCE

- **TASK FORCE DELIBERATIONS**

  ▪SIX MEETINGS BETWEEN DECEMBER 2005 AND SEPTEMBER 2006

  ▪EVALUATED NUMEROUS QI PROGRAM TOPICS (medication management, food services, elopement, communication, and others)

  ▪HEARD ADVICE FROM TECHNICAL EXPERTS PANEL (small group of experts in QI)

  ▪CONDUCTED FOCUS GROUP MEETINGS (administrators, direct care staff, residents, long term care ombudsmen, monitoring staff in county DSSs)

  ▪RESEARCHED OTHER STATE'S QI PROGRAMS: WASHINGTON AND CALIFORNIA

  ▪REVIEWED OF QUALITY IMPROVEMENT LITERATURE

  ▪HEARD PRESENTATION ON WAKE COUNTY HUMAN SERVICES SENIOR AND ADULT SERVICES SPECIALITY INTERVENTION TEAM (SASSI TEAM)

  ▪ESTABLISHED QI PILOT PROGRAM POLICIES AND PROCEDURES TO GUIDE WORK OF COUNTY DSSs AND HOMES PARTICIPATING IN PILOT

- **TASK FORCE CONCLUSIONS**

  ▪MEDICATION SAFETY CHOSEN AS PRIORITY TOPIC FOR QI PROGRAM
    - Directly impacts quality of care and quality of life for residents
    - High number of deficiencies in this area
    - broad appeal to adult care providers

  ▪MAINTAIN DISTINCT QI CONSULTATION AND MONITORING ROLES WITHIN ADULT CARE HOMES
    - QI role is collaborative and assists providers with implementing QI Program

III. QI PILOT PROGRAM

- COMMUNICATION ABOUT QI PILOT PROGRAM AND REQUEST FOR PARTICIPATION MAILED TO ALL 100 COUNTY DSSs OCTOBER 23, 2006
- DEADLINE TO SUBMIT PROPOSAL DECEMBER 15, 2006
- SIX COUNTY DSSs SUBMITTED PROPOSALS
- DIVISION OF AGING AND ADULT SERVICES TO SELECT AND NOTIFY PARTICIPANTS BY JANUARY 12, 2007
- FIVE QI PROGRAM INFORMATIONAL SESSIONS FOR COUNTY DSSs HELD OCTOBER 2006 THROUGH MID NOVEMBER 2006
- QI PILOT BEGINS APRIL 2, 2007 AND RUNS THROUGH FEBRUARY 29, 2008

IV. QUALITY IMPROVEMENT CONSULTATION PROGRAM TOPIC: *MEDICATION SAFETY*

- FOUR *MEDICATION SAFETY* COMPONENTS
  - COMPONENT 1 - RESIDENT SATISFACTION SURVEY
    - EIGHT QUESTION SURVEY ON RECEIPT OF MEDICATIONS

- SOLICITS RESIDENTS' OPINIONS ABOUT MAINTAINING DIGNITY AND PRIVACY DURING MEDICATION ADMINISTRATION

- DETERMINES IF RESIDENTS BELIEVE MEDICATIONS GIVEN IN A TIMELY MANNER

- SURVEY COMPLETED AT BEGINNING AND END OF QI PILOT TO MEASURE CHANGE

▪COMPONENT 2 - MEDICATION MANAGEMENT

- PROVIDER SELF-ASSESSMENT TO REVIEW ALL AREAS OF MEDICATION MANAGEMENT
  - Policies and Procedures
  - Prescribing Practitioners' Orders
  - Availability of Medications
  - Medication Storage
  - Medication Administration
  - Pharmaceutical Care
  - Qualifications of Medication Staff

- MEDICATION MANAGEMENT SELF-ASSESSMENT COMPLETED AT BEGINNING AND END OF QI PILOT TO MEASURE CHANGE

▪COMPONENT 3 - MEDICATION ADMINISTRATION OBSERVATION

- HOW WELL STAFF ATTEND TO RESIDENTS' DIGNITY AND PRIVACY

- DETERMINES TYPES OF ERRORS

- DETERMINES IF MEDICATIONS ADMINISTERED AS ORDERED

- OBSERVATIONS TO OCCUR AT REGULAR INTERVALS TO TRACT PROGRESS AND MEASURE CHANGE

- **COMPONENT FOUR - DEVELOPING A QUALITY IMPROVEMENT ACTION PLAN**
  - QI CONSULTANT AND ADULT CARE PROVIDER ANALYZE RESULTS FROM RESIDENT SATISFACTION SURVEYS AND PROVIDER SELF-ASSESSMENTS
  - QI CONSULTANT AND ADULT CARE PROVIDER PRIORTIZE AREAS FOR IMPROVEMENT
  - QI CONSULTANT PROVIDES CONSULTATION AND TECHNICAL ASSISTANCE AND "BEST PRACTICES" FOR ACHIEVING GOALS
  - IDENTIFIED IMPROVEMENT AREAS CHECKED OFF AS CHANGES IMPLEMENTED SUCCESSFULLY
  - ADDITIONAL IMPROVEMENT AREAS ADDED TO PLAN AS IDENTIFIED

V. EXPECTED OUTCOMES

- **QUALITY OF LIFE AND RESIDENT SATISFACTION INCREASE**
- **DECREASE IN 20% DEFICIENCY RATE* OVER TIME IN MEDICATION MANAGEMENT**

*Division of Facility Services, Adult Care Licensure Section, survey data for adult care homes from October 2005 through March 2006.

RESIDENT SURVEY: Receiving Medications

Date: _____ **Name of Home:** _____ **Interviewer:** _____

This home is working to improve residents' satisfaction with receiving their medications. We're asking residents to take a survey to help us learn what we're doing well, and what we may need to improve. It will take about 10 minutes. **The survey is voluntary. You do not have to participate**. If you have questions about this survey, you can contact Emily Saunders in Raleigh at the Division of Aging and Adult Services, and I can give you her phone number (919-733-3818). Are you willing to take the survey?

When answering each question, think about receiving your medications over just the last 7 days.

	Yes	No	Don't Know
1. The rules for this home say that you can get your medication up to 1 hour before or 1 hour later than it's scheduled to be given, and it is still on time. Over the last seven days, did you always get your medications on time? Comments:	☐	☐	☐
2. Over the last seven days, did you have to ask for any of your medications? *** 2a. If yes:** Did a staff person always bring you the medication in a timely way? Comments:	☐ ☐	☐ ☐	☐ ☐
3. Over the last seven days, did the staff ever tell you that any of your medications were unavailable? Comments:	☐	☐	☐
4. Over the last seven days, did the person who gave you your medication always watch you swallow it? Comments:	☐	☐	☐
5. When you got your medications over the last seven days, did the staff person always explain them to you in a way that you could understand? (For example: Tell you the names of your medications, or what health conditions the medications are for.) Comments:	☐	☐	☐

RESIDENT SURVEY: Receiving Medications, continued

Date: _____ **Name of Home:** _____ **Interviewer:** _____

	Yes	No	Don't Know
6. Over the last seven days, did the staff person always greet you or speak with you in a friendly or kind way when giving your medication to you? Comments:	☐	☐	☐
7. Over the last seven days, did the staff respect your privacy and dignity when giving you your medication? (For example: Did someone apply an ointment with other people watching, or put eye drops in your eyes while you were trying to eat a meal?) Comments:	☐	☐	☐
8. Over the last seven days, did you have any medication problems or concerns that you shared with the staff? * **8a. If yes**: Did the staff listen and respond to you? Comments:	☐ ☐	☐ ☐	☐ ☐

General Comments:

(**Interviewer:** Ask only if the resident expressed concerns that you listed on this survey.)
Do you want to list your name on the survey so that someone here can come talk with you to learn more about your concerns? You do not have to list your name. It's your choice.

Resident's Name:_____

MEDICATION MANAGEMENT SELF-ASSESSMENT TOOL

Name of Home: _____ **Date:**_____

Completed by:_____

NOTE: Questions in the self-assessment followed by a set of numbers refer to items on the *Regulatory Assistance Tool*. Your Quality Improvement Consultant can provide you with a copy. Look up the numbers that correspond to your "no" answers for tips on how to meet the regulation and, in some cases, details on helpful tools.

1. Policies and Procedures		
A system is in place – and is used – to:	Yes	No
1a. An updated medication policy and procedure manual is accessible to medication staff? (I.1,2)	☐	☐
1b. Medication staff receives orientation and in-service education on the policy and procedure manual? (I.2)	☐	☐
1c. There is a quality assurance system to assure that staff follows the home's policies and procedures? (I.3,4)	☐	☐

2. Medication Orders		
A system is in place – and is used – to:	Yes	No
2a. Assure that medication aide supervisors or designees follow a quality assurance system making certain that medication orders are clarified if incomplete or unclear, including "prn" psychotropic medication orders? (II.1,2,6)	☐	☐
2b. Follow-up with the prescribing practitioner if the practitioner did not respond timely for clarification of orders? (II.1,2)	☐	☐
2c. Assure that orders are correctly transcribed onto the MAR? (II.1)	☐	☐
2d. Assure that medication orders are sent to the pharmacy? (II. 2)	☐	☐
2e. Assure that medications are in the home for administration? (II.5 & IV.1)	☐	☐
2f. Assure that prescribing practitioner orders are followed up for renewal every 6 months? (II.4)	☐	☐

3. Telephone Orders (fill out only if your home has a policy permitting phone orders)		
A system is in place – and is used – to:	Yes	No
3a. Follow up on telephone orders, if allowed, to assure that the prescribing practitioner signed and dated the telephone order and the copy retained in the resident's record? (II.1,3)	☐	☐
3b. Assure that unsigned telephone order copy is available until the signed/dated copy is returned to the home and placed in the resident's record? (II.3)	☐	☐

MEDICATION MANAGEMENT SELF-ASSESSMENT TOOL, cont'd

4. Medication Labels		
A system is in place – and is used – to:	Yes	No
4a. Update labels when directions for administration of medications changes? (III.2)	☐	☐
4b. Document the release of medications sent out of the home with the resident/responsible person? (III.6)	☐	☐
4c. Assure that medications remain in the original containers? (III.5)	☐	☐

5. Medication Administration		
A system is in place – and is used – to:	Yes	No
5a. Identify residents prior to medication administration? (IV.15)	☐	☐
5b. Monitor and report medication errors in a non-punitive atmosphere?(IV.16)	☐	☐
5c. Evaluate medication errors? (IV.16)	☐	☐
5d. Develop a plan of correction to make changes based on the evaluation of the medication errors? (IV.16)	☐	☐
5e. Assure that adequate medication supplies are available and used by staff? (IV.17)	☐	☐
5f. Assure that infection control measures used during the medication administration are in accordance with the home's policies and procedures? (I.1 & IV.18)	☐	☐
5g. Assure that staff communicates with residents about their medications at a level of resident understanding? (best practice – not rule based)	☐	☐
5h. Assure that staff know the managers to whom they should communicate problems or concerns identified with residents' medication administration? (best practice – not rule based)	☐	☐
5i. There is no evidence of pre-charting or charting multiple residents' medications at one time? (IV.8, 9)	☐	☐
5j. Orders for monitoring medications, i.e., blood pressures, weights, pulses, blood sugar monitoring are obtained and documented as ordered? (I.1,2 & IV.5)	☐	☐

6. Pre-poured Medications (fill out <u>only</u> if your home has a policy permitting pre-pouring of medications)		
A system is in place – and is used – to:	Yes	No
6a. (If medications are pre-poured) Monitor that at all areas of the rules are followed for pre-poured medications? (IV.6)	☐	☐

MEDICATION MANAGEMENT SELF-ASSESSMENT TOOL, cont'd

7. Medication Storage		
A system is in place – and is used – to:	Yes	No
7a. Assure that medications are stored in a safe secure manner, including medications that are self-administered? (VI.1)	☐	☐
7b. Assure that only authorized staff have access to the keys for medication storage? (VI.2,3)	☐	☐
7c. Assure that medication areas are clean and uncluttered? (VI.5)	☐	☐
7d. Assure that medications for external use are stored separately from medications for internal use? (VI.9)	☐	☐

8. Medication Disposition		
A system is in place – and is used – to:	Yes	No
8a. Assure that discontinued or expired medications are stored separately from residents' current medication supply? (VII.2)	☐	☐
8b. Assure that any discontinued or expired medications are disposed of or returned to the pharmacy within 90 days in accordance with the home's policies and procedures? (I.1,2,3 & VII.3)	☐	☐
8c. Assure that there is designated staff responsible for disposing or returning medications to the pharmacy? (best practice – not rule based)	☐	☐

9. Controlled Substances		
A system is in place – and is used – to:	Yes	No
9a. Assure that receipt, administration and disposition of controlled substances is documented? (VIII.1)	☐	☐
9b. Assure that the controlled substance log accurately reflects the amounts of controlled substance in the home? (VIII.2)	☐	☐
9c. Assure that there is documentation of the home's response and follow-up if the count and documentation of controlled substances do not match? (VIII.2)	☐	☐
9d. Assure that controlled substances stored together are double locked? (VIII.3)	☐	☐

MEDICATION MANAGEMENT SELF-ASSESSMENT TOOL, cont'd

10. Pharmaceutical Care		
A system is in place – and is used – to:	Yes	No
10a. Obtain a medication regime review by the appropriate health professional on a quarterly basis? (IX.1)	☐	☐
10b. Follow up with the prescribing practitioner, the recommendations of the pharmacist or (in a Family Care Home) the RN. (IX.3,4)	☐	☐
10d. Review the findings of the pharmaceutical medication review with all medication staff? (best practice – not rule based)	☐	☐
10e. Assure emergency pharmacy services to meet the needs of the residents? (X.3)	☐	☐
10f. There is documentation of the follow-up with the prescribing practitioner in the resident's record? (IX.4)	☐	☐

11. Qualifications of Medication Staff		
A system is in place – and is used – to:	Yes	No
11a. Assure that medications aides have a medications skills validation checklist completed by the appropriate licensed health professional prior to administrating medications? (XI.1)	☐	☐
11b. Assure that medication aides successfully pass the medication exam given by the Division of Facility Services within 90 days of successful completion of the medication skills validation checklist? (XI.1)	☐	☐
11c. Assure that medication aides successfully completed the annual 6 hours of required continuing education? (XI.2)	☐	☐
11d. Assure that medication aides who perform other personal care tasks have completed the personal care aide training and competency requirements? (XI.3)	☐	☐
11e. Assure validation by an RN of Licensed Health Professional Support tasks completed by the medication aides. (XI.4)	☐	☐
11f. Assure that medication aides receive training on the care and treatment of residents with diabetes prior to giving insulin injections? (I.1 also Rule 10A NCAC 13F/G .0505)	☐	☐
11g. Assure that medication aides receive training on the desired and undesired effects of psychotropic medications? (II.7)	☐	☐

MEDICATION MANAGEMENT SELF-ASSESSMENT TOOL, cont'd

12. Self-Administration of Medications		
A system is in place – and is used – to:	Yes	No
12a. Assure residents who self-administer medications have prescribing practitioner orders to self-administer medications? (V.1)	☐	☐
12b. Evaluate all residents for possible self-administration of medications at the time of admission? (best practice – not rule based)	☐	☐
12c. Evaluate for possible self-administration of medications if a resident's improvement in condition may enable him/her to self-administer medications.(best practice – not rule based)	☐	☐
12d. Re-evaluate residents who self administer medications? (V.4)	☐	☐

13. On-going Monitoring of Medication Administration & Management (best-practice – not rule-based)		
A system is in place – and is used – to:	Yes	No
13a. Do on-going monitoring of sampled residents' records to assure that medication orders are complete or clarified, administered as ordered, medications are available for administration and medications are documented on the MAR appropriately? (best practice – not rule based)	☐	☐
13b. Share the results of the sampled records monitored with medication aides? (best practice – not rule based)	☐	☐
13c. Share information and ideas for improved medication safety in the home between the home's management staff and the medication aides? (best practice – not rule based)	☐	☐

MEDICATION PASS OBSERVATION WORKSHEET

Name of Home: _____ **Date(s):** _____ **Scheduled Time of Pass/Passes:** _____

Observed By: _____ **Medication Staff Observed:** _____

Instructions: Observe the administration of at least 25 medications.

1. (Before observing the med. pass) Review *Medication Pass Observation Guide* to know what to watch & listen for. Review MAR for each resident to be included in the observation & list resident's name, and drug name, dose & route of administration for each medication scheduled to be given.
2. (During observation) List details in "Observation Notes" that will help you determine in step 3 whether the resident's dignity & privacy were maintained, correct techniques were used, the Six Rights of Medication Administration were followed.
3. (During or after observation) For each medication, write "yes" or "no" in the appropriate column: Dignity & privacy maintained? Followed Six Rights of Medication Administration? Used correct administration technique?
4. (After observation) Review the prescriber's order for each medication. If different than medication as observed administered, list the order.
5. Add totals as directed at end of worksheet.

	Resident Name & Time Med. Actually Administered	Drug Name, Dose, & Route	Observation Notes	Maintained Dignity & Privacy? (Yes/No)	Followed 6 Rights of Med. Admin.? (Yes/No)	Used Correct Admin. Technique? (Yes/No)	Prescriber order different than med as administered? (If yes, list it)
1							
2							
3							
4							
5							
6							
7							

	Resident Name & Time Med. Actually Administered	Drug Name, Dose, & Route	Observation Notes	Maintained Dignity & Privacy? (Yes/No)	Followed 6 Rights of Med. Admin.? (Yes/No)	Used Correct Admin. Technique? (Yes/No)	Prescriber order different than med as administered? (If yes, list it)
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							

	Resident Name & Time Med. Actually Administered	Drug Name, Dose, & Route	Observation Notes	Maintained Dignity & Privacy? (Yes/No)	Followed 6 Rights of Med Admin.? (Yes/No)	Used Correct Admin. Technique? (Yes/No)	Prescriber order different than med as administered? (If yes, list it)
20							
21							
22							
23							
24							
25							
			Totals:	____ # of "Yes" Answers	____ # of "Yes" Answers	____ # of "Yes" Answers	____ # of prescriber orders listed

After adding up the totals, use the Medication Administration Analysis Worksheet to calculate your score. Your consultant will assist you.

Medication Review Worksheet

Name of Home:_____ **Date of Review:**_____

Resident's Name:_____ **Reviewer's Name:**_____

Use one worksheet per chart reviewed.

List Medication Orders from FL-2, DC Summary or 6-Month Renewal (use most current document) Date on document: _____	List Orders for New, Changed or Discontinued Medications	Date of Orders	MAR Documented as Ordered?		Medication Labeled Correctly?	
			Yes	No	Yes	No
1.			☐	☐	☐	☐
2.			☐	☐	☐	☐
3.			☐	☐	☐	☐
4.			☐	☐	☐	☐
5.			☐	☐	☐	☐
6.			☐	☐	☐	☐
7.			☐	☐	☐	☐
8.			☐	☐	☐	☐
9.			☐	☐	☐	☐
10.			☐	☐	☐	☐
11.			☐	☐	☐	☐
12.			☐	☐	☐	☐

List Medication Orders from FL-2, DC Summary or 6-Month Renewal (use most current document) Date on document: _____	List Orders for New, Changed or Discontinued Medications	Date of Orders	MAR Documented as Ordered?		Medication Labeled Correctly?	
			Yes	No	Yes	No
13.			☐	☐	☐	☐
14.			☐	☐	☐	☐
15.			☐	☐	☐	☐
16.			☐	☐	☐	☐
17.			☐	☐	☐	☐
18.			☐	☐	☐	☐
19.			☐	☐	☐	☐
20.			☐	☐	☐	☐

(add additional pages if needed)

Any MAR errors?	Yes ☐ No ☐	Any label errors?	Yes ☐ No ☐

After reviewing the required number of charts, your consultant will assist you in filling out the Medication Review Analysis Worksheet to calculate your score.

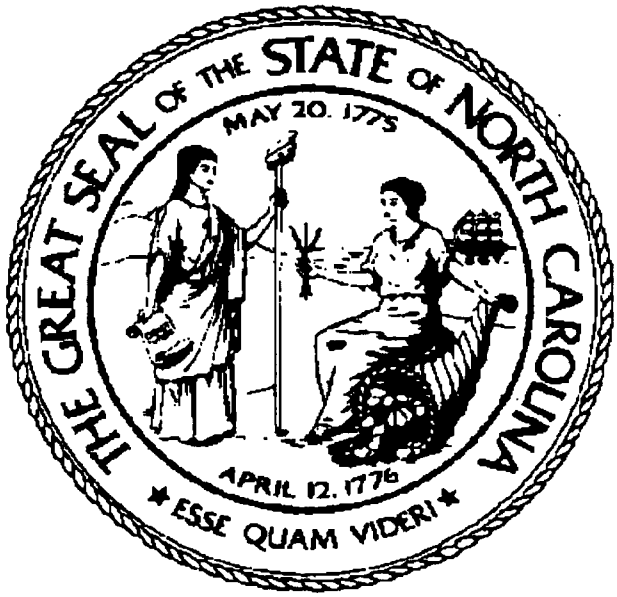
Quality Improvement Action Plan

Create a separate action plan for *each* of your goals.

Adult Care Home Name:			**Date:**	
Goal:				
Action Steps (What will be done?)	**Responsibilities** (Who will do it?)	**Resources** (Supplies, equipment, etc.)	**Timeline** (date/month) **Start**	**End**
1.				
2.				
3.				
4.				
5.				

Evidence of Success (What information will you use to know whether you are achieving your goal?)

ATTACHMENT 2



REPORT TO THE 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 THE PLAN FOR DEVELOPING A STAR RATING SYSTEM FOR ADULT CARE HOMES

North Carolina Department of Health and Human Services
Division of Facility Services

January 1, 2007

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North Carolina Department of Health and Human Services
Division of Facility Services

Overview

Section 10.41 of Session Law 2005-276 requires the Department of Health and Human Services to "develop a plan for implementing a star-rating system for adult care homes to improve quality of care." The following report outlines the Department's plan for the star-rating system.

Response to Legislative Request

The General Assembly enacted as part of Senate Bill 622, S.L. 2005-276 the following provision:

PLAN FOR STAR-RATING SYSTEM FOR ADULT CARE HOMES
SECTION 10.41. *The Department of Health and Human Services shall develop a plan for implementing a star-rating system for adult care homes to improve quality of care. The Department shall report on the status and details of the plan, including a recommended time line for implementation, 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 not later than January 1, 2007.*

In response to the above directive, the Department initiated a process to put together the plan for the star-rating system. Representatives from the provider community and advocacy community were contacted and consulted to discuss what factors would be considered for a star-rating system.

Findings and Recommendations

Results of Stakeholder Discussion and Basis of Rating

The primary focus of the discussions centered on what factors should be considered in determining a facility's star rating. The consensus was that the rating should be based on a number of factors including:

1. The facility's compliance with adult care home statutes and rules utilizing results from inspections conducted by the Division of Facility Services (DFS);

2. Any administrative action(s) taken against the facility, beginning with the first inspection for which the star-rating would be based, as a result of non-compliance with applicable statutes and rules;

3. Voluntary participation of the adult care home in any Department approved quality improvement initiatives; and

4. Whether or not the facility had achieved North Carolina New Organizational Vision Award (NC NOVA) designation pursuant to G.S. 131E, Article 5, Part 6.

Below is a discussion of each of the factors mentioned above.

1. Compliance with adult care home statutes and rules – There was discussion regarding what type of inspections and monitoring results should be utilized to help derive the rating. Currently, there are two levels of monitoring that are done for adult care homes. The first is local monitoring conducted by the 100 county Department of Social Services (DSS) every 2 – 3 months as required by G.S. 131D-2 and the second is annual monitoring conducted by DFS that will begin July 1, 2007 as a result of G.S. 131D-2(b)(1) and Session Law 2005-276. The consensus of the discussion determined that in order to promote consistency and credibility to a state wide rating system, the ratings should be based on inspections and monitoring conducted at the state level by DFS. Having the inspections and monitoring utilized for the ratings consolidated at the state level will promote the highest level of consistency and accountability. While it is recognized that the work conducted by county DSS's provides an important role in monitoring adult care homes at the local level, there is greater variability in how monitoring is conducted among the 100 county DSS's compared to how it is done by a single state agency such as DFS.

2. Administrative action(s) taken against the facility by DFS as a result of non-compliance with applicable statutes and rules, beginning with the first inspection for which the star-rating would be based – It was felt that basing the rating solely on state level inspections and monitoring without taking into consideration substantial non-compliance would not provide a true rating of an adult care home. Therefore, it was determined that if any of the following administrative actions were to be imposed against an adult care home, the rating should be adjusted to reflect the actions accordingly:

a. Penalties imposed as a result of a Type A or Type B penalty violation pursuant to G.S. 131D-34;
b. Suspension of admissions to the facility;
c. Provisional license; or
d. Intent to revoke the facility's license.

3. Voluntary participation of the adult care home in any Department approved quality improvement initiative – As a result of Session Law 2005-276, Section 10.40, the Department was directed to implement a pilot quality improvement initiative for adult care homes. The pilot program is currently in process with the intent of allowing county DSS's to provide quality improvement consultation to adult care home providers in a non-regulatory fashion.

4. Achievement of special licensure designation through the North Carolina New Organizational Vision Award (NC NOVA) pursuant to G.S. 131E, Article 5, Part 6 – The NC NOVA program, effective January 1, 2007 as a result of Senate Bill 1277, is an exciting and innovative program which North Carolina is leading the nation. The program is the first of its kind from a national perspective. In order to receive the special licensure designation, the facility must demonstrate it is meeting NC NOVA criteria which is focused on work force retention and reducing turnover. The program is voluntary and facilities striving to obtain NC NOVA designation must be evaluated by the Carolinas Center for Medical Excellence to assure they meet criteria prior to receiving the special licensure designation. As with the involvement in other Department approved quality improvement programs, the premise is that adult care homes should be given extra points toward achieving a higher star rating for striving to go above and beyond minimum licensing standards.

How the Star-rating System Would Potentially Work

Statutory authority to promulgate rules would be required, somewhat similar to the authority that requires star-ratings for day care providers pursuant to G.S. 110-90. Appendix A contains suggested statutory language that would direct the North Carolina Medical Care Commission to adopt rules for the issuance of star-rated certificates for adult care homes. After statutory authority is provided and with input from various stakeholders, rules could be developed that would create a point system, which would provide point ranges for each star-rating.

An adult care home would be assigned a rating of one to five stars (★ s) depending upon points assigned as the result of inspections, administrative actions imposed against the home by DFS, active involvement in Department approved quality improvement initiatives, whether the home had a special licensure designation pursuant to the North Carolina New Organizational Vision Award (NC NOVA) program. For example, an adult care home would begin with 100 points when its annual DFS inspection is conducted. If non-compliance with licensing standards is found, the home would receive point demerits for each instance of non-compliance. The total of the demerit points would be subtracted from 100 and the resulting score would determine the home's star-rating depending on where it fell on the star-rating scale. Imposition of administrative actions as a result of the inspection would increase the amount of demerits and result in a lower star-rating. Participation in a Department approved quality improvement program or achievement of the NC NOVA special licensure designation would provide the facility additional points which may result in a higher star-rating.

The rating would remain the same until the next annual survey unless the adult care home experiences any of the following occurrences:

- a complaint investigation is performed that results in cited non-compliance with licensing standards and administrative actions being taken against the home;
- the adult care home loses or gains the NC NOVA special licensing designation and the increase in points lost or gained from the rating, respectively, would have an effect on the overall rating; or
- the adult care home withdraws from voluntary participation in the Department approved quality improvement initiative.

If, after any of the above occurrences, the resultant score is lower than the score of the current star-rating, the rating would be downgraded accordingly and a new certificate issued.

In order to make the star-rating accessible for the public, it is recommended that each adult care home's rating be available via the internet on the DFS website (http://facility-services.state.nc.us) and printed on each home's rating certificate. Certificates will be

amended whenever the star-rating changes as the result of the annual survey or if downgraded due to results of a complaint investigation and/or administrative action.

Time Line for Implementation

Below is a time line based on what would be a reasonable implementation schedule given the tasks that would need to be accomplished in order to provide organization and credibility for the star-rating system.

Not later than June 30, 2007: passage of legislation as outlined in Appendix A and appropriation of state funds to address fiscal impact of implementing star-rating system.

Not later than June 30, 2008: Staff will be hired to implement the star-rating system, specifically, working with the DHHS Division of Information Resource Management to enhance the licensing database to accommodate star-rating system information and printing of star-rating certificates. Staff will also be simultaneously working to develop rules for adoption by the North Carolina Medical Care Commission to address "nuts and bolts" implementation of the star-rating system and staff will also be developing internal policies to implement star-rating system and will be involved in training DFS staff and county DSS staff concerning the system.

Not later than January 1, 2009: issuance of star-rating certificates to adult care homes.

Fiscal Impact

As with most initiatives of this nature, the cost of doing business will increase if the recommendations outlined above are enacted by the General Assembly. This cost will be in the form of:

- Additional staff resources that will be necessary to maintain the database for the star-rating system and to make the information publicly available via the internet; and
- Enhancement and maintenance of the database DFS currently utilizes to maintain licensing information for adult care homes in order to allow for tracking star-rated certificate information.

It is estimated that two additional staff will be needed to work with the Division of Information Resource Management concerning enhancements that will need to be made to the current licensing database to accommodate the star-rating system. These two staff will also be responsible for coordination of rule development for adoption of rules by the NC Medical Care Commission that would set forth specific requirements and criteria for implementing the star-rating system. In addition, once enhancement of the database has been completed, rules have been adopted and are in effect, and inspections have been completed, the two staff will be responsible for printing and mailing out star-rating certificates and maintenance of the DFS database with current star-rated licensing information.

One of these two staff should be a support-type staff person such as a processing assistant and the other should be a professional capable of developing and maintaining a web site that contains the information. The cost of these two positions, including salary and benefits, is estimated to be recurring funds of $38,000/year for the support staff position and $62,000/year for the professional position for a total of $100,000.

The cost of enhancing the database currently used by DFS to maintain licensing information and to allow tracking for star-rating certificates is estimated at approximately $50,000 (non-recurring funds). Maintenance of the database is estimated to cost approximately $5,000 annually (recurring funds).

Therefore, the total costs for implementing the system is estimated to be $150,000 for the first year ($100,000 for staff and $50,000 for database enhancement) and $105,000 recurring funds ($100,000 for staff and $5,000 database maintenance).

Appendix A

AN ACT TO CREATE A STAR-RATING SYSTEM FOR ADULT CARE HOMES

§ 131D-4.5. Rules adopted by Medical Care Commission.

The Medical Care Commission shall adopt rules as follows:

(1) Establishing minimum medication administration standards for adult care homes. The rules shall include the minimum staffing and training requirements for medication aides and standards for professional supervision of adult care homes' medication controls. The requirements shall be designed to reduce the medication error rate in adult care homes to an acceptable level. The requirements shall include, but need not be limited to, all of the following:

a. Training for medication aides, including periodic refresher training.

b. Standards for management of complex medication regimens.

c. Oversight by licensed professionals.

d. Measures to ensure proper storage of medication.

(2) Establishing training requirements for adult care home staff in behavioral interventions. The training shall include appropriate responses to behavioral problems posed by adult care residents. The training shall emphasize safety and humane care and shall specifically include alternatives to the use of restraints.

(3) Establishing minimum training and education qualifications for supervisors in adult care homes and specifying the safety responsibilities of supervisors.

(4) Specifying the qualifications of staff who shall be on duty in adult care homes during various portions of the day in order to assure safe and quality care for the residents. The rules shall take into account varied resident needs and population mixes.

(5) Implementing the due process and appeal rights for discharge and transfer of residents in adult care homes afforded by G.S. 131D-21. The rules shall offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes.

(6) 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.

(7) For the licensure of special care units in accordance with G.S. 131D-4.6, and for disclosures required to be made under G.S. 131D-8.

(8) For time limited provisional licenses and for granting extensions for provisional licenses. (1999-334, s. 1.1; 2000-111, s. 2.)

(9) For the issuance of a star-rated certificates to adult care homes. The star-rating shall be administered as follows:

a. Effective January 1, 2009, for any new certificate issued to an adult care home, the certificate shall have a rating of one to five stars; and

b. The rating shall be based on:

1. inspections and complaint investigations conducted by the Division of Facility Services to determine compliance with licensing statutes and rules pursuant to this Article;
2. any Type A or Type B penalties or other administrative actions imposed on the facility by the Division of Facility Services;
3. participation in any quality improvement programs approved by the Department; and
4. whether or not the facility has achieved North Carolina New Organizational Vision Award designation pursuant to G.S. 131E, Article 5, Part 6.

LONG TERM CARE INSURANCE PARTNERSHIP PROGRAM (LTCIP Program)

DEFICIT REDUCTION ACT OF 2005

Individuals exempt from estate recovery procedures if the state program provides for the disregard of any assets in an amount equal to the private long-term care insurance benefits paid on behalf of the individual

LTCIP PROGRAM

NORTH CAROLINA SESSION LAW 2006-0066 – SECTION 10.10

- DHHS shall develop North Carolina Long Term Care Partnership Program
- DHHS shall administer the Program following applicable Federal Law
- The Program shall offer incentives to individuals to ensure against the substantial costs of providing for their long-term care needs
- DHHS submit the proposed Program to Senate and House Appropriations Committees on Health and Human Services and Fiscal Research Division prior to submitting the State Plan

LTCIP PROGRAM

OVERVIEW

- Alliance between the Division of Medical Assistance and the Department of Insurance
- Long Term Care Insurance Partnership (LTCIP) provides incentives for the purchase of private long term care insurance
- Individuals purchase a "qualifying" policy allowed special resource disregard in Medicaid eligibility determination

LTCIP PROGRAM

GENERAL REQUIREMENTS

- Individual is a resident of the state when coverage begins
- Policy meets IRS requirements
- Policy meets NAIC model LTC insurance act and regulations
- Policy provides inflation protection for purchasers

LTCIP PROGRAM

GENERAL REQUIREMENTS

- The state Medicaid agency responsible for technical assistance related to the training of individuals selling these policies
- The issuer reports to the Secretary the amount of benefits paid and termination dates
- The state applies any requirements affecting the terms or benefits of these policies to all long-term care policies sold in the state

LTCIP PROGRAM

POLICIES ADDRESS THE FOLLOWING CONCERNS

- Rapidly increasing Medicaid expenditures for nursing home care
- The limited extent people use private insurance to protect themselves against the high cost of long term care
- Medicaid is only public program providing significant financial relief to individuals BUT requires individuals to become impoverished to qualify

LTCIP PROGRAM

DOLLAR FOR DOLLAR ASSET PROTECTION

- The dollar amount of the disregard is amount of benefits paid by the approved LTCIP policy up the actual cost of long term care
- Disregard in effect for the lifetime of the individual

LTCIP PROGRAM

ESTATE RECOVERY

- Medicaid Estate Recovery is required by Federal Law (Social Security Act – 42 USC 1396p)
- All assets in recipients' probate estate subject to recovery. Assets that were exempt (not counted) for Medicaid eligibility purposes may be subject to Estate Recovery
- Medicaid does not recover Medicaid payments made on behalf of the individual from the individual's assets properly disregarded under provisions of the long-term care partnership insurance disregard

LTCIP PROGRAM

DATA COLLECTION

- HHS Secretary to establish a National Clearinghouse for Long-term Care Information
- The Clearinghouse provide education on Medicaid long-term care benefits and eligibility requirements and
- Clearinghouse to list states with approved partnership programs.
- Prohibits the Clearinghouse from recommending a specific long-term care insurance product or provider.

LTCIP PROGRAM

AGENT TRAINING

State Medicaid Agency collaborates with DOI on training for individuals selling policies

LTCIP PROGRAM

STATE PLAN AMENDMENT REQUIREMENTS

- Policies must meet requirements of specific portions of the National Association of Insurance Commissioners' (NAIC) LTC Insurance Model Regulations and Model Act.
- State Medicaid agency may accept certification from the same authority that the policy meets the Internal Revenue Code definition of a qualified LTC insurance policy, and that it includes the requisite inflation protections.

LTCIP PROGRAM

STATE PLAN AMENDMENT REQUIREMENTS

- State Medicaid agency accepts certification of the Commissioner or other authority, not required to independently verify policies meet requirements
- To be a qualified Partnership policy, the issue date must not be earlier than the effective date of the Qualified Partnership SPA

LTCIP PROGRAM

COMMITTEE ACTIVITIES:

- Committee formed to develop a Long Term Care Insurance Partnership work plan.
- Committee representation:
  - Division of Medical Assistance
  - Department of Insurance
  - Department of Justice
  - Division of Aging and Adult Services
  - County Departments of Social Services
- Subcommittees for
  - Compliance/Monitoring,
  - Agent Training, and
  - Estate Recovery

LTCIP PROGRAM

Other Stakeholders

- Elder Law Association
- NC Health Care Facilities Association
- Private Insurance Companies

LTCIP PROGRAM

Awaiting CMS Guidance

- Exchange of existing policies
- Reciprocity between states with partnership programs
- Regulations on reporting requirements

LTCIP PROGRAM

AGENCY ROLES AND RESPONSIBILITES

DOI

- Certification of Partnership Policies/Exchange of Existing Policies
- Agent Training
- Data Collection
- Reciprocity Between States with Partnership Programs

DMA

- Medicaid Eligibility Policy
- Estate Recovery Procedures
- State Plan Amendment
- Additional Data Collection
- System Requirements
- Consumer Education

LTCIP PROGRAM

NEXT STEPS

- DOI provided guidance at NAIC meeting December
- LTCIP Planning Committee will meet on January 4, 2007 to discuss NAIC guidance
- LTCIP Planning Committee to development timelines
- The Planning Committee will be meeting monthly
- The sub-committees will meet as needed.

LTCIP PROGRAM

Thank you

WIN A STEP UP: A WINNING PROGRAM FOR NORTH CAROLINA'S ELDERS

Lowering nurse aide turnover to better serve NC's most frail and vulnerable citizens

WIN A STEP UP

To address NC's 117% annual nurse aide turnover rate, WIN A STEP UP requests $450,000 in FY07/08

This includes:

- $250,000 to bring the program back to original funding levels.

- $200,000 to develop a pilot program for the growing home health sector.

What is WIN A STEP UP?

WIN A STEP UP (**W**orkforce **I**mprovement for **N**ursing **A**ssistants: **S**upporting **T**raining, **E**ducation, and **P**ayment for **U**pgrading **P**erformance) enhances care for people living in NC nursing homes by **reducing our state's 117% annual nursing home aide turnover rate.**

The objectives of the program are to upgrade the skill base of nursing assistants, increase their career commitment and job satisfaction, and provide rewards and recognition to WIN A STEP UP participants. Nurse aides complete a 30-hour curriculum, agree to continue working for their employer, and are rewarded with a bonus or raise. Frontline supervisors are trained to help improve their style of management and communication with nurse aides.

The program is a partnership between NC's Department of Health and Human Services and UNC's Institute on Aging, with active participation from NC's nursing home industry.

WIN A STEP UP has a record of accomplishments

WIN A STEP UP was named by the US DHHS as **1 of 3 programs in the nation proven effective** in reducing nurse aid turnover.

WIN A STEP UP has reached 40 of NC's 100 counties, delivered 28,000 hours of training to 845 nurse aides in 53 nursing homes and 212 frontline nurse supervisors in 26 sites. However, thousands of NC's frontline aides and nurses have not yet had the opportunity to receive the training.

WIN A STEP UP is backed by evidence

A Robert Wood Johnson & Atlantic Philanthropies-sponsored evaluation of the program reported improvements in morale, retention, and quality of care delivered by frontline caregivers.

The program is a sound investment

The WIN A STEP UP program cost was $1239 per enrollee last year. Employers invested $842 per participant - almost 41% of total cost. Through streamlining and improvements, costs for the coming year are projected to be only $981 per enrollee, with a smaller share of program costs borne by public funds.

WIN A STEP UP is **a real bargain, especially when measured against the financial and human impact of nurse aide turnover.**

WIN A STEP UP is needed now more than ever!

WIN A STEP UP training can be critical for many NC nursing homes trying to qualify for the NC New Organizational Vision Award (NC NOVA), the new special licensure designation NC DHHS is rolling out for nursing homes in 2007.

Home health agencies, one of the fastest growing sectors providing skilled care for older adults, are also requesting WIN A STEP UP training to address nurse aide turnover.

FY06/07 funding has been substantially reduced

The program has received $450,000 annually from the NC DHHS for several years. However, lower-than-projected federal civil monetary penalty funds resulted in reduced funding of only $205,000.

Who will implement the training sessions?

The facility will provide a qualified instructor to teach the curriculum. Qualified trainers could include the staff development coordinator or another individual approved by the NC DHHS and WIN A STEP UP.

What is the facility's responsibility to the program?

Facilities must agree to commit staff time to the implementation of the program, completion of required forms and surveys, permit interviewing of NAs by WIN A STEP UP staff, and distribute a retention incentive to qualifying participants.

What is the NAs' responsibility to the program?

Participating NAs agree to attend and participate in the offered training sessions at the facility, complete required forms and surveys, and commit to continued employment at the facility for at least three months after the completion of the training package.

What are the incentive payments to participating NAs?

Participating NAs will be eligible for two types of incentives.

Training Session Incentives:

WIN A STEP UP will distribute a stipend of $35 to each participant for each training session completed.

Retention Incentives:

NAs who complete 8 of the 10 WIN A STEP UP training sessions and complete the retention period at the facility will receive a one-time bonus of $75 from WIN A STEP UP. They will also receive the retention incentive from the facility.

What are the retention incentive options for the facility?

The facility can choose from one of three retention incentive options to offer its qualifying NA participants:

1. Both a one-time bonus of at least $75.00 and a wage increase of at least $0.25/hr
2. A wage increase of at least $0.25/hr
3. A one-time bonus of at least $75.00

How can you bring WIN A STEP UP to your facility?

Contact Ally Woodside
at
(919) 218-1192
for more information.

WIN A STEP UP
720 Martin Luther King Jr. Blvd.
CB# 1030
Chapel Hill, NC 27599-1030
Phone: (919) 966-0494
Fax: (919) 966-0510

UNC Institute on Aging

dhhs

Is NA turnover a problem?

Reaching for the stars giving a helping hand

WIN A STEP UP

We've got a solution...

You already know what a costly problem turnover of your nursing assistants can be for you, your staff, and your residents. Nursing assistant turnover increases remaining employees' workloads and boosts your overtime costs. It also diverts staff focus away from more important resident care tasks as they spend a larger share of their time recruiting, screening, and training new employees.

The average nursing home in North Carolina experiences over 100% nursing assistant turnover each year. With the aging of the baby boom generation, keeping nursing assistants will increase as an urgent problem.

Fortunately, there is a proven program designed to address this problem—WIN A STEP UP. This tested program provides training, education, and rewards to participating nursing assistants as well as supervisory skills training to nurses and other managerial staff.

With this program you can:

- upgrade the skills of your nursing assistants
- increase the career commitment and job satisfaction of your nursing assistants
- provide rewards and recognition to exemplary nursing assistants
- keep nursing assistants working at your facility longer
- improve staff/supervisor relationships

What is WIN A STEP UP?

WIN A STEP UP is a partnership between the North Carolina Department of Health and Human Services and NC Institute on Aging at UNC Chapel Hill. It is a workforce improvement program that includes training and incentive payments for nursing assistants as well as continuing education for nurses and other supervisors

What are WIN A STEP UP program results?

The program has been well received by administrators and staff in facilities. Compared to similar non-participating peers in similar facilities, participating NAs demonstrated better retention and improved job satisfaction. By offering this proven program, you will begin to meet the most pressing needs of your NAs, and at the same time, may improve the overall quality of care for your residents.

Where does the funding for this program come from?

WIN A STEP UP is funded by the State of North Carolina's civil penalty monies. Thus, our program allows the fine money to be given back to facilities as an investment meant to improve quality of care.

Who is eligible to participate?

Any nursing home in North Carolina that is CMS certified, currently serves Medicaid residents, and has a desire to improve the retention and job satisfaction of their NAs may participate. However, preferences are given to facilities that have never received our program, and who agree to give a raise to their participating NAs as a retention incentive.

How are NA participants selected?

10 interested NAs, who have been with the facility for at least 90 days, will be selected through a drawing conducted by a WIN A STEP UP employee during a start up in-service at the facility.

What types of continuing education materials are provided?

The tested WIN A STEP UP curriculum currently has 10 training sessions for NAs. These training sessions focus on clinical proficiency, interpersonal skills and communication. Each session is designed for a 1- to 3-hour period. Facilities may choose to complete the courses in any order, but should meet at east once a week to complete the program in 16 weeks.

WIN A STEP UP provides a training manual for each participant in the program as well as instructor manuals, overheads, and other media for the trainer at no cost to the facility. The instructor manuals include lesson plans, teaching strategies and evaluation tools for each topic. Current topics are:

Clinical Skills

- Infection Control (1 session)
- Fecal Impaction and Hydration (1 session)
- Pressures Ulcers (1 session)
- Dementia Patient Care (1 session)

Interpersonal & Communication Skills

- A More Empathetic You (2 sessions)
- Me, Myself and I (1 session)
- Being Part of a Team (1 session)
- Advanced Communication (2 sessions)

Training in the "Coaching" style of supervision is also provided to as many as 10 supervisors per wave of participants at the facility and takes place over the course of two days prior to the start of the WIN A STEP UP NA classes.

ATTACHMENT 5

A White Paper

MANAGED CARE IMPROVES QUALITY AND LOWERS COST FOR MEDICAID-FINANCED LONG-TERM CARE

Developed by

AMERIGROUP®

December 2006

AMERIGROUP®

This paper was prepared by AMERIGROUP Corporation to summarize the challenges in providing Medicaid-financed long-term care (LTC) services to low-income elderly and persons with disabilities, and to highlight the advantages of a risk-based managed care solution as an alternative to a Fee-for-Service (FFS) model. The following sections provide:

1) An overview of LTC services and a description of the users of those services (Long-Term Care at a Glance)
2) The move toward managed LTC and examples of what some states are doing to address these issues (Facing the Medicaid Long-Term Care Spending Problem Head-on)
3) AMERIGROUP's model (AMERIGROUP's Approach: A Proven Risk-Based Model)
4) Examples of AMERIGROUP's successes in Florida and Texas (Turning SSI Theory into Concrete Results)

For purposes of this white paper, LTC services are defined as care or goods provided to an individual with the intent to prevent deterioration in function and improve his/her level of independence in the least restrictive, most cost-effective possible environment.

The Challenge: How to control long-term and acute care costs while improving quality of care for the vulnerable Medicaid populations needing long-term care services.

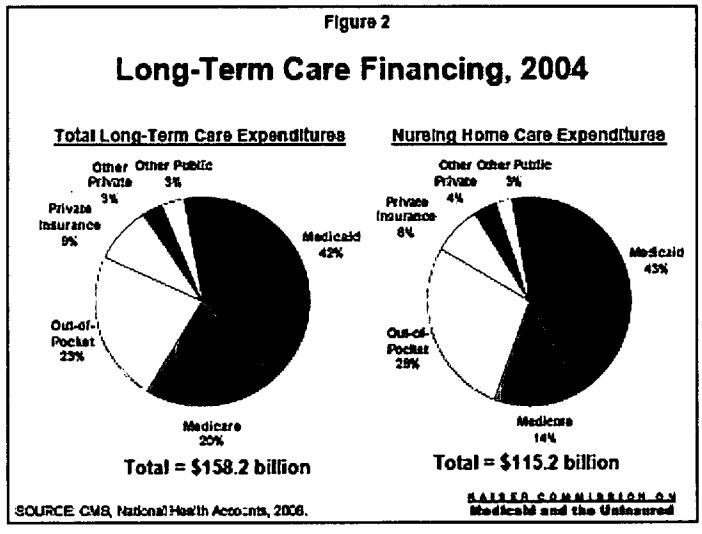
The Solution: *Transition the long-term care users from FFS models to comprehensive risk-based managed care models.*

The Goal: *Integrate medical services with community-based services to facilitate the "right services at the right time," ensuring person-centered, comprehensive, coordination of services across the spectrum of available services.*

1. Long-Term Care at a Glance

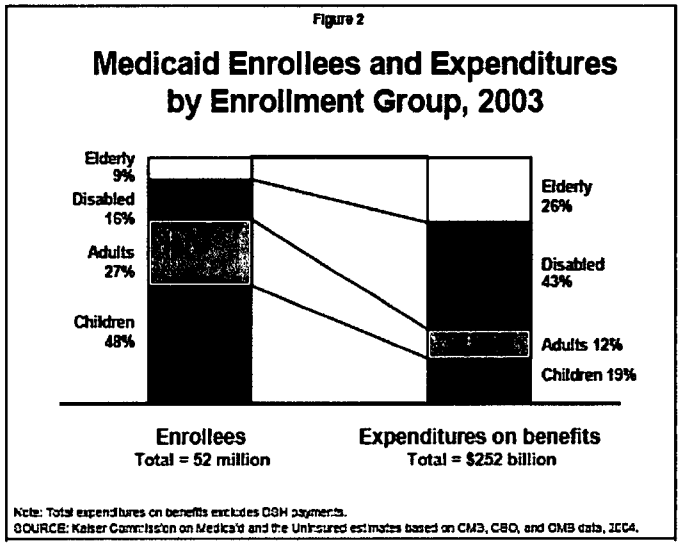
Nearly 10 million Americans need LTC services and supports to assist them with their activities of daily living. The following statistics provide a detailed understanding of the service utilization and expenditures related to this high risk population:

- The majority of beneficiaries who receive LTC services are age 65 and above while 37 percent are under age 65. Nearly $160 billion was spent on long-term services nationally in 2004. Medicaid was responsible for 42% of this spending. [1]

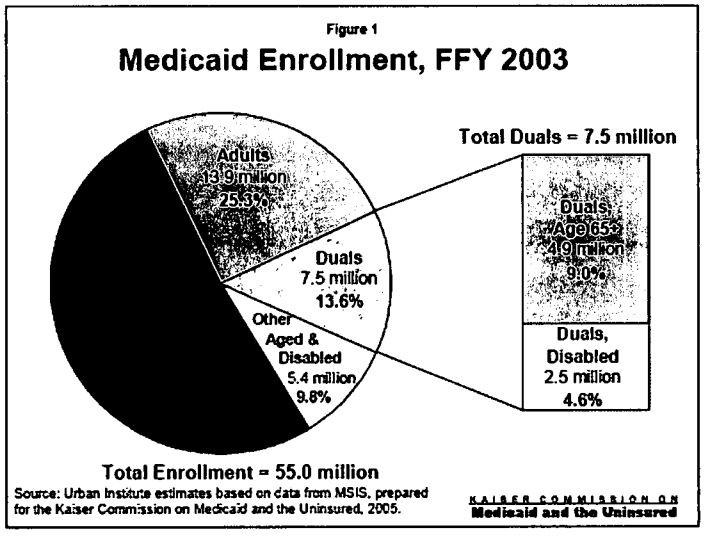


[1]. *Medicaid and Long-Term Care Services*, Kaiser Commission on Medicaid Facts, July 2006

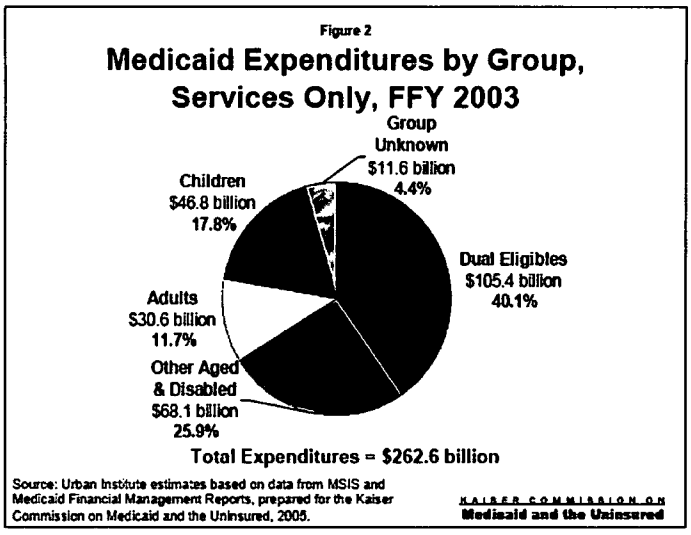
- In 2003, estimated Medicaid spending per disabled enrollee was $12,300 and $12,800 per elderly enrollee.[2]
- Sixty-nine percent of Medicaid spending in 2003 was attributable to the elderly and people with disabilities, who comprise only one-quarter of the Medicaid population.[2]



- The dual-eligible population accounts for only 13.6% of total Medicaid enrollment, but nearly half of Medicaid spending (40.1%).[3]
- Of the 40.1% Medicaid spending on dual-eligibles, LTC services comprise 65.8% of those expenditures.



[2] *The Medicaid Program at a Glance*, Kaiser Commission on Medicaid and the Uninsured, January 2005
[3] *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003,* Kaiser Commission on Medicaid and the Uninsured, July 2005.



[4]

- Individuals with disabilities look to Medicaid to supplement their healthcare needs, including Medicare coinsurance, home healthcare, personal care, nursing facility services, assisted living, and more.

Long-Term Care (LTC) Program Services

Long-term care users need a variety of services across a continuum of care settings. For these services to be the most effective, they must be integrated and coordinated with related medical, social, and behavioral health supports. Over the last 20 years, Medicaid-financed LTC has moved from an institutionally-based system of services to a home and community-based delivery model, from a traditional medical model of care delivery to a more holistic approach to patient care, including support services, and in some states from a fee-for-service to a risk-based managed care financing model.

[4] Ibid

LTC Population Characteristics

Member Profile

Disabled Children and Adults

Physical Disabilities
- Chronic Illness
- Trauma
- Blindness

Developmental Disabilities
- Mental Retardation
- Cerebral Palsy

Behavioral Disabilities
- Schizophrenia
- Manic Depression

Poor Elderly (Primarily Dual Eligibles)

- Low or no impairment
- Chronically ill and Disabled

Service Requirements

In addition to traditional physical and behavioral health services, SSI and Dual Eligibles benefit from a broad scope of services intended to improve their health and functional status:

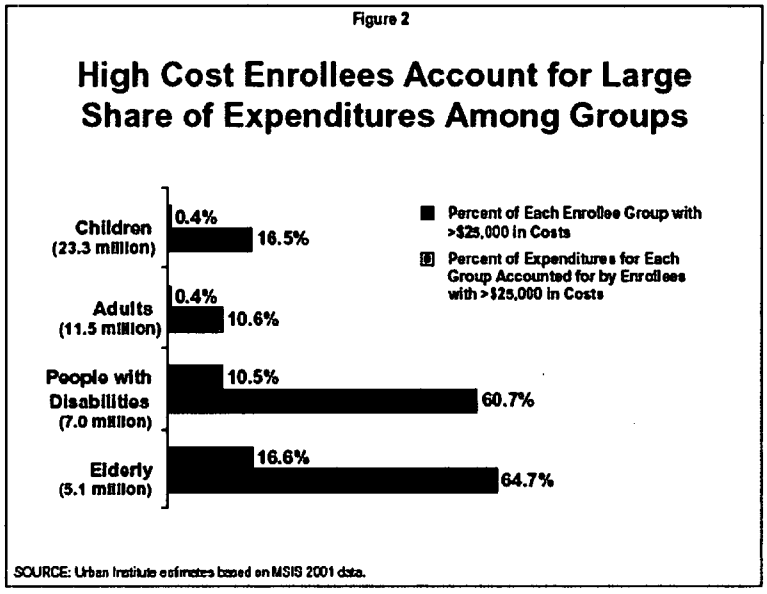
- Personal Care
- Adult Day Health
- Home Delivered Meals
- Skilled Nursing Facility
- Nursing Home
- Assisted Living
- Adult Foster Care
- Home / Environmental Modifications
- Durable Medical Equipment / Supplies
- Medical Transportation

As states worked within the fee-for-service system to better coordinate care for users of LTC services, they developed programs such as disease management for chronic illnesses, services offered through home and community-based (HCBS) waiver programs for the large number of people who wish to remain in their own homes, and consumer directed care where people can control their own care delivery.[5] For the elderly, services are needed as aging decreases mobility and mental acuity. For others with chronic conditions, services may be needed for an extended period of time, while those with progressive or life-limiting disabilities require lifetime needs.

The flexibility and consumer-directed aspects of legislation, such as Olmstead and the Deficit Reduction Act (DRA) of 2005 (which includes the Money Follows the Person (MFP) grants), have and will create greater demand for the services that, within the fee-for-service model, have a higher administrative burden and a reduced ability to predict costs.

According to a national study conducted by The Kaiser Commission on Medicaid and the Uninsured reported in March 2006, a small share of enrollees account for a very large share of the spending and in all cases, these enrollees fall into two key groups: people with disabilities and the elderly.[6]

[5] Saucier P, Fox-Grage W, *Medicaid Managed Long Term Care,* AARP, November 2005, Washington DC.
[6] *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?*: Kaiser Commission on Medicaid and the Uninsured, March 2006



Medicaid Risk-Based Managed Care Represents a Solution to the Country's Challenges

State Medicaid agencies have successfully utilized managed care models to deliver cost-effective, high quality services since the early 1980s. The Lewin Group's *Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies* final report (July 2004) demonstrates that states have experienced considerable cost savings, improved care coordination for members, and improved member satisfaction using a risk-based, integrated, managed care model instead of a fee-for-service delivery system. The studies were grouped into three categories:

1. State studies, which examine states' cost savings in their overall Medicaid managed care programs;
2. Targeted Medicaid managed care studies, which assess savings in Medicaid managed care programs targeted to specific populations; and
3. Specific service studies, which analyze Medicaid managed care program savings for specific services.

The studies reviewed by Lewin provide some evidence that managed care savings may be significant for the SSI-related Medicaid populations:

- In Texas, from 1998-2000, savings were $6.05 million or $4.11 PMPM, and from 1999 to 2002, $123 million or $91.67 PMPM.
- In Oklahoma, from 1998 to 2000, average managed care PMPM (per member per month) claims costs were 15% lower than the FFS cost of care (in the 12 months prior to enrollment in the MCO).
- In Kentucky, in 2000, savings for SSI dual-eligibles were $19.41 PMPM and for SSI non-dual eligibles $31.91 PMPM.

The following describes some of the significant advantages of a risk-based managed LTC model:

1. The financial incentives are aligned to meet the state's need to provide the most cost effective care in the most appropriate setting. The MCOs in full-risk arrangements:

- Have the systems and expertise to manage the high need and high cost members
- Bear the risk for all costs including hospital, physician and LTC services
- Have the flexibility to facilitate timely primary, preventive or other care and services in order to prevent avoidable high cost episodes of care (e.g., emergency room visits)

There is evidence that managed LTC, like managed acute care, reduces the use of high cost services like emergency rooms (ER), inpatient services, and nursing homes. Managed LTC also increases access to home and community-based services.[7] Additionally, in an integrated full-risk model, Managed Care Organizations (MCOs), have the flexibility to provide targeted services outside the state health plan to meet individuals' needs (e.g., modification to a bathroom) and avoid high cost ER and inpatient hospital visits. States are able to transfer risk and responsibility for managing services and costs to the plans that must monitor utilization and costs. The FFS model leaves the complete risk for costs and utilization with the state. The FFS model has increased administrative costs with no guaranteed cost savings to the state.

2. States can require that contracting MCOs have a comprehensive approach to healthcare delivery that coordinates patient care, ensures the appropriate use of services, and routinely monitors and measures health providers' performance to control cost and maintain or improve the quality of care. Most managed LTC programs include a care coordination mechanism to assist consumers and families with navigating the system.[8] The care coordination model brings together the member, physician, community-service providers, behavioral health providers, disease management staff, and the social worker in a team to ensure the needs of the member are addressed, and services are provided to support the member's goals. Models implemented in states that include comprehensive care coordination experience a higher rate of consumer satisfaction in addition to greater cost savings.

3. Through the comprehensive care coordination model, states and their contracted MCOs are uniquely positioned for success in facilitating consumer direction and the money-follows-the-person concept. If the comprehensive care coordination model is consumer centric, the strengths of individuals can be supported, including transitioning from a nursing home to a community setting and/or self-directed service plans that support and encourage members to select, hire, and fire their providers. The care coordinator in a full-risk model is available to educate members about their options, to provide support if a member is unable, or does not wish to manage all aspects of his/her service plan, or has a change in condition that requires a temporary change in the overall management of the services.

It is critical in meeting health policy goals that we care for these individuals in an integrated, coordinated manner that accounts for all of their bio-psycho-social needs, achieves the best long-term outcomes, and does so in a cost-effective manner. In an integrated program, a managed care entity covers both physical and behavioral healthcare, providing screening, assessment, care planning, case management, and coordinating community-based services and other services that help individuals fully participate in their communities. All diagnosis and treatment information for both physical and behavioral healthcare is available through a single entity. Health plans can actively intervene with members whose behavioral health issues are causing them to avoid medical treatment. Case managers can also work more effectively with providers, member and family, and social networks to detect, diagnose, and coordinate treatment for co-morbid behavioral health conditions. AMERIGROUP's model achieves these objectives.

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[7] Saucier P, Burwell B, Gerst K, *The Past, Present, and Future of Managed Long Term Care,* Office of the Assistant Secretary for Planning and Evaluation, Department of Health Services, April 2005, Washington DC.

[8] Ibid

2. Facing the Medicaid Long-Term Care Spending Problem Head-on

The use of managed care principles in developing care models for elderly and disabled LTC users makes fundamental sense. However, despite the documented advantages of Medicaid managed care models, by 2004, less than 3% of the publicly-funded LTC population received their services through a managed care program. By the passage of the Medicare Modernization Act of 2003 (MMA) seven states had developed managed LTC programs, Arizona, Florida, Massachusetts, Minnesota, New York, Texas, and Wisconsin. [9]

> A full risk managed care approach for long-term care provides **budget predictability**, as well as **organizational accountability** for clinical and financial results.

These states have demonstrated that managed care programs are especially effective with aged and disabled populations, given the chronic, complex nature of their conditions. As state and federal budget pressures challenge the Medicaid programs, more states are developing or expanding their risk-based managed LTC programs. It appears that California, Hawaii, Maryland, and Washington all hope to develop programs in the next several years, and Texas, Florida, and Minnesota have proposed expansions that could significantly increase the numbers of LTC users enrolled in managed care. [10]

In general, three models have emerged in terms of risk components that are included in the capitated payments: LTC services only, long-term and all other Medicaid covered services including primary and acute care, and the most comprehensive, the integration of both Medicaid and Medicare financing with the contractor assuming risk for all covered services.

The first Medicaid managed LTC program was developed in 1987 as a demonstration project. Florida's Frail Elder Program (FEP) in Dade County delivered both acute care and LTC services to frail elderly SSI recipients with voluntary enrollment. It was integrated into the state's Medicaid agency and continued for almost a decade as a capitated, risk-based contract. In 1998, the Florida Diversion program was created, which added additional counties to the managed LTC program. Florida integrated the Frail Elder Program into the expanded Diversion program and now covers more than two dozen counties.

Arizona implemented the Arizona Long-Term Care System (ALTCS) in 1989, and it remains the only statewide, mandated managed LTC program in the country. This comprehensive program enrolls the aged, blind, and disabled Medicaid eligibles who are either in nursing homes or at-risk of nursing home placement. It also integrates long-term services with all other Medicaid covered services. ALTCS relies on national managed care organizations, local service providers, as well as counties who serve as contractors to provide coverage in all 15 counties.

Texas Health and Human Services Commission (HHSC) chose to follow the experience of Arizona and implemented the Texas STAR+PLUS program in Houston as a mandatory program capitating primary, acute and LTC. After the program was operational for a period of time, HHSC commissioned a study by The Lewin Group to measure the success of the program. With the positive results in Houston documented by the Lewin study, the HHSC recommended that the STAR+ Plus program be expanded into new markets across the state.

Experience in the 1990s shows that states who have successfully implemented mandatory TANF or CHIP managed care programs often implement similar mandatory programs for their ABD populations

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[9] Saucier P, Burwell B, Gerst K, *The Past, Present, and Future of Managed Long Term Care,* Office of the Assistant Secretary for Planning and Evaluation, Department of Health Services, April 2005, Washington DC.
[10] Saucier P, Fox-Grage W, *Medicaid Managed Long-term Care,* AARP, November 2005, Washington DC.

recognizing the benefits achieved through that model. A number of other states wanted to build on their Medicaid managed acute care experience to develop managed LTC programs. For example, Colorado, Minnesota, and Wisconsin developed new managed LTC models. Minnesota was the first state to integrate Medicaid and Medicare financing for the entire aged population, despite the complexities of working with CMS on payment issues. After years in development, the Minnesota Senior Health Options (MSHO) program was implemented in 1997 under a combined Section 1115 Medicaid demonstration waiver and a Section 222 Medicare payment waiver.[11]

Wisconsin's Family Care Program is a managed LTC program that combines the state, federal, and local funding for community and institutional-based LTC services in a single capitated benefit.

In a study conducted by the USC/UCLA Center for Long Term Care Integration[12], the focus was on answering the question "is it worth the investment in time and money to create such a system?" The answer was a "resounding YES!" The study recognized innovative programs from multiple states, including: Texas, Wisconsin, Minnesota, and Arizona:

- ***The Texas STAR+PLUS program realized savings of $93 per member per month. This translated into a 17% savings over fee-for-service.*** Texas' STAR+PLUS Program is mandatory for all SSI recipients over age 18. The program provides support in home and residential settings, as well as physical and behavioral health services with the goal of promoting independence and reducing the rate of nursing home placement. This program also offers a consumer direction option in addition to the self-directed focus that AMERIGROUP offers to members.
    - Inpatient hospitalizations were reduced to 290.3 discharges per 1,000 member months from 329.7 under the previous fee-for-service Medicaid program.
    - The average length of stay (ALOS) for inpatient hospital care was reduced to 6.08 days from 7.39 days under FFS Medicaid.
    - Higher consumer satisfaction was realized, in addition to the positive economic results. Quality of care was improved in areas such as more appropriate use of antidepressants and other effective interventions.
- ***Wisconsin Family Care generated savings of $198 per member per month in one year over the fee-for-service, waiver, nursing home and residential care options its enrollees would have otherwise used.*** The Wisconsin Family Care program capitates LTC and home health nursing and therapy. The Care Management Organization is capitated for its members under the care of contracted providers.
- ***Minnesota Senior Health Options (MSHO) experienced high satisfaction among members. For example, 94% would recommend their care coordinator. 90% of MSHO enrollees felt their care improved since joining the program.*** MSHO is a state-level integrated program that includes both Medicaid and Medicare payment and services. Due to the success of the program it expanded into a new program called Minnesota Disability Health Options. At the time of the study, the program was growing by about 1,000 enrollees a year since 1998. The number of enrollees in nursing homes was proportionately decreasing.

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[11] Saucier P, Burwell B, Gerst K, *The Past, Present, and Future of Managed Long Term Care*, Office of the Assistant Secretary for Planning and Evaluation, Department of Health Services, April 2005, Washington DC.
[12] Cost Savings in Integrated Long Term Care Systems, 12/2003 USC/UCLA Center for Long Term Care Integration http://www.ltci.ucla.edu/Articles/Savings.pdf#search=%22Long%20Term%20Care%20Diversion%20Waiver%20Program%20savings%2C%20FL%22

- ***Between 1989 and 1998, The Arizona Long Term Care System (ALTCS) produced a 16% savings compared to a traditional Medicaid program for this same population.*** The ALTCS offers a full continuum of care and services for individuals in nursing facilities or who are assessed as requiring a nursing home level of care. It is unique in that Medicaid recipients from any program type, TANF, SSI, MNMI, that require a nursing home level of care receive services through the program. During the period of study, the proportion of people in institutions decreased from 95% to 50%. The number of individuals in institutions remained the same, while the number receiving home and community based services increased. Select outcomes of the program for the period 1989 to 1998 include:

  - Hospital ALOS reduced from seven days to five days
  - HCBS placement increased from 5% to 42%
  - Nursing home expenditures PMPM decreased from $1,424 to $1,110
  - Overall medical savings of $166 PMPM were realized.

  In addition to the programs listed above, Florida's LTC Community Diversion Program has realized significant savings:

- ***The State of Florida estimated that Florida's Long Term Care Community Diversion Program saves the State $2.40 for every $1 spent on the program. The Long Term Care Community Diversion Program has saved the State of Florida approximately 10% per member per year in its pilot program for older, dually-eligible beneficiaries at risk of institutionalization.*** Florida's Long Term Care Community Diversion Program is a full-risk nursing home diversion program offering wraparound services to older Medicare recipients at risk for institutionalization. The program has reduced custodial nursing home utilization and costs, increased home and community-based alternatives, and most importantly, improved member satisfaction.

  The USC/UCLA study concludes that integration of services is "a major step in improving care to this population." Coordination of care is very important. Integration of services not only helps to control costs, but also to reduce them, particularly in the areas of decreased utilization of: hospital care, nursing homes, and medical care that prevent deterioration.

3. AMERIGROUP's Approach: A Proven Risk-Based Model

AMERIGROUP works with, and listens to, our state clients to understand their requirements and desired outcomes. This information is utilized to develop efficient and effective programs to establish sustainable cost savings for the state while improving health outcomes for members. Since our first experience with the needs of the aged, blind and disabled populations in 1998, AMERIGROUP has approached the opportunity in a new way - a carefully coordinated system of care integrating *physical, behavioral, social, and long-term care* services that result in improved outcomes for members and sustainable significant cost savings for states.

AMERIGROUP integrates primary, acute, behavioral health, and LTC services into at-risk managed care through our *Integrated Medical Management Model* - IM^3. We also work to combine traditional and nontraditional services including, but not limited to, physician visits, home health, pest control, home adaptation, assisted living services, and transportation. Key components of AMERIGROUP's SSI model include:

- A risk-based model
- *An Integrated Medical Management Model* (IM^3)
  - *Early Case Finding*^{sm}

- *Continuous Case Finding*[sm]
- *Project 505*
- Case Management
- Disease Management

- Nursing home diversion program.

A Risk-Based Model

In each state, AMERIGROUP is at risk for a range of medical, behavioral, and LTC services. We are encouraged to provide innovative, cost effective care from the outset to prevent and/or delay the need for more costly institutionalization.

- *Risk Assumption:* Under a FFS arrangement, the state pays claims and assumes full financial risk of the program. The state assumes the risk between the level of normally anticipated claims and the level of stop-loss coverage and purchases stop-loss coverage to protect against extreme losses. Under a full-risk arrangement, the MCO assumes all financial risk and arranges for stop-loss if required, thus reducing the overall risk burden on the state.
- *Predictability*: Claim volumes and associated expenditures fluctuate from period to period under a FFS arrangement. Alternatively, risk arrangements allow states to pay a fixed dollar amount on a per member per month basis. Since the state has the authority to change its eligibility policies, the number of members it is willing to cover is already under its control. In addition, since the states set/administer managed care rates, the pricing component is also fully in the state's hands. By establishing a risk contract with an MCO, states can eliminate the uncertainty related to a key component of their medical costs - utilization of services.

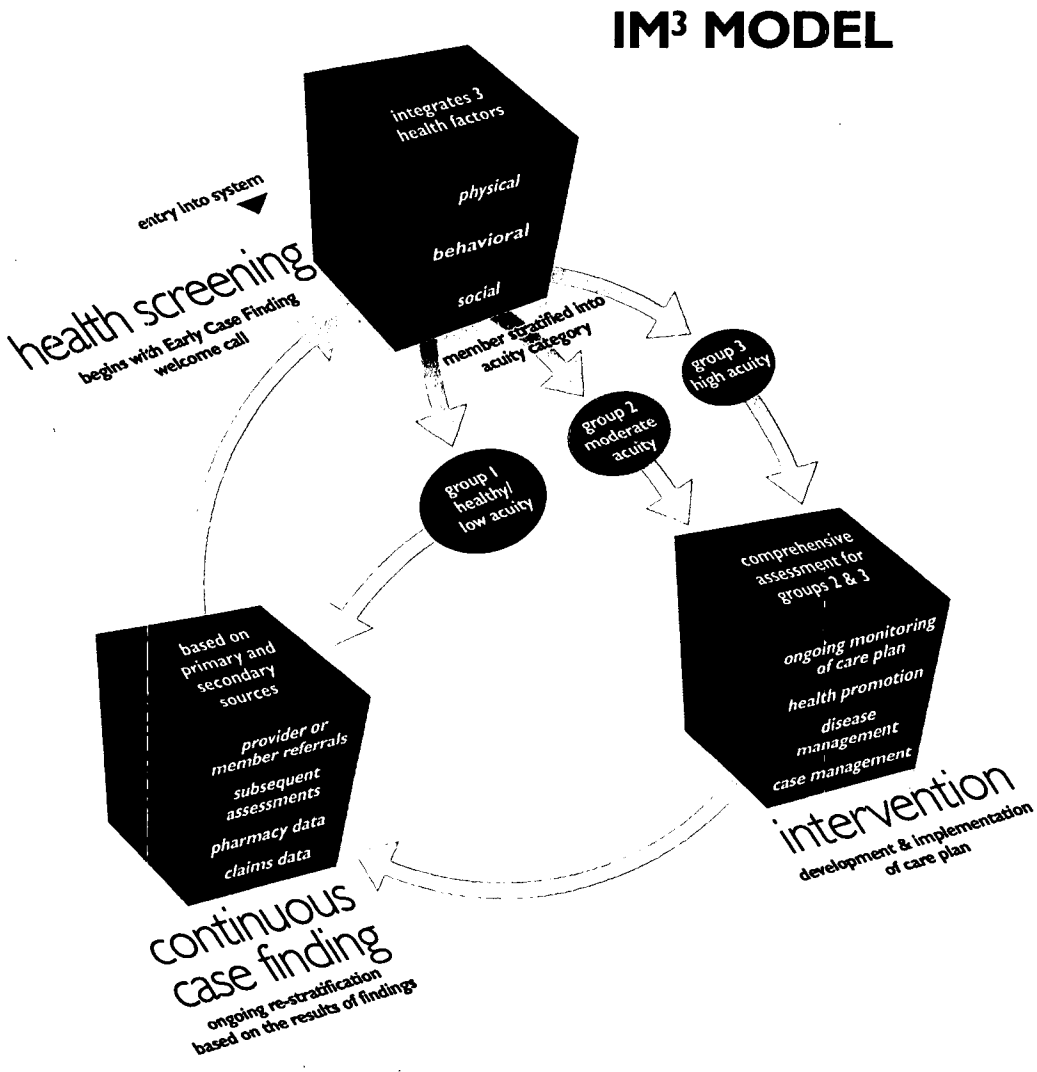
In summary, a risk arrangement ensures the state predictable, easy to budget expenses. A state can set the price, control eligibility, and transfer utilization risk to the MCO.

Integrated Medical Management Model (IM^3)

Our care management model uses physical, behavioral, and social factors to guide the coordination of members' care. The process involves a thorough assessment of member health status immediately upon enrollment, accurate stratification into appropriate levels of care, and effective management and monitoring of that care. Our innovative model is uniquely adapted to each of the member populations served by our state clients. Based on AMERIGROUP's experience, we recognize the unique needs of the varied Medicaid populations, from mothers and infants, to the fragile elderly or persons with disabilities, to members with co-occurring or co-morbid conditions, to persons with chronic and complex issues.

IM^3 is a process of early identification, comprehensive needs assessment, treatment plan development, and continuous monitoring and evaluation. The cornerstones of IM^3 are *Early Case Finding*[SM] (ECF) and *Continuous Case Finding*[SM] (CCF) programs, which were designed to easily identify members with complex or special healthcare needs, before a catastrophic event occurs. The ECF and CCF programs encompass aggressive efforts to identify all members who would benefit from case management activities. These efforts range from Welcome Calls and member outreach to trigger diagnoses lists and data analysis.

AMERIGROUP



Our ***Early Case Finding*** (ECF) health assessment process identifies and stratifies members into appropriate tiers based on needs. This process includes the use of a customized software tool that allows our health plans to adapt assessment questions to the specific needs of the state's Medicaid population. The initial health assessment determines a member's needs across three domains – physical, behavioral, and social – assigning an overall risk score. Based on the member's score (and a continuous reevaluation of the member's needs) the health plan provides support at the appropriate level of care and additional support services based on the member needs.

The importance of the medical home approach to providing high-quality and cost-effective healthcare services cannot be emphasized enough. We recognize the quality of care is greatly improved when members choose their PCP, one with whom they may have an established relationship, or with whom they feel comfortable developing a relationship.

The ***Continuous Case Finding (CCF)*** methodology guides performance of a number of ongoing analyses that identify and prioritize existing members for care management as needed. A Trigger Diagnoses List red flags the risk-score for each enrolled member (with one of these diagnoses) according to an in-house

developed predictive model using three domains: physical health, behavioral health, and social needs. Members are kept in the CCF queue and reviewed on a regular basis for incident needs. Behavioral health triggers include depression, reports of substance abuse, anxiety, and thought disturbances (e.g., visual, auditory hallucinations).

As part of IM^3, AMERIGROUP's ***Project 505*** targets SSI members at the greatest risk for hospital admission and extended stays. In 2005, a study conducted by AMERIGROUP Maryland identified 505 members who were the highest utilizers of inpatient days. Data revealed that this small number of AMERIGROUP's members accounted for more than 50 percent of the days of non-OB, non-NICU care. In *Project 505*, each AMERIGROUP health plan identifies members in need of field-based case management through the Risk Rank List (RRL), based on the number of hospital inpatient days and admissions for each member. Members with no chance of change, such as those with terminal disease, or other factors, are excluded from the program.

The program intensively works with the member using a team made up of a nurse, social worker, and administrative staff in each of its health plans. The team reaches out to members with a manageable illness who are willing to work to decrease their number of days of institutional care for enrollment in the program. Once the member is enrolled, an individual action plan is developed to eliminate triggers that lead to hospitalization. The goals of *Project 505* are to:

- Eliminate avoidable hospitalization of members
- Keep members' care local in their community
- Use field-based intensive case management
- Use multiple ancillary and support services, as needed, to accomplish the goal of reduced hospitalization
- Determine creative, innovative solutions for administering effective care.

AMERIGROUP Maryland implemented this field-based, intensive case management approach in April 2005. With *Project 505*, the health plan **reduced avoidable inpatient hospitalization by 55 percent.** Given that inpatient hospitalization costs approximately $2,000 per member, per day, the reduction yielded significant savings. Due to its success, *Project 505* is an important part of AMERIGROUP's IM^3.

Case management is a component of care coordination engaging a case manager in a member's care when an event triggers that member to access specific medical care services. Case managers are RNs who work very closely with care coordinators keeping them informed and providing consultation when appropriate. Care coordinators provide follow-up to case managers' interventions.

In Texas, Florida, Maryland, and New Jersey, AMERIGROUP maximizes integrated services, provides complete care coordination, reduces service overlap or redundancy, and assists the elderly and disabled with remaining independent as long as possible.

AMERIGROUP offers a complete array of **Disease Management** programs as part of our IM^3 model. AMERIGROUP has received full NCQA Patient and Practitioner Oriented Accreditation for the following disease management programs*:

- Asthma
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Congestive heart failure
- Diabetes

- Major depressive disorder
- HIV/AIDS
- Schizophrenia.

AMERIGROUP is proud to note that we received a high score of 99.61 out of a possible 100 points and we are the first and only organization to receive NCQA accreditation for Schizophrenia.

AMERIGROUP is aware that members do not have physical and behavioral health conditions independently of one another. In two of our markets, approximately 86% of AMERIGROUP's health plan membership has co-occurring physical and behavioral health disorders. Because of the high prevalence of co-morbidities, our care management program is member-centric. We eliminate barriers between physical and behavioral healthcare delivery systems to focus on the health of the whole person, wellness, and quality of life. As part of the IM^3 process, AMERIGROUP improved the recognition and treatment of those members who have psychiatric or substance abuse illnesses. In addition, AMERIGROUP is interested in working with our state clients to add disease management strategies to our programs to meet the needs of their Medicaid recipients.

In 2003, AMERIGROUP Corporation expanded its Behavioral Health Services Division to support the needs of members in its various health plan markets. As part of this expansion, AMERIGROUP transitioned the management and complete operations of behavioral health services from a subcontracted vendor to an internal department. As a fully integrated MCO, we achieve the best overall health outcomes for our members. Our approach is highly successful. AMERIGROUP's Behavioral Health Services Division has continually enhanced the behavioral health program in all of our health plans where the benefit is part of the state's managed care program.

Nursing Home Diversion Program and Home & Community Based Services

To reduce costs and provide appropriate care in the least restrictive, cost effective setting, a nursing home diversion program can offer home and community-based services to elderly, dually-eligible members who are at risk for institutionalization. Many elderly people prefer to receive care in their own homes. Home and community based services are designed for persons who are determined to be at-risk for nursing home placement, and meet certain criteria (customized for the Plan). Examples of such Diversion Program services may include:

- Periodic face-to-face scheduled visits and ad hoc visits for in-home crisis stabilization
- Coordination and support for provider appointments and recovery support groups
- Coordination and support for obtaining appropriate medications
- Home Nurse visitation to provide medication support and environmental assessments
- Housing assistance and other placement services to promote community integration
- Social outings and community outreach services.

All of these key components of AMERIGROUP's SSI Model lead to improved health and quality outcomes, as well as sustainable cost savings.

4. Turning SSI Theory into Concrete Results

AMERIGROUP has extensive experience working with states to develop and enhance their managed LTC programs. We have nine years experience managing LTC services for the Texas STAR+PLUS population on a full-risk basis. In Texas, we have proven that Medicaid managed care will produce savings and improve the quality of life for the SSI population as demonstrated in the following findings:

- Inpatient stays decreased 28%
- The number of members accessing community-based adult day care services increased 38%
- The number of members accessing personal assistance services increased 32%
- Includes a consumer-directed area option
- Proactively supports de-institutionalization through the state's Money Follows the Person program.

AMERIGROUP has four years experience coordinating and managing services for elderly, dually-eligible beneficiaries in Florida, as evidenced by our Long Term Care Community Diversion Program that successfully:

- Reduces custodial nursing home utilization and costs
- Offers a wider range of cost-effective home and community-based alternatives, enabling our members to live in comfortable, familiar environments and increasing member satisfaction
- Increases medical coordination and other LTC initiatives across the continuum
- Improves our pharmacy management service to members in assisted living facilities, improving checks for drug/drug and drug/disease interactions.

Based on our combined thirteen years of experience, AMERIGROUP is extremely qualified to assist states in the development and implementation of LTC services for eligible populations through a risk-based managed care model. We have demonstrated a strong commitment to the development of bench strength in the managed LTC delivery system as well as invested the resources to develop the management tools to be successful in LTC.

AMERIGROUP has worked with several states that have faced similar challenges, similar enrollment levels, and provider and consumer concerns related to the successful development and implementation of a risk-based managed care model. Our critical success factors have included:

- The use of integrated medical management -- IM^3
- Procedures, programs, and protocols designed and developed specifically for the aged, blind, and disabled population as opposed to being adopted from existing models for moms and kids
- Knowledgeable teams dedicated to this vulnerable population
- Technology to support and track care coordination, and
- The ability to integrate each state's needs with AMERIGROUP's existing programs.

States can realize significant cost savings, eliminate waiting lists, and improve the quality of healthcare to its vulnerable aged and disabled populations if it adopts an at-risk managed care model.

AMERIGROUP looks forward to the opportunity to work with states, officials, and advocates on the development of programs for the LTC population. We have been providing care to Medicaid members for more than 11 years. We have demonstrated successes managing the vulnerable aged and disabled populations through the offering and coordination of services that address their unique and complex needs.

CHCS Center for Health Care Strategies, Inc.

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Medicaid "Best Buys" for 2007: Promising Reform Strategies for Governors

By Melanie Bella, Stephen Goldsmith, and Stephen A. Somers

Issue Brief

DECEMBER 2006

This brief outlines a five-part strategy to help states improve health care quality for Medicaid's most chronically ill and costliest beneficiaries and curb increases in spending.

Time and time again, states have demonstrated, in the words of Justice Brandeis, that they are the nation's "laboratories for innovation," and Medicaid is one of the best opportunities for innovative leadership in the state policy arena. Medicaid serves 55 million Americans — 40 percent of our newborns, one third of our children, a disproportionate number of our racially and ethnically diverse citizens, most of those with disabilities, and many of our frailest seniors. The nation should get the highest quality and the best value for every health care dollar it spends — including the $330 billion spent in 2005 on Medicaid and the State Children's Health Insurance Program (SCHIP).

While external factors — ranging from the reauthorization of SCHIP in 2007 to developing solutions to covering the uninsured — will inevitably put pressure on states, Medicaid has ample opportunities to lead through innovative care management approaches that address the complex and costly health needs of its most vulnerable members. Improving the way care is delivered in Medicaid will not only target scarce public resources more effectively, it can also spill over to improve health care delivery as a whole, for state employees, retirees, and commercially insured populations. This analysis of Medicaid "Best Buys" outlines five of the most promising opportunities for improving the health of high-risk and high-cost Medicaid beneficiaries while slowing the rise in spending.

The growth in Medicaid spending is viewed by some as unsustainable. But efforts to curb that growth must recognize that Medicaid serves as: (1) the health care safety net for the increasing numbers of people losing employer-based insurance; (2) the primary source of revenue for safety-net institutions for the uninsured; and (3) the funder of last resort for long-term supports and services for people with disabilities and the frail elderly. Increasingly, policymakers are realizing that short-term fiscal fixes — cutting rates, coverage, or benefits — simply shift the costs to other payers (e.g., hospital uncompensated care pools) or to another day when people with preventable (and costly) health needs present themselves for publicly financed care.

The alternative for innovative state leaders is to pursue opportunities to get better value for every taxpayer dollar spent for Medicaid and to "bend the trend" in longer-term cost growth. In every state, a very small proportion of beneficiaries account for the bulk of Medicaid's expenditures. Up to 80 percent of spending is on approximately 20 percent of enrollees, primarily those with severe chronic illnesses and disabilities and the frailties associated with aging. By examining patterns of illness in their Medicaid populations, states can target opportunities to achieve both short- and long-term returns on investment in health care quality improvement.

Many state Medicaid agencies and their health plan contractors are already identifying high-risk, high-cost populations and coordinating their care more efficiently and effectively through care management programs. These Medicaid stakeholders are succeeding in improving quality for patient populations for whom there are likely to be quicker returns on investment — i.e., high-risk pregnant women, children with serious asthma, and adults with congestive heart failure. This should help them convince other state policymakers, including governors, legislators, and budget directors, to invest in longer-term quality improvement initiatives for other populations, such as those with diabetes, depression, and other combinations of chronic conditions. What follows is a five-part strategy for state leaders to consider as they face opportunities within Medicaid to both "do good and do well."

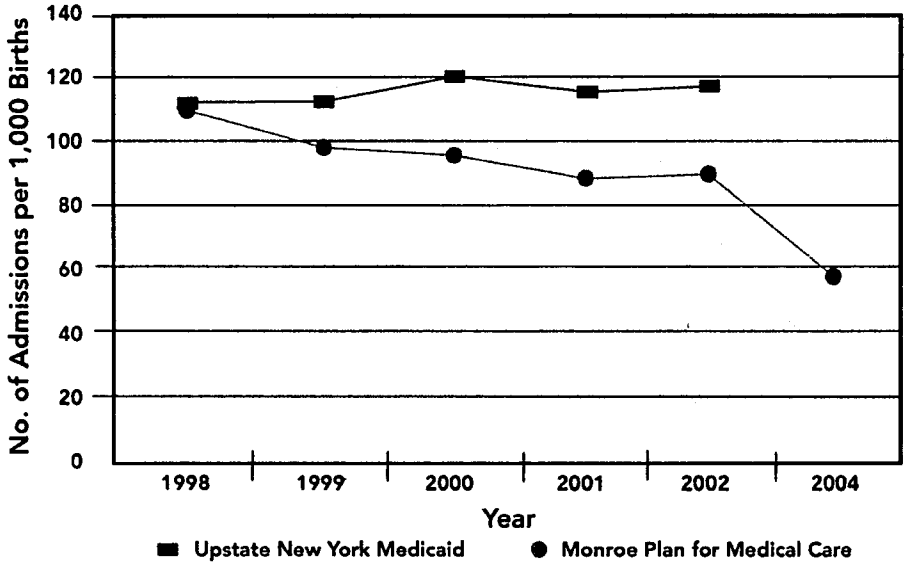
Five-Part Strategy for Medicaid Reform

1. Care Management Program for High-Risk Pregnancy

Policy Rationale: Medicaid covers up to half of all births in this country, thus accounting for a significant percentage of total Medicaid inpatient admissions. Hospital charges for a normal birth-weight baby average $5,800,[1] whereas a low-weight infant in need of intensive care can cost $1 million or more. Women from lower socioeconomic groups experience poorer birth outcomes than other mothers, putting Medicaid at risk for higher delivery claims and neonatal intensive care unit (NICU) expenses. Therefore, enhancing the potential for healthier newborns is a major opportunity for return on investment.

Managed care initiatives aimed at increasing the number of healthy births have substantially reduced NICU admission rates and have had positive returns on investment. For example, by improving its prenatal outreach program for Medicaid members, the Monroe Plan, a non-profit managed care organization in Rochester, New York, dramatically reduced NICU admissions, saving $2 for each dollar invested in the program.[2]

Neonatal Intensive Care Unit Admission Rates for Monroe Plan for Medical Care and Upstate New York Medicaid



Source: Stankaitis et al., "Reduction in Neonatal Intensive Care Unit Admission Rates in a Medicaid Managed Care Program." *American Journal of Managed Care*, May 2005; 11:166-172.

Recommendation:

- Implement a statewide program to reduce NICU admissions for high-risk pregnant women, including incentives for plans and providers to implement prenatal care outreach programs for high-risk pregnancies.

1 K.D. Cuevas, D.R. Silver, D. Brooten, J.M. Youngblut, C.M.Bobo, "The Cost of Prematurity: Hospital Charges at Birth and Frequency of Rehospitalizations and Acute Care Visits over the First Year of Life: A Comparison by Gestational Age and Birth Weight," *American Journal of Nursing*, July 2005, 105 (7): 56-64.

2 J.A. Stankaitis, H.R. Brill, and D.M. Walker, "Reduction in Neonatal Intensive Care Unit Admission Rates in a Medicaid Managed Care Program." *American Journal of Managed Care*, May 2005; 11:166-172.

2. Care Management Program for High-Risk Asthmatic Children

Policy Rationale: Medicaid provides care for one third of all children in the United States. Asthma care for children drives up costs considerably; approximately 12 percent of children in Medicaid are diagnosed with asthma with estimated costs for their care surpassing $16 billion annually.[3] Asthma accounts for 14 million lost school days for children and 14.5 million lost work days for adults.[4]

Care management for children with severe asthma can reduce the incidence of asthma attacks and keep children out of emergency rooms and hospitals. By targeting high-risk cases and creating financial incentives to reward improved care management, states can achieve significant savings. Several states, including California, New York and Arkansas, have demonstrated the substantial reductions in hospital-based care that can be achieved through targeted asthma interventions. For example, in California, 11 Medicaid health plans participating in a collaborative to improve asthma care observed a 21 percent decrease in asthma-related emergency department visits and a 35 percent decrease in asthma-related hospital admissions over two years.

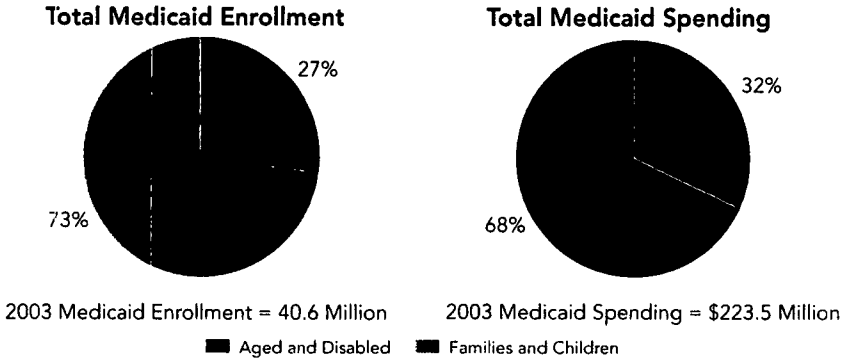
Recommendation:

- Enroll high-risk children with asthma into care management programs, with appropriate financial incentives, operated either by the state, health plans, or care management organizations.

3. Managed Care Models for Aged, Blind, and Disabled Medicaid Beneficiaries

Policy Rationale: Aged, blind, and disabled beneficiaries make up only 27 percent of Medicaid enrollees, but their care accounts for close to 70 percent of total Medicaid spending. Most of these beneficiaries are in unmanaged fee-for-service settings, with little to no coordination of their complex array of health care needs. Based on positive experiences managing care for "healthier" TANF populations (moms and kids) — the majority of whom are in managed care — states are recognizing opportunities to improve health outcomes, quality of life, and value for tax dollars by coordinating care more effectively for aged, blind, and disabled beneficiaries. Although there are challenges to enrolling the aged, blind and disabled population into managed care, states are using a variety of models, including enhanced primary care case management and comprehensive care management, to provide higher levels of care coordination for beneficiaries with chronic needs.

Medicaid Enrollment and Spending by Population



Source: Holahan and Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000–2003." *Health Affairs*, January 2005.

3 National Institutes of Health and National Heart, Lung and Blood Institute, "Morbidity & Mortality: 2004 Chart Book on Cardiovascular, Lung, and Blood Diseases," May 2004: 17. http://www.nhlbi.nih.gov/resources/docs/04_chtbk.pdf.

4 K.B. Weiss, et al., "An Economic Evaluation of Asthma in the United States," *The New England Journal of Medicine*, March 1992, 326 (13):862-6.

Managed care programs for aged, blind, and disabled beneficiaries can improve health outcomes, control costs, and provide a measure of budget predictability to the state. For example, CareOregon, a Medicaid managed care plan, implemented a case management program for high-risk aged, blind, and disabled Medicaid members that succeeded in reducing claims costs by approximately 50 percent compared to costs for similar high-risk members who were not case managed. Other states, such as Pennsylvania and Washington, are implementing promising state-based care management approaches.

Recommendations:

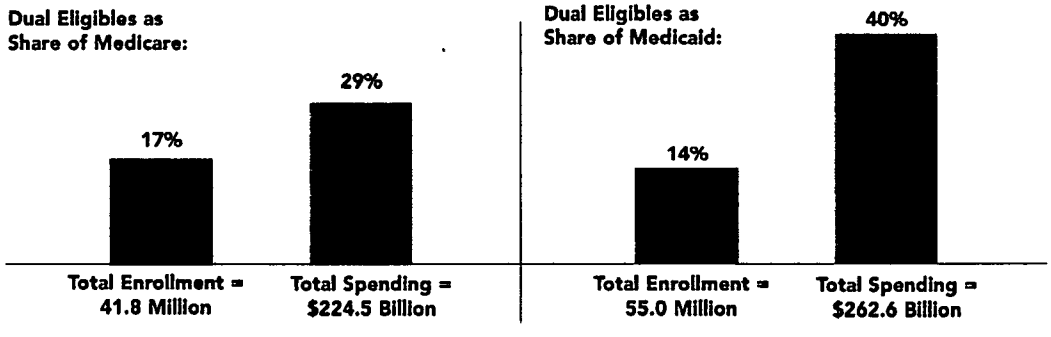
- Ensure that aged, blind, and disabled beneficiaries are enrolled in one or more models of managed care:
  - Full-risk or partial-risk capitation through a contract with a health plan.
  - Case management fee arrangement with a health plan, care management organization, or provider.
  - Partial-risk to non-risk arrangement through a contract with an administrative services organization.

4. Managed Care Models for Long-Term Care Supports and Services

Policy Rationale: Medicaid pays for nearly 50 percent of the nation's total spending on long-term care, creating a significant incentive for states to better manage the long-term care needs of Medicaid beneficiaries, including those who are also eligible for Medicare (the "dual eligibles"). These options include programs that manage long-term supports and services only, those that integrate acute and long-term care, and, ultimately, those that integrate Medicaid and Medicare.

Though not without its challenges, the biggest opportunity lies in improving care for the seven million dual eligibles, who represent only 14 percent of Medicaid's enrollment but drive over 40 percent of total Medicaid expenditures. Close to 70 percent of those expenditures are for long-term care, reinforcing the importance for states of actively managing long-term care supports and services and to integrate them with primary, acute, and behavioral services. Minnesota, through its Senior Health Options program that integrates Medicare and Medicaid services, significantly reduced the number of preventable hospital and emergency room admissions for enrollees residing both in nursing facilities and the community.

Dual Eligibles as a Share of Medicare and Medicaid Enrollment and Spending, 2002-2003



Source: Medicare data are from Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use File. Medicaid data are from KCMU estimates based on CMS data and Urban Institute estimates based on an analysis of 2001 MSIS data applied to CMS-64 FY2003 data.

States not ready to fully integrate Medicaid and Medicare services can still reap benefits by developing programs to better manage long-term care services and supports and integrate long term and acute services. Managed long-term care programs have been shown to improve quality, cost-effectiveness, and community placements in several states, including Arizona, Florida, Texas, and Wisconsin.

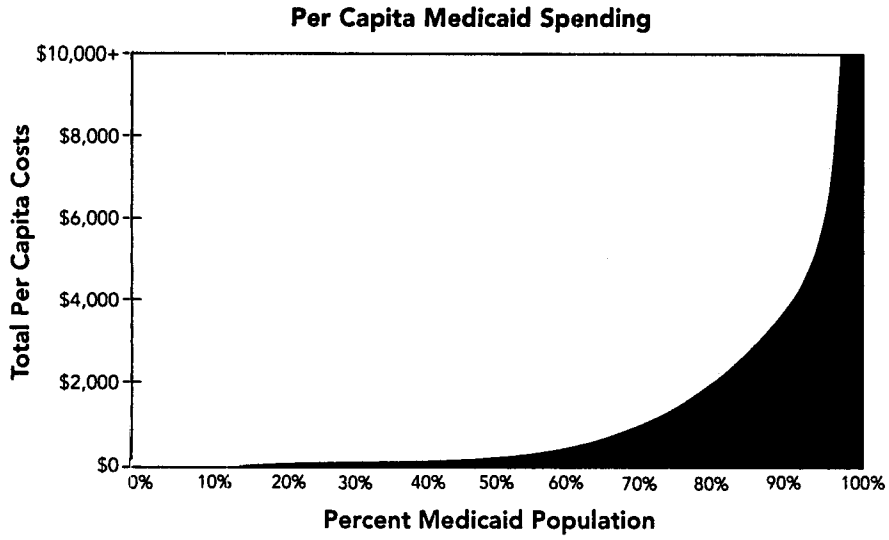
Recommendation:

- Implement a managed long-term care program for Medicaid beneficiaries.
- Implement a managed long-term care program for Medicaid beneficiaries that also integrates acute care services covered by Medicaid.
- Implement an integrated care program for dual eligibles with one of the following approaches:
  - Wraparound or partially capitated contract for one or all of the services covered by Medicaid (e.g., non-covered Medicare acute care services and drugs, behavioral health, care management, personal care services, nursing facility, and home- and community-based services).
  - Capitated contract with a Medicare Advantage Special Needs Plan for the full range of Medicaid services (e.g., primary, acute, behavioral, long-term care supports and services).

5. Care Management for High-Risk, High-Cost Members with Multiple Chronic Health Needs

Policy Rationale: The majority of Medicaid beneficiaries are relatively inexpensive, with a remarkably small number of beneficiaries driving a significant portion of total spending. Less than 5 percent of Medicaid beneficiaries account for close to 50 percent of total expenditures, with the top 1 percent responsible for over 25 percent of annual Medicaid costs nationally.[5] Most of these beneficiaries have multiple chronic physical and behavioral health conditions and/or disabilities, often further complicated by difficult socio-economic factors. Developing programs to better manage the care of this very small, high-cost group of beneficiaries offers tremendous opportunities to increase quality and control costs.

By using predictive modeling to identify patients who may become ill (and costly) and employing intense medical management for those with multiple diseases who are already very costly, some organizations have shown a significant decrease in cost and improvement in quality measures. By reducing the need for, and utilization of, hospitals and nursing homes, costs for these patients can eventually be brought under much better control.



Source: Sommers A. and Cohen M. *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?* Kaiser Commission on Medicaid and the Uninsured, March 2006.

Recommendations:

- Implement a care management program that focuses on the top 1 to 5 percent of highest-risk, highest-cost beneficiaries.
- Incorporate a targeted care management strategy for the top 1 to 5 percent of highest-risk, highest-cost beneficiaries into any managed care program or contract for aged, blind, and disabled beneficiaries.

5 Agency for Healthcare Research and Quality, "AHRQ Annual Report on Research and Financial Management, FY 2001," http://www.ahrq.gov/about/annrpt01/annrpt01.pdf.

About the Authors

Melanie Bella is a senior vice president at the Center for Health Care Strategies; Stephen Goldsmith is the Daniel Paul Professor of Government and the director of the Innovations in American Government Program at Harvard's Kennedy School of Government; and Stephen A. Somers is the president of the Center for Health Care Strategies.

About The Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit organization dedicated to improving the quality and cost effectiveness of publicly financed care for people with chronic health needs, the elderly, and racially and ethnically diverse populations. CHCS works with state and federal agencies, health plans, providers, and consumers to design programs that better serve high-need and high-cost populations. Its program priorities are: improving quality, reducing racial and ethnic disparities, and integrating care.

About the Government Innovators Network

The Government Innovators Network (www.innovations.harvard.edu) is an online marketplace of ideas and examples of government innovation for policy makers, policy advisors, and practitioners. It strives to stimulate new ideas and bring people and ideas together around innovations in governance. The Government Innovators Network was developed at the Roy and Lila Ash Institute for Democratic Governance and Innovation at the John F. Kennedy School of Government at Harvard University. The Ash Institute also administers the Innovations in American Government Awards Program. The Program identifies and promotes best practices and exemplary projects that can be adopted in other settings, providing public officials and senior executives with innovative leadership models.

Resources for State Government Officials

Seeking Higher Value in Medicaid: A National Scan of State Purchasers — This CHCS report provides a comprehensive look at the current Medicaid managed care environment from the perspectives of 14 states — California, Colorado, Florida, Georgia, Hawaii, Kentucky, Maryland, Michigan, Ohio, Oregon, Pennsylvania, Texas, Washington, and Wisconsin. Interviews with Medicaid directors and staff in these states offer valuable insights about states' plans for expanding managed care, promising practices for improving quality through value-based purchasing, and innovative trends in the Medicaid managed care marketplace. The report is available at www.chcs.org.

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CHCS Center for Health Care Strategies, Inc.
200 American Metro Blvd. Ste. 119
Hamilton, NJ 08619-2311
Phone: (609) 528-8400
Fax: (609) 586-3679
www.chcs.org

With the assistance of ASH INSTITUTE FOR DEMOCRATIC GOVERNANCE AND INNOVATION
HARVARD UNIVERSITY JOHN F. KENNEDY SCHOOL OF GOVERNMENT
79 John F. Kennedy Street
Cambridge, MA 02138
Tel: 617-495-0557
Fax: 617-496-4602
www.innovations.harvard.edu

oppaga
OFFICE OF PROGRAM POLICY ANALYSIS
& GOVERNMENT ACCOUNTABILITY

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The Nursing Home Diversion Program Has Successfully Delayed Nursing Home Entry

at a glance

The Nursing Home Diversion program has successfully delayed participants' entry into nursing homes. Frail elders participating in the Nursing Home Diversion program were more likely to delay entry into a nursing home than similar frail elders who were not enrolled in any Medicaid community-based waiver programs. Program participants also experienced shorter nursing home stays and were more likely to return to their homes to continue program services.

Although Nursing Home Diversion costs have exceeded the Medicaid Program's costs for other frail elders, these cost differences have narrowed due to recent rate reductions. When compared to other waiver programs, the Nursing Home Diversion program has higher costs but is more successful in delaying nursing home placements. Although the state could potentially serve Nursing Home Diversion participants in other programs, doing so could compromise their quality of life and strain the capacity of these other programs.

Scope

As required by Ch. 2005-133, *Laws of Florida,* OPPAGA reviewed the Long-Term Care Community Diversion pilot project, commonly referred to as the Nursing Home Diversion program. This report addresses three questions.

- How effective is the program in delaying nursing home entry of frail elders?
- Is the program an expansion of the Medicaid Program and is it cost-effective?
- Could the state serve program participants in other waiver programs at less cost?

A prior report described participant characteristics, the services they most frequently used, and differences in service use based on living situation or client characteristics. [1]

Background

Florida faces a growing demand for community-based long-term care alternatives to nursing homes as its elderly population increases. In 2004, Florida led the nation with 16.8% of its population (2.9 million individuals) age 65 and older. By 2010, Florida's elder population is expected to reach nearly 3.5 million. The largest increase will be seniors age 85 and older.

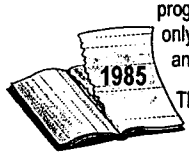
[1] *Service Use for Nursing Home Diversion Waiver Clients Depends on Living Situation, OPPAGA* Report No. 06-10, February 2006.

Providing alternatives to nursing home placement helps the state meet its goal of serving clients in the least restrictive settings. Florida has provided community-based long-term care alternatives to nursing homes since 1982. The state now operates five Medicaid home and community-based programs that help frail elders remain in their own homes or other less restrictive settings for as long as possible, thereby avoiding or delaying unnecessary and costly nursing home placement and enhancing quality of life. [2, 3] (See Exhibit 1.) These waiver programs differ in the breadth of services covered, criteria for enrollment, and forms of reimbursement. (Appendix A provides information about Florida's Medicaid home and community-based waiver programs that serve elders.)

Although state expenditures for community-based care have grown over time, state expenditures for nursing home and other institutional care consume two-thirds of the Medicaid Program's long-term care budget. Exhibit 2 shows the growth in the state's expenditures for community-based care since the early 1980s. In Fiscal Year 2004-05, home and community-based services expenditures totaled approximately $1.48 billion, while nursing home care expenditures were approximately $2.28 billion.

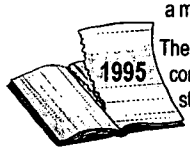
Exhibit 1
Five Medicaid Home and Community-Based Waiver Programs Serve Florida's Elderly and Disabled Population

The Aged and Disabled Adult waiver is a home and community-based services program that was implemented statewide on April 1, 1982. The Florida Department of Elder Affairs has operational responsibility.



The Channeling waiver is a home and community-based services program that was implemented on July 1, 1985. This program is only available in Broward and Dade counties and operates through an annual contract with an organized health care delivery system.

The Frail Elder program was implemented in 1986 as a home and community-based waiver program. This program operates in Broward and Dade counties through an annual contract with a managed care organization.

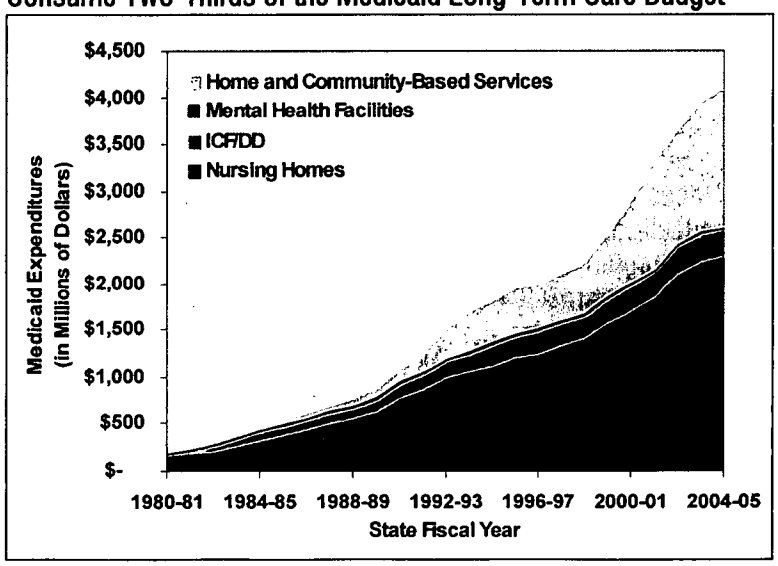


The Assisted Living for the Elderly waiver is a home and community-based services program that was implemented statewide on February 1, 1995. The Florida Department of Elder Affairs has operational responsibility.

The Nursing Home Diversion program is a home and community-based waiver program that was implemented in December 1998 in the Orlando area and now operates in 25 counties. The Department of Elder Affairs has operational responsibility and contracts with managed care providers for services.

Source: Agency for Health Care Administration and the Medicaid Summary of Services.

Exhibit 2
Home and Community-Based Services Expenditures Have Increased Over Time, But Nursing Homes and Other Facilities Consume Two-Thirds of the Medicaid Long-Term Care Budget [1]



[1] The home and community-based services portion of the budget includes Medicaid home health and personal care as well as all Medicaid waiver programs. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) funding goes to facilities that serve people with developmental disabilities.

Source: Agency for Health Care Administration.

[2] There are several additional Medicaid home and community-based programs. Some, for example, serve elders with developmental disabilities, traumatic brain injuries, Alzheimer's disease, and acquired immune deficiency syndrome.

[3] Premature or unnecessary nursing home placement wastes taxpayer dollars by providing expensive 24-hour institutional care when it is not needed. Medicaid nursing home care in Florida now averages $3,822 per month and more than $45,000 annually.

The Legislature created the Long-Term Care Community Diversion pilot project (commonly referred to as the Nursing Home Diversion program) in 1997. The program began operations in 1998 after receiving federal approval and now operates in 25 counties. [4] The federal government has approved expanding services to an additional 24 counties. Participants must be 65 years of age or older, be eligible to receive both Medicare and Medicaid benefits, require daily nursing services, or require assistance with activities of daily living. (For more information, see Appendix A.) In Fiscal Year 2004-05, the program served nearly 7,400 frail elders age 65 and older. This represented approximately 28% of the persons age 65 or older served by Florida's five Medicaid waiver programs for elders.

The Nursing Home Diversion program, administered by the Department of Elder Affairs, differs from Florida's other community-based care waiver programs in that it covers both medical and long-term care services. The program provides acute medical care, such as physician services and prescribed drugs, as well as long-term and ongoing services, such as personal care assistance, assisted living services, or nursing home care. Program providers are paid a capitated rate to cover all needed services, including Medicare co-payments, premiums, and deductibles. Since it is far more costly to pay for nursing home care than to pay for services needed to keep participants in the community, providers have a financial incentive to ensure that participants receive the services they need to avoid expensive nursing home placement for as long as possible. [5]

[4] Chapter 97-87, *Laws of Florida.* The federal Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) approved the waiver for this program in 1998.

[5] The Frail Elder program also obligates providers to cover nursing home care, but the obligation is for a limited time period. Frail Elder providers must pay for nursing home care until the end of the contract year during which a client entered a nursing home.

Questions and Answers —

How effective is the Nursing Home Diversion program in delaying nursing home entry of frail elders?

The Nursing Home Diversion program has successfully delayed participants from entering nursing homes. Frail elders participating in the program were more likely to delay entry into nursing homes than similar frail elders who were not enrolled in any Medicaid waiver programs. In addition, Nursing Home Diversion participants who entered a nursing home for an extended stay had shorter stays, on average, than similar non-waiver clients and were more likely to leave the nursing homes and return to their homes or residential settings to continue receiving community-based care.

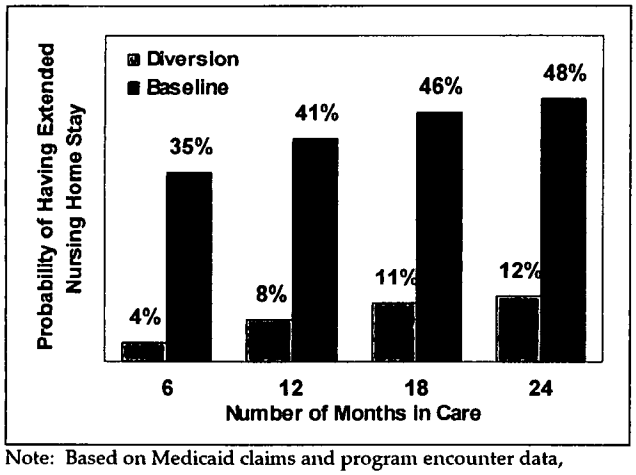
To examine how well the Nursing Home Diversion waiver program delays nursing home stays, we compared participants who enrolled in the program from January 2003 through December 2004 to a baseline group of Medicaid clients who met the criteria for the Nursing Home Diversion program but were not enrolled in any of the community-based care Medicaid waiver programs. [6,7] We compared the likelihood that elders in these two groups would have an extended nursing home stay over a two-year period. We also compared the likelihood that these elders would leave a nursing home after an extended stay and return to the community to resume long-term care services. (See Appendix B for details related to the data sources we used for this study, criteria for selecting comparison groups, and descriptions of the analyses conducted.)

[6] The baseline group included elders who were age 65 or older, eligible for both Medicaid and Medicare, and met the frailty criteria for the program. Furthermore, the baseline group was not enrolled in any of Florida's waiver programs during the two-year comparison period. (See Appendix B.)

[7] Our analyses were restricted to this timeframe because encounter data on nursing home use for program enrollees was limited and only sufficient to support analyses from January 2003 through December 2004.

Nursing Home Diversion participants were less likely to enter a nursing home for an extended stay than similar frail elders who were not enrolled in any Medicaid waiver programs. As shown in Exhibit 3, Nursing Home Diversion participants were less likely to enter a nursing home for an extended stay within 24 months after enrolling in the program than were clients in the baseline group. For example, after 6 months, program clients had a 4% probability of having entered a nursing home compared to a 35% probability for clients in the baseline group. By the end of 24 months, the probability of a Nursing Home Diversion client having entered a nursing home for an extended stay was 12% compared to 48% for the baseline group.

Exhibit 3
Elders Served by Nursing Home Diversion Were Less Likely to Have an Extended Nursing Home Stay



Note: Based on Medicaid claims and program encounter data, January 2003 – December 2004. An extended nursing home stay is defined as having at least 30 nursing home days within two months.
Source: OPPAGA analysis.

To further examine these outcomes, we conducted a regression analysis that controlled for demographic and health-related differences that could affect an individual's risk of entering a nursing home—frailty levels, chronic or serious health conditions, the presence of a caregiver, age, gender, race, region of the state, and whether or not the client died during the two years. [8] This analysis showed that new enrollees in the Nursing Home Diversion program were nine times less likely to enter a nursing home within 24 months for an extended stay than the baseline group.

Nursing Home Diversion participants were more likely than the baseline group to leave nursing homes to return for care in the community. Because elders typically prefer living in residential settings that afford them more independence, a successful diversion program should help participants return to their residences after initial nursing home placements and provide necessary services to assist them to remain in their communities. Our analysis showed that Nursing Home Diversion clients were four times more likely than the baseline group to leave nursing home placements and return to their homes or other less restrictive settings. In addition, program participants' nursing home stays were shorter, averaging 43 days, than the baseline group which stayed in nursing homes an average of 132 days.

Is the Nursing Home Diversion program an expansion of the Medicaid Program and is it cost-effective?

The Nursing Home Diversion program is an expansion of the Medicaid Program in the sense that its services may attract elders who are averse to going into a nursing home but will accept services to help them remain in their own homes. Over a three-year period, it cost the Medicaid Program more to serve Nursing Home Diversion program participants than it did to serve non-waiver clients. However, this cost difference has narrowed and may no longer exist due to recent rate reductions.

The Nursing Home Diversion program, like other similar long-term care alternatives, is an expansion of Medicaid but supports the state's goal to provide long-term care in the least restrictive settings. By keeping frail elders in the community, the Nursing Home Diversion program meets the Legislature's goal to maximize the placement of participants in the least restrictive appropriate settings. [9] However, research on home and community-based services acknowledges that diversion programs are limited in their ability to constrain overall long-term care costs because of

[8] Cox Regression analysis was used to account for these differences. (See Appendix B.)

[9] Section 430.705, *F.S.*

the "woodwork effect." This effect occurs when individuals in the community who have been getting along with limited assistance may take advantage of expanded home and community-based services.[10] When this occurs, demand for Medicaid increases and reduced nursing home spending is offset by spending for home and community-based care for people who would not have entered nursing homes.[11]

Although it cost the state more to serve Nursing Home Diversion participants than it did to serve similar frail elders in a baseline group, this cost difference has narrowed and may no longer exist due to recent rate reductions. Because of data limitations, we could not directly measure cost-effectiveness as a ratio of nursing home days diverted to dollars spent.[12] As an alternative, we compared the costs of serving frail elders in the Nursing Home Diversion program to similarly frail elders living in the community who met program criteria but were not enrolled in any Medicaid community-based waiver programs.

To examine these costs, we compared the three-year Medicaid expenses of Nursing Home Diversion participants who enrolled during the January 2001 to June 2002 period to the Medicaid costs of a baseline group of Medicaid clients who met the criteria for the Nursing Home Diversion program but were not enrolled in any of the state's waiver programs.[13] For the non-waiver baseline group, we counted all Medicaid expenses which included the costs of acute medical care such as physicians' visits, prescribed drugs, inpatient hospital stays and outpatient hospital procedures as well as the nursing home costs incurred by this group. We compared these costs to those incurred for the Nursing Home Diversion group, including the per-member per-month payments made to providers plus any other miscellaneous Medicaid costs.[14] We used regression analysis to account for demographic and health-related indicators that could influence costs.[15]

After adjusting for these influences, the state paid, on average, $99 more per month to provide Nursing Home Diversion services per elder than it paid for services to elders in the baseline group comprising similar Medicaid clients who were not enrolled in any Medicaid home and community-based waiver programs. (See Exhibit 4.) However, this difference in cost has narrowed and may no longer exist due to reductions in the per-member per-month rates paid to program providers. The average monthly rate during the time captured by our analysis was $2,295. But, in July 2005, the Department of Elder Affairs reduced monthly rates and by December 2005 the average rate was $1,961, which is below the average unadjusted monthly cost of $2,045 for elders in the baseline group.[16]

Although more costly, program participants may have a higher quality of life. As discussed earlier, frail elders in the Nursing Home Diversion program were nine times less likely to enter nursing homes for an extended stay. The services provided by the program help elders maintain their independence and relationships with family and friends, thereby enriching their quality of life. Entering a nursing home for what could be an extended period of time is often disruptive to elders and is considered a catastrophic event. By preventing or delaying this event, elders are typically happier and enjoy a better quality of life during their later years.

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[10] In other words, policymakers perceive that these individuals "come out of the woodwork" to sign up for these services once they become available.

[11] Doty, Pamela. 2000. *Cost-Effectiveness of Home and Community-Based Long-Term Care Services.* USHHS/ASPE Office of Disability, Aging and Long-Term Care Policy.

[12] Nursing Home Diversion program data did not permit developing effectiveness/cost ratios and comparing these between the two groups.

[13] Thus, we tracked the total Medicaid costs for all clients for a full 36 months (or until they left the Medicaid program) regardless of when they enrolled between January 2001 and June 2002.

[14] For example, if a Nursing Home Diversion participant disenrolled from the waiver and then received Medicaid hospice care, these costs would be included here.

[15] We used an Ordinary Least Squares technique to control for differences in frailty levels, chronic or serious health conditions, the presence of a caregiver, age, gender, race, region of the state, and death.

[16] The Department of Elder Affairs further reduced rates in January 2006 to reflect reduced prescription drug costs due to the implementation of Medicare Part D prescription drug coverage. Rates currently range between $1,374 in Palm Beach County and $1,837 in Miami-Dade. All Medicaid programs that serve elders will be affected by the implementation of Medicare Part D. However, the extent to which Medicare Part D will affect the costs of the Nursing Home Diversion program compared to other waiver programs is unknown at this time.

Exhibit 4
Average State Monthly Costs for Nursing Home Diversion Participants Were Higher Than Those for Elders Not Enrolled in Any Medicaid Community-Based Waiver Programs

	Average Monthly Costs	Difference in Monthly Costs	Adjusted Difference in Monthly Costs[1]	Average Months on Medicaid	Average Difference in Months
Nursing Home Diversion	$2,268			26.2	
Baseline Elders	2,045	$223	$99	19.5	6.7

[1] Analysis adjusts for differences in demographic and health-related indicators of the two groups. See Appendix B.
Source: OPPAGA analysis.

Elders enrolled in the Nursing Home Diversion program also benefit from the breadth of services available and continuous care management. Thus, program participants can easily move to assisted living if their need for care increases. In contrast, elders in the community without these services may be faced with either attempting to access the care they need on their own or going without needed assistance if service providers are difficult to find.

Quality of life differences for clients in the two groups also may be reflected by differences in months of care received. As shown in Exhibit 4, frail elders from the non-waiver baseline group averaged fewer months on Medicaid than did Nursing Home Diversion participants, reflecting the fact that a higher proportion of these elders died within a year after choosing not to enroll in the Nursing Home Diversion program or other community-based waiver programs. While 18.5% of program clients died within one year of enrolling in the program, 36.5% of baseline clients died within the same time. [17] Elders in the baseline group also experienced shorter periods of Medicaid eligibility. [18] When Nursing Home Diversion clients lose eligibility, case managers will work with clients to quickly resolve and re-establish Medicaid eligibility. [19] In the absence of this type of assistance, clients in our baseline group may not have re-established eligibility or may have taken longer to do so.

Could the state serve Nursing Home Diversion participants in other waiver programs at less cost?

It cost the state more on average to serve elders in the Nursing Home Diversion program than to serve similar elders in the Assisted Living for the Elderly (ALE) and Aged and Disabled Adult (ADA) waiver programs. [20] After adjusting for demographic and health-related indicators that could influence costs, it cost the state, on average, $212 per month less and $538 per month less, respectively, to serve elders on the ADA and ALE waivers than it cost to serve elders in the Nursing Home Diversion program. [21, 22]

Although the state might be able to serve Nursing Home Diversion clients less expensively in either the ADA or ALE waiver programs, there would be potential challenges and lost benefits of doing so, including increased risk of entering a nursing home and breaks in the continuity of care. In addition, savings would likely be less than expected if Nursing Home Diversion clients were shifted to these other waiver programs.

[17] Similar results were reported in a Connecticut study that showed that a higher proportion of clients who chose not to enroll in their state's Medicaid community-based waiver program died within the first six months. For more information see Sharon K. Long, et al. "Getting by in the Community: Lessons from Frail Elders" 2005 Journal of Aging and Social Policy, Vol. 17(1).

[18] Of the elders who were alive for the full 36 months in our study, Nursing Home Diversion program participants had, on average, 3 more months of Medicaid eligibility than elders who were in the non-waiver baseline group.

[19] Elders can lose Medicaid eligibility for a number of reasons such as changes in assets or income as well as failing to provide updated eligibility information.

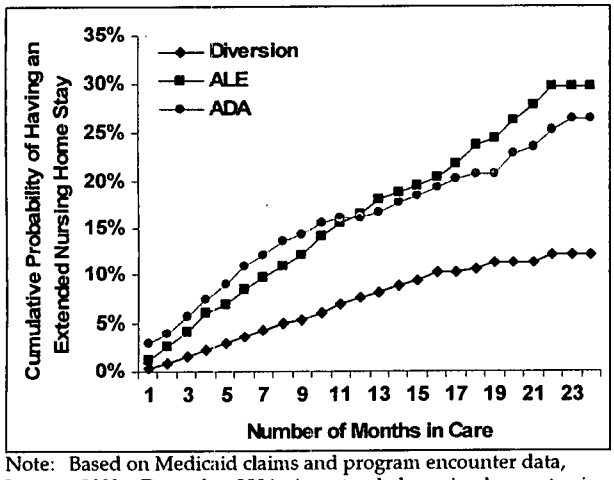
[20] We did not include the Channeling or Frail Elder programs in this comparison because they are only available to elders in Dade and Broward counties.

[21] This conclusion is based on the same statistical technique that we used in the prior section which controlled for differences in frailty levels, chronic or serious health conditions, the presence of a caregiver, age, gender, race, region of the state, and client death.

[22] Total Medicaid costs to serve each client are included in the analysis—all acute medical costs, community-based care, and nursing home costs.

ADA and ALE participants were more likely to enter a nursing home for an extended stay. Exhibit 5 shows that throughout the 24 months of our study, ADA and ALE clients were more likely to enter a nursing home than were clients who participated in the Nursing Home Diversion program. At the end of 24 months, Nursing Home Diversion participants had a 12% probability of having entered a nursing home for an extended stay compared to 30% and 26%, respectively, for ALE and ADA clients.

Exhibit 5
Nursing Home Diversion Participants Were Less Likely to Have an Extended Nursing Home Stay Than Were ADA and ALE Participants



Note: Based on Medicaid claims and program encounter data, January 2003 – December 2004. An extended nursing home stay is defined has having 30 nursing home days within two months.
Source: OPPAGA analysis.

Although several factors could contribute to this difference, a major difference is that unlike Nursing Home Diversion providers, ADA and ALE providers are not liable for nursing home care. When ADA or ALE participants need nursing home care, they are disenrolled from their waiver program and the Medicaid Program assumes the nursing home costs. Thus, ADA and ALE providers do not have a financial incentive to keep frailer and more medically complex clients out of nursing homes.

Breaks in coordination and continuity of care could affect clients' well-being. While both the ADA and ALE waivers provide care coordination, the care coordination provided to Nursing Home Diversion participants is more extensive and continuous. Both the ADA and ALE waiver programs provide fewer services than the Nursing Home Diversion program and neither provides acute medical care or nursing home care. In comparison, care coordination for Nursing Home Diversion clients includes providing and coordinating all care, including acute medical care and community-based long-term care. As such, Nursing Home Diversion clients do not need to disenroll to receive care in a nursing home as is the case for ADA and ALE clients. This type of continuous care coordination is important as it can affect the ease with which elders move between settings such as moving from home to a hospital or rehabilitation center and back home or to an assisted living facility or nursing home.

Shifting Nursing Home Diversion participants to the ADA and ALE waivers could diminish potential savings. Savings could be less than expected if frail elders in the Nursing Home Diversion program were shifted to ADA and ALE. Increasing the proportion of frail elders in these other waiver programs could affect overall Medicaid costs and/or access to needed services. For example, adding more frail elders to the ALE waiver could mean that assisted living daily rates might increase to accommodate a higher percentage of waiver clients needing more personal care, therapy, or other services to help them stay in assisted living facilities.

Shifting Nursing Home Diversion clients to other waiver programs could also hinder access to services needed to delay nursing home entry by straining the capacity of current providers. A recent report from the Agency for Health Care Administration identified several barriers that hinder individuals from receiving the community-based services they need to stay in the community. These barriers included waiting lists for services and a lack of residential alternatives to nursing homes, such as assisted living facilities, to meet current demands.

OPPAGA supports the Florida Legislature by providing evaluative research and objective analyses to promote government accountability and the efficient and effective use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). Cover photo by Mark Foley. *Florida Monitor:* www.oppaga.state.fl.us

Project supervised by Yvonne M. Bigos (850/487-9230)
Project conducted by Mary Alice Nye (850/487-9253), Steve Harkreader (850/487-9225), and Justin Graham
Becky Vickers, Staff Director (850/487-1316)
Gary R. VanLandingham, OPPAGA Director

Appendix A

Five Waiver Programs Serve Frail Elders in Florida

Table A-1
Waiver Programs Vary by Services Provided, Eligibility Criteria, and Reimbursement Mechanisms

Services	Eligibility	Reimbursement
Aged/Disabled Adult		
Implemented in 1982, this waiver program provides services to individuals who live in their own homes or with a caregiver. Services provided include companion services, adult day health care, attendant care, case aide, case management, chore services, consumable medical supplies, counseling, environmental accessibility adaptation, escort services, family training, financial risk reduction, health support, home-delivered meals, homemaker and personal care services, nutrition, personal emergency response systems, pest control, physical risk reduction, physical therapy, respite care, skilled nursing, specialized medical equipment and supplies, and speech therapy. The waiver program does not provide acute medical services or nursing home services. In Fiscal Year 2004-05, the program served 12,186 people for a cost of $82,777,286 for an average per client cost of $6,793.	To participate in this waiver program, clients must 1. be 65 years old or older or age 18 to 64 and determined disabled according to Social Security standards; 2. meet Supplemental Security Income, Medicaid for the Aged and Disabled, or Medicaid waiver assistance income and asset requirements; and 3. meet nursing facility level-of-care criteria as determined by Comprehensive Assessment Review and Evaluation Services (CARES).	Medicaid reimburses providers for those waiver services provided on a fee-for-service basis at the Medicaid fee or the provider's customary fee, whichever is lower.
Assisted Living for the Elderly		
Implemented in 1995, this waiver program provides services to people who reside in assisted living facilities. Services provided include case management, incontinence supplies and assisted living facility services, which include attendant call system and attendant care, behavior management, chore services, companion services, homemaker services, intermittent nursing services, medication administration, occupational therapy, personal care, physical therapy, specialized medical equipment and supplies, speech therapy, and therapeutic social and recreational services. The waiver program does not provide acute medical services or nursing home services. In Fiscal Year 2004-05, the program served 4,372 people for a cost of $25,886,807 for an average per client cost of $5,921.	To participate in this waiver program, clients must 1. be 65 years old or older or age 60 to 64 and be determined disabled according to Social Security standards; 2. meet nursing facility level-of-care criteria as determined by CARES; 3. meet Supplemental Security Income, Medicaid for the Aged and Disabled, or Medicaid waiver assistance income and asset requirements; and 4. meet one or more of the following: a) require assistance with four or more activities of daily living (ADLs); b) require assistance with three ADLs plus supervision or administration of medication; c) require total help with one or more ADLs; d) have a diagnosis of Alzheimer's disease or another type of dementia and require assistance with two or more ADLS; e) have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard ALF, but are available in an ALF licensed for limited nursing or extended congregate care; or f) be a Medicaid-eligible recipient who meets ALF criteria; be awaiting discharge from a nursing facility placement; and be unable to return to private residence because of a need for supervision, personal care, periodic nursing services, or a combination of the three.	Medicaid reimburses providers for assisted living services at a daily rate and case management services at a monthly rate. Incontinence supplies are reimbursed separately on a monthly basis.

Services	Eligibility	Reimbursement
Nursing Home Diversion		
Implemented in 1998, this waiver program provides services to elders who live in their own homes, with a caregiver, or in an assisted living facility. The program includes both acute and long-term care community services. Acute medical services include community mental health services, dental, hearing and visual services, independent laboratory and x-ray, inpatient hospital and outpatient hospital/emergency, physicians, prescribed drugs and transportation (optional) services. Community-based services include adult companion, adult day health care, assisted living, case management, chore services, consumable medical supplies, environmental accessibility and adaptation, escort services, family training, financial assessment and risk reduction, home delivered meals, homemaker services, nutritional assessment and risk reduction, personal care, personal emergency response systems, respite care, occupational, physical and speech therapies, home health and nursing facility services, The waiver also provides long-term nursing home care. In Fiscal Year 2004-05, the program served 7,373 people for a cost of $130,189,289 for an average per client cost of $17,658.	To participate in this waiver program, clients must 1. be 65 years of age or older; 2. Medicare Parts A & B & Medicaid eligible; 3. meet nursing facility level-of-care criteria as determined by CARES; and at risk of nursing home placement and meet one or more of the following clinical criteria; a) require assistance with five or more activities of daily living (ADLs); b) require assistance with four ADLs as well as require supervision or administration of medication; c) require total help with two or more ADLs; d) diagnosed with Alzheimer's disease or another type of dementia and require help with three or more ADLs; or e) diagnosed with a degenerative or chronic condition that requires daily nursing services; and 4. who can be safely served with home and community-based services.	Medicaid reimburses providers a per-person per-month capitated payment.
Channeling		
Implemented in 1985 this waiver program provides services to elders who live in their own homes or with a caregiver. Services provided include adult day health care, case management, chore services, companion services, counseling, environmental accessibility adaptation, family training, financial education and protection services, home health aide services, occupational therapy, personal care services, personal emergency response systems, physical therapy, respite care, skilled nursing, special home delivered meals, special drug and nutritional assessments, special medical supplies, and speech therapy. The waiver does not provide acute medical services or nursing home care. In Fiscal Year 2004-05, the program served 1,647 people for a cost of $12,772,919 for an average per client cost of $7,755.	To participate in this waiver program, clients must 1. be age 65 or older; 2. meet the nursing facility level of care criteria as determined by CARES; 3. meet Supplemental Security Income, Medicaid for the Aged and Disabled, or Medicaid waiver assistance income and asset requirements; 4. have two or more unmet long-term care service needs; and 5. reside in Broward or Dade counties.	Medicaid reimburses providers a negotiated per diem rate. The cost of care may not exceed 85% of the average Medicaid nursing facility rates in Broward and Dade counties.
Frail Elder		
Implemented in 1987 as a waiver, this program provides both mandatory and extended services to elders who live in their own homes or with a caregiver. Mandatory services include acute medical care services, care coordination, adaptive equipment, adult day health care, homemaker services, personal care, home health services, and supplies. Expanded services are provided as needed and include caregiver training, emergency response, financial education, identity bracelets, pharmacy management, respite care, and expanded home health (includes nutrition, occupational, physical, and speech therapies). The waiver pays for long-term nursing home care through the end of the Fiscal Year in which a client entered a nursing home. In Fiscal Year 2004-05, the program served 3,803 people for a cost of $50,936,140 for an average per client cost of $13,394.	To participate in this program, clients must 1. be age 21 and older (most are 65 and older); 2. receive Supplemental Security Income; 3. meet the nursing facility level of care criteria as determined by CARES; and 4. live in Broward or Dade counties.	The Frail Elder program is an optional benefit under the state's Medicaid HMO contracts in Broward and Dade counties. As such, providers receive a per-person per-month capitated payment.

Appendix B

Data and Methodology

To evaluate the Nursing Home Diversion program's effectiveness in diverting clients from nursing home care and to analyze the program's costs, we compared program participants to similarly frail elders who were not enrolled in a Medicaid home and community-based waiver program. The experience of clients who were not enrolled in any Medicaid community-based waiver program allowed us to project what the state's costs might have been if program participants had not enrolled in the program.

In addition, part of our legislative charge was to determine whether program clients could be more cost-effectively served on other waiver programs, such as the Aged and Disabled Adult waiver or the Assisted Living for the Elderly waiver. Comparing Nursing Home Diversion program costs to these other waivers requires adjustments to account for the programs' different eligibility criteria, services, and provider risk for nursing home costs. To account for these differences, we selected a cohort of frail elders from these other two waivers who met program criteria and included all Medicaid acute care and long-term costs for these clients, including nursing home expenses.

This technical appendix is divided into the following four sections.

- Data sources
- Medicaid recipients selected for study
- Diversion of clients from nursing home care
- Analysis of Nursing Home Diversion costs

Data sources

To assess whether the Nursing Home Diversion program successfully delays Medicaid recipients from entering nursing homes and is cost-effective, we used three databases.

- **Medicaid Long-Term Care Analysis File.** This file combines Medicaid eligibility and claims information provided by the Agency for Health Care Administration with death certificate information from the Department of Health. The file also contains client demographic characteristics such as age, gender, and race.
- **Nursing Home Diversion Encounter File.** This file contains information reported by providers on the services individuals received through the Nursing Home Diversion program.
- **Comprehensive Assessment Review and Evaluation Services (CARES) File and Client Information and Referral Tracking System (CIRTS) File.** These files contain information on medical, psychological, and functional impairment levels of individuals seeking admission to Medicaid-covered nursing home care and community-based services.

Staff of the Florida Policy Exchange Center on Aging at the University of South Florida obtained, compiled, and provided the data to OPPAGA. The center's director, Dr. Glenn Mitchell, provided valuable insight and technical assistance.

Data limitations. Because of differences in enrollment dates between the Nursing Home Diversion encounter file and the Medicaid claims information, our estimate of the time it takes new enrollees to have a long-term nursing home stay may be off by plus or minus one month. Approximately 90% of the program enrollees were identified in both the Medicaid

claims information and the program's encounter file. The initial enrollment month in the encounter file was within plus or minus one month of the initial enrollment month in the Medicaid data for the large majority of enrollees. For our analysis, we used the enrollment dates in the Medicaid claims information.

In addition, problems with provider encounter data have been reported by consultants and actuaries working with the Department of Elder Affairs including inconsistencies in how providers report service data, incomplete data received from some providers and no data received from other providers. These data limitations precluded us from directly measuring cost-effectiveness as a ratio of nursing home days diverted to costs.

Medicaid recipients selected for the study

Selection rules for diversion and cost analyses. We selected frail elders who met the Nursing Home Diversion program eligibility requirements for which we had information (see Appendix A, Table A-1) and were new enrollees in one of the following four types of care: [23]

- the Nursing Home Diversion waiver,
- the Aged and Disabled Adult (ADA) waiver,
- the Assisted Living for the Elderly (ALE) waiver, and
- non-waiver Medicaid-paid care (baseline group).

We considered Nursing Home Diversion, ADA, and ALE waiver program participants as "new enrollees" if they had not been enrolled in the same waiver program within the prior three months. We used this rule to minimize the likelihood that a brief transitional change in one's type of care was treated as a new enrollment. We considered non-waiver Medicaid recipients as "new enrollees" into non-waiver care during the month in which they first met eligibility requirements for the Nursing Home Diversion program if they had not received Medicaid-paid nursing home care in the prior three months, and received Medicaid services during the study period. We used this selection rule as a proxy for one of the Nursing Home Diversion eligibility requirements (whether clients could be "safely treated in the community"). We did this because the CARES and CIRTS assessment data does not include information directly related to whether non-waiver clients met this requirement.

Diversion analysis population and time period. For the diversion analysis we selected a cross-section of all recipients "newly enrolling" within a two-year period from January 2003 through December 2004, and examined their nursing home use through December 2004. Depending on when a person enrolled in this time period, we had between 1 and 24 months of data for each person. The available data in the Nursing Home Diversion encounter file, which provides information about nursing home use for Nursing Home Diversion clients, limited the time period we could analyze. Our statistical techniques adjust for the different number of months of data we have for individuals.

Cost analysis population and time period. For the cost analysis we selected a cohort of all recipients "newly enrolling" between January 2001 and June 2002. We then examined the total three-year Medicaid costs for each person in the cohort. Following individuals for three years allowed our analysis to reflect longer-term changes in services received and the associated Medicaid costs.

[23] The available data did not indicate whether individuals were diagnosed with degenerative or chronic conditions that require daily nursing services nor whether individuals could be safely served with home and community-based services. Our selection rules for the baseline group receiving non-waiver Medicaid-paid care were intended as a proxy for an indication that the elders could be safely served with home and community-based services.

Comparison of Nursing Home Diversion eligible groups in the analysis. Table B-1 indicates that, while the groups included in our analyses were relatively similar, there were some differences across care types in the Medicaid recipients' characteristics. For example, elders included in the analysis receiving services on the Assisted Living for the Elderly waiver had a higher rate of dementia and a lower rate of having an available caregiver. Having dementia and not having a caregiver are two factors that can increase the likelihood of entering a nursing home and increase Medicaid costs. We used statistical techniques to account for these remaining differences across care types.

Table B-1
Medicaid Recipients Included in the Study Were Similar in Demographic and Health-Related Characteristics

	Nursing Home Diversion	Assisted Living for the Elderly	Aged and Disabled Adult	Non-Waiver
Demographics				
Average age	82.4	83.2	81.1	81.9
Percentage female	76%	79%	76%	69%
Percentage white	62%	72%	46%	65%
Frailty and Caregiver Availability				
Average number of activities of daily living requiring some or total help (Maximum = 6)	3.4	3.2	4.4	4.4
Average number of instrumental activities of daily living requiring some or total help (Maximum = 8)	7.1	7.5	7.3	7.4
Average number of serious health conditions[1] (Ranges from 0 to 11)	3.5	3.5	4.0	3.5
Percentage with dementia	53%	71%	55%	53%
Percentage with incontinence	62%	67%	71%	63%
Percentage with available caregiver	28%	2%	77%	18%
(N)	5,758	818	995	13,208

[1] Serious health conditions include arthritis, bed sores, cancer, diabetes, emphysema, heart disease, incontinence, dementia, liver disease, pneumonia, and strokes.

Source: OPPAGA analysis of Medicaid claims and CARES/CIRTS assessments, January 2003 – December 2004.

Comparison of Medicaid recipients in the analysis to the population of ADA, ALE, and non-waiver Medicaid recipients. The recipients we selected for our analyses are not representative of all ADA enrollees, ALE enrollees, or persons in non-waiver Medicaid care. For example, 57% of ALE enrollees and less than 40% of ADA enrollees and non-waiver Medicaid recipients with long-term care assessments met the Nursing Home Diversion age, Medicare enrollment, and frailty criteria. We selected the most frail elders served in each care type by ensuring that they met Nursing Home Diversion waiver criteria and had been assessed for long-term care services. [24] Table B-2 shows the percentage of Medicaid recipients in these care types with complete CARES assessments who met the Nursing Home Diversion program eligibility requirements for which we have information.

[24] At least 94% of the waiver program populations had an identified complete CARES or CIRTS long-term care assessment, compared to only 14% of non-waiver Medicaid recipient seniors. Individuals included in our analyses all had an assessment, an indicator of potential interest in receiving long-term care services.

Table B-2
Percentage of Medicaid Recipients With CARES Assessments Who Met Nursing Home Diversion Eligibility Criteria But Did Not Participate in the Program

Type of Care	Percentage Meeting Program Eligibility Criteria [1]
Assisted Living for the Elderly	57%
Aged and Disabled Adult	36%
Non-Waiver Medicaid Care	39%

[1] The available data did not indicate whether individuals were diagnosed with degenerative or chronic conditions that require daily nursing services.

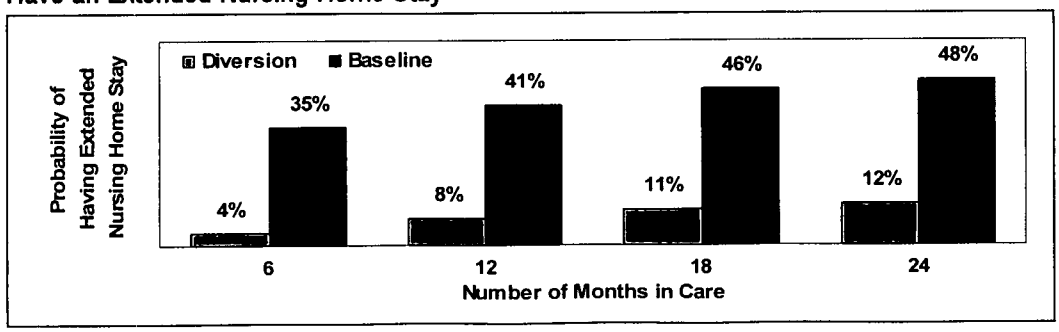
Source: OPPAGA analysis of Medicaid claims and CARES/CIRTS assessments, January 2003 – December 2004.

Self-selection issues. A variety of self-selection issues could affect the groups in our study. For example, elders have different attitudes about nursing home care. These different attitudes, which we could not measure, could cause them to choose different types of care and might contribute to different outcomes. For example, individuals with unfavorable opinions of nursing home care may be less likely to enter nursing homes regardless of their care alternatives and may be more likely to enter a home and community-based waiver. While our analysis indicates that reduced nursing home use among waiver enrollees is due to their waiver participation, reduced use may be due in part to the enrollees' opinions of nursing home care. To lessen the affect of these attitudinal differences, we included only those people in our study who had a CARES or CIRTS long-term care assessment, a potential indicator of their interest in receiving long-term care services.

Diversion of clients from nursing home care

To evaluate the extent to which program clients delay nursing home entry we used two statistical techniques, the Kaplan-Meier product-limit estimator and Cox's proportional hazard modeling, commonly referred to as survival/failure time analysis. Table B-3 below presents the *probability* of a "failure," i.e., entering a nursing home for an extended stay, given how long a new enrollee has been in care. Kaplan-Meier (1958) developed the method to estimate these probabilities, commonly referred to as the survival function. The Kaplan-Meier method is limited in its ability to consider differences in recipient characteristics across groups when estimating the survival function.

Table B-3
Elders Served by Nursing Home Diversion Were Less Likely to Have an Extended Nursing Home Stay



Note: Based on Medicaid claims and Nursing Home Diversion program encounter data, January 2003 – December 2004. An extended nursing home stay is defined has having at least 30 nursing home days within two months.

Source: OPPAGA analysis.

Because survival analysis cannot account for differences in client characteristics, we used Cox's proportional hazard modeling to calculate the *relative risk* of Nursing Home Diversion clients having a "failure", i.e., entering a nursing home for an extended stay, compared to that of similar clients in non-waiver care. This technique accounts for the time a person is in care, as well as differences in recipient characteristics across groups. We found that elders not enrolled in any waiver program were nine times more likely to enter a nursing home for an extended stay compared to similar clients served by the Nursing Home Diversion program. Our analysis accounts for differences among the two groups in functional impairments, mental health status, availability of a caregiver, availability of the diversion waiver, and recipients' age, gender, and race. Table B-4 describes how we defined an extended nursing home stay and the other factors included in our analyses.

The Legislature's charge to OPPAGA also included a question about whether program clients could be served on other waivers. As noted earlier, there are some limitations in making such a comparison because waiver programs provide different services, have different eligibility criteria and may attract different clients. However, the group of ALE and ADA clients we used for this analysis all met the Nursing Home Diversion program eligibility criteria. We used the Kaplan-Meier and Cox's proportional hazard techniques described above to compare program clients with clients served on the ALE and ADA waivers.

Analysis of Nursing Home Diversion costs

We used ordinary least squares regression to assess the costs of the Nursing Home Diversion program. For each person in our analysis cohort, we calculated total three-year Medicaid costs and the length of time spent in each of the four types of care. The regression analysis estimated the costs per month in each type of care. As with Cox's proportional hazard modeling, we used ordinary least squares regression to account for differences in client characteristics across the study groups (see Table B-4).

All clients, even those who are initially diverted from nursing homes, may eventually require the level of care that can only be provided in an institution. We assigned the costs of Medicaid-paid nursing home months of care that individuals received to the waiver they had been enrolled in prior to the nursing home entry. However, if a person was in more than one type of care, we assigned costs for months with nursing home care in proportion to the length of time the person spent in each type of prior care. For example, if a person had two months of ALE care and three months of ADA care before entering a nursing home, we apportioned two-fifths (40%) of the costs to ALE and three-fifths (60%) to ADA. In effect, this approach holds the other waivers responsible for the cost of nursing home entry, in a manner comparable to the risk faced by Nursing Home Diversion providers.

Adjusting for client differences across groups, monthly costs for Nursing Home Diversion care were the most expensive, costing $99 more than non-waiver care, $212 more than ADA waiver care, and $538 more than ALE waiver care.

Table B-4
Variables Used in Statistical Models

Variable	Description	Included in Analysis
Dependent Variables		
Months until extended nursing home stay	The number of months from newly enrolling to the beginning of the first month in which the recipient was in a nursing home for at least 30 days within two months.	Nursing home entry
Three-year total Medicaid costs	Total Medicaid expenditures for a three-year period beginning on the date of new enrollment in a waiver or newly becoming a non-waiver Medicaid recipient.	Cost analysis
Independent Variables: Type of Care		
Type of care of most recent enrollment	Yes or No: • Enrolled in the Nursing Home Diversion program • Enrolled in the Aged and Disabled Adult waiver • Enrolled in the Assisted Living for the Elderly waiver • Enrolled in non-waiver Medicaid care	Nursing home entry
Months in type of care	The number of months spent in: • Nursing Home Diversion waiver • Aged and Disabled Adult waiver • Assisted Living for the Elderly waiver • Medicaid paid non-waiver care	Cost analysis
Independent Variables: Impairments and Health		
Activities of daily living	The number of activities of daily living for which the recipient requires some or total help to perform. Activities of daily living include bathing, dressing, eating, toileting, transferring (e.g., from a wheelchair to a bed), and walking.	Nursing home entry and cost analysis
Instrumental activities of daily living	The number of instrumental activities of daily living for which the recipient requires some or total help to perform. Instrumental activities of daily living include light and heavy housework, preparing meals, taking medication, managing money, shopping, using the telephone, and driving.	Nursing home entry and cost analysis
Number of serious health conditions	The number of serious health conditions the recipient is experiencing. Serious health conditions include arthritis, bed sores, cancer, diabetes, emphysema, heart disease, incontinence, liver disease, pneumonia, and strokes.	Nursing home entry and cost analysis
Dementia	Indicates recipient has a diagnosis of Alzheimer's or other dementia.	Nursing home entry and cost analysis
Died	Indicates recipient died during the study period.	Nursing home entry and cost analysis
Independent Variables: Demographics		
Age	Indicates recipient's age.	Nursing home entry and cost analysis
Gender	Indicates if recipient is female.	Nursing home entry and cost analysis
Race	Indicates if recipient is white.	Nursing home entry and cost analysis
Other Independent Variables		
Caregiver	Indicates recipient has an available caregiver.	Nursing home entry and cost analysis
Planning and Service Area	Indicates the Department of Elder Affairs Planning and Service Area in which the recipient lives.	Nursing home entry and cost analysis
Did not meet diversion frailty criteria	Indicates whether a Nursing Home Diversion enrollee met the eligibility criteria by having a degenerative or chronic condition requiring daily nursing services, but did not meet the frailty criteria.	Nursing home entry and cost analysis
Nursing Home use in prior six months	Indicates whether the recipient was ever in Medicaid paid nursing home care in the six months prior to their enrollment.	Nursing home entry
Medicaid expenditures in prior six months	Indicates the average monthly Medicaid expenditures for the months in which recipients were in Medicaid in the six months prior to their enrollment.	Cost analysis

Statistical Model Performance. The regression model explained 49% of the variation in three-year total Medicaid costs. The explanatory power of the model is acceptable given the limits of social science research.

Nursing Home Diversion rate changes. Current rates for the program are lower than the rates included in our study. Because we followed enrollees for three years based on an enrollment window from January 2001 through June 2002, a large share of the cost for enrollees was paid under the old rates of $2,342 per month per enrollee. [25] In December 2005, just prior to the most recent rate reduction, the per-month cost averaged $1,961. The decrease in the program's monthly costs should result in smaller differences in cost among waiver programs.

Program rates were further reduced in January 2006 to reflect reduced prescription drug costs due to the implementation of Medicare Part D prescription drug coverage. Program rates currently range from $1,374 in Palm Beach County to $1,837 in Miami-Dade. All Medicaid programs that serve elders will be affected by the implementation of Medicare Part D. However, the extent to which Medicare Part D will affect the costs of the Nursing Home Diversion program compared to others is unknown at this time.

[25] The average program capitated rate during the time of our analysis was $2,295.

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Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?

By Anna Sommers and Mindy Cohen

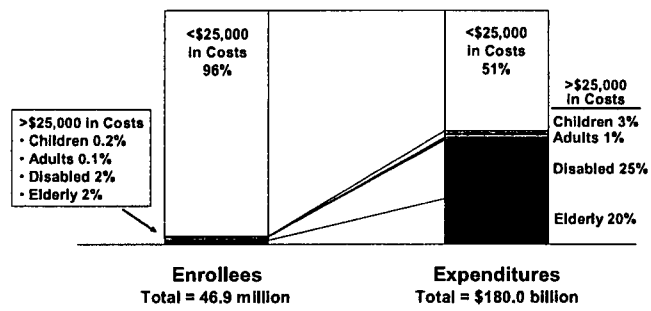
Overview

Achieving cost savings in the Medicaid program has become increasingly important to federal and state policy makers. In order to develop long-run cost saving reforms, it is helpful to understand how Medicaid spending is distributed and where the costs are concentrated.

Medicaid serves a very diverse population, including low-income children, parents and pregnant women, working disabled adults and severely disabled adults and children living in communities, and elderly and disabled living in institutions. Previous research has demonstrated that most Medicaid enrollees are low cost, with average spending well below average spending in the private market, after accounting for the poorer health status of Medicaid enrollees relative to individuals covered through the private market.[1] However, some Medicaid enrollees incur very high costs, and these individuals represent an area of possible cost reduction due to the high level of services they utilize and the large share of total Medicaid spending for which they are accountable.

Figure 1

Small Share of Medicaid Population Accounts for Large Share of Expenditures

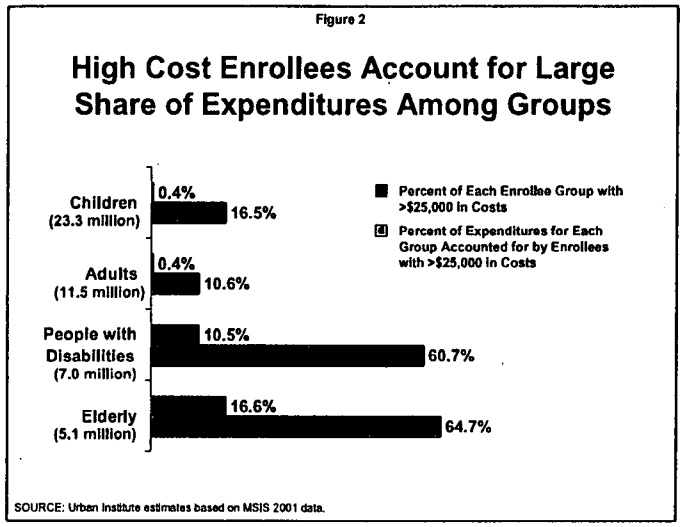


SOURCE: Urban Institute estimates based on MSIS 2001 data.

This brief presents new information on the distribution of Medicaid spending for all enrollees, including those residing in institutions, with a particular focus on "high-cost" individuals, defined here as those who spend above certain dollar amounts annually. In Federal Fiscal Year (FFY) 2001, the 7.6% of enrollees with annual spending exceeding $10,000 accounted for roughly two of every three Medicaid dollars spent nationally (65.3%), and the 3.6% of Medicaid enrollees with annual spending exceeding $25,000 accounted for nearly half (48.8%) of all Medicaid spending (Figure 1).

1330 G Street NW, Washington, DC 20005
Phone: 202-347-5270, Fax: 202-347-5274
Website: www.kff.org

Across all major eligibility groups, a small share of enrollees account for a very large share of spending; otherwise, most Medicaid enrollees are relatively low-cost (Figure 2). More than half (53.6%) of all enrollees had spending of less than $1,000 in 2001, while 11.2% had no Medicaid spending whatsoever. This skewed distribution in spending among enrollees suggests opportunities to develop cost-containment strategies that focus on a small group of very high-cost enrollees and the services they use, while maintaining access to an appropriate level of care.



Background, Data Sources, and Methods

On average, Medicaid spending grew over 10% annually between 2000 and 2003.[2] Recent research has attributed growth in Medicaid expenditures primarily to higher caseloads stemming from the economic downturn beginning in 2001.[3] Average spending per enrollee has also climbed, but not as fast as per enrollee spending in the private insurance market. Growth in Medicaid spending is a critical issue for both federal and state governments because they jointly finance Medicaid. In 2004, Medicaid accounted for 7% of the federal budget and an estimated 17% of state general fund spending.[4]

Both federal and state policy makers have proposed new Medicaid cost containment strategies. Last year, the Medicaid Commission established by Department of Health and Human Services Secretary Michael Leavitt recommended reforms to achieve $10 billion in savings over a 5 year period.[5] These proposed reforms were broad in scope and included recommendations to reduce the prices Medicaid pays for pharmaceuticals, toughen eligibility standards for elderly persons transferring assets prior to becoming eligible for Medicaid, increase copayments by enrollees, and reform managed care organization provider tax requirements. The National Governors Association (NGA) has also developed a set of proposals for short-run cost containment in Medicaid, proposing many of the same strategies proposed by Leavitt's Commission.[6] The Deficit Reduction Act of 2005 (DRA), signed into law on February 8, 2006, adopted several of these policies to generate an expected $11.5 billion in savings over the next 5 years.[7] The NGA has also acknowledged the need for "broader program and health care reforms" to

achieve sustainable growth in Medicaid over the long run. The analysis presented here provides additional data to help inform the development of such long-term cost containment strategies.

The concentration of medical spending among a small group of users is typical in all health insurance markets, including Medicare[8] and the employer-sponsored health insurance market.[9] A 2005 study by Schneider, Lambrew, and Shenouda examined the distribution of spending for Medicaid enrollees in 2002 among the non-institutionalized using the Medical Expenditure Panel Survey (MEPS).[10] This study found that the top 10% of non-institutionalized enrollees accounted for 72% of Medicaid spending for this population. Medicaid spent an average of $7,770 per beneficiary in this top 10 percentile, with 40% of these costs attributable to hospital care. Several chronic conditions conducive to medical management were commonly reported among these high-cost enrollees, including high blood pressure, heart disease, and diabetes. This suggests that potentially large cost savings might be realized by managing the care of these high cost users with concentrated spending. The analysis presented here includes all Medicaid enrollees, including the institutionalized – who account for nearly a third of all Medicaid spending – together with the non-institutionalized, providing one of the first comprehensive pictures of the distribution of spending in Medicaid.

This brief is based on analysis of the 2001 Medicaid Statistical Information System (MSIS) Summary File, examining the distribution of spending in Medicaid for all Medicaid enrollees – including those in long-term care institutions – and the characteristics of "high-cost" users. The MSIS data contains aggregated expenditure data for 46.9 million enrollees in 2001. For each Medicaid enrollee, the MSIS reports aggregated expenditures for 29 service categories, including five types of institutional spending and three types of capitated managed care or prepaid services. Unlike the MEPS, which tracks only the non-institutionalized population, the 2001 MSIS Summary File includes individuals residing in institutions, but does not include information on diagnoses or conditions, so we cannot draw conclusions about the composition of chronic conditions in this population.

The analysis begins with the distribution of spending for all Medicaid enrollees, both those enrolled for the full year and part of the year. The four major categories of enrollment – elderly, disabled, children, and adults – are then analyzed separately. The elderly and disabled are also examined by those with and without institutional spending. The disabled are defined as those classified as disabled by the Medicaid program for the purposes of Medicaid eligibility, and include adults age 21-64 and some children under age 21. Non-disabled adults and children are also analyzed by those with and without managed care spending. Capitated arrangements that pay health plans or providers a monthly or prospective lump sum for most services can obscure the identification of enrollees who would be high-cost based on services utilized, so our calculations of the distribution of medical spending may underestimate some individual beneficiary's actual use of high-cost services.[11] Spending data include capitated payments to HMOs, prepaid health plans (PHP), and to providers for Primary Care Case Management (PCCM). Adults include non-disabled parents, relative caretakers, and pregnant women. The child category includes all children under the age of 21 who were not classified as disabled by the Medicaid program, but includes some children with disabilities or special health care needs who were deemed eligible for Medicaid through criteria other than disability.

This analysis excludes individuals in MSIS with unknown eligibility, individuals with a negative annual expenditure total, lump sum payments in MSIS that could not be attributed to a particular beneficiary, and any Medicaid expenditures not reported in MSIS. Expenditures not reported in MSIS include any payments made by Medicaid to states reported as administrative costs or accounting adjustments, disproportionate share (DSH) payments to providers, and all payments to Medicare (premiums or copayments) on behalf of Medicaid enrollees.

Results

Distribution of Spending for All Enrollees

Table 1 shows the distribution of Medicaid expenditures by total expenditures per person and the share of all enrollment and expenditures represented by each expenditure interval.[12] In FFY 2001, those with spending over $25,000 (referred to here as "high cost") represented only 3.6% of enrollees, but accounted for almost half of all spending, 48.8% or $87.8 billion. Only 1.1% of enrollees had spending greater than $50,000, but this top one percent accounts for over a quarter (25.7%) of all Medicaid spending, or $46.2 billion. Those with spending under $5,000 (referred to here as "low-cost"), represented 85.7% of Medicaid enrollees in FFY 2001, but accounted for only 22.8% of all spending. More than half (53.6%) of all enrollees had spending of less than $1,000 in 2001, including more than one in ten Medicaid enrollees (11.2%) who had zero spending.

Table 1

Total Medicaid Enrollment and Expenditures: Total, Full and Part-Year, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of All Enrollment	Total Expenditures (millions)	% of All Expenditures
All	**United States**	**46,908**	**100.0%**	**$180,026**	**100.0%**
	$0	5,252	11.2%	$0	0.0%
	$0-$1000	19,874	42.4%	$8,267	4.6%
	$1000-$2000	8,465	18.0%	$11,720	6.5%
	$2000-$5000	6,618	14.1%	$21,037	11.7%
	$5000-$10000	3,100	6.6%	$21,460	11.9%
	$10000-$25000	1,886	4.0%	$29,706	16.5%
	$25000-$50000	1,184	2.5%	$41,625	23.1%
	$50000+	529	1.1%	$46,210	25.7%
	Mean (in dollars)			*$3,838*	
Full-Year Enrollees	**United States**	**26,148**	**55.7%**	**$142,554**	**79.2%**
	$0	1,017	2.2%	$0	0.0%
	$0-$1000	9,100	19.4%	$4,541	2.5%
	$1000-$2000	6,143	13.1%	$8,465	4.7%
	$2000-$5000	4,688	10.0%	$14,899	8.3%
	$5000-$10000	2,321	4.9%	$16,136	9.0%
	$10000-$25000	1,400	3.0%	$22,049	12.2%
	$25000-$50000	1,010	2.2%	$35,754	19.9%
	$50000+	469	1.0%	$40,711	22.6%
	Mean (in dollars)			*$5,452*	
Part-Year Enrollees	**United States**	**20,761**	**44.3%**	**$37,471**	**20.8%**
	$0	4,235	9.0%	$0	0.0%
	$0-$1000	10,774	23.0%	$3,726	2.1%
	$1000-$2000	2,322	4.9%	$3,256	1.8%
	$2000-$5000	1,930	4.1%	$6,138	3.4%
	$5000-$10000	779	1.7%	$5,324	3.0%
	$10000-$25000	487	1.0%	$7,658	4.3%
	$25000-$50000	174	0.4%	$5,871	3.3%
	$50000+	60	0.1%	$5,498	3.1%
	Mean (in dollars)			*$1,805*	

The second and third blocks in Table 1 show the distribution of Medicaid expenditures for full-year and part-year enrollees. The 26.1 million enrollees enrolled for the full year in Medicaid accounted for 55.7% of all enrollees and nearly four of every five Medicaid dollars (79.2%) in 2001. As would be expected, most of the high-cost enrollees – about 86% – were full-year enrollees. Most of those with no spending – 80.6% – were part-year enrollees, although a few part-year enrollees were high-cost.

Table 2 on the next page shows the distribution of Medicaid expenditures by institutional care status. Although institutionalized enrollees have the highest average expenditures ($36,062), non-institutionalized enrollees constitute the vast majority (96.6%) of enrollees and more than two-thirds (68.4%) of expenditures. Although a very small percentage of enrollees had institutional care, 3.4%, they accounted for a disproportionately large percentage of total expenditures, 31.6%. The bulk of this spending was attributable to an even smaller share of enrollees with spending over $25,000 who accounted for more than a quarter (27.1%) of all Medicaid spending in 2001. Non-institutionalized enrollees show a similar but slightly less skewed distribution.

Table 3 shows the distribution of Medicaid expenditures for the elderly. A total of 5.1 million elderly accounted for expenditures in Medicaid of $54.5 billion, an average of $10,656 per elderly beneficiary. Overall, 16.6% of the elderly had spending over $25,000, which accounted for 64.7% of the spending on the elderly, or 19.6% of all Medicaid spending. Elderly high-cost enrollees (with spending over $25,000) represented 848,000 enrollees and $35.2 billion. Although the elderly are generally considered to have above average spending as a group, nearly a third (31.2%) of the elderly enrollees had spending in Medicaid of less than $1,000, including the roughly 13% of all elderly enrollees with no spending. Expenditures for many elderly Medicaid enrollees may not reflect total spending on their medical care because expenditures that are covered through Medicare cannot be counted in this analysis; some elderly with low or no spending in Medicaid might instead have high spending in Medicare.

High-cost enrollees with institutional care accounted for 14.1% of elderly enrollees, but 54.7% of expenditures for the elderly. High-cost elderly enrollees without institutional care accounted for 2.4% of elderly enrollees and only 10.0% of expenditures for the elderly.

Table 2

Total Medicaid Enrollment and Expenditures by Institutional Care, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of All Enrollment	Total Expenditures (millions)	% of All Expenditures
All	**United States**	**46,908**	**100.0%**	**$180,026**	**100.0%**
	$0	5,252	11.2%	$0	0.0%
	$0-$1000	19,874	42.4%	$8,267	4.6%
	$1000-$2000	8,465	18.0%	$11,720	6.5%
	$2000-$5000	6,618	14.1%	$21,037	11.7%
	$5000-$10000	3,100	6.6%	$21,460	11.9%
	$10000-$25000	1,886	4.0%	$29,706	16.5%
	$25000-$50000	1,184	2.5%	$41,625	23.1%
	$50000+	529	1.1%	$46,210	25.7%
	Mean (in dollars)			*$3,838*	
With Institutional Care*	**United States**	**1,577**	**3.4%**	**$56,856**	**31.6%**
	$0	0	0.0%	$0	0.0%
	$0-$1000	12	0.0%	$6	0.0%
	$1000-$2000	16	0.0%	$24	0.0%
	$2000-$5000	66	0.1%	$235	0.1%
	$5000-$10000	121	0.3%	$909	0.5%
	$10000-$25000	386	0.8%	$6,873	3.8%
	$25000-$50000	700	1.5%	$25,063	13.9%
	$50000+	277	0.6%	$23,746	13.2%
	Mean (in dollars)			*$36,062*	
Without Institutional Care	**United States**	**45,332**	**96.6%**	**$123,170**	**68.4%**
	$0	5,252	11.2%	$0	0.0%
	$0-$1000	19,862	42.3%	$8,261	4.6%
	$1000-$2000	8,449	18.0%	$11,696	6.5%
	$2000-$5000	6,552	14.0%	$20,802	11.6%
	$5000-$10000	2,979	6.4%	$20,551	11.4%
	$10000-$25000	1,501	3.2%	$22,833	12.7%
	$25000-$50000	484	1.0%	$16,563	9.2%
	$50000+	252	0.5%	$22,464	12.5%
	Mean (in dollars)			*$2,717*	

* Institutional care includes nursing home and intermediate care facility services for the mentally retarded.

Table 3

Total Medicaid Enrollment and Expenditures for the Elderly, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of Elderly Enrollment	% of All Enrollment	Total Expenditures (millions)	% of Elderly Expenditures	% of All Expenditures
All	**United States**	**5,117**	**100.0%**	**10.9%**	**$54,526**	**100.0%**	**30.3%**
	$0	651	12.7%	1.4%	$0	0.0%	0.0%
	$0-$1000	947	18.5%	2.0%	$365	0.7%	0.2%
	$1000-$2000	502	9.8%	1.1%	$740	1.4%	0.4%
	$2000-$5000	946	18.5%	2.0%	$3,122	5.7%	1.7%
	$5000-$10000	555	10.8%	1.2%	$3,927	7.2%	2.2%
	$10000-$25000	667	13.0%	1.4%	$11,090	20.3%	6.2%
	$25000-$50000	691	13.5%	1.5%	$24,303	44.6%	13.5%
	$50000+	157	3.1%	0.3%	$10,980	20.1%	6.1%
	Mean (in dollars)				*$10,656*		
With Institutional Care*	**United States**	**1,261**	**24.6%**	**2.7%**	**$37,042**	**67.9%**	**20.6%**
	$0	0	0.0%	0.0%	$0	0.0%	0.0%
	$0-$1000	10	0.2%	0.0%	$5	0.0%	0.0%
	$1000-$2000	14	0.3%	0.0%	$21	0.0%	0.0%
	$2000-$5000	59	1.2%	0.1%	$211	0.4%	0.1%
	$5000-$10000	108	2.1%	0.2%	$814	1.5%	0.5%
	$10000-$25000	345	6.7%	0.7%	$6,151	11.3%	3.4%
	$25000-$50000	596	11.7%	1.3%	$21,169	38.8%	11.8%
	$50000+	128	2.5%	0.3%	$8,670	15.9%	4.8%
	Mean (in dollars)				*$29,378*		
Without Institutional Care	**United States**	**3,856**	**75.4%**	**8.2%**	**$17,484**	**32.1%**	**9.7%**
	$0	651	12.7%	1.4%	$0	0.0%	0.0%
	$0-$1000	937	18.3%	2.0%	$359	0.7%	0.2%
	$1000-$2000	488	9.5%	1.0%	$719	1.3%	0.4%
	$2000-$5000	886	17.3%	1.9%	$2,911	5.3%	1.6%
	$5000-$10000	446	8.7%	1.0%	$3,113	5.7%	1.7%
	$10000-$25000	322	6.3%	0.7%	$4,939	9.1%	2.7%
	$25000-$50000	95	1.9%	0.2%	$3,134	5.7%	1.7%
	$50000+	29	0.6%	0.1%	$2,310	4.2%	1.3%
	Mean (in dollars)				*$4,534*		

* Institutional care includes nursing home and intermediate care facility services for the mentally retarded.

Table 4 shows the expenditure distribution for adult and child enrollees eligible based on disability. A total of almost 7.0 million disabled accounted for expenditures in Medicaid of $74.7 billion, an average of $10,710 per disabled beneficiary. Overall, 10.6% of the disabled had spending over $25,000, which accounted for 60.7% of the spending on the disabled, or 25.2% of all Medicaid spending. Disabled high-cost enrollees (with spending over $25,000) represented 734,000 enrollees and $45.4 billion. Although the

Table 4

Total Medicaid Enrollment and Expenditures for the Disabled, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of Disabled Enrollment	% of All Enrollment	Total Expenditures (millions)	% of Disabled Expenditures	% of All Expenditures
All	**United States**	**6,972**	**100.0%**	**14.9%**	**$74,674**	**100.0%**	**41.5%**
	$0	538	7.7%	1.1%	$0	0.0%	0.0%
	$0-$1000	1,323	19.0%	2.8%	$523	0.7%	0.3%
	$1000-$2000	696	10.0%	1.5%	$1,025	1.4%	0.6%
	$2000-$5000	1,505	21.6%	3.2%	$5,209	7.0%	2.9%
	$5000-$10000	1,332	19.1%	2.8%	$9,402	12.6%	5.2%
	$10000-$25000	845	12.1%	1.8%	$13,152	17.6%	7.3%
	$25000-$50000	408	5.9%	0.9%	$14,420	19.3%	8.0%
	$50000+	326	4.7%	0.7%	$30,943	41.4%	17.2%
	Mean (in dollars)				*$10,710*		
With Institutional Care*	**United States**	**310**	**4.4%**	**0.7%**	**$19,560**	**26.2%**	**10.9%**
	$0	0	0.0%	0.0%	$0	0.0%	0.0%
	$0-$1000	1	0.0%	0.0%	$1	0.0%	0.0%
	$1000-$2000	2	0.0%	0.0%	$2	0.0%	0.0%
	$2000-$5000	6	0.1%	0.0%	$21	0.0%	0.0%
	$5000-$10000	12	0.2%	0.0%	$89	0.1%	0.0%
	$10000-$25000	39	0.6%	0.1%	$701	0.9%	0.4%
	$25000-$50000	103	1.5%	0.2%	$3,858	5.2%	2.1%
	$50000+	147	2.1%	0.3%	$14,888	19.9%	8.3%
	Mean (in dollars)				*$63,118*		
Without Institutional Care	**United States**	**6,663**	**95.6%**	**14.2%**	**$55,113**	**73.8%**	**30.6%**
	$0	538	7.7%	1.1%	$0	0.0%	0.0%
	$0-$1000	1,321	18.9%	2.8%	$523	0.7%	0.3%
	$1000-$2000	694	10.0%	1.5%	$1,023	1.4%	0.6%
	$2000-$5000	1,499	21.5%	3.2%	$5,188	6.9%	2.9%
	$5000-$10000	1,321	18.9%	2.8%	$9,313	12.5%	5.2%
	$10000-$25000	806	11.6%	1.7%	$12,450	16.7%	6.9%
	$25000-$50000	306	4.4%	0.7%	$10,562	14.1%	5.9%
	$50000+	178	2.6%	0.4%	$16,054	21.5%	8.9%
	Mean (in dollars)				*$8,272*		

* Institutional care includes nursing home and intermediate care facility services for the mentally retarded.

disabled are considered to have above average spending as a group, 19% of all disabled enrollees had spending less than $1,000, including about 8% who had no spending. As with the elderly, some of the disabled with low spending in Medicaid may have high costs through Medicare, since about 34% of the disabled are dually eligible for Medicaid and Medicare. The vast majority (95.6% of disabled enrollees had no institutional long-term care spending. However, high-cost disabled enrollees with institutional care accounted for a quarter (25.1%) of all spending for the disabled.

Tables 5 and 6 show the distribution of Medicaid expenditures for non-disabled children and adults, respectively. While these children and adults do not include those eligible for Medicaid based on disability, these groups can include children and adults with disabilities or chronic conditions more broadly defined. Non-disabled individuals also may have high spending due to an accident or illness that requires acute care treatment or long-term rehabilitation. These episodes are likely to be incurred over a short term but can still yield high expenditures. We also separately classify non-disabled children

and adults based on having any managed care spending (in the HMO, PHP, or PCCM spending categories).

Non-disabled children represent the largest number of enrollees in Medicaid – about 23.3 million in 2001. These children accounted for $30.8 billion (17.1% of all Medicaid spending) for an average of $1,320 per child (Table 5). It should be noted that children in Medicaid are often enrolled in managed care plans and approximately 69.3% were enrolled in managed care in 2001, based on reported spending in one of the three managed care spending categories. Because managed care plans are paid a capitated rate for each child, the distribution of actual services provided is difficult to observe. Children in managed care may have some spending outside of capitated payments for services used prior to enrollment in managed care and for services carved out of managed care contracts, but primarily their spending consists of capitated payments. Some children may have high levels of utilization that reflect high costs to managed care plans that cannot be observed using MSIS. Similarly, the percentage of children with no spending reported here will be low compared to the percentage of children with no utilization because children receiving no services who are enrolled in managed care will still have capitated spending. Nonetheless, spending for children reported in MSIS reflects total Medicaid spending for all children, regardless of their enrollment in a managed care plan.

Only a very small share of all non-disabled children – less than one-half of one percent – had spending over $25,000 and accounted for 16.5% of all spending for non-disabled children (Table 5). Another fraction of a percent of children has spending between $10,000 and $25,000 accounting for 9.5% of spending on children. Thus, about 285,000 children (1.2%) accounted for almost $8 billion in spending.

Most children enrolled in managed care had spending of less than $2,000. Calculations based on the data shown in Table 5 demonstrate that of all children enrolled in managed care, 86.0% of enrollees had spending under $2,000. Of children with no managed care spending, 31.4% had no spending at all (data not shown). Notably, although children in managed care account for 69.4% of all children in Medicaid, they account for only half of high-cost child enrollees (data not shown).

Non-disabled adults include low-income parents, pregnant women, and adults with no children in states with Section 1115 coverage expansions. Overall, less than one-half of one percent of non-disabled adults had spending over $25,000, accounting for 10.6% of all spending on non-disabled adults (1.2% of all Medicaid spending) (Table 6). Thus, about 44,000 adults accounted for just over $2 billion in spending, or about 1% of all Medicaid spending and 11% of spending on non-disabled adults. Almost half (49.4%) of non-disabled adults were enrolled in some form of managed care. Of those with managed care spending, two-thirds (66.8%) had total spending of less than $2,000. Although adults in managed care account for half of all adults in Medicaid, they account for a smaller share (36.7%) of high-cost adult enrollees.

Table 5

Total Medicaid Enrollment and Expenditures for Non-Disabled Children, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of Non-Disabled Children Enrollment	% of All Enrollment	Total Expenditures (millions)	% of Non-Disabled Children Expenditures	% of All Expenditures
All	**United States**	**23,327**	**100.0%**	**49.7%**	**$30,786**	**100.0%**	**17.1%**
	$0	2,242	9.6%	4.8%	$0	0.0%	0.0%
	$0-$1000	12,947	55.5%	27.6%	$5,786	18.8%	3.2%
	$1000-$2000	5,116	21.9%	10.9%	$6,899	22.4%	3.8%
	$2000-$5000	2,222	9.5%	4.7%	$6,642	21.6%	3.7%
	$5000-$10000	515	2.2%	1.1%	$3,467	11.3%	1.9%
	$10000-$25000	197	0.8%	0.4%	$2,925	9.5%	1.6%
	$25000-$50000	54	0.2%	0.1%	$1,877	6.1%	1.0%
	$50000+	33	0.1%	0.1%	$3,191	10.4%	1.8%
	Mean (in dollars)				*$1,320*		
With Managed Care*	**United States**	**16,183**	**69.4%**	**34.5%**	**$22,212**	**72.2%**	**12.3%**
	$0	0	0.0%	0.0%	$0	0.0%	0.0%
	$0-$1000	9,450	40.5%	20.1%	$4,618	15.0%	2.6%
	$1000-$2000	4,469	19.2%	9.5%	$5,991	19.5%	3.3%
	$2000-$5000	1,749	7.5%	3.7%	$5,172	16.8%	2.9%
	$5000-$10000	354	1.5%	0.8%	$2,355	7.7%	1.3%
	$10000-$25000	117	0.5%	0.3%	$1,722	5.6%	1.0%
	$25000-$50000	29	0.1%	0.1%	$987	3.2%	0.5%
	$50000+	15	0.1%	0.0%	$1,366	4.4%	0.8%
	Mean (in dollars)				*$1,373*		
Without Managed Care	**United States**	**7,144**	**30.6%**	**15.2%**	**$8,574**	**27.8%**	**4.8%**
	$0	2,242	9.6%	4.8%	$0	0.0%	0.0%
	$0-$1000	3,496	15.0%	7.5%	$1,168	3.8%	0.6%
	$1000-$2000	648	2.8%	1.4%	$907	2.9%	0.5%
	$2000-$5000	473	2.0%	1.0%	$1,470	4.8%	0.8%
	$5000-$10000	162	0.7%	0.3%	$1,111	3.6%	0.6%
	$10000-$25000	80	0.3%	0.2%	$1,203	3.9%	0.7%
	$25000-$50000	26	0.1%	0.1%	$890	2.9%	0.5%
	$50000+	18	0.1%	0.0%	$1,825	5.9%	1.0%
	Mean (in dollars)				*$1,200*		

* Managed care is defined here as HMO, prepaid health plan, or primary care case management services.

Table 6

Total Medicaid Enrollment and Expenditures for Non-Disabled Adults, MSIS 2001

	Total Expenditures Per Person	Enrollment (thousands)	% of Non-Disabled Adult Enrollment	% of All Enrollment	Total Expenditures (millions)	% of Non-Disabled Adult Expenditures	% of All Expenditures
All	**United States**	**11,492**	**100.0%**	**24.5%**	**$20,039**	**100.0%**	**11.1%**
	$0	1,821	15.8%	3.9%	$0	0.0%	0.0%
	$0-$1000	4,657	40.5%	9.9%	$1,593	7.9%	0.9%
	$1000-$2000	2,151	18.7%	4.6%	$3,057	15.3%	1.7%
	$2000-$5000	1,945	16.9%	4.1%	$6,064	30.3%	3.4%
	$5000-$10000	697	6.1%	1.5%	$4,665	23.3%	2.6%
	$10000-$25000	177	1.5%	0.4%	$2,539	12.7%	1.4%
	$25000-$50000	30	0.3%	0.1%	$1,025	5.1%	0.6%
	$50000+	14	0.1%	0.0%	$1,096	5.5%	0.6%
	Mean (in dollars)				*$1,744*		
With Managed Care*	**United States**	**5,682**	**49.4%**	**12.1%**	**$12,314**	**61.4%**	**6.8%**
	$0	0	0.0%	0.0%	$0	0.0%	0.0%
	$0-$1000	1,960	17.1%	4.2%	$865	4.3%	0.5%
	$1000-$2000	1,833	16.0%	3.9%	$2,601	13.0%	1.4%
	$2000-$5000	1,375	12.0%	2.9%	$4,120	20.6%	2.3%
	$5000-$10000	407	3.5%	0.9%	$2,721	13.6%	1.5%
	$10000-$25000	90	0.8%	0.2%	$1,275	6.4%	0.7%
	$25000-$50000	12	0.1%	0.0%	$402	2.0%	0.2%
	$50000+	4	0.0%	0.0%	$328	1.6%	0.2%
	Mean (in dollars)				*$2,167*		
Without Managed Care	**United States**	**5,811**	**50.6%**	**12.4%**	**$7,725**	**38.6%**	**4.3%**
	$0	1,820	15.8%	3.9%	$0	0.0%	0.0%
	$0-$1000	2,697	23.5%	5.7%	$728	3.6%	0.4%
	$1000-$2000	318	2.8%	0.7%	$455	2.3%	0.3%
	$2000-$5000	571	5.0%	1.2%	$1,944	9.7%	1.1%
	$5000-$10000	290	2.5%	0.6%	$1,943	9.7%	1.1%
	$10000-$25000	86	0.8%	0.2%	$1,264	6.3%	0.7%
	$25000-$50000	18	0.2%	0.0%	$623	3.1%	0.3%
	$50000+	9	0.1%	0.0%	$768	3.8%	0.4%
	Mean (in dollars)				*$1,329*		

* Managed care is defined here as HMO, prepaid health plan, or primary care case management services.

In addition, we examined spending for adults and children based on their full- and part-year enrollment in Medicaid (data not shown). Among children, 55% are full-year enrollees, compared to only 35% among adults. Among these full-year enrollees, average spending is much lower per child ($1,624) than per adult ($2,535). This difference is much higher than the overall averages presented in Tables 5 and 6. Therefore, differences in the length of time enrolled between adults and children obscure a greater difference in spending between adults and children.

Characteristics of High-Cost Enrollees

High-cost enrollees differ on important characteristics when compared to low-cost enrollees. High-cost Medicaid enrollees with over $25,000 in annual spending represent about 4% of all enrollees in 2001 and 49% of all spending. Low-cost enrollees, defined as having less than $5,000 in annual spending, represent 86% of all enrollees and 23% of all spending. Virtually all high-cost enrollees are elderly or disabled – 49% elderly and 43% disabled – and only 3% are non-disabled adults and 5% are non-disabled children (Table 7). High-cost enrollees classified as disabled have the highest average spending per enrollee of $61,794, followed by non-disabled children ($58,157). The elderly high-cost cases may have the lowest average spending because Medicare would cover most hospital and other acute care expenditures for most of these elderly. In contrast, 56% of low-cost enrollees are children.

A little over one third of high-cost enrollees are eligible through cash/1931 categories, a similar proportion as the low-cost enrollees, while another third of high-cost cases are classified for eligibility as "other," compared to only 15% of low-cost cases (Table 7). The "other" high-cost eligibles are virtually all disabled and aged, and include elderly in institutions covered at state option, the working disabled, and both elderly and disabled eligible solely through home and community-based waiver programs. This group is disproportionately high-cost. Among the "other" eligibles, 7.8% are high-cost compared to 3.6% overall.

Table 7

Characteristics of High-Cost and Low-Cost Medicaid Enrollees, 2001

	High-Cost Enrollees (Over $25,000)			Low-Cost Enrollees (Under $5,000)		
	Enrollment	Enrollment Percent	Average Spending per Enrollee	Enrollment	Enrollment Percent	Average Spending per Enrollee
Elderly	848,009	49%	$41,607	3,047,081	8%	$1,387
Disabled	734,097	43%	$61,794	4,060,655	10%	$1,664
Adult	43,923	3%	$48,301	10,574,244	26%	$1,013
Child	87,138	5%	$58,157	22,527,055	56%	$858
Cash	625,113	36%	$56,743	14,091,061	35%	$1,267
Poverty	122,202	7%	$50,035	12,861,528	32%	$844
Medically Needy	342,247	20%	$53,797	2,876,241	7%	$1,027
1115	15,865	1%	$48,976	4,180,648	10%	$697
Other*	607,728	35%	$44,527	6,199,270	15%	$1,040
Less than 21	189,674	11%	$63,273	24,251,593	60%	$887
21-64	657,649	38%	$60,241	12,709,285	32%	$1,183
65+	848,009	49%	$41,607	3,047,081	8%	$1,387
Unknown	17,835	1%	$52,294	201,076	1%	$1,245
Female	1,047,432	61%	$47,444	23,893,102	59%	$1,064
Male	664,864	39%	$57,259	16,204,047	40%	$958
Unknown	871	0%	$80,653	111,886	0%	$715
Hispanic/Latino	93,247	5%	$54,288	8,958,337	22%	$851
Black/Afr. American	296,752	17%	$52,796	10,224,939	25%	$1,024
White	1,113,315	65%	$49,273	16,747,703	42%	$1,082
Other	44,686	3%	$54,175	2,045,654	5%	$1,117
Unknown	165,167	10%	$59,506	2,232,402	6%	$1,131
TOTAL	**1,713,167**	**100%**	**$51,270**	**40,209,035**	**100%**	**$1,020**

Note: Totals do not include individuals with unknown eligibility or ineligibles, or individuals with negative spending.

* There were 299 individuals with known basis of eligibility but unknown MAS that were excluded from the totals in this MAS breakdown.

The medically needy account for 20% of high-cost cases, compared to 7% of low-cost cases (Table 7). Interestingly, this group has lower average spending relative to the cash eligibility group. It is important to note that not all medically needy enrollees have high medical costs. Medically needy programs allow states to cover individuals who are categorically eligible for Medicaid, but who have incomes above traditional limits established for state Medicaid programs. To qualify as medically needy, individuals can report medical expenditures to "spend down" their income to below medically needy income thresholds, which are set above categorical eligibility thresholds. Thus, many who qualify through this category have high medical costs. However, an individual with income above categorical income thresholds but below the medically needy threshold need not have *any* medical expenses to qualify. Thus, some medically needy enrollees can be expected to have spending comparable to low-cost enrollees. Nonetheless, the medically needy are disproportionately high-cost. While 3.6% of enrollees are high-cost overall, 9.3% of the medically needy are high-cost.

The majority of high-cost enrollees are female (61%), comparable to low-cost enrollees who are 59% female. However, the racial/ethnic distribution is very different between high-cost and low-cost cases, with 65% of high-cost cases reported as non-Hispanic White, 17% as Black/African-American, and 5% as Hispanic/Latino. In contrast, 42% of low-cost cases are reported as White non-Hispanic, 25% as Black/African-American, and 22% as Hispanic/Latino. This difference is likely due to a difference in the racial/ethnic distribution within the youngest and oldest age groups: compared to all Medicaid enrollees, a disproportionate share of children, the lowest cost group on average, are Black and Hispanic, while a disproportionate share of the elderly are White/non-Hispanic.

Table 8 shows the distribution of high-cost enrollees as a share of all enrollees in the state and in the U.S. Each state's total enrollment and enrollment as a share of U.S. total enrollment are presented for comparison. Shaded states are those with a disproportionately large share of high-cost enrollees relative to the state's share of all enrollees in Medicaid. In this table, states are considered to have a disproportionately large share of high-cost enrollees when the percentage point difference between a state's share of all high cost Medicaid enrollees and its share of all Medicaid enrollees is greater than 0.2 – one standard deviation above the mean difference. Not surprisingly, all Northeastern states except Vermont have a disproportionately high share of high-cost enrollees in their state relative to the state's share of the Medicaid population. This region has the highest average costs in the private insurance market, and constitutes the region with the highest costs of living. Some of the remaining shaded states, such as North Dakota and Ohio, rely heavily on institutional care to support the long-term care population. Notably, New York accounts for 7.5% of all Medicaid enrollees but 16.4% of all high-cost cases, a disproportionately high share.

Spending by Service among High-cost Enrollees

High-cost enrollees with per beneficiary spending over $25,000 spent a total of $87.8 billion, while low-cost enrollees with per beneficiary spending under $5,000 spent a total of $41.0 billion. Table 9 shows the distribution of spending across services for high-cost and low-cost cases. Nursing home care accounted for the largest share of spending on high-cost cases ($30.9 billion), followed by hospital care ($12.9 billion) and other acute care ($12.0 billion). Overall, 48% of spending for high-cost cases was attributable to long-term institutional care, including care for the mentally retarded and individuals with mental disease; while 16% was attributable to community-based long-term care, including home and community-based waiver services (HCBS) and other home health and personal attendant services not covered by waivers. In contrast, 75% of spending for low-cost enrollees was attributable to acute care services other than hospital care, including physician, outpatient services, and managed care payments, while 16% was for prescription drugs.

The distribution of spending by service for high-cost enrollees varied for the elderly, disabled, non-disabled adults, and non-disabled children (Table 9). Among the elderly, 71% of spending was for nursing home care, and spending for other services was distributed uniformly across other services. Among the disabled, spending was distributed fairly evenly across long term and acute care services. Spending on ICF/MR and institutional care for persons with mental disease was accountable for one-fifth of all spending for the disabled. Among non-disabled adults, hospital care accounted for the majority of spending, while prescription drugs accounted for 8% and other acute care accounted for 18% of spending. Among non-disabled children, spending on ICF/MR and institutional psychiatric care was accountable for 14% of spending, while hospital care accounted for 45% and other acute care accounted for 31%.

Table 8

High Cost Medicaid Enrollees: State Distribution, 2001

State	Number of Enrollees in State	Number of High Cost Enrollees	All Enrollees in State as Share of U.S. Total	High Cost Enrollees as Share of U.S. Total	High Cost Enrollees As Share of State's Enrollment
Total	**46,908,433**	**1,713,167**	**100%**	**100%**	**3.7%**
AK	99,655	4,416	0.2%	0.3%	4.4%
AL	778,218	22,301	1.7%	1.3%	2.9%
AR	550,320	14,131	1.2%	0.8%	2.6%
AZ	808,132	27,670	1.7%	1.6%	3.4%
CA	8,526,417	147,464	18.2%	8.6%	1.7%
CO	410,306	19,544	0.9%	1.1%	4.8%
CT	443,530	32,025	0.9%	1.9%	7.2%
DC	152,406	7,885	0.3%	0.5%	5.2%
DE	133,047	4,745	0.3%	0.3%	3.6%
FL	2,432,335	74,972	5.2%	4.4%	3.1%
GA	1,327,248	31,763	2.8%	1.9%	2.4%
HI	189,529	3,983	0.4%	0.2%	2.1%
IA	330,236	17,310	0.7%	1.0%	5.2%
ID	172,243	7,427	0.4%	0.4%	4.3%
IL	1,796,315	73,333	3.8%	4.3%	4.1%
IN	824,298	39,512	1.8%	2.3%	4.8%
KS	280,125	16,766	0.6%	1.0%	6.0%
KY	760,488	26,963	1.6%	1.6%	3.5%
LA	879,065	29,048	1.9%	1.7%	3.3%
MA	1,124,100	59,162	2.4%	3.5%	5.3%
MD	702,730	36,719	1.5%	2.1%	5.2%
ME	277,058	15,053	0.6%	0.9%	5.4%
MI	1,429,640	31,225	3.0%	1.8%	2.2%
MN	657,399	40,698	1.4%	2.4%	6.2%
MO	1,030,989	37,198	2.2%	2.2%	3.6%
MS	676,842	19,828	1.4%	1.2%	2.9%
MT	101,722	5,364	0.2%	0.3%	5.3%
NC	1,375,108	53,665	2.9%	3.1%	3.9%
ND	65,219	5,256	0.1%	0.3%	8.1%
NE	248,679	10,333	0.5%	0.6%	4.2%
NH	108,418	8,885	0.2%	0.5%	8.2%
NJ	921,957	54,746	2.0%	3.2%	5.9%
NM	423,402	9,774	0.9%	0.6%	2.3%
NV	166,979	5,058	0.4%	0.3%	3.0%
NY	3,521,765	280,833	7.5%	16.4%	8.0%
OH	1,650,712	88,289	3.5%	5.2%	5.3%
OK	676,868	20,685	1.4%	1.2%	3.1%
OR	594,219	10,003	1.3%	0.6%	1.7%
PA	1,645,703	67,396	3.5%	3.9%	4.1%
RI	193,089	11,745	0.4%	0.7%	6.1%
SC	871,631	22,320	1.9%	1.3%	2.6%
SD	106,130	5,038	0.2%	0.3%	4.7%
TN	1,580,778	19,956	3.4%	1.2%	1.3%
TX	2,723,764	83,806	5.8%	4.9%	3.1%
UT	214,347	6,473	0.5%	0.4%	3.0%
VA	700,032	25,715	1.5%	1.5%	3.7%
VT	151,891	5,232	0.3%	0.3%	3.4%
WA	1,000,307	18,263	2.1%	1.1%	1.8%
WI	664,148	36,741	1.4%	2.1%	5.5%
WV	351,103	13,724	0.7%	0.8%	3.9%
WY	57,791	2,726	0.1%	0.2%	4.7%

Source: Estimates based on Urban Institute calculations on MSIS 2001 Summary File.

Note: Totals do not include individuals with unknown eligibility, or individuals with negative spending. High cost cases defined as Medicaid spending >$25,000 in FFY 2001. Shaded states denote a share of high-cost cases disproportionately high (>0.2 percentage point difference or one standard deviation) relative to the state's share of total enrollment.

Table 9

Medicaid Spending for High Cost and Low Cost Enrollees - Column Percents

Service Groups	Total				Elderly				Disabled			
	High Cost		Low Cost		High Cost		Low Cost		High Cost		Low Cost	
	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent
Total Medicaid Spending	**$87,835**	**100%**	**$41,024**	**100%**	**$35,283**	**100%**	**$4,226**	**100%**	**$45,362**	**100%**	**$6,757**	**100%**
Nursing Home	$30,888	35%	$181	0%	$25,083	71%	$167	4%	$5,733	13%	$12	0%
ICFMR/Mental Health*	$11,031	13%	$18	0%	$1,091	3%	$1	0%	$9,236	20%	$5	0%
HCBS	$9,065	10%	$125	0%	$1,044	3%	$75	2%	$7,742	17%	$45	1%
Other Community Long-Term Care**	$5,322	6%	$666	2%	$2,111	6%	$127	3%	$2,930	6%	$205	3%
Hospital	$12,902	15%	$2,892	7%	$1,362	4%	$216	5%	$8,020	18%	$204	3%
Drugs	$6,649	8%	$6,574	16%	$2,436	7%	$2,108	50%	$3,833	8%	$2,202	33%
Other Acute Care***	$11,978	14%	$30,567	75%	$2,156	6%	$1,531	36%	$7,869	17%	$4,085	60%

Service Groups	Non-Disabled Adults				Non-Disabled Children			
	High Cost		Low Cost		High Cost		Low Cost	
	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent	Spending (in millions)	Percent
Total Medicaid Spending	**$2,122**	**100%**	**$10,714**	**100%**	**$5,068**	**100%**	**$19,327**	**100%**
Nursing Home	$28	1%	$1	0%	$43	1%	$1	0%
ICFMR/Mental Health*	$15	1%	$1	0%	$689	14%	$12	0%
HCBS	$216	10%	$2	0%	$65	1%	$3	0%
Other Community Long-Term Care**	$38	2%	$34	0%	$243	5%	$300	2%
Hospital	$1,265	60%	$1,284	12%	$2,255	45%	$1,188	6%
Drugs	$169	8%	$887	8%	$211	4%	$1,377	7%
Other Acute Care***	$391	18%	$8,505	79%	$1,562	31%	$16,447	85%

High cost is defined as those spending more than $25,000 and low cost is defined as those spending less than $5,000.

Note: Totals do not include individuals with unknown eligibility or ineligibles, or individuals with negative spending.

* ICFMR/Mental Health includes intermediate care facility services for the mentally retarded, services in institutions for mental disease for the elderly, and inpatient psychiatric care for children under age 21.

** Other Community Long-Term Care includes home health, personal care, hospice, targeted case management, and private duty nursing.

*** Other Acute Care services include physician, outpatient, clinic, lab and x-ray, HMO, prepaid health plan, primary care case management, nurse practitioner, dental, and other practitioners, rehabilitation, and other therapies, and transportation.

Conclusion

This analysis demonstrates that fewer than 5% of Medicaid enrollees spent more than $25,000 in 2001 but these 1.7 million enrollees accounted for nearly half of all spending in Medicaid. For all four major population groups served by Medicaid – the elderly, disabled, and non-disabled adults and children – a small share of enrollees in each group account for a very large share of spending. Otherwise, most Medicaid enrollees are low-cost. More than half of all enrollees had spending of less than $1,000, and 86% had less than $5,000. This very skewed distribution in spending among enrollees suggests an opportunity for controlling Medicaid expenditures by developing cost containment strategies focused on a small group of high-cost individuals. The challenge is to promote strategies for cost containment that continue to provide an appropriate level of care for those most in need. Although research has demonstrated that it is less expensive to provide care to the non-disabled population through Medicaid rather than through the private market,[13] caring for many high-cost users has been the primary responsibility of Medicaid, especially those who are institutionalized or have severe disability. Therefore, it is more difficult to assess what the "appropriate" level of spending is for such high-cost users.

High-cost enrollees are primarily elderly and disabled, but otherwise appear to be a heterogeneous group in terms of their eligibility categories and demographics. A number of states have a disproportionate share of high costs enrollees, including states in the Northeast where health care costs are higher and states that rely heavily on institutional care. While individuals qualifying through medically needy categories are perceived to be high-cost, and they do account for 20% of high-cost cases, not all medically needy are high-cost. Similarly, some disabled enrollees appear to have low annual costs. The corollary to these findings is that there may be some individuals with high medical expenses that cannot be identified here because the bulk of expenses are incurred in Medicare. Since the first step to developing intervention strategies for any high-cost group is identification of those at risk of incurring high costs prospectively,

capacity to track and link overall Medicaid and Medicare costs for individuals dually eligible should be developed. Special needs managed care plans established through the Medicare Modernization Act that are expected to serve the dually eligible could provide information systems for compiling such data.

Spending distributions among high-cost enrollees exhibit different service use patterns by eligibility group, suggesting that spending patterns may be a function of different cost drivers, and intervention strategies for the elderly, disabled, adults, and children would need to vary. The broad distribution of spending for the high-cost disabled suggests that interventions would require assessment of service use in integrated care settings. Some high-cost enrollees who incur costs episodically through hospital admissions may be difficult to identify prospectively, while others served in long-term care settings, such as ICF/MR and nursing homes may be more suitable for prospective identification.

The data we use do not track specific medical diagnoses, or identify specific providers. Further analysis is best conducted by states using more detailed claims data to identify potential interventions appropriate within a state based on its program and delivery structure. Because managed care capitation arrangements obscure actual costs across enrollees of managed care plans, some high-cost users can only be identified by managed care plans. Special needs plans under Medicare Part D will provide an opportunity to further understand service use patterns among high-cost users within managed care settings. However, reduced spending for high-cost users in managed care will only translate into savings to the Medicaid program if capitation rates are adjusted to reflect such savings.

Our analysis shows that fewer than 5% of enrollees account for almost half of all Medicaid spending, or about $88 billion. Achieving savings for this group may be difficult due to their complex health needs. The amount of savings that could be achieved through a combination of care coordination, reduced emphasis on institutionalization, and reductions in service duplication over the long run has not yet been enumerated. Studies on cost savings associated with state-based disease management programs in Medicaid show promise but are so far inconclusive.[14] Given that the private insurance market has also faced dramatic increases in costs, fundamental changes that reshape delivery systems, and reform or integrate financing strategies across markets may be required to achieve long-run Medicaid cost containment. Regardless, because spending in the program is so skewed, strategies that focus on providing more appropriate and efficient care to high cost cases may hold the greatest potential for reigning in long-run Medicaid cost growth without adversely affecting access to necessary and appropriate care.

Endnotes

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[11] Enrollees are identified as recipients of managed care based on having positive expenditures for HMO, PHP, or PCCM service categories. A handful of enrollees have positive spending in these categories but zero spending across all service categories when expenditures are summed. They are included as managed care recipients nonetheless.

[12] Note that due to rounding, the percentages and amounts used in text of the report may not match those the reader may calculate using data presented in tables.

[13] Hadley and Holahan, 2004.

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1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

PACE—Program of All-Inclusive Services for the Elderly

PACE is a national program that is the most closely integrated plan available. Enrollees, who must be certified as needing a nursing home level of care, receive care from PACE employees—from physicians to home care workers. Adult day health care is central to the provision of all non-home-care services in the program. The number of participants per site is around 150-200.

PACE sites receive a capitated monthly Medicaid and Medicare payment, set at a percentage below the total cost of care for nursing facility residents. After enrolling, PACE members' costs tend to be lower than the capitation rate.

Hospitalization rates for PACE enrollees, who are nursing home certifiable, are lower than those for the average Medicare population, a group much *less* ill and disabled than PACE enrollees.

Compared to qualified people with high functional impairment who declined to enroll in PACE, enrollees of similar impairment levels had:

- 83% fewer hospital days, and
- 76% fewer nursing home days.

Discussion

Around the United States, there are a number of programs designed to improve care provided to aged, blind, and disabled Medicaid beneficiaries. For those who are also Medicare beneficiaries (dual eligibles) this requires an extra level of coordination if services are not provided by a single health plan certified by both programs.

Integrating the various types of services needed by people with chronic diseases, disabilities, and functional impairments is a major step in improving care to this population. Physician and hospital care must be coordinated with the personal assistance and home nursing provided if providers are to have a full picture of the person's needs and changes in condition.

Intuitively, it might seem that this should *increase* costs. It appears, however, that integration can help *control* or even *decrease* costs through a number of positive outcomes, particularly:

1. Decreased use of hospital care due to earlier intervention and improved monitoring.
2. Decreased use of nursing homes due to better supportive services to compensate for functional impairments, as well as better medical care that prevents some deterioration.

Integrating Medicare and Medicaid further improves the quality of care and the financial benefits of integration. This enables capturing savings from better management of medical care paid for by Medicare to help provide enhanced Medicaid-paid supportive services and long term care.

It does take a long time to develop integrated systems, however. Six to eight years appears to be the average for state-initiated programs. It will take even longer in California, where county participation is optional and county-designed projects require intensive stakeholder involvement. The investment California is making in integration is very likely to yield very positive results once the programs reach maturity.

California Center for Long Term Care Integration
Andrus Gerontology Center, GER-306
University of Southern California
Los Angeles, CA 90089-0191

Phone: 213/821-5340 Fax: 213/821-5560
Web: www.ltci.ucla.edu
Funded by: CA DHS Office of Long Term Care

Minnesota Senior and Disabled Health Options

Minnesota Senior Health Options (MSHO) is one of only two state-level integrated programs that includes both Medicaid and Medicare payment and services. MSHO has been sufficiently successful that it was recently expanded into a new program called Minnesota Disability Health Options which does not require dual eligibility. The program is available in the Twin Cities and a number of other counties. Three health plans won contracts to implement the program. There were almost 5,000 enrollees as of January 2003; the program has been growing by about 1,000 enrollees a year since 1998. Almost 2/3 of enrollees are in nursing homes, but this number and the proportion are decreasing. 16% are nursing-home-certifiable community residents.

Member satisfaction has been very high. For example, 94% would recommend their care coordinator. 90% of MDHO enrollees feel their care has improved since joining the program.

Outcome evaluations have not yet been published for either program. When they have, we will update this issue brief. One must assume that outcomes have been positive, since both CMS and the state have approved expansion of the program.

Wisconsin Partnership

Wisconsin Partnership is the other state-level program that integrates Medicare and Medicaid. The program serves aged and disabled members who are sufficiently ill or disabled to be at a nursing-home certifiable level of care. Only 3% are in nursing homes and 16% live in a supportive residential care setting. They average over eight chronic health conditions, three functional limitations, and seven medications. The program was designed to build on the PACE model, but give members more choice in medical provider and not require attendance at an adult day health center. Rather than being added to existing health plans, the program was implemented by nonprofit community organizations.

Adding Medicare to the initial capitation of only Medicaid improved financial performance substantially.

Positive results include:

- Halving the increase in pharmacy expense experienced nationally.
- About 25% the rate of nursing home admissions compared to Community Options Program members, who are also nursing home certifiable.

Florida Community Diversion Program

- Florida's capitated Medicaid program for nursing home certifiable people serves a very disabled population. About 63% of participants need assistance with four or more activities of daily living. Another 28% need daily nursing care because of chronic conditions.
- Each contracting managed care health plan chooses their own care management approach—skill set of care managers, caseload, location, etc. Contractors also develop their own provider networks. Units of service provided varied substantially by contractor.
- Health plans did not release cost information to evaluators.
- Contractors felt that lack of Medicare integration was a care coordination problem, since they did not have access to medical records.
- Participants had almost twice as many functional impairments as traditional waiver programs for the nursing home certifiable population (4.5 vs. 3 impairments), as well as higher prevalence of dementia, lung disease, and incontinence.
- Compared to people in nursing homes, the savings were at least $10,285 per year (depending on region) per member, or $902 per member per month.

Texas STAR+Plus

Texas STAR+Plus mandates enrollment of the entire aged, blind, and disabled Medicaid population of Harris County (Houston area); around 55,000 people. Those needing ongoing long term care services constitute 25% of enrollees. A care manager must authorize provision of any long term care services, such as in-home care, adult day health, or nursing home placement. The program includes all Medicaid medical and supportive services, paying a fixed amount per person per month, contracting with commercial managed care plans.

The independent evaluation of the program's first two years of operation, February 2000 to January 2002, found:

- Cost savings of about $93 per member per month. This was a 17% savings over the expected results had the program not been implemented.
- Lower rate of inpatient hospital use compared to the rate for this population preceding the program's implementation (290.3 discharges per 1,000 member months vs. 329.7 under the Medicaid FFS system)
- Average length of stay (ALOS) for inpatient hospital care dropped over the two-year period from 6.73 to 6.08 days. Under FFS Medicaid ALOS was 7.39 days.
- In addition to positive economic results, there was high consumer satisfaction. They also found improved quality of care in some dimensions, such as more appropriate use of antidepressants and other effective interventions.

Arizona Long Term Care System (ALTCS)

ALTCS enrolls aged, blind, and disabled Medicaid eligibles who are either in nursing homes or at risk of nursing home placement; 38% developmentally disabled and 62% aged or physically disabled. From 1989 to 2001 the enrolled population grew from 10,000 to 32,000. During the period, the proportion of people in institutions changed from 95% to 50%. The number of individuals in institutions remained static, while the number receiving home and community-based services increased.

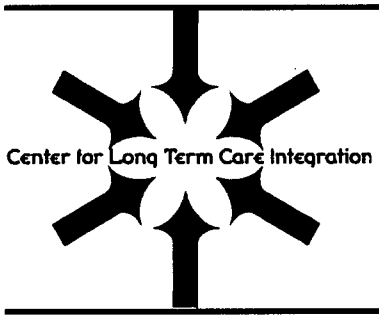
Select outcomes of the program for the period 1989 to 1998 include:

- Reduced hospital average length of stay from 7 to 5 days.
- Increased HCBS placement from 5% to 42%
- Nursing home expenditures per member per month decreased from $1,424 to $1,110
- Overall medical savings of $166 per member per month
- Overall savings 16% over traditional Medicaid for the population.

Wisconsin Family Care

Wisconsin Family Care, which capitates long term care (LTC) and some medical care (home health nursing and therapy), reported a savings in 2001 of $198 per member per month over the fee-for-service, waiver, nursing home, and residential care package its clients would have used otherwise.

- Aging and Disability Resource Centers provide information, assistance, assessment, physical/mental eligibility determination, and short-term care planning and management
- Care Management Organization (CMO) receives a capitated payment to purchase care for their clients, contracting with providers.
- The CMO provides interdisciplinary case management - RN & social worker at minimum
- The services under capitation include: (1) Long Term Care Services, such as adult day health, home modifications, meals, and supportive home care, and (2) Health Services: Therapy, home health, mental health, skilled nursing. Some providers are under a capitated contract and others are fee for service.
- Enrollment as of 12/31/2002 was 6,966 (5,283 aged 65+).



Policy Issue Brief #2:

Cost Savings in Integrated Long Term Care Systems

Introduction

Creating an integrated care system for Medicaid-eligible aged, blind, and disabled people is a long and arduous process. The experience of other states' pilot programs shows that it takes about six to eight years to determine feasibility, design the program, negotiate waivers with CMS, negotiate contracts, and begin enrolling consumers. Is it worth the investment in time and money to create such a system?

The experience of Texas, Wisconsin, Minnesota, Arizona, and other states indicates that the answer to that question is a resounding, "YES!" These innovative programs have produced impressive results—improving care while saving Medicaid dollars.

This issue brief presents some of the findings from evaluations of capitated programs covering Medicaid long term care services and at least some medical services. Most include only Medicaid-covered services, but some have also included Medicare.

Integrating What? Integration Programs Around the US

	Medicaid LTC	Medicaid Acute	Medicare	Population	Enrollment	Medicaid Savings
AZ LTC System	Capitated	Capitated	FFS	ABD	Mandatory	$166 (16%) PMPM
FL Community Diversion	Capitated	Capitated	FFS	NHC	Voluntary	$800+ PMPM vs. SNF
MN Senior Health Options	Capitated	Capitated	Capitated	Dual Eligibles	Voluntary	N/A
PACE	Capitated	Capitated	Capitated	NHC	Voluntary	5-15% mostly to Medicare
TX STAR+Plus	Capitated	Capitated	FFS	ABD	Mandatory	$91 PMPM (17%)
WI Family Care	Capitated	Mostly FFS	FFS	At risk	Voluntary	$198 PMPM
WI Partnership	Capitated	Capitated	Capitated	NHC	Voluntary	No info yet

Capitated = Paid a fixed monthly amount per member
LTC = Long term care
PMPM = Per member per month
FFS = Fee for service
NHC = Nursing home certifiable
ABD = Aged, blind, or disabled Medicaid beneficiary
Savings = **Medicaid**; compared to expected or actual costs for a comparable population.

Proposed Recommendations –
Subcommittee on Mentally Ill Residents of Adult Care Facilities

The Subcommittee on Mentally Ill Residents of Adult Care Facilities met on October 11, November 14 and December 12, 2006, hearing from representatives of government agencies, private organizations, and providers on issues relating to North Carolinians with mental illness residing in adult care facilities. The Subcommittee considered the information they were given and made the following recommendations for consideration and adoption by the Commission on Aging and the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

The Subcommittee on Mentally Ill Residents of Adult Care Facilities recommends that the General Assembly:

1. Appropriate funds to the Department of Health and Human Services and the Housing Finance Agency to increase the stock of current housing options available to North Carolinians with mental illness (including independent living units, supported housing units and group homes).
2. Support Department of Health and Human Services and Housing Finance Agency efforts to develop new options for housing for North Carolinians with mental illness that are appropriate for and meet their needs.
3. Support the development of a "Transitional Residential Treatment Program" to provide 24-hour residential treatment and rehabilitation for adults who have a pattern of difficult behaviors, related to mental illness, which exceed the capabilities of traditional community residential settings.
4. Authorize the Commission on Aging and the Legislative Oversight Committee on MH/DD/SAS to explore the need for the General Assembly to enact statutes authorizing rules to regulate facilities that provide housing for adults with mental illness in the same location with adults without mental illness. Rules authorized shall address at least the following issues: housing of individuals with mental illness in the same bedroom or area of a facility with individuals without mental illness and training of staff to provide care appropriate to each individual resident's needs with specific training addressing the needs of persons with mental illness.
5. Support ongoing efforts to develop a Uniform Screening Tool that would include the requirement that the Department of Health and Human Services notify Local Management Entities (LMEs) of the mental illness status of any individual admitted to an adult care home facility within the LME's catchment area. The Department of Health and Human Services shall specify which Division will be responsible for providing the notification and what resources will be required to accomplish the notification.
6. Authorize the Department of Health and Human Services to use funds appropriated for fiscal year 2007-2008 to increase the number of participants in the State/County Special Assistance In-Home Program for Adults to 2,000 persons.

December 13, 2006

To: The Aging Study Commission Members

From: Lou Wilson and Roger Bone

Re: Joint Adult care Home and Mentally Ill Issues

We are very disappointed with the recommendations from the Joint Committee regarding the mentally ill population in adult care homes. While we support the expansion for consumers having options and choice we can no longer continue to ignore more than 8,000 people who are mentally ill and/or developmentally disabled who currently live in adult care homes or the challenges faced by facilities in providing services to the consumers.

A report commissioned by the Department in 2004 found that over 40% of the adult care home population carried an active diagnosis of mental illness. (Adult Care Home Mental Health Needs Assessment Report of Findings, First Health, July 15, 2004).

Adult care homes are part of North Carolina's Home and Community Based Services program. This subject is not an either/or situation in terms of the residential settings – all settings are viable.

People who are mentally ill and live in adult care homes should be treated as they would if they lived in any other setting. Federal law protects their rights to such treatment. They should:

- make their own choices with regard to living arrangements
- receive the services and supports they need to live successfully in the setting of their choice

Therefore, please consider the following recommendations:

1) Staff training-Training is most important for monitoring behavior changes and responding with appropriate interventions when dealing with challenging behaviors exhibited by some residents with mental illness.

The current training requirements for direct care staff, including aides and supervisors, in adult care homes are focused primarily on personal care with little emphasis on training related to the additional skills that are needed to care for residents who also have cognitive impairment and/or mental illness.

Recommendation: require rules to assure that all direct care staff are trained appropriately to meet the needs of the mentally ill population living in the facilities.

2) Services-The types of mental health services that are often needed by some residents in long term care settings includes: evaluation and assessment of residents who are exhibiting behaviors that appear to be related to mental illness; development of person centered plans that include consideration of each individual's needs for a wide range of services or supports; and provision of ongoing treatment and rehabilitative services, and cooperation and support for others who are providing service and support for the individual.

Recommendation: Changes in the law to assure " Right to Treatment" for mentally ill persons living in adult care homes similar to Article 3- GS 122C which applies only to persons living in Home and Community Based group Homes.

3) Licensure-

Recommendation: require new rules for any facility who houses more than three mentally ill persons and require the home's license to be designated as a community residential setting and contracts for appropriate mental health services from a mental health professional.

Thank you for your assistance.

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — January 3, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stacy Flannery	NCHCFA
[illegible]	[illegible] Assoc.
Evelyn Hawthorne	EHGR
Ann Eller	DHHS
Josh McKeg	Governor's
Bob Konrad	NC - Institute on Aging
Kathryn Wassill	NC - Inst. on Aging
Jon Morgan	NC - Inst. on Aging
Chuck Stone	SEANC / NCAHC
Rosanne Bragg-Cook	NCAOA

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — January 3, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Polly Williams	NC Justice Center / Triangle Oak
Marjorie Morris	Division of Medical Assistance
Charlotte Gibbons	Division of Medical Assistance
Suzanne Merrill	DAAS
Emily Saunders	DAAS
[illegible]	[illegible] group
John Singleton	"
[illegible]	"
[illegible]	"
James Hopkins	"

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — January 3, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jerry Cooper	NCALA
Mary Edwards	DAAS
Jeff Horton	DHHS-DFS
Melanie Rash Williams	NCCPPR
Dennis Streets	DHHS-DAAS
Glenda Artis	DHHS-DAAS
Angela Floyd	DHHS-DMA
TRACY COLVARD	DHHS-DMA
Bill Wilson	AARP
Mary Bettel	AARP
ANTHONY ALVARADO	NCAGE

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — January 3, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	[illegible]
[illegible]	HHS
Jim Edge	DHHC
Caroline Lee	Wake County Human Services

December 14, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be three meetings of the NC Study Commission on Aging during January.

DAY:	Wednesday	TIME:	9:30 AM
DATE:	January 3, 2007		
LOCATION:	Room 643 Legislative Office Building		

DAY:	Tuesday	TIME:	10:00 AM
DATES:	January 9, 2007 & January 23, 2007		
LOCATION:	Room 643 Legislative Office Building		

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Tuesday, January 9, 2007
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Recommendations from the House Study Committee on State Guardianship Laws

Drupti Chauhan, Erika Churchill, and Wendy Graf Ray, House Study Committee on State Guardianship Laws Staff, Research Division, NCGA

III. Draft Recommendations for Commission Consideration

Theresa Matula, Commission Staff, Research Division, NCGA

IV. Discussion and Vote on Recommendations

Instruction to Staff to Prepare Report for 2007

V. Approval of Minutes

VI. Meeting Adjourned

Next Meeting:
January 23, 2007 at 10:00 a.m.
Room 643

NORTH CAROLINA STUDY COMMISSION ON AGING

JANUARY 9, 2007
MINUTES
10: AM
ROOM 643

The meeting was opened by Representative Beverly Earle at 10:15 am in Room 643 of the Legislative Office Building. Representative Beverly Earle asked for a moment of silence for two legislative members of the General Assembly, Senator Robert Holloman and Representative Howard Hunter.

The following members were present:

Representative Beverly Earle	Senator Charlie Dannelly
Representative Jennifer Weiss	Senator Stan Bingham
Representative Alice Bordsen	Senator Katie Dorsett
Representative Bob England	Senator Austin Allran
Ms. Florence Solyts	Ms. Regina Fisher
Ms. Judy Pelt	Mr. Sam Marsh
Shawn Parker, Staff	Theresa Matula, Staff
Ben Popkin, Staff	Mr. Jackie Sheppard

Rep Earle asked for the first presenter Ms. Wendy Ray, to come before the committee to discuss the recommendation. The House Study Committee on the State Guardianship Laws was established by the Speaker of the House of Representatives. The committee consists of 16 members appointed by the Speaker of the House. Nine recommendation were presented to the committee:

1. The committee recommends that the terminology used in the statues should be changed from "incompetent adult" to "incapacitated person" and the definition should be amended to base the determination of incompetence or incapacity on the person's functional abilities. This would allow guardianships to be tailored to

the individual's needs and facilitate the use of limited guardianships where appropriate.

2. The committee recommends that the statutes be amended to add more detailed provisions setting out the powers, duties, and liabilities of guardians of the person.
3. The committee recommends that the General Assembly appropriate funds to cover guardianship services provided by county departments of social services, Local Management Entities (LMEs), local health departments, and county departments on aging, and to cover essential legal and medical consultation.
4. The committee recommends that independent counsel be provided to represent the respondent when there is a conflict between what the respondent wants and what the guardian ad litem feels is in the respondent's best interest.
5. The committee recommends that clerks of superior court be granted the authority to order law enforcement officers to transport alleged incompetents to necessary locations where the multi-disciplinary evaluation will be performed if the alleged incompetent refuses to attend on their own.
6. The committee recommends that the total amount of personal property that can be sold without a court order be increased to $15,000.00
7. The committee recommends that the Division of Motor Vehicles be authorized to not automatically revoke a driver's license of an incompetent, if the clerk of superior court recommends the incompetent be allowed to retain the driver's license.
8. The committee recommends that training be provided to all individuals involved in guardianship, including the guardian's ad litem of alleged incompetents.
9. The committee recommends the creation of a joint legislative study committee on state guardianship laws comprised of both members and appointees of the House of Representatives and the Senate.

(For Recommendations and Findings see attachment II)

Ms. Theresa Matula, Staff presented to the committee an overview of draft recommendations. Here are the topics for the recommendations. For full details of the recommendations see attachment III.

1. Support Senior Centers
2. Expand Dental Care for Special Care Populations
3. Expand Health Care Personnel Registry/Funds
4. Support Project C.A.R.E.
5. Additional HCCBG Funds
6. Amend the Penalty Review Committee
7. Study Safe Transportation of Passengers in Wheelchairs

8. Adult Protective Services Pilot Program
9. Study Medically Needy Income Standard
10. Support for NC Rx
11. Funds for Mentally Ill Housing Options
12. Study Housing Concerns and Staff Training Required for Mixed Populations
13. Increase SA In-Home Slots
14. Support for the Transitional Residential Treatment Program and for LME Notification of Mental Health Determination Using the Uniform Screening Tool
15. Authorize Star-Rated Certification Rules
16. Funds for WIN A STEP UP
17. Support Recommendations from the House Study Committee on State Guardianship Laws.

There were some changes to be made to six of the recommendations presented to the committee. At this time a motion was made by Representative Alice Bordsen. She made a motion was to accept the recommendations subject to changes to be made, and to accept the recommendation from the Guardianship Study Committee. The motion was seconded by the committee.

The meeting adjourned at 12:50 pm.

Beverly Earle

Representative Beverly Earle, Presiding

Ann Raeford

Ann Raeford, Committee Assistant

Attachments

Attachment I	Agenda
Attachment II	House Study Committee on State Guardianship Laws
Attachment III	Overview Draft Recommendations Study Commission on Aging
Attachment IV	Visitor's Registration

Final 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 30, 2005

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

Final Report on Geriatric Mental Health Specialty Teams

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 final report provides a summary of the Division's efforts to meet the requirements described within S.B. 1148.

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 21 community-based Geriatric Mental Health Specialty Teams. Nine of the teams serve multiple counties. These teams are available to provide support, training, and consultation to long term care facilities and other organizations throughout the State. In as much as the creation of the specialty teams represented a new approach to serving elderly persons with mental illness, the Division has standardized 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, caregivers and other agencies 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 support, training and consultation to the staff serving the identified individuals and developing linkages with community providers serving older individuals.

Each team consists of a registered nurse and a masters prepared therapist. The teams operate on an itinerant basis and thus provide the majority of services to the staff 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 or caregiver in the transition of individuals from a State hospital to a long term care facility or other community setting;
- provide consultation to staff or caregiver in identifying and addressing issues that may threaten successful community placement;
- provide crisis-oriented support, either face-to-face or via telephone to the agency staff or caregiver during normal business hours;
- provide individual case consultation to staff of long term care facilities or caregiver regarding behaviors that may result in hospitalization or a need for more intensive services;
- provide training to staff or caregiver on the development and implementation of intervention plans as needed;
- train facility staff, caregivers and other agencies 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 and caregiver.

* 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.

As a means of monitoring the activities of the Geriatric Teams, each team is required to submit to the Division a quarterly activity report.

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 hours of individual case consultations with facility staff; 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.

During fiscal year 2004-2005 the Geriatric Specialty Teams provided a total of 2,230 hours of hospital discharge planning; 2,720 hours of training to staff of long term care facilities; 3,703 hours of individual case consultations with facility staff; 7,721 hours of technical assistance and program development and 4,271 hours of community development and education. These services were provided to 209 nursing facilities; 356 adult care homes; 220 human service agencies; 56 local hospitals and 27 private medical facilities. This increased level of services reflects the fact that the teams have become better known in their communities resulting in more requests for their services from long term care facilities and agencies that serve older adults.

As the purpose of the teams is to support the staff providing services to the individuals residing in the long term care facility or family home, the Geriatric Specialty Teams do not track the number of individuals served. The teams do track the hours spent training staff and the hours spent providing case consultation to staff regarding a specific individual the staff is serving. Beginning in SFY2006, the teams will be tracking both the hours spent in case consultations and the number of individuals for which consultation is provided.

The Geriatric Specialty Teams and LME staff meet on a quarterly basis in each region with a representative from the Division. The focus of these meetings has been to discuss the purpose of the teams in order to ensure team consistency throughout the state. The meetings also have offered an opportunity for training on topics pertinent to the participants. The team members use this meeting to share ideas on needed training for team members and to discuss success stories and barriers.

A survey of 37 team members was conducted in FY 04-05 to obtain information about the experience and training the team members have had regarding working with older persons with mental illnesses. All 37 team members had at least 3 years experience and appropriate training to work with this population. Of the 37 team members who were surveyed, 31 had over 5 years experience and 15 of these had over 15 years experience.

In FY 05-06, all of the Geriatric Specialty Team funding has been allocated to the LMEs on a recurring basis with reimbursement based on expenditures. The actual expenditures are currently being tracked and will be available for FY 05-06.

Standardization Activities

The Department was required by SB 1148 to develop and implement a standardized screening and referral process for the Geriatric Specialty Teams which addressed issues of service orders and authorization. The Division assessed the operation of the Geriatric Specialty Teams and reviewed service provision and funding needs. Funds were identified in SFY 04-05 and allocated in SFY 05-06 from within Mental Health Block Grant resources available to the Division to fully support each approved position for the Geriatric Specialty Teams. As a result, the need for a screening and referral process, forms, service orders or authorizations that had been needed to provide billable services have been eliminated. In the event that an individual residing at a long term care facility or family home requires mental health service, the Geriatric Specialty Team will make the referral to the appropriate LME.

Geriatric Specialty Team Study Committee

SB 1148 called 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 was formed. The committee first convened on October 28, 2004. Study committee members included representatives of the following interests: nursing homes, adult care homes, area programs, persons with mental illness, Division of Aging and Adult Services, Friends of Residents in Long Term Care and the Division of MHDDSAS. Through this study, consideration was 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.

At its initial meeting, the study committee agreed that a review of demographic and service information was necessary before meaningful study or recommendations could be achieved. Specifically, the committee requested the following data:

1) a roster of Geriatric Mental Health Specialty Team service areas including the number of people served and the facilities served by type (nursing home, family care home, or adult care home);
2) a list of Local Management Entities including phone numbers and a contact persons;
3) a summary of long term care facility information including number of facilities and number of beds by type and by county;
4) a summary of mental health diagnostic information from the adult care home licensure renewal applications; and
5) a summary of completed Geriatric Specialty Team Non-Unit Cost Reimbursement (Non-UCR) Activity Reports.

In addition, the study committee requested qualitative information about the work and challenges of the Geriatric Mental Health Specialty Teams.

In response, DMHDDSAS staff presented the requested service and demographic data during the November 29, 2004 Study Committee meeting. Also, representatives from three Geriatric Mental Health Specialty Teams serving both urban and rural geographic areas gave a presentation on the operations of their teams, including challenges as well as successes.

After reviewing and discussing the data and considering the information provided by the Geriatric Specialty Team members, the study committee made the following recommendations:

1. The mission of the Geriatric Mental Health Specialty Teams should remain unchanged as originally established with their specific focus on improving care for older adults with mental illness who are being reintegrated into the community when they are discharged from State psychiatric hospitals and on providing training and technical assistance to nursing homes, adult care homes, caregivers and other agencies that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization.

2. The Geriatric Mental Health Specialty Teams should continue to operate and be administered through their Local Management Entities as originally established.

3. Each Team should be fully funded with 100% non-UCR funds. The rationale for such funding took into consideration that teams were funded at 80% requiring them to supplement funding through billable direct client services. Often the provision of direct client billable services reduced team availability to provide community capacity building activities such as education, training and technical assistance. As a result, beginning with FY 05-06, the teams are funded at 100%. The teams no longer need or are required to provide direct client services.

4. The study committee was concerned about the inappropriate placement of some mentally ill persons under the age of 60 in long term care facilities. The committee, therefore, recommended continued study and consideration of creating Long Term Care Mental Health Specialty Teams for non-geriatric persons as part of the requirements of HB 1414 Section 10.2. (a) "Study Issues Related to Mentally Ill Residents of Long-Term Care facilities." The HB 1414 study committee recommended a pre-admission screening and assessment that will have the capacity to identify whether individuals are appropriate for a long term care setting. In addition, that committee recommended that potential funding for the development of long term care specialty teams be explored. The purpose of those teams would be to provide training and technical assistance to facilities that serve younger adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization.

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

December 13, 2006

The Honorable Charlie Dannelly, Co-Chair
North Carolina Study Commission on Aging
North Carolina General Assembly
Room 2010, Legislative Building
Raleigh, NC 27601

Dear Senator Dannelly :

Session Law 2006-110 directed the Department of Health and Human Services to collaborate with providers and advocates of home and community-based services to review and make recommendations addressing the biases identified in the North Carolina Institutional Bias Study Combined Report prepared by The Lewin Group, and submit a report to the Study Commission on Aging. In addition, Session Law 2006-109 required DHHS to submit a final report on its review of the Community Alternatives Program for Disabled Adults (CAP/DA) relative to the Medicaid Institutional Bias Study by August 30, 2007.

Because the Division of Medical Assistance has already presented to the Study Commission on Aging an interim report on the report's eight recommendations related to CAP/DA, we chose to focus attention on the two additional recommendations that more generally apply to Medicaid and long-term services and supports. We invited input from many different stakeholders about these two recommendations. Attached is the report.

Also attached are applicable pages from the Lewin report pertaining to the two recommendations and some additional information that compares North Carolina to other states. For a full copy of the North Carolina Institutional Bias Study Combined Report please see http://www.ncdhhs.gov/dma/LTCReport.pdf.

Sincerely yours,

Carmen

Carmen Hooker Odom

CHO:ds

Attachment

cc: Dan Stewart
Jackie Sheppard
Dr. Allen Dobson
Dennis Streets
Mark Benton
Lynn Muchmore
Daphne Lyon
Legislative Library (2)

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

December 13, 2006

The Honorable Beverly M. Earle, Co-Chair
North Carolina Study Commission on Aging
North Carolina General Assembly
Room 634, Legislative Office Building
Raleigh, NC 27601

Dear Representative Earle:

Session Law 2006-110 directed the Department of Health and Human Services to collaborate with providers and advocates of home and community-based services to review and make recommendations addressing the biases identified in the North Carolina Institutional Bias Study Combined Report prepared by The Lewin Group, and submit a report to the Study Commission on Aging. In addition, Session Law 2006-109 required DHHS to submit a final report on its review of the Community Alternatives Program for Disabled Adults (CAP/DA) relative to the Medicaid Institutional Bias Study by August 30, 2007.

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Sincerely yours,

Carmen Hooker Odom

Carmen Hooker Odom

CHO:ds

Attachment

cc: Dan Stewart
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Mark Benton
Lynn Muchmore
Daphne Lyon
Legislative Library (2)

Summary Report on Non-CAP/DA Recommendations Pertaining to Institutional Bias

Bias # 2: Lack of simplified access and consistent support coordination system (State Administration/Local Operation)

The lack of simplified access and consistent service coordination systems across Medicaid services makes it more difficult to coordinate the range of long-term care services and supports in the community than in an institution.

Recommendation: Study ways to improve the efficiency and effectiveness of the eligibility process and case management.

Recommended State Actions

1. **Simplify Access**
   - Support development of Aging and Disability Resource Connections (ADRCs) throughout North Carolina to make access to information and assistance and entry into service system more seamless for consumers.
   - Define essential ADRC functions and let communities decide how best to designate and organize local system that meets these expectations—encouraging use of existing capacity and networking as much as possible to maximize available resources (e.g., Senior Centers, Independent Living Centers, County Departments of Social Services, Councils and Departments on Aging, Area Agencies on Aging).
   - Assure that system works well for both public and private consumers.
   - Consider the special communicative needs of persons with hearing and visual losses.
   - Complete implementation of NC Care Link as a web-based information and referral resource for use by the ADRCs and direct use by consumers and service professionals.

2. **Streamline Screening, Assessment and Case Management**
   - Complete and implement web-based uniform screening and assessment tool(s) for use statewide with Medicaid and other funding sources to promote coordination and efficient use of resources and seamlessness for consumers.
   - Better manage chronic care through a holistic approach that takes into account medical, social and behavioral factors, through such efforts as the expansion of Community Care of North Carolina (CCNC) for assisting the Aged, Blind and Disabled (ABD) populations, and the implementation of PACE.
   - Recognize and assure appropriate use and support of the various levels and types of case management.
   - Use new case management tools to support quality assurance and inform utilization management programs.

3. **Strengthen Stewardship of Resources**
   - Assure periodic re-assessment or re-evaluation (at least annually) of each individual in every long-term care setting so that that only appropriate services are being provided—that people receive the right service in the right amount in the right place at the right time by the right provider. While taking into account consumer choice, it is vital to consider the cost-effectiveness of services and supports, especially for publicly supported clients.
   - Better educate case managers and hospital discharge planners about options and resources, including the value of self-directed care, and equip them with tools to assist their cost-effective use of Medicaid. Schools of Social Work, Nursing and other appropriate entities should also greater emphasize this education.
   - Continually examine how resources are being used and how they can best be managed through reformed policies and practices.

Bias # 3: Medical needy requirements inconsistent across settings (State Policy)

Medically needy requirements leave little money for persons to pay for living expenses if they prefer to remain in the community, while institutions provide room and board.

Recommendation: Increase medically needy income standard from the current monthly standard of $242 to a level at least comparable to the national average Supplemental Security Income (SSI) [$416 for a single individual.] This would require the General Assembly to pass legislation to amend the Medicaid State Plan and appropriate additional funds to cover the increased Medicaid costs.

Recommended State Actions

1. There is universal agreement that this is an important goal for North Carolina, but there is also consensus that such a reform should not be at the expense of assuring adequate funding for the existing service system.

2. Concerned about the financial feasibility of the recommendation, there are several recommendations:

   a) Study whether Medicaid can cover some rather than all services for a population covered by an adjusted medically needy income standard.
   b) Consider a phased adjustment of the standard over some number of years.

Relevant State Activity

- The DHHS Office of Long Term Services and Supports (LTS) and its LTS Cabinet has undertaken a "**Connect-the-Dots**" initiative to develop a common set of priority goals and to promote collaboration among the various DHHS programs and projects. Two recent products of this work include the development of a **DHHS Long Term Services and Supports Action Plan** and the securing of a 5-year, $2.3 million federal CMS **Systems Transformation grant** (with 5% match) to build upon prior and current efforts to achieve a more consumer/caregiver friendly; accessible; efficient; and integrated system of long term services and supports. Following a nine-month strategic planning period that ends in June 2007, the project will pursue the following key outcomes and products:

  - Implementation of a statewide, comprehensive, consumer friendly, web-based information and assistance/intake system that includes information on long term care options and financing, chronic disease management and community resources; number of Aging and Disability Resources Centers/Connections to increase from two to seven [the readiness of senior centers will be assessed].
  - A coordinated DHHS process for implementing self-direction concepts/care delivery options will be implemented; consumers will have more self-directed care options under Medicaid and other public funding with associated Administrative Rules implemented; providers, direct care staff, consumers/caregivers will have better understanding of person-centered services; training and resource information will also be available through NC Care Link and Aging and Disability Resource Centers/Connections.
  - An Information Technology (IT) plan for nine Medicaid long-term care programs will be completed; a refined IT model for next generation case management will be developed and tested; an automated prior approval/PASARR screening process will be developed and implemented for nursing facility care; automated screening, assessment and planning system for adult care homes and CAP/C will be developed and implemented; and an enhanced quality monitoring/utilization management program will be developed and implemented with specifications for analytic tools.

- The Office of Rural Health is expanding the **NC Community Care Networks**, at the direction of the NC General Assembly, to include **management of chronic conditions for the aged, blind, and disabled populations and for those enrolled in CAP-DA**. Eight Community Care Networks (with one targeted county per network: Carolina Collaborative Community Care – Cumberland County; Community Care Plan of Eastern Carolina – Bertie County; Community Health Partners – Lincoln County; Community Care Partners of Greater Mecklenburg – Mecklenburg County; Northern Piedmont Community Care Network – Durham County; Southern Piedmont Community Care Network – Rowan County; NW Community Care Network – Surry County; and Central Carolina Health Network/AccessCare – Chatham County) have chosen to participate in the pilot, which will focus largely on the non-aged, 'straight Medicaid' until CMS approves North Carolina's request to realize some of the Medicare savings from effective management of chronic conditions. DMA has submitted to CMS a Medicare 646 waiver demonstration proposal—that if approved, would provide the same service approach to dually eligible as is used for the strictly Medicaid population and would

allow use of some of the Medicare cost-savings to expand service population and services coverage.

- The Division of Medical Assistance (DMA) is implementing the **PACE program**, at the direction of the NC General Assembly, in two pilot sites (Wilmington, an urban model through Elderhaus, and Alamance/Caswell, a rural model through Piedmont Health Services). These are projected to become operational in 2007 or early 2008. In addition, St. Josephs of the Pines in Moore County is showing interest. PACE—Program for All-Inclusive Care for the Elderly—allows for management of acute and chronic care for dually eligible (Medicare/Medicaid) recipients, typically in connection with adult day services.

- DMA has recently submitted to CMS a proposal to participate in the **Money Follows the Person Rebalancing Demonstration** that would provide enhanced federal financial participation (87.5% vs. 65%) for one year to facilitate the movement of individuals residing in nursing facilities, some psychiatric facilities, and state or privately operated intermediate care facilities to home and community-based services in residences where no more than four unrelated individuals reside. Included among the proposed activities are implementation of effective and fair means of identifying, screening, and assessing people who are candidates for transitioning to the community and facilitating self-directed services.

- DMA, DAAS, and others continue to pilot consumer-directed care. DMA's **CAP/CHOICE HCBS waiver**, in Duplin and Cabarrus counties, allows individuals to coordinate their own care. DAAS continues to pilot consumer-directed care associated with in-home aide and adult day services funding under the Home and Community Care Block Grant.

- The Division of Aging and Adult Services (DAAS) is in the third year of a federal grant ($900,000+) to pilot **Aging and Disability Resource Centers/Connections (ADRCs) as visible and trusted means of providing uniform and seamless access to information, counseling, and long-term services and supports**. Forsyth and Surry are serving as the pilot counties. The ADRC project has supported the following key outcomes and products:
  - Initial funding for development of NC Care Link and the site for one of its four pilots.
  - Revision of Seniors' Plus into Benefits Navigator—a DAAS program using trained volunteers to provide information and counseling about public benefits.
  - Collaboration among local agencies and organizations to develop a uniform 'no-wrong door' approach to accessing information, services and supports.
  - Piloting and then statewide implementation of a simplified mail-in adult application for Medicaid.
  - Link to the Chronic Care Management Project of the NC Community Care Network in Surry County (early stages).

- DHHS is developing **NC Care Link, a web-based comprehensive information system for use by consumers and service professionals**. Currently being piloted, it

is projected for full implementation by fall 2007. Data contributors have been identified to assure coverage for 66 counties; possibilities are being pursued for the remaining counties. Additional features of NC Care Link include self-directed decision tools and the electronic sharing of client information locally among participating providers.

- With the support of the General Assembly, DAAS has continued to expand **the State-County Special Assistance In-Home Option (SA/IH)**, which provides an alternative to Adult Care Home placement for individuals who can live at home safely with additional supportive services and discretionary income. A services assessment is required to determine whether an applicant/recipient can remain safely at home, and what support services and additional income are needed to assure the applicant's needs are met. The case manager's role is essential in helping the clients remain at home. All SA/IH recipients receive ongoing case management. The case manager establishes the amount of the SA/In-Home payment, works with the client and client's family to determine how the payments are used, and monitors to assure that the payments are used as intended.

- DAAS is administering its second federal grant to support **Project C.A.R.E. (Caregiver Alternatives to Running on Empty)** to offer information, counseling, and respite to family caregivers of persons with Alzheimer's disease and other dementias. Project C.A.R.E. is currently offered in partnership with the Western Alzheimer's Chapter and the Mecklenburg County Department of Social Services in ten counties.

- DAAS is continuing efforts to strengthen **Senior Centers as effective community focal points** for information, assistance and engagement. These efforts include voluntary certification of Centers of Merit and Excellence and the training of Center managers through the Ann B. Johnson Institute.

- DAAS recently presented a report of its work with the Adult Protective Services Task Force to the North Carolina Study Commission on Aging that included a series of recommendations to reform Adult Protective Services. Reforms under what is called **the 'Adult Protective Services Clearinghouse Model'** include: (1) redefining "protective services" as an array of activities including intake, screening, and evaluation of reports regarding abuse, neglect or exploitation or substantial risk of vulnerable or elder adults, and (2) providing county departments of social services the opportunity to offer vulnerable and elder adults three components of protective services that may be as simple as APS Information and Referral or more comprehensive as APS Outreach, or APS Intervention.

The Lewin Group

North Carolina Institutional Bias Study Combined Report

Prepared for:

North Carolina Department of Health and Human Services

April 2006

III. BIAS FINDINGS AND RECOMMENDATIONS

As noted in the Introduction, the goal of this study is to determine whether an institutional bias exists in North Carolina's Medicaid-financed LTC services and, if so, what steps should be taken to ameliorate any bias. Lewin reviewed policies and related administrative practices that may generate a bias for the use of institutional services over home and community-based services. Lewin also conducted interviews with key informants such as state staff, providers, and consumers. The interviews assessed the application of policies in practice and operational implications (whether intended or not) that may also contribute to or ameliorate an institutional bias.

The review focused on four areas:

- **Medicaid long term care benefits-** the medical criteria and necessity rules and practices, and the amount, scope and duration of mandatory and optional benefits
- **Long term care availability and accessibility-** the Medicaid income and financial eligibility rules, eligibility process, and medical/functional assessment and care planning; the process for accessing long term care services, and provider capacity
- **Cost containment practices-** a variety of measures to manage costs including prior approval, spending caps, utilization management, case management, and rate setting
- **Long term care provider regulation and oversight-** the different mechanisms in place to assure quality in long term care, including facility and personnel licensing and certification, utilization management, and prior approval

It is worth noting here that Medicaid is governed by both federal and state statutes and rules, and then implemented on a state and local level. To the extent possible, we have noted whether North Carolina Medicaid LTC policy or practice results from a federal requirement, state requirement, or state/local practice. North Carolina has limited ability by itself to change federal rules and requirements. However, where the institutional bias results from state decisions and rules or from the consequences of applying state and federal rules at the state and local level, North Carolina will have correspondingly greater freedom to develop appropriate responses to limit or correct the bias.

Our overall findings are reviewed below, along with recommendations for steps the state could take to alleviate bias. In some cases, the factors that lead to bias are the result of federal policies that the state has little opportunity to change, or stem from larger health care and social system characteristics that can be influenced, but not controlled, by changes to the Medicaid program. Nonetheless, all of the possible contributors to bias identified during this study are discussed here to provide the broader context for future policy analysis and decision-making. Although Lewin identified potential biases that are affected by state and federal policies, our recommendations focus on changes that can be made at the state level to minimize institutional bias. Where possible, Lewin has noted whether the change would require legislative action.

Georgia, personal support services may be offered at home if the provider is licensed as a "Private Home Care Provider."[29] Similar to North Carolina's PCS and PCS-Plus, New York's reimburses for three levels of PCS to meet the needs of individuals with varying needs. Like all other states, North Carolina also offers personal care and other supports through its home and community-based waiver, CAP/DA.

B. Long Term Care Availability and Accessibility

1. Accessing Long Term Care

In North Carolina, there are multiple points of entry into HCBS waiver programs and Medicaid State Plan services. While the 100 county Departments of Social Services (DSS) process financial eligibility applications, as will be discussed in greater detail in the following sections, medical/functional eligibility determinations for Medicaid long term care benefits can be completed by any physician in the state. To the extent possible, county DSS staff work closely with hospitals to identify individuals who are being discharged and assisting them to set up support services in the community. However, tight staffing levels in the counties limit these efforts.

In October 2005, North Carolina completed work on a new simplified Adult Mail-In Medicaid application (AMIM) for community based long term care services. The application form, which is available on-line, can be downloaded, completed and mailed to the county DSS office or lead agency. The application is approximately 10 pages in length, plus instructions.[30] The availability of this application should improve the accessibility of long term care services, however, one limitation of the application is that it is not used to determine eligibility for the Special Assistance program.

In addition to financial eligibility, individuals are screened medically to ensure that they require services at the nursing home level of care. The screening process is used to determine if an individual meets the medical and functional criteria for LTC before qualifying for these services, and to identify the most appropriate services for their needs. The medical/functional screen generally assesses an individual's ability to conduct "activities of daily living" (ADLs), such as eating, bathing, dressing, and toileting, and "instrumental activities of daily living" (IADLs), which include personal hygiene, light housework, and medication management. During interviews with state staff, providers and consumers, Lewin staff did not hear any comments or complaints about the timeliness of conducting medical/functional assessments, suggesting that this is not a barrier to community care.

Both nursing facility services and the CAP waivers require that individuals need nursing facility level of care services. Some home and community-based services, such as personal care services and hospice, are available to all Medicaid beneficiaries who meet the clinical criteria or demonstrate medical necessity and do not require a separate medical/functional assessment as part of the eligibility process. Currently, physician recommendation is required for both the medical screening of level of care and service authorization for state plan LTC services.

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[29] Georgia Department of Community Health, *Policies and Procedures for Personal Support Services*, Revised October 1, 2005.

[30] The application can be found at: http://info.dhhs.state.nc.us/olm/forms/dma/dma-5000.pdf.

Bias #2: Lack of simplified access and consistent support coordination system (State Administration/ Local Operation)

The lack of simplified access and consistent service coordination systems across Medicaid services makes it more difficult to coordinate the range of LTC services and supports in the community than in an institution.

Recommendation:

Study ways to improve efficiency and effectiveness of the eligibility process and case management.

Simplified access and greater coordination of home and community-based services would benefit individuals with chronic illnesses and disabilities in the community and their families. With the exception of the two Aging and Disability Resource Center (ADRC) pilot sites in Forsyth and Surry counties, North Carolina lacks a streamlined and coordinated system for obtaining information for making decisions about long term care and accessing services.

For state plan personal care services, no entity currently coordinates the financial and medical/functional eligibility process either in Adult Care Homes or for In Home PCS. However, North Carolina recently embarked on an initiative for greater centralization of access to In Home PCS through review of the eligibility. For the CAP/DA program, North Carolina has 96 lead agencies that provide information to consumers about community-based LTC options. The large number of varied agencies contributes to inconsistency in the process. Lack of central management makes it difficult for DMA to communicate with lead agencies, collect information and data about their activities, and identify program trends. On the other hand, nursing home residents benefit from facility staff who coordinate and complete all the necessary paperwork for Medicaid benefits based on the facility's self interest to receive Medicaid payments.

It should be noted that the other states examined as part of this study also struggle with simplifying the access process for long term care. Similar to North Carolina, both Florida and Georgia are pursuing the ADRC model in pilot sites, but currently lack state-wide, robust single-point-of-entry systems. The comparison states for this study are also struggling to simplify the eligibility process and to better coordinate the financial eligibility and medical/functional assessment processes. In Florida, the state plans to co-locate financial and medical/functional eligibility either physically or virtually. Georgia plans to co-locate Medicaid eligibility specialists (who conduct the financial eligibility process) at local ADRCs to assist individuals with the application process. Both Florida and Georgia have plans for developing consistent, statewide systems. Florida's legislature authorized statewide Aging Resource Centers. Georgia is the process of developing a single point of entry program that will be built off of their "Gateway" system. Gateway is a computerized screening tool that helps to link consumers with available services. The tool, which has been tested for reliability, predicts whether an individual will be eligible for services and helps identify providers in his or her county.

North Carolina could improve outreach about Medicaid and other social services programs. Although there is a toll-free number for information and assistance, it does not appear to be well advertised. North Carolina should consider implementing a single point of entry approach

for LTC services in the state. North Carolina can build upon the activities and lessons of the federal Aging and Disability Resource Center grant. At the least, North Carolina should consider organizing the lead agencies and county DSS by region, so that DMA can work with regional coordinators to disseminate information to and get information from these entities. DMA should also resurrect lead agency staff training programs (e.g., about the CAP waivers and the benefits allowed under each waiver). DMA could also develop written materials for use by the lead agencies and county DSS. DMA may also consider working closely with the State Health Insurance Information Program (SHIIP) to improve outreach about community-based services options.

While services coordination or case management can assist beneficiaries in accessing services, maximizing beneficiary independence, reducing fragmentation of care, and managing costs, it lacks consistency in North Carolina. In nursing facilities, all services are literally provided "under one roof." The range of providers (e.g. physician, nurses, nurse aides, dieticians) can communicate easily about a person's care plan and health status. However, in home and community-based settings, providers for different services are often employed by different agencies and greater effort is needed to ensure that they coordinate appropriately. All CAP/DA waiver participants receive case management through the Lead Agencies, but only an average of one hour per month and this varies by Lead Agency. Only Adult Care Home PCS residents who qualify as enhanced care residents (17 percent of ACH-PCS recipients in SFY2005) receive Medicaid funded Adult Care Home Case Management services and Special Assistance/In Home participants (two percent of IH-PCS recipients in February 2005) receive the Medicaid At Risk Case Management program, both provided by county DSS staff. Also, in contrast to ACH-PCS and CAP/DA case management, counties must pay the full Medicaid match for At Risk Case Management provided to SA/In Home recipients (63.63% federal Medicaid dollars and 36.37% county dollars). At times, this impacts county DSS' ability to fill the SA/In-Home slots timely due to limited staffing resources. [31] North Carolina hopes to address these disparities in part through the emerging Community Care Networks. Also, the CAP/Choice HCBS waiver being piloted in two counties allows individuals to coordinate their own care (but is currently limited to a small number of participants).

Among the comparison states, Florida is seeking to improve its care coordination process through a new comprehensive waiver that would use a managed long term care model, Florida Senior Care, for adults over age 60 and a separate program for individuals with physical disabilities. Several other states have used managed care models to help coordinate care for their LTC waiver enrollees, including Arizona, Minnesota, New York, and Wisconsin. In the past Vermont applied managed care elements to its fee-for-service delivery systems, but recently received approval for a comprehensive 1115 waiver for long term care services.

North Carolina should consider implementing strategies to improve the efficiency and effectiveness of the existing case managers, which may include some strategies tested in managed LTC models. The state should also consider reducing case manager to beneficiary ratios. Specifically, the state should convene periodic face-to-face meetings for case managers to learn about activities in other counties and provide a forum for training and education. These

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[31] North Carolina Department of Health and Human Services, Division of Aging and Adult Services, Special Assistance In-Home Program: Final Report, February 2005. http://www.dhhs.state.nc.us/ltc/SAInHomeFinalReport2005.pdf

meetings could highlight changes in state policies, allow for consistent information to be shared with agency staff, and would assist in building bridges between and among the different organizations responsible.

2. *Eligibility for Long Term Care*

Medicaid LTC program and service eligibility rules and processes were also examined to determine whether there is an institutional bias. LTC services require a formal clinical component as part of the eligibility process; that is, in addition to determining whether an individual meets the financial (e.g., income, assets) and categorical (e.g., age, disability) requirements of eligibility, the person must also be assessed on a functional and clinical basis. As with Medicaid benefits, Medicaid eligibility rules generally have both a federal and state component. Certain groups of individuals must be covered (mandatory groups), while states can choose whether to cover others (optional groups). In addition, within most eligibility groups, states can determine how income and assets are counted and how other eligibility criteria are met. The rules and processes for how persons become eligible for Medicaid and how they are assessed for LTC may contribute to an institutional bias if they make it easier for an individual to be eligible for institutional care than home and community-based services.

a) *Medical/Functional Eligibility*

No Bias Found: Medical/functional eligibility for Medicaid long term care services (State Administration)

- While level of care appropriately differs for the alternative settings, all require physician approval to receive services.
- Lewin did not identify an institutional bias related to medical/functional eligibility criteria or processes.

A physician must certify that individuals meet the nursing facility level of care to become eligible for either nursing facility or CAP/DA services, while adult care home residents must meet ACH level of care for ACH-PCS. ***Table 1*** shows that for nursing facility, CAP/DA, ACH-PCS and nursing facilities, the FL-2 form must be signed by a physician to authorize services. In November 2005, a new process has been put in place for In Home PCS that involves prior authorization by a third party that applicants meet the two unmet activities of daily living (ADLs) and a chronic medical condition. For home health, private duty nursing, and hospice services, physician approval is also necessary but may occur on a per-service basis. Although bias could be introduced as a result of the lack of clear criteria and consistent application by physicians, there was no evidence that physicians steer individuals to one setting over another. As a result, while the forms differ somewhat, the processes are fairly similar and do not appear to bias nursing facility care relative to home and community-based services.

Bias #3: Medical needy requirements inconsistent across settings (State Policy)

Medically needy requirements leave little money for persons to pay for living expenses if they prefer to remain in the community, while institutions provide room and board.

Recommendation:

Increase medically needy income standard from the current monthly standard of $242 to a level at least comparable to the national average SSI ($416 for a single individual).[35] This would require the General Assembly to pass legislation to amend the Medicaid State Plan and appropriation additional funds to cover the increased Medicaid costs.

North Carolina's medically needy requirements, which require beneficiaries to "spend down" to a low level of income, contribute to an institutional bias. Individuals residing in institutions can count the full cost of nursing facility care toward their spenddown amount, while persons living in the community can count only the cost of health care and social supports (not room and board). After a North Carolina resident becomes eligible for Medicaid through the medically needy provision, he or she has $242/month to spend on housing, food, and other expenses. This allowance is likely to be insufficient to support a person living in the community.[36]

Thirty-one states have a medically needy eligibility group for the aged, blind, and disabled; of those 31 states, 24 have higher medically needy income standards than North Carolina. The average medically needy income level in the country is $416.20.[37] Of the comparison states, Florida and New York also have medically needy groups, with income standards of $180 and $642 respectively.[38] Georgia does not have a medically needy eligibility category. North Carolina should consider increasing its medically needy income standard from the current monthly standard of $242 to a level at least comparable to the national medically needy average ($414 for single individual). A higher medically needy limit would assist individuals who wish to stay in their home to more realistically be able to maintain a household by allowing for more resources available for housing costs and food.

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[35] Data derived from: National Association of State Medicaid Directors. Aged, Blind, and Disabled Medicaid Eligibility Survey. Available at: http://www.nasmd.org/eligibility/. Data provided in *Appendix C*.

[36] Nursing facility residents that wish to maintain a household also retain $242 /month during the first six months of their stay.

[37] Ibid.

[38] Ibid.

Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities
General Assembly of NC Session 2004
House Bill 1414 Section 10.2(a) & (b)

Prepared For: The North Carolina Study Commission on Aging
December 1, 2005.

Final Report and Recommendations

I. Summary of Recommendations

Over the past year, the NC Department of Health and Human Services has worked closely with a Study Group, comprised of long term care provider associations, advocacy organizations and state government staff, convened in response to the Special Provision at Section 10.2(a) & (b) of HB 1414. The following report represents the Department's effort to summarize the work of the Study Group and prioritize their recommendations to support ongoing efforts within the Department to improve both long term care services and support persons with mental illness with appropriate treatment and services.

The Department is making the following recommendations, discussed in detail within the report as indicated:

- Expansion of mental health specialty teams to provide training and technical assistance to long term care facilities. (page 12)
- Design and implementation of an automated screening, assessment and care planning system to be used prior to admission to long term care services.(page 13)
- Conducting a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness. (page 14)
- Strengthening training curriculums in all law enforcement training programs to improve law enforcement response in long term care settings. (page 15)
- Further evaluation of a number of statutes and rules to provide appropriate guidance to long term care facility operators according to the needs and characteristics of residents served.(page 10-11)

II. Introduction

On February 10, 2004, the North Carolina Study Commission on Aging heard presentations regarding people with mental illness who live in long-term care facilities.

The Commission considered many questions regarding this issue, including:

- Are adult care homes appropriate housing options for persons with mental illness?
- Is staffing and training at both nursing facilities and adult care homes adequate to meet the needs of diverse population groups?
- Do existing laws and rules provide the best guidance to those who operate these facilities?

- Does mixing younger people with mental illness with the frail elderly in adult care homes and nursing facilities compromise the health and safety of residents?

To address these issues, the Commission recommended that the General Assembly require the Department of Health and Human Services (DHHS) to work with long-term care providers and advocates to study these and other related issues.

During its 2004 session, the legislature approved House Bill 1414, which included the Special Provision at 10.2(b) directing the Department of Health and Human Services to convene a Study Group to provide recommendations on the following study areas:

1. Do current State statues and Departmental rules adequately address the populations served by long-term care facilities?
2. Would the development of separate licensure categories for adult care homes and nursing facilities improve care for the various populations served in those facilities?
3. Are adult care home rules easy to understand, attainable under current staffing patterns and include appropriate guidance to facility operators to best serve the needs of their residents?
4. Do these rules support residents' freedom of choice, as well as their autonomy, dignity, and independence?
5. What is the most effective way to identify mentally ill individuals that have mental health treatment needs?
6. Can the criteria for admission of mentally ill individuals to long-term care facilities be improved to ensure that the health and safety of all residents are safeguarded?
7. What changes need to be made to improve the quality of care for mentally ill individuals in adult care homes and nursing facilities? What is the potential cost associated with implementing these recommendations?
8. What specific problems exist as a result of mixing aging and mentally ill populations?

DHHS was also asked to include in this report how it defines "mentally ill" for purposes of this study.

For purposes of this study, the definition of mental illness is drawn directly from General Statute 122C-3(21):

> Mental illness means an illness which so lessens the capacity of the individual to use self control, judgment and discretion in the conduct of his affairs and social relations so as to make it necessary or advisable to be under treatment, care, supervision, guidance or control.

This is a functional definition that can include a broad spectrum of conditions including serious depression, schizophrenia, bipolar disorder and other psychiatric diagnoses where functioning can be improved or restored with appropriate medication and rehabilitative treatment. Dementia also meets this functional definition and is a progressive brain dysfunction that leads to a gradually increasing restriction of daily activities. The most well known type of dementia is Alzheimer's disease.

Developing the Study

NC DHHS Assistant Secretary for Long Term Care Jackie Sheppard convened the Study Group in December, 2004. The Study Group met for ten sessions and included representation of long term care provider associations, advocacy organizations and state government staff. A number of committees were formed to address particular study issues, some of which joined with existing DHHS committees to build on existing discussions and Department efforts. (See Attachment A: Study Group Members, Meetings and Subcommittees)

The Study Group reached agreement on statements of consensus (Attachment B: Consensus Statements) and presented a draft report to the Department in September 2005. The draft report included lengthy discussion of the issues and a number of recommendations.

This report represents the Department's effort to summarize the work of the Study Group and prioritize their recommendations to support ongoing efforts within the Department to improve both long term care services and support persons with mental illness with appropriate treatment and services.

III. Scope and Context of the Report

The issue of serving the mental health needs of long term care residents is not new and pre-dates the current re-design of the publicly funded MH/DD/SAS system. In fact, state agencies and long-term health care providers have been engaged in a discussion of how best to provide this care for a decade or more.

Long term care facilities as referenced in the Special Provision include adult care homes and nursing facilities. The two are designed to meet different needs and operate under different statutes and rules. A nursing facility provides care for persons who have ailments for which medical and nursing care is indicated, but are not sick enough to require general hospital care. Nursing care is their primary need, but they also require continuing medical supervision.

An adult care home is a facility which provides residential care for older adults or adults with disabilities whose principal need is a home with the shelter and personal care their age or disability requires. Medical care in an adult care home is usually occasional, incidental, and/or short term intermittent, but includes the supervised administration of medication.

While neither of these types of care is designed to provide for the mental health needs of their residents, many residents of both adult care homes and nursing homes have mental health issues.

While comparing results from different population studies is complicated by the difference in parameters and indicators used, a report commissioned by the Department in 2004 found that over 40% of the adult care home population carried an active diagnosis of mental illness. (Adult Care Home Mental Health Needs Assessment Report of Findings, First Health, July 15, 2004).

A limited sample study of nursing facility residents done as part of the Adult Care Cost Modeling Report found a similar percentage, 41.8%, to have a psychiatric or mood disorder diagnosis (Myers and Stauffer 2003). Comprehensive national studies indicate that as high as 80% of nursing facility residents have diagnosable psychiatric disorders, with dementia being the most prevalent condition. (Mental Health Services in Nursing Homes: Models of Mental Health Services in Nursing Homes: A Review of the Literature Psychiatric Services, November 1, 2002)

When the locus of care for persons with mental illness first shifted from the large state hospitals to the community decades ago, there were few residential options available to persons with mental illness, and many adult care homes stepped forward to fill that gap, providing shelter for those who had none.

North Carolina's current mental health reform effort is designed to improve the state's capacity to meet the needs of persons with mental illness according to evidence based practices, but many with mental illnesses continue to live in long term care settings because there are not yet more appropriate alternatives available to them in their communities.

As a result, long term care facilities have been an unavoidable choice for many individuals with mental illness, despite the fact that these facilities are not designed to provide psychiatric treatment or the rehabilitative services to allow persons with mental illnesses, particularly younger adults, to achieve a greater measure of independence.

Members of the committee agreed that without a large investment of new resources into community-based services, people facing the challenge of mental illness are likely to continue to be served in adult care homes and nursing facilities.

The Department has taken steps in addressing some of the challenges posed by this issue. Since 2001, for example, the Department has been engaged in a Department-wide effort to improve the quality of long term care services as outlined in the Institute of Medicine's Long Term Care Plan for NC. While the resources to implement the full range of changes suggested by the report have not been available, the Department has implemented a number of the recommendations and other initiatives in an ongoing effort to improve long term care services for all residents.

The NC DHHS Division of Medical Assistance has also undertaken population studies to assess the needs, both physical and behavioral, of current long term care populations and is moving forward with an automated screening and assessment tool that will be used for Medicaid providers and recipients needing long term care services. Further information on this effort is included in Recommendation B.

In addition, the NC DHHS Division of MH/DD/SAS has funded 21 geriatric mental health specialty teams. These teams provide training and case consultation to adult care homes and nursing facilities to help staff understand and manage some of the challenging behaviors of older adults.

The Division is also piloting a specialized long term geriatric behavioral unit for nursing facility residents and a Special Care Unit in an adult care home. These pilots are designed to serve persons who exhibit persistent behaviors that pose potential danger to the individual and/or to

other residents. Expanding both of these initiatives are included in Recommendations A and C.

The NC DHHS Division of Aging and Adult Services is also involved in a wide variety of initiatives targeted at improving the long term care delivery system, including:

- Implementing the Aging and Disability Resource Center Grant to create a coordinated system of information and access for all persons seeking long-term support.
- Convening a multidisciplinary taskforce called SAFE-in-Long Term Care composed of individuals in the fields of law enforcement, long term care, advocacy and state government to raise awareness regarding appropriate responses to crimes occurring in long term care settings.
- Initiating the Quality Improvement Consultation Program for Adult Care Homes as directed by recently passed legislation "to promote better care and improve quality of life in a safe environment for residents in adult care homes through consultation and assistance with adult care home providers."

In addition, the Department has implemented North Carolina's response to the 1999 US Supreme Court's Olmstead decision by coordinating Department wide efforts to reduce reliance of institutional care by addressing a variety of system issues including transportation, strengthening the direct care work force and expanding the availability and improved access to affordable community housing.

IV. Summary of Study Group Discussions

The Study Group's discussions covered a gamut of issues and concerns raised in the Special Provision that can be captured under four themes:

- Health and safety
- Screening and disclosure
- Training of staff, and
- Services to residents with mental illness.

A. Health and Safety

While many persons with a diagnosis of mental illness reside in long term care settings without difficulties, others, because of the nature of their illness, inadequate treatment, or lack of expertise among facility staff, can exhibit behaviors that can impact other residents and/or pose a potential safety risk to staff and residents.

Licensed skilled nursing facilities in NC are well-equipped to care for the frail older adult, medically complex residents that they serve. Many of these residents have age-related dementia or Alzheimer's disease, and some have mental illness that is effectively managed. However, industry representatives report that these facilities are increasingly struggling with safety issues related to a growing number of residents with challenging behaviors that have an impact on the safety of residents in the facilities.

In adult care homes some older adult residents and their significant others cite concerns about the safety and the vulnerability of other older adults due to reports of behavior problems such as verbal/physical/sexual abuse by some younger residents. The facilities, however, have found that the needed services and alternative placements to address these unexpected acute challenging behaviors are not widely available or accessible.

While there is currently no comprehensive information available as to the scope and breadth of these problems, the NC DHHS Long Term Care Ombudsman Program receives and investigates complaints made by or on behalf of long term care residents. The Ombudsman Program is an advocacy program, not a regulatory agency. In the course of their work, the program's staff have reviewed situations in which persons exhibit aggressive behaviors, engage in illicit drug use and/or alcohol abuse that negatively impact the health and safety of other residents. The Ombudsman staff also report concerns that the needs of persons with mental illness are not always being met. These reports include the inappropriate use of infringement of the patient rights as a behavior modification tool and even reports by some residents with mental illness that their health concerns are often disregarded and not reported to health professionals.

It was also noted that law enforcement must be called by the facility when the safety of residents or staff are in danger. Complaints received by the Ombudsman Program indicate law enforcement officials can be hesitant to arrest or detain residents who commit criminal acts. The law enforcement response is complicated by the need to carefully assess and differentiate between a criminal act and psychosis requiring treatment. (See Attachment C: 2005 Regional Program Survey by the Long Term Care Ombudsman Program)

B. Screening and Disclosure

Members of the Study Group agreed that a good screening mechanism is a critical component to appropriate placement but that current tools are either inadequate or not used appropriately. They agreed that while a framework for this approach is already established through assessment and care planning requirements, the critical component of screening persons for appropriate placement within a continuum of long-term care is missing. The Study Group felt that this is the area in greatest need of attention from a regulatory standpoint. Such a tool would allow for the adequate evaluation by the facility of the needs of the potential resident and the determination by the facility of its ability and resources to meet those needs.

The Study Group also felt that disclosure by facilities of what services can and cannot be provided and disclosure by referral sources of resident history, condition and needs are not adequately addressed in statute or rule. In addition, facilities report that some residents who were initially admitted were later found to have persistent behaviors that pose a potential threat to themselves or other residents. In many cases these individuals have not responded to interventions and services that are available to the facility, yet do not meet the statutory criteria for involuntary commitment to a psychiatric hospital.

1. Nursing facilities Currently, nursing facilities are subject to stringent Federal regulations related to Medicare and Medicaid. All nursing facility residents are subject to the Pre-

admission Screening and Annual Resident Review regulations, commonly called the PASARR. The PASARR Program was established by Congress to ensure that every individual seeking admission to a Medicaid certified nursing facility (NF) is properly assessed to determine if he/she requires nursing facility care and if he/she has a major mental illness (MI), mental retardation (MR) or a related condition (RC) that requires specialized services.

Every new admission to a certified nursing facility, regardless of payment source, is subject to a Level I screening prior to admission, with the exception of individuals readmitted after treatment in a hospital unless there has been a significant change in status. After receiving the Level I screen, if individuals are suspected of having either mental illness or mental retardation or a related condition, a Level II evaluation must be completed with the recipient by a qualified professional to assess whether nursing facility services and specialized services are needed. Recommendations based on the Level II evaluations are forwarded to the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services for final determination of services and placement for the individual. All persons identified as MI or MR/RC by this process receive an annual resident review designed to assess their care needs or whenever there is a significant change in the resident's condition. It should be noted that PASARR does not include screening and evaluation for nursing facility residents who have dementia and who may have significant challenging behaviors.

The PASARR process is not without some flaws for persons with psychiatric illness, however, particularly in the admission screening process. For example, the PASARR by regulation excludes screening for dementia. Dementia and certain related challenging behaviors can pose immense concerns for Nursing facilities and the residents for whom they care. Also, at the time of the PASARR screening, behaviors may not always be evident. Current or long-term residents may develop dementia and related behavior issues that are not related to the primary reason for admission to the nursing facility. A limited number of nursing facilities have the ability to deal with ambulatory residents with more challenging behaviors, such as a person who roams and rummages in other resident rooms. Although this person is not violent, he/she is at risk of being injured by other residents who react strongly to having someone handling his/her possessions. Additionally, over time, a resident may develop a new psychiatric illness and /or develop behavior/symptoms related to another diagnosis. Facility operators also stated that often there is an inability to get appropriate services for these long-term residents who develop new psychiatric disorders, and once these problems manifest there are limited discharge/care and/or treatment opportunities available.

2. Adult Care Homes Similarly for persons entering an adult care home, the facility will review the FL2 (the current screening tool) and if the home feels it can meet the needs of the individual and has a vacancy the person is admitted. Study Group members agreed that in some instances the FL2 does not include all the information it could/should contain in order for the adult care home to make a sound admission decision. The home may decide to meet the potential resident before deciding whether they can meet the individual's needs, however, it may be days before the symptoms of the illness manifest. The home then cannot meet the needs of the resident, is not trained in handling those specific behaviors and/or has no place to refer the resident or get support. They have now accepted a resident with no viable options available for assistance. This resident may even be a danger to himself or others. Additionally, as the resident "ages in place" exacerbation of old conditions may develop, as well as new conditions.

A program similar to PASARR for adult care homes is not currently available. Study Group members indicated that this inconsistency in systems has been used by referring agencies or doctors to by-pass the assurances required by nursing facilities, by placing the resident in an adult care home who only have exclusionary criteria rather than defined admission criteria. As a result, the adult care home has no way of knowing that a person should have received such a screening, and subsequently the resident may not receive services or needed support from trained staff. The true picture of resident needs may only come to light after they are placed and the challenging behaviors emerge.

C. Training of Staff

Typically, mental health crisis situations are unpredictable, although at times there is evidence of a person's escalating behaviors. Members of the Study Group were in agreement that presently there is not enough trained staff, particularly nursing assistants, personal care and medication aides, to care for residents with mental illness. Training is most important for monitoring behavior changes and responding with appropriate interventions when dealing with challenging behaviors exhibited by some residents with mental illness. An understanding of mental illness and how it impacts behavior can result in more effective interventions and prevention of crisis situations.

The current training requirements for direct care staff, including aides and supervisors, in adult care homes are focused primarily on personal care with little emphasis on training related to the additional skills that are needed to care for residents who also have cognitive impairment and/or mental illness. It was also noted that instructors, who provide the training that is currently required, usually do not have the experience and/or education that is directly related to the care of residents who have cognitive impairment and/or mental illness. Likewise, nursing facility direct care staff, while highly trained to manage clinical issues of facility residents, do not receive training specific to managing and de-escalating challenging behaviors.

Nursing assistants, personal care and medication aides in adult care homes often have not had the training needed for appropriate interaction with residents based on their particular mental illness, and specifically to administer and/or monitor the side effects of psychotropic medications. When there is a need for facility staff to be involved in implementing an appropriate behavior plans, this does not routinely occur because the plans are not developed and agreed upon with participation by the resident and approval by the attending physician or supervision of a qualified mental health professional.

D. Services to residents with mental illness

The Local Management Entities (LMEs) for the public mental health, developmental disabilities and substance abuse system of services have responsibility for access to the available services by providing screening, triage, and referral to appropriate provider agencies. LME's also have a responsibility to assure crisis services. These responsibilities include responding to the needs of their communities including the needs of residents in long term care facilities. The types of mental health services that are often needed by some residents in long term care settings includes: evaluation and assessment of residents who are exhibiting behaviors that appear to be related to mental illness; development of person

centered plans that include consideration of each individual's needs for a wide range of services or supports; and provision of ongoing treatment and rehabilitative services, and cooperation and support for others who are providing service and support for the individual.

The Study Group found that statute and rules related to both adult care homes and nursing facilities do not address coordination or linkages to these resources that would provide a more systematic and operational framework for meeting the needs of residents who require additional services.

Long term care providers report that greater involvement of mental health professionals is needed to do evaluations; to assist in the development of care plans; to provide treatment for some residents; and to provide consultation, training, and support for facility staff who are caring for residents with challenging behaviors related to cognitive impairment or mental illness. They also report that access to psychiatric consultation, evaluations, and treatment is difficult particularly if it is not provided on site and that the availability of gero-specialists, social workers, psychologists and psychiatrists is extremely limited.

Other concerns raised related to activities that are offered for older adults frequently do not meet the diverse needs of younger residents, and are often not an integral part of the personal care plan. It was also noted that there are not alternative residential options for providing stabilization of acute behavior that becomes problematic in the nursing facility or adult care home but does not meet the criteria for involuntary commitment to a psychiatric hospital.

Finally, the Study Group agreed that at the current time, the availability of mental health resources, the capacity to perform timely and thorough evaluations, development of person centered plans, and access to the broad array of services and supports needed for persons with mental illness varies greatly across the state. Poor coordination, unavailable transportation to rehabilitation activities, and few on-site mental health services were identified as additional barriers to assure the provision and coordination of needed services in many areas.

V. Rules and Statute Review

A. Discussion

Subcommittee members were asked to complete charts to gauge opinion on whether the statutes and rules adequately address the population served in adult care homes. The results collected served as a basis for discussion of the issues by a majority of subcommittee members and the Adult Care Home Mental Health Workgroup.

Statutes and rules governing adult care homes do not make direct references to the specific populations served such as persons with mental illness, those who are medically frail and those of advanced age. Addressing the needs of these populations is encompassed, in part at least, in the context of an array of care and services mandated by statute and promulgated in rule, and in the requirements for admission, assessment, care planning and training.

Addressing specific populations and their particular needs in law and rule has a number of pitfalls, not the least of which is the inevitable failure to take into account the wide range of

persons being served and their wide range of needs. In addition, singling out one group of residents should not be done at the expense of another group who may have some of the same needs but also a number of other specialized needs as well. Rules would inevitably become more complex and extensive without necessarily promoting attention to the particular needs of individual residents. The primary concern should be one of adequately addressing needs of individuals rather than generically addressing populations.

Subcommittee members felt that well-designed screening, assessment and care planning instruments would better accomplish the intention of the current adult care admission rule:

> "Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted to an adult care home when, in the opinion of the resident, physician, family or social worker, and the administrator, the services and accommodations of the home will meet his particular needs." (Rules 10A NCAC 13F and 13G .0701 Admission of Residents.)

There was no clear indication from results of Subcommittee discussions that adult care home rules were not understandable and not supportive of residents' freedom or the autonomy, dignity and independence philosophy of assisted living. Based on the Adult Care Home Cost Modeling Report (December, 2004), current staffing patterns are insufficient to meet all the requirements in rule. Again, the Subcommittee felt that the combination of improved screening and disclosure would help assure appropriate admission of residents so that facilities are able to meet residents' needs, make residents and their responsible persons aware when residency in a facility will no longer be viable, and protect the health and safety of all residents in the home.

A number of rules and statutes were identified as needing further evaluation and attention in relation to providing appropriate guidance to facility operators according to needs and characteristics of residents served. These are listed in detail below:

B. Recommendations: NC General Statutes 131D and 131E

The Department of Health and Human Services recommends to the NC General Assembly the following:

1. Assure definitions of abuse, neglect and exploitation are consistent with definitions of these terms in other statutes that impact adult care homes or types of residents in these homes.(GS131D-2(a))
2. Qualify "provide services" as "services established by rule" to provide greater clarity and avoid the possible misconception that these facilities provide any and all services "to assure quality of life...." etc. Coordination of services provided by community resources needs to be addressed since facilities cannot be expected to be providers of all services that may be needed. Additional funds would be needed to implement this coordination. (GS131D-4.1)
3. Evaluate current staffing requirements that are based on requiring specific amounts of staff time per resident in relation to a more "outcome" orientation to staffing which

would focus greater attention on whether the needs of residents are being met rather than number of staff present. (GS131D-4.3)

4. Address coordination of services to take into account services needed that the facility cannot directly provide (see #2 above). (GS131D-4.4)
5. Establish a mandate for screening of potential adult care home residents. Additional funds would be necessary for the development and implementation of this screening.(GS131D-4.5)
6. Establish a mandate for:
   - full disclosure in writing by all facilities to residents and their responsible persons such as required of special care units in 131D-8; and
   - full disclosure of information about potential residents to the facility so that facilities are fully aware of the resident's history and care needs in order to make informed decisions about admitting residents. (GS131D-2)

The study group also discussed the possibility of suggesting that there be exceptions to a Resident's and Patient's Bill of Rights in situations where they may make implementation of specific behavior plans difficult. However, deleting any of these Rights would risk changing the nature and character of these facilities. Rights may now be restricted in accordance with approved plans of care. If the deletion of Rights are necessary in order to provide appropriate treatment to a particular individual in an adult care home or nursing home, that individual would likely be more appropriately placed in a licensed mental health facility.

C. Recommendations: Administrative Rules for Adult Care Homes of Seven or More Beds (10A NCAC 13F) and Family Care Homes (10A NCAC 13G)

The Department of Health and Human Services recommends that the NC Medical Care Commission:

1. Strengthen training on caring for residents with cognitive impairments and/or mental health needs. Training should include specific methods for de-escalation of challenging behaviors and the implementation of appropriate behavior plans for residents with challenging behaviors. Training by qualified instructors is critical to enabling staff to meet resident needs. Additional training of staff upon employment and on an annual basis needs to be considered. This would require additional funds for trainers and staff time for training, including staff coverage while staff is being trained. Any mandatory requirements for additional training should be conditioned upon the availability of necessary resources. The use of mental health specialty teams like the geriatric specialty teams should be explored. (10A NCAC 13F and 13G .0501-.0502: Personal Care Training)
2. Evaluate the feasibility of a more outcome-based orientation to staffing and explore outcome-based measures. Staffing ratios are not directly related to residents receiving appropriate care and services and reliance on this kind of staffing requirement may even have a negative impact on care. Greater attention should be given to assuring staffing to meet the needs of residents. Increased funds will be needed to increase staff time. Thorough screening, assessment and care planning processes are critical to the effectiveness of an outcome-oriented approach. (10A NCAC 13F .0604-.0605: Staffing)

3. Require that admission of residents be dependent on facility review and evaluation of the results of a pre-admission screening process and all other information regarding the resident's mental and physical condition, needs and history provided to the facility. (10A NCAC 13F and 13G .0701: Admission of Residents)
4. Require that the examination of a resident who has been an inpatient of a psychiatric facility within 12 months prior to admission and does not have a current plan for psychiatric care be examined by a mental health professional. The allowance of 30 days for the examination should be considered for possible reduction. (10A NCAC 13F .0703(e) and 13G .0702(e):TB Test and Medical Examination)
5. Include requirements regarding facility disclosure to residents and responsible persons here or in a separate rule. (10A NCAC 13F and 13G .0704:Resident Contract)

VI. Recommendations for improving the quality of care for persons with mental illness in long term care facilities

A. The Department of Health and Human Services recommends the expansion of mental health specialty teams to provide training and technical assistance to long term care facilities.

The Department and the Study Group believe that the quality of care for persons with mental illness in long term care facilities can be supported and improved by making it possible for facility staff to have access to training, technical assistance, case consultation, and assistance with referrals to mental health treatment services. A geriatric mental health specialty team model has been a successful strategy to address needs of both long term care staff and residents with mental illness. However, current funding has been made available to fund only 21 such teams and the staffing qualifications and focus of these teams are on the specific needs and issues of older (age 60 and over) long term care residents. The current small number of these teams makes it impossible for them to meet the needs of all long-term care facilities for this kind of consultation and training.

Mental health specialty team staff with the training, experience, and skills would be needed to help long term care staff address the challenging behaviors of younger residents in long term care are also needed. For example, 5,867 or 24% of all adult care home residents are under the age of 65, However 3,117 or 62% of adult care home residents under age 65 have a mental health diagnosis.[1]

In order to increase the availability of mental health specialty teams to address behavioral issues presented by long term care residents of all ages, proposed initial steps are:

1. To add 12 additional geriatric mental health specialty staff to existing teams. These staff would supplement the capacity of current teams that are serving areas with large number of long term care facilities. These staff will be qualified mental health professionals who have experience working with older adults with mental illness. These staff will focus on training, consultation and support to facilities for residents 60 and older who may present behavioral challenges that are related to

[1] 2005 Adult care home population census information from the NC Division of Facility Services

dementia or other mental health diagnoses. The cost per staff is approximately $65,000 per year for staff, travel, and training materials.

2. To add 25 qualified mental health specialty staff that are mental health clinicians who have training and experience about the needs of younger individuals who have major mental illness some of whom may exhibit behaviors that are not consistent with the expectations of staff and other residents in long term care settings. These staff will focus on training, consultation and support to facilities for residents under the age of 60 years old. The cost of one person would be approximately $65,000 per year for staff, travel, and training materials.

Currently the cost of a two person Geriatric Mental Health Specialty Team is $130,000 per year or $65,000 to cover the costs of each team member. This includes staff salaries and benefits, transportation/travel costs associated with travel to long term care facilities throughout the geographic area served, and a small amount of money for training materials and supplies used when providing training to long term care facility staff.

The cost of implementing this recommendation to fund a total of 37 additional team members would be approximately $2,405,000 per year. Additional background information, data about the number, type and location of long term care facilities that was used to develop the proposed action steps is included in Attachment E.

B. The Department of Health and Human Services requests support of the design and implementation of an automated screening system to be used prior to admission to a nursing facility, adult care home, or other home and community based services; and the design and implementation of an automated assessment and care planning system to be used once the setting of care is determined.

The Department is currently working on an integrated, web-based system that will streamline the screening and assessment processes for Medicaid providers and recipients needing long term care services. The overall design of the new system will include among other things, the capacity to identify persons with mental illness, substance abuse and/or mental retardation prior to admission to a nursing facility, an adult care home or before receiving other home and community services. The Division of Medical Assistance will work with the Division of MH/DD/SAS to see that the design complements the diagnostic assessment process underway for persons who meet the DMH/DD/SA target population criteria.

The new process will meet the requirements of the federally mandated Pre-Admission and Annual Resident Review (PASARR) program. If the mental health portion of the screening identifies the need for a more thorough mental health evaluation, then a qualified mental health professional should perform the evaluation and determine needed mental health services or supports. Overall, the new automated screening and assessment system should promote one's independence, self-management of health, and be formed around person-centered planning concepts.

The detailed work plan for the integrated access and management system for Medicaid will be available December 2005. The estimated resources required to implement the system will be determined through a formal bid process, but it is estimated to cost $1 million for design and development and $2.3 million for annual operating costs. At this time it is anticipated that

current expenditures will be redirected to support this system. The need for additional resources, primarily for ongoing operations and training to implement the new system are estimated at $248,000 per year.

C. The Department of Health and Human Services requests $620,000 for a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness.

The Department believes that there is a need to increase choice and treatment options for people with mental illness of all ages, particularly those who would benefit from more than the residential care and personal assistance than adult care homes are designed and funded to provide - and those with both medical and behavioral issues that nursing facilities are not equipped to manage. Improved screening and background disclosure of residents will inevitably result in persons being found inappropriate for either adult care or a nursing facility. Without alternative settings to meet these needs the state will remain dependent upon more costly care in the State psychiatric hospitals.

At this time the Department does not support creating a separate licensure category for adult care homes that serve persons with mental illness. On October 1, 2005 the General Assembly ratified SB 572 - An Act To Create A Licensure Category For Assisted Living Communities That Serve Only Frail Older Adults (see Attachment D). Assisted Living Communities that wish to serve only the frail elder population are now able to acquire a license that designates them as communities that serve only the frail elder population. While facilities wishing to serve only a population of persons with mental illness do not have that option as either an adult care home or nursing facility, they can apply for license as a mental health facility.

The Department believes that attention and resources must be devoted to creating a range of housing and treatment options that meet the needs of persons with mental illness that are consistent with evidenced based treatments. As a first step, a study should be undertaken to quantify the need, in terms of projected numbers to be served and the types and designs of alternative residential and treatment settings. The scope of this study would include a review of models used in other states, applicable Federal and State policies and regulations, potential funding sources, and development of cost estimates to develop a continuum of residential services, including, but not limited to:

- Community based residential options for providing stabilization of acute behavior that does not meet the criteria for involuntary commitment to a psychiatric hospital, including facilities that can provide both the nursing care and the psychiatric stabilization and treatment that are needed before return to a nursing facility is considered, as well as facilities that can provide both the personal care and psychiatric stabilization and treatment that are needed before return to an adult-care home is considered.
- Long term acute care hospitals specializing in the care of older people who have both medical and acute behavioral or psychiatric care needs or "swing beds" designed specifically for people with nursing care needs and acute behavioral or psychiatric care needs. The average length of stay of a long-term acute hospital is approximately 28

days. This length of stay would lend itself to the observation, stabilization, and intervention time necessary to return the older adult to the nursing facility

- Specialized long term geriatric behavioral units for nursing facility residents who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents. A single pilot of this model has recently begun operations.
- Specialized long term geriatric behavioral units for adult-care home residents who exhibit persistent behaviors that pose potential danger to the individual and/or to other residents, including a review of the current ACH- 12 bed special MH unit rules (10A NCAC 13F Section .1400) to determine if there needs to be any changes in staffing requirements and other areas
- Community based supportive housing, housing with supportive services, for adults with mental illness in their communities.

D. The Department of Health and Human Services supports strengthening training curriculums in all law enforcement training programs to improve law enforcement response in long term care settings.

The Department will work with key officials in the Training and Standards Division of the Department of Justice in order to promote the use of N.C. Intervention Training and to facilitate the development of new mental health training curricula for law enforcement officers. The new curriculum should include identification of major mental illnesses, action steps for crisis response by law enforcement officers and alternatives to involuntary commitments. Officers at every level should be afforded access to available and newly developed training modules addressing their response to individuals with mental illness.

With appropriate and adequate training, law enforcement officers can develop skills to address the safety issues confronting staff and residents while de-escalating the situation. This training is highly encouraged for "first responders." Facilities are encouraged to have a "crisis plan" in place in order to avoid unnecessary demands on emergency hospital resources.

These efforts will build upon the Division of Aging and Adult Services' multidisciplinary taskforce called SAFE-in-Long Term Care. S.A.F.E. is an acronym that stands for Strategic Alliances For Elders in Long Term Care. SAFE is composed of individuals in the fields of law enforcement, long term care, advocacy and state government. This taskforce was convened to raise awareness regarding appropriate responses to crimes occurring in long term care settings and ensuring that justice is served. SAFE seeks to eliminate this lack of knowledge and awareness about these crimes by providing education and training to the general public and especially those professionals who have an obligation to protect society's most vulnerable from harm.

VII. Attachments

A Study Group Members, Meetings and Subcommittees
B Consensus Statements
C 2005 Regional Program Survey by the Long Term Care Ombudsman Program
D Session Law 2005-66
E Detail for Expanding Mental Health Specialty Teams in LTC settings

December 14, 2006

MEMORANDUM

TO: Members, NC Study Commission on Aging

FROM: Senator Charlie Dannelly, Co-Chair
Representative Beverly Earle, Co-Chair

SUBJECT: Meeting Notice

There will be three meetings of the NC Study Commission on Aging during January.

DAY:	Wednesday	TIME:	9:30 AM
DATE:	January 3, 2007		
LOCATION:	Room 643 Legislative Office Building		

DAY:	Tuesday	TIME:	10:00 AM
DATES:	January 9, 2007 & January 23, 2007		
LOCATION:	Room 643 Legislative Office Building		

Please advise Commission Assistants Dee Hodge (919-733-5955; dannellyla@ncleg.net) or Ann Raeford (919-715-2530; earlela@ncleg.net) if you will be unable to attend.

Agenda

North Carolina Study Commission on Aging

Tuesday, January 23, 2007
10:00 a.m.
Legislative Office Building
Room 643

I. Welcome and Introductions

Senator Charlie Dannelly, Cochair
Representative Beverly Earle, Cochair

II. Presentation of Draft Study Commission on Aging Report

Theresa Matula, Shawn Parker, Ben Popkin, Commission Staff, Research Division, NCGA

Discussion and Vote on the Report

III. Approval of Minutes

IV. Meeting Adjourned

North Carolina Study Commission on Aging

MINUTES
Wednesday, January 23, 2007
10:00 AM
Room 643, Legislative Office Building

The North Carolina Study Commission on Aging met on Tuesday, January 23, 2007, at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were: Senator Charlie Dannelly, Co-Chair; Rep. Beverly Earle, Co-Chair; Senators Austin Allran and Katie Dorsett: Representatives Alice Bordsen, Debbie Clary, Bob England, and Jennifer Weiss; Ms. Judy Pelt, Ms. Linda Howard, Ms. Florence Soltys, Mr. Brad Allen and Mr. Sam Marsh. Mr. Jackie Sheppard, Ex-officio Member was also present.

Senator Charlie Dannelly presided.

PRESENTATIONS

Presentation of Draft Study Commission on Aging Report

Ms. Theresa Matula, Commission Staff, NCGA Research Division, began with a brief description of each element of the report to be submitted to the governor and the 2007 General Assembly. Commission Members were furnished with copies. See Attachment 1. Commission Recommendations begin on page 25 of the report. There are seventeen (17) recommendations which include fourteen (14) bill drafts. Three recommendations do not require legislation changes. Ms. Matula told Commission members that the wording in Recommendation 11 has been revised regarding funds for the mentally ill housing options. The Commission directed DHHS to provide the appropriate amounts for funding. DHHS suggested $1.5 million in 2007-2008 to provide rental assistance for 250 units and $3 million in 2008-2009 to continue the funding for the 250 units and additional assistance for another 250 units. The second recommendation that was revised was Recommendation 16 for the Win-A-Step-Up Program. It was amended to include funding of $200,000 for 2007-2008 and $200,000 for 2008-2009 to develop a pilot program in home health agencies. Ms. Matula told Commission members that a statement was added indicating that the Win-A-Step-Up Program shall continue to enhance and enrich curriculum components with information and exercises involving appropriate care for individuals with Dementia, anxiety, depression, and other severe mental health problems.

Ms. Matula told Commission members that of the current mobile dental units patients, 80% are Medicaid patients. The other 20% are private pay. There are additional details included in the background information of Recommendation 2.

At this point, Ms. Matula began discussing the each recommendation in detail. She discussed Recommendations 1-6. Please see Attachment 1, pages 25-31 for details. Next, Mr. Shawn Parker, Commission Staff, NCGA Research Division, discussed Recommendations 7-10. Please see Attachment 1, pages 31-34. Mr. Ben Popkin, Commission Staff, NCGA Research Division, discussed Recommendations 11-14. Please see Attachment 1, pages 34-38 for details. Ms. Matula then returned to discuss Recommendations 15-17. Please see Attachment 1, pages 38-41 for details.

Discussion and Vote on the Report

There was some discussion regarding the recommendations. The first concerns were regarding Recommendation 15 – Authorize Star-Rated Certificate Rules. Commission members mentioned that providers seem to have a problem with developing a star rating system. The discussion involved comparison with the star rating system for child day cares. Rep. Bordsen stated that the difference is that in child day cares, the incentive is to do better. The star rating for adult care homes is meant to provide information to consumers. Mr. Jeff Horton with the NC Assisted Living Association, stated that the ratings need to be meaningful. The ratings are expected to be beneficial to persons who are looking to place their loved ones in adult care homes. The Commission decided to work on details and clarification when the bill reaches the various legislative committees.

After discussion, Representative Earle moved to approve the report as amended. The motion carried unanimously.

Minutes from the meetings on September 27, 2006 and January 3, 2007 were approved unanimously.

Senator Dannelly thanked the members and staff for their commitment to the Commission.

The meeting adjourned at 11:30am.

Charlie S. Dannelly

Senator Charlie Dannelly, Co-Chair
Presiding

Beverly Earle

Rep. Beverly Earle, Co-Chair

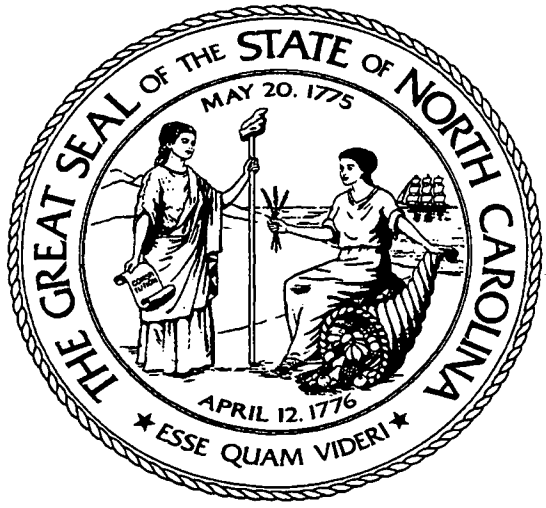
Dee Hodge

Dee Hodge
Commission Assistant

ATTACHMENT 1

NORTH CAROLINA

STUDY COMMISSION ON AGING



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REPORT TO THE GOVERNOR AND THE 2007 REGULAR SESSION OF THE 2007 GENERAL ASSEMBLY

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North Carolina
Study Commission On Aging

January 24, 2007

To: Governor Michael Easley
Lieutenant Governor, Beverly Perdue, 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 2007 Regular Session of the 2007 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 2006 Regular Session of the General Assembly. Proposed legislation is contained within this report.

Respectfully submitted,

Senator Charlie S. Dannelly
Co-Chair

Representative Beverly M. Earle
Co-Chair

North Carolina Study Commission On Aging

2006-2007 Membership List

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Senator Stan W. Bingham

Senator Julia Boseman (resigned)
Senator Katie Dorsett (appointed 8/31/06)

Senator Vernon Malone

Mr. Brad Allen

Mr. Sam Marsh

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Representative Debbie A. Clary

Representative Bob F. England, MD

Representative Jennifer Weiss

Ms. Katherine Fox Price (resigned)
Ms. Regina Duffy Fisher (appointed 2/22/06)

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Ms. Linda Howard

Ex Officio:
Mr. Jackie Sheppard, Assistant Secretary,
Long Term Care and Family Services,
Department of Health and Human Services

Clerks:
Dee Hodge
919/733-5955

Ann Raeford
919/715-2530

Staff:
Theresa Matula,
Shawn Parker,
Ben Popkin
Research Division
919/733-2578

Carol Shaw
Fiscal Research Division
919/733-4910

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2007-SHZ-6: AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, FOR THE PURCHASE OF AN ADDITIONAL MOBILE DENTAL UNIT, AND TO REQUIRE THE BOARD OF GOVERNORS OF THE UNIVERSITY OF NORTH CAROLINA TO STUDY THE DEDICATION OF ONE OR MORE DENTAL SCHOLARSHIP-LOAN PROGRAM SLOTS TO DENTISTS SERVING SPECIAL CARE POPULATIONS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

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2007-SQZ-5: AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REVIEW OPTIONS FOR INCREASING MEDICAID MEDICALLY NEEDY INCOME LIMITS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2007-RDZ-7: AN ACT TO APPROPRIATE FUNDS TO INCREASE AVAILABILITY OF HOUSING OPTIONS FOR NORTH CAROLINIANS WITH MENTAL ILLNESS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2007-RDZ-8: AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY RULES AND REGULATIONS REGARDING HOUSING INDIVIDUALS WITH MENTAL ILLNESS IN THE SAME FACILITY VICINITY AS INDIVIDUALS WITHOUT MENTAL ILLNESS, AND TO RECOMMEND STAFF TRAINING REQUIREMENTS FOR DIRECT CARE WORKERS IN LONG TERM CARE FACILITIES TO PROVIDE APPROPRIATE CARE TO RESIDENTS WITH MENTAL ILLNESS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

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SPECIAL ASSISTANCE IN-HOME PROGRAM OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING

2007-SHZ-10: AN ACT TO AUTHORIZE THE MEDICAL CARE COMMISSION TO ADOPT RULES ALLOWING THE ISSUANCE OF STAR-RATED CERTIFICATES TO ADULT CARE HOMES, AND TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, FOR ADDITIONAL POSITIONS AND DATABASE ENHANCEMENT TO SUPPORT THE PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2007-SHZ-9: AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, FOR THE WIN A STEP UP PROGRAM FOR NURSE AIDES EMPLOYED BY NURSING HOMES, AND FOR A PILOT OF THE WIN A STEP UP PROGRAM FOR NURSE AIDES EMPLOYED BY HOME CARE AGENCIES, AND TO REQUIRE A STUDY OF THE FEASIBILITY OF BECOMING A SELF-SUSTAINING PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

PREFACE

Chapter 120, Article 21, of the North Carolina General Statutes, charges the North Carolina Study Commission on Aging 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 of the North Carolina Study Commission on Aging during the 2006-2007 interim. The Study Commission on Aging met on nine occasions and held public hearings in Charlotte and Burlington. The Commission studied a variety of topics that impact a wide range of programs and services for older adults in North Carolina.

EXECUTIVE SUMMARY

The North Carolina Study Commission on Aging met nine times and conducted two public hearings during the 2006-2007 interim. In response to the study and evaluation of services to older adults, the North Carolina Study Commission on Aging makes the following recommendations to the Governor and the 2007 Session of the 2007 General Assembly:

Recommendation 1: Support for Senior Centers

The Study Commission on Aging recommends that the General Assembly appropriate an additional $500,000 for FY 07-08 and $500,000 for FY 08-09 to the Senior Center General Purpose fund to provide additional support for Senior Centers.

Recommendation 2: Expand Dental Care for Special Care Populations

The Study Commission on Aging recommends that the General Assembly appropriate $200,000 for FY 07-08 to the Department of Health and Human Services, Division of Public Health, to purchase an additional mobile dental unit for a new or existing non-profit mobile dental care provider to serve special care populations in geographic areas of the State that are not currently served by mobile dental units. The Department shall report to the Commission on the status of this project by September 1, 2008.

The Study Commission on Aging recommends that the General Assembly require the Board of Governors of The University of North Carolina to study the feasibility of requiring one or more of the Board of Governors' Dental Scholarship-Loan Program slots be dedicated to individuals who will predominately serve special care populations, primarily disabled individuals and the elderly, and to report findings and recommendations to the Commission by January 15, 2008.

Recommendation 3: Expand Health Care Personnel Registry/Funds

The Study Commission on Aging recommends that the General Assembly expand the Health Care Personnel Registry to include any unlicensed staff of a health care facility that has direct access to residents, clients, or their property, and appropriate an additional $1,700,000 for FY 07-08 and $1,700,000 for FY 08-09 to add staff and improve upon existing allegation response times.

Recommendation 4: Support Project C.A.R.E.

The Study Commission on Aging recommends that the General Assembly appropriate $500,000 to the Department of Health and Human Services, Division of Aging and Adult Services, for FY 07-08, and $500,000 for FY 08-09, to fund Project C.A.R.E. which provides support to individuals with dementia and their caregivers.

Recommendation 5: Additional HCCBG Funds

The Study Commission on Aging recommends that the General Assembly appropriate an additional $5,000,000 to the Department of Health and Human Services for FY 07-08 and $5,000,000 for FY 08-09 for the Home and Community Care Block Grant (HCCBG).

Recommendation 6: Amend the Penalty Review Committee Statutes

The Study Commission on Aging recommends that the General Assembly enact legislation to change the Penalty Review Committee process.

Recommendation 7: Study Safe Transportation of Passengers in Wheelchairs

The Study Commission on Aging recommends that the General Assembly direct the Department of Transportation to study appropriate methods of transporting passengers seated in wheelchairs, to develop guidelines for the installation and use of wheelchair tiedown systems, and to report findings and recommendations to the Study Commission on Aging and the Joint Legislative Transportation Oversight Committee by February 1, 2008.

Recommendation 8: Adult Protective Services Pilot Program

The Study Commission on Aging recommends that the General Assembly appropriate $1,492,000 to the Department of Health and Human Services, Division of Aging and Adult Services, for FY 07-08 and $1,930,000 for FY 08-09 to enact a pilot program to assess proposed changes to the adult protective services statutes and to report on the evaluation of the pilot by March 1, 2009.

Recommendation 9: Study Medically Needy Income Standard

The Study Commission on Aging recommends that the General Assembly enact legislation to require the Department of Health and Human Services, Division of Medical Assistance, to study the medically needy income standard and determine the best method of increasing the standard while providing improved consistency across long-term care settings and report to the Study Commission on Aging by September 1, 2008.

Recommendation 10: Support for NC Rx

The Study Commission on Aging supports the NC Rx program, funded through the Health and Wellness Trust Fund, which assists seniors having difficulty paying for prescription drugs, and expresses gratitude for the SHIIP program and the many volunteer organizations that provide information to citizens enrolling in Medicare prescription drug programs.

Recommendation 11: Funds for Mentally Ill Housing Options

In response to the Commission on Aging and Mental Health Oversight Subcommittee report, the Study Commission on Aging recommends that the General Assembly appropriate to the Department of Health and Human Services and the Housing Finance Agency, $1,506,600 for FY 07-08, to provide rental assistance for at least 250 units, and $3,013,200 for FY 08-09, to continue rental assistance for the units in FY 07-08 and to provide rental assistance for at least an additional 250 units, which shall increase the availability of housing options for North Carolinians with mental illness, particularly for those individuals that are transitioning out of State psychiatric hospitals and those that are transitioning out of long-term care facilities.

Recommendation 12: Study Housing Concerns and Staff Training Required for Mixed Populations

In response to the Commission on Aging and Mental Health Oversight Subcommittee report, the Study Commission on Aging recommends that the General Assembly direct the Department of

Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and the Division of Mental Health, to analyze the rules and regulations in North Carolina and in other states regarding the provision of appropriate care and the housing of residents with mental illness in the same facility vicinity as those without mental illness. The Department shall also analyze and recommend appropriate staff training requirements to enable direct care workers in long-term care facilities to simultaneously provide appropriate care to mentally ill residents and those that are not mentally ill. The Department shall present findings, recommendations, and any required statutory or rule changes to the Study Commission on Aging and the Joint Legislative Mental Health Oversight Committee by March 1, 2008.

Recommendation 13: Increase SA In-Home Slots

In response to the Commission on Aging and Mental Health Oversight Subcommittee report, the Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to increase the total number of State/County Special Assistance In-Home Program slots to 2000 in FY 07-08.

Recommendation 14: Support for the Transitional Residential Treatment Program and for LME Notification of Mental Health Determination Using the Uniform Screening Tool

In response to the Commission on Aging and Mental Health Oversight Subcommittee report, the Study Commission on Aging expresses support for development, by the Department of Health and Human Services, of a "Transitional Residential Treatment Program" to provide 24-hour residential treatment and rehabilitation for mentally ill adults who have a pattern of difficult behaviors that exceed the capabilities of traditional community residential settings, and support the continued development of a Uniform Screening Tool, including the requirement that the appropriate Local Management Entities (LMEs) be notified of the status of the individual's mental health and the admission of that individual to a facility.

Recommendation 15: Authorize Star-Rated Certificate Rules

The Study Commission on Aging recommends that the General Assembly enact legislation to give the Medical Care Commission the authority to adopt rules allowing the issuance of star-rated certificates to adult care homes and to appropriate to the Department of Health and Human Services, Division of Facility Services, $153,000 for FY 07-08, to be used for salaries for two positions and for database enhancement, and $108,000 for FY 08-09, for salaries and database maintenance, for implementation of the Star Rating system.

Recommendation 16: Funds for WIN A STEP UP

The Study Commission on Aging recommends that the General Assembly appropriate to the Department of Health and Human Services, Division of Facility Services, $200,000 for FY 07-08 and $200,000 for FY 08-09 to develop and pilot a WIN A STEP UP (**W**orkforce **I**mprovement for **N**ursing **A**ssistants: **S**upporting **T**raining, **E**ducation, and **P**ayment for **U**pgrading **P**erformance) Program for nurse aides employed by home care agencies; to appropriate $200,000 for FY 07-08 and $325,000 for FY 08-09, in addition to fine and penalties collections provided by the Division, to continue the program in nursing homes; and to direct the WIN A STEP UP Program to study the feasibility of becoming a self-sustaining program and to report to the House and Senate Appropriations Subcommittees on Health and Human Services by May 1, 2008. The WIN A STEP UP program shall continue to enhance and enrich curriculum components with information and exercises involving appropriate care for individuals with dementia, anxiety, depression, and other severe mental health problems.

Recommendation 17: Support Recommendations from the House Study Committee on State Guardianship Laws

The Study Commission on Aging supports the recommendations of the House Study Committee on State Guardianship Laws.

Aging North Carolina: The 2007 Profile

Prepared by the Department of Health and Human Services, Division of Aging and Adult Services

North Carolina's Demographic Shift: North Carolina is in the midst of a significant demographic change as the state's 2.3 million baby boomers (those born between 1946 and 1964) begin to enter retirement age. Today, the proportion of the state's population who are seniors, ages 65 and older, is roughly 12 percent. By 2030, when the youngest baby boomers are retirement age, the proportion should reach 17.7 percent or 2.1 million older North Carolinians including the surviving boomers who will be between ages 66 and 84. The figure below shows the milestones of the baby boomers expressed in terms of some major federal and state age-related programs (eligibility age in parenthesis). For example, last year (2006), the oldest boomers (i.e., born in 1946) became eligible to receive services under the Older Americans Act.

Baby Boomer Milestones

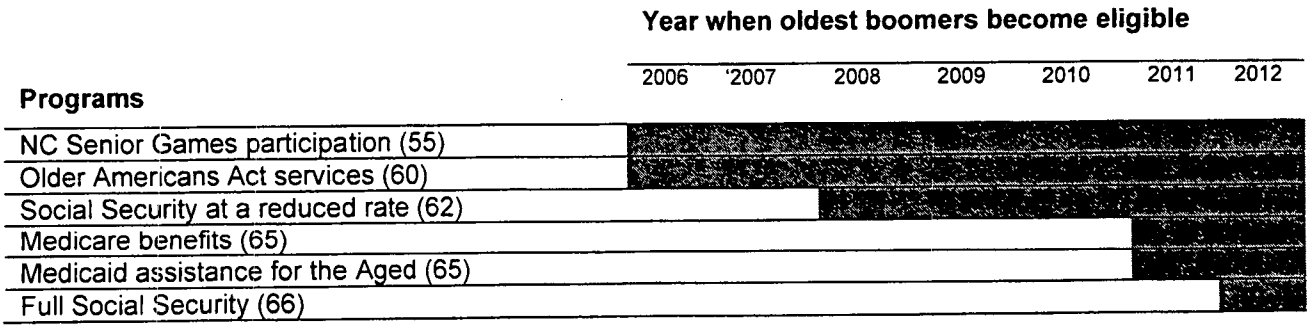
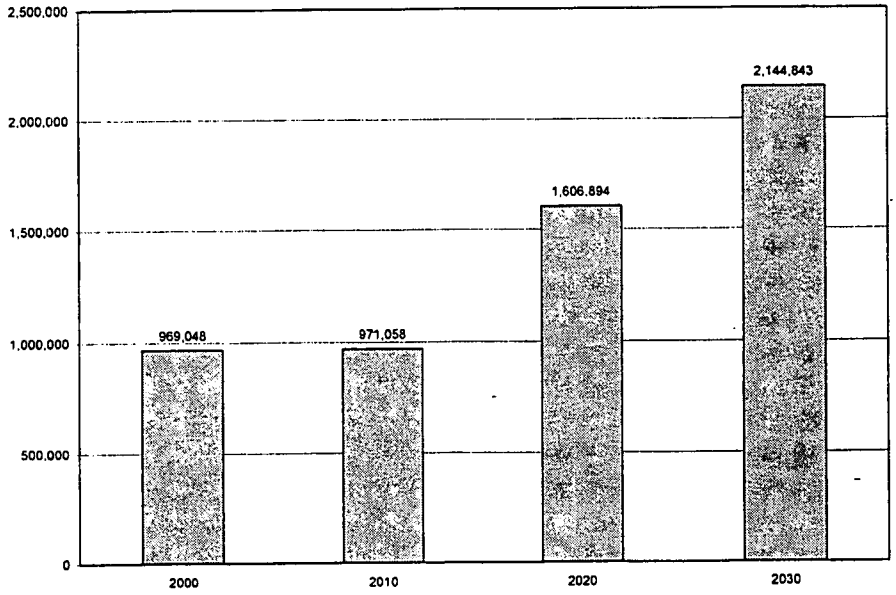


Figure A: Growth of Older North Carolinians Age 65+ (2000-2030)



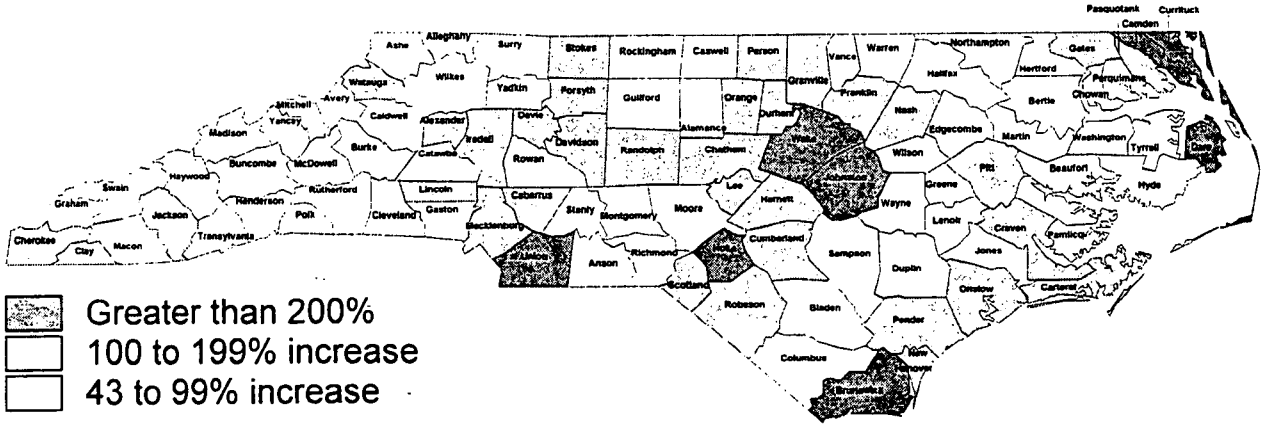
The impact of the aging baby boomers is clearly indicated in the projected growth of North Carolinians age 65+ between 2010 and 2030 as shown in Figure A. [1] As that bar graph shows, there is little expected growth in the older population between 2000 and 2010. This is because the Great Depression and World War II were times when the entire country experienced the

lowest birth rates the country had ever experienced up until that time. The small number of people born during those two times (1929 to 1945) will be 65 to 81 years old in 2010. Because of retirement migration to North Carolina, we will not see an actual decline in the number of older adults in that period, as some states will, but the growth will be modest.

Figure B shows the projected growth of the older population by county between 2000 and 2030. During this period, growth for the state as a whole is projected at 50 percent, while the population 65 and older is expected to grow 121 percent, and the population 85 and older, 144 percent. [1]

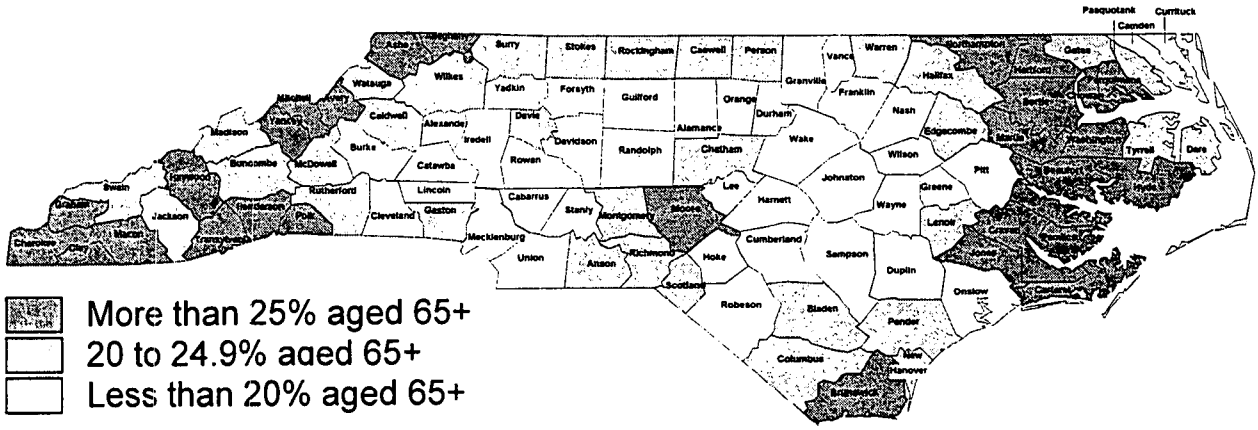
The eight counties with more than 200 percent growth can be divided into two very different categories. Union, Wake, Johnston, and Hoke are experiencing rapid growth in their overall population as expanding parts of metropolitan areas, and they will remain relatively "young" (The proportion of their population projected to be over 65 is lower than that of the state as a whole.) The remaining four counties—Brunswick, Camden, Currituck, and Dare—by contrast, are projected to see disproportionate growth in their aging population. Brunswick and Dare, in particular, are projected to have substantially higher percentages of older adults (26.4 percent and 24.1 percent respectively), compared to 17.7 percent for the state as a whole.

Figure B. Projected Growth of Population Ages 65 and Older from 2000 to 2030



Based on 2000 Census counts (www.census.gov) and April 2030 projections (2006, Demographic Unit, Office of State Budget and Management

Figure C. Percent of County Population Projected to Be Ages 65 and Older in 2030



Note: The proportion in the state is 17.7%
Based on April 2030 projections (2006, Demographic Unit, Office of State Budget and Management

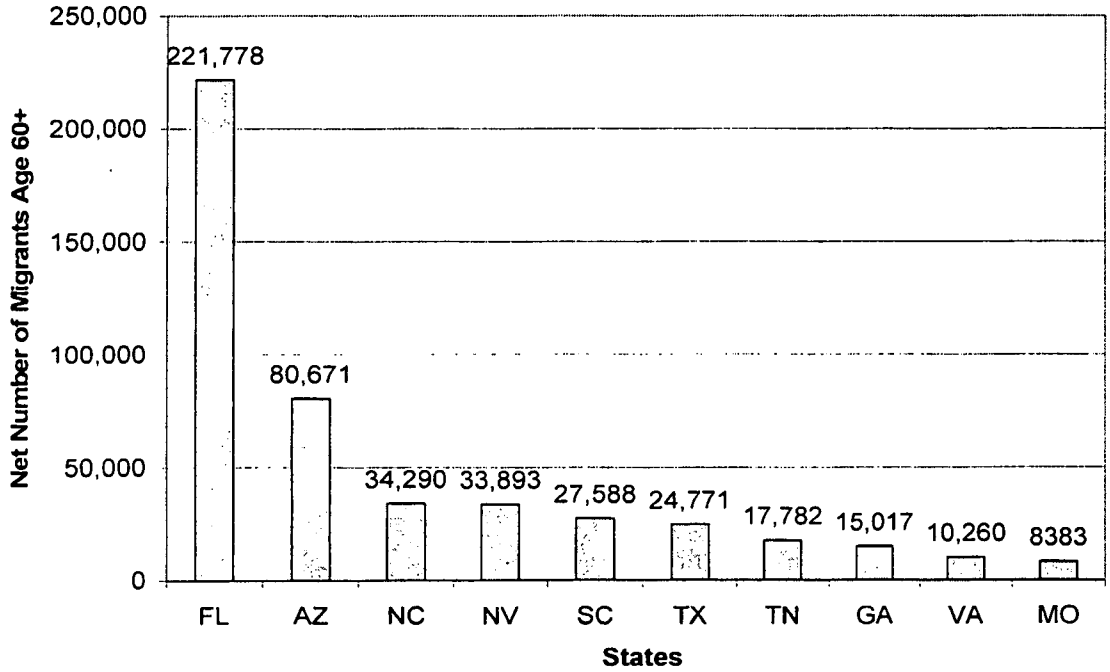
Figure C shows the counties that will have the largest concentration of older adults in 2030. All are in areas attractive to retirees, but many are also counties that will continue to lose younger residents because of modest economic opportunities.

There are several factors that contribute to the different rates of aging of the state's 100 counties [2]. These include:

- 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, and other counties with attractions to specific groups of older adults (e.g. golf courses).

Although decreases in both fertility and mortality are the major factors in the aging of the state's population, migration also plays a key role. As shown in Figure D, North Carolina ranked third nationally as a retirement migration destination 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. [3] The latest data estimates that 22,893 older adults (60+) relocated to North Carolina from other states and abroad in just one year between 2004 and 2005 [4]. That means that in 2005, 17 out of every 100 people 60 and older living in the state had been living out of the state the year before.

Figure D: Top Ten States with Net Number of Migrants Age 60+ (1995-2000)



According to the most recent life tables from the NC State Center for Health Statistics, if age-specific mortality remains unchanged, 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 other racial groups. However, at the oldest ages, African Americans, in particular, have a life expectancy that is the same or slightly greater than that of whites. This is known as the "crossover effect." [5]

Life Expectancies (in Years) by Age Group, Gender, and Race

	NC	White		All other Races*	
Age Groups	Combined	Male	Female	Male	Female
(At Birth)	75.6	73.8	79.6	68.0	75.8
60-64	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

*This group is primarily African American, but other much smaller racial groups including Asian and American Indian, are included. Source: NC Center for Health Statistics (2002). *Healthy Life Expectancy in North Carolina, 1996-2000*

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 and faith communities as well as others must identify and respond to the challenges and opportunities of these demographic shifts.

In the 2003-2007 State Aging Services Plan, the NC Division of Aging and Adult Services introduced a new initiative–Livable and Senior-Friendly Communities–to raise awareness of the aging of our population and to promote North Carolina's communities becoming senior-friendly as well as livable for all people through collaboration among citizens, agencies, organizations, and programs, in both the public and private arenas. This initiative will form the core around which the 2007–2011 State Aging Services Plan will be organized. A livable and 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 livable and senior-friendly community will work to address a wide range of issues and concerns (e.g., air quality, housing, long-term care services, employment, and enrichment opportunities) that, as a whole, affect the quality of life of seniors and others in the community. Also, a livable and 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. [6] 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 and 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, as it is thirty-eighth among states in the proportion of the population over 65. [7]

- Estimated NC population age 65+ in 2006: 1,050,849 (12.0 percent of total population)
- Estimated NC population age 85+ in 2006: 131,612 (1.5 percent 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, ethnicity/race, residence, rurality, disability, health status, grandparents raising grandchildren, and veteran status.

1. Gender: Older women represent 58.9 percent of the 65+ age group and 71.1 percent of the 85+ age group. [8] 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. [9]

- Marital Status: Because men have shorter life expectancy, and because they tend to marry younger women, at ages 65 and older, women are more than twice as likely to be unmarried as men in their age group. [10] Data show that being unmarried (widowed, divorced, separated, or never married) increases a woman's vulnerability to poverty. According to the Social Security Administration, in 2004 fully 74 percent of unmarried beneficiaries of either sex rely on Social Security for half or more of their income (compared to 64 percent of married beneficiaries) and 43 percent rely on Social Security for 90 percent or more of their income compared to 21 percent of their married counterparts. [11]

Percent Unmarried by Age Group

	Age 65-74	Age 75-84	Age 85+
Unmarried Women in NC	45.0	65.0	89.6
Unmarried Men in NC	20.9	26.0	41.4

Source: American Community Survey (2006). *Table B12002.*

- Ethnicity/Race: Altogether 18.7 percent of persons age 65+ are members of ethnic minority groups in North Carolina. [12] Compared to the nation as a whole, North Carolina's population age 65+ includes a larger proportion who are African American (15.7 percent in NC compared to 8.3 percent nationally) and a smaller proportion of Latinos (1.1 percent in NC compared to 6.2 percent nationally). American Indians, Asian Americans, and other ethnic groups account for 1.9 percent of the age group 65 and older. In North Carolina as well as nationally, older adults from most ethnic minority groups show both a higher poverty rate and a lower life expectancy when compared with the non-Latino white population. Poverty rates for the two largest racial groups are shown in the table below. [Note: See the Demographic Shift section for the information on life expectancy.]

Percent Below Poverty Level for the Older Population of North Carolina by Gender, Race, and Age Group

	White		African American	
	Male	Female	Male	Female
Age Group 65 - 74	4.3	8.8	15.6	24.6
Age Group 75+	7.7	15.3	25.4	30.8
Data from 2005 American Community Survey reflecting poverty in 2004.				

- Residence: The 2000 Census showed that in North Carolina, 81.4 percent of householders ages 65 and older owned their homes (with or without mortgage), yet among homeowners in that age group, over 61,000 reported incomes for 1999 that were below poverty. This figure means that 11.8 percent of the homeowners over age 65 were poor, compared to 7.5 percent for homeowners of all age groups. [13] This has implications for both helping some older adults be responsible for their own needs (e.g. reverse mortgages) and for the need for property tax relief to older adults. Among renters age 65+ who provided information, 63.2 percent, or 72,739 households, spent more than 30 percent of their household income on rent [14]. Furthermore, 5,000 North Carolina homeowners and renters age 65+ lacked

complete plumbing facilities in their homes. [15]

- Rurality: Among all age groups, 39.8 percent of North Carolina residents live in rural areas compared to only 21.0 percent for the country as a whole. [16] The percentage among older adults is no doubt higher (based on the percentages of older adults in the predominantly rural counties), but there is no age-specific figure available. In 2000, North Carolina's rural population (3,202,238) was almost as large as the one in Texas (3,647,747), 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 percent) 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 percent to 61.8 percent, 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. At the same time North Carolina has made the transition away from an agricultural economy so that only 1.1 percent of its people live on farms, only slightly more than the 1.0 percent for the nation as a whole. A 2002 report from Making a Difference in Communities (MDC) highlights a long list of challenges that 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. [17]

- Disability: In North Carolina, 43.0 percent of the non-institutionalized civilian population ages 65 and older reported having one or more disabilities by the US Census definition—44.4 percent of women and 41.0 percent of men, according to the 2005 American Community Survey. [18] The Census Bureau defines disability as "a long-lasting physical, mental, or emotional condition that makes 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." This definition is very broad and leads to counting a number of people who, indeed, have difficulties but are able to function independently and would not meet the average person's perception of a person with a disability.

- 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. [19] In particular, the coastal plain 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 [20]. 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). [5] Diabetes mellitus is the sixth leading cause of death for the older North Carolina population in general, but like stoke, it is a more serious threat to the African American community, being the fourth highest cause of death in African Americans of all ages in our state [19].

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 (2006). *Leading Causes of Death – 2005.*

An important factor in health status is physical activity. A sedentary life style is known to increase a person's risk of heart disease, diabetes, and other chronic conditions. Unfortunately, in a multi-year study North Carolinians age 65+ were ranked 48th among the 50 states in physical activity with nearly 40 percent of residents aged 65 and older reporting that they did not engage in any physical activity in the past month. [21] The 2005 Behavioral Risk Factor Surveillance System (BRFSS) shows that nearly 70 percent of adults in that age group do not participate in recommended levels of physical activity [22]. The BRFSS also shows over one third of people age 65+ say that their general health status is fair or poor.

- Grandparents Raising Grandchildren: According to the 2005 American Community there were 82,149 NC grandparents who reported that they had one or more grandchildren living with them *for whom they are responsible*. This represents nearly half of all grandparents whose grandchildren live with them and 1.7 percent of all North Carolina grandparents. Among those grandparents responsible for their grandchildren, over 49 percent live in households in which neither parent of the child is present. [23] According to AARP, 47 percent of NC grandparents responsible for their grandchildren are African American; 2 percent are Hispanic/Latino; 2 percent are American Indian or Alaskan Native; and 47 percent are white [24]. Given the relative sizes of these populations, it is clear that this is an even larger issue in the African American community than among other ethnic groups.[24]

- Veteran Status: Of the estimated 756,216 veterans living in NC in 2006, over 262,000, or 35 percent, were age 65 and older. Another 255,000 (34 percent) were ages 50 to 65, most of whom were Vietnam-era veterans. [25]. The group of veterans from the Vietnam-era contains proportionally more disabled members than survivors of other wars due to quicker and more advanced medical treatment. [26] The Veterans Administration has frequently written about the aging of the veterans as a major challenge to its health care system in coming years.

In summary, North Carolina has a large, economically and ethnically diverse older population. With this diversity come both special assets and special challenges. Even the most vulnerable older adults often give as much to their communities as they receive. Nevertheless, we must be aware that those who face disabilities, disparities of income and health care, and the responsibilities of caring for grandchildren are more likely to need public services and supports. While meeting these disparate needs of today's older adults, our state is also witnessing the first minor steps of the transition of the baby boomers into retirement ages. This will transform the

age structure of the state and bring a new generation of older adults with some of the same historic challenges, but also new attitudes, new challenges, and new resources.

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[25] US Department of Veterans' Affairs *VetPop2004 Version 1.0 State and National Tables (yearly projections)* http://www1.va.gov/vetdata/docs/1l.xls

[26] US Department of Veterans' Affairs (2002) *VA History in Brief http://webpages.charter.net/wisconsinlegion-7thdistrict/VA_History.htm#Vietnam_War*

Pertinent Web Sites for Related Information

- NC Division of Aging and Adult Services (http://www.dhhs.state.nc.us/aging/demo.htm)
- Demographics Unit, NC Office of Budget and Management (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

September 12, 2006

The North Carolina Study Commission on Aging met on Tuesday, September 12, 2006, at 10:00 a.m.. in Room 643 of the Legislative Office Building. Senator Charlie Dannelly presided. He introduced Senator Katie Dorsett as the Commission member replacing Senator Julia Boseman, who resigned. At this meeting, the Commission heard several updates concerning legislative actions of interest to seniors and the potential Commission work schedule for the coming interim.

Mr. Shawn Parker, Aging Commission Staff, was the first presenter. He provided members with a handout entitled Summary of Substantive Legislation Related to Aging. (Appendix A.) Mr. Parker stated that within the Appropriations Act, Senate Bill 1741, there are number provisions that impact older adults specifically relating to the utilization of Medicaid, housing, and healthcare issues. Mr. Parker explained that Theresa Matula would provide an overview of legislation recommended by the Study Commission on Aging later in the meeting, but beyond bills specifically endorsed by the Commission, the General Assembly enacted legislation that expanded the Special Assistance In-Home program, increased from Class 1 to Class A1 the penalty for committing assault or battery upon a handicapped person, and created a Stroke Advisory Council within the Justus Warren Heart and Stroke Prevention Task Force.

Mr. Parker told Commission members that there were also a number of studies established including: studies of the following topics: regulation of pharmacy benefit management, geriatric care providers, the feasibility of establishing a prescription drug cost management office, rural health care access and needs, the Fair Housing Act, and no-fault compensation for injuries to elderly and disabled persons.

Ms. Carol Shaw, Commission Staff, gave a presentation on budget actions affecting older adults. She furnished members with a handout on funds appropriated in S.L. 2006-66 and provided a breakdown for the use of those funds. Ms. Shaw stated that there was over $10 million appropriated for housing for disabled persons and funding for the Housing Trust Fund was increased by $5 million. Both of these items were left off the list and could potentially affect the elderly.

Ms. Theresa Matula, Commission Staff, provided members with a handout entitled 2006 Recommendation Status Report. (Appendix A.) Ms. Matula told Commission members that 8 of the 12 recommendations made in 2006 were enacted by the General Assembly. The recommendations that were not enacted included reenacting the long-term care insurance tax credit, providing additional funds for the Housing Trust Fund, and expanding the Health Care Personnel Registry.

Ms. Matula continued by handing out a list of potential future meeting dates for the Commission. She also presented information on the possibility of working with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. On August 29, 2006, the co-chairs of the Study Commission on Aging sent a letter to Representative Verla C. Insko and Senator Martin L. Nesbitt, Co-chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services requesting assistance in addressing issues related to serving mentally ill individuals residing in long-term care (LTC) facilities. A copy of the letter is contained in Appendix B.

September 27, 2006

The North Carolina Study Commission on Aging met on September 27, 2006, at 10:00 a.m. in Room 643 of the Legislative Office Building. Representative Earle was the presiding Co-Chair. Topics covered during this meeting include: current and future long term care facility screening and assessment, geriatric mental health specialty teams, and the Department of Health and Human Services recommendation for a study of residential choices and treatment options for individuals with mental illness.

The first presentation was by Lynne Perrin, Division of Medical Assistance, Department of Health and Human Services (DHHS). She presented information on current and future long-term care facility screening and assessment. Ms. Perrin reported that a contract has been awarded for the design and implementation of a Uniform Screening Program. The Department plans rapid development and testing of the program with an implementation date of September 2007. The goal of the new uniform screening program is to ensure timely and appropriate placement of Medicaid recipients. Objectives of the program are to: reduce inappropriate placements; reduce paperwork of referring agencies; provide a clearer picture of the applicant's needs to providers to whom the applicant shall be referred; provide recipients with a clearer set of service options responsive to their current needs and to encourage choice; reduce the costs of screening through streamlined processes, procedures, automation, consolidation of screening responsibilities and attendant staffing reductions; and foster the creation of a more coherent, comprehensive system of long term care services.

The second presentation was on Geriatric Mental Health Specialty Teams. The presenters on this topic were Bonnie Morell, with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS, and Barbara Warren, a geriatric mental health specialty team member employed with New River Behavioral Healthcare. Dr. Morell provided the Commission with a brief history of the Geriatric Mental Health Specialty Teams, the responsibilities, and the location and staffing of teams. She reported that in January 2007, funding will be made available so that teams may add an additional position to focus on needs related to younger adults in long term care and the names of the teams will change to Mental Health Specialty Teams. Ms. Warren provided further explanation of the types of services provided by a Geriatric Mental Health Specialty Team.

The meeting concluded with Jackie Sheppard, Department of Health and Human Services Assistant Secretary for Long-Term Care and Family Services, discussing the Department's plans for a study of residential choices and treatment options for individuals with mental illness.

October 3, 2006

The North Carolina Study Commission on Aging conducted the first of two public hearings this interim on October 3, 2006, at 10:00 a.m. in the John Robert Kernodle Senior Activities Center in Burlington, North Carolina. Representative Earle was the presiding Co-Chair. At this hearing, forty (40) people spoke to Commission members about a number of concerns including: Senior Center funding, Senior Games, funding for the Home and Community Care Block Grant and support for Project C.A.R.E. (See Appendix C. for the Public Hearing Summary.)

October 11, 2006

The North Carolina Study Commission on Aging met on Wednesday, October 11, 2006, at 10:00 a.m. in Room 544 of the Legislative Office Building. Representative Beverly Earle was the presiding Co-Chair. At this meeting, the Commission heard presentations on Special Care Units,

Adult Day Care Awareness, and Adult Protective Services Task Force Collaboration.

The first presenter was Mr. Doug Barrick with the Division of Facility Services Adult Care Licensure Section, Department of Health and Human Services (DHHS). He furnished Commission members with a handout entitled Adult Care Home Alzheimer's Special Care Units (SCU). He stated that special care units are defined as any section, wing, r hallway within an adult care home separated by closed doors from the rest of the home, or a program provided by an adult care home that is designated or advertised especially for the care of residents with Alzheimer's Disease, or related disorders.

Ms. Carol Shaw, Commission Staff, was the next presenter. She furnished Commission members with a brief presentation and handout entitled Recent Changes in Reimbursement for Special Care Units (SCU). She stated that in October of 2002, DHHS established an Adult Care Home Cost Modeling Committee which met for two years. The report from the Committee recommended that reimbursement modeling should account for resident mix and facility size. Also, the Committee concluded that reimbursement models should differentiate between the traditional adult care home resident and those in SCUs to reflect the higher staffing need of SCUs, and rates should reflect the different costs associated with types of facilities based on populations served and the staffing levels required.

Ms. Shannon Crane, Adult Day Care Consultant, Division of Aging, DHHS, was the next presenter. Ms. Crane told Commission members that enacted legislation required the Division of Aging and Adult Services and the Division of Medical Assistance to provide education and training, if necessary, to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health services; and to report on the status of the Partners in Caregiving Study recommendations. Ms. Crane stated that the Division of Aging and Adult Services (DAAS) and CAP met in early June of 2006. She explained that the following issues had already been implemented:

- A general information sheet was generated for CAP case managers and consultants and was posted on the website;
- A special CAP section was developed on the DAAS website;
- A system providing CAP notification of new adult day health programs was developed; and
- Notices to adult day health programs were mailed which included information on the CAP case manager(s), encouraged programs to provide brochures and other information to individuals, and encouraged adult day health program directors and/or their board members to join the CAP advisory meeting in their area.

Further, Ms. Crane provided that initiatives in progress include:

- Department of Medical Assistance (DMA)-CAP plans to contact representatives of the Office of Research Demonstrations and Rural Health Development to discuss educating the Community Care Networks;
- A presentation by DAAS Adult Day Services staff to be included as a part of the day set aside for CAP Case managers at the next Association of Home and Hospice Care Conference; and
- DMA-CAP tracking of the effectiveness of this awareness campaign through both numbers enrolled in and expenditures to adult day health programs.

Ms. Suzanne Merrill, Adult Services Section Chief, Division of Aging and Adult Services, DHHS, provided copies of the Adult Protective Services Task Force Report to the Commission. Ms. Merrill stated that the report was prepared in response to Session Law 2005-23. This law directed the Adult Protective Services (APS) Task Force to collaborate with stakeholders and

others interested in improving APS and report those finding to this Commission and the House Study Committee on Guardianship Laws. After collaborating, reviewing feedback, and researching other states' APS laws and policies, recommendations were developed to strengthen North Carolina's APS Program.

Next, Ms. Nancy Warren, Adult Services Program Administrator, Division of Aging and Adult Services, DHHS, continued the presentation by reviewing the core recommendations from the APS Task Force. Mr. John Eller, Director, Mecklenburg County Department of Social Services (DSS) for Adults Division, spoke briefly on the importance of implementing the changes recommended. Ms. Jan Elliott, Director of the Scotland County DSS, told Commission members that the North Carolina Association of County Directors of Social Services Board endorsed the APS Clearinghouse Model in September of 2006. She stated that implementation of the model requires adequate funding and that the directors support a pilot as the first step. As such the pilot would provide a phased-in approach allowing fine tuning and funding processes to take place over several years.

October 17, 2006

The North Carolina Study Commission on Aging conducted the second public hearing this interim at 10:30 a.m. on October 17, 2006, at the Shamrock Senior Center in Charlotte, North Carolina. Senator Charlie Dannelly was the presiding Co-Chair. The Commission heard from thirty-three (33) individuals during this hearing.

The issues mentioned with greatest frequency at both public hearings were: Support for Senior Centers, Increase/Continue Support for Senior Games, Increase/Continue Funding for Alzheimer's and Project C.A.R.E., Increase Funding for the Home and Community Care Block Grant, Resolving Issues Related to Mentally Ill in Long-Term Care Facilities, and Increased Funding/Support for Senior Friendly Housing. (See Appendix C for the Public Hearing Summary.)

October 25, 2006

The North Carolina Study Commission on Aging met at 10:00 a.m. on October 25, 2006, in Room 643 of the Legislative Office Building. Representative Beverly Earle presided. Ms. Theresa Matula, Commission Staff, presented the Commission with an overview of comments made by members of the public at the two public hearings conducted during the interim. Public Hearings took place on October 3, 2006 at the John R. Kernodle Senior Activities Center in Burlington, and on October 17, 2006 at the Shamrock Senior Center in Charlotte.

Dr. Bill Milner and Dr. Ford Grant, with Access Dental Care, and Carolinas Health Care/Carolinas Mobile Dentistry, presented the Commission with information relating to the provision of dental care to older adults. Drs. Milner and Grant provided information about the operations of non-profit mobile dental care units currently serving the special care population which includes patients who have intellectual or physical disabilities. Drs. Milner and Grant also spoke about the great need for this type of dental service and the challenges faced by providers.

Barbara Ryan, Division of Facility Services, Department of Health and Human Services (DHHS), presented the Commission with information on two separate topics. The first topic was the Penalty Review Committee. Ms. Ryan provided an overview of legislative changes to the Penalty Review Committee (PRC) process resulting from Session Law 2005-276, Section 10.40A(1). Ms. Ryan explained some of the challenges brought about by the 2005 statutory changes and presented recommendations for continued refinement of the PRC process. Ms. Ryan then presented the Commission with a status report of the online posting of violations and

penalties levied by the Adult Care Section.

November 15, 2006

The North Carolina Study Commission on Aging met on November 15, 2006, at 10:00 a.m. in Room 544 of the Legislative Office Building. Representative Beverly Earle called the meeting to order and presided until Senator Dannelly arrived. During the meeting, the Commission heard presentations on the Community Alternatives Program for Disabled Adults (CAP/DA), Special Assistance In-Home Slots, securing wheelchairs in vans, liability insurance for long-term care facilities, and registered sex offenders in long-term care facilities.

Prior to the presentations, Theresa Matula, Commission Staff, provided information and handouts on dental care in North Carolina and the new North Carolina (NC) Rx program. Ms. Matula gave the Commission a copy of the 2005 NC Oral Health Summit Access to Dental Care Report as a follow-up to questions on the distribution of dentists. She also provided a handout, containing excerpts from the report, on dental issues of interest to the Commission. The Commission also received information, a copy of the application, and contacts for the new NC Rx senior prescription drug assistance program.

Tracy Colvard with the Division of Medical Assistance, Department of Health and Human Services (DHHS), presented information on the Community Alternatives Program for Disabled Adults (CAP/DA) as required by S.L. 2006-109. Session Law 2006-109 was enacted in response to a previous Commission recommendation and required the Department to examine the Community Alternatives Program for Disabled Adults (CAP/DA) in light of issues identified in the Medicaid Institutional Bias Study, and to make an interim report of its findings to the Commission on or before August 30, 2006, and a final report on or before August 30, 2007. Mr. Colvard reported on the number of CAP/DA slots across the State and the utilization of these slots. The Commission discussed the situation with Mr. Colvard, including reasons why the utilization rate may not be higher in some counties.

The next presenter was Geoff Santoliquido with the Division of Aging and Adult Services, DHHS. He provided the Commission information about the status of Special Assistance (SA) In-Home slots. Mr. Santoliquido gave a history of the SA In-Home Slots and discussed efforts to support and promote the program.

The Commission then heard from Dr. Robert Sullivan regarding the issue of securing wheelchairs in vans for safe passenger transport. Dr. Sullivan explained that while certified passenger restraint systems are mandated for adults and children seated in vans, there is no law regulating restraint systems for persons seated in wheelchairs. He pointed out that the majority of incidents involving persons transported in wheelchairs occur during ordinary driving maneuvers, not during a collision. He presented further observations about the situation based on incident reports filed with the Division of Facility Services by nursing homes. The material he distributed contained information and research on wheelchair tie down systems and letters of support from a number of organizations.

Next the Commission heard from Jeff Weber, an attorney with Anderson Weber & Henry on the issues of liability insurance for long term care facilities. In response, Bill Hale, with the Department of Insurance provided the Commission with a list of the North Carolina General Statutes that require liability insurance.

Mr. Weber also spoke on the topic of registered sex offenders residing in long-term care facilities. Ben Popkin, Commission Staff, followed this presentation with a summary of a General Accounting Office (GAO) report on, LTC Facilities: Information on Residents Who Are

Sex Offenders or Are Paroled for Other Crimes.

December 13, 2006

The North Carolina Study Commission on Aging met in Room 643 of the Legislative Office Building at 10:00 a.m. on December 13, 2006. Representative Beverly Earle presided.

Dennis Streets, Director, Division of Aging and Adult Services, Department of Health and Human Services (DHHS), presented the Commission with recommendations addressing biases identified by the North Carolina Institutional Bias Study Report, as required by Session Law 2006-110. Recommendations were developed in collaboration with providers and advocates of home and community-based services and were presented to the Commission in the form of a summary report.

Karisa Derence, Division of Aging and Adult Services, DHHS, presented the Commission with information relating to the NC Alzheimer's Demonstration Program, Project C.A.R.E. (Caregiver Alternatives to Running on Empty). The goal of Project C.A.R.E. is to "increase access, choice, use, and quality of respite care to low-income rural and minority communities." The project is currently serving ten counties in the western region of the State, with plans to expand to additional counties upon receipt of pending expansion grants. However, Ms. Derence explained that the grant funding for Project C.A.R.E. in the western part of the State is ending in June 2007.

Steve Freedman, Division of Aging and Adult Services, DHHS, presented the Commission with information on the State's 163 recognized Senior Centers. Senior Centers are designated as community focal points by the Older Americans Act and provide a wide range of services and activities to the State's older adults. Mr. Freedman provided detail on the funding of Senior Centers, with particular attention to the Senior Center Outreach and General Purpose Fund, which is used to support senior center operation and development costs.

January 3, 2007

The North Carolina Study Commission on Aging met on Wednesday, January 3, 2007, at 9:30 a.m. in Room 643 of the Legislative Office Building. Senator Charlie Dannelly presided. At this meeting, the Commission heard several reports and updates concerning ongoing programs.

Suzanne Merrill and Emily Saunders, Division of Aging and Adult Services, Department of Health and Human Services (DHHS) presented a progress report on the Quality Improvement Consultation Program for adult care homes. Ms. Merrill reported to the Commission that the Program is comprehensive and addresses multiple facets as directed by the authorizing legislation. She spoke on how a stakeholder task force was developed, met, and concluded that medication safety should be chosen as a priority for the Quality Improvement Program.

Jeff Horton, Division of Facility Services (DFS), DHHS, provided the Commission with a report overview on the plan for developing a Star Rating System for adult care homes. Mr. Horton reported that the focus of the report was on which factors should be considered in determining a facility's star rating. The factors included: results from inspections conducted by DFS, administrative actions taken against the facility, voluntary participation in quality improvement initiatives, and achieving NC NOVA designation. For the Star Rating System to be effective, Mr. Horton stated that statutory authority to promulgate rules would be required, as well as appropriations to provide additional staff resources to fulfill this initiative.

Ms. Angela Floyd, Division of Medical Assistance, DHHS, provided the Commission with an update on the newly established Long Term Care Insurance Partnership Program. Ms. Floyd

indicated that this program was established by Session Law 2006-66 and is an alliance between the Division of Medical Assistance, DHHS, and the Department of Insurance. The goal of the partnership is to provide incentives for the purchase of private long term care insurance.

Dr. Bob Konrad, Cecil G Sheps Center, University of North Carolina, presented on the WIN A STEP UP Program. Dr. Konrad explained that the Program was established to address North Carolina's nurse aide turnover rate. The Program is a partnership between DHHS and the UNC Institute on Aging with active participation from the nursing home industry. The objectives of the program are to upgrade the skill base of nursing assistants, and to increase their career commitment and job satisfaction. Dr. Konrad requested $450,000 to bring the program back to original funding levels and to develop a pilot program for the growing home health sector.

Next, Ms. Laura Hopkins, Vice President of Ameriplus, Amerigroup Corp, presented on approaches to Medicaid services to the aged, blind, and disabled; and long term care populations. Ms. Hopkins gave an overview of her managed care organization, Amerigroup, and stated that they are currently serving over 1 million members in ten states. Ms. Hopkins went on to explain four models of care that states use to provide access to health care for Medicaid SSI recipients and the benefits of using a coordinated approach and a managed care model.

Mr. Ben Popkin, Commission Staff, provided to the Commission the findings and recommendations from the Joint Subcommittee on Mentally Ill Residents in Adult Care Homes, which is the Subcommittee formed by the Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

January 9, 2007

The North Carolina Study Commission on Aging met in Room 643 of the Legislative Office Building at 10:00 a.m. on January 9, 2007. Representative Beverly Earle presided over the first half of the meeting.

The first item on the agenda was a presentation by Committee staff of the recommendations from the House Study Committee on State Guardianship Laws. Representative Alice Bordsen, Co-Chair of the Committee, spoke briefly on the mission and proceedings of the Committee. Wendy Ray, Drupti Chauhan, and Erika Churchill, Committee Staff, then presented the Committee's final report to the members of the Commission, including presentation of Study Committee's recommendations to the 2007 House of Representatives. The Commission discussed the Committee's recommendations at length. Senator Dannelly then assumed the Chair and presided over the remainder of the meeting.

Theresa Matula, Commission Staff, presented the Commission with draft recommendations based on presentations and input from the public hearings conducted during the interim. Ms. Matula read each proposed recommendation, provided background detail for each, and responded to questions. Members of the Commission engaged in a full discussion of the draft recommendations, incorporated changes, and voted to approve the recommendations as amended. The Commission then directed staff to prepare a report in preparation for a final meeting on January 23, 2007.

January 23, 2007

The North Carolina Study Commission on Aging met on January 23, 2007, at 10:00 a.m. in Room 643 of the Legislative Office Building. Senator Dannelly was the presiding Co-Chair. During the meeting, staff reviewed the Commission's draft report to the Governor and the 2007 Regular Session of the 2007 General Assembly.

COMMISSION RECOMMENDATIONS

The North Carolina Study Commission on Aging makes the recommendations presented in this section to the Governor and the 2007 Session of the 2007 General Assembly. Each recommendation is followed by background information, and any corresponding legislative proposals appear Appendix D of this report.

Recommendation 1: Support for Senior Centers

The Study Commission on Aging recommends that the General Assembly appropriate an additional $500,000 for FY 07-08 and $500,000 for FY 08-09 to the Senior Center General Purpose fund to provide additional support for Senior Centers.

Background 1: Support for Senior Centers

Increasing funding and support for Senior Centers was the most frequently mentioned item during the public hearings conducted on October 3, 2006 in Burlington and on October 17, 2006 in Charlotte. The Senior Tar Heel Legislature, the Governors Advisory Council on Aging, and the NC Coalition on Aging all support additional funding for Senior Centers. Further, the demographics in North Carolina indicate a continued need for senior centers.

On December 13, 2006, the Commission heard a presentation by the Division of Aging and Adult Services on Senior Centers. According to the Division, Senior Centers are designated as community focal points through the Older Americans Act. Services offered through Senior Centers include: health and wellness programs, arts and humanities, intergenerational programs, employment assistance, transportation services, and volunteer opportunities. 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." The Division reports that there are currently 163 recognized Senior Centers in North Carolina. Primary sources of funding are: 1) the Home and Community Care Block Grant, 2) local government, and 3) the State's Senior Center General Purpose and Outreach Funds. According to the Division, federal and State funding is not sufficient to develop and sustain senior centers, effective centers must achieve strong private and public support locally. A 2002 Senior Center Capacity Survey [see http://www.ncdhhs.gov/aging/scenters/websurvey.pdf] reported that while 92% of centers rely on State funds in their budgets, their most widespread primary funding sources are local government and the Home and Community Care Block Grant. According to the Division, State support of Senior Centers is most effective when it is used as a tool to help focus their development and growth so that they are becoming prepared for the future while continuing to serve today's seniors.

The State supports Senior Centers by funding the Senior Center Outreach and General Purpose funds. The Senior Center General Purpose fund was initiated in 1997, and is used for any purpose that supports operations or development including: equipment purchases/repairs, building maintenance, supplies, administrative costs, activities, and construction. The State appropriation for the 2006-2007 fiscal year (FY) is $1,265,316 for Senior Center General Purpose funding and $100,000 for Senior Center Outreach. An additional 25% local cash or in-kind match is required for State funds. Senior Centers receive funding in "shares" – one share for uncertified centers (117 centers), two shares for Centers of Merit (8 centers), and three shares for Centers of Excellence (38 centers). The value of the share amount decreases as the number of Senior Centers increases and as centers become Centers of Merit or Centers of Excellence. The shares for the 2006-2007 FY

translated to: $5,123 for Uncertified Centers, $10,245 for Centers of Merit, and $15,368 for Centers of Excellence. Based on the current number of Centers, the appropriation of an additional $500,000 would translate to an additional $2,024 per share per year.

Recommendation 2: Expand Dental Care for Special Care Populations

The Study Commission on Aging recommends that the General Assembly appropriate $200,000 for FY 07-08 to the Department of Health and Human Services, Division of Public Health, to purchase an additional mobile dental unit for a new or existing non-profit mobile dental care provider to serve special care populations in geographic areas of the State that are not currently served by mobile dental units. The Department shall report to the Commission on the status of this project by September 1, 2008.

The Study Commission on Aging recommends that the General Assembly require the Board of Governors of The University of North Carolina to study the feasibility of requiring one or more of the Board of Governors' Dental Scholarship-Loan Program slots be dedicated to individuals who will predominately serve special care populations, primarily disabled individuals and the elderly, and to report findings and recommendations to the Commission by January 15, 2008.

Background 2: Expand Dental Care for Special Care Populations

On October 25, 2006, the Commission heard presentations by Dr. Bill Milner and Dr. Ford Grant on non-profit mobile dental care units that are currently serving North Carolina's special care population. Carolinas Health Care/Carolinas Mobile Dentistry has two mobile dental units serving the Charlotte area, and Access Dental Care has two mobile dental units serving the Greensboro area. The mobile dental care units provide special care dental services to frail elderly and developmentally disabled populations. According to Dr. Milner, the nonprofit practice is the most workable model to date. The nonprofit practice model has been expanded to: accept special needs patient referrals from local providers; serve the rapid influx of retirees in North Carolina; relieve the gap in service from the deinstitutionalization of the mental health hospital system; and support special care patients, families, local providers, and organizations representing special needs patients.

Currently, the mobile dental units are primarily serving the residents of skilled nursing facilities, intellectually and mentally disabled (MR/DD) group home residents attending day centers, and individuals with intellectual and developmental disabilities that live at home in the community. According to information provided by Dr. Milner, the clinics have three sources of revenue: private pay patients, which constitute approximately twenty percent (20%) of the patients seen; Medicaid patients, which accounts for approximately eighty percent (80%) of the patients seen; and a retainer fee. According to Dr. Milner the retainer fee is required for the non-profits to breakeven in the treatment of more time intensive special needs patients. The mobile dental units enter into a contract with entities at a rate of $6.00/bed/month to provide on-site dental care. The providers report that there is a waiting list for those wanting on-site dental services and there are only two areas of the State in which these services are available.

During the presentation, Drs. Milner and Grant suggested that the State: 1) support and expand comprehensive quality programs; 2) coordinate services using the existing network; and 3) train a statewide workforce of medical and dental providers. Dr. Milner reported that an additional $200,000 would provide the funding to expand the program to cover an additional service region.

In order to better serve this population, recruitment efforts need to be expanded and training opportunities increased for special care dental providers who will serve patients regardless of the disability. A special set of dental and interpersonal skills are required to serve this population.

North Carolina does not currently have a formal dental program to train special care providers. UNC-Chapel Hill School of Dentistry provides students with exposure to the special care patient through short student rotations and courses.

On November 15, 2006, the Commission received a copy of the 2005 NC Oral Health Summit Access to Dental Care Summit Proceedings and Action Plan along with excerpts from the Plan. The information showed the distribution of dentists by county and information on dental services to institutional and other difficult-to-serve populations

The Board of Governors' Dental Scholarship-Loan Program is funded by the General Assembly and provides an annual stipend of $5,000 plus tuition, mandatory fees, medical insurance, laptop computer and required dental equipment. This program is available to students who have been admitted to the UNC-Chapel Hill School of Dentistry, demonstrate a financial need, and have a desire to practice dentistry in North Carolina. The above recommendation requires the Board of Governors to study the feasibility of requiring one or more of the Dental Scholarship-Loan Program slots to be dedicated to individuals who will predominately serve special care populations, primarily disabled individuals and the elderly. There are a total of 32 slots in the Dental Scholarship-Loan Program, eight slots for each of the four classes in the four-year program.

The Study Commission on Aging recommends that the General Assembly appropriate $200,000 to purchase an additional mobile dental unit to serve special care populations in geographic areas of the State that are not currently served, and require the Board of Governors of The University of North Carolina to study the feasibility of requiring one or more of the Dental Scholarship-Loan Program slots be dedicated to individuals who will predominately serve special care populations.

Recommendation 3: Expand Health Care Personnel Registry/Funds

The Study Commission on Aging recommends that the General Assembly expand the Health Care Personnel Registry to include any unlicensed staff of a health care facility that has direct access to residents, clients, or their property, and appropriate an additional $1,700,000 for FY 07-08 and $1,700,000 for FY 08-09 to add staff and improve upon existing allegation response times.

Background 3: Expand Health Care Personnel Registry/Funds

The Health Care Personnel Registry contains the names of health care personnel (aides providing hands-on care: adult care home personal aides that supervise or perform specific tasks, nurse aides, in-home aides, in-home personal care aides who provide hands-on services, and unlicensed assistant personnel who provide hands-on care) working in health care facilities that have been subject to findings, or accused and an investigation is required, for the following acts:

- Neglect or abuse of a resident in a health care facility or person to whom home care (G.S. 131E-136) or hospice services (G.S. 131E-201) are being provided.
- Misappropriation of the property of a resident in a health care facility or resident of a place where home care or hospice services are being provided.
- Misappropriation of the property of the health care facility.
- Diversion of drugs belonging to a health care facility or to a patient or client.
- Fraud against a health care facility or against a patient or client for whom the employee is providing services.

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."

During the prior interim, on January 18, 2006, in response to S.L. 2005-276, Section 10.40A(q), the

Department of Health and Human Services presented a report that recommended an expansion of the Health Care Personnel Registry and information on the need for additional staff resources. The additional staffing is needed process the increased number of allegation reports as a result of the proposed expansion, and to manage enacted expansions over the last five years. (The Department reported that in the last five years, allegations have increased 280% and there has been a 62% increase in cases needing investigations.) The Department estimated that it needs $1.7 million for: 18 investigator positions, 3 regional supervisor/investigator positions, and 6 administrative support positions.

The Study Commission on Aging made a recommendation to the General Assembly reflecting the above request. In response, Senate Bill 1275 and House Bill 2050 were introduced during the 2006 Session. Senate Bill 1275 was referred to the Senate Committee on Health Care where a committee substitute was adopted and the bill was referred to the Senate Committee on Appropriations/Base Budget. House Bill 2050 received a favorable report in the House Committee on Aging and was referred to the House Committee on Appropriations. These bills expanded the definition of "health care personnel" to be defined as any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. (Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.) However, the funding was not appropriated during the 2006 Session and the Department expressed reluctance in implementing further expansion of the Health Care Personnel Registry without additional staff. As such, the Study Commission on Aging recommends that the General Assembly expand the Health Care Personnel Registry to include any unlicensed staff of a health care facility that has direct access to residents, clients, or their property, and appropriate an additional $1,700,000 for additional staff in an effort to improve upon existing allegation response times

Recommendation 4: Support Project C.A.R.E.

The Study Commission on Aging recommends that the General Assembly appropriate $500,000 to the Department of Health and Human Services, Division of Aging and Adult Services, for FY 07-08, and $500,000 for FY 08-09, to fund Project C.A.R.E. which provides support to individuals with dementia and their caregivers.

Background 4: Support Project C.A.R.E.

Increasing/continuing funding and support for Alzheimer's caregivers and Project C.A.R.E. was the third most frequently mentioned item during the public hearings conducted on October 3, 2006, in Burlington and on October 17, 2006, in Charlotte. On December 13, 2006, the Commission heard a presentation from the Division of Aging and Adult Services and the Western Carolina Alzheimer's Association on Project C.A.R.E. (Caregiver Alternatives to Running on Empty). The Division of Aging and Adult Services has been awarded two (2) three-year federal Project C.A.R.E. grants since 2001. Project C.A.R.E., which provides support to caregivers of persons with dementia, has currently been implemented in ten western counties and has served over 1,500 families through 90 local provider agencies. Currently, over 450 Project C.A.R.E. families rely on the program to support their efforts to provide long-term care at home. The Project involves the Division of Aging and Adult Services, the Duke Center for the Study of Aging and Human Development Family Support Program, the Western Carolina Chapter of the Alzheimer's Association, the Mecklenburg County Department of Social Services, and several Area Agencies on Aging.

Project C.A.R.E is a community based public/private partnership that provides access to dementia-

specific respite care and support for families. The goal of Project C.A.R.E. is to increase the quality, access, choice, and use of respite care to underserved, low-income rural and minority communities. Project C.A.R.E. is based on a family consultant model and includes the following features: quick response to family needs, in-home assessment and individualized care, a family-centered holistic approach, personal relationships offering ongoing support, links to community resources and network building, and quality control. According to the Division of Aging and Adult Services, in 2000, an estimated 132,329 older adults in North Carolina had mild, moderate, or severe Alzheimer's disease. By 2025, the total number is expected to increase by 91% to 253,176. More than 70% of people with Alzheimer's are cared for at home by unpaid family and friends. In order to continue their care, families need a strong network of community support that includes dementia-specific information, respite care, counseling, problem-solving skills, training, and educational resources.

Project C.A.R.E. currently operates with a budget of $545,454 (federal grant plus local match), however federal funding for the existing program will be terminated at the end of the federal grant cycle on June 30, 2007. The Department of Health and Human Services, Division of Aging and Adult Services needs $500,000 to sustain Project C.A.R.E. activities in ten western counties. If $500,000 is appropriated, there would be a 25% matching requirement in the amount of $166,666, for total funds amounting to $666,666. It is anticipated that the level of local interest and current activity in services in the ten county area will yield sufficient funding to meet matching requirements. Funding is used for direct respite services (51%), for administrative cost (8.5%), and for the cost of family care consultants and the services of the Duke Family Support Program. (The Division contracts with Duke to: train Family Care Consultants, provide information and assistance personnel, make site visits to ensure quality, and to support the Division in policy development related to the program. The Family Care Consultants provide the direct services of case management and counseling and therefore, these are considered direct service costs and not administrative expenses.)

An additional advantage to this appropriation is the possibility that if the State provides funds for the existing program infrastructure and service capacity, North Carolina will be eligible to receive another $1 million three-year federal grant through the United States Administration on Aging Alzheimer's Disease Demonstration Grants to States Program. This new federal funding would then be used to replicate Project C.A.R.E. in eastern North Carolina, moving toward the ultimate goal of statewide expansion.

Recommendation 5: Additional HCCBG Funds

The Study Commission on Aging recommends that the General Assembly appropriate an additional $5,000,000 to the Department of Health and Human Services for FY 07-08 and $5,000,000 for FY 08-09 for the Home and Community Care Block Grant (HCCBG).

Background 5: Additional HCCBG Funds

Preserve and expand the Home and Community Care Block Grant (HCCBG) was another frequently mentioned issue during the public hearings conducted by the Commission. The Senior Tar Heel Legislature and NC Coalition on Aging are both requesting an increase of $5 million for the HCCBG, and the Governor's Advisory Council on Aging is requesting and additional $10 million.

In 2006, through Senate Bill 1273 and House Bill 2056, the Study Commission on Aging recommended that the General Assembly appropriate an additional $5 million in funding for the Home and Community Care Block Grant (HCCBG). The General Assembly responded by providing $4,000,000 in recurring funding for the HCCBG. According to the Division of Aging

and Adult Services, all of the $4 million that was appropriated has been allocated and it is anticipated that the funds will help meet about 3,000 service needs this year. However the need continues with 10,800 waiting for services, primarily in-home aide and home-delivered meals.

The HCCBG, established by G.S.143B-181.1(a)(11), is the consolidation of 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 includes federal funds, State funds, local funds, and a consumer contribution component. It gives counties discretion, flexibility, and authority in determining services, service levels, and service providers; and streamlines and simplifies the administration of services.

With input from older adults, county commissioners approve an annual funding plan that defines services to be provided, the funding levels for these services, and the community service agencies to provide these services. Counties can select from among 18 eligible services including: 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, Institutional Respite Care, Mental Health Counseling, Senior Center Operations, Senior Companion, Skilled Home (Health) Care, Transportation, and Volunteer Program Development. Counties make the decision on which services to provide, however congregate nutrition and home-delivered meals are provided in almost every county under the HCCBG.

Any person age 60 and older is eligible for services under the HCCBG. However, 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).

The focus of the HCCBG is to support the frail elderly in their preference to be cared for at home; improve and maintain the physical and mental health of older adults; assist older adults and their caregivers with accessing services and information; provide relief to family caregivers so that they can continue their caregiving; and allow older adults to remain actively engaged with their communities.

The Study Commission on Aging recognizes the importance of services funded by the Home and Community Care Block Grant and recommends that the General Assembly appropriate an additional $5,000,000.

Recommendation 6: Amend the Penalty Review Committee Statutes

The Study Commission on Aging recommends that the General Assembly enact legislation to change the Penalty Review Committee process.

Background 6: Amend the Penalty Review Committee Statutes

On October 25, 2006, the Commission heard a presentation on the Penalty Review Committee (PRC) process. S.L. 2005-276, Section 10.40A(l), amended the Penalty Review Committee to provide that it must meet at least semiannually to review violations and penalties imposed by the Adult Care Licensure Section; provide a forum for residents, guardians or families of residents, local department of social services, and providers; and make recommendations to the Department for changes in policy, training, or rules as a result of its review and publish a report. The revised process requires the Department to notify families or guardians of affected residents of the right to request a review of the Department's penalty decision before the decision becomes final and further

requires the Penalty Review Committee to meet to conduct the review and inform the family member or guardian of the results within 60 days of the receipt of a review request. This modified PRC process allows those individuals (or families) who request the PRC the opportunity for one within 60 days.

The changes resulted in the statute requiring notification to families (not residents). However, because of state and national laws regarding the release of healthcare and personal information, and the fact that state and county inspection reports must be legally defensible and thus provide very specific information regarding the resident's status and details diagnosis, behavior, and received treatments and medications, the Department was advised by the Attorney General's office that informed consent was needed for release of information to the family unless the family member is a legal guardian or has Power of Attorney (POA) for the resident. As a result, the statutory changes became more difficult and time consuming to implement. Additionally the Department reported that residents and family members thus far are not generally requesting the PRC and therefore the meetings are occurring less frequently – out of 51 families notified, only four requested PRCs and two actually attended. The statutory changes actually made the process more difficult and time consuming to implement. The Department suggested that the process be amended to delete the semiannual meeting requirements; to provide public notice of meetings via the website and to parties involved; and to require the licensed provider to post notices of a scheduled PRC meeting in a conspicuous place available to residents, family members and the public. During the presentation, Commission members expressed interest in notifying guardians and those with Power of Attorney for residents that are involved.

Recommendation 7: Study Safe Transportation of Passengers in Wheelchairs

The Study Commission on Aging recommends that the General Assembly direct the Department of Transportation to study appropriate methods of transporting passengers seated in wheelchairs, to develop guidelines for the installation and use of wheelchair tiedown systems, and to report findings and recommendations to the Study Commission on Aging and the Joint Legislative Transportation Oversight Committee by February 1, 2008.

Background 7: Study Safe Transportation of Passengers in Wheelchairs

On November 15, 2006, the Commission heard a presentation on wheelchair transportation safety restraints. During the presentation, the Commission learned that transportation of passengers seated in wheelchairs within motor vehicles is a relatively new experience and that while certified passenger restraint systems are mandated for adults and children seated in vans, there is no law regulating restraint systems for persons seated in wheelchairs. The presentation pointed out that the majority of incidents involving persons transported in wheelchairs occur during ordinary driving maneuvers, and do not involve a collision. Statistical tabulations often omit these events since police are rarely summoned and the injured are driven for medical care by the vehicle operator. However, the Division of Facility Services tabulates incident reports filed by nursing homes which yields the following insights: 1) problems occur despite well-intentioned efforts to secure the chairs and apply restraints; 2) van operators lack knowledge that wheelchairs must be specifically designed for use in vehicles, restraint systems must be property attached to the chair, and restraint systems must be property applied to the passenger seated in the chair; 3) and finally, the situation resembles that of child safety restraints.

The report distributed to the Commission included letters from the following entities expressing support for exploring the safe transport of individuals in wheelchairs: The University of North Carolina Highway Safety Research Center, NC Health Care Facilities Association, AARP of North Carolina, NC Coalition on Aging, the Governor's Advisory Council on Aging, and the Senior Tar

Heel Legislature.

The presentation offered the following solutions from research by the University of Michigan Traffic Research Institute:

1) Whenever possible, transfer the rider to a seat and use the seatbelt.

2) If transfer to a seat is not possible, use a wheelchair and tiedown system that protects the occupant.

a. Use a Transit Wheelchair (WC/19 compliant) with securement points for tiedown straps, arm rests that permit the lap belt to cross the pelvis and a shoulder strap to cross the chest.
b. Secure the wheelchair to the vehicle with four tiedown straps.
c. Apply both lap and shoulder belts to the rider. The seatbelt must fit snugly cross the pelvis and be anchored at a 45 degree angle on each side. The shoulder strap must be in contact with the middle of the chest and shoulder and it must avoid contact with the neck.

Based on the presentation, the Study Commission on Aging recommends that the General Assembly direct the Department of Transportation to study appropriate methods of transporting passengers seated in wheelchairs.

Recommendation 8: Adult Protective Services Pilot Program

The Study Commission on Aging recommends that the General Assembly appropriate $1,492,000 to the Department of Health and Human Services, Division of Aging and Adult Services, for FY 07-08 and $1,930,000 for FY 08-09 to enact a pilot program to assess proposed changes to the adult protective services statutes and to report on the evaluation of the pilot by March 1, 2009.

Background 8: Adult Protective Services Pilot Program

On October 11, 2006, the Commission received a report, prepared in response to S.L. 2005-23, which directed the Adult Protective Services (APS) Task Force to collaborate with stakeholders and others interested in improving APS, and to report those findings to the Study Commission on Aging and the House Study Committee on Guardianship Laws. The APS Clearinghouse Model: NC's System of Protection, is the product of a collaborative effort among the Division of Aging and Adult Services, the NC Association of County Directors of Social Services, representatives from the Attorney General's office, stakeholders, and other interested parties. The presentation focused on nine core recommendations. The goals of the APS Clearinghouse Model are to: increase North Carolina's ability to reach out to citizens to offer voluntary services, enable the State to respond to high risk situations before harm occurs and provide the opportunity to assist older adults who are victimized, but not incapacitated; allow APS to intervene before the adult's health deteriorates to life-threatening levels; and allow APS to provide information and services to a greater number of adults.

The first step in the implementation of the APS Clearinghouse Model requires a pilot of the APS Clearinghouse Model. This requires funding for staff in county departments of social services to carry out the pilot and funding for 3 staff positions in the Division of Aging and Adult Services (DAAS) to plan and conduct the pilot. The total budget for the pilot in FY 07-08 is $1,492,027, broken down as follows: $1,212,805 for county staff (24.103 FTEs for 9-months), $154,472 for DAAS staff (3.0 FTEs for 9-months), $18,000 for public education, $6,750 for essential services, and $100,000 for evaluation of the pilot. The total budget for the pilot in FY 08-09 is $1,930,107, broken down as follows: $1,617,308 for county staff, $188,049 for DAAS staff, $18,000 for public education, $6,750 for essential services, and $100,000 for evaluation of the pilot. Funds designated as essential services would be used for basic safety, health, or housing needs in a crisis situation while a Medicaid or Special Assistance application is pending. These essential services funds are

used to help alleviate immediate mistreatment experienced by vulnerable adults. It is anticipated that the evaluation would be performed by a contractor selected through the RFP process. The contractor would be on board from the beginning to: define the focus of the overall evaluation; identify measurement tools; determine outcomes; determine a valid sample of county DSSs to participate in the pilot; and to collect, track and analyze data.

In response to the information the Commission received on the APS Clearinghouse Model, the Commission recommends that the General Assembly appropriate funding for a pilot program to assess proposed changes to the adult protective services statutes and to require a report on the evaluation of these changes.

Recommendation 9: Study Medically Needy Income Standard

The Study Commission on Aging recommends that the General Assembly enact legislation to require the Department of Health and Human Services, Division of Medical Assistance, to study the medically needy income standard and determine the best method of increasing the standard while providing improved consistency across long-term care settings and report to the Study Commission on Aging by September 1, 2008.

Background 9: Study Medically Needy Income Standard

During the prior interim, the Commission heard presentations on the Medicaid Institutional Bias Study. The study was mandated by Section 10.3 of S.L. 2004-124 for the purpose of identifying any bias that favors support for individuals in institutional settings over support for individuals living at home.

In response to a Commission recommendation, S.L. 2006-110 was enacted and required the Department of Health and Human Services to collaborate with providers and advocates of home and community-based long-term care services to review the Institutional Bias report and make recommendations on ways to address the identified biases. On November 15, 2006, the Commission heard a presentation on the Community Alternatives Program for Disabled Adults (CAP/DA) in response to S.L. 2006-109. A number of the biases identified in the Institutional Bias report involved the CAP/DA program. On December 13, 2006, the Commission heard a presentation on recommendations to address two of the biases. One of the identified biases stated that medically needy requirements leave little money for persons to pay for living expenses if they prefer to remain in the community, while institutions provide room and board. It was recommended that the medically needy income standard be increased from the current monthly standard of $242 to a level at least comparable to the national average Supplemental Security Income (SSI). On February 9, 2006, in response to a request, the Commission received a memo from the Division of Medical Assistance indicating the medically needy income limits by state in 2002. This information indicated that NC had the seventh lowest rate and that the average rate was $416. During the December 2006 presentation, the Department reported that there was consensus among stakeholders that while adjusting the medically needy income standard is an important goal for NC, it should not be at the expense of adequate funding for the existing service system. It was recommended that stakeholder concern about financial feasibility could be addressed by studying whether Medicaid can cover some rather than all services and the consideration of a phased adjustment of the standard over time. As such, the Commission recommends that the General Assembly enact legislation to require the Department of Health and Human Services, Division of Medical Assistance, to study the medically needy income standard and determine the best method of increasing the standard while providing improved consistency across long-term care settings.

Recommendation 10: Support for NC Rx

The Study Commission on Aging supports the NC Rx program, funded through the Health and Wellness Trust Fund, which assists seniors having difficulty paying for prescription drugs, and expresses gratitude for the SHIIP program and the many volunteer organizations that provide information to citizens enrolling in Medicare prescription drug programs.

Background 10: Support for NC Rx

Because prescription drug costs can be a significant burden for older adults, the Commission actively monitored North Carolina Senior Care and the federal Medicare Part D program. The Commission has heard numerous presentations on the efforts of the Seniors' Health Insurance Information Program (SHIIP) to reach those in need of prescription drug plan information and assistance. The Commission is appreciative of the efforts of SHIIP and numerous other volunteers who have provided information to North Carolina citizens and helped them to navigate programs that provide prescription drug assistance.

On November 15, 2006, the Commission heard a brief presentation on the new NC Rx program and received a list of toll free numbers and websites for additional information on the NC Rx program. NC Rx is a new premium assistance plan that provides up to $18 dollars per month toward the monthly premium of participating Medicare Prescription Drug Plans. (Currently, the lowest priced plan in North Carolina has a premium of $17.80.) The NC Rx program also screens income and assets of applicants to determine if they qualify for "extra help" from the federal assistance program. The Commission appreciates the efforts of the Health and Wellness Trust Fund in providing NC Rx and its predecessor, NC Senior Care.

Recommendation 11: Funds for Mentally Ill Housing Options

In response to the Commission on Aging and Mental Health Oversight Subcommittee report, the Study Commission on Aging recommends that the General Assembly appropriate to the Department of Health and Human Services and the Housing Finance Agency, $1,506,600 for FY 07-08, to provide rental assistance for at least 250 units, and $3,013,200 for FY 08-09, to continue rental assistance for the units in FY 07-08 and to provide rental assistance for at least an additional 250 units, which shall increase the availability of housing options for North Carolinians with mental illness, particularly for those individuals that are transitioning out of State psychiatric hospitals and those that are transitioning out of long-term care facilities.

Background 11: Funds for Mentally Ill Housing Options

On August 29, 2006, the Co-Chairs of the Study Commission on Aging wrote the Co-Chairs of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, to ask for assistance in addressing issues related to serving mentally ill individuals residing in long-term care (LTC) facilities. As a result, a Subcommittee of the Commission and the Oversight Committee was appointed to bring a renewed focus to researching these issues. The Commission heard recommendations from the Subcommittee during their meeting on January 3, 2007. These recommendations were based in part on information received during the meetings outlined below.

On November 14, 2006, the Subcommittee heard from Dr. Bonnie Morell, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Dr Morell addressed adult care services and presented the Subcommittee with information about current residential options for adults with mental illness. Last year, the public mental health system served over 174,000 adults with mental illness, 1,149 of whom lived in licensed mental health homes; 5,000 in adult care

homes (ACH); and many of the remainder lived independently in the community and received services. In order to live independently, these individuals must either receive a rent subsidy or have enough money to pay rent, and be able to receive necessary services as appropriate to their needs. Nationally, approximately ten percent (10%) of adults with serious mental illness need specialized housing.

During the course of its meetings, the Subcommittee also heard from several individuals representing a range of housing options available to adults with mental illness. Ms. Debra King, Executive Director of CASA (Community Alternatives for Supportive Abodes), an independent nonprofit housing development corporation which develops, owns and manages decent, safe and affordable housing for special populations in Wake County, spoke about her organization's experiences securing affordable housing in Wake County. Among the issues raised were – adequate funding, competing regulations, local land use policies, on-going operational dollars and public resistance to locating housing for adults with special needs near their own homes.

The Subcommittee also heard from John Tote, Executive Director of the Mental Health Association in North Carolina, Inc., the State's largest private, non-profit mental health organization. Mr. Tote gave a brief overview of the Association's Community-Based Residential Options, including the HOMES and HUD 202 and 811 programs, which provide funding for community-based group homes, apartment complexes, condominiums and scattered site housing for persons with severe and persistent mental illness. Additionally, the Subcommittee heard from Tommy Gund, Executive Director of Adventure Homes, Kenneth A. Burrow, Vice President Therapeutic Alternatives/Brookstone and Jay Poole, Visiting Assistant Professor, University of North Carolina at Greensboro.

The Study Commission on Aging appreciates the work and dedication of the Subcommittee and recommends that the General Assembly appropriate funding to increase the availability of housing options for North Carolinians with mental illness, particularly for those individuals that are transitioning out of State psychiatric hospitals and those that are transitioning out of long-term care facilities.

Recommendation 12: Study Housing Concerns and Staff Training Required for Mixed Populations

In response to the Commission on Aging and Mental Health Oversight Subcommittee report, the Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and the Division of Mental Health, to analyze the rules and regulations in North Carolina and in other states regarding the provision of appropriate care and the housing of residents with mental illness in the same facility vicinity as those without mental illness. The Department shall also analyze and recommend appropriate staff training requirements to enable direct care workers in long-term care facilities to simultaneously provide appropriate care to mentally ill residents and those that are not mentally ill. The Department shall present findings, recommendations, and any required statutory or rule changes to the Study Commission on Aging and the Joint Legislative Mental Health Oversight Committee by March 1, 2008.

Background 12: Study Housing Concerns and Staff Training Required for Mixed Populations

The Commission heard recommendations from the Study Commission on Aging and Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services Subcommittee during a meeting on January 3, 2007. These recommendations were based in part on information received during the meetings outlined below.

During the Subcommittee meeting on October 11, 2006, Jeff Horton, Chief Operating Officer of the Division of Facility Services (DFS), presented the Subcommittee with information about facilities for the mentally ill. Mr. Horton said that there was no level of care between the hospital inpatient setting, the adult care home setting, and independent living setting. DFS licenses 287 mental health facilities which are categorized as supervised living for adults with mental illness. These facilities are licensed to have two - six beds. There are 1,319 facilities for supervised living for adults with developmental disabilities, 300 are special mental retardation homes for adults with developmental disabilities.

Dr. Bonnie Morell, Division of MH/DD/SAS, provided the Subcommittee with data on the number of adults with mental illness living in adult care homes. Based on 2005 data, there were 24,831 residents in adult care homes and 5,000 of those had a mental illness of which 1,479 were under 50 years of age. Dr. Morell shared her belief that the main issue is not the resident's age, but whether or not they have a mental illness that is associated with behaviors that do not fit appropriately with the setting the person is in and the people with whom they are interacting. Data regarding State hospitals discharging patients to adult care homes showed that in Fiscal Year (FY) 2002, 5.5% of the discharges were to adult care homes, and in FY 2006 the number had decreased to 3.7%, which indicates that efforts are being made to provide appropriate placement upon discharge.

Barbara Ryan, from the Division of Facility Services, told the Subcommittee that out of the 582 adult care homes that renewed their licenses in September of 2005, 115 had a population of 50% or greater mentally ill residents. Out of the 546 family care homes which have two-six beds, 222 had 50% or greater with a diagnosis of mental illness.

In addition to the presentations heard by the Subcommittee, the Commission as a whole heard a presentation on September 27, 2006, regarding the Department's recommendation for a Study of Residential Choices and Treatment Options for Individuals with Mental Illness.

The Study Commission on Aging appreciates the work by the Subcommittee. In response to the Subcommittee's report, the Commission recommends that the General Assembly direct the Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and the Division of Mental Health, to work together to analyze the rules and regulations in North Carolina and in other states regarding the provision of appropriate care and the housing of residents with mental illness in the same facility vicinity as those without mental illness; and to analyze and recommend appropriate staff training requirements for direct care workers in long-term care facilities.

Recommendation 13: Increase SA In-Home Slots

In response to the Commission on Aging and Mental Health Oversight Subcommittee report, the Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to increase the total number of State/County Special Assistance In-Home Program slots to 2000 in FY 07-08.

Background 13: Increase SA In-Home Slots

On November 15, 2006, the Commission heard a presentation on Special Assistance In-Home Slots. The Special Assistance (SA) In-Home Program provides an alternative to adult care home placement for individuals who can live at home safely with additional support services. Participation is voluntary on the part of the county departments of social services. Individuals who wish to receive an SA In-Home payment must have income below the federal poverty level; be eligible for Medicaid; be eligible for SA; have an FL-2 indicating a need for Adult Care Home level of care; and have an assessment and service plan that indicates the individual can live safely

at home with services. Participating counties receive an allocation authorizing a certain number of participants or slots. The distribution of the program across the State and the number of SA In-Home slots has steadily risen since the authorization of 400 slots for a demonstration project in Section 11.21 of S.L. 1999-237. During the last two years, slots were increased to 1,000 in Section 10.39 of S.L. 2005-276, and most recently the number of slots increased from 1000 to 1500 with the enactment of S.L. 2006-156.

The Study Commission on Aging received recommendations from the Study Commission on Aging and Joint Legislative Mental Health Oversight Committee Subcommittee during the January 3, 2007 meeting. The Subcommittee also considered the SA In-Home program and presented a recommendation that DHHS increase the maximum number of assignments to the special assistance in-home program to 2,000 persons.

In response to the presentations to the Study Commission on Aging, and the recommendation by the Subcommittee, the Commission recommends that the General Assembly direct the Department of Health and Human Services to increase the total number of State/County Special Assistance In-Home Program slots to 2000 in the 2007-08 fiscal year.

Recommendation 14: Support for the Transitional Residential Treatment Program and for LME Notification of Mental Health Determination Using the Uniform Screening Tool

In response to the Commission on Aging and Mental Health Oversight Subcommittee report, the Study Commission on Aging expresses support for development, by the Department of Health and Human Services, of a "Transitional Residential Treatment Program" to provide 24-hour residential treatment and rehabilitation for mentally ill adults who have a pattern of difficult behaviors that exceed the capabilities of traditional community residential settings, and support the continued development of a Uniform Screening Tool, including the requirement that the appropriate Local Management Entities (LMEs) be notified of the status of the individual's mental health and the admission of that individual to a facility.

Background 14: Support for the Transitional Residential Treatment Program and for LME Notification of Mental Health Determination Using the Uniform Screening Tool

Prior to the work of the Subcommittee, during the meeting on September 27, 2006, the Commission heard presentations on current and future long-term care facility screening and assessment, including the implementation of the Uniform Screening Tool.

The Commission received recommendations from the Study Commission on Aging and Joint Legislative Mental Health Oversight Committee Subcommittee during the January 3, 2007 meeting. These recommendations were based in part on information received during the meetings outlined below.

At the Subcommittee's meeting on November 14, 2006, Dr. Michael Lancaster, Chief of Clinical Policy, Division of MH/DD/SAS, Department of Health and Human Services (DHHS), presented the Subcommittee with information about two types of long term care facilities currently providing housing for adults with mental illness. Nursing Facilities provide care for persons who have health conditions for which medical and nursing care is indicated – over 40% of the nursing facility population has a psychiatric or mood disorder diagnosis. Adult Care Homes provide residential care for older adults or adults with disabilities whose primary need is a home and the personal care their age and disability requires – over 40% of the adult care home population carries an active diagnosis of mental illness. Dr. Lancaster then described ongoing efforts to develop a "Transitional Residential Treatment Program" to provide 24-hour residential treatment and rehabilitation for adults who have a pattern of difficult behaviors, related to mental illness, which exceed the

capabilities of traditional community residential settings.

In the Subcommittee meeting on October 11, 2006, Julia Bick from the Office of the Secretary of the Department of Health and Human Services gave an overview of the Department's report on the *Study of Mentally Ill Residents in Long Term Care Facilities.* The Department has already implemented certain initiatives presented in their report. Beginning January 1, 2007, funding will be made available to expand the mental health specialty teams to hire an additional position to focus on the needs of younger adults in long term care setting. The Department is currently developing an RFP to identify/locate the population and the needs of the population within the adult care home system and the mental health system. While this study is underway, the Department is moving forward to develop aspects of the plan focusing on the need for a higher level of supervision and support along with a separate program to provide adequate staffing and treatment to address the needs of this population. A draft service definition (which may be covered as a Medicaid service) has been proposed to address the high end of this continuum. The Department reported this would be a small community-based facility (Residential Treatment Model) if approved by the Centers for Medicaid and Medicare Services (CMS), or funded as a State service if supported by the legislature. The facility, with 12 beds or less, would treat those not meeting the criteria for admittance to a State hospital but having problematic behavior not being adequately treated in an adult care home.

Additionally, Julia Budzinski, Division of Medical Assistance, DHHS, reported to the Subcommittee on Uniform Screening and addressed several initiatives that directly affect adult care homes, including a Uniform Screening program for all Medicaid long term care services and a future integrated assessment system. There will be one form to replace the multiple forms involved with the eight separate existing processes. The new form will be a web-based program which should reduce inappropriate placements, reduce paperwork, and provide a better picture of the population's needs. Ms. Budzinski said that the goal was to provide people with the correct service, to increase choice, and to provide appropriate placement. The system will be web-based and the pilot program should be implemented by the first of the year.

The Commission appreciates the work of the Subcommittee and expresses support for development of a "Transitional Residential Treatment Program" to provide 24-hour residential treatment and rehabilitation for mentally ill adults who have a pattern of difficult behaviors that exceed the capabilities of traditional community residential settings, and support for the continued development of a Uniform Screening Tool, including the requirement that the appropriate Local Management Entities (LMEs) be notified of the status of the individual's mental health and the admission of that individual to a facility.

Recommendation 15: Authorize Star-Rated Certificate Rules

The Study Commission on Aging recommends that the General Assembly enact legislation to give the Medical Care Commission the authority to adopt rules allowing the issuance of star-rated certificates to adult care homes and to appropriate to the Department of Health and Human Services, Division of Facility Services, $153,000 for FY 07-08, to be used for salaries for two positions and for database enhancement, and $108,000 for FY 08-09, for salaries and database maintenance, for implementation of the Star Rating system.

Background 15: Authorize Star-Rated Certificate Rules

Session Law 2005-276, Section 10.41, required the Department of Health and Human Services to develop a plan for implementing a star-rating system for adult care homes to improve quality of care. On January 3, 2007, the Commission received a report and heard a presentation on this requirement. Consensus from stakeholder input concluded that the rating should be based on a

number of factors including the following:

1. The facility's compliance with adult care home statutes and rules utilizing results from inspections conducted by the Division of Facility Services;
2. Any administrative action(s) taken against the facility, beginning with the first inspection for which the star-rating would be based, as a result of non-compliance with applicable statues and rules;
3. Voluntary participation of the adult care home in any Department approved quality improvement initiatives; and
4. Whether or not the facility had achieved North Carolina New Organizational Vision Award (NC NOVA) designation pursuant to G.S. 131E, Article 5, Part 6.

The Department indicated that in order to issue star-rating certificates to adult care homes beginning January 1, 2009, they would need passage of legislation consistent with the above recommendation by June 30, 2007.

The Division has identified two costs with the Star Rating system:

1. Salaries for a Facility Survey Consultant and a support position (Processing Assistant IV). The cost of these positions will be $102,942. These staff will work to implement the Star Rating system, specifically working with the Division of Information Resource Management, DHHS, to enhance the licensing database to accommodate star-rating system information and the printing of certificates. The staff will also be responsible for developing rules for adoption by the Medical Care Commission, developing internal policies for system implementation, developing and maintaining a website that contains star-rating information, and training staff of the Division of Facility Services (DFS) and county Departments of Social Services on the system.

2. The second cost is for enhancement and maintenance of the data base for the Star Rating system. The anticipated cost of enhancement to the database currently used by DFS to maintain licensing information and to allow tracking for star-rating certificates will be $50,000 (non-recurring) in FY 2007-08. The cost for maintenance of the database is estimated at $5,000 annually.

The appropriation need for FY 07-08 is $152,942 (salaries plus database enhancement) and $107,942 (salaries plus database maintenance) for FY 08-09.

The Commission recognizes the value that an evaluation system would provide for consumers and recommends that the General Assembly enact legislation to give the Medical Care Commission the authority to adopt rules allowing the issuance of star-rated certificates to adult care homes and to provide the funds necessary to support the system.

Recommendation 16: Funds for WIN A STEP UP

The Study Commission on Aging recommends that the General Assembly appropriate to the Department of Health and Human Services, Division of Facility Services, $200,000 for FY 07-08 and $200,000 for FY 08-09 to develop and pilot a WIN A STEP UP (**W**orkforce **I**mprovement for **N**ursing **A**ssistants: **S**upporting **T**raining, **E**ducation, and **P**ayment for **U**pgrading **P**erformance) Program for nurse aides employed by home care agencies; to appropriate $200,000 for FY 07-08 and $325,000 for FY 08-09, in addition to fine and penalties collections provided by the Division, to continue the program in nursing homes; and to direct the WIN A STEP UP Program to study the feasibility of becoming a self-sustaining program and to report to the House and Senate Appropriations Subcommittees on Health and Human Services by May 1, 2008. The WIN A STEP UP program shall continue to enhance and enrich curriculum components with information and exercises involving appropriate care for individuals with dementia, anxiety, depression, and other

severe mental health problems.

Background 16: Funds for WIN A STEP UP

On January 3, 2007, the Commission heard a presentation on the WIN A STEP UP program which seeks to enhance care for nursing home residents by reducing the turnover rate for nursing home aides. During the program, nurse aides complete a 30-hour curriculum, agree to continue working for their employer, and are rewarded with a bonus or salary increase. Additionally, frontline supervisors are trained to help improve their style of management and communication with nurse aides. According to the presentation, the objectives of the program are to upgrade the skill base of nursing assistants, increase career commitment and job satisfaction, and provide rewards and recognition to WIN A STEP UP participants.

The current funding source for WIN A STEP UP is fine and penalty money collected from nursing homes as a part of the nursing home inspection and enforcement process that the Division of Facility Services conducts as a contractor for the federal government. The money must only be used for programs which have an impact on the quality of care for nursing home residents. The amount the Division has to spend has grown smaller during the past two years. Additionally, while WIN A STEP UP is a good program, the Division reports that it wants to begin spending the funds on other programs to try additional innovative ways to improve quality. As such it was envisioned that WIN A STEP UP would begin to obtain funding from other sources.

Prior to the 2006-07 Fiscal Year (FY) the WIN A STEP UP program had a budget of approximately $450,000, funded with collections from fines and penalties. The breakdown of expenditures in FY 05-06 is as follows: 45% Personnel; 33% Nursing Assistant Stipends for completion of education modules; 7% Program Travel; 5% Program Tracking; Communication, Student Support; 4% Program Supplies (Curriculum printing, manuals, pins, certificates, training materials); 3% Consultant Expenses; 3% Retention Bonuses to participants.

During FY 06-07, of the $250,000 received from the Division of Facility Services, $205,000 went to the WIN A STEP UP program and $45,000 was for other data/research services. The WIN A STEP UP program anticipates receiving the following from the Division of Facility Services collected through fines and penalties: $250,000 in FY 07/08, $125,000 in FY 08-09, and no funding FY 09-10. For FY 07-08, WIN A STEP UP requested $250,000 and $325,000 for FY 08/09 in appropriations from the General Assembly. The success of the WIN A STEP UP program has allowed increased program efficiency: the State's cost share for WIN A STEP UP has decreased from 59.5% to 47.7% and the employer share has increased from 40.5% to 52.3%; the $1000 facility incentive has been eliminated; and the participant stipend per completed module has decreased from $70 to $35. It is anticipated that WIN A STEP UP could become self-sustaining at some point in the future.

During the Commission's meeting on January 3, 2007, information was also presented on developing a WIN A STEP UP pilot program for aides employed by home care agencies. The Commission expressed support for funding this endeavor during the meeting on January 9, 2007. The two year project for developing WIN A STEP UP for the home health aides would consist of adapting the current nursing home curriculum, field testing the program, and evaluating of the program's impact. Specific activities would include: curriculum adaptation, coaching supervision workshops, implementation, and evaluation. Development of a WIN A STEP UP program for home health aides would require $200,000 for Fiscal Year 2007-08 and the same amount for FY 08-09.

Recommendation 17: Support Recommendations from the House Study Committee on State Guardianship Laws

The Study Commission on Aging supports the recommendations of the House Study Committee on State Guardianship Laws.

Background 17: Support Recommendations from the House Study Committee on State Guardianship Laws

On January 9, 2007, the Commission heard a presentation from the House Study Committee on the State Guardianship Laws. The House Study Committee on the State Guardianship Laws met seven times during the 2006 interim and made nine recommendations as follows:

> **Recommendation 1.** The Committee recommends that the terminology used in the statutes should be changed from "incompetent adult" to "incapacitated person" and the definition should be amended to base the determination of incompetence or incapacity on the person's functional abilities. This would allow guardianships to be tailored to the individual's needs and facilitate the use of limited guardianships where appropriate.
>
> **Recommendation 2.** The Committee recommends that the statutes be amended to add more detailed provisions setting out the powers, duties, and liabilities of guardians of the person.
>
> **Recommendation 3.** The Committee recommends that the General Assembly appropriate funds to cover guardianship services provided by county departments of social services, Local Management Entities (LMEs), local health departments, and county departments on aging, and to cover essential legal and medical consultation.
>
> **Recommendation 4.** The Committee recommends that independent counsel be provided to represent the respondent when there is a conflict between what the respondent wants and what the guardian ad litem feels is in the respondent's best interest.
>
> **Recommendation 5.** The Committee recommends that clerks of superior court be granted the authority to order law enforcement officers to transport alleged incompetents to necessary locations where the multi-disciplinary evaluation (MDE) will be performed if the alleged incompetent refuses to attend on their own.
>
> **Recommendation 6.** The Committee recommends that the total amount of personal property that can be sold without a court order be increased to $15,000.00.
>
> **Recommendation 7.** The Committee recommends that the Division of Motor Vehicles be authorized to not automatically revoke a driver's license of an incompetent, if the clerk of superior court recommends the incompetent be allowed to retain the driver's license.
>
> **Recommendation 8.** The Committee recommends that training be provided to all individuals involved in guardianship, including the guardians *ad litem* of alleged incompetents.
>
> **Recommendation 9.** The Committee recommends the creation of a joint legislative study commission on State guardianship laws comprised of both members and appointees of the House of Representatives and the Senate.

The Study Commission on Aging appreciates and supports the work of the House Study Committee on State Guardianship Laws.

APPENDICES

APPENDIX A

2006 Recommendation Status Report

North Carolina Study Commission on Aging
Recommendations
to the
2005 North Carolina General Assembly, 2006 Regular Session

Prepared by Staff for the
North Carolina Study Commission on Aging

September 12, 2006

2006 RECOMMENDATION STATUS REPORT

RECOMMENDATION	RESULT
Recommendation 1: Increase Adult Day Care Reimbursement Rates The Study Commission on Aging recommends that the General Assembly appropriate funds to the Adult Day Care Fund and to the Home and Community Care Block Grant for a $5.00 per day rate increase for adult day care and adult day health care.	In response to this recommendation, SB 1270 and HB 2058 were introduced and both were referred to House and Senate Appropriations Committees. • The General Assembly provided $1,043,750 in recurring funding for an increase in the daily rates for adult day care and adult day health care programs by $5.00. Of the total funds, $556,556 was allocated to the State Adult Day Care Fund and $487,194 was allocated to the Home and Community Care Block Grant Program.
Recommendation 2: Increase CAP Awareness of Adult Day Health Options and Update The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Aging and Adult Services, and the Division of Medical Assistance, to provide education, and training if necessary, to ensure that case managers with the Community Alternatives Program (CAP) are aware of Adult Day Health Services and that this option is being considered in all situations appropriate for the client. The Department shall report by July 30, 2006, to the Study Commission on Aging on these efforts, and shall also provide a status report on changes implemented as a result of the Adult Day Services Study.	In response to this recommendation, SB 1278 and HB 2054 were introduced. • Senate Bill 1278 was enacted and S.L. 2006-108 directs the Department of Health and Human Services to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health programs, and requires the Department to make a status report on the Partners in Caregiving study recommendations. The Department is required to report on the status of its activities under this act to the North Carolina Study Commission on Aging not later than July 30, 2006. The act became effective July 13, 2006.
Recommendation 3: Health Care Personnel Registry The Study Commission on Aging recommends that the General Assembly enact legislation and appropriate funding for staff support to expand the Health Care Personnel Registry to include unlicensed staff that have access to residents or clients and or their property and are employed in health care facilities as defined in G.S. 131E-256; and expand the definition of health care facilities to include all MH/DD/SAS day treatment programs, agencies and/or community service providers as defined in 10A NCAC 27G.0602(10)(b), which includes unlicensed MH/DD/SAS community based services providers and multiunit assisted housing with services as defined in G.S. 131D-2(7a); and prohibit health care facilities defined under G.S. 131E-256 from hiring any person who has a substantiated finding on the Health Care Personnel Registry.	In response to this recommendation, SB 1275 and HB 2050 were introduced. • SB 1275 was referred to the Senate Committee on Health Care. In the Senate Committee on Health care, a committee substitute for SB 1275 was adopted and once reported in, the bill referred to the Senate Committee on Appropriations/Base Budget. • HB 2050 received a favorable report in the House Committee on Aging and was referred to the House Committee on Appropriations.

RECOMMENDATION	RESULT
Recommendation 4: Telemonitoring Evaluation The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Medical Assistance, to evaluate the use of telemonitoring equipment as a tool to improve the health of home-based individuals through increased monitoring and responsiveness resulting in increased stabilization rates and decreased hospitalization rates, the evaluation must include a representative number of older adults. The Department shall report to the Commission on the cost effectiveness of telemonitoring and the benefits to individuals and healthcare providers by August 1, 2007.	In response to this recommendation, SB 1280 and HB 2053 were introduced. • S.L. 2006-66, Sec. 10.9C (SB 1741, Sec. 10.9C), *allows* the Department of Health and Human Services, Division of Medical Assistance to implement a pilot program to evaluate the use of telemonitoring equipment in home care services and community-based long-term care services. The program must include a representative number of older adults and must evaluate the use of telemonitoring equipment as a tool to improve the health of home care clients and community-based long-term care clients through increased monitoring and responsiveness, and resulting in increased stabilization rates. The section requires the Department to report on the implementation of the pilot program and its findings on the cost-effectiveness of telemonitoring and the benefits to individuals and health care providers. The report must be made to the Study Commission on Aging, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division by July 1, 2007. This section became effective July 1, 2006. • Additionally, Senate Bill 1280 was enacted and varies from the above provision. S.L. 2006-194 *requires* the Department of Health and Human Services, Division of Medical Assistance, to implement a pilot program to evaluate the use of telemonitoring equipment in home and community based services and requires the Division to determine *remuneration* to home care agencies and other providers for participation. The program must include a representative number of older adults, be implemented by October 1, 2006, and evaluate the use of telemonitoring equipment as a tool to improve the health of home and community based recipients through increased monitoring and responsiveness, and resulting in increased stabilization rates and decreased hospitalization rates. The Department shall report to the Study Commission on Aging by August 1, 2007 and the report must include findings and recommendation on the cost-effectiveness of telemonitoring and the benefits to individuals and health care providers. The act also implements a one-year moratorium, beginning January 1, 2007, on the licensing of new home care agencies offering in-home aide services. However, the moratorium does not prevent the Department from issuing licenses to certified home health agencies or to agencies that need a new license for an existing home care agency being acquired. This act became effective August 3, 2006.

RECOMMENDATION	RESULT
Recommendation 5: LTC Ombudsman The Study Commission on Aging recommends that the General Assembly appropriate funding for 10 Long Term Care Ombudsman positions and related travel expenses.	In response to this recommendation SB 1271 and HB 2057 were introduced. • SB 1271 was referred to the Senate Committee on Appropriations/Base Budget. • HB 2057 was referred to the House Committee on Appropriations. • The General Assembly provided $492,136 in recurring funding for eight long-term care ombudsman positions including benefits and travel and $100,000 for a contract for the Quality Improvement Program authorized in Section 10.40A(p) of S.L. 2005-276. Additionally, S.L. 2006-221, Sec. 13B (SB 198, Sec. 13B) clarifies that of the funds appropriated to the Department of Health and Human Services for Long Term Care Quality Improvement must be allocated to the Area Agencies on Aging to support eight regional long term care ombudsman positions including benefits and travel and $100,000 for a contract for the Quality Improvement Program authorized in S.L. 2005-276, Section 10.40A(p). This section also clarifies that the long term care ombudsman positions are not State positions.
Recommendation 6: NC NOVA Special Licensure Designation The Study Commission on Aging recommends that the General Assembly enact legislation implementing the North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation in which long-term care providers may participate on a voluntary basis in an effort to improve recruitment, retention, development, and job satisfaction of the direct care workforce, and improve the care provided to long-term care clients, residents, and patients.	In response to this recommendation, SB 1277 and HB 2055 were introduced. • SB 1277 was enacted and S.L. 2006-104 establishes the North Carolina New Organizational Vision Award (NC NOVA). NC NOVA is a voluntary special licensure designation that will be rewarded to adult care homes, home care agencies, and nursing homes that have been determined through written and on-site review, by an independent review organization, to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff, and the care provided to long-term care clients and residents. The NC NOVA program will be implemented by the Department of Health and Human Services. This act becomes effective January 1, 2007.

RECOMMENDATION	RESULT
Recommendation 7: Housing The Study Commission on Aging recommends that the General Assembly appropriate an additional $10 million dollars for the Housing Trust Fund with $4 million of the total amount going to the Urgent Repair Program to provide grants for emergency home repairs for elderly homeowners and other homeowners with special needs.	In response to this recommendation, SB 1272 and HB 2051 were introduced. • SB 1272 was referred to the Senate Committee on Appropriations/Base Budget. • HB 2051 was referred to the House Committee on Appropriations.
Recommendation 8: Posting of Fines and Penalties for LTC Facilities The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Facility Services to post by October 15, 2006, the substantiated infractions, fines, and penalties assessed to long-term care facilities.	In response to this recommendation, SB 1274 and HB 2059 were introduced. • SB 1274 was referred to the Senate Committee on Health Care. • HB 2059 received a favorable report in the House Committee on Aging, passed 2nd and 3rd reading in the House and was sent to the Senate where it was referred to the Senate Committee on Health Care. *Note: The Division of Facility Services has indicated that they plan have fines and penalties posted online by October 1, 2006 and they plan to update them monthly.*
Recommendation 9: LTC Insurance Tax Credit The Study Commission on Aging recommends that the General Assembly enact House Bill 118 or Senate Bill 37 Reenact Long-Term Care Insurance Tax Credit.	HB 118 was referred to the House Committee on Finance and SB 37 was referred to the Senate Committee on Finance.

RECOMMENDATION	RESULT
Recommendation 10: Medicaid Institutional Bias – CAP/DA Slots The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to review the CAP/DA program including slot distribution and re-distribution to ensure that the CAP/DA waiting list is managed as efficiently as possible, identification and alleviation of identified biases, implementation of a uniform screening/assessment tool, and other strategies to ensure maximum operational efficiency and effectiveness for those individuals qualifying for CAP/DA services, and to make an interim report to the Study Commission on Aging by August 30, 2006 and a final report by August 30, 2007.	In response to this recommendation, SB 1276 and HB 2055 were introduced. • SB 1276 was enacted and S.L. 2006-109 requires the Department of Health and Human Services to review and report on the Community Alternatives Program for Disabled Adults (CAP/DA) in response to the institutional bias report. The report must include actions taken and planned by the Department in response to each bias identified in the institutional bias study. The inclusion of the following information is also required in the report: ➢ Information on the utilization of CAP/DA slots, including a history of slots used per year over the last 10 years and the anticipated need during the next 10 years. ➢ A description of the CAP/DA slot allocation formula; and a breakdown of slots by county, including the reallocation of any unused slots. ➢ Strategies to ensure that the CAP/DA waiting list is managed as efficiently as possible, including consideration of whether there should be an expiration date tied to unused slots so that they may be reallocated in a timely manner to areas with waiting lists. ➢ Implementation of a uniform screening/assessment tool and other strategies to ensure maximum operation efficiency and effectiveness for those individuals qualifying for CAP/DA services. This should include information on whether the lists should be prioritized by risk of institutionalization. The Department must submit an interim report to the NC Study Commission on Aging on or before August 30, 2006, and a final report on or before August 30, 2007. The act became effective July 13, 2006. *Note: The Department has requested an extension on the interim reporting date to November 1, 2006.*

RECOMMENDATION	RESULT
<u>Recommendation 11:</u> Medicaid Institutional Bias – Recommendations to Address Biases The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to work with providers and advocates of home and community based services to review the North Carolina Institutional Bias Study Report prepared by The Lewin Group and to make recommendations on ways to address the biases identified in the report and to report to the Study Commission on Aging by October 15, 2006.	In response to this recommendation, SB 1279 and HB 2052 were introduced. • SB 1279 was enacted and S.L. 2006-110 directs the Department of Health and Human Services to collaborate with providers and advocates of home and community-based services to make recommendations addressing the biases identified in the institutional bias report prepared by The Lewin Group. (Institutional bias refers to the policies and practices within Medicaid that make it easier for a beneficiary to access institutional care than services in home and community based settings.) The Department is required to report its findings and recommendations to the NC Study Commission on Aging on or before October 15, 2006. This act became effective July 13, 2006.
<u>Recommendation 12:</u> Additional Funds for Home and Community Care Block Grant The Study Commission on Aging recommends that the General Assembly appropriate an additional $5 million in funding for the Home and Community Care Block Grant (HCCBG).	In response to this recommendation, SB 1273 and HB 2056 were introduced. • SB 1273 was referred to the Senate Committee on Appropriations/Base Budget. • HB 2056 was referred to the House Committee on Appropriations. • The General Assembly provided $4,000,000 in recurring funding for the Home and Community Care Block Grant.

Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2006 Session

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

Enacted Legislation

Change Progress Report Date: Quality Improvement Consultation Program for Adult Care Homes

S.L. 2006-66, Sec. 10.1 (SB 1741, Sec. 10.1), amends S.L. 2005-276, Section 10.40A(p), to require the progress report on the Quality Home Improvement Consultation Program on or before January 1, 2007, (previously April 1, 2006). The report must be submitted to the Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and to the House of Representatives Subcommittee on Health and Human Services, and must address the following topics:

- Principles and philosophies that are resident-centered and promote independence, dignity, and choice for residents;
- Approaches to develop continuous quality improvement with a focus on resident satisfaction and optimal outcomes;
- Dissemination of best practice models that have been used successfully elsewhere;
- A determination of the availability of standardized instruments, and their use to the extent possible, to assess and measure adult care home performance according to quality of life indicators;
- Utilization of quality improvement plans for adult care homes that identify and resolve issues that adversely affect quality of care and services to residents. The plans include agreed upon time frames for completion of improvements and identification of needed resources;
- Training required to equip county departments of social services' staff to implement the Program;
- A distinction of roles between the regulatory role of the Department's Division of Facility Services and the quality improvement consultation and monitoring responsibilities of the county departments of social services; and
- Identification of staffing and other resources needed to implement the Program.

Transfer of Assets Rewrite

S.L. 2006-66, Sec. 10.5 (SB 1741, Sec. 10.5)Repeals GS 108A-58 and enacts GS 108A-58.1 to update provisions on ineligibility for Medicaid assistance based on transfer of assets for less than fair market value. Incorporates provisions provided by federal law. Allows waiver of penalty if Department determines it would impose an undue hardship.

Pilot Projects to Control Cost and Improve Quality of Care for Aged, Blind, and Disabled Medicaid Recipients

S.L. 2006-66, Sec. 10.7A (SB 1741, Sec. 10.7A) expands the scope of the Community Care of NC care management model, to provide that the initiatives may include pilot projects to control costs and improve care for the aged, blind, and disabled recipients of Medicaid. Also amends section 10.14 of SL 2005-276 to authorize use of funds for grants through the Office of Rural Health and Community Care for cost containment programs

Extend Effective Date on Changes to Liens on Real Property for Purposes of Estate Recovery Under Medicaid

S.L. 2006-66, Sec. 10.9 (SB 1741, Sec. 10.9) revises the implementation date of the Health Coverage for Workers with Disabilities Act, which was created by Section 10.18 of S.L. 2005-276. The section of the act calling for its implementation will now become effective on July 1, 2007.

DHHS to Study Strategies to Offset the Cost to Pharmacists of Providing Service to Medicaid Recipients Enrolled in Medicare Part D

S.L. 2006-66, Sec. 10.9D (SB 1741, Sec. 10.9D) directs the Department of Health and Human Services to study issues relating to the provision of pharmacy services to Medicaid recipients enrolled in Medicare Part D and to develop strategies to assist pharmacists to provide services to this population. Specific items to be addressed include the special circumstances of pharmacists providing services to long-term care facilities and the impact of the Deficit Reduction Act of 2005 on the payment for generic drugs under Medicaid. Findings and recommended strategies will be reported not later than April 1, 2007 to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

Private-Public Long-Term Care Partnership Program

S.L. 2006-66, Sec. 10.10 (SB 1741, Sec. 10.10), directs the Department of Health and Human Services to develop a North Carolina Long-Term Care Partnership Program in an effort to reduce future Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid. The Department must structure the program in accordance with federal laws and guidelines for qualified State long-term care partnerships. Prior to submitting the Program for federal approval of the State Plan amendment, the Department must submit the proposed Program 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. The Program is prohibited from becoming effective until it is reviewed in accordance with this section.

Independent-And Supportive-Living Apartments Initiative

S.L. 2006-66, Sec. 10.30 (SB 1741, Sec. 10.30), requires that the independent and supportive living apartments for persons with disabilities constructed from funds appropriated in this act must be affordable to persons with incomes at the Supplemental Security Income level. The section further provides that if the North Carolina Housing Finance Agency is able to finance the apartments for less than the amount appropriated, any remaining funds, as well as any interest earned on the amount appropriated, may be used to finance additional apartments, group homes, and transitional housing for individuals with disabilities.

Special Assistance In-Home Assignments

S.L. 2006-156 (HB 2576) allows the Department of Health and Human Services to use funds appropriated for the 2006-2007 fiscal year to increase the maximum number of assignments to the special assistance in-home program to 1,500 persons.

Assault Handicapped/Increase Penalty

S.L. 2006-179 (SB 488) increases from Class 1 to Class A1 the penalty for committing assault or battery upon a handicapped person. The range of punishment for a Class 1 misdemeanor is a minimum of 1-45 days of community service with a maximum of up to 120 days active, depending on the person's prior record. The range of punishment for a Class A1 misdemeanor is 1-150 days, with the possibility of an active sentence even if the person has no prior convictions.

This act becomes effective December 1, 2006, and applies to offenses committed on or after that date.*

Stroke Advisory Council

S.L. 2006-197 (HB 1860) directs the Justus-Warren Heart Disease and Stroke Prevention Task Force to establish and maintain a Stoke Advisory Council. The Council will advise the Task Force regarding the development of a statewide system of stroke care.

Studies

Legislative Research Commission

Pharmacy Benefits Manager

The Legislative Research Commission may study issues regarding the regulation of pharmacy benefit management.

Joint Legislative Health Care Oversight Committee

Geriatric Care Providers

The Joint Legislative Health Care Oversight Committee to study the methods of increasing the number of geriatric care providers in the State.

Prescription Drug Cost Management Office

The Committee may study the feasibility of establishing an Office for Prescription Drug Cost Management ("Office") in the Department of Administration or other appropriate State agency to manage the cost of prescription drugs incurred by State agencies and programs that cover or provide prescription drugs. The responsibilities of the Office shall include negotiating prescription drug price discounts with participating pharmaceutical manufacturers and pharmacists for prescription drugs paid for, in whole or in part, with State funds.

Rural Health Care Access and Needs

The Committee may study, in consultation with the Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development, the health care needs in rural areas of the State and other health professional shortage areas of the State without inpatient services and with a high percentage of uninsured residents

State Fair Housing Act Study

The North Carolina Human Relations Commission is required to study whether the State Fair Housing Act should be amended to make it an unlawful discriminatory housing practice to refuse to enter into a residential real estate transaction with a person based upon the fact that the person receives public assistance due to age or physical or mental disability. The Commission shall report its findings and recommendations to the 2007 General Assembly upon its convening.

Study No-Fault Compensation for Injuries to Elderly and Disabled Persons

The Commissioner of Insurance, the North Carolina Industrial Commission and the Department of Health and Human Services may jointly study the utility, efficacy, and advisability of creating a system of no-fault

compensation, with such compensation based on scheduled amounts and subject to limits on total compensation paid, for injuries resulting from regular and ordinary course of care provided at nursing homes, homes for the elderly, other long-term care facilities, and assisted living facilities. If the study is conducted, the findings and recommendations must be presented to the 2007 General Assembly upon its convening.

Study Commission on Aging Recommendations

NC NOVA-Special Voluntary Licensure Designation

S.L. 2006-104 (SB 1277) establishes the North Carolina New Organizational Vision Award (NC NOVA). NC NOVA is a voluntary special licensure designation that will be rewarded to adult care homes, home care agencies, and nursing homes that have been determined through written and on-site review, by an independent review organization, to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff, and the care provided to long-term care clients and residents. The NC NOVA program will be implemented by the Department of Health and Human Services.

Adult Day Awareness/Status of Study Recommendations

S.L. 2006-108 (SB 1278) directs the Department of Health and Human Services to ensure that Community Alternatives Program (CAP) case managers are aware of adult day health programs, and requires the Department to make a status report on the Partners in Caregiving study recommendations. The Department is required to report on the status of its activities under this act to the North Carolina Study Commission on Aging not later than July 30, 2006.

Pilot Program to Evaluate Telemonitoring in Equipment in Home Care Services

S.L. 2006-66, Sec. 10.9C (SB 1741, Sec. 10.9C), authorizes the Department of Health and Human Services, Division of Medical Assistance to implement a pilot program to evaluate the use of telemonitoring equipment. The evaluation will include a representative number of older adults and shall focus on whether or not the use of this equipment results in decreased hospital rates and increased stabilization rates for home-based individuals. The section requires the Department to report its findings to the Study Commission on Aging, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division by July 1, 2007.

Note: Also see the summary in this Chapter of S.L. 2006-194 (SB 1280) DHHS Evaluate Telemonitoring/Home Care Licenses.

CAP/DA Review and Report

S.L. 2006-109 (SB 1276) requires the Department of Health and Human Services to review and report on the Community Alternatives Program for Disabled Adults (CAP/DA) in response to the institutional bias report. The report must include actions taken and planned by the Department in response to each bias identified in the institutional bias study. The inclusion of the following information is also required in the report:

Information on the utilization of CAP/DA slots, including a history of slots used per year over the last 10 years and the anticipated need during the next 10 years.

A description of the CAP/DA slot allocation formula; and a breakdown of slots by county, including the reallocation of any unused slots.

Strategies to ensure that the CAP/DA waiting list is managed as efficiently as possible, including consideration of whether there should be an expiration date tied to unused slots so that they may be reallocated in a timely manner to areas with waiting lists.

Implementation of a uniform screening/assessment tool and other strategies to ensure maximum operation efficiency and effectiveness for those individuals qualifying for CAP/DA services. This should include information on whether the lists should be prioritized by risk of institutionalization.

The Department must submit an interim report to the NC Study Commission on Aging on or before August 30, 2006, and a final report on or before August 30, 2007.

Review of NC Institutional Bias Report

S.L. 2006-110 (SB 1279) directs the Department of Health and Human Services to collaborate with providers and advocates of home and community-based services to make recommendations addressing the biases identified in the institutional bias report prepared by The Lewin Group. (Institutional bias refers to the policies and practices within Medicaid that make it easier for a beneficiary to access institutional care than services in home and community based settings.)

The Department is required to report its findings and recommendations to the NC Study Commission on Aging on or before October 15, 2006.

DHHS Evaluate Telemonitoring/Home Care Licenses

S.L. 2006-194 (SB 1280) requires the Department of Health and Human Services, Division of Medical Assistance to evaluate the use of telemonitoring equipment for home and community-based recipients by establishing a pilot program to be implemented by October 1, 2006. The Division of Aging will determine an appropriate remuneration to home care agencies participating in the pilot. The evaluation will include a representative number of older adults and shall focus on whether or not the use of this equipment results in decreased hospital rates and increased stabilization rates for home and community-based recipients and requires the Department to report its findings to the Study Commission on Aging by August 1, 2007.

This act also implements a one-year moratorium, beginning January 1, 2007, on the licensing of new home care agencies offering in home aide services. However, the moratorium does not prevent the Department from issuing licenses to certified home health agencies or to agencies that need a new license for an existing home care agency being acquired.

Note: Also see the summary in this Chapter of S.L. 2006-66, Sec. 10.9C (SB 1741, Sec. 10.9C), DHHS Pilot Program to Evaluate Telemonitoring in Equipment in Home Care Services.

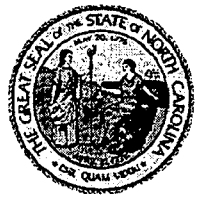
Long Term Care Quality Improvement Program/Long Term Care Ombudsman Positions

S.L. 2006-221, Sec. 13B (SB 198, Sec. 13B) clarifies that of the funds appropriated to the Department of Health and Human Services for Long Term Care Quality Improvement must be allocated to the Area Agencies on Aging to support eight regional long term care ombudsman positions including benefits and travel and $100,000 for a contract for the Quality Improvement Program authorized in S.L. 2005-276, Section 10.40A(p). This section clarifies that the long term care ombudsman positions are not State positions.

** Trina Griffin contributed to the summary of SB 488*

APPENDIX B

North Carolina Study Commission On Aging



Legislative Building 16 West Jones Street Raleigh, NC 27601

August 29, 2006

Representative Verla C. Insko
Co-Chair, Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, and Substance Abuse Services
Legislative Building
16 West Jones Street
Raleigh, NC 27601

Senator Martin L. Nesbitt
Co-Chair, Joint Legislative Oversight Committee on
Mental Health, Developmental Disabilities, and Substance Abuse Services
Legislative Office Building
300 N. Salisbury Street
Raleigh, NC 27603

Dear Verla and Martin:

As the Co-Chairs of the North Carolina Study Commission on Aging, we are writing to ask the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services for assistance in addressing issues related to serving mentally ill individuals residing in long-term care (LTC) facilities. Perhaps if your Committee and our Commission bring a renewed focus to researching these issues this interim we can develop solutions to better serve these residents.

The Study Commission on Aging has been looking into this issue over the last few years and we are committed to addressing it again this interim. During our second meeting this interim, the Study Commission on Aging plans to focus on Geriatric Mental Health Specialty Teams; the Department's progress toward an automated screening, assessment and care planning system; and perhaps other recommendations mentioned in the report resulting from S.L. 2004-124, Section 10.2.

One issue that may need further exploration is long-term care licensing categories. Session Law 2005-66 created a new adult care home licensure category for those facilities that serve individuals 55 years of age or older, and any adult with a primary diagnosis of Alzheimer's disease or other form of dementia. Perhaps the State needs to determine whether is possible for one facility to meet the needs of mentally ill individuals under the age of 55 residing in long-term care facilities, mentally ill individuals 55 years of age and older that reside in these facilities, and long-term care residents that suffer from dementia and Alzheimer's. Page 14 of the report for S.L. 2004-124, Section 10.2 indicated that, "At this time the Department does not support creating a separate licensure category for adult care homes that serve persons with mental illness." However, it may be that the range of knowledge and care required by this variety of residents, in addition to the other residents typically found in a long-term

care facility, presents a scope broader than the training typically found in long-term care providers and staff. If so, we wonder whether there is a way to achieve greater efficiency and effectiveness through some type of coordination of those residents that present similar care needs and that utilize similar services. Somewhat related to this idea of specialized care, the Study Commission on Aging plans to take a look at the current role of Special Care Units. However, it might be helpful for the State to examine how other states combine populations in long-term care facilities.

Additionally, page 8 of the report from S.L. 2004-124, Section 10.2 mentions that responsibilities of Local Management Entities (LMEs) include "responding to the needs of their communities including the needs of residents in long term care facilities." The structure of the mental health system, types and locations of providers, and the role of the LME, are not areas with which the Commission is a whole is knowledgeable. However, we wonder whether there is a way to strengthen the link between the mental health system and those residents in long-term care facilities.

In summary, we are requesting that the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, join the Study Commission on Aging's renewed focus and study of issues related to mentally ill residents in long-term care facilities. Perhaps both your Committee and our Commission could even consider some joint recommendations to the General Assembly. As a starting point, perhaps elements of these joint recommendations might include the following requests:

- An examination of whether other states combine young mentally ill individuals with residents 55 years of age and older in long-term care facilities, and an exploration of whether the State should have several types of long-term care facilities to best serve individuals; and
- an examination of whether there is a way to strengthen identification, care coordination, and accountability between the mental health system and those individuals residing in long-term care facilities in need of mental health services.

We appreciate your Committee's efforts thus far in improving the lives of mentally ill residents in North Carolina. We hope that you might join us this interim in an exploration of the best ways to serve mentally ill individuals residing in long-term care facilities.

Sincerely,

Senator Charlie S. Dannelly
Co-Chair

Representative Beverly M. Earle
Co-Chair

c: Senator Austin Allran
Senator Stan Bingham
Senator Vernon Malone
Representative Alice Bordsen
Representative Debbie Clary
Representative Bob England
Representative Jennifer Weiss
Mr. Brad Allen
Ms. Linda Howard
Ms. Regina Duffy Fisher
Ms. Florence Gray Soltys
Mr. Sam Marsh
Ms. Judy Pelt

APPENDIX C

Burlington, NC
October 3, 2006

Charlotte, NC
October 17, 2006

NC Study Commission On Aging Public Hearings Fall 2006

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)

Fall 2006 Public Hearings

Date	Location	Number of Speakers
October 3, 2006	Burlington, NC	40
October 17, 2006	Charlotte, NC	33

The issues mentioned with the greatest frequency were:

- Increase Funding/Continue Support for Senior Centers (23)
- Increase/Continue Support for Senior Games (11)
- Increase /Continue Funding for Alzheimer's and Project C.A.R.E. (10)
- Increase Funding for Home and Community Care Block Grant (7)
- Resolve Issues Related to Mentally Ill in LTC Facilities (6)
- Increase Funding/Support for Senior Friendly Housing (6)

NC Study Commission on Aging – Fall 2006 Public Hearings
Frequency of Issues Expressed by Speakers

	BURLINGTON	CHARLOTTE	TOTAL
PROGRAM SUPPORT			
Increase Funding for Home and Community Care Block Grant	5	2	7
Increase Funding for Home & Community Based Services	1		1
Increase Funding for Home Care		1	1
Increase Funding for Transportation Services	1	1	2
Increase Funding/Continue Support for Senior Centers	16	7	23
Support for Congregate and Home Delivered Meals for Seniors		1	1
Increase/Continue Support for Senior Games	9	2	11
Increase Medically Needy Income Limit	1		1
Increase Funding for Area Agency on Aging	2	2	4
Increase Funding /Expand Dental Care for Special Needs Population	2	1	3
Support for State/County Special Assistance (SA) In -Home	1		1
Eliminate Institutional Bias	1	1	2
Expand Win-A-Step Up to Home Care		1	1
Support for Community Alternatives Program for Disabled Adults (CAP/DA)	1	1	2
Decrease Social Worker Case Load	1		1
Increase Funding/Support for Senior Adult Planning	1	2	3
Strengthen Disaster Planning/Emergency Preparedness	1	1	2
Increase Support for Family Caregivers	2		2
Increase/Continue Funding for Alzheimer's and Project C.A.R.E.	6	4	10
HOUSING/TAXES			
Increase Funding/Support for Senior Friendly Housing	4	2	6
Support/ Increase Funding for NC Housing Trust Fund	2	1	3
Property Tax Relief/ Support for Homestead Exemption	1	1	2
Support Impact Fees	1		1

	BURLINGTON	CHARLOTTE	TOTAL
LONG-TERM CARE FACILITIES			
Require Increase in Nursing Hours of Care in Nursing Homes		1	1
Resolve Issues Related to Mentally Ill in LTC Facilities	3	3	6
Increase Funding/Support for Mentally Ill in LTC Facilities		4	4
Require Adequate Heating and Cooling Regulation in LTC Facilities	1		1
Increase Wages/ Support for Direct Care Workers	2		2
Provide Background Checks on Facility Administrators	1		1
Implement Star Rating System for Adult Care Homes		1	1
Support Resident Councils for Adult Care Homes	1		1
MEDICAL CARE/INSURANCE/ PRESCRIPTION DRUGS			
Support for Prescription Drug Assistance Program	1	2	3
Restore Long Term Care Insurance Tax Credit	2	1	3
Increase MDs that Accept Medicaid		1	1
Raise Medically Needy Income Limit	1	1	2
Establish Medical Malpractice Limits	1		1
Support for National and State Health Care System		1	1
OTHER			
Auto Insurance Discounts for Seniors Taking Driving Safety		1	1
Concern Regarding Financial Exploitation of Older Adults		2	2
Support for Victim Legal Assistance		1	1
Support for Judicial System Reform		1	1
Concern for Immigration Issues		1	1
Concern for Disabled Child Outliving Parent Caregiver		1	1
Totals	72	53	125

Prepared by Aging Commission Staff

APPENDIX D

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-8 [v.3] (01/09)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 10:47:52 AM

Short Title: Senior Center Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE ADDITIONAL FUNDS TO THE SENIOR CENTER GENERAL PURPOSE FUND, 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 Senior Center General Purpose Fund, the sum of five hundred thousand dollars ($500,000) for the 2007-2008 fiscal year, and the sum of five hundred thousand dollars ($500,000) for the 2008-2009 fiscal year, to be used as additional funding for Senior Centers.

SECTION 2. This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-6 [v.5] (01/09)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 10:48:46 AM

Short Title: Special Care Pop. Dentistry Funds and Study. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, FOR THE PURCHASE OF AN ADDITIONAL MOBILE DENTAL UNIT, AND TO REQUIRE THE BOARD OF GOVERNORS OF THE UNIVERSITY OF NORTH CAROLINA TO STUDY THE DEDICATION OF ONE OR MORE DENTAL SCHOLARSHIP-LOAN PROGRAM SLOTS TO DENTISTS SERVING SPECIAL CARE POPULATIONS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of two hundred thousand dollars ($200,000) for the 2007-2008 fiscal year, to be used by a new or existing non-profit mobile dental care provider to purchase an additional mobile dental unit to serve special care populations, the frail elderly and developmentally disabled, in geographic areas of the State that are not currently served by mobile dental units.

SECTION 1.(b) The Department of Health and Human Services, Division of Public Health, shall report to the North Carolina Study Commission on Aging by September 1, 2008, on the status of the activities authorized in this section.

SECTION 2.(a) The Board of Governors of The University of North Carolina shall study the feasibility of permanently dedicating one or more of the Board of Governors' Dental Scholarship-Loan Program slots to individuals who will predominately treat special care populations, primarily developmentally disabled individuals and the elderly.

1 **SECTION 2.(b)** The Board of Governors shall report findings and
2 recommendations on the study authorized in this section to the North Carolina Study
3 Commission on Aging on or before January 15, 2008.
4 **SECTION 3.** This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-3 [v.3] (11/15)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 10:49:25 AM

Short Title: Health Care Personnel Registry/Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE HEALTH CARE PERSONNEL REGISTRY BY AMENDING THE DEFINITIONS OF HEALTH CARE FACILITIES AND HEALTH CARE PERSONNEL, AND TO APPROPRIATE FUNDS TO THE DIVISION OF FACILITY SERVICES FOR ADDITIONAL STAFFING, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(a1) The Department shall include in the registry a brief statement of any individual disputing the finding entered against the individual in the health care personnel registry pursuant to subdivision (1) of subsection (a) of this section.

(b) For the purpose of this section, the following are considered to be "health care facilities":

(1) Adult Care Homes as defined in G.S. 131D-2.
(2) Hospitals as defined in G.S. 131E-76.
(3) Home Care Agencies as defined in G.S. 131E-136.
(4) Nursing Pools as defined by G.S. 131E-154.2.
(5) Hospices as defined by G.S. 131E-201.
(6) Nursing Facilities as defined by G.S. 131E-255.
(7) State-Operated Facilities as defined in G.S. 122C-3(14)f.
(8) Residential Facilities as defined in G.S. 122C-3(14)e.
(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.
(10) Licensable Facilities as defined in G.S. 122C-3(14)b.
(11) Multiunit Assisted Housing with Services as defined in G.S. 131D-2.
(12) Community-Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C.
(13) Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program in accordance with G.S. 143B-181.1(a)11.

(c) For the purpose of this section, the term "health care personnel" means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.~~the following are considered to be "health care personnel":~~

~~(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.~~

~~(2) A nurse aide.~~

~~(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.~~

~~(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.~~

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer <u>at a health care facility</u> or potential employer <u>at a health care facility</u> of any person listed on the Health Care Personnel Registry information concerning the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

(i) In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel

to petition the Department to have his or her name removed from the registry upon a determination that:

(1) The employment and personal history of the nurse aid does not reflect a pattern of abusive behavior or neglect;

(2) The neglect involved in the original finding was a singular occurrence; and

(3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of one million seven hundred thousand dollars ($1,700,000) for the 2007-2008 fiscal year and one million seven hundred thousand dollars ($1,700,000) for the 2008-2009 fiscal year to establish positions to handle increases in allegations and investigations resulting from this act and prior acts expanding the coverage of the Health Care Personnel Registry.

SECTION 3. Section 1 of this act becomes effective January 1, 2008. Section 2 of this act becomes effective July 1, 2007. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-7 [v.2] (01/09)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 10:50:00 AM

Short Title: Project C.A.R.E for Dementia Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF AGING AND ADULT SERVICES, FOR PROJECT C.A.R.E. WHICH PROVIDES SUPPORT FOR INDIVIDUALS WITH DEMENTIA AND THEIR CAREGIVERS, 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 five hundred thousand dollars ($500,000) for the 2007-2008 fiscal year, and the sum of five hundred thousand dollars ($500,000) for the 2008-2009 fiscal year, to fund Project C.A.R.E. which provides support to individuals with dementia and their caregivers.

SECTION 2. This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-4 [v.4] (11/15)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 10:50:31 AM

Short Title: Home & Community Care Block Grant Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE ADDITIONAL 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 five million dollars ($5,000,000) for the 2007-2008 fiscal year, and the sum of five million dollars ($5,000,000) for the 2008-2009 fiscal year, to be used as additional funding for the Home and Community Care Block Grant (HCCBG).

SECTION 2. This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-11 [v.6] (01/09)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 11:10:55 AM

Short Title: Penalty Review Committee Changes. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AMEND THE PENALTY REVIEW COMMITTEE PROCESS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-34(h) reads as rewritten:

"(h) The Secretary shall establish a penalty review committee within the Department, which shall meet as often as needed, but no less frequently than once each quarter of the year. ~~at least semiannually to review violations and penalties imposed by the Adult Care Licensure Section; provide a forum for residents, guardians or families of residents, local department of social services, and providers; and make recommendations to the Department for changes in policy, training, or rules as a result of its review and publish a report.~~ to review administrative penalties assessed pursuant to this section and pursuant to G.S. 131E-129 as follows:

(1) The Secretary shall administer the work of the Committee and provide public notice of its meetings via website, and provide direct notice to the following parties involved in the penalties the Committee will be reviewing:

a. The licensed ~~provider;~~ provider, who upon receipt of the notice, shall post the notice of the scheduled Penalty Review Committee meeting in a conspicuous place available to residents, family members, and the public;

b. The local department of social services that is responsible for oversight of the facility involved;

c. The residents affected; and

d. ~~The families or guardians of the residents affected.~~ Those individuals lawfully designated by the affected resident to make health care decisions for the resident.

(2) The Secretary shall ensure that the Nursing Home/Adult Care Home Penalty Review Committee established by this subsection is comprised of nine members. At least one member shall be appointed from each of the following categories:

a. A licensed pharmacist;

b. A registered nurse experienced in long term care;

c. A representative of a nursing home;

d. A representative of an adult care home; and

e. Two public members. One shall be a "near" relative of a nursing home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. One shall be a "near" relative of a rest home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. For purposes of this subdivision, a "near" relative is a spouse, sibling, parent, child, grandparent, or grandchild.

(3) Neither the pharmacist, nurse, nor public members appointed under this subsection nor any member of their immediate families shall be employed by or own any interest in a nursing home or adult care home.

(4) Repealed by Session Laws 2005-276, s. 10.40A(l), effective July 1, 2005.

~~(4a) The Department of Health and Human Services shall notify families or guardians of affected residents of the right to request a penalty review committee review of the Department's penalty decision before the decision becomes final. Within 60 days of receipt of a request from a family member or guardian for review of the Department's penalty decision, the penalty review committee shall meet to conduct the review and shall inform the family member or guardian of the results of the review.~~

(4b) Prior to serving on the Committee, each member shall complete a training program provided by the Department of Health and Human Services that covers standards of care and applicable State and federal laws and regulations governing facilities licensed under Chapter 131D and Chapter 131E of the General Statutes.

(5) Each member of the Committee shall serve a term of two years. The initial terms of the members shall commence on August 3, 1989. The Secretary shall fill all vacancies. Unexcused absences from three consecutive meetings constitute resignation from the Committee.

(6) The Committee shall be cochaired by:

1 a. One member of the Department outside of the Division of
2 Facility Services; and
3 b. One member who is not affiliated with the Department."
4 **SECTION 2.** This act becomes effective October 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SQz-6 [v.4] (01/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 11:05:29 AM

Short Title: Transport of Indiv. in Wheelchair Study. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF TRANSPORTATION TO STUDY ISSUES RELATING TO INDIVIDUALS BEING TRANSPORTED IN VEHICLES WHILE SEATED IN WHEELCHAIRS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Transportation shall study issues relating to the vehicular transportation of individuals seated in wheelchairs. The study shall include reviewing appropriate methods of transporting passengers who remain seated in wheelchairs while in motor vehicles and developing guidelines for the installation and use of wheelchair tiedown systems. The Department shall report its findings and any recommendations to the North Carolina Study Commission on Aging not later than February 1, 2008.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-RDz-5 [v.4] (01/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 11:04:06 AM

Short Title: Funds for Adult Protect. Services Pilot Prog. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO ENACT A PILOT PROGRAM TO ASSESS PROPOSED CHANGES TO THE ADULT PROTECTIVE SERVICES STATUTES, 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 one million four hundred ninety-two thousand dollars ($1,492,000) for the 2007-2008 fiscal year, and one million nine hundred thirty thousand dollars ($1,930,000) for the 2008-2009 fiscal year to design and implement a pilot program to assess proposed changes to the adult protective services statutes. The proposed changes include the implementation of an Adult Protective Services Clearinghouse Model that is intended to enhance the capacity of county departments of social services in responding to the needs of all abused, neglected, or exploited adults.

SECTION 2. This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SQz-5 [v.3] (01/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/15/2007 3:48:33 PM

Short Title: Medicaid Income Limits Level Study. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REVIEW OPTIONS FOR INCREASING MEDICAID MEDICALLY NEEDY INCOME LIMITS, 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, Division of Medical Assistance shall study the medically needy income standard. The study shall include determining a method for increasing the current standard while providing improved consistency across long-term care settings. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging not later than September 1, 2008.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-RDz-7 [v.6] (01/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 11:03:21 AM

Short Title: Funds for Housing Options for Mentally Ill. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO INCREASE AVAILABILITY OF HOUSING OPTIONS FOR NORTH CAROLINIANS WITH MENTAL ILLNESS, 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 the sum of one million five hundred six thousand six hundred dollars ($1,506,600) for the 2007-2008 fiscal year, and three million thirteen thousand two hundred dollars ($3,013,200) for the 2008-2009 fiscal year. The funds shall be used to increase the availability of housing options for North Carolinians with mental illness through the provision of rental assistance for both North Carolina Housing Finance Agency-financed apartments and other publicly-subsidized apartments, with priority given to those individuals that are transitioning out of State psychiatric hospitals and those that are transitioning out of long-term care facilities.

The Department of Health and Human Services and the North Carolina Housing Finance Agency shall collaborate to determine the most efficient and effective use of the appropriated funds to provide the greatest number of additional housing units to North Carolinians with mental illness.

SECTION 2. This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-RDz-8 [v.3] (01/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 11:04:49 AM

Short Title: Study Housing/Training-Mentally Ill in ACH. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY RULES AND REGULATIONS REGARDING HOUSING INDIVIDUALS WITH MENTAL ILLNESS IN THE SAME FACILITY VICINITY AS INDIVIDUALS WITHOUT MENTAL ILLNESS, AND TO RECOMMEND STAFF TRAINING REQUIREMENTS FOR DIRECT CARE WORKERS IN LONG TERM CARE FACILITIES TO PROVIDE APPROPRIATE CARE TO RESIDENTS WITH MENTAL ILLNESS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1(a). The Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and Division of Mental Health, shall study rules and regulations in North Carolina and other states regarding the provision of appropriate care and housing of individuals with mental illness in the same facility vicinity with individuals without mental illness and shall make recommendations relating to the housing of these individuals.

SECTION 1(b). The Department of Health and Human Services, Division of Facility Services, Division of Aging and Adult Services, and Division of Mental Health, shall study the need for training direct care workers in long-term care facilities to provide appropriate care to facility residents with mental illness and facility residents without mental illness, and shall make recommendations for appropriate training of these workers.

SECTION 1(c). The Department of Health and Human Services shall present its findings and recommendations in response to the studies authorized in Section 1(a) and Section 1(b), along with any required statutory or rule changes, to the Study Commission on Aging and the Joint Legislative Oversight Committee on Mental

1 Health, Developmental Disabilities, and Substance Abuse Services on or before March
2 1, 2008.
3 **SECTION 2.** This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SQz-3 [v.4] (01/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/15/2007 3:51:51 PM

Short Title:	Special Assistance In-Home Assign.	(Public)
Sponsors:	Unknown.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE NUMBER OF ASSIGNMENTS TO THE SPECIAL ASSISTANCE IN-HOME PROGRAM OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. Funds appropriated to the Department of Health and Human Services for the 2007-2008 fiscal year may be used to increase the maximum number of assignments to special assistance in-home program to 2,000 persons.

SECTION 2. This act becomes effective July 1, 2007.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-10 [v.8] (01/09)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 10:58:52 AM

Short Title: ACH Star Rating Authorization/Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE MEDICAL CARE COMMISSION TO ADOPT RULES ALLOWING THE ISSUANCE OF STAR-RATED CERTIFICATES TO ADULT CARE HOMES, AND TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, FOR ADDITIONAL POSITIONS AND DATABASE ENHANCEMENT TO SUPPORT THE PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-4.5 reads as rewritten:

"**§ 131D-4.5. Rules adopted by Medical Care Commission.**

The Medical Care Commission shall adopt rules as follows:

(1) Establishing minimum medication administration standards for adult care homes. The rules shall include the minimum staffing and training requirements for medication aides and standards for professional supervision of adult care homes' medication controls. The requirements shall be designed to reduce the medication error rate in adult care homes to an acceptable level. The requirements shall include, but need not be limited to, all of the following:

a. Training for medication aides, including periodic refresher training.

b. Standards for management of complex medication regimens.

c. Oversight by licensed professionals.

d. Measures to ensure proper storage of medication.

(2) Establishing training requirements for adult care home staff in behavioral interventions. The training shall include appropriate

responses to behavioral problems posed by adult care residents. The training shall emphasize safety and humane care and shall specifically include alternatives to the use of restraints.

(3) Establishing minimum training and education qualifications for supervisors in adult care homes and specifying the safety responsibilities of supervisors.

(4) Specifying the qualifications of staff who shall be on duty in adult care homes during various portions of the day in order to assure safe and quality care for the residents. The rules shall take into account varied resident needs and population mixes.

(5) Implementing the due process and appeal rights for discharge and transfer of residents in adult care homes afforded by G.S. 131D-21. The rules shall offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes.

(6) 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.

(7) For the licensure of special care units in accordance with G.S. 131D-4.6, and for disclosures required to be made under G.S. 131D-8.

(8) For time limited provisional licenses and for granting extensions for provisional licenses.

(9) For the issuance to adult care homes of star-rated certificates, which shall contain a rating of one to five stars. The rating shall be based on the following:

a. Inspections and complaint investigations conducted by the Department to determine compliance with licensing statutes and rules.

b. Any Type A or Type B penalties, or other administrative actions, imposed on the facility by the Department.

c. Participation in any quality improvement programs approved by the Department.

d. The facility's attainment of the North Carolina New Organizational Vision Award special licensure designation authorized in Part 6, Article 5, of Chapter 131E. "

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of one hundred fifty-three thousand dollars ($153,000) for the 2007-2008 fiscal year, and the sum of one hundred eight thousand dollars ($108,000) for the 2008-2009 fiscal year. These funds shall be used to implement the Star Rating program in accordance with Section 1 of this act, including two new positions and enhancement and maintenance of a database for the program.

1 **SECTION 3.** Section 1 of this act becomes effective when it becomes law
2 and requires the issuance of certificates beginning January 1, 2009. Section 2 of this act
3 becomes effective July 1, 2007. The remainder of this act becomes effective when it
4 becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-9 [v.3] (01/09)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/17/2007 10:56:04 AM

Short Title: WIN A STEP UP Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF FACILITY SERVICES, FOR THE WIN A STEP UP PROGRAM FOR NURSE AIDES EMPLOYED BY NURSING HOMES, AND FOR A PILOT OF THE WIN A STEP UP PROGRAM FOR NURSE AIDES EMPLOYED BY HOME CARE AGENCIES, AND TO REQUIRE A STUDY OF THE FEASIBILITY OF BECOMING A SELF-SUSTAINING PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of two hundred thousand dollars ($200,000) for the 2007-2008 fiscal year, and the sum of three hundred twenty-five thousand dollars ($325,000) for the 2008-2009 fiscal year, to be used in addition to fine and penalty collections provided by the Department, to continue the WIN A STEP UP (Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance) program for nurse aides employed by nursing homes.

SECTION 1.(b) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Facility Services, the sum of two hundred thousand dollars ($200,000) for the 2007-2008 fiscal year, and the sum of two hundred thousand dollars ($200,000) for the 2008-2009 fiscal year, to be used to develop, pilot, and evaluate a WIN A STEP UP (Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance) program for nurse aides employed by home care agencies.

1 **SECTION 1.(c)** The WIN A STEP UP program shall continue to enhance
2 and enrich curriculum components with information and exercises involving appropriate
3 care for individuals with dementia, anxiety, depression, and other severe mental health
4 problems.
5 **SECTION 1.(d)** The Department shall require the WIN A STEP UP
6 program to study the feasibility of becoming a self-sustaining program and to report to
7 the House and Senate Appropriations Subcommittees on Health and Human Services by
8 May 1, 2008.
9 **SECTION 2.** This act becomes effective July 1, 2007.

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — January 23, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shonda K. Corbett	NCCU - Graduate
Melanie Bash Whitman	NCC PPR
Ann Eller	DHHS
Suzanne Merrill	DHHS-DFAS
Jean Reaves	NCCOA
J. Goldsmith	NHO
Larry Nunn	DMA
Evelyn Hausenloy	NCMA
Jim Elder	DHHC

VISITOR REGISTRATION SHEET

NC STUDY COMMISSION ON AGING — January 23, 2007

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dennis Streets	DHHS - Div. of Aging & Adult Services
Steven Freedman	Division of Aging/Adult Services
Bonnie Moull	DHHS DMH/DD/SAS
Julia Bick	DHHS - Housing
Mary Edwards	Div. of Aging & Adult Services
Julia Leggett	Alliance of Disability Advocates
Robert Sullivan	DHHS - DFS - Nursing Home Licensure
Jeff Horton	DHHS DSS
Chad Essick	Poyner & Spruill, LLP

VISITOR REGISTRATION SHEET

NC Study Commission on Aging — 1-23-2007

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robyn Burge	412 Morson Ave National Association of Social Workers Intern
Charmaine Turner	NASW (Intern)
Mary Belton	AARP - NC
Polly Williams	NC Justice Center
Sandra Truett	NC-DHHS
Jerry Cooper	NCALA
Stacy Flannery	NCHCFA
Roger Bone	Bone + Assoc.