2008

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES

ATTENDANCE

North Carolina Study Commission on Aging 2007-2008 Session

DATES / NAMES	January 24		February 28		March 6		March 28		April 10		April 24		May 12			
Senator Vernon Malone – Co-Chair	√		√		α		√		√		√		√			
Representative Jean Farmer-Butterfield – Co-Chair	√		√		√		√		√		α		√			
Senator Stan Bingham	√		√		√		√		√		√		α			
Senator Katie Dorsett	√		√		√		√		α		√		α			
Senator James Forrester	√		√		√		√		√		α		α			
Senator A.B. Swindell	α		α		√		√		α		α		α			
Representative Alice Bordsen	√		√		√		α		α		α		√			
Representative Joe Boylan	√		√		√		α		α		√		√			
Representative Bob England	√		√		√		α		√		α		√			
Representative Garland Pierce	α		α		√		√		α		√		√			
Mr. Anthony Peace	√		α		√		√		√		√		√			
Ms. Judy Pelt	√		α		√		α		√		α		√			
Ms. Jean Reaves	√		√		√		√		√		α		√			
Mr. David Lowa	√		√		√		α		√		α		√			
Honorable Karen Gottovi	√		√		√		√		√		√		α			
Honorable Edd Nye	√		√		√		α		√		α		α			
Mr. Jackie Sheppard, ExOfficio	√		√		√		√		√		√		√			
Theresa Matula, Staff	√		√		√		√		√		√		√			
Shawn Parker, Staff	√		√		√		√		√		√		√			
Ben Popkin, Counsel	√		√		√		√		α		√		√			
Bonnie McNeil, Commission Clerk	√		√		α		α		√		√		√			
Ruth Merkle, Commission Clerk	√		√		√		√		√		α		√			

NORTH CAROLINA STUDY COMMISSION ON AGING
Thursday, January 24, 2008
10:00 AM
Room 544, Legislative Office Building

MINUTES

The North Carolina Study Commission on Aging met Thursday, January 24, 2008, at 10:00 a.m. in Room 544, Legislative Office Building. The following members were present: Co-chairs Senator Vernon Malone and Representative Farmer-Butterfield; Senators Bingham, Dorsett, Forrester, Swindell; Representatives Bordsen, Boylan, England and Commission members David Lowa, Karen Gottovi, Edd Nye, Anthony Peace, Judy Pelt, Jean Reaves and Jackie Sheppard. Committee staffs Theresa Matula, Shawn Parker, Ben Popkin, and Commission Assistants Bonnie McNeil and Ruth Merkle were in attendance. Agenda (Attachment 1) and Visitor Registration Sheet (Attachment 2) are attached.

The meeting was called to order at 10:00 a.m. by Co-chair Senator Vernon Malone. Senator Malone opened the meeting with brief comments and introduced the Sergeant-at-Arms and staff. Representative Farmer-Butterfield made brief opening remarks.

Senator Malone introduced Teresa Matula to address the Commission. Ms. Matula stated that the Commission was a statutorily created commission and did an overview of Commission responsibilities and tentative meeting schedule (Attachment 3) Teresa Matula also presented the NC Study Commission on Aging Budget Estimate for 2007-2008 (Attachment 4).

Senator Dorsett made a motion that the NC Study Commission on Aging 2007-2008 Commission budget be adopted. Motion carried.

Senator Dorsett stated that last year the public hearings were a great importance to people throughout the State and noticed that we only have one that is scheduled, and feel that it is important that people in the other areas have an opportunity, that may not be able to get to Wilson or Raleigh and suggests we take some of these meetings here in Raleigh, not add additional meetings but to move to other parts of the State to hold a public hearing.

Senator Malone introduced Shawn Parker to discuss 2007 Study Commission Recommendation Status Report (Attachment 5). There was no discussion.

Ben Popkin, Staff Attorney was recognized to discuss Summary of Substantive 2007 Legislation of Related to Aging (Attachment 6).

Senator Malone introduced Melanie Bush to discuss the 2007 Budget for Aging Services and Programs (Attachment 7).

Senator Malone introduced Theresa Matula to discuss the Older Adults in NC: An Overview (Attachment 8)

Senator Malone introduced Dennis Streets, Director, Division of Aging and Adult Services, DHHS. Mr. Street discussed growth projections for the 60 plus age group and recommendations for a Statewide Aging Study (Attachment 9.)

Meeting adjourned at 11:55 a.m.

Vernon Malone

Senator Vernon Malone, Presiding

Bonnie McNeil

Bonnie McNeil, Committee Clerk

Agenda

North Carolina Study Commission on Aging

Thursday, January 24, 2008
10:00 a.m.
Legislative Office Building
Room 544

I. Welcome and Introduction of Members
Representative Jean Farmer-Butterfield, Cochair
Senator Vernon Malone, Cochair

II. Overview of Commission Responsibilities
Tentative Meeting Schedule
Presentation and Approval of Commission Budget
Theresa Matula, Commission Staff, Research Division, NCGA

III. 2007 Study Commission Recommendation Status Report
Shawn Parker, Research Division Staff, NCGA

IV. Summary of Substantive 2007 Legislation of Related to Aging
Ben Popkin, Research Division Staff, NCGA

2007 Budget for Aging Services and Programs
Melanie Bush, Fiscal Research Division Staff, NCGA

V. Older Adults in NC: An Overview
Theresa Matula, Research Division Staff, NCGA

VI. Report to the General Assembly on Recommendations for a Statewide Aging Study (S.L. 2007-355)
Dennis Streets, Director, Division of Aging and Adult Services, DHHS

VII. Next Meeting:
Thursday, February 28, 2008
1:00

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — January 24,2008

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TRACY COLVARD	Association for Home & Hospice Care
Jim Brewer	AHHC
Lauren Akers	NC Center for Public Policy Research
Steve Freedman	Division of Aging / Adult Services
Ann C. Keller	DHHS
Jan Moxley	DHHS
Thomas Goldsmith	NHO
John Hammond	STHL
Richard Hatch	AARP, NCCOA, STHL
Joan Pelletier	Triangle J AAA NC4A

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — **Name of Committee**

January 24,2008 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Suzanne Merrill	DHHS/DAAS
Teresa Johnson	NC Adult Day Services Assn.
André Carson	FORLTC

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — January 24,2008

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Bethel	AARP - NC
Erin McLaughlin	MHA-NC
Mary Edwards	DAAS
DAVID BARNES	Poyner Spruill LLP
John Motley	GOV office
Roger Bone	Bone & Assoc - NCALTCF
Lyn Wilson	NCALTCF.
JACK COZORT	Womble
Evelyn Lawhorne	NCACA
Ronnie Bragg-Cash	Coalition on Aging NCAOA
Steve Metcalf	The Poly Group

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — January 24,2008

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
Jack Cozort	Womble

North Carolina Study Commission on Aging

Co-chairs:
Representative Jean Farmer-Butterfield
Senator Vernon Malone

Creation and Purpose
G.S. 120-180

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.

Membership
G.S. 120-182

Senator Vernon Malone	Representative JeanFarmer-Butterfield
Senator Stan Bingham	Representative Alice Bordsen
Senator Katie Dorsett	Representative JoeBoylan
Senator JamesForrester	Representative Bob England
Senator A.B. Swindell	Representative Garland Pierce
Mr. Anthony Peace	Ms. Karen Gottovi
Ms. Judy Pelt	Mr. David Lowa
Ms. Jean Reaves	Mr. Edd Nye

Mr. Jackie Sheppard– ex officio, non-voting

Subcommittees
G.S. 120-186.1

The Commission cochairs shall appoint subcommittees as needed to assist with the completion of the work of the Commission.

Reports
G.S. 120-187

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.

Staff

- Clerks
  - Bonnie McNeil
    (919) 733-5880
  - Ruth Merkel
    (919) 733-5898
- Research Staff
  - Theresa Matula, Shawn Parker, Ben Popkin
    (919) 733-2578

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.
120-185. Commission; public hearings.
120-186. Commission; authority.
120-186.1. Commission; Alzheimer's Subcommittee, Long-Term Care Subcommittee, and other subcommittees.
120-187. Commission; reports.
120-188. Commission; staff; meeting place.

§ 120-180. Commission; creation.

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

§ 120-181. Commission; duties.

The Commission shall study the issues of availability and accessibility of health, mental health, social, and other services needed by older adults. In making this study the Commission shall:
(1) Study the needs of older adults in North Carolina;
(2) Assess the current status of the adequacy and of the delivery of health, mental health, social, and other services to older adults;
(3) Collect current and long range data on the older adult population and disseminate this data on an ongoing basis to agencies and organizations that are concerned with the needs of older adults;
(4) Develop a comprehensive data base relating to older adults, which may be used to facilitate both short and long range agency planning for services for older adults and for delivery of these services;
(5) Document and review requests of federal, State, regional, and local governments for legislation or appropriations for services for older adults, and make recommendations after review;
(6) Evaluate long-term health care and its non-institutional alternatives;
(7) Propose a plan for the development and delivery of State services for older adults that, if implemented, would, over 10 years, result in a comprehensive, cost-effective system of services for older adults;
(8) Study all issues and aspects of gerontological concerns and problems, including but not limited to Alzheimer's Disease; and
(9) Carry out any other evaluations the Commission considers necessary to perform its mandate.
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.

NC Study Commission on Aging

Tentative Meeting Dates

Interim 2007-2008

Meetings:

Thursday, January 24, 2008	10:00 a.m. - 12:00 noon
Thursday, February 28, 2008	1:00 p.m. - 3:00 p.m.
Thursday, March 20, 2008	10:00 a.m. - 12:00 noon
Thursday, April 10, 2008	10:00 a.m. - 12:00 noon
Monday, May 12, 2008	Time to Be Determined

Public Hearing

March 6, 2008	10:00 a.m. - 12:00 noon Wilson, NC

NORTH CAROLINA STUDY COMMISSION ON AGING

2007-2008 COMMISSION BUDGET ESTIMATE

1.	Legislative Members Subsistence $104 x 10 (*number of legislative members*) x 1 ½ (*Half of members using two days subsistence*) x 6 (*number of meetings*)	$9,360
2.	Non-Legislative Members Subsistence $102.75 x 6 (*number of non-legislative members*) x 1 ½ (*Half of members using two days subsistence*) x 6 (*number of meetings*)	$5,549
3.	Travel Expenses $58.00 * x 10 (*number of GA members*) x 6 (*number of meetings*) $50.00 ** x 6 (*number of public members*) x 6 (*number of meetings*) * Average 200 miles round trip x $.29 = $58.00 ** Average 200 miles round trip x $.25 = $50.00	$5,280
4.	Clerical Staff Average of $613 ** x 3 (*number of meetings*) ** $613 = average salary with benefits for 5 day work week	$1,839
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	$1,500
10.	Reserve	$25,222
TOTAL		**$50,000**

Rev. 10/18/05

2007 Recommendation Status Report

North Carolina Study Commission on Aging
Recommendations
to the
2007 Regular Session

Prepared by Staff for the
North Carolina Study Commission on Aging

January 24, 2008

2007 Recommendation Status Report

Recommendation	Result
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.	In response to this recommendation, HB 195 and SB 53 were introduced and both were referred to House and Senate Appropriations Committees. • The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473), contains $200,000 in non-recurring funding for FY 07-08 for the Senior Center General Purpose Fund.
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.	In response to this recommendation, HB 201 and SB 52 were introduced. • A Committee Substitute for HB 201 received a favorable report in House Aging and was referred to Appropriations. SB 52 was referred to Senate Appropriations. The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473), provides $200,000 in non-recurring funding for FY 07-08 for a mobile dental provider to deliver services to the frail elderly and persons with disabilities in unserved areas. • S.L. 2007-323, Section 9.5, enacts G.S. 116-40.10 Board of Governors' Dental Scholarship Loan Program. The program provides a four-year scholarship loan of relevant tuition and fees, mandatory medical insurance, required laptop computers to any first-year students, required dental equipment, and an annual stipend of $5,000 per year to any student who has been accepted for admission to the School of Dentistry at the University of North Carolina at Chapel Hill. The Board of Governors adopts the standards for awarding the scholarship loans. The recommendation by the Commission on Aging is not included in this provision.

RECOMMENDATION	RESULT
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.	In response to this recommendation, HB 95 and SB 109 were introduced. • The statutory changes included in these bills is contained in Section 2 of S.L. 2007-544 (SB 56). • The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contains $583,000 in recurring funding and $40,274 in non-recurring funding for FY 07-08. For FY 08-09, $803,000 in recurring funding and $2,750 in non-recurring funding is provided.
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.	In response to this recommendation, SB 165 and HB 96 were introduced and referred to Appropriation Committees.
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).	In response to this recommendation HB 98 and SB 59 were introduced and referred to Appropriations Committees. • The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contains $536,000 in recurring funding for FY 07-08 and FY 08-09.
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.	In response to this recommendation HB 94 and SB 56 were introduced. • S.L. 2007-544 (SB 56) was enacted and Section 1 contains the changes to 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.	In response to this recommendation, HB 93 and SB 57 were introduced. • HB 93 received a favorable report in House Aging, passed 2nd and 3rd reading in the House and crossed over to the Senate where it was referred to the Senate Committee on Transportation. • SB 57 was referred to the Senate Committee on Transportation.

RECOMMENDATION	RESULT
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.	In response to this recommendation, HB 198 and SB 108 were introduced and referred to Appropriations Committees.
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.	In response to this recommendation, HB 92 and SB 110 were introduced and referred to Appropriations Committees. • HB 92 received a favorable report in House Aging Committee, passed 2nd and 3rd reading in the House, and was referred to the Appropriations Committee in the Senate. • SB 110 received a favorable report in Senate Health and was referred to the Appropriations Committee.
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.	No bills were introduced in response to this recommendation. • The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contains $250,000 in non-recurring funding for FY 07-08 to provide grants-in-aid to community organizations to assist seniors in enrolling in NC Rx and Medicare Part D.

RECOMMENDATION	RESULT
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 disabilities, particularly for those individuals that are transitioning out of State psychiatric hospitals and those that are transitioning out of long-term care facilities.	In response to this recommendation, HB 199 and SB 51 were introduced. • HB 199 was referred to the House Committee on Mental Health Reform, and if favorable, to the Committee on Appropriations. SB 51 was referred to the Committee on Appropriations. The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contains $7,500,000 in non-recurring funding to the North Carolina Housing Trust Fund for the financing of additional independent and supporting living apartments for people with disabilities. The apartments shall be affordable to those with incomes at the Supplemental Security Income (SSI) level.
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.	In response to this recommendation, HB 196 and SB 164 were introduced. • S.L. 2007-156 (SB 164) enacted.

RECOMMENDATION	RESULT
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.	In response to this recommendation, HB 197 and SB 58 were introduced. • S.L. 2007-323, Sec. 10.14 (HB 1473, Sec. 10.14) amends Part 3 of Article 2 of Chapter 108A of the General Statutes to add a new section pertaining to Special Assistance in-home payments. The section provides that the Department of Health and Human Services may use funds from the existing State-County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. The payments may be made for up to 15% of the caseload for all State-County Special Assistance for Adults. The standard monthly payment to individuals enrolled in the 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, unless a lesser payment amount is appropriate for the individual as determined by the local case manager. The Department is required to implement Special Assistance in-home eligibility policies and procedures to assure that in-home program participants are those individuals who need and, but for the in-home program would seek, placement in an adult care home facility. The policies and procedures must also include the use of a functional assessment. The Department must make this in-home option available to all counties on a voluntary basis and, to the maximum extent possible, must consider geographic balance in the dispersion of the payments to individuals across the State. The provision requires that for State fiscal year 2007-08, qualified individuals must not receive payments at rates less than they would have been eligible to receive in State fiscal year 2006-07.

RECOMMENDATION	RESULT
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.	No bills were introduced in response to this recommendation.
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.	In response to this recommendation, HB 248 and SB 752 were introduced. • S.L. 2007-544 (SB56) was enacted and Section 3 contains the provisions related to this recommendation. The act requires that the certificates issued to adult care homes contain a rating based, at a minimum, on inspections and substantiated complaint investigations conducted by the Department of Health and Human Services to determine compliance with licensing statutes and rules. Specific areas to be reviewed are listed in the act. • The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contains $500,000 non-recurring funding in FY 08-09 to assist adult care homes with the implementation of the adult care home rated certificate program.

RECOMMENDATION	RESULT
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 (Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance) 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.	In response to this recommendation, HB 97 and SB 99 were introduced and referred to the Appropriations Committees.
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.	This recommendation expresses support for recommendations from the House Study Committee on State Guardianship Laws.

Attachment 6

Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2007 Session

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

January 24, 2008

Enacted Legislation

Extend Restriction on Home Care Licenses

S.L. 2007-125 (SB 748) extends the restriction on the Department of Health and Human Services from issuing licenses to new home care agencies that intend to offer in-home aide services. The initial restriction began on January 1, 2007 and was scheduled to expire December 31, 2007. The restriction is extended to give the Department time to assure compliance with newly adopted home care rules and will expire at the end of the 2008 calendar year. The act specifies that extending the restriction will give the Department additional time to work with existing home care agencies to assure compliance with the newly adopted home care rules. As with the earlier law, this act does not prevent the Department from issuing licenses to certified home health agencies that intend to offer in-home aide services or to agencies that need a new license due to the acquisition of an existing home care agency.

This act became effective June 27, 2007. (SP)

Senior Center Outreach

S.L. 2007-323, Sec. 10.11 (HB 1473, Sec. 10.11) requires that of the funds appropriated for the 2007-009 fiscal biennium, the Department of Health and Human Services, Division of Aging and Adult Services, must enhance senior center programs:

- 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 prevents State funding from exceeding seventy-five percent (75%) of reimbursable costs.

This section became effective July 1, 2007. (TM)

Quality Improvement Consultation Program for Adult Care Homes

S.L. 2007-323, Sec. 10.12 (HB 1473, Sec. 10.12) requires the Division of Aging and Adult Services, Department of Health and Human Services, 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 based on a timetable for statewide implementation.

The Program must address these 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 Health Service Regulation 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 of Aging and Adult Services is required to conduct a pilot test of the Program. Pursuant to the section, no more than four county departments of social services are allowed to 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. Recommendations regarding expansion of the pilot to other counties, or statewide implementation 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.

This section became effective July 1, 2007. (TM)

State-County Special Assistance

S.L. 2007-323, Sec. 10.13 (HB 1473, Sec. 10.13) provides that effective January 1, 2007, the maximum monthly rate for residents in adult care home facilities is $1,148 per month per resident, unless adjusted by the Department of Health and Human Services, and effective October 1, 2007, the maximum monthly rate for residents in adult care home facilities increases to $1,173, unless adjusted by the 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. Effective July 1, 2007, the Department must recommend rates for State-County Special Assistance and for Adult Care Home Personal Care Services. The Department may recommend rates based on appropriate cost methodology and cost reports submitted by adult care homes that receive Special Assistance funds and must ensure that cost reporting is done for Special Assistance and Adult Care Home Personal Care Services to the same standards as apply to other residential service providers.

This section became effective July 1, 2007. (TM)

Special Assistance In-Home

S.L. 2007-323, Sec. 10.14 (HB 1473, Sec. 10.14) amends Part 3 of Article 2 of Chapter 108A of the General Statutes to add a new section pertaining to Special Assistance in-home

payments. The section provides that the Department of Health and Human Services may use funds from the existing State-County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. The payments may be made for up to 15% of the caseload for all State-County Special Assistance for Adults. The standard monthly payment to individuals enrolled in the 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, unless a lesser payment amount is appropriate for the individual as determined by the local case manager. The Department is required to implement Special Assistance in-home eligibility policies and procedures to assure that in-home program participants are those individuals who need and, but for the in-home program would seek, placement in an adult care home facility. The policies and procedures must also include the use of a functional assessment. The Department must make this in-home option available to all counties on a voluntary basis and, to the maximum extent possible, must consider geographic balance in the dispersion of the payments to individuals across the State. The provision requires that for State fiscal year 2007-08, qualified individuals must not receive payments at rates less than they would have been eligible to receive in State fiscal year 2006-07.

This section became effective July 1, 2007. (TM)

Reenact Long-Term Care Credit

S.L. 2007-323, Sec. 31.5 (HB 1473, Sec. 31.5). Long-term care insurance is designed to protect individuals against the high costs of long-term care. The General Assembly enacted a long-term care insurance tax credit in 1998. It expired in 2004. This section of the act reenacts the individual income tax credit for premiums paid on long-term care insurance. The credit amount is equal to 15% of the premium paid each year on a long-term care insurance policy. The credit may not exceed $350 for each policy for which the credit is claimed. The credit differs from the former credit in that, to be eligible to claim it, a taxpayer's adjusted gross income must not exceed a stated amount. For married taxpayers filing jointly, the income limitation is $100,000.

This section becomes effective for taxable years beginning on or after January 1, 2007, and expires for taxable years beginning on or after January 1, 2013. (CA)

Medicaid Hardship/Estate Recovery/Data Share

S.L. 2007-442 (HB 1537) amends the Medicaid estate recovery provisions to allow the Department of Health and Human Services to continue as a fifth class creditor; amends the law regarding required data sharing by health insurers and the Department of Health and Human Services; and codifies the provisions setting forth the Medicaid hardship waiver process.

Medicaid Estate Recovery Plan. – This portion of the act amends S.L. 2005-276, Section 10.21C, which allowed the Department of Health and Human Services to impose liens against real property for Medicaid estate recovery. The act repeals the following four sections: 1) G.S. 108A-70.6 which pertained to the postponement of estate recovery in cases of undue hardship, 2) G.S. 108A-70.7 which provided direction when estate recovery is not cost effective, 3) G.S. 108A-70.8 which added a notice of estate recovery, and 4) G.S. 108A-70.9 which required county departments of social services to provide information and assistance. This portion of the act further amends the Medicaid Estate Recovery Plan to allow the Department to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid for the recipient. This section of the act also amends medical care services listed under the definition of "medical assistance," to specify that medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient if the recipient is 55 years of age or older, no longer include Medicare premiums, private duty nursing, home health aide services, home health therapy, speech pathology services, but now include prescription

drugs (replacing the requirement that prescription drugs must be related to nursing facility services or home and community-based services). This portion of the act also grants the Department the authority to adopt rules to waive whole or partial recovery when the recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective.

Data Sharing. – This portion of the act amends the requirements of insurers to provide certain information to the Department of Health and Human Services. It adds the following definitions:

- "Subscriber" – means the policyholder or covered person of the insurance.
- "Applicant" – means an applicant or former applicant of medical assistance benefits.
- "Recipient" – means a present or former recipient of medical assistance benefits.
- "Request" – means any inquiry by the Department or Division for the purpose of determining the existence of insurance where the Department or Division may have expended public assistance benefits.

This portion of the act also allows information to be provided to the Division or its authorized contractor, to determine what period the individual or the individual's spouse or dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer.

Medicaid Hardship. – This final portion of the act amends the Medicaid laws by adding a new section regarding a waiver of the transfer of assets penalty due to hardship. The act makes the following changes:

- *Notice of the Right to Request a Waiver* - Prior to the imposition of a period of ineligibility for long-term care services because of an asset transfer (penalty period), the county Department of Social Services (DSS) must notify the individual of their right to request a waiver of the penalty period because it will cause an undue hardship.
- *Process for Medicaid Applicant* - The determination of whether to waive the penalty period must be processed as part of the Medicaid application and subject to application processing standards set forth in the administrative rules when a waiver of penalty period due to undue hardship is requested by a Medicaid applicant requesting Medicaid pay for institutional care.
- *Process for Medicaid Recipient* - When an ongoing Medicaid recipient applies for institutional care, or is receiving Medicaid payment for institutional care, receives notice of the right to request a waiver of the penalty period because it will cause and undue hardship, the recipient has 12 calendar days from the date of the notice to request a waiver. The process for the waiver request is as follows:
  - 5 work days from receipt of a request for waiver, the county DSS must notify the individual in writing of the information and documentation necessary for approving the waiver.
  - 12 calendar days from the date of the notice above, the individual must provide the necessary information and documentation to establish the undue hardship.
  - At the end of the first 12 calendar day period, if the necessary information and documentation has not been received by the county DSS, the DSS must notify the individual of the necessary information and documentation and the individual will be given an additional 12 calendar days to provide information.
  - If the individual fails to request a waiver within 12 calendar days, the county DSS must impose the transfer of assets penalty in accordance with G.S. 108A-79.
  - By the end of the second 12 calendar day notice, if the necessary information and documentation has not been received by the county DSS, the DSS will deny the request for waiver and notify the individual of the denial in accordance with G.S. 108A-79.
  - The county DSS shall make a determination of whether the imposition of the penalty period would cause an undue hardship to the individual if the DSS

receives the necessary information and documentation within the specified time frames. The county DSS must complete the determination and notify the individual, pursuant to G.S. 108A-58.2(g), that: 1) an undue hardship exists the waiver is approved, or 2) an undue hardship does not exist and the request for a waiver has been denied. During the determination process, if the county DSS identifies the need for additional information and documentation, the individual must be notified in writing given a new period of time to provide the information.

- Under the changes a facility in which an institutionalized individual is residing may request an undue hardship waiver on behalf of the individual with the written consent of the individual or the personal representative of the individual.
- This portion of the act also provides that while the determination on a request for a waiver is pending, Medicaid is prevented from making payments for nursing facility services or intermediate care facility for the mentally retarded services to hold a bed for the individual. If an individual is institutionalized and receiving Medicaid payment for services, Medicaid will maintain the same level of services until the last day of the month after the later of the expiration of the ten day workday period following the notice required by law, or the date the decision of a local appeal hearing described in the law is issued if the individual requests an appeal, whichever comes later.
- *Undue hardship* – This portion of the act provides that undue hardship exists if the imposition of the penalty period would deprive the individual of medical care, such that health or life would be endangered, or of food, clothing, shelter, or other necessities of life. The individual must provide the information and documentation necessary to demonstrate to the Director of the county DSS, or designee, that:
  - The individual currently does not have alternative source of income or resources available to provide the medical care or food, clothing, shelter or other necessities of life that the individual would be deprived of due to the imposition of the penalty; and
  - The individual or person acting on their behalf, is making a good faith effort to pursue all reasonable means to recover the transferred asset, or the fair market value of it, which may include seeking the advice of an attorney and pursuing legal remedies and cooperating with any attempt to recover the transferred asset or the fair market value.

With regard to undue hardship the following definitions apply:

- "health or life would be endangered" – means a medical doctor with knowledge of the individual's medical condition certifies in writing that in his or her professional opinion, the individual will be in danger of death or the individual's health will suffer irreparable harm if a penalty period is imposed.
- "other necessities of life" – includes basic, life sustaining utilities, including water, heat, electricity, phone, and other items or activities that without which the individual's health or life would be endangered.
- "income" – means all income of the individual and to the community spouse less an amount for the community spouse equal to the minimum monthly maintenance needs allowance as determined under 42 U.S.C. 1396r-5(d)(3)(A)(ii) without regard to any adjustment that would be made under 42 U.S.C. 1396r-5(e3) plus fifty percent (50%) of other income in excess of the minimum monthly maintenance needs allowance as described in this section.
- "resources" – means all resources of the individual and of the community spouse except for the excluded home, the equity of a motor vehicle up to $30,000, other personal property, and an amount of other resources for the community spouse equal to sixty percent (60%) of the community spouse resource allowance as determined under 42 U.S.C. 1396r-5(f)(2)(A) which is not less than the amount specified in 42 U.S.C. 1396r-5(f)(2)(A)(i) or greater than sixty percent (60%) of the amount specified in 42 U.S.C. 1396r-5(f)(2)(A)(ii).

- Other changes relative to this provision include:
  - The specification that an undue hardship does not exist when the application of a transfer of assets penalty merely causes the individual an inconvenience or restricts his or her lifestyle.
  - A requirement that during a penalty period that has been waived due to undue hardship, an acquisition by the individual of new or increased income or resources will be treated as a change in situation and evaluated pursuant to rules adopted by the Department of Health and Human Services.
  - The disapproval of 10A NCAC 21B.0314, adopted by the Department of Health and Human Services on January 19, 2007 and approved by the Rules Review Commission on March 15, 2007.
  - Uncodified language that provides that unless require by federal law, the Department of Health and Human Services, Division of Medical Assistance must limit notification of estate recovery to the application process for Medicaid, and to following the death of the recipient.

Reporting Requirement. - The act requires the Department of Health and Human Services to report by April 15, 2008, to the chairs of the Senate and House of Representatives appropriations Committees and the chairs of the Senate and House of Representatives appropriations Subcommittees on Health and Human Services. The report must include the following information:

- For the previous twenty four months, the total expenditure for personal care services for each year, and the total expenditure for each setting in which personal care services were provided.
- For the period beginning October 1, 2007, the total number of deceased recipients that received personal care services, the average expenditure for personal care services for those recipients, and the average value of the estate of those recipients.
- For the period beginning October 1, 2007, for each estate against which recovery is sought for the provision of personal care services, the total amount of personal care services provided, and the value of the estate.
- Recommendations, if any, by the Department for a threshold to begin recovery from the estate of a deceased recipient of personal care services.

This act became effective August 23, 2007. (TM)

Licensure Changes relating to Hospitals, Adult Care Homes, and Mental Health Facilities

S.L. 2007-444 (HB 772) makes a number of changes relating to the laws regulating the licenses of hospitals, adult care homes, and persons employed in mental health facilities or as medication aides as follows:

Licensed Hospitals- The act authorizes the Secretary of the Department of Health and Human Services to suspend admissions in a hospital or a particular service or unit of a hospital where conditions are considered dangerous to the health and safety of its patients after considering the following factors:

- The character and degree of impact the conditions would have on a patient's health and safety;
- The character and degree of impact the suspension would have on the functionality of the hospital and its ability to serve current patients and the community;
- If all other reasonable means for correcting the problem have been exhausted.

The section further provides that the facility may contest any adverse action on its license within 20 days after the Department mails notice. The section directs the Department to provide consultation to assist the hospital in correcting any conditions that led to a suspension of

admissions or specific services in an effort to lift the suspension as soon as the Secretary is satisfied that the condition has improved.

The act authorizes the Division of Health Service Regulation (Formerly Division of Facility Services) to temporarily waive rules pertaining to hospitals during times of emergencies declared in accordance to the laws of the North Carolina Emergency Management Act or upon request of an emergency management agency defined in G.S. 166A-4 to the extent necessary to allow the facility to provide temporary shelter and services. The section provides the Division the authority to identify which rules and to what extent they may be waived in advance of an emergency.

Licensed Mental Health Facilities- The act amends G.S. 122C-80 to allow private entities to conduct the required State criminal history check for potential employees of licensed mental health facilities.

Medication Aides- The act makes technical corrections relating to Medication Aides and the Health Care Personnel Registry.

Licensed Adult Care Homes- The act prohibits a new license from being issued due to a change of ownership of an adult care home if outstanding fees, fines, or penalties imposed by the State against the home have not been paid. The section requires investigations of violations at an adult care home must be completed within 60 days.

This act became effective August 23, 2007. (SP)

Smoking Prohibited Inside Long Term Care Facilities

S.L. 2007-459 (HB 1294) prohibits smoking inside long-term care facilities, including adult care homes, nursing homes, skilled nursing facilities, State psychiatric hospitals, and other licensed facilities that provide long-term care services. The act requires owners, managers, or operators of a long-term care facility to:

- conspicuously post a sign stating that smoking is prohibited;
- direct any person smoking inside the facility to extinguish any lighted tobacco product; and
- provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

The act directs home care agencies to prohibit their employees from smoking while providing services in an individual's home. The home care agency is required to inform its clients about the prohibition. Any owner, manager, or operator of facilities or home care agency not complying with the act can be fined by the Department of Health and Human Services an administrative penalty of up $200 per violation.

The provision relating to State psychiatric hospitals becomes effective January 1, 2008 the remainder of the act became effective October 1, 2007. (SP)

Silver Alert System/Missing Persons Alert

S.L. 2007-469 (HB 38) establishes the Silver Alert System and exempts emergency medical services personnel locating missing persons from the private protective services act.

The Silver Alert System will provide a statewide system for the rapid dissemination of information regarding a missing person who is believed to be suffering from dementia or other cognitive impairment. The System will be established within the North Carolina Center for Missing Persons. The Center is required to make every effort to disseminate the information as quickly as possible when the missing person is 18 years of age or older, and the person's status as missing has been reported to a law enforcement agency. A missing person report may be submitted by a parent, spouse, guardian, legal custodian, or person responsible for the supervision of the missing individual. The Center is required to adopt guidelines and develop procedures for issuing an alert for a person believed to be suffering from dementia or other

cognitive impairment, to provide education and training to encourage broadcaster participation, and to ensure that specific health information about the missing person is not made public through the alert or otherwise. Additionally, the Center must work with the Department of Transportation to develop a procedure for the use of overhead permanent changeable message signs to provide information on the missing adult.

The act also amends the definition of private protective services to specify that it does not prevent credentialed emergency medical services personnel from engaging in search and rescue activities at the request of either the State, a political subdivision of the State, or one of following types of facilities: adult care home, health care facility, or facility licensed to offer mental health, developmental disabilities, or substance abuse services. For purposes of these changes, search and rescue is defined as the activities and documents relating to efforts to locate an individual following the individual's disappearance. However, the exemption from the definition of private protective services does not apply if the emergency medical service provider provides services beyond emergency search and rescue and if the activities meet the definition of private protective services.

The act became effective August 29, 2007. (TM)

Adult Care Home or Nursing Home/Expedited Certificate of Need

S.L. 2007-473 (HB 1685) requires the Department of Health and Human Services, Division of Health Service Regulation, to develop an expedited certificate of need review process for a current holder of a certificate of need for an adult care home or a nursing home, allowing the relocation from one licensed facility or campus to another. The expedited certificate of need review process will be available only to a facility that meets the following criteria:

- The facility currently holds a certificate of need for an adult care home or nursing home.
- The facility proposes to move from one licensed facility or campus to another licensed facility or campus.
- Both the current and the proposed facilities or campuses are located within the same county.
- The relocation of the adult care home or nursing home would not result in an increase in the total number of adult care home beds or nursing home beds for that facility or campus.

The Division is required to implement the expedited certificate of need review process no later than October 1, 2007. On or before May 1, 2008, the Department must define the minimum review criteria necessary to determine the need for relocation of a facility by the circumstances required under this act and report to the General Assembly.

This act became effective August 29, 2007, and applies to certificate of need applications for relocation of adult care homes and adult care home beds or nursing homes and nursing home beds within the same county filed on or after the date of implementation of the expedited review process by the Department of Health and Human Services, Division of Health Service Regulation. (TM)

Penalty Review/Long-Term Care Changes

S.L. 2007-544 (SB 56) amends the Penalty Review Committee, expands the Health Care Personnel Registry, and authorizes the Medical Care Commission to adopt rules for the issuance of rated certificates to adult care homes.

Penalty Review Committee. –

- The act amends the Penalty Review Committee, established within the Department of Health and Human Services, to require that the Committee meet as often as

needed, but no less frequently than once each quarter of the year to review administrative penalties assessed to adult care homes and nursing homes. The act also makes changes to the notice requirements for Committee meetings to:

- Require that public notice of Committee meetings be made via Web site.
- Require that direct notice of the Committee meetings be made to the licensed provider, who must post the notice of the scheduled Penalty Review Committee meeting in a conspicuous place available to residents, family members, and the public.
- Require that direct notice be provided to the local department of social services that is responsible for oversight of the facility involved and to the residents affected.
- Replace the requirement of providing direct notice to "families or guardians of the residents affected" with a requirement that direct notice be provided to those individuals lawfully designated by the affected resident to make health care decisions for the resident.

➢ Changes to the Penalty Review Committee regarding notification to families and training of Committee members represent a return to statutory language that was in place prior to S.L. 2005-276 because the prior language allowed the process to function more efficiently and effectively.

Health Care Personnel Registry. –

➢ The act expands the Health Care Personnel Registry, maintained by the Department of Health and Human Services, which contains the names of all health care personnel working in health care facilities that have been subject to findings of neglect, abuse, diversion of drugs, fraud, or misappropriation of property. Individuals ("health care personnel") and entities ("health care facilities") subject to the provisions of the Health Care Personnel Registry are defined by law. This act adds the following entities to the list of defined health care facilities:

- Licensable Facilities – those that provide services for one or more minors, or for two or more adults, who are mentally ill, developmentally disabled, or substance abusers as defined by G.S. 122C-3(14)b.
- Multiunit Assisted Housing with Services as defined in G.S. 131D-2.
- 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.
- Agencies providing in-home aide services funded through the Home and Community Care Block Grant in accordance with G.S. 143B-181.1(a)11.

➢ The act also expands the definition and coverage of "health care personnel" to include any unlicensed health care facility staff 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.

Issuance of Rated Certificates to Adult Care Homes. –

➢ Section 10.41, S.L. 2005-276 (SB 622) required the Department of Health and Human Services to develop a plan for implementing a rating system for adult care homes. The report from this requirement indicated that the Medical Care Commission needed authority to adopt rules for the issuance of certificates. This act gives the Medical Care Commission the authority to adopt rules for the issuance of rated certificates to adult care homes.

➢ The act requires that the certificates issued to adult care homes contain a rating based, at a minimum, on inspections and substantiated complaint investigations conducted by the Department of Health and Human Services to determine compliance with licensing statutes and rules. Specific areas to be reviewed include:

- Admission and discharge procedures.
- Medication management.
- Physical plant.
- Resident care and services, including food services, resident activities programs, and safety measures.
- Residents' rights.
- Sanitation grade.
- Special Care Units.
- Use of physical restraints and alternatives.

➢ The act requires that initial ratings awarded to a facility must be based on inspections, penalties imposed, and investigations of substantiated complaints that revealed noncompliance with statutes and rules, that occurred on or after the act becomes law.

➢ The act also specifies that Type A penalties will affect a facility's rating for 24 months from the date the penalty is assessed and Type B penalties will affect the rating for 12 months from the date the penalty is assessed.

➢ Adult care homes are required to display the rating certificate in a location visible to the public. Certificates must include the Web site address for the Department of Health and Human Services, which can be accessed for specific information regarding the basis for the facility rating. For access by the public on request, adult care homes must also maintain on-site a copy of information provided by the Department regarding the basis of the facility rating. The Web site and the on-site materials must provide information on quality improvement efforts undertaken by the facility including: participation in any quality improvement programs approved by the Department and the facility's attainment of the NC NOVA (New Organizational Vision Award) special licensure designation.

➢ With regard to adult care home rated certificates the act also includes:
  - A requirement that the Department of Health and Human Services provide to the North Carolina Study Commission on Aging a copy of emergency, temporary, and permanent rules adopted.
  - The written intent of the General Assembly to provide funding for technical assistance to adult care homes for the 2008-2009 fiscal year. (This funding is provided in Section 10.54, S.L. 2007-323.)
  - A requirement that the Department of Health and Human Services, Divisions of Health Service Regulation, Aging and Adult Services, and Medical Assistance, study the structure and cost of a system to reward adult care homes which receive high ratings and to report to the North Carolina Study Commission on Aging not later than March 1, 2008.
  - A requirement that the Divisions of Health Service Regulation and Aging and Adult Services study expanding the rated certificate system to other facilities and services licensed and certified by the Department and report to the NC Study Commission on Aging by October 1, 2009.
  - A requirement that the Division of Health Service Regulation make and interim report on the implementation of the rated certificate system to the NC Study Commission on Aging not later than October 1, 2009, and a final report to the Commission not later than October 1, 2010.

The portion of the act pertaining to the Penalty Review Committee becomes effective October 1, 2007; the changes to the Health Care Personnel Registry become effective January 1, 2008; the rated certificates authorized by the act must be issued beginning January 1, 2009; and the remainder of the act became effective August 31, 2007. (TM)

Studies

Study Respite Care

S.L. 2007-39 (HB 424) requires the Department of Health and Human Services, Division of Health Service Regulation, Division of Medical Assistance, and the Division of Aging and Adult Services, to study the availability and delivery of respite care which provides temporary relief for family members and others who care for individuals with disabilities, chronic or terminal illnesses, dementia, or the elderly. The Department is required to examine the following issues:

- The need and availability of respite care in North Carolina.
- The delivery and licensing of respite care in other states and possible models for North Carolina.
- The application process for a grant under the Lifespan Respite Care Act of 2006, 42 U.S.C.
- The need for separate statutory language pertaining to respite care.
- The need, proposed structure, and development timeline for a separate licensure category for respite care.
- The development of a Medicaid waiver covering a proposed new licensure category for respite care.

The Department is required to present findings and recommendations, including any proposed statutory changes and new licensure categories, to the North Carolina Study Commission on Aging on or before March 1, 2008.

This act became effective May 11, 2007. (TM)

Study Housing/Training Mentally Ill in Adult Care Homes

S.L. 2007-156 (SB 164) directs the Department of Health and Human Services (Department) to study:

- The rules and regulations relating to the housing of individuals with mental illness in adult care homes that also house individuals without mental illness;
- The need for training direct care workers in long-term care facilities to provide appropriate care to residents with or without mental illness;
- The fiscal impact that the implementation of the training requirements would have on adult care homes; and
- The amount of funding necessary to support a successful training model.

The act requires the Department to present its findings and recommendations, including any statutory or rule changes, to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before March 1, 2008.

This act became effective June 29, 2007. (SP)

Study Older Adult Programs/Various Counties

S.L. 2007-355 (SB 448) requires the Department of Health and Human Services to conduct a study in select counties of older adult programs, services, and populations, and to provide recommendations on the structure of a similar study to include all North Carolina counties.

- The Department of Health and Human Services, Division of Aging and Adult Services, to work with the Division of Health Service Regulation; Division of Medical Assistance; Division of Public Health; and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to study programs and

services for older adults in Brunswick, Buncombe, Gaston, Henderson, Moore, and New Hanover Counties which currently have, or are projected by 2030 to have, the largest numbers of individuals age 60+ when compared to individuals age 17 and younger. The Division is required to make an interim status report on the study to the North Carolina Study Commission on Aging on or before November 1, 2007. On or before April 1, 2008, the Division must make a final report of its findings and recommendations to the 2008 Regular Session of the 2007 General Assembly, the North Carolina Study Commission on Aging, and to the board of county commissioners of each county studied. In conducting the study, the Division shall utilize existing data and resources and shall include the Area Agencies on Aging serving each county studied. The study must include the following for each county studied:

- A profile of the current older adult population.
- A profile of the projected growth for the older adult population.
- An assessment of the anticipated impact on programs and services that address the needs of the older adult population.
- Identification of programs and services that are currently in place.
- Identification of programs and services that are needed to meet the growth projections.
- Current funding sources for programs and services serving the older adult population.
- Anticipated funding needs for programs and services serving the older adult population.
- A delineation of the programs and services that are shared or offered jointly with another county.

➢ Additionally, in response to growth projections for the age 60+ population, the Division of Aging and Adult Services is required to make recommendations on a study to include all counties in North Carolina. In conducting the study, the Division must evaluate similar studies conducted in other states. On or before January 1, 2008, the Division is required to make recommendations on the appropriate funding level and criteria to be included in a study to be conducted of all counties in North Carolina. The findings and recommendations on a statewide study must be presented to the North Carolina Study Commission on Aging.

This act became effective August 17, 2007. (TM)

Penalty Review/Long-Term Care Changes-Studies Related to Rated Certificates

S.L. 2007-544 (SB 56). See Enacted Legislation this document.

AGING STUDY COMMISSION
BUDGET ACTIONS FY 2007-2009: SESSION LAW 2007-323, HOUSE BILL 1473

SIGNIFICANT LEGISLATIVE BUDGET ACTIONS

DIVISION OF AGING AND ADULT SERVICES

Pilot for Adult Care Home Quality Improvement
- $264,000 in nonrecurring funds in each year of the FY 2007-09 biennium;
- To improve independence, dignity, and choice for residents in 4 counties: Alamance, Buncombe, Nash, and Rutherford.

Area Agencies on Aging
- $300,000 in recurring funds for the FY 2007-09 biennium;
- Distributed to the 17 Area Agencies on Aging for services and planning activities statewide.

Senior Center General Purpose Fund
- $200,000 in nonrecurring funds in FY 2007-08;
- To provide additional funding for senior centers.

Home and Community Care Block Grant
- $536,000 in recurring funds in each year of the FY 2007-09 biennium;
- To develop and enhance community-based services and protections for older adults.

DIVISION OF HEALTH SERVICE REGULATION

Certificate of Need Program
- $852,687 in recurring funding and $28,418 in nonrecurring funding in FY 2007-08 and $852,687 in recurring funding in FY 2008-09
- 9 positions to meet the increased volume of applications, appeals, and determinations related to the development of healthcare facilities and services.

Construction Program
- $789,720 in recurring funding and $34,676 in nonrecurring funds in FY 2007-08 and $789,720 in recurring funds in FY 2008-09;
- 8 new positions for the Construction Program to review construction plans for health care and local confinement facilities.

Regulatory and Complaint Staff
- $261,665 in recurring funds FY 2007-08 and $288,887 in recurring funds in FY 2008-09;
- To increase staff and oversight in acute health care facilities' regulation and complaint investigations.

Health Care Personnel Registry and Rating System for Adult Care Homes
- $583,000 in recurring funds and $40,274 in nonrecurring funds in FY 2007-08 and $805,750 in recurring funds in FY 2008-09;
- 14 positions and costs to expand the Health Care Personnel Registry to include all unlicensed staff of a health care facility who have direct access to residents, clients, or their property;
- To implement a Rating System for adult care homes.

Technical Assistance for Adult Care Homes
- $500,000 in nonrecurring funds for FY 2008-09;
- For technical assistance to assist adult care homes with implementation of the adult care home rating program.

SIGNIFICANT SPECIAL PROVISIONS

DIVISION OF AGING AND ADULT SERVICES

Section 10.11 SENIOR CENTER OUTREACH

- Directs the Division to use funds appropriated to:
  - Expand outreach capacity of senior centers to reach unserved or underserved areas and provide start-up funds for new senior centers;
  - Requires county commissioners in counties receiving start-up funds for a new center to endorse the need and commit local funds to support operations.

Section 10.12 QUALITY IMPROVEMENT CONSULTATION PROGRAM FOR ADULT CARE HOMES

- Directs the Division to develop and conduct a pilot quality improvement consultation program for adult care homes to promote better care and improve quality of life for residents of adult care homes.

Section 10.13 STATE-COUNTY SPECIAL ASSISTANCE

Effective October 1, 2007:

- Increases the maximum monthly rate for residents in adult care facilities from $1,148 per month to $1,173 per month;
- Continues the separate maximum monthly rate for residents of special care units at $1,515 per month;
- Allows adjustments to the Special Assistance rate in order to shift some costs to the Medicaid Program. The provision also allows a limited income disregard (subject to federal approval) for individuals whose countable income would exceed the Special Assistance rate once costs are shifted to Medicaid.

Section 10.14 SPECIAL ASSISTANCE IN-HOME

- Codifies authorization language for the Special Assistance In-Home Program;
- Allows up to 15% of the total caseload for the Special Assistance Program to be allocated to the Special Assistance In-Home Program;
- Sets the maximum monthly payment for in-home assistance at 75% of the rate paid for individuals living in an adult care home.

DIVISION OF MEDICAL ASSISTANCE

Section 10.39A SKILLED NURSING FACILITY REIMBURSEMENT RATE

- Directs the Division of Medical Assistance to rebase the rates for the case-mix reimbursement system for skilled nursing facilities:
  - Effective January 1, 2008, one-half of the rate rebasing shall be implemented using 2005 audited cost data;
  - Effective October 1, 2008, the remaining half of the rate rebasing shall be implemented using 2006 audited cost data.
- Requires that inflationary increases for skilled nursing facilities for the 2007-2009 biennium include the rebasing of rates for the case-mix reimbursement system.
- Increases the provider assessment fee by $2.00 over the biennium to reduce State appropriations needed to rebase the rates.

Section 10.40F PILOT PROGRAM/MEDICAID DUAL ELIGIBLES SPECIAL NEEDS PLAN

- Directs DHHS to evaluate and establish a pilot program in at least two regions of the State;
- Pilot to offer nursing facility certifiable, dual-eligible Medicaid recipients services through a Special Needs Plan (SNP) that will work with the Community Care of North Carolina Program (CCNC).

Section 10.46 CONTINUE EFFORTS TO EXPAND COMMUNITY CARE OF NORTH CAROLINA AND IMPROVE QUALITY OF CARE FOR AGED, BLIND, AND DISABLED MEDICAID RECIPIENTS

- Directs DHHS to continue to expand the Community Care of North Carolina (CCNC) care management model to Medicare and Medicaid dually eligible persons, focusing on aged, blind, and disabled persons;
- Will manage access and utilization of:
  - personal care services,
  - private duty nursing,
  - home health,
  - durable medical equipment,
  - specialty care,
  - residential services,
  - home infusion therapy,
  - pharmacy, etc.



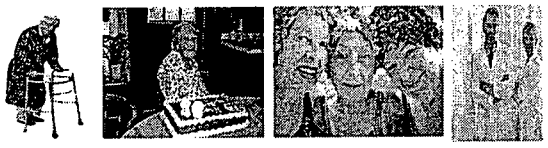
Older Adults in North Carolina: An Overview

N.C.'s Older Adults

Who? How? Where? What?

- Who Are They?
- How Many Are There?
- Where Do They Live?
- What Types of Programs and Services are Available in NC?

Who Are They?



Older Adults Are...



Snapshot of Older Adults in NC

(Source: NC DHHS Division of Aging and Adult Services, Year 2000)

28.3% of persons age 65+ live alone

54.3% of persons age 65+ living in community have 0 disabilities
20.6% of persons age 65+ living in community have 1 disability
25.1% of persons age 65+ living in community have 2 or more disabilities

14.5% of persons age 18-44 care for adult 60+
23.8% of persons age 45-64 care for adult 60+
15.7% of persons age 65+ care for adult 60+

42.2 per 1000 persons age 65+are in a nursing home
36.5 per 1000 persons age 65+are in an adult care home

$28,521 medan household income for age group65-74
$19,303 medan household income for age group75+

10.5% of persons age 65 -74 are below poverty
16.9% of persons age 75+ are below poverty

3.5% of persons 65+ are in the labor force

How Many Are There?

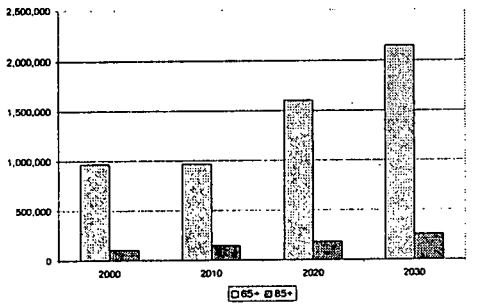
North Carolina's Older Adult Population Is Growing

Factors:

- **Baby Boomers (1946-1964)**
- **Migration – North Carolina is a popu lar retirement destination**
- **Increasing Life Expectanc y**

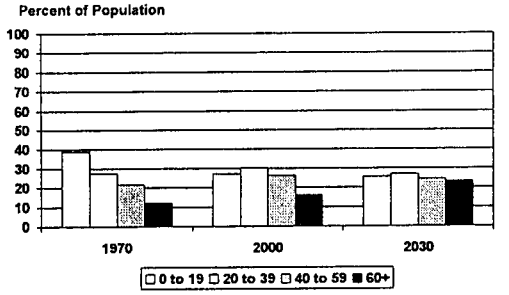
Projected Growth of Older North Carolinians 65+ and 85+

(Source: NC DHHS Division of Aging and Adult Services and UNC)



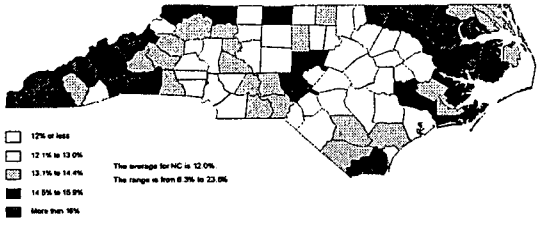
NC Population by Age Group 1970 to 2030

(Source: NC DHHS Division of Aging and Adult Services and UNC)

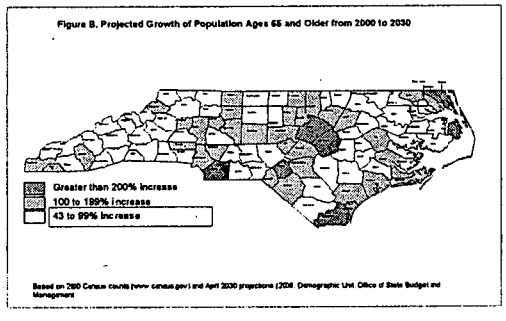


Where Do They Live?

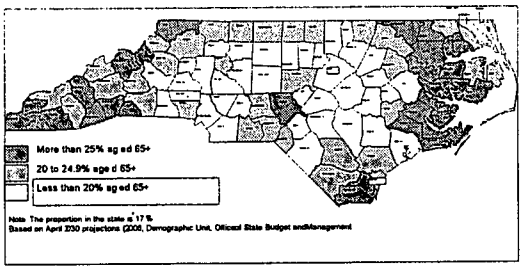
Percent of Population Age 65+ in North Carolina, Year 2000



Projected Growth of 65+ Population from 2000 to 2030



Percent of County Population Projected to Be Age 65+ in 2030



What Types of Programs and Services are Available in NC?

Range of Services and Programs

Healthy/ Active

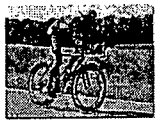
End of Life Care

Overview of Types of Programs and Services

- There are **many programs and services that support older adults** whether they are active, live in their home with services, or live in a long-term care facility.
- This portion of the presentation is designed to just give you an **overview**, it does not cover all of the services and programs offered.

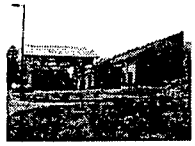
Senior Games



- Provides year-round health promotion and education for individuals 55 years of age and older.
- Serves all NC counties with over 500,000 participants.
- Local Senior Games in Spring.
- Spring Qualifiers participate Senior Games State Finals held in Raleigh in the Fall.
- Every 2 years, State finals winners qualify to represent North Carolina at the National Senior Games.

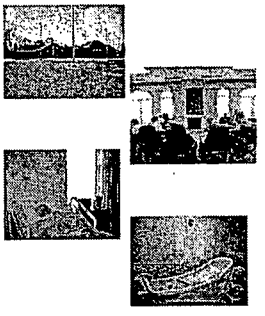
Senior Centers




Locations in the community for older adults to:
- participate in recreational, educational, and health-promoting activities;
- obtain information & individual assistance with community programs and services
- and interact with others.

- There are 163 recognized centers with two certification levels:
  - Center of Merit
  - Center of Excellence.

Adult Day Care and Adult Day Health Care



- Models: Social & Health
  - 46 Adult Day Care
  - 54 Adult Day/Adult Day Health
  - 3 Adult Day Health only
  - 103 programs in 56 counties
- Programs provide physically and mentally stimulating activities, nutritious meals and snacks.
- Often provide care while primary caregiver works.
- State provides some funding, but in most cases much of the funding is provided through fund-raising or the support of the sponsor (eg. church, etc).

Support for Adults to Remain in their Homes/Community

- **State/County Special Assistance In-Home Program** - An alternative to placement in an adult care home for individuals who could live at home safely with additional support services and income. The standard monthly payment is up to 75% of the monthly payment the individual would receive if the individual resided in an adult care home.
- **Community Alternatives Program for Disabled Adults (CAP/DA)**- A package of services allowing adults who qualify for nursing facility care to remain in their private residences. The program is available in all North Carolina counties and contributes to the quality of the participants and their families/caregivers, while providing care that is cost-effective in comparison to the Medicaid cost for nursing facility care.

Home and Community Care Block Grant Funding (HCCBG)

- **The focus of the HCCBG is to support persons 60+ with their desire to live in the community.**
- HCCBG is the **consolidation of several funding sources** (State, federal, local, and consumer contribution)
- **Counties have discretion, flexibility and authority** to determine services, service levels, and service providers.
- **18 Eligible Services**:
  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.
- There are **thousands on waiting lists for services**, primarily in-home aide and home-delivered meals.
- The **Commission historically supports HCCBG funding increases.**

Options For Care When an Individual Can no Longer Live in their Home or with Relatives

Assisted Living Residence

- Any group housing and services program for two or more unrelated adults, that makes available at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal agreement with one or more licensed home care or hospice agencies. Services are delivered in self-contained apartment units or single or shared room units with private or area baths.
- Types:
  - Adult Care Homes (including Family Care Homes)
  - Adult Care Homes That Serve Only Elderly Persons
  - Multiunit Assisted Housing with Services (MAHS)

Multiunit Assisted Housing with Services

- An assisted living residence in which hands-on personal care services and nursing services are arranged by housing management and provided by a licensed home care or hospice agency.
- Residents, or their agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision.
- These are not licensed, but are required to register with the Division of Health Service Regulation.

Adult Care Homes

(Source: NC DHHS Division of Health Service Regulation)

- Adult Care Homes provide 24-hour scheduled services for aged or disabled persons whose principal need is a home with shelter or personal care. Medical care is usually occasional.
  - Family Care Homes (2-6 beds)
  - Adult Care Homes (7 beds and up)
- In 1997 a moratorium was placed on new adult care home beds. In 2001, they became regulated under the Certificate of Need Law.
- 41,814 adult care home beds in NC
- Licensed by the Department of Health and Human Services, Division of Health Service Regulation. Rules are adopted by the Medical Care Commission.
- Approximately 70% of adult care home residents receive State/County Special Assistance.

Adult Care Homes

Additional Information

State/County Special Assistance

- A cash supplement to help low-income individuals pay for care in adult care homes.
- Individuals apply at Departments of Social Services.

Special Care Units

- A wing or hallway within an adult care home designated for residents with Alzheimer's disease or other dementias, a mental health disability, or other special needs disease.

Nursing Homes

- Nursing homes are for chronic or convalescent patients, who, on admission, are not as a rule acutely ill and who do not usually require special facilities (operating room, x-ray facilities, laboratory facilities, etc.) A nursing home provides medical and nursing care, but the patient is not sick enough to require general hospital care. Some patients are admitted for short-term rehabilitative or convalescent care following hospitalization, most patients are in need of long-term care.
- 42,212 licensed beds in nursing homes. (Quantity is regulated by the Certificate of Need Law.)
- Licensed by the Department of Health and Human Services, Division of Health Service Regulation. Rules are adopted by the Medical Care Commission.
- Nursing homes that receive Medicare or Medicaid must be certified in accordance with federal law.

Continuing Care Retirement Communities

- Continuing Care Retirement Communities (CCRC) furnish lodging together with nursing services, medical service, or other health related services, under an agreement effective for the life of the individual, or for a period longer than one year.
- Involves a contract or agreement and usually requires a large up front fee (entrance fee) and monthly fees.
- Currently 56 facilities.
- Typically provide 3 levels of care: independent living, assisted living, and skilled nursing care.
- Regulated by the Department of Insurance, and the Division of Health Service Regulation if the facility has licensed adult care or nursing home beds.

Medicare/Medicaid

Medicaid

- Medicaid is a state administered program available to certain low-income individuals and families who fit into an eligibility group recognized by federal and state law.
- Depending on medical status and level of care needs, Medicaid recipients over the age of 65 may be eligible for the following range of programs through NC Medicaid:

Adult Care Home	CAP/Choice
CAP/DA	CAP/MRDD
Hospice Care	Home Health Care
Nursing Facility	Home Infusion Therapy
Personal Care Services	Private Duty Nursing

Medicare & Dually Eligible

Medicare – A health insurance program for people:

- Age 65 or older.
- Under age 65 with certain disabilities.
- All ages with End-Stage Renal Disease

Medicare has Two Parts:

- Part A (Hospital Insurance)
- Part B (Medical Insurance)

Medicare Part D – Prescription Drug Coverage

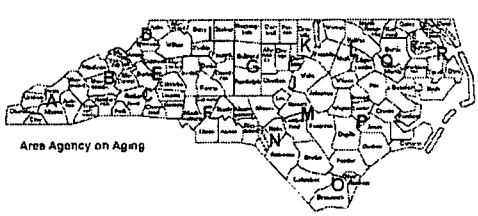
- **Dually Eligible** - describes those individuals who have Medicare as their primary medical insurance and Medicaid as their secondary coverage. (May not all be over 65.)
- According to DMA, for SFY 06-07 NC had:

98,259 Dually Eligible Recipients
3,356 Medicaid Only Recipients
101,515 Total Recipients over age 65 Served

Additional Information and Resources

Area Agencies on Aging

Located in the regional Councils of Government. AAAs have functions in five basic areas: (1) advocacy; (2) planning; (3) program and resource development; (4) information brokerage; and (5) funds administration and quality assurance.



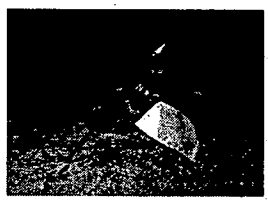
Area Agency on Aging

Department of Health and Human Services

- **Office of Long-Term Services and Supports**
  Jackie Sheppard, Assistant Secretary for Long-Term Care and Family Services
- **Division of Aging and Adult Services**
  Dennis Streets, Division Director
- **Division of Health Service Regulation**
  Bob Fitzgerald, Division Director
- **Division of Medical Assistance**
  William W. Lawrence, Jr., MD, FAAP, Acting Medicaid Director

Recommendations for a Statewide Aging Study

Communities and Aging Carolinians—on Edge



Dennis W. Streets

N.C. Division of Aging and Adult Services

1

Background to Report

- Senator Soles responded to Brunswick municipalities by introducing S.B. 448
- Members of the House Aging Committee expressed interest and broadened the scope—adding five counties (Buncombe, Gaston, Henderson, Moore, and New Hanover) and asking DHHS/DAAS to offer recommendations for a comprehensive statewide aging study
- DAAS submitted an interim report on the six counties on November 1, 2007 and will submit a final report by April 1, 2008
- DAAS submitted the report for the comprehensive study on January 2, 2008

2

Senate Bill 448 (Section 2 of S.L. 2007-355)

In response to growth projections for the population age 60 and older, the General Assembly directed the Division of Aging and Adult Services to make recommendations to the NC Study Commission on Aging on a study to include all counties. DAAS was to evaluate similar studies conducted by other states in identifying the criteria to be included in such a study and in recommending an appropriate level of funding to support this effort.

3

Background to Planning for an Aging North Carolina

- Since 1989, DAAS has been charged with producing a state aging services plan
- In its 1991 Plan and subsequently, DAAS has proposed investing in planning at the state, regional and local levels
- Since 2003, DAAS has promoted the concept of livable and senior-friendly communities

4

Context—Driving Forces

- Demographic shift
- Concern about level of awareness and interest
- National expectations, initiatives, and opportunities

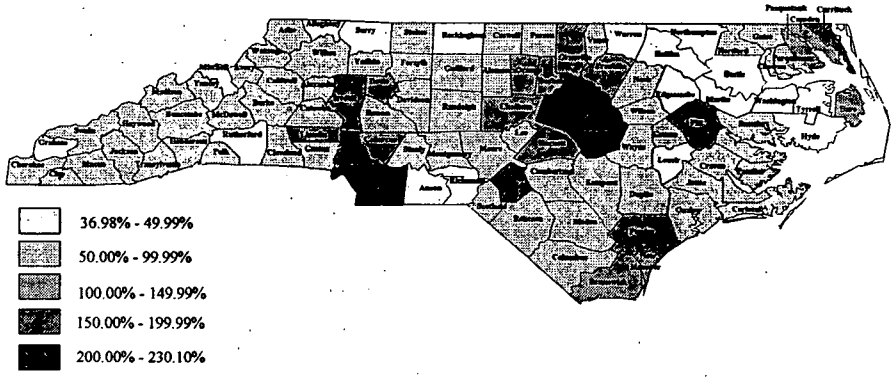
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Startling Statistics

- Today 28 of our counties have more persons age 60 and older than 17 and younger— projected to increase to 75 counties by 2030
- Even among the 25 more 'youthful' counties tremendous growth among older persons is expected—with Wake having the highest projected rate among all counties—projected to grow from 81,000 seniors in 2005 to more than 267,000 in 2030 (230%)

6

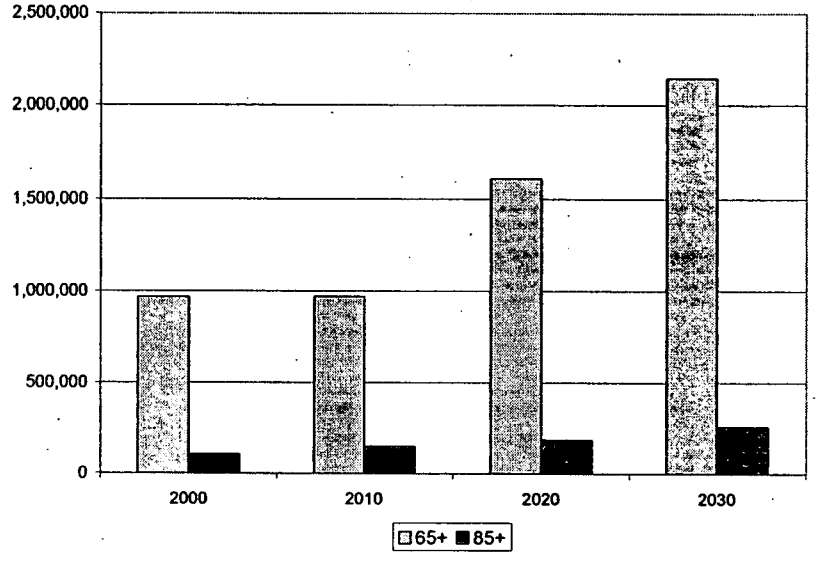
Projected growth of older population 60+ from 2005-2030



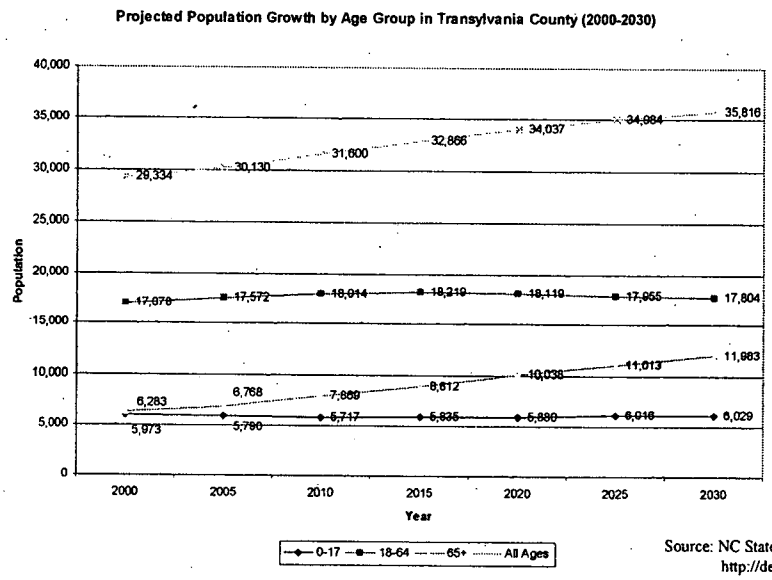
Source: NC State Demographics
http://demog.state.nc.us/

7

Projected Growth of Older North Carolinians, 2000 to 2030



An 'Extreme'Coun ty Example



Source: NC State Data Center
http://demog.state.nc.us/

9

Existing Awareness and Interest

- The national 2005 *The Maturing of America* survey found that less than half of American communities have started addressing the needs of their aging population—"although many communities have some programs to address the needs of older adults, few have undertaken a comprehensive assessment to make their communities "elder friendly" or "livable communities for all ages."
- Among the 278 NC local governments that were contacted for this survey, only 18% of cities and towns responded along with 31 counties

10

What We Learned from NC Respondents—Just a Sample



Item	NC	National
Access to prescription programs	~~81%~~ 78%	~~66%~~ 64%
Access to Dial-a-Ride service (door-to-door para-transit)	44%	47%
Road signage that meets the needs of older drivers	20%	30%

11

National Expectations, Initiatives, and Opportunities

- The 2006 amendments to the Older Americans Act give State Units on Aging and Area Agencies on Aging an enabling charge (not a requirement) but no new funding—to assess the aging readiness of the state and regional planning and service areas
- In 2006, NC was selected as one of eight states to help develop a national model for comprehensive planning for aging
- NC has received grants under the federal *Choices for Independence* initiative in all three areas—empowering individuals with information, providing choices for high-risk, and building prevention into community living

12

Observations on Current Capacity

- It is beyond the *current* capacity of any entity to undertake a comprehensive assessment of the aging of North Carolina's population
- NC has far to go in understanding and responding to the many and varied implications of its aging population

13

Findings from Other States

- Among 20 states that responded to our request, 15 indicated that they had undertaken a comprehensive statewide study in the past 5 years
- Among the 15 states, 13 had used outside entities to do some or all of the study
- The reported cost ranged from $20,000 to $500,000 for the *survey(s)*

14

States that Reported a Statewide Aging Study within Past 5 Years

- Arizona
- Connecticut
- Colorado
- Florida
- Georgia
- Illinois
- Indiana
- Kentucky
- Minnesota
- Nevada
- New York
- Texas
- Vermont
- Washington
- Wisconsin

15

Notable Findings

- Leadership in some states came from the Governor's Office and/or Legislature
- States emphasized that the important work does not end in a study—it is just the beginning
- Some states have set in place expectations and processes for regular updates
- There was strong positive sentiment on its value

16

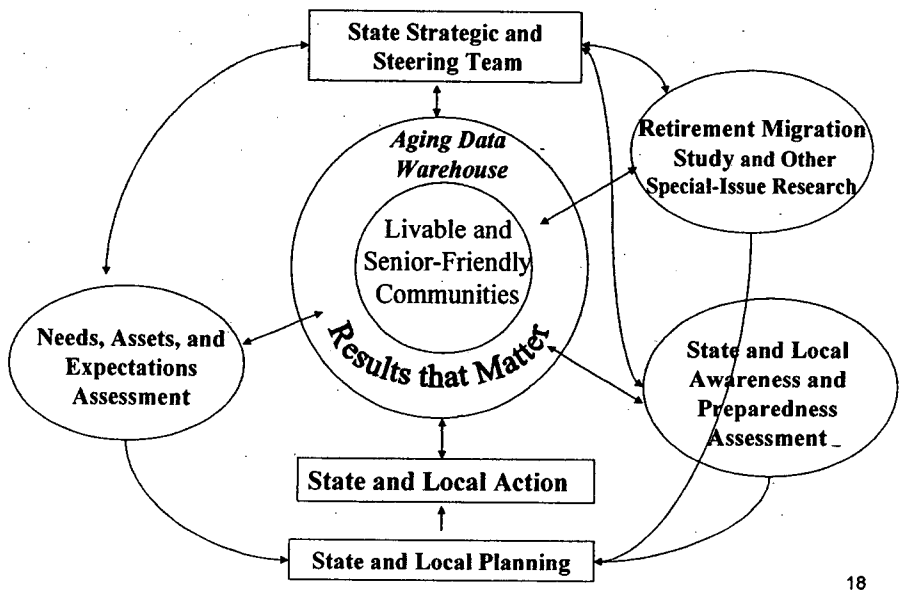
Recommendations

Undertake *Project CACE, Communities and Aging Carolinians—on Edge*

- Create state strategic and steering team
- Assess consumer needs, assets, and expectations
- Assess state and local awareness and preparedness
- Conduct special studies
- Support state and local planning
- Create an aging data warehouse

17

Project CACE



18

State Strategic and Steering Team

Build on experience of Minnesota, New York and Texas

- Recommend that executive and legislative branches appoint this blue-ribbon group and assure adequate resources for its work
- Provide overall management for Project CACE

Fiscal Note: $225,000 [R]

19

Consumer Needs, Assets, and Expectations Assessment

Build on experience of Colorado, Florida, Kentucky, Minnesota, Texas and Wisconsin

- Conduct survey twice over 5-year period
- Focus on population age 45+ and use livable and senior-friendly community framework
- Assure adequate representation of target populations
- Produce state and regional (AAA) summaries, and findings for county-types that can be supplemented with focus groups, key informant input, etc.
- Promote linkage between academic institutions and local planners

Fiscal Note: $200,000;$175,000 [NR]

20

State Executive Assessment

Build on experience of Minnesota, New York and Texas

- Legislature and/or Governor requires all relevant state agencies to assess the implications of the aging population on their programs and services and report findings and recommendations
- Would be done every other year over 5-year period
- Use web-based application to facilitate response and minimize cost
- State Strategic and Steering Team would prepare summary document for Governor and General Assembly

"The Project 2015 initiative has provided a process of planning, engagement and action by 36 participating New York State government agencies to prepare for the impact of the aging and increasing diversity of our state's population....In the years since the initial strategic planning took place, [participating] agencies have successfully used their planning document (agency brief) as the basis for adopting new approaches to better serve our aging, more diverse population."

21

Examples of Agencies to Be Included

- Administration
- Agriculture and Consumer Services
- Commerce
- Community Colleges
- Correction
- Crime Control and Public Safety
- Cultural Resources
- Employment Security Commission
- Environment and Natural Resources
- Health and Human Services
- Housing Finance Agency
- Insurance
- Justice
- Labor
- Revenue
- State Personnel
- Transportation

22

Local Assessment

Build on 2005 *Maturing of America* survey

- Work closely with the NC Association of County Commissioners and NC League of Municipalities
- Would be done every other year over 5-year period
- Use web-based application to facilitate response and minimize cost
- Use core set of questions based on livable and senior-friendly community framework, with counties able to add limited number to meet specific local needs
- State Strategic and Steering Team would prepare summary document, to include promising practices and new initiatives—with input from AAAs working with local academic institutions

Fiscal Note: $75,000 for each of 3 years [NR]

23

Special Studies

- Retirement Migration
- Other studies as determined by the State Strategic and Steering Team

Fiscal Note: $50,000 [R]

24

State and Local Planning and Development

- Assure adequate resources to effectively use information gathered
- Assure adequate local and regional capacity to plan and respond to the aging population—increase support for AAAs and provide base support for each county

Planning is only as good as the action it inspires.

Fiscal Note: $3,495,000 [R]

25

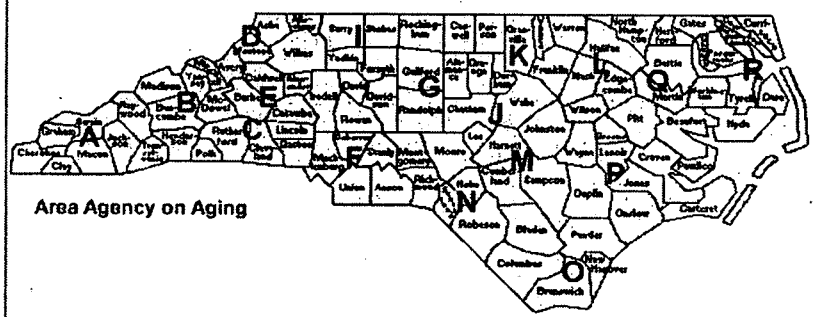
Example Core Elements of *Local Aging Leadership Planning Team*

- Integrates or at least connects with other local planning (e.g., Healthy Carolinian, smart growth, mental health reform, DSS social planning)
- Has solid connections with Senior Tar Heel Legislature and Community Advisory Committees—*Is citizen-driven*
- Reports significant work and issues to county officials
- Has ways to involve many interests/entities while still maintaining a manageable number of committee members and a manageable structure
- Encourages use of service provider collaborative (e.g., Senior Roundtable) as a group to address the Planning Committee's recommendations
- Uses livable and senior-friendly community framework

26

Area Agencies on Aging

Located in the regional Councils of Government. AAAs have functions in five basic areas: (1) funds administration and quality assurance; (2) planning; (3) program and resource development; (4) information brokerage; and (5) advocacy.



Area Agency on Aging

27

Relevant AAA Roles

- Encourage and facilitate local Aging Leadership Planning Teams and other local and regional planning that involves not only local governments but also the private sector
- Research information and mine data to produce reports to aid state, regional and local planning
- Use regional summaries and county-type reports to inform local governments and agencies and support local Aging Leadership Planning Teams
- Identify, document and disseminate 'promising practices' and offer relevant training and tools
- Assist with program, resource and systems development as needed
- Assist with tracking and measuring outcomes of work

28

Aging Data Warehouse

- Accessible information is vital for effective planning
- Information on services, costs, and results is fragmented
- State Strategic and Steering Team would examine state of affairs and consider need for results-based data warehouse

Fiscal Note: To be determined

29

Total Fiscal Notes

- $3,720,000 in recurring funds
- $600,000 in non-recurring
- Cost of aging data warehouse to be determined in future

These funds would be less than 0.143% of what we are currently spending publicly—not counting Social Security, Medicare, or VA benefits—less than $1 in planning for each $1,000 spent for services and supports.

30



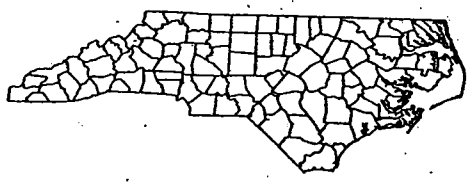
"To me there is something thrilling and exalting in the thought that we are drifting forward into a splendid mystery—into something that no mortal eye hath yet seen, and no intelligence has yet declared."—Edwin H. Chapin

Making Places More Livable and *Senior-Friendly* = Better Communities for All—

It's a Personal and Community Responsibility

"The future is not some place we are going to, but one we are creating. The paths are not to be found, but made, and the activity of making them changes both the maker and the destination"— John Schaar





Report to the North Carolina General Assembly on Recommendations for a Statewide Aging Study

January 1, 2008

North Carolina Department of Health and Human Services
Division of Aging and Adult Services

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Executive Summary

In what has been called the "calm before the storm," North Carolina is beginning to experience a major shift in its age demographic. By 2030, it is projected that more than 75 counties will have more residents age 60 and older than 17 and younger. This rather startling statistic was given as one of the reasons why the 2007 General Assembly directed the Division of Aging and Adult Services to make recommendations to the North Carolina Study Commission on Aging by January 1, 2008, on a study to include all of the state's counties and what it would cost. The Division was further instructed to evaluate similar studies conducted by other states.

This report is organized in seven sections:

(1) a statement of the legislative request;
(2) background information that reviews the history of state planning for aging and introduces the concept of livable and senior-friendly communities;
(3) a discussion of the importance for North Carolina to invest in studying and planning for its aging population—which includes the demographics, the level of awareness and interest among local and state governments, and federal expectations, initiatives, and opportunities;
(4) an overview of the approach used by the Division in preparing this report;
(5) a presentation of findings and observations, which includes results of a survey conducted of other State Units on Aging;
(6) recommendations for consideration by the North Carolina Study Commission on Aging and the 2008 General Assembly, focused on six areas: creating a state strategic and steering team; conducting a survey to assess consumer needs, assets, and expectations; surveying state and local governments to assess their awareness, preparedness, and activities; supporting the conduct of special studies in such areas as retirement migration; supporting state and local planning; and creating an aging data warehouse; and
(7) a conclusion that presents summary fiscal notes.

In reviewing the work of other states, the Division concluded that what is needed goes beyond conducting a one-time study. The Division is proposing a five-year comprehensive initiative—*Project CACE (Communities and Aging Carolinians—on Edge)*. The name appropriately reflects the urgency of strengthening North Carolina's knowledge of its aging population and how prepared we are to respond at the state, regional, and local levels. It also suggests that with an appropriate investment our state can move to the forefront of assuring an informed and effective response to an aging population.

Legislative Request: Section 2 of S.L. 2007-355 (S.B. 448)—in response to the growth projections for the population age 60 and older—directed the Division of Aging and Adult Services to make recommendations to the North Carolina Study Commission on Aging by January 1, 2008, on a study to include all counties in North Carolina. It further instructed the Division to evaluate similar studies conducted by other states in identifying the criteria that should be included in the study and recommending an appropriate funding level for the study (see Attachment A). Presumably, this work was also to extend and enrich the Division's efforts relative to Section 1 of S.L. 2007-355 (S.B. 448), for which the Division is to utilize existing data and resources and include Area Agencies on Aging (AAAs) in studying six counties that currently have, or are projected by 2030 to have, the largest numbers of individuals age 60 and older when compared to individuals age 17 and younger. In conducting the six-county study, with the final report due to the Study Commission on Aging by April 1, 2008, the Division is to consider:

1. A profile of the current older adult population.
2. A profile of the projected growth for the older adult population.
3. An assessment of the anticipated impact on programs and services that address the needs of the older adult population.
4. Identification of programs and services that are currently in place.
5. Identification of programs and services that are needed to meet the growth projections.
6. Current funding sources for programs and services serving the older adult population.
7. Anticipated funding needs for programs and services serving the older adult population.
8. A delineation of the programs and services that are shared or offered jointly with another county.

Background: Under State Law (G.S. 143B-181.1A) since 1989, the Division of Aging and Adult Services (then named Division of Aging) has been charged with preparing a plan that includes a detailed analysis of the needs of older adults in North Carolina based on existing data; an analysis of services currently provided and of additional services needed; and recommendations on expansion and funding of current and additional services. The Division has consistently produced and submitted plans to the General Assembly based on its capacity and access to data and assistance from cooperating agencies. Its methods of identifying and analyzing consumer and service needs have varied over the years, including: use of community forums and hearings; review of local and area plans; soliciting input from local planning committees; review of plans, reports, and other information provided by fellow state agencies; securing background papers from experts in aging associated with NC's colleges and universities; and consideration of other secondary data (e.g., published articles, reports on special projects). While these state plans have provided a useful framework for state and local planning and policymaking, analysis and recommendations have been limited by the inability to have a comprehensive and standardized ongoing mechanism to assess consumer needs, assets and expectations and to capture the effect of the publicly funded services in meeting these needs over time.

Beginning with the *1991 State Aging Services Plan*, the Division of Aging and Adult Services has proposed investing in planning for the aging of North Carolina's population. In each subsequent state plan (1993, 1995, 1999, 2003, and most recently, 2007)—the Division has made a case for supporting a comprehensive examination of the nature and implications of the state's aging population.

In the *1991 Plan*, the Division acknowledged that:

"North Carolina's older citizens represent both a growing challenge to the state's human services system and an increasingly rich resource for state and local communities. A comprehensive state plan supported by AAA [Area Agency on Aging] leadership and individual county programs on aging must be designed to assist those whose independence is impaired as they advance in age, as well as to facilitate the continued independence of the majority of older adults." [p.57]

A major emphasis of the *1991 State Plan* was the idea of supporting "comprehensive county-based programs on aging that address the challenges of high-risk older adults and capitalize on the opportunities of all adults for self-help and contribution to others." In fact, a fundamental recommendation was that "county-based programs on aging [would] be in place in all 100 counties by the year 2000 to meet the needs of the rapidly growing older population." To support the development and implementation of county plans on aging, the *State Plan* included a recommendation of the Department's Advisory Committee on Home and Community Care for the General Assembly to appropriate $2,540,000 annually beginning in State Fiscal Year 1991-92 to provide $20,000 for each county and $30,000 for each AAA. These funds were not appropriated. In the years that followed—without any minimum support and incentive—local response to preparing for an aging population has varied tremendously. While all counties are required to develop a funding plan for the Home and Community Care Block Grant, only some—albeit an increasing number—have undertaken a more comprehensive look at the implications of their aging population. The *1991 State Plan* also pointed to the importance of "conducting research, program evaluation, and development efforts that examine the changing needs of older adults and their families and that examine the capabilities of present and proposed service delivery systems and concepts."

The *1999-2003 State Aging Plan* reemphasized the importance of comprehensive local, regional, and state planning:

"Area Agencies on Aging can help stimulate interest and commitment to more comprehensive planning at the regional and local levels relative to the aging of the community that includes participation and support from business, civic groups, religious leaders, and many others....[such planning should consider] how the county and regional shifts in demographics are affecting and will affect the local tax structure and receipts, economic development and the local workforce, housing and land use, crime and law enforcement, transportation, fire and emergency services, health and human services, volunteerism, local education and recreation, and a host of other areas. There are few areas of county governance and interest that are unaffected by the aging of the population." [p.95]

With the *2003-2007 State Aging Plan*, the Division of Aging and Adult Services began introducing the idea of senior-friendly communities, which included support of planning and evaluation as a key building block:

"While nearly every community in North Carolina will see greater numbers of older adults in the future, many may not readily or easily see the effect of this aging nor respond proactively to tap the resources and meet the needs of their seniors. The proposed senior-friendly community is

not only a desirable goal but a necessity for the interests of older adults, their families, and also for the communities themselves." [p.40]

In using the concept and vision of livable and senior-friendly communities to frame the current *2007-2011 State Aging Services Plan*, the Division of Aging and Adult Services outlined its objectives in terms of eight components believed to be essential in achieving such communities: physical and accessible environment, healthy aging, economic security, technology, safety and security, social and cultural opportunity, access and choice in services and supports, and public accountability and responsiveness. The concept of senior-friendly communities evolved into livable and senior-friendly communities out of focus group discussions with high school students, the faith community, business leaders, aging boomers, older adults, and others—all of whom expressed that while there may be needs and interests specific to an older cohort, many of the goals of a community should be applicable to people of all ages. For example, a more walkable community is important for the health and engagement of all citizens. Interest in the livable and senior-friendly community framework has steadily grown among stakeholders at the national, state, and local levels. This interest is discussed in Chapter 2 of the *2007-2011 State Plan* (see Attachment H).

"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;*
- *land use, housing and transportation;*
- *public safety, workforce and economic development;*
- *recreation, education/lifelong learning; and*
- *volunteerism/civic engagement policies and programs.*

The first baby boomers have begun turning 60 this year, yet most communities are unprepared to handle the increased demands that this population shift will create. 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. Planning must not occur in a vacuum. State and local governments are already mandated to develop and implement long-term planning in a variety of arenas, but these plans are often developed without input as to how community infrastructure and broader service systems will be impacted by the aging of the population. Given the magnitude of the aging of this nation's population, these plans will only be cost-effective and efficient if they incorporate aging into the process. Communities need to have support to ensure that their policies, programs and services promote livable communities for all ages—communities that are good places to grow up and to grow old."

—*Livable Communities for All Ages & The Older Americans Act,* National Association of Area Agencies on Aging, March 2006, http://www.n4a.org/pdf/MakingTheCase_LivableComms_2006.pdf

Context: This is an important period vis-à-vis aging, both in North Carolina and nationally, for a number of reasons. Three of these reasons are discussed below.

Demographics

The State legislation calling for this report (S.B. 448) acknowledged the aging of North Carolina. In what could be termed the "calm before the storm"—North Carolina will soon experience a dramatic shift in its demographics as measured by the number and proportion of older adults, as well as the relative rate of growth (see Attachment B for demographic tables and charts). This is well captured in the rather startling statistic that while today 28 counties have more persons age 60 and older than 17 and younger, by 2030, 75 counties are projected to show this demographic pattern. Even among counties that will have more younger than older people over the next 20 to 25 years, the aging of their population is impressive. For example, Wake County is projected to have the highest growth rate for the population age 60 and older between 2005 and 2030 (230 percent). There are multiple factors contributing to the aging of the population, including increased life expectancy, the in-migration of retirees, the out-migration of younger residents (especially in rural areas), lowered birth rate, and the aging of the boomers. Our change in demographics will surely have implications for public policy at the state and local levels, not only in terms of health and human services but in virtually all domains (e.g., taxes and revenue, transportation, housing, labor and commerce, education, and recreation). The complexity of the effect of the change in demographics becomes even greater when taking into account such other factors as the variance in income and educational levels; the presence of health disparities; and geographic location. The Division of Aging and Adult Services has explored some of these changes in its state plans and in a special series of reports in 1997 on North Carolina's baby boomers at mid-life.

"North Carolina, with the rest of the US, faces two distinct challenges in the area of aging. The first is to provide support and opportunities to the remaining members of the "the greatest generation"—those who were young men and women during World War II, and who are now in their 80s and older, as well as today's "young old" as they age and grow more vulnerable. The second is to prepare for the transition of the "baby boomers" into retirement ages, the first of whom turned 60 in 2006. The boomers 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."
—2007-2011 North Carolina Aging Services Plan

Awareness and Interest

To help cities and counties better meet the needs of an aging population and leverage the experience and talent of older Americans, five national organizations (i.e., National Association of Area Agencies on Aging, International City/County Management Association, National Association of Counties, National League of Cities, and Partners for Livable Communities) collaborated on an initiative to assess the "aging readiness" of America's communities. Funded by the MetLife Foundation, the initiative—known as *The Maturing of America: Getting Communities on Track for an Aging Population*, began in November 2005, with a survey of 10,000 local governments (278 in North Carolina). The survey examined such areas as health care, transportation, public safety and emergency services, housing, taxation and finance, workforce development, civic engagement and volunteerism, aging and human services, and policies that benefit older adults. The survey (see Attachment C) was designed to answer three key preparedness questions: (1) whether efforts are being made to assess and put into place programs, policies and services that address the needs of older adults and their caregivers; (2)

whether cities and counties are able to ensure that their communities are "livable" for all ages—not only good places to grow up but good places to grow old; and (3) how well equipped an area is to harness the talent, wisdom, and experience of older adults to contribute to the community at large. After the first survey phase was completed, a more in-depth survey was sent to 500 communities whose initial responses indicated a high degree of readiness. This secondary data was then compiled for a "promising practices" guide to help other cities and counties across the nation increase their capacity to effectively serve the growing segment of aging Americans.

The survey found that only 46 percent of American communities have started addressing the needs of the rapidly increasing aging population—"although many communities have some programs to address the needs of older adults, few have undertaken a comprehensive assessment to make their communities "elder friendly" or "livable communities for all ages." Among the 278 NC local governments that were contacted, only 33 (or 18%) of the cities and towns responded, as did 31 counties. While it is likely respondents were more aware of and preparing for their aging population than non-respondents, it is encouraging that:

- Nearly half (45%) reported that their local government had a planning process in place that considers the needs of older adults (although there is no indication of the focus or comprehensiveness of this process);
- Nearly half (47%) reported that they had solicited information from older adults in their community in the past three years to determine their needs (e.g., survey, needs assessment, town hall meeting); and
- Overall half (53%) reportedly had begun to plan for a growing senior population.

In fact, Buncombe County, which responded to the survey, was recognized in the final report as offering a "promising practice" with its community transportation program—called Mountain Mobility—providing several mobility options to older adults.

"Survey findings indicate that local governments generally offer basic health and nutrition programs, but as yet do not have the policies, programs or services in place to promote the quality of life and the ability of older adults to live independently and contribute to their communities for as long as possible. These services might include job retraining, flextime and other job accommodations, home chore services, home modification and senior-friendly housing options, tax relief, roadway redesign or public transportation assistance as well as volunteer opportunities targeted to older adults. The needs of older adults are often interrelated. For example, providing housing will not be sufficient if residents lack transportation to get to basic services such as medical offices, the pharmacy or grocery store. These interdependent needs of older adults may require a completely new comprehensive, holistic approach to service delivery organization and management. America's communities need to take a fresh look at their existing policies, programs and services to see if they address the needs of an aging population. Those communities who have already begun to test their 'aging readiness' are now reaching out to their older citizens to engage them in discussions about what changes to local government services may be needed to enhance their quality of life and ensure that they can grow old successfully in the community."
—The Maturing of America: Getting Communities on Track for an Aging Population, http://www.n4a.org/pdf/MOAFinalReport.pdf

The low response of North Carolina's local governments could be viewed as an indicator that the aging of the population is not yet seen as a driving force for decisions about policies and programs. Here is another illustration—a Chamber of Commerce in one of the county areas identified by S.B. 448, while sponsoring a recent regional amenities survey, expressed interest in reaching "more retiree age people...to get a full picture of the wants and needs of citizens." Yet, there was little evidence in the survey instrument that the interests of seniors were considered. For example, a survey question about activities that included 38 items had no items pertaining directly to senior activities (unlike some questions targeted toward children—"Be active in children's school activities," "Coach children's sports"). In a question asking how the region was "as a place to live for the following kinds of people," none of the nine choices (e.g., recent college graduates looking into the job market; young, single people; families with children) were targeted toward older adults. The demographic question about the respondent's age gave four age intervals between 20 and 54, but only one among those aged 55 and older.

Still there are signs of growing awareness and interest about the aging of our population among communities across the state. In 2005, North Carolina was selected as one of eight states to work with the U.S. Administration on Aging toward developing a comprehensive planning model for aging. The Division of Aging and Adult Services and the 17 AAAs are partnering in this work, which has largely focused on strengthening local planning for aging. Three principles have guided the work—planning for an aging population should: (1) be citizen-driven; (2) use a process as simple in design as possible; and (3) be outcome-based. Encouraged and facilitated by AAAs and others, communities are forming or strengthening local Aging Leadership Planning Teams, who are undertaking their own needs assessments and other activities (see Attachment D for information on three such teams in Buncombe, Caldwell, and Cherokee counties). The previous work of the Division and AAAs since the early 1990s has helped inform this latest effort. The Division presented to the 2004 Aging Study Commission about the work of two counties—Mecklenburg and New Hanover—in recommending support for such planning efforts. These two counties, joined by their AAAs, had volunteered to work with the Division in assessing and planning for core long-term services and supports—a priority recommendation of the *2001 Long-Term Care Plan for North Carolina*. The Division had developed an evaluation tool for each of 22 core long-term services and supports to aid local planning. A major issue today is that there is great variance in the sophistication of local activities and in local capacity for planning. Also, there is rarely the opportunity to compare one county's findings with another because of the differences in the indicators and methods used (Attachment E illustrates the emergence of local planning for aging but also the variance in survey tools among three counties—Buncombe, Caldwell, and Cherokee).

There are other signs of the growing awareness about the importance of addressing our aging population among policymakers and those who work to influence state policy. S.B. 448 is evidence of this as is the fact that the N.C. Center for Public Policy Research plans to focus on aging in a 2008 issue of its Journal, *North Carolina Insight*, for the first time since 1985. One of the center's proposed articles will reportedly summarize its research findings to improve and shape future state aging policy plans.

Federal Expectations, Initiatives, and Opportunities

The federal Older Americans Act, enacted in 1965, came about in a nationwide climate of concern for the needs of older adults. While the importance of planning and coordination was recognized, little funding followed. There are now federal efforts underway that may help shape

North Carolina's response to an aging population—if North Carolina is sufficiently prepared to respond. The 2006 amendments to the federal Older Americans Act (OAA) gave both the State and Area Agencies on Aging (AAAs) an *enabling* charge (not a requirement)—but no new funding—to assess the readiness of the state and the regional planning and service areas, respectively, for the anticipated aging of the population over the next 10 years. In the case of the State, the OAA [Public Law 109-135, Section 307(a)(28)(A-B)] suggests that such an assessment include:

- *"the projected change in the number of older individuals in the State;*
- *an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;*
- *an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and*
- *an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services."*

The enabling charge for the AAAs [Public Law 109-135, Section 306(b)(1-3)] is even more expansive and in many ways mirrors the livable and senior-friendly community framework:

"An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted. Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness; and

(K) any other service as determined by such agency."

The primary issue for both North Carolina's Division of Aging and Adult Services (as the designated State Unit on Aging) and its AAAs remains one of capacity. The Division and AAAs regularly research information and mine data to produce reports to aid state, regional and local planning (e.g., *NC County Profiles, Aging Program Expenditures Data, Baby Boomers at Mid-Life—The Future of Aging in North Carolina,* Caregiver Statistics, County Disability Rates)—working largely from existing data (e.g., U.S. Census, Behavioral Risk Factor Surveillance System). Many of the Division's documents and sources are catalogued on its Demography and Planning webpage (http://www.ncdhhs.gov/aging/demo.htm). Still, the wherewithal to undertake the assessment described in the Older Americans Act is beyond the reach of the Division and AAAs both in terms of personnel availability and expertise, and especially resources needed for quality surveys. It is noteworthy, for example, that despite an increase of $300,000 in State support of AAAs awarded during the 2007 Legislative Session, State support for AAAs is still $270,000 less than what they received in 2001. Today, State support for AAAs totals $772,200, on an average of $45,423 per AAA. These limited funds help support a wide range of duties of which planning is but one—others include compliance monitoring and quality assurance in the administration of the Home and Community Care Block Grant and other service funds; provision of information and assistance (including serving as regional data hubs and major data contributors to NC careLINK, the Department's web-based community resource database); resource, program, and systems development; public/consumer and provider education and training (e.g., AAAs continue to have an important role in Medicare Part D outreach, education, and counseling); and special projects (e.g., evidence-based Chronic Disease Self-Management). The strength of local planning for aging statewide is certainly affected by the capacity of AAAs to assist.

While North Carolina has far to go in understanding and responding to the many and varied implications of an aging population, the Department of Health and Human Services has succeeded in securing federal grants to begin to reshape the future of services and supports for older North Carolinians and their families. These opportunities have included the Systems Transformation grant from CMS, and also grants from the U.S. Administration on Aging. For example, the U.S. Administration on Aging is promoting conceptually and through grant opportunities its *Choices for Independence* initiative. North Carolina has already received grants under this initiative—to pilot Aging and Disability Resource Centers/Connections and an evidence-based Chronic Disease Self-Management project. The significance of these federally funded initiatives in relation to a strengthened capacity for statewide planning is that state and community awareness and support are essential to applying and sustaining successful policy reforms and innovative programs. AAAs can have an especially important role in helping assure that changes and innovations happen in concert with the strengths of existing infrastructure and approaches whenever possible.

In testimony to the U.S. House Subcommittee on Select Education (March 2006), U.S. Assistant Secretary on Aging Josephina Carbonell indicated that over the last 40 years the Older Americans Act (OAA) and the aging services network has produced a wide array of innovative programs to help older Americans retain their independence in the community. But she stated, "We must look forward to the changing realities facing our nation." Some of these realities include increasing numbers of people living longer and the expanded demand for long-term care. She outlined the components of the Administration's Choices for Independence (Choices) proposal: empowering consumers, targeting high-risk individuals, and building prevention into long-term care. Choices aims to help non-Medicaid eligible elderly take greater control of their long-term care and to empower middle-aged individuals to plan ahead for their long-term care. Assistant Secretary Carbonell stated, "The aging services network created by the OAA and led by AoA is well positioned to help ensure the modernization of long-term care in our country."

Approach: In preparing this report, the Division of Aging and Adult Services primarily followed the directive of the General Assembly to examine what other states have done. Working through the National Association of State Units on Aging (NASUA), the Division surveyed all of the other 49 states and the District of Columbia, using a brief set of questions (see Attachment F for survey questions). It supplemented this NASUA survey with a search of the Internet for secondary sources of information. The Division also consulted with personnel of the UNC Institute on Aging and its current class of Senior Leaders, staff of the HW Odum Institute for Research in Social Science at UNC-Chapel Hill, and with leadership of the NC Association of Area Agencies on Aging.

Findings and Observations: Among the 20 states that responded to a survey that the Division of Aging and Adult Services conducted in November 2007, through NASUA, 15 indicated that they had undertaken a comprehensive statewide study of aging within the past 5 years. While some of these studies were targeted to a specific topic (e.g., long-term care), others were much broader in scope.

Among the 15 states that had undertaken a study, 10 reportedly assessed the anticipated impact on programs and services that address the needs of an aging population; 13 identified new programs and services that are needed to meet growth projections; and 8 examined anticipated funding needs for programs and services serving the older adult population (although Minnesota qualified its response as shown below).

"The larger insight is that, in many instances, the anticipated future funding needs (based on current use rates and current service models applied to increased population) are completely unsustainable. The new models that will need to be designed have not yet been developed, so we can't estimate how much they are likely to cost. As the "market" is changing—so are the expectation, preferences, values, etc. of our target population (viz. older people)."—Minnesota

The reporting states used a variety of methods in conducting their studies. The identified methods included: public forums and public hearings; focus groups; telephone, mail, web, and face-to-face surveys; key informant interviews; observation; and use of strategic planning committees and advisory groups.

Among the 15 states that had conducted studies, 13 had used outside entities (either private vendors or universities) to do some or all of the study. The reported cost of the studies ranged from $20,000 to $500,000. Funding sources primarily included: state appropriations, federal Older Americans Act funds, and foundations. Further details about the state survey findings are provided in Attachment G.

"To ensure that such data are available for the state's long-term care planning, legislative and other policymaking activities, the Connecticut General Assembly in its 2006 session authorized and funded a comprehensive statewide Long-Term Care Needs Assessment ~ the first in over twenty years (Public Act 06-188, Section 38)."

Other notable findings from the states that had conducted studies included:

- New York is an example of how at least some costs associated with its *Project 2015* were shared by the many different participating state agencies. This was a project of the Governor.
- Several states emphasized that the important work in considering and responding to an aging population does not end in a study; it is rather just the beginning of what needs to take place through awareness-building, training, community and policy dialogues, program and policy reforms, etc. In fact, Kentucky reports requesting $1.2 million for this purpose.
- Some states have set in place expectations and processes for regularly updating their studies, realizing the value of tracking changes in service needs and expectations.
- While there seems to be general recognition about the importance of providing local report data, most of the studies appear unable to provide county-specific data because of the needed survey sample size that affects study costs.

Although not explicitly asked about the value of their study, some volunteered strong positive opinions about its worth.

"The survey has been incredibly helpful. It continues to be used by entities throughout the state to increase funding for various projects....Based on the current community-based service delivery systems, the total yearly expenditure is projected to grow from $24 million in 2004 to $41 million in 2012. The cost to meet all the needs as identified in the survey would grow to $162 million by 2012....The Strengths and Needs Assessment will be used to set priorities for programs and services for older adults as plans are made to accommodate the increasing population of older adults in Colorado."

"Planning for the future involves all age groups and constituencies and the participation of elders in the process is essential. [Kentucky Elder Readiness Initiative] KERI is also concerned with regional differences. What is appropriate for Paducah may not apply to Louisville or reflect the needs and potential of Hazard or Somerset. Finally, KERI is part of a process of continuous planning; it is not a report to be placed on a shelf but rather a statewide movement to prepare for a better future. Participation of the media in this movement is vital."

Recommendations: North Carolina has an opportunity to build on the experiences of other states and step forward with a major commitment that is essential to state and local-level preparedness for an aging population that would make it a national leader. The following

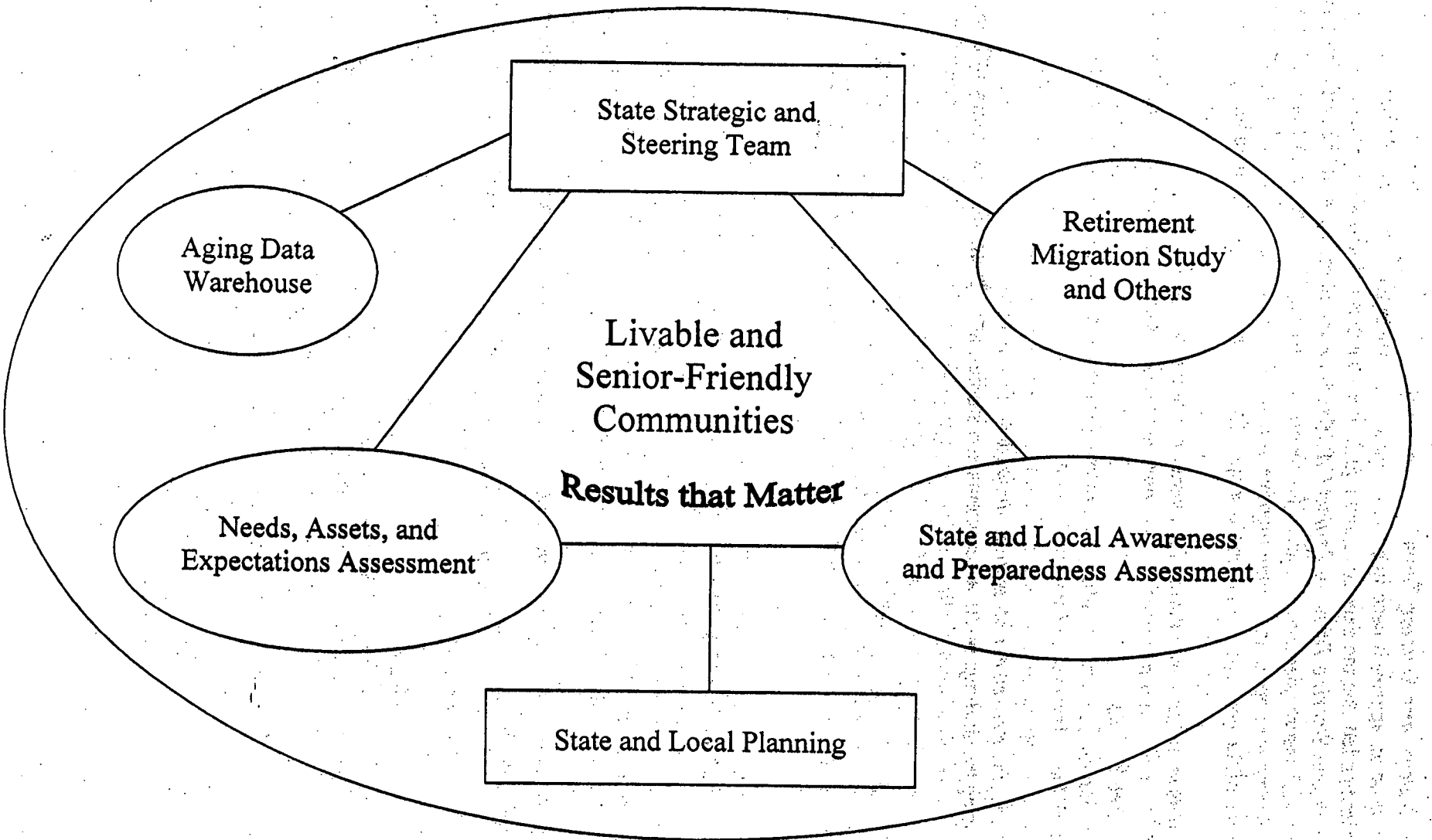
schematic presents an overview of the proposed components of a five-year comprehensive initiative—termed *Project CACE (Communities and Aging Carolinians—on Edge)*. The name captures the fact that the aging of our population has significance for individual citizens and communities across the state. Preparedness for aging is both a personal and community responsibility, and an assessment of preparedness must involve both individuals and communities. The recommended overall goal for *Project CACE* is to strengthen North Carolina's capacity at the state, regional, and local levels for assuring an informed and effective response to an aging population. The project would build on the livable and senior-friendly community (LSFC) framework introduced in the *2007-2011 State Aging Services Plan*, which was presented to the General Assembly in March 2007. The vision is to create livable and senior-friendly communities across North Carolina that are strong in all eight areas of the LSFC framework: physical and accessible environment, healthy aging, economic security, technology, safety and security, social and cultural opportunity, access and choice in services and supports, and public accountability and responsiveness (see Attachment H for the *State Plan* chapter outlining the LSFC framework). This is a framework consistent with many of the states that responded to the NASUA survey.

The reference to "*on edge*" in the term *CACE* suggests that North Carolina is on the cusp of a major societal change. It also suggests that North Carolina can move to the forefront of progressive understanding and action on behalf of its aging population that should give it an advantage for the future. The initiative is described for a five-year period to allow sufficient time to complete the tasks and evaluate its effectiveness and the value of continuing any or all of the activities. Each of the initiative's recommended components identified below is further discussed after the schematic, with fiscal notes provided as needed

- ***Create state strategic and steering team***
- ***Assess consumer needs, assets, and expectations***
- ***Assess state and local awareness and preparedness***
- ***Conduct special studies***
- ***Support state and local planning***
- ***Create an aging data warehouse.***

Although each of these six components represents a separate set of activities, they come together to make up a single, integrated approach to assuring livable, senior-friendly communities that are both meeting the needs of and capitalizing on the opportunities provided by the unique demographic events before us. It is part of the task of the *State Strategic and Steering Team* to make sure that these activities do not become ends in themselves but continue to function in a fully integrated manner. The assessments (consumer needs, assets, and expectations and state and local awareness preparedness) along with the special studies all provide information needed for planning at the local and state levels. The planning effort will also benefit from secondary data in the aging data warehouse. Still, planning is only valuable when it produces action, and we can only truly know if the action is worthwhile when we can measure results. Effective local and state planning will have objectives and outcome measures based on information synthesized from the assessments and special studies as well as the activities needed to meet these objectives. Data from the aging data warehouse can then be used to help measure the achievement of these objectives; thus providing information for use by local and state planning entities and the *State Strategic and Steering Team* to adjust their actions as needed to keep moving toward the livable and senior-friendly community objectives.

Project CACE, Communities and Aging Carolinians—on Edge



State Strategic and Steering Team

Building on an approach used in several states—including Minnesota, New York and Texas—it is recommended that the executive and legislative branches collaborate to establish a state-level *Strategic and Steering Team* for *Project CACE* (whose membership should be of a blue-ribbon nature) and assure adequate resources for its ongoing work. While details of the collaborative arrangement for appointing Team membership and providing necessary staff support await approval of the concept, the proposed scope of the Team's work could include:

- Envisioning and articulating the overall mission of *Project CACE*
- Designing and implementing the *Consumer Needs, Assets, and Expectations Assessment* (described below)
- Designing and implementing the process for the *State and Local Awareness and Preparedness Assessment* (described below)
- Securing other studies to supplement the information needed for comprehensive planning, including the *Retirement Migration Study* (described below)
- Using the findings of the assessments and studies, as well as other secondary information, to produce reports to guide policy and program development, and to design and implement the process to strengthen state and local planning (described below)
- Evaluating the utility and effectiveness of *Project CACE* to recommend to the Governor and the General Assembly any necessary changes in its mission or design and to relate its merits for continued support, and to otherwise identify action needed to ready North Carolina for its aging population.

The possibility of using the Governor's Advisory Council on Aging (GAC), already established in State Law (G.S. 143B-181), to serve as this strategic and steering team should be considered. The GAC's membership is appointed by the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives. The composition, as spelled out in statute, includes representatives of various state agencies and citizens at large. As shown below, the GAC's prescribed duties are certainly consistent with the activities proposed for *Project CACE*:

- Make recommendations to the Governor and DHHS Secretary for improving human services to older adults;
- Study ways to promote public understanding of aging problems and consider the need for new State aging programs;
- Advise DHHS in preparing a plan describing the quality, extent, and scope of services for older North Carolinians;
- Study all State programs serving older adults and advise the Governor and DHHS Secretary on coordination of programs to avoid duplication and overlapping of services; and
- Advise the Governor and DHHS Secretary on any matter they may refer to it.

While the GAC has functions similar to those described for the *CACE* strategic and steering team, there may be several practical questions about the GAC's capacity to serve as this team. First, GAC funding was cut by the General Assembly in SFY 2001-02 from $8,000 to $4,000. These funds help the Division of Aging and Adult Services, which provides staff support to the GAC, with the cost of the required four meetings, including the per diem and travel expenses of members. Second and more importantly, while the GAC effectively raises awareness about important issues and influenced some policy matters through its symposia and reports—again staffed by DAAS—its statutory charge does not include all of what is recommended in *Project*

CACE, especially in terms of the assessments. Third, the GAC has no official responsibility to report directly to the General Assembly or its Study Commission on Aging. Fourth, current DAAS staff support available to the GAC is minimal compared to what would be needed for the *CACE* strategic and steering team. An option for connecting the GAC with *Project CACE* would be to have the Governor-appointed GAC chair serve on the *CACE* team and strengthen DAAS staff capacity to serve both the GAC and the *CACE* team.

Fiscal note: To support the Team's work, it is suggested that there be an annual recurring appropriation of $225,000 to include $150,000 in staff support, $50,000 for special studies, and $25,000 for other expenses (e.g., travel, meeting costs, equipment, publications).

Consumer Needs, Assets, and Expectations Assessment

Again building on an approach used by other states—most notably, Colorado, Florida, Kentucky, Minnesota, Texas, and Wisconsin—it is recommended that North Carolina support an ongoing assessment of the needs, assets, and expectations of its older population and the aging boomer cohort. Specifically, it is recommended that North Carolina conduct a survey twice over a five-year period, in years one and four. Reasons for surveying twice include expanding the pool of respondents to enrich the findings; allowing for some tracking of the effect of state and local actions on the lives of consumers; and providing a longitudinal glimpse of what happens to consumers' needs, assets, and expectations—given that half of the respondents would be repeat contacts (see below). It is also possible that the Strategic and Steering Team would elect to add a few questions to address any emerging concerns. It is further recommended that North Carolina conduct this survey in such a way that useful information is available at the local as well as state levels. While ideally the survey size would be sufficient to provide county-specific reports, this is impractical. Based on input from key informants, including personnel with the HW Odum Institute for Research in Social Science at UNC-Chapel Hill, the following strategies are recommended to assure a manageable project that provides a good representation of consumer input for statewide and regional analysis to inform state and local planning. There are also suggestions for supplementing the survey data with other information to aid local planning.

<u>Survey Design</u>

- Research existing tools (national and from other states) that can provide a prototype for North Carolina's survey instrument and also enable benchmarking for use in analysis (see Attachment I for sample tools from other states). Another advantage of using existing instruments is that many have already had their tools validated.
- Adapt survey tool(s) based on input from key informants, possibly using three to four focus groups representative of various areas of the state, to develop North Carolina's survey instrument.
- Identify variables (e.g., county-type, age, rurality) that would facilitate branching of questions for interviewing and analysis of data.
- Use techniques to assure adequate representation of target populations and appropriate subgroups (e.g., minority, rural, low income, in-migrating retirees).

<u>Survey Implementation</u>

- *Year One:* complete at least 2,500 telephone interviews with target population (interview lasting 20 minutes or less).
- *Year Four:* complete at least 2,500 telephone interviews with target populations (i.e., 1,250 as repeat interviewees; 1,250 as new respondents).

Products

- State summary report
- Regional summary report for each of the 17 Area Agencies on Aging
- Report that provides findings for county-types (e.g., similar demographics) that can be used with local focus groups to validate and enrich information.

Post-Survey Activity

- The *State Strategic and Steering Team* will use available reports to inform state agencies and make recommendations to the Governor and General Assembly.
- Area Agencies on Aging will use regional summaries and county-type reports to inform local governments and agencies and support local Aging Leadership Planning Teams.
- Working with the UNC Institute on Aging, data will be made available to colleges and universities for further analysis and use locally. The survey instrument will be made available as well to aid counties and municipalities wanting to conduct a local study to enrich the data available for planning and evaluation. Another option could involve use of a supplemental questionnaire with key local informants. Colorado employed this approach to increase its understanding of the needs and strengths of older adults in smaller counties (see Attachment J). This is an activity that could be undertaken by AAAs working with local colleges.

Additional suggestions for this assessment include:

- Use the expertise of the University of North Carolina system to plan and administer the assessment. This may include working through such entities as the UNC Institute on Aging and the Odum Institute for the overall coordination of the project (see Attachment K). Whenever possible, other academic institutions should be informed of the initiative and encouraged to participate (e.g., assist with local surveys, conduct focus groups, mine available data for additional analysis) to promote greater connectedness between the academic institutions and local planners. An important byproduct of this involvement of academic institutions across the state would be increased opportunities for students and faculty in applied research.
- Use the livable and senior-friendly community framework to design the assessment project because it will provide a comprehensive approach and will support emerging efforts by the Division, AAAs, and local Aging Leadership Planning Teams. Use of this framework is consistent with a national trend and would further facilitate comparative analysis among North Carolina communities and with those of other states. The scope of the studies of many other states parallels well the areas of NC's LSFC framework (see Attachment I for examples of this). It is also a framework that many NC communities are beginning to adopt (see Attachments D and E for examples of related local planning initiatives).
- Include in the survey persons age 45 and older (that includes the youngest of boomers as of 2009) to assess current and projected service needs and perceptions about the livability and senior-friendliness of communities. This age criteria also corresponds to how public data are more commonly organized, which should enrich analysis.
- Assure through over-sampling an adequate representation of subgroups at particular social and economic risk (e.g., low income, minority, rural).

"The results of Colorado's statewide strengths and needs assessment are reinforced by the AdvantAge Initiative 2003 National Survey of Older Adults. That survey found that, while the majority of older adults in the United States are thriving, a small, but sizeable minority—the 'Frail Fraction'—is struggling. In planning for the future, communities must address both aspects of their aging population. A community that is prepared to both meet the needs and cultivate the strengths of its older population is considered to be elder-friendly."

Fiscal note: $200,000 for survey design, implementation, analysis, and reporting associated with the Year One Survey; $175,000 for the Year Four Survey (some savings to be realized in survey design).

State and Local Awareness and Preparedness Assessment

As previously discussed, while there seems to be growing awareness and sensitivity vis-à-vis population aging, there is still ample evidence that the attention it garners at the state and local levels is inadequate. Whatever planning occurs appears limited and/or fragmented. More importantly, little is known about the extent to which population aging is being considered by those planning future policies and programs. Therefore, two initiatives are recommended—one focused on the state, the other locally.

State Executive Assessment

The aging of the population is a driving force that has implications for nearly all, if not all, state agencies. While the Division of Aging and Adult Services seeks input from many of these agencies when it produces its four-year *State Aging Services Plan,* it generally has not had a substantive means of capturing the attention of these agencies and encouraging their consideration of population aging in their respective planning and policy and program development. Several states (e.g., Minnesota, New York, and Texas) provide a model for having the legislature and/or governor require such an assessment of their state agencies (see Attachment L for information on the process used by Texas). If North Carolina invests in a comprehensive, statewide, and long-term consumer assessment, it only seems prudent to assure that the information collected is considered by state agencies in guiding their future work. It also seems logical that an assessment of each state agency's planning and preparedness be conducted and shared to promote collaboration and identify assets and problems.

It is recommended that the *State Strategic and Steering Team* would plan and direct a process every other year over a five-year period that would have each relevant department, office, and system of state government assess the implications of the aging population on its programs and services, and to report its findings and recommendations for consideration (using a prescribed reporting format). Use of a web-based application is recommended to facilitate response and analysis of agency reports, and to minimize the expense of survey administration. The *State Strategic and Steering Team* would prepare a summary document to be presented to the Governor and the General Assembly. It is also expected that the *State Strategic and Steering Team* would share the results of the consumer assessment and any special studies with state agencies to guide their future planning for policy and programs. Affected departments, offices, and systems would likely include: Administration, Agriculture and Consumer Services, Commerce, Community Colleges, Correction, Crime Control and Public Safety, Cultural Resources, Employment Security Commission, Environment and Natural Resources, Health and Human Services, Housing Finance Agency, Insurance, Justice, Labor, Revenue, State Personnel, and Transportation. A simple but important example of how issues involving the aging of the

population extend beyond human services and supports was a recently reported finding of the NC Justice Center that 42 percent of the state's workforce lack paid sick time, which has implications for workers with family caregiving responsibilities.

> *"The Project 2015 initiative has provided a process of planning, engagement and action by 36 participating New York State government agencies to prepare for the impact of the aging and increasing diversity of our state's population....In the years since the initial strategic planning took place, [participating] agencies have successfully used their planning document (agency brief) as the basis for adopting new approaches to better serve our aging, more diverse population."*

Fiscal note: The costs associated with this activity are included in the note for the Local Assessment.

Local Assessment

As reviewed previously, North Carolina's local governments had a less than optimal showing in response to the 2005 *Maturing of America* survey. More importantly, information about North Carolina's local preparedness is generally unavailable. It is vital for state and local planning that more be known about local awareness and what steps are underway to enhance community livability and senior-friendliness. It is, therefore, recommended that the *State Strategic and Steering Team* plan and oversee administration of a survey of local governments—working closely with the NC Association of County Commissioners and the NC League of Municipalities. Similar to the assessment of State agencies, the local government survey would be web-based and conducted in years one, three, and five of *Project CACE* to measure changes in awareness and activity. It is estimated that the implementation of the survey would take two to three months. The State Strategic and Steering Team would release a report of the findings for each of the three years. The report would include promising practices and new initiatives. Through the UNC Institute on Aging, colleges and universities would be encouraged to work with AAAs to conduct qualitative research on promising practices and initiatives and produce profiles that can be shared with other governments.

The survey used in the *Maturing of America* project could serve as a model (see Attachment C), along with similar surveys produced by other states (see Attachment M for survey approach planned for Illinois), to facilitate comparison with state and national benchmarks whenever possible. Focus groups of key informants, representative of all areas of the state, will assist with development of the survey instrument. There should be a core set of standardized questions—framed by the LSFC concept—to facilitate comparative analysis. To meet other local needs for information, a limited number of additional questions could be added at the request of county officials.

Fiscal note: $75,000 would be needed to support administration, analysis, and reporting of the survey in each of the three years.

Retirement Migration Study and Other Studies

To inform and supplement the consumer assessment and other components of *Project CACE*, it is recommended that there be state support for applied research deemed by the *State Strategic and Steering Team* to be essential for future planning of policies and programs. One such area is likely to be the implications of retirement migration on North Carolina and its communities. As

of the 2000 Census, North Carolina ranked third among states in the net migration of retirees with a net migration number of 34,290 among persons age 60 and older in the five-year period between 1995 and 2000—only trailing Florida and Arizona. 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. 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. 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. Older migration of persons among counties and within counties is another important factor for state and local policy and program planning. It is certainly a factor for some, if not all, of the six counties identified in Section 1 of S.B. 448 (i.e., Buncombe, Brunswick, Gaston, Henderson, Moore, and New Hanover). Yet, North Carolina knows far too little about these emerging subgroups of migrating retirees and the implications of their movement for public policy and programs. There are many other subgroups (e.g., persons with Alzheimer's disease, persons with sensory impairments) and sub-issues that may warrant special examination.

"Because of variability in the migration of older adults across counties and communities within counties as well as an opportunity to examine closely the dynamics of African Americans returning to home areas with advancing years, Eastern North Carolina provides a natural educational, research, and policy laboratory. University partners with long-standing relationships with regional, local, and state service providers are positioned ideally to compile information to assist counties and municipalities challenged with meeting the needs of older natives and immigrants, their families, and service providers."
—Dr. Jim Mitchell, East Carolina University Brody School of Medicine, Center on Aging

Fiscal note: It is estimated that an annual, recurring appropriation of $50,000 would be needed for these special studies, determined by the *State Strategic and Steering Team*, this is referenced in the fiscal note for this Team.

State and Local Planning and Development

It is clearly not sufficient to conduct assessments and publish reports. A vital step in the effective use of the information gathered is the provision of findings to stakeholders in a form that aids their understanding and application of the information. This transmission can be accomplished in a number of ways but should at least include:

- Publishing and presentation of reports targeted to specific agencies and communities whenever possible;
- Developing tools and offering training sessions to familiarize stakeholders with the relevance of the information—this could be done in a number of venues, including possibly working with the UNC School of Government and participating academic institutions;
- Making the survey data available for further analysis whenever possible; and
- Creating a web-site for ready access to all products and for sharing ideas and asking questions.

While state-level interest and leadership are essential, no less important is assuring adequate local and regional capacity for using the information and other tools provided to plan and respond to the aging population. A key component is the resources available for NC's 17 Area Agencies on Aging and the Councils of Government to facilitate local and regional planning that

involves not only local governments but also the private sector. In addition, as was first proposed in the *1991 State Aging Plan*, counties—and their cities and town—should be supported in their local planning for an aging population. The value of supporting local efforts was reiterated in the *2001 Long Term Care Plan for North Carolina*:

"Local communities and regional coalitions have been leaders in the effort to reform the long-term care delivery system....By acting as incubators of new long-term care systems change, these counties assumed a risk that their initiative would not be in-line with state long-term care policy. Yet, the [Long-Term Care] Task Force wants to support these local leaders—in that their experiences at the local level have helped to inform and improve statewide policy efforts."

Fiscal note: It is recommended that the General Assembly:
(1) increase support for Area Agencies on Aging by (a) restoring the $270,000 for recurring AAA State support, reduced in 2001, and (b) funding an additional position at each AAA targeted to facilitate regional and community planning for aging, at a total State cost of $1.2 million, which would grow to $1.6 million with a 25% match participation rate (personnel for these positions would have knowledge and skills appropriate for such tasks as effective use of technology—e.g., GIS mapping, strong working relationships with city, county, and regional planners, facilitation of focus groups, and data analysis and presentation);
(2) provide $20,000 in recurring funds to each county for a total amount of $2 million; and
(3) provide $25,000 in recurring funds for the use of consultants to support the work of the AAAs, counties, and State staff involved in *Project CACE* (e.g., development and presentation of training curricula and tools). All State staff support needed for this activity is shown in the fiscal note for the *State Strategic and Steering Team*.

Aging Data Warehouse

Accessible information is vital for effective planning at the state and local levels. This includes information to help planners and the public alike assess whether efforts on behalf of aging adults are creating the intended results for individuals, families, and communities. Unfortunately information on services, costs, and results currently mirrors the often fragmented nature of the current service system for aging adults. Such information is stored in categorical programs that do not interface, making it difficult to assess service and access barriers as well as intended results.

Absent access to information to assess state and local planning and intervention, there is no way to systematically evaluate and learn from those efforts. It is like driving without a clear destination in mind or indicators to tell you when you have arrived or when you are hopelessly lost. Therefore a component of *Project CACE* is a proposed Data Warehouse for Aging. It is recommended that the *State Strategic and Steering Team* include in its assessment of state agencies, questions about what applicable secondary data elements are currently available, how they are stored, and their capacity for being integrated with other data sets. The team would also assess which elements are currently missing and critical for the creation of a result-based data warehouse.

The Team's findings would determine the overall design for an Aging Data Warehouse, modifications and links to existing information sets, and recommendations for its subsequent deployment. The *State Strategic and Steering Team* would include a state fiscal note in its recommendations.

Fiscal note: No current note is needed.

Conclusion: Now is the time for North Carolina to invest in its first comprehensive study of its older population and the readiness of communities and the state to respond. By supporting *Project CACE*, North Carolina's legislative and executive branches will have a solid foundation of information for use in formulating and supporting sound policies and programs that maximize the assets of the aging population and assure effective stewardship of resources. They will have increased ability to measure the effect of local and state activity in order to shape future legislative and executive actions to build on successes and modify less effective approaches. This effort will assist North Carolina in better meeting the needs and expectations of our aging population as our communities strive to be among the nation's most livable and senior-friendly. In the absence of the information that *Project CACE* can provide, North Carolina runs the risk of being ill-prepared for a demographic future that it has never before experienced. An investment in local planning is especially important because this is largely where the development of livable and senior-friendly communities must occur.

Fiscal Note: The total proposed annual, recurring cost of *Project CACE* is $3,770,000, with additional non-recurring costs totaling $600,000 – as outlined below.

Item	Recurring	Non-Recurring
Support of State Strategic and Steering Team	$225,000	
Consumer Survey – Year One		$200,000
Consumer Survey – Year Four		$175,000
State and Local Assessments – Year One		$75,000
State and Local Assessments – Year Three		$75,000
State and Local Assessments – Year Five		$75,000
Support of Special Studies	$50,000	
Restore AAA State Support	$270,000	
Fund *Project CACE* Position at Each AAA	$1,200,000	
Support Local Planning Statewide	$2,000,000	
Support Use of Special Consultants for Project CACE activities	$25,000	
Aging Data Warehouse	To be recommended in future	
Total	$3,770,000	$600,000

Attachment B
Demographics

Comparison of Estimated and Projected Population Growth in NC Counties for Age Groups 0-17 and 60+ between 2005 and 2030

Counties in **bold** are those where the population 60+ is greater than 0-17. Counties in *italics* are those where the population 0-17 is greater than 60+. Both **bold** and *italicized* counties are ranked in descending order by the population 60+

2005			2030		
County/State	0-17	60+	County/State	0-17	60+
HENDERSON	**20,068**	**26,581**	**BUNCOMBE**	**55,919**	**78,806**
BRUNSWICK	**17,729**	**22,239**	**NEW HANOVER**	**46,701**	**68,883**
MOORE	**16,600**	**22,046**	**GASTON**	**45,279**	**56,125**
CARTERET	**11,358**	**15,784**	**DAVIDSON**	**45,445**	**50,864**
HAYWOOD	**11,371**	**14,789**	**BRUNSWICK**	**26,998**	**47,864**
BEAUFORT	**10,168**	**10,345**	**HENDERSON**	**29,485**	**46,035**
MACON	**6,137**	**9,433**	**ROWAN**	**39,937**	**40,560**
TRANSYLVANIA	**5,686**	**8,899**	**MOORE**	**22,297**	**37,880**
CHEROKEE	**5,050**	**7,259**	**ORANGE**	**30,633**	**36,595**
JACKSON	**6,609**	**7,160**	**CRAVEN**	**19,937**	**30,852**
DARE	**7,011**	**7,089**	**CLEVELAND**	**25,919**	**29,367**
WATAUGA	**6,331**	**6,969**	**CARTERET**	**11,221**	**29,122**
ASHE	**4,827**	**6,306**	**ROCKINGHAM**	**20,784**	**28,844**
POLK	**3,673**	**5,544**	**NASH**	**25,714**	**28,573**
NORTHAMPTON	**4,716**	**5,036**	**BURKE**	**22,846**	**27,027**
WARREN	**4,301**	**4,535**	**CALDWELL**	**18,089**	**24,878**
YANCEY	**3,687**	**4,521**	**LINCOLN**	**22,896**	**24,187**
MADISON	**4,295**	**4,436**	**HAYWOOD**	**13,447**	**23,779**
MITCHELL	**3,168**	**4,118**	**WILSON**	**21,847**	**23,466**
AVERY	**3,315**	**3,974**	**SURRY**	**19,860**	**23,404**
CHOWAN	**3,228**	**3,537**	**CHATHAM**	**18,638**	**23,281**
PAMLICO	**2,384**	**3,426**	**WILKES**	**17,171**	**22,539**
PERQUIMANS	**2,444**	**3,173**	**RUTHERFORD**	**15,088**	**21,451**
CLAY	**1,676**	**3,004**	**PENDER**	**14,119**	**20,516**
ALLEGHANY	**2,046**	**2,895**	**GRANVILLE**	**16,567**	**18,754**
GRAHAM	**1,719**	**2,085**	**STANLY**	**15,714**	**18,380**
HYDE	**1,015**	**1,220**	**LENOIR**	**12,139**	**17,272**
TYRRELL	**816**	**839**	**HALIFAX**	**11,269**	**17,220**
MECKLENBURG	*202,930*	*92,070*	**DARE**	**10,381**	**17,145**
WAKE	*193,891*	*80,141*	**BEAUFORT**	**10,429**	**16,685**
GUILFORD	*105,134*	*69,210*	**COLUMBUS**	**13,432**	**16,311**
FORSYTH	*80,021*	*54,880*	**MACON**	**8,824**	**15,937**
BUNCOMBE	*46,360*	*43,824*	**STOKES**	**12,551**	**15,663**
CUMBERLAND	*84,338*	*36,190*	**MCDOWELL**	**11,452**	**14,891**
GASTON	*45,837*	*33,681*	**DAVIE**	**13,520**	**14,714**
NEW HANOVER	*36,429*	*31,859*	**EDGECOMBE**	**9,885**	**14,001**
DURHAM	*58,509*	*31,355*	**TRANSYLVANIA**	**5,497**	**13,922**
DAVIDSON	*36,739*	*28,053*	**JACKSON**	**8,327**	**13,650**
CATAWBA	*36,516*	*25,501*	**PASQUOTANK**	**9,566**	**13,443**
ALAMANCE	*33,546*	*24,851*	**PERSON**	**10,163**	**13,218**
ROWAN	*32,469*	*23,886*	**CHEROKEE**	**5,686**	**12,789**

Data retrieved from North Carolina State Data Center Website on 06/14/2006

Comparison of Estimated and Projected Population Growth in NC Counties for Age Groups 0-17 and 60+ between 2005 and 2030

Counties in **bold** are those where the population 60+ is greater than 0-17. Counties in *italics* are those where the population 0-17 is greater than 60+. Both **bold** and *italicized* counties are ranked in descending order by the population 60+

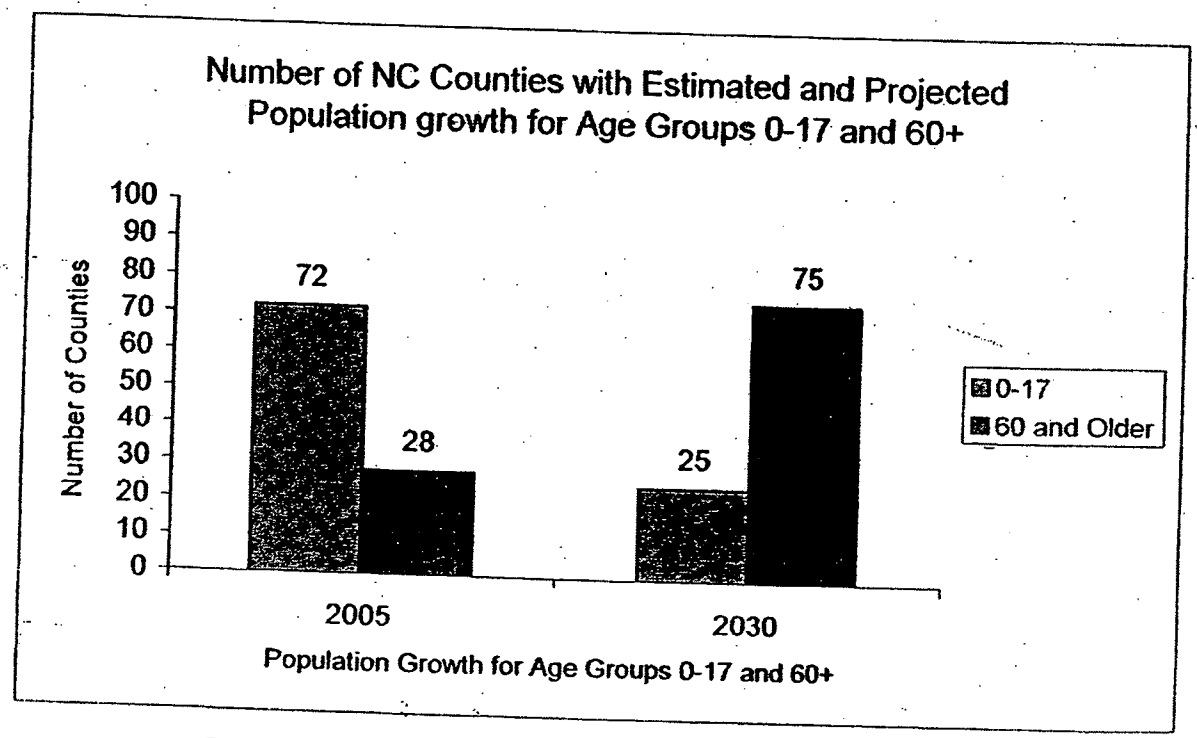
2005			2030		
County/State	0-17	60+	County/State	0-17	60+
RANDOLPH	*33,579*	*23,434*	**WATAUGA**	**6,234**	**12,338**
IREDELL	*35,393*	*23,174*	**RICHMOND**	**10,768**	**12,292**
CABARRUS	*39,392*	*22,567*	**ALEXANDER**	**10,657**	**12,127**
UNION	*45,330*	*20,408*	**YADKIN**	**11,178**	**11,970**
JOHNSTON	*38,797*	*19,333*	**BLADEN**	**8,447**	**10,979**
WAYNE	*29,456*	*19,028*	**SCOTLAND**	**9,320**	**10,616**
PITT	*33,731*	*18,846*	**CURRITUCK**	**8,614**	**10,095**
ROCKINGHAM	*20,666*	*18,668*	**ASHE**	**5,042**	**9,996**
CLEVELAND	*24,186*	*18,199*	**POLK**	**4,925**	**9,161**
ROBESON	*35,707*	*18,004*	**MONTGOMERY**	**7,892**	**8,900**
CRAVEN	*21,760*	*17,455*	**HERTFORD**	**4,664**	**8,525**
BURKE	*20,477*	*16,933*	**ANSON**	**6,012**	**7,938**
NASH	*22,529*	*15,517*	**CASWELL**	**5,711**	**7,610**
ONSLOW	*40,622*	*15,364*	**MADISON**	**4,729**	**7,596**
CALDWELL	*17,879*	*15,340*	**YANCEY**	**3,871**	**7,444**
ORANGE	*24,795*	*15,176*	**WARREN**	**4,502**	**7,441**
SURRY	*16,967*	*15,152*	**MARTIN**	**4,794**	**7,360**
HARNETT	*26,995*	*13,957*	**NORTHAMPTON**	**4,283**	**7,219**
WILKES	*15,015*	*13,796*	**AVERY**	**2,991**	**7,108**
RUTHERFORD	*14,438*	*13,699*	**BERTIE**	**3,498**	**6,395**
WILSON	*19,191*	*13,593*	**MITCHELL**	**3,290**	**6,150**
LENOIR	*13,873*	*11,817*	**CLAY**	**1,972**	**5,617**
LINCOLN	*16,549*	*11,579*	**PAMLICO**	**2,142**	**5,526**
CHATHAM	*12,395*	*11,310*	**CHOWAN**	**3,059**	**5,433**
HALIFAX	*13,573*	*11,282*	**PERQUIMANS**	**2,694**	**5,114**
STANLY	*14,251*	*11,241*	**SWAIN**	**3,921**	**4,909**
SAMPSON	*16,246*	*10,710*	**ALLEGHANY**	**2,165**	**4,390**
COLUMBUS	*13,144*	*10,572*	**WASHINGTON**	**2,479**	**4,284**
EDGECOMBE	*13,459*	*9,396*	**GATES**	**3,023**	**3,984**
PENDER	*9,961*	*9,223*	**CAMDEN**	**3,362**	**3,816**
DUPLIN	*13,447*	*8,829*	**JONES**	**2,018**	**3,586**
LEE	*12,627*	*8,670*	**GRAHAM**	**1,890**	**3,213**
MCDOWELL	*9,654*	*8,649*	**HYDE**	**745**	**1,852**
RICHMOND	*11,610*	*8,551*	**TYRRELL**	**694**	**1,304**
GRANVILLE	*12,452*	*8,510*	*WAKE*	*334,957*	*251,140*
STOKES	*10,767*	*8,245*	*MECKLENBURG*	*318,045*	*232,782*
FRANKLIN	*13,732*	*8,018*	*GUILFORD*	*132,614*	*127,408*
VANCE	*11,807*	*7,536*	*FORSYTH*	*101,221*	*98,550*
DAVIE	*9,252*	*7,415*	*CUMBERLAND*	*87,812*	*71,551*

Data retrieved from North Carolina State Data Center Website on 06/14/2006

Comparison of Estimated and Projected Population Growth in NC Counties for Age Groups 0-17 and 60+ between 2005 and 2030

Counties in **bold** are those where the population 60+ is greater than 0-17. Counties in *italics* are those where the population 0-17 is greater than 60+. Both **bold** and *italicized* counties are ranked in descending order by the population 60+

2005			2030		
County/State	**0-17**	**60+**	**County/State**	**0-17**	**60+**
YADKIN	*8,791*	*7,262*	*DURHAM*	*79,738*	*65,921*
PASQUOTANK	*8,914*	*7,011*	*UNION*	*84,602*	*59,650*
PERSON	*8,579*	*6,946*	*JOHNSTON*	*69,408*	*50,912*
BLADEN	*7,921*	*6,565*	*IREDELL*	*55,725*	*50,715*
ALEXANDER	*8,447*	*6,345*	*CABARRUS*	*66,860*	*50,284*
SCOTLAND	*9,838*	*6,140*	*CATAWBA*	*47,572*	*46,073*
MONTGOMERY	*6,584*	*5,290*	*RANDOLPH*	*43,799*	*43,756*
MARTIN	*5,739*	*5,163*	*ALAMANCE*	*46,507*	*42,593*
HERTFORD	*5,337*	*5,055*	*PITT*	*41,652*	*40,862*
ANSON	*6,248*	*4,847*	*ROBESON*	*38,927*	*34,430*
CASWELL	*5,249*	*4,451*	*ONSLOW*	*44,404*	*32,058*
BERTIE	*4,630*	*4,212*	*HARNETT*	*38,913*	*31,529*
HOKE	*12,086*	*4,082*	*WAYNE*	*32,407*	*31,453*
CURRITUCK	*5,352*	*3,936*	*FRANKLIN*	*20,228*	*19,448*
GREENE	*4,920*	*3,299*	*SAMPSON*	*22,539*	*19,214*
WASHINGTON	*3,194*	*2,987*	*DUPLIN*	*18,404*	*15,670*
SWAIN	*3,165*	*2,897*	*LEE*	*16,199*	*14,649*
GATES	*2,644*	*2,191*	*VANCE*	*13,532*	*12,475*
JONES	*2,319*	*2,168*	*HOKE*	*21,164*	*11,080*
CAMDEN	*2,081*	*1,664*	*GREENE*	*6,409*	*6,135*
NORTH CAROLINA	2,091,889	1,424,450	NORTH CAROLINA	2,760,896	2,811,519



Data retrieved from North Carolina State Data Center Website on 06/14/2006

	Projected increase in Population age 60 and older (2005-2030)							
	2005	Population Increase						2030
	60+ Pop	2005-2010		2005-2020		2005-2030		60+
County/State	(Base year)	growth	%	growth	%	growth	%	Population
ALAMANCE	24,661	2,280	9.25	8,944	36.27	16,339	66.25	41,000
ALEXANDER	6,404	1,109	17.32	3,186	49.75	5,212	81.39	11,616
ALLEGHANY	2,906	358	12.32	1,034	35.58	1,437	49.45	4,343
ANSON	4,825	243	5.04	1,139	23.61	1,866	38.67	6,691
ASHE	6,381	952	14.92	2,626	41.15	3,933	61.64	10,314
AVERY	3,941	547	13.88	1,472	37.35	2,447	62.09	6,388
BEAUFORT	10,391	1,749	16.83	4,735	45.57	6,318	60.80	16,709
BERTIE	4,213	295	7.00	1,418	33.66	1,930	45.81	6,143
BLADEN	6,519	745	11.43	2,537	38.92	3,640	55.84	10,159
BRUNSWICK	23,406	8,056	34.42	20,636	88.17	31,698	135.43	55,104
BUNCOMBE	43,608	7,485	17.16	22,610	51.85	35,928	82.39	79,536
BURKE	16,620	1,834	11.03	5,381	32.38	8,539	51.38	25,159
CABARRUS	22,532	5,236	23.24	16,954	75.24	31,287	138.86	53,819
CALDWELL	15,288	2,127	13.91	6,040	39.51	9,362	61.24	24,650
CAMDEN	1,731	394	22.76	1,435	82.90	2,500	144.43	4,231
CARTERET	16,120	3,067	19.03	9,328	57.87	13,590	84.31	29,710
CASWELL	4,398	414	9.41	1,621	36.86	2,492	56.66	6,890
CATAWBA	25,277	3,999	15.82	12,191	48.23	19,859	78.57	45,136
CHATHAM	11,372	2,403	21.13	7,675	67.49	12,440	109.39	23,812
CHEROKEE	7,418	1,530	20.63	3,940	53.11	5,738	77.35	13,156
CHOWAN	3,559	504	14.16	1,482	41.64	2,049	57.57	5,608
CLAY	3,078	705	22.90	1,946	63.22	2,791	90.68	5,869
CLEVELAND	17,918	1,497	8.35	5,521	30.81	9,188	51.28	27,106
COLUMBUS	10,458	1,225	11.71	3,621	34.62	5,258	50.28	15,716
CRAVEN	18,031	3,439	19.07	10,587	58.72	15,426	85.55	33,457
CUMBERLAND	35,351	5,257	14.87	19,391	54.85	32,049	90.66	67,400
CURRITUCK	4,111	1,035	25.18	3,876	94.28	6,647	161.69	10,758
DARE	7,118	1,253	17.60	5,343	75.06	8,455	118.78	15,573
DAVIDSON	27,893	3,933	14.10	12,581	45.10	21,103	75.66	48,996
DAVIE	7,499	1,575	21.00	4,727	63.04	7,757	103.44	15,256
DUPLIN	8,785	1,029	11.71	3,724	42.39	6,380	72.62	15,165
DURHAM	31,194	6,542	20.97	21,444	68.74	34,316	110.01	65,510
EDGECOMBE	9,260	930	10.04	3,266	35.27	3,901	42.13	13,161
FORSYTH	54,930	9,242	16.83	29,188	53.14	46,157	84.03	101,087
FRANKLIN	8,040	1,609	20.01	6,136	76.32	11,255	139.99	19,295
GASTON	33,777	5,996	17.75	16,344	48.39	25,428	75.28	59,205
GATES	2,245	413	18.40	1,282	57.10	2,148	95.68	4,393
GRAHAM	2,085	273	13.09	707	33.91	1,032	49.50	3,117
GRANVILLE	8,389	1,233	14.70	5,025	59.90	8,932	106.47	17,321
GREENE	3,266	431	13.20	1,632	49.97	2,562	78.44	5,828
GUILFORD	69,004	11,298	16.37	35,455	51.38	59,132	85.69	128,136
HALIFAX	11,232	805	7.17	3,412	30.38	5,034	44.82	16,266
HARNETT	13,931	2,144	15.39	8,527	61.21	16,814	120.69	30,745
HAYWOOD	14,665	1,506	10.27	4,738	32.31	7,824	53.35	22,489
HENDERSON	26,820	3,987	14.87	11,872	44.27	19,481	72.64	46,301
HERTFORD	5,069	532	10.50	1,893	37.34	2,578	50.86	7,647
HOKE	4,173	1,030	24.68	3,964	94.99	7,791	186.70	11,964
HYDE	1,206	34	2.82	301	24.96	446	36.98	1,652

	Projected increase in Population age 60 and older (2005-2030)							
	2005	Population Increase						2030
	60+ Pop	2005-2010		2005-2020		2005-2030		60+
County/State	(Base year)	growth	%	growth	%	growth	%	Population
IREDELL	23,278	5,289	22.72	17,138	73.62	30,612	131.51	53,890
JACKSON	7,106	1,408	19.81	3,624	51.00	5,342	75.18	12,448
JOHNSTON	19,473	4,444	22.82	16,117	82.77	32,292	165.83	51,765
JONES	2,163	303	14.01	964	44.57	1,422	65.74	3,585
LEE	9,265	1,426	15.39	4,969	53.63	8,431	91.00	17,696
LENOIR	11,742	1,171	9.97	3,809	32.44	5,078	43.25	16,820
LINCOLN	11,597	2,427	20.93	7,711	66.49	13,306	114.74	24,903
MCDOWELL	8,576	1,087	12.67	3,478	40.56	5,594	65.23	14,170
MACON	9,556	1,460	15.28	4,249	44.46	6,560	68.65	16,116
MADISON	4,435	595	13.42	1,885	42.50	2,943	66.36	7,378
MARTIN	5,138	490	9.54	1,565	30.46	1,985	38.63	7,123
MECKLENBURG	92,379	25,226	27.31	85,226	92.26	157,156	170.12	249,535
MITCHELL	4,077	338	8.29	1,153	28.28	1,709	41.92	5,786
MONTGOMERY	5,308	696	13.11	2,323	43.76	3,423	64.49	8,731
MOORE	22,299	3,088	13.85	9,620	43.14	15,862	71.13	38,161
NASH	15,449	2,531	16.38	8,199	53.07	12,721	82.34	28,170
NEW HANOVER	32,528	7,451	22.91	23,349	71.78	38,306	117.76	70,834
NORTHAMPTON	5,048	362	7.17	1,450	28.72	2,078	41.16	7,126
ONSLOW	15,337	3,455	22.53	10,023	65.35	13,081	85.29	28,418
ORANGE	15,025	3,602	23.97	12,616	83.97	19,364	128.88	34,389
PAMLICO	3,443	389	11.30	1,256	36.48	1,785	51.84	5,228
PASQUOTANK	7,231	1,575	21.78	4,719	65.26	7,490	103.58	14,721
PENDER	9,435	2,600	27.56	7,576	80.30	12,717	134.79	22,152
PERQUIMANS	3,289	583	17.73	1,632	49.62	2,407	73.18	5,696
PERSON	6,904	929	13.46	3,585	51.93	5,742	83.17	12,646
PITT	18,868	4,138	21.93	14,125	74.86	22,819	120.94	41,687
POLK	5,507	479	8.70	1,828	33.19	3,044	55.28	8,551
RANDOLPH	23,250	3,262	14.03	11,064	47.59	18,790	80.82	42,040
RICHMOND	8,556	818	9.56	2,418	28.26	3,664	42.82	12,220
ROBESON	18,012	3,003	16.67	9,776	54.27	15,549	86.33	33,561
ROCKINGHAM	18,515	1,805	9.75	6,237	33.69	9,234	49.87	27,749
ROWAN	23,623	2,274	9.63	8,669	36.70	15,104	63.94	38,727
RUTHERFORD	13,636	1,217	8.92	4,152	30.45	6,806	49.91	20,442
SAMPSON	10,680	969	9.07	4,206	39.38	7,599	71.15	18,279
SCOTLAND	6,128	1,044	17.04	2,865	46.75	3,792	61.88	9,920
STANLY	11,095	1,055	9.51	3,571	32.19	6,086	54.85	17,181
STOKES	8,186	1,164	14.22	4,097	50.05	6,623	80.91	14,809
SURRY	15,104	1,291	8.55	4,297	28.45	7,404	49.02	22,508
SWAIN	2,928	508	17.35	1,438	49.11	2,153	73.53	5,081
TRANSYLVANIA	9,018	1,373	15.23	3,634	40.30	5,095	56.50	14,113
TYRRELL	851	29	3.41	229	26.91	376	44.18	1,227
UNION	21,136	7,910	37.42	25,065	118.59	47,434	224.42	68,570
VANCE	7,407	916	12.37	3,088	41.69	4,538	61.27	11,945
WAKE	80,918	28,000	34.60	100,152	123.77	186,195	230.10	267,113
WARREN	4,546	306	6.73	1,370	30.14	2,161	47.54	6,707
WASHINGTON	2,991	344	11.50	1,071	35.81	1,253	41.89	4,244
WATAUGA	6,938	1,262	18.19	3,661	52.77	5,044	72.70	11,982
WAYNE	18,902	1,923	10.17	7,566	40.03	11,235	59.44	30,137

	Projected increase in Population age 60 and older (2005-2030)							
	2005	Population Increase						2030
	60+ Pop	2005-2010		2005-2020		2005-2030		60+
County/State	(Base year)	growth	%	growth	%	growth	%	Population
WILKES	13,678	1,622	11.86	5,181	37.88	7,694	56.25	21,372
WILSON	13,541	1,902	14.05	6,371	47.05	9,605	70.93	23,146
YADKIN	7,247	814	11.23	2,578	35.57	4,464	61.60	11,711
YANCEY	4,544	703	15.47	1,950	42.91	2,858	62.90	7,402
NC	1,426,984	257,336	18.03	841,782	58.99	1,412,514	98.99	2,839,498
Reference								
North Carolina State Demograhphics								
http://demog.state.nc.us/								

Attachment G
Other State Summaries

Attachment G

A Summary of Other States

The information presented below was largely collected via a short survey conducted through the National Association of State Units on Aging (NASUA) in November 2007. The states listed below reported that they had conducted a statewide aging study within the last five years.

Arizona

Study Report: *Aging 2020* [www.azgovernor.gov/seniors]

Scope and Methods:

A series of focus groups was conducted around the state.

Cost and Funding Sources: Paid $30,000 for the Center for Civic Participation to do the invitations, facilitate the sessions, and transcribe the results of 40 public forums. Used sponsorship and donation funds to cover the cost.

Contact Person:
Melanie Starns, mstarns@az.gov, Governor's Office on Aging

Connecticut

Study Reports: *Long Term Care Needs Assessment, 2007* and *Balancing the System: Working Towards Real Choice for Long-Term Care in Connecticut*
[http://www.cga.ct.gov/coa/incl_longtermcare.htm]

Scope and Methods:

A team of researchers from the University of Connecticut Health Center's Center on Aging oversaw the design and implementation of the project. In addition to carrying out a comprehensive literature review on both Connecticut-specific and national data, Center on Aging staff conducted statewide mail, telephone and in-person surveys of both Connecticut residents and providers of long-term care services. Project staff also conducted a full review of Connecticut's existing array of services and long-term care system rebalancing efforts. In order to help identify structural strengths, weaknesses and gaps in the current system, and to compare Connecticut's rebalancing progress to that of other states, the research team hired as consultants Dr. Robert Kane and Dr. Rosalie Kane from the University of Minnesota (national experts).

Cost and Funding Sources:
Payment was made from funds authorized by the state legislature through the Commission on Aging ($300,000) and $80,000 from the Ombudsman program.

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Florida

Study Report: *Assessing the Needs of Elder Floridians, 2004*
[http://elderaffairs.state.fl.us/english/Stats/AssessNeeds.html]

Scope and Methods:

The data needed to prepare this report came mainly from two sources: A Statewide Needs Assessment Survey of Older Floridians and small area Census Bureau tabulations prepared specially for the Planning and Evaluation Unit of the Florida Department of Elder Affairs. Many other sources were used for specific items, such as the number of elder Floridians who receive Food Stamps or the number of nursing home beds in a particular county. The Florida Department of Elder Affairs conducted a statewide survey to measure the needs of residents age 60 and older who were not already clients—focusing on 14 areas of need: living situation; self-care limitations; household management tasks; caregiving; health and health promotion;, information and assistance; nutrition; senior centers; transportation; advocacy and perspective on aging; housing; abuse, neglect and exploitation; volunteerism; and employment. The Department used the Survey Research Center at the Bureau of Business and Economic Research at the University of Florida to assist with the survey—with a target of completing 100 surveys for each of Florida's 11 Planning and Service Areas (over-sampling for "hard-to-reach" rural, poverty and minority populations).

Cost and Funding Sources: It cost about $30,000 [source not identified].

Contact Persons:
Horacio Soberon-Ferrer, Ferrerh@elderaffairs.org, 850-414-2089

Georgia

Study Report: *State Plan on Aging, Federal Fiscal Year 2008 – 2011* [see http://aging.dhr.georgia.gov/portal/site]

Scope and Methods:

As a part of the state strategic planning process, the Georgia Division of Aging Services (DAS) collaborated with Georgia State University and Kennesaw State University on a project to solicit and collect representative public input. The primary project objectives were to ascertain the level of consumer knowledge about programs and services provided through DAS, the perceived value of and barriers to DAS programs and services, as well as to obtain consumer suggestions for recommended improvements to the service delivery system and ideas for new DAS initiatives.

Target Constituent Populations included:
- Citizens over age 60
- Citizens age 50-60

Attachment G

Indiana

Study Report: [Not yet published.]

Scope and Methods:

Indiana is in the midst of a three-year study, having conducted training for communities in preparation for a statewide survey of 4,500 older citizens, which will begin in January. They also conducted interviews with multiple state units to learn about impact of demographics and preparation currently being done. This has not been published yet. The project is using a survey process designed by The AdvantAge Initiative of the Center for Home Care Policy and Research, Visiting Nurse Service of New York [http://www.vnsny.org/advantage/] focused on four components of an "elder-friendly community"—addressing basic needs, optimizing physical health and well-being, maximizing independence for the frail and disabled, and promoting social and civic engagement. The survey uses 33 indicators that communities can use to measure how well they are meeting the needs and aspirations of their older residents. The AdvantAge Initiative started as a national survey and now being conducted under contract by various communities across the country. For a couple of communities in Indiana that participated earlier (in the original national project) and a more recent one as well, visit: http://www.cicoa.org/TheAdvantAgeInitiative/TheAdvantAgeInitiative.html

http://www.cfsjc.org/publications/research.cfm

Cost and Funding Sources:

The Center on Aging and Community at Indiana University has received about $38,000 annually in a contract with the State Department on Aging. This offsets a research salary at 10%, pays for a graduate student assistant researcher, and pays for training for aging personnel around Indiana. This has been derived from the U.S. Administration on Aging Planning Demonstration Grant. In the coming year, we will expend around $300,000 additional funds for the survey and this is funded by new State money, the AAAs, and private foundations.

Contact Person:

Philip B. Stafford, Ph.D., staffor@indiana.edu

Kentucky

Study Reports: *The Kentucky Elder Readiness Initiative*
[www.mc.uky.edu/gerontology/keri.htm]

Scope and Method:
The Kentucky Elder Readiness Initiative (KERI), announced in August 2005, is a collaborative venture involving the Department of Aging and Independent Living of the

Attachment G

1. At the state level background materials were developed to frame the issues (see fact sheets, county profiles, etc. at above website).

2. North Carolina's work on livable and senior-friendly communities was featured at a state-level forum called, Boomers Mean Business.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_057723

3. Regional meetings, co-sponsored by AAAs and local businesses, invited key leaders and community stakeholders to facilitated discussions about impacts on the local community.

4. The themes and major topics from these community-level meetings were summarized into the *Blueprint.*

5. Meanwhile 22 state agencies identified a liaison for this project—and each liaison was responsible for going back to their state agency to identify the impacts of the demographic shift on their agency's business.

6. This has created any number of local and regional studies, projects, initiatives and other spin-offs—more around the themes of Communities for a Lifetime and Age-Friendly Communities. Some of these have been funded with foundation dollars, some supported by AAAs, some funded by communities themselves—and combinations of these. I would venture that at least half of them have been primarily volunteer.

Survey of Older Minnesotans—In 2005 the Minnesota Board on Aging (MBA) contracted with an independent firm (Clearwater Research, Inc. in Boise Idaho) to conduct a statewide telephone survey of persons aged 50 and over in Minnesota. The MBA conducts such a survey approximately every five years to monitor the changing needs, assets and expectations of older persons in the state and uses this information to improve the design and targeting of public programs for older persons and to help researchers and policymakers better understand Minnesota's older population.

The survey includes questions in the following general areas:

- Economic status—working, income sources, assets, attitudes about work/retirement
- Health status—general health, activities of daily living, transportation
- Housing status—own/rent, accommodations needed, living arrangements, planning to move, housing conditions
- Family/social status—children, friends, sources of support, community and personal concerns

Cost and Funding Sources: ***Transform 2010*** was done almost entirely by in-house staff. ***Survey of Older Minnesotans*** costs between $150,000 and 200,000—the sources depend on the year it is done, some public, and some private philanthropy.

methodology, and key elements of success in implementing the Project 2015 initiative), the following 13 components can be characterized as the major building blocks, or basic framework, of the Project 2015 planning initiative:

1. 36 Participating Agencies: Cabinet-level, selected by the Governor
2. One Lead Managing Agency: Designated by the Governor
3. Dedicated Management Team: Remained constant throughout project
4. Kick-Off Meeting: Initial charge to Commissioners given by the Governor
5. 36 Agencies -Project Designee: Selected by each Commissioner
6. Agency-Specific Work Plans: Completed/submitted 1st month of project
7. Current and Projected Demographic Data: Provided to all agencies
8. Monthly State Agency Work Group Meetings: Attended by all Designees
9. Individualized Technical Assistance: Provided by Management Team
10. Three-Part Brief: Written by each agency
11. White Paper Developed and Printed: Compilation of 36 briefs and articles
12. Governor's Symposium: Project 2015's next steps deliberated
13. White Paper Distributed to Wider Audience: As basis for further discussion

Cost and Funding Sources:
Project 2015 was conducted by New York State. The cost was approximately $100,000. There were no designated additional funds for the project. Different costs were absorbed or handled by different state agencies:

- Data projections were prepared, presented and distributed by the New York State Data Center.
- Project management staff were provided by the Office for the Aging.
- Meeting facilitators were provided through the Governor's Office of Employee Relations.
- AV and media costs were provided through the Office for Technology.
- Rooms were provided by the Office of General Services.
- An evaluation of the process was conducted by the New York State Office for the Aging together with the University at Albany' Center for Excellence in Aging.
- Copies of the product were made through the Department of Taxation and Finance.
- Large-print and other meeting materials were prepared by the Office of Advocate for Persons with Disabilities.
- Braille copies of publications were prepared by the Department of Correctional Services.

Contact Persons:
Jennifer Rosenbaum, Project 2015 Principal, jennifer.rosenbaum@ofa.state.ny.us, 518-473-4936

Vera Prosper, Project 2015 Principal, vera.prosper@ofa.state.ny.us, 418-474-4382

Texas

Study Reports: *Aging Texas Well Indicators Survey Results 2005*
[http://www.dads.state.tx.us/news_info/publications/studies/atw_results_report.pdf]

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Cost and Funding Sources:
The Indicators Survey was conducted by the Survey Research Center (SRC) at the University of North Texas via telephone. This survey was covered by the operating budget of the department. Due to the consolidation of state agencies, no principals with knowledge of the cost of the survey remain in the agency. Anecdotal references to the cost are between $15,000-$25,000.

The Survey Responses study was conducted internally by the Texas Department on Aging (the legacy agency of the Department of Aging and Disability Services). Cost of the survey was part of normal operations of the department.

Contact Person:
Michael Wilson, PhD, Aging Texas Well Coordinator, 512 438 5471, Michael.Wilson@dads.state.tx.us

Vermont

Study Report: *Shaping the Future of Long Term Care and Independent Living, 2006-2016* [http://www.dail.vermont.gov/dail-publications/publications-annual-reports/shaping-the-future-2006-2016]

Scope and Methods:
Vermont's *Shaping the Future of Long Term Care and Independent Living 2006-2016* is a yearly report describing both the need for long term care in Vermont and the use of Vermont's long term care services. This report is in its 5th edition and is intended to be a living document, adjusted annually to reflect changing demographics and trends (such as disability rates, nursing home use rates, and program use rates). Using a model developed jointly by The Lewin Group and Vermont that incorporates both demographic and program use data, Vermont is able to project the need for long term care services and make recommendations for addressing that need. By using a rolling 10-year forecast of long term care need and use, Vermont continually plans and adjusts for the future.

Cost and Funding Sources: Cost varies depending on the year. Funded by the Vermont Department of Disabilities, Aging & Independent Living.

Contact Person:
Julie Wasserman, julie.wasserman@dail.vt.state.us, 802-241-2320

Washington

Study Reports: *Interim Report to the Governor and Legislature—Joint Task Force on Long-Term Care Financing and Chronic Care Management* [http://www.governor.wa.gov/ltctf/reports/ltctf_interim_report_200701.pdf] The final Long-Term Care Task Force report is due at the end of 2007 and will be posted at this website.

were used to produce a series of six topical presentations with PowerPoint slideshows, as well as a series of six two-page topical briefs that are used as handouts.

Cost and Funding Sources:
The survey was administered by the Wisconsin Department of Health and Family Services through its (then) Bureau of Aging and Long Term Care Resources, through a contract with the University of Wisconsin Survey Center which staffed the interviews. Costs included approximately 50% of one staff FTE for one year, plus approximately $177,000 for the contract with the Survey Center. Of this, $100,000 came from state general purpose revenue, and the remainder from Older Americans Act Title III funds.

Contact Person:
Cindy Ofstead, Population Analyst, Wisconsin Bureau of Aging and Disability Resources, 608-267-3202, ofstecm@dhfs.state.wi.us

2008

NORTH CAROLINA STUDY COMMISSION ON AGING

MINUTES

The North Carolina Joint Study Commission on Aging
Representative Jean Farmer-Butterfield, Co-Chair
Senator Vernon Malone, Co-Chair

February 28, 2008
1:00 PM
Room 544

The Joint Study Commission on Aging met on Thursday, February 28, 2008, in Room 544 of the Legislative Office Building.

The following commission members were present: Rep. Jean Farmer-Butterfield (Co-Chair); Senator Vernon Malone, Co-Chair; Sen. Stan Bingham; Rep. Alice Bordsen; Sen. Katie Dorsett; Rep. Joe Boylan; Sen. James Forrester; Rep. Bob England; Honorable Karen Gottovi; Mr. David Lowa; Ms. Jean Reaves; Honorable Edd Nye; and Mr. Jackie Sheppard, Ex-officio member. Also in attendance were Research staff Theresa Matula, Shawn Parker and Ben Popkin, and commission clerks Ruth Merkle and Bonnie McNeil.

A visitor registration sheet and copy of the Agenda are attached as part of these minutes.

Representative Farmer-Butterfield chaired the meeting. She recognized the Sargeants-at-Arms, research staff and commission assistants. Sen. Vernon Malone was also recognized and asked if he had any comments; he had none.

The Chair introduced individual speakers from associations and organizations representing older adults (a list of the speakers and their written comments are attached for the record).

1. Ms. Ann Johnson, Chairperson - Governor's Advocacy Council on Aging
2. Ms. Gail Kirk, President - NC Guardianship Association
3. Mr. John K. Eller, Director - Cabarrus County Department of Social Services
4. Ms. Peggy Smith, Program Director - Alzheimer's Association – Eastern North Carolina Chapter
5. Ms. Jackie Rivers - Alzheimer's Association – Western North Carolina Chapter
6. Mr. Tracy Colvard - Association of Home and Hospice Care
7. Ms. Tonya Jones, Board Member - Direct Care Workers Association of North Carolina
8. Ms. Theresa Johnson, Executive Director - NC Adult Day Service Association
9. Ms. Evelyn Hawthorne, Legislative Consultant - NC Assisted Living Association
10. Ms. Joan M. Pelletier, Vice-Chair - Triangle J Area Agency on Aging
11. Dr. Bill Milner, Chair - NC Dental Society, Committee on Aging
12. Mr. Alan Winston - North Carolina Association on Aging
13. Ms. Roxanne Bragg-Cash, President - NC Coalition on Aging
14. Dr. Gordon H. DeFriese, Ph.D., Co-Director, FutureCare of North Carolina, Professor of Social Medicine and Epidemiology, Emeritus, UNC – Chapel Hill
15. Mr. Ed Regan, Executive Director - NC Retired Governmental Employees Association
16. Dr. Lacy Presnell - NC Retired School Personnel

17. Ms. Stacie Nelson, Chair - NC Senior Center Alliance, Nash County Dept. of Aging
18. Ms. Judith Brunger, Executive Director - The Carolinas Center for Hospice and End of Life Care
19. Mr. Charles Dickens - Senior Tar Hill Legislature
20. Ms. Diana Hatch, State President – AARP NC Chapter
21. Ms. Lou Wilson, Executive Director, North Carolina Association, Long Term Care Facilities

Following comments from the speakers, the Chair recognized commission Co-Chair Senator Malone. He commented that from what he heard from the speakers, they like the services that older adults are receiving and they want them continued or expanded. He asked Ms. Lou Wilson, Executive Director of the North Carolina Association of Long-Term Care Facilities (NCALTCF), about the Association's attempt to establish a web-based system for assessing ACH resident needs and developing responsive service plans, and inquired as to who was going to pay for it. Ms. Wilson replied that the Association was paying for it from fees collected from the providers.

Representative Farmer-Butterfield commented that she noticed a frequency in the number of requests for funding and services that the staff will need to assess. She was also pleased that the various local and state agencies are collaborating to address services and needs for older adults.

For the final presentation, the Chair recognized Mr. Steve Freedman, Service Operations Section Chief, Division of Aging and Adult Services, DHHS; Dr. Charles Dickens, Speaker, Senior Tar Heel Legislature; and Ms. Lisa Gwyther, Family Support Program Director, Duke Center for the Study of Aging and Human Development. They spoke to the commission regarding a program called "Project C.A.R.E." (**C**aregiver **A**lternatives to **R**unning on **E**mpty), a national best practice model for Respite Care. (written copies of their statements are attached).

Mr. Freedman commented that the program provides choices and options for families and is a model for respite care. (Attachment III-A)

Dr. Dickens said that family caregivers of patients with dementia and alzheimers disease experience health issues or death more often than comparable caregivers. He added that Project C.A.R.E. is the best program for respite services for caregivers of patients with dementia and alzheimers disease and that it is a way for caregivers to get services. It also enables patients to stay in their homes as long as possible, and saves public funding for institutionalization. (Attachment III-B)

Ms. Gwyther explained that the key feature of the program is how best to provide "time out" to caregivers. She called it a "family-centered" program that needs to be expanded to those who don't qualify for Medicaid, as well as minorities, poor people, and people living in rural areas. These are the populations Project C.A.R.E. wants to target for future expansion. (Attachment III-C).

Rep. Farmer-Butterfield opened the floor to commission members for comments or if they had any questions on Project C.A.R.E.

Jean Reaves stated that the Commission has to realize that caregivers need help.

Karen Gottovi commented that the presentation was very comprehensive. She added that the federal grants for this program have made a huge difference to families for respite care and that it would be a shame to let funding for Project C.A.R.E. expire.

David Lowa commented that he thought $500,000 is too little and that a more productive amount of funding must be considered.

There being no further comments, the Chair announced that the Commission on Aging will hold a Public Hearing on Thursday, March 6, at the Upper Coastal Plain Business Development Center in Wilson.

The meeting was adjourned at 3:00 pm.

Respectfully submitted,

Representative Jean Farmer-Butterfield
Co-Chair, Commission on Aging

Ruth Merkle
Commission Clerk

5/01/08

Agenda

North Carolina Study Commission on Aging

Thursday, February 28, 2008
1:00 p.m.
Legislative Office Building
Room 544

I. Welcome

Representative Jean Farmer-Butterfield, Cochair
Senator Vernon Malone, Cochair

II. Brief Remarks by Associations and Organizations Representing Older Adults

(Note: 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.)

III. Project C.A.R.E. (Caregiver Alternatives to Running on Empty)

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

Dr. Charles Dickens, Speaker, Senior Tar Heel Legislature,

Lisa Gwyther, Family Support Program Director, Duke Center for the Study of Aging and Human Development

IV. Public Hearing:

Thursday, March 6, 2008
10:00 – 12:00
Upper Coastal Plain Business Development Center, 3rd Floor
121 West Nash Street, Wilson, NC

Next Meeting:

Thursday, March 20, 2008
10:00 – 12:00
Room 544, Legislative Office Building

Website for Study Commission on Aging:
http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38

ATTENDANCE

North Carolina Study Commission on Aging

(Name of Committee)

DATES	January 22	February 28	March 6	March 20	April 10	May 12									
Sen. Vernon Malone, Co-Chair		✓													
Rep. Jean Farmer-Butterfield, Co-Chair		✓													
Sen. Stan Bingham		✓													
Rep. Alice Bordsen		✓													
Sen. Katie Dorsett		✓													
Rep. Joe Boylan		✓													
Sen. James Forrester		✓													
Rep. Bob England		✓													
Sen. A.B. Swindell, IV															
Rep. Garland Pierce		ex. ab													
Mr. Anthony Peace		ex ab.													
Honorable Karen Gottovi		✓													
Ms. Judy Pelt															
Mr. David Lowa		✓													
Ms. Jean Reaves		✓													
Honorable Edd Nye		✓													
Mr. Jackie Sheppard, Ex-Officio		✓													
Theresa Matula, Research Staff		✓													
Shawn Parker, Research Staff		✓													
Ben Popkin, Counsel		✓													
Bonnie McNeil, Commission Clerk		✓													
Ruth Merkle, Commission Clerk		✓													

VISITOR REGISTRATION SHEET

Study Comm on Aging — 2/28/08

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jack Cogdell	Womble
Teresa Johnson	NC Adult Day Services Assn, FORLTC
Andre Cason	FORLTC
Jeff Horton	DHHS DHSR
Marie McBride	STHL
Mary Horne Odom	Guest former STHL
Joyce Massey Smith	NC DHHS/DAAS
Susan McCracken	NCACDSS
John Carroll	NCACDSS
Larry Nason	NC DMA
LaVerne Blue	NC DHHS/DAAS

VISITOR REGISTRATION SHEET

Study Comm on Aging — 2.28.08

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Roxanne Bozz-Cash	Coalition on Aging/Franklin Co Dept of agency
Jan Withers	DSDHH
Jim Marden	Johnston COA
Tony Presnell	North Carolina Retired School Personnel
Ed Regan	N.C. R.G.E.A.
Jan Smith	DHHS
Evelyn Faulkner	NCALA
Joyce Peters	IPASS
Roger Bone	Bone + Assoc
Jim Wilson	NCAHTCF
Craig Souza	NCHCAO

Presenters for the February 28, 2008 Commission on Aging Meeting

Ms. Gail Kirk, President
NC Guardianship Association

Mr. John K. Eller, Director
Cabarrus County Department of Social Services

Ms. Peggy Smith, Program Director
Alzheimer's Association – Eastern North Carolina Chapter

Ms. Jackie Rivers
Alzheimer's Association – Western North Carolina Chapter

Mr. Tracy Colvard
Association of Home and Hospice Care

Ms. Tonya Jones, Board Member
Direct Care Workers Association of North Carolina

Ms. Theresa Johnson, Executive Director
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Ms. Evelyn Hawthorne, Legislative Consultant
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Ms. Joan M. Pelletier, Vice-Chair
Triangle J Area Agency on Aging

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UNC – Chapel Hill

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Dr. Lacy Presnell
NC Retired School Personnel

Ms. Stacie Nelson, Chair
NC Senior Center Alliance
Nash County Dept. of Aging

Ms. Judith Brunger, Executive Director
The Carolinas Center for Hospice and End of Life Care

Mr. Charles Dickens
Senior Tar Hill Legislature

Ms. Diana Hatch, State President – AARP NC Chapter

<u>Cancelled but will send in their comments:</u>

Ms. Gillian Hampton, Director
Generations Adult Day Health Care Center,
Ashe County

Mr. Anthony Cherry
NC Family Care Facilities Association

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Generations Adult Day Health Care Center,
Ashe County

Mr. Anthony Cherry
NC Family Care Facilities Association

#1

Study Commission on Aging
Report by the Governor's Advisory Council on Aging
Ann B. Johnson, Chairperson
February 28, 2008

The increase in the length of the lifespan is a tribute to the success of medical technology- but there are too many older adults who face: the awful silence of a telephone that rarely rings; ... severely arthritic hands; . . . reading about community events knowing you won't ask for a ride; . . .or listening to the experts offer "sex after sixty," as one of the desirable activities and patting the empty pillow beside them.

We must recognize the interdependence of generations over the lifespan. We must build creative supports for what exists . . . grandmothers taking care of grandchildren. You already know about the growing number of those in their 60's or even older, who are caretakers for that group over age 80! And many a widow or widower is rationing medications and limiting expenditures in order to hold on to a house to die in and leave as an inheritance.

The list could go on . . .

It is not enough to back up the bus to the senior center and transport a group of adults to the elementary school for an hour or two of contact between the ages. We must build on public policy set in the Older American's Act of 1965. We must regard institutional care as the less desirable alternative to home and community care. We must bolster support for caregivers and the array of services that will, in fact, make choice possible. We must make the policy of "aging in place" a reality by encouraging new approaches to living arrangements.

The senior center as a social institution needs recognition for what it can be . . . making not only activities- but services- acceptable, affordable and accessible. Where else in the human services system do we find the user-friendly potential of the senior center? It is here that the older adult may be involved as decision maker, paid or volunteer staff, participant in activities and recipient of services when appropriate. The senior center concept has moved from a closed membership system to a geographic service area.

We should be very proud of the existing efforts which clearly promise quality in the system of future service delivery. In place are: a certification that designates centers of merit or excellence; an institute of six modules certifying center managers; and the Senior Center Alliance, a membership group of practitioners. We should celebrate!

A review of the last twenty years shows efforts to conquer the fragmented service system. I urge you to revise the 2008 budget to increase the amount for senior centers by $1 million, in order to achieve their potential, meet the need that exists and grow larger as the number of older adults increases.

The Governor's Advisory Council on Aging was surveyed this month for their legislative agenda items. Six items showed clear support. The survey results are attached to a copy of this presentation along with an introduction about the Governor's Advisory Council on Aging.

Governor's Advisory Council on Aging
Recommendations for 2008

1. Appropriate at least $10 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 (over 11,000 older adults are on waiting lists).

2. Appropriate $1 million for FY2008-2009 to the Division of Aging and Adult Services for allocation to the Senior Center General Purpose Fund.

3. Provide $500,000 in recurring funds to sustain and expand Project C.A.R.E. or Caregiver Alternatives to Running on Empty. The program currently serves 14 counties and the ultimate goal of the program is to serve all 100 counties.

4. Appropriate $1.35 million to be allocated to the Office of Rural Health and Community Care to recruit dentists for underserved areas in North Carolina including dentists that would focus on providing care in long-term care facilities. The Division of Public Health and the Office of Rural Health and Community Care would use the model of existing mobile dental clinics to provide access to care for residents residing in long-term care facilities, as well as seniors and the disabled living at home.

5. 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.

6. Appropriate $2 million for use by the North Carolina Division of Public Health to assist with the provision of 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.

The Governor's Advisory Council on Aging

The Governor's Advisory Council on Aging (GAC) consists of 33 members including 29 members appointed by the Governor, two members appointed by the President Pro Tempore of the Senate and two members appointed by the Speaker of the House of Representatives. The GAC is staffed by the Division of Aging and Adults Services.

The GAC has the following duties:

1. Make recommendations to the Governor and the Secretary of Health and Human Services aimed at improving human services to the elderly.
2. Study ways and means of promoting public understanding of the problems of the aging and consider the need for new State programs in the field of aging.
3. Advise DHHS in the preparation of a plan describing the quality, extent and scope of services being provided, or to be provided, to elderly persons in North Carolina.
4. Study the programs of all State agencies which provide services for elderly persons and advise the Governor and the Secretary of Health and Human Services on the coordination of program to prevent duplication and overlapping of such services.
5. Advise the Governor and the Secretary of Health and Human Services upon any matter which the Governor and the Secretary may refer to it.

#2

2/28/08

I. Look at collaboration with various agencies such as NCDAAS, DSS, Administrator of Court etc. to stream line guardianship efforts and funding with which to promote training and PR. It is advisable for the Commission to look for this type of collaboration in order for all concerned to work collective and raise awareness re guardianship and it alternatives. Key point being reducing duplication.

II. "Baby Boomers" are now entering the aging population in greater numbers than ever before creating an even greater need for people who are trained and knowledgeable to be qualified guardians. This automatically means there will be a great need for guardianship services to be available from county services. Collaboration of training, PR, knowledge etc. will ensure that the infrastructure and money is in place to provide those needed guardians. Another aspect of training is to protect the rights of the elderly.

III. Another often overlooked aspect of the aging population is those individuals who have mental retardation and other developmental disabilities. This population is aging just like everyone else and they will have very specific challenges. As a state we should start planning for and addressing this segment of our population, as well as the critical need for guardianship services.

IV. Another issue is one of having access to evaluations that are appropriate to determine whether an individual will be benefited by being found to be incompetent and having a guardian appointed. I.e. even though the legal definition of incompetency has been met are the cognitive deficits so severe as to make the person functionally at risk? One would ask whether or not a test of one's functional capacity or incapacity should be mandated before a person is found incompetent. Sometimes relatives and other well meaning individuals appear to expect the elderly to maintain a standard of behavior that is above that of the ordinary person.

By Gale A. Kirk, Board Member and Past President
North Carolina Guardianship Association

#3

John Eller
Cabarrus County
DSS

2/28/08

NC Social Services Consortium

NC Assoc. of County Directors of Social Services
NC Assoc. of County Boards of Social Services
NC Social Services Association

Build on North Carolina's History of protection for elder citizens

Our state was a pioneer in enacting the first Elder Abuse Law in 1973, but the statute has not been updated in more than 30 years. We need to revise our elder abuse statute and launch a pilot Adult Protective Services (APS) program that will help protect our elder citizens and put our state in the forefront of national efforts to prevent the abuse, neglect and exploitation of older adults. In 2005, The NC Division of Aging and Adult Services (NCDAAS) was directed by the General Assembly (Session Law 2005-23), to identify ways to improve adult protective services, and we presented recommendations to the 2007 Aging Study Commission to broaden and strengthen North Carolina's APS program. NCDAAS outlined the basic components of a proposed system of protection for vulnerable adults, "Adult Protective Services Clearinghouse Model"—with proposed changes in services, staffing, training and rules. The Study Commission's recommendation led to bills in the House (H198) and Senate (S108) for a pilot project in 9 counties to be supported by $1,492,000 in FY 2007-08 and $1,930,000 in FY 2008-09. Support for this project did not make it into the Budget Bill. *(This item relates to Objective#24 of the 2007-2011 State Aging Services Plan).*

(01) **The APS Clearinghouse pilot** would enable county departments of social services to provide three levels of "protective services" to vulnerable and elder adults who've been abused, neglected or exploited – or who are at risk:

(a) *Information & Referral* for those who consent to be served and do not need outreach services or intervention services,

(b) *Outreach* would include the planning and arrangements for services for a client who consents to receive those services, or

(c) *Intervention* for clients who have no responsible caregiver to arrange or provide needed services. Intervention services could be provided with the client's consent or involuntarily – if the client lacks the ability to comply with a court order and lacks a caregiver who is willing and able to arrange services.

(02) **Statutory Change:** To make the pilot program effective, we must also 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* to support a broader system of protection for vulnerable and older adults who have been abused, neglected or exploited – or who are at risk.

(a) Current state law limits Adult Protective Services (APS) to *disabled persons* aged 18 and older. The focus of protective services should be changed from disabled adults to vulnerable and elder adults, and the definition of "vulnerable adult" should be based on the adult's functional strengths and limitations.

(b) Like Florida, Virginia, Louisiana and other states, North Carolina should use age 60 or older as a benchmark for defining elders eligible for APS.

(c) The definition of "abuse" should be broadened by deleting the intentionality requirement and replacing the term "caretaker" with "caregiver." These changes would put our state in line with the current thinking about best practice for vulnerable elder adults.

(d) The definition of "essential services" should include those steps necessary to safeguard vulnerable adults' rights and resources.

(e) The term "substantial risk" should be added to support the provision of services to elder adults at risk of abuse, neglect or exploitation.

(f) "Protective Services" should be redefined to permit the array of service options described above as the Adult Protective Services Clearinghouse pilot.

Estimated Cost: $1.9 million for a one-year, nine county pilot program

NC Social Services Consortium

NC Assoc. of County Directors of Social Services
NC Assoc. of County Boards of Social Services
NC Social Services Association

Protect our state's most vulnerable elder citizens

The Problem: Elder citizens who are unable to care for themselves or handle their own affairs are often judged incompetent, and if they lack private resources, they become wards of the state. Today, more than 70 % of these North Carolinians – almost 3,000 elder citizens – are under the guardianship of their county department of social services (local DSS). That number will certainly grow. By 2030 the number of persons in our state aged 60 or older will double. By then, 75 counties will have more residents over age 60 than age 17 or younger.*

During the 2007 Session of the NC General Assembly, House Bill 795 was introduced to appropriate funds for guardianship services ($5,121,783). This had been a recommendation of the House Study Committee on State Guardianship Laws, endorsed by the 2007 Aging Study Commission. Related funding did not get included in the Budget Bill. There is no specific funding for public agent guardianships to support the mandate for local human services agencies to provide guardianship services.**

Local social service departments often use Social Services Block Grant (SSBG) funds to provide guardianship services, but that pool of money is already heavily stressed, and as the years go by, less is available for adult services.** The system is under-funded. Additional needy clients are coming. The system and those it serves face a crisis. Without more public services, this population will be at a significantly greater risk of abuse, neglect or exploitation.

The Best Response: Guardianship services can be both extensive and expensive, and given the vulnerability of the typical client, they must be performed with great care. Under the oversight of the local Clerk of Court, a multi-disciplinary evaluation (MDE) team should evaluate the needs of the client and recommend arrangements for care, which then must be approved by the Clerk of Court. Guardianships should be established only as a last resort, and public agencies – most often the county department of social services – should assume guardianship responsibilities only when there is no other appropriate individual or corporation available to serve.

Most local departments of social services restrict their involvement to serving as a "guardian of the person" – one who assumes responsibility for the ward's care, comfort and maintenance and for the ward's personal property. Generally, an attorney will be appointed as a "guardian of the estate" – assuming responsibility for managing the ward's estate, which might include receiving assets due to the ward, performing contracts entered into by the ward, buying or selling property and paying the ward's debts. A "general guardian" might do all of these things, and *in cases where the ward has no property or assets, that role usually falls to the local DSS.* The guardian of the estate or general guardian is responsible for filing annual accountings with the Clerk of Court.

The large volume of work needed to care for these wards is blatantly obvious. Anyone who has assumed responsibility for an aging parent who is ill or frail can appreciate the burden involved. With caseloads growing, no specific funding allocated for guardianships, and *ad hoc* funding sources shrinking, we are headed for a crisis that can only be addressed through increased funding for these services.

Estimated Cost: $5.1 million

*Division of Aging & Adult Services, NC DHHS, 2008 report
** House Study Committee on State Guardianship Laws, 2007 report

#24 / Peggy Smith

Ruth Merkle (Rep. Farmer-Butterfield)

From: Alice Watkins [awatkins@alznc.org]
Sent: Tuesday, February 26, 2008 2:08 PM
To: Rep. Jean Farmer-Butterfield
Subject: Presentation for the Aging Commission
Follow Up Flag: Follow up
Flag Status: Completed

PRESENTATION FOR NORTH CAROLINA AGING STUDY COMMISSION

Co-Chairs – Senator Vernon Malone
Representative Jean Farmer-Butterfield

I am Alice Watkins, Executive Director of the Eastern North Carolina Chapter of the Alzheimer's Association. Our Chapter has the responsibility of covering 51 counties of North Carolina—from the Triangle to the Coast—educating, advocating and providing resources and assistance to families suffering from the effects Alzheimer's disease and related dementias. Legislature allocates $75,000 each year to our Chapter to assist with these services. We are grateful for this support but $75,000 divided by 51, is less than $1,500 per county—about 1/3 the cost of care for 1 individual for 1 month in a long term care facility. Education conferences and workshops in local communities, support groups, 800 Helpline, free resources and counseling are all provided by special events and corporate and individual donors to the Chapter at no cost to the State and taxpayers of North Carolina.

National statistics tell us that more than 70% of dementia patients are taken care of in the home, yet there is so little assistance to families who are dealing with dementia. They also tell us that dementia patients cost 3 times more than regular Medicare and Medicaid assisted patients; that lost production, illness of caregivers, insurance and in-home care are costing the United States more than 200 billion dollars each year—two times the 100 billion cost estimated to restore New Orleans and cities destroyed by Hurricane Katrina. The funds needed for Katrina repair are over years, the cost of Alzheimer's disease and related dementias is annually.

Ladies and Gentlemen, we have to plan better, work smarter and budget for programs that are really going to make a difference—respite care can make that difference. We can prevent the destruction of families who are suffering the burdens of caregiving; we can offer a quality of life to those individuals suffering from dementia—many who have made North Carolina what it is today—and we can provide for the future with the funds saved from depression, chronic illnesses and loss of production by caregivers—respite care can do this. Project Care has been in place in the western part of the state for a number of years but access to this program has not been available. We have operated an "Emergency Respite" program. To insure the caller is in an emergency situation, we make contact with local county and state agencies. Whatever the choice of assistance by the State of North Carolina, Respite is the answer for families who are being destroyed financially, mentally, emotionally and physically. I beg you to address this need immediately. If more information is needed, my office is less than 5 minutes from the Legislative Building. I will be happy to meet to discuss these issues.

Alice W. Watkins
Executive Director
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***We can make a difference but we need your help as we respond to citizens in 51 of North**

Carolina's 100 counties—from the Research Triangle area to the coast. Consider the Eastern North Carolina Chapter when making annual contributions, establishing a planned giving program or asset distribution. Through programs and services, we will offer a quality of life to individuals with dementia and their families; through research, we will one day live in a world without Alzheimer's disease .

#5

Alzheimer's Association - Western Carolina Chapter

Jackie Rivers, Executive Director
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www.alz.org/northcarolina

I am Jackie Rivers and I have the privilege of serving as the Executive Director of the Alzheimer's Association - Western Carolina Chapter. I appreciate the opportunity to be here today to emphasize the critical importance of state funding to continue and to expand the Project C.A.R.E. respite program. I am also here to recommend the enactment of a state mandate to establish a comprehensive plan for dealing with the projected epidemic of Alzheimer's disease in North Carolina..

You've already heard (or will hear) much about Project C.A.R.E. today from partners and supporters – urging legislation for $500,000 in recurring funds from the North Carolina General Assembly. Passage of a bill supporting Project C.A.R.E. is imperative for this program to continue to provide respite dollars to caregivers. The Alzheimer's Association is one of the primary providers of Project C.A.R.E. through three of the four Western Carolina Chapter offices, and we are able to connect families and individuals with free Chapter programs and services. The issues these families are facing continue to change - the disease is being diagnosed in younger and younger individuals. Just last week, we received a call from a mother whose son had just been diagnosed; her son was only 29 years old. The Association is able to help families in very unique ways. We received a call on our 24 hour Helpline recently from a woman who had dementia and she was lost - the only phone number that she could remember was ours – we were able to keep her on the line while contacting her son so that he could get to where she was. Caring for someone with Alzheimer's or dementia is not a 9-5 job – it is a round-the clock job - caregivers face many challenges – giving them a chance to take a break from their care giving role makes a tremendous difference.

Another issue the Alzheimer's Association Chapters is advocating is a State Alzheimer's plan. North Carolina can be commended for work toward preparing plans for a variety of potential diseases and disasters. At the same time it is striking that our state doe not have a plan to deal with the anticipated tripling of persons diagnosed with Alzheimer's disease and related dementia. Alzheimer's disease is a challenging problem – where earlier diagnosis of the disease leads to an entirely new set of public policy issues. A State Alzheimer's Plan will help North Carolina create the infrastructure and accountability necessary to build dementia-capable programs and services for the growing number of people with the disease. A state plan will also help North Carolina confront the challenges of Alzheimer's by updating

existing plans, and tackling a wide range of Alzheimer issues as it brings stakeholders to the table where discussion leads toward constructive solutions.

Again, thank you for the opportunity to speak on behalf of the increasing numbers of North Carolina residents who look to Alzheimer's Association for support and solutions

Association for & Hospice Care of North Carolina

#6

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Study Commission on Aging

2/28/09

Presentation by **Tracy Colvard** from the Association for Home and Hospice Care

- We want to thank the Study Commission for their partnership and cooperation with home care and hospice over many years and how they have pioneered and championed many of our mutual legislative goals. In the short time that we have this afternoon, I want to provide an update on a very important program in North Carolina.

- Home Care and Hospice presented before the Study Commission on Aging 3 years ago about the plan to restructure NC's in-home personal care services program which is better known as PCS - a long standing Medicaid program that serves aged and disabled consumers with licensed home care agency in-home aide services under the supervision of registered nurses. Home Care and Hospice partnered with DHHS and various stakeholders to restructure PCS which took almost 2 years to do. Fortunately for a lot of elderly, disabled adults, and even children in NC, the restructuring efforts have been very successful. The growth in PCS was a concern 3 years ago. **Today, PCS is projected to come in slightly under budget this fiscal year - despite the growth in our aging population.** Thoughtful and well planned restructuring has brought the PCS budget under control by putting in place clear admission criteria and task/time guidance and ensured that appropriate patients are served with appropriate services. We are very proud that our association and our members helped achieve this goal for North Carolina and its citizens.
- Restructuring was a multi-prong approach - for example: our home care licensure rules now have strict requirements regarding agency director qualifications and aide qualifications. The PCS policy requires certification of the registered nurses performing the patient assessment. Two time points of physician prior approval of the services are still required and the new NC Medicaid Uniform Screening Tool (MUST) will also be required. The admission criteria and assessment tool were completely re-worked to mirror proven national models. The program has strengthened provider accountability through a contract for utilization review and ongoing audits to assure compliance with policies and procedures. Our Association and its partners, such as DHHS, will continue our joint efforts to ensure that this program is a sustained, viable option for our citizens.

- The Association for Home and Hospice Care looks forward to continuing to work closely with the Study Commission on Aging to make sure we continue to provide high quality services to our most vulnerable folks.

#7

Good Afternoon!

I am Tonya Jones, a board member of the Direct Care Workers Association. It is an honor to be able to come and speak to you this afternoon.

I have been with the Direct Care Workers Association for 3 years now. I have been a direct care worker for 18 years. I started working in a retirement home when I was in high school and I am presently still working as a direct care worker. I have worked up the career ladder and was able to receive my Certified Nursing Assistant Certificate, be trained and listed as a Medication Aide, and also have an Activities Director Certificate.

I am not here to tell you about me but I am here to tell you about the Direct Care Workers Association. The association was started in 2003. We are a non-profit, education-based organization for direct care workers and others who support our mission to improve the quality of care provided to health and long term care consumers and their families through education, professional development and public awareness about direct care workers. We also help promote personal growth for direct care workers and provide opportunities for peer networking to discuss best practices and problem solving solutions to work related issues. We are also working to become a credible statewide information source for the general public and others about direct care issues and initiatives. The packet you have will give you more details about who we are and what we do.

The Association also gives direct care workers a way to have a voice in important meetings about long term care. One example of this voice was our participation on the Partner Team for the creation of NC NOVA. By all the Partners working together we have developed a voluntary program that can help reduce turnover and create better workplaces for direct care workers -- because there is a link between job quality and quality care.

To help support NC NOVA, the Direct Care Workers Association periodically sponsors some Coaching Supervision and Peer Mentoring training sessions. These are just two small pieces of NOVA. I have personally seen the changes in the company that I work for since these two programs have been put in place where I work. We have seen dramatic changes in the staff turnover rate in the past year. We have a peer mentoring program started that has really helped us to give the quality of care to all of our residents. Families of our residents have seen the differences. I strongly believe that this training and the other parts of NC NOVA are some of the key answers that we all have been looking for.

I have always seen other associations for other professionals such as my administrator who had opportunities to attend training conferences and I used to go to the North Carolina Activities Professional Association. It is so good to see that the people who actually do the hands-on work providing care for the elderly, children and developmentally disabled now have an association that they can belong to and attend training,

share ideas about how to do our jobs better and support each other. I have seen such a difference since our staff have become members. They have the feeling of belonging to an association that means something to them and it makes our staff feel like they are special and have some where to go to get more training that they may need.

Other states, like our state, face high turnover rates for direct care workers. We are essential to quality care and the number of people who need care is only increasing.

I hope you will take a moment to look through the packet and learn more about our Association. If you take away anything that I have said today, I hope that you remember how important and valuable direct care workers are to the health and long term care field and much we are needed as "professionals."

#9

3/28/08

North Carolina Adult Day Services Association (NCADSA)
Presentation to Study Commission on Aging

By Teresa D. Johnson, Executive Director
February 28, 2008

Good Morning, Representative Farmer-Butterfield, Senator Malone and members of the Commission. My name is Teresa Johnson, and I am Executive Director of the NC Adult Day Services Association. I am speaking to you today on behalf of about 3,500 aged and disabled adults who attend the 101 adult day centers daily across North Carolina among 56 counties.

We appreciate your past support of home and community-based services, particularly adult day programs. Because of your support, family caregivers can continue working outside the home, receive help with the physical care of a loved one, avoid the guilt of placing a loved one in institutional care and have respite from what can be a "24/7" responsibility.

The adult day program environment recognizes and attends to emotional and intellectual needs, as well as physical. Programs serve adults who may need supervision, social interaction, and assistance with more than one activity of daily living (e.g. eating, walking, toileting, bathing, dressing). Services offered in the centers include health monitoring, medication supervision, personal care and recreational/therapeutic activities. Nutritious lunches and snacks are served and special diets are provided. Adult day centers are open an average of 10 hours per day, although the state only requires that they operate 6 hours per day.

You've heard the projections about the growing number of people who are aged and disabled and need supervised care and want to continue living in their communities to receive services. The average length of stay in an adult program is two years. Where else can you purchase quality health care for less than $6 per hour, and for 10-12 hours per day? Even when considering the economics of the value alone, you can see that expanding the support of adult day services is a wise investment of our tax dollars.

Our Association has considered a number of issues for a legislative agenda that can impact adult day services and the people who use them. The legislative brochure you just received includes the issues we will focus most of our efforts on this year. Most of the items are bills that the Study Commission introduced last session but need additional support in this short session to move them forward, so I will give mere mention to them.

- **Appropriate an additional $7 Million for Home and Community Care Block Grant Funding.** The NC General Assembly appropriated only an additional $500,000 in the last legislative session despite the fact that a waiting list continues to exist and the number of North Carolinians over the age of 60 continues to grow. An additional appropriation is needed to reduce the waiting lists, get people basic supports that they need and provide these supports in the way they want—at home, in the community. HCCBG funds are available to each county and can fund 17 different programs including Adult Day Care and Adult Day Health.

- **Appropriate Funds to Reimburse Adult Day Services An Additional $5 Per Day.** Adult day programs benefited from a $5 rate increase for State Adult Day Care Fund and Home and Community Care Block Grant in 2004 and again in 2005 after a seven-year drought without increases. Medicaid CAP increased the reimbursement for adult day health effective January 2007, the first time since 1999. Despite those rate increases, costs still exceed the public reimbursements. The increase in the minimum wage, besides typical costs of doing business, has added to the increased costs. There is no system for annual increases in any of these public reimbursements for adult day programs, unlike other services. It is time for adult day services to be recognized as the partner in health care that it has become.

- **Strengthen the quality and consistency of the Adult Protective Services delivery system in North Carolina.** The current Adult Protective Services statutes are outdated and often vague. HB 198 and SB 108 were introduced and referred to Appropriations Committees in the 2007 legislative session.

- **Support Project C.A.R.E.** Project C.A.R.E. (Caregiver Alternatives to Running on Empty) is an extremely important and cost effective initiative that provides support to individuals with dementia and their caregivers. This Alzheimer's demonstration has been funded by AoA under the Older Americans Act but the federal grant funds are due to end this June. We are hoping that the General Assembly will support sustaining the current project in 14 counties and that we can then secure additional federal funds (and possibly foundation funds) to begin expanding this program to other counties, especially in the eastern part of the state.

- **Support Study of Safe Transportation of Passengers in Wheelchairs.** In the 2007 legislative session, the Study Commission on Aging recommended 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 tie-down systems. HB 93 received a favorable report in House Aging, passed 2nd and 3rd reading in the House and crossed over to the Senate where it was referred to the Senate Committee on Transportation.

Other legislation NCADSA will follow:

- Limits for categorically and medically needy Medicaid eligibility for aged, blind and disabled persons from $2,000 to $6,000 for individuals and from $3,000 to $9,000 for couples.
- Mobile dental care
- Guardianship.

You have an additional handout which includes a chart comparing the growth among North Carolina's adult day programs since 1993. Thank you for the opportunity to speak on behalf of the people attending adult day programs who may have developmental disabilities, stroke survivors, Alzheimer's or other dementias, or other inconveniences of aging. When you support legislation for those citizens who are most vulnerable, you are making a commitment to improving our state's system of care for adults who need supervision. Together, we are working to build better lives for adults in adult day programs every day. We are positively impacting the lives of participants, families, communities, our state and nation.

North Carolina
Adult Day Services Association

Teresa Johnson
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ATTACHMENT to Presentation by NC Adult Day Services Association (NCADSA)

Comparison of Growth Among NC Adult Day Centers							
	1993	1997	1999	2001	2004	2007	% Change 1997-2007
Sample Size	*N=39*	*N=39*	*N=53*	*N=64*	*N=85*	*N=33*	
# of Certified Centers	72	81	98	114	107	104	+28%
Certified Capacity (mean)	26.9	30	26.64	30.09	29	39.3	+31%
Certified Capacity (median)	Unknown	30	24	24	24	36	+20%
Enrollment (mean)	25.3	28	23.28	26.92	29	39.85	+42%
Enrollment (median)	Unknown	27	23	21	26	36	+33%
Daily Attendance (mean)	15.3	17	14.77	20	19	26.22	+54%
Daily Attendance (median)	Unknown	17	15	15	17	21.24	+25%
Occupancy/Utilization (mean)	60.1%	61%	57%	67%	64%	69.7%	+14%
Occupancy/Utilization (median)	61.8%	66%	59%	67%	64%	71%	+8%

SOURCE: 2007 Salary and Benefits Survey, NCADSA

It is encouraging that adult day programs have grown in enrollment and use, not just capacity, but the additional slots make the occupancy/utilization figures appear stagnant.

The outcome of a Special Provision that was included in the State budget bill, approved in July of 2004 (Section 10.21(a) S.L. 2004-124) has strengthened adult day programs. The legislation resulted in extensive studies of reimbursements; technical assistance, training and resources for providers to support and sustain the industry; and recommendations for changes to systems and reimbursement methodology. Other states such as Wisconsin, Illinois and Nebraska--just to name a few-- have recognized the forethought of North Carolina's forward thinking legislators and are considering replicating the North Carolina project. No other State has funded such an endeavor. Investing in a follow-up study to measure the impact of the project would strengthen North Carolina's progress in leading the way for stronger and more responsive home and community-based services so that these funds were not just a one-shot deal.

We Further Urge Support For The Following:

➢ Appropriate Funds to Reimburse Adult Day Services An Additional $5 Per Day.

Adult day programs lose about $13 per day by serving publicly funded clients in adult day care and adult day health. The average daily cost (open avg 10 hours) is $53 compared to $40 public reimbursement. [1]Rates reported in the 2005 Adult Day Services Study Final Report requested by Special Provision Section 10.21(a) S.L. 2004-124.

➢ Strengthen the quality and consistency of the Adult Protective Services delivery system in North Carolina.

The current Adult Protective Services statutes are outdated and often vague. HB 198 and SB 108 were introduced and referred to Appropriations Committees in the 2007 legislative session.

➢ Support Project C.A.R.E.

Project C.A.R.E. (Caregiver Alternatives to Running on Empty) is an extremely important and cost effective initiative that provides support to individuals with dementia and their caregivers. This Alzheimer's demonstration has been funded by AoA under the Older Americans Act but the federal gran[redacted]ue to end this June. We are hoping that the General Assembly will support sust[redacted]urrent project in 14 counties and that we can then secure additional federal funds (and possibly foundation funds) to begin expanding this program to other counties, especially in the eastern part of the state.

➢ Support Study of Safe Transportation of Passengers in Wheelchairs

In the 2007 legislative session, the Study Commission on Aging recommended 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 tie-down systems. HB 93 received a favorable report in House Aging, passed 2nd and 3rd reading in the House and crossed over to the Senate where it was referred to the Senate Committee on Transportation.

What Are Adult Day Services Programs?

"Adult Day Services" are daytime programs designed to meet the needs of adults who require supervised care during the day, while returning to their homes or the homes of their loved ones in the evenings.

Regular use of the health and social services offered in these programs helps reduce the risk of hospitalization and provides access to health and social services in a supportive environment. Many family caregivers can continue working when they take advantage of adult day programs for their loved ones. Adult Day Health should be approved as a Medicaid-funded service by the NC General Assembly to help re-balance and address the institutional bias. Approval would also keep the soaring number of aging adults who need supervision in their homes and communities, out of more costly long term care facilities for as long as possible.

An estimated 3,500 adults attend adult day programs daily in North Carolina.[1]

[1] 2007 NC Adult Day Services Association

Support is requested for the sustainability of the home and community-based services, with your consideration for the following:

Appropriate an additional $7 Million for Home and Community Care Block Grant Funding.

Home and Community Care Block Grant (HCCBG) funding is specifically for those individuals over the age of 60 who have a need for community-based services that are not otherwise paid for by Medicaid. A waiting list continues to exist and the number of North Carolinians over the age of 60 continues to grow. An additional appropriation is needed to reduce the waiting lists, get people basic supports that they need and provide these supports in the way they want—at home, in the community. HCCBG funds are available to each county and can fund 17 different programs including Adult Day Care and Adult Day Health.

NC Adu Services Association
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2008

LEGISLATIVE PRIORITIES

2008



Promoting availability, accessibility, quality and cost-effective adult day services in North Carolina.

North Carolina Adult Day Services Association

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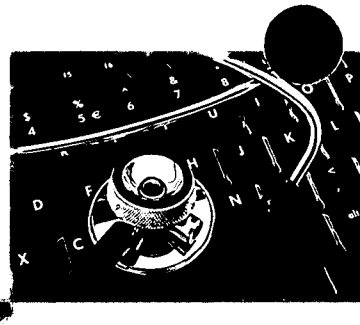
Lasting Lifestyles

Nurturing Innovative Solutions For Chronic Care and Disability Services



CHRONIC CARE... LOOMING CHALLENGES







More people are living longer but with chronic conditions or disabilities. And with the aging of the Baby Boomers, the number of persons with chronic conditions is expected to soar.

Already, the cost of medical care for persons with chronic conditions in the U.S. is astronomical – in excess of a trillion dollars a year. Both Medicare and Medicaid spending for medical and long term care is staggeringly high and a huge burden on federal and state budgets.

Current models for care are unequal to the challenges of rising demand and soaring costs of health care.

New ways must be found to promote self-care that can prevent or delay the onset of chronic conditions and lessen the consequences following on-set.

- ***The medical care costs of people with chronic diseas accounts for 75% of the nation's $1.4 trillion medical care costs.***
- ***Seven out of 10 deaths are the result of * chronic diseases.****

Centers for Disease Control and Prevention, 2007.

Lasting Lifestyles℠ is a new model for meeting the challenges of consumers, informal care-givers, professionals and payers dealing with chronic conditions and disabilities.

Lasting Lifestyles℠



Purpose

Lasting Lifestyles[SM] has three goals:

- Enhance the self-care capacities of persons with chronic diseases or disabilities;
- Help informal caregivers shoulder their caregiving responsibilities; and
- Help organizations and professionals providing services and supports to person with chronic conditions or disabilities to become more effective.

Model

Lasting Lifestyles[SM] is a comprehensive Web portal that creates an on-line virtual community that unites consumers, informal caregivers, and local professionals. **Lasting Lifestyles**[SM] is community oriented and has a local identity that is trusted, safe and secure.

Through this Web-based virtual community, users share information and work together on-line to better manage chronic diseases and enhance daily living. Professionals are able to more easily reach and assist their clientele using a variety of communication, monitoring, and teaching tools.

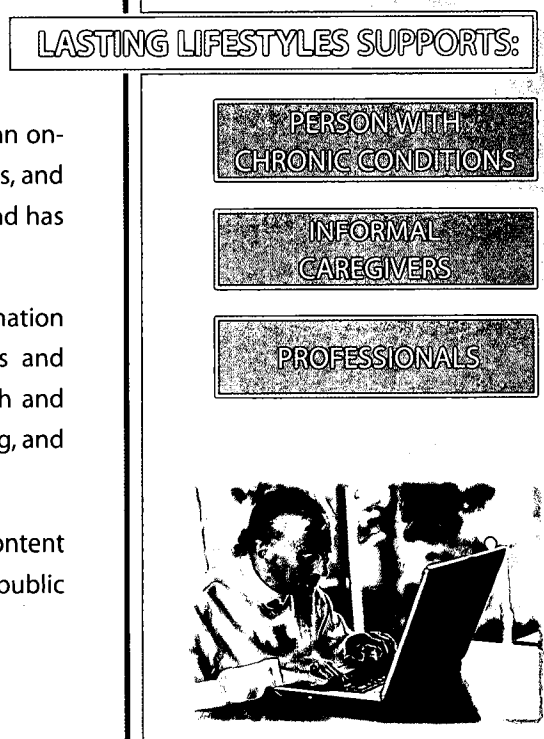
Lasting Lifestyles[SM] is not just a Web site. We create educational content that can be accessed through our Web site and through local public access television as well.

Sponsorship

Lasting Lifestyles[SM] is designed for sponsorship by organizations interested in finding new and innovative ways to reach and support persons with chronic conditions or disabilities.

As a service, **Lasting Lifestyles**[SM] is ideally suited for collaboration and joint sponsorship by multiple community or national organizations. Multiple agencies can share **Lasting Lifestyles**[SM] and use it to assist those they already serve. Other organizations can contribute educational content or expertise. **Lasting Lifestyles**[SM] can also be configured to support local or national advertising. And corporations can offer it as a benefit to their employees, especially working caregivers.

VieBridge, Inc. staff help sponsors set up the service and host the Web site and help coordinate the acquisition and placement of content on the Web site.



Lasting Lifestyles is designed to be sponsored by:

- Community health and social service agencies;
- Local governments;
- State agencies with programs that serve persons with chronic illnesses or long term care needs;
- Associations and support groups focused on specific chronic conditions;
- Employers; and
- Corporations with products or services targeting persons with chronic conditions or disabilities.

SUPPORTING CONSUMERS...





J.D. says...

"I enjoy reading up on issues regarding health and wellness. I email my family and friends on a regular basis using the Lasting Lifestyles™ program. It's a great way to stay in touch."



Lasting Lifestyles℠

Many individuals with chronic conditions or disabilities struggle to stay independent and comply with a plan of care. They are forced to navigate a confusing, service delivery system and too often are ill-equipped to self-manage their own care.

Lasting Lifestyles[SM] offers a new way for communities to meet the complex and often changing needs of persons with chronic conditions or disabilities. Lasting Lifestyles helps consumers by:

Promoting Consumer Empowerment & Self Management.

We provide consumers a broad range of information and tools vital to self-management. Among the many tools built into **Lasting Lifestyles**[SM], we feature:

- Self-assessment and risk screening tools;
- Test results tracking;
- Vital signs monitoring and analysis;
- Daily task reminders;
- Medications inventory and reminders;
- Nutrition planning tools;
- Fitness planning and monitoring tools;
- Video library of educational interviews and training resources; and,
- Disease self-management resource centers.

Focusing On Wellness.

We help consumers embrace wellness and shift their focus from sickness or impairment. We encourage wholeness, balance, and centeredness.

Reducing Isolation.

Lasting Lifestyles[SM] is not just a health and wellness site. We encourage and support social networking for individuals with chronic diseases or disabilities and their informal caregivers. Through **Lasting Lifestyles**[SM] users can find and communicate with others having similar interests, safely and securely.

Acknowledging Diversity

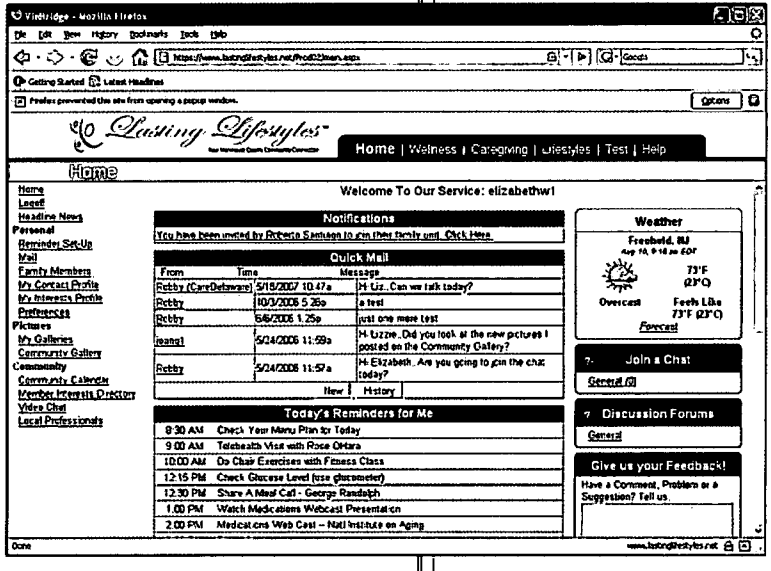
Individuals with chronic conditions or disabilities are remarkably diverse in terms of needs, preferences, and circumstances. **Lasting Lifestyles**[SM] recognizes the unique needs of users and allows for personalization of the information and tools. Users decide what **Lasting Lifestyles**[SM] resources to use and when.

Helping Consumers to be *Better* . . .

INFORMED

CONNECTED

EMPOWERED



www.lastinglifestyles.net

SUPPORTING INFORMAL CAREGIVERS...



W.M. wife's Norma says...

"It makes a big difference in my life, because things are easy to find. It tells me what Walter can have to eat and what he can't. Instead of looking in a cook book, it makes it so easy. You just click on the food, and the information comes up on the screen. The numbers, such as calcium and phosphorus are more accurate than in a book, and everything is broken down."



*Lasting Lifestyles*SM



Informal caregivers are the mainstay of support for many persons with chronic conditions or disabilities. Caregiving can sometimes be a lonely, exhausting experience.

Hands-on Caregivers.

For hands-on caregivers **Lasting Lifestyles**[SM] is a resource center with helpful tips, a source of affirmation and reinforcement, and a place to get connected to other caregivers.

Long Distance Caregivers.

Family members are often separated from each other by distance and busy schedules.

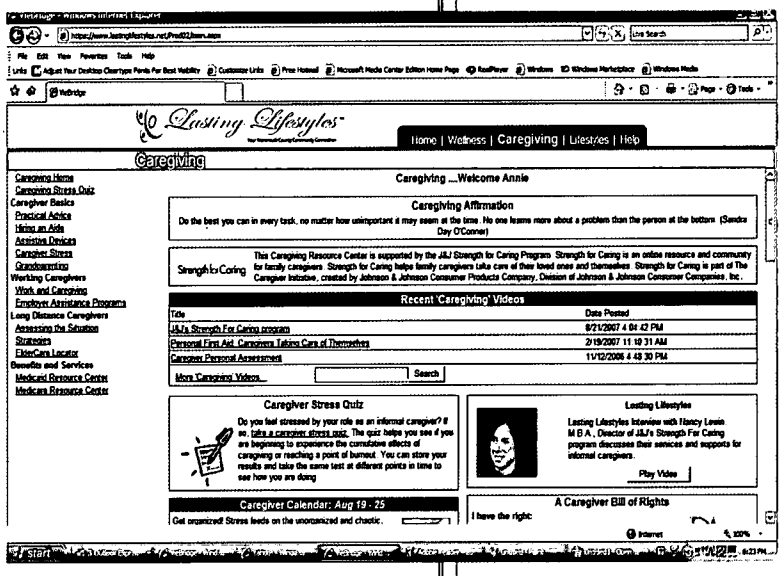
Long distance caregiving is often frustrating, inconvenient, and all too often ineffective. **Lasting Lifestyles**[SM] connects distance family members to a loved one in new ways and with new results such as:

- Expanded options for remote monitoring of a loved one's vital signs;
- Expanded options for sharing interests with a loved one who is isolated, bored or lonely; and
- Improved access by the distance caregiver to local professionals caring for their loved ones.

Working Caregivers.

For working caregivers with a busy schedule, **Lasting Lifestyles**[SM] provides tools and information that help make each day of caregiving easier and more productive.

Informal caregivers using **Lasting Lifestyles**[SM] will discover they are not alone. As they connect to community resources and professionals, they will find the information and advice they need to help their loved one make good choices.



www.lastinglifestyles.net

We Help...

Hands-on Caregivers

Long Distance Caregivers

Working Caregivers

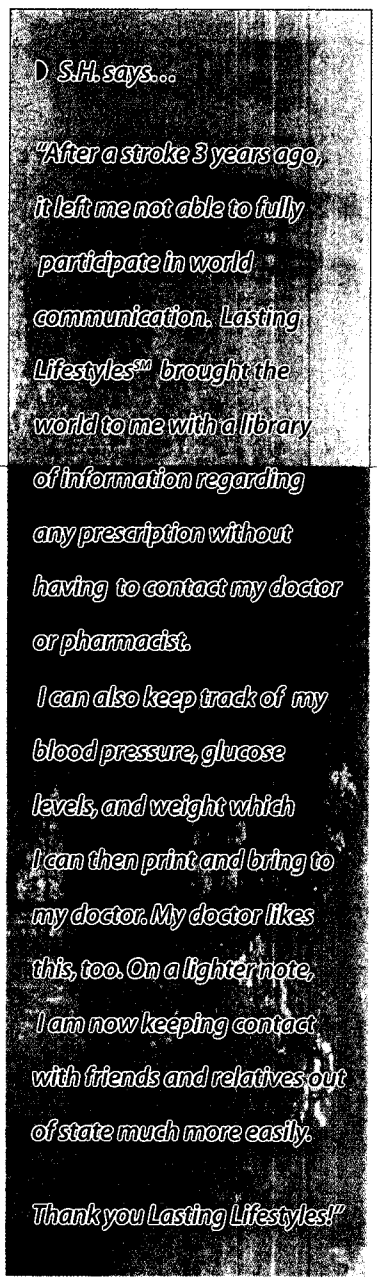
SUPPORTING COMMUNITY PROFESSIONALS...

Multiple Tools.

Lasting Lifestyles[SM] helps professionals more effectively help persons with chronic conditions or disabilities. **Lasting Lifestyles**[SM] provides a tightly integrated set of tools for:

- Assessing consumer needs;
- Developing plans of care;
- Budgeting services taking into account problem acuities;
- Authorizing services;
- Incorporating best practice and disease management protocols;
- Monitoring the status of clients;
- Conducting video chats with clients or informal caregivers;
- Monitoring clients' vital signs using telehealth technologies;
- Teaching and educating clients through distance learning; and
- Building professional skills through on-line courses and technical assistance supports.

Lasting Lifestyles[SM] helps care managers and clinicians to tightly manage services, adopt an outcomes framework and support person-centered planning. Professionals will gain new ways to implement disease management protocols and best practice guidelines. And just as important, **Lasting Lifestyles**[SM] introduces innovative methods for client communication and education.



NEW OPTIONS FOR COMMUNICATIONS WITH CLIENTS OR PATIENTS

- On-line messaging;
- Video chats;
- Ask a Question;
- On-line questionnaires for consumer responses/self-reporting;
- Telehealth functionality;
- Patient journaling;
- Consumer access to plans of care;
- Communicating test results;
- On-line educational information; and
- Information on office practice policies and guide.





Integrated with Consumer Version Of Lasting Lifestyles℠.

Professionals are able to integrate their tools on **Lasting Lifestyles℠** with our fully-featured consumer version of **Lasting Lifestyles℠**. This unique design forms a communications and support network that makes it easy for professionals to work with patients, informal caregivers, volunteers, and other professionals.

We also provide the option of individual resource centers for specific professional practices. Professionals can have their own resource page on the consumer portal for **Lasting Lifestyles℠** to support their practice. We provide a resource center template that can be customized to fit the preferences for content and tools that the participating professionals want their client to use on **Lasting Lifestyles℠**.

Comprehensive

Support For Professionals

to...

ASSESS

PLAN

AUTHORIZE

MONITOR

EDUCATE

COUNSEL

OUTCOMES MANAGEMENT SUPPORT

Lasting Lifestyles℠ supports outcome identification and tracking. Our Web platform and tools make it easy to set outcomes, collect outcomes data and track progress for individual patients or caseloads.



BENEFITS TO PROFESSIONALS:

- Enhances assessment, planning and monitoring;
- Leverages professional expertise;
- Improves communications with clients; and
- Supports use of outcomes and best practice guidelines.

www.lastinglifestyles.net

DELIVERING TIMELY & RELEVANT CONTENT...

Lasting Lifestyles[SM] is content rich and designed for frequent updating. Both national and local content are brought together in one comprehensive Web portal. We coordinate the acquisition of national content used across the community sites.



Creation of Local Content.

We work closely with community sponsors to create and integrate local content that results in a community "identity" for **Lasting Lifestyles**[SM].

Community oriented content can be focused and organized in ways that respond to the interests and circumstances of specific target populations. **Lasting Lifestyles**[SM] is designed to make it easy for local agencies and professionals to provide local content in multiple formats including contributed articles, video or audio interviews, serving as an "Ask a Question" expert, facilitating a local discussion forum or moderating a chat room.

Our community sponsors determine the amount and frequency of local content along with the network of contributing organizations and professionals who support **Lasting Lifestyles**[SM] locally.

Content Sharing and Collaboration.

We are able to make **Lasting Lifestyles**[SM] rich in content, yet affordable, by encouraging multiple communities using **Lasting Lifestyles**[SM] to share content and creativity.

L.S.. says...

"The information is just wonderful! I read a lot about diabetes and bronchitis. The health information that I find really makes a difference in my life. The wellness resources in the library is nothing like what you find on Lasting Lifestyles[SM]. The website is so easy to use and bright looking.

Lasting Lifestyles[SM] Productions.

Lasting Lifestyles[SM] takes full advantage of the growing availability of broad-band connectivity to extensively use multi-media content as a centerpiece of **Lasting Lifestyles**[SM]. Our **Lasting Lifestyles**[SM] **Productions** affiliate produces an on-going video and audio interview series on topics related to chronic conditions, disabilities and wellness.

Each professionally-produced show is designed to showcase local experts, caregivers or consumers on key topics related to chronic illnesses or disabilities. Once produced, the interviews are packaged for use on both the Web portal and local public access television. This two-pronged approach to consumer education puts us in the vanguard in the use of Web/TV convergence to support health education and consumer self-care.





Lasting Lifestyles[SM]

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PROVEN TECHNOLOGIES & RESULTS...

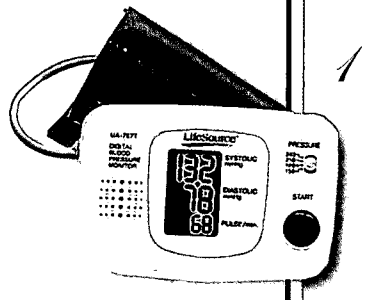
Robust Platform.

The **Lasting Lifestyles**[SM] Web architecture is designed to flexibly accommodate small to very large installations at very affordable pricing. Our Web portal is built on the latest Microsoft .NET 2.0 framework and a 3-tier architecture. This robust architecture is the newest and most comprehensive development platform for Web portals today.

Comprehensive Multi-Media Capabilities.

As a Web portal, **Lasting Lifestyles**[SM] is built for broadband access. Lasting Lifestyles integrates rich multi-media capabilities including:

- Streaming videos;
- Video conferencing and chats;
- Webcasting; and
- Distance learning functionality based on video content.



Integrated Telehealth Functionality.

Lasting Lifestyles[SM] uses a modular model for telehealth that supports remote monitoring of key vital signs (blood pressure, weight, glucose, etc.) using separate devices that can be connected to a regular PC. Users install and use only the devices they need.

Lasting Lifestyles[SM] communicates with vital signs monitoring devices and uploads vitals signs data and patient self-reporting data to **Lasting Lifestyles**[SM]. This information can be used by consumers, informal caregivers, and community professionals. Professionals can monitor vital signs of numerous patients and be alerted to out-of-norm readings.

Security.

Lasting Lifestyles[SM] is compliant with federal health data privacy and security requirements. All users are required to register. Consumer-specific information is protected using a variety of password, encryption and other security measures at our central hosting location.

Comprehensive Support.



Lasting Lifestyles[SM] is easy to navigate and use. We support users through on-line helps, tutorials, and a help desk. We make it easy for community sponsors to set up and use **Lasting Lifestyles**[SM]. Our step-by-step implementation guide, content management tools and marketing kit makes it easy to organize local content, recruit participating organizations and conduct community outreach and marketing.

PROVEN *Results*

Lasting Lifestyles[SM] is a tested product. A two-year evaluation project funded by the Robert Wood Johnson Foundation showed positive results:

1. Improved client oversight/ monitoring as evidenced by the adoption and use by participants of vitals signs monitoring devices (BP, glucose, and a scale).
2. Enhanced client self-care knowledge as measured by testing of participants' level of knowledge about their conditions and related treatment standards.
3. Reduced utilization of acute care and ER services as evidenced by comparative utilization before and after enrollment in the service.
4. Enhanced patient/informal caregiver capacities to participate in decision-making about treatment/care.

User input and insights further verify the value and benefits of **Lasting Lifestyles**[SM] every day.

Lasting Lifestyles℠ was developed by VieBridge, Inc. a leading health technology company providing Web solutions to improve chronic care and disability services. Our health care specialists work with a wide range of local health delivery systems, community organizations and many federal and state agencies who fund or manage chronic/long term care programs.

Our technical staff bring to Lasting Lifestyles℠ widespread health IT industry experience as well as extensive experience with telehealth technologies in the provision of home care.

When developing Lasting Lifestyles℠, we worked closely with community agencies and local health providers. And several major foundations provided financial support and assistance during development and testing of Lasting Lifestyles℠ including the Robert Wood Johnson Foundation, Verizon Foundation, Merck Foundation, REACH Foundation, and Gannett Foundation.

Lasting Lifestyles℠ is now being implemented in multiple communities with the support of both large public agencies as well as community organizations that provide services to consumers with chronic conditions.

To learn more about VieBridge, Inc.

go to: www.viebridge.com

VieBridge℠ Inc.

www.lastinglifestyles.net

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#9

NC ASSISTED LIVING ASSOCIATION

2008 AGING STUDY COMMISSION ISSUES

Issues

- Require Multiunit Assisted Housing (MAH) with Services providers to register and impose financial penalty for failure to register. Policy has been in place for many years to require registration of MAH, but no enforcement tools were given to the Department of Health Services Regulation. With the introduction of Certificate of Need for adult care homes at the turn of the last century, North Carolina has experienced a surge in MAH to avoid the CON process, cost and subsequent regulation and inspections. Many of the MAHs are de facto unlicensed adult care homes and avoiding inspections by DHSR and others. Requiring regulatory enforcement will enable DHSR to get a real count of the MAH and be able to investigate the facilities when issues arise. **Suggested language follows.**

- Protect seniors in adult care homes – and state coffers -- by implementing an income disregard policy. The income disregard policy would preserve residents' Special Assistance and Medicaid eligibility to allow them to remain in their chosen adult care homes. The policy would preserve state resources by preventing the residents' more expensive and inappropriate transfers to nursing homes. In 2005, the Adult Care Home Cost Modeling Committee issued a report summarizing 2 year's worth of work. The comprehensive report made constructive recommendations on a myriad of adult care issues, including income disregard. **The specific recommendation appears from the Cost Modeling report follows.**

- Enhance Long Term Care Insurance Tax Credit – 2007 budget bill reinstated the LTCTC at $350 per year. Increase the tax credit to an amount equal to 3/4 of their premiums or $1000 per year, whichever is less. **NCALA has convened a working group to explore this issue.**

For More Information

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- Enable full implementation of S 572 enacted by the 2005 General Assembly that created a separate licensure category for frail elderly persons in NC Adult Care Homes. The bill required rules be adopted. The Medical Care Commission has never promulgated rules.

Details

Multiunit Assisted Housing with Services changes:
Amend 131D-2 as follows:

(7a) Effective July 1, 1996, "multiunit assisted housing with services" means an assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency, through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's established plan of care. Multiunit assisted housing with services programs are required to register with the Division of Facility Services and to provide a disclosure statement. The disclosure statement is required to be a part of the annual rental contract that includes a description of the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

7(b) (1) The General Assembly finds that the public's interest is maintained by helping consumers understand the difference between multiunit housing with services programs and other adult care providers and nursing homes. There is therefore established a program housed in the Department of Health and Human Services, Division of Health Services Regulation that identifies and tracks multiunit housing with services providers.

(2) Effective January 1, 2010, all buildings meeting the definition of multiunit housing with services shall register annually with the Division of Health Services Regulation and shall pay a registration fee not to exceed $350. Any individual or corporation that establishes, conducts, manages, or operates a multiunit housing with services subject to registration under this section and fails to register is guilty of a Class 3 misdemeanor, and upon conviction shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

Income Disregard Recommendation from Cost Modeling Report:

The Department should adopt 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 EIS (Eligibility Information System) "Track Record."

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.

#10

Joan Pellettier

North Carolina Association of Area Agencies on Aging Comments to the Study Commission on Aging Regarding 2008 Legislative Agenda 2.28.08

Honorable Senators and Representatives, and Members of the Study Commission:

I am Joan Pellettier and appear before you as Vice-Chair of the North Carolina Association of Area Agencies on Aging. We appreciate this opportunity to speak to you about issues we see facing older adults and our five Legislative Priorities for the 2008 Short Session of the NC General Assembly.

The Baby Boom has arrived. The first Baby Boomer began receiving Social Security on January 1 -- just two months ago. We have all been talking about the changing demographics and what we could anticipate when this day arrived. It is now here. I am pleased to say that North Carolina has begun to address some of the major changes that will be required in order to meet the challenges ahead of us.

Area Agencies on Aging are being called on to assist communities in evaluating their current system of care and help develop plans to implement improvements. With the aid of federal grants, North Carolina is beginning to expand Aging and Disability Resource Connections across our state to provide easy access to information and services. Area Agencies on Aging are leaders in helping communities implement evidence based health promotion programs, which help older adults remain healthy and independent -thus reducing or postponing the need for more costly institutionalization. We are looking at ways to implement more diversified funding options like consumer directed care to help families maximize the dollars available to them.

With these initiatives and many others, our communities need assistance in evaluating current service delivery systems and community infrastructure, developing plans to address gaps, identifying strategies and building coalitions in order to implement changes. The NC Division of Aging and Adult Services Director, Dennis Streets, has presented you with a plan for a comprehensive statewide aging study that would significantly and positively impact our ability to systemically plan for the Aging of North Carolina. There is some exciting work happening in North Carolina but much is yet to be done.

It is within the context of these types of changes that we bring to your attention **five areas**.

First of all, we thank you for the tremendous support you gave us last year, when we asked that the Administrative support funding for Area Agencies on Aging be restored to the 2001 level ($1,042,200 or $57,900 per region). The increase granted (from $27,777 to $45,424 per region) enabled many of us to retain our current staff to continue doing the work we do. However, we

have still not had the total amount restored to the 2001 level. While we administer over 23 million dollars in service funding, there continue to arise significant advocacy initiatives on behalf of older adults, for which there is no funding for area agencies, like the Part D Prescription Drug program and, more recently, the transition to digital television that will impact many older adults.

The **second issue** is increased funding for the Home and Community Care Block Grant (increase by $7M). Services funded under HCCBG, such as transportation, home delivered meals, in home aide, respite care for families, and adult day care, are essential services needed to help older adults remain in their home- where they want to be. Supporting seniors in the community helps postpone or reduce more costly interventions, including institutionalization, and reduces the impact on Medicaid. There are seniors on waiting lists across the state. The NC Division of Aging and Adult Services reports that there are more than 11,500 older adults on waiting list in North Carolina (85% are waiting for in-home services such as in-home aide and home delivered meals).

The **third** area of interest is increased funding for senior centers. The Senior Center is a focal point for many of our communities and provides programs that contribute to the physical, mental, and economic well being of older adults. We believe that funding needs to be increased by $5M (recurring) in order to address the needs of current and developing senior centers. The $200,000 provided as non-recurring funds was a big help as our senior centers struggle to retain staff and maintain facilities. Please help us make this $200,000 recurring funds.

All the things we have talked about help keep seniors active and independent in the community. The **fourth** area is another important support service for older adults to remain in the community. North Carolina has been proactive in establishing our NC Prescription Drug Assistance Program to supplement Medicare Part D and help low-income individuals who do not qualify for the federal "extra help" subsidy. However, there are thousands of older adults and persons with disabilities whose income and assets are just over the eligibility guidelines but who struggle to pay premiums, deductibles and co-pays. Many states have established "wrap around" programs to provide just this type of assistance. Expanding the NC Prescription Drug Assistance Program in this way is a key support needed by many older adults.

The **fifth** and last area today addresses support for our older adult and disabled population residing in long term care nursing facilities. Those individuals who receive Medicaid have a personal needs allowance of $30. This $30 must cover the cost of clothing not to mention small pleasures like a birthday card to a special relative, a piece of chocolate or even a tube of lipstick or a magazine. This allowance has not increased since 1988 and we all know the significant rise in costs since that time. We ask your consideration to raise this personal needs allowance to $50 per month.

Our older adult population and their caregivers are very special. These important supports will make a difference in the quality of life of many North Carolinians. Thank you for the opportunity to speak to you today.

North Carolina Association of Area Agencies on Aging
2008 Legislative Agenda

The following five issues are the North Carolina legislative priority items for which the Area Agency on Aging Directors would like to specifically request passage:

1. **Support legislation to increase recurring state funding by $270,000 for administrative support for Area Agencies on Aging.**

As of June 30, 2001 there was $1,042,200 available in Area Agency on Aging (AAA) administrative support funds. By the June 30, 2003, only $472,200 was available which meant that each AAA had been reduced in funding from $57,900 to $27,777. Action by the North Carolina Legislature in the 2007 session partially restored this funding and currently each AAA receives $45,424. AAA Directors are extremely grateful for this support but need this increased funding to help meet growing responsibilities.

Area Agencies on Aging: administer over 23 million dollars in services funding; provide leadership and support to enroll North Carolinians in the Medicare Part D program; provide technical assistance and administrative support to the work of the Senior Tar Heel Legislature; and are key players in a Division of Aging and Adult Services strategic planning initiative regarding planning for North Carolina's rapidly increasing population of older adults and their caregivers.

2. **Support legislation to increase recurring funding for the Home and Community Care Block Grant by $7 million.**

Home and community based services help impaired adults 60+ remain in their homes. Key services provided with Home and Community Care Block Grant funds include home-delivered meals, transportation, adult day care/day health care, in-home aide, and respite care for family caregivers. With the approaching Boomer generation there will be an increase in the demand for services. The N.C Division of Aging and Adult Services reports that there are 11,500 older adults on the waiting list in North Carolina as of January 2008. It is estimated by the N.C. Division of Aging and Adult Services that it would take $14 million of additional Home and Community Care Block Grant funds to address this need.

3. **Support legislation that will increase recurring funding for senior centers by $5 million.**

Currently, there are 163 senior centers in North Carolina that are either operational or under development in 98 counties. Senior centers offer a wide array of programs and services, provide an essential link to other community programs and benefits that contribute to the physical, mental, and economic well being of older adults, and support their efforts to remain independent in their communities.

Action by the North Carolina Legislature in their 2007 session provided an increase of $200,000 in non-recurring funds. However, senior centers continue to struggle to meet the rising costs of operations, including maintaining staff

positions, keeping satellite locations open, maintaining facilities and equipment and to provide programs and services to meet the needs of the current seniors in the community.

4. **Support legislation that would increase Medicaid nursing home residents' personal needs allowance in nursing homes from $30 per month to $50 per month.**

The personal needs allowance of residents in NC nursing homes has not increased since 1988. $30.00 per month is not sufficient to cover the cost of personal needs. 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.

5. **Support legislation to provide increased funding for a NC Prescription Drug Assistance Program to supplement Medicare Part D and help low-income individuals who do not qualify for the "extra help" subsidy available from the Medicare Part D program.**

All older persons and persons with disabilities on Medicare are eligible to enroll in a Medicare Part D Plan regardless of income or assets. Offered by private companies, the premiums, deductibles and co-payments for the Plans vary. Low income individuals who qualify are eligible for "extra help" from the Social Security Administration to assist with these costs.

However, there are thousands of older persons and persons with disabilities in North Carolina whose income and assets are over these limits who cannot afford the out-of-pocket costs. Most states have established programs which "wrap around" the Medicare Part D program to assist persons who do not qualify for the for "extra help" benefits, but need assistance paying for the premiums, deductibles, and co-pays of their Plan. North Carolina has not established such a program.

The North Carolina Association of Area Agencies on Aging will continue to be supportive of the appropriate efforts of other advocacy groups that pursue legislative action on issues of importance to older adults. This is consistent with our mandated responsibilities as outlined in Section 306 of the Older Americans Act that states "the area agency on aging will serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon policies, programs, hearings, levies, and community actions which will affect older individuals."

#11 Bill Dr Milner, DDS

Dental Care for North Carolina's Special Care Populations

Thanks to the NC Aging Study Commission!

Study Commission initiated legislation to create a new special care dental program in Durham/Orange/Chatham Counties passes in 2008.

What is needed next?

- Support the NC Senior Tar Heel Legislature, NC Governor's Advisory Council on Aging and NC Association of Retired Persons request to appropriate money for new and existing special care dental programs.
- Direct the NC Division of Medical Assistance to study a dental Medicaid behavior reimbursement code for special care patients.
- Study the funding of a special care residency program to train future dental providers.
- Include dental care reimbursement for the NC Money Follows the Person (MFP) Program administered by the NC Division of Medical Assistance.
- Follow up on the Study Commission's proposed Governor's Scholarship for a UNC School of Dentistry student. [Section 9.5.(a), Chapter 116-40.10]

Who Are These Special Care Citizens?

- There is no consistent access to dental care for the more than 200,000 North Carolinians who are homebound or live in nursing homes or group homes.
- These are individuals of all ages, and they have a variety of complicated intellectual and physical disabilities such as profound retardation, autism, cerebral palsy, dementia, cerebral vascular disorders (stroke), head injuries, multiple sclerosis, and muscular dystrophy.

What Are The Problems?

- North Carolina has no statewide oral health system to serve patients with special care needs.
- Nursing home facilities and group homes have few qualified community dentists to care for their residents.
- State deinstitutionalization policies have put people with mental disabilities into communities ill-equipped to treat their dental needs.
- Local dental providers are reluctant to treat the medical and behavior needs of patients with special care needs. Nursing home facilities and group homes are challenged to meet each resident's daily oral hygiene needs.
- There are no specialty training programs for providers wanting to serve this population.
- Uncontrolled oral infections result in more costly infections such as aspiration pneumonia, uncontrolled diabetes and endocarditis.
- Medicaid rates do not keep up with inflation.
- The two non-profit programs that serve these individuals (Access Dental Care/Carolinas Mobile Dentistry) are stretched to the financial breaking point. These organizations provide comprehensive care to 7400 residents in 16 piedmont counties with an 80% Medicaid/20% Private Pay mix.

#13

Roxanne Bragg - Cash

North Carolina Study Commission on Aging

2/28/2008

Report from North Carolina Coalition on Aging

The North Carolina Coalition on Aging is a State Wide alliance of 41 organizations committed to improving the quality of life for older adults through legislative and other governmental and community action. The coalition promotes the dignity, self-determination, and well-being of the elderly.

Legislative Priorities:

- Appropriate $5million for the Home and community Care Block Grant in recurring funds.
- Appropriate $2 million in recurring funds to the Division of Aging and Adult Services for allocation to the Senior Center General Purpose Fund
- Increase the asset limits for categorically and medically needy Medicaid eligibility for aged, blind and disabled persons from $2,000 to $6,000 for individuals and from $3,000 to $9,000 for couples.

#14
Dr. Gordon
DeFriece

FutureCare
of North Carolina, Inc.

A Non-Profit Educational and Research Foundation

Improving the Quality of Skilled Nursing Care in Partnership with the Members of the
NORTH CAROLINA HEATLH CARE FACILITIES ASSOCIATION

Two Developments of Interest and Importance to the Concern for our Growing Population of Older Adults in NC

First, there is the initiative of the member facilities of the North Carolina Health Care Facilities Association under the banner of:

Journey to National Best

The Journey to National Best in skilled nursing care is North Carolina's deliberate effort to transform our skilled nursing homes into facilities and services of the future. Our aim is to aggressively and strategically plan to meet the demands and expectations of our long-term health care consumers and families. To strengthen and transform NC nursing homes, we are focusing on the issues that contribute meaningfully to the lives of our residents and the staff who care for them.

The purpose of the Journey to National Best is not to mandate changes, but to strategically plan for the future. Our mission is a collaborative effort between consumers, policy makers, stakeholders and providers. NCHCFA members are leading workgroups to research, develop and articulate our goals in five dimensions or guideposts.

Illustrative of the initiatives being undertaken as part of the Journey to National Best are these:

Leadership Development in the Field of Long-Term Care:
We are making a number of efforts to recruit into the field of long-term care administration the best and brightest young people with college backgrounds relevant to this field, and to streamline the process through which such persons can qualify for licensure to practice. In addition, we are sponsoring a series of leadership development programs designed to enable some who already work in this field to advance to positions of administrative responsibility.

Improving the Physical Facilities and Design of Nursing Homes for the Future.
We have engaged architectural consultants and technology experts to help assemble the best and most effective new technologies and design elements of nursing homes throughout the country so that owners and administrators of these facilities will have

access to these ideas and tested innovations as further capital investments are considered. These information resources will be available on-line to all NC nursing care facilities and consultation is available to assist facilities in making such decisions as they consider renovations and/or new construction. It is likely that older adults of the future will have stronger preferences for single bed rooms and more home-like environments and many NC nursing facilities are taking steps to meet these expectations.

Two steps that will help ensure the likelihood of these changes for the future are the rebasing of the rates of reimbursement for long-term care under the state's Medicaid program and the reclassification of rates of payment under the so-called "fair rental value" provisions of these programs.

Neither rebasing or Fair Rental Value has been approval by CMS. Rebasing was included in the most recently passed state budget. The State Department of Health and Human Services sent all of the information needed for a decision on both matters to CMS approximately four weeks ago. Once approved, both of these items should offer significant opportunities to nursing facilities for expansion and renovation.

Rebasing: Under rebasing, facilities will have their rates reset using more up-to-date cost reporting information. This is a truing-up of the rates compared to regular inflationary increases. Since October 2003, nursing facilities have only received one inflationary adjustment. This was a 1.18% rate adjustment in January 2005. Comparing historical staffing statistics to nursing facility Medicaid rates has shown when rates increase, nursing hours per day increase. Unfortunately, when rates haven't kept up with costs, staffing is usually one of the areas that can be reduced. The last time nursing facility providers had a significant rate adjustment (when the case-mix based reimbursement was implemented), cost reporting information shows that providers put this money back into the facilities.

Fair Rental Value: This is the new system of capital reimbursement. Under the current system, every nursing facility receives $6.10 in their Medicaid rate for capital payment. If a provider modernizes their building or does any renovations, they get the same $6.10. It doesn't matter if you have a $9 million new building or a 60 year old building, you gat the same $6.10. Under Fair Rental Value, a provider's rate is determined on the characteristics of the nursing facility building. New buildings receive a higher FRV payment that older buildings. Providers have the opportunity to reduce the age of their buildings by doing renovations, buying new equipment, adding beds and replacing buildings. One of the strengths of FRV is the ability for the provider to see what impact an improvement will have on their rate. This gives the provider better information that can be used in evaluating the financial impact of any planned improvement. It will also help in obtaining any needed financing because they can show how their rate will change.

Raising the Standards of Care and Services Provided by NC's Nursing Homes
NC skilled nursing facilities are constantly exploring ways in which the quality and level of care in these care settings can be advanced. Several facilities in our state are now considering the use of nurse practitioners as adjuncts to medical and nursing staff.

Medication aides have greatly reduced the time that nursing staff must spend in the dispensing of medications. A new initiative proposed under the umbrella of FutureCare of North Carolina (a new non-profit educational and research foundation sponsored by the NC Health Care Facilities Association) will introduce a new educational technology for enhancing the interventional skills of nursing home nursing personnel at every level. This initiative we hope will begin this fall with a traveling patient care simulator that will be able to help further develop nursing team performance in the event of acute events in the nursing home environment.

Increasing Public Understanding and Trust of Facilities Providing Skilled Nursing Care: We are anxious to invite greater public involvement in and familiarity with the inner workings of nursing homes in our state. The media have for the most part ignored the many positive aspects of care and services provided in this industry. In recent months, we have observed far more interest in the exciting new developments in skilled nursing care and we are working to bring into the these facilities a greater level of community awareness and transparency, as well as to better integrate long-term care with the larger spectrum of health care services and programs at the community level.

FutureCare of North Carolina, Inc.

As part of this effort, the members of the NC Health Care Facilities Association have launched a new educational and research foundation, **FutureCare of North Carolina, Inc.** for the specific purpose of advancing the levels and quality of care provided in this industry for the people of North Carolina.

This foundation will work with all elements of the NC nursing home industry to foster new and innovative approaches to serving our growing clientele and to assist facilities in our state in achieving the highest standards of care.

#16

Ruth Merkle (Rep. Farmer-Butterfield)

From: Lacy Presnell [lacypresnell@hotmail.com]
Sent: Monday, February 25, 2008 3:31 PM
To: Rep. Jean Farmer-Butterfield; Ruth Merkle (Rep. Farmer-Butterfield)
Subject: MEETING ON AGING THURSDAY 02-28-08

THANKS !! I PLAN TO ATTEND AND SPEAK BRIEFLY AT THE MEETING THURSDAY AT 1:00 P. M. I REPRESENT MORE THAN 13,000 MEMBERS OF THE NORTH CAROLINA RETIRED SCHOOL PERSONNEL. WE HAVE MEMBERS AND LOCAL ORGANIZATIONS IN ALL 100 COUNTIES>

MY COMMENTS WILL BE BRIEF AND POSITIVE !

OUR MEMBERS APPRECIATE THE TWO WONDERFUL BENEFITS PROVIDED BY THE STATE OF NORTH CAROLINA. THE RETIREMENT SYSTEM HAS BEEN FUNDED SINCE 1941 AND THE HEALTH PLAN SINCE 1971. WHEN I BEGAN LOBBYING MORE THAN 17 YEARS AGO, THE PRIORITY WAS RETIREMENT SYSTEM FUNDING AND COLA'S (FIRST) AND THE HEALTH PLAN SECOND. THOSE PRIORITIES HAVE REVERSED. THE HEALTH PLAN IS NUMBER ONE AND RETIREMENT BENEFITS SECOND!! BOTH ARE IMPORTANT AND WE COMMEND THE GENERAL ASSEMBLY FOR LOOKING AFTER BOTH AND WE WANT YOU TO CONTINUE.

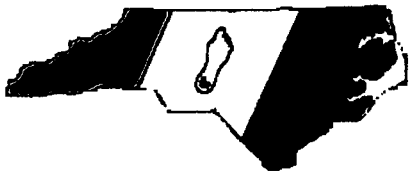
OUR MEMBERS ALSO WISH TO COMMEND THIS COMMITTEE AND THE GENERAL ASSEMBLY FOR ALL YOUR EFFORTS FOR OUR AGING POPULATION. WE ESPECIALLY WANT YOU TO CONTINUE AND IMPROVE INFORMATION REGARDING NURSING HOMES. ACCURATE INFORMATION IS NECCESSARY NOT ONLY FOR THE PATIENTS BUT FOR THEIR FAMILIES.

WE SALUTE YOUR COMMITTEE FOR YOUR EFFORTS, AND OUR MEMBERS ARE AVAILABLE, WILLING AND ENTHUSIASTIC TO ASSIST YOUR COMMITTEE AS YOU CONTINUE TO IMPROVE LIFE FOR OUR AGING POPULATION!! THANK YOU !!!!!!

Lacy Presnell >lacypresnellhotmail.com<

#19

North Carolina



Senior Tar Heel Legislature

February 28, 2008

Officers:

Speaker
Charles Dickens
(Buncombe County)
4 Arrow Place
Asheville, N.C. 28805

Speaker Pro Tempore
Edwin S. Deaver
(Cumberland County)
P.O. Box 127
Hope Mills, N.C. 28348

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Betty Hunt
(Randolph County)
1206 Ben Lambeth Road
Asheboro, N.C. 27205

Secretary
Barbara Fountain
(Surry County)
130 Solitude Trail
Siloam,, N.C. 27047

Representative Jean Farmer-Butterfield
Senator Vernon Malone
North Carolina Study Commission on Aging
North Carolina General Assembly
House of Representatives
State Legislative Building
Raleigh, NC 27601-1096

Dear Representative Farmer-Butterfield and Senator Malone:

It is my pleasure to present to you the five 2008 Legislative Priorities of the North Carolina Senior Tar Heel Legislature (NCSTHL), which were adopted unanimously on October 3, 2007. The enclosed Fact Sheets provide the full statement of our priorities

Each year the NCSTHL Delegates consider a number of aging issues and select the five that are most pressing. We do not differentiate among these five priorities. Indeed, we consider them to be of equal priority.

We welcome your interest in holding this public session and for giving us the opportunity to appear. We stand ready to provide additional information on the NCSTHL legislative priorities.

Respectfully submitted,

Charles H. Dickens

Charles H. Dickens
Speaker

Enclosures

cc: Mary Edwards, DAAS

2101 Mail Service Center• Raleigh, NC 27699-2101 • Phone No. (919)733-3983 • Fax No. (919)733-0443

The 2008 Legislative Priorities of the North Carolina Senior Tar Heel Legislature

Presented by Charles H. Dickens, Speaker

Raleigh, February 28, 2008

Representative Farmer-Butterfield, Senator Malone, and Commission Members:

I am Charles Dickens, the Speaker of the North Carolina Senior Tar Heel Legislature. Thank you for this opportunity to present our 2008 Legislative Priorities.

Each year the Senior Tar Heel Legislators consider many important aging issues. During our deliberations we look at current situations and projected trends. We know, for example, that we are entering an era of rapid growth in the older population as the Baby Boomers enter their sixties.

We are recommending five legislative priorities to the General Assembly. We consider them to be of equal importance.

We are requesting a $5 million increase for the Home and Community Care Block Grant. Last year the General Assembly provided an additional $536,000, but much more is needed. Over 11,000 people are on the waiting list for these home and community based services.

We request $2 million for senior centers, an increase of $634,684 . Last year the General Assembly provided $200,000 in non-recurring funds for senior centers. As the older population grows, so does the demand for senior center services.

We request an additional $15,000 in recurring funds for the operation of the Senior Tar Heel Legislature. We now receive $3,000 a year, but our current expenses are $18,000. During the state's budget crisis earlier this decade our funds were reduced from $9,000 to $3,000, but the General Assembly did not restore those funds when the state's budgetary situation improved.

We urge the General Assembly to address dental care for older adults with special needs and in rural areas. Last year $200,000 in non-recurring funds were provided for a mobile dental clinic. We recommend that $1.35 million be allocated to recruit dentists for underserved areas and for serving residents in long-term care facilities.

We are asking the General Assembly to appropriate $500,000 to sustain Project C.A.R.E. (Caregiver Alternatives to Running on Empty). This program provides information, referral, consultation and linkage to caregivers of persons afflicted with Alzheimer's disease. By helping families keep loved ones at home longer, less time will be required for institutional care. The resulting savings in public funds are substantial. Project C.A.R.E. now serves caregivers in 14 counties and should be extended to other counties. Urgent action is needed because the federal funding for Project C.A.R.E. ends on June 30, 2008.

We thank you for holding this public session and for giving us this opportunity to tell you the legislative priorities of the Senior Tar Heel Legislature.

FACT SHEET

North Carolina Senior Tar Heel Legislature

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

The Senior Tar Heel Legislature was created to:

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

There is one delegate to the Senior Tar Heel Legislature from each of the 100 counties in the state. Most counties also have an alternate delegate. Delegates and alternates must be age 60 or older. The North Carolina Division of Aging and Adult Services provides staff support for the Senior Tar Heel Legislature in cooperation with the 17 Area Agencies on Aging who are responsible for conducting the selection of delegates and alternates. Current officers of the Senior Tar Heel Legislature are: Charles Dickens, Speaker (Buncombe); Edwin Deaver, Speaker Pro Tempore (Cumberland); Betty Hunt, Deputy Speaker Pro Tempore (Randolph); and Clara Fountain, Secretary (Surry).

2008 Legislative Priorities

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. There are over 11,000 people on the waiting list for Home and Community Care Block Grant services.

Increase funding for senior centers by $634,684 for a total of $2 million per year. There are 164 senior centers in North Carolina currently operational or under development in 98 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 $1,365,316. With limited funding, many senior centers are short-staffed and unable to grow their services, activities, space

and operating hours, at the time expectations for senior centers have grown (e.g., participation in Medicare Part D education and counseling).

Appropriate an additional $15,000 in Recurring Funds for the operation of the Senior Tar Heel Legislature. The Senior Tar Heel Legislature currently receives $3,000 per year to cover the expenses of the Senior Tar Heel Legislature. However, the costs of the meeting space, breaks, mailings, and a meal are approximately $6,000 per meeting or $18,000 per year. The Senior Tar Heel Legislature requests an additional $15,000 be appropriated from the General Fund to the Division of Aging and Adult Services to cover the costs of the Senior Tar Heel Legislature's three scheduled meetings per year.

Provide Dental Care for Older Adults with Special Needs and in Rural Areas. The Senior Tar Heel Legislature recommends that $1.35 million be allocated to the Office of Rural Health and Community Care to recruit dentists for underserved areas in North Carolina including dentists that would focus on providing care in long-term care facilities. The Division of Public Health and the Office of Rural Health and Community Care would use the model of existing mobile dental clinics to provide access to care for residents residing in long-term care facilities, as well as seniors and the disabled living at home.

Provide funding to sustain Project C.A.R.E. (Caregiver Alternatives to Running on Empty). The Senior Tar Heel Legislature recommends that $500,000 in recurring funds be appropriated from the General Fund to the Division of Aging and Adult Services to sustain Project C.A.R.E., which currently serves 14 counties, and to expand it into other counties.

NORTH CAROLINA SENIOR TAR HEEL LEGISLATURE
2008 FACT SHEET

Project C.A.R.E: "Caregiver Alternatives to Running on Empty"

A National Best Practice Model for Respite Care

The Senior Tar Heel Legislature recommends that the General Assembly provide funding to sustain Project C.A.R.E. The Senior Tar Heel Legislature recommends that $500,000 in recurring funds be appropriated from the General Fund to the Division of Aging and Adult Services to sustain Project C.A.R.E, which currently serves 14 counties, and to expand it into other counties.

The North Carolina Alzheimer's Demonstration Program, Project C.A.R.E., uses a family consultant model to provide consumer-directed respite care and comprehensive support to dementia caregivers. The goal of the program is to increase quality, access, choice, and use of respite and support services to low-income rural and minority families caring for a person with dementia at home or within a hospital setting. Through the integration of dementia-capable services and the development of family-centered and caregiver-focused community care networks, Project C.A.R.E. will help 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 through the Division of Aging and Adult Services with expert consultation and technical assistance provided by the Duke Family Support Program. Project C.A.R.E. is implemented at the local level through Family Consultants employed by and/or supported through the local Alzheimer's Association. The program is currently based within the Mecklenburg County Department of Social Services and two area offices of the Western Carolina Alzheimer's Chapter. The Mountain Area office in Asheville serves as the project training and data management center for all new and existing program sites and staff.

Project C.A.R.E. employs Family Consultants with expertise in Alzheimer's disease and related disorders. The Consultants visit the homes of referred or self-referred dementia caregivers in crises and offer timely, individualized assessment, guidance, counseling, support, advocacy, coaching and education. 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.

The Project C.A.R.E. model builds upon, enhances and sustains existing home and community-based services by using local providers to deliver respite care while serving as a direct link to the expertise and resources of the Alzheimer's Association. Project C.A.R.E. also connects families to the NC Family Caregiver Support Program, Aging and Disability Resource Connections (ADRC), Hospice and other caregiver-focused initiatives creating a strong network of community support for Alzheimer's families. This comprehensive system of care strengthens the family's capacity to manage the ongoing and diverse challenges inherent in caring for a person with dementia-- enabling families to provide care at home longer.

There are currently three pilot sites set up to serve the following fourteen counties: Charlotte (Mecklenburg County), Winston-Salem (Forsyth, Surry, and Stokes); and Asheville (Polk, Henderson, Transylvania, Rutherford, Madison, McDowell, Buncombe, Haywood, Jackson and Swain).

FUNDING

→ **Total federal funding (Title IV OAA): $325,000** (1 year grant – ends June 30, 2008)
→ **Total budget**: **$433,333** (includes 25% local match)
→ **Funds for direct respite services**: **$226,950** (minimum required: 50%)
→ **Flexible spending cap for respite care:** $1500 - $2000 per family (Note: the initial $2500 annual cap
was reduced due to reductions in program funds– i.e., recent expansion into four additional counties
occurred without any additional funding.)
→ ***State funding level needed to sustain Project C.A.R.E. after June 2008**: **$500,000 + local match**
(*Restores $2500 annual cap with equal distribution of respite funding across existing service areas.)

NORTH CAROLINA SENIOR TAR HEEL LEGISLATURE
2008 FACT SHEET

HOME AND COMMUNITY CARE BLOCK GRANT

The Senior Tar Heel Legislature recommends that the General Assembly increase funding for home and community based services for older adults by increasing the Home and Community Care Block Grant (HCCBG) by $5 million.

The N.C. General Assembly established the HCCBG in 1992. The Block Grant consolidated several funding sources and represented an important step toward establishing a well coordinated service delivery system to meet the needs of older adults. The HCCBG makes funds available for an array of home and community based services which assist impaired older adults to remain in their homes. Eighteen services can be funded through the Block Grant.

Key services such as the following are funded with the Block Grant: adult day/day health care, care management, home delivered meals, home health, housing and home improvement, information and assistance, in–home aide services, respite care, senior companion and transportation. Decisions regarding which services are offered and the agencies to provide these services in each particular county are determined at the county level. In SFY 06-07, 59,177 persons across the state received Block Grant services.

Information about numbers of person served and waiting list information for several of the key home and community based services funded is as follows:

Service	Persons Served in 2007	Waiting List 2007
Adult Day/Day Health Care	1,150	151
Home Delivered Meals	17,617	3,433
In-Home Aide Services	7,854	5,857
Transportation	12,991	168

As of June 30, 2007, with approximately 55% of providers reporting, there are a total of 11,512 individuals reported waiting for HCCBG services.

Effective July 1, 2007, the General Assembly appropriated an additional $536,000 for Home and Community Care Block Grant Services. SFY 07-08 funding for the Block Grant is $56,772,048. Of this amount, 53% ($29,959,810) is state funding and 10% ($5,677,205) is required local match. The remaining funding of $21,135,033 is federal funding.

The Division of Aging estimates an increase of $5 million would result in an additional 950 persons receiving services (2% increase) over SFY 07-08 client service projections. The increase in projected persons is based on past client increases with additional state appropriations. The Division projects that 58,000 persons will be served during SFY 07-08. 54,177 were served during SFY 06-07.

For SFY 2005-06, the "typical" profile of older adults receiving services funded through the HCCBG was as follows:

72% were female
average age was 77
49% lived alone
72% of clients were unable to manage their own care
48% of all clients had an income at or below poverty
Services relieved a caregiver over 20% of the time.

Special Issues

- While the provision of in-home aide services is a total of 35% of the Block Grant, one of the reasons the provision of the service has not grown is due to an acute shortage of aides available to meet the growing need. Historically this occupation has been underpaid and under benefited. In order to service the population that currently needs and will need in-home aide services, priority needs to be given to strengthening and stabilizing this occupation as a positive employment choice.

- There are currently 106 adult day care/day health centers located in 57 North Carolina counties. Due to the lack of funding, North Carolina has seen a drop in the number of centers operating. There were 125 centers in 68 counties in 2000. In 2004, the General Assembly appropriated increased funding to provide for a $5.00 per day rate increase for adult day care and adult day health care ($460,000 of the Block Grant increase was earmarked for adult day care/day health care and $520,000 was appropriated for a rate increase for day care/day health care funded by the State Adult Day Care Fund). Additional funding for the Block Grant would be most helpful to further support adult day care and day health care centers.

- The need for home delivered meals also continues to grow. Many of the people receiving these meals have a marginal nutritional status with 90% of clients at risk of malnutrition. Additional funding is needed to provide weekend, emergency, and other supplemental meals.

- Information and Assistance (I&A) helps people access home and community based services. There is a growing need for individuals and their families to know how to navigate the service network and receive the counseling they need to cope with the serious problems of aging. Current funding supports only 37 local I&A programs. Additional funding is needed to encourage the development of I&A programs in other counties and for the development of a more sophisticated service.

NORTH CAROLINA SENIOR TAR HEEL LEGISLATURE
2008 FACT SHEET

SUPPORT FOR SENIOR CENTERS

The Senior Tar Heel Legislature recommends that the General Assembly increase funding for senior centers by $634,684 for a total of $2 million per year.

Currently there are 164 senior centers in North Carolina that are either operational or under development in 98 counties in the state. Three counties without a senior center in existence or under development are: Gates and Hoke.

Senior centers provide a wide array of programs and services and an essential link to other community programs and benefits that contribute to the physical, mental, and economic wellbeing of older adults and support their efforts to remain independent in their communities.

Although in recent years the State's funding to senior centers has remained level, overall the State's financial support of senior centers has declined by over $300,000 in the last four years. Senior centers continue to financially struggle to meet the rising costs of operations, including maintaining staff positions, keeping satellite locations open and maintaining facilities and equipment and to provide programs and services to meet the needs of the current seniors in the community as well as the future influx of baby boomers.

Current Funding to Senior Centers

Currently there are three funding streams for senior centers through the Division of Aging and Adult Services (DAAS). These are as follows:

Senior Center Operations is an allowable service through the Home and Community Care Block Grant (HCCBG) and is funded at the discretion of counties. The number of centers funded for operations reflect those with full time programs and the capacity to meet DAAS Senior Center Operations service standards.

Senior Center Outreach funding is provided to develop new services and to expand existing services in senior centers for the purpose of reaching unserved and underserved elderly through a statewide outreach of services.

Senior Center General Purpose funding provides existing senior centers and developing senior centers with funding for any purpose that supports operations or development. Expenditures include equipment purchases/repairs, building maintenance, supplies, administrative costs, activities and construction.

General Purpose funding is allocated based on a share formula. Uncertified senior centers receive one share, Centers of Merit receive two shares and Centers of Excellence receive three shares. General Purpose funding provides an incentive for centers to obtain certification.

Many senior centers are struggling financially as operating costs rise and budgets shrink. This will be compounded as centers try to positively position themselves to meet the needs of the future baby boomers in their communities. The availability of additional funding for certified centers does provide an incentive for senior centers to become certified. However, as additional senior centers become certified, without an increase in state appropriations, the level of funding for certified centers will probably decrease.

NORTH CAROLINA SENIOR TEAR HEEL LEGISLATURE
2008 FACT SHEET

PROVIDE DENTAL CARE FOR OLDER ADULTS WITH SPECIAL NEEDS AND IN RURAL AREAS

The Senior Tar Heel Legislature recommends that an additional $1.35 million be allocated to the Office of Rural Health and Community Care to recruit dentists for underserved areas in North Carolina including dentists that would focus on providing care in long-term care facilities.

According to the "2005 North Carolina Oral Health Summit Access to Dental Care," a report produced by North Carolina Public Health and the North Carolina Institute of Medicine, the dentist-to-population ration was 4.1 dentists per 10,000 people. The reports states that, "This rate placed North Carolina 47th out of the 50 states, well below the national average of 5.8 dentists per 10,000 people. This illustrates the state's continuing need for dentists throughout the state. Even more staggering is the unequal distribution of dentists across counties." The report continues by explaining that four counties have no practicing dentists and 79 counties qualify as federally designated dental health shortage areas. According to the report, this "shortage and the uneven distribution of dental professionals in North Carolina are major barriers to accessing dental care in the state."

The Office of Rural Health and Community Care Provider Incentive Program seeks to address the health care access problems resulting from a shrinking supply of primary medical and dental providers in rural and underserved areas of the state. The primary focus is to place medical and dental providers who agree to serve the low-income population in these areas, thereby making quality health care services available to those who can least afford it. Currently, incentive funds are exhausted within the first quarter of the fiscal year.

The Senior Tar Heel Legislature requests that the additional funding be used to increase the number of mobile dental clinics that treat special care need patients, including residents of long term care facilities and seniors and the disabled living at home. There are currently several mobile dental clinics across the state serving a small percentage of older people in long term care facilities. Additional funds would allow for an increase in the number of mobile dental clinics to provide access to care for residents residing in long-term care facilities, as well as seniors and the disabled living at home.

#20

Dee HATCH

Presentation to the N.C. Study Commission on Aging
Dee Hatch, State President for AARP North Carolina
February 28, 2008

I am Dee Hatch, State President for AARP North Carolina which has over 1.1 million members here in North Carolina. We thank the Commission for your good work over the years to put forth bills which address the pressing needs of our state's older citizens, and we appreciate the opportunity to address you today.

Older adults and their families still have many problems and challenges requiring the attention of our General Assembly, and I want to share with you the seven issues which AARP North Carolina has identified as our priorities for the legislative short session.

- **Increase funding for the Home and Community Care Block Grant** which helps people 60 and over stay in their homes. There are over 11,500 older adults on the waiting list for these services. The General Assembly appropriated $536,000 in the last session for the Block Grant. With the growth in our older adult population and the increased cost of service delivery, this funding, although appreciated, did little to address the waiting list across the state.

- **Expand programs and support for family caregivers** by appropriating funds for Project C.A.R.E. (Caregiver Alternatives to Running on Empty). Project C.A.R.E. provides respite support to caregivers of persons with dementia. You recommended $500,000 for Project C.A.R.E. last year and we ask that you again recommend at least this amount for the short session. Legislation was introduced last year to establish paid sick days to ensure all employees can address their own health needs and the health needs of their families. We encourage your support of this.

- **Increase funding for the Housing Trust Fund** which finances the construction and rehabilitation of affordable housing. If older adults are to continue to stay in their communities, they must have adequate housing. The Housing Trust Fund is a major resource for assisting low and moderate income older adults with housing needs; however, this funding is just a fraction of that needed to address the housing problems that exist.

(cont.)

- **Increase funding to expand dental care services, including mobile dental care programs, for older and disabled adults.** There is a particular need to expand services to special needs populations such as nursing home and adult care home residents and persons with dementia. The challenges of serving those with special needs, many of whom are on Medicaid, make it almost impossible for them to get the dental care they need without added resources.

- **Increase funding for senior centers.** The state appropriation for the 163 senior centers in the state is less than $1.6 million. Additional state funding is needed to expand and strengthen programs and services offered at these centers. In the last session, $200,000 in non-recurring funding was appropriated in Senior Center General Purpose Funding. At a minimum, this funding needs to be made recurring.

- **Strengthen state elder abuse and guardianship laws.** These laws, which have not been changed in many years, need to be amended to better protect our state's most vulnerable citizens. We recommend that the Commission propose that funds be appropriated to enact a pilot program to assess proposed changes to the adult protective services statutes as recommended by the Adult Protective Services Task Force. We also encourage the Commission to again support the recommendations of the House Study Committee on State Guardianship Laws.

- **Address issues related to the appropriate placement of individuals with mental illness.** The placement of individuals with mental health needs in facilities with frail older adults continues to present challenges and has resulted in instances where older residents have been put at risk or actually harmed. Steps need to be taken to ensure there are appropriate care options for persons with mental health needs. Last session, legislation was passed (Senate Bill 64) as recommended by this Commission, to direct the Department of Health and Human Services to study this issue. A special provision was also included in the budget bill directing the Department to develop a Transitional Residential Treatment Program service definition to provide 24-hour residential treatment and rehabilitation for adults who have a pattern of difficult behaviors related to mental illness, which exceeds the capabilities of traditional residential settings. These measures are a good beginning, but we ask the Commission to continue to examine this issue and to recommend further steps for addressing this pressing challenge.

Thank you again for providing me this opportunity to share AARP North Carolina's legislative priorities. AARP looks forward to working with you to improve the status of older adults in our state.

#21



Presentation to the NC Aging Study Commission

February 28, 2009

By Lou Wilson, Executive Director, NCALTCF

Good Evening-Madam Chairperson, Senator Malone, Committee Members and Guest.

My name is Lou Wilson; I am Executive Director of the NC Association, Long Term Care Facilities. We are a trade association representing about 600 facilities/ groups from the mountains to the coast. Thank you for allowing me to speak with you today about adult care homes.

Most of you are aware that for the past several years various studies and reports in NC have called for improvements in adult care homes and offered recommendations for what those improvements should be.

Today I want to let you know that we are launching a new, potentially very significant partnership between ACH providers and DHHS. What we might call a public-private partnership that will immediately address several key long-standing recommendations for improved care for ACH residents.

The members of our Association have decided to fund the development of a new Web-based system for assessing ACH resident needs and developing responsive service plans. We view this as a critical first step toward meaningful improvement in our services. This new system will give us a more complete and accurate picture of ACH residents and their service needs. The same system will be used to support staff training, quality improvement and improved provider compliance with federal and state regulations. The system will be far more efficient and effective than what we have now, which is too little and too fragmented.

Specifically, the new Web service will provide automated tools for:

- **Resident Assessment**
- **Care Planning**
- **Resident Monitoring**
- **Staff development and training**
- **Staff Peer Support and Networking**

I am extremely excited about the staff development component which will include information in the form of tips, case studies, blogs, articles, best practice guidelines, quizzes and training content, including hundreds of education/training videos.

Difficulties in securing Medicaid/state funding to support needed reforms led us to offer our resources and assistance to DHHS to get the ball rolling. None of us can afford any more delays with meaningful improvement in ACH services delivery, critical management tools, and a more appropriate means of paying for needed ACH resident services.

Over the next year we will be working closely with DHHS staff, in particular DMA and DHSR, to develop and test the new Web service. Provider fees are being used to help pay for development costs and potentially the operating costs once in full production. At the same time, we are discussing ways DHHS can support the effort through supportive policies and funding for training materials and content we need to address priority concerns related to staff capacities and quality of care.

We expect to release the proposed Web service in phases, starting this Spring. Development and testing of the Web service will continue through December, 2008. As we have said providers fees are paying for this initiative and we anticipate that user fees will pay for the continued operation of the services. But we hope at some point that the state will consider paying for the service for the 25,000 Medicaid residents we care for on a daily basis.

Having launched this initiative we are simultaneously declaring our intent to work closely with DHHS to renew and refocus efforts to develop a service model for ACH facilities that fits the changing needs for congregate care in North Carolina. This service model will also meet CMS issues and concerns about the current Medicaid funding for ACHs and the concerns of our providers have about the mismatch between the critical needs of ACH residents and the current level of funding.

Let me simply say, after years of talk, we have started taking action. While we are not here to guarantee smooth sailing or miraculous results, this new public-private initiative represents a new way of tackling basic issues affecting our residents and providers. And we are more confident that practical solutions to longstanding problems of ACH care will emerge from this collaboration.

I think it is important that in the months ahead we keep you informed on this new initiative, show you what is being developed and indicate where and how we need your support, moving forward.

This Commission's steadfast attention and support for enhanced ACH resident care has been a driving force for improvements in our industry.

We thank you for your support to our residents and providers.

Project C.A.R.E. (Caregiver Alternatives to Running on Empty)

Charles H. Dickens, Speaker, North Carolina Senior Tar Heel Legislature

Raleigh, February 28, 2008

Representative Farmer-Butterfield, Senator Malone, and Commission Members:

I am Charles Dickens, the Speaker of the North Carolina Senior Tar Heel Legislature. Thank you for having this panel on Project C.A.R.E. (Caregiver Alternatives to Running on Empty).

As you know, the North Carolina Senior Tar Heel Legislature has made Project C.A.R.E. one of five legislative priorities for 2008. We recommend that the General Assembly provide $500,000 in recurring funds to sustain Project C.A.R.E., a program which currently serves 14 North Carolina counties. This is a matter of great urgency because federal funding for current program sites is scheduled to end June 30, 2008. We also urge that Project C.A.R.E. be extended to other counties.

A brief look at some key facts provides a useful framework for discussing this program.

- **The population of the United States is increasing and growing older.**
- **The oldest of the Baby Boomers are now in their sixties, and we expect a surge in demand for aging services in coming years.**
- **Until medical science finds ways to prevent or cure Alzheimer's and related dementias, the number of persons suffering from these diseases will grow as the population of older adults increases.**
- **About 45 percent of those who live to be 85 years old will be afflicted with various dementias, mainly Alzheimer's disease.**
- **North Carolina currently has an estimated 150,000 older adults with Alzheimer's disease, a figure expected to rise to 294,000 by 2030. These estimates do not include all types of dementia nor those individuals with early onset Alzheimer's, a form of the disease that strikes middle aged and even younger adults.**
- **As the number of people with dementia increases so does the number of caregivers, thereby driving up the demand for caregiver support, usually referred to as respite care services.**
- **Family caregivers of those with Alzheimer's experience higher risks of illness and death, particularly older spouses. One study found that strained spouse caregivers for people with Alzheimer's disease had a 63 percent greater risk of dying than persons of the same age and gender who were not Alzheimer's caregivers.**

Relatively few family members have the training that might help prepare them for the role of caring for to a loved one afflicted with dementia. The question that stares us in the face then is this: <u>How can we help family caregivers of persons afflicted with Alzheimer's and related dementias?</u> To help us answer this question, let's first look at issues that are specific to dementia caregiving.

- **The enormous personal burden on caregivers includes emotional strain and grieving, unexpected financial drain, social isolation as the demands of caregiving increase, and the caregivers' own health problems, particularly if they themselves are elderly.**

- **Caregivers have unique needs because of the complexity of the disease process. Dementia diseases may follow an unpredictable course. The caregiver must deal with constantly changing needs, and the level of care changes as the disease runs its course.**

- **Persons afflicted with Alzheimer's and related dementias may live for years, and caregivers face years and even decades of providing care. Persons afflicted with these dementias eventually lose the ability to understand and communicate, may exhibit unusual behaviors, wander, and may even threaten their own or the caregiver's safety.**

- **Caregivers need respite care and dementia-specific support services.**

<u>Our best current option to help family caregivers is Project C.A.R.E.</u> This program provides information, referral, consultation and linkage to caregivers of persons afflicted with Alzheimer's disease. Eligible families receive financial support to help pay for respite services. By helping families keep loved ones with Alzheimer's and related dementias in the home longer, less time is required for any institutional care.

The main focus of Project C.A.R.E. is to serve families who are in the greatest economic need and are unable to pay for respite on their own. Most Project C.A.R.E. recipients are just above Medicaid eligibility or on a waiting list for Medicaid or other public funds. Those who can afford to pay for respite care services generally fall into the "consultation only" category. Caregivers at all economic levels find the consultation, referral, information, and linkage services to be very important resources.

There are two important features of Project C.A.R.E. that I shall address. First, there is the help caregivers get to maintain their mental and physical health and the knowledge and skills they gain to help them deal with the person for whom they are caring. Most families prefer to keep their loved ones at home as long as possible. The result is a higher quality of life for both persons with dementia and their families. When caregivers receive Project C.A.R.E. services, it makes a real difference in their lives. This point is made in an article that appeared in the February 21 edition of the *Smoky Mountain Times* telling the story of Ardis Thomas, a courageous wife who, for 18 years, has been caring for her husband Dempsey at home as Alzheimer's disease steadily steals him away. She tells what a difference Project C.A.R.E. is making in her life. It is good to have

this kind of news about a caregiver. Too often we read sadder stories about caregivers who break under the unrelenting strain, kill the person they are caring for and then commit suicide. There should be little argument with the fact that caregivers need help to prevent burnout. Project C.A.R.E. provides that help.

The second major feature I want to discuss is the way Project C.A.R.E. can affect public expenditures for the care of persons afflicted with Alzheimer's and related dementias. The program enables caregivers to keep their loved ones at home as long as possible. As a result, there are substantial savings in public funds because of the shorter time that persons afflicted with Alzheimer's and related dementias will spend in any institutional care.

Public financing of institutional care is a complex topic. These costs are specific to each individual and vary depending on level of care that has to be provided and the kind of institution providing the care. As the disease progresses, the level of care may change, the kind of institution may change, and the cost of providing the necessary care may change.

Although there is no single number that describes the savings in public funds that result from delaying institutionalization for one year, I believe that the minimum savings are remarkable. Using current North Carolina rates for assistance, it costs a minimum of $23,000 per individual per year to provide institutional care for an Alzheimer's patient in an Adult Care Home Special Care Unit. Many of these individuals require a higher level of care. The most recent data from Jackson County, for example, show public costs going as high as $52,000 per individual per year.

Project C.A.R.E. must continue to operate if it is to keep providing services for caregivers and if the public purse is to continue to benefit from reduced costs for institutional care. If the General Assembly acts this spring to provide the $500,000 required to sustain Project C.A.R.E., we shall be able to move to the next question: <u>How do we bring the benefits of Project C.A.R.E. to the all counties in North Carolina, particularly those in eastern North Carolina?</u>

I have no wish to be tiresome, but I must repeat that the future of Project C.A.R.E. is in doubt. Federal grant funding for this program ends June 30, 2008. Action by the General Assembly is urgently needed after it convenes on May 13. If federal funding is not replaced by state support, over 500 families will lose critically important support and respite services, as will all those families who might have been served in the future. Hopes of expanding Project C.A.R.E. to other counties will fade away.

If the General Assembly does provide $500,000 in annual recurring funds, Project C.A.R.E. will be able to do the following:

- Sustain services in the 14 counties currently being served.
- Restore the annual family spending cap on respite care services to the original $2,500.
- Pursue federal funding and private foundation grants for program expansion.

- **Use expansion funding to establish new program sites in eastern North Carolina and the upper Piedmont.**

- **Move toward statewide implementation.**

Based on the experience we have gained in the 14 counties with Project C.A.R.E., we have gained valuable insights that will help us expand the program.

- **We know that the expansion must be done in stages to maintain the quality of services and level of program fidelity.**

- **We know that the largest expense, as it should be, will be the funding for direct respite care services for caregivers.**

- **We know that once Project C.A.R.E. becomes established within a community the demand for respite care will increase. A very important reason for the increase in demand is that families begin telling their stories of how Project C.A.R.E. helped them. Then other families in need are emboldened to reach out for help.**

- **We have every reason to expect delays in the time institutional care must begin. According to recent survey data, "approximately 92% of client families report that Project C.A.R.E. services allowed them to provide care at home longer." Another survey found that families that did not receive respite support were more likely to have placed their loved one in a long term care facility.**

Project C.A.R.E. has many supporters, including several key organizations have declared it to be among their top legislative priorities. In addition to the Senior Tar Heel Legislature, they are the North Carolina Association on Aging, the North Carolina AARP, the North Carolina Adult Day Services Association, and the Governor's Advisory Council on Aging.

I shall conclude my remarks with a brief account of the Regional Forums for Project C.A.R.E. that the Senior Tar Heel Legislature is sponsoring. We have a statutory duty to inform older adults about matters before the General Assembly. At these Regional Forums we shall explain the Project C.A.R.E. approach and hear from caregivers about their experiences before and after becoming program participants. Community partnering and respite provider perspectives will be highlighted. Members of the General Assembly will be invited to attend and will be offered the opportunity to speak. The first Regional Forum is scheduled for March 11 in Haywood County. Discussions and planning activities have begun for forums in Forsyth County, Mecklenburg County, Rutherford County, and Wake County. Other locations, particularly in Eastern North Carolina, are being explored.

Thank you for the opportunity to speak today.

Project C.A.R.E. (Caregiver Alternatives to Running on Empty)

Lisa P. Gwyther, MSW, Duke Aging Center Family Support Program
Raleigh, NC February 28, 2008

Representative Farmer-Butterfield, Senator Malone and Commission Members:

I'm Lisa Gwyther, a social worker with the Duke Aging Center. I have worked with people with memory disorders and their families for 30 years as founder and director of Duke's Family Support Program. In addition, I direct education for the Bryan Alzheimer's Disease Research Center at Duke.

A brief history of NC's support for families facing Alzheimer's is important.

- In 1984, with a mandate from the Administration on Aging, the NC Division of Aging and Adult Services recognized and responded to the unmet need for information and support services for families facing Alzheimer's. Subsequently, based on a state appropriation of $200,000, the Division has contracted with Duke and the two state Alzheimer's Association Chapters to offer a unique statewide Duke information clearinghouse and statewide Alzheimer's Association support system currently available to every North Carolinian. Project C.A.R.E. has the potential to strengthen the State's response to any NC family facing AD.
- In 1999, Division staff worked with Duke's Family Support Program and Western NC Alzheimer's Association to write a successful Administration on Aging funding proposal for Project C.A.R.E. A two-sided summary of facts about how PC works is in the handout.

Why Project C.A.R.E.?

- The key features of this dementia-specific family-centered program are solidly grounded in evidence-based research and the NC experience on how best to provide respite or time outs for families caring for relatives with Alzheimer's or a related disorder. We intentionally designed the Program to be dementia-specific and family-centered based on what we knew it would take to make a meaningful difference in the lives of Alzheimer's families.
- Project CARE is dementia-specific because the evidence base exists to provide quality personalized services in ways uniquely suited to the expectable changes in the course of a progressive or degenerative dementia.
- Project CARE is family-centered because Alzheimer's affects entire families and the quality and personalization of long term services and supports for the immediate future depends upon supporting this rich but stretched-beyond-capacity care source. Project

C.A.R.E. is ethical family policy of which any NC community could be proud.

- **The Program addresses two immediate public health threats – the increasing numbers of people affected by AD and the known risks to health of family members who provide 80% of all care their relatives with Alzheimer's require over an 8 to 20 yr. course.**

Why NC funding for Project C.A.R.E. Now?

Today, we have a pivotal opportunity for a first-ever state legislative investment of $500K to integrate and expand Project C.A.R.E. within NC's Long Term Services and Supports program. $500K is a small amount relative to NC's total public costs for long-term care. Today, we can build on a successful 7 yr federally-funded experience or we can lose a well-developed program and key leveraged partners ready to help us expand this program beyond 14 counties in Western Carolina.

What do you need to know about Alzheimer's (AD) family care?

Caring for someone with AD is different, more stressful and even more complex than family care for other chronic illnesses. Sadly, people with AD are primarily older and more likely to have those other multiple complex chronic conditions, which are only made worse and more costly by confusion and memory loss.

1) **Family care is low tech, intense, personal and unrelenting. Families must plan, organize, decide, and initiate everything affecting their relatives while remaining constantly vigilant as the person's behavior and capacities become unreliable and unpredictable. Families become care managers, decision makers, and direct care providers 24/7 for many years of overwhelming uncertainty.**
2) **We know this type of unrelenting chronic stress has long-term negative health consequences that make these presumably well family caregivers vulnerable to an array of serious chronic conditions. In essence, families as our defacto long-term Alzheimer's care system come to need the same long term services they are providing. Actually, there is direct evidence from CDC studies in NC that 30-40% of current family caregivers for people over 60 in NC are disabled themselves.**
3) **As Alzheimer's progresses, the person becomes less aware of his/her capacities and needs for help, and less able to understand and follow directions, reasonable explanations or safety precautions. People with Alzheimer's are often resistive to those closest to them, People with AD are also terrified living in a world that no longer makes sense.**
4) **Families must make decisions and take over despite vehement objections from their impaired relatives and sometimes from well-**

meaning family members or friends who just don't understand. All the while these responsible family caregivers feel overwhelmingly sad and lonely watching their loved ones suffer the loss of capacities, identity and control.

5) If families seek help, they find an aging and disability service system designed only for acute short term needs of cooperative independent frail older people. The community-based service system offers one-size-fits-all minimalist services and unrealistically long waiting lists. Services are focused only on the elder (not younger persons who also have memory disorders, and with no consideration of the needs of families trying desperately to help their loved ones remain in a familiar home and community.)

6) By the time families look for outside help, respite or a break, they need a whole array of other information and supports. But without timely help, guidance and concrete supports, they are most likely to wait for something to break down, forcing hospitalization and placement decisions without ever learning about or trying to use community supports. This year Project C.A.R.E. is testing a unique partnership with Mission Hospital in Asheville offering respite options that could help hospitalized people with AD return home with the special help they need at a most vulnerable time.

7) In NC, there is an ever-larger "no care" zone for Alzheimer's families – these families are rural, poor, minorities, people unfamiliar with and/or ineligible for Medicaid or public social services. At the same time, they lack resources to hire private home help. These are the people who incorrectly assume Medicare will pay for health care and they reasonably but incorrectly assume Alzheimer's is a disease legitimizing care. These are the people who don't call, read or request information from the Alzheimer's Association because they don't know they are dealing with Alzheimer's and they don't know the potential value of the help available. They are isolated by the demands of care, a relative's bizarre behavior and these families are often too overwhelmed and fatigued by juggling Alzheimer's care with other family and work commitments to know where to start.

8) There is ample research evidence that the risks of isolated family care increase the likelihood of elder mistreatment or neglect. These families assumed family, church or neighbors would just fill in. These are people who assumed care was just about what doctors and nurses did and not the intimate 24/7 personal care helping with bathing or helping an opposite-sex resistive parent to the toilet.

9) Project CARE's prompt in-home guidance from trained and experienced family consultants (not family therapists or case managers with all the scary stigmatizing effects of those words) is simple for families to access and use when they need it. There is no blaming about "why didn't you buy long-term care insurance?"

10) **Project C.A.R.E's family consultant is a member of your community, respectfully standing on your home turf, and offering just the right concrete help (in the form of up to $2000/yr for each family to spend in a way that permits maximum consumer-or-family-direction). This is real family support, without forcing families to give up control or their diverse values and preferences. This family consultant model sets Project C.A.R.E. apart from standard services that offer everyone that survives long waiting lists, a very small amount of the same thing.**

11) **We know the buck stops with the family – ultimately everything that happens to a person with diminished thinking and memory, is the responsibility of his/her family. Families generally want to honor commitments to each other, but they can't do it alone. The family consultant may help families become aware of options, like adult day services, that they would never have considered because "Mama doesn't like being around all those old sick people". Often, the fresh perspective of the family consultant helps large extended families resolve conflicts about what help is best. Sometimes, what family consultants do best is to mobilize other relatives and friends to further support family care.**

12) **Now Project C.A.R.E. is integrating their specialized knowledge with NC's emerging network of Aging and Disability Resource Connections, making sure people calling for help anywhere in NC find specialized dementia-capable help on the phone or online.**

We have an opportunity in NC to build upon a strong foundation and public/private partnerships to expand this program with minimal state support. NC Foundations are watching the NC legislature, eager to jump on a successful program with a sustainable base in a state appropriation. County agencies and families outside our current 14 county service area are asking for Project C.A.R.E. The Program's consumer-directed base has the right protections and supports to expand the potential work force and to meaningfully educate and support families who prefer to care at home.

NC's Project C.A.R.E. deserved to win those national best practice awards listed on your handout. But now federal agencies, the national Alzheimer's Association and NC foundation leaders are asking, "if NC has such a model program, why is there no state investment?"

We have shown that Project C.A.R.E. changes communities – NC is working toward senior-friendly, livable communities where people can continue to actively participate despite chronic illness or disabilities. Project C.A.R.E is creating public/partnerships and community investments resulting in liveable dementia-friendly and dementia capable communities.

Project C.A.R.E. has even stabilized and enhanced workforce development in home care and adult day centers, particularly in isolated rural non-farm communities where mills and plants have closed and unemployment is high. Well-trained home care aides serving families in African-American Forsyth County neighborhoods are now willing to travel to serve families in rural Surry and Stokes Counties where dementia-capable home care services weren't available.

Project C.A.R.E. Family Consultants have successfully leveraged and coordinated the fragmented service systems to make them work for Alzheimer's families in a way that enriches local service systems now and for future users.

SUMMARY

Project C.A.R.E. is minimalist – a small state investment offers specific, targeted comprehensive, quality support addressing a growing public health threat to family members of all ages. Project C.A.R.E. is not just another aging program – it's a family program with positive economic and social benefits to entire communities. We are all at risk of Alzheimer's or of becoming an Alzheimer's family caregiver – we owe it to families now and in the future, to provide meaningful support while we wait for eventual prevention, delay, treatment or cures for Alzheimer's disease.

APPROACH:

Project C.A.R.E. Family Consultants use a family-centered, home-based assessment intervention. In-home assessments are preferred because they are responsive to caregiver time and energy constraints. During the home [redacted] the Consultant:

- assesses the family care environment;
- identifies the needs and preferences of both the caregiver and the person with dementia;
- facilitates discussion and mutual understanding among family members;
- connects the family with community resources; and
- ensures the provision of quality respite care and support services.

The personalized approach of the Family Consultant fosters family trust, offers individualized caregiving and coping skills, and encourages caregiver self-care. Project C.A.R.E. helps families learn the value of quality dementia-specific respite services and feel empowered to make self-directed, informed decisions about care.

The Project C.A.R.E. model builds upon, enhances and sustains existing home and community-based services by using local providers to deliver respite care while serving as a direct link to the expertise and resources of the Alzheimer's Association. Project C.A.R.E. also connects families to the NC Family Caregiver Support Program, Aging and Disability Resource Connections (ADRC), Hospice and other caregiver-focused initiatives creating a strong network of community support for Alzheimer's families. This comprehensive system of care strengthens the family's capacity to manage the ongoing and diverse challenges inherent in caring for a person with dementia, enabling families to provide care at home longer.

"Upon arrival into the home, families are often paralyzed by their experience. I begin, first, by teaching the caregiver how to accept [redacted]lp, practice better self care and make informed care decisions."

~Project C.A.R.E. Family Consultant

"That one day a week means everything to me. I am a different person— my friends all tell me I am a different person"

~Project C.A.R.E. Client

FUNDING:

- Total federal funding (Title IV OAA): **$325,000** (1 year grant – ends June 30, 2008)
- Total budget: $433,333 (includes 25% local match)
- Funds for direct respite services: **$226,950** (minimum required: 50%)
- Flexible spending cap for respite care: $1500 - $2000 per family [Note: The initial $2500 annual cap was reduced due to reductions in program funds– i.e., recent expansion occurred without any additional funding.]
- ***State funding level needed to sustain Project C.A.R.E. after June 2008**: $500,000 + local match [*Will cover current program expenses, restore $2500 annual respite cap and allow equal distribution of direct respite care funding across service areas.]

PROGRAM MANAGEMENT:

- **NC DAAS State Project Director** – Karisa Derence (existing position: in-kind match)
- **Western Carolina Alzheimer's Association** - 3 Full-time Family Consultants + 1 Family Consultant Supervisor/Outreach Specialist for thirteen counties (currently funded through federal grant)
- **Mecklenburg County Department of Social Services** – 1 Part-time Family Consultant + 1 Part-time Family Consultant Supervisor/Outreach Specialist (county funded positions)
- **Duke Family Support Program** - provides consultation and training support to Project C.A.R.E. staff, local providers, referral sources and client families (funded through DAAS Alzheimer's Support Program)
- **Four Area Agencies on Aging (Regions A, B, C, I, and F)** - Family Caregiver Resource Specialists assist with outreach, training, client referrals, needs assessment and community resource inventories (funded by the NC Family Caregiver Support Program)

**For more information, please contact Karisa Derence at (919) 733-0440 or karisa.derence@ncmail.net*

IIIA Steve Freedman

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"

A National Best Practice Model for Respite Care

SUMMARY:

The North Carolina Alzheimer's Demonstration Program, Project C.A.R.E: "Caregiver Alternatives to Running on Empty" uses a family consultant model to provide consumer-directed respite care and comprehensive support to dementia caregivers. ***The goal of the program is to increase quality, access, choice, and use of respite and support services to low-income rural and minority families caring for a person with dementia at home or within a hospital setting.*** Through the integration of dementia-capable services and the development of family-centered and caregiver-focused community care networks, Project C.A.R.E. can help 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 through the Division of Aging and Adult Services (DAAS) with expert consultation and technical assistance provided by the Duke Aging Center Family Support Program. Project C.A.R.E. is implemented at the local level through Family Consultants employed by and/or supported through the local Alzheimer's Association. The program is currently based within the Mecklenburg County Department of Social Services and two area offices of the Western Carolina Alzheimer's Chapter. The Mountain Area office in Asheville serves as the project training and data management center for all new and existing program sites and staff.

Project C.A.R.E. employs Family Consultants with expertise in Alzheimer's disease and related disorders. The Consultants visit the homes of referred dementia caregivers in crises and offer timely, individualized assessment, guidance, counseling, support, advocacy, coaching and education. Their aim is to match families with the most appropriate and preferred local respite and community services tailored to their unique situation and 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 currently **three pilot sites** set up to serve the following **fourteen counties**: Charlotte (Mecklenburg County), Winston-Salem (Forsyth, Surry, and Stokes); and Asheville (Polk, Henderson, Transylvania, Rutherford, Madison, McDowell, Buncombe, Haywood, Jackson and Swain).

"Your support and encouragement was most timely and brought a sense of order into our lives."
~Project C.A.R.E. Client

"Getting a break certainly helps me keep a smile on, and makes me a better person to give him the care he needs and deserves."
~Project C.A.R.E. Client

"It is wonderful to know she is cared for and safe when I'm at work. We could never have kept (our mother) at home this long without Project C.A.R.E. It has been so very, very helpful to us."
~Project C.A.R.E. Client

NATIONAL RECOGNITION:

- **2005 National Best Practice Model** – US Administration on Aging and RTI International
- **2005 National Innovative Program Clearinghouse Award** – National Alzheimer's Association
- **2005 National Conference of State Legislators** – featured by the National Alzheimer's Association as a national model for home and community-based care coordination
- **2004 Geriatric Best Practice Award** – Southeast Regional Geriatric Best Practices Initiative

The North Carolina Joint Study Commission on Aging
Representative Jean Farmer-Butterfield, Co-Chair
Senator Vernon Malone, Co-Chair

PUBLIC HEARING
Thursday, March 6, 2008
10:00 AM
Upper Coastal Plain Development Center
121 West Nash Street, 3rd Floor
Wilson, NC

The Joint Study Commission on Aging held a Public Hearing on Thursday, March 6, 2008, in Wilson, North Carolina.

The following commission members were in attendance: Representative Jean Farmer-Butterfield (Co-Chair); Senator Stan Bingham; Senator Katie Dorsett; Representative. Joe Boylan; Senator A.B. Swindell, IV; Representative Garland Pierce; Mr. Anthony Peace; Honorable Karen Gottovi; Ms. Judy Pelt; Mr. David Lowa; Ms. Jean Reaves and Mr. Jackie Sheppard, Ex-officio member. Also present were Research staff Theresa Matula and Shawn Parker and commission clerk Ruth Merkle.

A visitor registration sheet and copy of the Agenda are attached as part of these Minutes.

Representative Farmer-Butterfield chaired the meeting and introduced the commission members, research staff, commission clerk and the sargeants-at-arms. Wilson City Manager Grant Goings welcomed the commission members and visitors and gave brief remarks. Rep. Farmer-Butterfield then recognized Mr. Greg Godard, Executive Director of the Upper Coastal Plain Council of Governments, who welcomed the public to Wilson.

Following remarks by Mr. Goings and Mr. Godard, Rep. Farmer-Butterfield opened the floor to the public. A list of the speakers and written comments are attached for the record. (See attachments 1-43).

The following speakers made comments but did not leave a copy of their remarks:
Mr. Brad Allen, President of the North Carolina Senior Games, spoke in support of Senior Games and its benefits to aging North Carolinians.
Ms. Rebecca Bayse representing the JW Faison Senior Center of Northampton County, a recently certified private non-profit senior center, requested that funding for senior centers be increased.
Ms. Harriett Van Dyne, a resident of Northampton County, spoke of the lack of transportation services for seniors and the need for more funding for these services.
Ms. Alicia Johnson, a resident of Nash County and the primary caretaker for her father. She spoke on his behalf and asked that the general assembly continue funding senior centers.

Ms. Mary Rick Todd, Manager of supportive housing for a housing agency. She requested recurring funds of $20 million each year for the Housing Trust Fund. Her comments also focused on the predatory lending crisis; specifically, including wording in the current statute for mandatory face-to-face counseling for seniors considering reverse mortgages.
Ms. Carolyn Fulchun of Wilson, North Carolina. She spoke in support of Senior Games.
Ms. Josephine Harrison, an advocate for her sister. She asked for continued legislative support for mental heath and aging services.
Ms. Janet Wilhalf, a caregiver for her disabled brother. She requested increased funding for adult day care centers.
Ms. Janet Baker, a caregiver for her husband. She requested increased funding for adult day care centers.
Ms. Roxanne Bragg-Cash – President of the North Carolina Coalition on Aging and Director of the Franklin County Department of Aging. She requested increased funding for community block grant programs and senior centers.
Mr. Charlie Byrd, on behalf of the Pitt County Senior Center. He spoke in support of home and community care block grants.
Ms. Cynthia Davis, Area Agency on Aging. She supported increased funding for home and community care block grants, senior centers, and senior games. She also encouraged "Medicare Advantage" protection for seniors.

Following the public comments, Rep. Farmer-Butterfield thanked the speakers for coming and assured them that their concerns had been heard and shall receive serious consideration. She also expressed appreciation to Heather Proctor and Selena Beaman of the Upper Coastal Plain Area Agency on Aging, and Greg Godard from the Upper Coastal Plain Council of Governments for their untiring support and for the use of their facility. Representative Farmer-Butterfield ended her remarks by encouraging the public to call, write or email the commission members and those on the Appropriations Committee.

The Public Hearing ended at 12:05 pm.

Respectfully submitted,

Representative Jean Farmer-Butterfield
Co-Chair, Commission on Aging

Ruth Merkle
Commission Clerk

Ruth, These are the people who spoke, Record their names + association or get these from Heather + Greg Godard at area agency on Aging - Upper Coastal Plains Region L in Wilson.

SIGN-UP SHEET

To Speak Before the Study Commission on Aging

To: Members of the Public

Those wishing to make remarks should sign-up on this sheet. Names on the list will be called by the chair and each individual will have five minutes to address the Commission.

If possible, please furnish hard copies of your remarks to the Commission Assistant.

URGENT Save this list also ~~William Pop~~ Thanks Jan

PLEASE PRINT CLEARLY

1- Greg Godard — Exc. Director - UCPCOG

Name of Individual (Please Print)	Name of Association (If Applicable)
2- Anessa Williams	
3- Steve Smith	Interim Health Care
4- Jane Banks ✓	Ashe Services for Aging
5- Mary Owen —	Ashe Services for Aging
6- BRAD ALLEN	N.C. SENIOR GAMES INC.
7. Donetta Steiner	Creative Living Center
8. EFTON SAGER	EAST CAROLINA CUG PRESIDENT
9. Bill Hayes	Pitt County Memorial Hospital
10 Heather Proctor	Upper Coastal Plain Area Agency on Aging
11 Carolyne Everett ✓	Grace Martin Harwell Senior Center
12 Rebecca Bayse ✓	JW Faison Senior Center
13 Harriet Van Dyne ✓	
14 Judith Moss ✓	NC Sr. Games
15 WILLIAM MILLER ✓	AARP Advocacy
16 Bushy Brown ✓	
17 Jean Harris ✓	RAAC / HCCBG Committee
18 Robert Cook	Multiple Sclerosis
19 Richard C Hatch	AARP
20 Diana D. Hatch	AARP
21 ~~Mary~~ Bethel (Mary)	AARP
~~22 Bill Miller~~	~~AARP~~
~~23 Bill Hill~~	
22-24 ✓ JOHN THOMAS	HOSPICE OF WAKE COUNTY / HORIZONS HOME CAR
24-26 ✓ AL Keyes ✓	AARP ADVOCACY
25-27 Chip Moffin ✓ Chip Moffin	AARP ADVOCACY
25-27 Tonya cedars ✓	Eastern Carolina Council Area Agency on Aging
26-28 Audrey Tyson ✓	ECCAAA STHL - Lenoir Co.
27-29 Jamie Wilson ✓	Nash County Senior Center

	Name of Individual	Name of Association or Organization
	Agnes Moore	Nash County Senior Center
29	EDWARD L. THOMPSON ✓ (NO)	NASH County Senior Ctr.
30	Alesia Johnson ✓	Nash County Senior Ctr.
31	D.H. Wilson	AANP. ✓
	~~[illegible]~~ ✓	~~Geriatric / Adult Mental Health Specialty~~
32	Mary Reed Todd ✓	North Carolina Nurses Association Legislative
33	Jessie McDonald	Pitt Co. Senior Games
	~~Gordon Walker~~	~~Pitt Co Senior Games~~
34	Carolyn Fulghum ✓	Greenville Pitt Ct.
35	Josephine Harrison ✓ ✓	Nash County resident
36	Dale Banks ?	Ashe Services for Aging
37	~~Mary Owen~~ ?	" " "
38	Tom PAULING ✓	Greenville-Pitt County Sr Games

Name of Individual	Name of Association or Organization
Doris Hovington ✓	Wright Sr. Center / NCADSA
Janice Bafery	"
~~Esmeralda Reeves~~	~~"~~
Dan Mura ✓	Nash Co. OSS
~~Carol Brewer~~ ✓	Nash Co. DSS
~~Renee Nicholas~~ ✓	Wright's Center Roy Nut NC
~~Roxanne Boggs-Cash~~	NC Coalition on Aging / Franklin Co. Dept of Aging
~~Charlie Byrd~~	Pitt County Senior Center
~~Bill Pickett~~	
~~Cynthia Davis~~	TRIAD EAST
Lady from audience	not signed up

Speakers at the March 6, 2008, Public Hearing in Wilson, North Carolina

1. Mr. Greg Godard, Executive Director, Upper Coastal Plain Council of Governments
2. Ms. Anessa Williams, Personal Care Service Worker
3. Mr. Steve Williams, President, Interim Health Care
4. Mr. James Banks, Executive Director, Ashe Services for Aging, Inc.
5. Ms. Mary Owen, Finance Officer, Ashe Services for Aging, Inc.
6. Mr. Brad Allen
7. Ms. Donetta Steiner, Executive Director, Creative Living Center
8. Mr. Efton Sager, Wayne County Commissioner
9. Mr. Bill Hayes, Pitt County Memorial Hospital
10. Ms. Heather Proctor, Director of the Upper Coastal Plain Area Agency on Aging
11. Ms. Carolyn Everett, Grace Martin Harwell Senior Center, Washington, NC
12. Ms. Rebecca Bayse, JW Faison Senior Center, Northampton County
13. Ms. Harriett Van Dyne,
14. Ms. Judith Moss, Tarboro, NC
15. Mr. William Miller, AARP, Edenton, NC
16. Ms. Becky Brown, Wilson, NC
17. Ms. Jean F. Harris, Conetoe, NC
18. Mr. Robert Cook, Wilson, NC
19. Mr. Richard Hatch, AARP North Carolina
20. Ms. Diana (Dee) Hatch, AARP State President
21. Ms. Mary Bethel, AARP North Carolina
22. Mr. John Thoma, Chief Executive Officer of Hospice of Wake County
23. Mr. Al Keyes, AARP, Jacksonville, NC
24. Mr. E.C. Modlin, AARP and retired Director of the Cumberland County Dept. of Social Services
25. Ms. Tonya Cedars, Director, Eastern Carolina Council Area Agency on Aging
26. Ms. Audrey Tyson, Sr. Tar Heel Delegate for Lenoir County
27. Ms. Jamie Wilson, Sr. Center Coordinator, Nash County Senior Center
28. Ms. Agnes Moore, Nash County Council on Aging
29. Ms. Alesia Johnson, Nash County Senior Center
30. Mr. Bill Wilson, Advocacy Co-Director, AARP North Carolina
31. Ms. Mary Rick Todd, North Carolina Housing Finance Agency
32. Ms. Carolyn Fulchun, Greenville –Pitt County Senior Games
33. Ms. Josephine Harrison, Nash County
34. Mr. Tom Pauling, Greenville-Pitt County Senior Games
35. Ms. Doris Howington, President, NCADSA, The Wright's Center, Rocky Mount
36. Ms. Janet Wilhalf, Rocky Mount, NC
37. Ms. Janice Baker, Rocky Mount, NC
38. Ms. Mary Murray, Nash County Social Services
39. Ms. Jean Browder, Social Worker
40. Ms. Roxanne Bragg-Cash, NC Coalition on Aging
41. Mr. Charlie Byrd, Pitt County Senior Center
42. Ms. Cynthia Davis, AAA Agency on Aging

Submitted Comments: Mr. Ken Bowen, Washington, NC

L. Greg Godard

North Carolina Regional Councils
Comments to the Study Commission on Aging
Regarding 2008 Legislative Agenda for Aging Issues
March 6, 2008

Honorable Senators and Representatives, and Members of the Study Commission:

I am Greg Godard, Executive Director of the Upper Coastal Plain Council of Governments and Chief Executive Officer of the Upper Coastal Plain Development Corporation the operator of the Business Development Center/Small Business Incubator. We are happy to host this important meeting. Welcome to our region.

I am here today representing the 17 North Carolina Regional Councils. I appreciate this opportunity to speak to you and to personally thank you for the support you gave us last year when we sought restoration of Area Agency on Aging funding to the 2001 level. As you know, we did receive partial restoration and we remain thankful for the increase.

In 2001, seven years ago now, as one of your recommendations each of our AAAs received $57,900 in Administrative Support Funding. Today, we are receiving only $45,424. The North Carolina Regional Councils highlight *Aging and Long Term Care Needs for the Older Adult Population* as one of our four priorities in our 2008 Legislative Agenda. I have provided you a copy of my comments and the agenda.

We have one request for Aging Programs and that is to Restore Administrative Support Funding to the 2001 Level. It is the only message I am here to deliver to you today.

The North Carolina Regional Councils are seeking legislative action to increase the current funding by $212,000 (recurring). This amount will bring the AAAs back to the 2001 funding level and will assist us with administering the over 23 million dollars in service funds in our state and help with the ever increasing advocacy initiatives undertaken by the Area Agencies on Aging.

For example, AAAs assisted thousands of older adults with choosing a Medicare Prescription Drug Plan during open enrollment from November 15 – December 31. This six week period is an intense time for our agencies annually.

Other current advocacy initiatives include the transition to digital television which will impact many older adults and the new economic-stimulus package signed into federal law in February. In order for older adults to receive the rebate, granted them in the stimulus package, they must complete certain sections of Form 1040A. The older adults that will most benefit from the $300 rebate are the same ones who would normally not file a tax return. These advocacy initiatives, and many more each year, take a great deal of staff resources.

Again, I come with only one message; please support our efforts to Restore Administrative Support Funding to the 2001 Level. Help us to continue to provide needed assistance to our older adults and family caregivers in North Carolina.

Thank you for the opportunity to speak to you today. I will be happy to answer any questions,

NORTH CAROLINA REGIONAL COUNCILS
2008 Regional Legislative Priorities

Funding for Regional Planning Services

Seek an increase in state funding for the seventeen regional councils, as lead regional organizations, to assist more local governments with community and economic development activities. Additional funds will enable regional councils to provide more assistance to Tier 1 counties and other distressed communities. Current funding is $59,950, including $10,000 in Non-Recurring funds appropriated in the 2007 Session. *The objective is to make the$10,000 increase recurring in the2008-09budget, and ultimately increase funding to $100,000 per region, or a total of $1.7 million.* [NCLM Goal 2.4; NCACC page 10]

Funding for Regional Water Resource Management

Seek funding for regional councils to develop and implement multi-jurisdictional water resource management planning in every region. Interlocal, regional cooperation among local governments, water users, and other stakeholders is recognized as the most effective way to protect water supplies, maintain water quality and address drought and other problems. Regional infrastructure alliances take time and professional staff, which regional councils are in a position to offer. *Regional Councils will seek an appropriation of $1.4 million in the 2008 Session. Working in partnership with DENR and other agencies to secure funding, regional councils support policies and legislation that foster regional approaches to water infrastructure.* [Concept adopted by NCLM Board in August 2006]

Funding for Rural Transportation Planning Organizations

Continue support of North Carolina's RPO program by maintaining current levels of funding and enhancing the influence of rural areas in the transportation planning and programming process. [NCACC p. 10; related to NCLM 4.16]

Aging and Long Term Care Needs for the Older Population

Seek legislative action to ensure that there is adequate funding for services and planning activities for the 17 Area Agencies on Aging. *This would restore funding for professional and administrative services to the 2001 level of $57,900. In 2007 the General Assembly added $300,000 to Area Aging Agencies funding, raising each region to $45,424. The objective in 2008 is to increase the funding by $212,000 (recurring) to bring it back to the 2001 level.*

2. Anessa Williams

Study Commission on Aging
Public Hearing
Wilson, NC
3/6/08

- We want to thank the Study Commission for their partnership and cooperation with home care and hospice issues over many years and look forward to this commission continuing to be at the forefront of such important decisions regarding these services. In the short time that we have this afternoon, I want to provide an update on a very important program in North Carolina.

- NC's in-home personal care services program, which is better known as PCS, was mandated by the General Assembly 3 years ago to be restructured. PCS is a long standing Medicaid program that serves aged and disabled consumers with licensed home care agency in-home aide services under the supervision of registered nurses. Home Care and Hospice partnered with DHHS and various stakeholders to restructure PCS which took almost 2 years to do. Fortunately for a lot of elderly, disabled adults, and even children in NC, the restructuring efforts have been very successful. The growth in PCS was a concern 3 years ago. **Today, PCS is projected to come in slightly under budget this fiscal year - despite the growth in our aging population.** Thoughtful and well planned restructuring has brought the PCS budget under control by putting in place clear admission criteria and task/time guidance and ensured that appropriate patients are served with appropriate services. We are very proud that we helped achieve this goal for North Carolina and its citizens.

- PCS restructuring was a multi-prong approach - for example: our home care licensure rules now have strict requirements regarding agency director qualifications and aide qualifications. The PCS policy requires certification of the registered nurses performing the patient assessment. Two time points of physician prior approval of the services are still required and the new NC Medicaid Uniform Screening Tool (MUST) will also be required. The admission criteria and assessment tool were completely re-worked to mirror proven national models. The PCS program has also strengthened provider accountability through a contract for utilization review and ongoing audits to assure compliance with policies and procedures.

- Thank you for allowing us to be here today. Senator Malone and Representative Farmer-Butterfield...this concludes my remarks.

3. Steve Smith

Remarks to the Aging Study Commission of the N.C. General Assembly
Thursday March 6, 2008 Wilson, N.C.

I am Stephen M. Smith, president of Interim HealthCare of the Eastern Carolinas. This is our twenty-fifth year of providing home care to approximately 1,200 citizens of southeastern North Carolina. In-home aide services, and specifically the Medicaid Personal Care Services (PCS) and the Community Alternative Program for Disabled Adults (CAP-DA) , both non-mental health services, prevent or delay the institutionalization of thousands of elderly and disabled adults, thus providing them their freedom and independence, while at the same time being significantly more cost-effective than institutional care.

I want to leave you today with ten recommendations, centered around three major issues: quality; efficiency and a qualified stable workforce.

First quality. I urge the passage of House Bill 964, which enhances the Home Care licensure laws. Secondly, I encourage that the focus on standards surveys be placed on home care agencies who have been licensed less than three years, and who have never been surveyed. Given limited resources, I recommend that the current moratorium on the issuance of new home care licenses be continued. Further, I recommend that home care agencies be prohibited from the giving of any item of material value to patients. Additionally, I think it would be fair and prudent to afford home care agencies a " cure period" to resolve patient complaints, before a Medicaid patient can transfer to a new agency. Constant transfers creates inefficiencies and churns the Nurse Aide workforce. Along that line, I am deeply concerned about the Nurse Aide workforce that is so desperately needed for an effective and efficient long term care

system in North Carolina. Due to time limitations, let me just say that an extensive study of this workforce is needed.

The State is entitled to a network of efficient Medicaid providers. I have several suggestions. Continue to require all providers of In-Home Aide Services to submit one single timely and accurate annual cost report, which reflects actual costs in providing these services. Home Care agencies not complying with this requirement should be dis-enrolled from the program.

The use of telephony, data transmission through the telephone, should be permitted for the reporting of time , attendance and clinicaldata. Requirements to document minor clock-time deviations from the patient care plan should be relaxed, which may allow nurse aides to car pool or take public transportation to provide services to clients. It creates a " paper-chase".

Existing agencies need to be allowed to be efficient by building economies of scale. This is beneficial to the State, the agency and the patients. A large network of small, undercapitalized, unsophisticated home care agencies is in no one's interest.

Lastly, I urge the continued cooperation with, and the inclusion of, the Association of Home and Hospice Care of North Carolina in all significant decisions impacting home heath and in-home aide services. This is the oldest and largest state home care association in the nation, and brings a wealth of objective and well-meaning talent to the issues affecting our State's elderly and disabled citizens.

Thank you for the opportunity to speak to you today.

Stephen M. Smith, M.P.H.
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#4

Aging Study Commission of the North Carolina General Assembly Presentation

By: Jane M. Banks, Executive Director
Ashe Services for Aging, Inc.
March 6, 2008

I am Jane Banks, the Executive Director of Ashe Services for Aging, Inc. which is located in Ashe County. I appreciate this opportunity to speak with you regarding the needs of adults with developmental disabilities. This age group is relatively new in connection to aging services. Sixty years ago, individuals with Down's syndrome typically lived to age nine. The life-expectancy now for adults with DD is almost the same as for other Americans – the early 70's.

As in many communities, Ashe County citizens with developmental disabilities, and their caregivers, face not only the effects of the disability, but physical and social isolation as well. Currently there are 397 individuals with developmental disabilities known to reside in Ashe County. Often individuals are faced with facility placement because of a lack of information about developmental disabilities, limited family coping skills, and few alternatives to placement.

Seventy-six percent of adults with lifelong disabilities live at home and have become dependent on the caregiver support of parents – parents who are aging themselves and are experiencing greater needs for their own support. According to *A Blueprint for Change,* a major issue is the "hidden" nature of this population, only coming to the attention of the service system when a crisis arises. Parents have often tried to shelter their children with DD from taunting and any type of agency involvement. These individuals are often limited in their social as well as developmental skills. One participant who came to us upon the death of his mother was 64 years old. He had no other family member to take over the responsibility of his care. The local DSS assisted in his placement in a group home, and he became a participant of the grant in our Adult Day/Health Care program. It was a much easier transition for him than to have been placed in a sheltered workshop due to his age, physical limitations and social development. He quickly became adjusted to the center and made friends with other participants.

Male with DD

People with DD can begin to experience the typical effects of aging as early as 45-55 years of age, and it is imperative that the aging service system prepares to provide appropriate services to this population. Since most adult day care funds will not reimburse for participants who live in a group setting, and the rules for group homes require the individuals to be out of the home for eight hours a day, these folks are forced to attend sheltered workshops. Many of these people have spent the majority of their adult life in a group home. They are acclimated to this environment and are comfortable with their surroundings. However, when they are no longer able, due to aging and physical limitations, to participate in a sheltered workshop, and wish to "retire," they are faced with the possibility of having to leave their long-time homes for facility placement. It is inappropriate to uproot these people from their home. Our Adult Day/Health Care program offered an effective alternative for DD retirees.

In 2003, after submitting proposals to the North Carolina Council on Developmental Disabilities, Ashe Services for Aging's Generations Adult Day/Health Care Center received a remarkable three-year service grant. This grant, along with support from the county, local businesses, and individuals, enabled individuals with developmental disabilities, including some who live in group homes, to attend our Adult Day/Health Care facility.

By providing group services in a single location, our program can better utilize funding and staff to provide the most efficient and effective program possible. We are able to provide our participants with the stimulation and enrichment offered in a day program along with medical monitoring. In addition, participants have an opportunity to socialize with a variety of individuals. Currently, our youngest participant is 21 years of age, and our oldest is 90. Many of our participants have health concerns or early dementia. Our DD participants were able to make a smooth transition into this environment and have meshed well with the other participants.

In *The Wit to Win,* the New York State Office for the Aging/Developmental Disabilities Project found that older adults with developmental disabilities can be integrated successfully into existing aging programs. That project also found that such inclusion was beneficial for participants and led to new friendships and a decline in problem behaviors. Through our Adult Day/Health Care program we have helped individuals with DD maintain an active lifestyle, combat isolation, and experience greater community inclusion, by providing a safe, stimulating environment and opportunities for them to learn new skills, increase their feelings of worth, and find dignity and purpose to their lives. Being our in midst, we have also seen a reduction in behaviors that might have caused them to be singled out in the community.

With our ever-increasing aging population, which includes individuals with DD, it is imperative that we explore issues of alternative funding to provide community services to persons with DD, providing respite to parents of adult children with DD, allowing for "retirement" of older adults with DD in group homes, and planning for future needs of adults with DD when their primary caregiver is no longer able to provide for them.

Jane M. Banks
Executive Director
Ashe Services for Aging, Inc.
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PO Box 9
West Jefferson, NC 28694
336-246-2461

#5

Aging Study Commission of the North Carolina General Assembly Presentation

By: Mary Owen, Finance Officer
Ashe Services for Aging, Inc.
March 6, 2008

My name is Mary Owen, and I have been the Finance Officer at Ashe Services for Aging since 1983. Ashe County is located in the Northwest corner of the state and is a rural, mountain county.

Our agency began as a very small, non-profit, in 1977. We started off with funding from the Older American Act, client donations, and County matching funds. Since our inception, we have continuously looked for ways to help the senior population and disabled adults in our county. Gradually, we were able to expand our services to the increasing number of rural Ashe County seniors who desperately needed our help. The start up of the CAP/DA Program was an answer to a lot of these people's prayers. Many of them lived on the same family property their parents had farmed. Through this program, these older adults, who had very little but their homes, were, with some assistance, able to remain at home as opposed to having to move into a much more costly long-term care facility. Ashe Services for Aging was one of the first CAP/DA and Personal Care Service providers in the state.

Our agency provides many different services including, congregate and home delivered meals, senior center and health promotion activities, as well as intergenerational day care. The service we have always felt was the most vital, and most needed, is our in-home aide program. To have a person come in and assist with everyday activities that most of us, at a younger age, take very much for granted, is a saving grace for many of our clients. It helps them remain independent and maintain their dignity as well as being much more cost effective than nursing home care.

In the beginning phase of Medicaid-financed in-home aide services, very little was required of the person or the agency that provided the service. Since that time, each aide now must have a specified number of hours of ongoing training each year, background checks, vaccinations, and liability insurance coverage. All of these requirements are important and improve the quality of care. However, they also increase service costs.

Our agency has strived to be a leader in providing the best quality of care. Therefore, we have participated in the Accreditation process and have been accredited five times in three-year increments.

In 1989, our agency started providing health insurance and a 401K retirement plan for all of our employees. At a later date, we also incorporated paid holidays for all employees. In a rural area such as ours, aides have to travel between the homes of clients, and we reimburse our aides at a rate of .375¢ per mile. Our belief is that the best care is provided by the best treated employees.

According to the NC Study Commission on Aging, they are in agreement with our philosophy. One of the recommendations suggested in the study was the implementation of a special licensure designation called NOVA (New Organizational Vision Award). According to the Commission's study, direct care workers are among the occupations with the largest projected job growth as well as one of the highest occupations for job turnover rates in the state.

Projections are that North Carolina will need 30,590 additional care workers between 2002 and 2012. The focus of this program is workforce development and retention of direct care workers. In 2004, the median hourly wage for a personal care aide was $8.06. The Commission stated to improve development, recruitment, and retention of these workers would also improve the care provided to long-term care clients.

This is also an important issue to unemployment in the state. As manufacturing jobs moved out of our county, we recruited, trained, and put these unemployed people to work. They were forced to accept jobs at a lower rate of pay and become trained in a job they were unfamiliar with, but it was a job and not an unemployment check.

Another issue discussed in the Commission's report is the migration of older adults to the state. According to the Study, North Carolina has the fourth highest migration rate in the country. The influx of older retirees brings a boost to the state's economy but also creates a great need for more direct care workers. As people age, they will still need help whether it's provided privately or through state-provided funds.

All of this information is only a background for the issue I bring to your attention today. When Medicaid started financing in-home aide services, the rates each year were raised accordingly with Cost of Living increases. As time passed, more was required of providers and workers to meet the requirements of the programs. In the last five years, the Cost of Living has increased 18%, and the reimbursement rate has increased 6.8%. This does not fully address the rising cost of providing health insurance, workers compensation, and professional liability coverage for these employees.

The Division of Medical Assistance bases rate increases on PCS cost reports that providers compile and send in each year for the prior fiscal year's costs. Therefore, the data is always a year behind. I have been completing this cost report for our agency from the beginning. A cost report only reflects what funds you have expended. It does not show projections of costs to come, and it does not provide for increases in wages for employees. You can't spend what you don't have. At this time, our cost for an in-home aide per hour is $12.34.

Wage	$ 9.00
FICA	.69
Unemployment	.09
Workers Comp	.29
Health Insurance	2.00
Retirement	.27
	$12.34

The cost reflects our highest-paid aide who has been employed with us since August of 1989. She makes $9.00 per hour. This cost does not include training, background checks, vaccinations, liability insurance, travel, supervision, supplies such as gloves, or any administrative cost and facility overhead. This must be paid from the $2.54 left from the current reimbursement rate of $14.88. If the rate had increased at the 18% cost of living, it would be $16.43.

Home care is the best possible care as well as being the most cost effective. It is also a growing employment need, and answer, as seniors move into our state and jobs move out. These folks in our rural county, and the rest of North Carolina, need our help and your help also. To keep up with this pace, reimbursement rates must stay level with the cost of living.

If agencies such as ours do not receive the support they need, more and more will go out of business. This will leave many hard-working, caring people without a job; but more importantly, many older adults will have no one to help them. They will be left to die at home or with no alternative but to move into a much more costly nursing home facility. These facilities are an important part of our long-term care system, but they are not the answer for everyone.

Please consider the future of our seniors in North Carolina, the retirees moving in, but more importantly, the native North Carolinians who have helped to make this state one where others want to live. Home care is the choice most prefer, and it is the one most affordable.

Thank you.

7. Donetta Steiner

Creative Living Center is an adult day health program designed to enhance the quality of life for senior and disabled adults and provide an alternative to residential health care placement. CLC is the only day health program in Pitt county and in 2007 we served 36 clients from Greenville, Tarboro, Williamston, Bethel, Winterville, Farmville, and Grimesland NC. We serve a very diverse group of individuals including low income and minority participants who would not have access to services without our program. In addition to recreational and therapeutic programs, our center also provides comprehensive health care services for many individuals who are considered to be high risk. CLC helps promote independence among our participants so that they can age independently in their homes. This program not only prevents premature nursing home or rest home placement, but also gives families and caregivers an opportunity to maintain full-time employment so that they can maintain financial stability thus having a positive effect on the economy. As the population of aging individuals continues to grow, so will the need for programs like Creative Living Center.

We currently have the capacity to serve 36 participants and have an enrollment of 23 participants. Enrollment is not an indicator of the need for the service, but is an indicator of eligibility. While there are multitudes of individuals in need of day services, many are not provided these services due to a lack of availability of services and most likely the lack of funds to pay for such services. In my experience as Executive Director for Creative Living Center, I have had to turn away individuals in desperate need of services due to one simple reason: money.

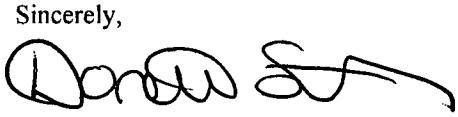
Creative Living Center has several types of funding methods for our participants; we currently have participants that are funded by CAP, Social Services Block Grant, Home and Community Care Block Grant as well as through private pay rates based on the individual's level of care and income. In addition, CLC also conducts fundraising efforts and receives money from local organizations including the local United Way. In 2007 United Way of Pitt County supplied CLC with $40,000 towards our operating expenses (approximately 20% of our entire budget). In 2008 United Way changed their focus to community impact and our funding decreased to $36,000 (approximately 18% of our entire budget) and in 2009 and thereafter it will likely decrease further, with a possibility of being completely cut. This in combination with the current recession, increase of minimum wage and other operating expenses, does not prepare our program for sustainability much less the type of growth that is predicted for our future. It costs approximately $72 per day/per person to run our program, and our current reimbursement rates for both grants and private pay fees range from $22 - $54, all of which cause us to incur a significant loss. Thus as the number of participants increase, so does the need for outside funding.

It is very important that we recognize not only the need for maintaining the current services for the aging population, but also the need for proper planning and investing to ensure that services are available for the influx of individuals who will be part of this population in the near future.

In closing, I would like to thank you for your past support of our program and I would like to encourage you to strongly consider increasing the amount of funding for the Home and Community Care Block Grant as well as raising the reimbursement rate for adult day services by $5 per person per day.

Thank you for your time and consideration.

Sincerely,



Donetta Steiner
Creative Living Center Executive Director

Presentation to the
North Carolina Study Commission
On Aging

March 6, 2008

Good morning. Thank for allowing me the opportunity to come before you on behalf of Eastern Carolina Council Area Agency on Aging. My name is Efton Sager and I am a Wayne County Commissioner and the President of the Board of Directors for Eastern Carolina Council which serves Carteret, Craven, Duplin, Greene, Jones, Lenoir, Onslow, Pamlico and Wayne Counties. I would like to share with you some of the needs of older adults within our region.

First, I would like to thank you for your support for the Home & Community Care Block grant. However, in order to continue to provide high quality services for our older residents and their familis additional resources are still needed. In our region, we have approximately 500 eligible individuals waiting for services.

Some of these services include home delivered meals, in-home aide services, transportation, as well as others. The NC Senior Tar Heel Legislature is requesting an increase of $5 million dollars, we ask that you support that request.

Secondly, our Area Agency on Aging works with our member counties to evaluate their current services and assists them with planning and developing a coordinated system of care to meet the needs of our growing older adult population. Eastern Carolina Council consists of nine counties. In order for our Area Agency on Aging to continue supporting these critical endeavors this additional funding is necessary. We would like to ask that you increase the AAA funding by $270,000.

Third, our senior centers are focal points for information and services for older adults throughout our region. The services, programs, and information they are providing to seniors and their families have become and continue to be more complex. Last

year, the North Carolina General Assembly appropriated $200,000 in non-recurring funds for senior centers. We would like to ask that this become recurring funding to continue to help senior centers continue to meet the increasing demand of our senior population.

Lastly, one of the major issues our service provider network and volunteers has had to deal with is Medicare Advantage plans. We have seen an incredible number of incidents throughout our nine county region of very aggressive, misleading, and fraudulent sales tactics from these insurance plans. Once seniors are enrolled into a Medicare Advantage plan their traditional Medicare plan is terminated. Seniors are finding out that their physicians do not accept the new plan, nor do many hospitals, thereby leaving the senior with exorbitant out of pocket costs. The Area Agencies on Aging, local service providers, and the Senior's Health Insurance Information volunteers are trying to work with these older adults to restore their Medicare benefits. We realize that this is a federal issue, however, we felt that as representatives of older North

Carolinians you needed to know some of these issues. Please be assured that our Area Agency on Aging as well as neighboring AAA's are working very closely with the NC Department of Insurance, hospitals, and the aging network to find some solutions to these problems.

Thank you for you time today. And thank you for your support.

9. Bill Hayes
Pitt County
Memorial Hospital

Medicare Advantage Consumer Protection

Problem:

According to the Medicare Rights Center agent commissions range between $400 to $500 dollars to sell Medicare Advantage plans to Medicare eligible individuals. It's a quick one-time sale and may be an incentive to commit fraud against seniors.

Common Abuses that are occurring in eastern NC:

Agents are enrolling seniors that have dementia or have a power-of-attorney.

Seniors with retirement health benefits through employers have bought into an agents sales pitch that the Medicare Advantage plan is a supplement or is free. The senior later realizes that they were scammed AND cannot re-enroll into their retirement benefits.

Notices regarding changes to Medicare are sent to seniors in order to get their personal information. These notices are not used for providing updates, instead they are used to gain authorization to make a visit or call so they can push their Medicare advantage plan. (attached example)

Agents are aggressively asking seniors to sign Medicare Advantage "no obligation" papers, but instead the papers that have been signed change their Medicare benefit coverage to the Medicare Advantage plan.

Agents are coming from outside the region...even other states, to scam seniors into enrolling in a Medicare advantage plan. These agents are not familiar with, nor care about which healthcare providers accept the Medicare Advantage plan.

Agents that have scammed seniors into signing up with a Medicare advantage plan can no longer be located or contacted by the senior. The phone number that was provided to the senior is no longer in service. The senior does not know how to dis-enroll.

Agents that have been terminated from a Medicare advantage plan for breaking marketing rules, often continue their deceptive marketing practices under a different Medicare Advantage plan.

Agents constantly inform seniors that they can go to any provide that accepts Medicare.

Agents are enrolling individuals with Medicaid into the Medicare Advantage program.

Agents are still going door to door, going into nursing homes, and approaching individuals at shopping centers such as Lowes.

Identify Theft!!!

Agents that commit fraud against seniors have a significant impact on the health of this fragile population. The senior becomes so distraught due to being scammed that their health becomes at risk.

Proposed Solutions:

Cut the commission rate significantly. The surplus money than can be used for enriching the senior's benefits.

Limit the agents to county of residence or at least a maximum of two/three counties.

If an agent is terminated from one plan, they are no longer eligible to market other Medicare advantage plans in North Carolina.

Insurance Companies that offer Medicare Advantage plans rely only on educating their agents. This is not enough. Insurance companies need to be held responsible for any and all marketing infractions that occur.

Submitted by:

William Hayes
Direct, Managed Care Division
Pitt County Memorial Hospital
University Health Systems of Eastern North Carolina

Jan 29 08 10:33a

IMPORTANT: NEW MEDICARE CHANGES

Your Medicare benefits have been reduced by Congress due to increases in your Deductibles and "Part A" Co-Insurance payment. Now, Medicare pays less of your health care cost and you are responsible for the unpaid balance.

Also, the DRG PROSPECTIVE PAYMENT SYSTEM is still in effect and sets PER AILMENT CEILINGS on MEDICARE'S payment to a hospital. Because of these CEILINGS, many hospitals are now transferring patients to lower cost nursing homes or extended care facilities.

For FREE information on your current Deductibles and Co-Insurance payments as well as per ailment ceilings set by Medicare and the benefits now in effect, return this postage paid inquiry card today!

Name_____
Date of Birth_____ 9545 BHI M-10-0782510
Spouse_____
Date of Birth_____
Phone_____

3582683

PLEASE VERIFY ADDRESS AND INCLUDE PHONE #. NOT AFFILIATED WITH OR ENDORSED BY ANY GOVERNMENT AGENCY.

#10

North Carolina Area Agencies on Aging
Comments to the Study Commission on Aging
3.6.2008

Honorable Senators and Representatives, and Members of the Study Commission:

I am Heather Proctor and appear before you as the Director of the Upper Coastal Plain Area Agency on Aging. I echo Mr. Godard with a welcome to our region.

I am here today representing the 17 North Carolina Area Agencies on Aging. I appreciate this opportunity to speak to you and to also personally thank you for the support you gave us last year in our efforts to restore AAA funds to the 2001 level.

I am also here today to speak to you about two other issues that we believe are critical. The first is increased Home and Community Care Block Grant funding. Services funded under HCCBG are essential services that are needed to help older adults remain in their home, which is where they want to be. There are seniors on waiting lists in my region and thousands more on waiting lists across North Carolina. Increased Home & Community Care Block Grant funding is needed to help them today.

While increased funding for community based services is needed today, it is imperative that we continue to move toward Livable and Senior-Friendly Communities in our state. That is how we will meet the needs of our citizens tomorrow.

The North Carolina Division of Aging and Adult Services presented a "Report to the North Carolina General Assembly on Recommendations for a Statewide Aging Study". While I am no expert on the content of this report, I and my colleagues support a five-year comprehensive initiative – termed Project CACE (Communities and Aging Carolinians – on Edge). As the report states, the overall goal for project CACE is to strengthen North Carolina's capacity at the state, regional, and local levels for assuring an informed and effective response to an aging population. We agree that Project CACE can move North Carolina to the forefront of progressive understanding and action on behalf of our older adults. I understand that Dennis Streets spoke to you about Project CACE in January and I hope you will consider supporting the recommendations he outlined at that time.

Right out of college, I accepted the position of Director of the Northampton County Office on Aging. On my first day I was told we must plan today for baby boomers. I heard that repeatedly, at the county, regional, state and even national level. Just this year, the Baby Boomers arrived with the first receiving Social Security on January 1. I stand before you knowing that we have made great strides in building an aging network to serve our older adults and family caregivers. However, many in the network, began 2008 with a bit of a sigh, because we also know that we are still not ready for the growth of the older adult population and it is now upon us.

Increased Home & Community Care Block Grant funding and implementation of Project CACE will help North Carolina come together to assure Livable and Senior Friendly Communities. Thank you.

Grace Martin Harwell Senior Center
310 W. Main St.
PO Box 1988
Washington, N. C. 27889
252-975-9368

On February 21, 2007, The Grace Martin Harwell Senior Center was certified as a North Carolina Senior Center of Excellence. Before that date, we averaged around 65 clients a day. By increasing our services, programs and outreach, our average daily attendance is more than 100 and continually increasing.

We have used our increased General Purpose Funds to support the growth and increased activity. Thank you for helping us to serve our senior adult population. Without those funds, we would have to cut back on programs and services.

Our center is operated by the City of Washington with a population just over 9000. If the General Purpose Funding decreases, the city will be unable to make up the difference.

It would be unfortunate to have offered these services and programs for such a short time, only to have to discontinue them because the General Purpose Funds were not repeated. I ask on behalf of our seniors for you to seriously consider increasing the General Purpose Funds to support the hard work senior centers are doing to meet their goals of Center of Excellence.

→Carolyne Everett, Supervisor
Grace Martin Harwell Senior Center

14. Judith Moss

Public Hearing
Study Commission on Aging
March 6, 2008

I am Judith Moss from Tarboro and am a participant and ambassador with the North Carolina Senior Games program. I would first like to thank the General Assembly and the Division of Aging and Adult Services for their support in the past. This support has helped over 60,000 seniors in North Carolina benefit from a program that promotes healthy lifestyles, prevents many health problems through education and exercise, and provides opportunities for socializing and having fun.

--North Carolina Senior Games is the largest program of its kind in the nation, involving more than 60,000 residents 55 years old and better in 54 local programs in all 100 counties. Around 3,000 compete at the State Finals in the fall.

–North Carolina is the only state whose senior games program also includes both sports and arts events.

–NCSG is a year-round health, wellness, and recreation program, providing activities and events that keep seniors engaged both mentally and physically. Healthy lifestyles help reduce health care costs.

I invite each of you to visit a local program this Spring. The flyer lists the location and dates for each of the 54 local program across the state. We also hope that you will be able to attend the State Finals in the fall. It is truly a big family reunion as seniors from around the state come together again to compete and enjoy each other's company.

As the cost of health care continues to rise, prevention allows for more effective and less expensive use of health care dollars. The Senior Games program believes prevention is the key.

We ask you to continue to be a senior games partner and advocate as we continue to reach out to more and more of our growing senior population.

15.

March 6, 2008

To: Members of the Study Commission on Aging
From: William Miller
Re: Importance of funding for Senior Centers

Thank you for allowing me to speak at this morning's public hearing. I am Bill Miller, a volunteer member of AARP's Executive Council as well as a volunteer on the AARP state Advocacy Council. I live in Edenton, North Carolina, a town to which my wife and I retired almost twelve years ago.

If there is one characteristic of senior centers that applies broadly across North Carolina it is that they are serving an increasingly larger population as our state draws more retirees. It is also true that retirees tend to become more involved in community activities and remain physically active into later years than previous generations have. In the northeast of North Carolina, my home area, the Chowan County Senior Center promotes and improves the well-being of older adults in Chowan County by responding to diverse needs and interests. The center provides various programs and activities and has a very well-equipped fitness room; in addition, the center provides a variety of day and overnight trips, which are well-supported by those who belong to the center. The center also has a nutrition site which serves lunch five days a week and also acts a distribution point for the local Meals on Wheels program. This center is not yet certified as a center of Merit or Excellence, but that process of evaluation will shortly be underway. I would also like to point out that, within Region R, Washington County's Senior Center has already met the rigorous evaluation standards and is now a Center of Excellence; another positive note for Region R is that House Bill 1063, sponsored by Representative Annie Mobley, would appropriate two million dollars to build the first Senior Center in Gates County. That would then mean that only two counties in North Carolina would not have Senior Centers; we're making progress!

It bothers me that the state appropriation for senior centers is less than $1.6 million for the 163 centers in North Carolina; that amounts to less than $10,000 per center. At a time when more and more seniors are using these facilities for health and recreational purposes, it seems we are being shortsighted in not recognizing the benefits that senior centers provide in extending life spans for all of us.

The broader issue for senior centers is, however, continued funding. As you know, the General Assembly appropriated $200,000 in Senior Center General Purpose Funding last year, but that is not recurring funding. It is vitally important that funding continue to be provided – in larger amounts and as recurring funding. This has been a focus of the advocacy work done by AARP as well as by other groups working for seniors. I hope that, as you hear testimony from others this morning, that you will keep in mind the importance of providing at least the same level of funding as last year and that you will work to make this funding recurring and not just a one time amount.

Thank you for your consideration of this important issue, on behalf of all North Carolina seniors.

William Miller
AARP Volunteer
100 Blount Street
Edenton, NC 27932

1-800-STAPLES www.staples.com

16. BECKY BROWN

3-6-08

My name is Becky Brown. I have a nursing/public health background. My husband & I have lived in Wilson Co. for 18 years. We have taken care of his parents in our home. After moving here we took care of his mother for a number of years after on.

Medical people seek to do their patients no harm. A Nurse's ~~work~~ goal is always to promote healing of the patient. If the patient appears to be dying the nurse ~~seeks~~ strives to keep her patient as comfortable as possible.

This thought of comfort for the patient brings me to my concern. My concern is the introduction of advanced directives which would negate that comfort. The most important comfort is food & fluid. Even artificially administered foods & fluids give comfort. If a person is dying food & fluids may ~~(subjectively)~~ extend the person's life a short time but will not stop death from happening. They only keep the person more comfortable. ~~This~~ Dying when it will happen, quality of life are all very subjective. Who does the government think it can direct these decisions about what

to do, when to do & how much to do for a patient. This is better left in the hands of the health care providers.

Being economically distressed with 9,000+ older adults, Edgecombe County is challenged to serve its citizens and utilize the services/moneys available. A recount census for the Town of Princeville has still not corrected the 2000 count--thus causing a loss of needed funding.

The Home and Community Care Block Grant often adheres to the status quo--funding the same providers year after year. While a strong caregivers program enables the older adult to remain in the home, more home-delivered meals in the rural areas would likewise delay the move to a facility. More in-home aides will keep residents at home. There is always a waiting list.

Edgecombe County Block Grant has allocated funds for home improvements for two years, though not very much, and worked with the Housing and Economic Development Department to meet urgent needs, small repairs. This, too, has a waiting list.

The recent five-county Older Adults Resource Guide by Upper Coastal Plain provides an invaluable aid for those needing services and information with assistance in a central location rather than being fragmented.

The 5-star code for adult care homes will not only help those deciding on a home but will also make facilities better through accountability and competition.

The small adult care homes for 5-7 need to be monitored more often than once a year due to findings of poor nutrition, inactivity, and even lack of supervision. Mixing the younger mental residents with the frail and elderly creates an unsafe enviornment and different needs.

Begun in 1997 in Edgecombe County, The Council on Aging strongly supports a senior center to keep the burgeoning group independent and active with programs to enhance the latter years.--health checks, exercise, information, etc.

Finally, the Adult Protective Services (APS) Clearinghouse Model is renewing long overdue attention to increased elder abuse, which often goes unreported. "Old Age should not be plagued by abuse, neglect, and exploitation". . . (A HIDDEN CRIME by Marie-Therese Connolly). Senate Bill 108 and House Bill 198 deal with issues to give seniors not only longer lives but better lives. APS Clearinghouse Model will do something about "crimes" once ignored.

Marketing, monitoring, collaboration, commitment, creativity -- these can help us advocate for the adults, increase and improve services, and get the maximum from the tax dollars.

Jean F. Harris
P. O. Box 53
Conetoe, NC 27819
Phone: 252-823-6527

Adult Care Home Community Advisory Committee (resthomes)
Home and Community Care Block Grant Committee
Regional Area Agency on Aging Board
Hospice Volunteer

18. ROBT COOK

National
Multiple Sclerosis
Society

Aging Study Commission
Public Hearing
Wilson, NC
March 6, 2008

Hi, I am Robert Cook.

I am a recently retired Wilson native and a care partner for a person living with MS. Thank you to the Chairs Farmer-Butterfield and Vernon Malone for holding a public hearing in Wilson today on Aging Issues.

Today, I am representing the National Multiple Sclerosis Society as a care-partner that has watched my wife age with a chronic illness - MS. Although someone may be diagnosed with MS at any age, once the disease progresses, even a young person may need many of the same services of older individuals.

Therefore, the National MS Society joins with many of our counterparts in the Aging Community to request that members of the General Assembly and members of the Aging Study Committee support the following in the short session:

- Increased funding for the **North Carolina Prescription Drug Program** to expand the benefit to all low-income Medicare beneficiaries which would include individuals younger than 65 that qualify for Medicare due to a disability.

- Continue to support **dental care services for older and disabled adults**.

- Increase funding for the **Housing Trust Fund** which will allow individuals to rehabilitate their homes. Homes that are more accessible allow individuals to retain their independence.

- Another program that helps individuals remain in their homes is the **Home and Community Block Grant.** Additional funds are needed due to the growth of North Carolina's population and increased cost of service delivery.

- Legislation introduced last year to establish paid sick days to ensure all employees can address their own health needs and the health needs of their families.

- A resolution to the President and Congress calling for an **end to the 2 Year Medicare Waiting Period.** When the federal government extended Medicare coverage to people with significant disabilities it imposed a 24 month wait for coverage from the date a person's Social Security Disability Insurance begins. This is a time in a person's life when the need for health coverage is most dire. At any given time, about four hundred thousand Americans with disabilities are uninsured while they wait for Medicare benefits.

Thank you again for providing me this opportunity to share the National Multiple Sclerosis Society's legislative priorities.

19. Richard HATCH

STATEMENT BY RICHARD C. HATCH AT PUBLIC HEARING OF NC STUDY COMMINSSION ON AGING WILSON, NC MARCH 6, 2008

Thank you Madam Chairman and members of the Commission. I am Dick Hatch, Coordinator of AARP North Carolina's State Advocacy Team. I am also an Alternate Delegate to the North Carolina Senior Tar Heel Legislature and a Delegate to the North Carolina Coalition on Aging.

AARP-North Carolina, the Senior Tar Heel Legislature and the Governor's Advisory Council on Aging all ask the Study Commission on Aging to again recommend appropriation of funds to expand dental care services, including mobile dental care programs, for older and disabled adults.

Based on recommendations of the Study Commission on Aging, the General Assembly's 2007 Regular Session appropriated $200,000 "for a mobile dental provider to deliver services to the frail and elderly and persons with disabilities in unserved areas". Because of that appropriation, a new mobile dental service will soon be operating in Durham, Orange and Chatham Counties.

This new service will augment only two other similar programs in North Carolina—one based in Mecklenburg County, and the other in Guilford County. This doesn't begin to satisfy the need. Numerous other communities have requested this service. AARP North Carolina asks that additional funds be appropriated to expand the mobile dental care service.

Many low-income older and disabled adults on Medicaid find it difficult to find a dentist who will serve them. The current Medicaid reimbursement rate for many dental care services is less than the cost of providing the service. AARP North Carolina recommends that the Medicaid reimbursement rates for dental services be increased to 80% of the National Dental Advisory Service reimbursement level, as recommended in the 2008 Public Health Task Force Report.

Failure of individuals to receive needed dental care services can have dire consequences on their quality of life and even can result in their death. Therefore, AARP-North Carolina asks the General Assembly to PUT THE MONEY WHERE THE MOUTH IS and appropriate funds to expand dental services, including mobile dental care programs, for older and disabled adults.

Thank you, Madame Chairman and Study Commission members.

20. DIANA (DEE) HATCH

Presentation to the NC Study Commission on Aging

Diana D. Hatch, State President, AARP-North Carolina
Public Hearing, Thursday, March 6
Subject: CAREGIVER SUPPORT

Good Morning. I am Dee Hatch, AARP North Carolina State President, an organization of more than 1.1 million members in North Carolina. I am here to urge your support for one of our greatest resources – family caregivers.

There are two urgent concerns that deserve your attention in regard to caregiving.. The first is to recommend the appropriation of at least $500,000 for **Project C.A.R.E. (Caregivers Alternatives to Running on Empty).** This family-centered, home-based service is especially designed for caregivers of people diagnosed with Alzheimer's disease. Their demanding task can last for years, all the while seeing someone dear to them continue to sink deeper into dementia.

The model program, now in Western North Carolina, provides consumer-directed respite care and comprehensive support to caregivers of dementia patients. The federal funding of $325,000 is due to run out June 30 of this year. Just at a time when the foundation has been laid and the potential is there to expand this service to many additional caregivers across the state.

In the long run, Project C.A.R.E. will save the state millions of dollars, since Alzheimer patients will be able to remain at home for a longer period of time. With support from the state, the potential is there to attract additional grants from private and public sources as well.

Our second request is for your support of **House Bill 1711 to Establish Paid Sick Days** to help people who are caring for their parents or employees in the workforce who are caring for older or disabled adults. An adult child might need to take off time to take a parent to the doctor, or be able to respond to an emergency.

This bill would apply to all employees who are eligible for overtime pay, but not to executive, administrative, professional, domestic or agricultural employees. It is estimated that a policy of paid sick leave would exceed the costs. It would reduce the spread of contagious diseases at work, and provide for short-term medical leaves. The longer we can help someone to care for their loved ones at home, the lower the public cost of institutional care.

According to the Rosalyn Carter Institute for Caregiving, "There are only four kinds of people in this world – those who have been caregivers; those who are currently caregivers; those who will be caregivers; and those who will need caregivers."

Thank you for all the good work you do to support North Carolina's aging community and for your willingness to travel throughout the state to listen to the public's views.

Include with comments of MARY Bethel [redacted] #21

AARP North Carolina asks the Study Commission on Aging to put forth legislation that will strengthen state elder abuse and guardianship laws.

Elder Abuse Laws

North Carolina's elder abuse law was enacted in 1973 and has not been reviewed or had any significant changes made to it in over 30 years.

In November 2002 an Adult Protective Services Task Force convened to look at our state laws and to develop recommendations to strengthen the North Carolina adult protective service system.

The Task Force, in collaboration with stakeholders, developed a new proposed system for protection called the clearinghouse model which seeks to serve vulnerable and elder adults who are abused, neglected, or exploited or are at significant risk of abuse, neglect or exploitation. Under current law, there can only be intervention if the person is deemed to be disabled and they have actually been abused, neglected or exploited.

In 2007, this Commission recommended legislation (House Bill 198 and Senate Bill 108) to appropriate funds to enact a pilot program to assess proposed changes to the adult protective service law and to implement the clearinghouse model. No action was taken on this bill. We ask that the Commission again support this legislation.

Guardianship Laws

There have been many concerns raised in the last several years about our current guardianship laws including the confusion surrounding the law, the rise in demand for guardianship, the lack of resources for public guardians, and better training and information for all involved in the guardianship process.

A House Study Committee on State Guardianship Laws was convened in 2006 with a broad representation of stakeholders on this Committee. The Committee met for four months and developed an extensive array of excellent recommendations for strengthening our current laws.

Legislation was introduced in the 2007 legislative session to establish a Joint Legislative Study Commission on State Guardianship Laws to build on the work of the House Study Committee.

We ask that the Study Commission on Aging again advocate for this legislation (House Bill 250) to establish a Joint Study Commission or proceed with proposing legislation to actually implement the recommendations of the House Study Committee on State Guardianship Laws.

#22

HOSPICE of Wake County

Partners in Caring

Comments to North Carolina Study Commission on Aging

March 6, 2008

Wilson, NC

I am John Thoma, Chief Executive Officer of Hospice of Wake County, Inc. + HORIZONS HOME CARE a non-profit Hospice, Home Care and Palliative Care provider with a 29 year history of serving residents of Wake, Chatham, Durham, Franklin, Granville, Harnett and Johnston Counties.

I applaud the work that the Study Commission on Aging is doing. I applaud your recommendations to increase in-home special assistance and to increase Home and Community Care Block Grant funding. I applaud your research and comprehensive approach to annually assessing the needs of older adults and services available.

I have two requests for the commission: RAISE AWARENESS OF END OF LIFE CARE OPTIONS

1) Include in your annual report + review on "Older Adults in NC: an Overview" statistics on the Hospice Inpatient and Residential care options that are available to individuals who can no longer live in their home or with relatives. There is a rapidly growing inventory of Hospice Inpatient facilities across North Carolina. Hospice Inpatient facility beds and Hospice Residential facility beds are licensed by the Division of Health Services Regulation, and annual data on licensed Hospice beds is available from DHSR.

2) You will find when reviewing the data that the availability of Hospice Residential facility beds is not keeping up with the current need and will be woefully inadequate in the future. I ask the Commission to explore recommendations that will encourage the development of Hospice Residential facility beds, such as technical assistance grants for new facilities or Medicaid funding for existing Hospice Residential Care.

Thank you for the opportunity to speak today.

1300 St. Mary's Street, Suite 400, Raleigh, North Carolina 27605 • 919.828.0890 • toll free 888.900.3959 • fax 919.719.0395 • www.hospiceofwake.org

#23

Good morning, I am Al Keyes member of the AARP Advocacy Council from Jacksonville and the Chair of the Nursing Home and Adult Care Home Community Advisory Committee for Onslow County.

I want to speak to you about the need for the General Assembly to continue to address the issues related to the placement of individuals with mental illness in facilities, particularly adult care homes, with frail older adults. This is an issue of great importance in our state as studies conducted in this state indicate that over 40% of persons residing in adult care homes have diagnosis of mental illness. In many instances these individuals are younger and end up in facilities which are geared to older and frailer residents.

I am aware that senate Bill 164 passed last year which (1) directs the Department of Health and Human Services to study rules and regulations regarding housing individuals with mental illness in the same facility as individuals without mental illness and (2) directs the Department to recommend staff training requirements for direct care workers in adult care home to provide appropriate care to residents with mental illness. In addition, special provisions was included in the budget bill last session which directed the department to develop a Transitional Residential Treatment Program service definition to provide 24 hour residential treatment and rehabilitation for adults who have a pattern of behaviors relating to mental illness, which exceedes the capabilities of traditional residential settings.

I am grateful for the legislative action that passed last year, and I further acknowledge it is a good beginning for starting to get a handle on this problem, but the time for action is now particularly in light of everything that is going on in our state at this time related to mental health reform. It is fine to study the problem and to develop service definitions but we now need to move forward in implementing practical and cost effective steps to ensure that the needs of both persons with mental illness and those of frail older adults in need of assisted living are better met.

As advocates, we encourage the Study Commission on Aging to work hand and hand with the joint Legislative Oversight Committee on mental Health Developmental Disabilities and Substance Abuse Services on this important Issue'

I wish to thank the Commission for the opportunity to address you today.

#24

Study Commission on Aging Public Hearing
March 6,2008
Wilson, N.C.

My name is Chip Modlin and I am an advocacy volunteer for AARP North Carolina, a member of the Governors Advisory Council an Aging and the retired Director of the Cumberland County Department of Social Services.

I would like to talk about the need for more state funding for the Home and Community Care Block Grant which provides funding for services such as home delivered meals, in-home aid services, and transportation assistance. I am aware that every key aging advocacy and provider group in the state has this as a priority for the short legislative session.

From my experience these funds play an important role in helping people, primarily those whose income is just above the Medicaid limit, stay in their own homes. The latest waiting list data for Cumberland County has over 400 people on the waiting list for Block Grant services including 225 who are waiting for in-home aid services. Statewide there are over 11,500 on the waiting list for services. Timely provision of in-home aid service is not only cost effective in the provision of care to the aging but it may also prevent the need for more costly acute care in a hospital or long term facility. Working with the aging to stay in their own homes is also a strong motivational factor contributing to their emotional and physical wellbeing. As a volunteer with the meals on wheels program I have also observed what a life line these meals can be to our aging population since more than 50% of the Home and Community Care Block Grant participants are at risk of malnutrition. Transportation is always at or near the top of the list of needs of seniors and the known waiting list is included in the 400 waiting for block grant services.

The General Assembly appropriated $536,000 in recurring funding last year for the Block Grant. With the growth in the older adult population across the state and the increased cost of service delivery this funding did little to address the waiting list across the state. The 60+ population is projected to be the fastest growing segment of the population in Cumberland County and expected to almost double by 2030. With the Baby Boomers beginning to seek services it is critical for the state to begin to plan for these needs.

Thank you for what you are already doing for our aging population and for the opportunity to address you this morning.

E.C. Modlin, ACSW (chip)
2811 Millbrook Rd.
Fayetteville, N.C. 28303 Tel: 910 485 5262

#25

Comments for
Aging Study Commission
Public Hearing
March 6, 2008

Good morning. My name is Tonya Cedars and I am the Director for the Eastern Carolina Council Area Agency on Aging. Thank you for the opportunity to appear before you today. I would like to take just a short bit of time to share with you some of the needs of older adults and their families in my region.

1. First, thank you so very much for your support last year with the additional AAA funding. This increase allowed many AAA's to retain staff and continue to offer services throughout our region. In order to keep up with changing demands, we would like to ask for your support for an additional $270, 000 to restore the AAA funding to the 2001 level.
2. Statewide, we know that the Baby Boomers have arrived. We are seeing a tremendous influx of retirees moving into our region. In light of this trend, I would like to request an increase in funding for the Home & Community Care Block grant. This funding allows counties to provide critical services to keep older adults living in and participating in their communities much longer. Currently, there are approximately 500 eligible older adults waiting for a variety of services in Eastern Carolina's Region. The Senior Tar Heel Legislature, NC4A, NCAOA and others are recommending an additional $5M.
3. Senior Centers are focal points in each of our communities for older adults and their families. In order to keep up with the growing demand we would like to request that the Senior Center General Purpose funding be made recurring.

4. Finally, I would like to voice my concern regarding Medicare Advantage plans. I do realize that this is a federal issue, but would like to bring it to your attention. Seniors throughout Eastern North Carolina have been targeted by very aggressive, misleading and often fraudulent sales tactics for enrollment into this product. Once enrolled, seniors are finding that their physicians and the hospitals they use do not participate in these plans. Unfortunately, this realization occurs after or during a hospital stay and they have already incurred large medical bills. Again, I do realize that much of this is beyond your scope, however, I did want to inform the Commission of this concern.

Thank you again for your time and your commitment to improving the quality of lives for older North Carolinians and their families.

ECC
EasternCarolinaCouncil
TONYA CEDARS
Director, Area Agency on Aging

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#26

COMMENTS FOR
AGING STUDY COMMISSION
PUBLIC HEARING
MARCH 6, 2008

Good morning, my name is Audrey Tyson and I am the Senior Tar Heel Delegate for Lenoir County. I know that you have received a copy of the Senior Tar Heel Legislature's current list of priorities; however, I would like to take just a moment to re-emphasize these needs:

1. Increase funding for home and community based services for older adults by increasing the Home and Community Care Block Grant by $5 million.
2. Increase funding for senior centers by $634,684 for a total of $2 million per year.
3. Provide Dental Care for Older Adults with Special Needs and in Rural Areas.
4. Provide funding to sustain Project C.A.R.E.

Thank you for the opportunity to speak to you today.

#27

the NASH Celebrates Aging

Nash County Aging Department

"Responding to the need for programs and services, which assist older adults to age in place as long as possible."

March 6, 2008

Good morning. My name is Jamie Wilson. I am the Senior Center Coordinator at the Nash County Senior Center. Today I would like to share with you the words of some of our senior center participants that were not able to speak for themselves today.

Services:

- Senior Center Activities
- Home Delivered Meals
- Congregate Nutrition
- Caregiver Resources
- Discount Nutritional Supplements
- General Transportation
- Medical Transportation
- HASTEN Emergency Response System
- Information & Case Assistance
- Support Groups
- Foot Care Clinic
- Health Screenings
- Health Promotions
- Insurance Counseling
- Legal Aid
- Income Tax Assistance
- and more...

Thomasina Carter – 76
I receive social security, but I have living expenses such as insurance premiums, co-pays, healthcare expenses, taxes, and food and household items.

Many seniors cannot afford expensive dental work or glasses on top of their other bills. There should be some help for seniors to have their necessary medical needs met. Dental work and glasses are necessities not luxuries. Seniors also need a space like the senior center so they will not be alone. Seniors can play games, use the computer, exercise and meet new people by coming to the senior center.

Frances Poland – 72
To me the senior center is the difference between insane and sane. Seniors come to the senior center to enjoy the company of others. Everyone is friendly and willing to help each other out. There are so many that need services provided by senior centers, but because of limited funds everyone cannot be helped. There also needs to be more senior centers so they are convenient to more people. My family has seen a change in my behavior and even my appearance since I started coming to the senior center. I am better now.

Irene Childress – 71
The senior center keeps me from being depressed. When I come to the senior center I enjoy being with other people and I am not lonesome like I am at home. While I am at the senior center I do not think about my financial problems or medical problems. I think senior centers reduce the cost of health care by improving seniors' mental health with social programs and physical health with fitness programs. Senior centers need continued support from the State to continue making a difference in the lives of North Carolina older adults.

Eleanor Kronsbien – 66
As a displaced housewife, I came to the senior center after relocating to the area. I was tired of sitting at home, looking at four walls and called to find out how I could participate. The senior center has become my social life. I did not know anyone when I started coming, and I was welcomed in and encouraged to get involved. As a person with a disability, the senior center helped me focus less on my disability and more on my abilities. I have used my skills for worthwhile projects. I was given a sense of well being for doing something good for others after having others do for me for so long.

These are just a few examples of how senior centers enhance the quality of life of older adults. I extend my sincere appreciation for the additional $200,000 in Senior Center General Purpose funds that was allocated last year. Senior centers are in great need of having these funds on an annual basis. Your consideration in making the $200,000 recurring would be greatly appreciated.

103 North Alston Street • Nashville, North Carolina 27856
252-459-7681(phone) • 252-459-7118 (fax)

#28



Nash County Senior Center
103 North Alston Street, Nashville, NC 27856

Mrs. Agnes Moore
Senior Center Participant
Aging Advocate

My name is Agnes Moore and I live in Nash County. I serve on the Nash County Council on Aging, the Regional Aging Advisory Committee, and I am a trained volunteer evaluator for the Senior-Friendly Business Certification Program.

For the current year, senior centers were awarded an additional, **non-recurring** $200,000 in the Senior Center General Purpose grant. I thank you for your part in making that allocation possible. And I am here today to ask you for it again, and again, and again. The staff of senior centers across the state are very resourceful; they work hard, and make the most out of what they get their hands on. They have used this funding source for a variety of needs including funding part-time salaries.

This grant is divided into smaller and smaller portions each year as new centers open their doors and centers are certified as Centers of Merit or Centers of Excellence. With each center's grant amount already projected to decrease, it will be a devastating hit to lose the $200,000. Please work to make the $200,000 allocation recurring funds for senior centers.

I would also like to draw attention to over 11,000 senior North Carolinians who sit on waiting lists for services. Our aging service providers have made phone calls to follow-up on waiting list clients to learn that they have passed away. People are dying in our state waiting for services. An additional 7 million dollars for Home and Community Care Block Grant Services would go a long way to help those who are waiting.

Thank you for this opportunity to communicate our needs to you.

#30

AARP North Carolina
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Housing Trust Fund

Good morning, I am Bill Wilson, advocacy co-director of AARP North Carolina. AARP North Carolina represents over 1.1 million citizens in our state age 50 and over. I am here today to ask the Study Commission on Aging to include additional funding for the NC Housing Trust Fund in your recommendations to the full General Assembly.

AARP North Carolina is particularly concerned that older citizens be able to live in a setting that is the most appropriate and desirable. The number of elderly persons grew 17% between 1990 and 2000, from 802,000 to 969,000. North Carolina gained more elderly persons than 45 other states during this decade.

- The Trust Fund helps make urgent repairs and needed renovations that allows older citizens to remain in their homes.
- The Fund also helps build apartments where rents are lower than the market rate and lower than rents on apartments built with tax credits alone. The owner is responsible for paying back the loan, but has less debt due to the lower interest rate.
- The Fund provides for supportive housing developments, such as group homes for the developmentally disabled or domestic violence shelters, to be built where the owner then charges very low rents because they are repaying the principal loan only.
- First time homebuyers benefit when Habitat for Humanity and the agency jointly participant in the first mortgage. Habitat services the loan and pays the agency its share.

AARP supports additional recurring funding of $50 million for the NC Housing Trust Fund. A $50 million appropriation would help over 6,000 families each year, generate over 3,000 jobs annually, increase State and local tax revenues by over $30 million each year, while leveraging over $200 million in total investments in affordable housing.

(over)

Erik D. Olsen, President
William D. Novelli, Chief Executive Officer

While AARP supports all the programs funded by the Trust Fund, we have a special interest in the repair and renovation of existing homes for older adults and disabled adults so they may remain in their homes.

AARP appreciates the General Assembly's investment in independent and supportive living apartments for people with disabilities and the $5 million in undesignated funds to the Trust Fund passed in the 2007 Session. This was a significant increase in the Fund and we ask that you continue this commitment in the 2008 session. Thank you for giving us this opportunity today and for the great support the Commission gives to our older adults.

Bill Wilson
Associate State Director – Advocacy
AARP North Carolina

#34

North Carolina Study Commission on Aging
March 6, 2008

My name is Tom Pauling. I am a member of the Greenville-Pitt County Senior Games and an ambassador for the North Carolina Senior Games. This year will be my seventh year participating in the Senior Games. I play on basketball and softball teams and also participate in golf. I have had the opportunity to qualify for and participate in the 2005 National Senior Olympics in Pittsburgh, PA and the 2007 National Senior Games in Louisville, KY where my 55+ softball team won a silver medal. I am looking forward to participating again in 2008.

Each of us grows older every day. It is an inevitable fact of life. The Senior Games has given me an opportunity to remain physically active as I age and at the same time improves my quality of life. I really look forward to the competition and the camaraderie that I've enjoyed with both my teammates and opponents. I have developed many new friendships with people like me from all over North Carolina and other states.

The Senior Games is not just for sports. It includes Silver Arts which allows those persons over the age of 55 to participate in creative expression. Those activities include art, sculpture, photography, writings, dance, drama, knitting, quilting, and woodworking. The Silverstriders is a national award winning walking program. There are even Senior Cheerleaders.

There was a time when people were afraid to grow older. Now with programs like the Senior Games, growing older can be healthy and fun. I am 62 and we have a member of our local Senior Games who is in his 90's and won numerous gold medals last year in track at the National Olympics. Each day brings a new challenge and something to eagerly anticipate. I have a friend who couldn't wait until his 55th birthday so he could participate in basketball.

I want to thank you for your attendance here today and your interest in the ever growing older population in this state and nation. We couldn't have this wonderful program without the support of our legislators. Thank you for your past support and I am grateful for and request your continued support.

#35

THE CARE CONNECTION®

News From the North Carolina Adult Day Services Association www.NCADSA.org

North Carolina Adult Day Services Association

Doris Huntington Pres.
NCADSA
The Wright Center
501 Raleigh Road
Rocky Mount NC
27803

February 2008

Our Mission

The North Carolina Adult Day Services Association promotes the availability, accessibility, quality and cost-effectiveness of adult day services in North Carolina.

NCADSA Board Adopts 2008 Legislative Agenda

The NC Adult Day Services Association considered a number of issues that can impact adult day services and the people who use them. We will focus most of our efforts on advocating for the issues identified below.

- **Appropriate an additional $7 Million for Home and Community Care Block Grant Funding.** The NC General Assembly appropriated only an additional $500,000 in the last legislative session despite the fact that a waiting list continues to exist and the number of North Carolinians over the age of 60 continues to grow. An additional appropriation is needed to reduce the waiting lists, get people basic supports that they need and provide these supports in the way they want—at home, in the community. HCCBG funds are available to each county and can fund 17 different programs including Adult Day Care and Adult Day Health.

- **Appropriate Funds to Reimburse Adult Day Services An Additional $5 Per Day.** Adult day programs benefited from a $5 rate increase for State Adult Day Care Fund and Home and Community Care Block Grant in 2004 and again in 2005 after a seven-year drought without increases. Medicaid CAP increased the reimbursement for adult day health effective January 2007, the first time since 1999. Despite those rate increases, costs still exceed the public reimbursements. The increase in the minimum wage added to the increased costs. There is no system for annual increases in any of these public reimbursements for adult day programs, unlike other services. It is time for adult day services to be recognized as the partner in health care that it has become.

- **Strengthen the quality and consistency of the Adult Protective Services delivery system in North Carolina.** The current Adult Protective Services statutes are outdated and often vague. HB 198 and SB 108 were introduced and referred to Appropriations Committees in the 2007 legislative session.

(Continued on page 2)

(Continued from page 1)

- **Support Project C.A.R.E.** Project C.A.R.E. (Caregiver Alternatives to Running on Empty) is an extremely important and cost effective initiative that provides support to individuals with dementia and their caregivers. This Alzheimer's demonstration has been funded by AoA under the Older Americans Act but the federal grant funds are due to end this June. We are hoping that the General Assembly will support sustaining the current project in 14 counties and that we can then secure additional federal funds (and possibly foundation funds) to begin expanding this program to other counties, especially in the eastern part of the state.

- **Support Study of Safe Transportation of Passengers in Wheelchairs.** In the 2007 legislative session, the Study Commission on Aging recommended 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 tie-down systems. HB 93 received a favorable report in House Aging, passed 2nd and 3rd reading in the House and crossed over to the Senate where it was referred to the Senate Committee on Transportation.

North Carolina Adult Day Services Association
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Other legislation to follow:

- Limits for categorically and medically needy Medicaid eligibility for aged, blind and disabled persons from $2,000 to $6,000 for individuals and from $3,000 to $9,000 for couples.
- Mobile dental care
- Guardianship

NCADSA Supports Changes to Rated Certificate Program for Adult Care Homes

NCADSA recently supported modifications to the Star Rating Bill (S56) for adult care homes. Teresa Johnson represented NCADSA at the public hearing conducted by the Medical Care Commission on January 22, 2008. At least 10 other organizations supported the changes, including AARP, Friends of Residents in Long Term care (FORLTC), NC Mental Health Association and NC Regional LTC Ombusdman Association. It was tremendously impressive at the hearing that so many state organizations went on record with agreed upon recommendations of how the proposed rules should be changed.

Over 150 comments were received regarding the proposed rules. Based on the comments received, the proposed rules were changed significantly to reflect the recommendations made by advocates. Most of the changes of substance presented to the Commission were contained in Section 10A NCAC 13G.1604 which pertains to "rating calculation".

Changes in the rule will have a great impact on insuring that the ratings truly reflect the quality of care provided by facilities.

The Wright's Center

Doris Howington
Executive Director

The Wright's Adult Day Health Care Center was the first to open its doors in Rocky Mount in September 1989. We opened with a total of 4 participants.

Today we are licensed for 51 and average 45 per day. Our program provides nutritious meals and snacks, transportation to and from the Center, and stimulating activities to nurture the educational, physical, Heath, spiritual and social needs of those we serve. We serve Nash, Edgecombe & Wilson Co.

We prevent premature institutionalization, and prevent seniors and disabled adults from slipping into depression while remaining at home during the day.

At the Center they meet new friends, and get at least one hot meal during the day. Breakfast and snacks are also provided.

An Increase in Block Grant funding will make life for the primary caregivers, to whom we provide respite.

We need your help. Appropriate $7 million for HCCBG and the $5 increase for Adult Day Services.

#38

March 5, 2008

I have been a Social Worker for 28 years. There has been a continued need and request for In-Home Services in order to provide individuals with the quality of care needed to remain at home. People thrive mentally and physically when allowed to remain in familiar surroundings. Families are not always able to financially provide the care needed to keep their loved ones at home; therefore, additional funds for In-Home Services would be an asset. For those individuals who have a caregiver, additional funding would allow for respite (i.e. grocery shopping, run errands, pay bills, etc.).

At the present time, Nash County provides in-home services for 40 individuals, 3 hours per day. There are 108 individuals on our In-Home Service Inquiry List.

We would appreciate your attention to the above need and concern.

Thank you,

Mary Murray

Mary Murray
Social Worker II

#39

March 5, 2008

Adult Protective Service funds are needed for substantiated cases. The funds would be used to provide services to prevent a disabled adult from abuse, neglect, and exploitation. Some examples include in-home services, medications, and cost of care in a facility.

Guardianship funds are needed to provide services for potential wards as well as active wards in our county. Prior to Adjudication of Incompetency, funds are sometimes needed to provide physician services to support the petition for individuals, who would not otherwise have resources. Our active wards may need clothes, personal items, and payment for cost of care in a facility, just to name a few.

We would appreciate your attention to the above needs and concerns.

Sincerely,

Jeanne G. Browder

Jeanne G. Browder
Social Worker III

Written comments - did not Speak

#43

Ken Bowen
309 Willows Ct.
Washington, NC 27889
1-252-940-4521

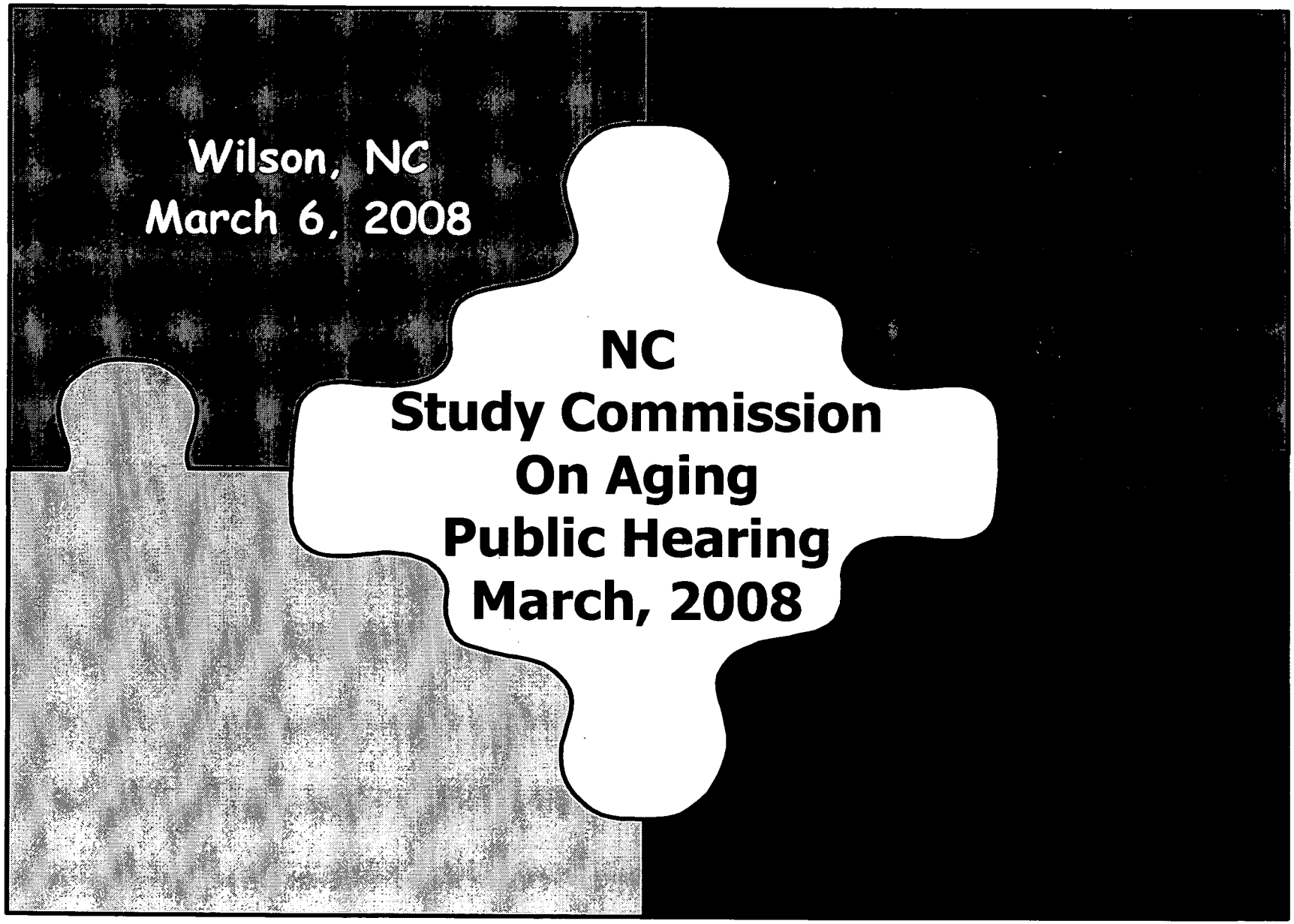
I am concerned about a problem that affects all the people who drive the streets and highways of North Carolina especially Senior citizens. The problem is talking on the cell phone while attempting to drive. On Saturday, March 1, I was almost hit ten times within a two hour period by drivers talking on the cell phone while trying to make turns at intersections and side streets. I was stopped at the street or intersection. The drivers were distracted This is a problem that is rapidly getting worse as more people get cell phones. Some drivers are talking on the cell phone, smoking, and trying to drive safely - but, many are unsuccessful. There are additional distractions in some of these cars - for example, Children and music. The cell phone

is just another distraction. North Carolina should be a leader to pass a law making it illegal to drive on any street, road, and highway - not just in city limits. If its necessary to talk on the cell phone, the driver should drive to a place where he/she can stop and make or receive a call. This problem will only get worse if something is not done now. One death due to this problem is one too many. Senior Citizens are not in most cases guilty of this problem, but, they are a prime candidate to be involved in this kind of accident.

Thank you for listening, and I am sure you will take action to help correct this problem.

Ken Bowen
Beaufort County
Washington, NC

FOR MARCH 6 MINUTES - (ATTACHMENT)



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)

March 2008 Public Hearing

Date	Location	Number of Speakers
March 6, 2008	Wilson, NC	42

The issues mentioned during the hearing with the greatest frequency were:

- **Increase Senior Center Funds/Make 2007-08 Increase Recurring (15)**
- **Increase Home and Community Care Block Grant (HCCBG) Funds (13)**
- **Increase Funds for Adult Day Reimbursement/Support Adult Day Care (6)**
- **Increase Funds for Area Agencies on Aging (5)**
- **Support for Adult Protective Services/Enact & Fund APS Clearinghouse Model Pilot (5)**
- **Support for Senior Games (5)**

Frequency of Issues Expressed by Speakers

	WILSON TOTAL
Increase HCCBG Funds	13
Increase Senior Center Funds/Make 2007-08 Increase Recurring	15
Increase Funds for Adult Day Reimbursement/Support Adult Day	6
Increase Funds for Area Agencies on Aging	5
Provide Funding for Project C.A.R.E.	3
Increase Asset Limit for Medicaid- Aged, Blind and Disabled	1
Support for Adult Protective Services/ Enact & Fund APS Clearinghouse Model Pilot	5
Increase Funds for New & Existing Special Care Dental Programs (Care in Underserved Areas, LTC, Disabled Seniors at Home)	4
Support/Fund Older Adult Pop. Growth Study	2
Increase Funds and Legislation for Guardianship Services	3
Increase Funds for Housing Trust Fund/Recurring Funding	3
Increase Medicaid Reimbursement Rate for Dental Care	1
Need Transportation Funding for Seniors	4
Increase CAP/DA and PCS Rates to Maintain Qualified Workers	1
Support for Home & Hospice Care	2
Continue Moratorium on New Home Care Agencies	1
Prohibit Home Care From Giving to Clients	1
Extend Grace Period to Resolve Medicaid Issues Prior to Patient Transfer	1
Focus on Addressing the Needs of Developmentally Disabled Older Adults	2
Support for Senior Games	5
Support for Community Alternatives Program (CAP)	1
Medicare Advantage Plans – Concern for Aggressive and Misleading Sales Tactics	3
Support for Respite Services/Support for Family Caregivers	2
Advance Directives/Leave Decision in Hands of Health Care Providers	1
Support for the Star Rating System	1
Increase Monitoring of Family Care Homes	1
Concern for Mixing Mentally Ill & Frail Elderly	2
Expand NC Support for Prescription Drug Coverage	1
Support for HB 1711 Establish Paid Sick Days	1
Increase Funds for In-Home Services to Reduce Waiting Lists	1
Raise Awareness of End of Life Options	1
Increase Licensed Hospice Beds	1
Concern Over Reverse Mortgages – Require Face to Face Counseling	1

Prepared by Aging Commission Staff

NORTH CAROLINA STUDY COMMISSION ON AGING
Friday, March 28, 2008
10:00 AM
Room 544, Legislative Office Building

MINUTES

The North Carolina Study Commission on Aging met Friday, March 28, 2008 at 10:00 a.m in room 544, Legislative Office Building. The following members were present: Co-Chairs Senator Vernon Malone and Representative Jean Farmer-Butterfield, Senators Dorsett, and Swindell, Representative Garland Pierce and Public Members Anthony Peace, Jean Reaves, and Jackie Sheppard. Commission Staff Member Theresa Matula and Commission Assistants Ruth Merkle and Amber Harris were also in attendance. The Visitor Registration Sheet (Attachment 1) and the Agenda (Attachment 2) are attached.

The meeting was to order at 10:00 a.m by Co-Chair Senator Malone. Senator Malone opened the meeting with brief comments.

Co-Chair Representative Farmer-Butterfield stated that Senator Dorsett will host a public hearing in Greensboro in the current interim and Representatives Garland Pierce and Bob England will host hearings in the next interim.

Senator Malone stated that dates for the hearing will be set in the near future and called on Theresa Matula to present the first item on the agenda.

Theresa Matula explained reports from staff that represented issues most frequently presented in previous Commission meetings. (Attachment 3) She also explained the staff report that presented issues on the most commonly mentioned issues in Public Hearings. (Attachment 4) Theresa Matula stated that one organization, Friends of Residents in Long Term Care, had not had the opportunity to submit their legislative priorities to the commission, and that a handout was given to all the members with this information. (Attachment 5)

Senator Malone thanked Ms. Matula for her comments and called on the next speaker, Victor Marshall.

Mr. Marshall introduced the UNC Institute on Aging presented a report by the Institute which also included background information on the organization. (Attachments 6 and 7) He also presented recommendations for legislative actions by the organization.

Mr. Marshall was asked by public member Anthony Peace whether or not the study by the Institute on Aging included information on long-term care. Mr. Marshall stated that it did not but that he would follow up with a staff person from the institute to get that information.

Larry Nason, Chief of the Facility and Community Care Section of the Division Medical Assistance at DHHS, presented the Respite Care Study Report. (Attachment 8)

Questions were asked by Senator Dorsett, Jackie Sheppard and Representative Farmer-Butterfield. The questions were answered by Karissa Darins, who works with the Division of Aging and Adult Services and is the state Director of Project Care.

Representative Farmer-Butterfield asked whether or not respite care mobile station were accessible or cost-effective in North Carolina. Ms. Darins stated that she did not have the information readily available, but that she would find the information for Representative Farmer-Butterfield.

Representative Farmer-Butterfield stated that it would be in the interest of the state to maintain funding for Project Care.

Senator Malone asked that Ms. Darins provide information on mobile respite care to members of the committee. Ms. Darins stated that she would do so.

Public Member Jean Reeves asked if information in the report presented by Larry Nason reflected information about non-residential respite care and that it was important for members of the committee to recognize that over-night respite care was an important issue to consider when reading the Respite Care Study Report.

Senator Malone called on Jackie Sheppard and Bonnie Morrell to present their reports on the Mentally Ill in Adult Care Homes. (Attachment 9) Mr. Sheppard deferred to Ms. Morrell to present the report.

Ms. Morrell presented the report to the committee.

Senator Dorsett asked a question regarding whether or not the report presented a partial alternative to housing the mentally ill with the aging and she suggested that the difference in age of those who are mentally ill and those who are aging makes a situation in which they are housed together difficult.

Ms. Morell explained that there was a difficulty in finding a place to house those people who are mentally ill and are currently living in adult care homes.

Senator Dorsett followed up with a question answered by Ms. Morell.

Representative Jean Farmer-Butterfield voiced a similar concern to Senator Dorsett's about housing the mentally ill with the aging and expressed that she wanted more specificity from the report about what to do with those people who are mentally ill and living in adult care facilities.

Ms. Morell reiterated a part of the report that would help to answer Representative Farmer-Butterfield's question.

Public Member Karen Gottovi asked for clarification on one part of the report. Her question was answered by Jackie Sheppard. Ms. Gottovi followed up with another question which was also answered by Jackie Sheppard.

Representative Farmer-Butterfield commented that the commission needed to be made aware of proposals and criterion that is made available to the commission before the public and that it was important that the resources be distributed throughout the state.

Public Member Jean Reaves commented on the importance of adults in adult care homes not being forgotten by community organizations.

Representative Farmer-Butterfield asked a question that was answered by Barbara Ryan of the Adult Care licensure Section of DHHS.

Jeff Horton Chief Operating Officer of the Division of Health Service Regulation presented a report on the Reward System for Adult Care Home Ratings. (Attachment 10)

Senator Dorsett asked a question answered by Mr. Horton. Senator Dorsett followed up with a comment on the feasibility of the rating system.

Karen Gottovi followed up with additional comments on the rating system.

Senator Malone made the recommendation that members of the committee take time to read the reports presented at the meeting.

There being no further business, the chair adjourned the meeting at 12:00 pm.

Senator Vernon Malone, Presiding

Amber Harris, Committee Clerk

Agenda

North Carolina Study Commission on Aging

Friday, March 28, 2008
10:00 a.m.
Legislative Office Building
Room 544

I. Welcome

Representative Jean Farmer-Butterfield, Cochair
Senator Vernon Malone, Cochair

II. Summary of Issues Most Frequently Mentioned During Organization Presentations on February 28, 2008

Summary of Issues Most Frequently Mentioned During Public Hearing on March 6, 2008

Theresa Matula, Commission Staff, Research Division, NCGA

III. Comments on the Statewide Aging Services Study &Workforce Initiatives

Victor Marshall, Director, UNC Institue on Aging

IV. Respite Care Study Report (S.L. 2007-39)

Larry Nason, Chief, Facility and Community Care Section, Division of Medical Assistance, DHHS

V. Mentally Ill in Adult Care Homes Report (S.L. 2007-156)

Jackie Sheppard, Assistant Secretary, LTC and Family Services, DHHS

Bonnie Morrell, Best Practice & Community Innovations Team Leader, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, DHHS

VI. Reward System for Adult Care Homes with High Ratings Report (S.L. 2007-544, Sec. 3d)

Jeff Horton, Chief Operating Officer, Division of Health Service Regulation, DHHS

VII. Next Meeting:

Thursday, April 10, 2008
10:00

VISITOR REGISTRATION SHEET

Commission on Aging — **Name of Committee**

March 28, 2008 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gary Cayner	DAAS
Steve Freedman	DAAS
Mary Bethea	AARP-NC
Angie Downs	DRNC
Jim Rogers	Assoc - Home Care & Hospice
Dick Hutch	AARP / NC Coalition on Aging / STHL
Jeff Horton	DHHS
Barbara Ryan	DHSR
Don Barnett	DHSR
Julie Budzinski	DMA
Larry Nau	DMA

VISITOR REGISTRATION SHEET

Commission on Aging — March 28, 2008

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ann Eller	DHHS
[illegible]	Triangle J ~~AAA~~ NC4A
Karisa Derenca	DAAS
HEATHER CARTER	DAAS
Bob Konrad	Friends of Residents in LTC
Victor Marshall	UNC Institute on Aging
Diane D. Hatch	AARP
Mary Horne Odom	AARP + former legislator
Marie McBride	STHL
Glenda Artis	DHHS - Division of Aging and Adult Services
Kathryn Lanier	Div of Aging & Adult Serv

VISITOR REGISTRATION SHEET

Commission on Aging — **Name of Committee**

March 28, 2008 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Roger Bone	Bone & Associates
Jane Smith	DHHS
Lee B. Nelson	NCALTCF
Joanne Skorns	NHSHA
Evelyn Hawthorne	NCHCA - NCOTA
Jerry Cooper	NCHCA
CHARLES JACKSON	DMA
Erin McLaughlin	MHA-NC
Denise Rogers	DAAS
Mary Edwards	DAAS
Suzanne Merrill	DAAS

VISITOR REGISTRATION SHEET

Commission on Aging — March 28, 2008

Name of Committee — **Date**

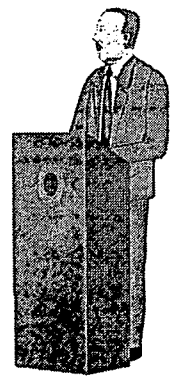
VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jill Passmore	Triangle J Area Agency on Aging jmpassmore@aol.com PO Box 12276 RTP NC 27709
Bonnie Morell	NC Div MH/DD/SAS
Mitch Kokai	John Locke Foundation
Judy Brunger	The Carolinas Center for Hospice & End of Life Care
Jim Brewer	Assoc. for Home & Hospice Care

Attachment 3

3

Summary of Issues Most Frequently Mentioned On February 28, 2008 By Organizations Representing Older Adults



March 28, 2008

Prepared by Staff for the
North Carolina Study Commission on Aging

Organizations Making Presentations on February 28, 2008

Governor's Advisory Council on Aging
Ann Johnson
NC Association of County Directors of Social Services
John Eller
Alzheimer's Association, Western NC Chapter
Jackie Rivers
Direct Care Workers Association of NC
Tonya Jones
NC Assisted Living Association
Evelyn Hawthorne
NC Dental Society, Committee on Aging
Bill Milner
NC Coalition on Aging
Roxanne Bragg-Cash
NC Retired Governmental Employees Association
Ed Regan
NC Senior Center Alliance
Stacie Nelson
Senior Tar Heel Legislature
Charles Dickens
NC Association Long Term Care Facilities
Lou Wilson
NC Guardianship Association
Gale Kirk
Alzheimer's Association, Eastern NC Chapter
Peggy Smith
Association for Home & Hospice Care
Tracy Colvard
NC Adult Day Services Association
Teresa Johnson
NC Association of Area Agencies on Aging
Joan Pellettier
NC Association on Aging
Alan Winstead
Future Care of NC
Gordon DeFriese
NC Retired School Personnel
Lacy Presnell
The Carolinas Center for Hospice and End of Life Care
Judith Brunger
AARP, NC Chapter
Dee Hatch

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: Funding/Funding Related, Not Directly Related to Funding

For Summary Purposes, the issues with the highest frequency were:

- **Increase Home and Community Care Block Grant (HCCBG) Funds** *(8)*
- **Increase Senior Center Funds** *(7)*
- **Provide Funding for Project C.A.R.E.** *(6)*
- **Support for Adult Protective Services/Enact & Fund APS Clearinghouse Model Pilot** *(4)*
- **Increase Funds for New & Existing Special Care Dental Programs (Care in Underserved Areas, LTC, Disabled Seniors at Home)** *(4)*

	Governor's Adv. Council on Aging	NC Guardianship Association	NC Assoc.County Directors Social Svs.	Alzheimer's Assoc. Eastern Chapter	Alzheimer's Assoc. Western Chapter	Assoc. for Home & Hospice Care	Direct Care Workers Assoc.	NC Adult Day Services. Assoc.	NC Assisted Living Assoc.	NC Assoc. of Area Agencies on Aging	NC Dental Society, Com. On Aging	NC Assoc. on Aging	NC Coalition on Aging	Future Care of NC	NC Retired Gov. Employees Assoc.	NC Retired School Personnel	NC Senior Center Alliance	Carolinas Centr. for Hospice & EndCare	Senior Tar Heel Legislature	AARP NC	NC Assoc. LTC Facilities
FUNDING/FUNDING RELATED																					
Increase HCCBG Funds *(8)*	x							x		x		x	x				x		x	x	
Increase Senior Center Funds *(7)*	x									x		x	x				x		x	x	
Increase Funds-Alzheimer's Chapters*(1)*				x																	
Increase Funds-Adult Day Reimbursement*(1)*								x													
Increase Funds-Area Agencies on Aging*(1)*										x											
Provide Funds-Additional NC Prescription Drug Assistance to Those Not Qualifying for Medicare Part D Federal Asst. *(1)*										x											
Provide Funding for Project C.A.R.E. *(6)*	x				x			x				x							x	x	
Increase LTC Insurance Tax Credit*(1)*									x												
Increase Asset Limit for Medicaid- Aged, Blind and Disabled*(2)*	x												x								
Provide Funds to Division of Public Health for Indoor Plumbing for Older Adults*(1)*	x																				
Support for Adult Protective Services/ Enact & Fund APS Clearinghouse Model Pilot*(4)*			x					x				x								x	
Increase Funds for New & Existing Special Care Dental Programs (Care in Underserved Areas, LTC, Disabled Seniors at Home) *(4)*	x										x								x	x	
Support/Fund Older Adult Pop. Study*(1)*												x									
Increase Funds-Guardianship Services*(2)*			x									x									
Increase Funds-Senior Tar Heel Legislature*(1)*																			x		
Increase Funds- Housing Trust Fund*(1)*																				x	
Increase Medicaid Nursing Homes Residents Personal Needs Allowance*(1)*										x											
Require DHHS to Adopt Special Assistance & Medicaid Income Disregard Policy*(1)*									x												
Retirement Contribution Rates for Government Employees, Health Plan Benefit*(2)*															x	x					
Collaboration to Streamline Guardianship Efforts (including training) and Funding*(2)*		x																		x	
Include Dental Care Reimbursement for NC Money Follows Person Program - Medicaid*(1)*											x										

	Governor's Adv. Council on Aging	NC Guardianship Association	NC Assoc.County Directors Social Svs	Alzheimer's Assoc. Eastern Chapter	Alzheimer's Assoc. Western Chapter	Assoc. for Home & Hospice Care	Direct Care Workers Assoc.	NC Adult Day Services. Assoc.	NC Assisted Living Assoc.	NC Assoc. of Area Agencies on Aging	NC Dental Society, Com. On Aging	NC Assoc. on Aging	NC Coalition on Aging	Future Care of NC	NC Retired Gov. Employees Assoc.	NC Retired School Personnel	NC Senior Center Alliance	Carolinas Centr. for Hospice & EndCare	Senior Tar Heel Legislature	AARP. NC	NC Assoc. LTC Facilities
NOT DIRECTLY RELATED TO FUNDING																					
Pursue Rules for S.L. 2005-66 (ACH Licensure Category for Elderly Only) *(I)*									x												
Review Evaluations that Determine Incompetency *(I)*		x																			
Promote Limited Guardianship as Readily Accepted Option*(I)*		x																			
Increased Training for Guardianship*(I)*			x																		
Address Mentally Ill Mixed with Frail Elderly*(I)*																				x	
Continue Support for Information on LTC Providers*(I)*																x					
Require Registration of Multiunit Assisted Housing w/ Services (MAHS) *(I)*									x												
Develop State Alzheimer's Plan*(I)*					x																
Enact Legislation to Study Safe Transport of Passengers in Wheelchairs*(I)*								x													
Require Study on Dedication of Bd. Of Gvnors' Dental Scholarship-Loan Program Slots for Providers Serving Special Populations*(I)*											x										
Direct DHHS-Medical Assistance – to study dental Medicaid behavior reimbursement code for Special Care Patients*(I)*											x										
Study Funding of Special Care Residency Program to Train Future Dental Providers*(I)*											x										
Info. on Direct Care Workers Assn. *(I)*							x														
Info. on PCS Restructuring*(I)*						x															
Info. on Future Care of NC*(I)*														x							
Create Task Force- Quality End of Life Care *(I)*																		x			
Remove Barriers- Referrals for Hospice Care*(I)*																		x			
Continue Emphasis-Advance Care Planning*(I)*																		x			
Increase Availability of Palliative Care & Pain Management in Hospitals& Nursing Homes*(I)*																		x			
ACH/DHHS Partnership for Improved Care of Residents & Web-based System for Resident Assessment, Care Planning, Monitoring, Staff Development, and Peer Support*(I)*																					x



Friends of Residents in Long Term Care
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Raleigh, NC 27605
919.782.1530 voice
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Friends of Residents in Long Term Care

Priorities for the 2008 Short Session of the General Assembly

TOP PRIORITIES

1. Support legislation to address problem of mixed populations in adult care homes

2. Support enhancement and provision of dental services in long term care facilities

3. Monitor implementation of the star rating system for adult care homes and support expansion funds for technical assistance and regulation to improve quality and transparency

ADDITIONAL PRIORITIES

4. Increase funding for Home and Community Care Block Grant by $7 million

5. Increase Medicaid personal needs allowance to nursing home residents from $30/month to $50/month

6. Study requiring air conditioning in adult care homes

7. Support labor enhancements for direct care workers in long term care facilities

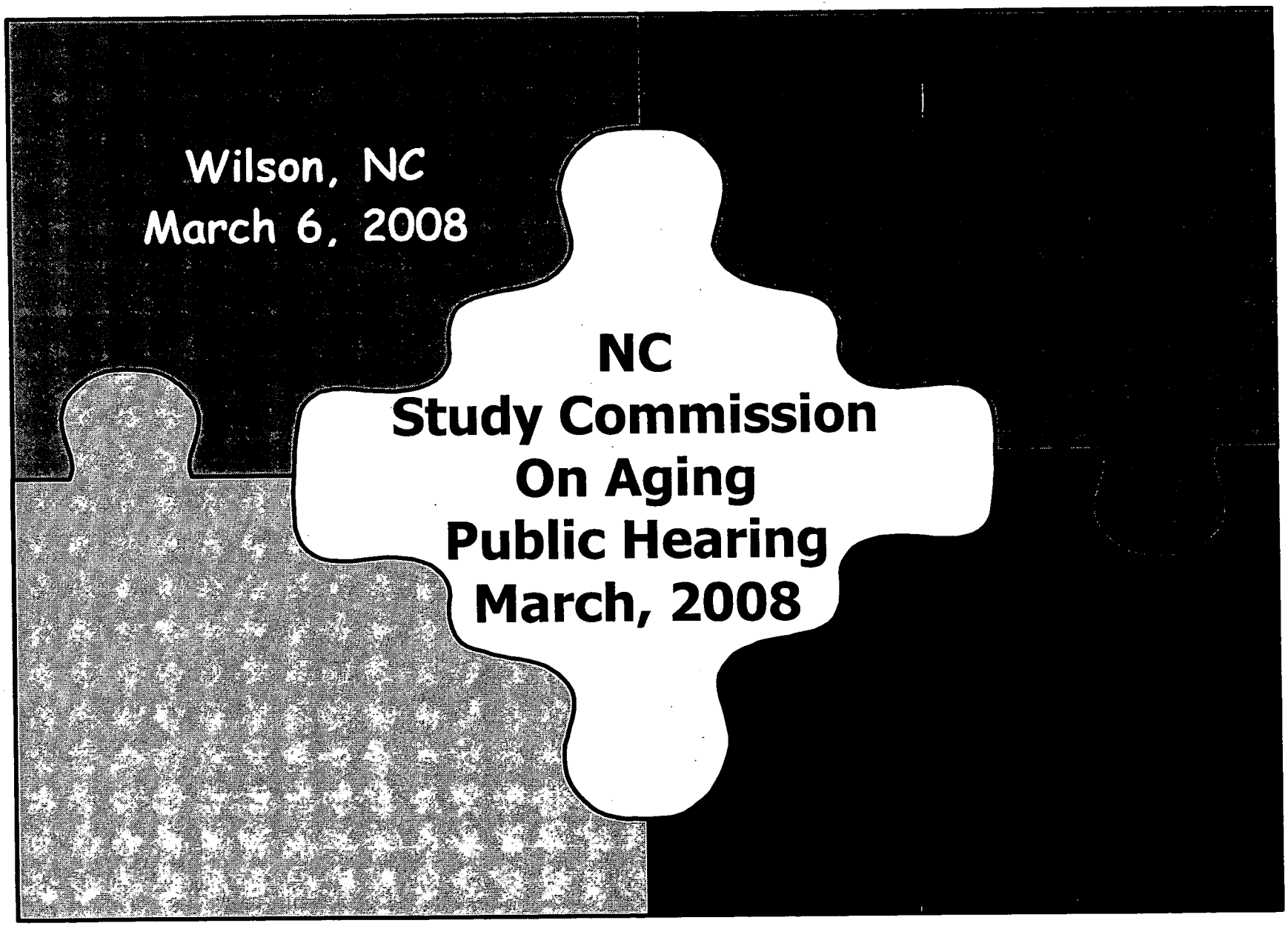
8. Strengthen elder abuse and guardianship laws

9. Improve disaster preparedness of long term care facilities and local planning efforts

For more information contact:

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Paula A. Wolf
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(919) 846-2296


Wilson, NC
March 6, 2008
NC
Study Commission
On Aging
Public Hearing
March, 2008

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)

March 2008 Public Hearing

Date	Location	Number of Speakers
March 6, 2008	Wilson, NC	42

The issues mentioned during the hearing with the greatest frequency were:

- **Increase Senior Center Funds/Make 2007-08 Increase Recurring (15)** ✓
- **Increase Home and Community Care Block Grant (HCCBG) Funds (13)** ✓
- **Increase Funds for Adult Day Reimbursement/Support Adult Day Care (6)** ✓
- **Increase Funds for Area Agencies on Aging (5)** ✓
- **Support for Adult Protective Services/Enact & Fund APS Clearinghouse Model Pilot (5)** ✓
- **Support for Senior Games (5)** ✓

Frequency of Issues Expressed by Speakers

	WILSON TOTAL
Increase HCCBG Funds	✓13
Increase Senior Center Funds/Make 2007-08 Increase Recurring	✓15
Increase Funds for Adult Day Reimbursement/Support Adult Day	✓6
Increase Funds for Area Agencies on Aging	5
Provide Funding for Project C.A.R.E.	3
Increase Asset Limit for Medicaid- Aged, Blind and Disabled	1
Support for Adult Protective Services/ Enact & Fund APS Clearinghouse Model Pilot	5
Increase Funds for New & Existing Special Care Dental Programs (Care in Underserved Areas, LTC, Disabled Seniors at Home)	4
Support/Fund Older Adult Pop. Growth Study	2
Increase Funds and Legislation for Guardianship Services	3
Increase Funds for Housing Trust Fund/Recurring Funding	3
Increase Medicaid Reimbursement Rate for Dental Care	1
Need Transportation Funding for Seniors	4
Increase CAP/DA and PCS Rates to Maintain Qualified Workers	1
Support for Home & Hospice Care	2
Continue Moratorium on New Home Care Agencies	1
Prohibit Home Care From Giving to Clients	1
Extend Grace Period to Resolve Medicaid Issues Prior to Patient Transfer	1
Focus on Addressing the Needs of Developmentally Disabled Older Adults	2
Support for Senior Games	5
Support for Community Alternatives Program (CAP)	1
Medicare Advantage Plans – Concern for Aggressive and Misleading Sales Tactics	3
Support for Respite Services/Support for Family Caregivers	2
Advance Directives/Leave Decision in Hands of Health Care Providers	1
Support for the Star Rating System	1
Increase Monitoring of Family Care Homes	1
Concern for Mixing Mentally Ill & Frail Elderly	2
Expand NC Support for Prescription Drug Coverage	1
Support for HB 1711 Establish Paid Sick Days	1
Increase Funds for In-Home Services to Reduce Waiting Lists	1
Raise Awareness of End of Life Options	1
Increase Licensed Hospice Beds	1
Concern Over Reverse Mortgages – Require Face to Face Counseling	1

Prepared by Aging Commission Staff

Institute on Aging
Interinstitutional Program of The University of North Carolina

Comments from the Director, UNC Institute on Aging, to Aging Study Commission. 28 March 2008

Victor W. Marshall, Ph.D., Director, UNC Institute on Aging

I will first tell you about the UNC Institute on Aging, as I think most of you do not know much about it, and then briefing you on four initiatives that you might be dealing with legislatively, or simply that I think you should be aware of. As I tell you about the IOA, I hope you will realize that the Institute can be a tremendous resource to this committee– and that we are committed to being helpful.

The IOA was established in 1996 as an 'inter-institutional program' of the UNC system, but located on the campus of UNC at Chapel Hill. Our mandate includes providing state-of-the-art information to policy makers, program managers, service providers, clinicians, and the general public to ensure that research findings in aging are reflected in policy recommendations, in professional practice, and in the health and human service systems serving the needs of older adults.

Our mission statement is: To enhance the well-being of older people in North Carolina by fostering statewide collaboration in research, education and service. We have base budget funding of about $600,000 a year but each year we generate about $1.7 million additional funding through research grants and contracts, to support our activities. We have about 40 people on staff, counting students and other part-timers, but the FTE is about 20 people. Given our mission, we are a pretty small outfit, but we work actively in partnerships, which enables us to have a bigger impact.

I have time to alert you to only a few things that we do.

We initiated and sustain, as the lead partner, the North Carolina Conference on Aging. The other partners are the NCDAAS, NCAAA, NCAOA, Governor's Advisory Council on Aging, AARP, and several universities. The conference brings together academic researchers with the aging service network, several state government agencies and the advocacy groups, and an increasing representation from the private sector. The 7th annual conference will be in Greenville in October and, like the previous two, is expected to attract over 600.

We sponsor the Senior Leadership in Aging Program, which has just accepted nine seniors leaders, from across the state, for its next 18 month session. The program provides mentorship and seed funding for leader-generated projects. The idea is to increase volunteer leadership and advocacy skills. Several graduates of the program are in the Senior Tar Heel Legislature.

The IOA established (again with partners) and provides ongoing support to the North Carolina Healthy Aging Coalition, working with 25 organizations to enhance the health of older North Carolinians.

The IOA established and supports the North Carolina Gerontology Consortium, linking 11 universities in the UNC system– from Asheville and Appalachian State to Elisabeth City and Wilmington– to collaborate in developing and sharing distance education courses in aging.

We have also just created a North Carolina College Aging Network (NCCAN), which so far includes fifteen members from nine different small, independent colleges. NCCAN will support professors who are often the only faculty member in gerontology education in their entire college.

We are in the process of establishing the North Carolina Lifelong Access Libraries Collaboration, designated a Center of Excellence and Innovation by the Libraries for the Future foundation in New York. The collaboration will work with public libraries across the state to foster civic engagement of seniors and make libraries more age-friendly. Partners include the State Librarian and the Division on Aging and Adult Services. Funding comes from the New York-based foundation and from the Vice-Chancellor for Engagement at UNC Chapel Hill. The initiative is being announced this very day at a national librarianship conference in Minneapolis.

The Center for Aging and Diversity, a center within the Institute, has conducted a large 'train the trainer' program with vulnerable populations in North Carolina's African American community and with Native Americans. In partnership with the Eastern Carolina chapter of The Alzheimer's Foundation, the program provides training for the very difficult caregiving that is found with dementia, but also trains people to train others, so that it will have a multiplier effect.

These are just examples of many more projects at the IOA. Of more direct potential benefit to you, our outstanding library and information service is available for you to use (see flyer in your packet). You should all be receiving our electronic newsletter, which comes monthly with news of research, education and services in aging. Our website must be of use to someone because it receives 82,000 hits per month. Our digital library is easy to use. You can enter key words, such as 'long term care' or alzheimers and find digital reports, papers and even websites full of information for you to read or download free for your own use.

Spending time on our website will give you a more comprehensive idea of IOA activities, including our extensive research program (which I have not highlighted today). In addition, Representative Farmer-Butterfield is a member of our Statewide Advisory Council and has a good idea of what we do.

While the Institute cannot propose a legislative agenda, I would like now to comment on four initiatives that should concern this committee and which touch on the IOA's basic mandate or relate directly to activities and programs of the Institute.

1) Recommendations for a Statewide Aging Study

In response to Senate Bill 448, Session Law 2007-355, the Division of Aging and Adult Services (DAAS) submitted "Report to the North Carolina General Assembly on Recommendations for a Statewide Aging Study" (January 1, 2008).

Section 2 of this bill requested the DAAS to "make recommendations on a study to include all counties in North Carolina. The Division shall evaluate similar studies conducted by other states and shall make recommendations on the criteria that should be included and an appropriate funding level for a study to include all North Carolina counties".

The Report proposed Project CACE, Communities and Aging Carolinians – on Edge which has six integrated components. These included the design and implementation of a "State and Local Awareness and Preparedness Assessment", and the securing of supplementary studies such as the Retirement Migration Study. Specifically, the report recommends "an ongoing assessment of the needs, assets, and expectations of its older population and the aging boomer cohort". An initial survey with follow-up over a five year period is recommended, and active collaboration would be engaged with the Area Agencies on Aging (AAAs).

The UNC Institute on Aging is mentioned, in relation to project coordination. The IOA is uniquely positioned for both project coordination and implementation because of its survey research expertise, its formal mandate and positive record of working with other academic institutions across the state, and its many partnerships with the AAA's and other local-level service agencies in the 'aging network'. Total funds for this proposed initiative are $3.72 million recurring and $600,000 non-recurring. The Institute on Aging considers this project to be of critical importance because it will generate the needed data to support planning for the aging of the baby boom generations, in a broader context including economic and social, as well as health factors, and in a manner that takes into account the rapidly changing demographic structure of North Carolina's aging and older population. The related migration study that would be part of this initiative reflects a demand from several counties across the state (not just in the eastern part) for the development of a knowledge base to guide economic, social and health policy in the context of the very large and historically unprecedented in-migration of the elderly to North Carolina.

2) Addressing Public Health Issues of Older Adults

The Institute on Aging is currently working in partnership with the Division of Public Health, the Division of Aging and Adult Services, the Healthy Aging Coalition, and the UNC Geriatric Education Center to address the growing public health issue of older adult falls. Thirty percent of adults 65 and older who live in the community fall each year. Falls are the cause of fatal and nonfatal injuries for persons over the age of 65. In North Carolina, older adult falls accounted for 27% of all injury-related emergency department visits in 2006, and hospitalization rates

due to falls increased by 35% between 2001 and 2005. Given the association of falls and fall-related injuries with increasing age, these rates are expected to grow rapidly as North Carolina's older adult population increases.

Specific funding is needed to educate health care professionals and other older adult service providers about fall prevention, evaluation and management; oversee and support demonstration projects designed to prevent falls among older adults and to prevent or reduce injuries associated with such falls; and raise awareness among older adults themselves and their caregivers and families about what they can do to prevent falls. In the interim, the IOA is working with our partner organizations to develop the North Carolina Falls Prevention Coalition, to bring together NC health care professionals and service providvers to addrss this issue in a more systematic way. Thus the Institute on Aging supports these falls prevention initiatives. The Institute on Aging and its partners have yet to identify someone who will lead this charge legislatively, but we are hopeful that this can be addressed soon.

3) Support for the Win A Step Up Program

The IOA's Win A Step Up program has conducted skills upgrading for direct care workers and managers in nursing homes and other settings, reaching more than half of the counties in the state. The goal is to reduce the huge turnover rate in this sector, enhance caring skills and continuity of care, and increase job satisfaction. The program recently received honorable mention in a national recognition competition from the Rosalynn Carter Foundation.

The Study Commission on Aging recommended (Recommendation 16, 2007 session of the General Assembly, p.7) "that the General Assembly appropriate to the Department of Health and Human Services, Division of Facility Services (now the Division of Health Service Regulation), $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."

This recommendation was not adopted, and the program has continued with reduced financial support. Legislation that is consistent with Recommendation Number 16 of the 2007 North Carolina' Study Commission's report would allow the IOA, which houses and conducts this award-winning program, to develop and

pilot a WIN A STEP UP Program for nurse aides employed by home care agencies; to continue the program in nursing homes with support from fines and penalties collections provided by the Division of Health Service Regulation; to allow the WIN A STEP UP Program to continue its study of the feasibility of becoming a self-sustaining program across all types of long term care; and to enhance and enrich the curriculum with information and exercises involving appropriate care for individuals with dementia, anxiety, depression, and other severe mental health problems.

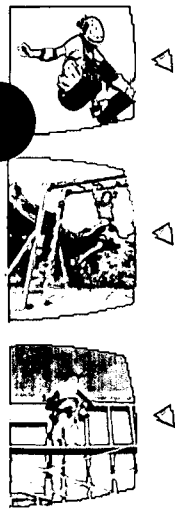
4) Aging Workforce Initiatives

The Institute on Aging has agreed to be provide administrative support for a Forum on North Carolina's Aging Workforce. The forum was initiated by the Governor's Advisory Council on Aging, and the Workforce Development Board of the Department of Commerce will also play an important role in developing the conference. This will be a two-day conference , September 23-24 in Raleigh, and we expect to find additional partnership support from the corporate sector and non-governmental organizations. With the leading edge of the baby boomers now eligible for early retirement at age 63, and the average retirement age 62 in fact, North Carolina faces severe labor force shortages in the future. Throughout the developed world, nations and corporations are in the process of a huge policy shift– from encouraging early retirement to fostering retention of workers to later ages. We simply cannot afford to lose the talent of older workers; however, if we are to encourage them to delay their retirement, we need to make work more flexible, more rewarding, and more healthy, and to make adjustments to pension and health care provisions to facilitate things like phased retirement. I have no doubts that the legislature will, at some point in the near future, be wishing to consider legislation to make work more flexible and to increase our ability to use the talents of workers to later ages. All members of the legislature will be invited to attend this forum, but we are particularly hopeful that you, as members of the Aging Study Commission, will mark your calendars for this event.

Concluding Comments

I thank you for this opportunity to address you. And I invite you to view the Institute on Aging as a resource to assist you in your deliberations. We were created to serve North Carolina, and that includes the North Carolina Study Commission on Aging.

For contact:
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(919) 843-8067
Victor_marshall@unc.edu
Institute Website www.aging.unc.edu

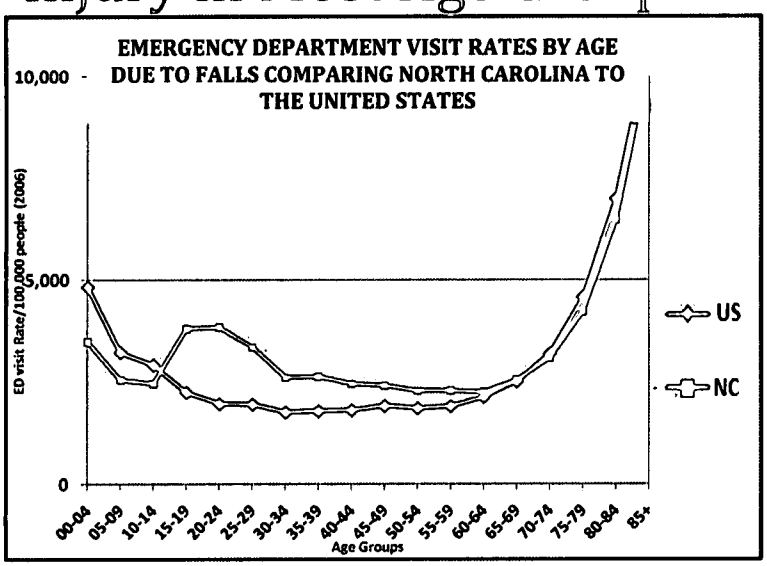


Fac... NC falls

IN NORTH CAROLINA, FALLS RESULTED IN NEARLY 140,000 EMERGENCY DEPARTMENT (ED) VISITS IN 2006.

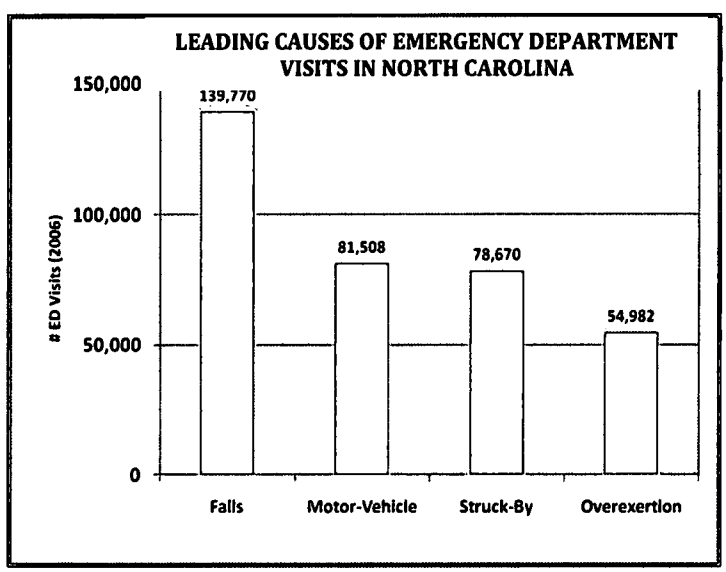
- 438 people died from falls in 2006.
- Individuals who fall and are then discharged from a hospital pay, on average, over $19,000 for hospital care (based on 2004 - 2005 data).

Falls: The Leading Cause of Injury in Most Age Groups



Falls: The #1 Known Cause Of ED Visits Due To Unintentional Injury

- A 70% higher rate of ED visits due to falls was identified in 15-19 year olds in NC versus the US.
- Males account for 68% more ED visits from falls than females.
- The death rate due to falls is almost double in white individuals than in African-Americans.
- 9% of ED visits due to falls resulted in a traumatic brain injury diagnosis.



The Personal & Financial Burden of Older Adult Falls

NC falls



In 2006, the death rate due to falls was 2,000% higher in older adults (over 65 years of age) than for those individuals younger than 65.

- 25% of institutional falls result in severe injury.

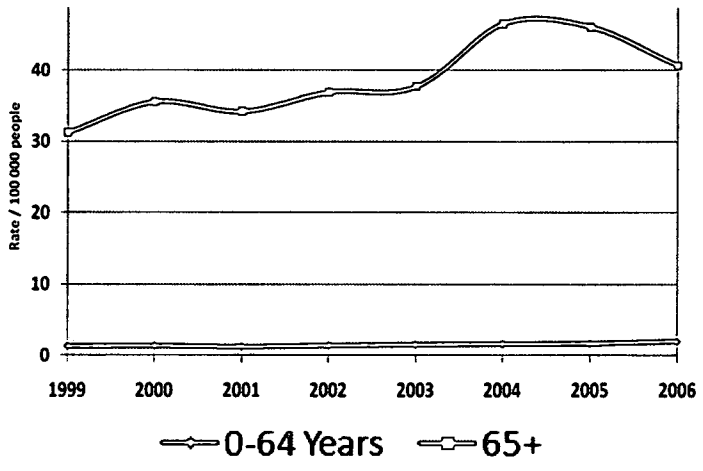
Falls Are Devastating

- Falls are the leading cause of fatal and nonfatal injuries for persons over the age of 65 in North Carolina.
- In 2006, only 12% of North Carolinians were over 65 years of age, but accounted for 71% of fall-related deaths.
- In older adults, the hospitalization rate from falls is 17 times greater than the rate from motor-vehicle related injuries.

Falls Increase Hospitalizations

- The hospitalization rate due to falls increased by 35% between 2001 and 2005.
- Falls in older adults accounted for 27% of all injury-related ED visits in 2006.
- As indicated below, the death rate in older adults has continued to increase over time.

DEATH RATES DUE TO FALLS COMPARING THOSE YOUNGER THAN 65 TO THOSE 65 YEARS OLD AND OLDER 1999-2006, NORTH CAROLINA



Falls Affect Independence

- 1 in 3 independently living older adults falls each year.
- Falls increase the likelihood of being admitted to a nursing home, and the subsequent loss of independence.

THE TIME TO ACT IS NOW!

By 2030, 75% of North Carolina's counties are projected to have more people 60 and older than 17 and younger. This shift in the percentage of older adults will result in a falls "epidemic" unless North Carolina addresses the issue systematically across all sectors.

North Carolina Injury & Violence PREVENTION Branch

UNC Institute on Aging Information Center

Get More Information

The Information Center is a program of the UNC Institute on Aging. Access to resources is available in person or electronically via the internet.

For more information, please contact Danielle Borasky, Associate Director for Library and Information Services at 919-966-9444 or email at aginginfo@unc.edu. Visit the Information Center web site at: www.aging.unc.edu/infocenter/.

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The Institute on Aging is an interinstitutional program of the University of North Carolina

Overview

The UNC Institute on Aging Information Center is a central source of aging-related information for North Carolina professionals. A rich set of resources, tools, and services is available in a specialized library that has both print and digital components. Resources are of interest to researchers, educators, health professionals, government officials, and others across the state.

Valuable Resources

The Information Center collects, organizes and provides access to print and electronic resources. A wide range of topics is covered, but especially focus on North Carolina aging, diversity, healthy aging, older workers, rural aging, and long term care issues. Materials are available for use in-house and via the internet whenever possible. Collections include:

- Books
- Journals and other periodicals
- Theses and dissertations written by students in North Carolina
- Reports and unpublished papers
- Web sites
- Digital documents

Staff are available to provide assistance to those seeking information about aging, including assistance locating resources, answers to reference questions, research assistance, and instruction in the use of aging-related resources.

Access Anywhere, Anytime

All the collections of the Information Center are searchable via AgeLib, a web-based digital library of aging resources. AgeLib is both a library catalog and digital library that links directly to electronic resources on the Internet and allows users to search the entire Information Center collection. Users can search by several fields, including subjects listed in the AARP Thesaurus of Aging Terminology.

Specialized Information Products

The Information Center creates specialized information products such as tutorials, bibliographies, webliographies, digitized documents, databases and other aids to find information. These helpful products are usually targeted to a specific group or interest. For example, some of the items available include a tutorial for students doing research on aging topics, a webliography of healthy aging links for our Healthy Aging Network, and a collection of online slides for use by gerontologists making presentations. These and other products are available on the Information Center web site.

September 2005

Senior Leadership Enhancement Initiative

Get More Information

The Senior Leadership Enhancement Initiative is a program of the UNC Institute on Aging.

For additional information on the Senior Leadership Enhancement Initiative or the application process contact: William E. Lamb, Associate Director for Public Service, UNC Institute on Aging, by phone (919-966-9444) or by e-mail (bill_lamb@unc.edu).

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The Senior Leadership Enhancement Initiative is a program sponsored by the UNC Institute on Aging. This initiative recognizes the importance of older adult leadership in addressing issues affecting citizens and provides the support necessary to complement the skills and experiences brought by the participants to the program. The program is open to any person (60+) currently residing in North Carolina.

Are You a Senior Leader?

The program is open to any older person currently residing in North Carolina. Applicants for the Senior Leadership Enhancement Initiative should have:

- Potential to emerge as a statewide leader on aging issues in North Carolina
- An interest in personal leadership development activities
- Desire to explore, through seminars, readings and mentored experiences, the issues related to an aging society; and
- Been recently retired from the formal workplace or similarly ready to devote time to developing and implementing an individual development plan

Benefits of Participation

Participants in the Senior Leadership Initiative engage in a year-long program that includes a series of seminars, tutorials, and networking opportunities related to emerging aging issues in North Carolina and the development of an individualized personal leadership development plan tailored to the unique needs of each participant. Participants receive a stipend of $2000 to assist in the implementation of the personal leadership development plan. In addition, participants have special opportunities to network with aging and long-term care leadership across North Carolina.

Senior Leaders Make a Difference

Seniors Leaders come from all over North Carolina, and their projects have an impact on the state. Recent senior leaders have explored topics such as developing leadership skills, becoming an active advocate, promoting family involvement, and more.

Information for Potential Applicants

Generally, three Senior Leader positions are available each year. Applications forms are generally due in January, with acceptance decisions made in March. Watch the Institute on Aging web site for annual announcements. Application forms can be downloaded from the web site at http://www.aging.unc.edu/seniorleaders/.

North Carolina Gerontology Consortium

Get More Information

The administrative home of the Consortium is the UNC Institute on Aging. For more information on the Consortium, contact Jim Mitchell, Institute on Aging Consortium Liaison at mitchellj@mail.ecu.edu.

Information about the Consortium is available on the web site at www.aging.unc.edu/ncgc/.

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Overview

The North Carolina Gerontology Consortium is an inter-institutional arrangement among a group of UNC System campuses. Currently, the Consortium includes Appalachian State University, East Carolina University, Elizabeth City State University, UNC Asheville, UNC Chapel Hill, UNC Charlotte, UNC Greensboro, UNC Wilmington, Western Carolina University and Winston-Salem State University.

Needs Assessment

The Consortium was created coincident with a statewide workforce survey conducted by the UNC Institute on Aging. The majority of respondents reported that they wanted access to education in gerontology to improve their knowledge and skills in serving North Carolina's rapidly growing and diverse older population. The workforce survey also indicated that workers were willing to pursue educational opportunities offered via distance technologies.

Meeting Critical Needs

Aging education has been inaccessible to potential students due to driving distances to the campuses, employment, families, and other life commitments. Therefore, the goals of the North Carolina Gerontology Consortium are to:

- Improve access to courses, continuing education, and certificate and degree programs in aging throughout the state among students and those in the aging services workforce;
- Expand the range of courses available to students;
- Expand the network of scholars in gerontology and geriatrics throughout North Carolina;
- Provide an organizational structure to coordinate curricula and to improve teaching skills in using distance education technologies and
- Use statewide resources more cost-effectively through collaboration by faculty on courses, projects and grant writing.

A Statewide Collaboration

The Consortium's governing body is the Coordinating Committee. The Coordinating Committee is made up of faculty representatives from each participating campus. (text deleted) The Committee sets policies and procedures for carrying out the Consortium's goals. The governance structure of the Consortium is designed so that faculty can share instructional resources in gerontology and geriatrics among participating institutions. The Consortium does not offer degrees; these are awarded by academic units of the member campuses. The Institute on Aging provides staff to help manage the Consortium.

September 2005

Center for Aging & Diversity

Get More Information

The Center for Aging and Diverisity is part of the UNC Institute on Aging.

For more information, contact Peggye Dilworth-Anderson, PhD, Director, at dilworth@email.unc.edu, or visit the Center's web site at www.aging.unc.edu/cad/.

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The Institute on Aging is an interinstitutional program of the University of North Carolina

Overview

The Center for Aging and Diversity addresses health disparities in later life, provides a forum in which to discuss and examine ethnic, racial and cultural variation in life course processes and disseminates research findings to the academic and lay community on the health of older diverse populations.

Researching Health Disparities

The Center conducts research studies relevant to older minority populations, particularly in the area of health disparities. Research at the Center is funded by a number of national organizations including the National Institute on Aging, the Alzheimer's Association, and the GlaxoSmithKline Global Community Partnership Program.Our research is concentrated in four areas: Dementia caregiving in diverse populations; Family caregiving; Social support and family health outcomes; and Health disparities.

Training the Next Generation of Researchers

The Center supports the training of junior scholars, graduate students and post-doctoral students who are interested in aging and diversity issues by supporting and encouraging their progress. The Center participates in the Carolina Program in Healthcare and Aging Research (CPHAR) and sponsors the Ethnicity, Culture, Race and Aging (ECRA) Seminar Series, which is required of all CPHAR students, and open to others interested in aging and diversity. The Center also provides guidance, sponsors collaborative support, and offers mentoring for junior faculty, post-doctoral fellows and graduate students as they conduct their research programs in aging and diversity.

A Resource for Information

One goal of the Center is to serve as a resource for information about aging and diversity. The Center maintains several collections of resources, including an online bibliography: Social & behavioral research on Alzheimer's Disease and dementia in diverse populations. This bibliography was funded by a grant from the Alzheimer's Association and is updated regularly. The Center also maintains a collection of links to web sites related to aging and diversity. These resources are available by visiting the Center's web site at www.aging.unc.edu/cad/.

Integrating Community Participation

The Community Research Advisory Committee, which includes eighteen prominent members most of whom live in the Durham, North Carolina community, advises the Center on which communities to hold seminars or information sharing and gathering meetings; some members of the Committee assist with selecting pilot investigators for future studies. The Committee also helps researchers identify needed areas of research in their communities, helps researchers identify, gain and maintain access to samples of elders for their research projects, and provides on-going strategies for building community relations to enhance research in the older ethnic minority communities.

Healthy Aging Initiatives

Get More Information

Healthy Aging initiatives at the UNC Institute on Aging are under the direction of Mary Altpeter, PhD, Associate Director for Program Development (mary_altpeter@unc.edu).

For more information, visit the IOA web site, Healthy Aging section, at www.aging.unc.edu/groups/healthyaging. The site includes a a comprehensive set of links to healthy aging web resources, including the CDC, NCOA, AoA, healthy aging programs and organizations, databases, reports, and news items

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The Institute on Aging is an interinstitutional program of the University of North Carolina

Overview

The Institute on Aging participates in several national and state level projects that promote healthy aging.

NC Healthy Aging Network (NCHAN)

The NCHAN is an eight-year Special Interest Project (SIP) funded by the Centers for Disease Control (CDC). It is led by a partnership between the UNC Institute on Aging and the Program on Aging and Carolina Geriatric Education Center of the UNC School of Medicine.

HAN Definition of Healthy Aging

Healthy aging is the development and maintenance of optimal physical, mental and social well-being and function in older adults. It is most likely to be achieved when physical environments and communities are safe, and support the adoption and maintenance by individuals of attitudes and behaviors known to promote health and well-being; and by the effective use of health services and community programs to prevent or minimize the impact of acute and chronic disease on function.

Conducting Research and Research Translation

The NCHAN collaborates with the HAN, a CDC-funded national nine-campus Healthy Aging Research Network, to advance the prevention research agenda for public health and aging. The mission of NCHAN is to work with national, state and local partners to:

- conduct research to better understand the determinants of healthy aging in older adult populations;
- identify interventions that are effective in enhancing the health and quality of life of older adults; and
- assist in the translation of such research into sustainable community-based programs throughout the state.

NC Healthy Aging Coalition (NCHAC)

The North Carolina Healthy Aging Coalition (NCHAC) is a multi-disciplinary, multi-network group comprised of key leaders from over 25 organizations from across the state with an interest in health promotion and/or aging.

Enhancing Capacity through Partnerships

The NCHAC's vision is that North Carolina will create and sustain programs, policies and environments to foster healthy aging and the health, well-being and independence of its citizens.

To foster optimal health and well-being, the NC Healthy Aging Coalition:

- builds statewide partnerships to increase public awareness of the evidence base for health promotion and prevention in aging,
- plans and develops resources, programs, provider capacity and policies to foster evidence-based practice, and
- disseminates knowledge to foster effective evidence-based programs and healthy environments.

Aging and Workforce Studies

Get More Information

For more information about the UNC Institute on Aging or the projects and staff mentioned here, please visit the Institute's web site at www.aging.unc.edu, or by phone at 919-966-9444.

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The Institute on Aging is an interinstitutional program of the University of North Carolina

November 2005

Overview

One of the priority areas of the UNC Institute on Aging is its research on workforce issues that relate to aging. Most of the projected growth in the labor force between 2000 and 2050 will be composed of workers aged 55+, and workers aged 55+ will account for a larger share of the labor force. This workforce aging and the attendant population aging will have major influences on the organization of work and the demand for particular services. Ongoing research at the Institute focuses on how this new trend may influence or complicate work experiences, recruitment, retention, careers, and the situation of older workers in various occupations/industries.

Studying Workforce Aging Issues

Workforce Aging in the New Economy (WANE)

The Workforce Aging in the New Economy (WANE) project explores the relationships among workforce aging, employment growth in information technology (IT) labor markets, and the transformation of employment relations in the new economy. Focusing on the IT industry, WANE uses a mixed method case study design to conduct in-depth investigations into these issues. WANE is an multi-national collaboration with research teams in four regions: Canada, the European Union, Australia and the United States. The U.S. component is based at the UNC Institute on Aging. WANE is funded by the Social Sciences and Humanities Research Council of Canada through its Initiative on the New Economy Program.

Workforce Issues in Library & Information Science (WILIS)

WILIS is a collaborative research project designed to study the educational, workplace, career and retention issues faced by library and information science (LIS) graduates. There are increasing concerns about aging of the LIS workforce; the lack of minority presence in the field; and the need for succession planning. By examining LIS graduates from 1964 to 2004, this research will be uniquely situated to offer insight on the work experiences, aspirations and expectations of both long and short career workers. The WILIS project is funded by the federal government's Institute for Museum and Library Services (IMLS). WILIS is a partnership of the UNC School of Information and Library Science and the UNC Institute on Aging.

The Long Term Care Workforce

Workforce Improvement for Nursing Assistants Supporting Training, Education and Payment for Upgrading Performance (WIN A STEP UP)

WIN A STEP UP is aimed at improving the situation of nursing assistants in the long-term care industry in North Carolina. As the population ages, the demand for long term care services is expected to increase. Nursing assistants provide 80 to 90% of the direct resident care, yet nursing assistant turnover levels in North Carolina's nursing homes have exceeded 100% for the last three years. This situation is only expected to worsen. Research conducted through and in tandem with this project includes intervention evaluation research, research on recruitment and retention issues, and on human resource practices. WIN A STEP UP is a partnership of the NC Department of Health and Human Services and the UNC Institute on Aging.

Aging & Workforce Studies - Key Research Staff

Victor W. Marshall, PhD

Dr. Marshall is Director of the UNC Institute on Aging (IOA); Professor of Sociology; Adjunct Professor of Health Behavior and Health Education at UNC; and Team Leader for the US component of the WANE project. He received his B.A. from the University of Calgary and his PhD in sociology from Princeton University. As Director of CARNET: the Canadian Aging Research Network, he developed an extensive research program, Issues of an Aging Workforce, that gathered case study data from several firms in both Canada and the United States to investigate the impact of workforce aging on human resources policy. Subsequently, he led a research program examining four large-scale surveys to investigate the changing retirement transition and its impact on health. Victor Marshall has held a number of executive positions in the field of aging, including Vice-President of the Canadian Association on Gerontology, Board Member of the Southern Gerontological Society, Executive Committee of the International Association on Gerontology, and Chair of the Fellowship Committee, Gerontological Society of America. His expertise in the areas of work, aging and the life course has led to numerous publications. His latest two books are Restructuring Work and the Life Course and Social Dynamics of the Life Course.

Thomas R. Konrad, PhD

Dr. Konrad is a Senior Scientist at the Institute on Aging, and is a Senior Fellow and Co-Director of the Program on Health Professions and Primary Care (PHP&PC) at the Sheps Center, with academic appointments as Professor of Social Medicine (School of Medicine) and Health Policy and Administration (School of Public Health), and Research Professor in the Division of Pharmaceutical Policy and Evaluative Sciences (School of Pharmacy). Working in conjunction with other investigators at the Institute and elsewhere, Dr. Konrad has directed or collaborated on over 40 health care workforce studies over the past 32 years, publishing nearly 100 articles in peer-reviewed journals, many on topics of substantive and methodological concern to health workforce researchers and policymakers. He is currently examining the causes and effects of aging and retirement of health professionals.

Joanne Gard Marshall, PhD

At the Institute, Dr. Marshall is Principal Investigator of the WILIS project and Co-Investigator of the WANE project. Dr. Marshall joined the School of Information and Library Science (SILS) at the University of North Carolina at Chapel Hill (UNC) as Dean and Professor in January 1999. In July 2004, she returned to the faculty as an Alumni Distinguished Professor. Prior to 1999, Dr. Marshall was a faculty member at the Faculty of Information Studies, University of Toronto for 12 years, where she taught courses in health sciences information, special libraries, research methods and online information retrieval. She received a B.A. from the University of Calgary; an M.H.Sc. from McMaster University; an M.L.S. from McGill University; and a PhD from the University of Toronto. Her areas of research interest include health information needs and services; value and impact of library and information services; aging workforce issues; and competencies of library and information professionals. Dr. Marshall is author of numerous library and information science (LIS) publications that are widely cited. She is Past President of the Medical Library Association.

Jennifer Craft Morgan, PhD

Jennifer Craft Morgan recently completed her dissertation on job satisfaction, retention and career commitment issues using data from the WIN A STEP UP project. She is currently Research Scientist at the Institute on Aging coordinating both the US Workforce Aging in the New Economy research team and the Workforce Issues in Library and Information Science research team and working as a co-investigator on the WIN A STEP UP and related projects. She has collaborated with each of the principal investigators above on grant proposal development, and report and article writing. She is currently developing grant proposals in the program area of older workers and retirement and care of the aging. Specifically, she is interested in the intersection of work, aging, gender and health.

2005 REVISED EDITION

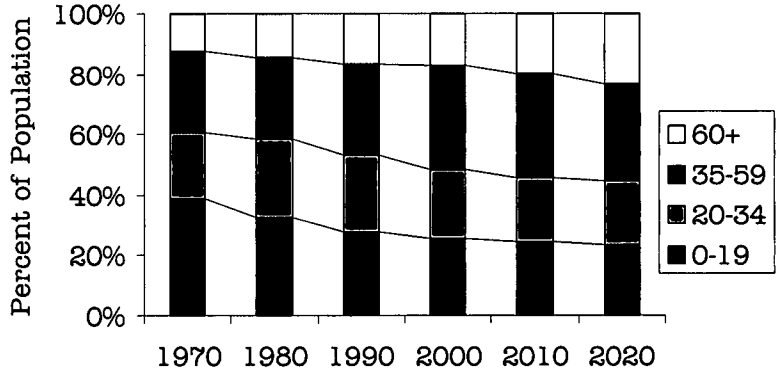
GENDER, RACE & CLASS

ENDURING INEQUITIES IN LATER LIFE
A NORTH CAROLINA PERSPECTIVE

Gender, race and class are critical concerns for older adults in NC

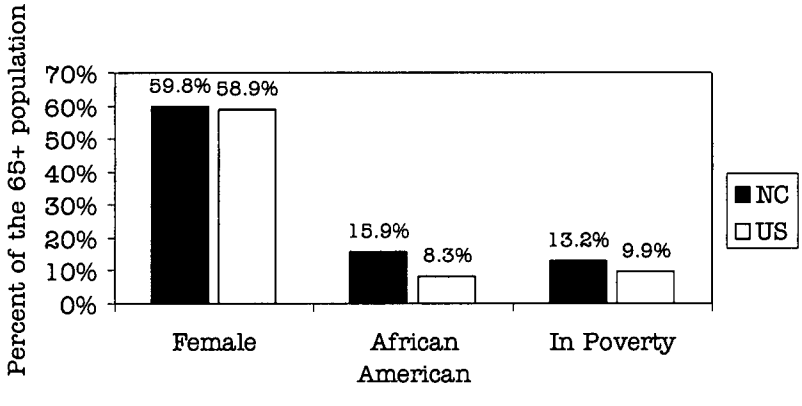
The population of North Carolina is steadily growing older. In 1970, the median age in the state was 26.5 years, and it rose to 35.3 years in 2000.[1] By 2020, the median age in North Carolina is expected to be 38.4 years. The older population is increasing while younger age groups are declining, as illustrated in Figure 1. The implications of an older population include increased demand for support services, need for long term care solutions, etc. The effects of aging are compounded by the additional effects of race, class, and gender. People in these categories are at higher risk for health and social problems. The term 'quadruple jeopardy' refers to the simultaneous effects of being old, minority, female, and poor. In North Carolina, women, minorities, and low-income persons are a significant portion of the elderly population. In fact, the percent of those populations is larger in NC than the overall U.S., as shown in Figure 2.

Figure 1: Population Shift in North Carolina



source: 1970-1990 data from US Census Bureau, Population Estimates Program (2); 2000-2020 data from NC State Demographics Unit, County/State Projections (3)

Figure 2: How North Carolina's Aging Population Compares to the Overall US



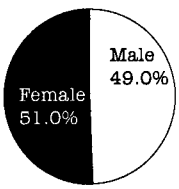
source: NC Division on Aging, 2003-2007 State Aging Services Plan, p12

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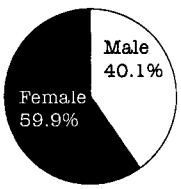
GENDER & AGE: As they age, women and men face different challenges in areas such as health and living conditions.

Gender of the Population in NC

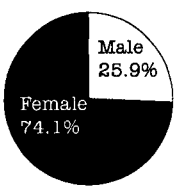
All Ages



Age 65+



Age 85+

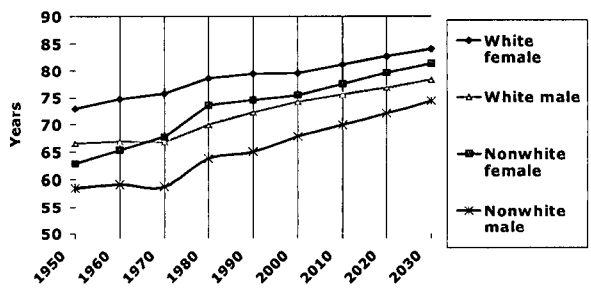


source: U.S. Census Bureau, Census 2000 Summary File 1

Compared to the overall population in North Carolina, which has a nearly equal proportion of women to men, the over 65 population has an unequal proportion of women to men (3 women for every 2 men). In higher age groups, this proportion increases dramatically.

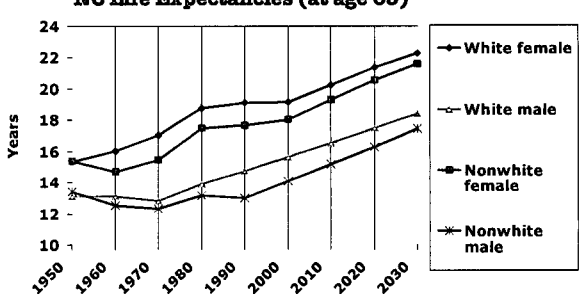
One reason for the higher numbers of elderly women is that women have a higher life expectancy than men. In North Carolina, women of all races have higher life expectancies at birth and at age 65, than men. These striking differences can be seen in the two charts at right. Women live longer, report higher rates of physical disability, and spend more years in a disabled state. They also make up a substantially larger proportion of the nursing home population and are more vulnerable in terms of need for formal and informal care.[1] Older women are more at risk for certain health problems. For example, nearly two-thirds of all Americans with arthritis are women, and they consequently require assistance with activities of daily living, such as bathing, dressing, eating, and walking.[2] Race also plays a role in the effects of aging on women; both charts at right illustrate that nonwhite women have shorter life expectancies than white women. In sum, women live longer than men, are more likely to live alone and in poverty, and are more likely to need assistance as they age, but less likely to have a spouse for assistance.

NC Life Expectancies (at birth)



Source: NC State Demographics Unit (7)

NC Life Expectancies (at age 65)



Source: NC State Demographics Unit (7)

Facts About Gender & Aging:

► Older men are more likely to be married than older women. In NC, there are 2½ times more unmarried women aged 65-84 than unmarried men.[3] One implication: when health fails, men are more likely to have a spouse for assistance.

► Women are more likely to live alone. In 2003, 40% of older women lived alone, compared to 19% of older men.[4]

► There is a higher rate of poverty among elderly women than elderly men. In 2003, 12% of women over 65 were living in poverty, compared with 8% of men. African American women 75 and older are six times more likely to be poor than men in general.[5]

► Women outnumber men in nursing homes. In 1999, almost 75% of nursing home residents over 65 were women.[6]

References

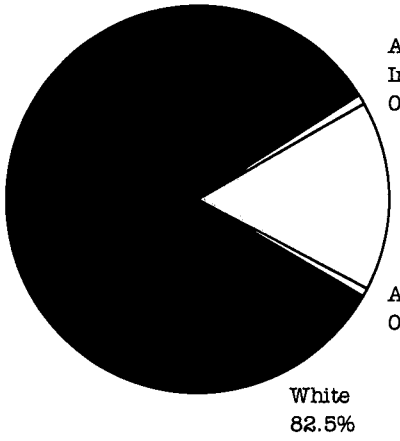
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2. National Academy on an Aging Society. "Arthritis: a leading cause of disability in the United States," March 2000.
3. NC Division of Aging and Adult Services. (2003). The 2003-2007 North Carolina aging services plan. http://www.dhhs.state.nc.us/aging/sasp2003.pdf
4. Federal Interagency Forum on Aging-Related Statistics. (2004).Older Americans 2004: key indicators of well-being. http://agingstats.gov/chartbook2004/OA_2004.pdf
5. Institute for Research on Women & Gender. (2002). Aging in the twenty-first century: difficult dialogues program consensus report. http://www.stanford.edu/group/IRWG/ResearchPrograms/DifficultDialogues/1/ConsensusReport.pdf
6. See #4.
7. NC State Demographics Unit, North Carolina Life Expectancies. (2005). Available: http://demog.state.nc.us/demog/vitalr4.html

RACE & AGE: As the U.S. grows more diverse, the elderly population is also becoming more racially and ethnically complex.

The elderly population of North Carolina is primarily white. However, North Carolina has a significantly higher percentage of black elderly (16%) than the overall U.S. (8%). In contrast, North Carolina has a much lower percentage of Hispanic elderly (0.6%) than the U.S. (5%). The percentages of minority elders are expected to increase in North Carolina in the future.

Older adults often have different characteristics, needs and concerns based on their racial or ethnic background. One example is health disparities. For example, the percentage of older people in North Carolina with diabetes is much higher among minorities, while Alzheimer's Disease is more common among older white persons.[1] There are also significant financial disparities based on race. In 2001, the median net worth of households headed by older white persons was five times higher ($205,000) than for blacks ($41,000).[2] Geographic location and access to health care are additional issues that affect older minorities. In North Carolina, the highest percentages of minority elders live in the most rural counties where access to services like transportation and health care is difficult. For example, the top five counties with the most minority elders are: Bertie (51%), Robeson (51%), Warren (49%), Hertford (49%), Northhampton (48%). All five of these counties are designated shortage areas for health professionals.[3]

Racial Composition of North Carolina's Over Age 65 Population



Comparison with Overall U.S.
In 2000, the racial composition of the over 65 population in the U.S. was:
White: 86.9%
Black: 8.1%
Asian: 2.3%
Some Other Race: 1.3%
Two or More Races: 1.0%
American Indian: .4%
Hispanic: 5.0%*

*** About the Hispanic Population**
Note: Persons of Hispanic origin may be of any race. The racial categories in the chart at left include Hispanics. The 65+ Hispanic population in North Carolina comprised 0.6% of the total 65+ population, primarily concentrated in the white and black race categories.

Source: U.S. Census Bureau, Census 2000 Summary File 1; figure for "Some other Race" in NC is .2% and "Two or More Races" in NC is .4%.

Facts About Race & Aging:

► In North Carolina, minority men and women don't live as long as whites, yet they have more years of poor health from chronic disease and other health issues. Minority women have the most years of poor health (16.5 years), while white men have the fewest (10.6 years).[4]

► In 2001, minority women in North Carolina died of several diseases (including breast cancer, diabetes, and colorectal cancer) at significantly higher rates than white women.[5]

► There are differences by race and ethnicity in the prevalence of chronic conditions. For example, older black people report 17% more hypertension and 9% more diabetes than older white people.[6]

► Older whites were far less likely than blacks and Hispanics to be living in poverty—about 8 percent compared with 24 percent of older blacks and 21 percent of older Hispanics.[7]

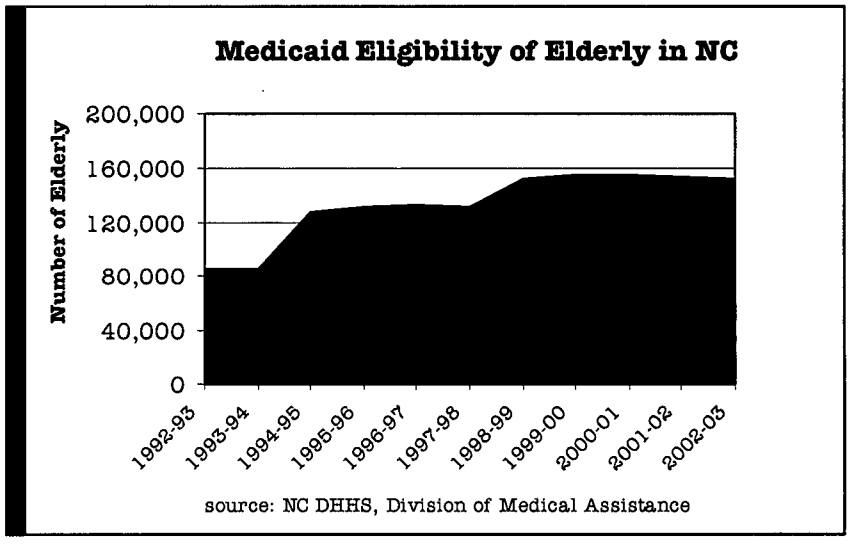
► Race is a major factor in the use of long term care services by frail elders. In a 1994 study, whites had the highest use of regular home health care, Hispanics were more likely to use mobile meal service, and blacks had the highest church and social center participation.[8]

► The median age of all minorities in North Carolina is projected to increase at a greater rate than for the general population, from 30.4 years in 2000 to 35.1 years in 2030.[9]

References
1. State Center for Health Statistics. (2003). A health profile of older North Carolinians. Raleigh, NC..
2. Federal Interagency Forum on Aging-Related Statistics. (2004).Older Americans 2004: key indicators of well-being.
3. NC Division of Aging, 1999-2003 State Aging Services Plan.
4. CDC, Chronic Disease Notes & Reports vol 16, no 2/3
5. North Carolina Program for Women's Health Research. (2003). 2003 North Carolina women's health report card.
6. See number 2.
7. See number 2.
8. Mui, A.C. & Burnette, D. (1994). Long term care service use by frail elders: is ethnicity a factor? *The Gerontologist, 34*, 190-198.
9. NC Office of State Planning, State Demographics Unit. (2004). Past and Expected Trends.

CLASS & AGE: In this time of rising health care costs, poverty and low socioeconomic status are especially problematic for older adults.

North Carolina elderly are twice as likely as younger adults to have incomes below the federal poverty level. Elderly blacks and American Indians are more than twice as likely as other elderly to live in poverty. In 2000, 13.2% of elderly North Carolinians were classified as living in poverty, and 23.3% were living near poverty. [1]



source: NC DHHS, Division of Medical Assistance

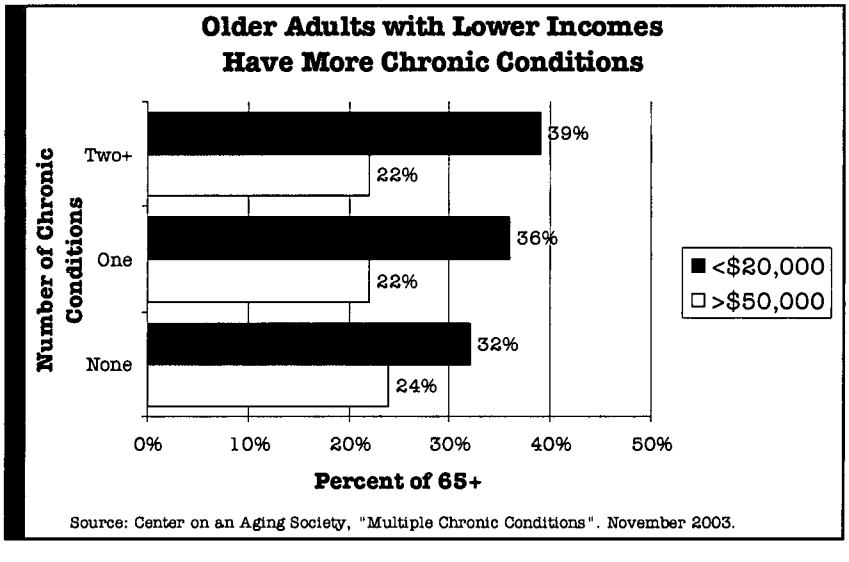
Facts About Class & Aging

► Low socioeconomic status is correlated with increased health problems (see chart at right) and other common problems of aging.

► Older women (12%) have higher rates of poverty than men (8%). Poverty rates are higher for black (24%) and Hispanic (21%) older adults than whites (8%).[2]

► In 2001, the median net worth of households headed by older white persons was $205,000; for blacks, it was $41,000.[3]

Age, sex, race, ethnicity, marital status, living arrangements, educational attainment, former occupation, and work history are characteristics associated with significant income differences. For example, better educated adults tend to have higher incomes, higher standards of living, and above-average health. In North Carolina, 41.6% of older adults do not have a high school degree.[4] The state has about 3½ times more poor minority males than poor white males, and 2½ times more poor minority females than white females.[5] Medicaid is one safety net for older adults in poverty. In North Carolina, older adults are eligible for Medicaid if their income is equal to 100% of the poverty level and have limited other resources. Increasing numbers of older adults in NC are eligible for this safety net (see chart above). The expensive health needs of older adults represents a growing burden for the Medicaid system: in FY 2003, North Carolina spent $1.8 billion on Medicaid for the elderly. While this population represents 13.9% of total Medicaid recipients, it received 27.4% of total Medicaid resources available.[6]



Source: Center on an Aging Society, "Multiple Chronic Conditions". November 2003.

References
1. NC Division of Aging and Adult Services. (2003). The 2003-2007 North Carolina aging services plan.
2. Federal Interagency Forum on Aging-Related Statistics. (2004).Older Americans 2004: key indicators of well-being.
3. see number 2.
4. North Carolina Study Commission on Aging (2004). Report to the Governor and the 2004 Session of the 2004 General Assembly.
5. see number 1.
6. Division of Medical Assistance. (2003). Medicaid Tables For State Fiscal Year 2003, Table 10: Medicaid Service Expenditures by Recipient Group.

Issues of gender, race, and class will continue to be relevant in understanding and serving the needs of North Carolina's older population. To learn more about current programs & activities, visit some of the following sites on the World Wide Web:

► North Carolina Organizations

NC Commission of Indian Affairs
http://www.doa.state.nc.us/doa/cia/indian.htm

NC Division of Aging - Women & Aging Information
http://www.dhhs.state.nc.us/aging/women.htm

NC Division of Medical Assistance (Medicaid)
http://www.dhhs.state.nc.us/dma/

NC Division of Social Services, Adult & Family Services
http://www.dhhs.state.nc.us/dss/afs/afs_hm.htm

NC State Demographics
http://demog.state.nc.us/

UNC Center on Aging and Diversity
http://www.aging.unc.edu/cad/index.html

UNC CH Minority Health Project
http://www.minority.unc.edu/

► National Organizations

Center for Aging in Diverse Communities
http://medicine.ucsf.edu/cadc/

National Center on Women & Aging
http://heller.brandeis.edu/national/ind.html

National Hispanic Council on Aging
http://www.nhcoa.org/

National Indian Council on Aging
http://www.nicoa.org/

National Resource Center on Native American Aging
http://www.und.nodak.edu/dept/nrcnaa/

Older Women's League
http://www.owl-national.org/

► Reports & Data

A health profile of older North Carolinians
http://www.schs.state.nc.us/SCHS/pdf/Elderly.pdf

Aging in the twenty-first century: difficult dialogues program consensus report
http://www.stanford.edu/group/IRWG/ResearchPrograms/DifficultDialogues/1/ConsensusReport.pdf

Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin
http://www.access.gpo.gov/eop/ca/index.html

Health United States with Health & Aging Chartbook, 1999
http://www.cdc.gov/nchs/data/hus/hus99.pdf

Health and Retirement Study (HRS) and Asset and Health Dynamics Among the Oldest Old (AHEAD)
http://www.umich.edu/~hrswww/index.html

NC State Demographics Unit
http://demog.state.nc.us/

The State of Aging and Health
http://www.miahonline.org/press/content/State_of_Aging_Report.pdf

Trends in Health & Aging
http://www.cdc.gov/nchs/about/otheract/aging/trenddata.htm

US Census Bureau Poverty Information
http://www.census.gov/hhes/www/poverty.html

Women's Health and Aging Study
http://www.nia.nih.gov/healthinformation/publications/reports/womenshealthagingstudy.htm

Work Group on Minority Aging Newsletter
http://www.nia.nih.gov/newsandevents/workgrouponminorityaging.htm

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November 2005, revised edition
Suggested citation: UNC Institute on Aging. (2005). Gender, Race and Class: Enduring Inequalities in Later Life, A North Carolina Perspective. Chapel Hill, NC. Available online: www.aging.unc.edu/infocenter/resources/2005/grcfactsrevised.pdf.
Please feel free to copy this document.

For more information, contact:
UNC Institute on Aging Information Center
720 Martin Luther King Blvd. Suite 100
CB #1030
Chapel Hill, NC 27599-1030
phone: (919) 966-9444
www.aging.unc.edu

UNC IOA
Institute on Aging

Attachment 8

Larry Mason

MAR 27 2008

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

Dempsey Benton, Secretary

March 20, 2008

The Honorable Vernon Malone, Co-Chair
North Carolina Study Commission on Aging
North Carolina General Assembly
Room 314, Legislative Office Building
Raleigh, NC 27603

Dear Senator Malone:

Session Law 2007-39 (House Bill 424), "Study Respite Care," required the department to study the availability and delivery of respite care and present its findings and recommendations, including any proposed statutory changes and new licensure categories, to the Study Commission on Aging on or before March 1, 2008. On February 29, 2008, I informed you that the report was being finalized and would be submitted to the Commission before its March 20, 2008 meeting. It is my pleasure to submit the required report at this time.

Please direct all questions concerning this report to Tara Larson, Acting Deputy Director for Clinical Policy and Programs in the Division of Medical Assistance at (919) 855-4260.

Sincerely,

Dan Stewart for

Dempsey Benton

DB:tl

Enclosure

cc: Dan Stewart
Jackie Sheppard
William W. Lawrence, Jr., M.D.
Dennis Streets
Robert Fitzgerald
Michael Lancaster, M.D.
Leza Wainwright
Lynn Muchmore
Jim Slate
Rob Kindsvatter
Sharnese Ransome
Jennifer Hoffmann
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

Dempsey Benton, Secretary

March 20, 2008

The Honorable Jean Farmer-Butterfield, Co-Chair
North Carolina Study Commission on Aging
North Carolina General Assembly
Room 611, Legislative Office Building
Raleigh, NC 27603

Dear Representative Farmer-Butterfield:

Session Law 2007-39 (House Bill 424), "Study Respite Care," required the department to study the availability and delivery of respite care and present its findings and recommendations, including any proposed statutory changes and new licensure categories, to the Study Commission on Aging on or before March 1, 2008. On February 29, 2008, I informed you that the report was being finalized and would be submitted to the Commission before its March 20, 2008 meeting. It is my pleasure to submit the required report at this time.

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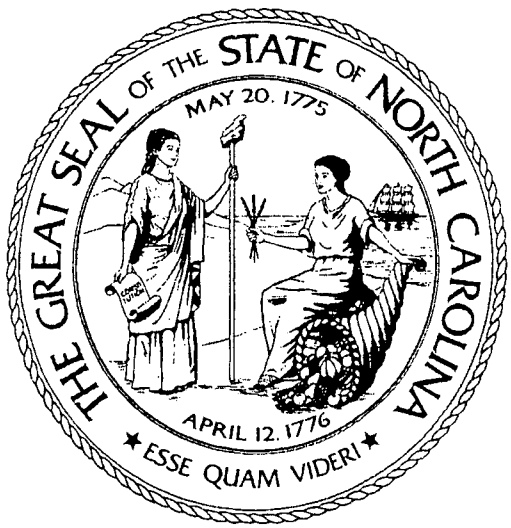
DB:tl

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Study Respite Care
Session Law 2007-39

Report to the 2007 General Assembly
Study Commission on Aging



State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

March 20, 2008

III. DEFINITION - RESPITE

The General Assembly defines a Respite Care Program under 143B-181.10 (a) as a service that is established to provide needed relief to caregivers of impaired adults who cannot be left alone because of a mental or physical problems; (b) limited to those unpaid primary caregivers who are caring for people years 60 years of age or older or their spouses or those unpaid primary caregivers 60 years of age or older who are caring for persons 18 years of age or older, who require constant supervision and who cannot be left alone either because of memory impairment, physical immobility or other problems that renders them unsafe alone.[1] **(For other state respite definitions, see Attachment B - NC Respite Regulations)**

Respite programs provide temporary relief for caregivers, enabling them to meet personal needs and supporting their efforts to provide the majority of care for their family member.[2] Respite programs primarily aim to serve the caregiver rather than the care recipient as often occurs in most services.

IV. NEED AND AVAILABILITY OF RESPITE CARE IN NORTH CAROLINA

It is a challenge to determine the exact need for respite services in North Carolina because the focus of service provision has traditionally been on the care recipient rather than the caregiver. Additionally, many caregivers receive relief from caregiving duties, but do not identify the service as respite and therefore, when surveyed about respite services they may use, the caregivers indicate that they do not use any. The explanation as to why caregivers do not identify the relief they receive from caregiving duties as respite is complex and uncertain. Reasons may include limited exposure to the word (respite) and its meaning as well as the multiple definitions of respite care that currently exist. These multiple definitions and levels of care are reflected in federal and state policies and funding sources. Additionally, there are a wide variety professionals and paraprofessionals involved with respite services.

Still, it is possible when looking at service data to identify the importance of respite. When reviewing the most recent report on the Special Assistance In-home Program (July 2007), of the 1,039 persons who received services through the Special Assistance In-Home program (FY '05-'06), 80% had a primary caregiver; 48% had a secondary caregiver; and 50% of the primary caregivers lived with the person receiving services. These caregivers were informal, unpaid caregivers and included relatives, friends, and neighbors.

The data available on waiting lists of the Division of Aging and Adult Services for services that may provide respite also illustrate the need for respite in North Carolina. The following table outlines the numbers of persons on waiting lists for services that may provide a form of respite as of July 2007 in North Carolina:

---

[1] NC General Statute
[2] Group Respite Policy and Procedures, July 1998p.1, III definition of service

"The Department should explore ways to invest in family caregiving so that it can be sustained as the primary resource for long-term care, reducing the risk for needing formal, publicly-financed services."[4] Further evidence of this paradigm shift in service provision is illustrated in the North Carolina Aging Services Plan 2007-2011 which includes as one of its 40 objectives, the development and incorporation of a caregiver assessment as part of family-centered care planning, and the expansion of caregiver support services.

The need for respite services in North Carolina is also emphasized within the vision and mission of DHHS' Long-Term Services and Supports Cabinet (LTS Cabinet). The LTS Cabinet was formed by the IOM's 2001 Long-Term Care Plan and was intended to include all DHHS Division Directors that affect long-term care policy.

- ***Vision Statement for the North Carolina LTS Cabinet***
  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.

- ***Mission Statement for the LTS Cabinet***
  To create a statewide, integrated, person and *family-centered* system for those who need long-term services and supports so that they can live and participate more fully in communities of their choice.

Additionally, the DAAS' North Carolina Performance Outcome Measures Project (POMP) points to the need for respite care services in North Carolina and the need for additional respite care services for caregivers already receiving services to reduce incidents of institutionalization for care recipients. In 2002, a survey was conducted of a representative sample of caregivers who received Home and Community Care Block Grant (HCCBG) services and caregivers receiving Family Caregiver Support Program (FCSP) services. In 2003, almost three-quarters of these same caregivers who were surveyed in 2002 were surveyed again. Caregivers in 2002 who indicated that they needed more respite and/or adult care services than they were currently receiving were significantly more likely to have placed the person they were caring for in a facility by 2003. Those that were receiving any type of in-home aide service (in-home respite, personal care, or homemaker) in 2002 were significantly less likely to have placed the person they were caring for in a facility by 2003.

Availability

Below is an inventory of respite availability by DHHS Divisions. Although other sources of respite funding may be available, those identified below are the primary sources of respite funding and programs within DHHS.

Division of Aging and Adult Services

HCCBG awards a combination of federal Older Americans Act funds and state appropriations to counties through Area Agencies on Aging (AAA) to serve adults at risk of institutionalization aged sixty (60) and over who require services to remain in

---

[4] 2001 Institute of Medicine, LTC Plan p.96

- Institutional respite (institutional setting such as a nursing home or assisted living for a short period of time)
- Summer camps, after-school programs or child day-care (for grandparents caring for grandchildren)
- Other short-term respite options (e.g., respite camps and caregiver retreats)
- Other as approved by DAAS

Additionally, under FCSP, caregivers are provided with information, access to services (including transportation), counseling, training, support groups, and supplemental services. Supplemental Services may be especially beneficial to working caregivers. Through the National Family Caregiver Support Program, in North Carolina, the Eastern Branch of the Cherokee Indians (EBCI), also receive respite.

Project C.A.R.E. (Caregiver Alternatives to Running on Empty) is specifically designed to provide respite care and support to caregivers of persons with dementia and is a federally funded Alzheimer's Demonstration Program. Families enrolled in the program received an annual spending cap of up to $2000 and had the option to chose between adult day services, group respite, private or agency in-home care, and overnight residential respite.

Project C.A.R.E. is currently available in 14 western counties.

DAAS Funding Expenditures

SADCF: Including local match, $4,540,264 was awarded in SFY 06-07. A total of $4,443,626, or 97.9%, in State Adult Day Care Fund resources was expended to serve 1,396 older and adults with disabilities.

HCCBG: Including local match, $6,095,200 of HCCBG funds were expended in communities to provide respite services. These respite services included: Institutional Respite; Group Respite; In-Home Aide Respite; Adult Day Care and Adult Day Health programs. A total of $55,474,000, or 99.8%, in HCCBG funding was expended in communities to serve 59,177 older adults.

FCSP: During SFY 2006-07, the North Carolina Family Caregiver Support Program (FCSP) provided respite services to 1,533 unduplicated caregivers, or 41,330 units of service, at a cost of $1,600,551.

Project C.A.R.E.: During SFY 2006-7, Project C.A.R.E., provided a total of $229,419 for direct respite care services.

Division of Medical Assistance

Respite is also defined in Section 12.1.7 of **Medicaid's** Clinical Policy for the Community Alternative Program for Disabled Adults (CAP/DA). In this program, Respite care provides temporary support to the client's primary unpaid caregiver(s) by taking over the tasks of the caregiver(s) for a limited time. It may be used to meet a wide range of needs, including family emergencies; planned absences (such as

Therefore, within a waiver program, respite is basically provided as requested if it fits within the current individual's waiver budget for all waiver services whether the waiver be CAP/DA, CAP/C or CAP/MRDD. By report from the Medicaid Program Managers, respite is not utilized as often as it might be because of the limitation within CAP program funding.
The exception to this principle occurs within the CAP/MR/DD waiver which utilizes a flexible budget plan. Under this option, all of it s wavier participants do not have a capped individual budget. This allows a pool of available funds to all participants under the waiver so that unused funds budgeted for individuals with less extensive needs could be utilized by those with more extensive needs.

Under the CAP/MR/DD waiver, both federal and state rules permit family members to become paid caregivers with the exception of legally responsible family members (parents/guardians of minor children and spouses). This mostly occurs in the delivery of personal care services with recipients employing closely related family members as their personal care attendant.

Division of Social Services

DSS provides respite care within the Family Support Child Welfare Section to families and children that meet the criteria and definition below through contracts with private providers located throughout the State. There are no financial eligibility requirements.

DSS does not have a definition of respite as a State statute or rule. However, DSS does use a definition based on the Friends NRC (National Referral Center in Chapel Hill, NC). NRC defines respite as follows:

"Short-term care services provided for families of children under the age of 18 living with natural, adoptive, foster parents or relatives, or any family who has taken on the role of caregiver who meet one or more of the following categories:

- The child(ren) are in danger of abuse or neglect;
- The child(ren) have experienced abuse or neglect;
- The child(ren) has/have developmental disabilities, chronic or terminal illnesses or mental health issues."

Currently, DSS has eight (8) contracts, each for $30,000 for a total of $240,000 for this fiscal year. The contracts are renewed annually except in rebid years. For example, Youth Focus has one (1) contract with The Children's Home as the subcontract. The Jackson County FRC (Family Resource Center) has two (2) contracts, one for voucher-based respite and the other for center-based respite. In SFY 2006-07, DSS provided respite services to 288 unduplicated clients. The goal of respite is to enable the family to remain intact and to keep the child(ren) living in their home or community.

As shown in the **NC Expenditure By Respite Program charts (See Attachment C)**, one can see that there are differences in the amount of the total respite expenditures

However, not all NC options are offered throughout the state and/or are available through each division of DHHS.

Populations targeted by DHHS respite programs include caregivers of persons with developmental disabilities, frail older adults, and persons with dementia and related disorders. Other State respite programs target medically fragile children in the CAP/C programs as well as children who are at risk for abuse or neglect and those who have developmental disabilities, chronic or terminal illness or mental health issues.

From a resource utilization perspective, Adult Day Care is the most common respite service provided to family caregivers nationwide. Whether this service is in greater demand than the others is unknown. Licensure for respite care in institutions is represented in six (6) states New Mexico, Idaho, Alabama, Missouri, Iowa and Washington that would be similar to NC's 24-hour respite in NFs, ACHs and State Developmental Centers.

In the research of other states and in the study group's discussion, it appears barriers to providing and coordinating a comprehensive program of respite care are similar in different states. Top barriers are listed as the complexity and fragmentation of different eligibility criteria, different target client populations, as well as different regulatory requirements. This is very evident in NC as we have both licensed and certified programs, several different funding streams and several different programs providing services to various target populations. While the fragmentation makes respite care more difficult to administer, it does provide for the needs of a diverse population.

Model Programs

The Respite Study Group opted to highlight North Carolina's current respite care models in this report rather than adopt another state's respite care model, as the existing respite care models in North Carolina have proven to be successful in effectively serving targeted populations and addressing diverse and state specific needs. North Carolina has four (4) recognized Best Practice Model Programs. A brief description of each is included below:

1. **The North Carolina Alzheimer's Demonstration Program, Project C.A.R.E. (Caregiver Alternatives to Running on Empty),** uses a family consultant model to provide consumer-directed respite care and comprehensive support to dementia caregivers. The goal of the program is to increase quality, access, choice, and use of respite and support services to low-income rural and minority families caring for a person with dementia at home or within a hospital setting. Through the integration of dementia-capable services and the development of family-centered and caregiver-focused community care networks, Project C.A.R.E. can help create a seamless, coordinated delivery system that is responsive to the needs, values and preferences of families caring for a member with Alzheimer's.

   Project C.A.R.E. is administered through the Division of Aging and Adult Services (DAAS) with expert consultation and technical assistance provided by the Duke Aging Center Family Support Program. Project C.A.R.E. is implemented at the local level through Family Consultants employed by and/or supported through the local Alzheimer's Association. The program is currently based within the Mecklenburg County Department of Social Services and two area offices of the Western Carolina Alzheimer's Chapter. The Mountain Area office in Asheville serves as the project training and data management center for all new and existing program sites and staff.

   Project C.A.R.E. employs Family Consultants with expertise in Alzheimer's disease and related disorders. The Consultants visit the homes of referred dementia caregivers in crisis and offer timely, individualized assessment, guidance, counseling, support, advocacy, coaching and education. Their aim is to match families with the most appropriate and preferred local respite and community services tailored to their unique situation and needs. Through Project C.A.R.E., dementia caregivers may spend up to $2,000 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. The Project C.A.R.E. model builds upon, enhances and sustains existing home and community-based services by using local providers to deliver respite care.

   The personalized approach of the Family Consultant fosters family trust, offers individualized caregiving and coping skills, and encourages caregiver self-care. Project C.A.R.E. helps families learn the value of quality dementia-specific respite services and feel empowered to make self-directed, informed decisions about care. Special emphasis is placed on targeting underserved, low-income rural and minority communities that have limited knowledge of and access to dementia-specific respite care and support services. In 2004, Project C.A.R.E.

VI. THE APPLICATION FOR A GRANT UNDER THE LIFESPAN RESPITE CARE ACT OF 2006, 42 U.S.C.

(See Attachment D: Lifespan Respite Act of 2006, 42 U.S.C.)

The Lifespan Respite Act of 2006 was enacted to assist family members who are the primary caregivers for children and/or adults with special needs in accessing respite care services that are both affordable and of high quality. The program would be administered through Aging and Disability Resource Connections (ADRC) that would be part of the state's long term care system. DHHS is currently piloting the ADRC concept in several counties under several federal grants. The ADRC is to be a convenient, one-stop, no-wrong door approach to providing information and referral for long-term care services; counseling and planning to determine an individual's current or future long-term care needs; and assistance in applying for long-term care programs.

As of this writing, the Lifespan Respite Care Act of 2006, 42 U.S.C. has not received funding by Congress. Once funded, the DHHS/DAAS will make application for funding under this authority.

VII. THE NEED FOR SEPARATE STATUTORY LANGUAGE PERTAINING TO RESPITE CARE AND THE NEED, PROPOSED STRUCTURE AND DEVELOPMENT TIMELINE FOR A SEPARATE LICENSURE CATEGORY FOR RESPITE CARE.

The NC Respite Study Group did not see a need for separate statutory language for respite care. As one can see from **ATTACHMENT B**, there are separate state statutes and administrative codes for respite care that apply to the various programs in several divisions within DHHS. After a thorough review of these citations, the NC Respite Study Group believed that the existing Licensure and Certification systems of DHSR and DAAS respectively, allow for all levels and types of respite care. What is needed is consistent state funding for the current respite care models available in North Carolina. For example, the national award winner, "Caregiver Alternatives to Running on Empty" (Project C.A.R.E.) is currently being funded by a one-year grant through the U.S. Administration on Aging's Alzheimer's Disease Demonstration Grants to States Program (ending June 30, 2008). Unless continuation funding is provided by the state, Project C.A.R.E. will cease to operate and will no longer be a source of respite services to caregivers in North Carolina.

VIII. THE DEVELOPMENT OF A MEDICAID WAIVER COVERING A PROPOSED NEW LICENSURE CATEGORY FOR RESPITE CARE.

NC Medicaid currently recognizes Respite as a billable service only under a waiver program. Medicaid does not recognize Respite as an optional service under its State Plan.

With the passage of the Deficit Reduction Act (DRA) of 2005, the Federal Government allowed states to determine which additional services to provide via a waiver based in the authority of this national legislation. States were eager to pursue such an innovative opportunity. However, since that time, Federal advice has been slow to reach the states, and it now appears that states will not be able to use this option as liberally as first thought. The Federal Government has decided that states will be able to have only

respite services for caregivers. This would include creation and on-going maintenance of a statewide inventory system of respite care programs, services, and resources through the ADRC initiative and NCcareLINK to improve access and choices to respite care for caregivers and care recipients.

2. DAAS will further study the place of group respite programs in the long-term care continuum and assess the adequacy of service standards and funding.

3. Medicaid will continue to study the potential of Respite as a State Plan Service

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ATTACHMENTS

Attachment A	Study Group Members and Their Organizations
Attachment B	NC Respite Regulations
Attachment C	NC Expenditures by Respite Program
Attachment D	Lifespan Respite Act
Attachment E	Estimated Prevalence and Economic Value of Family Caregiving, by State (2006)
Attachment F	Side by Side Comparison in Other States

Attachment A: Study Group Members and Their Organizations

Last	First	Organization
Artis*	Glenda	Division of Aging and Adult Services
Budzinski*	Julie	Division of Medical Assistance
Colvard	Tracy	Division of Medical Assistance
Comin	Margaret	Division of Medical Assistance
Cooper	Jerry	NC Assistant Living Association
Crane	Shannon	Division of Aging and Adult Services
Derence*	Karisa	Division of Aging and Adult Services
Grady	Elizabeth	Division of Medical Assistance
Gwyther	Lisa	Duke Bryan Alzheimer's Disease Research Center
Harper	Trish	Division of Medical Assistance
Jackson*	Charles	Division of Medical Assistance
Jenkins	Carol	Division of Medical Assistance
Johnson	Cedric	Division of Medical Assistance
Johnson	Teresa	NC Adult Day Services
Jones	Ellison	Triangle J Area on Aging
Joos	Cynthia	Division of Services for the Blind
Kingsberry	Adelle	Division of Medical Assistance
MaCleod	Jane	NC Respite Coalition
Morse	Margaret	Center for Aging Research and Educational Services, UNC
Reaves	Jean	NC Aging Study Commission
Salmon	Mary Anne	Center for Aging Research and Educational Services, UNC
Smith	Kathie	Association for Home & Hospice Care of NC
Speroff*	Beverly	Division of Health Service Regulation
Stancil	Candace	Division of Medical Assistance
Stephenson	Phyllis	NC Respite Coalition
Riddle*	Jody	Division of Aging and Adult Services
Urso*	Chris	Division of Aging and Adult Services
Waddle	Fred	NC Easter Seals
Waite	Linda	Division of Social Services
Wilson	Lou	NC Association of Long-term Care Facilities
Williamson	Sallie	Mid-East Commission Area Agency on Aging

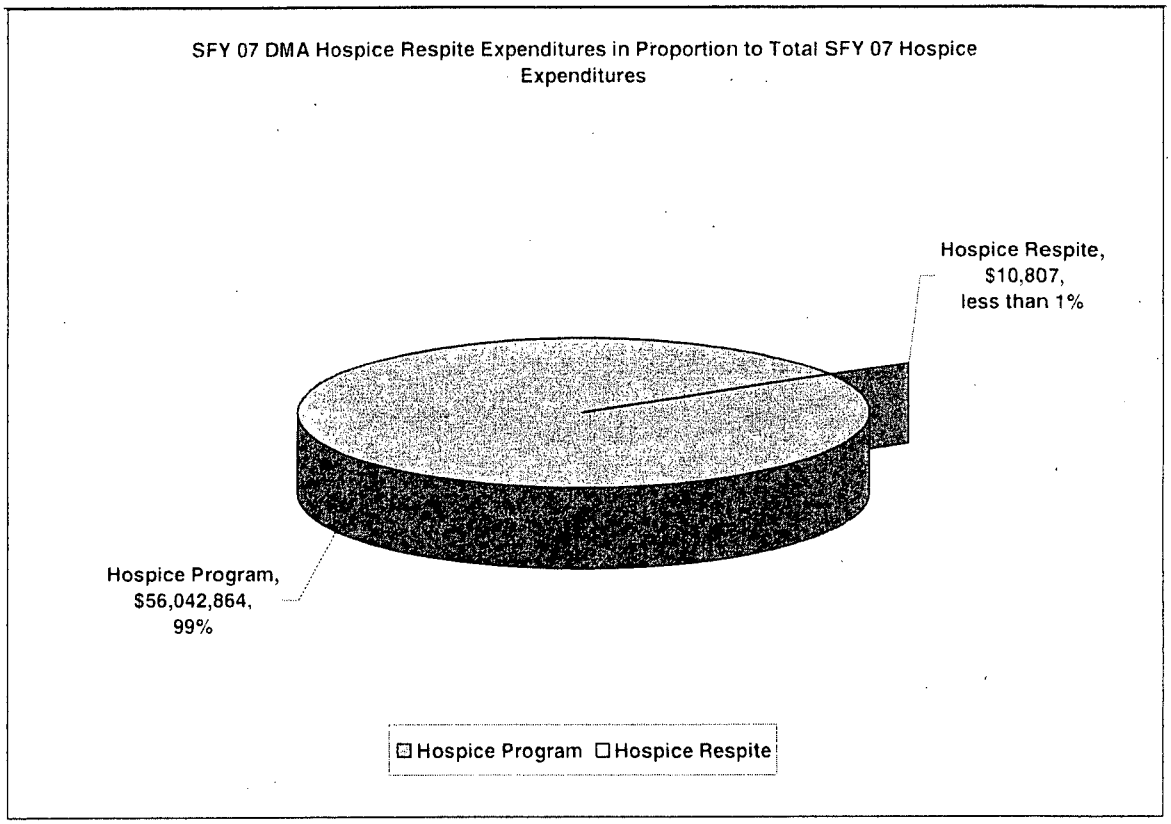
* Indicates core planning group

Respite Type	Definition of Provider	Licensure/Certification	Respite Definition	Admissions/Eligibility/Rules	Overnight	Payor
DAAS Adult Day Care DAAS Adult Day Health	§ 131D-6 (Adult Day Care) "Adult day care program" 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. 10A NCAC 06S .0102 (Adult Day Health) "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.	DAAS Certified	10A NCAC 06R 0201 "Respite care," as a component of adult day care programs, means a service provided to give temporary relief to the family or caregiver. Primarily, respite is provided to families caring for children or adults with disabilities or families caring for frail or disabled older adults. 10A NCAC 06S .0102 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.	10A NCAC 71R .0903 Day Care Services for Adults (b) Target Population. Adults who because of age, disability or handicap need the service to enable them to remain in or return to their own homes. Within the target population, eligible clients shall be provided day care services for adults in the following order of priority: (1) adults who require complete, full-time daytime supervision in order to live in their own home or prevent impending placement in substitute care (e.g. nursing home, domiciliary home), and adults who need the service as part of a protective services plan; (2) adults who need help for themselves with activities of daily living or support for their caregivers in order to maintain themselves in their own homes or both; (3) adults who need intervention in the form of enrichment and opportunities for social activities in order to prevent deterioration that would lead to placement in group care; (4) individuals who need time-limited support in making the transition from independent living to group care, or individuals who need time-limited support in making the transition from group care to independent living.	No	1) Medicaid under for Adult Day Health within a waiver program only 2) Home and Community Care Block Grant (HCCBG) and State Adult Day Care Fund(SADCF)

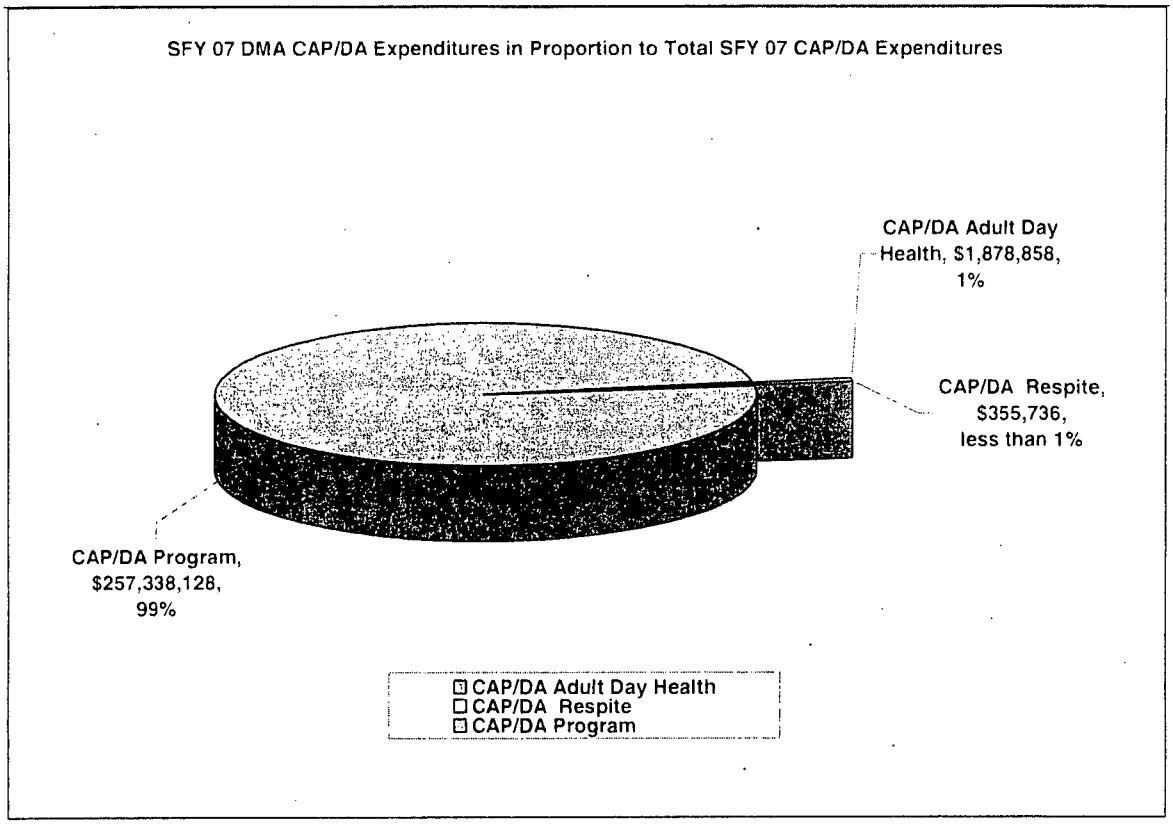
Respite Type	Definition of Provider	Licensure/Certification	Respite Definition	Admissions/Eligibility/Rules	Overnight	Payor
DAAS Sponsored Respite, Residential Respite (or "institutional respite") and Group Respite	Contracted Vendors Nursing Homes Residential Care Facilities and Assisted Living Facilities Individuals employed privately through a home health agency or as part of a government program	None	§ 143B-181.10 A respite care program is established to provide needed relief to caregivers of impaired adults who cannot be left alone because of mental or physical problems. 10A NCAC 06B .0101 Institutional Respite Care Service is temporary placement of an individual who requires constant care or supervision, or both, out of his or her home to provide the primary, unpaid caregiver temporary relief from caregiving responsibilities § 143B-181.10 A respite care program is established to provide needed relief to caregivers of impaired adults who cannot be left alone because of mental or physical problems.	§ 143B-181.10 Those eligible for respite care under the program established by this section are limited to those unpaid primary caregivers who are caring for people 60 years of age or older and their spouses, or those unpaid primary caregivers 60 years of age or older who are caring for persons 18 years of age or older, who require constant supervision and who cannot be left alone either because of memory impairment, physical immobility, or other problems that renders them unsafe alone. 10A NCAC 06B .0201 SCREENING OF CLIENT (a) Screening is a preliminary process used to determine if client eligibility is met. (b) A screening instrument must be completed for each unpaid primary caregiver who requests service. (c) The screening instrument must address: (1) Caregiver identification information; (2) Ability of the person requiring care to perform activities of daily living; (3) Ability of the person requiring care to perform instrumental activities of daily living; (4) Physical functioning of the person requiring care; (5) Caregiver's perception of the emotional well-being of the person requiring care; (6)Extent of support provided by the primary caregiver; (7) Services currently received by the person requiring care or the caregiver	Yes (Institutional only when provided in a DHHS licensed facility).	1) State Funded 2) HCCBG 3) DAAS in consultation with the Councils of Government in each region of the State of North Carolina

Respite Type	Definition of Provider	Licensure/Certification	Respite Definition	Admissions/Eligibility/Rules	Overnight	Payor
MH Community Respite-In Private Home	§ 122C Private home respite means the individual is served in the provider's home or an hourly or overnight basis	DHSR-for licensable facilities	10A NCAC 27G .5101 Private home respite—the individual is served in the provider's home on an hourly or overnight basis. Private home respite services serving individuals are subject to licensure under G.S. 122C, Article 2, when: (1) more than two individuals are served concurrently; or; Either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.	§ 122C-3. 1) State Funded - Individuals must meet the state definition of a developmental disability or mental illness 2) Individual with a developmental disability meeting ICF-MR level of care	Yes-may be day or overnight, group, enhanced or nursing	1) State Funded (DMH/DD/SAS) 2) CAP-MR/DD (Medicaid)
MH Community Respite	§ 122C-3 Facility means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers	DHSR	10A NCAC 27G.5101 (a) Community respite is a service which provides periodic relief for a family or family substitute on a temporary basis. While overnight care is available, community respite services may be provided for periods of less than 24 hours on a day or evening basis. Respite care may be provided by the following model: Center-based respite - the individual is served at a designated facility. While an overnight capacity is generally a part of this service, a respite center may provide respite services to individuals for periods of less than 24 hours on a day or evening basis.	§ 122C-3. 1) State Funded - Individuals must meet the state definition of a developmental disability or mental illness 2) Individual with a developmental disability meeting ICF-MR level of care	Yes-may be day or overnight	1) State Funded (DMH/DD/SAS) 2) CAP-MR/DD (Medicaid)

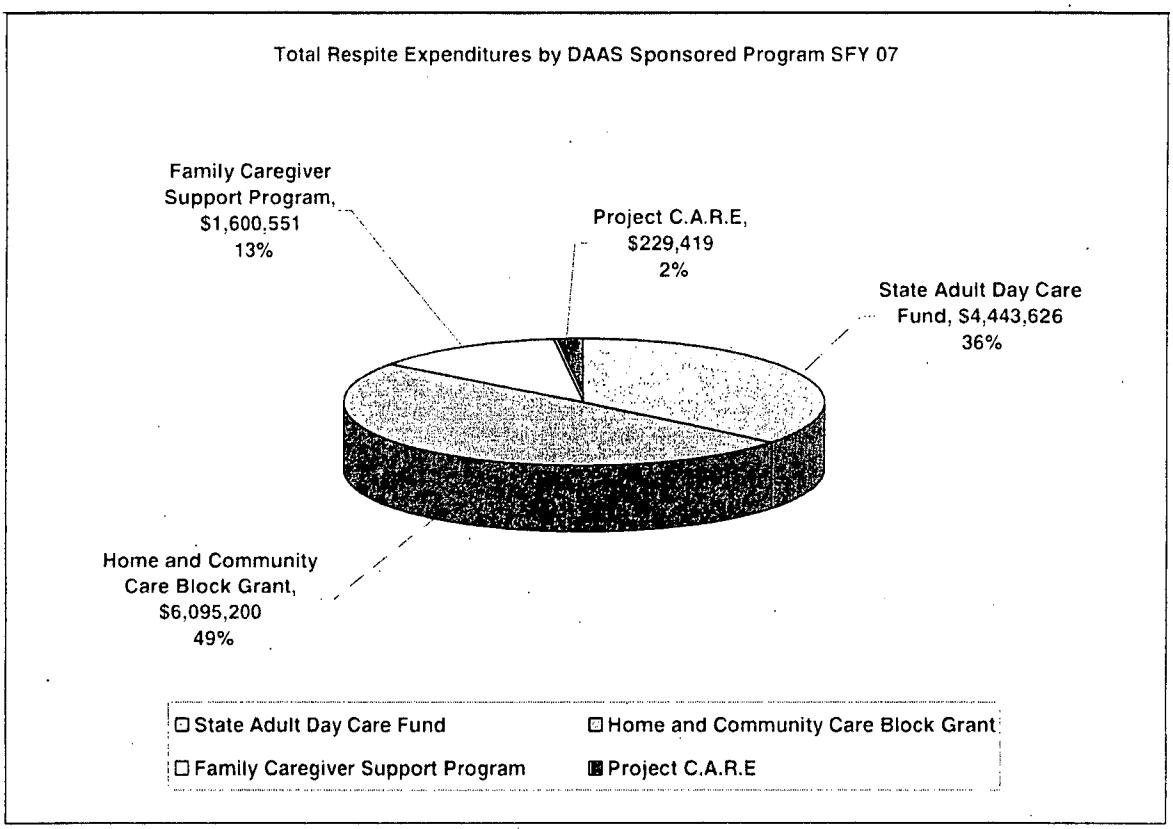
Attachment C: NC Expenditures by Respite Program



Source: 2007 DRIVE Claims Data



Source: 2007 DRIVE Claims Data



Source: Division of Aging and Adult Services

Attachment D: Lifespan Respite Act (H.R. 3248)

PUBLIC LAW 109–442—DEC. 21, 2006 120 STAT. 3291
Public Law 109–442
109th Congress
An Act

To amend the Public Health Service Act to establish a program to assist family caregivers in accessing affordable and high-quality respite care, and for other purposes.
Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.
This Act may be cited as the "Lifespan Respite Care Act of 2006".

SEC. 2. LIFESPAN RESPITE CARE.
The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXIX—LIFESPAN RESPITE CARE
"SEC. 2901. DEFINITIONS.
"In this title:

"(1) ADULT WITH A SPECIAL NEED.—The term 'adult with a special need' means a person 18 years of age or older who requires care or supervision to—

"(A) meet the person's basic needs;
"(B) prevent physical self-injury or injury to others; or
"(C) avoid placement in an institutional facility.

"(2) AGING AND DISABILITY RESOURCE CENTER.—The term 'aging and disability resource center' means an entity administering a program established by the State, as part of the State's system of long-term care, to provide a coordinated system for providing—

"(A) comprehensive information on available public and private long-term care programs, options, and resources;
"(B) personal counseling to assist individuals in assessing their existing or anticipated long-term care needs, and developing and implementing a plan for long-term care designed to meet their specific needs and circumstances; and
"(C) consumer access to the range of publicly supported long-term care programs for which consumers may be eligible, by serving as a convenient point of entry for such programs.

"(3) CHILD WITH A SPECIAL NEED.—The term 'child with a special need' means an individual less than 18 years of age42 USC 300ii. Lifespan Respite Care Act of 2006.

"SEC. 2902. LIFESPAN RESPITE CARE GRANTS AND COOPERATIVE AGREEMENTS.

"(a) PURPOSES.—The purposes of this section are—

"(1) to expand and enhance respite care services to family caregivers;
"(2) to improve the statewide dissemination and coordination of respite care; and
"(3) to provide, supplement, or improve access and quality of respite care services to family caregivers, thereby reducing family caregiver strain.

"(b) AUTHORIZATION.—Subject to subsection (e), the Secretary is authorized to award grants or cooperative agreements for the purposes described in subsection (a) to eligible State agencies for which an application is submitted pursuant to subsection (d). Intergovernmental relations. 42 USC 300ii–1.
VerDate 14-DEC-2004 11:52 Jan 03, 2007 Jkt 059139 PO 00442 Frm 00002 Fmt 6580 Sfmt 6581 E:\PUBLAW\PUBL442.109 APPS06 PsN: PUBL442
PUBLIC LAW 109–442—DEC. 21, 2006 120 STAT. 3293

"(c) FEDERAL LIFESPAN APPROACH.—In carrying out this section, the Secretary shall work in cooperation with the National Family Caregiver Support Program of the Administration on Aging and other respite care programs within the Department of Health and Human Services to ensure coordination of respite care services for family caregivers of children and adults with special needs.

"(d) APPLICATION.—

"(1) SUBMISSION.—Each Governor desiring the eligible State agency of his or her State to receive a grant or cooperative agreement under this section shall submit an application on behalf of such agency to the Secretary at such time, in such manner, and containing such information as the Secretary shall require.
"(2) CONTENTS.—Each application submitted under this section shall include—

"(A) a description of the eligible State agency's—

"(i) ability to work with other State and community- based agencies;
"(ii) understanding of respite care and family caregiver issues across all age groups, disabilities, and chronic conditions; and
"(iii) capacity to ensure meaningful involvement of family members, family caregivers, and care recipients;

"(B) with respect to the population of family caregivers to whom respite care information or services will be provided or for whom respite care workers and volunteers will be recruited and trained, a description of—

"(i) the population of family caregivers;
"(ii) the extent and nature of the respite care needs of that population;

"(C) assurances that, where appropriate, the eligible State agency will have a system for maintaining the confidentiality of care recipient and family caregiver records; and

"(D) a memorandum of agreement regarding the joint responsibility for the eligible State agency's lifespan respite program between—

"(i) the eligible State agency; and
"(ii) a public or private nonprofit statewide respite coalition or organization.

"(E) PRIORITY; CONSIDERATIONS.—When awarding grants or cooperative agreements under this section, the Secretary shall—

"(1) give priority to eligible State agencies that the Secretary determines show the greatest likelihood of implementing or enhancing lifespan respite care statewide; and
"(2) give consideration to eligible State agencies that are building or enhancing the capacity of their long-term care systems to respond to the comprehensive needs, including respite care needs, of their residents.

"(F) USE OF GRANT OR COOPERATIVE AGREEMENT FUNDS.—

"(1) IN GENERAL.—

"(A) REQUIRED USES OF FUNDS.—Each eligible State agency awarded a grant or cooperative agreement under this section shall use all or part of the funds—

"(i) to develop or enhance lifespan respite care at the State and local levels;
"(ii) to provide respite care services for family caregivers caring for children or adults;
"(iii) to train and recruit respite care workers and volunteers;
"(iv) to provide information to caregivers about available respite and support services; and
"(v) to assist caregivers in gaining access to such services.
VerDate 14-DEC-2004 11:52 Jan 03, 2007 Jkt 059139 PO 00442 Frm 00004 Fmt 6580 Sfmt 6581 E:\PUBLAW\PUBL442.109 APPS06 PsN: PUBL442 PUBLIC LAW 109–442—DEC. 21, 2006 120 STAT. 3295

"(B) OPTIONAL USES OF FUNDS.—Each eligible State agency awarded a grant or cooperative agreement under this section may use part of the funds for—

"(i) training programs for family caregivers to assist such family caregivers in making informed decisions about respite care services;
"(ii) other services essential to the provision of respite care as the Secretary may specify; or
"(iii) training and education for new caregivers.

"SEC. 2904. REPORT.
"Not later than January 1, 2009, the Secretary shall report to the Congress on the activities undertaken under this title. Such report shall evaluate— 42 USC 300ii–3. 42 USC 300ii–2. VerDate 14-DEC-2004 11:52 Jan 03, 2007 Jkt 059139 PO 00442 Frm 00005 Fmt 6580 Sfmt 6581 E:\PUBLAW\PUBL442.109 APPS06 PsN: PUBL442

120 STAT. 3296 PUBLIC LAW 109–442—DEC. 21, 2006
LEGISLATIVE HISTORY—H.R. 3248:
HOUSE REPORTS: No. 109–716 (Comm. on Energy and Commerce).
CONGRESSIONAL RECORD, Vol. 152 (2006):
Dec. 6, considered and passed House.
Dec. 8, considered and passed Senate.
Æ
"(1) the number of States that have lifespan respite care programs;
"(2) the demographics of the caregivers receiving respite
care services through grants or cooperative agreements under this title; and
"(3) the effectiveness of entities receiving grants or cooperative agreements under this title.
"SEC. 2905. AUTHORIZATION OF APPROPRIATIONS.
"There are authorized to be appropriated to carry out this title—
"(1) $30,000,000 for fiscal year 2007;
"(2) $40,000,000 for fiscal year 2008;
"(3) $53,330,000 for fiscal year 2009;
"(4) $71,110,000 for fiscal year 2010; and
"(5) $94,810,000 for fiscal year 2011.".
SEC. 3. GAO REPORT ON LIFESPAN RESPITE CARE PROGRAMS.
Not later than January 1, 2011, the Comptroller General of
the United States shall conduct an evaluation and submit a report
to the Congress on the effectiveness of lifespan respite programs,
including an analysis of cost benefits and improved efficiency in service delivery.
Approved December 21, 2006.
Evaluation.
42 USC 300ii–4.
VerDate 14-DEC-2004 22:32 Jan 03, 2007 Jkt 059139 PO 00442 Frm 00006 Fmt 6580 Sfmt 6580 E:\PUBLAW\PUBL442.109 APPS24 PsN: PUBL442

Attachment F: Side-by-Side Comparison in Other States [6]

Table 5: Respite Care

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs.	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
ALABAMA																		
FC	Alabama CARES	X		X	X	X	X				X		X				X	
MC	Elderly & Disabled Waiver	X			X						X		X			X		
ALASKA																		
FC	Family Caregiver Support Program	X		X	X					X				X				X
SC	Innovative Respite	X			X			Special activities			X		X				X	
ARIZONA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	AZ Long-Term Care System (ALTCS)	X		X	X	X					X		X			X		
SC	Non-Medical Home and Community Based Services	X		X	X	X	X				X			X				X
ARKANSAS																		
FC	Caring for the Caregiver Arkansas Caregivers	X		X	X	X					X		X					X
MC	ElderChoices Medicaid Waiver	X		X	X	X	X				X		X			X		
CALIFORNIA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Multipurpose Senior Services Program (MSSP)	X		X	X	X						X		X				X
SC	Adult Day Health Care Program	X		X							X			X				X
SC	Alzheimer's Day Care Resource Center (ADCRC)	X		X							X			X				X
SC	Caregiver Resource Centers (CRCs)	X		X	X	X	X			X			X			X		
SC	In-Home Supportive Services (IHSS)	X			X						X			X				X
COLORADO																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Home and Community-Based Services for the Elderly, Blind and Disabled	X		X	X	X						X	X			X		

Notes: Table is based on the Part I Survey (Question 20).
Program Type: FC=National Family Caregiver Support Program; MC=Aged/Disabled Medicaid HCBS Waiver; SC=State-Funded Program
Program Name: FCSP=Family Caregiver Support Program; HCBS=Home and Community-Based Services
CG=Caregiver; CR=Care Receiver; N/A=Not Applicable; NR=No Response; Svcs.=Services

[6] *The State of the States in Family Caregiver Support: A 50-State Study* (NOVEMBER 2004) includes a series of data tables comparing how state programs responded to key survey questions. :Lynn Friss Feinberg, M.S.W; Sandra L. Newman, M.P.H.; Leslie Gray, M.P.H; Karen N. Kolb, M.S. all of the National Center on Caregiving; Family Caregiver Alliance In Collaboration With: Wendy Fox-Grage, M.P.A., M.S.G; National Conference of State Legislatures

Attachment F Continued

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs.	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
ILLINOIS																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Community Care Program (CCP)	X		X								X			X			X
MC	Home Services program	X		X	X						X		X				X	
INDIANA																		
FC	Caring and Compassion	X		X	X		X				X		X			X		
MC	Aged & Disabled Medicaid Waiver	X		X	X	X	X				X			X				X
SC	CHOICE	X			X		X				X			X				X
IOWA																		
FC	Iowa Family Caregiver	X		X	X	X												
MC	Elderly Waiver	X		X	X	X	X			X				X				X
KANSAS														X				X
FC	Family Caregiver Support Program	X		X	X	X	X				X		X			X		
MC	Home & Community Based Frail Elder Waiver	X		X	X	X					X		X			X		
SC	Senior Care Act Program	X		X	X		X				X			X				X
KENTUCKY																		
FC	Family Caregiver Support Program	X		X	X						X		X				X	
SC	Adult Day / Alzheimer's Respite	X		X	X		X				X			X				X
LOUSIANA																		
FC	Family Caregiver Support Program	X			X						X		X			X		
MC	Medicaid Home and Community-Based Waiver		X						X			X			X			X
MAINE																		
FC	Family Caregiver Program	X		X	X	X				X			X				X	
MC	MaineCare	X		X	X	X												
SC	Home-Based Care	X		X	X	X					X		X			X		
SC	Partners in Caring	X		X	X	X	X				X		X			X		
MARYLAND																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Medicaid Waiver for Older Adults	X		X	X	X					X		X			X		
SC	Respite for Caregivers of Adults with Functional Disabilities	X		X	X	X	X				X		X			X		
MASSACHUSETTS																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Home and Community-Based Waiver	X		X	X	X	X				X			X				X
SC	Home Care Program	X		X	X	X	X				X			X				X

Attachment F Continued

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs.	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
NEW HAMPSHIRE																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X			X		
MC	Elderly and Chronically Ill Waiver	X		X	X	X	X				X		X			X		
NEW JERSEY																		
FC	Family Caregiver Support Program	X		X	X						X			X				X
MC	Community Care Program for the Elderly and Disabled	X		X	X	X	X	Assisted living			X		X			X		
MC	Enhanced Community Options (ECO)	X		X	X	X	X	Assisted living			X		X			X		
SC	New Jersey Statewide Respite Care Program (SRCP)	X		X	X	X	X				X		X			X		
SC	Adult Day Services Program for Persons with Alzheimer's Disease or Related Dementias	X		X						X			X			X		
SC	Jersey Assistance for Community Caregiving	X		X	X	X	X	Assisted living			X		X			X		
NEW MEXICO																		
FC	Family Caregiver Support Program	X		X	X	X					X			X				X
MC	Disabled and Elderly Home and Community-Based Services Waiver	X			X					X			X			X		
NEW YORK																		
FC	Eldercare Family Support Program (EFSP)	X		X	X	X					X			X				X
SC	Respite Program	X		X	X	X	X				X		X			X		
NORTH CAROLINA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Community Alternatives Program for Disabled Adults (CAP/DA)	X		X	X	X	X				X		X			X		
SC	Respite Care Program	X		X	X						X			X				X
NORTH DAKOTA																		
FC	Family Caregiver Support Program	X		X	X	X	X			X			X			X		
MC	Aged & Disabled Waiver	X		X	X	X	X			X			X			X		
SC	Family Home Care	X			X	X	X			X			X			X		
OHIO																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	PASSPORT HCBS Waiver Program	X		X	X						X			X				X
SC	Alzheimer's Respite Program	X		X	X	X	X				X			X				X

Attachment F Continued

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
UTAH																		
FC	Caregiver Support Program	X		X	X	X	X				X		X			X		
MC	Medicaid Aging Waiver	X		X	X	X					X			X				X
SC	Home and Community-Based Alternatives	X		X	X	X	X				X		NR	NR	NR			X
VERMONT																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Home-Based Medicaid Waiver	X		X	X	X				NR	NR	NR	X			X		
VIRGINIA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Elderly and Disabled Waiver	X		X	X	X	X			X			X			X		
SC	Caregiver Grant Program		X						X			X			X			X
SC	Respite Care Initiative Grant	X		X	X			Companion services; Hospice		X			X			X		
SC	Respite Care Grant Program 2003	X		X				Transportation to adult day care			X			X				X
WASHINGTON																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Community Options Program Entry System (COPES)		X						X			X			X			X
SC	WA Family Caregiver Support Program	X		X	X	X	X				X			X				X
SC	Respite Care Services	X		X	X	X	X				X			X				X
WEST VIRGINIA																		
FC	Family Caregiver Support	X		X	X		X				X			X				X
MC	Medicaid Aged and Disabled Waiver		X						X			X			X			X
WISCONSIN																		
FC	Family Caregiver Support Program	X		X	X	X	X			X			X			X		
MC	Community Options Program Waiver (COP-W)	X		X	X	X	X			X				X				X
SC	Alzheimer's Family & Caregiver Support Program	X		X	X	X	X				X			X				X
WYOMING																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Home and Community-Based Services Waiver for Elderly and Physically Disabled	X		X	X							X		X				X
SC	Community Based In-Home Services Program (CBIHS)	X		X	X			Chore services; Hospice			X			X				X

STUDY of RESPITE CARE

Report to the NC Study Commission on Aging

March 28, 2008

NC Department of Health and Human Services

1

House Bill 424

- Directed DHHS to study Respite Care and recommend ways to improve the current respite care delivery system
- Study group was formed to include community and other stakeholders with a core group of leadership representing the Division of Medical Assistance (DMA), Division of Aging and Adult Services (DAAS) and the Division of Health Service Regulation (DHSR) to complete the respite study

2

Core Planning Group

Glenda Artis	Division of Aging and Adult Services
Julie Budzinski	Division of Medical Assistance
Karisa Derence	Division of Aging and Adult Services
Charles Jackson	Division of Medical Assistance
Jody Riddle	Division of Aging and Adult Services
Beverly Speroff	Division of Health Service Regulation
Chris Urso	Division of Aging and Adult Services

3

Report to Address:

- The need and availability of respite care in North Carolina
- The delivery and licensing of respite care in other states and possible models for North Carolina
- The application process for a grant under the Lifespan Respite Care Act of 2006, 42 U.S.C.
- The need for separate statutory language pertaining to respite care
- The need, proposed structure, and development timeline for a separate licensure category for respite care
- The development of a Medicaid Waiver covering a proposed new licensure category for respite care

4

Need for Respite Care in NC

- Many different definitions, types, provider agencies and sources of funds (public and private)
- Difficult to determine the exact need for respite services because services are generally discussed in terms of recipient care rather than caregiver services
- Caregivers often receive relief from caregiving duties, but do not identify the service as "respite care"
- Wide variety of professionals and paraprofessionals involved in providing respite services

5

Need for Respite Care in NC

The July 2007 report on the Special Assistance In-home Program reports that of the 1,039 persons who received these in-home services:

- 80% had a primary caregiver;
- 48% had a secondary caregiver; and
- 50% of the primary caregivers lived with the person receiving services. These caregivers were informal, unpaid caregivers and included relatives, friends, and neighbors.

6

Need for Respite Care in NC (continued)

List maintained by the DAAS from 7/1/07 to 3/31/08

Type of Respite Service	Persons on Waiting List
Home Delivered Meals	3,649
In-Home Personal Care	3,343
Home Management	1,981
Adult Day Services	151
In-Home Respite	530
Family Caregiver Support Program Project C.A.R.E.	45* 113**
Total	9,812

7

Need for Respite Care in NC (continued)

- A DAAS survey found that about 92% of client families report that Project C.A.R.E. respite services allowed them to provide care at home longer
- NC currently has over 150,000 older adults with Alzheimer's disease and this number is projected to rise to over 294,000 by 2030
- Over 70 percent of people with Alzheimer's disease are cared for at home by unpaid family and friends

8

Need for Respite Care in NC (continued)

The 2001 Long-Term Care Plan by the NC Institute of Medicine recommends:

- The Department's long-term care policies and program activities should be designed to strengthen the capacity of families to perform caregiving functions
- The Department should explore ways to invest in family caregiving so that it can be sustained as the primary resource for long-term care, reducing the risk for needing formal, publicly-financed services

9

Need for Respite Care in NC (continued)

The DHHS LTC Cabinet has recognized the need for family supports such as respite care

- ***Vision Statement for the North Carolina LTS Cabinet***
  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.
- ***Mission Statement for the LTS Cabinet***
  To create a statewide, integrated, person and *family-centered* system for those who need long-term services and supports so that they can live and participate more fully in communities of their choice.

10

Need of Respite Care in NC (continued)

A DAAS Performance Outcome Measures Project Survey (2002-2003) Found:

- Caregivers who indicated that they needed more respite and/or adult care services than they were currently receiving 2002 were significantly more likely to place the person they were caring for in a facility by 2003.
- Caregivers receiving any type of in-home aide service (in-home respite, personal care, or homemaker) in 2002 were significantly less likely to place the person they were caring for in a facility by 2003.

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Availability of Respite Care Division of Aging and Adult Service

Types:

- *Group Respite* provides temporary relief for caregivers, enabling them to meet personal needs and supporting their efforts to provide the majority of care for their family member
- *Institutional Respite* provides temporary relief for caregivers in a residential setting that meets the LOC needs for the recipient
- *Adult Day Care*, as defined in NC General Statute 131D-6, is 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 18 years and older who may be physically or mentally disabled
- *Adult Day Health* offers health care services in addition to the services offered by the Adult Day Care Program to adults 18 years and older that require health monitoring by trained medical staff

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Availability of Respite Care in NC
Division of Aging and Adult Services

- The Home and Community Care Block Grant awards a Federal Older Americans Act funds and state appropriations to counties through Area Agencies on Aging (AAA) to serve adults at risk of institutionalization aged 60 and over who require services to remain in the community
- The State Adult Day Care Fund (SADCF) uses federal Social Services Block Grant funds and state appropriations to provide adult day care services to disabled adults age eighteen (18) and older who are at risk for institutionalization

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Availability of Respite Care
Division of Aging and Adult Services

Caregivers served by the North Carolina Family Caregiver Support Program (FCSP) received one or more of the following services provided under the program's scope of respite care:

- In-home respite (personal care, homemaker, Senior Companions/home visitors)
- Community respite (adult day center, group respite center, mobile day respite, or other nonresidential program)

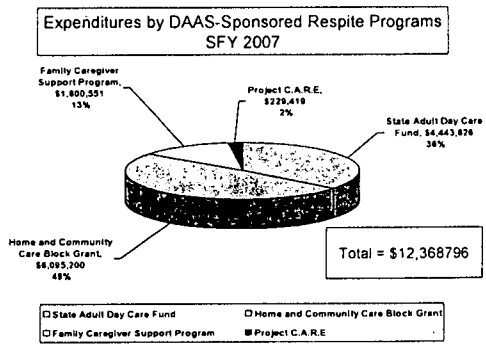
14

Availability of Respite Care
Division of Aging and Adult Services

Project C.A.R.E. (Caregiver Alternatives to Running on Empty)

- Is specifically designed to provide respite care and support to caregivers of persons with dementia and is a federally funded Alzheimer's Demonstration Program
- Families enrolled in the program received an annual spending cap of up to $2000 and had the option to chose between adult day services, group respite, private or agency in-home care, and overnight residential respite
- Available in 14 western counties

15



Source: Division of Aging and Adult Services

16

Availability of Respite Care in NC
Division of Medical Assistance

Waiver Programs (CAP/DA, CAP/Choice, and CAP/Children)

- Temporary support to the client's primary unpaid caregiver(s) by taking over the tasks of the caregiver(s) for a limited time
- May be used to meet a wide range of needs, including family emergencies; planned absences, relief from the daily responsibility and stress of caring for a special needs person; or to provide time for the caregiver(s) to shop, run errands, and perform other tasks
- Respite is available in-home, where the respite worker goes into the client's home, or as institutional respite where the client goes into a facility that is licensed to provide the appropriate LOC

17

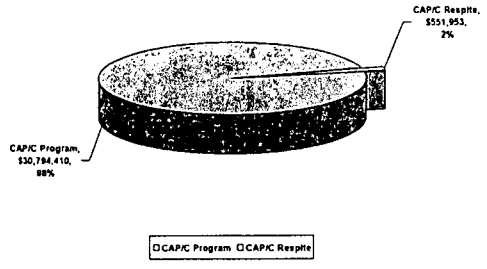
Availability of Respite Care in NC
Division of Medical Assistance

Hospice Care

- Medicaid reimburses a "Short-Term Inpatient Care" (general and respite), which is provided in a hospice inpatient unit, a hospital, or nursing facility under a contractual arrangement with a hospice agency
- The inpatient stay is generally of short duration for the management of symptoms or for palliative care that cannot be provided in any other setting
- An inpatient stay (respite) provides short-term relief for the caregiver
- Relief for the hospice recipient's caregiver is available with either Medicare or Medicaid reimbursement

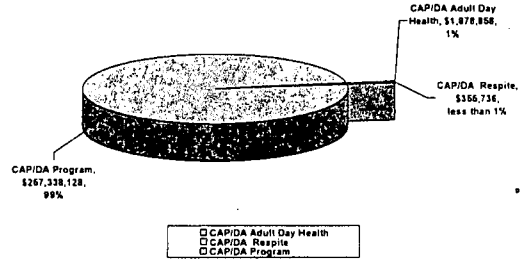
18

SFY 2007 CAP/C Respite Expenditures as Part of Total CAP/C Expenditures



Source: 2007 DRIVE Claims Data

SFY 2007 CAP/DA Respite Expenditures as Part of Total CAP/DA Expenditures



Source: 2007 DRIVE Claims Data

Availability of Respite Care in NC
DMHDDSAS

- Respite care provided by DMHDDSAS
  - Provides intermittent relief for the caregiver
  - Accommodates a wide range of needs (i.e. emergencies, planned absences)
  - Provides time for the caregiver to handle personal tasks and
  - Provides respite to the client from the primary caregiver

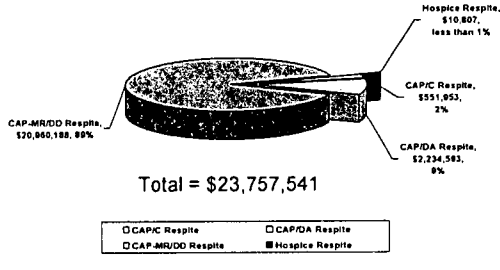
- A person must meet the definition of a

Availability of Respite Care in NC
Division of MHDDSAS

CAP/MRDD Waiver

- Types of Respite Care offered by DMH:
  - In-home respite
  - Institutional respite
  - Facility respite
- Respite is funded both with state dollars and through the Medicaid CAP/MRDD waiver program
- Under the CAP/MR/DD waiver, both federal and state rules permit family members to become paid caregivers with the exception of legally responsible family members

Total Medicaid Expenditures for Respite by Program SFY 2007



Total = $23,757,541

Source: Division of Mental Health and 2007 DRIVE Claims Data

Availability of Respite Care in NC
Division of Social Services

DSS definition based on the Friends NRC (National Referral Center in Chapel Hill)

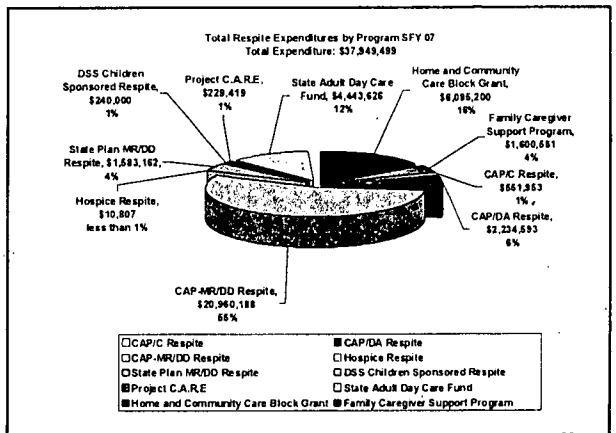
Short-term care services provided for families of children under the age of 18 living with natural, adoptive, foster parents or relatives, or caregiver family who are caring:

- The child(ren) are in danger of abuse or neglect
- The child(ren) have experienced abuse or neglect
- The child(ren) has/have developmental disabilities, chronic or terminal illnesses or mental health issues

Availability of Respite Care in NC
Division of Social Services

- DSS provides respite care within the Family Support Child Welfare Section to families and children
- DSS has eight contracts for respite care, each for $30,000, for a total of $240,000 per year
- In SFY 2007, DSS provided respite services to 288 unduplicated clients
- County DSS contract for respite care with local adult day care and adult day health providers with funds provided through the

25



Source: Division of Mental Health, Division of Social Services, Division of Aging and Adult Services and 2007 DRIVE Claims Data
*Family Support/Child Welfare Section

26

Respite Care in Other States

- Respite care in other states - The NC Respite Study Group reviewed *The State of the States in Family Caregiver Support: A 50-State Study* published November 2004 by the Family Caregiver Alliance in collaboration with the National Conference of State Legislatures
- Every state has at least two respite programs, one of which is for older adults

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Possible Models for NC

Four Model Programs:

1. Alzheimer's Demonstration Program, Project C.A.R.E. (Caregiver Alternatives To Running On Empty)
   - In 2004, Project C.A.R.E. received the Geriatric Best Practice Award from the Southeast Regional Geriatric Best Practices Initiative
   - In 2005, the program received a National Innovative Program Clearinghouse Award from the National Alzheimer's Association and was featured at the National Conference of State Legislators as a national model for home and community based care coordination
   - Project C.A.R.E. was further recognized as a National Best Practice Model by the U.S. Administration on Aging and RTI International

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Possible Models for NC (continued)

2. Jackson County Family Resource Center
3. A Small Miracle, Inc.
4. Senior Companion Respite Program

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The Application Process for a Grant Under the Lifespan Respite Care Act of 2006

- Lifespan Respite Act (H.R. 3248)

PUBLIC LAW 109–442—DEC. 21, 2006 120 STAT. 3291
Public Law 109–442
109th Congress
An Act

- Not yet funded by Congress
- Once funded, the DHHS/DAAS will make application for funding under this authority

30

Need, proposed structure, and development timeline for a separate licensure category for respite care

- The NC Respite Study Group did not see a need for separate statutory language for respite care
- After a thorough review of existing statutes and rules, the NC Respite Study Group concluded that the existing licensure and certification systems used by DHSR and DAAS allow for appropriate regulation of all levels and types of respite care
- What is needed is consistent and predictable state funding for the current respite care models available in North Carolina

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Respite Care as a Medicaid Optional Service Under the State Plan

- Currently NC Medicaid only provides Respite Care as a billable service under its waiver programs
- Respite care is not provided as a "regular Medicaid" benefit under the State Plan
- NC Respite Study Group recommends that DMA study the feasibility of including Respite Care as an Optional Medicaid Service under the State Plan

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The NC Respite Study Group Recommends:

1. That the NC General Assembly:
   - Provide a recurring annual state appropriation of $500,000 to sustain Project C.A.R.E prior to June 30, 2008
   - Support an increase in the State Adult Day Care Fund to expand services to include adults 18 years of age and older, since the HCCBG fund is restricted to adults 60 years of age and over
   - Provide state funding to continue the expansion of Aging and Disability Resource Connections (ADRC) to increase information about and access to respite services for caregivers

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The NC Respite Study Group Further Recommends:

- That DAAS study and determine the place of group respite programs in the long-term care continuum and assess the adequacy of service standards and funding
- That Medicaid will study the feasibility of providing respite care as a State Plan Service

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Attachment 9

Study of Rules and Regulations Regarding Housing Individuals with Mental Illness in the Same Facility Vicinity as Individuals without Mental Illness

General Assembly of NC Session 2007
Session Law 2007-156
Senate Bill 164

Prepared For:
The North Carolina Study Commission on Aging

March 1, 2008

Study of Rules and Regulations Regarding Housing Individuals with Mental Illness in the Same Facility Vicinity as Individuals without Mental Illness

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Study of Rules and Regulations Regarding Housing Individuals with Mental Illness in the Same Facility Vicinity as Individuals without Mental Illness

General Assembly of NC
Session Law 2007-156
Senate Bill 164

Prepared For: The North Carolina Study Commission on Aging
March 1, 2008

Final Report and Recommendations

I. Summary

The Department of Health and Human Services is submitting this study pursuant to Session Law 2007-156, "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 Adult Care Homes to Provide Appropriate Care to Residents with Mental Illness, as Recommended by the North Carolina Study Commission on Aging." Session Law 2007-156 states:

> **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, Developmental Disabilities, and Substance Abuse Services, 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, Developmental Disabilities, and Substance Abuse Services, shall study the need for training direct care workers in adult care homes 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. The study shall address the fiscal impact that the implementation of training requirements would have on these facilities and the amount of funding needed to support a successful training model.
>
> **Section 1.(c)** The Department of Health and Human Services shall present its findings and recommendations in response to the studies authorized in subsections (a) and (b) of this section, along with any required statutory or rule changes, to the Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before March 1, 2008.

Over the past several years, the Department of Health and Human Services has worked to improve the care to individuals who have mental illness and are residing in adult care homes, while acknowledging that other housing and treatment options need to be available to serve this population. During the 2005 Session of the General Assembly, a report entitled "Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities" was presented to the General Assembly in response to HB 1414 Section 10.2(a) & (b) (see Attachment 1). This report references the 2005 Study, expands upon a description of the system needed to support individuals with mental illness residing in facilities and makes additional recommendations.

The Department is making recommendations for a comprehensive system of screening, assessment, planning, and services for individuals with mental illness who present or are referred for services in adult care homes. The details are outlined in this report; the recommendations are summarized below:

- Develop and automate a comprehensive assessment and care plan system for adult care homes.
- Expand required minimum training levels for adult care home staff.
- Require initial screening, and follow-up mental health assessments for adult care home residents or potential residents referred through the initial screening, as well as annual reassessments.
- Expand capacity to provide local mental health rehabilitative services to individuals with mental illness residing in adult care homes who need these services.
- Implement a project to pilot a new service definition for a Transitional Residential Treatment Program to provide 24-hour residential treatment and rehabilitation of adults who have a pattern of difficult behaviors related to mental illness. The service would exceed the capabilities of traditional community residential settings (recommendation also submitted to the Joint Legislative Oversight Committee on MH/DD/SAS on October 25, 2007 by the Department).

II. Background and Accomplishments

In this report Adult Care Homes include facilities licensed as either adult care homes (seven or more beds) or family care homes (six or fewer beds).

A. Data of Individuals with Mental Illness in Adult Care Homes

For over sixty years licensed adult care homes have provided the citizens of North Carolina a place for assistance with activities of daily living and 24-hour supervision. These services have been provided, not only for those aging and failing in health, but also for younger individuals who have mental illness.

Data submitted by adult care homes on annual licensure renewal application denotes the number of individuals with a primary diagnosis of mental health residing in the home on September 30 of the preceding year. See Table 1.

Table 1: Number of Individuals with Primary Diagnosis of Mental Illness Residing in Adult Care Homes by License Type

	2002			2003			2004		
License Type	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI
Adult Care Home	4,495	24,633	18.2%	4,918	17,766	27.7%	4,450	14,442	30.8%
Family Care Home	1,093	2,871	38.1%	1,200	2,277	52.7%	1,258	2,096	60.0%
	2005			2006			2007		
License Type	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI	Total Number of MI Residents	Total Number of Residents in Facility	Percentage of Residents with MI
Adult Care Home	5,006	24,831	20.2%	5,068	25,100	20.2%	5,079	26,706	19.0%
Family Care Home	1,145	2,578	44.4%	1,202	2,644	45.5%	1,155	2,495	46.3%

Source: Facility Reported September 30 Census data on Annual License Renewal Applications, Division of Health Services Regulation

No information on residents with a mental heath diagnosis was collected in the licensure renewal application prior to 2002.

B. Recommendations from the 2005 "Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities"

The 2005 report on "Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities" to the North Carolina Study Commission on Aging included the recommendation to address several regulatory areas. Recommendations identified the need to increase staff training and to evaluate staffing requirements. Currently staffing requirements average a staff-resident ratio of 1:17-20 on the first and second shifts and 1:25-30 on the third shift. Staffing should be based on the ability of staff to manage specific needs of the individuals residing in each facility, rather than a standard staffing ratio with no consideration of the facility's unique populations. Additionally, three recommendations referenced the following:

(1) the common need for each potential resident to have a pre-admission screening identifying the appropriateness for placement in an adult care home with the facility to review and evaluate this information prior to any admission;
(2) the need to assure that residents (who in the past year had been served in inpatient mental health treatment settings) be seen by a mental health professional if no current services were in place; and
(3) the need for facilities to disclose their expectations and policies for residents and responsible parties.

The need for additional funds to implement these changes was identified.

C. **Implementation of Recommendations from the 2005 Study**

A stakeholder review of the Adult Care licensure rules was implemented in the fall of 2006 through the Division of Medical Assistance's (DMA) Adult Care Restructuring Committee. This committee was convened to address funding and service concerns held by the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services (CMS) in relation to home based care. A subcommittee was established representing home care and adult care home providers, provider associations and the DHHS Divisions of Mental Health, Developmental Disabilities and Substance Abuse Services, Aging and Adult Services, Health Service Regulation, and Medical Assistance to review current requirements and recommend changes to meet the needs of the current population residing in adult care homes. While the review process has resulted in identifying some preliminary rule changes, further work is needed.

Since the 2005 study recommendations were made, a pre-admission screening tool and a comprehensive resident assessment have been developed. These screening and assessment processes would meet the identified needs in the 2005 study to promote appropriate placement and identify care, service and referral services needed. Funding is not available for full implementation.

Revising the focus of staffing rules to determine the minimum number of staff present in the building based on the needs of the facility's population rather than a resident census number would require a change in the funding and reimbursement mechanism. To implement staffing changes, DMA would need to have historical data collected and analyzed to determine residents' needs at admission and as they age in place. The Division would then correlate these data to staff hours required to provide those services. One reimbursement mechanism is a case-mix system based on a prospective payment system (PPS) currently utilized by the Medicare program in nursing homes. Based on analysis of assessment data, utilization groupings were determined and reimbursement rates were established based on resident service need characteristics reported on the comprehensive assessment.

Changes in funding formulas and resultant increases in payments to facilities would need to occur to implement further increases in required staffing. Currently DMA is reviewing this and other payment methodologies.

As a result of the recommendation in the 2005 report on "Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities" and Senate Bill 164's mandate to study North Carolina staff training needs, a stakeholder workgroup (See Attachment 2) convened to identify the kind of training needed to meet the needs of caring for residents who have mental illness in adult care homes. The focus of the meeting included the identification of staff who should be trained, the frequency of the training, and qualifications of the trainers and the content of programs. Since many of the stakeholders were those involved in daily interactions with mentally ill residents in adult care homes, consensus on identified needs and approaches was reached. See Section IV. below for the group's recommendations.

A recommendation was made by the Department of Health and Human Services in its 2005 "Study of Issues Related to Persons with Mental Illness in Long-Term Care Facilities" to conduct a study to inform the development of a residential continuum designed to meet the needs of persons with mental illness. The Department (through Division of Mental Health, Developmental Disabilities, and Substance Abuse) followed through on its recommendation by developing a contract with the Technical Assistance Collaborative, Inc., which will be in effect until 12/30/08, to study and develop recommendations to be included in a report to the Legislative Oversight Committee as required by SL 2007-0323 Section 10.49 (h1). This contract will initially provide information about North Carolina's housing needs and current resources, identify best practice housing and service models that have been shown to be effective in other states, and provide recommendations and a plan for implementation for additions and/or changes to North Carolina's residential service array that will maximize available federal and state resources. The study will provide a report to address specifically the following:

(1) the need in terms of numbers to be served and range of residential and treatment settings to meet these needs; assess the current population in long term care facilities and identify specific service needs of persons with cognitive disabilities and behavioral issues that current long term care options are not designed to address; and, quantify the need, types and functionality of residential and treatment settings to create a spectrum of options to meet the variety of needs as identified above;
(2) identify housing and service models meeting the criteria of evidence-based best practices being used in other states to address the needs not currently being met in long term care settings in North Carolina, including a description of the population(s) being served, the scope, nature and type of residential service(s), and the funding mechanisms used to provide both

the supportive service and housing components in the development and ongoing operations.

III. Rules and Regulations Regarding Appropriate Care and Housing of Individuals with Mental Illness in the Same Facility Vicinity as Individuals without Mental Illness

A. Study of Rules in Other States

A review of other states' policies and rules regarding the care of residents diagnosed with mental illness in assisted living facilities proved to be problematic in that assisted living is defined differently in every state, thereby impacting the effectiveness of any comparisons. A number of states have different levels of assisted living which further complicates meaningful comparisons. In addition, funding sources for assisted living vary significantly among states.

In order to focus the scope of the study, a review of the Assisted Living State Regulatory Review 2007 was conducted. Each state was reviewed by searching for the common denominators of mental health or mental illness and Medicaid funding for comparison purposes. States that matched were contacted. Eight states replied by telephone or e-mail to questions regarding population mix, specific rules for residents with mental illness, additional training, case management by the mental health system, assessment and care plan by a mental health professional, and staffing. The states queried were Arizona, Colorado, Florida, Idaho, Michigan, Texas, Washington, and Wisconsin. Table 2 entitled "State Regulatory Responses to Residents with Mental Illness in Assisted Living Facilities" categorizes and compares the responses. All of these states except Arizona allow for mixed populations, which according to this study means that residents with mental illness diagnoses can be admitted to an assisted living facility. Only a few states, such as Arkansas, do not allow admission of persons with a mental illness to an assisted living facility. The rest of this report summarizes additional information from the review.

Arizona

There are three licensed levels of care in assisted living facilities: Supervisory Care Services - general supervision only; Personal Care Services - assistance with activities of daily living; and Directed Care Services - programs and services provided to persons who are incapable of recognizing danger, summoning assistance, expressing need, or making basic care decisions. Admission requirements prohibit acceptance or retention of residents requiring physical or chemical restraints, or requiring behavioral health residential services or services the assisted living residence is not licensed or able to provide. Residents with diagnoses of mental illness are not mixed with other populations in assisted living facilities.

Colorado
While there are no additional rules specifically addressing the population with mental illness, staff training must be provided based on specific needs of the population served including residents in secured environments and individuals with severe and persistent mental illness. Within one month of hire, facilities must provide adequate training to staff in several areas including identifying and dealing with difficult situations and behaviors.

Florida
Populations are mixed but there is a limited mental health license category when facilities serve three or more residents with chronic mental illness. There are specific rules for this type of assisted living facility which include additional training requirements, case management through the state's mental health system and an assessment and care plan developed by a mental health professional.

Idaho
Policies and procedures on behavior management are required. These policies and procedures must address evaluation of behavior management and development of interventions for each behavioral symptom. The resident's medication regime must be evaluated every six months to assure medications to treat behavioral symptoms are necessary and at lowest possible doses. Training for facility staff admitting residents with mental illness diagnoses must include an overview of mental illnesses: address symptoms and behaviors specific to the mental illness, resident's adjustment to the new living environment, behavior management, communication, activities of daily living, integration with rehabilitation services and stress reduction for facility personnel and resident. In addition, there are requirements for mental health contracted beds which state that a facility may enter into an agreement with the Department to provide short-term care to certain residents designated by the mental health program of the Department who are temporarily distressed and unable to meet their basic needs. These rules address personnel, written contract, resident assessment and staff orientation and training.

Michigan
Homes for the Aged provide supervised personal care to homes serving 21 or more residents who are 60 years of age or older. These homes may not accept anyone with a mental condition disturbing to other residents or personnel, and a resident who shows serious mental disturbances must be removed from the home. Adult Foster Care facilities provide 24-hour personal care, protection and supervision for individuals who have mental illness, physical handicaps or those who are aged who cannot live alone but do not need continuous nursing care. These facilities can be certified to provide specialized services for residents with mental illness and are required to meet specific rules addressing the population being served. Licensed

facilities certified to provide a specialized program for persons with mental illness are required to meet a higher standard of training. Case management is typically provided by local mental health authorities through contracts with private agencies for this function, including assessment and care planning.

Texas

There are four types of assisted living facilities categorized according to evacuation ability of residents, ability to follow directions under emergency conditions, need for attendance during sleeping hours, assistance with activities of daily living versus medication supervision only, transfer assistance and contracted services. Facility policies must address the types of clients admitted and how they will be served. There is no specific training for residents with mental illness diagnoses but staff must receive on-the-job training in behavior management such as prevention of aggressive behavior and de-escalation techniques.

Washington

Boarding Homes are licensed to provide domiciliary care for seven or more residents or for three to six residents if licensed prior to or on July 1, 2000. These homes may provide optional services which include care for residents with mental illness for which special rules apply. Each home is required to disclose on a standardized form the scope of care and services it offers, including services for persons with mental illness. Caregivers must complete skill-based special needs training whenever the home serves a resident with mental illness.

Wisconsin

Three programs fall under the umbrella term of assisted living and are categorized according to level of resident independence, nursing hours required, physical plant arrangement and number of residents. Residents with mental illness diagnoses are not prohibited from admission to any of these types of facilities but admission depends on assessment, including level of independence. The facilities providing care, treatment and other services to five or more unrelated adults who need supportive or protective services or supervision because they cannot or do not wish to live independently and do not require more than three hours of nursing care per week are categorized by size, ability to evacuate and disability/condition,(including mental illness). Some rules specific to the population being served apply, including training requirements. These facilities must ensure that residents of different ages, development levels or behavior patterns, as identified in their assessment and service plans, are compatible. If there is regulatory evidence of incompatibility among different populations of residents, the state can restrict whom the facility can serve, the regulatory agency reports this is done rarely and has proven to be problematic in its implementation.

B. Rules in North Carolina

North Carolina is unique in having rules for adult care home special care units for residents with mental health disorders. These rules, however, are only for those facilities that advertise themselves as providing special care to residents with mental health disorders as mandated by G.S. 131D-8. No additional funding was provided for operation of these special care units. One facility did establish and operate such a special care unit and has since closed.

All direct care staff and their supervisors in licensed facilities in North Carolina are required to be trained and competency validated. Personal care aides and their direct supervisors receive a five-hour training module on behavioral interventions as a part of the required personal care aide training program (10A NCAC 13F/G .0501).

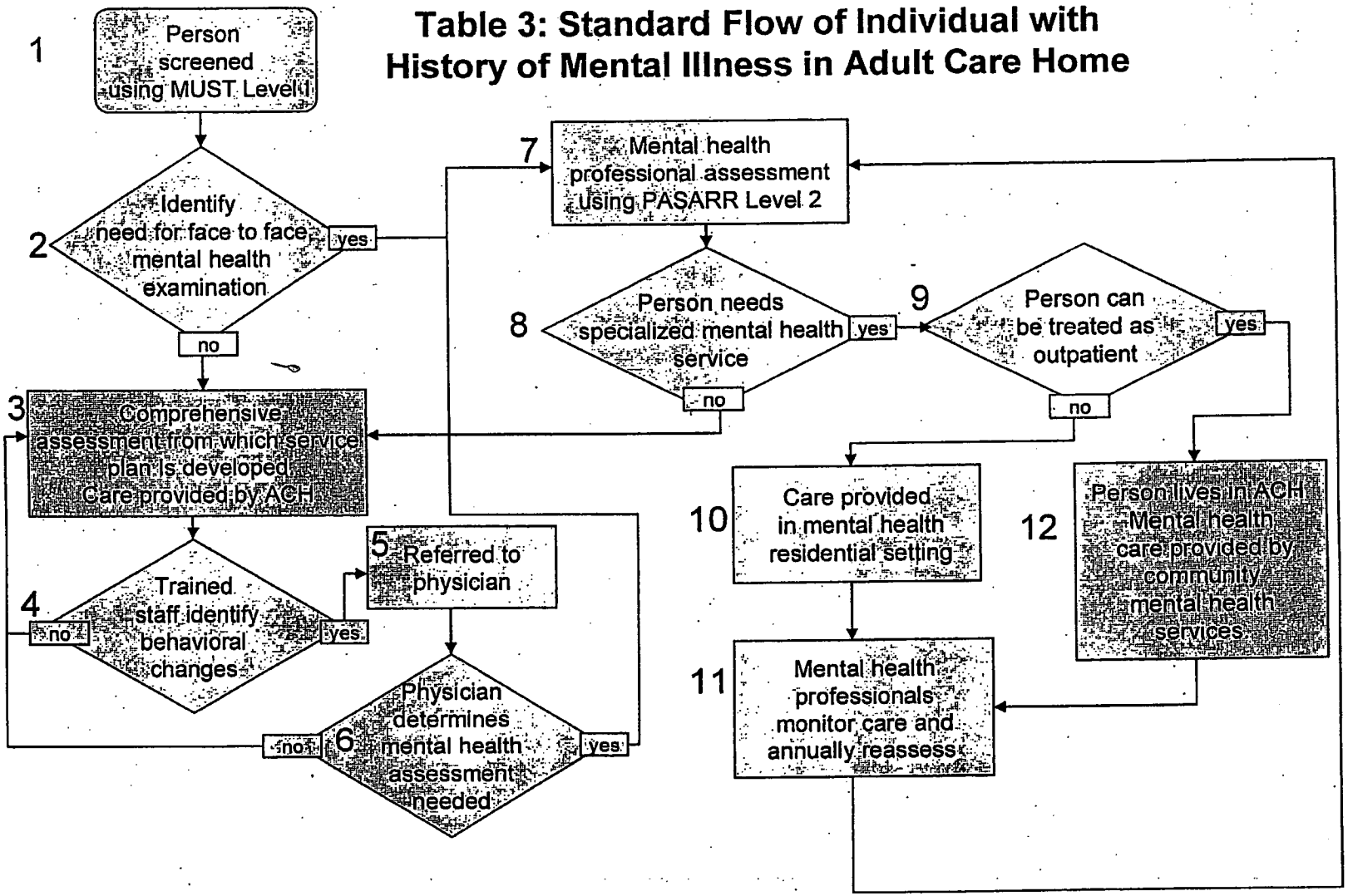
Following are other rules related to care and management of residents with mental illness:

- 10A NCAC 13F/G .0902(d)(2): This rule states, "When the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan as required in Rule .0802 of this Subchapter."
- 10A NCAC 13F/G .1002: 10A NCAC 13F/G .1002: This rule requires personal care aides and their direct supervisors to receive annual training on the effects of psychotropic medications, including alternative behavior interventions. In addition, the rule requires psychotropic medications ordered "as needed" by a prescribing practitioner, to be administered only "if the following have been provided by the practitioner or included in an individualized care plan developed with input by a registered nurse or licensed pharmacist: (1) detailed behavior-specific written instructions, including symptoms that might require use of the medication; (2) exact dosage; (3) exact time frames between dosages; and (4) the maximum dosage to be administered in a twenty-four hour period." [Paragraph (g)]
- 10A NCAC 13F .1212(g) and 13G .1213(g): This rule on accident and incident reporting requires referral of a resident who is threatening or assaultive to the Local Management Entity (LME) for Mental Health Services or mental health provider for emergency treatment. It also requires cooperation of the facility with assessment personnel assigned to the case by the LME or mental health provider to enable them to provide the earliest possible assessment.
- 10A NCAC 13F/G .1211: This rule requires facilities to have written policies and procedures on the management of physical aggression or assault by a resident.

Table 2: State Regulatory Responses to Residents with Mental Illness In Licensed Assisted Living Facilities

State	Population Mix Allowed	Specific Rules for Individuals with Mental Illness	Additional Training Requirements for Serving Individuals with Mental Illness	Case Management by Mental Health System	Assessment/Care Plan by Mental Health Professional	Staff Ratio/ Meet the Needs
ARIZONA	No	No	No	No	No	Meet needs
COLORADO	Yes	No	Yes	No/Medicaid Case Management	No	Meet needs
FLORIDA	Yes	Yes, when 3 admitted	Yes	Yes	Yes	Ratios
IDAHO	Yes	Yes	Yes	No	No	Meet needs
MICHIGAN	Yes	Certification Process w/ funding through community mental health	Yes	Yes	Yes	Ratios
NORTH CAROLINA	Yes	Mental Health Special Care Units 10A NCAC 13F .1401-1410	Mental Health Special Care Units 10A NCAC 13F .1409	No	Mental Health Special Care Units 10A NCAC 13F .1407	Meet needs
TEXAS	Yes	No	No	No	No	Meet needs
WASHINGTON	Yes	Yes	Yes	No	Yes	Meet needs
WISCONSIN	Yes Compatibility rule	No	Yes	No/Medicaid Case Management	No	Meet needs

Table 3: Standard Flow of Individual with History of Mental Illness in Adult Care Home



C. Recommended System for Supports to Individuals with Mental Illness in Adult Care Homes

A system that is designed to meet the needs of individuals with mental illness in adult care homes has multiple service processes and components, including the development of additional resources to serve the needs of these individuals in other community and home settings. Table 3 shows the recommended flow of service provision to a person with mental illness who is screened for adult care home admission. The numbers below correspond to the numbers on Table 3.

1. Person screened using (Medicaid Uniform Screening Tool) MUST Level I

The Division of Medical Assistance (DMA) currently has a mandated "level of care" form (FL-2) which must be signed by a physician designating the appropriate level of care for the potential resident. DMA will introduce the MUST screening tool by October 1, 2008, The MUST primarily will replace the existing FL-2 and FL-2e forms to screen for level of care for several of the long term care programs. The MUST Level 1 will be implemented for Adult Care Homes as soon as funding is available and a contract can be executed. Those programs initially using the MUST will be the nursing facilities, the Pre-Admission Assessment Screening and Annual Resident Review (PASARR) Program, adult care homes, Personal Care Services, Personal Care Services Plus, Community Alternatives for Disabled Adults (CAP/DA and CAP Choice), Community Care Alternatives for Fragile Children (CAP/C) and Private Duty Nursing (PDN). Other programs will be added at a later date. The tool will indicate which of the mentioned Medicaid Programs best fit the individual's profile and any alternative program fits that may be available.

Eligible screeners for the MUST program include:

a. Professionals making a referral to Medicaid for long-term care services and supports, including
   1) Physicians;
   2) Physician Assistants, Family Nurse Practitioners, and other mid-level practitioners;
   3) RNs and LPNs;
   4) Medical/Clinical Social Workers, Qualified Professionals and Psychologists;
   5) Hospital discharge planners and case managers;
   6) Case managers from regional, local and community organizations.

b. Staff of Aging Disability Resource Centers (ADRCs), Departments of Social Services and other providers, agencies and networks whose administrator determines the potential screener has the experience and informal training needed to complete the screenings.

All MUST Screeners are to be Medicaid-approved by participating in the MUST training and by demonstrating competency in the use of the tool as

evidenced by passing the MUST Online Test. Ongoing approval will be monitored through several of DMA's quality assurance initiatives. Authority to screen may be revoked.

All persons (no matter the payer source) seeking admission to an adult care home will be screened using MUST. If the prospective resident's choice is to enter an adult care home then he will be screened utilizing the Pre-admission Screening and Annual Resident Review (PASARR) function of the MUST to assess whether the individual has mental health, mental retardation or related conditions which may need specialized services to meet the person's needs.

2. **Identify need for face to face mental health examination**
   YES--If MUST screening identifies one or more of the conditions described in #1, a face to face comprehensive mental health evaluation is arranged (see #7 below).
   NO--If MUST screening results indicate that a face to face mental health evaluation is not necessary then the recipient will be approved to enter an adult care home and the MUST will have the PASARR number entered and this number will be included in the MUST letter and screening form.

3. **Comprehensive assessment from which service plan is developed. Care provided by Adult Care Home**
   If the results of the MUST Level 1 screening (see #1 and #2 above) or the Pre-Admission Assessment Screening Annual Resident Review (PASARR) Level 2 assessment (see #7) reveal that the potential resident does not need specialized Mental Health Services then he can be admitted to the adult care home of his choice. The adult care home will complete a comprehensive assessment from which a service plan will be developed. Care is provided to the resident by adult care home staff.

4. **Trained staff identify behavioral changes**
   While persons residing in adult care homes may initially be assessed as not needing a comprehensive mental health evaluation or specialized mental health service, some individuals may present with signs or symptoms of mental illness after admission. Staff persons in adult care homes need training to enable them to identify those signs and symptoms that might represent a change in mental health status. This step assumes that staff has training as identified in Section IV of this report.
   YES—If a trained staff person identifies that a resident has behavioral changes, he/she will refer the resident to a physician for further assessment. See #5.
   NO—If trained staff do not notice any behavioral changes, the adult care home continues providing care and staff continue to observe.

5. **Referred to physician**

Some signs and symptoms that present as potential mental illness may actually be caused by physical illness, medications or other reasons. For this reason, when adult care home staff notices behavioral or symptom changes, the individual will be referred to his or her physician for assessment.

6. **Physician determines mental health assessment needed**
   YES—If a physician determines that a mental health assessment is needed, the physician will refer the individual to a mental health professional for an assessment using the PASARR Level 2. See #7
   NO—If a physician determines that a mental health assessment is not needed, the adult care home staff continues to provide care and observes the resident.

7. **Mental health professional assessment using PASARR Level 2**
   If MUST Level 1 Screening (see # 2 above) results indicate that a face to face mental health evaluation is necessary then the potential adult care home resident will meet with a mental health professional to complete the PASARR Level 2 Assessment. No admission to an adult care home can happen until the results of the assessment are complete. Persons who are already admitted to the facility will not routinely receive MUST Level 1; however, if signs and symptoms are shown by a person residing in the facility, the physician will make a determination regarding whether a PASAAR Level 2 assessment by a mental health professional is needed (see # 4, 5 and 6).

8. **Person needs specialized service**
   The PASARR Level 2 Assessment will determine whether the individual needs a specialized mental health service.
   YES— If a PASAAR Level 2 assessment of an individual choosing to reside in an adult care home indicates that specialized mental health services are needed, this information will be sent to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The individual's service needs (either rehabilitative services in the community or care provided in a specialized mental health setting) will be communicated to the Local Management Entity (LME) that is responsible for services in the catchment area where the individual lives. The LME then contacts the individual and determines which of the providers of the needed mental health service(s) he prefers. A referral to the chosen provider(s) is made and the needed services are delivered.
   NO--If the person does not need a specialized service, the person can be admitted to the adult care home of his choice. The adult care home will then complete the comprehensive assessment from which a care plan will be developed. Care is provided to the resident by adult care home staff (see #3).

9. **Person can be treated as outpatient**

The types of specialized mental health services that would most commonly be needed by people who qualify for and choose to live in an adult care home are services such as community mental health treatment services, monitoring and management of medications prescribed to treat mental illness, psycho-social rehabilitation services, and individualized plans to address the illness and to promote recovery as described in more detail in # 12.

Yes--If the results of the PASARR Level 2 assessment (#7) indicate that the potential resident does not need specialized mental health residential services but does need and can benefit from community mental health services such as those described above, then the potential resident can be admitted to the adult care home after appropriate services are deemed available and have been scheduled by the LME and chosen mental health provider. The person would receive annual PASAAR Level 2 screening to assure that the setting continues to be appropriate.

NO--If the results of the PASARR Level 2 assessment reveal that the potential resident does need specialized mental health residential services then he may not be admitted to the adult care home. Appeal Rights will be issued.

10. **Care provided in mental health residential, supervised living or other setting**
    Individuals who are identified as needing care in a residential mental health setting will be diverted from adult care homes into licensed mental health homes or other settings that meet their needs.

11. **Mental health professionals monitor care and annually reassess the need for specialized mental health services within the PASAAR Level 2.**
    The assessment described in # 7 needs to be done when there is a significant change in behavior or at least annually because people's needs change over time. DMH/DD/SAS will have ongoing responsibility for working with the LME so that individuals who have a mental illness for which they need specialized mental health services continue to receive those services. The goal is that these individuals have access to service providers who can most appropriately address their needs through community treatment and rehabilitative services or specialized residential services.

12. **Person lives in Adult Care Home. Mental health care provided by community mental health services.**
    Individuals with mental illness may reside in an adult care home with appropriate community mental health services arranged and/or provided by the Local Management Entity and mental health provider of choice (see #9).

D. Needs for Implementation of Recommended System

The section above describes the recommended system for screening, assessment and care planning, and needed mental health service coordination for individuals who have mental illness and who are entering adult care homes. It also addresses the diversion of individuals who are determined inappropriate for residing in adult care homes into other more appropriate mental health settings. While some of the processes are in place or are pending, some of the recommendations require additional processes and funding. Table 4 summarizes the estimated financial resources.

Table 4: Summary of Needs to Implement Recommended System

Item Number from Table 3	Description	Recurring Costs	Nonrecurring Costs
Item 3	Develop and automate a comprehensive assessment and care plan system for residents in adult care homes.	$580,000	
Item 4	Expand required minimum training levels	$4,500,000	
Item 7	Require PASAAR level II assessments of adult care home residents or potential residents who are referred for this level of evaluation	$281,840	$1,764,000
Item 8	Determination of specialized mental health care needed based on PASAAR Level II assessment	$334,000	
Item 12	Develop additional capacity to serve residents in adult care homes who need mental health services	$14,860,000	
Item 10	Pilot program to develop a residential program for people with mental illness currently in adult care homes but who require a different residential setting (1 six-bed facility)	$378,056	
TOTAL		$20,933,896	$1,764,000

1. A rule change is needed to require MUST Level 1 screening as described in C.1 above.

2. A rule change is needed to require adult care home staff to complete a comprehensive assessment (as described in C.3 above) of a resident to evaluate and plan for his needs upon admission, upon significant changes and annually This cannot be implemented until funded. This comprehensive assessment tool is a critical component to ensure that needs are identified and care and necessary referrals for specialized services can be planned, implemented and communicated. This tool needs to be implemented as soon as possible.

   An estimated $580,000 funding will be required for the Department to continue development and automation of a comprehensive assessment and care plan system.

3. A rule supported by funding would be necessary to expand required minimum training levels as mentioned in C.4 above and as described in more detail in Section IV in this report.

   An estimated $4,500,000 would be required annually to implement the recommended training system in adult care homes.

4. The Division of Medical Assistance currently provides PASAAR Level 2 assessments for nursing facility patients through a contract. It is anticipated that this contract would be expanded to conduct PASAAR Level 2 assessments for adult care home residents or potential residents who are referred for this level of evaluation (see C.7 above). A new rule would require the PASAAR Level 2 assessment for individuals referred by the MUST Level 1 screening process.

   It is anticipated that $1,764,000 initially and $281,840 annual funding is needed to implement the PASAAR Level 2 assessment in adult care homes.

5. After the PASAAR Level 2 assessment is completed, DMH/DD/SAS staff will make the final determination about whether the individual needs specialized mental health screening, contact the LME to arrange for services and follow up to be sure services are provided. This will be done both at the initial PASAAR Level 2 assessment and annually for those individuals residing in adult care homes who are determined to need mental health services, as described in C.7 and C.11. Currently this is done for nursing facility residents. Additional staff will be needed in DMH/DD/SAS because of the anticipated large increase in the number of individuals in adult care homes who will require specialized services when compared to the number who are currently in nursing facilities.

   An estimated $334,000 funding annually for at least five additional DMH/DD/SAS positions would be needed.

6. The ability of an individual to reside in an adult care home and receive appropriate services as described in C.9 above depends upon the capacity and resources of local mental health providers. "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. The types of mental health services that are often needed by some residents in long term care settings include: 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 the 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." (From 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 2, 2005).

An estimate of funding required for additional capacity to serve residents in adult care homes who need mental health services is **$14,860,000 to provide psychiatry, medication checks and rehabilitative services.**

6. The Department recognizes that there are serious concerns about residents with mental illness who are currently in assisted living facilities and who exhibit behaviors related to their illness. This makes it necessary to begin developing a new type of residential facility on a pilot basis that is designed to provide treatment and supervision at a level that is not currently available in community based residential services in North Carolina.

   As specified in SL 2007-0323 Section 10.49 (i), the Division of MH/DD/SAS has developed "a service definition for a Transitional Residential Treatment Program to provide 24-hour residential treatment and rehabilitation of adults who have a pattern of difficult behaviors related to mental illness, which exceed the capabilities of traditional community residential settings." This definition, an operating cost estimate, and daily rate were submitted to the co-chairs of the Joint Legislative Oversight Committee on MH/DD/SAS on October 25, 2007 by the Department.

   The estimated annual operating cost of each 6 bed facility of this type is $378,056. The Division of MH/DD/SAS had planned to implement one such facility as a pilot project contingent upon the ability to identify State funds. A separate report about this service definition and funds needed is being submitted to the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services by March 1, 2008 as required by SL 2007-0323. Development of this type of specialized facility is contingent on funding.

   The Division of MH/DD/SAS continues to explore the types of housing and residential services that can appropriately meet the varied needs of adults with mental illness. As described in Section II.B of this report, the Department has entered into a contract to study housing needs that will specifically identify housing and service models meeting the criteria of evidenced based best practices being used in other states to address the needs of persons not currently being met in long term care settings in North Carolina. The results will be used to explore and implement,

contingent upon funding availability, additional housing alternatives for individuals whose needs can not be met within current assisted living facilities. When this study is completed by December 2008, it will be possible to provide a realistic description and estimated costs for the development of more appropriate housing alternatives for residents with mental illness who are currently living in assisted living facilities. Currently, Medicaid is not a major reimbursement source for residential service for adults with mental illness. If housing and residential alternatives are to be developed, it is anticipated that additional state funding would be required.

IV. Need for Training Direct Care Workers in Adult Care Homes for Appropriate Care of Individuals with Mental Illness

A. Training Currently Available

Personal care aides and their direct supervisors receive a five-hour training module on behavioral interventions as a part of the required personal care aide training program. This training is a one time requirement for this staff category and can occur prior to or during the first six months of employment. Additionally, personal care aides and their supervisors are required to have annual training on the effects of psychotropic medications including alternative behavior interventions.

B. Proposed Training Requirements

A stakeholder workgroup meeting was held on January 4, 2008 to discuss the training needs of staff caring for residents with mental illness residing in licensed adult care homes (see Attachment 2 for participants). The focus of the meeting was to generate recommendations for training requirements for staff to ensure appropriate care for and response to residents with mental illness. Agreement was reached on the following recommendations.

1. Types of Training

Three types of training were identified as being needed:

- Basic Orientation Training: Provide to all staff in all facilities within the first week of employment.
- Specialized Training (Phase Two): Provide to all personal care aides and their direct supervisors when a facility admits a resident who has a mental illness as a primary diagnosis or when a new staff is hired by a facility serving one or more individuals with mental illness as primary diagnosis.
- Annual Training: Provide an in-service training addressing needs and care of residents with mental illness for personal care aides and their direct supervisors in facilities serving at least one resident with a primary diagnosis of mental illness.

Discussion concluded that this approach would help ensure that each adult care home and every resident with a current mental health diagnosis

is in an environment where staff would have the knowledge and competence to identify significant changes as well as be able to respond to the resident in a manner which would de-escalate the likelihood of conflict and physical harm to residents or staff. Staff with basic competence in understanding certain behaviors of residents with mental illness and responding to conflict resulting from those behaviors should improve the facility environment. Staff would have a protocol of responses for their own use and know when to obtain assistance from mental health providers or law enforcement. Standardized training would help ensure that each staff member knows the acceptable and appropriate response to residents with mental illness, thereby promoting an appropriate environmental culture for staff.

2. **Content**
   Training would include the nature/needs of residents based on:
   - Diagnosis
   - Behaviors
   - Escalation - symptoms/signs

   A subcommittee with leadership by DMH/DD/SA and staff from Therapeutic Alternatives will convene a group of experts to develop recommendations for training program components. Data available would include facility staff response to DMH/DD/SA Geriatric and Adult Mental Health Specialty Team staff questionnaires. Discussion included development of train the trainer programs for designated facility staff through DMH/DD/SA Geriatric and Adult Mental Health Specialty Teams contracts with other mental health professionals or persons of expertise in the mental health field, creating a Quality Improvement program through the Division of Aging and Adult Services, accessing online training materials and media possibly through university libraries, and training available through current programs including North Carolina Intervention.

3. **Training Requirements and Trainer Qualifications**
   Table 5 summarizes the training recommendations.

Table 5: Training Requirements, Time Frames, and Teacher Qualifications

Training Type	When Required	Class Duration	Staff to be Trained	Qualifications of Trainer
Basic Orientation	All facilities; within first week of employment	2 hours	All facility staff	Trained and competency validated staff
Specialized (Phase Two)	All facilities serving one or more persons with mental illness within six months of first admittance (existing employees) or start date (new employees)	12 hours	Aides and Direct Supervisors	Mental Health Professional
Annual Training	All facilities serving one or more persons with mental illness	4 hours	Aides and Direct Supervisors	Mental Health Professional
Based on recommendations of ACH-MI Training Workgroup, January 4, 2008				

4. **Estimated Costs**

The workgroup agreed there would be substantial cost due to staff turnover, the number of staff to be trained, and cost of trainers. Estimated costs were subsequently determined based on the assumption of 100 % staff turnover. Estimated cost to provide required training including staff coverage for resident care during training would be $4,500,000 annually.

Attachment 1

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

[1] 2005 Adult care home population census information from the NC Division of Facility Services

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.

Attachment 2

Members of the ACH-MI Training Workgroup

Jerry Cooper, NC Assisted Living Association

Tom Ensley, Cleveland County DSS

Dorian Frederickson, Regional LTC Ombudsman

Bonnie Morell, Division of Mental Health

Jill Passmore, Friends of Residents in Long Term Care and Regional LTC Ombudsman

Angel Powell, Family Care Home Administrator

Kellie Retterer, Therapeutic Alternatives

Polly Welsh, NC Health Care Facilities Association

STAFF
Barbara Ryan, Chief, Adult Care Licensure Section
Doug Barrick, Policy Coordinator, Adult Care Licensure Section

Study of Rules and Regulations Regarding Housing Individuals with Mental Illness in the Same Facility Vicinity as Individuals without Mental Illness

Session Law 2007-156
Senate Bill 164
Presented to the NC Study Commission on Aging
By the Department of Health and Human Services
on March 28, 2008

NC Actions Taken Since 2004 Session HB 1414 Study

- The 20 Geriatric Mental Health Specialty teams have an additional staff person with clinical training about younger adults with mental illness
- Automated screening has been developed and planned to be operational September 12, 2008. The screening will indicate the appropriate level of care/service for the individual.

2

NC Actions Taken Since 2004 Session HB 1414 Study

- Contractor is currently conducting a study about a residential continuum designed to meet needs of persons with mental illness
- The study is scheduled to be completed by December 2008 and will help guide policy and services
- Training for law enforcement officers and Strategic Alliances For Elders in Long Term Care (S.A.F.E.) taskforce

3

Session Law 2007-156

- Study rules in NC and other states regarding appropriate care and housing of residents with and without mental illness in the same facility and make recommendations
- Study need for training direct care workers to provide appropriate care to facility residents with mental illness in the same facility with individuals without mental illness and make recommendations.

4

Population in Adult Care Homes

As of Sept. 30, 2006:

- 26,706 people lived in Adult Care Homes (7 or more beds). Of those residents, 5,079 individuals or 19 percent had a mental illness
- 2,495 people lived in Family Care Homes (2 to 6 beds). Of those residents 1,155 individuals or 46.3 percent had a mental illness.
- Source: 2007 Annual License Renewal Application

5

Review of Rules and Regulations in Other States

- Contacted 8 states that had been identified in a national regulatory review as serving mental health population and/or accessed Medicaid funding to support care.
- Arizona, Colorado, Florida, Idaho, Michigan, Texas, Washington, and Wisconsin.

6

Review of Rules and Regulations in Other States

- All states, except Arizona, allowed population mix
- NC and 4 states (Florida, Idaho, Michigan, Washington) had specific rules about mental illness
- All states, except two (Arizona, Texas), had additional training requirements about mental illness

7

Rules in North Carolina

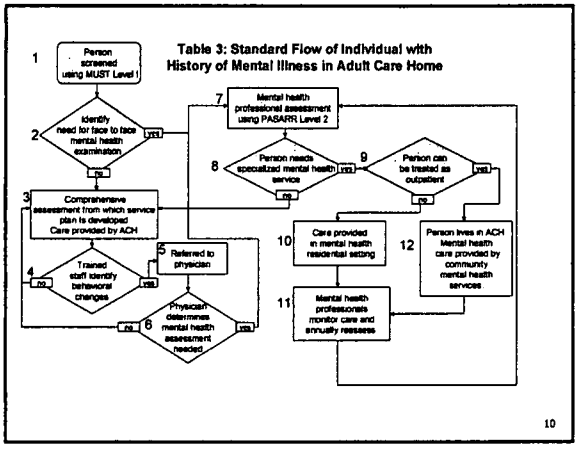
- NC requires direct care workers and their supervisors to receive 5 hours of training on behavioral interventions
- NC has rules about care and management: physician services, psychotropic medication, accident and incident reporting, and requires facilities to have a policy on management of aggression/assault by a resident.
- NC was the only state that had rules regarding special care units for mental illness

8

Recommendations

- Implement a comprehensive system of screening, assessment, planning, and services for individuals with mental illness who seek admission to an adult care home.

9



10

Recommendations Regarding Implementation this System

Rule changes/additions and addition al resources would be needed to:

- Require screening (MUST), assessments (PASARR), training for facility staff and
- Develop and pilot a new residential service to provide treatment and rehabilitation for adults who have difficult behaviors related to mental illness.
- Additional capacity to serve ACH residents who need mental health services

11

Recommended New Training Requirements

- All ACH staff should be required to have a basic 2 hour orientation.
- All aides and direct supervisors should be required to have 12 hours of specialized training and to have 4 additional hours of training annually if facility serves one or more residents with mental illness.

12

REPORT TO THE NORTH CAROLINA STUDY COMMISSION ON AGING CONCERNING THE STRUCTURE AND COST OF A SYSTEM TO REWARD ADULT CARE HOMES WHICH RECEIVE HIGH RATINGS

North Carolina Department of Health and Human Services

March 1, 2008

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Report to the
North Carolina Study Commission on Aging
Concerning the Structure and Cost of a System to Reward Adult Care Homes Which Receive High Ratings

Response to Legislative Request

The General Assembly enacted as part of Senate Bill 56, S.L. 2007-544 the following provision:

> **SECTION 3.(d)** The Department of Health and Human Services, Divisions of Health Service Regulation, Aging and Adult Services, and Medical Assistance shall study the structure and cost of a system to reward adult care homes which receive high ratings. The Department shall report findings and recommendations on this study to the North Carolina Study Commission on Aging not later than March 1, 2008.

The rating system to which Section 3.(d) refers is contained in Sections 3.(a) and 3.(b).

In response to the above directive, the Department met and studied the structure and cost of a reward system for adult care homes which receive high ratings.

Background

Senate Bill 56, S.L. 2007-544 Section 3.(a) put in place requirements for the North Carolina Medical Care Commission to adopt rules for the issuance of rated certificates to adult care homes. Section 3.(b) of the law contained minimal requirements and other parameters on which the rated certificates would be based. It should be noted that the rules were adopted by the Medical Care Commission on February 8, 2008, and are on the March 20, 2008, agenda of the Rules Review Commission It appears the rules will be based on a merit/demerit point system where facilities start with 100 points and receive merit points for exceeding adult care home licensing standards and demerit points for non-compliance with standards including the imposition of fines and penalties. Ratings will be based on the annual inspection conducted by the Division of Health Service Regulation. Subsequent inspections between annual inspections can also affect the rating if administrative actions are imposed or corrected. Facilities will receive anywhere from zero to three stars the first year and zero to four stars the second year, with zero stars being the lowest rating and four stars being the highest. See table below.

Star Rating Points for Adult Care Home

Star Rating	Number of Points
4 Star	100 or more points for 2 consecutive annual inspections
3 Star	90 – 100 points
2 Star	80 – 89.9 points
1 Star	70 – 79.9 points
0 Star	69.9 or less points, including actions to revoke license
Adopted by Medical Care Commission on 2/8/2008; to go before the Rules Review Committee on 3/2/2008	

Results of Discussion and Basis of Reward System

The discussion concerning a reward system for adult care homes with high ratings concentrated on four areas:

1. What is considered a "high rating"?
2. Should the reward include an increased monthly allocation of State/County Special Assistance for residents residing in the facility?
3. Should the reward include an increased Medicaid reimbursement rate for residents who are Medicaid beneficiaries?
4. If increased State/County Special Assistance and/or Medicaid rates are not options, what other reward(s) could be used?

1. What is considered a "high rating"?

The rating system adopted by the Medical Care Commission on February 8, 2008, is based on a 100 point scale, with the possibility of facilities acquiring more than 100 points if they receive merit points for going above and beyond licensing requirements. It seems reasonable that any facility that achieves a 4 Star Rating (100 points or higher on two consecutive annual surveys by the Division of Health Service Regulation) would have received a "high rating" and should therefore be eligible to receive a reward.

2. Increased monthly allocation of State/County Special Assistance

Increasing the monthly payment for State/County Special Assistance is not considered a viable option. Special Assistance is used to pay for the resident's room and board and is comprised of 50% county and 50% state funds and is paid directly to the resident in the facility. Increasing the monthly payment of Special Assistance to residents in a specific adult care home that has achieved a high rating would impact both county and state budgets around the state with little notice that the increased rate is forthcoming. Special Assistance rates are set by the N.C. General Assembly for the entire state, not for single counties. Implementing a system to increase rates in those counties that have adult care homes with high ratings would be extremely difficult, if not impossible, to implement. At the point a resident moved in or out of an adult care home, the Special Assistance rate would have to be adjusted based on the status of the home. With an average of 23,000 Special Assistance recipients in adult care homes, this would create significant work load

issues for staff in county departments of social services. Counties pay all the costs for staff to determine eligibility for the Special Assistance Program. In addition, it should be noted adult care homes in North Carolina have residents who receive Special Assistance and these homes would be unfairly penalized by a reward system that relied on Special Assistance.

3. Increased Medicaid reimbursement for facilities with residents who are Medicaid beneficiaries

The purpose of Medicaid reimbursement in adult care homes is for personal care services provided to Medicaid beneficiaries. These services primarily include assistance with medications and activities of daily living. The Medicaid rates set for Personal Care services in adult care home are not facility specific. Since Medicaid reimbursement rates are based on the cost of providing care and services to residents, adjusting the rate to reward an adult care home for receiving a high rating on its annual inspection would not be in compliance with rate setting standards and federal regulations. Only the cost incurred to provide the service can be used to determine the rate. In addition, it should be noted that not all adult care homes in North Carolina have residents who are Medicaid beneficiaries and these homes would be unfairly penalized by a reward system that relied on enhanced Medicaid reimbursement.

4. Other reward options if increased State/County Special Assistance and/or Medicaid rates are not available

Considering the unavailability of enhanced State/County Special Assistance or Medicaid reimbursements for adult care homes that receive high ratings, another reward system was considered which would reward eligible facilities with a monetary grant. The grant would be used to make facility enhancements that have a positive impact on improving the quality of life for residents in adult care homes. The grant could be modeled after a current grant program in North Carolina administered by the North Carolina Coalition for Long-Term Care Enhancement (a coalition supported by the Division of Health Service Regulation). In this program, the Coalition awards nursing homes "enhancement grants," utilizing funds from civil monetary penalties collected from nursing homes as a result of federal nursing home enforcement. Nursing home providers use the grant money to fund facility enhancements that have a positive effect on the quality of life or quality of care for nursing home residents. A similar system could be award enhancements grants for adult care homes that receive high ratings. .

The funding for the Adult Care Home grant program would differ from the North Carolina Coalition for Long-Term Care Enhancement grant program. The North Carolina Coalition for Long-Term Care Enhancement grants are funded by fines imposed and collected from Nursing Homs under federal regulations. Fines collected from Adult Care Homes are under state regulations, and accordingly have to be transferred to the appropriate Local Education Authorities. Since the state would be prohibited from using adult care home civil fines and penalty collections, the General Assembly would have to appropriate funds from which grants could be dispersed

How the Enhancement Grant System Would Work

The grant system could be modeled after the North Carolina Coalition for Long-Term Enhancement, which is used for distributing enhancement grants to nursing homes. The Coalition was started in the fall of 1996 and has been a highly successful, cooperative effort among regulators, providers, advocates, and other experts to foster and support the philosophies of the Eden Alternative™ and other environmental transformation concepts. The goal is to make facilities better places to live for residents and better places to work for employees.

The Coalition developed the grant program in an effort to enhance the quality of life for long term care residents through the promotion and support of physical plant enhancements. Funded by civil monetary penalties collected through the federal nursing home enforcement process and with approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, these grants encompass a variety of current culture change philosophies and enhancement ideas. From 1998 to 2007, nearly $1 million in grants have been awarded to over 50 nursing homes for enhancements geared toward improving the quality of life for residents.

For example, a state owned facility, Longleaf Neuro-Medical Center in Wilson, received a grant in June 2004. This facility houses residents with behavioral challenges. With the grant money, the facility transformed, with the help of residents, an area into a habitat called "Paradise." When the residents were in the new "Paradise" area, it was noted their behaviors calmed substantially.

The Coalition's Mission Statement reads, "The NC Coalition for Long-Term Care Enhancement is a growing network dedicated to transforming care settings into vibrant and vigorous environments, thereby improving the quality of life for these residents and staff." The goals the Coalition has identified are: 1) To bring together a diverse group dedicated to improving the quality of life in care settings, 2) To educate people on philosophies of cultural and environmental enhancements in institutions 3) To support those organizations that choose to adopt cultural and environmental enhancements and 4) To advocate change which promotes human growth in care giving environments.

By using the philosophy of the Coalition, enhancement grants could be dispersed as rewards to adult care homes that achieve high ratings on annual inspections. A Grant Committee would be formed of adult care home stakeholders including provider representatives, advocates, Division of Health Service Regulation staff and others. Once an adult care home receives a 4 Star Rating (100 or more points for two consecutive annual inspections), it would be eligible to apply for an enhancement grant. The committee would meet monthly and consider grant applications. Grant money would be distributed using a contractual arrangement between the Department and the adult care facility. Similar to the Coalition's philosophy, the grant money would be used for facility enhancements geared toward improving the quality of life of adult care home residents. An administrative officer would monitor the grant money use and expenditures (position included below in "Fiscal Impact").

Time Line for Implementation

Below is a time line based on a reasonable implementation schedule given the tasks that would need to be accomplished in order to provide an effective enhancement grant system.

Not later than June 30, 2009: appropriation for adult care home reward program for facilities that receive 4 Star Rating for the period of January 1 – June 30, 2010.
Not later than June 30, 2010: recurring appropriations for adult care home reward program for facilities that receive 4 Star Rating for the period of July 1, 2010 – June 30, 2011.

Fiscal Impact

The primary fiscal impact with an Enhancement Grant system would be the amount of appropriations allocated by the General Assembly for exclusive use as grant funds. To make the grants worth the facility's time in terms of planning what to do with the grant money and filing a grant application, we recommend the General Assembly allocate a minimum of at least $500,000 non-reverting funds on a recurring basis. According to current inspection results data, this would be enough money to provide grant amounts of $1,000 - $2,000 for facilities that receive high ratings. The General Assembly will need to determine how much to allocate for such purposes. More appropriations would create larger grant amounts and vice versa.

Additional fiscal impact with an Enhancement Grant system would be the cost to administer the program. An additional staff position will be necessary to coordinate and organize the Grant committee, process grant applications, track grant distribution and expenditures to assure grant money is spent appropriately. The staff position should be one with excellent organizational skills such as an administrative officer level position that has the ability to exercise judgment and discretion in applying and interpreting policies and procedures, plan work of the grant committee and monitor grant distribution and facility expenditures. The cost of this position, including salary and benefits, is estimated to be recurring annual funds of $50,000.

Therefore, the recommended total costs for implementing the system are estimated to be $300,000 for January 1 – June 30, 2010 ($250,000 for Enhancement Grants and $50,000 for the administrative officer position) and $550,000 of recurring funds for State fiscal year 2010-2011 ($500,000 for Enhancement Grants and $50,000 for the administrative officer position).

Attachment 1: **DHHS - Division of Health Service Regulation**

Adult Care Home Rating Worksheet

Procedure: DHSR shall complete the rating worksheet upon conclusion of the facility's annual inspection or other activity affecting the rating. Conclusion of the inspection is defined as when DHSR staff has returned to the office and the statement of deficiencies is mailed to the facility. If issues affecting the rating change between annual inspections, a new certificate shall be mailed to the facility.

Reason for Rating Issuance

☐ Annual Inspection Date of inspection:	☐ Identification of Type A or Type B Violation Date of violation:	☐ Administrative action Date of action:
☐ Follow-up Inspection Date of inspection:	☐ Identification of uncorrected Type B Violation Date of identification:	☐ Other Date:

Merit Points Earned	Demerit Points	Statute or Rule – Category	Measurement Evaluated
		13F .0300 – Physical Plant Requirements	For each citation of noncompliance with the rules related to physical plant, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13F .0700 – Admission & Discharge Requirements	For each citation of noncompliance with the rules related to admission and discharge, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13F .0800 – Resident Assessment & Care Plan	For each citation of noncompliance with the rules related to resident assessment & care plan, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13F .0900 – Resident Care & Services	For each citation of noncompliance with the rules related to resident care & services, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13F .1000 – Medication Management	For each citation of noncompliance with the rules related to medication management, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13F .1300 – Special Care Units for Alzheimer's & Related Disorders	For each citation of noncompliance with the rules related to special care units for Alzheimer's & related disorders, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13F .1400 – Special Care Units for Mental Health Disorders	For each citation of noncompliance with the rules related to special care units for mental health disorders, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13F .1500 – Use of Physical Restraints & Alternatives	For each citation of noncompliance with the rules related to physical restraints and alternatives, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		G.S. 131D-21 – Residents' Rights	For each citation of noncompliance with the statutes related to residents' rights, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		Type A Violation	For each citation of noncompliance, which results in a Type A violation, the facility shall receive a demerit of 10 points. (total citations_____x 10 = _____)
		Type B Violation	For each Type B violation that is identified, the facility shall receive a demerit of 3.5 points and if the Type B remains uncorrected on follow-up, the facility shall received an additional 3.5 demerits (total Type B violations uncorrected _____x 3.5 = _____)
		Suspension of Admissions	If the facility's admissions are suspended, the facility shall receive a demerit of 10 points.
		Notice of Revocation of License Issued	If a notice of revocation of license is issued, the facility shall receive a demerit of 31 points.
		Type A Violation deficiency corrected	For each citation, which is corrected, which previously resulted in a Type A violation, the facility shall receive a merit of 2.5 points and shall receive an additional 2.5 points if no Type A violations are identified on the next annual inspection. (total citations_____x 2.5 = _____)
		Uncorrected Type B Violation corrected	For each uncorrected Type B violation that is corrected, the facility shall receive a merit of 1.25 points (total Type B violations corrected _____x 1.25 = _____)
		Correction of citations (non-Type A and non-Type B)	If the facility corrects citations on follow-up, the facility shall receive a merit of 1 point. (total citations corrected _____x 1.25 = _____)
		Suspension of Admissions removed	If the facility's admissions have been suspended and the suspension is removed, the facility shall receive a merit of 5 points.
		G.S. 131D-10(d)(2) – Participation in Quality Improvement Program approved by DHHS	If the facility participates in a quality improvement program approved by DHHS, it shall receive a merit of 2.5 points.
		G.S. 131E – NC NOVA designation awarded	If the facility is a NC NOVA designated, the facility shall receive a merit of 2.5 points.
		Emergency power back-up	The facility shall receive 2 merit points for new emergency power arrangements and 1 point for existing emergency power arrangements.
		Automatic sprinklers	The facility shall receive 3 merit points for newly installed sprinklers and 2 points for existing sprinklers.

Family Care Home Rating Worksheet

Procedure: DHSR shall complete the rating worksheet upon conclusion of the facility's annual inspection or other activity affecting the rating. Conclusion of the inspection is defined as when DHSR staff has returned to the office and the statement of deficiencies is mailed to the facility. If issues affecting the rating change between annual inspections, a new certificate shall be mailed to the facility.

Reason for Rating Issuance

☐ Annual Inspection Date of inspection:	☐ Identification of Type A Violation Date of violation:	☐ Administrative action Date of action:
☐ Follow-up Inspection Date of inspection:	☐ Identification of uncorrected Type B Violation Date of identification:	☐ Other Date:

Merit Points Earned	Demerit Points	Statute or Rule – Category	Measurement Evaluated
		13G .0300 – The Building (physical plant requirements)	For each citation of noncompliance with the rules related to physical plant, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13G .0700 – Admission & Discharge Requirements	For each citation of noncompliance with the rules related to admission and discharge, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13G .0800 – Resident Assessment & Care Plan	For each citation of noncompliance with the rules related to resident assessment & care plan, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13G .0900 – Resident Care & Services	For each citation of noncompliance with the rules related to resident care & services, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13G .1000 – Medication Management	For each citation of noncompliance with the rules related to medication management, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		13G .1300 – Use of Physical Restraints & Alternatives	For each citation of noncompliance with the rules related to physical restraints and alternatives, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		G.S. 131D-21 – Residents' Rights	For each citation of noncompliance with the statutes related to residents' rights, the facility shall receive a demerit of 2 points. (total citations_____x 2.0=_____)
		Type A Violation citation	For each citation of noncompliance, which results in a Type A violation, the facility shall receive a demerit of 10 points. (total citations_____x 10 = _____)
		Type B Violation	For each Type B violation that is identified, the facility shall receive a demerit of 3.5 points and if the Type B remains uncorrected on follow-up, the facility shall received an additional 3.5 demerits (total Type B violations uncorrected _____x 3.5 = _____)
		Suspension of Admissions	If the facility's admissions are suspended, the facility shall receive a demerit of 10 points.
		Notice of Revocation of License Issued	If a notice of revocation of license is issued, the facility shall receive a demerit of 31 points.
		Type A Violation deficiency corrected	For each citation, which is corrected, which previously resulted in a Type A violation, the facility shall receive a merit of 2.5 points and shall receive an additional 2.5 points if no Type A violations are identified on the next annual inspection. (total citations_____x 2.5 = _____)
		Uncorrected Type B Violation corrected	For each uncorrected Type B violation that is corrected, the facility shall receive a merit of 1.25 points (total Type B violations corrected _____x 1.25 = _____)
		Correction of citations for one star facilities without Type A or Type B	If the facility corrects citations on follow-up, the facility shall receive a merit of 1 point. (total citations corrected _____x 1 = _____)
		Suspension of Admissions removed	If the facility's admissions have been suspended and the suspension is removed, the facility shall receive a merit of 5 points.
		G.S. 131D-10(d)(2) – Participation in Quality Improvement Program approved by DHHS	If the facility participates in a quality improvement program approved by DHHS, it shall receive a merit of 2.5 points.
		G.S. 131E – NC NOVA designation awarded	If the facility is a NC NOVA designated, the facility shall receive a merit of 2.5 points.
		Emergency power back-up	The facility shall receive 2 merit points for new emergency power arrangements and 1 point for existing emergency power arrangements.
		Automatic sprinklers	The facility shall receive 3 merit points for newly installed sprinklers and 2 points for existing sprinklers.

Attachment 3: Adopted Rules for Adult Care Homes

10A NCAC 13F .1601 is adopted with changes as published in 22:11 NCR, pp. 938-942, as follows:

SECTION .1600 – RATED CERTIFICATES

10A NCAC 13F .1601 SCOPE

(a) This Section ~~shall apply~~ applies to all licensed adult care homes that have been in operation for more than one year.

(b) As used in this Section a "rated certificate" means a certificate issued to an adult care home on or after January 1, 2009 and based on the factors contained in G.S. 131D-10.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. April 1, 2008.

10A NCAC 13F .1602 is adopted with changes as published in 22:11 NCR, pp. 938-942, as follows:

10A NCAC 13F .1602 ISSUANCE OF RATED CERTIFICATES

(a) A rated certificate shall be issued to ~~the~~ a facility by the Division of Health Service Regulation within 45 days completion of ~~the activity set out in~~ a new rating calculation pursuant to Rule ~~.1604.~~ .1604 of this Subchapter.

(b) If the ownership of the facility ~~experiences a change of ownership,~~ changes, the rated certificate in effect at the time of the change of ownership shall remain in effect until the next annual survey or until a new ~~rating~~ certificate is issued pursuant to Rule .1604(b) of this Subchapter.

(c) The certificate and any worksheet the Division ~~uses~~ used to calculate the ~~rating~~ rated certificate shall be ~~posted in a place in the facility visible to residents, staff and visitors.~~ displayed in a location visible to the public.

(d) The facility may contest the ~~rating~~ rated certificate by requesting a contested case hearing pursuant to G.S. 150B. The ~~rating~~ rated certificate and any subsequent ~~ratings shall~~ certificates remain in effect during any contested case hearing process.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. April 1, 2008.

10A NCAC 13F .1603 is adopted with changes as published in 22:11 NCR, pp. 938-942, as follows:

10A NCAC 13F .1603 STATUTORY AND RULE REQUIREMENTS AFFECTING RATED CERTIFICATES

The following Statutes and Rules ~~shall~~ comprise the standards that contribute to rated certificates:

(1) G.S. 131D-21 Resident's Rights;

(2) 10A NCAC 13F .0300 Physical Plant Requirements;

(3) 10A NCAC 13F .0700 Admission and Discharge Requirements;

(4) 10A NCAC 13F .0800 Resident Assessment and Care Plan;

(5) 10A NCAC 13F .0900 Resident Care and Services;

(6) 10A NCAC 13F .1000 Medication Management;

(7) 10A NCAC 13F .1300 Special Care Units for Alzheimer's and Related Disorders;

(8) 10A NCAC 13F .1400 Special Care Units for Mental Health Disorders; and

(9) 10A NCAC 13F .1500 Use of Physical Restraints and Alternatives.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. April 1, 2008

10A NCAC 13F .1604 is adopted with changes as published in 22:11 NCR, pp. 938-942, as follows:

10A NCAC 13F .1604 RATING CALCULATION

(a) Ratings shall be based on:

(1) Inspections completed pursuant to G.S. 131D-2(b)(1a)a;

(2) Statutory and Rule requirements contained in Rule ~~.1603;~~ .1603 of this Section;

(3) Type A or uncorrected Type B penalty violations identified pursuant to G.S. 131D-34; and

(4) Other items ~~contained~~ listed in Subparagraphs (c)(1) and (c)(2) of this Rule.

(b) The initial rating a facility receives shall remain in effect until the next inspection. If an activity occurs which results in the assignment of additional merit or demerit points, a new certificate shall be issued pursuant to Rule ~~.1602(a).~~ .1602(a) of this Section.

(c) The rating shall be based on a 100 point scale. Beginning with the initial rating and repeating with each annual inspection, the facility shall be assigned 100 points and shall receive merits or demerits, which shall be added or subtracted from the 100 points, respectively. The merits and demerits shall be assigned as follows:

(1) Merit Points

(A) If the facility corrects citations of noncompliance with the statutes or rules listed in Rule .1603 of this Subchapter, which are not related to the identification of a Type A violation or an uncorrected Type B violation, the facility shall receive 1.25 merit points for each corrected deficiency;

(B) If the facility receives ~~only standard~~ citations on its annual inspection with no Type A or Type B violations and the rating from the annual inspection is one ~~star,~~ or zero stars, the facility may request DHSR to conduct a follow-up inspection not less than 60 days after the date of the annual inspection. The follow-up inspection will be completed depending upon the availability of

DHSR staff. As determined by the follow-up review, the facility shall receive 1.25 merit points for each corrected deficiency;

(C) If the facility corrects the citation for which a Type A violation was identified, the facility shall receive ~~5~~ 2.5 merit ~~points;~~ points and shall receive an additional 2.5 merit points following the next annual inspection if no further Type A violations are identified;

(D) If the facility corrects a previously uncorrected Type B violation, the facility shall receive ~~2.5~~ 1.25 merit points;

(E) If the facility's admissions have been suspended, the facility shall receive 5 merit points if the suspension is removed;

(F) If the facility participates in any quality improvement program approved by the Department, the facility shall receive 2.5 merit points;

(G) If the facility receives NC NOVA special licensure designation, the facility shall receive 2.5 merit points;

10A NCAC 13F .1605 is adopted with changes as published in 22:11 NCR, pp. 938-942, as follows:

10A NCAC 13F .1605 CONTENTS OF RATED CERTIFICATE

(a) The certificate shall contain a rating determined pursuant to Rule .1604 of this Subchapter. ~~The rating shall be printed on the certificate in bold type with a font not lessthan 24 points.~~

(b) The certificate or accompanying worksheet from which the score is derived shall contain a breakdown of the point merits and demerits by the factors listed in Rules .1603 and .1604(c) of this Subchapter in a manner that the public can determine how the rating was assigned and the factors that contributed to the rating.

(c) The certificate shall be printed on the same type of paper that is used to print the facility's license.

(d) The Division of Health Service Regulation shall issue the certificate pursuant to Rule .1602 of this Subchapter.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. April 1, 2008.

Attachment 4: Adopted Rules for Family Care Homes

10A NCAC 13G .1601 is adopted with changes as published in 22:11 NCR, pp. 938-942, as follows:

SECTION .1600 – RATED CERTIFICATES

10A NCAC 13G .1601 SCOPE

(a) This Section ~~shall apply~~ applies to all licensed family care homes that have been in operation for more than one year.

(b) As used in this Section a "rated certificate" means a certificate issued to a family care home on or after January 1, 2009 and based on the factors contained in G.S. 131D-10.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. April 1, 2008.

10A NCAC 13G .1602 is adopted with changes as published in 22:11 NCR, pp. 938-942, as follows:

10A NCAC 13G .1602 ISSUANCE OF RATED CERTIFICATES

(a) A rated certificate shall be issued to ~~the~~ a facility by the Division of Health Service Regulation within 45 days completion of ~~the activity set out in~~ a new rating calculation pursuant to Rule ~~.1604.~~ .1604 of this Subchapter.

(b) If the ownership of the facility ~~experiences a change of ownership,~~ changes, the rated certificate in effect at the time of the change of ownership shall remain in effect until the next annual survey or until a new ~~rating~~ certificate is issued pursuant to Rule .1604(b) of this Subchapter.

(c) The certificate and any worksheet the Division ~~uses~~ used to calculate the ~~rating~~ rated certificate shall be ~~posted in a place in the facility visible to residents, staff and visitors.~~ displayed in a location visible to the public.

(d) The facility may contest the ~~rating~~ rated certificate by requesting a contested case hearing pursuant to G.S. 150B. The ~~rating~~ rated certificate and any subsequent ~~ratings shall~~ certificates remain in effect during any contested case hearing process.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. April 1, 2008.

10A NCAC 13G .1603 is adopted with changes as published in 22:11 NCR, pp. 938-942, as follows:

10A NCAC 13G .1603 STATUTORY AND RULE REQUIREMENTS AFFECTING RATED CERTIFICATES

The following Statutes and Rules ~~shall~~ comprise the standards that contribute to rated certificates:

(1) G.S. 131D-21 Resident's Rights;

(2) 10A NCAC 13G .0300 The Building;

(3) 10A NCAC 13G .0700 Admission and Discharge Requirements;

(4) 10A NCAC 13G .0800 Resident Assessment and Care Plan;

(5) 10A NCAC 13G .0900 Resident Care and Services;

(6) 10A NCAC 13G .1000 Medications; and

(7) 10A NCAC 13G .1300 Use of Physical Restraints and Alternatives.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. April 1, 2008.

10A NCAC 13G .1604 is adopted with changes as published in 22:11 NCR, pp. 938-942, as follows:

10A NCAC 13G .1604 RATING CALCULATION

(a) Ratings shall be based on:

(1) Inspections completed pursuant to G.S. 131D-2(b)(1a)a;

(2) Statutory and Rule requirements contained in Rule ~~.1603;~~ .1603 of this Section;

(3) Type A or uncorrected Type B penalty violations identified pursuant to G.S. 131D-34; and

(4) Other items ~~contained~~ listed in Subparagraphs (c)(1) and (c)(2) of this Rule.

(b) The initial rating a facility receives shall remain in effect until the next inspection. If an activity occurs which results in the assignment of additional merit or demerit points, a new certificate shall be issued pursuant to Rule ~~.1602(a).~~ .1602(a) of this Section.

(c) The rating shall be based on a 100 point scale. Beginning with the initial rating and repeating with each annual inspection, the facility shall be assigned 100 points and shall receive merits or demerits, which shall be added or subtracted from the 100 points, respectively. The merits and demerits shall be assigned as follows:

(1) Merit Points

(A) If the facility corrects citations of noncompliance with the statutes or rules listed in Rule .1603 of this Subchapter, which are not related to the identification of a Type A violation or an uncorrected Type B violation, the facility shall receive 1.25 merit points for each corrected deficiency;

(B) If the facility receives ~~only standard~~ citations on its annual inspection with no Type A or Type B violations and the rating from the annual inspection is one ~~star,~~ or zero stars, the facility may request DHSR to conduct a follow-up inspection not less than 60 days after the date of the annual inspection. The follow-up inspection will be completed depending upon the availability of

DHSR staff. As determined by the follow-up review, the facility shall receive 1.25 merit points for each corrected deficiency;

(C) If the facility corrects the citation for which a Type A violation was identified, the facility shall receive ~~5~~ 2.5 merit ~~points;~~ points and shall receive an additional 2.5 merit points following the next annual inspection if no further Type A violations are identified;

(D) If the facility corrects a previously uncorrected Type B violation, the facility shall receive ~~2.5~~ 1.25 merit points;

(E) If the facility's admissions have been suspended, the facility shall receive 5 merit points if the suspension is removed;

(F) If the facility participates in any quality improvement program approved by the Department, the facility shall receive 2.5 merit points;

(G) If the facility receives NC NOVA special licensure designation, the facility shall receive 2.5 merit points;

(H) On or after the effective date of this Rule, if the facility permanently installs a generator or has a contract with a generator provider to provide emergency power for essential functions of the facility, the facility shall receive 2 merit points. For purposes of this Section, essential functions mean those functions necessary to maintain the health or safety of residents during power outages greater than 6 hours. If the facility has an existing permanently installed generator or an existing contract with a generator provider, the facility shall receive 1 merit point for maintaining the generator in working order or continuing the contract with a generator provider; and

(I) On or after the effective date of this Rule, if the facility installs automatic sprinklers in compliance with the North Carolina Building Code, the facility shall receive 3 merit points. If the facility has an existing automatic sprinkler, the facility shall receive 2 merit points for subsequent ratings for maintaining the automatic sprinklers in good working order.

(2) Demerit Points

(A) For each citation of noncompliance with the statutes or rules listed in Rule .1603 of this Subchapter, the facility shall receive a demerit of 2 points. The facility shall receive demerit points only once for citations in which the findings are identical to those findings used for another citation;

(B) For each citation of a Type A violation, the facility shall receive a demerit of 10 points;

(C) For each citation of a Type B violation, the facility shall receive a demerit of 3.5 points and if the Type B violation remains uncorrected ~~Type B violation,~~ as the

result of a follow-up inspection, the facility shall receive ~~a~~ an additional demerit of ~~5~~ 3.5 points;

(D) If the facility's admissions are suspended, the facility shall receive a demerit of 10 points; however, if the facility's admissions are suspended pursuant to G.S. 131D-4.2, the facility shall not receive any demerit points; and

(E) If the facility receives a notice of revocation against its license, the facility shall receive ~~a~~ demerit of ~~15~~ 31 points.

(d) Facilities shall be given a rating of ~~one~~ zero to four stars depending on the score assigned pursuant to Paragraph (a), (b) or (c) of this Rule. Ratings shall be assigned as follows:

(1) Four stars shall be assigned to any facility whose score is 100 points or greater ~~and has received NC NOVA special licensure designation;~~ on two consecutive annual inspections;

(2) Three stars shall be assigned for scores of 90 – 99.9 points;

(3) Two stars shall be assigned for scores of 80 – 89.9 points; ~~and~~

(4) One star shall be assigned for scores of ~~79.9~~ 70 – 79.9 ~~points or lower.~~ points; and

(5) Zero stars shall be assigned for scores of 69.9 points or lower.

History Note: *Authority G.S. 131D-4.5; 131D-10;*

10A NCAC 13G .1605 is adopted with changes as published in 22:11 NCR, pp. 938-942, as follows:

10A NCAC 13G .1605 CONTENTS OF RATED CERTIFICATE

(a) The certificate shall contain a rating determined pursuant to Rule .1604 of this Subchapter. ~~The rating shall be printed on the certificate in bold type with a font not less than 24.~~

(b) The certificate or accompanying worksheet from which the score is derived shall contain a breakdown of the point merits and demerits by the factors listed in Rules .1603 and .1604(c) of this Subchapter in a manner that the public can determine how the rating was assigned and the factors that contributed to the rating.

(c) The certificate shall be printed on the same type of paper that is used to print the facility's license.

(d) The Division of Health Service Regulation shall issue the certificate pursuant to Rule .1602 of this Subchapter.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. April 1, 2008.

Structure and Cost of a System to Reward Adult Care Homes Which Achieve High Ratings

Jeff Hort
Division of Health Servic[illegible]gulation
N.C. Department of Health [illegible]man Services

Overview

- Senate Bill 56, S.L. 2007-544 Section 3.(a) put in place requirements for the North Caroli[illegible] Medical Care Commission to adopt rules for the issuance of rated certificates to adult care homes. Section 3.(b) of the law contained minimal requirements and other parameters on which the rated certificates would be based.

Overview (cont'd)

- Rules were adopted by the Medical Care Commission on February 8, 2008.
- The rules are based on a merit/demerit point system where facilities start with 100 points and receive merit points for exceeding adult care home licensing standards and demerit points for non-compliance with standards including the imposition of fines and penalties.
- Ratings will be based on the annual inspection conducted by the Division of Health Service Regulation.
- Subsequent inspections between annual inspections can also affect the rating if administrative actions are imposed or corrected.
- Facilities will receive anywhere from zero to three stars the first year and zero to four stars the second year, with zero stars being the lowest rating and four stars being the highest.

Overview (cont'd)

Star Rating	Number of Points
4 Star	100 or more points for 2 consecutive annual inspections
3 Star	90 – 100 points
2 Star	80 – 89.9 points
1 Star	70 – 79.9 points
0 Star	69.9 or less points, including actions to revoke

Response to Legislative Request

- The General Assembly enacted as part of S.L. 2007-544, Senate Bill 56 the following provision:
- SECTION 3.(d) The Department of Health and Human Services, Divisions of Health Service Regulation, Aging and Adult Services, and Medical Assistance shall study the structure and cost of a system to reward adult care homes which receive high ratings. The Department shall report findings and recommendations on this study to the North Carolina Study Commission on Aging not later than March 1, 2008.
- The rating system to which Section 3.(d) refers is contained in Sections 3.(a) and 3.(b).
- In response to the above directive, the Department met and studied the structure and cost of a reward system for adult care homes which receive high ratings.

Basis of Reward System

- What is considered a "high rating"?
- Should the reward include an increased monthly allocation of State/County Special Assistance for residents residing in the facility?
- Should the reward include an increased Medicaid reimbursement rate for residents who are Medicaid beneficiaries?
- If increased State/County Special Assistance and/or Medicaid rates are not options, what other reward(s) could be used?

What is considered a "high rating"?

- **It seems reasonable that any facility that achieves a 4 Star Rating (100 points or higher on two consecutive annual surveys by the Division of Health Service Regulation) would have received a "high rating" and should therefore be eligible to receive a reward.**

Increased monthly allocation of State/County Special Assistance

- **Increasing the monthly payment for State/County Special Assistance is not considered a viable option. Special Assistance is used to pay for the resident's room and board and is comprised of 50% county and 50% state funds and is paid directly to the resident in the facility.**
- **Increasing the monthly payment of Special Assistance to residents in a specific adult care home that has achieved a high rating would impact both county and state budgets around the state with little notice that the increased rate is forthcoming. Special Assistance rates are set by the N.C. General Assembly for the entire state, not for single counties.**

Increased monthly allocation of State/County Special Assistance (cont'd)

- Implementing a system to increase rates in those counties that have adult care homes with high ratings would be extremely difficult, if not impossible, to implement. At the point a resident moved in or out of an adult care home, the Special Assistance rate would have to be adjusted based on the status of the home. With an average of 23,000 Special Assistance recipients in adult care homes, this would create significant work load issues for staff in county departments of social services. Counties pay all the costs for staff to determine eligibility for the Special Assistance Program.
- In addition, it should be noted some adult care homes in North Carolina have residents who do not receive Special Assistance and these homes would be unfairly penalized by a reward system that relied on Special Assistance.

Increased Medicaid reimbursement for facilities with residents who are Medicaid beneficiaries

- The purpose of Medicaid reimbursement in adult care homes is for personal care services provided to Medicaid beneficiaries.
- These services primarily include assistance with medications and activities of daily living. The Medicaid rates set for Personal Care services in adult care home are not facility specific.
- Since Medicaid reimbursement rates are based on the cost of providing care and services to residents, adjusting the rate to reward an adult care home for receiving a high rating on its annual inspection would not be in compliance with rate setting standards and federal regulations.

Increased Medicaid reimbursement for facilities with residents who are Medicaid beneficiaries **(cont'd)**

- **Only the cost incurred to provide the service can be used to determine the rate.**
- **In addition, it should be noted that not all adult care homes in North Carolina have residents who are Medicaid beneficiaries and these homes would be unfairly penalized by a reward system that relied on enhanced Medicaid reimbursement.**

Other reward options if increased State/County Special Assistance and/or Medicaid rates are not available

- **Considering the unavailability of enhanced State/County Special Assistance or Medicaid reimbursements for adult care homes that receive high ratings, another reward system was considered which would reward eligible facilities with a monetary grant.**
- **The grant would be used to make facility enhancements that have a positive impact on improving the quality of life for residents in adult care homes.**
- **The grant could be modeled after a current grant program in North Carolina administered by the North Carolina Coalition for Long-Term Care Enhancement (a coalition supported by the Division of Health Service Regulation)**

Other reward options if increased State/County Special Assistance and/or Medicaid rates are not available (cont'd)

- The Coalition awards nursing homes "enhancement grants," utilizing funds from civil monetary penalties collected from nursing homes as a result of federal nursing home enforcement.
- Nursing home providers use the grant money to fund facility enhancements that have a positive effect on the quality of life or quality of care for nursing home residents.
- A similar system could be award enhancements grants for adult care homes that receive high ratings.

How the Enhancement Grant System Would Work

- As mentioned previously, the grant system could be modeled after the North Carolina Coalition for Long-Term Enhancement, which is used for distributing enhancement grants to nursing homes
- The Coalition's Mission Statement reads, "The NC Coalition for Long-Term Care Enhancement is a growing network dedicated to transforming care settings into vibrant and vigorous environments, thereby improving the quality of life for these residents and staff."
- The goals the Coalition has identified are: 1) To bring together a diverse group dedicated to improving the quality of life in care settings, 2) To educate people on philosophies of cultural and environmental enhancements in institutions 3) To support those organizations that choose to adopt cultural and environmental enhancements and 4) To advocate change which promotes human growth in care giving environments.

How the Enhancement Grant System Would Work (cont'd)

- By using the philosophy of the Coalition, enhancement grants could be dispersed as rewards to adult care homes that achieve high ratings on annual inspections.
- A Grant Committee would be formed of adult care home stakeholders including provider representatives, advocates, Division of Health Service Regulation staff and others.
- Once an adult care home receives a 4 Star Rating (100 or more points for two consecutive annual inspections), it would be eligible to apply for an enhancement grant. The committee would meet monthly and consider grant applications.

How the Enhancement Grant System Would Work (cont'd)

- Grant money would be distributed using a contractual arrangement between the Department and the adult care facility
- Similar to the Coalition's philosophy, the grant money would be used for facility enhancements geared toward improving the quality of life of adult care home residents.
- An administrative officer would monitor the grant money use and expenditures

Fiscal Impact

- To make the grants worth the facility's time in terms of planning what to do with the grant money and filing a grant application, we recommend the General Assembly allocate a minimum of at least $500,000 non-reverting funds on a recurring basis.
- According to current inspection results data, this would be enough money to provide grant amounts of $1,000 - $2,000 for facilities that receive high ratings.
- The General Assembly will need to determine how much to allocate for such purposes. More appropriations would create larger grant amounts and vice versa.

Fiscal Impact

- An additional staff position will be necessary to coordinate and organize the Grant committee, process grant applications, track grant distribution and expenditures to assure grant money is spent appropriately.
- The cost of this position, including salary and benefits is estimated to be recurring annual funds of $50,000.

Fiscal Impact

- **Therefore, the recommended total costs for implementing the system are estimated to be $300,000 for January 1 – June 30, 2010 ($250,000 for Enhancement Grants and $50,000 for the administrative officer position); and**
- **$550,000 of recurring funds for State fiscal year 2010-2011 ($500,000 for Enhancement Grants and $50,000 for the administrative officer position).**

Time Line for Implementation

- **<u>Not later than June 30, 2009</u>: appropriation for adult care home reward program for facilities that receive 4 Star Rating for the period of January 1 – June 30, 2010.**
- **<u>Not later than June 30, 2010</u>: recurring appropriations for adult care home reward program for facilities that receive 4 Star Rating for the period of July 1, 2010 – June 30, 2011.**

SECTION 3.(a) 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 of certificates to adult care homes as authorized under G.S. 131D-10."

SECTION 3.(b) Article 1 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10. Adult care home rated certificates.**

(a) Rules adopted by the North Carolina Medical Care Commission for issuance of certificates to adult care homes shall contain a rating based, at a minimum, on the following:

(1) Inspections and substantiated complaint investigations conducted by the Department to determine compliance with licensing statutes and rules. Specific areas to be reviewed include:
   a. Admission and discharge procedures.

b. Medication management.
c. Physical plant.
d. Resident care and services, including food services, resident activities programs, and safety measures.
e. Residents' rights.
f. Sanitation grade.
g. Special Care Units.
h. Use of physical restraints and alternatives.

(b) The initial ratings awarded to a facility pursuant to the rules adopted under this section shall be based on inspections, penalties imposed, and investigations of substantiated complaints that revealed noncompliance with statutes and rules, that occurred on or after the act becomes law.

(c) Type A penalties shall affect the rating for 24 months from the date the penalty is assessed. Type B penalties shall affect the rating for 12 months from the date the penalty is assessed.

(d) Adult care homes shall display the rating certificate in a location visible to the public. Certificates shall include the Web site address for the Department of Health and Human Services, Division of Health Service Regulation, which can be accessed for specific information regarding the basis of the facility rating. For access by the public on request, adult care homes shall also maintain on-site a copy of information provided by the Department of Health and Human Services, Division of Health Service Regulation, regarding the basis of the facility rating. In addition to information on the basis of the rating, the Department of Health and Human Services, Division of Health Service Regulation, shall make information available via its Web site and in the materials available on-site at the facility regarding quality improvement efforts undertaken by the facility including:

(1) Participation in any quality improvement programs approved by the Department.

(2) The facility's attainment of the North Carolina New Organizational Vision Award special licensure designation authorized in Article 5, Chapter 131E of the General Statutes."

SECTION 3.(c) The Department of Health and Human Services shall provide a copy of emergency, temporary, and permanent rules adopted pursuant to this section to the North Carolina Study Commission on Aging at the same time the Department submits the adopted rules to the Rules Review Commission for its review under Chapter 150B of the General Statutes.

SECTION 3.(d) The Department of Health and Human Services, Divisions of Health Service Regulation, Aging and Adult Services, and Medical Assistance shall study the structure and cost of a system to reward adult care homes which receive high ratings. The Department shall report findings and recommendations on this study to the North Carolina Study Commission on Aging not later than March 1, 2008.

SECTION 3.(e) It is the intent of the General Assembly to provide funding for technical assistance to adult care homes for the 2008-2009 fiscal year.

SECTION 3.(f) The Department of Health and Human Services, Division of Health Service Regulation and Division of Aging and Adult Services, shall study expanding the rated certificate system to other facilities and services licensed and certified by the Department. The Department shall report to the North Carolina Study Commission on Aging on the expansion of the rating system by October 1, 2009.

SECTION 3.(g) The Department of Health and Human Services, Division of Health Service Regulation, shall report on the implementation of the rated certificate system. The Department shall make an interim report to the North Carolina Study Commission on Aging not later than October 1, 2009, and a final report to the Commission not later than October 1, 2010.

SECTION 4. Sectio n 1 of this act becomes effective October 1, 2007. Section 2 becomes effective January 1, 2008. Certificates authorized under Section 3 shall be issued beginning January 1, 2009. The remainder of this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 28th day of July, 2007.

s/ Beverly E. Perdue
President of the Senate

s/ Joe Hackney
Speaker of the House of Representatives

s/ Michael F. Easley
Governor

Approved 10:12 p.m. this 31st day of August, 2007

The North Carolina Joint Study Commission on Aging
Representative Jean Farmer-Butterfield, Co-Chair
Senator Vernon Malone, Co-Chair

April 10, 2008
1:00 PM
Room 544

The Joint Study Commission on Aging met on Thursday, February 28, 2008, in Room 544 of the Legislative Office Building.

The following commission members were present: Rep. Jean Farmer-Butterfield, Co-Chair; Senator Vernon Malone, Co-Chair; Sen. Stan Bingham; Sen. James Forrester; Rep. Bob England; Honorable Karen Gottovi; Mr. David Lowa; Honorable Edd Nye; Mr. Anthony Peace; Ms. Judy Pelt; Ms. Jean Reaves; and Mr. Jackie Sheppard, Ex-officio member. Also in attendance were Research staff Theresa Matula and Shawn Parker, and commission clerks Ruth Merkle and Bonnie McNeil.

A visitor registration sheet and copy of the Agenda are attached as part of these minutes.

Representative Farmer-Butterfield chaired the meeting. She recognized the Sargeants-at-Arms, research staff and commission assistants and welcomed the audience.

The Chair recognized Ms. Jane Baker, Executive Director, NC State Board of Examiners for Nursing Home Administrators, and Mr. Steve Fleming, Director of Wellspring Retirement Center in Greensboro and Chair, NC State Board of Examiners for Nursing Home Administrators. They presented proposed legislation that would allow the State Board of examiners for Nursing Home Administrators to obtain criminal history background checks on nursing home administrators. Their written statement is included with these minutes.(Attachments #1A, 1B and 1C).

Member David Lowa asked if the criminal background checks would be used in the same manner as the checks that are in place for other employees. Mr. Fleming responded that they would, and that the proposed legislation would provide additional checks and balances. Ms. Baker added that they have not had any problems thus far with nursing home administrators.

Representative Farmer-Butterfield recognized Ms. Pamela Weaver Best, Deputy Legal Counsel for the Administrative Office of the Courts. She gave a presentation to the commission on Guardianship in North Carolina. A written statement is attached (Attachment #2) and included with these minutes.

Following Ms. Weaver-Best's presentation, Representative Farmer-Butterfield disclosed that for purposes of full disclosure and transparency, she is Director of Guardianship for the Arc of North Carolina.

Representative Melanie Goodwin was recognized and discussed House Bill 796, "No Auto. Revoke/Driv. Lic/Incompetent Person." A copy of the bill is attached and included in the minutes.
HB 796 authorizes the Division of Motor Vehicles to consider recommendations from the clerk of court in determining whether to revoke the driver's license of a person adjudicated incompetent

under the Guardianship laws, as recommended by the House Study Committee on State Guardianship Laws.

Commission member David Lowa asked if the revocation of a person's license would take place after a declaration of incompetency. Rep. Goodwin remarked that it would.

Mr. James C. Stanford, Orange County Clerk of Superior Court, and Co-Chair, Legislative Committee, NC Conference of Clerks of Superior Court, spoke on the propose legislation. He commented that a provision in Chapter 20 of the Guardianship laws automatically revokes the license of a person declared incompetent. The proposed legislation recommends that revocation not be automatic if the clerk includes a suggestion that the person retain their right to drive in North Carolina.

Rep. Goodwin then spoke on HB 794, "Raise Ceil'g/Personal Prop. Sale/Guardianship". A copy of this bill is attached and included with the minutes. This bill would raise the ceiling on tangible personal property that a guardian is allowed to sell without a court order from $1,500 to $5,000 per accounting period, and no more than $15,000 over the term of the estate.

Mr. Stanford was recognized and commented that he supported both bills. Rep. Farmer-Butterfield explained to the commission members that they would receive copies of the bills at the next meeting.

Following Representative Goodwin's presentation, the commission heard from Mr. Jeff Mobley, Statewide Hard of Hearing and senior Citizen Program Coordinator, Division of Services for the Deaf and the Hard of Hearing, DHHS. A copy of his statement is attached and included with these minutes (Attachment #5).

Representative Farmer-Butterfield inquired about implantations for persons with hearing loss. Senator Forrester commented on the possible need for increasing sounds for cars approaching crosswalks, particularly newer hybrid models. Mr. Mobley responded that that is a concern that should be addressed. He also addressed Rep. Farmer-Butterfield's comments about implantations, stating that Medicare will pay for the surgery for adults, but for children the Medicaid requirements are very stringent.

Mr. Dennis Streets of the Division of Aging and Adult Services, DHHS, was recognized and reported on Senate Bill 448, "Aging Study of Six Counties." A copy of his report is attached and included as part of the minutes (Attachment #6).

Commission member Jean Reaves commented that on slide 10, regarding the overall percent of persons living at or below the poverty level, are minority as compared to the rest of the State, and who have severe disabilities, was the selection of counties purposely chosen or was it by accident. Mr. Streets responded that the major reason those six counties were selected was because they were at the top of the list for having the most persons aged 60 and older.

Following Mr. Streets' presentation, Theresa Matula of the Research staff was recognized and presented the commission's 13 draft recommendations to the Governor and 2008 North Carolina General Assembly. A copy of the recommendations is attached and included with the minutes (Attachment #7).

Senator Forrester commented that he assumes that all the money requested in the recommendations will compete with expansions in the budget, and suggested that the commission

prioritize its recommendations. Representative Farmer-Butterfield replied that it is up to the commission to decide which recommendations to prioritize.

Senator Forrester was recognized for a follow-up question. He asked whether persons who are declared incompetent by the courts have more motor vehicle accidents than other drivers. Representative Farmer-Butterfield commented that she did not have that answer, but she gave the example of persons with mental illness who have "periodic" episodes but otherwise are competent drivers. Shawn Parker of the Research staff replied that the Commissioner is directed by statute to revoke the license of a person deemed incompetent, but that the bill Rep. Goodwin discussed would direct them to consider what a clerk of the court may recommend.

Senator Forrester followed with a concern about patient forms continually being expanded. Mr. Lowa added that the MUST (Medicaid Uniform Screening Tool) form, which is used to determine a patient's level of care, does not have to be signed by a physician but it is lengthy and may take a patient or their guardian considerable time to fill out.

Representative Bob England commented that the report of draft recommendations is going to be a significant document, and that recommendation #6, regarding adult care home residents, depends on the implementation and success of PASARR. Theresa Matula responded that DHHS intends to have a September implementation date, depending on when PASARR Level II is in place.

Mr. Andre Carson, a member of the audience, asked about the expediency of FL-2 when there is a medical emergency. He commented that only a physician can fill out an FL-2 form. Mr. Lowa commented that the forms should be completed within 30 minutes but even in an emergency, a patient will have to wait before they know what services are approved. Rep. England responded that the physician makes his recommendation based on what is on the patient's chart.
The Chair recognized Margaret Coleman, Facilities Services Manager for the Division of Medical Assistance (DMA), to respond to the visitor's question on expediency. She commented that the manual review process should take no more than a day or two and once it is in the system approval can be instantaneous.

There being no more discussion, Representative Farmer-Butterfield requested that the commission vote on the proposed recommendations collectively rather than individually and then come back and prioritize them.

Representative England asked for clarification of the last sentence on page 9. Theresa Matula responded that the screening and assessment piece is an important piece and that the proposed funding is needed to provide assessments for residents in adult care homes who need mental health services and to develop appropriate facilities for them.

On a follow-up to his question, Representative England requested that there be an opportunity to include additional recommendations before the commission takes a final vote. Representative Farmer-Butterfield confirmed that additional recommendations will be included. Theresa Matula added that the staff will incorporate any additional recommendations into the final draft and that an advance copy will be sent by mail to all the commission members. Representative Farmer-Butterfield suggested that DHHS and DMA be included when incorporating considerations for emergency situations.

Commission member Karen Gottovi recommended that they be given a copy of all advance documents prior to the next meeting.

Rep. England introduced a motion to approve the commission's draft recommendations as written. The motion passed. Member Jean Reaves followed with a request that the commission prioritize the recommendations before the next meeting.

Representative Farmer-Butterfield announced that the commission would hold a Public Hearing on April 24 in Jamestown, NC.

There being no further business, the meeting was adjourned at 11:50 am.

Respectfully submitted:

Representative Jean Farmer-Butterfield
Co-Chair, Commission on Aging

Ruth W. Merkle
Commission Clerk

ATTENDANCE

North Carolina Study Commission on Aging

(Name of Committee)

DATES	January 22	February 28	March 6	March 20	April 10	May 12									
Sen. Vernon Malone, Co-Chair					✓										
Rep. Jean Farmer-Butterfield, Co-Chair					✓										
Sen. Stan Bingham					✓										
Rep. Alice Bordsen					ab										
Sen. Katie Dorsett					ab										
Rep. Joe Boylan					ab										
Sen. James Forrester					✓										
Rep. Bob England					✓										
Sen. A.B. Swindell, IV					ab										
Rep. Garland Pierce					ab										
Mr. Anthony Peace					✓										
Honorable Karen Gottovi					✓										
Ms. Judy Pelt					✓										
Mr. David Lowa					✓										
Ms. Jean Reaves					✓										
Honorable Edd Nye					✓										
Mr. Jackie Sheppard, Ex-Officio					✓										
Theresa Matula, Research Staff					✓										
Shawn Parker, Research Staff					✓										
Ben Popkin, Counsel															
Bonnie McNeil, Commission Clerk					✓										
Ruth Merkle, Commission Clerk					✓										

NORTH CAROLINA GENERAL ASSEMBLY

STATE LEGISLATIVE BUILDING
16 W. Jones Street
Raleigh, North Carolina 27601-1030

April 2, 2008

MEMORANDUM

TO: Members of the North Carolina Study Commission on Aging

FROM: Representative Jean Farmer-Butterfield, Co-Chair
Senator Vernon Malone, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the North Carolina Study Commission on Aging:

DAY:	Thursday	TIME:	10:00 am
DATE:	April 10, 2008		
LOCATION:	Room 544 Legislative Office Building		

Commission members, please advise Ruth Merkle, Commission Assistant at 733-5898, or e-mail butterfieldla@ncleg.net, or Bonnie McNeil, Commission Assistant, at 733-5880, or e-mail malonela@ncleg.net if you are unable to attend.

Posted:

cc: Committee
Record
Interested Parties

Agenda

North Carolina Study Commission on Aging

Thursday, April 10, 2008
10:00 a.m.
Legislative Office Building
Room 421

I. Welcome

Representative Jean Farmer-Butterfield, Cochair
Senator Vernon Malone, Cochair

II. Criminal Background Checks for Nursing Home Administrators

Jane Baker, Executive Director, NC State Board of Examiners for Nursing Home Administrators
Steve Fleming, Chair, NC State Board of Examiners for Nursing Home Administrators
WELLSPRING RETIREMENT

III. Guardianship

- **Introduction**
  Pamela W. Best, Deputy Legal Counsel, Administrative Office of the Courts
- **Revocation of Drivers License and Raising the Ceiling on the Sale of Personal Property**
  Representative Melanie Goodwin

IV. Hearing Challenges for Older Adults

Jeff Mobley, Statewide Hard of Hearing and Senior Citizen Program Coordinator, Division of Services for the Deaf and the Hard of Hearing, DHHS

V. Aging Service Levels and Needs Study

Dennis Streets, Division of Aging and Adult Services, DHHS

VI. Commission Recommendations to Governor and 2008 NCGA

- **Presentation of Draft Recommendations**
  Theresa Matula, Commission Staff, Research Division, NCGA
- **Vote on Draft Recommendations and Direct Staff to Prepare Report**

VII. Public Hearing:

Thursday, April 24, 2008
10:00 – 12:00

Jamestown Town Hall
301 E. Main Street,
Jamestown, NC

Next Meeting:

Monday, May 12, 2008
10:00

VISITOR REGISTRATION SHEET

NC Commission on Aging — **Name of Committee**

April 10, 2008 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Bethea	AARP-NC
Dennis Streets	NC Div. of Aging and Adult Services
Bob Konrad	Friends of Residents in Long Term Care
Mary Edwards	DAA-S
Heather Burkhardt	DAAS
Swarna Reddy	DAAS
Margaret Kelly	Lumber River Area Agency on Aging
Jan Withers	Div Svcs Deaf & Hard of Hearing
Jeff Mobley	Div Svcs Deaf & Hard of Hearing
Carolyn Edmonds	Div. Svcs Deaf & Hard of Hearing
Mark Whisenant	Div. Svcs Deaf & HH

VISITOR REGISTRATION SHEET

NC Commission on Aging — **Name of Committee**

April 10, 2008 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Cyr	DAAS
Steve Freedman	DAAS
Tonya Cedars	Eastern Carolina Council
Lauren Akers	NCCPPR
Teresa Johnson	NC ADServices Assn
André Carson	FORLTC
Abby Emanuel	NMSS
Annette Newkirk	Governor's Office
Jeff Hunt	DHHS
Margaret Cornin	DHHS-DMA
Joanne Stevens	Nursing

VISITOR REGISTRATION SHEET

NC Commission on Aging — **Name of Committee**

April 10, 2008 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Lugar	DHHS
Suzanne Merrill	DHHS/DAAS
Susan Williamson	NC Assoc. Nonprofit Homes Aging
Jane Baker	NC State Board of Examiners for Nursing Home Administrators
Stephen Fleming	NC State Board of Examiners for Nursing Home Administrators
DAVID BARNES	Poyner + Spruill

VISITOR REGISTRATION SHEET

NC Commission on Aging — **Name of Committee**

April 10, 2008 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cassandra Raynor-Simpson	Wayne Co Dept of Social Services 301 N Herman St Goldsboro NC
Donna D. Hatch	AARP 255 Hillsborough St Ral. NC
Dick Hatch	AARP, NC Coalition on Aging & Senior Task Force Legislative
TRACY COLVARD	Association for Home & Hospice Care
JIM BREWER	AHHC of NC
CHARLES JACKSON	DIV OF MEDICAL ASST.
John Smith	DHHS
Sabrina Lea	DHHS
Ann Keller	DHHS
Nancy Warren	DHHS
Rosalyn Bethea Ford	DHHS

Presentation #1A
Jane Baker
Steve Fleming

This amendment allows the NC State Board of Examiners for Nursing Home Administrators to obtain criminal history record checks

Background – Article 20 of Chapter 90 of the NC General Statutes contains the Nursing Home Administrator Act. The Board of Examiners for Nursing Home Administrators is charged with licensing nursing home administrators. [The facilities themselves are licensed by DHHS.] Nursing home administrators are persons who administer, manage, supervise, or are in general administrative charge of the nursing home.

Other Boards Requiring Criminal History Record Checks – Numerous other occupational licensing boards require criminal history record checks including physicians, dentists, nurses, psychologists and pharmacists.

Amendment – This amendment would give the Board the authority to require criminal history record checks on

- Applicants from North Carolina
- Applicants seeking licensure by reciprocity
- Persons renewing their licenses

The criminal history check is not mandatory. The Board will have the discretion on whether or not to require criminal history record checks. The Board may require the applicant to obtain the record check from a Board-approved reporting service or may request the Department of Justice to conduct the check.

Before denying licensure based on a conviction, the Board would be required to consider several factors. The Board and Board staff would also be immune from civil liability for actions based on information provided in a person's criminal history record check.

Fees – If the applicant is required to use a reporting service, the applicant would submit the fee directly to the reporting service. However, if the Board chooses to use the Department of Justice, the Board would collect any remit the fees required by the Department of Justice. Such a fee could not exceed the actual cost to DOJ.

Recomm. #10

§90-288.01. Criminal history record checks of applicants for licensure.

(a) Definitions. The following definitions shall apply in this section.

(1) Applicant. -- A person applying for initial licensure either pursuant to G.S. 90-278 or G.S. 90-287 or applying for renewal of licensure pursuant to G.S. 90-286.

(2) Criminal History. -- A history of conviction of a State crime, whether a misdemeanor or felony, that bears on an applicant's fitness for licensure as a nursing home administrator. The crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act in Article 5 of Chapter 90 of the General Statutes and alcohol-related offenses including sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(b) Criminal History Record Check. -- The Board may require a criminal history record check of an applicant. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure to an applicant. The Board may require the applicants to obtain criminal history record checks from one or more reporting services designated by the Board to provide criminal history record checks. Each applicant is required to pay the designated service for the cost of the criminal history record check. In the alternative, the Board may provide to the North Carolina Department of Justice the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential. The Board shall collect any fees required by the Department of Justice and shall remit the fees to the Department of Justice for expenses associated with conducting the criminal history record check.

(c) Convictions. -- If the applicant's criminal history check reveals one or more convictions listed under subsection (a)(2) of this section, the conviction shall not

automatically bar licensure. The Board shall consider all of the following factors regarding the conviction:

(1) The level of seriousness of the crime.

(2) The date of the crime.

(3) The age of the person at the time of the conviction.

(4) The circumstances surrounding the commission of the crime, if known.

(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.

(6) The person's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.

(7) The subsequent commission by the person of a crime listed in subsection (a) of this section.

(c) Denial of Licensure. – If the Board refuses to issue or renew a license based on information obtained in a criminal history record check, the Board must disclose to the person the information contained in the criminal history record check that is relevant to the Board's actions. The Board shall not provide a copy of the criminal history record check to the person. A person has the right to appear before the Board to appeal the Board's decision. An appearance before the Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(d) Limited Immunity. – The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for its actions based on information provided in a person's criminal history record check.

§ 114-19.11. Criminal record checks of applicants for licensure as nursing home administrators.

The Department of Justice may provide to the North Carolina State Board of Examiners for Nursing Home Administrators from the State and National Repositories of Criminal Histories the criminal history of any applicant for licensure as a nursing home administrator under Article 20 of Chapter 90 of the General Statutes. Along with the request, the Board shall provide to the Department of Justice the fingerprints of the applicant, a form signed by the applicant consenting to the criminal record check and use of fingerprints and other identifying information required by the State and National Repositories, and any additional information required by the Department of Justice. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Board shall keep all information obtained pursuant to this section confidential. The Department of Justice may charge a fee to offset the cost incurred by it to conduct a criminal record check under this

section. The fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information.

GS 114-19.10 NHA DRAFT Amendment Final

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section. The fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information.

4/10/08 1C

Background Information

Adult Protective Services Presentation
to the
Study Commission on Aging
October 2006

Jane Baker + Steve Fleming

A New System of Protection
The Adult Protective Services (APS) Clearinghouse Model

North Carolina was a pioneer in enacting the first Elder Abuse Law in 1973. This law, North Carolina General Statute 108A, "Protection of the Abused, Neglected or Exploited Disabled Adult Act", has not been reviewed nor had any significant changes made to it in 30 or more years.

Accomplishments:

Comprehensive Review of North Carolina's APS Program - March 2002 a needs assessment of North Carolina's APS program conducted - identified strengths and weaknesses of the APS Program.

APS Task Force Convened - November 2002 an APS Task Force convened to address the critical needs identified from the assessment and develop recommendations to strengthen North Carolina's APS service delivery system. The Task Force determined North Carolina's Adult Protective Services (APS) program must be strengthened and prepared to respond to the following challenges:

- Aging of North Carolina's population;
- Projected increases in the number of vulnerable and elder adults who may be victims of abuse, neglect or exploitation;
- Increased emphasis on community-based treatment for vulnerable and elder adults with chronic mental illness, mental retardation, and substance abuse; and
- Increased incidences of financial exploitation and violence against vulnerable and elder adults.

The APS Clearinghouse Model (CHM) – The Task Force, in collaboration with stakeholders, developed a new system of protection. The APS Clearinghouse Model (CHM), seeks to serve vulnerable and elder adults who are abused, neglected or exploited or are at significant risk of abuse, neglect or exploitation.

Introduction of Legislation to Pilot the APS CHM - NC Study Commission on Aging and the House Study Committee on State Guardianship Laws supported the vision of the model by introducing Bills in the House and Senate to fund a pilot of the APS CHM. Although there was bi-partisan support, the Bills did not pass the House or Senate.

What Remains to be Done:

- Clarify and strengthen G.S. 108 A to support a broader system of protection for vulnerable and elder adults who are abused, neglected or exploited or at significant risk of abuse, neglect or exploitation.
- Provide adequate funding to design, implement and evaluate a time limited APS CHM pilot.
- Provide funding for the 100 county departments of social services to hire additional staff to carry out the APS CHM.
- Provide funding to county departments of social services for the provision of essential services.
- Establish a mandatory competency-based training and continuing education program for APS social workers and supervisors.
- Establish an APS caseload standard.
- Enhance technology and data collection systems to strengthen accountability and support implementation of an APS CHM pilot and statewide implementation.
- 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.

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 & Human 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 Model: 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 Model: 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
    - 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 Model: 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 10 NCAC 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 adult's 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 'vulnerable adult' 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 been abused, 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 collection 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

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

SESSION LAW 2005-23

HOUSE BILL 45

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' ADULT PROTECTIVE SERVICES TASK FORCE TO COLLABORATE WITH OTHERS INTERESTED IN IMPROVING ADULT PROTECTIVE SERVICES AND REPORT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Adult Protective Services Task Force, shall collaborate with stakeholders and other persons interested in improving adult protective services and report its findings and recommendations to the North Carolina Study Commission on Aging and to the Legislative Study Commission on State Guardianship Laws on or before April 1, 2006.

SECTION 2. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 20th day of April, 2005.

s/ Beverly E. Perdue

s/ President of the Senate

s/ James B. Black

Speaker of the House of Representatives

s/ Michael F. Easley

Governor

Approved 7:45 p.m. this 28th day of April, 2005

APS Task Force Report to North Carolina Study Commission on Aging and House Study Committee on State Guardianship Laws

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I. EXECUTIVE SUMMARY

This report was prepared in response to Session Law 2005-23. This law directed the North Carolina Department of Health and Human Services, Division of Aging and Adult Services, Adult Protective Services Task Force to collaborate with stakeholders and other persons interested in improving adult protective services, and report findings and recommendations to the NC Study Commission on Aging and the Study Committee on State Guardianship Laws. The report contains recommendations to broaden and strengthen North Carolina's Adult Protective Services (APS) Program to respond to the dramatically changing vulnerable and older adult demographics in the State. We must be prepared to respond to the:

1. **Aging of North Carolina's population**
   - North Carolina's older population increased 20.5% between 1990 and 2000, giving the state the 12th fastest growing older population. This rate of growth exceeds the national average growth rate of 12%.
   - By 2030, 75 counties are projected to have more persons age 60 years of age and older than age 17 years of age and under.
   - Among the top 20 most populous states, North Carolina has the highest percentage of seniors living in rural areas.
2. **Increased risk of mistreatment of vulnerable and older adults**
   - Vulnerable adults 18 years of age and older, who, as a result of a physical or mental limitation that impairs their ability, may be more at risk of abuse, neglect and exploitation.
   - Older adults may also be more at risk of abuse, neglect and exploitation due to isolation from social support systems. Victims of elder abuse are more likely to be isolated from friends and relatives. This social isolation, as is seen with the abuse of children, can increase family stress thus heightening the potential for abuse.
   - Elder mistreatment literature also concludes advanced age may produce physical changes (and often illness) that make older adults less able to protect themselves and these changes, plus ageism, can decrease an elder's feelings of self-determination and personal power; potentially putting them at risk of mistreatment. [Journal of Elder Abuse & Neglect, Vol.3(2) 1991]
3. **Increased emphasis on community-based treatment**
   - The Division of MH/DD/SAS indicates that each year almost 6% (about 380,000) of adults in North Carolina face serious mental health problems.

- 20% of the disabled adults receiving APS during the 2005-06 fiscal year had a mental or emotional health diagnosis.
- The population of adults in North Carolina facing serious mental health problems is expected to increase as vulnerable and older adults move into community-based treatment settings due to downsizing of State institutions, and the transfer of institutional funding to the community.
- The number of adults in North Carolina receiving publicly-funded community mental health services increased by 26% between 1999 and 2005.
- The prevalence of mental health problems among adults 65+ is as follows: 11.4% suffer anxiety; 6.4% have a cognitive impairment; and 4.4% experience depression and mood disorders.
- Older adults with developmental disabilities are increasing outliving their parents and are at risk of losing their primary support which may put them at risk.

4. Increased incidences of financial exploitation and violence against vulnerable and older adults

- Crimes and financial exploitation against vulnerable and older adults are among the fastest growing in the country.
- Older victims may be reluctant to step forward to report this victimization, and unless they disclose this information or someone learns about it, the victimization may continue.
- Results from a National Abuse Incidence Study indicate that financial abuse was found at higher rates among elders 60 to 70 years of age than among those 80 years of age.
- The Adult Protective Services Register (APS-R) data indicates 13% of all APS reports evaluated during 2005-06 involved exploitation.

After much discussion, extensive research of other states' APS laws and policies, review of elder abuse literature, and extensive dialogue with numerous stakeholders, a totally new system of protection for adults in North Carolina, an Adult Protective Services Clearinghouse Model (CHM) was developed. The CHM will be a significant change from the current APS law, and will enhance county departments of social services capacity to respond to the needs of all abused, neglected or exploited adults. The APS Task Force and stakeholders are convinced North Carolina's APS Program must be prepared to respond to all instances of mistreatment of adults, not just those adults currently defined in APS law as 'disabled adults'. The CHM accomplishes this by:

1. Changing the emphasis of APS to a multifaceted array of protective services rather than problem-solving, symptom-based interventions.

2. Providing county departments of social services the opportunity to offer three components of protective services:

   - APS Information and Referral,
   - APS Outreach, or
   - APS Intervention.

3. Broadening the target population for Adult Protective Services CHM to include (1) vulnerable adults 18 years of age and older with physical or and mental impairments who have been abused, neglected or exploited; (2) elder adults 60 years of age and older without a physical or mental health incapacity who have been abused, neglected or exploited; and (3) vulnerable and elder adults at substantial risk of abuse, neglect or exploitation.

4. Ensuring additional rights and protections for vulnerable and elder adults in keeping with the basic tenets of APS: respect for all adults' freedom, dignity and autonomy; consideration of least restrictive alternatives.

5. Establishing competency-based training requirements for APS staff.

6. Establishing staffing requirements and caseload standards for APS.

7. Providing state funding to support the Adult Protective Services CHM.

8. Developing and implementing a time limited pilot of the Adult Protective Services CHM to demonstrate feasibility of the new system of protection.

9. Obtaining state funding to support a time limited pilot of the Adult Protective Services CHM to demonstrate feasibility of the new system of protection.

What follows is background information and the recommendations, findings and fiscal implications for strengthening North Carolina's Adult Protective Services program.

II. INTRODUCTION

North Carolina is a pioneer in the area of Adult Protective Services (APS). In 1973, North Carolina enacted the first Elder Abuse Law in the United States. In 1975, this law was amended by the North Carolina General Assembly and became known as General Statute 108A, The Protection of the Abused, Neglected, or Exploited Disabled Adult Act. Support for passage of the 1975 amendments was largely the result of a grassroots effort as county departments of social services and other advocates realized that a legal tool other than guardianship was needed to protect all abused, neglected or exploited adults incapacitated by a physical or mental disability. This Act provided for the protection of abused, neglected, or exploited disabled adults eighteen years of age and older.

The mandate to protect is carried out by North Carolina's 100 county departments of social services. The nature of Adult Protective Services intervention and the vulnerability of the population served require consideration of certain ethical principles, including:

- Respect for freedom, dignity and autonomy
- Consideration of least restrictive alternatives and interventions
- Utilization of community-based, family-centered and strength-based prevention and intervention strategies; and
- Emphasis on a multifaceted array of protective services rather than problem-solving, symptom-based interventions.

Ms. Nora McIver is an 80 year old widow who lives alone. Her neighbor called 911 after finding her lying on the floor of her home where she had fallen fracturing her hip. Ms. McIver was subsequently hospitalized. A physical examination found Ms. McIver dehydrated, malnourished and mentally confused. Her doctors indicate she is currently unable to care for herself and will require assistance to obtain the necessary services to meet her basic needs. She does not have family or friends to assist her.

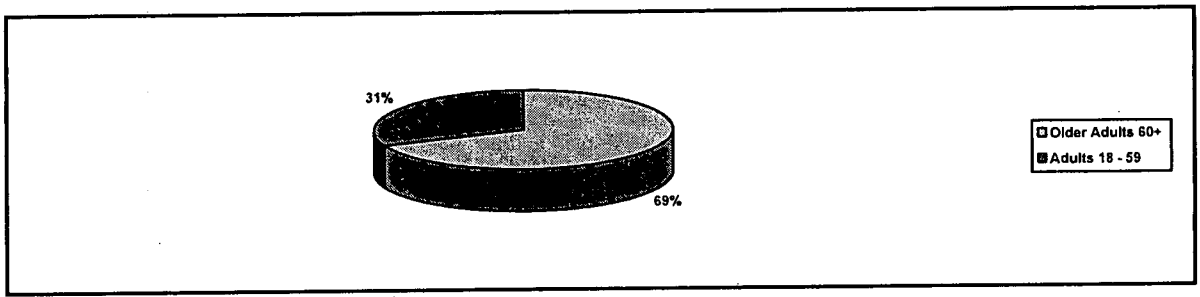
Scenarios like this are likely to increase as more adults live longer and possibly suffer serious age-related chronic illnesses. The proportion of older adults (60 years of age and older) in this State is currently estimated at 40% of the State's total population. By 2030 their proportion is expected to reach almost 50% of the State's total population.

ADULT PROTECTIVE SERVICES IN NORTH CAROLINA

Who Are the Disabled Adults and Their Families?

In North Carolina, Adult Protective Services data from the 100 county departments of social services is collected via the Adult Protective Services Register (APS-R). In use since April 1993, county departments of social services enter a variety of information (e.g., specific demographics about the adult, information about the perpetrator of mistreatment) into the APS-R about reports made to their agencies alleging mistreatment of vulnerable and older adults. During state fiscal year 2005-2006, county departments of social services received 14,001 reports alleging abuse, neglect and exploitation of disabled adults, and of those, 6,667 were evaluated for APS. Data from the APS-R indicates:

- Older adults comprised more than two-thirds (69%) of all disabled adults receiving Adult Protective Services during SFY 2005-06, while adults 18 to 59 years comprised the remaining 31%.



Source: Adult Protective Services – Register

- Women accounted for 62% of the adults receiving Adult Protective Services.
- 78% of all the adults receiving Adult Protective Services lived alone in domestic settings or with family members, while 22% lived in a long term care facility, state institution or shelter.
- 47% or nearly half of the disabled adults evaluated for APS had multiple disabilities. 60% had a physical illness, 24% had a diagnosis of Alzheimer's disease and related disorders, while 20% had a mental illness or emotional impairment.

What is Happening to Them?

- In 76% of the APS reports, the most common forms of mistreatment reported involved self and caretaker neglect.
  - 53% of the neglect reports involved self neglect.
  - 47% of the reports involved caretaker neglect.
- 12% of the APS reports involved abuse.
- 12% of the APS reports involved exploitation.
- The most frequently named perpetrator of mistreatment is an adult child, followed by a spouse, long term care facility staff or other relatives.

How Does Adult Protective Services Respond?

North Carolina General Statute 108A mandates county departments of social services to conduct a prompt and thorough evaluation of all reports alleging a disabled adult is in need of protective services. Prompt refers to the timeframe in which the evaluation must be initiated. The evaluation must be initiated as follows:

- Immediately upon receipt of the report if the report alleges a danger of death to the disabled adult;
- Within 24 hours if the report alleges danger or irreparable harm to the disabled adult; and
- Within 72 hours if the report does not allege danger of death or irreparable harm to the disabled adult.

The statewide average to initiate APS evaluations is 1.8 days. During 2005-06 over half of the APS reports (4,747) received were initiated within 24 hours of receipt of the report. 2,256 of the reports were initiated the same day.

A thorough evaluation includes a visit to, and a private interview with the disabled adult, and consultation with others having knowledge of the facts of the particular allegations; and a functional assessment to determine whether the disabled adult has been abused, neglected or exploited and is need of protective services. The functional assessment is tied to the disabled adult's strengths and limitations to perform major life activities.

The thorough evaluation may also include the review of records, including records maintained by facilities licensed by the NC DHHS, related to the care and treatment of the disabled adult by any individual, facility or agency acting as a caretaker for the disabled adult.

Staff and physicians of local health departments, mental health agencies and other public or private agencies must cooperate when requested in the thorough evaluation, including immediate accessible evaluations and in-home evaluations when necessary.

After the completion of the evaluation, a written report of the case indicating whether Adult Protective Services are needed is made to:

- The District Attorney and/or law enforcement if abuse, neglect or exploitation is found during the evaluation;
- The complainant who made the report alleging the disabled adult has been abused, neglected or exploited; and

- Other licensing agencies, if violations of licensure standards have been found during the course of the APS evaluation.

APS evaluations alleging abuse or neglect must be completed within 30 days; while evaluations alleging exploitation must be completed within 45 days. Statewide, county departments of social services on average complete APS evaluations alleging:

- abuse within 20.0 days
- neglect within 21.1 days
- exploitation within 28.4 days.

Once the APS evaluation is completed, a determination is made as to whether the disabled adult is in need of protective services. If the disabled adult is found to be in need of protective services, authorization is required to provide these services. Authorization is obtained from:

- **The disabled adult**
  If the disabled adult has the capacity to consent to the provision of protective services and refuses or withdraws consent, protective services are not provided, or are terminated. During 2005-06 consent to the provision of protective services was given by the disabled adult in 47% of the cases. Consent was denied or withdrawn by the disabled adult in 15% of cases.

- **Legal representative or surrogate**
  When the adult lacks the capacity to consent to services, consent may be obtained from others with the legal authority to consent on the disabled adult's behalf, such as a guardian. Consent to the provision of services was obtained from a legal surrogate in about 7% of the cases.

- **Court Order**
  When the adult lacks the capacity to consent to services and no one authorized by law or order is available to consent, a petition may be filed with the district court for a court order to provide these services. A court order authorizing the provision of protective services may also be obtained when an APS report alleges the disabled adult will suffer death or irreparable harm. The order authorizes the removal of the conditions creating the emergency when no other person authorized by law or order is available to consent to emergency protective services. APS court orders were obtained in 20% of the cases. Guardianship court orders were obtained in 11% of the cases.

III. NATIONAL and STATE TRENDS

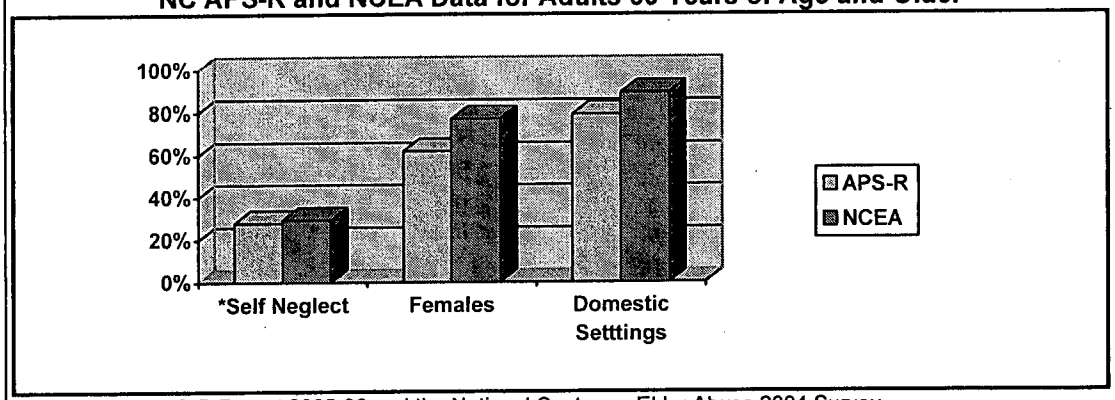
APS Register Data and National Center on Elder Abuse (NCEA) Data

Data from North Carolina's Adult Protective Services Register (APS-R) is consistent with national data when looking at APS reports for adults 60 years of age and older. The NCEA is a national consortium of five organizations advocating for elder rights. The consortium published the results of a survey titled, *Abuse of Adults Age 60+, A 2004 Survey of Adult Protective Services*. The survey summarizes data on the abuse of individuals 60 years of age and older from all 50 states, the District of Columbia and Guam. Although national uniform APS reporting requirements do not exist and APS programs are tailored to the laws and regulations of the specific states, the national data and NC's APS data do share some similarities.

During 2005-06 the APS-R indicates 69% of the total 6,667 APS reports accepted for evaluation involved disabled adults 60 years of age and older. While the APS-R system does not collect data specifically for adults 60 years of age and older for specific categories of mistreatment, some general conclusions can be drawn knowing that 69% of all reports are about adults 60 years of age and older.

The chart below illustrates some similarities between NCEA and APS-R data:

NC APS-R and NCEA Data for Adults 60 Years of Age and Older



Source: NC APS-R Report 2005-06 and the National Center on Elder Abuse 2004 Survey

NC APS-Register Data

28% of all reports on adults 60 years of age and older alleged self neglect

62% of the reports on adults 60 years of age and older found women to be the most frequent victims of mistreatment

79% of the disabled adults age 60 years and older lived in domestic settings (living alone or with family)

NCEA Data :

29.4% of the total reports alleged self neglect

77.1% of the total reports found women to be the most frequent victims of mistreatment

89% of the reports were on adults living in domestic settings

National Center on Elder Abuse Survey Report

In 2004 the National Center on Elder Abuse (NCEA) on behalf of one of its partners, the National Association of Adult Protective Services Administrators (NAAPSA), published the *Report on Problems Facing State Adult Protective Services Programs and Resources Needed to Resolve Them*. This report was compiled from a survey of 42 states' APS programs. North Carolina was one of the 42 states responding to this survey. Two questions were asked of survey participants:

1. What do you see as the most significant problems facing the field of Adult Protective Services at this time?
2. What assistance do you need to improve Adult Protective Services to vulnerable adults?

The following areas were the most frequently identified from the survey:

(57%) Insufficient funding at state and national levels
A lack of federal funding earmarked for APS was the most serious obstacle to program operation followed by: acknowledgement and support for APS programs at the state level as well as over-all cutbacks; the necessity of competing with child welfare services for reduced Social Services Block Grant (SSBG) funds as populations in need of APS increase; and concomitant increases in APS referrals reducing the effectiveness of any additional dollars made available.

(43%) Staffing issues/problems
An inability to obtain and retain enough staff with expertise in APS to effectively operate existing programs; large caseloads and low wages resulting in high staff turnover; and lack of funds prohibiting the provision of necessary training to develop staff expertise in APS.

(22%) Lack of public awareness of APS issues/problems
The general public does not understand the phenomena of adult abuse or have sufficient knowledge to address abuse, neglect or exploitation.

(17%) APS is not a priority in state legislatures – competition with child welfare programs
State legislatures do not understand the phenomena of adult abuse or have sufficient knowledge to address abuse, neglect or exploitation; APS was not a priority for legislature funding.

Implications for National and State Policy

The survey concludes from a global perspective that the major problem facing the Adult Protective Services delivery system is a lack of federal, state and local support. Federal and state agencies must address the problems through strong legislative initiatives. State Adult Protective Services Programs need to be adequately funded as a system of care for the growing population of mistreated older adults and adults with

disabilities, so that states can maintain, expand and improve the quality of Adult Protective Services Programs. "The need for protective services for older and disabled adults with disabilities who are victims of abuse, exploitation and neglect continues to grow. Federal and state agencies must address this problem now through strong legislative initiatives which include sufficient funding to meet the protective needs of our most vulnerable citizens". (NCEA, 2003)

The information contained in the NCEA survey supports the need for a comprehensive review of North Carolina's Adult Protective Services delivery system. Findings from the survey further indicate a need to identify strengths and significant problems in North Carolina's APS service delivery system to improve responses to an increasing vulnerable and older adult population.

IV. THE CHALLENGE

North Carolina's Adult Protective Services program must be strengthened and prepared to respond to the following challenges:

- Aging of North Carolina's population;
- Projected increases in the number of vulnerable and older adults who may be victims of abuse, neglect or exploitation;
- Increased emphasis on community-based treatment for vulnerable and older adults with chronic mental illness, mental retardation, and substance abuse; and
- Increased incidences of financial exploitation and violence against vulnerable and older adults.

A recent report by the President's Council on Bioethics, *Taking Care: Ethical Caregiving in our Aging Society*, speaks of the first ever "mass geriatric society". Other states such as Oregon, Wisconsin, Ohio, New Jersey, Michigan, and Texas have undertaken initiatives to respond to the needs of the projected increases in the numbers of vulnerable and older adults, many of whom may be victims of mistreatment.

1. The Aging of North Carolina's Population

- North Carolina ranked 11th nationally in total population and ranked 10th in the number of persons age 50 and older in 2004.

- North Carolina's older population increased 20.5% between 1990 and 2000, giving the state the 12th fastest growing older population. This rate of growth exceeds the national average growth rate of 12%.

- In 83 of North Carolina's 100 counties, the rate of increase among those age 65 years of age and older is expected to exceed the growth of the total population between 2000 and 2010.

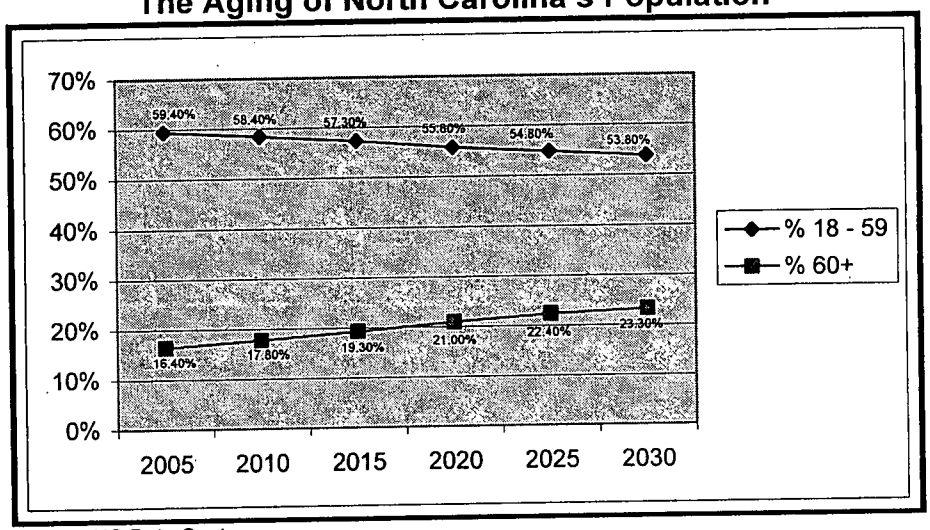
- By 2030, 75 counties are projected to have more persons age 60 years and older than age 17 years and under.

- North Carolina ranks 11th highest in the proportion of the poor among older adults with 12.7% below the federal poverty level in 1999.

- Another 23.2% are considered near-poor with incomes between 100% and 200% of poverty.

- Among the top 20 most populous states, North Carolina has the highest percentage of seniors living in rural areas.

The Aging of North Carolina's Population



Source: NC Data Center

In 2005 North Carolina's total population was 8,663,674. By 2030 the State's total population is projected to increase to 12,067,013. As the overall population increases, the population of adults age 18 – 59 years of age is expected to decrease from 59.4% the State's total population in 2005 to 53.8% by 2030. The population of adults age 60 years of age and older is expected to increase from16.4% of the State's total population in 2005 to 23.3% by 2030. (See data chart above)

2. Risk factors for mistreatment of vulnerable and older adults

The mistreatment of vulnerable and older adults is recognized as a growing problem. (*Journal of Elder Abuse & Neglect, Vol. 3(2) 1991, Elder Mistreatment: A Taxonomy with Definitions by Delphi, Margaret F. Hudson)*

The mistreatment of older adults is often distinguished from other forms of violence by several key risk factors including:

- the age of the victim;
- an established relationship connoting trust between the victim and the perpetrator;
- the intentionally of the harmful behavior;
- the distinction between neglect and abuse on the basis of commission and omission; and
- the different forms of neglect and abuse.

The following risk factors for elder abuse have been identified from empirical studies and clinical accounts:

(1) Shared living situations are a major risk factor for elder abuse based on the increased opportunity for contact between the perpetrator of mistreatment and the victim and the conflict and tension caused by the shared living arrangement;

(2) Higher rates of physical abuse are prevalent in patients with dementia than people without this disorder based on disruptive and aggressive behaviors of the victims that create stress on the caregivers thus causing caregivers to retaliate. We know that almost half of North Carolina family caregivers of persons age 60 years and older are providing care for someone with dementia. [Behavioral Risk Factor Surveillance Survey through the State Division of Health Statistics];

(3) Victims of elder abuse are more likely to be isolated from friends and relatives. This social isolation, as is seen with the abuse of children, can increase family stress thus heightening the potential for abuse. The presence of others can lead to intervention and sanctions for those who mistreat;

(4) A key pathological characteristic of some perpetrators is mental illness, (especially depression) and alcohol misuse. Several studies have established that a history of mental illness is more common among those who commit elder abuse than in the general population; and

(5) Perpetrators of elder abuse tend to be heavily dependent on the persons they are mistreating for financial support. In some instances mistreatment results from attempts by the financially dependent (especially adult children) relative to obtain resources from the victim.

Physical impairment of the older adult is not listed in this study as a risk factor for elder abuse, although some impairment may be a predisposing factor for abuse since this diminishes the adult's ability to protect him or herself or to escape an abusive situation. Reis and Nahmiash (Validation of the Indicators of Abuse (IoA) screen, Gerontologist 1998;38:471-80) did not find that impairment of activities of daily living predicted elder abuse. They conclude there is very little evidence that the victim's health and functional status is a risk factor for mistreatment. [The Lancet 2004; Volume 364:1263-72, Elder Abuse, Mark S. Lachs, Karl Pillmer.]

4. Increased emphasis on community-based treatment for vulnerable and older adults with chronic mental illness, mental retardation, and substance abuse

Data from the APS-R indicates 20% of the disabled adults receiving APS during the 2005-06 fiscal year had a mental or emotional health diagnosis. This population is expected to increase as vulnerable and older adults move into community-based treatment settings due to downsizing of State institutions, and the transfer of institutional funding to the community.

The Division of MH/DD/SAS indicates that each year almost 6% (about 380,000) of adults in North Carolina face serious mental health problems. The number of adults in North Carolina receiving publicly-funded community mental health services increased by 26% between 1999 and 2005. That Division has prioritized target populations who represent the

most severe types of disabilities to receive mental health services. Adults 65 and older with a serious mental illness are one of the targeted populations.

The 2005 Mental Health State Plan, *Blueprint for Change*, indicates that 2,000 (30.8%) of adults age 65+ reported some level of physical disability, while 12.6% reported a mental disability. The U. S. Department of Health and Human Services noted that older adults often do not recognize the need for or availability of mental health treatment. The lack of sufficient insurance coverage and inadequate screening result in a gross under utilization of mental health services.

The estimate of the prevalence of mental health problems among adults 65+ is believed to be much higher than the numbers reflect due to the lack of diagnosis and treatment and the comorbidity with other illness affecting many older adults. Of those 65 years of age and older, the estimate is that, 11.4% suffer anxiety; 6.4% have a cognitive impairment; and 4.4% experience depression and mood disorders. The estimated prevalence of heavy alcohol use varies between 3% and 25%. It is estimated that only about half of older adults who acknowledge mental health problems receive treatment from any health care provider. In addition, a new sub-population is emerging. Older adults with developmental disabilities are increasingly outliving their parents and are at risk for losing their primary support. The population of adults diagnosed with a developmental disability in North Carolina is estimated to be between 5,400 to 13,000.

In 2000 it was estimated that 20% of the U.S. population 65 years of age and older had a mental illness. For the same year, North Carolina's percentage was identical to the national percentage. The percentages for the U.S. and North Carolina are again estimated to increase at the same rate by 2030.

COMPARISON OF US AND NC POPULATIONS WITH A MENTAL ILLNESS DIAGNOSIS

	POPULATION 65+		ESTIMATED POPULATION 65+ WITH MENTAL ILLNESS DIAGNOSIS	
	US[1]	NC[2]	US[3]	NC[4]
2000	35,061,000	969,112 (.03%)	7,000,000 (20%)	193,485 (20%)
2030	71,453,000	2,142,136 (.03%)	15,000,000 (21%)	449,695 (21%)

Source: [1] US Census Bureau, [2] N C State Data Center. [3] Jeste DV, et al (1999). Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next 2 decades. Archives of General Psychiatry 56:848-853.

[4] NC DAAS estimates using the following formula:

$$\text{(Est. NC pop. 65+ with MI in 2000)} = \frac{\text{(Est. US pop. 65+ with MI in 2000)} \times \text{(NC pop. 65+ in 2000)}}{\text{(US pop. 65+ in 2000}}$$

5. Increasing incidences of financial exploitation and violence against vulnerable and older adults.

For example, an 80 year old, recently widowed woman was befriended by a 40 year old neighbor, who told the widow her late husband asked him to take care of her when he died. She had always depended on her husband for emotional and physical support, and they had no children. During the next 2 years, the neighbor using deception and coercion, convinced the widow to build an addition to her home where he and his girlfriend lived. He convinced the widow to change her will, arranged to be her power of attorney, and transferred large sums of her cash into his personal accounts. Preying on the widow's motherly instincts, he convinced her to adopt him as her legal son. After being legally adopted he arranged to have the widow placed in a long term care facility after transferring more than $500,000 of her assets into his name.

Crimes and financial exploitation against vulnerable and older adults are among the fastest growing in the country. Results from a National Abuse Incidence Study indicate financial abuse was found at higher rates among elders 60 to 70 years of age than among those 80+. The APS-R data indicates a total of 13% of the disabled adults reported to departments of social services were victims of exploitation during 2005-06. Ten percent (10%) of the total reports alleging exploitation involved exploitation of assets. Elderly victims may be reluctant to step forward to report this victimization, and unless they disclose this information or someone learns about it, the victimization may continue.

An article in Newsweek, *The Final Indignity*, by Susanna Schrosdorff, reports "as many as 5 million people are victims of financial exploitation every year". The article also asks the question, "With an enormous number of baby boomers heading for retirement, are we on the verge of an elder fraud epidemic?"

In 2005, the North Carolina General Assembly responded to the increasing victimization and exploitation of vulnerable and older adults by passing Session Law 2005-272 titled, An Act to Amend the Offense of Exploitation of an Elder or Disabled Adult and to Increase the Penalty for that Offense. This law is intended to provide increased protection for 'disabled adults' 18 years of age and older, and 'elder adults' who are defined as persons 60 years of age and older. The General Assembly also passed the Identity Theft Protection Act of 2005 which reduces the use of social security numbers and gives consumers the right to freeze their credit.

The concern about the lack of public awareness of abuse, neglect and exploitation of vulnerable and elder adults and the increasing incidence of abuse, neglect and exploitation of vulnerable and elder adults prompted bi-partisan sponsorship in the US Congress of the Elder Justice Act. Passage of this Act would:

- Establish an Office of Adult Protective Services within the US Department of Health & Human Services;
- Improve quality, quantity and accessibility of information on abuse, neglect and exploitation of elder adults;
- Develop forensic capacity for law enforcement and investigators to elevate elder crime to the same importance as crimes against women and children;
- Fund states' APS programs;
- Expand and enhance training about elder mistreatment, and
- Create model state laws and practices.

V. RESPONDING TO THE CHALLENGE:

A COMPREHENSIVE REVIEW OF NORTH CAROLINA'S APS PROGRAM

In March 2002, the Adult Services Section of the NC Division of Aging and Adult Services (Division) in collaboration with the NC Association of County Directors of Social Services (NCACDSS) conducted an APS needs assessment in 31 county departments of social services. The needs assessment was completed in August 2002. A balanced sample of quality and timeliness baseline data from rural and urban, and large and small counties was collected. The data reflected the strengths and weaknesses of North Carolina's Adult Protective Program.

North Carolina APS Task Force

In November 2002, an APS Task Force was convened by the Adult Services Section of the Division to address the critical needs identified from the assessment and develop recommendations to strengthen the quality and consistency of the APS service delivery system in all 100 counties of North Carolina. The Task Force which has continued its work, is made up of representatives from county departments of social services from across the state, and the Division. The Task Force began its efforts with development of a mission statement and goals.

Mission

To provide protection for vulnerable disabled and elder adults who have been abused, neglected, or exploited or at significant risk of harm. To ensure these adults are protected and their essential needs are met with utmost consideration given for their quality of life, utilizing a collaborative community and family-centered approach. County departments of social services, in partnership with the North Carolina Division of Aging and Adult Services, value and respect the individual's right to self determination and recognize the inherent value of all people as we carry out our mission.

Goals

- Strengthen APS service delivery across all 100 counties.
- Develop APS standards beyond current policies and procedures, including staffing and work load standards.
- Expand the Division's training for county APS staff to include a comprehensive program of basic, intermediate and advanced curricula.
- Develop a Quality Assurance System to ensure quality and accountability.
- Encourage and support improved interagency cooperation in APS.
- Seek legislative support/funding to strengthen APS.

An APS Clearinghouse Model: North Carolina's System of Protection

The culmination of collaboration between the APS Task Force and key stakeholders is a totally new system of protection for vulnerable and elder adults in North Carolina. After much discussion, extensive research of other states' APS laws and policies, and elder abuse literature, a new system of protection for adults in North Carolina, an Adult Protective Services Clearinghouse Model (CHM) was developed. The CHM will enhance county departments of social services capacity to respond to the needs of all abused, neglected or exploited adults. The Task Force and stakeholders are convinced North Carolina's APS Program must respond to all instances of mistreatment of adults, not just those adults currently defined in APS law as "disabled adults". The CHM accomplishes this by enabling county departments of social services to offer services voluntarily to new populations of adults abused, neglected and exploited or at substantial risk including: (1) vulnerable adults 18 years of age and older with physical or and mental impairments that limit at least two major life activities; (2) elder adults 60 years of age and older who do not have a physical or mental health incapacity; and (3) vulnerable and elder adults at substantial risk of abuse, neglect or exploitation.

Once the CHM was developed and new target populations identified, additional rights and protections were included in the recommended changes to the APS law in keeping with the basic tenets of APS: respect for all adults' freedom, dignity and autonomy; consideration of least restrictive alternatives; and an emphasis on a multifaceted array of protective services rather than problem-solving, symptom-based interventions. The proposed law:

- Redefines "protective services" as an array of activities including intake, screening, and evaluation of reports regarding abuse, neglect or exploitation or substantial risk of abuse, neglect, or exploitation of vulnerable or elder adults.
- Provides county departments of social services the opportunity to offer vulnerable and elder adults three components of protective services which may be as simple as APS Information and Referral or more comprehensive as APS Outreach or APS Intervention.
- Provides the opportunity to offer protective services to vulnerable and elder adults, with their consent, when they possess sufficient understanding or ability to consent to services, or make or communicate important decisions concerning their person, family of property.
- Provides the opportunity to offer protective services to vulnerable and elder adults at substantial risk when there is a reasonable probability they are at substantial risk of being abused, neglected or exploited.

The Task Force acknowledges the Governor's Advisory Council on Aging concern about identifying adults 60 years of age and older who do not have a physical or mental incapacity within the target population to receive and benefit from the Adult Protective Services CHM. The concern is that North Carolina's CHM identifies adults 60 years of age and older as a group. It is felt this identification devalues and labels this group of adults as being incapable of protecting themselves, and unable to take action on their own behalf. The Task Force acknowledges that many adults age 60 years of age and older without a physical or mental incapacity will not need protective services. On the other hand, there are adults age 60 years of age and older without a physical or mental incapacity who will need and can benefit from protective services. The new system of protection is designed so that NC citizens 60 years of age and older without a physical or mental incapacity will be afforded the same right to be free from abuse, neglect or exploitation as will be afforded to vulnerable adults and adults at substantial risk of abuse, neglect or exploitation.

What follows are recommendations, findings and fiscal implications to strengthen North Carolina's Adult Protective Services Program.

VI. 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 10 NCAC 71A to support a broader system of protection for vulnerable and elder adults who have been abused, neglected, or exploited, or who are at substantial risk of abuse, neglect or exploitation.

1. Redefine 'protective services' as the provision of an array of activities to protect vulnerable and elder adults who have been abused, neglected, or exploited, or who are at substantial risk of abuse, neglect or exploitation.

2. County departments of social services must provide "protective services" to all vulnerable and elder adults in North Carolina who are abused, neglected, or exploited, or at substantial risk of abuse, neglect or exploitation. The new system of protection, "Adult Protective Services Clearinghouse Model" (CHM), is designed to accomplish this. The Adult Protective Services CHM is composed of three components:

- **APS Information & Referral** will be provided to vulnerable and elder adults who require referral to public and private agencies and community resources. Information and referral services may be provided to a vulnerable or elder adult with the adult's consent if the adult is alleged to have been abused, neglected, exploited, or at substantial risk of abuse, neglect, or exploitation and does not need outreach services or intervention services.

- **APS Outreach** will be provided to vulnerable and elder adults who have been or who are at substantial risk of being abused, neglected, or exploited, and need protective services other than information and referral services. APS Outreach is the planning, coordination, arrangement, mobilization, and management of essential services for vulnerable and elder adults. Outreach services may be provided to a vulnerable or elder adult with the adult's consent if the adult has been abused, neglected, or exploited or is at substantial risk of abuse, neglect, or exploitation.

- **APS Intervention** will be provided to vulnerable adults who have been or who are at substantial risk of being abused, neglected, or exploited, and have no responsible caregiver or other responsible person willing and able to provide or arrange for the provision of

emergency or essential services. APS Intervention is the provision of emergency or essential services to vulnerable adults. Intervention services may be provided to a vulnerable adult with the adult's consent, or in the case of a vulnerable adult who lacks the ability to consent pursuant to a court order, if the adult is unable to obtain the services himself or herself, and has no able, willing, and responsible person who can obtain the services for him or her.

3. Change the focus of the provision of protective services from disabled adults to vulnerable and elder adults.

4. Base the definition of 'vulnerable adult' on the adult's functional strengths and limitations.

5. Recognize age 60 and older as a definition for elder adults who have been or who are at substantial risk of being abused, neglected or exploited.

6. Acknowledge APS as a voluntary intervention provided to vulnerable and elder adults, with adults' consent.

7. Broaden the definition of 'abuse' by: deleting the intentionality requirement from the definition in keeping with elder mistreatment literature; replace 'caretaker' with 'caregiver' in the definition of 'abuse'; and including 'persons who are in a significant social or family relationship with the vulnerable adult or elder adult' in the definition of 'caregiver'.

8. Refine the definition for 'essential services' to include those services that are necessary to safeguard the vulnerable adult's rights and resources.

9. Add 'substantial risk' to the definitions to support the provision of services to vulnerable and elder adults at risk of abuse, neglect or exploitation.

10. Anticipate approximately 432 additional APS reports per year by broadening the target population to include adults 60 years of age and older.

Findings to Support Core Recommendation 1:

1. The current APS Program is narrow in scope and only targets 'disabled adults'. G.S. 108A-101(d) defines a 'disabled adult' as "any person 18 years of age or over or any emancipated minor who is present in the State of North Carolina and who is physically or mentally incapacitated due to mental retardation, cerebral palsy, epilepsy or autism; organic brain damage, mental or physical illness or continued consumption or absorption of substances."

This definition does not acknowledge the adult's functional strengths or limitations, and is based on a diagnosis. This leads to inconsistency in determining who meets the definition; and therefore, some disabled adults do not qualify to receive needed services.

2. The current APS statute supports involuntary intervention with disabled adults who meet the APS criteria. This narrow definition of APS does not enable county departments of social services to provide outreach services on a voluntary basis to all abused, neglected or exploited vulnerable and elder adults who have the capacity to consent to or refuse these services.

3. The current APS law provides strict filters that county departments of social services are mandated to apply when screening reports alleging a disabled adult has been abused, neglected or exploited and offers only two alternatives:

   (1) screen-in the report for an involuntary evaluation, or

   (2) screen-out the report if the criteria (disabled adult, abused, neglected or exploited, and currently in need of APS) are not met.

   Under NC's current program, resources vary from one county department of social services to another. Some county departments of social services have resources to offer services to vulnerable adults who have been abused, neglected or exploited, but do not meet the APS criteria. Other county departments of social services do not have the resources outside of the mandates of APS. The narrow criteria creates inconsistency in the delivery of services to disabled adults across the state.

4. The current APS statute does not support the provision of services to disabled adults unless they have already been abused, neglected or exploited. This narrow interpretation does not acknowledge the increase in the numbers of vulnerable and elder adults at 'substantial risk' of abuse, neglect or exploitation.

5. The current APS statute does not include adults age 60 years of age or older as a target population to receive adult protective services.

   Other states, such as Florida, Virginia, Illinois, Massachusetts, Louisiana, and Wisconsin use 60 years of age or older as benchmarks when defining "elders" in their Adult Protective Services laws. Elder mistreatment literature concludes advanced age may produce physical changes (and often illness) that make older adults less able to protect themselves and these changes, plus ageism (devaluing older adults increases an adult's risk of

mistreatment), can decrease an elder's feelings of self-determination and personal power, potentially putting them at risk of mistreatment. [Journal of Elder Abuse & Neglect, Vol.3(2) 1991]

Total Proposed Budget: $15,212,202

(Includes $300,000 per year to serve adults 60 years of age and older)

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: NC's System of Protection.

1. County departments of social services will require 8 additional FTE social work positions to carry out APS Intake and Screening.
2. County departments of social services will require 154 additional FTE social work positions to carry out APS Intervention.
3. County departments of social services will require 42 additional FTE social work positions to carry out APS Outreach.
4. County departments of social services will require 8 additional FTE social work positions to carry out APS Information & Referral.

Findings to Support Core Recommendation 2:

1. Currently the 100 county departments of social services have 150.96 FTEs to carry out the APS mandate:
   - 35.47 FTEs to carry out APS intake and screening; and
   - 115.49 to conduct APS evaluations and plan and mobilize services to protect disabled adults from abuse, neglect or exploitation.
2. During FY 2005-06 county departments of social services received 14,001 reports alleging abuse, neglect or exploitation of disabled adults, and of those, 6,667for APS. The number of reports is expected to increase because the APS CHM broadens the target population to receive protective services to include vulnerable and elder adults who are abused, neglected or exploited or who are at substantial risk of abuse, neglect or exploitation.
3. The Social Services Block Grant (SSBG) is the primary funding source for APS. SSBG allocations to states have remained at the same level for many years and may be cut in 2007. As a result of SSBG funding remaining at the same level, county departments of social services have been unable to expand their APS Programs without cutting other programs funded with SSBG or using 100% county dollars. With competing priorities for county dollars at the local level, it has been difficult for DSSs to tap into this revenue.
4. In 2000, the General Assembly appropriated $2,000,000 to be used by county departments of social services to fund additional APS positions. This appropriation was the first and only one specifically for the APS Program. While no county match is required, the allocation is not sufficient to fund APS positions in all 100 county

departments of social services. Currently 53 county departments of social services receive this funding.

Proposed Budget: $13,992,000	**FTEs: 212 positions**

Core Recommendation 3:
Provide adequate staff in the Division of Aging and Adult Services to support county departments of social services to carry out the APS Clearinghouse Model: NC's System of Protection.

1. 5.0 FTEs will be needed in the Division to carry out the APS Clearinghouse Model. This includes developing policies and procedures for a pilot, developing assessment tools, developing and conducting intermediate and advanced training to strengthen the skills of APS staff to carry out their expanded duties to protect vulnerable and elder adults from abuse, neglect or exploitation; and providing consultation and technical assistance on the new APS law, the policies and procedures and social work practice.

2. .28 FTE of an attorney position will be needed in the Office of the NC Attorney General to provide legal consultation to Division staff.

Findings to Support Core Recommendation 3:

1. The current number of Division staff is not adequate to manage all the changes needed to implement the APS Clearinghouse Model. For example additional staff will be needed to manage a CHM demonstration pilot, develop competency-based training, implement a new APS statute; revise and implement administrative rules, and provide training, consultation, and technical assistance to support county departments of social services.

2. The Division currently has 1.75 FTE positions to implement APS the statutes; implement and revise (as needed) administrative rules, identify training needs, develop training curricula, provide training, consultation and technical assistance to 100 county departments of social services around APS statues, policies, and social work practice.

Proposed Budget: $346,202	**FTEs: 5.28 FTE positions**

Core Recommendation 4:
Establish a mandatory competency-based training and continuing education program for APS social workers and supervisors in county departments of social services.

APS Social Workers shall complete:

1. Standardized pre-service training prior to social workers assuming direct client contact responsibilities. The standardized training will have a scorable exam to indicate completion of the pre-service training.

3. A minimum of 66 hours of available training on APS intake, screening, evaluation, service provision, and social work practice on working with vulnerable and elder adults and their families. All training will be completed within 2 months of assuming direct client contact responsibilities.

4. A minimum of 18 hours of specialized intermediate and advanced training on the delivery of Adult Protective Services and work with vulnerable and elder adults and their families within 12 months of assuming direct client contact responsibilities.

5. A minimum of 24 hours of additional training annually for continuing education credit relevant to APS practice.

APS Supervisors shall complete:

1. Standardized APS supervisor orientation within 1 month of assuming direct APS supervisory responsibilities.

2. A minimum of 66 hours of available training on APS intake, screening, evaluation, service provision, and social work practice on working with adults and their families. All training shall be completed within 2 months of assuming direct supervisory responsibilities.

3. A minimum of 18 hours of specialized intermediate and advanced training in the delivery of APS and work with vulnerable and elder adults within 12 months of assuming supervisory responsibilities.

4. A minimum of 24 hours additional training annually for continuing education credit relevant to APS practice.

APS Intake and After-Hours staff shall complete a minimum of:

1. Available training on APS intake and screening procedures.

2. An APS home visit with a trained APS social worker or supervisor within 2 months of assuming intake or after-hours responsibilities.

Findings to Support Core Recommendation 4:

1. The current APS statute does not contain training requirements. Current APS training consists of a 5 day basic curriculum developed and taught by Division staff, and four specialized advanced training curricula for county department of social services staff who have completed the basic training curriculum. The training needs of county departments of social services APS staff continue to increase as they deal with increasingly difficult and complex issues of protecting vulnerable and elder adults.

Proposed Budget: **Costs to county departments of social services associated with attending training have been built into the total cost for county FTEs (See Core Recommendation #1.)**	

Core Recommendation 5:
Provide funding to county departments of social services for the provision of essential services for vulnerable adults who have been abused, neglected or exploited, or who are at substantial risk of abuse, neglect, or exploitation.

1. 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.

Findings to Support Core Recommendation 5:

1. The APS statute requires that essential services needed to protect vulnerable adults be provided at no cost to vulnerable adults if they are unable to pay.

2. The majority of vulnerable adults determined to need essential services are unable to pay.

3. Social Services Block Grant (SSBG) funds and all-county funds, in addition to public benefits when eligible, are being utilized to provide essential services. These funding sources are not adequate.

Proposed Budget **$513,000**

Core Recommendation 6:
Establish a caseload standard based on an in-depth job analysis of the time and tasks associated with implementation of the APS Clearinghouse Model: NC's System of Protection.

1. Adult Protective Services social workers will be assigned no more than 12 concurrent APS cases.

2. Workers with less than full time responsibility for Adult Protective Services will be assigned fewer than 12 APS cases commensurate with the percentage of time assigned to APS.

3. The Adult Protective Services supervisor/worker ratio will not exceed an average of one FTE supervisory position to five APS social work positions.

Findings to Support Core Recommendation 6:

1. The current APS statute does not contain caseload requirements. The recommended caseload size of 1:25 ratio is more than 20 years old. It does not reflect the:

   - Anticipated increases in the numbers of vulnerable and elder adults in North Carolina who may be abused, neglected and exploited, or at substantial risk of abuse, neglect or exploitation; or

   - Complexity involved and specialization needed when intervening with vulnerable and elder adults who are mistreated.

Proposed Budget:
Costs associated with standards for caseload size and supervisor/worker ratio are built into the costs for county staff FTEs (See Recommendation #2).

Core Recommendation 7:
Enhance technology and data collection systems to strengthen accountability and support implementation of an APS Clearinghouse Model pilot and statewide implementation.

1. Enhance the current system of statistical and demographic data collection to reflect the additional data elements that will be needed to support the APS Clearinghouse Model pilot and statewide implementation.

Findings to Support Core Recommendation 7:

1. The data collection tool (DSS 5026) for reporting to the APS Register will need to be revised to capture the new data elements in the APS Register.

2. The current APS Register does not have the capability to collect statistical and demographic information needed for the APS Clearinghouse Model.

Proposed Budget:
Costs associated with enhancement of the APS Register can be covered under the current budget. No additional funding required.

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.

1. Develop printed materials, such as, brochures, news print, videos, public service announcements, or web sites for public consumption.

2. Encourage local public awareness with community partners and outreach to the public regarding the problems of elder abuse.

3. Encourage local public awareness about county departments of social services' mandate to protect all vulnerable and elder adults who have been abused, neglected or exploited or who are at substantial risk of abuse, neglect or exploitation.

Findings to Support Core Recommendation 8:

1. The general public often does not understand the phenomena of adult abuse or have knowledge about the issues and problems associated with abuse, neglect or exploitation of vulnerable and elder adults. APS research indicates that only 1 in 14 instances of mistreatment are actually reported.

2. Increased public awareness is needed to address issues of under-reporting and to more proactively assure mistreated vulnerable and elder adults are protected.

3. Adult Protective Services is not a priority for local, state and federal funding.

4. A public awareness campaign will require funding.

Proposed Budget: $61,000

Core Recommendation 9

Design and implement a time limited CHM pilot.

1. Design and implement a time limited pilot for twelve months.

2. Provide funding for staff in county departments of social services to carry out the CHM pilot based on workload standards described in Recommendation 6.

3. Provide funding for 3 of the 5 staff positions needed in the Division of Aging and Adult Services to plan and carry out the CHM pilot.

Findings to Support Core Recommendation 9:

1. The APS Clearinghouse Model is a new and more comprehensive system of protection for vulnerable and elder adults who are abused, neglect or exploited or who are at substantial risk of abuse, neglect or exploitation.

2. A pilot will be needed to document findings and effectiveness of the APS CHM.

3. No funding is currently available to support a pilot of the APS CHM.

Total Proposed Pilot Budget: $1,822,085 **$1,617,308 County Staff** **$ 179,027 Division Staff** **$ 18,000 Public Awareness** **$ 6,750 Essential Services**	**Total FTEs: 27.103** **24.103 County Staff** **3.0 Division Staff**

ATTACHMENTS

List of Stakeholders

Adult Protective Services Task Force Membership

Adult Protective Services Work Group/Sub Work Group Membership

Draft of North Carolina General Statute 108A Proposed Changes

Adult Protective Services Clearinghouse Model

Key Stakeholders

State Government

NC Division of Social Services
NC Division of Facility Services
NC Division of Medical Assistance
NC Division of MH/DD/SAS
NC Division of Public Health
NC Division of Services for the Blind
NC Division of Services for the Deaf and Hard of Hearing
NC Division of Vocational Rehabilitation
Office of Economic Opportunity

County Government

NC Association of County Directors of Social Services
NC Adult Services Committee
NC Association of County Commissioners
NC Association of County Boards of Social Services
NC Association of Area Agencies on Aging
NC LTC Ombudsman Program
NC Council of Community Programs
NC Association of Local Health Directors

Legal

NC Office of the Attorney General
NC Institute of Government
NC Bar Association, Elder Law Section
NC Association of County Department of Social Services Attorneys
Wake Forest School of Law, Elder Law Clinic
Carolina Legal Assistance
Administrative Office of the Courts
NC Association of Clerks of Superior Court
North Carolina Association of District Court Judges

Advocacy/Support Organizations

NC Adult Protective Services Association
NC Senior Tar Heel Legislature
NC Coalition on Aging
NC Association on Aging
Governor's Advisory Council on Aging
Friends of Residents in Long Term Care
NC Association of LTC Facilities
NC Health Care Facilities Association
NC Assisted Living Association
Family Care Facilities Association
NC Adult Foster Care Association
Coalition for Continuity of Care in Geriatric Communities
NC Adult Services Association
Orange County Coalition of Elder Abuse
NC Adult Day Services Association
NC Association of Non-Profit Homes for the Aging
Association of Home & Hospice Care of NC
Alzheimers Association – Western and Eastern Chapters
NC Council for Developmental Disabilities
NC Public Health Association
NC Senior Citizens Association
The Carolina Centers for Hospice and End of Life Care
NC Guardianship Association
Association of NC Boards of Health
NC-AARP
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North Carolina General Statute 108A Proposed Changes
~~**NORTH CAROLINA ADULT PROTECTIVE SERVICES STATUTES**~~

Chapter 108A, Article 6. **Protection of Vulnerable and Elder Adults**
~~Protection of the Abused, Neglected, or Exploited Disabled Adult Act, July 1985~~

108A-99. Short Title. - This Article may be cited as the "Protection of Abused, Neglected, or Exploited Vulnerable and Elder Adults Act."

~~108A-99. Short Title. "Protection of the Abused, Neglected, or Exploited Disabled Adult Act."~~

G.S. 108A-100. Legislative intent and purpose.
Determined to protect the increasing number of vulnerable and elder adults in North Carolina who are abused, neglected, exploited, or at substantial risk of being abused, neglected, or exploited, the General Assembly enacts this Article to provide protective services for such persons consistent with their right to personal autonomy and self-determination.

~~108A-100. Legislative intent and purpose. Determined to protect the increasing number of~~ disabled ~~adults in North Carolina who are abused, neglected, or exploited, the General Assembly enacts this Article to provide protective services for such persons~~.

108A-101. Definitions.

(a) "Abuse" means the infliction or threat of infliction of physical pain, injury or mental anguish; unreasonable confinement or deprivation of services that are necessary to maintain the vulnerable or elder adult's mental and physical health by a caregiver or by a person who has a significant personal, family, or social relationship with the adult.

~~(a) The word "abuse" means the willful infliction of physical pain, injury or mental anguish, unreasonable confinement, or the willful deprivation by a caretaker of services which are necessary to maintain mental and physical health.~~

(b) "Caregiver" means a person or entity that is providing, or is responsible for providing, care for a vulnerable or elder adult by virtue of a personal, social, or family relationship with the adult or by contract, agreement, or operation of law. "Caregiver" includes, but is not limited to, guardians, health

care agents, and attorneys-in-fact. "Caregiver" also includes, but is not limited to, nursing homes, adult care homes, home health agencies, adult day services, and their employees or agents. "Caregiver" does not include acute care hospitals, emergency services personnel, or other persons, agencies, or entities that provide only emergency or acute care to a vulnerable or elder adult.

~~(b) The word "caretaker" shall mean an individual who has the responsibility for the care of the disabled adult as a result of family relationship or who has assumed the responsibility for the care of the disabled adult voluntarily or by contract.~~

(c) "Consent" means that a vulnerable or elder adult possesses sufficient understanding or ability to consent to protective services or make or communicate important decisions concerning his or her person, family, or property; or consent given on behalf of a vulnerable or elder adult by a lawfully authorized person or entity. The director may determine a vulnerable or elder adult's ability to consent based on observations, medical or mental health assessment, the risk and benefits, or other available information.

~~(c) The word "director" shall mean the director of the county department of social services or his representative in the county in which the person resides or is present.~~

(d) "County social services department" means a county social services department that administers public assistance and social services programs under this Chapter or a consolidated human services agency established pursuant to G.S. 153B-77(b)(3).

~~(d) The words "disabled adult" shall mean any person 18 years of age or over or any lawfully emancipated minor who is present in the State of North Carolina and who is physically or mentally incapacitated due to mental retardation, cerebral palsy, epilepsy or autism; organic brain damage caused by advanced age or other physical degeneration in connection therewith; or due to conditions incurred at any age which are the result of accident, organic brain damage, mental or physical illness, or continued consumption or absorption of substances.~~

(e) "Director" means the director of a county social services department or the director's representative as authorized in G.S. 108A-14.

~~(e) A "disabled adult" shall be "in need of protective services" if that person, due to his physical or mental incapacity, is unable to perform or obtain for himself essential services and if that person is without able, responsible, and willing persons to perform or obtain for his [him] essential services.~~

(f) "Elder adult" means an individual who is 60 years of age or older and who is present in the State.

~~(f) The words "district court" shall mean the judge of that court.~~

(g) "Emergency services" means essential services that are necessary to protect a vulnerable adult from death or, serious, and irreparable physical or mental harm and are provided pursuant to a court order entered pursuant to G.S. 108A-112.

~~(g) The word "emergency" refers to a situation where (i) the disabled adult is in substantial danger of death or irreparable harm if protective services are not provided immediately, (ii) the disabled adult is unable to consent to services, (iii) no responsible, able, or willing caretaker is available to consent to emergency services, and (iv) there is insufficient time to utilize procedure provided in G.S. 108A-105~~

(h) "Essential services" means services that are necessary to protect a vulnerable or elder adult's rights and resources and ensure his or her health, safety, and well-being. "Essential services" include, but are not limited to, social, medical, psychiatric, psychological, and legal services; in-home services; adult placement services; assistance in obtaining adequate food, clothing, shelter, and health care; protection from health and safety hazards; protection from physical mistreatment; and protection from exploitation.

~~(h) The words "emergency services" refer to those services necessary to maintain the person's vital functions and without which there is reasonable belief that the person would suffer irreparable harm or death. This may include taking physical custody of the disabled person.~~

(i) "Exploitation" means (1) the illegal or improper use of a vulnerable or elder adult or his resources for another's profit or advantage; (2) the transfer, acquisition, conversion, or theft of a vulnerable or elder adult's money, property, or resources by any person or entity, including, but not limited to, a guardian, attorney-in-fact, or other individual with legal or fiduciary

authority; or (3) causing or requiring a vulnerable or elder adult to engage in any activity, including sexual behavior, or labor that is improper or illegal or refused by the vulnerable or elder adult. "Exploitation" includes, but is not limited to, forging checks; obtaining or attempting to obtain a vulnerable or elder adult's money, property, or resources through misrepresentation, deception, fraud, coercion, intimidation, force, or threat of force; concealing or retaining possession of a vulnerable or elder adult's money, property, or resources without authority or just cause to do so; and using undue influence, coercion, deceit, or misrepresentation to induce a vulnerable or elder adult to execute a contract, deed, will, or other legal document affecting the adult's money, property, or resources.

~~(i) The words "essential services" shall refer to those social, medical, psychiatric, psychological or legal services necessary to safeguard the disabled adult's rights and resources and to maintain the physical or mental well-being of the individual. These services shall include, but not be limited to, the provision of medical care for physical and mental health needs, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from health and safety hazards, protection from physical mistreatment, and protection from exploitation. The words "essential services" shall not include taking the person into physical custody without his consent except as provided for in G.S. 108A-106 and in Chapter 122 of the General Statutes.~~

(j) "Lacks the ability to consent" means that a vulnerable or elder adult lacks sufficient understanding or ability to consent to protective services or to make or communicate important decisions concerning his or her person, family, or property. The court shall make the determination following procedures in G. S. 108A-111, 112,113, or 114. A decision to refuse protective services cannot be the sole evidence for finding the vulnerable or elder adult lacks the ability to consent. The vulnerable or elder adult may be determined to lack the ability to consent due to coercion, duress, fear of reprisal, undue influence or dependency.

~~(j) The word "exploitation" means the illegal or improper use of a disabled adult or his resources for another's profit or advantage.~~

(k) "Major life activities" means "major life activities" as defined in G.S. 168A-3(7a)b.; activities of daily living (ADLs), such as bathing and feeding oneself, going to the toilet, dressing and

grooming oneself, taking medication, walking (independently or with assistance), using a wheelchair, getting in and out of one's bed, bathtub, vehicle, etc., and other activities related to self-care; and instrumental activities of daily living (IADLs), such as cooking, shopping, using a telephone, doing housework, driving, managing finances, etc.

~~(k) The word "indigent" shall mean indigent as defined in G.S. 7A-450.~~

(l) "Neglect" means (1) a caregiver's failure or refusal to provide or obtain adequate food, clothing, shelter, health care, or other essential services necessary to ensure a vulnerable or elder adult's health, safety, or welfare; (2) the abandonment or desertion of a vulnerable or elder adult by a caregiver; (3) a vulnerable or elder adult's inability, failure, or refusal to provide himself or herself, or make arrangements to provide himself or herself, with adequate food, clothing, shelter, health care, or other essential services necessary to ensure his or her health, safety, or welfare; or (4) other acts or behaviors by a vulnerable or elder adult that jeopardize his or her health, safety, or welfare.

~~(l) The words "lacks the capacity to consent" shall mean lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person, including but not limited to provisions for health or mental health care, food, clothing, or shelter, because of physical or mental incapacity. This may be reasonably determined by the director or he may seek a physician's or psychologist's assistance in making this determination.~~

(m) "Obstruct or interfere" means obstructing or interfering with an adult protective services evaluation conducted pursuant to this Article or the provision of protective services pursuant to this Article by a person or entity other than the vulnerable or elder adult who is the subject of the evaluation or the recipient of protective services. Obstructing or interfering includes, but is not limited to, refusing to allow the director to enter the premises where the vulnerable or elder adult is located if the vulnerable or elder adult has consented to the evaluation or protective services, or lacks the ability to consent; refusing to allow the director to interview the vulnerable or elder adult if the vulnerable or elder adult has consented to the evaluation or protective services or lacks the ability to consent; refusing to release confidential or privileged information or records concerning the vulnerable or elder adult if the vulnerable or

elder adult has consented to the release of the information or records or lacks the ability to consent; obstructing or interfering with the examination or evaluation of the vulnerable or elder adult by a physician or other health care provider or expert if the vulnerable or elder adult has consented to the evaluation or protective services or lacks the ability to consent; refusing to disclose the whereabouts of a vulnerable or elder adult; refusing to provide information or records to the director as required by G.S. 108A-104; or any other conduct that obstructs or interferes with the director's ability to conduct an evaluation or provide protective services pursuant to this Article. Obstruct or interfere also means the refusal of a vulnerable adult who lacks the ability to consent to allow the director to enter the adult's home, to interview the adult, to take photographs of the adult or the adult's home, to obtain confidential or privileged information or records concerning the adult, or to cooperate in connection with the examination or evaluation of the adult by a physician or other health care provider or expert.

~~(m) The word "neglect" refers to a disabled adult who is either living alone and not able to provide for himself the services which are necessary to maintain his mental or physical health or is not receiving services from his caretaker. A person is not receiving services from his caretaker if, among other things and not by way of limitation, he is a resident of one of the State-owned hospitals for the mentally ill, centers for the mentally retarded or North Carolina Special Care Center [,] he is, in the opinion of the professional staff of that hospital or center, mentally incompetent to give his consent to medical treatment, he has no legal guardian appointed pursuant to Chapter 33, Chapter 35, or guardian as defined in G.S. 122-36(n), and he needs medical treatment.~~

(n) "Physical or mental impairment" means a physical or mental impairment as defined in G.S. 168A-3(7a)a. or a physical or mental impairment resulting from alcohol or substance abuse.

~~(n) The words "protective services" shall mean services provided by the State or other government or private organizations or individuals which are necessary to protect the disabled adult from abuse, neglect, or exploitation. They shall consist of evaluation of the need for service and mobilization of essential services on behalf of the disabled adult.~~

(o) "Protective services" means services to protect vulnerable or elder adults from abuse, neglect, or exploitation. "Protective services" include the intake, screening, and evaluation of

reports regarding the abuse, neglect, or exploitation of vulnerable or elder adults pursuant to this Article; information and referral services; outreach services; and intervention services.

(1) "Information and referral services" mean the provision of information to vulnerable and elder adults and the referral of vulnerable and elder adults to public and private human services agencies and community resources pursuant to this Article. Information and referral services may be provided to a vulnerable or elder adult with the adult's consent if the adult has been alleged to have been abused, neglected, exploited, or at substantial risk of abuse, neglect, or exploitation and does not need outreach services or intervention services.

(2) "Outreach services" means the planning, coordination, arrangement, mobilization, and management of essential services for vulnerable and elder adults pursuant to this Article. Outreach services may be provided to a vulnerable or elder adult with the adult's consent if the adult has been abused, neglected, or exploited or is at substantial risk of abuse, neglect, or exploitation.

(3) "Intervention services" means the provision of emergency or essential services to vulnerable adults pursuant to this Article. Intervention services may be provided to a vulnerable adult with the adult's consent, or in the case of a vulnerable adult who lacks the ability to consent pursuant to a court order entered under G.S. 108A-111, 112, or 113, if the adult has been abused, neglected, exploited, or at substantial risk of abuse, neglect, or exploitation, is unable to obtain the services himself or herself, and has no able, willing, and responsible person who can obtain the services for him or her.

(p) "Substantial risk" means a reasonable probability that a vulnerable or elder adult will be abused, neglected, or exploited unless protective services are provided.

(q) "Vulnerable adult" means a person who (1) is 18 years of age or older or a lawfully emancipated minor, (2) is present in this State, and (3) has a physical or mental impairment that substantially limits at least two major life activities.

G.S. 108A-102. Responsibility for adult protective services.

Each county department of social services shall provide, under the supervision of the Department of Health and Human Services and pursuant to this Article, protective services for vulnerable or elder

adults who have been, or are at substantial risk of being, abused, neglected, or exploited.

~~108A-102. Duty to report; content of report; immunity.~~

~~(a) Any person having reasonable cause to believe that a disabled adult is in need of protective services shall report such information to the director.~~

~~(b) The report may be made orally or in writing. The report shall include the name and address of the disabled adult; the name and address of the disabled adults caretaker; the age of the disabled adult; the nature and extent of the disabled adult's injury or condition resulting from abuse or neglect; and other pertinent information.~~

~~(c) Anyone who makes a report pursuant to this statute, who testifies in any judicial proceeding arising from the report, or who participates in a required evaluation shall be immune from any civil or criminal liability on account of such report or testimony or participation, unless such person acted in bad faith or with a malicious purpose.~~

G.S. 108A-103. Reporting abuse, neglect, or exploitation of vulnerable or elder adults.

(a) Any person having reasonable cause to believe that a vulnerable or elder adult has been, or is at substantial risk of being, abused, neglected, or exploited shall report such information to the director in the county in which the adult resides or is present.

(b) The report may be made orally or in writing. The person making the report shall provide, to the extent known to the person who made the report, the vulnerable or elder adult's name, age, address, physical or mental condition, and location; the caregiver's name and address; the name and address of the person believed to be responsible for the abuse, neglect, or exploitation; information regarding the nature and extent of the suspected abuse, neglect, or exploitation and the injury or damage resulting there from; and other pertinent information requested by the director.

~~108A-103. Duty of director upon receiving report.~~

~~(a) Any director receiving a report that a disabled adult is in need of protective services shall make a prompt and thorough~~

~~evaluation to determine whether the disabled adult is in need of protective services and what services are needed. The evaluation shall include a visit to the person and consultation with others having knowledge of the facts of the particular case. When necessary for a complete evaluation of the report, the director shall have the authority to review and copy any and all records, or any part of such records, related to the care and treatment of the disabled adult that have been maintained by any individual, facility or agency acting as a caretaker for the disabled adult. This shall include but not be limited to records maintained by facilities licensed by the North Carolina Department of Human Resources. Use of information so obtained shall be subject to and governed by the provision of G.S. 108A-80 and G.S. 122-8.1. The director shall have the authority to conduct an interview with the disabled adult with no other persons present. After completing the evaluation the director shall make a written report of the case indicating whether he believes protective services are needed and shall notify the individual making the report of his determination as to whether the disabled adult needs protective services.~~

~~(b) The staff and physicians of local health departments, mental health clinics, and other public or private agencies shall cooperate fully with the director in the performance of his duties. These duties include immediate accessible evaluations and in-home evaluations where the director deems this necessary.~~

~~(c) The director may contract with an agency or private physician for the purpose of providing immediate accessible medical evaluations in the location that the director deems most appropriate.~~

~~(d) The director shall initiate the evaluation described in subsection (a) of this section as follows:~~

~~(1) Immediately upon receipt of the complaint if the complaint alleges a danger of death in an emergency as defined in G. S. 108A-101(g).~~

~~(2) Within 24 hours if the complaint alleges danger of irreparable harm in an emergency as defined by G. S. 108A-101(g).~~

~~(3) Within 72 hours if the complaint does not allege danger of death or irreparable harm in an emergency as defined by G. S. 108A-101(g).~~

~~The evaluation shall be completed within 30 days for allegations of abuse or neglect and within 45 days for allegations of exploitation.~~

G.S. 108A-104. Evaluation of reports of abuse, neglect, or exploitation of vulnerable or elder adults.

(a) The director shall evaluate all reports alleging that a vulnerable or elder adult has been, or is at substantial risk of being, abused, neglected, or exploited.

(b) The director shall initiate evaluations:
  (1) Immediately upon receipt of a report if the report alleges a danger of death.
  (2) Within 24 hours from receipt of a report if the report alleges a danger of serious and irreparable harm.
  (3) Within 72 hours from receipt of a report if the report does not allege a danger of death or serious, and irreparable harm.

(c) Unless the person making the report otherwise requests, the director shall notify the person making the report whether the director has accepted the report for evaluation.

(d) The evaluation shall determine whether the vulnerable or elder adult who is the subject of a report (1) has been, or is at substantial risk of being, abused, neglected, or exploited; (2) needs protective services (and, if so, what type of protective services); (3) lacks the ability to consent; and (4) has anyone willing, able, and responsible who can provide or arrange for the provision of essential services.

(e) Except as otherwise provided herein, the evaluation shall include a home visit to, and private interview with, the vulnerable or elder adult. A home visit and interview are not required if the information provided to the director indicates that the adult is not at substantial risk of abuse, neglect, or exploitation. Unless the director reasonably believes that a vulnerable or elder adult lacks the ability to consent and may be under undue influence, fear of reprisal, coercion, duress from others, or dependency, the director shall honor a vulnerable or elder adult's refusal to be visited or interviewed or the adult's request that others be present during the interview or evaluation.

(f) In conducting an evaluation, the director may interview the vulnerable or elder adult's caregiver, neighbors, family, friends, or others; take photographs of the vulnerable or elder adult and the adult's residence with the adult's consent; make arrangements for the physical or mental evaluation of the vulnerable or elder adult with the adult's consent; obtain

nonconfidential information and records; and obtain confidential or privileged information and records regarding the vulnerable or elder adult from health care providers, financial institutions, or others with the adult's consent; and take any other action that the director deems necessary to conduct a thorough evaluation.

(g) If any person or entity, other than the vulnerable or elder adult who is the subject of the evaluation, obstructs or interferes with the director's evaluation, the director may obtain a court order pursuant to G.S. 108A-114.

(h) If a vulnerable adult who lacks the ability to consent obstructs or interferes with the director's evaluation, the director may obtain a court order pursuant to G.S. 108A-114.

(i) The director may contract with a public agency or qualified private health care provider to provide immediate and accessible physical and mental evaluations of vulnerable and elder adults under subsection (f).

(j) Upon the director's request, local health departments, hospitals, area mental health authorities and local management entities, and other public or private health care or human services providers shall cooperate with the director in the director's evaluation of reports of abuse, neglect, or exploitation of vulnerable or elder adults and the provision of protective services pursuant to this Article.

(k) The director shall complete evaluations of reports alleging the abuse or neglect of vulnerable or elder adults within 30 days and complete evaluations of reports regarding the exploitation of vulnerable or elder adults within 45 days.

(l) After completing an evaluation, the director shall document in the adult's protective services case record the director's findings and determinations with respect to whether the vulnerable or elder adult was, or is at substantial risk of being, abused, neglected, or exploited; whether the adult needs protective services; what protective services are needed; what protective services have been and will be provided; and whether the elderly or vulnerable adult lacks the ability to consent.

(m) Upon completion of an evaluation, the director shall provide written notice to the individual who made the report unless the person who made the report has waived notice. The notice shall indicate whether the director is, or will be, providing protective services to the vulnerable or elder adult and whether the director has referred the case to law enforcement officials or the district attorney pursuant to G.S. 108A-105 or to a licensing agency pursuant to G.S. 108A-106.

~~108A-104. Provision of protective services with the consent of the person; withdrawal of consent; caretaker refusal.~~

~~(a) If the director determines that a disabled adult is in need of protective services he shall immediately provide or arrange for the provision of protective services, provided that the disabled adult consents.~~

~~(b) When a caretaker of a disabled adult who consents to the receipt of protective services refuses to allow the provision of such services to the disabled adult, the director may petition the court for an order enjoining the caretaker from interfering with the provision of protective services to the disabled adult. The petition must allege specific facts sufficient to show that the disabled adult is in need of protective services and consents to the receipt of protective services and that the caretaker refuses to allow the provision of such services. If the judge finds by clear, cogent, and convincing evidence that the disabled adult is in need of protective services and consents to the receipt of protective services and that the caretaker refuses to allow the provision of such services, he may issue an order enjoining the caretaker from interfering with the provision of protective services to the disabled adult.~~

~~(c) If a disabled adult does not consent to the receipt of protective services, or if he withdraws his consent, the services shall not be provided.~~

G.S. 108A-105. Referral to law enforcement.

The director shall adopt, in consultation with the district attorney and appropriate law enforcement officials, written procedures governing the referral of cases involving the abuse, neglect, or exploitation of vulnerable or elder adults to the district attorney or law enforcement officials. The director shall refer cases involving abuse, neglect, or exploitation of vulnerable or elder adults to the district attorney or appropriate law enforcement officials in accordance with these procedures and, upon request, shall provide the district attorney or law enforcement officials with any information, including the identity of the person who made the report, that may be relevant and necessary to the investigation or prosecution of a criminal proceeding involving the abuse, neglect, or exploitation of a vulnerable or elder adult.

~~108A-105. Provision of protective services to disabled adults who lack the capacity to consent; hearing, findings, etc.~~

~~(a) If the director reasonably determines that a disabled adult is in need of protective services and lacks capacity to consent to protective services, then the director may petition the district court for an order authorizing the provision of protective services. The petition must allege specific facts sufficient to show that the disabled adult is in need of protective services and lacks capacity to consent to protective services.~~

~~(b) The court shall set the case for hearing within 14 days after the filing of the petition. The disabled adult must receive at least five days' notice of the hearing. He has the right to be present and represented by counsel at the hearing. If the person, in the determination of the judge, lacks the capacity to waive the right to counsel, then the court shall appoint a guardian ad litem pursuant to G.S. 1A-1, Rule 17. If the person is indigent, the cost of representation shall be borne by the State.~~

~~(c) If, at the hearing, the judge finds by clear, cogent, and convincing evidence that the disabled adult is in need of protective services and lacks capacity to consent to protective services, he may issue an order authorizing the provision of protective services. This order may include the designation of an individual or organization to be responsible for the performing or obtaining of essential services on behalf of the disabled adult or otherwise consenting to protective services in his behalf. Within 60 days from the appointment of such an individual or organization, the court will conduct a review to determine if a petition should be initiated in accordance with Chapter 35, Article 1A, or Article 2, as appropriate; for good cause shown, the court may extend the 60 day period for an additional 60 days, at the end of which it shall conduct a review to determine if a petition should be initiated in accordance with Chapter 35, Article 1A, or Article 2, as appropriate. No disabled adult may be omitted to a mental health facility under this Article.~~

~~(d) A determination by the court that a person lacks the capacity to consent to protective services under the provision of this Chapter shall in no way affect incompetency proceedings as set forth in Chapter 33, 35 or 122 of the General Statutes of North Carolina, or any other proceedings, and incompetency proceedings as set forth in Chapters 33, 35, or 122 shall have no conclusive effect upon the question of~~

~~capacity to consent to protective services as set forth in this Chapter.~~

G.S. 108A-106. Referral to licensing agencies.

The Department of Health and Human Services shall adopt, in consultation with appropriate licensing agencies, written procedures governing the referral of cases involving the abuse, neglect, or exploitation of vulnerable or elder adults to appropriate licensing agencies. The director shall refer cases involving the abuse, neglect, or exploitation of vulnerable or elder adults to appropriate licensing agencies in accordance with these procedures and, upon request, shall provide a licensing agency with any information, including the identity of the person who made the report, that may be relevant and necessary to the licensing agency's investigation or administrative proceedings involving the abuse, neglect, or exploitation of a vulnerable or elder adult.

~~108A-106. Emergency intervention; findings by court; limitations; contents of petition; notice of petition; court authorized entry of premises; immunity of petitioner.~~

~~(a) Upon petition by the director, a court may order the provision of emergency services to a disabled adult after finding that there is reasonable cause to believe that:~~
~~(1) A disabled adult lacks capacity to consent and that he is in need of protective services;~~
~~(2) An emergency exists; and~~
~~(3) No other person authorized by law or order to give consent for the person is available and willing to arrange for emergency services.~~

~~(b) The court shall order only such emergency services as are necessary to remove the conditions creating the emergency. In the event that such services will be needed for more than 14 days, the director shall file an additional petition with the court in accordance with G.S. 108A-105.~~

~~(c) The petition for emergency services shall set forth the name, address, and authority of the petitioner; the name, age and residence of the disabled adult; the nature of the emergency; the nature of the disability if determinable; the proposed emergency services; the petitioner's reasonable belief as to the existence of the conditions set forth in subsection (a) above; and facts showing petitioner's attempts to obtain the disabled adult's consent to the services.~~

(d) Notice of the filing of such petition, and other relevant information, including the factual basis of the belief that emergency services are needed and a description of the exact services to be rendered, shall be given to the person, to his spouse, or if none, to his adult children or next of kin, to his guardian, if any. Such notice shall be given at least 24 hours prior to the hearing of the petition for emergency intervention; provided, however, that the court may issue immediate emergency order ex parte upon finding as fact (i) that the conditions specified in G.S. 108A-106(a) exist; (ii) that there is likelihood that the disabled adult may suffer irreparable injury or death if such order be delayed; and (iii) that reasonable attempts have been made to locate interested parties and secure from them such services or their consent to petitioner's provision of such service; and such order shall contain a show-cause notice to each person upon whom served directing such person to appear immediately or at any time up to and including the time for the hearing of the petition for emergency services and show cause, if any exist, for the dissolution or modification of the said order. Copies of the said order together with such other appropriate notices as the court may direct shall be issued and served upon all of the interested parties designated in the first sentence of this subsection. Unless dissolved by the court for good cause shown, the emergency order ex parte shall be in effect until the hearing is held on the petition for emergency services. At such hearing, if the court determines that the emergency continues to exist, the court may order the provision of emergency services in accordance with subsections (a) and (b) of this section.

(e) Where it is necessary to enter a premises without the disabled adult's consent after obtaining a court order in compliance with subsection (a) above, the representative of the petitioner shall do so.

(f) (1) Upon petition by the director, a court may order that:

a. The disabled adult's financial records be made available at a certain day and time for inspection by the director or his designated agent; and

b. The disabled adult's financial assets be frozen and not withdrawn, spent or transferred without prior order of the court.

(2) Such an order shall not issue unless the court first finds that there is reasonable cause to believe that:

a. A disabled adult lacks the capacity to consent and that he is in need of protective services;

~~b. The disabled adult is being financially exploited by his caretaker; and~~

~~c. No other person is able or willing to arrange for protective services.~~

~~(3) Provided, before any such inspection is done, the caretaker and every financial institution involved shall be given notice and a reasonable opportunity to appear and show good cause why this inspection should not be done. And, provided further that any order freezing assets shall expire ten days after such inspection is completed, unless the court for good cause shown, extends it.~~

~~(g) No petitioner shall be held liable in any action brought by the disabled adult if the petitioner acted in good faith.~~

G.S. 108A-107. Adult protective services register.

(a) The Department of Health and Human Services shall maintain an adult protective services register in accordance with rules adopted by the Social Services Commission.

(b) The director shall submit information regarding adult protective services cases to the Department in accordance with rules adopted by the Social Services Commission.

(c) Information in the adult protective services register may be used or disclosed only in accordance with rules adopted by the Social Services Commission.

~~108A-107. Motion in the cause. Notwithstanding any finding by the court of lack of capacity of the disabled adult to consent, the disabled adult or the individual or organization designated to be responsible for the disabled adult shall have the right to bring a motion in the cause for review of any order issued pursuant to this Article.~~

G.S. 108A-108. Provision of protective services: information and referral.

If the director determines that a vulnerable or elder adult needs information and referral services, the director shall provide information and referral services to the vulnerable or elder adult with the adult's consent.

~~108A-108. Payment for essential services. At the time the director, in accordance with the provisions of G.S. 108A-103 makes an evaluation of the case reported, then it shall be determined, according to regulations set by the Social Services Commission, whether the individual is financially capable of paying for the essential services. If he is, he shall make reimbursement for the costs of providing the needed essential services. If it is determined that he~~

~~is not financially capable of paying for such essential services, they shall be provided at no cost to the recipient of the services.~~

G.S. 108A-109. Provision of protective services: outreach.

If the director determines that a vulnerable or elder adult (1) has been abused, neglected, or exploited or is at substantial risk of abuse, neglect, or exploitation, and (2) needs protective services other than information and referral services, the director shall provide outreach services to the vulnerable or elder adult with the adult's consent.

~~108A-109. Reporting abuse. Upon finding evidence indicating that a person has abused, neglected, or exploited a disabled adult, the director shall notify the district attorney.~~

G.S. 108A-110. Provision of protective services: intervention.

If the director determines that a vulnerable adult (1) has been, or is at substantial risk of being, abused, neglected, or exploited, (2) needs emergency or essential services, and (3) is unable to obtain essential services and has no responsible caregiver or other responsible person who is able and willing to provide or arrange for the provision of emergency or essential services, the director shall provide or arrange for the provision of emergency or essential services with the adult's consent, or in the case of an adult who lacks the ability to consent, pursuant to a court order entered pursuant to G.S. 108A-111, 112, or 113.

~~108A-110. Funding of protective services. Any funds appropriated by counties for home health care, boarding home, nursing home, emergency assistance, medical or psychiatric evaluations, and other protective services and for the development and improvement of a system of protective services, including additional staff, may be matched by State and Federal funds. Such funds shall be utilized by the county department of social services for the benefit of disabled adults in need of protective services.~~

G.S. 108A-111. Protective services: involuntary intervention.

(a) If the director determines that a vulnerable adult (1) has been, or is at substantial risk of being, abused, neglected, or exploited; (2) needs emergency or essential services; (3) is unable to obtain essential services and has no responsible caregiver or other responsible person who is able and willing to provide or arrange for the provision of emergency or essential services; and (4) lacks the ability to consent, the director may file a special proceeding in the district court pursuant to this section.

(b) Venue for a special proceeding pursuant to this section is in the county in which the vulnerable adult resides or is present.

(c) The petition shall name the vulnerable adult as the respondent, be verified, and allege specific facts sufficient to show that the vulnerable adult (1) has been, or is at substantial risk of being, abused, neglected, or exploited; (2) needs emergency or essential services; (3) is unable to obtain essential services and has no responsible caregiver or other responsible person who is able and willing to provide or arrange for the provision of emergency or essential services; and (4) lacks the ability to consent. The petition also must set forth the nature and extent of the emergency or essential services that the director deems necessary. The petition may include a verified motion seeking an ex parte order authorizing the provision of emergency services pursuant to G.S. 108A-112.

(d) A copy of the petition and summons must be promptly served on the vulnerable adult and any next of kin known to the director, and, in cases involving abuse, neglect, or exploitation by a caregiver, on the vulnerable adult's caregiver, pursuant to G.S. 1A-1, Rule 4, Rules of Civil Procedure. A sheriff who serves the notice and summons shall do so without demanding fees in advance.

(e) Upon the filing of a petition under this section, the clerk of superior court shall appoint an attorney to represent the vulnerable adult in the proceeding pursuant to G.S. 7A-451(a)(11) and rules adopted by the Office of Indigent Defense Services. Notwithstanding G.S. 7A-450 and G.S. 7A-451, a vulnerable adult who is the respondent in an adult protective services proceeding shall be deemed indigent for the purpose of appointment of counsel. If the court subsequently determines that the vulnerable adult is not indigent or is partially indigent, the court may enter an order pursuant to G.S. 7A-455 requiring the vulnerable adult to pay some or all of the value of the legal services rendered by court-appointed counsel. The court shall dismiss the court-appointed attorney if the vulnerable adult retains legal counsel. The court may appoint a guardian ad litem for the vulnerable adult pursuant to G.S. 1A-1, Rule 17, if the court determines that the appointment of a guardian ad litem is necessary and appropriate.

(f) The court shall hold a hearing and enter an order authorizing or denying the provision of essential services without the vulnerable adult's consent within 14 days after the petition is filed. The vulnerable adult must receive at least five days' notice of the hearing.

(g) The court may enter an order authorizing the provision of essential services if it finds that the vulnerable adult (1) has been, or is at substantial risk of being, abused, neglected, or exploited; (2) needs essential services; (3) is unable to obtain essential services and has no responsible caregiver or other

responsible person who is able and willing to provide or arrange for the provision of essential services; and (4) lacks the ability to consent. If the court authorizes the director to provide or arrange for the provision of essential services, the order shall state the nature, extent, and duration of the essential services that may be provided and designate the individual, agency, or organization that will be responsible for arranging, providing, or obtaining essential services or consenting to the provision of essential services for the vulnerable adult. The court may not order that essential services be provided for a period in excess of 90 days. The court may not appoint a guardian for the vulnerable adult or commit the vulnerable adult to a mental health facility under this Article. The court, however, may order the director to file a proceeding pursuant to Chapter 35A if it finds that the vulnerable adult may be incompetent and may need a guardian.

(h) If the court enters an order authorizing essential services, the vulnerable adult [, or] the vulnerable adult's attorney or guardian ad litem [, or the adult's caregiver or next of kin, if any,] may file a motion in the cause requesting that the order be modified or dissolved.

(i) A finding by the court that a vulnerable adult lacks the ability to consent is inadmissible in a guardianship proceeding under Chapter 35A, in involuntary commitment proceedings under Chapter 122C, or in any other legal proceeding. A judicial determination regarding a vulnerable adult's capacity made in a guardianship proceeding under Chapter 35A or in an involuntary commitment proceeding under Chapter 122C does not have conclusive effect on the issue of the vulnerable adult's ability to consent in an adult protective services proceeding under this Article.

~~108A-111. Adoption of standards. The Department and the administrative office of the court shall adopt standards and other procedures and guidelines with forms to insure the effective implementation of the provisions of this Article.~~

G.S. 108A-112. Protective services: involuntary emergency services.

(a) The director may, by filing a verified motion in an adult protective services proceeding pursuant to G.S. 108A-111 or as part of the petition in an adult protective services proceeding pursuant to G.S. 108A-111, request the court to authorize the provision of emergency services to a vulnerable adult.

(b) The court may enter an order authorizing the provision of emergency services if it finds that there is reasonable cause to believe that the vulnerable adult (1) has been, or is at substantial risk of being, abused, neglected, or exploited; (2)

needs emergency services; (3) is unable to obtain emergency services and has no responsible caregiver or other responsible person who is able and willing to provide or arrange for the provision of emergency services; (4) lacks the ability to consent; and (5) will suffer death or serious, and irreparable physical or mental harm if emergency services are not provided.

(c) A copy of a verified motion, or the petition and summons, and notice of hearing shall be served promptly on the vulnerable adult, the vulnerable adult's attorney, the vulnerable adult's next of kin, if any, and in cases involving abuse or neglect by a caregiver, on the vulnerable adult's caregiver, at least 24 hours before the hearing on the director's request for authorization to provide emergency services. The court, however, may issue an ex parte order authorizing emergency services if it determines that the conditions specified in subsection (b) exist and that the vulnerable adult may suffer death or serious and irreparable harm unless an ex parte order is entered.

(d) If the court issues an order authorizing emergency services, ex parte or otherwise, the vulnerable adult or the vulnerable adult's attorney, or the vulnerable adult's caregiver or next of kin may file a motion to modify or dissolve the order and the district court shall hear and make a decision on the motion as soon as possible after it has been served on the director and other parties.

(e) Unless previously dissolved by the court, an order authorizing emergency services shall remain in effect until the court enters an order authorizing or denying the provision of emergency or essential services under G.S. 108A-111.

(f) An order authorizing emergency or essential services under this section or under G.S. 108A-111 may authorize the director or other public officials, including law enforcement officials, to enter the premises in which a vulnerable adult is located in order to take physical custody of the vulnerable adult; to consent to necessary medical treatment of the vulnerable adult; to place the vulnerable adult in an appropriate health care facility or other custodial arrangement; or to take other actions necessary to protect the vulnerable adult from death or serious physical or mental injury.

(g) An order under this section may be issued by telephone if other means of communication are impractical. Any written order pursuant to telephonic communication shall bear the name and title of the person communicating by telephone, the signature and title of the official entering the order, and the hour and date of the authorization.

(h) A chief district court judge may enter an administrative order authorizing the director to file a petition or petition and motion

requesting emergency services pursuant to this section in the magistrate's office if the clerk of superior court's office is closed and there is an emergency situation requiring the prompt issuance of an order authorizing emergency services. A chief district court judge may enter an administrative order authorizing a magistrate to issue an order authorizing emergency services pursuant to this section if no district court judge is readily available to issue the order and there is an emergency situation requiring the prompt issuance of an order authorizing emergency services. Any petition filed or order issued under this subsection shall be filed in the clerk's office as soon as that office is open for business.

G.S. 108A-113. Protective services: special proceeding to enjoin financial exploitation.

(a) If the director determines that a vulnerable or elder adult has been, or is at substantial risk of being, exploited, and (1) the vulnerable or elder adult consents, or (2) the director determines that the adult is a vulnerable adult who lacks the ability to consent, and has no responsible caregiver or other responsible person who is able and willing to act on behalf of the adult, the director may file a petition in district court naming any person or financial institution that has or may have property or financial assets belonging to the adult as respondent and requesting an order enjoining the respondent from using, converting, selling, transferring, spending, or withdrawing the adult's financial assets or property without prior order of the court.

(b) Venue for special proceedings under this section shall be in the county in which the respondent resides or does business or in the county in which the adult's property or financial assets are located.

(c) The petition shall be verified and include a concise statement of the basis for the director's determination regarding financial exploitation and a description of the adult's property or financial assets.

(d) The court shall hold a hearing and make a determination with respect to the director's petition within 5 days of service of the petition and summons on the respondent.

(e) The court may issue a temporary restraining order pursuant to G.S. 1A-1, Rule 65, or an injunction against the respondent if the court finds that the vulnerable or elder adult has been or is at substantial risk of being exploited; that the adult has consented to the proceeding or lacks the ability to consent; that the respondent has property or financial assets belonging to the adult; and that an injunction prohibiting the use, conversion, sale, transfer, etc. of the adult's financial assets or property

without prior order of the court is necessary to protect the adult or the adult's property.

G.S. 108A-114. Orders to enjoin interference with evaluation or provision of protective services.

(a) If any person or entity, including, but not limited to, a vulnerable or elder adult's caregiver or a vulnerable adult who lacks the ability to consent, obstructs or interferes with the director's evaluation pursuant to G.S. 108A-103 or with the provision of protective services pursuant to this Article, the director may file a petition in district court naming that person or entity as respondent and requesting an order enjoining the respondent from obstructing or interfering with the director's evaluation or with the provision of protective services or granting any other relief that is necessary to allow the director to conduct an evaluation or provide protective services pursuant to this Article.

(b) Venue for special proceedings under this section shall be in the county in which the respondent resides or does business or in the county in which the obstruction or interference occurred.

(c) The petition shall be verified and include a concise statement of the basis for the evaluation or the authority under which protective services are provided, specifically describe the conduct that is alleged to constitute obstruction or interference with the evaluation or provision of protective services, and specify the relief sought.

(d) The petition and summons shall be served promptly on the respondent.

(e) The court shall hold a hearing and make a determination with respect to the director's petition within 5 days of service of the petition and summons on the respondent.

(f) The court may issue a temporary restraining order pursuant to G.S. 1A-1, Rule 65, or an injunction against the respondent if the court finds that the respondent has unlawfully and without just cause obstructed or interfered with an evaluation or the provision of protective services pursuant to this Article.

(g) No order shall be granted under this section unless the court finds that the respondent has unlawfully and without just cause obstructed or interfered with an evaluation or the provision of protective services pursuant to this Article and that the relief granted is necessary to enable the director to protect the vulnerable or elder adult.

(h) An order under this section may authorize the director or other public officials, including law enforcement officials, to enter the premises where a vulnerable adult is located in order to conduct a home visit or to interview or take physical custody of a vulnerable adult.

(i) An order under this section may be issued by telephone if other means of communication are impractical. Any written order pursuant to telephonic communication shall bear the name and title of the person communicating by telephone, the signature and title of the official entering the order, and the hour and date of the authorization.

(j) A chief district court judge may enter an administrative order authorizing the director to file a petition under this section in the magistrate's office if the clerk of superior court's office is closed and there is an emergency situation requiring the prompt issuance of an order enjoining interference with an evaluation or the provision of protective services. A chief district court judge may enter an administrative order authorizing a magistrate to issue an order enjoining interference with an evaluation or the provision of protective services pursuant to this section if no district court judge is readily available to issue the order and there is an emergency situation requiring the prompt issuance of an order enjoining interference with an evaluation or the provision of protective services. Any petition filed or order issued under this subsection shall be filed in the clerk's office as soon as that office is open for business.

G.S. 108A-115. Payment for emergency and essential services.

(a) A vulnerable adult who receives emergency or essential services pursuant to this Article is responsible for paying the cost of those services if he or she has the financial ability to pay for those services, as determined under rules established by the Social Services Commission, and is not eligible to receive the services without charge under available federal or state programs.

(b) If a vulnerable adult is not financially able to pay for emergency or essential services under the rules established by the Social Services Commission and is not eligible to receive the services without charge under available federal or state programs, the county is responsible for paying the cost of the emergency or essential services when provided under Adult Protective Services Intervention.

(c) Vulnerable adults who are receiving protective services pursuant to this Article shall be given priority for county, state, or federally funded services offered by the county.

G.S. 108A-116. Funding for protective services.

(a) Counties may use available federal, state, and county funding for the provision of protective services under this Article.

(b) Any funds appropriated by counties for home health care, adult care home, nursing home, emergency assistance, medical or psychiatric evaluations, and other protective services and for

the development and improvement of a system of protective services, including additional staff, may be matched by State and federal funds. Such funds shall be utilized by the county department of social services for the benefit of vulnerable or elder adults in need of protective services. The state shall reimburse fifty percent of any county funds expended on the required provision of protective services for eligible vulnerable adults that are not available by any other means of funding.

G.S. 108A-117. Confidentiality.

All information and records obtained or created by the director pursuant to this Article, including the identity of a person making a report pursuant to G.S. 108A-104, are confidential and may not be used or disclosed by any person except (1) with the consent of the individual to whom the information pertains or a person acting lawfully on behalf of that individual; (2) pursuant to a valid court order; (3) to the extent necessary to provide protective services to or protect the health, safety, and well-being of a vulnerable or elder adult who lacks the ability to consent, and has no responsible caregiver or responsible person who is willing and able to provide or arrange for the provision of protective services; or (4) as otherwise required by this Article or other applicable law or by rules adopted by the Social Services Commission.

G.S. 108A-118. Immunity from liability.

Anyone who makes a report pursuant to G.S. 108A-104, who testifies in any judicial proceeding pursuant to this Article, or who participates in an evaluation or files a judicial proceeding pursuant to this Article shall be immune from any civil or criminal liability on account of such report, testimony, participation, or filing unless such person acted in bad faith or with a malicious purpose.

G.S. 108A-119. Training requirements.

(a) The Department of Health and Human Services, Division of Aging and Adult Services shall establish minimum, competency-based training requirements for adult protective services staff that equal or exceed those under this section.

(b) Adult protective services social workers shall complete:

(1) Standardized pre-service training provided by the supervisor and the Division of Aging and Adult Services prior to the worker assuming direct client contact responsibilities. This training shall have a scoreable exam.

(2) A minimum of sixty-six hours of available training on adult protective services intake, screening, evaluation, service provision; and social work practice on working with adults and their families. All training shall be

completed within two months of assuming direct client contact responsibilities.

(3) A minimum of eighteen hours of specialized intermediate and advanced training in the delivery of adult protective services and work with vulnerable and elder adults within twelve months of assuming direct client contact responsibilities that the Division of Aging and Adult Services determines is necessary to adequately meet training needs.

(4) A minimum of twenty-four hours of additional training annually for continuing education credit.

(c) Adult protective services intake and on-call workers shall complete:

(1) Available training on adult protective services intake and screening procedures.

(2) An adult protective services home visit with a trained adult protective services social worker or supervisor within two months of assuming direct client contact.

(d) Adult protective services supervisors shall complete:

(1) Standardized adult protective services supervisor's orientation within one month of assuming supervisory responsibilities.

(2) A minimum of sixty-six hours of available training on adult protective services intake, screening, evaluation, service provision; and social work practice on working with adults and their families. All training shall be completed within two months of assuming direct supervisory responsibilities.

(3) A minimum of eighteen hours specialized intermediate and advanced training in the delivery of adult protective services and work with vulnerable and elder adults within twelve months of assuming supervisory responsibilities that the Division of Aging and Adult Services determines is necessary to adequately meet training needs.

(4) A minimum of twenty-four hours of additional training annually for continuing education credit

(e) The Division of Aging and Adult Services may grant an exception in whole or in part to the requirements under this section.

(f) The Division of Aging and Adult Services shall ensure that training opportunities are available for county departments of social services to meet the requirements of this subsection.

G.S. 108A-120. Staffing requirements.

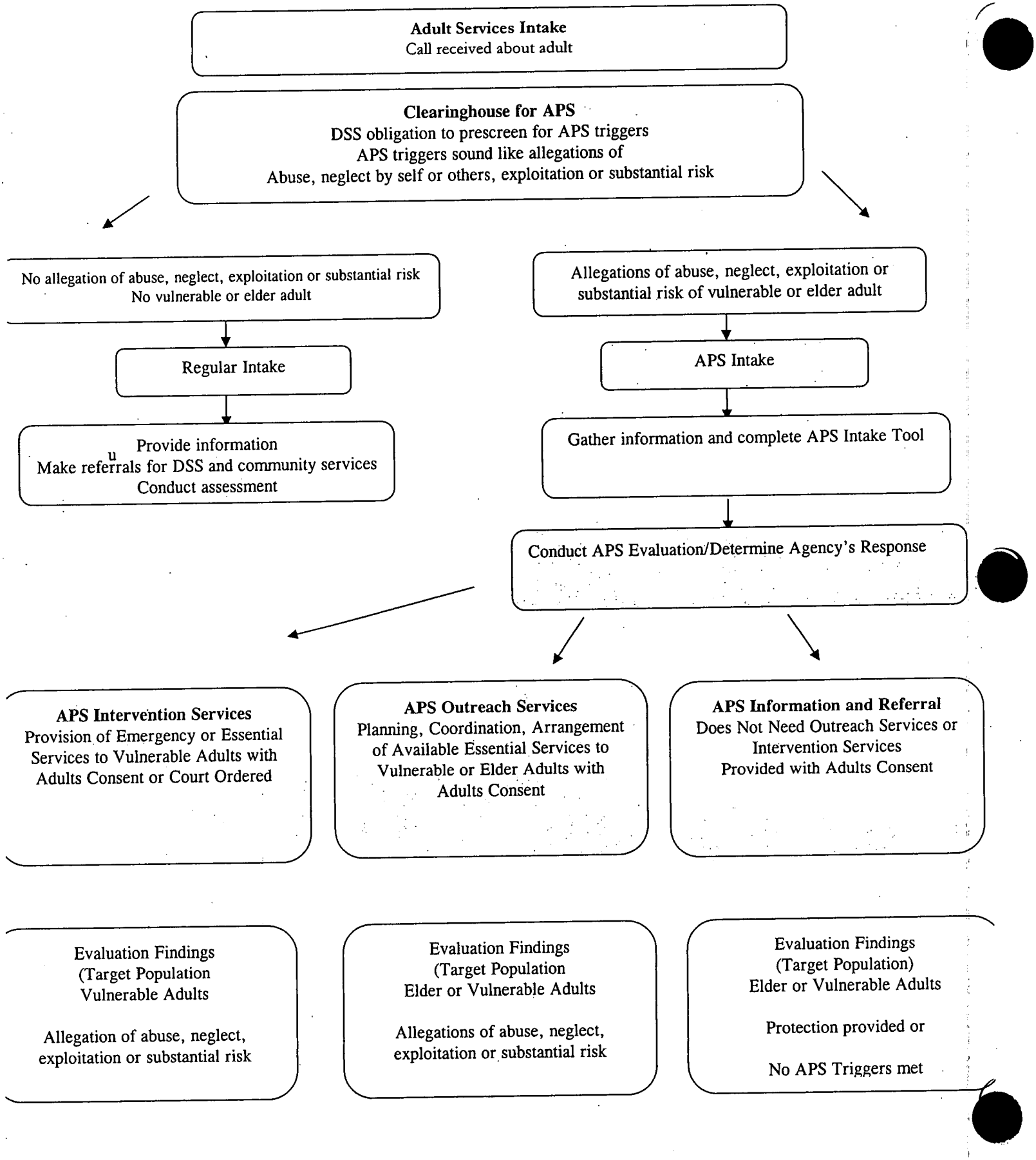
(a) The Department of Health and Human Services, Division of Aging and Adult Services shall establish maximum workload

limits for adult protective services staff that do not exceed those under this section.

(b) Adult protective services workers shall be assigned no more than twelve concurrent adult protective services cases. Workers with less than full time responsibility for adult protective services shall be assigned fewer than twelve adult protective services cases commensurate with the percentage of time assigned to adult protective services.

(c) Supervisor to worker ratios shall not exceed an average of one full time equivalent supervisory position to five full time equivalent adult protective services social work positions.

Clearinghouse Model for Access to Adult Protective Services



Attach # 2

GUARDIANSHIP IN NORTH CAROLINA

Presentation to the
North Carolina Study Commission on Aging

Pamela Weaver Best, Deputy Legal Counsel
Administrative Office of the Courts
Raleigh, North Carolina
April 10, 2008

I. OVERVIEW

A. Many adults are declared incompetent due to a developmental disability, accident, or illness that affects the individual so that the individual "...lacks sufficient capacity to manage the adult's own affairs or ...make or communicate important decisions concerning the adult's person, family or property...." G.S. §35A-1101(7)

B. A guardian must be appointed when
   1. The adult failed to execute durable and health care powers of attorney
      a. Durable Power of Attorney: Written document in which the person signing (the "principal") appoints someone else (the "attorney in fact") to make day to day "business" decisions for the principal.
      b. Health Care Power of Attorney: Written document in which the person signing (the "principal") appoints someone else (the "attorney in fact") to make health care decisions for the principal.

   Or

   2. The attorney-in-fact has breached his or her fiduciary duty (A position of trust; duty to act for another's benefit) and the power of attorney must be revoked, but the principal is no longer capable of making the revocation.

C. The "players"
   1. Petitioner. Person or agency (e.g., DSS) that seeks to have someone declared incompetent.
   2. Respondent. Alleged incompetent person.
   3. Guardian *ad litem* (GAL). Attorney appointed by the clerk to represent the Respondent.
   4. Ward. This is the respondent after he or she has been declared in competent.
   5. Guardian. The person appointed by the Clerk to make decisions for the Ward.

D. Bifurcated process
   1. Determination of incompetency. [Article 1 of Chapter 35A of the NC General Statutes]
   2. Appointment of Guardian. [Article 5]

II. DETERMINATION OF INCOMPETENCY

A. Incompetent adult [G.S. §35A-1101, et. seq.]
   1. An adult or emancipated minor who lacks sufficient capacity to manage the adult's own affairs or to make or communicate important decisions concerning the adult's person, family or property.

Recomm # 11

2. Whether the lack of capacity is due to mental illness, mental retardation, epilepsy, cerebral palsy, autism, inebriety, senility, disease, injury or similar cause or condition.

B. Incompetent Minor
   1. Presumed incompetent because of age.

III. APPOINTMENT OF GUARDIAN

A. Types of Guardians (**all of which can be limited**)
   1. Guardian of Person [G.S. §35A-1240, et. seq.]
      a. In general, responsible for making personal care decisions
   2. Guardian of the Estate [G.S. §35A-1250, et. seq.]
      a. In general, responsible for making financial decision
   3. General Guardian General of the Estate [G.S. §35A-1202 (7)]
      a. Handles both personal care and financial decisions

B. Limited guardians
   1. Clerks have explicit authority to determine whether the "...nature and extent of the ward's capability...." justifies appointment of a limited guardian. [G.S. § 35A-1212(a)] If the clerk so finds, the clerk may order the ward to retain certain legal rights and privileges to which the ward was entitled before the adjudication of incompetence. For example, allowing a ward to:
      a. Handle some amounts of money
      b. Make or assist in making medical decisions for him or herself
      c. Make or assist in making decisions about personal, social and religious activities

C. Minors
   1. A guardian of the person or general guardian cannot be appointed for a minor unless:
      a. The minor is at least 17 ½ years of age and who, other than by reason of minority, lacks sufficient capacity to make or communicate important decisions concerning the child's person, family or property whether the lack of capacity is due to mental illness, mental retardation, epilepsy, cerebral palsy, autism, inebriety, disease, injury, or similar cause or condition. [G.S. §35A-1105]
         1) Allows sufficient time to create guardianship before the minor becomes an adult.
      b. The minor has no parents living or whose parents' parental rights have been terminated. [G.S. §35A-1224(a)]
   2. A Guardian of the Estate for a minor can be appointed even if the parents are living. [G.S. §35A-1224(a)]

D. Adults
   1. If the clerk or jury finds the adult incompetent the clerk must consider the following priority in appointing a guardian. [G.S. §35A-1214]

a. Individuals, preferably family. See also, public guardian below.
b. Corporations that are chartered for this purpose (e.g., ARC of NC)
c. Disinterested public agent (e.g., local health, social services or mental health departments)

2. Public guardians are individuals (not public agencies) appointed by the clerk for a term to serve as guardian in specified cases. [G.S. §35A-1270 et. seq.]

NOTE: All guardians--whether individuals, corporations, or state agencies--have the same fiduciary and legal duties and obligations.

IV. POWERS AND RESPONSIBILITIES OF GUARDIANS

A. What a Guardian Can Do

1. The powers of guardians are in the following statutes
   a. Guardian of the Estate [G.S. §35A-1240, et. seq.]
   b. Guardian of the Person [G.S. §35A-1250, et. seq.]
   c. General Guardian

B. What a Guardian Cannot Do

1. Consent to or file for a divorce [G.S. §50-5.1]
2. Consent to sterilization of the ward [G.S. §35A-1245]

C. What a Guardian Must Not Do

1. Violate fiduciary duties by using the ward's property and assets for purposes other than for the ward's benefit.
2. Minor's funds should not be used by the minors parents for maintenance (food, shelter, clothing) and education of the minor, since the parents are legally obligated to pay for their children's maintenance and education until the children reach age 18.

#3

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 1

HOUSE BILL 796

Short Title:	No Auto. Revoke/Driv. Lic./Incompetent Person.	(Public)
Sponsors:	Representatives Bordsen, Goodwin (Primary Sponsors); and Alexander.	
Referred to:	Transportation, if favorable, Judiciary II.	

March 15, 2007

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE DIVISION OF MOTOR VEHICLES TO CONSIDER RECOMMENDATIONS FROM THE CLERK OF COURT IN DETERMINING WHETHER TO REVOKE THE DRIVERS LICENSE OF A PERSON ADJUDICATED INCOMPETENT UNDER THE GUARDIANSHIP LAWS AS RECOMMENDED BY THE HOUSE STUDY COMMITTEE ON STATE GUARDIANSHIP LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-17.1(a) reads as rewritten:

"(a) The Commissioner, upon receipt of notice that any person has been legally adjudicated incompetent or has been involuntarily committed to an institution for the treatment of alcoholism or drug addiction, shall forthwith make inquiry into the facts for the purpose of determining whether such person is competent to operate a motor vehicle. If a person has been adjudicated incompetent pursuant to the guardianship laws under Chapter 35A of the General Statutes, in making an inquiry into the facts, the Commissioner shall consider the clerk of court's recommendation regarding whether the incompetent person should be allowed to retain his or her driving privilege. Unless the Commissioner is satisfied that such person is competent to operate a motor vehicle with safety to persons and property, he shall revoke such person's driving privilege. Provided that if such person requests, in writing, a hearing, he shall retain his license until after the hearing, and if the revocation is sustained after such hearing, the person whose driving privilege has been revoked under the provisions of this section, shall have the right to a review by the review board as provided in G.S. 20-9(g)(4) upon written request filed with the Division."

SECTION 2. This act is effective when it becomes law and applies to persons adjudicated incompetent under Chapter 35A of the General Statutes on or after that date.

#4

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 2

HOUSE BILL 794

Committee Substitute Favorable 4/23/07

Short Title: Raise Ceil'g/Personal Prop. Sale/Guardianship. (Public)

Sponsors:

Referred to:

March 15, 2007

A BILL TO BE ENTITLED

AN ACT TO RAISE THE CEILING ON THE TOTAL AMOUNT OF PERSONAL PROPERTY A GUARDIAN IS ALLOWED TO SELL WITHOUT A COURT ORDER UNDER THE LAWS PERTAINING TO GUARDIANSHIP AS RECOMMENDED BY THE HOUSE STUDY COMMITTEE ON STATE GUARDIANSHIP LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 35A-1251(17)a. reads as rewritten:

"In the case of an incompetent ward, a general guardian or guardian of the estate has the power to perform in a reasonable and prudent manner every act that a reasonable and prudent person would perform incident to the collection, preservation, management, and use of the ward's estate to accomplish the desired result of administering the ward's estate legally and in the ward's best interest, including but not limited to the following specific powers:

...

(17)a. Without a court order to lease any of the ward's real estate for a term of not more than three years, or to sell, lease or exchange any of the ward's personal property including securities, provided that the aggregate value of all items of the ward's tangible personal property sold without court order ~~over the duration of the estate shall not exceed one thousand five hundred dollars ($1,500).~~shall not exceed five thousand dollars ($5,000) per accounting period, and shall not exceed the total aggregate amount of fifteen thousand dollars ($15,000) over the duration of the estate. When any item of the ward's tangible personal property has a value which when increased by the value of all other tangible personal property previously sold in the estate without a court order would exceed ~~one thousand five hundred dollars ($1,500),~~ five thousand dollars ($5,000) in the current accounting period, or the total aggregate amount of fifteen thousand dollars ($15,000) over the

duration of the estate, a guardian may sell the item only as provided in subdivision (17)b.

...."

SECTION 2. G.S. 35A-1252(14)a. reads as rewritten:

"In the case of a minor ward, a general guardian or guardian of the estate has the power to perform in a reasonable and prudent manner every act that a reasonable and prudent person would perform incident to the collection, preservation, management, and use of the ward's estate to accomplish the desired result of administering the ward's estate legally and in the ward's best interest, including but not limited to the following specific powers:

...

(14)a. Without a court order to lease any of the ward's real estate for a term of not more than three years, or to sell, lease or exchange any of the ward's personal property including securities, provided that the aggregate value of all items of the ward's tangible personal property sold without court order ~~over the duration of the estate shall not exceed one thousand five hundred dollars ($1,500).~~shall not exceed five thousand dollars ($5,000) per accounting period, and shall not exceed the total aggregate amount of fifteen thousand dollars ($15,000) over the duration of the estate. When any item of the ward's tangible personal property has a value which when increased by the value of all other tangible personal property previously sold in the estate without a court order would exceed ~~one thousand five hundred dollars ($1,500),~~five thousand dollars ($5,000) in the current accounting period, or the total aggregate amount of fifteen thousand dollars ($15,000) over the duration of the estate, a guardian may sell the item only as provided in subdivision (14)b.

...."

SECTION 3. This act is effective when it becomes law.

AH. #5

Hearing loss and its impact on the Senior Adult Community in North Carolina
Prepared for the Aging Study Commission
March 20, 2008

Background

It is common that as people age, sensory and physical capabilities gradually deteriorate. Prevalent among these age-related sensory losses is the decline in the sense of hearing.

When the average American thinks about hearing loss, what typically comes to mind are images such as a person who uses sign language; the older adult who cups his hands behind his ears and continuously asks in a high-pitched, querulous voice, "huh?" or "what's that?"; a child with a noticeable difference in speech patterns. Current studies by the National Institute on Deafness and Other Communication Disorders (NIDCD) estimate that the hearing loss population exceeds 31 million in the United States, approximately 10% of the overall population, an average of 1 out of every 10 people. Because North Carolina has become a haven for retirees, average statistics estimates are higher for the state, both currently and projected. Based on statistics from the 2000 U.S. Census Bureau and the National Center for Health Statistics, it is estimated that over one (1) million North Carolinians have some form of hearing loss. That is one (1) out of eight (8) North Carolinians.

Hearing loss occurs at all ages, encompassing all ethnic and socioeconomic groups. However, it is the older adult population that has the highest percentage of people with some form of hearing loss. The impact of such sensory loss is not only on the senior himself but also on family, friends and caregivers. The National Institute on Deafness and Other Communication Disorders (NIDCD) reports that one (1) out of every three (3) persons by age 65 has some form of hearing loss.

At age 80 and above, the percentage of hearing loss increases to about half of this population. The Hearing Loss Association of America (HLAA) reports that 50% of men and 35% of women 65 and over have some degree of hearing loss.

These numbers are only expected to grow due to baby boomers entering senior adulthood, improved medical treatments resulting in a longer life span, and the continual noise factors to which people expose themselves. The Better Hearing Institute (BHI) reports one (1) in every six (6) "Boomers" have some hearing loss due to the effects of age coupled with years of hearing abuse. AARP reports 10 million persons aged 45 to 64 have hearing loss. By the year 2030, it is projected that 78 million individuals in the United States will have been diagnosed with hearing loss (NIDCD). The Center for Disease Control (CDC) cites 17% of the total national adult population will be impacted by hearing loss.

For the State of North Carolina, projected total population for the year 2030 is estimated to be over 12 million. This would mean an increase in the estimated population with hearing loss to two and one half (2.5) million citizens. That is about one (1) out of five (5), or 20% of the population. Using State Demographic information, the NC Division of Services for the Deaf and the Hard of Hearing estimates the current hearing loss population among senior adults to be 166,420 for ages 65-74 with a projected increase in 2030 to 342,897. For senior adults ages 75 and up, current numbers indicate 207,483 persons with hearing loss and a projected increase to 438,801 for the year 2030.

In the face of these daunting estimates, there is actually very little accurate information in the mainstream media about hearing loss in general. By virtue of its stigma as a hidden disability, with most undergoing a gradual, unnoticed decline, information available on statistics, impact, treatment, adaptive technology, etc. are oftentimes vague and sometimes misleading such as articles about "miraculous" technology that bring people back from a world of silence to one of "perfect" hearing. While some assistive technology is amazing, nobody has yet been able to duplicate the complex ear mechanism with which we were born. No device, regardless of its level of success, will ever restore lost hearing.

Record #9

The Issues

Misconceptions about hearing loss may be broken down into four categories: a) the nature of hearing loss (briefly described above), b) abilities and self-perceptions of people with hearing loss, c) hearing aids and assistive technology and d) language and communication.

The gradual loss of hearing in most individuals creates a false sense of "normalcy" for the population making it an invisible disability. Unless one is viewed using sign language to communicate or there is a glimpse of a hearing aid, this disability would never be noted. This creates an extremely limited availability of resources for the population dealing with hearing loss, particularly those who are labeled "hard of hearing."

There are some common challenges faced by senior adults who experience hearing loss. These challenges include: a) retaining or regaining a sense of psychological security, or well-being, b) making necessary modifications to daily living skills, c) learning skills of inter-dependency (asking for help), d) learning to adapt to new communication modes, e) maintaining healthy human contact, f) maintaining healthy family dynamics, and g) sustaining economic independence and personal control. Few people are prepared to face these challenges associated with hearing loss. Below is listed a few of the key issues that are faced by senior adults with hearing loss in North Carolina daily:

1) Hearing Aids and Limited Insurance Coverage-- One of the first challenges that the hard of hearing person faces is the cost of hearing aids. These devices can often cost several thousand dollars and are rarely covered by any insurance. Neither Medicare nor NC Medicaid offer hearing aid coverage for adults. North Carolina along with bordering states of Virginia, Kentucky, South Carolina, Georgia, and Tennessee are in the list of 16 states that do not provide this coverage. In addition, there is virtually no insurance coverage for hearing aids in North Carolina.

2) Many people report difficulty finding a trustworthy professional to assist them with hearing aids. The lack of a 30-day mandated trial period for hearing aids in North Carolina, one of 14 states without such a policy, instills in some individuals this lower level of trust toward the hearing health care professional.

3) A myriad of emotional responses resulting from difficulties in communicating often lead to increased mental health concerns for senior adults. Better Hearing Institute reports that hearing loss, particularly in older individuals not using hearing aid or assistive devices, has been directly linked to short-term memory loss, fatigue, anxiety and depression.

4) Among senior adults, hearing loss is one of the most prevalent and chronic, but treatable, disabling condition. Hearing loss is ranked third, only behind arthritis and hypertension.

5) Hearing loss has also been linked to lower incomes—on average, those with hearing loss but do not wear hearing aids earn up to $12,000 per year less than peers using hearing aids.

Addressing the Issues

It is critical that these issues surrounding hearing loss be thoroughly studied and based on the information gathered in a comprehensive study, potential solutions be brought forth for legislative consideration. The Department of Health and Human Services would welcome the authority to convene a group of professionals from within the hearing loss field such as direct service providers, audiologists, hearing aid dispensers and fitters, as well as consumers to investigate the impact of hearing loss on North Carolina citizens and to conduct a comprehensive study on the subject. A comprehensive study should contain at a minimum:

1) An evaluation of the extent of hearing loss on North Carolina's population and anticipated future growth in hearing loss.

2) A complete description of the impact of hearing loss on the individual as well as the family and community.

3) A detailed inventory of the technology available for assisting individuals in dealing with hearing loss, including, but not limited to the costs of such technology, access issues in parts of the state, and availability of qualified service providers.

4) A thorough evaluation of potential solutions that could address the resource problems inherent in access to the assistive technology available to address hearing loss.

5) An assessment of other surrounding states' processes for dealing with identified issues related to hearing loss.

Attach. #6

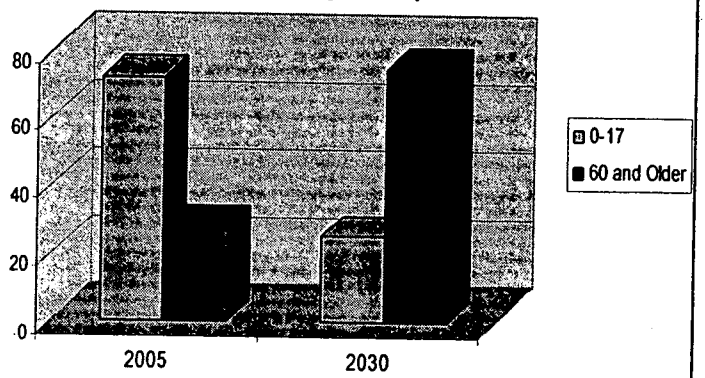
(1)

Aging Study of Six Counties



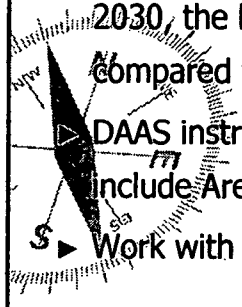
Response to Senate Bill 448, Section 1
of S.L. 2007-355,
Division of Aging and Adult Services
April 10, 2008

Number of NC Counties with Estimated and Projected Population Growth for Age Groups 0-17 and 60+



Aging Study of Six Counties

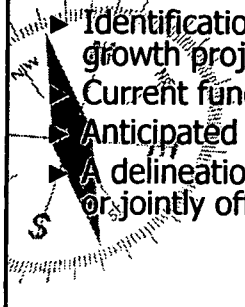
- Legislative Request – Section 1 of S.L. 2007-355
- Study programs and services for older adults in Brunswick, Buncombe, Gaston, Henderson, Moore, and New Hanover
- These counties currently have, or are projected to have by 2030, the largest numbers of individuals age 60+ when compared to 0-17
- DAAS instructed to use existing data and resources and to include Area Agencies on Aging
- Work with DHSR, DMA, DPH, DMH/DD/SA, and others



Aging Study of Six Counties (cont'd)

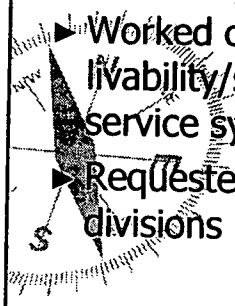
Study included

- A profile of current older population
- A profile of projected growth of older population
- An assessment of anticipated impact on programs and services that address the needs of older adult population
- Identification of programs and services in place
- Identification of programs and services needed to meet the growth projections
- Current funding sources for programs and services
- Anticipated funding needs for programs and services
- A delineation of the programs and services that are shared or jointly offered with another county



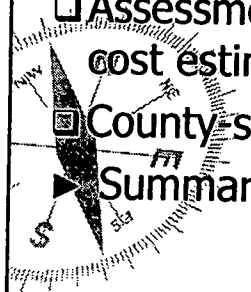
APPROACH

- Utilized livable and senior-friendly framework
- Tapped existing resources to profile demographics and services/programs
- Secured migration study information from ECU
- Worked closely with AAAs to secure opinions on livability/senior-friendliness and the adequacy of service system and to identify any local plans
- Requested information from appropriate DHHS divisions

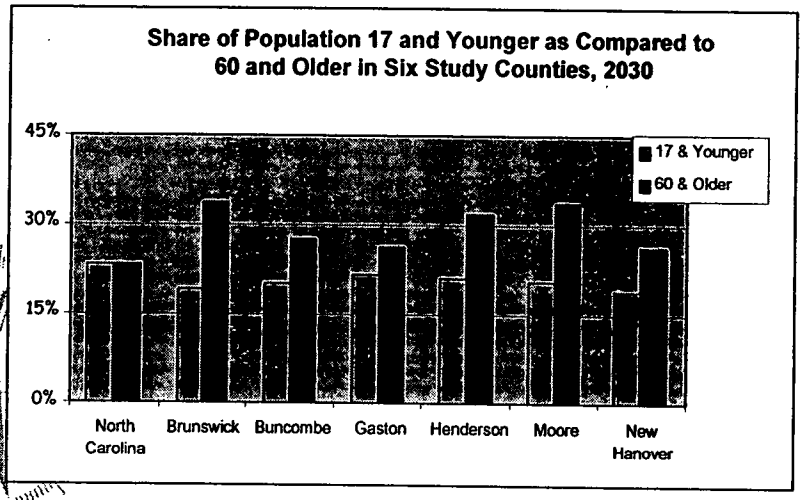


Products

- Report for each of the six counties
  - Demographic profile
  - Current programs and expenditures
  - Assessment of future needs and projected cost estimates
  - County-specific plans and reports
- Summary state report

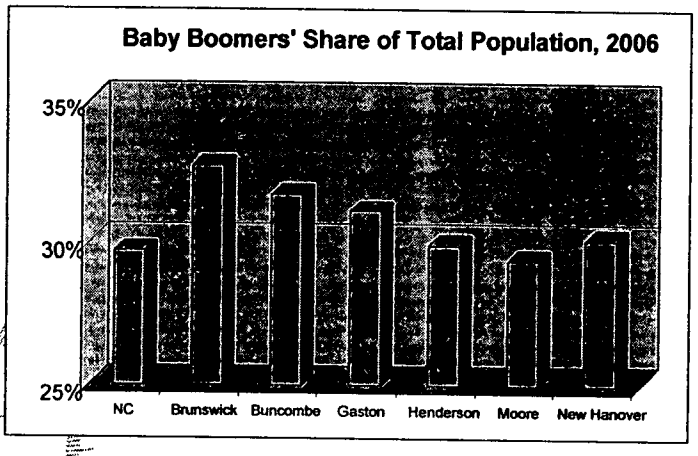


Demographics



Source: Division of Aging and Adult Services

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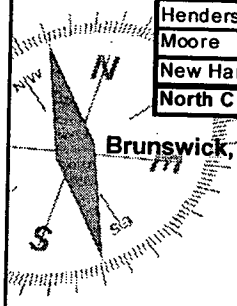
Five of the counties had a higher percentage of baby boomers than statewide (29.7%)

NC Division of Aging and Adult Services

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Projected Increase in Population Age 60 and Older (2008-2012)

County	2008 60+ Pop. (Base Year)	Population Increase 2008 - 2012 #	%	2012 60+ Population
Brunswick	28,540	5,173	18.10%	33,713
Buncombe	48,324	5,607	11.60%	53,931
Gaston	37,751	3,998	10.60%	41,749
Henderson	29,193	2,987	10.20%	32,180
Moore	24,176	2,264	9.40%	26,440
New Hanover	36,937	5,967	16.20%	42,904
North Carolina	1,583,636	202,069	11.13%	1,785,705



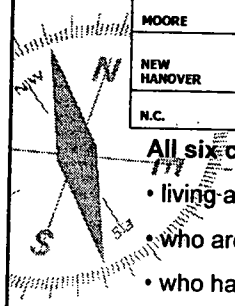
Brunswick, Buncombe, New Hanover – exceed the state rate

Source: Division of Aging and Adult Services

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2008 County Profiles, Percentage of Persons Age 60 and Older in Terms of Selected Demographic Indicators

COUNTY	% of 60+ Poor*	% of 60+ Minority*	% of 60+ Rural*	% of 60+ Poor Minority*	% 60+ Native Americans*	% of 60+ Severe Disabilities**	% of 60+ Who Are 70+
BRUNSWICK	8.5	8.6	66.4	0.7	0.2	8.5	45.1
BUNCOMBE	10.1	6.1	29.2	0.6	0.1	10.9	52.5
GASTON	11.3	10.6	22.2	1.2	0.1	10.7	49.8
HENDERSON	8.2	2.4	46.8	0.2	0.1	9.9	55.9
MOORE	9.6	9.7	59.0	0.9	0.2	11.2	56.4
NEW HANOVER	8.8	13.2	4.5	1.2	0.1	10.1	48.8
N.C.	12.4	17.9	43.5	1.2	0.6	11.3	49.6



All six counties have a lower percent of 60+ persons

- living at or below poverty level than statewide
- who are minority as compared to the State
- who have severe disabilities

Source: Division of Aging and Adult Services

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Socio-economic Indicators of Six Selected Counties vs. North Carolina							
	NC	Brunswick	Buncombe	Gaston	Henderson	Moore	New Hanover
Persons age 65+ with no disabilities	54.3%	59.6%	58.5%	50.4%	63.9%	66.0%	57.5%
Median household income for age groups 65-74	$28,521	$32,327	$29,940	$24,564	$32,707	$41,540	$38,487
Median household income for age groups 75+	$19,303	$21,230	$22,268	$18,750	$26,957	$33,822	$25,242
Average monthly social security amount received by 65+	$786	$795	$790	$823	$821	$828	$838
Population age 65+ without a high school diploma	41.6%	31.0%	31.4%	52.2%	22.5%	21.0%	27.4%
Labor Force Participation Rate 65+	14.4%	13.7%	12.4%	14.4%	11.3%	14.5%	13.6%
Unemployment rate of persons age 65+	8.3%	4.9%	4.7%	4.7%	10.8%	21.8%	4.9%
Persons 65+ who were living alone	28.3%	22.0%	28.7%	27.6%	24.0%	21.0%	27.9%
Older households (age 75+) without a car	21.3%	16.8%	22.1%	17.5%	12.4%	10.1%	20.2%

Source: U.S. Census, 2000

Health Professional Shortage Areas, 2006

Counties	Health Professional Shortage Areas (HPSA), 2006	
	Dental	Primary Care
Brunswick	Part County or Special Population	Part County or Special Population
Buncombe	Not a DHPSA	Part County or Special Population
Gaston	Part County or Special Population	Part County or Special Population
Henderson	Part County or Special Population	Part County or Special Population
Moore	Not a DHPSA	Not a HPSA
New Hanover	Part County or Special Population	Part County or Special Population

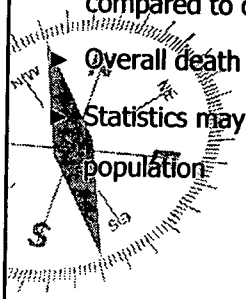
Source: NC Office of Rural Health and Community Care

None of the counties are designated as 'whole-county shortage areas'

Only Moore County does not have an area that is short of primary medical or dental care

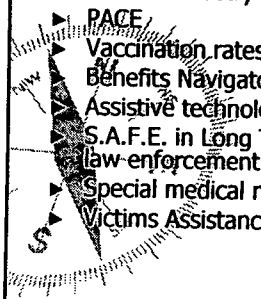
Healthy Aging—
Interesting Findings from Gaston County

- Had 'code orange' days (17) in 2006, presumed to be unhealthy for sensitive groups
- Had highest death rates for COPD, pneumonia, and influenza as compared to other five counties and the state as a whole (2002-06)
- Overall death rate for persons 65-84 exceeded the state figure
- Statistics may be related to the socio-economic status of the older population



Some Core Indicators for a Livable and Senior-Friendly Community

- Walkability audits
- Chronic care program
- Evidence-based health promotion programs
- Food and Nutrition Services utilization
- Mobile dentistry
- PACE
- Vaccination rates
- Benefits Navigator volunteers
- Assistive technology instructors
- S.A.F.E. in Long Term Care trained law enforcement
- Special medical needs registry
- Victims Assistance program
- Senior Tar Heel Legislature
- Aging and Disability Resource Connections
- Adult day services
- Emphasis on Medicaid home and community care
- Interagency case staffing
- Multipurpose senior center
- NC NOVA
- Project C.A.R.E. (Alzheimer's caregiver support)
- Special Assistance In-home Option
- Adult Care Home Quality Improvement Consultation program
- Aging Leadership Planning Team



Core Indicator Assessment of Six Counties

Using the 26 core indicators to illustrate activities, programs, and services

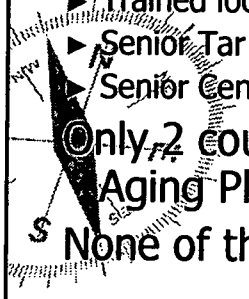
- Henderson – "most livable and senior-friendly," with 17 elements
- Brunswick and Moore counties had the fewest (9)

Only 3 indicators were present in all counties

- Trained local law enforcement officers (Project S.A.F.E.)
- Senior Tar Heel Legislature
- Senior Centers

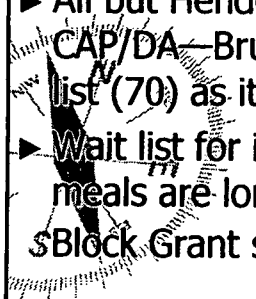
Only 2 counties (Buncombe, Henderson) have Aging Planning Leadership Teams

None of the counties has NC NOVA or ADRC



Findings about Availability of Programs and Services, as Reported by DHHS Divisions

- All six counties showed a rate less than the state's in 2006 for the relative amount of Medicaid spent for home and community care as compared to what was spent for nursing home stays for persons age 60+
- All but Henderson County had persons on wait list for CAP/DA—Brunswick had as many persons on the wait list (70) as it had allocated slots (70)
- Wait list for in-home aide services and home-delivered meals are longest among Home and Community Care Block Grant services



(9)

Current Expenditures (2006-2007)

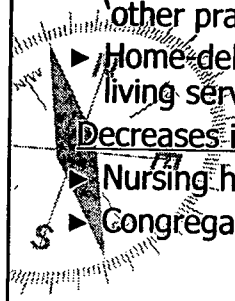
Services show increases as well as decreases between 2005-06 and 2006-07

Increases in

- Low-Income Energy Assistance (LIEAP)
- Services funded by Medicaid for persons with mental illness and developmental disabilities (e.g., CAP/MR, 'other practitioners')
- Home-delivered meals, hospice, and VR's independent living services (in most of the six counties)

Decreases in

- Nursing home expenditure
- Congregate nutrition (except Gaston)



Assessment of Future Needs and Projected Cost Estimates

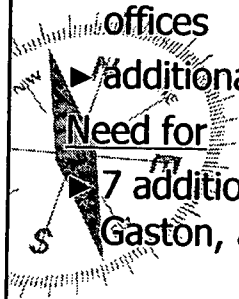
DHSR – 2008 State Medical Facilities Plan

No need for

- additional nursing home or adult care home beds
- Medicare-certified Home Health agencies or offices
- additional Hospice Home Care offices

Need for

- 7 additional inpatient Hospice beds in Brunswick, Gaston, and Henderson



Top Areas of Concern Identified by Survey of Livability and Senior-Friendly Communities in the Six Studied Counties

Area	Item	# Counties for which Concern Reported (out of 6)
Physical & Accessible Environment	-Housing & utilities -Transportation	6
Technology	-Assistive & adaptive devices -Medical alert	6
Healthy Aging	Preventive care	5
Economic Security	Health care cost	5
Safety & Security	-Fraud & exploitation -Outreach to isolated & vulnerable	5
Social & Cultural Opportunities	Community sensitivity	5
Public Accountability & Responsiveness	Planning & coordination	4
Access & Choice in Services & Supports	-Caregiver support -Home & community services	4

Source: Survey conducted by Area Agencies on Aging and their local partners, 2008.

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LSFC Concerns from Survey Respondents...

Physical And Accessible Environment

- Seniors cannot afford the basic maintenance for minor home repair. The minor turns major and impacts the senior's safety. *(Brunswick respondent)*
- *The electric, oil and gas prices are astronomical in comparison to the monthly Social Security check. (Brunswick respondent)*
- *No transportation to get to markets or medical appointments or to meet social needs. (Moore respondent)*

Healthy Aging

- *Need to emphasize comprehensive approach to preventive care that includes nutrition, wellness and social connectedness. (Henderson)*

NC Division of Aging and Adult Services

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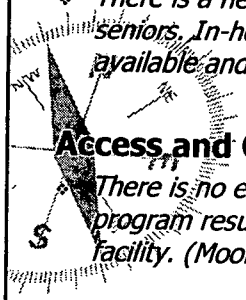
LSFC Concerns from Survey Respondents...

Economic Security

- *Heath care insurance costs are becoming prohibitive for some folks. Long-term care costs will rise. (Moore)*

Technology

- *There is a need for medical alert devices to be available for all seniors. In-home monitoring services need to be more widely available and affordable. (Brunswick)*



Access and Choices in Services and Supports

- *There is no elder day care available in the county. Lack of such a program resulted in my husband's admission to an assisted living facility. (Moore)*

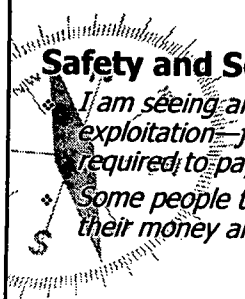
LSFC Concerns from Survey Respondents...

Public Accountability and Responsiveness

- *Assessments of aging residents are vital to the community. (Moore)*

Social and Cultural Opportunity

- *I think [there] is still a ways to go as far as sensitivity to aging is concerned. [There needs to be greater awareness that] not all older adults are healthy and wealthy. (Moore)*



Safety and Security

- *I am seeing an increased number of criminal cases involving exploitation—just last week two caregivers pled guilty and are now required to pay back all monies to the victims. (Brunswick)*
- *Some people take advantage of elderly residents living alone by taking their money and home with promises. (Moore)*

Top Areas of Concern Identified by Survey on Comprehensive and Coordinated Service System in the Six Studied Counties

Area	Item	# Counties for which Concern Reported (out of 6)
Supportive Services	-General transportation	6
	-Adult day care; Adult day health care; Family caregiving counseling; In-home aide (homemaker and personal care); Respite; Medical transportation	3
Nutrition	-Home-delivered meals	6
	-Nutrition counseling	4
Senior Centers	Senior Centers	4
Health Care	-Dental care; Mental health counseling	5
	-Medication management/counseling; primary health care	4
Residential Care	-CAP/DA	4
	-SA In-Home Option	3

Source: Survey conducted by Area Agencies on Aging and their local partners, 2008.

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Concerns from survey respondents...

Supportive Services

- *No public transportation. A crying need in this community. (Moore)*

Nutrition

- *Mobile market needed for homebound who cannot get to the store. (New Hanover)*

Senior Centers

- *Because the county is large, there should be several senior centers in different parts of the county (Moore)*

Health Care

- *More dental care providers needed for Medicaid clients and low-income older adults. Need for greater [health] education and outreach. (Gaston)*

NC Division of Aging and Adult Services

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Observations and Recommendations—Limitations of Six-County Study

1. Focus limited to health and human services

- The recommended comprehensive aging study would take a broader perspective and would tap the information and require the involvement of all relevant stakeholders.

2. Uses existing data, resources, and information systems

- gives only a snapshot in content and time
- does not take into account programs and services provided privately without government oversight or funding
- difficult to access data from systems that do not interface

Recommended study would

- add significant knowledge about consumer needs, interests, and assets, including that of boomers
- inform all stakeholders about current and projected capacity to respond to an aging population at local and state levels
- support specialized studies, including implications of in-migrating retirees.

Observations and Recommendations

3. Focus on six counties

- the six counties are not necessarily representative of all counties
- all of NC will soon encounter issues of an aging population

Recommended study would

- offer a more comprehensive, systematic approach to inform all regions and all counties

4. Limited input from consumers, advocates, and local officials

- cautions must be taken given the limited number of respondents and their representativeness
- only two counties (Buncombe and New Hanover) and two towns (Stanley and Southern Pines) responded to the 2005 national *Maturing of America survey*

Recommended study would

- seek input from consumers, advocates, and local officials in a more systematic way and would provide AAAs with greater capacity to assist

Observations and Recommendations

5. Uncertain capacity at the local and state levels

- only two of the six counties appear to have an ongoing, local citizen-driven planning process
- county governments and AAAs have limits to what they can currently do to support comprehensive planning
- there is no state-level body that enjoys the influence and resources to direct an ongoing means to focus broad attention on aging



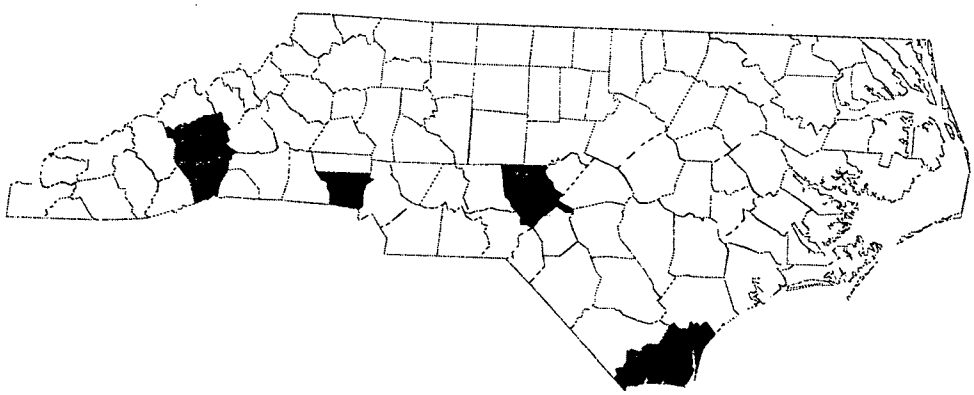
Recommended study would
increase capacity within counties and AAAs to support meaningful planning, evaluation, and development activities
create and support a State Strategic and Steering Team

Bottom Line: **Value of Investing in Project C.A.C.E.**

(15)

Aging Study of Brunswick, Buncombe, Gaston, Henderson, Moore, and New Hanover Counties—A Response to Senate Bill 448, Section 1 of S.L. 2007-355

STATE REPORT



April 1, 2008

North Carolina Department of Health and Human Services
Division of Aging and Adult Services

daas
NORTH CAROLINA
Division of Aging and Adult Services

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- East Carolina University (ECU) Report on Later-Life Migration Flows

Overview

This report summarizes the work of the Division of Aging and Adult Services (DAAS), of the NC Department of Health and Human Services, in responding to the legislative request of the 2007 General Assembly for a study of six counties relative to the aging of their populations and the availability and need for programs and services. The report gives an overview of the legislative request and the approach that DAAS took in preparing the study. It also contains a copy of the individual reports prepared for each of the six counties that are being submitted to their respective Board of County Commissioners. This executive summary gives an overview of what was presented in the county reports and also offers a comparative discussion of the six counties in terms of their demographics and projected growth, current programs and expenditures, and their future service needs and the projected cost of meeting them. This summary concludes with some observations and recommendations for a more comprehensive study of the aging of North Carolina, as previously presented in a related report submitted to the General Assembly in January 2008.

Legislative Request

Section 1 of S.L. 2007-355 directed the Department of Health and Human Services, Division of Aging and Adult Services (DAAS), to work with the Division of Health Service Regulation; Division of Medical Assistance; Division of Public Health; and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to study programs and services for older adults in Brunswick, Buncombe, Gaston, Henderson, Moore, and New Hanover counties. These counties currently have, or are projected to have by 2030, the largest numbers of individuals age 60 and older when compared to individuals age 17 and younger. In conducting the study, the Division was directed to utilize existing data and resources and to include the Area Agencies on Aging serving each county studied. For each of the six counties, the Division was to include:

1. A profile of the current older adult population.
2. A profile of the projected growth for the older adult population.
3. An assessment of the anticipated impact on programs and services that address the needs of the older adult population.
4. Identification of programs and services that are currently in place.
5. Identification of programs and services that are needed to meet the growth projections.
6. Current funding sources for programs and services serving the older adult population.
7. Anticipated funding needs for programs and services serving the older adult population.
8. A delineation of the programs and services that are shared or offered jointly with another county.

The General Assembly further directed DAAS to make an interim report on the study to the North Carolina Study Commission on Aging on or before November 1, 2007, which was done. This State Report meets the other legislative requirement for a final report of the findings and recommendations to be submitted to the 2008 Regular Session of the 2007 General Assembly, the NC Study Commission on Aging, and to the Board of County Commissioners of each county studied.

In addition, S.L. 2007-355 directed DAAS to offer recommendations for a comprehensive, statewide study after examining what other states have done. DAAS submitted its report on this to the General Assembly in January and presented recommendations to the Study Commission on Aging at its first meeting in 2008. This report of recommendations for a statewide study is available on the DAAS website at http://www.ncdhhs.gov/aging/demograpic/agingstudy.htm.

Approach

In undertaking this study, the Division of Aging and Adult Services (DAAS) followed the instructions given by the General Assembly in profiling each of the six counties. North Carolina's older population is not only increasing but is truly diverse. To reflect the diversity of North Carolina's communities and the needs of its older adults, the livable and senior-friendly concept was utilized to frame a number of tables and charts in this study. The livable and senior-friendly community initiative provides a very practical, tested framework to enable places in North Carolina, regardless of their size, to respond to the changing and unique needs, wants, and assets of their older population as well as to accommodate residents of all ages.

The profile of the current older adult population and their projected growth was pulled from existing data that DAAS regularly maintains for the purposes of local, regional, and state planning. DAAS has produced charts and tables showing population growth, including projections between 2000 and 2030 utilizing current U.S. Census information. In addition, DAAS consulted with Dr. Jim Mitchell and Dr. Don Bradley of East Carolina University to examine the volume and composition of later-life migration flows into the six counties. They also examined how later-life migrants compare to seniors already living in these counties. North Carolina has a number of experts in Gerontology whose contribution to the larger study envisioned by the General Assembly in Section 2 of S.L. 2007-355 would be invaluable.

In order to identify programs currently available, funding sources, as well as, projected future needs, DAAS used several existing resources to begin framing part of the profile, including the (1) *County Aging Profiles-* http://www.ncdhhs.gov/aging/cprofile/cprofile.htm; (2) *County Data Packages-* *http://www.ncdhhs.gov/aging/expenddata.htm;* and (3) *Inventory of State Resources for Older Adults-* http://www.ncdhhs.gov/aging/stplan/NC_Aging_Services_Plan_2007.pdf.

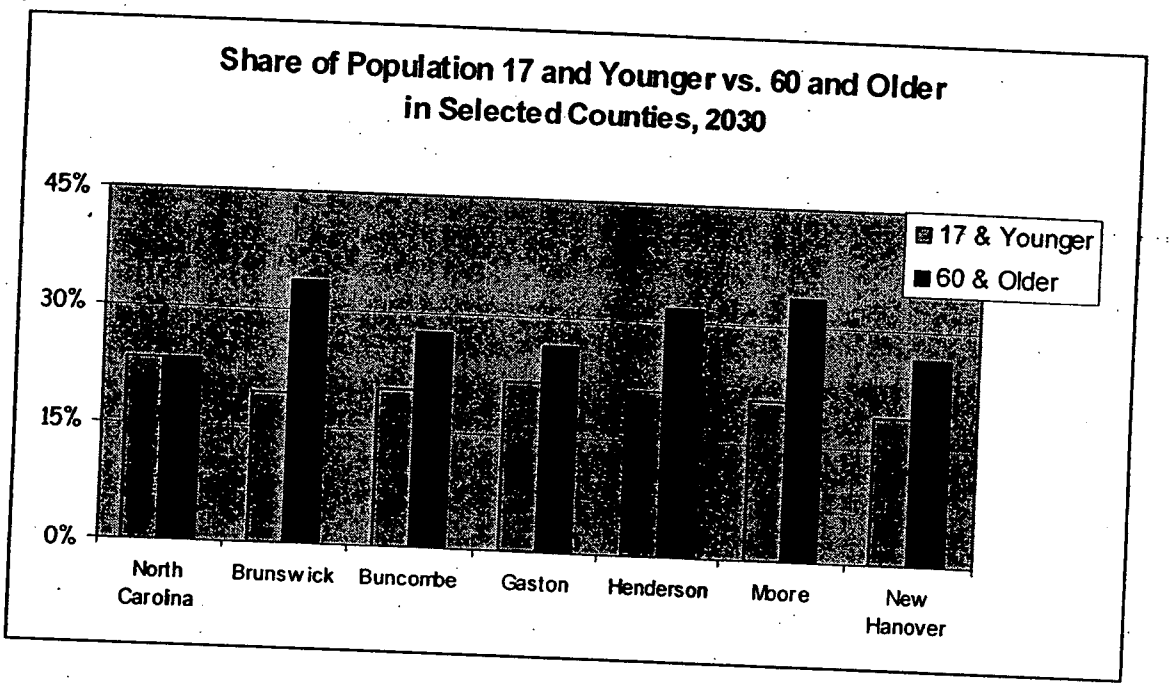
DAAS worked closely with each Area Agency on Aging (AAA) serving the six study counties to assess priority concerns. The AAAs used assessment tools that are part of the *2008-2012 Area Plans on Aging.* AAAs also identified local surveys and plans that are relevant to assessing available and needed programs and services.

In addition, DAAS requested relevant information and views from all appropriate Department of Health and Human Services divisions (i.e., Division of Medical Assistance; Division of Public Health; Division of Social Services; Division of Health Service Regulation; Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Vocational Rehabilitation; Division of Services for the Blind; Division of Deaf and Hard of Hearing; etc.) about the availability and adequacy of programs and services for each county being

studied. These divisions also provided information about special initiatives relative to these counties.

Demographics and Projected Growth

The General Assembly identified the six counties included in the study mandated by Session Law 2007-355 primarily because they were ones that have, or are projected to have by 2030, the largest numbers of individuals age 60 and older when compared to individuals age 17 and younger. In fact, the General Assembly cited in the Bill that "in 2005, 28 counties in North Carolina had more persons age 60 than persons age 17 and younger, and of those counties, Henderson, Brunswick, and Moore Counties had the largest number of 60+ persons."



It also noted "that by 2030, 75 of North Carolina's counties will have more persons age 60 and older than 17 and younger." While this common characteristic of the six counties is noteworthy, it is but one of many indicators of the aging of North Carolina's population. As suggested in the interim report submitted by DAAS in October 2007, in some ways these counties are not especially representative of the state's aging experience.

Below are some comparative findings among the six counties and relative to the state, as presented in the profile prepared for each county.

- All six counties currently have a higher proportion of their population who are age 60 and older than is the case statewide; the same is projected for year 2030. In 2005, 16.4 percent of the state's population were persons age 60+. Among the six counties, this ranged from a high of 27.4 percent in Moore County to 17.5 percent in Gaston County. While the state figure for 2030 is projected at 23.3 percent, the counties range from 33.9 percent in Moore to 26.5 percent in Gaston.

- In examining the projected rate of growth in the population 60+ over the next four years (2008-2012), half of the counties—Brunswick, Buncombe, and New Hanover—are expected to exceed the state rate of 11.13 percent. The growth rate varies among the six counties from 18.1 percent for Brunswick to 9.4 percent for Moore. In examining the growth rate for the period 2006-2030, only two counties—Brunswick and New Hanover—are projected to have a higher rate than statewide for the population groups age 65-84 and age 85 and older (Henderson County's is nearly the same for the state vis-à-vis the group 85+).

Projected Increase in Population Age 60 and Older (2008-2012)

	2008	Population Increase								2012
	60+ Pop	2008 - 2009		2008 - 2010		2008 - 2011		2008 - 2012		60+
County	(Base Year)	#	%	#	%	#	%	#	%	Population
Brunswick	28,540	1,621	5.7%	2,922	10.2%	3,927	13.8%	5,173	18.1%	33,713
Buncombe	48,324	1,412	2.9%	2,769	5.7%	4,058	8.4%	5,607	11.6%	53,931
Gaston	37,751	1,016	2.7%	2,022	5.4%	2,950	7.8%	3,998	10.6%	41,749
Henderson	29,193	820	2.8%	1,614	5.5%	2,250	7.7%	2,987	10.2%	32,180
Moore	24,176	630	2.6%	1,211	5.0%	1,687	7.0%	2,264	9.4%	26,440
New Hanover	36,937	1,666	4.5%	3,042	8.2%	4,419	12.0%	5,967	16.2%	42,904
North Carolina	1,583,636	50,576	2.81%	100,684	5.57%	147,881	8.15%	202,069	11.13%	1,785,705

- As of 2008, all six counties had a lower percent of their 60+ population estimated to be living at or below poverty (ranging from 8.2 percent in Henderson County to 11.3 percent in Gaston) than is true statewide (12.4 percent). These counties also had a lower percent of their older population who are minority (ranging from 2.4 percent in Henderson to 13.2 percent in New Hanover) as compared to the state (17.9 percent). There is considerable variance in terms of the rurality of the older populations of these counties—ranging from 4.5 percent in New Hanover to 66.4 percent in Brunswick (as compared to 43.5 percent for NC).

2008 County Profiles of Percentage of Persons Age 60 and Older

COUNTY	% of 60+ Poor*	% of 60+ Minority*	% of 60+ Rural*	% of 60+ Poor Minority*	% 60+ Native Americans**	% of 60+ Severe Disabilities***	% of 60+ who are 70+
Brunswick	8.5	8.6	66.4	0.7	0.2	8.5	45.1
Buncombe	10.1	6.1	29.2	0.6	0.1	10.9	52.5
Gaston	11.3	10.6	22.2	1.2	0.1	10.7	49.8
Henderson	8.2	2.4	46.8	0.2	0.1	9.9	55.9
Moore	9.6	9.7	59.0	0.9	0.2	11.2	56.4
New Hanover	8.8	13.2	4.5	1.2	0.1	10.1	48.8
North Carolina	12.4	17.9	43.5	1.2	0.6	11.3	49.6

- Further evidence of the generally higher socio-economic status of these six counties comes from information contained in their statistical profiles.

None of the six counties are designated as '*whole-county* shortage areas' for either primary medical care or dental care, even though only Moore County has no area that is short of primary medical care or dental care. The median household income for age groups 65-74 and 75+ exceed the comparable statewide figure in all but Gaston County. The average monthly Social Security funding received by beneficiaries age 65+ exceeds the statewide average in all six counties. Five of the counties have a lower proportion of their population age 65+ without a high school diploma, as compared to the state figure of 41.6 percent—the exception is Gaston with a percentage of 52.2%. Five of the counties have a lower percentage of persons 65+ who were living alone as of 2000, than is true statewide (28.3 percent)—the exception being Buncombe at nearly the statewide figure (28.7). Buncombe was also the only exception in terms of having a higher percent of older households (age 75+) without a car (22.1 percent in Buncombe, compared to the statewide figure of 21.3 percent). It is probably not surprising given the association between socio-economic status and disability, that all but Gaston County have a higher percentage of community-dwelling persons 65+ reporting no disabling conditions than is the case statewide (54.3 percent)—Gaston's figure is 50.4 percent. Because vision loss is a specific impairment that can present multiple issues for older persons, the Division of Services for Blind has provided statistics for each of the six counties showing the number of persons age 55+ with a visual impairment.

Socio-economic Indicators of Six Selected Counties vs. North Carolina

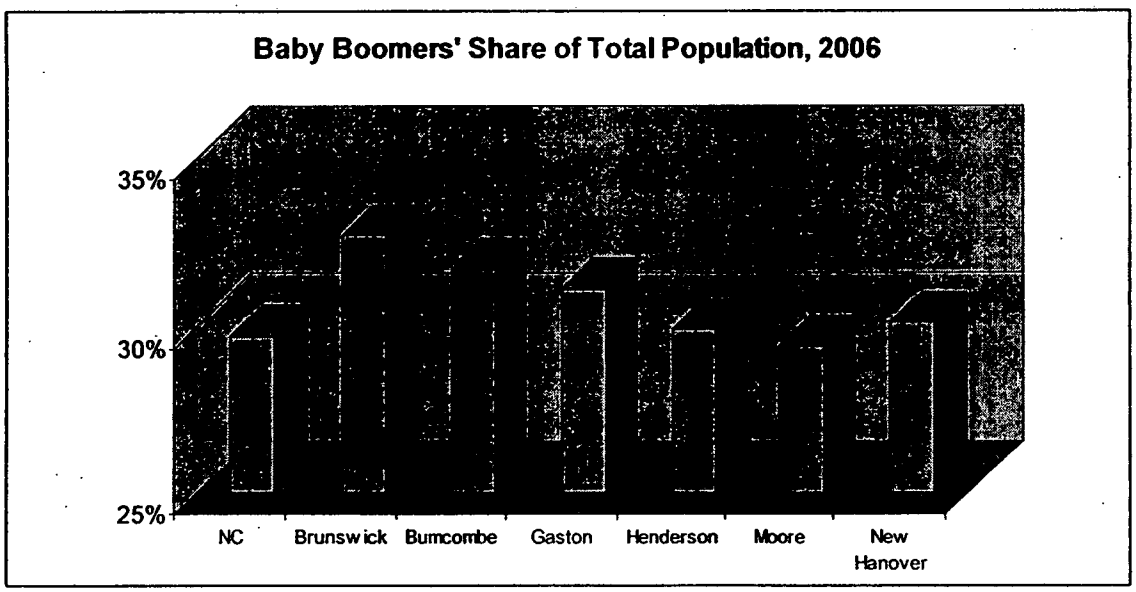
	NC	Brunswick	Buncombe	Gaston	Henderson	Moore	New Hanover
Persons age 65+ with no disabilities	54.3%	59.6%	58.5%	50.4%	63.9%	66.0%	57.5%
Median household income for age groups 65-74	$28,521	$32,327	$29,940	$24,564	$32,707	$41,540	$38,487
Median household income for age groups 75+	$19,303	$21,230	$22,268	$18,750	$26,957	$33,822	$25,242
Average monthly social security amount received by 65+	$786	$795	$790	$823	$821	$828	$838
Population age 65+ without a high school diploma	41.6%	31.0%	31.4%	52.2%	22.5%	21.0%	27.4%
Labor Force Participation Rate 65+	14.4%	13.7%	12.4%	14.4%	11.3%	14.5%	13.6%
Unemployment rate of persons age 65+	8.3%	4.9%	4.7%	4.7%	10.8%	21.8%	4.9%
Persons 65+ who were living alone	28.3%	22.0%	28.7%	27.6%	24.0%	21.0%	27.9%
Older households (age 75+) without a car	21.3%	16.8%	22.1%	17.5%	12.4%	10.1%	20.2%

Source 2000 Census data.

- Only one county—Gaston—is reported to have had 'code orange' days in 2006 presumed to be 'unhealthy for sensitive groups.' Interestingly, Gaston had the highest death rates for chronic lower respiratory diseases and for pneumonia and influenza as compared to the other five counties and the state as a whole during 2002-2006. In fact, Gaston's death rates for the top ten causes of death for its population age 65-84 exceeded the state rate relative to seven of the causes, and it had the highest rates for nine of the top ten causes in comparison to the other five counties—the one exception being Alzheimer's disease. Its overall death rate for persons 65-84 exceeded the state figure and exceeded all of the other counties except for Moore, which has a similar rate of 4,215 per 100,000 population. Gaston is one of the three counties among the six with an overall death rate for the population age 85+ that exceeded the state figure. These comparative statistics for Gaston may also be related to the socio-economic status of its older population.

- All six counties have a higher percentage of their population age 65+ who are Veterans, as compared to the statewide figure (26.8 percent)—ranging from Brunswick (36.9 percent) to Gaston (27.3 percent).

- As far as the future of aging, five of the counties had a higher percentage of their total population who are baby boomers (born between 1946 and 1964), as of 2006, than is the case statewide (29.7 percent)—the exception is Moore County with a slightly lower percentage (29.4). Leading the six counties in terms of the proportionate share of its population who are boomers is Brunswick (32.7 percent).



The aging of the baby boomers is one of the factors associated with North Carolina's dramatic demographic shift. Another factor is the migration of retirees to North Carolina. As of the 2000 Census, North Carolina ranked third among states in the net-migration of retirees. The contributions of Dr. Don Bradley and Dr. Jim Mitchell of East Carolina University to this report highlight aspects of this trend and suggest important implications for North Carolina of retirees moving to our state and within our state. Here are a few findings contained in their report on Later-Life Migration Flows:

- Later-Life Migrants-defined as non-institutionalized persons age 60 and older who report having moved across state lines are consistently overrepresented in the Coastal and Mountain regions of North Carolina. Henderson, Brunswick, and New Hanover counties especially have large shares of North Carolina's later-life in-migrants. For example, the Henderson County area received more than twice as many later-life migrants in 2000 and 2006 than would be expected based on the percentage of older North Carolinians living in this area.

- The ECU researchers suggest that "the impact of older migrants for receiving communities is only partly a function of the number of new arrivals, equally important are the characteristics of older in-migrants." They report that "later-life migrants born outside North Carolina as compared to resident seniors, are somewhat younger, less likely to be disabled, twice as likely to have a college degree, and report substantially higher family income." This certainly seems to be the case when examining the data for the six counties–with the possible exception of Gaston.

Current Programs and Expenditures

While North Carolina has many programs, services, and supports available to seniors and their family caregivers, there is considerable variance throughout the state in terms of their availability. This variance is evident even among these six counties. In applying the eight components of the livable and senior-friendly community framework introduced in the *2007-2011 State Aging Services Plan*, the DAAS identified 26 core indicators to illustrate some of the activities, programs, and services that support such a community. It further developed a set of criteria to evaluate the status of each of the six counties in terms of these core indicators. Henderson County was found to be the most livable and senior-friendly in terms of these indicators, judged to have 17 of the 26 elements. In contrast, Brunswick and Moore counties had the fewest (9), followed by Gaston (12), New Hanover (15), and Buncombe (16). Only 3 of the 26 indicators were present in all six counties—local law enforcement officers trained to investigate alleged crimes against long-term care residents (Project S.A.F.E.), the presence of Senior Centers, and appointed representatives for the Senior Tar Heel Legislature. Even among these three indicators, there are differences in status. For example, three of the six counties—Buncombe, Moore, and New Hanover—have multipurpose Senior Centers that have achieved voluntary state certification status as either Centers of Merit or Centers of Excellence. Gaston County's senior center is still in development. For three of the core indicators, none of the six counties were found to have the activity, program or service, and for another six indicators, only one or two counties were participating. It is certainly true that some of these indicators reflect demonstrations or new and emerging programs (e.g., Aging and Disability Resource Connections, the Adult Care Home Quality Improvement Consultation Program, NC NOVA, Project C.A.R.E., and mobile dentistry). Still, in a few instances, the general absence of the indicator is telling and concerning. For example, when comparing the relative amount spent by Medicaid in 2007, on home-based care to that spent for nursing home care for persons age 60 and older, all six counties showed a rate less than that for the state as a whole (46.9 percent). In another example, New Hanover is the only county among the six with a Food and Nutrition Services (formerly Food Stamps) utilization rate higher than the state's for eligible persons age 65 and older, and the state rate itself is quite low (30.4 percent). And only two of the six counties—Buncombe and Henderson—have citizen-driven local Aging Leadership Planning Teams that can identify and advocate for improvements in programs, services, and supports to aid seniors and their families. These are the same two counties that have produced aging planning reports over the past few years to guide their future work.

Common characteristics as well as differences among the six counties were also found in an examination of information made available through the Divisions of Aging and Adult Services, Medical Assistance, Health Service Regulation, and Services for the Blind. Here are some of the more prominent findings:

- According to the Division of Medical Assistance, all but Henderson County had persons on the wait list for the Community Alternatives Program for Disabled Adults (CAP/DA). It is especially noteworthy that Brunswick County had as many persons on the wait list (70) as it had allocated slots (70). The CAP/DA program provides an alternative to nursing facility care. Wait list information about services under the Home and Community Care Block Grant (HCCBG) is also available in the county reports. Typically, the wait list for in-home aide services and home-delivered meals are the longest among the 18 fundable HCCBG services. These two services are especially important to helping individuals remain in the community.

- In examining the change in expenditures from fiscal years 2006 to 2007 for persons age 60 and older, several services showed an increase across all counties while several others showed a decrease. A major increase was evident in the federal Low-Income Energy Assistance Program administered by the Division of Social Services through County Departments of Social Services. Significant increases were also evident in several services funded by Medicaid for persons with mental illness and developmental disabilities, including the Community Alternatives Program for Persons with Mental Retardation (CAP/MR) and Other Practitioners (which included the Community Support Service). Other services showing an increase in most of the six counties were home-delivered meals, hospice, and independent living services (under the Division of Vocational Rehabilitation). On the other hand, in all counties, expenditures for nursing homes showed a decline. The same was nearly true for congregate nutrition, with Gaston County being the one exception. Expenditures for adult day care were also noted to decrease in three of the four counties where public funds were expended.

- The information on the Long-Term Care Ombudsman Program should also be of interest to the counties as it tracks complaints received about the quality of life and quality of care for residents in adult care homes and nursing homes over the past three years. More information about the nature of these complaints can be secured from the State or Regional Ombudsmen (see http://www.ncdhhs.gov/aging/ombud.htm for contact information).

Assessment of Future Needs and Projected Cost Estimates

One of the requirements of the six-county study is to identify programs and services to meet the needs of the growing senior population and estimate the funding requirements as well. Assistance in this assessment was provided by Area Agencies on Aging and by other divisions within the Department of Health and Human Services.

The most definitive determination is that of the 2008 State Medical Facilities Plan produced by the Division of Health Service Regulation. The Division of Health Service Regulation concluded for all six counties that there is not a need for any additional nursing home or adult care home beds, nor any need for additional Medicare-certified Home Health agencies or offices. While it also did not find a need for additional Hospice Home Care offices in any of the six counties, the Plan established that three of the six counties—Brunswick, Gaston, and Henderson—each has a need for seven additional inpatient Hospice beds.

Summary of Need Determination-2008 North Carolina State Medical Facilities Plan

County	Adult Care Home Beds	Nursing Home Beds	Home Health Agencies or Offices	Hospice Home Care Offices	Inpatient Hospice Beds
Brunswick	0	0	0	0	7
Buncombe	0	0	0	0	0
Gaston	0	0	0	0	7
Henderson	0	0	0	0	7
Moore	0	0	0	0	0
New Hanover	0	0	0	0	0

Source: Division of Health Services Regulation

From the survey work of the Area Agencies on Aging and their local partners, it is possible to get a glimpse of major concerns about the livability and senior-friendliness of the six counties that must be addressed now and well into the future. Areas of high concern identified by stakeholders in all six counties are organized below by the eight components of the livable and senior-friendly community framework. Sample respondent comments bring a personal feel to the concerns.

Top Areas of Concern Identified by Survey of Livability and Senior-Friendly Communities in the Six Studied Counties

Area	Item	# of Counties that reported concern (out of six)
Physical & Accessible Environment	Housing & Utilities	6
	Transportation	6
Healthy Aging	Preventive Care	5
Economic Security	Health Care Cost	5
Technology	Assistive & Adaptive Devices	6
	Medical Alert	6
Safety & Security	Fraud & Exploitation	5
	Outreach to Isolated & Vulnerable	5
Social & Cultural Opportunities	Community Sensitivity	5
Access and Choice in Services and Supports	Caregiver Support	4
	Home and Community Services	4
Public Accountability and Responsiveness	Planning and Coordination	4

Source: Survey conducted by Area Agencies on Aging and their local partners, 2008.

Physical and Accessible Environment

- Seniors cannot afford the basic maintenance for minor home repair. The minor turns major and impacts the senior's safety. [Brunswick respondent]
- The electric, oil and gas prices are astronomical in comparison to the monthly Social Security check. [Brunswick respondent]
- Transportation is a problem now and as gas prices rise will become more limited or more expensive. Without an integrated transportation system, seniors of this county will not be able to continue an active lifestyle. We will all reach a non-driving age eventually; yet there's no transportation to get to markets or medical appointments or to meet social needs. [Moore respondents]

Healthy Aging

- Need more in the way of education on healthy aging. [Brunswick respondent]
- Need to emphasize a comprehensive approach to preventive care that includes nutrition, wellness, and social connectedness. [Henderson respondent]

Economic Security

- Health care insurance costs are becoming prohibitive for some folks. Long-term care costs will rise. [Moore respondent]

Technology

- There is a need for medical alert devices to be available to all seniors. In-home monitoring services need to be more widely available and affordable. [Brunswick respondents]
- Medical alert systems are a significant step in allowing notification of emergency responders when necessary. [Moore respondent]

Safety and Security

- I am seeing an increased number of criminal cases involving exploitation—just last week two caregivers pled guilty and are now required to pay back all monies to the victims. [Brunswick respondent]
- Some people take advantage of elderly persons living alone by taking their money and home with promises. [Moore respondent]

Social and Cultural Opportunity

- I think [there] is still a ways to go as far as sensitivity to aging is concerned. [There needs to be greater awareness that] not all older adults are healthy and wealthy. [Moore respondents]

Access and Choice in Services and Supports

- Need for home and community services, including information and assistance, Senior Centers, and legal services. [Henderson respondent]
- There is no elder day care available in the county. Lack of such a program (at any cost) resulted in my husband's admission to an assisted living facility. [Moore respondent]

Public Accountability and Responsiveness

- Assessments of aging residents are vital to the community. [Moore respondent]

The Area Agencies also surveyed a diverse group of stakeholders to assess concerns vital to developing a comprehensive and coordinated system for supportive services, nutrition services, multipurpose senior centers, health care, and residential care. The areas of high concern relative to each of these service system components are identified below, along with sample respondent comments.

Areas of Concern Vital to Comprehensive Program for Aging

Area	Item	# of Counties that reported concern (out of six)
Supportive Services	Adult Day Care	3
	Adult Day Health Care	3
	Family Caregiving Counseling	3
	In-home aide (homemaker)	3
	In-home aide (personal care)	3
	Respite	3
	Transportation-general	6
	Transportation-medical	3
Nutrition	Home-delivered meals	6
	Nutrition counseling	4
Senior Centers	Senior Centers	4
Health Care	Dental care	5
	Medication management/ counseling	4
	Mental Health Counseling	5
	Primary Health Care	4
Residential Care	CAP/DA	4
	Special Assistance In-home Option	3

Source: Survey conducted by Area Agencies on Aging and their local partners, 2008.

Supportive Services

- Better transportation system needed—more user-friendly. [New Hanover respondent]
- Limited capacity of transport system. [Brunswick respondent]
- Current transportation services do not provide enough options for older adult needs. [Gaston respondent]
- Greatly needed for me. I have no care and do not drive. No public transportation. A crying need in this community. [Moore respondent]

Nutrition

- More funding and volunteers are needed. [New Hanover respondent]
- Mobile market needed for homebound who cannot go or get to the store. [New Hanover respondent]
- Lack of volunteers. [Brunswick respondent]
- More service delivery options needed to accommodate expanded rural locations. [Gaston respondent]
- Current waiting list due to need for volunteer drivers. [Buncombe respondent]
- We have a waiting list and spend a lot of staff resources trying to recruit and retain volunteers. [Moore respondent]

Senior Centers

- More funding and space are needed. [New Hanover respondent]
- Need more senior centers or community centers that offer more programs appropriate for older adults. [Buncombe respondent]
- Because the county is large, there should be several senior centers in different parts of the county. Central location is reasonable but many seniors live more than 15 miles away so regional meal/exercise sites are needed. [Moore respondents]

Health Care

- More dental care providers needed for Medicaid clients and low-income older adults. Need for greater education and outreach [relative to mental health counseling]. [Gaston respondents]
- Dental care is a very serious void in our area, especially for needy patients. Cost is a primary problem, especially for individuals who don't qualify for Medicaid but who can't afford to pay privately. [Moore respondents]

Residential Care

- Need more funding. [New Hanover respondent]

Generally, while it is possible to identify needed programs and services for the six counties through surveys and the examination of wait list information as is provided for HCCBG and CAP/DA services, it is more difficult to project the cost of meeting these needs. Still, the Division of Aging and Adult Services was able to secure estimates for some services and programs, including the Home and Community Care Block Grant, the State Adult Day Care Fund, the State In-Home Fund, and the Special Assistance In-Home Program. Additionally, the Division of Services for the Blind gave a general projection of the need for additional funding based on expected growth in the number of seniors who are blind or otherwise visually impaired. It identified affordable housing, transportation, and long-term

care facilities as particular concerns, along with the need for specialized services and training.

Observations and Recommendations

While it is hoped that the six counties will find their report useful, it certainly has its limitations and should be considered only as a starting point. Here are some of the limitations that led to the major recommendation for supporting a comprehensive, five-year study of the aging of North Carolina's population. While the report for the comprehensive study was presented to the Aging Legislative Study Commission at its January 2008 meeting, here are some highlights pertinent to addressing the limitations of the six-county study.

Limitations of Six-County Study	Recommendations for Comprehensive Study
Focus on health and human services	While the availability and quality of health and human services is vital to an aging population, it is only one component of what is necessary for a livable and senior-friendly community. The recommended comprehensive aging study would take a broad perspective and tap the information and require the involvement of all relevant stakeholders.
Use of existing data, resources, and information systems	While use of existing data and resources was practical for the purpose of the limited study, it gives only a partial snapshot in content and time. It also does not take into account programs and services that are provided privately without government oversight or funding. An especially large hurdle is easily accessible data from systems that do not interface. The recommended comprehensive aging study would add significantly to what is known about consumer needs, interests, and assets and to what is known about current and projected capacity to respond to an aging population at the local and state levels. The recommended study would also support specialized studies, including one on the implications of in-migrating retirees. The value of this can be seen in the work on later-life migration flows, contributed by the ECU researchers.
Focus on six counties	While the six counties were identified based on one rather interesting demographic phenomenon, they are not necessarily representative of all counties and more importantly, all of NC will soon encounter issues associated with an aging population. Now is the time for a more comprehensive, more systematic approach.

Limitations of Six-County Study	Recommendations for Comprehensive Study
Limited input from consumers, advocates, and local officials	While Area Agencies on Aging effectively led an effort to get input from various local stakeholders through two assessments, cautions must be taken in drawing conclusions based on the number and representativeness of the respondents and the validity of the survey tools used. In addition, only two of the counties—Buncombe and New Hanover—and only two towns in the study areas—Stanley in Gaston and Southern Pines in Moore—responded to the 2005 national Maturing of America survey. The recommended comprehensive aging study would seek input from consumers, advocates, and local officials in a more systematic way and would provide Area Agencies on Aging with greater capacity to assist with this.
Uncertain capacity at the local and state levels to use and follow up on the study's findings	While it is possible that there are sufficient means in each of the six counties to make use of the report's findings, there are also doubts about this. Only two counties appear to have an ongoing local, citizen-driven planning process, and county government and Area Agencies on Aging have limits to what they can currently do to support such a process. The recommended aging study places an emphasis on increasing capacity within counties and Area Agencies on Aging to support meaningful planning, evaluation, and development activities. Equally important, there needs to be a state-level body that enjoys the influence and resources to direct an ongoing means of focusing broad attention on the aging of the state's population. The proposed comprehensive study recommends creation and support of a State Strategic and Steering Team.

Appendix

Aging Study of Brunswick County

Aging Study of Buncombe County

Aging Study of Gaston County

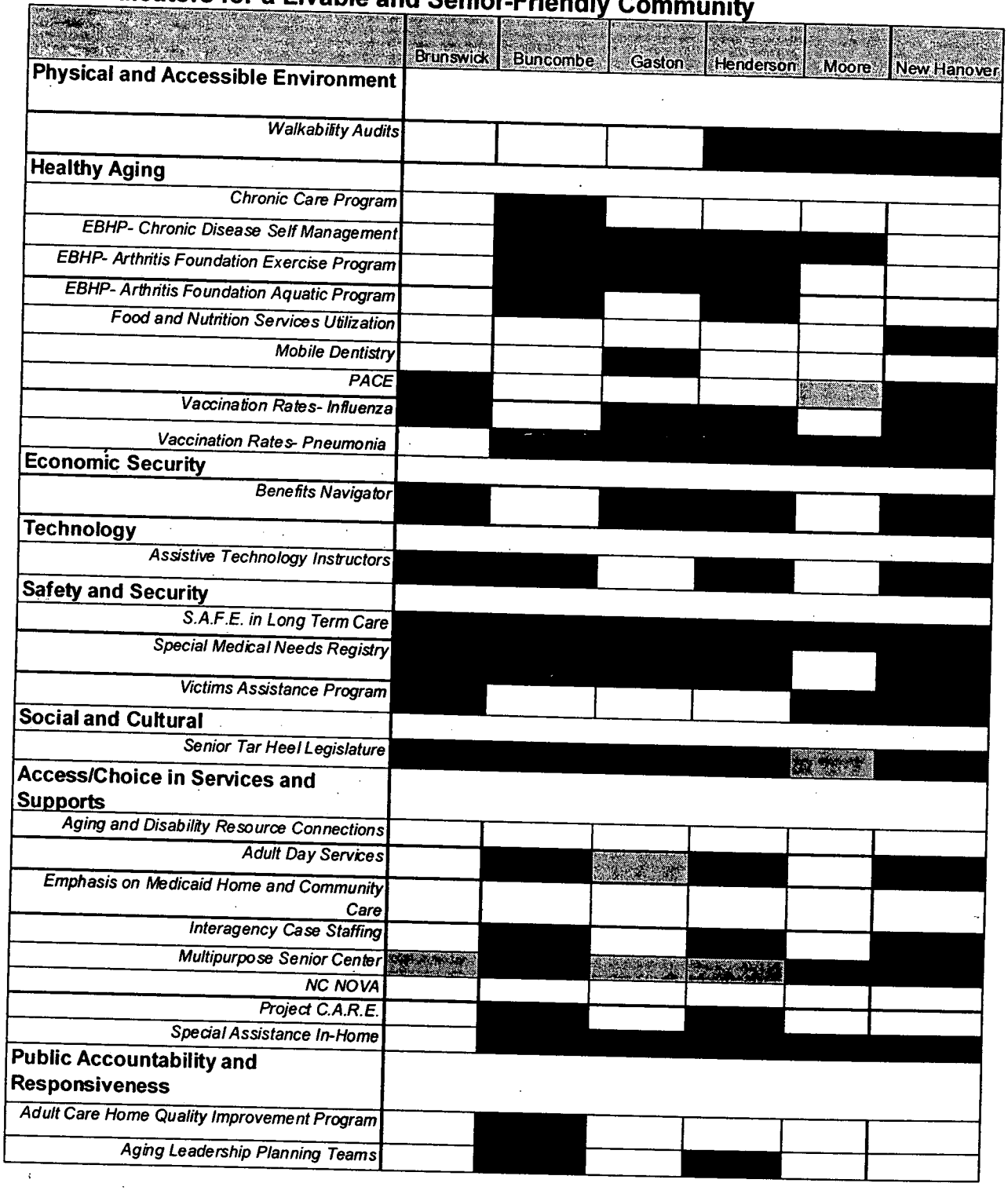
Aging Study of Henderson County

Aging Study of Moore County

Aging Study of New Hanover County

East Carolina University (ECU) Report on Later-Life Migration Flows

Core Indicators for a Livable and Senior-Friendly Community



Core Indicators for a Livable and Senior-Friendly Community: Descriptions

Physical and Accessible Environment

Walkability Audits: A walkability audit broadly assesses pedestrian facilities, destinations, and surroundings along and near a walking route and identifies specific improvements that would make the route more attractive and useful to pedestrians. Walkabilty is an important component to livable and senior-friendly communities.

- **Black:** County has conducted audits within the past two years to assess the walkability of downtown areas, neighborhoods, etc., especially for people with special needs.
- **White:** County has not conducted walkability audit within the past two years.

Healthy Aging

Chronic Care Program: The North Carolina General Assembly directed the N.C. Department of Health and Human Services in 2005 to "expand the scope of Community Care of North Carolina (CCNC) care management model to recipients of Medicaid and dually eligible individuals with chronic conditions and long-term care needs...." In the chronic care initiative, the CCNC networks, in partnership with community long term care provider organizations, are expected to provide a comprehensive and integrated package of screening and assessment, case management and care coordination, in addition to the primary, preventive and medical coordination and treatment that is available to all enrollees. The Office of Rural Health and Community Care is administering this program.

- **Black:** County is participating in the Chronic Care Program.
- **White:** County is not participating in the Chronic Care Program.

Evidence-Based Program, Chronic Disease Self Management (CDSMP): The NC Division of Aging and Adult Services (DAAS) and Division of Public Health (DPH) received a 3 year grant from the U.S. Administration on Aging to carry out a campaign to implement and sustain the Stanford University Chronic Disease Self-Management Program (CDSMP) to reduce the risk of disease and disability among seniors. NC will target low-income, minority, and/or rural older adults experiencing chronic health conditions such as hypertension, arthritis, heart disease, stroke, lung disease, and diabetes. The program is currently available in 46 counties.

- **Black:** County has a Master CDSMP trainer.
- **White:** County has no Master CDSMP trainer.

Evidence-Based Program, Arthritis Foundation Exercise Program (AFEP): Formerly People with Arthritis Can Exercise or PACE, is an evidenced-based health promotion, community-based recreational exercise program developed by the Arthritis Foundation. The program's demonstrated benefits include improved functional ability, decreased depression, and increased confidence in one's ability to exercise. AFEP is offered by the Arthritis Foundation.

- **Black:** County has AFEP courses available.
- **White:** County does not have AFEP courses available.

Evidence-Based Program, Arthritis Foundation Aquatic Program (AFAP): An evidence-based water exercise program created by the Arthritis Foundation for people with arthritis and related conditions. The classes are conducted by a trained instructor and are designed to improve flexibility, joint range of motion, endurance, strength, and daily function and to decrease pain. The Division of Public Health is administering this program.

- **Black:** County has AFAP courses available.
- **White:** County does not have AFEP courses available.

Food and Nutrition Services Utilization for those 65+: Food and Nutrition Services (FNS), previously known as Food Stamps, is a federal food assistance program that helps low-income families. The purpose of Food and Nutrition Services is to end hunger and improve nutrition and health. It helps eligible low-income households buy the food they need for a nutritionally adequate diet. The state participation rate for the Food and Nutrition Services program for those 65+ and eligible is 30.4% as of December 2007. The Division of Social Services administers this program.

- **Black:** County utilization rate is at or above that of the state.
- **White:** County utilization rate is below that of the state.

Mobile Dentistry: Mobile dentistry improves access to dental care for seniors and persons with disabilities who have difficulty receiving care in private dental offices due to their medical, physical and/or mental condition. The service is provided by a fully mobile state-of-the-art dental office staffed by a dentist, dental hygienist, and dental assistants providing oral hygiene and dental care.

- **Black:** County has access to mobile dentistry services.
- **White:** County does not have access to mobile dentistry services.

Programs of All inclusive Care for the Elderly (PACE): PACE is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The Division of Medical Assistance is administering this program.

- **Black:** County has an active PACE program or has received approval from the state and CMS to implement a PACE program.
- **Gray:** County has completed a feasibility study or is in the planning phase for PACE.
- **White:** County does not have a PACE program.

Influenza Vaccination: The 2010 NC Healthy Carolinians immunization objective is to increase the proportion of adults 65 years of age or older who have ever been vaccinated annually against influenza. According to CCME, the state vaccination rate is 33.7% based on 2004 CMS data of Medicare-only beneficiaries.

- **Black:** County immunization rate is at or above that of the state rate.
- **White:** County immunization rate is below that of the state rate.

Pneumonia Vaccination: The 2010 NC Healthy Carolinians immunization objective is to increase the proportion of adults 65 years of age or older who have ever been vaccinated against pneumococcal disease. According to CCME, the state vaccination rate is 45.6% based on 2004 CMS data of Medicare-only beneficiaries.

- **Black:** County immunization rate is at or above the state rate.
- **White:** County immunization rate is below the state rate.

Economic Security

Benefits Navigator: Benefits Navigator is a program using trained volunteers to help older adults and persons with disabilities access public benefits they need for economic security and well-being. The training focuses on Medicaid, MQB (or Medicare-Aid), Social Security, Food and Nutrition Services, and the Low Income Energy Assistance Program. DAAS administers this program. Medicare information and counseling is addressed by the Seniors Health Insurance Information Program (SHIIP).

- **Black:** County has at least one trained Benefits Navigator volunteer.
- **White:** County has no trained Benefits Navigator volunteers.

Technology

Technology Instructor: Technology instructors are employees of the Division of Services for the Blind (DSB) that provide older adults who have vision loss with local access to training in the use of assistive technology like large print and/or speech output for computers that enable them to handle their correspondence, personal finances, and medication independently.

- **Black:** DSB has a technology instructor to serve the county.
- **White:** DSB does not have a technology instructor to serve the county.

Safety and Security

Strategic Alliances for Elders (S.A.F.E) in Long Term Care: Program staff train patrol officers, investigators, and other local law enforcement personnel about the unique situations and challenges that may present themselves when investigating alleged crimes against residents of long term care settings. DAAS works with the NC Justice Academy to administer this program.

- **Black:** County has SAFE law enforcement officers trained.
- **White:** County has no SAFE law enforcement officers trained.

Special Medical Needs Registry: Special Medical Needs Registries contain the names and addresses of individuals with medical and other special needs. The registry is an emergency preparedness tool and is used for communicating with and for people having special medical needs, to aid pre-event emergency planning and for evacuation and sheltering during actual emergencies.

- **Black:** County maintains special medical needs registry.
- **White:** County does not maintain special medical needs registry.

Victims Assistance Program: The Division of Aging and Adult Services and the Office of the Attorney General have developed a Victims Assistance Program. This program provides intense training to volunteers to help them become effective mentors to victims of fraud. The goals of this program are to reduce the ongoing incidence of consumer fraud and to establish a protocol for early detection of signs and symptoms of fraud among the vulnerable aging population.

- **Black:** County has a trained Victims Assistance Program volunteer.
- **White:** County does not have a trained Victims Assistance Program volunteer.

Social and Cultural

Senior Tar Heel Legislature (STHL): The Senior Tar Heel Legislature, established by state statute, assesses the legislative needs of older citizens by convening a forum modeled after the North Carolina General Assembly. It also provides information to senior citizens on the legislative process and promotes citizen involvement and advocacy. Delegates and alternates must be age 60 or older. DAAS provides staff support to the STHL.

- **Black:** County has at both a delegate and alternate.
- **Gray:** County has a delegate only.
- **White:** County has neither a delegate nor alternate.

Access and Choice in Services and Supports

Aging and Disability Resource Connection (ADRC): ADRCs are a no wrong door portal of entry into long term services and supports. ADRCs are visible and trusted places where people can turn for information on the full range of long term support options. They serve elderly persons, younger individuals with disabilities, family caregivers, as well as persons planning for future long term support needs. The Office of Long Term Services and Supports is coordinating the piloting, promotion of ADRCs, and expansion of ADRCs.

- **Black:** County has an ADRC project.
- **White:** County does not have an ADRC project.

Adult Day Services: Adult day services provide an organized program of services during the day in a community group setting 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. There are two types of adult day services in NC: (1) adult day care, and (2) adult day health. DAAS is responsible for certifying adult day services.

- **Black:** County has both certified adult day and day health services.
- **Gray:** County has at least one certified adult day center or adult day health program.
- **White:** County does not have a certified adult day center or adult day health program.

Emphasis on Medicaid Home and Community Care: The amount Medicaid spent on home-based care (CAP/DA, CAP/MR, home health and PCS) for every $100 spent in nursing homes for clients age 60+ gives an indication of the balance between support of helping older adults age in place with home and community services as compared to placement in a facility. The state figure for 2006 is 46.9%.

- **Black:** County's percentage of Medicaid expenditures on home/community care dollars versus nursing home dollars exceeds the State average.
- **Gray**: County's percentage of Medicaid expenditures on home/community care dollars versus nursing home dollars is nearly the same as the State figure of 46%-47%.
- **White:** County's percentage of Medicaid expenditures on home/community care dollars versus nursing home dollars is below the State figure.

Interagency Case Staffing for Aging and Adult Services: An interagency/interdisciplinary group meets regularly to discuss, manage, and locate resources for complex or challenging cases. This approach is considered to be an effective tool for helping consumers and targeting resources.

- **Black:** County has active case staffing group that meets on a regular basis.
- **White:** County does not have an active case staffing group.

Multipurpose Senior Centers: A multipurpose senior center is a community facility where older adults come together for services and activities that reflect their skills and interests and respond to their diverse needs. Centers are a resource for the entire community, providing services and information on aging, and assisting family and friends who care for older persons. DAAS administers a voluntary certification program that recognizes Centers of Excellence and Centers of Merit based on established criteria and a peer review process.

- **Black:** County has at least one certified Senior Center of Merit or Excellence.
- **Gray:** County has at least one multipurpose senior center or is in the planning stage of developing a multipurpose senior center, but none that is certified.
- **White:** County does not have a multipurpose senior center.

NC New Organizational Vision Award (NOVA): NC NOVA is a voluntary, special licensure model which covers a comprehensive set of workplace expectations. The program seeks to recognize providers who actively support and empower their direct care workforce across long term care related settings. The Carolinas Center for Medical Excellence (CCME) reviews the applications for NC NOVA.

- **Black:** County has an agency or facility that has obtained NC NOVA licensure status.
- **White:** County does not have an agency or facility that has obtained NC NOVA licensure status.

Caregiver Alternatives to Running on Empty (Project C.A.R.E): Project C.A.R.E. uses a consumer-directed, family consultant model to provide comprehensive respite support to dementia caregivers. Through an in-home intervention, Alzheimer's families are assisted in resolving caregiving issues, connected with community resources and if eligible, provided with funding for respite care. DAAS is administering this federally funded Alzheimer's demonstration program in 14 counties.

- **Black:** County is participating in Project C.A.R.E.
- **White:** County is not participating in Project C.A.R.E.

State/County Special Assistance In-Home Program (SA-IH): The State/County Special Assistance In-Home Program for Adults provides a cash supplement to help Medicaid-eligible individuals who are at risk of entering an Adult Care Home and would like to remain at home. SA/IH provides an alternative to placement in an Adult Care Home for individuals who could live at home safely with additional support services and income. DAAS administers this program, working with county departments of social services. It is currently available in 91 counties.

- **Black:** County is participating in SA/IH program.
- **White:** County is not participating in SA/IH program.

Public Accountability and Responsiveness

Adult Care Home Quality Improvement Program (ACHQI): A quality improvement pilot program, established by the General Assembly, designed specifically for Adult Care and Family Care Homes. Participating homes receive consultative support from county departments of social services to assess, improve, and monitor the safety of medication use in their environments. Other areas for quality improvement are planned for the future. DAAS is responsible for administering this program in four counties (Alamance, Buncombe, Nash and Rutherford).

- **Black:** One or more adult care homes or family care homes participate in the ACHQI program.
- **White:** No adult care homes or family care homes in the county participate in the ACHQI program.

Aging Leadership Planning Teams: Aging Leadership Planning Teams are citizen-driven and broadly focused planning teams at the county level. Teams lead in planning for aging through a collaborative process. They utilize the livable and senior-friendly community framework to plan for culture and systems changes in the community to promote independence, dignity and choice for older adults.

- **Black:** County has an Aging Leadership Planning Team that meets on an ongoing basis.
- **White:** County does not have an Aging Leadership Planning Team.

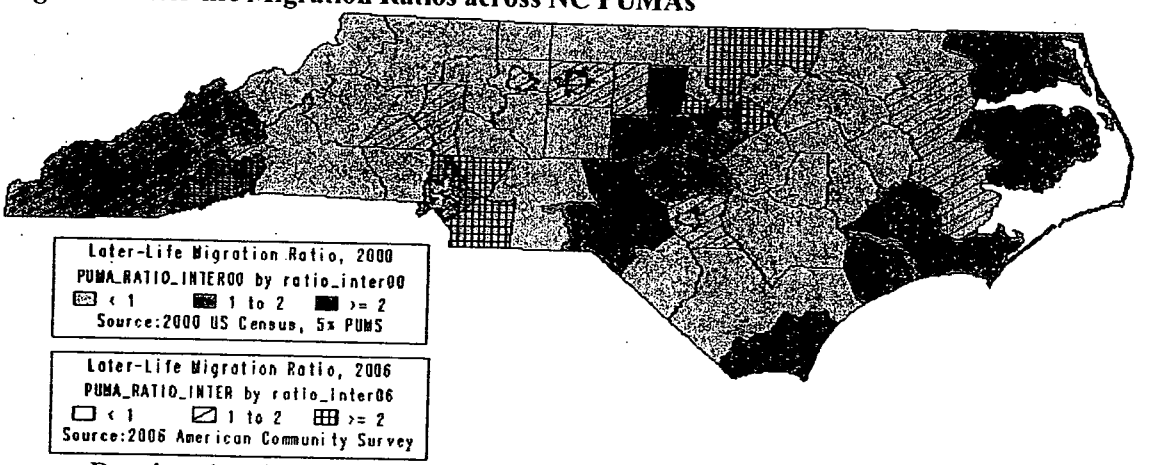
Volume and Composition of Later-life Migration Flows for North Carolina and Selected Counties

In order to characterize the volume and composition of later-life migration flows into selected North Carolina counties, we employ individual-level data from the Census Bureau. The descriptive statistics that follow represent weighted estimates based on individual-level Public Use Microdata Sample (PUMS) data from the 2000 US Census and the 2006 American Community Survey (ACS). Our estimates are subject to sampling error. Though space limitations prohibit treatment of this issue here, technical documentation is available on the Census Bureau website (www.census.gov). The advantage of PUMS data is that we can identify and characterize older in-migrants. However, individual level data provide limited spatial information; the smallest geographic units defined are Public Use Microdata Areas (PUMA's), which are bounded so as to include no less than 100,000 persons. PUMAs in North Carolina sometimes comprise parts of counties, whole counties, or groups of counties.

In the discussion to follow, a later-life migrant is defined as a non-institutionalized person over the age of 60 who reports having moved across state lines. In the 2000 Census respondents were asked if they had moved within the previous five years; the reporting period for the 2006 ACS covers moves in the year prior to the interview. Thus, estimates from the 2000 and 2006 data are not directly comparable.

Figure 1 below depicts the later-life migration ratio across PUMA's in North Carolina from the 2000 Census and the 2006 ACS. The later-life migration ratio for a given PUMA is calculated by dividing the percentage of later-life migrants moving to that PUMA by the percentage of North Carolinians 60+ living in that same PUMA. Results in Figure 1, are not surprising. Later-life migrants appear to be pretty consistently overrepresented in coastal and mountain regions of the state. Henderson and Transylvania counties in 2000 and 2006, for example, received more than twice as many later-life migrants than would be expected based on the percentage of North Carolinians aged 60 and older living in these two counties.

Figure 1. Later-life Migration Ratios across NC PUMAs



Based on data from the 2000 US Census, North Carolina received an estimated 73,157 non-institutionalized later-life migrants between 1995 and 2000. Table 1, provides specific estimates from the 2000 Census for PUMAs containing counties of special interest. Henderson and Transylvania Counties along with Brunswick and New Hanover Counties stand out; between 1995-2000 they both received no less than about 4,900 later-life migrants comprising well over 10% of the 60 and older population. Worth noting, two PUMAs experienced negative net migration during the period, S. Buncombe County and Gaston and Lincoln Counties. However,

we should point out that PUMA-level estimates aggregate different kinds of communities. Areas adjacent to the Charlotte metro area may be sharply impacted by later-life migration though this effect may be diluted by low-levels of in-migration in the rest of Gaston and Lincoln Counties.

Table 1. Later-Life Migration Flows for Selected North Carolina PUMAs, 2000

	No. of In-Migrants	No. of Out Migrants	Net-Migration	In-Migrants as a Pct. of 60+ Pop.	Share of NC In-Migrants	Later-Life Migration Ratio
N. Buncombe and Madison Counties*	1,942	1,344	598	.086	.027	1.454
S. Buncombe County*	937	1,221	-284	.046	.013	.772
Henderson and Transylvania Counties	4,941	2,353	2,588	.160	.068	2.704
Gaston and Lincoln Counties	849	1,001	-152	.021	.012	.357
Moore, Richmond, Hoke, and Scotland Counties	3,252	1,378	1,874	.093	.044	1.561
Brunswick and New Hanover Counties	5,804	2,369	3,435	.133	.079	2.246
*PUMA of origin codes, aggregate all of Buncombe and Madison Counties. Out-migrants are apportioned to the S. Buncombe and N. Buncombe and Madison PUMAs assuming a constant out-migration rate among those 60 and older.						
Source: 2000 US Census, 5% Public Use Microdata Sample (PUMS)						

The impact of older migrants for receiving communities is only partly a function of the number of new arrivals, equally important are the characteristics of older in-migrants. Table 2 compares selected characteristics of later-life migrants both those native to North Carolina and those born outside the state to resident seniors, persons aged 60 or older who did not report a move between 1995 and 2000. Though space limitations prohibit a full discussion, from Table 2 it is evident that later-life migrants born outside North Carolina as compared to resident seniors, are somewhat younger, less likely to be disabled, twice as likely to have a college degree, and report substantially higher family income.

Table 2. Demographic Profile of Later-Life Migrants and Resident Seniors, 2000

	Aged 60-64	Aged 65-74	Aged 75 and older	Disabled	Married	College Degree	White	Homeowner	Median Family Income
Later-Life Migrants, non-natives	.334	.401	.265	.329	.626	.304	.904	.623	$42,800
Later-Life Migrants, NC natives	.367	.388	.245	.425	.472	.183	.655	.595	$31,300
Resident Seniors	.245	.429	.325	.423	.604	.141	.825	.844	$30,700
Source: 2000 US Census, 5% Public Use Microdata Sample (PUMS)									

Table 3 examines the characteristics of later-life migrants and resident seniors across each of the PUMAs containing the study counties. Results suggest that in most cases the statewide patterns observed in Table 2 are replicated in the PUMAs analyzed. Gaston and Lincoln counties comprise an exception; non-native later-life migrants may have somewhat higher earnings than resident seniors but they otherwise do not appear to be positively selected. Notably senior adults move for widely varying reasons. The characteristics of a particular community condition the kinds of older migrants who are attracted. Not all receiving areas will be able to offer the kinds of amenities desired by highly-educated affluent seniors.

Table 3. Demographic Profile of Later-Life Migrants and Resident Seniors across Selected North Carolina PUMAs, 2000.

Panel A. Moore, Richmond, Hoke, and Scotland Counties									
	Aged 60-64	Aged 65-74	Aged 75 and older	Disabled	Married	College Degree	White	Homeowner	Median Family Income
Later-Life Migrants, non-natives	.246	.461	.292	.235	.810	.386	.908	.774	$57,800
Later-Life Migrants, NC natives	.561	.281	.158	.362	.348	.216	.754	.536	$37,470
Resident Seniors	.218	.443	.338	.403	.588	.195	.785	.855	$32,400
Panel B. Gaston and Lincoln Counties									
	Aged 60-64	Aged 65-74	Aged 75 and older	Disabled	Married	College Degree	White	Homeowner	Median Family Income
Later-Life Migrants, non-natives	.391	.254	.355	.638	.439	.078	.922	.459	$39,000
Later-Life Migrants, NC natives*	.	.	.	.	.	.	.	.	.
Resident Seniors	.258	.433	.309	.442	.607	.089	.913	.833	$28,400
Panel C. Henderson and Transylvania Counties									
	Aged 60-64	Aged 65-74	Aged 75 and older	Disabled	Married	College Degree	White	Homeowner	Median Family Income
Later-Life Migrants, non-natives	.302	.494	.204	.201	.791	.447	.988	.880	$42,200
Later-Life Migrants, NC natives	.425	.349	.226	.235	.547	.277	.947	.721	$32,900
Resident Seniors	.189	.422	.389	.333	.664	.265	.978	.903	$34,200
Panel D. N. Buncombe and Madison Counties									
	Aged 60-64	Aged 65-74	Aged 75 and older	Disabled	Married	College Degree	White	Homeowner	Median Family Income
Later-Life Migrants, non-natives	.307	.375	.318	.346	.707	.325	.984	.687	$47,000
Later-Life Migrants, NC natives*	.	.	.	.	.	.	.	.	.
Resident Seniors	.248	.409	.343	.415	.646	.152	.985	.898	$30,000
Panel E. S. Buncombe									
	Aged 60-64	Aged 65-74	Aged 75 and older	Disabled	Married	College Degree	White	Homeowner	Median Family Income
Later-Life Migrants, non-natives	.274	.329	.397	.327	.362	.353	.939	.435	$36,104
Later-Life Migrants, NC natives*	.	.	.	.	.	.	.	.	.
Resident Seniors	.209	.421	.370	.381	.618	.219	.886	.817	$35,600
Panel F. Brunswick and New Hanover Counties									
	Aged 60-64	Aged 65-74	Aged 75 and older	Disabled	Married	College Degree	White	Homeowner	Median Family Income
Later-Life Migrants, non-natives	.436	.406	.159	.219	.717	.331	.990	.774	$50,300
Later-Life Migrants, NC natives	.480	.417	.103	.226	.716	.222	.661	.803	$39,100
Resident Seniors	.232	.445	.322	.407	.641	.183	.871	.868	$35,000
*Insufficient number of cases available for analysis.									
Source: 2000 US Census, 5% Public Use Microdata Sample									

Data from the 2006 ACS allow us to update results from the 2000 Census somewhat. For 2006, among non-institutionalized North Carolinians aged 60 and older, an estimated 27,606 had arrived from out-of-state within the previous year. Table 4 presents later-life migration estimates for selected PUMA's. As in 2000, Henderson and Transylvania counties and Brunswick and New Hanover counties captured particularly large shares of all the later-life in-migrants arriving in the state, 5.5% and 6.9% respectively.

Table 4. Later-Life Migration* across Selected PUMAs, 2006.

	No. of In-Migrants	No. of Out-Migrants	Net-Migration		In-Migrants as a Pct. of 60+ Pop.	Share of NC In-Migrants	Later-Life Migration Ratio
N. Buncombe and Madison Counties**	569	655	-86		.022	.021	1.132
S. Buncombe County**	694	547	147		.032	.025	1.656
Henderson and Transylvania Counties	1,527	501	1,026		.046	.055	2.378
Gaston and Lincoln Counties	237	189	48		.005	.009	.261
Moore, Richmond, Hoke, and Scotland Counties	506	342	164		.012	.018	.646
Brunswick and New Hanover Counties	1,917	1,951	-34		.034	.069	1.781
*Interstate move reported by respondent within the year prior to the interview.							
**PUMA of origin codes, aggregate all of Buncombe and Madison Counties. Out-migrants are apportioned to the S. Buncombe and N. Buncombe and Madison PUMAs assuming a constant out-migration rate among those 60 and older.							
Source: 2006 American Community Survey, Public Use Microdata Sample (PUMS)							

Table 5 provides descriptive statistics for later-life migrants and resident seniors in North Carolina. Findings again demonstrate that non-native later-life migrants appear to be particularly well-educated. Moreover, there remains a substantial income gap between later-life migrants and resident seniors.

Table 5. Demographic Profile of Later-Life Migrants* and Resident Seniors for North Carolina as a Whole, 2006

	Aged 60-64	Aged 65-74	Aged 75 and older	Disabled	Married	College Degree	White	Homeowner	Median Family Income
Later-Life Migrants, non-natives	.308	.428	.264	.375	.492	.345	.841	.484	$56,800
Later-Life Migrants, NC natives	.508	.337	.154	.344	.411	.254	.643	.680	$42,000
Resident Seniors	.288	.395	.317	.394	.594	.190	.821	.808	$45,000
*Interstate move reported by respondent within the year prior to the interview.									
Source: 2006 American Community Survey Public Use Microdata Sample (PUMS)									

The 2006 ACS does not include a sufficient number of cases to allow us to construct demographic profiles across North Carolina PUMA's. An updated PUMA-specific descriptive analysis will have to await the collection of additional ACS data. The ACS was fully implemented in 2005 and ACS data are collected on a yearly basis. In the future, multiple years can be aggregated to produce PUMA-specific descriptive profiles. These and other issues related to later-life migration can be addressed through the proposed Retirement Migration Initiative of the Center on Aging of the ECU Brody School of Medicine including participation of investigators from multiple UNC campuses.

Reference:
Dr. Don Bradley
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Rebuilding hope

Habitat for Humanity teams with Brunswick Senior Services to provide home renovations to seniors in need

By Linda Bordner,
Star-News Correspondent
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Photo | Courtesy of Habitat for Humanity
Habitat for Humanity volunteers Don West (left) and Doug Macomb make home repairs at homes of Brunswick County seniors referred by Brunswick Senior Services.

WANT TO HELP?
Inspired by farmer and Bible scholar Clarence Jordan of Georgia, Millard and Linda Fuller founded Habitat for Humanity after giving away their worldly possessions in order to pursue the 'theology of the hammer.' Volunteers need to have construction skills to help. For further information, call 454-0007.

In her Brunswick County home, a senior living alone lifted a prayer toward heaven. Independent her whole life, she was usually the one helping others, but when the floor in her house gave way she found herself not knowing where to turn.

Meanwhile, Gary Knapp, Habitat for Humanity executive director for Brunswick County, faced a smaller dilemma. With time between new home jobs, his volunteer crews wanted work to keep their considerable skill pool busy, and felt the urge to do more to help others.

Enter Jim Russell, dynamic president of Brunswick Senior Resources. Russell's problem was how to help the seniors he met keep the independence they cherished while their home repair needs escalated faster than his minor home repair program could fix.

Fortunately for all concerned, the two forces combined in a partnership benefiting everyone. When Knapp learned there were local seniors desperately needing the very skills he had at his disposal, he and Russell decided to collaborate to meet the need.

"The largest cost in any rehabilitation project is the labor involved," Knapp said. Because his skilled crews are volunteers it eliminates that portion of the price. "Also, through associations we have, we get materials donated or at reduced costs," he adds.

What makes the partnership even more perfect is that nearly all the Habitat volunteers are seniors themselves, retired contractors, carpenters and electricians. Together their combined experience easily exceeds levels found at most paid construction sites.

"If I had my choice, I would have done it myself, but I couldn't. I really needed help," said Miss Alzada, who requested that her last name be withheld from this article.

When the Minor Home Repair arm of Brunswick Senior Resources assessed her floor issues, it became clear the project exceeded the scope of minor repairs.

Even the experienced Habitat crew found the task daunting at first. But once Miss Alzada met them, she had faith they could help. The feeling was mutual. Immediately a bond between the seasoned construction workers and the spirited senior made them look forward to their time together.

"Definitely I had been praying for help," Miss Alzada says. "I believe God always has a plan for us. That these men would get up every day and volunteer their time, I can't say enough good things about them."

What made it even more special to her was the simple presentation outside her renovated kitchen after work was complete. "They gave me this Bible," she says, rereading the handwritten inscription, "And they all signed it."

"I read it every day," she says, adding she had just read her favorite scripture, the 91st Psalm, that morning.

Knapp's own background encompasses 36 years in management and human resources. He retired here from Charlotte, where he was already involved with Habitat for Humanity. His wife Sylvia now works

at Brunswick Community College as liaison for the early college program.

"We love it here," Knapp says of Brunswick County. "This is home."

His introduction to Habitat offers potential for area businesses to model.

"I was looking for team-building exercises," he recalls. To meet the challenge, he summoned his company managers from across the country to join forces and together build a Habitat house for a family in need.

He still smiles remembering the huge impact the effort had on participants. For him, it was nothing short of life changing, eventually leading to his post-retirement career here.

This spring, Novant Health and Brunswick Community Hospital will sponsor their own Habitat house project. "They're sending doctors, nurses and many people who maybe never held a hammer in their lives," he says. "That's an important point. You don't have to have construction skills to volunteer. There are lots of other things people can do. Anyway, we can teach folks how to pound a nail."

Knapp sees several differences between Habitat's usual new house construction and senior home repair projects they tackle. "For the new homeowner, it's a long-term collaborative effort. Their living situation is usually such that they can live in their current, if not suitable, livable conditions."

Senior jobs differ in that "We have to get out there quickly," he explains, in order to make the home even livable. He describes these short-term projects as mainly "emergency-related," such as failing floors where the refrigerator falls through. With the fourth such project just completed, no one is happier with the partnership than Russell. "It happened over 40 years," he says of typical house issues confronting seniors, "But the solution must be done rapidly."

Russell calls the collaboration "more than a two-way street," adding, "Habitat has brought expertise that we can't buy, with a dedication that's highly unusual." He cites one job with a conservative renovation cost estimate of $15,000, yet through Habitat, came in around $1,000.

Calling their help an answer to her prayers, Miss Alzada says she includes each and every volunteer that helped her, in her daily prayers, as well as the entire program and anyone like her who needs them.

"This was real cute," she says. "This past Sunday, one of them called and said his wife had some curtains to give me, and they came over and put curtains over my new windows. It's caring. They went beyond what I'd have thought."

"I thank the Lord for it. I can't express the joy I have coming into my house each day and seeing it so pretty and nice. They made me another person." She calls it "a wonderful experience," which has inspired her to donate so others can feel the same.

"I want to give back for these wonderful men and this program," she says, adding, "When it was all done, I said, Lord, I knew you had a plan."

Att. #

(7)

Overview
DRAFT Recommendations for the Study Commission on Aging

4/8/08

Recommendation 1: Senior Center Funds

The Study Commission on Aging recommends that the General Assembly appropriate an additional $500,000 for FY 08-09 to the Senior Center General Purpose Fund with the intent that it shall become part of the continuation budget.

Recommendation 2: Additional HCCBG Funds

The Study Commission on Aging recommends that the General Assembly appropriate an additional $2,500,000 to the Department of Health and Human Services for FY 08-09 for the Home and Community Care Block Grant (HCCBG).

Recommendation 3: Funds for 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 08-09 to fund Project C.A.R.E. (Caregiver Alternatives to Running on Empty) which provides support to individuals with dementia and their caregivers.

Recommendation 4: Adult Protective Services Pilot Program

The Study Commission on Aging recommends that the General Assembly appropriate $1,497,087 to the Department of Health and Human Services, Division of Aging and Adult Services, for FY 08-09 to enact the first year of a two-year pilot program to assess proposed changes to the adult protective services statutes and to report to the Study Commission on Aging on the evaluation of the pilot by March 1, 2010.

Recommendation 5: Statewide Aging Study

The Study Commission on Aging recommends support for a comprehensive, five-year statewide study of the older adult population and the State's readiness to respond to the coming wave of older adults by recommending that the General Assembly take the following steps: establish an appointment process for a steering committee; appropriate $175,000 to the Department of Health and Human Services, Division of Aging and Adult Services, for the establishment of two positions to support the work of the study; appropriate $3,820,000 to the Division of Aging and Adult Services for FY 08-09, to fund the first year of the study; and direct the Department of Health and Human Services, Division of Aging and Adult Services, to make annual reports to the General Assembly on the status of the study.

Recommendation 6: Adult Care Home Residents

The Study Commission on Aging recommends that the General Assembly appropriate $1,764,000 for FY 08-09 to the Department of Health and Human Services, Division of Medical Assistance, for development of the PASARR Level II assessment which is a face-to-face mental health evaluation for adult care home residents, or potential residents, that are referred for this level of evaluation; to appropriate $580,000 to support assessment and service plan development for each resident; and to appropriate $567,084 for FY 08-09 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to fund three (3) geographically diverse Transitional Residential Treatment Program pilot sites, which shall begin in January 2009. Additionally, the Department of Health and Human Services, Division of Health Service Regulation, Division of Medical Assistance, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall work with adult care home providers to build on recent studies to determine the most appropriate and cost effective way to provide training to adult care home employees by tailoring the training to resident assessment results and utilizing web-based formats as appropriate, and to provide an interim report to the Study Commission on Aging by November 1, 2008, and a final report by November 1, 2009.

Recommendation 7: Support for a Reward System for Adult Care Homes with High Ratings

The Study Commission on Aging expresses support for the creation of a reward system for adult care homes that achieve high ratings and at the appropriate time, the Commission anticipates supporting the concepts outlined in the Department's report on S.L. 2007-544, Section 3(d). *(No Bill Needed at this time.)*

Recommendation 8: Support for Respite Care

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Aging and Adult Services, to study the adequacy of service standards and funding for group respite services, and whether opportunities exist to streamline and enhance the provision of respite services; and to direct the Department of Health and Human Services, Division of Medical Assistance, to study the feasibility of providing respite care as a State Plan Service, the Department shall provide a report on both issues to the Commission on Aging by November 1, 2009.

Recommendation 9: Study Older Adult Hearing Loss

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to study the current and anticipated impact of hearing loss on North Carolina's older adult population; the availability and access to qualified professionals for treatment and hearing aid purchase assistance for low income individuals; to develop an inventory of the technology available to assist individuals; and to evaluate resources and programs available in other states, with a report to the Study Commission on Aging by November 1, 2008.

Recommendation 10: Criminal Background Checks for Nursing Home Administrators

The Study Commission on Aging recommends that the General Assembly enact legislation to give the North Carolina Board of Nursing Home Administrators the authority to require a criminal history record check for nursing home administrator license applicants.

Recommendation 11: Support Guardianship Study Recommendations

The Study Commission on Aging recommends that the General Assembly enact legislation to authorize the Division of Motor Vehicles to consider recommendations from the clerk of court in determining drivers license revocation of an incompetent individual, and to raise the ceiling on the amount of personal property a guardian is allowed to sell without court order, which are both based on recommendations from the House Study Committee on State Guardianship Laws to the 2007 General Assembly.

Recommendation 12: Study Safe Transport of Passengers in Wheelchairs

The Study Commission on Aging recommends that the General Assembly enact House Bill 93, Transport of Individuals in Wheelchairs Study, as it directs the Department of Transportation to study appropriate methods of transporting passengers seated in wheelchairs, to develop guidelines for the installation and use of wheelchair tie-down systems, and to report findings and recommendations to the Study Commission on Aging and the Joint Legislative Transportation Oversight Committee. (House Bill 93 is currently in the Senate Committee on Transportation and was a recommendation to the 2007 General Assembly from the Study Commission on Aging.) *(Existing Bill)*

Recommendation 13: Study Medically Needy Income Standard

The Study Commission on Aging recommends that the General Assembly enact House Bill 92, Medicaid Income Limits Level Study, as it requires 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. (House Bill 92 is currently in Senate Appropriations and was a recommendation to the 2007 General Assembly from the Study Commission on Aging.) *(Existing Bill)*

Background for DRAFT Recommendations for the Study Commission on Aging

4/8/08

Recommendation 1: Senior Center Funds

Recommendation 1: Senior Center Funds

The Study Commission on Aging recommends that the General Assembly appropriate an additional $500,000 for FY 08-09 to the Senior Center General Purpose Fund with the intent that it shall become part of the continuation budget.

Background 1: Support for Senior Centers

During 2007, the Study Commission on Aging recommended 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. The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contained $200,000 in non-recurring funding for FY 07-08 for the Senior Center General Purpose Fund.

Increasing senior center funds generally, or specifically making the FY 2007-2008 increase recurring, were the most frequently mentioned items during the Wilson public hearing on March 6, 2008. Increasing senior center funding was the second most frequently mentioned item during the February 28, presentations to the Commission by organizations representing older adults. It was listed as a priority by the Governor's Advisory Council on Aging, and the Senior Tar Heel Legislature, among others.

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 of Aging and Adult Services reports that there are currently 164 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.

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 2007-08 FY is $1,465,316 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 receipt of State funds. For FY 2007-08, Senior Centers received a $200,000 increase in General Purpose funds on a non-recurring basis.

Senior Centers receive funding in "shares" – one share for Uncertified Centers (108 centers), two shares for Centers of Merit (8 centers), and three shares for Centers of Excellence (48 centers). The State allocation distribution for the 2007-2008 FY is: $5,467 for Uncertified Centers, $10,936 for Centers of Merit, and $16,404 for Centers of Excellence.

Recommendation 2: Additional HCCBG Funds

The Study Commission on Aging recommends that the General Assembly appropriate an additional $2,500,000 to the Department of Health and Human Services for FY 08-09 for the Home and Community Care Block Grant (HCCBG).

Background 2: Additional HCCBG Funds

Increasing Home and Community Care Block Grant (HCCBG) Funds was the issue mentioned most frequently during the February 28, presentations to the Commission by organizations representing older adults, and the second most frequently mentioned item at the public hearing in Wilson on March 6. Eight (8) of the 21 organizations that spoke on February 28, supported increasing HCCBG Funds including the Governor's Advisory Council on Aging and the Senior Tar Heel Legislature, among others.

In 2007, the Study Commission on Aging recommended 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). The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contained $536,000 in recurring funding for FY 07-08 and FY 08-09.

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 decide 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), a funding source in the HCCBG, gives priority to serving the "socially and economically needy" and focuses particular attention on the low income minority elderly and on 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 that are 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.

Recommendation 3: Funds for Project C.A.R.E.

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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 08-09 to fund Project C.A.R.E. (Caregiver Alternatives to Running on Empty) which provides support to individuals with dementia and their caregivers. 3rd most frequent item on 2/28/08

Background 3: Support Project C.A.R.E.

Providing funding for Project C.A.R.E. (Caregiver Alternatives to Running on Empty) was the third most frequently mentioned item during the February 28, presentations to the Commission by organizations representing older adults. The Governor's Advisory Council and the Senior Tar Heel Legislature both mentioned this item as a legislative priority for their organizations.

In 2007, the Study Commission on Aging recommended 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. In response to this recommendation, SB 165 and HB 96 were introduced during the 2007 Session and referred to Appropriation Committees, but did not receive further action.

A statistical abstract, "2008 Alzheimer's Disease Facts & Figures," of US data on Alzheimer's disease published by the Alzheimer's Association recently reported that it is anticipated that between 2000 and 2010, North Carolina will experience a 31% increase in the number of people age 65+ with Alzheimer's disease. According to the report, in 2007, there were 311,578 Alzheimer/dementia caregivers providing 268,953,971 hours of unpaid care per year with an economic value of $2,845,533,016. The report notes that in 2005, Alzheimer's disease was the seventh-leading cause of death for people of all ages and the fifth-leading cause of death for people age 65 and over.

The Commission heard a presentation on Project C.A.R.E. during the meeting on February 28, 2008. The goal of Project C.A.R.E. is to increase quality, access, choice, and use of respite and support services to low-income rural and minority families caring for a person with dementia at home or within a hospital setting. The program is administered through the Division of Aging and Adult Services with assistance from the Duke Aging Center Family Support Program. A Project C.A.R.E. in-home visit: assesses the family care environment; identifies the needs and preferences of both the caregiver and the person with dementia; facilitates discussion and mutual understanding among family members; connects the family with community resources; and ensures the provision of quality respite care and support services.

Project C.A.R.E. began with the Alzheimer's Association, Western Chapter, in 2001. Funding thus far has been provided by the U.S. Administration on Aging's Alzheimer's Disease Demonstration Grants, leveraged through grants provided by private foundations, and supplemented by Family Caregiver Support Programs. Initially, the program served six (6) counties. There are currently three (3) Project CARE pilot sites set up to serve 14 counties: Charlotte (Mecklenburg County); Winston-Salem (Forsyth, Surry, and Stokes); and Asheville (Polk, Henderson, Transylvania, Rutherford, Madison, McDowell, Buncombe, Haywood, Jackson, and Swain). The program received national recognition as a model and best practice in 2004 and 2005. Grant funding is no longer an option for this particular program and State funding is needed to continue the program.

The total budget for the program is $433,333, which includes a 25% local match. The federal funding portion of that total is $325,000 and will end June 30, 2008. 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 14 western and piedmont 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 14-county area will yield sufficient funding to meet matching requirements. A possible advantage to this appropriation is that if the State funds the existing program infrastructure and service capacity, North Carolina may be eligible to receive grants to replicate Project C.A.R.E. in Eastern North Carolina, moving toward the ultimate goal of statewide expansion.

Recommendation 4: Adult Protective Services Pilot Program

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The Study Commission on Aging recommends that the General Assembly appropriate $1,497,087 to the Department of Health and Human Services, Division of Aging and Adult Services, for FY 08-09 to enact the first year of a two-year pilot program to assess proposed changes to the adult protective services statutes and to report to the Study Commission on Aging on the evaluation of the pilot by March 1, 2010.

Support for Adult Protective Services/Enact and Fund the Adult Protective Services (APS) Clearinghouse Model Pilot was the fourth most frequently mentioned item during the organization presentations on February 28, and was the fifth most frequently mentioned item during the public hearing on March 6.

In 2007, the Study Commission on Aging recommended 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. In response to this recommendation, HB 198 and SB 108 were introduced and referred to Appropriations Committees, but no further action was taken. (were not funded).

S.L. 2005-23 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 goals of the APS Clearinghouse Model are to: increase North Carolina's ability to reach out to citizens to offer voluntary services; enable North Carolina 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.

Exploring feasibility of the APS Clearinghouse Model requires implementation of a pilot. The pilot will require funding for staff in county departments of social services to carry out the pilot, and funding for three (3) staff positions in the Division of Aging and Adult Services (DAAS) to plan and conduct the pilot. The total budget for the APS Pilot in FY 08-09 is $1,497,087, broken down as follows: $1,212,805 for county staff (24.103 FTEs for 9-months), $159,532 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. An additional $1,930,107 is needed for FY 09-10 which would be utilized for the following: $1,617,308 for county staff, $188,049 for DAAS staff, $18,000 for public education, and $6,750 for essential services and $100,000 for evaluation of the pilot.

Recommendation 5: Statewide Aging Study

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The Study Commission on Aging recommends support for a comprehensive, five-year statewide study of the older adult population and the State's readiness to respond to the coming wave of older adults by recommending that the General Assembly take the following steps: establish an appointment process for a steering committee; appropriate $175,000 to the Department of Health and Human Services, Division of Aging and Adult Services, for the establishment of two positions to support the work of the study; appropriate $3,820,000 to the Division of Aging and Adult Services for FY 08-09, to fund the first year of the study; and direct the Department of Health and Human Services, Division of Aging and Adult Services, to make annual reports to the General Assembly on the status of the study.

Background 5: Statewide Aging Study

S.L. 2007-355, Section 1, required several divisions within the Department of Health and Human Services to study programs and services for older adults in Brunswick, Buncombe, Gaston, Henderson, Moore, and New Hanover Counties. These counties currently have, or are projected by 2030 to have, the largest numbers of individuals age 60+ when compared to individuals age 17 and younger.

(1) Since growth projections for the age 60+ population are anticipated to increase overall in North Carolina, S.L. 2007-355, Section 2, required the Division of Aging and Adult Services to make a recommendation on a study to include all counties in North Carolina. The Division was required to evaluate similar studies conducted by other states and to make recommendations on the criteria that should be included and an appropriate funding level for a study to include all North Carolina counties. On January 24, 2008, the Division made a report to the Commission on a statewide study.

(2) The report recommends the establishment of a steering committee to: oversee the design and implementation of a consumer needs assessment and an expectations assessment; oversee the design and implementation of the State and local awareness and preparedness assessment; identify the need for and to obtain additional studies to supplement the information needed for comprehensive planning; produce reports for the Governor and General Assembly to guide policy and program development based on the findings of the assessments and studies; and to identify action needed to ready North Carolina for its growing older adult population. The Committee would be appointed by the General Assembly and the Governor.

The report recommends two positions to support the steering committee: a Human Services Planner/Evaluator IV (pay grade 74), and an Administrative Assistant III (pay grade 67). The cost for these positions is $175,000.

(3) The use of a consumer survey is recommended in years one and four for design, implementation, analysis, and reporting associated with conducting a survey of consumer needs, assets, and expectations. The anticipated cost is $200,000 for FY '08-'09 and $175,000 for FY '11-'12. (It is anticipated that there would be some savings in survey design the second year.) The report recommends funds for design, implementation, analysis and reporting associated with conducting a survey of state and local governments at a cost of $75,000 in FY 08-09, FY10-11 and FY 12-13. Additionally, the report recommends $75,000 per year to secure the services of consultants to conduct special studies and otherwise support the work of the steering committee.

(4) With regard to support for program services, the report recommends:

- $1,470,000 per year to strengthen the capacity of Area Agencies on Aging (AAA) for support of regional and local planning (this includes restoring the $270,000 in recurring AAA State support reduced in 2001, and adding a position at each AAA to facilitate regional and community planning for aging at a cost of $1,200,000 million per year (which would total $1.6 million with a 25% match participation rate)).
- Awarding $20,000 to each county to aid the work of citizen-driven local aging leadership planning teams for a total cost of $2,000,000 per year. (all 100 counties)

Recommendation 6: Adult Care Home Residents

The Study Commission on Aging recommends that the General Assembly appropriate $1,764,000 for FY 08-09 to the Department of Health and Human Services, Division of Medical Assistance, for development of the PASARR Level II assessment which is a face-to-face mental health evaluation for adult care home residents, or potential residents, that are referred for this level of evaluation; to appropriate $580,000 to support assessment and service plan development for each resident; and to appropriate $567,084 for FY 08-09 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to fund three (3) geographically diverse Transitional Residential Treatment Program pilot sites, which shall begin in January 2009. Additionally, the Department of Health and Human Services, Division of Health Service Regulation, Division of Medical Assistance, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall work with adult care home providers to build on recent studies to determine the most appropriate and cost effective way to provide training to adult care home employees by tailoring the training to resident assessment results and utilizing web-based formats as appropriate, and to provide an interim report to the Study Commission on Aging by November 1, 2008, and a final report by November 1, 2009.

Background 6: Adult Care Home Residents

S.L. 2007-156 (SB 164) directed 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 adult care homes to provide appropriate care to residents with mental illness.

On March 28, 2008, the Commission heard a presentation of the report prepared in response to S.L. 2007-158. The report provides an overview of how eight (8) other states handle placement of mentally ill individuals in assisted living/adult care home facilities; information on the limited use of adult care home special care units for residents with mental health disorders; revisions to staffing rules; recommendations and cost figures on the screening, assessment, and the provision of services to mentally ill individuals in adult care homes; and proposed training recommendations and associated costs.

The report indicates the percentage of residents with mental illness as compared to the total number of residents. The report indicates that family care homes (facilities with six or fewer beds) had in the following years, the percentage of adults with mental illness: 2002 = 38.1%, 2003 = 52.7%, 2004 = 60%, 2005 = 44.4%, 2006 = 45.5%, and 2007 = 46.3%. Adult care homes (seven or greater beds) had in the following years, the percentage of adults with mental illness: 2002 = 18.2%, 2003 = 27.7%, 2004 = 30.8%, 2005 = 20.2%, 2006 = 20.2%, and 2007 = 19%.

(1) The report provides a process to assess and provide care to meet the needs of adult care home residents, especially mentally ill residents. The key first step to providing care is to assess the type of care needed through the implementation of screening and assessment programs. Currently a physician designates the appropriate level of care for a potential resident using the FL-2 form. The Department has developed the Medicaid Uniform Screening Tool (MUST, Level I) which is anticipated to replace the FL-2 form in September 2008. If the MUST screening determines that additional mental health assessment is needed, the individual would be referred for the PASARR, Level 2 Assessment. The PASARR Level 2 Assessment will determine whether the individual needs a specialized mental health service. According to the report, if a PASARR Level 2 assessment indicates that specialized mental health services are needed, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) will be notified and service needs will be communicated to the Local Management Entity (LME). The LME will then contact the individual. The Department estimates the PASARR Level II costs for FY '08-09 as $1,764,000 and $281,840 on a recurring basis.

(2) The report outlines the need for $580,000 to develop and automate a comprehensive assessment and care plan system for residents in adult care homes. This assessment, care planning, and training system is being developed through VieBridge, Inc. with funding from the North Carolina Association Long Term Care Facilities (NCALTCF). The NCALTCF and the Department of Health and Human Services, Divisions of Health Service Regulation and Medical Assistance, have worked in a collaborative arrangement on this system. The funding would be used to support the assessment and care planning system for adult care

home residents and statewide implementation is anticipated January 1, 2009.

The report provides information on development of Transitional Residential Treatment Programs. This new type of 6-bed residential facility would provide 24-hour residential treatment and rehabilitation of adults who have a pattern of difficult behaviors related to mental illness which exceed the capabilities of traditional community residential settings. The Department would like to pilot three (3) sites at an annual cost of $378,056/site and anticipates being able to utilize funds beginning in January 2009. This would require an appropriation of $567,084 for FY 2008-2009 ($378,056 x 3 = $1,134,168 / 2= $567,084.)

The report outlines three layers of training: Two (2) hours of Basic Orientation training for all facility staff; Twelve (12) hours of Specialized (Phase Two) Training for aides and direct supervisors of all facilities serving one or more persons with mental illness; and four (4) hours of Annual Training for aides and direct supervisors of all facilities serving one or more persons with mental illness. An annual cost of $4,500,00 was provided for the training.

The report also suggests the following to take place after screening and assessment: $334,000 for PASAAR Level II assessments to determine specialized mental health care needs and $14,860,000 to develop capacity to care for adult care home residents needing mental health services.

Recommendation 7: Support for a Reward System for Adult Care Homes with High Ratings

The Study Commission on Aging expresses support for the creation of a reward system for adult care homes that achieve high ratings and at the appropriate time, the Commission anticipates supporting the concepts outlined in the Department's report on S.L. 2007-544, Section 3(d). *(No Bill Needed at this time.)*

Background 7: Support for a Reward System for Adult Care Homes with High Ratings

In response to recommendations from the Study Commission on Aging, S.L. 2007-544 (SB 56) was enacted and Section 3 contained provisions related to a rating system for adult care homes. Section 3(d) required the Department of Health and Human Services to study the structure and cost of a system to reward adult care homes that receive high ratings and to report findings and recommendations to the Study Commission on Aging no later than March 1, 2008.

On March 28, 2008, the Commission heard the report on the structure and cost of a system to reward adult care homes receiving high ratings. The report recommended a system modeled after the grant program for nursing homes that is funded on civil monetary penalties. According to the report, the program for nursing homes, which was started in 1996, has been a highly successful, cooperative effort among regulators, providers, advocates, and others to make facilities better places for residents to live and better places for employees to work. Under North Carolina law, fines collected from adult care homes are transferred to local education agencies and therefore, the General Assembly would have to appropriate funds for the reward system for adult care homes.

The report recommends that an adult care homes that achieves a 4 Star Rating (100 points or higher on two consecutive annual surveys by the Division of Health Service Regulation) would receive a high rating and therefore eligible for the reward. The Star Rating System is effective January 2009, thus January 2010 would be the first time facilities might be eligible for rewards, assuming a score of 100 points during the 2009 cycle and during the 2010 cycle. The Department also requested an administrative officer position at a cost of $50,000, to coordinate and administer the grants in response to decisions made by a Grant Committee consisting of adult care home stakeholders, including provider representatives, advocates, Division of Health Service Regulation staff, and others. As such, the estimated costs for this reward system are $300,000 for FY 2009-2010 ($250,000 for rewards and $50,000 for the position) and $550,000 for FY 2010-2011.

(Funding would have to be appropriated by Gen. Assembly for reward system)

Recommendation 8: Support for Respite Care

Recommendation 8: Support for Respite Care

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Aging and Adult Services, to study the adequacy of service standards and funding for group respite services, and whether opportunities exist to streamline and enhance the provision of respite services; and to direct the Department of Health and Human Services, Division of Medical Assistance, to study the feasibility of providing respite care as a State Plan Service, the Department shall provide a report on both issues to the Commission on Aging by November 1, 2009.

Background 8: Support for Respite Care

S.L. 2007-39 directed the Department of Health and Human Services to study the availability and delivery of respite care. On March 28, 2008 the Commission heard a presentation on the Department's report. The Department reported that there is a need for respite care and that the provision of respite care is important for the State from an economic perspective. The report provided an overview of the various respite programs available in North Carolina as well as information on programs in other states. One of the issues noted was the fragmentation of services both in North Carolina and other states. The fragmentation is due to varying eligibility criteria, target client populations, regulatory requirements, programs, and funding streams. The report suggested that, "While the fragmentation makes respite care more difficult to administer, it does provide for the needs of a diverse population." Four model programs for respite care are defined in the report: Project C.A.R.E, Jackson County Family Resource Center, A Small Miracle, Inc. and Senior Companion Respite Program.

The report indicated that the study group did not see a need for separate statutory language for respite care, but believed that consistent state funding was needed under the existing systems. The study group agreed that respite care delivery could be enhanced if Medicaid included respite as a State Plan Service. The report stated that, a respite service, defined as an Optional Medicaid State Plan Service, should be offered to all who qualify, regardless of where the recipient lives or the recipient's diagnosis, and should be based on needs. Further, the report suggested the State may limit the definition, duration, and scope, and that an assessment of caregiver capability was integral to the process. The report indicated that the Division of Medical Assistance would pursue an internal review of this option.

No money attached to this recommendation

Recommendation 9: Study Older Adult Hearing Loss

Recommendation 9: Study Older Adult Hearing Loss

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to study the current and anticipated impact of hearing loss on North Carolina's older adult population; the availability and access to qualified professionals for treatment and hearing aid purchase assistance for low income individuals; to develop an inventory of the technology available to assist individuals; and to evaluate resources and programs available in other states, with a report to the Study Commission on Aging by November 1, 2008.

Background 10: Study Older Adult Hearing Loss

On April 10, 2008, the Commission heard a presentation from the Department of Health and Human Services on hearing loss for older adults. Based on NC demographic information, the Department of Health and Human Services, Division of Services for the Deaf and the Hard of Hearing, estimated "the current hearing loss population among senior adults to be 166,420 for ages 65-74 with a projected increase in 2030 to 342,897. For senior adults ages 75 and up, current numbers indicate 207,483 persons with hearing loss and a projected increase to 438,801 for the year 2030." Although hearing loss occurs at all ages, the Department shared that the National Institute on Deafness and Other Communication Disorders (NIDCD) reports that one (1) out of every three (3) persons by age 65 has some form of hearing loss. The Department's report highlighted a lack of readily-available and accurate information on the impact, treatment, and adaptive technology options for individuals with hearing loss. The lack of information is compounded by the often gradual loss of hearing. The Department pointed out the following issues faced by older adults with hearing loss:

1) "Hearing Aids and Limited Insurance Coverage- One of the first challenges that the hard of hearing person faces is the cost of hearing aids. These devices can often cost several thousand dollars and are rarely covered by any insurance. Generally neither Medicare nor NC Medicaid offer hearing aid coverage for adults. North Carolina along with bordering states of Virginia, Kentucky, South Carolina, Georgia, and Tennessee are in the list of 16 states that do not provide this coverage. In addition, there is virtually no insurance coverage for hearing aids in North Carolina.
2) Many people report difficulty finding a trustworthy professional to assist them with hearing aids. The lack of a 30-day mandated trial period for hearing aids in North Carolina, one of 14 states without such a policy, instills in some individuals this lower level of trust toward the hearing health care professional.
3) A myriad of emotional responses resulting from difficulties in communicating often lead to increased mental health concerns for senior adults. Better Hearing Institute reports that hearing loss, particularly in older individuals not using hearing aid or assistive devices, has been directly linked to short-term memory loss, fatigue, anxiety and depression.
4) Among senior adults, hearing loss is one of the most prevalent and chronic, but treatable, disabling condition. Hearing loss is ranked third, only behind arthritis and hypertension. Hearing loss has also been linked to lower incomes—on average, those with hearing loss but do not wear hearing aids earn up to $12,000 per year less than peers using hearing aids."

Recommendation 10: Criminal Background Checks for Nursing Home Administrators

The Study Commission on Aging recommends that the General Assembly enact legislation to give the North Carolina Board of Nursing Home Administrators the authority to require a criminal history record check for nursing home administrator license applicants.

Background 10: Criminal Background Checks for Nursing Home Administrators

G.S. 131E-265 provides that an offer of employment by a nursing home to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant.

G.S. 90-278 gives the NC State Board of Examiners for Nursing Home Administrators the authority to issue licenses to qualified persons as nursing home administrators. Therefore, a criminal record background check is not required for nursing home administrators because they have an occupational license.

On April 10, 2008, the Commission heard a presentation on this issue by the NC State Board of Examiners for Nursing Home Administrators.

Recommendation 11: Support Guardianship Study Recommendations

Recommendation 11: Support Guardianship Study Recommendations

The Study Commission on Aging recommends that the General Assembly enact legislation to authorize the Division of Motor Vehicles to consider recommendations from the clerk of court in determining drivers license revocation of an incompetent individual, and to raise the ceiling on the amount of personal property a guardian is allowed to sell without court order, which are both based on recommendations from the House Study Committee on State Guardianship Laws to the 2007 General Assembly. HB 794

Background 11: Support Guardianship Study Recommendations HB 796

The House Study Committee on State Guardianship Laws was established by the Speaker of the House on February 17, 2006. The Committee was directed to submit a final report on the results of its study on or before December 31, 2006.

In the final report, Finding 6 indicates that the Committee found that guardians currently have the authority to sell up to $1,500 worth of personal property without a court order in order to meet the monetary needs of the ward. The Committee further found that the amount of a ward's personal property that guardians are allowed to sell is outdated and insufficient. As a result, the House Study Committee on State Guardianship recommended that the total amount of personal property that can be sold without a court order be increased to $15,000. In response to this recommendation, House Bill 794 was introduced. A Committee Substitute for House Bill 794 received a favorable report in the House Committee on Aging and was referred to House Judiciary II. It was not heard in House Judiciary II and House Bill 794 is not eligible for consideration during the 2008 Session.

In the final report, Finding 7 indicates that the Committee on State Guardianship Laws found it unnecessary for the Division of Motor Vehicles to automatically revoke the drivers license of an individual who has been declared incompetent. The Committee recommended that the Division of Motor Vehicles be authorized to not automatically revoke the drivers license of an incompetent if the clerk of superior court recommends the incompetent be allowed to retain the drivers license. In response to this recommendation, House Bill 796 was introduced. House Bill 796 received a favorable report in the House Committee on Aging and was referred to House Judiciary II. It was not heard in House Judiciary II and House Bill 796 is not eligible for consideration during the 2008 Session.

On April 10, the Commission heard a presentation on guardianship and on the issues surrounding an increase in the amount of a ward's personal property that a guardian can sell, and on the automatic revocation of the driver license of an incompetent.

→ will require the introduction of 2 new bills

Recommendation 12: Study Safe Transport of Passengers in Wheelchairs

The Study Commission on Aging recommends that the General Assembly enact House Bill 93, Transport of Individuals in Wheelchairs Study, as it directs the Department of Transportation to study appropriate methods of transporting passengers seated in wheelchairs, to develop guidelines for the installation and use of wheelchair tie-down systems, and to report findings and recommendations to the Study Commission on Aging and the Joint Legislative Transportation Oversight Committee. (House Bill 93 is currently in the Senate Committee on Transportation and was a recommendation to the 2007 General Assembly from the Study Commission on Aging.) *(Existing Bill)*

Background 12: Study Safe Transport of Passengers in Wheelchairs

The Study Commission on Aging recommended that the 2007 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. House Bill 93 and Senate Bill 57 were introduced. House Bill 93 was referred to the Senate Committee on Transportation on 3/13/2007 and is still eligible for consideration during the 2008 Session.

This recommendation to the 2007 Session was based on a wheelchair transportation safety restraints presentation made to the Commission on 11/15/06. 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 without 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.

Recommendation 13: Study Medically Needy Income Standard

The Study Commission on Aging recommends that the General Assembly enact House Bill 92, Medicaid Income Limits Level Study, as it requires 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. (House Bill 92 is currently in Senate Appropriations and was a recommendation to the 2007 General Assembly from the Study Commission on Aging.) *(Existing Bill)*

Background 13: Study Medically Needy Income Standard

The Study Commission on Aging recommended that the 2007 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. House Bill 92 and Senate Bill 110 were introduced. House Bill 92 was referred to the Senate Committee on Appropriations on 3/14/2007 and is still eligible for consideration during the 2008 Session.

This recommendation to the 2007 Session was based on presentations to the Commission 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 12/13/06, 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). The Department reported that there was consensus among stakeholders that while this 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.

(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.)

4/10/08 mtg

Study Respite Care

Report to the 2007 General Assembly
Study Commission on Aging



State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

March 20, 2008

Attach# 8
Recommendation #8

Study of Respite Care
General Assembly of NC Session Law 2007-39
(House Bill 424)

Prepared For: The North Carolina Study Commission on Aging
March 1, 2008

Report and Recommendations

I. INTRODUCTION

On May 2, 2007, House Bill 424 was enacted. This bill directs the Department of Health and Human Services (DHHS) to study Respite Care and recommend ways to improve North Carolina's current respite care delivery system. The Division of Health Service Regulation (DHSR, formerly Division of Facility Services), the Division of Medical Assistance (DMA) and the Division of Aging and Adult Services (DAAS) were given the responsibility to complete the work delineated in this bill.

A DHHS study group was formed to include community and other stakeholders with a core group of leadership representing the staff of DAAS, DMA, and DHSR. **(See Attachment A: HB 424 Study Group Participants and Their Organizations)**

II. HOUSE BILL 424 IS STATED AS FOLLOWS:

A BILL TO BE TITLED
AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY RESPITE CARE AND TO RECOMMEND WAYS TO IMPROVE THE CURRENT RESPITE CARE DELIVERY SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1(a). The Department of Health and Human Services, Division of Facility Services, Division of Medical Assistance, and the Division of Aging and Adult Services, shall study the availability and delivery of respite care which provides temporary relief for family members and others who care for individuals with disabilities, chronic or terminal illnesses, dementia, or the elderly. The study shall examine the following:

(1) The need and availability of respite care in North Carolina.
(2) The delivery and licensing of respite care in other states and possible models for North Carolina.
(3) The application process for a grant under the Lifespan Respite Care Act of 2006, 42 U.S.C.
(4) The need for separate statutory language pertaining to respite care.
(5) The need, proposed structure, and development timeline for a separate licensure category for respite care.
(6) The development of a Medicaid Waiver covering a proposed new licensure category for respite care.

SECTION 1(b). In response to the study authorized in this section, the Department of Health and Human Services shall present findings and recommendations, including any proposed statutory changes and new licensure categories, to the Study Commission on Aging on or before March 1, 2008.

SECTION 2. This act is effective when it becomes law.

III. DEFINITION - RESPITE

Respite is defined by Webster's Dictionary as a noun, "an interval of rest or relief", as a transitive verb "put off or delay", and as an adjective "providing or being temporary care in relief of a primary caregiver".

The General Assembly defines a Respite Care Program under 143B-181.10 (a) as a service that is established to provide needed relief to caregivers of impaired adults who cannot be left alone because of a mental or physical problems; (b) limited to those unpaid primary caregivers who are caring for people years 60 years of age or older or their spouses or those unpaid primary caregivers 60 years of age or older who are caring for persons 18 years of age or older, who require constant supervision and who cannot be left alone either because of memory impairment, physical immobility or other problems that renders them unsafe alone.[1] **(For other state respite definitions, see Attachment B - NC Respite Regulations)**

Respite programs provide temporary relief for caregivers, enabling them to meet personal needs and supporting their efforts to provide the majority of care for their family member.[2] Respite programs primarily aim to serve the caregiver rather than the care recipient as often occurs in most services.

IV. NEED AND AVAILABILITY OF RESPITE CARE IN NORTH CAROLINA

Need

It is a challenge to determine the exact need for respite services in North Carolina because the focus of service provision has traditionally been on the care recipient rather than the caregiver. Additionally, many caregivers receive relief from caregiving duties, but do not identify the service as respite and therefore, when surveyed about respite services they may use, the caregivers indicate that they do not use any. The explanation as to why caregivers do not identify the relief they receive from caregiving duties as respite is complex and uncertain. Reasons may include limited exposure to the word (respite) and its meaning as well as the multiple definitions of respite care that currently exist. These multiple definitions and levels of care are reflected in federal and state policies and funding sources. Additionally, there are a wide variety professionals and paraprofessionals involved with respite services.

Still, it is possible when looking at service data to identify the importance of respite. When reviewing the most recent report on the Special Assistance In-home Program (July 2007), of the 1,039 persons who received services through the Special Assistance In-Home program (FY '05-'06), 80% had a primary caregiver; 48% had a secondary caregiver; and

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[1] NC General Statute

[2] Group Respite Policy and Procedures, July 1998p.1, III definition of service

50% of the primary caregivers lived with the person receiving services. These caregivers were informal, unpaid caregivers and included relatives, friends, and neighbors.

The data available on waiting lists of the Division of Aging and Adult Services for services that may provide respite also illustrate the need for respite in North Carolina. The following table outlines the numbers of persons on waiting lists for services that may provide a form of respite as of July 2007 in North Carolina:

Type of Respite Service	Number of Persons on Waiting List
Home Delivered Meals	3,649
In-Home Personal Care	3,343
Home Management	1,981
Adult Day Services	151
In-Home Respite	530
Family Caregiver Support Program	45*
Project C.A.R.E.	113**
Total	9,812

* This figure is based on data from 7/1/07-3/13/08

** This figure is the average over a year's time. Only Winston-Salem and Asheville sites maintain a waiting list. Charlotte-Mecklenburg Department of Social Services does not.

This figure of 9,812 North Carolinians waiting for services that may provide respite only includes persons who have inquired about services and does not include caregivers who may be in need of respite, and have not attempted to access these services. Further evidence of the importance of respite is evident in the experience of DAAS with Project C.A.R.E. (The Alzheimer's demonstration). DAAS has found through a performance-based survey that about 92% of client families report that Project C.A.R.E. services allowed them to provide care at home longer. Data on Project C.A.R.E. is especially important because the program assists people with Alzheimer's disease or other dementia. North Carolina currently has over 150,000 older adults with Alzheimer's disease. By 2030, this number is projected to rise to over 294,000. Over 70 percent of people with Alzheimer's disease are cared for at home by unpaid family and friends. As the number of people with Alzheimer's increases, so will the number of caregivers, thereby driving up the demand for caregiver support, including respite.

The possible economic impact of not providing adequate respite services is illustrated in data compiled by Peter S. Arno (see Attachment E). There were approximately one million caregivers in North Carolina providing an estimated total of $10.7 billion dollars worth of services to care recipients in 2006. These findings appear to indicate that investing in respite care is important not only for the state's workforce and commerce, but for the preservation of state dollars associated with health and human services. If caregivers did not provide care to family and friends, many more care recipients might be institutionalized at the state's expense and the health of caregivers will worsen. For example, spousal caregivers of persons with Alzheimer's disease have a 63 percent greater risk of dying than non-caregiving persons of the same age and gender.

The paradigm shift to include caregivers' needs in service provision for the care recipient and to expand available respite services as part of the long-term care continuum has begun in North Carolina as evidenced by the 2001 Long-Term Care Plan by the North Carolina Institute of Medicine (IOM) Task Force on Long-Term Care to DHHS. One

of the IOM priority recommendations under "Availability and Need for Long-Term Care Services", states: "The Department's long-term care policies and program activities should be designed to strengthen the capacity of families to perform caregiving functions."[3] Another priority recommendation under "Financing Long-Term Care", states: "The Department should explore ways to invest in family caregiving so that it can be sustained as the primary resource for long-term care, reducing the risk for needing formal, publicly-financed services."[4] Further evidence of this paradigm shift in service provision is illustrated in the North Carolina Aging Services Plan 2007-2011 which includes as one of its 40 objectives, the development and incorporation of a caregiver assessment as part of family-centered care planning, and the expansion of caregiver support services.

The need for respite services in North Carolina is also emphasized within the vision and mission of DHHS' Long-Term Services and Supports Cabinet (LTS Cabinet). The LTS Cabinet was formed by the IOM's 2001 Long-Term Care Plan and was intended to include all DHHS Division Directors that affect long-term care policy.

- ***Vision Statement for the North Carolina LTS Cabinet***
  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.

- ***Mission Statement for the LTS Cabinet***
  To create a statewide, integrated, person and *family-centered* system for those who need long-term services and supports so that they can live and participate more fully in communities of their choice.

Additionally, the DAAS' North Carolina Performance Outcome Measures Project (POMP) points to the need for respite care services in North Carolina and the need for additional respite care services for caregivers already receiving services to reduce incidents of institutionalization for care recipients. In 2002, a survey was conducted of a representative sample of caregivers who received Home and Community Care Block Grant (HCCBG) services and caregivers receiving Family Caregiver Support Program (FCSP) services. In 2003, almost three-quarters of these same caregivers who were surveyed in 2002 were surveyed again. Caregivers in 2002 who indicated that they needed more respite and/or adult care services than they were currently receiving were significantly more likely to have placed the person they were caring for in a facility by 2003. Those that were receiving any type of in-home aide service (in-home respite, personal care, or homemaker) in 2002 were significantly less likely to have placed the person they were caring for in a facility by 2003.

Availability

Below is an inventory of respite availability by DHHS Divisions. Although other sources of respite funding may be available, those identified below are the primary sources of respite funding and programs within DHHS.

[3] 2001 Institute of Medicine, LTC Plan p.49

[4] 2001 Institute of Medicine, LTC Plan p.96

Division of Aging and Adult Services

HCCBG awards a combination of federal Older Americans Act funds and state appropriations to counties through Area Agencies on Aging (AAA) to serve adults at risk of institutionalization aged sixty (60) and over who require services to remain in the community. Through local planning, counties choose from eighteen services to meet identified needs to assist older adults avoid institutionalization and maintain their independence. These services can provide respite for the caregiver.

The State Adult Day Care Fund (SADCF) uses federal Social Services Block Grant funds and state appropriations to provide adult day care services to disabled adults age eighteen (18) and older who are at risk for institutionalization. These funds are administered through county departments of social services. These services also can provide respite for the caregiver.

Group Respite provides temporary relief for caregivers, enabling them to meet personal needs and supporting their efforts to provide the majority of care for their family member. Group Respite differs from adult day care or adult day health in relation to the number of hours a program may operate and that group respite providers are unable to provide any personal care to participants.

Group Respite is currently provided in only five (5) regions of the state with a total of five (5) programs.

Institutional Respite provides temporary relief for caregivers in a residential setting that meets the care recipients' needed level of care.

Adult Day Care, as defined in NC General Statute 131D-6, is 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 18 years and older who may be physically or mentally disabled.

Adult Day Health offers health care services in addition to the services offered by the Adult Day Care Program to adults 18 years and older that require health monitoring by trained medical staff.

To date, there are only 102 Adult Day Care Programs located in 56 counties throughout North Carolina. Fifty-five (55) of the 102 programs are adult day care and adult day health combination programs, forty-four (44) of the 102 programs are adult day care only programs, and three (3) of the 102 programs are adult day health only programs.

The North Carolina Family Caregiver Support Program (FCSP) was authorized by the Older Americans Act 2000. It is administered by DAAS in partnership with the State's 17 AAAs.

Caregivers served by the FCSP received one or more of the following services provided under the program's "scope of respite":

- In-home respite (personal care, homemaker, Senior Companions/home visitors)
- Community respite (adult day center, group respite center, mobile day respite, or other nonresidential program)
- Emergency respite program (in-home)

- Emergency respite program (out of home)
- Institutional respite (institutional setting such as a nursing home or assisted living for a short period of time)
- Summer camps, after-school programs or child day-care (for grandparents caring for grandchildren)
- Other short-term respite options (e.g., respite camps and caregiver retreats)
- Other as approved by DAAS

Additionally, under FCSP, caregivers are provided with information, access to services (including transportation), counseling, training, support groups, and supplemental services. Supplemental Services may be especially beneficial to working caregivers. Through the National Family Caregiver Support Program, in North Carolina, the Eastern Branch of the Cherokee Indians (EBCI), also receive respite.

Project C.A.R.E. (Caregiver Alternatives to Running on Empty) is specifically designed to provide respite care and support to caregivers of persons with dementia and is a federally funded Alzheimer's Demonstration Program. Families enrolled in the program received an annual spending cap of up to $2000 and had the option to chose between adult day services, group respite, private or agency in-home care, and overnight residential respite.

Project C.A.R.E. is currently available in 14 western counties.

DAAS Funding Expenditures

SADCF: Including local match, $4,540,264 was awarded in SFY 06-07. A total of $4,443,626, or 97.9%, in State Adult Day Care Fund resources was expended to serve 1,396 older and adults with disabilities.

HCCBG: Including local match, $6,095,200 of HCCBG funds were expended in communities to provide respite services. These respite services included: Institutional Respite; Group Respite; In-Home Aide Respite; Adult Day Care and Adult Day Health programs. A total of $55,474,000, or 99.8%, in HCCBG funding was expended in communities to serve 59,177 older adults.

FCSP: During SFY 2006-07, the North Carolina Family Caregiver Support Program (FCSP) provided respite services to 1,533 unduplicated caregivers, or 41,330 units of service, at a cost of $1,600,551.

Project C.A.R.E.: During SFY 2006-7, Project C.A.R.E., provided a total of $229,419 for direct respite care services.

Division of Medical Assistance

Respite is also defined in Section 12.1.7 of **Medicaid's** Clinical Policy for the Community Alternative Program for Disabled Adults (CAP/DA). In this program, Respite care provides temporary support to the client's primary unpaid caregiver(s) by taking over the tasks of the caregiver(s) for a limited time. It may be used to meet a wide range of needs, including family emergencies; planned absences (such as vacations, hospitalizations or business trips); relief from the daily responsibility and stress of caring for a special needs person; or to provide time for the caregiver(s) to shop, run errands, and perform other

tasks. It may also be used to provide respite to the client from the primary caregiver(s). Respite is available as in-home respite, in which the respite worker goes into the client's home; or as institutional respite, in which the client goes into a facility that is licensed to provide and appropriate level of care.

In Section 11.1.6 of **Medicaid's** Community Alternative Program for Medically Fragile Children (CAP/C). Respite care provides temporary support to a family caring for a CAP/C child. It may be used as day, evening or overnight care to meet a range of client needs. These include family emergencies; planned absences, such as vacations, hospitalizations or business trips, relief from the stresses of caregiving, shopping and giving a child respite from his family. Respite care is available as in-home respite in which the respite worker goes into the client's home, and as institutional respite in which the client goes into a facility licenses to provide the appropriate level of care.

It is important to emphasize that Medicaid does fund Adult Day Health services (medical model) under its waiver programs. It does not fund Adult Day Care services (social model). This restriction in use of funds is typical nationwide as the focus of Medicaid is on health care delivery.

Additionally, Medicaid reimburses a "Short-Term Inpatient Care" (general and respite), which is provided in a hospice inpatient unit, a hospital, or nursing facility under a contractual arrangement with a hospice agency. The inpatient stay (general) is of a short duration either for the management of symptoms or for palliative care that cannot be provided in any other setting. An inpatient stay (respite) provides short-term relief for the caregiver. Relief for the hospice recipient's caregiver is available with either Medicare or Medicaid reimbursement.

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Respite under the CAPMR/DD program mirrors respite provided under CAP/DA in that it may provide:

- Intermittent relief for the caregiver.
- Accommodate a wide range of needs (i.e. emergencies, planned absences)
- Provide time for the caregiver to handle personal tasks and
- Provide respite to the client from the primary caregiver

These services are also tailored to individual or group recipients across private and provider operated settings. According to DMH, a person must meet the definition in §122-3 of having a developmental disability or a mental illness in order to receive respite care services.

DMH offers in-home respite, facility respite and institutional respite funded both with state dollars and through the waiver program. Those receiving CAP/MR/DD waiver respite services can receive Medicaid funding; while those receiving respite outside of the waiver may be eligible for respite through funding with state funds.

Therefore, within a waiver program, respite is basically provided as requested if it fits within the current individual's waiver budget for all waiver services whether the waiver be

CAP/DA, CAP/C or CAP/MRDD. By report from the Medicaid Program Managers, respite is not utilized as often as it might be because of the limitation within CAP program funding. The exception to this principle occurs within the CAP/MR/DD waiver which utilizes a flexible budget plan. Under this option, all of it s wavier participants do not have a capped individual budget. This allows a pool of available funds to all participants under the waiver so that unused funds budgeted for individuals with less extensive needs could be utilized by those with more extensive needs.

Under the CAP/MR/DD waiver, both federal and state rules permit family members to become paid caregivers with the exception of legally responsible family members (parents/guardians of minor children and spouses). This mostly occurs in the delivery of personal care services with recipients employing closely related family members as their personal care attendant.

Division of Social Services

DSS provides respite care within the Family Support Child Welfare Section to families and children that meet the criteria and definition below through contracts with private providers located throughout the State. There are no financial eligibility requirements.

DSS does not have a definition of respite as a State Statute or Rule. However, DSS does use a definition based on the Friends NRC (National Referral Center in Chapel Hill, NC). NRC defines respite as follows:

> "Short-term care services provided for families of children under the age of 18 living with natural, adoptive, foster parents or relatives, or any family who has taken on the role of caregiver who meet one or more of the following categories:
>
> - The child(ren) are in danger of abuse or neglect;
> - The child(ren) have experienced abuse or neglect;
> - The child(ren) has/have developmental disabilities, chronic or terminal illnesses or mental health issues."

Currently, DSS has eight (8) contracts, each for $30,000 for a total of $240,000 for this fiscal year. The contracts are renewed annually except in rebid years. For example, Youth Focus has one (1) contract with The Children's Home as the subcontract. The Jackson County FRC (Family Resource Center) has two (2) contracts, one for voucher-based respite and the other for center-based respite. In SFY 2006-7, DSS provided respite services to 288 unduplicated clients. The goal of respite is to enable the family to remain intact and to keep the child(ren) living in their home or community.

As shown in the **NC Expenditure By Respite Program charts (See Attachment C)**, one can see that there are differences in the amount of the total respite expenditures within waiver programs. The information is primarily derived from paid claims data. It is evident that across funding streams and target populations, assumptions are made about medical needs, access to service or available data, but no matter what respite service, it is important to recognize the caregiver is primary to the success of all home and community based services. Without appropriate respite services, many consumers of publicly funded services would be in need of a higher and more expensive level of care.

County DSS agencies contract for respite services with local adult day care and adult day health providers to fund participants attending these programs through the SADCF. Medicaid, as the primary payor of long-term care services and supports, pays for respite only under its waiver programs.

In the CAP/MR/DD waiver, a "Respite Rate" reimburses only respite. In nursing facilities (NFs), the respite rate is the regular NF rate. In an Adult Care Home (ACH), Medicaid reimburses for personal care. Adult Day Health Services can be covered under Medicaid only through the waiver programs. Although we have expenditure data, the data is based on paid claims, and in many instances, is paid out of different pots of money with the services that are not exactly the same by definition.

V. THE DELIVERY AND LICENSING OF RESPITE CARE IN OTHER STATES AND POSSIBLE MODELS FOR NORTH CAROLINA

The NC Respite Study Group reviewed *The State of the States in Family Caregiver Support: A 50-State Study* published November 2004 by the Family Caregiver Alliance in collaboration with the National Conference of State Legislatures. This study includes a series of data tables comparing how state programs responded to key survey questions. **(See Attachment F: Published Side by Side Comparison).** This chart indicates that every state has at least one respite service for older adults and at least two (2) respite programs identified. The variety was found in the states of California, Florida and New Jersey (each with six (6) different programs). In only one state, North Dakota, did the caregiver have to live with the care recipient in order to receive respite services. Only Minnesota, specifically mentioned that they paid for out-of-home respite provided by a friend or neighbor and only Hawaii, mentioned weekend support groups.

Because this study "Side by Side Comparison" chart was not as recent as the NC Respite Study Group would have preferred, the Study Group surveyed, via email, agencies from around the nation. Information on the provision of respite services was gathered to review best practices and possible models that may be useful in designing improved respite services in NC. The group also wanted to know which states currently licensed respite providers and what types of respite are offered by those providers. Twenty-five (25) states responded stating whether their state currently licensed respite care providers.

Among those states that responded (**See the table on page 12**), 14 states currently provide a type of respite through licensed providers. They are represented in the following tables. Of these, only two (2) Licensure Categories are not found in NC-- hospitals found in the States of Washington and Minnesota and Adult Foster Care found in Minnesota. Other respite service categories mirror most of those found in NC. However, not all NC options are offered throughout the state and/or are available through each division of DHHS.

Populations targeted by DHHS respite programs include caregivers of persons with developmental disabilities, frail older adults, and persons with dementia and related disorders. Other State respite programs target medically fragile children in the CAP/C programs as well as children who are at risk for abuse or neglect and those who have developmental disabilities, chronic or terminal illness or mental health issues.

From a resource utilization perspective, Adult Day Care is the most common respite service provided to family caregivers nationwide. Whether this service is in greater

demand than the others is unknown. Licensure for respite care in institutions is represented in six (6) states New Mexico, Idaho, Alabama, Missouri, Iowa and Washington that would be similar to NC's 24-hour respite in NFs, ACHs and State Developmental Centers.

In the research of other states and in the study group's discussion, it appears barriers to providing and coordinating a comprehensive program of respite care are similar in different states. Top barriers are listed as the complexity and fragmentation of different eligibility criteria, different target client populations, as well as different regulatory requirements. This is very evident in NC as we have both licensed and certified programs, several different funding streams and several different programs providing services to various target populations. While the fragmentation makes respite care more difficult to administer, it does provide for the needs of a diverse population.

Provider Licensure Categories and Respite Service Categories by State.

Provider Licensure Categories						
Alabama	**Georgia**	**Idaho**	**Missouri**	**Illinois**	**Iowa**	**Minnesota**
Institutional (overnight)	In home	License Adult Day	In Home	Adult Day Care	Nursing Facility	In Home
In Home	Adult Day Care	License Residential	Nursing Facility	In home	Adult Day Care	Medicaid-certified Hospital
Adult Day Program					In home	Adult Foster Home

Respite Service Categories						
Alabama	**Georgia**	**Idaho**	**Missouri**	**Illinois**	**Iowa**	**Minnesota**
Adult Day Services	Skill level 1	Adult Day	Advance Respite	Personal Assist.	Specialized Respite	Home Health
In home	Skill level 2	In Home	Advance Block	Homemaker	Group Respite	Personal Care
	Skill level 3		Advance Daily	In home		Adult Day Services
			Institutional			Care Companion
			Nurse Respite			Alzheimer's

Provider Licensure Categories						
Nebraska	**New Mexico**	**New York**	**Oregon**	**Pennsylvania**	**North Dakota**	**Washington**
Adult Day Services	Adult Day Care	Adult Day Services	In home	Home Health Care	Adult Day Care	Nursing Homes
In home	In home	In home	Adult Day Care	Homemaker	In home	Adult Day Health
	Institutional (overnight)					Home Health Care
						Hospitals

Respite Service Categories						
Nebraska	**New Mexico**	**New York**	**Oregon**	**Pennsylvania**	**North Dakota**	**Washington**
Early Development	Adult Day Care	Adult Day Services	In home	In home (overnight)	Adult Day Care	Nursing facility
Area Agency/Aging	Family Caregiver	In home	Adult Day Care	Adult Day Care	Adult Day Health	Adult Day Health

Model Programs

The Respite Study Group opted to highlight North Carolina's current respite care models in this report rather than adopt another state's respite care model, as the existing respite care models in North Carolina have proven to be successful in effectively serving targeted populations and addressing diverse and state specific needs. North Carolina has four (4) recognized Best Practice Model Programs. A brief description of each is included below:

1. **The North Carolina Alzheimer's Demonstration Program, Project C.A.R.E. (Caregiver Alternatives to Running on Empty),** uses a family consultant model to provide consumer-directed respite care and comprehensive support to dementia caregivers. The goal of the program is to increase quality, access, choice, and use of respite and support services to low-income rural and minority families caring for a person with dementia at home or within a hospital setting. Through the integration of dementia-capable services and the development of family-centered and caregiver-focused community care networks, Project C.A.R.E. can help create a seamless, coordinated delivery system that is responsive to the needs, values and preferences of families caring for a member with Alzheimer's.

   Project C.A.R.E. is administered through the Division of Aging and Adult Services (DAAS) with expert consultation and technical assistance provided by the Duke Aging Center Family Support Program. Project C.A.R.E. is implemented at the local level through Family Consultants employed by and/or supported through the local Alzheimer's Association. The program is currently based within the Mecklenburg County Department of Social Services and two area offices of the Western Carolina Alzheimer's Chapter. The Mountain Area office in Asheville serves as the project training and data management center for all new and existing program sites and staff.

   Project C.A.R.E. employs Family Consultants with expertise in Alzheimer's disease and related disorders. The Consultants visit the homes of referred dementia caregivers in crisis and offer timely, individualized assessment, guidance, counseling, support, advocacy, coaching and education. Their aim is to match families with the most appropriate and preferred local respite and community services tailored to their unique situation and needs. Through Project C.A.R.E., dementia caregivers may spend up to $2,000 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. The Project C.A.R.E. model builds upon, enhances and sustains existing home and community-based services by using local providers to deliver respite care.

   The personalized approach of the Family Consultant fosters family trust, offers individualized caregiving and coping skills, and encourages caregiver self-care. Project C.A.R.E. helps families learn the value of quality dementia-specific respite services and feel empowered to make self-directed, informed decisions about care. Special emphasis is placed on targeting underserved, low-income rural and minority communities that have limited knowledge of and access to dementia-specific respite care and support services. In 2004, Project C.A.R.E. received the Geriatric Best Practice Award from the Southeast Regional Geriatric Best Practices Initiative. In 2005, the program received a National Innovative Program Clearinghouse Award from the National Alzheimer's Association and was featured

at the National Conference of State Legislators as a national model for home and community based care coordination. Project C.A.R.E. was further recognized as a National Best Practice Model by the U.S.4 Administration on Aging and RTI International.

2. **JACKSON COUNTY FAMILY RESOURCE CENTER** was founded in 1995 when a taskforce sponsored open community meetings across the county. The data collected indicated a definite need to support and develop a family resource center whose mission would be to create a framework where families could access comprehensive services in an impartial and empowering environment. The primary focus is to support and enhance the presence of healthy children and strong families in a caring community, while fostering personal development.

   Family Rest Stop is a good example of one of their model programs. In operation since September 1998, this respite program serves Jackson County and six (6) surrounding counties in western NC. Respite services are provided Saturdays from 9:00 a.m.-3:00 p.m. using the facilities of the Family Resource Center and the Webster Child Development Center. It is a time for children to relax, have fun and a time for parents to have a break from caregiving. Other highlighted services include Circle of Parents, Family Focus Classes, Family Caregiver and Voucher Respite, Ancillary Services, Volunteer Services, a resource library and others.

3. **A SMALL MIRACLE, INC.** is a CAP-MR/DD agency that provides comprehensive services to children and adults of all ages with all types of disabilities. It provides one-on-one services to children and adults in a 24-county region of Eastern-Central North Carolina, including respite care. Founded by a parent of a child with autism, the agency is particularly sensitive to the needs of families caring for autistic children. A Small Miracle, Inc. provides opportunities to network with other parents and information on doctors, dentists and other medical specialists

   Individual Caregiver/Training and Education (ICTE) is a prime example of one of A Small Miracle's excellent services. ICTE allows family members to learn more about their loved one's disability as well as the best educational, therapeutic and biomedical interventions available to address them.

4. **SENIOR COMPANION RESPITE PROGRAM** is offered through a local Family Caregiver Support Program in eastern NC. This program targets family caregivers who live in rural areas. Respite care services are provided by peers. Peers may provide supervision, cueing and/or prompting a care recipient as well as providing companionship. Many times, the senior companions are neighbors and are generally known by the family caregiver. This program is working well in Jones County and Carteret County. During SFY 07-08, the program will be expanding into Craven County.

VI. THE APPLICATION FOR A GRANT UNDER THE LIFESPAN RESPITE CARE ACT OF 2006, 42 U.S.C.

(See Attachment D: Lifespan Respite Act of 2006, 42 U.S.C.)

The Lifespan Respite Act of 2006 was enacted to assist family members who are the primary caregivers for children and/or adults with special needs in accessing respite care

services that are both affordable and of high quality. The program would be administered through Aging and Disability Resource Connections (ADRC) that would be part of the state's long term care system. DHHS is currently piloting the ADRC concept in several counties under several federal grants. The ADRC is to be a convenient, one-stop, no-wrong door approach to providing information and referral for long-term care services; counseling and planning to determine an individual's current or future long-term care needs; and assistance in applying for long-term care programs.

As of this writing, the Lifespan Respite Care Act of 2006, 42 U.S.C. has not received funding by Congress. Once funded, the DHHS/DAAS will make application for funding under this authority.

VII. THE NEED FOR SEPARATE STATUTORY LANGUAGE PERTAINING TO RESPITE CARE AND THE NEED, PROPOSED STRUCTURE AND DEVELOPMENT TIMELINE FOR A SEPARATE LICENSURE CATEGORY FOR RESPITE CARE.

The NC Respite Study Group did not see a need for separate statutory language for respite care. As one can see from **ATTACHMENT B**, there are separate state statutes and administrative codes for respite care that apply to the various programs in several divisions within DHHS. After a thorough review of these citations, the NC Respite Study Group believed that the existing Licensure and Certification systems of DHSR and DAAS respectively, allow for all levels and types of respite care. What is needed is consistent state funding for the current respite care models available in North Carolina. For example, the national award winner, "Caregiver Alternatives to Running on Empty" (Project C.A.R.E.) is currently being funded by a one-year grant through the U.S. Administration on Aging's Alzheimer's Disease Demonstration Grants to States Program (ending June 30, 2008). Unless continuation funding is provided by the state, Project C.A.R.E. will cease to operate and will no longer be a source of respite services to caregivers in North Carolina.

VIII. THE DEVELOPMENT OF A MEDICAID WAIVER COVERING A PROPOSED NEW LICENSURE CATEGORY FOR RESPITE CARE.

NC Medicaid currently recognizes Respite as a billable service only under a waiver program. Medicaid does not recognize Respite as an optional service under its State Plan.

With the passage of the Deficit Reduction Act (DRA) of 2005, the Federal Government allowed states to determine which additional services to provide via a waiver based in the authority of this national legislation. States were eager to pursue such an innovative opportunity. However, since that time, Federal advice has been slow to reach the states, and it now appears that states will not be able to use this option as liberally as first thought. The Federal Government has decided that states will be able to have only one waiver under the DRA authority. NC Medicaid has not made the decision how they will use their opportunity. To date, only a couple of states have developed a waiver.

However, the NC Respite Study Group agreed that the respite care delivery system in NC could be enhanced if Medicaid would consider the possibility of including respite as a State Plan Service. A respite service, defined as an Optional Medicaid State Plan Service, should be offered to all who qualify, regardless of where the recipient lives or the recipient's diagnosis. The service should be based on individual needs. The State may limit the definition, duration and scope of the respite service. Integral to this process

would be an assessment of caregiver capability. DMA will use the information generated within the NC Respite Study Group to pursue an internal review of this option. Additional steps would include the development of a fiscal note and submission of a State Medicaid Plan Amendment (SPA). Because of the technological implications of initiating this new state plan service, if approved by the DHHS and CMS, the timeline would be determined based on the implementation of the new MMIS system. Cost of the system changes needed within the current system and the time needed to complete those changes would make any other timeline unworkable.

The initial impetus for building the case for a decision of this magnitude is the examination and documentation of caregiver support research and the viability, and documentation that respite care will result in the lowering of the overall cost of providing long-term care.

For example, caregivers who spend 40 hours or more are more than twice as likely as those spending fewer than 20 hours per week to say their health became a lot worse as a result of caregiving (23% vs. 9%). Similarly, caregivers who perform three or more Activities of Daily Living (ADLs) are almost twice as likely as those who are not performing any to say their health is a lot worse (19% vs. 10%). Seventy-five percent (75%) of these caregivers in declining health believe they did not have a choice of whether to take on their caregiving responsibility.[5]

IX RECOMMENDATIONS FOR IMPROVED RESPITE SERVICE PROVISION OF SERVICE WITHIN NC

The NC Respite Study Group recommends:

1. **That the NC General Assembly**

   A. Secure a recurring state appropriation of $500K to sustain Project C.A.R.E: "Caregiver Alternatives to Running on Empty" prior to June 30, 2008.

   B. Support an increase in the State Adult Day Care Fund (SADCF). Increasing the SADCF would assist in expanding services as this fund is for adults 18 years of age and older whereas the HCCBG fund is restricted to adults 60 years of age and over.

   C. Secure state funding to continue the expansion of Aging and Disability Resource Connections (ADRC) to increase information and access on respite services for caregivers. This would include creation and on-going maintenance of a statewide inventory system of respite care programs, services, and resources through the ADRC initiative and NCcareLINK to improve access and choices to respite care for caregivers and care recipients.

2. DAAS will further study the place of group respite programs in the long-term care continuum and assess the adequacy of service standards and funding.

3. Medicaid will continue to study the potential of Respite as a State Plan Service

[5] Caregivers in Decline, Evercare Study, Report of Findings , September 2006

List of Acronyms

AAA	Area Agency on Aging
ACH	Adult Care Home
ADC	Adult Day Care
ADDG	Alzheimer's Disease Demonstration Grants to States
ADH	Adult Day Health
ADRC	Aging and Disability Resource Connections
AOA	Administration on Aging
CAP/C	Community Alternatives Program for Medically Fragile Children
CAP/DA	Community Alternatives Program for Disabled Adults
CAP/MRDD	Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities
DAAS	Division of Aging and Adult Services
DHHS	Department of Health and Human Services
DHSR	Division of Health Service Regulation
DMA	Division of Medical Assistance
DMH/DD/SAS	Division of Mental Health/Developmental Disabilities and Substance Abuse
DRA	Deficit Reduction Act
DRIVE	Data Retrieval and Information Validation Engine
DSS	Division of Social Services
EBCI	Eastern Branch of the Cherokee Indians
FCA	National Center on Caregiving Family Caregiver Alliance
Friends NRC	Friends National Referral Center
FSCP	Family Caregiver Support Program
HCBS	Home and Community Based Services
HCCBG	Home and Community Care Block Grant
HHS	Health and Human Services
IOM	North Carolina Institute of Medicine Task Force on Long-Term Care
LTS	Long-term Services and Supports
MMIS	Medicaid Management Information Systems
MUST	Medicaid Uniform Screening Tool
NASUA	National Association of State Units on Aging
NCAC	North Carolina Administrative Code
NF	Nursing Facilities
NFCA	National Family Caregiver Association
Project C.A.R.E.	Caregiver Alternatives to Running on Empty
POMP	NC Performance Outcome Measures Project
UNC – CARES	University of North Carolina - Chapel Hill, Center for Aging Research and Educational Services
U.S.C.	United States Code

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ATTACHMENTS

Attachment A	Study Group Members and Their Organizations
Attachment B	NC Respite Regulations
Attachment C	NC Expenditures by Respite Program
Attachment D	Lifespan Respite Act
Attachment E	Estimated Prevalence and Economic Value of Family Caregiving, by State (2006)
Attachment F	Side by Side Comparison in Other States

Attachment A: Study Group Members and Their Organizations

Last	First	Organization
Artis*	Glenda	Division of Aging and Adult Services
Budzinski*	Julie	Division of Medical Assistance
Colvard	Tracy	Division of Medical Assistance
Comin	Margaret	Division of Medical Assistance
Cooper	Jerry	NC Assistant Living Association
Crane	Shannon	Division of Aging and Adult Services
Derence*	Karisa	Division of Aging and Adult Services
Grady	Elizabeth	Division of Medical Assistance
Gwyther	Lisa	Duke Bryan Alzheimer's Disease Research Center
Harper	Trish	Division of Medical Assistance
Jackson*	Charles	Division of Medical Assistance
Jenkins	Carol	Division of Medical Assistance
Johnson	Cedric	Division of Medical Assistance
Johnson	Teresa	NC Adult Day Services
Jones	Ellison	Triangle J Area on Aging
Joos	Cynthia	Division of Services for the Blind
Kingsberry	Adelle	Division of Medical Assistance
MaCleod	Jane	NC Respite Coalition
Morse	Margaret	Center for Aging Research and Educational Services, UNC
Reaves	Jean	NC Aging Study Commission
Salmon	Mary Anne	Center for Aging Research and Educational Services, UNC
Smith	Kathie	Association for Home & Hospice Care of NC
Speroff*	Beverly	Division of Health Service Regulation
Stancil	Candace	Division of Medical Assistance
Stephenson	Phyllis	NC Respite Coalition
Riddle*	Jody	Division of Aging and Adult Services
Urso*	Chris	Division of Aging and Adult Services
Waddle	Fred	NC Easter Seals
Waite	Linda	Division of Social Services
Wilson	Lou	NC Association of Long-term Care Facilities
Williamson	Sallie	Mid-East Commission Area Agency on Aging

* Indicates core planning group

Attachment B: North Carolina Respite Regulations

Respite Type	Definition of Provider	Licensure/Certification	Respite Definition	Admissions/Eligibility/Rules	Overnight	Payor
Nursing Home	§ 131E-101-(6) "Nursing home" means a facility, however named, which is advertised, announced, or maintained for the express or implied purpose of providing nursing or convalescent care for three or more persons Unrelated to the licensee.	DHSR	10 NCAC 13D.2001 "Respite care" means services provided for persons admitted to a nursing facility on a temporary basis, not to exceed 30 days.	10A NCAC 13D.2202 Admissions (a) No patient shall be admitted except by a physician or other persons legally authorized to admit patients. Admission shall be in accordance with facility policies and procedures.	Yes	Medicaid under waiver & special hospice
Adult Care Home	§ 131D-2 (1b) "Adult care home" is 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	DHSR	10 NCAC 13F.0907 (a) For the purposes of this Subchapter, respite care is defined as supervision, personal care and services provided for persons admitted to an adult care home on a temporary basis for temporary caregiver relief, not to exceed 30 days.	10A NCAC 13F.0701 Admission of Residents (a) 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.	Yes	Medicaid under waiver
Family Care Home	§ 131D-2(5) "Family care home" means an adult care home having two to six residents.	DHSR	10 NCAC 13G.0907 (a) For the purposes of this Subchapter, respite care is defined as supervision, personal care and services provided for persons admitted to a family care home on a temporary basis for temporary caregiver relief, not to exceed 30 days.	10A NCAC 13F.0701 Admission of Residents (a) 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.	Yes	Medicaid under waiver

Respite Type	Definition of Provider	Licensure/Certification	Respite Definition	Admissions/Eligibility/Rules	Overnight	Payor
DAAS Adult Day Care DAAS Adult Day Health	§ 131D-6 (Adult Day Care) "Adult day care program" 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. 10A NCAC 06S .0102 (Adult Day Health) "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.	DAAS Certified	10A NCAC 06R 0201 "Respite care," as a component of adult day care programs, means a service provided to give temporary relief to the family or caregiver. Primarily, respite is provided to families caring for children or adults with disabilities or families caring for frail or disabled older adults. 10A NCAC 06S .0102 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.	10A NCAC 71R .0903 Day Care Services for Adults (b) Target Population. Adults who because of age, disability or handicap need the service to enable them to remain in or return to their own homes. Within the target population, eligible clients shall be provided day care services for adults in the following order of priority: (1) adults who require complete, full-time daytime supervision in order to live in their own home or prevent impending placement in substitute care (e.g. nursing home, domiciliary home), and adults who need the service as part of a protective services plan; (2) adults who need help for themselves with activities of daily living or support for their caregivers in order to maintain themselves in their own homes or both; (3) adults who need intervention in the form of enrichment and opportunities for social activities in order to prevent deterioration that would lead to placement in group care; (4) individuals who need time-limited support in making the transition from independent living to group care, or individuals who need time-limited support in making the transition from group care to independent living.	No	1) Medicaid under for Adult Day Health within a waiver program only 2) Home and Community Care Block Grant (HCCBG) and State Adult Day Care Fund(SAD CF)

Respite Type	Definition of Provider	Licensure/Certification	Respite Definition	Admissions/Eligibility/Rules	Overnight	Payor
DAAS Adult Day Care DAAS Adult Day Health Continued...				10A NCAC 06S .0402 Additional Enrollment and Participation Requirements (a) Adult day health programs may serve persons 18 years of age or older who need day health services in order to support their independence and who require one or more of the following during the hours of the day health program: (1) Monitoring of a medical condition; or (2) Provision of assistance with or supervision of activities of daily living; or (3) Administration of medication, special feedings or provision of other treatment or services related to health care needs. (b) Day health programs shall not enroll or continue to serve persons whose needs exceed the capability of the program. (c) Each individual's service plan, in addition to the requirements set forth in 10A NCAC 06R .0501, shall include the health needs and the goals for meeting the health needs of the individual.		(SADCF)

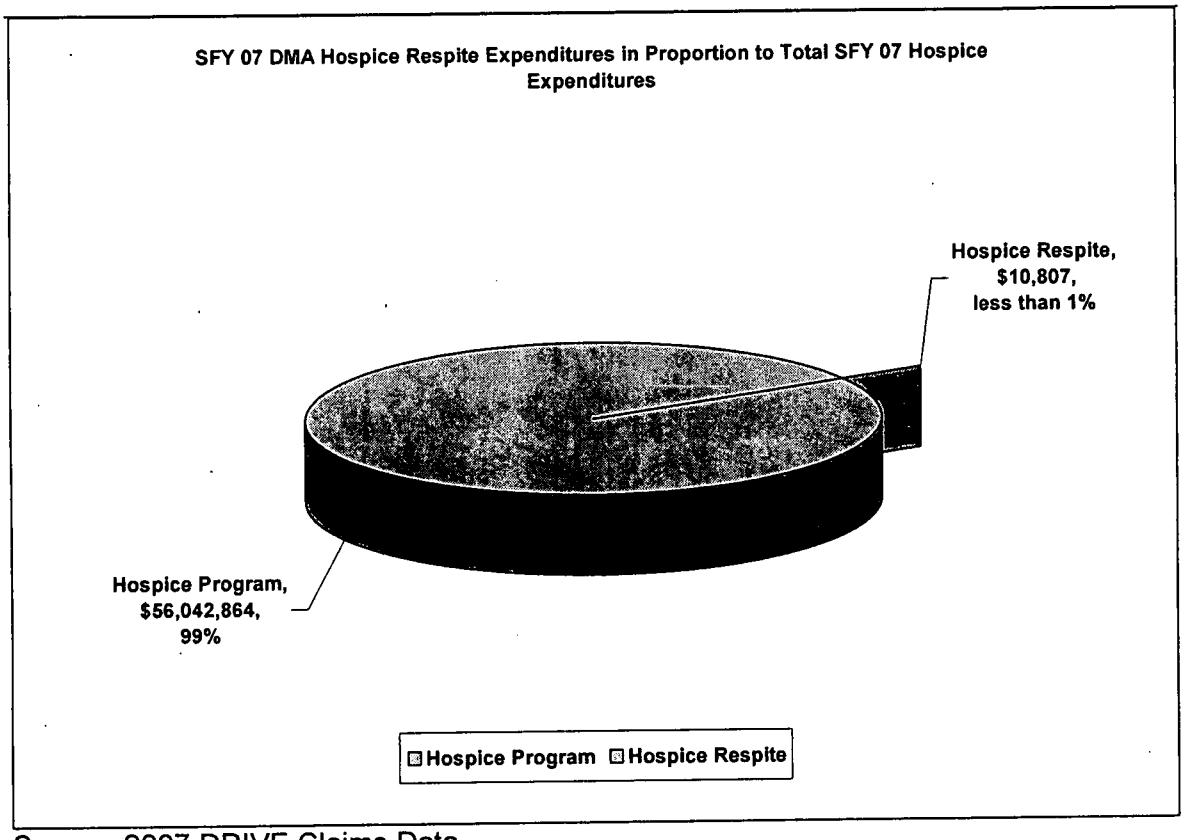
Respite Type	Definition of Provider	Licensure/Certification	Respite Definition	Admissions/Eligibility/Rules	Overnight	Payor
DAAS Sponsored Respite, Residential Respite (or "institutional respite") and Group Respite	Contracted Vendors Nursing Homes Residential Care Facilities and Assisted Living Facilities Individuals employed privately through a home health agency or as part of a government program	None	§ 143B-181.10 A respite care program is established to provide needed relief to caregivers of impaired adults who cannot be left alone because of mental or physical problems. 10A NCAC 06B .0101 Institutional Respite Care Service is temporary placement of an individual who requires constant care or supervision, or both, out of his or her home to provide the primary, unpaid caregiver temporary relief from caregiving responsibilities § 143B-181.10 A respite care program is established to provide needed relief to caregivers of impaired adults who cannot be left alone because of mental or physical problems.	§ 143B-181.10 Those eligible for respite care under the program established by this section are limited to those unpaid primary caregivers who are caring for people 60 years of age or older and their spouses, or those unpaid primary caregivers 60 years of age or older who are caring for persons 18 years of age or older, who require constant supervision and who cannot be left alone either because of memory impairment, physical immobility, or other problems that renders them unsafe alone. 10A NCAC 06B .0201 SCREENING OF CLIENT (a) Screening is a preliminary process used to determine if client eligibility is met. (b) A screening instrument must be completed for each unpaid primary caregiver who requests service. (c) The screening instrument must address: (1) Caregiver identification information; (2) Ability of the person requiring care to perform activities of daily living; (3) Ability of the person requiring care to perform instrumental activities of daily living; (4) Physical functioning of the person requiring care; (5) Caregiver's perception of the emotional well-being of the person requiring care; (6)Extent of support provided by the primary caregiver; (7) Services currently received by the person requiring care or the caregiver	Yes (Institutional only when provided in a DHHS licensed facility).	1) State Funded 2) HCCBG 3) DAAS in consultation with the Councils of Government in each region of the State of North Carolina

Respite Type	Definition of Provider	Licensure/Certification	Respite Definition	Admissions/Eligibility/Rules	Overnight	Payor
DSS (all children)	Contracted Vendors (8 current providers)	DSS	As defined by Friends National Referral Center: Short-term care services provided for families of children under the age of 18 living with natural, adoptive, foster parents or relatives, or any family who has taken on the role of caregiver who meet one or more of the following categories: a) the child(ren) are in danger of abuse or neglect; b) the child(ren) have experienced abuse or neglect; c) The child(ren) has/have developmental disabilities, chronic or terminal illnesses	No statute	Yes	DSS State Funds
MH Community Respite Institutional	§ 122C-3 Facility means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers	DHSR	10A NCAC 27G .5101 (a) Community respite is a service which provides periodic relief for a family or family substitute on a temporary basis. While overnight care is available, community respite services may be provided for periods of less than 24 hours on a day or evening basis. Respite care may be provided by the following model: Center-based respite - the individual is served at a designated facility. While an overnight capacity is generally a part of this service, a respite center may provide respite services to individuals for periods of less than 24 hours on a day or evening basis.	§ 122C-3. 1) State Funded - Individuals must meet the state definition of a developmental disability or mental illness 2) Individual with a developmental disability meeting ICF-MR level of care	Yes-may be day or overnight	1) State Funded (DMH/DD/ SAS) 2) CAP-MR/DD (Medicaid)

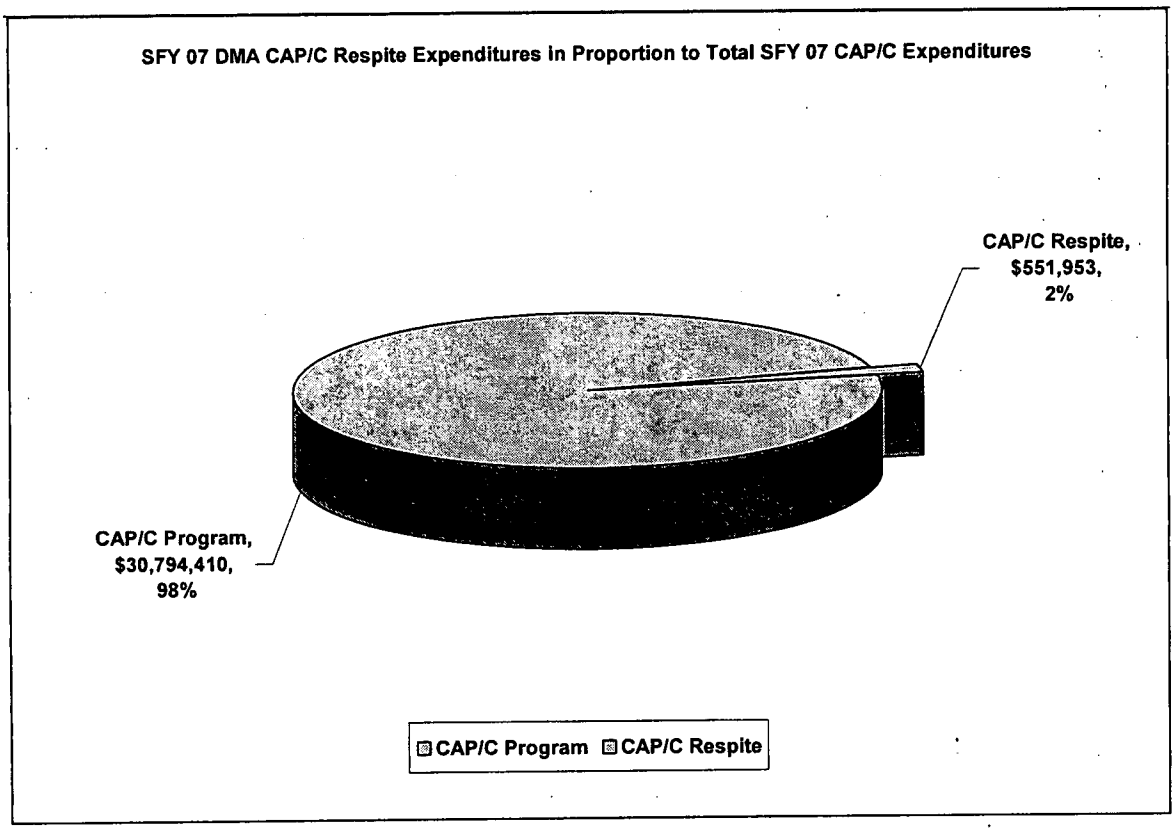
Respite Type	Definition of Provider	Licensure/Certification	Respite Definition	Admissions/Eligibility/Rules	Overnight	Payor
MH Community Respite-In Private Home	§ 122C Private home respite means the individual is served in the provider's home or an hourly or overnight basis	DHSR-for licensable facilities	10A NCAC 27G .5101 Private home respite—the individual is served in the provider's home on an hourly or overnight basis. Private home respite services serving individuals are subject to licensure under G.S. 122C, Article 2, when: (1) more than two individuals are served concurrently; or; Either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.	§ 122C-3. 1) State Funded - Individuals must meet the state definition of a developmental disability or mental illness 2) Individual with a developmental disability meeting ICF-MR level of care	Yes-may be day or overnight, group, enhanced or nursing	1) State Funded (DMH/DD/SAS) 2) CAP-MR/DD (Medicaid)
MH Community Respite	§ 122C-3 Facility means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers	DHSR	10A NCAC 27G.5101 (a) Community respite is a service which provides periodic relief for a family or family substitute on a temporary basis. While overnight care is available, community respite services may be provided for periods of less than 24 hours on a day or evening basis. Respite care may be provided by the following model: Center-based respite - the individual is served at a designated facility. While an overnight capacity is generally a part of this service, a respite center may provide respite services to individuals for periods of less than 24 hours on a day or evening basis.	§ 122C-3. 1) State Funded - Individuals must meet the state definition of a developmental disability or mental illness 2) Individual with a developmental disability meeting ICF-MR level of care	Yes-may be day or overnight	1) State Funded (DMH/DD/SAS) 2) CAP-MR/DD (Medicaid)

Respite Type	Definition of Provider	Licensure/Certification	Respite Definition	Admissions/Eligibility/Rules	Overnight	Payor
MH Community Respite-In Private Home	§ 122C Private home respite means the individual is served in the provider's home or an hourly or overnight basis	DHSR-for licensable facilities	10A NCAC 27G .5101 Private home respite—the individual is served in the provider's home on an hourly or overnight basis. Private home respite services serving individuals are subject to licensure under G.S. 122C, Article 2, when: (2) more than two individuals are served concurrently; or; Either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.	§ 122C-3. 1) State Funded - Individuals must meet the state definition of a developmental disability or mental illness 2) Individual with a developmental disability meeting ICF-MR level of care	Yes-may be day or overnight	1) State Funded (DMH/DD/SAS) 2) CAP-MR/DD (Medicaid)

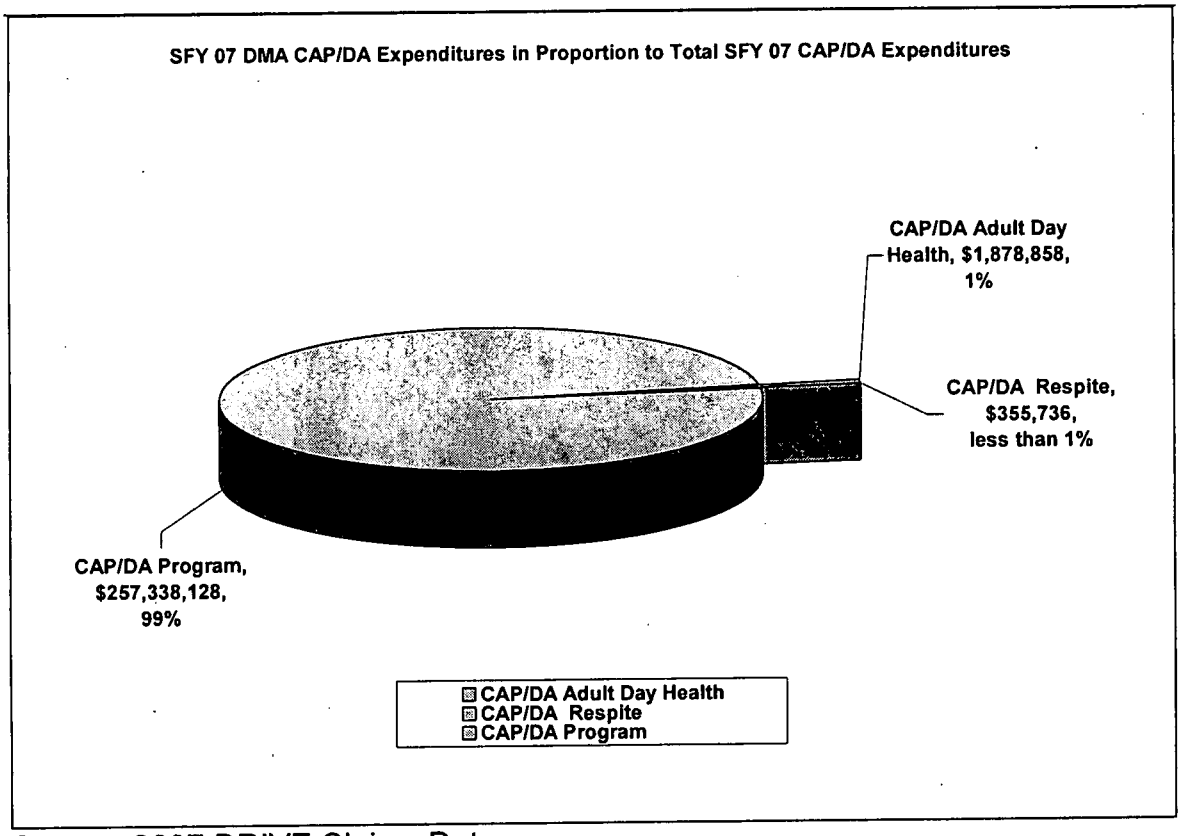
Attachment C: NC Expenditures by Respite Program



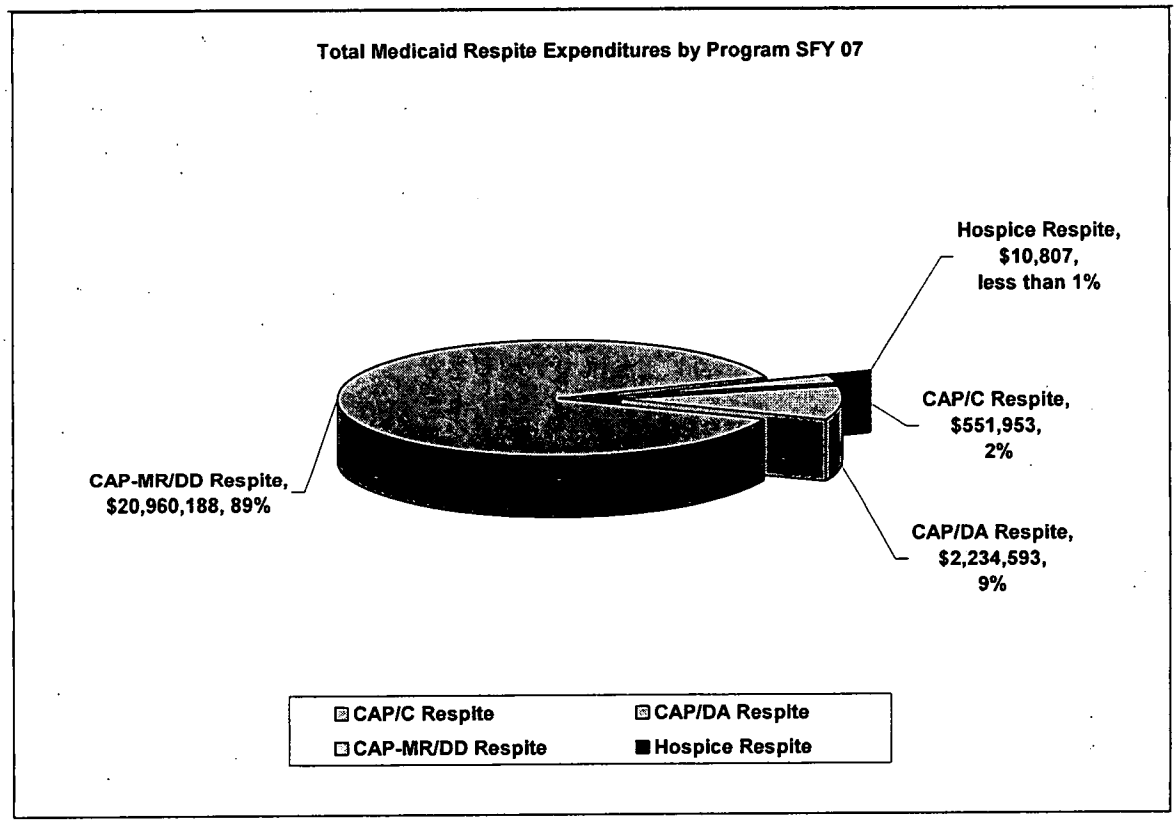
Source: 2007 DRIVE Claims Data



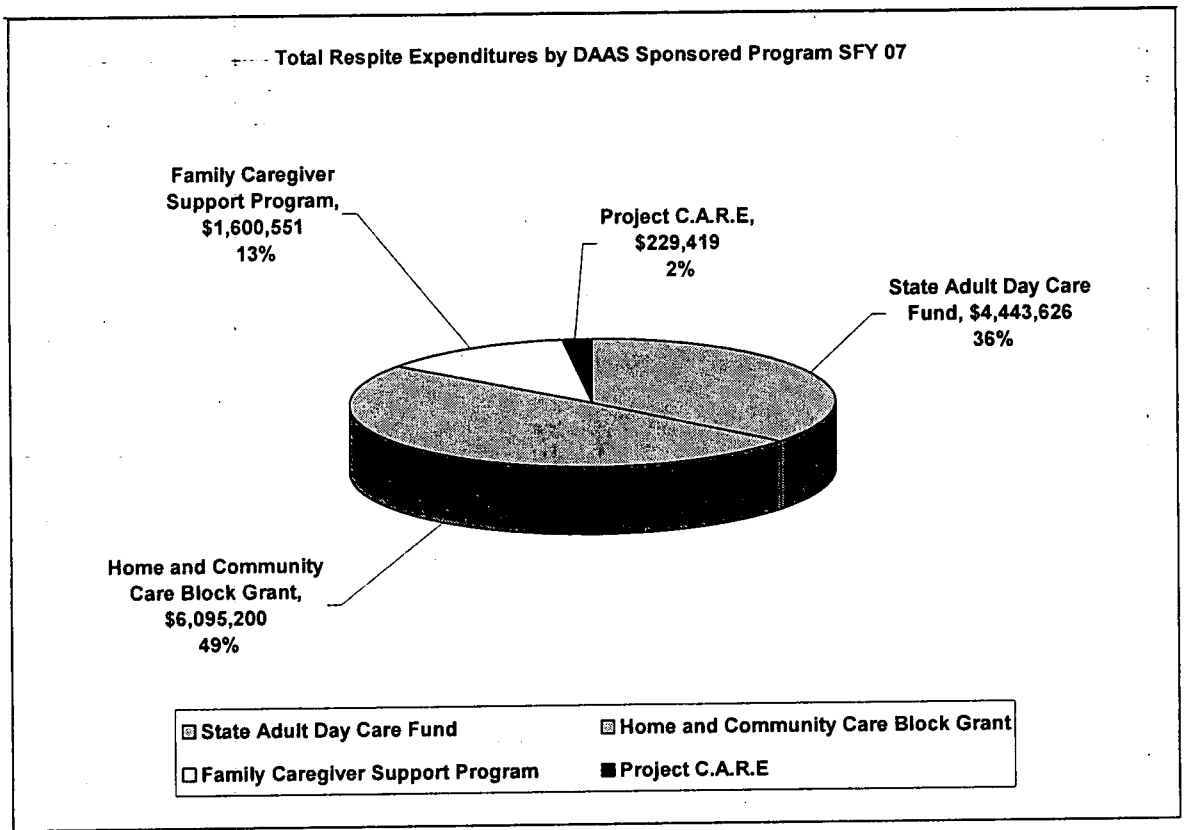
Source: 2007 DRIVE Claims Data



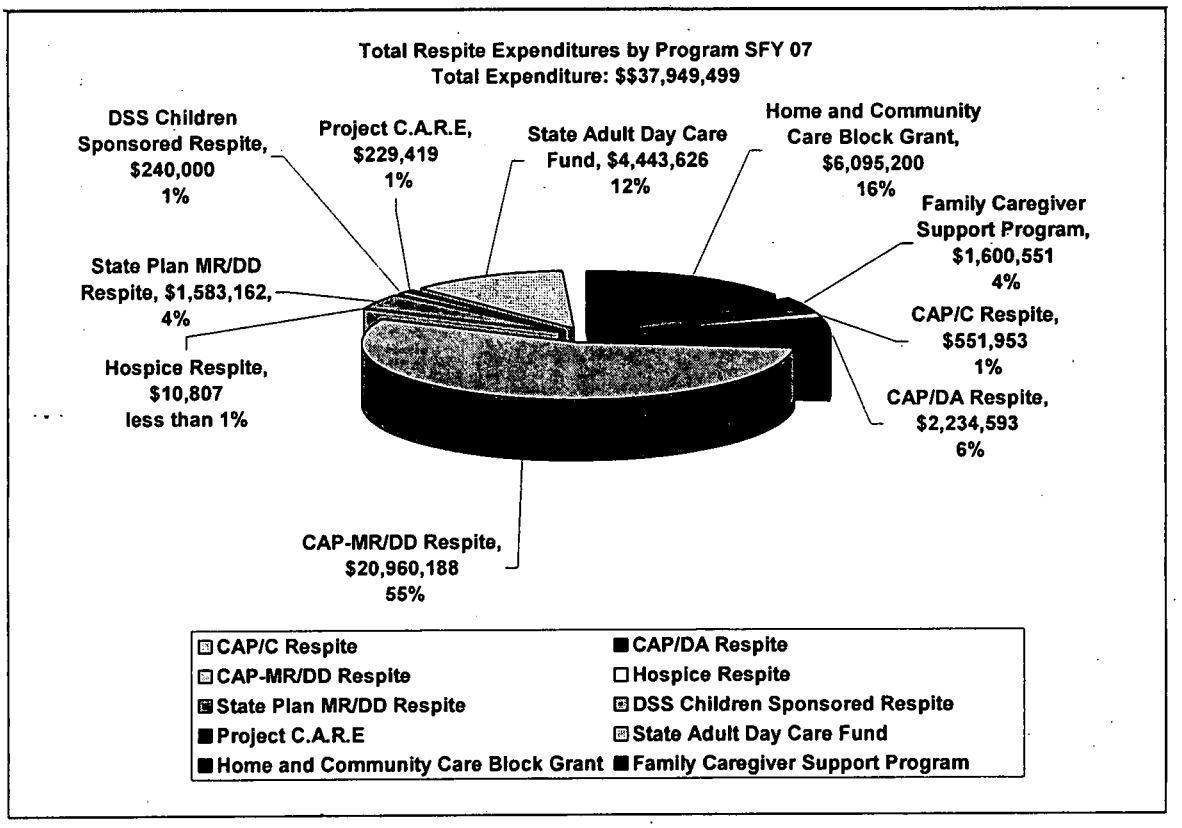
Source: 2007 DRIVE Claims Data



Source: Division of Mental Health and 2007 DRIVE Claims Data



Source: Division of Aging and Adult Services



Source: Division of Mental Health, Division of Social Services, Division of Aging and Adult Services and 2007 DRIVE Claims Data
*Family Support/Child Welfare Section

Attachment D: Lifespan Respite Act (H.R. 3248)

PUBLIC LAW 109–442—DEC. 21, 2006 120 STAT. 3291
Public Law 109–442
109th Congress
An Act

To amend the Public Health Service Act to establish a program to assist family caregivers in accessing affordable and high-quality respite care, and for other purposes.
Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.
This Act may be cited as the "Lifespan Respite Care Act of 2006".

SEC. 2. LIFESPAN RESPITE CARE.
The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXIX—LIFESPAN RESPITE CARE
"SEC. 2901. DEFINITIONS.
"In this title:

"(1) ADULT WITH A SPECIAL NEED.—The term 'adult with a special need' means a person 18 years of age or older who requires care or supervision to—

"(A) meet the person's basic needs;
"(B) prevent physical self-injury or injury to others; or
"(C) avoid placement in an institutional facility.

"(2) AGING AND DISABILITY RESOURCE CENTER.—The term 'aging and disability resource center' means an entity administering a program established by the State, as part of the State's system of long-term care, to provide a coordinated system for providing—

"(A) comprehensive information on available public and private long-term care programs, options, and resources;
"(B) personal counseling to assist individuals in assessing their existing or anticipated long-term care needs, and developing and implementing a plan for long-term care designed to meet their specific needs and circumstances; and
"(C) consumer access to the range of publicly supported long-term care programs for which consumers may be eligible, by serving as a convenient point of entry for such programs.

"(3) CHILD WITH A SPECIAL NEED.—The term 'child with a special need' means an individual less than 18 years of age42 USC 300ii. Lifespan Respite Care Act of 2006.

42 USC 201 note.

Dec. 21, 2006

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120 STAT. 3292 PUBLIC LAW 109–442—DEC. 21, 2006
age who requires care or supervision beyond that required of children generally to—

"(A) meet the child's basic needs; or
"(B) prevent physical injury, self-injury, or injury to others.

"(4) ELIGIBLE STATE AGENCY.—The term 'eligible State agency' means a State agency that—

"(A) administers the State's program under the Older Americans Act of 1965, administers the State's program under title XIX of the Social Security Act, or is designated by the Governor of such State to administer the State's programs under this title;
"(B) is an aging and disability resource center;
"(C) works in collaboration with a public or private nonprofit statewide respite care coalition or organization; and
"(D) demonstrates—

"(i) an ability to work with other State and community- based agencies;
"(ii) an understanding of respite care and family caregiver issues across all age groups, disabilities, and chronic conditions; and
"(iii) the capacity to ensure meaningful involvement of family members, family caregivers, and care recipients.

"(5) FAMILY CAREGIVER.—The term 'family caregiver' means an unpaid family member, a foster parent, or another unpaid adult, who provides in-home monitoring, management, supervision, or treatment of a child or adult with a special need.

"(6) LIFESPAN RESPITE CARE.—The term 'lifespan respite care' means a coordinated system of accessible, community-based respite care services for family caregivers of children or adults with special needs.

"(7) RESPITE CARE.—The term 'respite care' means planned or emergency care provided to a child or adult with a special need in order to provide temporary relief to the family caregiver of that child or adult.

"(8) STATE.—The term 'State' means any of the several States, the District of Columbia, the Virgin Islands of the United States, the Commonwealth of Puerto Rico, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

"SEC. 2902. LIFESPAN RESPITE CARE GRANTS AND COOPERATIVE AGREEMENTS.

"(a) PURPOSES.—The purposes of this section are—

"(1) to expand and enhance respite care services to family caregivers;
"(2) to improve the statewide dissemination and coordination of respite care; and
"(3) to provide, supplement, or improve access and quality of respite care services to family caregivers, thereby reducing family caregiver strain.

"(b) AUTHORIZATION.—Subject to subsection (e), the Secretary is authorized to award grants or cooperative agreements for the purposes described in subsection (a) to eligible State agencies for which an application is submitted pursuant to subsection (d). Intergovernmental relations. 42 USC 300ii–1.
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PUBLIC LAW 109–442—DEC. 21, 2006 120 STAT. 3293

"(c) FEDERAL LIFESPAN APPROACH.—In carrying out this section, the Secretary shall work in cooperation with the National Family Caregiver Support Program of the Administration on Aging and other respite care programs within the Department of Health and Human Services to ensure coordination of respite care services for family caregivers of children and adults with special needs.

"(d) APPLICATION.—

"(1) SUBMISSION.—Each Governor desiring the eligible State agency of his or her State to receive a grant or cooperative agreement under this section shall submit an application on behalf of such agency to the Secretary at such time, in such manner, and containing such information as the Secretary shall require.
"(2) CONTENTS.—Each application submitted under this section shall include—

"(A) a description of the eligible State agency's—

"(i) ability to work with other State and community- based agencies;
"(ii) understanding of respite care and family caregiver issues across all age groups, disabilities, and chronic conditions; and
"(iii) capacity to ensure meaningful involvement of family members, family caregivers, and care recipients;

"(B) with respect to the population of family caregivers to whom respite care information or services will be provided or for whom respite care workers and volunteers will be recruited and trained, a description of—

"(i) the population of family caregivers;
"(ii) the extent and nature of the respite care needs of that population;

"(iii) existing respite care services for that population, including numbers of family caregivers being served and extent of unmet need;
"(iv) existing methods or systems to coordinate respite care information and services to the population at the State and local level and extent of unmet need;
"(v) how respite care information dissemination and coordination, respite care services, respite care worker and volunteer recruitment and training programs, or training programs for family caregivers that assist such family caregivers in making informed decisions about respite care services will be provided using grant or cooperative agreement funds;
"(vi) a plan for administration, collaboration, and coordination of the proposed respite care activities with other related services or programs offered by public or private, nonprofit entities, including area agencies on aging;
"(vii) how the population, including family caregivers, care recipients, and relevant public or private agencies, will participate in the planning and implementation of the proposed respite care activities;
"(viii) how the proposed respite care activities will make use, to the maximum extent feasible, of other VerDate 14-DEC-2004 11:52 Jan 03, 2007 Jkt 059139 PO 00442 Frm 00003 Fmt 6580 Sfmt 6581 E:\PUBLAW\PUBL442.109 APPS06 PsN: PUBL442 120 STAT. 3294 PUBLIC LAW 109–442—DEC. 21, 2006 Federal, State, and local funds, programs, contributions, other forms of reimbursements, personnel, and facilities;
"(ix) respite care services available to family caregivers in the eligible State agency's State or locality, including unmet needs and how the eligible State agency's plan for use of funds will improve the coordination and distribution of respite care services for family caregivers of children and adults with special needs; "(x) the criteria used to identify family caregivers eligible for respite care services;
"(xi) how the quality and safety of any respite care services provided will be monitored, including methods to ensure that respite care workers and volunteers are appropriately screened and possess the necessary skills to care for the needs of the care recipient in the absence of the family caregiver; and "(xii) the results expected from proposed respite care activities and the procedures to be used for evaluating those results;

"(C) assurances that, where appropriate, the eligible State agency will have a system for maintaining the confidentiality of care recipient and family caregiver records; and

"(D) a memorandum of agreement regarding the joint responsibility for the eligible State agency's lifespan respite program between—

"(i) the eligible State agency; and
"(ii) a public or private nonprofit statewide respite coalition or organization.

"(E) PRIORITY; CONSIDERATIONS.—When awarding grants or cooperative agreements under this section, the Secretary shall—

"(1) give priority to eligible State agencies that the Secretary determines show the greatest likelihood of implementing or enhancing lifespan respite care statewide; and
"(2) give consideration to eligible State agencies that are building or enhancing the capacity of their long-term care systems to respond to the comprehensive needs, including respite care needs, of their residents.

"(F) USE OF GRANT OR COOPERATIVE AGREEMENT FUNDS.—

"(1) IN GENERAL.—

"(A) REQUIRED USES OF FUNDS.—Each eligible State agency awarded a grant or cooperative agreement under this section shall use all or part of the funds—

"(i) to develop or enhance lifespan respite care at the State and local levels;
"(ii) to provide respite care services for family caregivers caring for children or adults;
"(iii) to train and recruit respite care workers and volunteers;
"(iv) to provide information to caregivers about available respite and support services; and
"(v) to assist caregivers in gaining access to such services.
VerDate 14-DEC-2004 11:52 Jan 03, 2007 Jkt 059139 PO 00442 Frm 00004 Fmt 6580 Sfmt 6581 E:\PUBLAW\PUBL442.109 APPS06 PsN: PUBL442 PUBLIC LAW 109–442—DEC. 21, 2006 120 STAT. 3295

"(B) OPTIONAL USES OF FUNDS.—Each eligible State agency awarded a grant or cooperative agreement under this section may use part of the funds for—

"(i) training programs for family caregivers to assist such family caregivers in making informed decisions about respite care services;
"(ii) other services essential to the provision of respite care as the Secretary may specify; or
"(iii) training and education for new caregivers.

"(2) SUBCONTRACTS.—Each eligible State agency awarded a grant or cooperative agreement under this section may carry out the activities described in paragraph (1) directly or by grant to, or contract with, public or private entities.

"(3) MATCHING FUNDS.—

"(A) IN GENERAL.—With respect to the costs of the activities to be carried out under paragraph (1), a condition for the receipt of a grant or cooperative agreement under this section is that the eligible State agency agrees to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 25 percent of such costs.

"(B) DETERMINATION OF AMOUNT CONTRIBUTED.—Non- Federal contributions required by subparagraph (A) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(g) TERM OF GRANTS OR COOPERATIVE AGREEMENTS.—

"(1) IN GENERAL.—The Secretary shall award grants or cooperative agreements under this section for terms that do not exceed 5 years.
"(2) RENEWAL.—The Secretary may renew a grant or cooperative agreement under this section at the end of the term of the grant or cooperative agreement determined under paragraph (1).

"(h) MAINTENANCE OF EFFORT.—Funds made available under this section shall be used to supplement and not supplant other Federal, State, and local funds available for respite care services.

"SEC. 2903. NATIONAL LIFESPAN RESPITE RESOURCE CENTER.

"(a) ESTABLISHMENT.—The Secretary may award a grant or cooperative agreement to a public or private nonprofit entity to establish a National Resource Center on Lifespan Respite Care (referred to in this section as the 'center').

"(b) PURPOSES OF THE CENTER.—The center shall—

"(1) maintain a national database on lifespan respite care;
"(2) provide training and technical assistance to State, community, and nonprofit respite care programs; and
"(3) provide information, referral, and educational programs to the public on lifespan respite care.

"SEC. 2904. REPORT.
"Not later than January 1, 2009, the Secretary shall report to the Congress on the activities undertaken under this title. Such report shall evaluate— 42 USC 300ii–3. 42 USC 300ii–2. VerDate 14-DEC-2004 11:52 Jan 03, 2007 Jkt 059139 PO 00442 Frm 00005 Fmt 6580 Sfmt 6581 E:\PUBLAW\PUBL442.109 APPS06 PsN: PUBL442

120 STAT. 3296 PUBLIC LAW 109–442—DEC. 21, 2006
LEGISLATIVE HISTORY—H.R. 3248:
HOUSE REPORTS: No. 109–716 (Comm. on Energy and Commerce).
CONGRESSIONAL RECORD, Vol. 152 (2006):
Dec. 6, considered and passed House.
Dec. 8, considered and passed Senate.
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"(1) the number of States that have lifespan respite care programs;
"(2) the demographics of the caregivers receiving respite
care services through grants or cooperative agreements under this title; and
"(3) the effectiveness of entities receiving grants or cooperative agreements under this title.
"SEC. 2905. AUTHORIZATION OF APPROPRIATIONS.
"There are authorized to be appropriated to carry out this title—
"(1) $30,000,000 for fiscal year 2007;
"(2) $40,000,000 for fiscal year 2008;
"(3) $53,330,000 for fiscal year 2009;
"(4) $71,110,000 for fiscal year 2010; and
"(5) $94,810,000 for fiscal year 2011.".
SEC. 3. GAO REPORT ON LIFESPAN RESPITE CARE PROGRAMS.
Not later than January 1, 2011, the Comptroller General of
the United States shall conduct an evaluation and submit a report
to the Congress on the effectiveness of lifespan respite programs,
including an analysis of cost benefits and improved efficiency in service delivery.
Approved December 21, 2006.
Evaluation.
42 USC 300ii–4.
VerDate 14-DEC-2004 22:32 Jan 03, 2007 Jkt 059139 PO 00442 Frm 00006 Fmt 6580 Sfmt 6580 E:\PUBLAW\PUBL442.109 APPS24 PsN: PUBL442

Attachment E:

Table 1: Number of Caregivers and the Economic Value of Caregiving, by State, 2006

State	Total State Population	Number of Caregivers	Economic Value per Hour	Total Economic Value (millions)
Alabama	4,600,000	570,000	$7.72	$4,700
Alaska	670,000	68,000	$12.28	$900
Arizona	6,170,000	570,000	$9.14	$5,600
Arkansas	2,810,000	360,000	$9.19	$3,600
California	36,500,000	4,000,000	$10.37	$45,000
Colorado	4,750,000	540,000	$10.68	$6,200
Connecticut	3,500,000	380,000	$11.65	$4,800
Delaware	853,000	100,000	$10.64	$1,150
District of Columbia	582,000	59,000	$10.11	$640
Florida	18,090,000	1,720,000	$9.29	$17,300
Georgia	9,360,000	1,310,000	$8.57	$12,100
Hawaii	1,285,000	106,000	$10.91	$1,250
Idaho	1,466,000	162,000	$8.70	$1,520
Illinois (1)	12,830,000	1,500,000	$9.98	$16,200
Indiana	6,310,000	720,000	$9.58	$7,500
Iowa	2,980,000	310,000	$10.59	$3,500
Kansas	2,760,000	280,000	$9.19	$2,800
Kentucky	4,210,000	520,000	$9.48	$5,400
Louisiana	4,290,000	560,000	$7.34	$4,400
Maine	1,322,000	154,000	$10.09	$1,680
Maryland	5,620,000	600,000	$9.79	$6,300
Massachusetts	6,440,000	700,000	$11.74	$8,900
Michigan	10,100,000	1,280,000	$9.71	$13,400
Minnesota	5,170,000	610,000	$10.91	$7,100
Mississippi	2,910,000	460,000	$7.66	$3,800
Missouri	5,840,000	590,000	$9.15	$5,900
Montana	945,000	110,000	$8.61	$1,030
Nebraska	1,768,000	179,000	$9.90	$1,910
Nevada	2,500,000	260,000	$10.47	$3,000
New Hampshire	1,315,000	147,000	$10.64	$1,680
New Jersey	8,720,000	980,000	$10.61	$11,200
New Mexico	1,955,000	200,000	$8.86	$1,930
New York	19,310,000	2,200,000	$10.27	$24,000
North Carolina	8,860,000	1,080,000	$9.14	$10,700
North Dakota	636,000	56,000	$9.10	$550
Ohio	11,480,000	1,310,000	$9.79	$13,800
Oklahoma	3,580,000	370,000	$8.67	$3,500
Oregon	3,700,000	420,000	$10.26	$4,600
Pennsylvania	12,440,000	1,370,000	$9.77	$14,500
Rhode Island	1,068,000	117,000	$11.41	$1,440
South Carolina	4,320,000	560,000	$9.01	$5,500
South Dakota	782,000	86,000	$9.40	$880
Tennessee	6,040,000	770,000	$8.71	$7,200
Texas	23,500,000	2,700,000	$8.21	$24,000
Utah	2,550,000	330,000	$9.06	$3,200
Vermont (2)	624,000	56,000	$10.57	$640
Virginia	7,640,000	900,000	$10.18	$9,900
Washington	6,400,000	650,000	$10.15	$7,100
West Virginia	1,818,000	270,000	$8.30	$2,500
Wisconsin	5,560,000	600,000	$10.45	$6,800
Wyoming	515,000	55,000	$9.74	$570
United States	**299,000,000**	**34,000,000**	**$9.63**	**$350,000**

his table is unchanged from the original release. Notes: (1) Data on caregiving prevalence were missing for Illinois, so the ational average prevalence was used; (2) in Vermont, the median wage for home health aides (one of the inputs to the value er hour calculation), was not available and was estimated as 1.084 times the median wage for personal care aides (the ational ratio of the median wage of home health aides to personal care aides)

http://assests.aarp.org/rgcenter/:1/dd158r_caregiving.pdf

Attachment F: Side-by-Side Comparison in Other States [6]

Table 5: Respite Care

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs.	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
ALABAMA																		
FC	Alabama CARES	x		x	x	x	x				x		x				x	
MC	Elderly & Disabled Waiver	x			x						x		x			x		
ALASKA																		
FC	Family Caregiver Support Program	x		x	x					x				x				x
SC	Innovative Respite	x			x			Special activities			x		x				x	
ARIZONA																		
FC	Family Caregiver Support Program	x		x	x	x	x				x			x				x
MC	AZ Long-Term Care System (ALTCS)	x		x	x	x					x		x			x		
SC	Non-Medical Home and Community Based Services	x		x	x	x	x				x			x				x
ARKANSAS																		
FC	Caring for the Caregiver Arkansas Caregivers	x		x	x	x					x		x					x
MC	ElderChoices Medicaid Waiver	x		x	x	x	x				x		x			x		
CALIFORNIA																		
FC	Family Caregiver Support Program	x		x	x	x	x				x			x				x
MC	Multipurpose Senior Services Program (MSSP)	x		x	x	x						x		x				x
SC	Adult Day Health Care Program	x		x							x			x				x
SC	Alzheimer's Day Care Resource Center (ADCRC)	x		x							x			x				x
SC	Caregiver Resource Centers (CRCs)	x		x	x	x	x			x			x			x		
SC	In-Home Supportive Services (IHSS)	x			x						x			x				x
COLORADO																		
FC	Family Caregiver Support Program	x		x	x	x	x				x		x				x	
MC	Home and Community-Based Services for the Elderly, Blind and Disabled	x		x	x	x						x	x			x		

Notes: Table is based on the Part 1 Survey (Question 20).
Program Type: FC=National Family Caregiver Support Program; MC=Aged/Disabled Medicaid HCBS Waiver; SC=State-Funded Program
Program Name: FCSP=Family Caregiver Support Program; HCBS=Home and Community-Based Services
CG=Caregiver; CR=Care Receiver; N/A=Not Applicable; NR=No Response; Svcs.=Services

[6] *The State of the States in Family Caregiver Support: A 50-State Study* (NOVEMBER 2004) includes a series of data tables comparing how state programs responded to key survey questions. :Lynn Friss Feinberg, M.S.W; Sandra L. Newman, M.P.H.; Leslie Gray, M.P.H; Karen N. Kolb, M.S. all of the National Center on Caregiving; Family Caregiver Alliance In Collaboration With: Wendy Fox-Grage, M.P.A., M.S.G; National Conference of State Legislatures

Attachment F Continued

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs.	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
CONNECTICUT																		
FC	Family Caregiver Support Program	X		X	X	X	X	Live-in home health aide			X		X			X		
MC	Home Care Program for Elders	X		X	X	X	X				X			X				X
SC	Statewide Respite Care Program	X		X	X	X		Live-in home health aide			X		X			X		
SC	Personal Care Assistance State-Funded Pilot Program	X		X	X	X	X				X		X					X
DELAWARE																		
FC	CARE Delaware	X		X	X	X	X				X		X			X		
MC	Elderly & Disabled Waiver	X		X	X	X					X		X			X		
DISTRICT OF COLUMBIA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Elderly and Physical Disabilities Waiver	X			X	X	X			X			X			X		
FLORIDA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Aged & Disabled Adult Medicaid HCBS Waiver	X		X	X	X	X				X			X				X
SC	Respite for Elders Living in Everyday Families (RELIEF)	X			X					X			X			X		
SC	Home Care for the Elderly	X		X	X	X	X			X				X				X
SC	Community Care for the Elderly	X		X	X	X	X				X			X				X
SC	Alzheimer's Disease Initiative	X		X	X	X	X				X			X				X
GEORGIA																		
FC	Family Caregiver Support Program	X		X	X	X	X	Extended respite (more than one weekend)			X			X				X
MC	Community Care Services Program (CCSP)	X		X	X	X	X				X			X				X
HAWAII																		
FC	Family Caregiver Support Program	X		X	X	X	X	Weekend support groups				X		X				X
MC	Nursing Home Without Walls	X		X	X	X	X			X				X				X
SC	Kupuna Care	X		X	X							X		X				X
IDAHO																		
FC	Family Caregiver Support Program	X		X	X	X				X				X				X
MC	HCBS Aged & Disabled Waiver	X		X	X					X			X			X		
SC	Senior Services Act, Respite Program	X		X	X	X				X				X				X

Attachment F Continued

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs.	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
ILLINOIS																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Community Care Program (CCP)	X		X								X			X			X
MC	Home Services program	X		X	X						X		X				X	
INDIANA																		
FC	Caring and Compassion	X		X	X		X				X		X			X		
MC	Aged & Disabled Medicaid Waiver	X		X	X	X	X				X			X				X
SC	CHOICE	X			X		X				X			X				X
IOWA																		
FC	Iowa Family Caregiver	X		X	X	X					X			X				X
MC	Elderly Waiver	X		X	X	X	X			X				X				X
KANSAS																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X			X		
MC	Home & Community Based Frail Elder Waiver	X		X	X	X					X		X			X		
SC	Senior Care Act Program	X		X	X		X				X			X				X
KENTUCKY																		
FC	Family Caregiver Support Program	X		X	X						X		X				X	
SC	Adult Day / Alzheimer's Respite	X		X	X		X				X			X				X
LOUISIANA																		
FC	Family Caregiver Support Program	X			X						X		X			X		
MC	Medicaid Home and Community-Based Waiver		X						X			X			X			X
MAINE																		
FC	Family Caregiver Program	X		X	X	X				X			X				X	
MC	MaineCare	X		X	X	X					X		X			X		
SC	Home-Based Care	X		X	X	X					X		X			X		
SC	Partners in Caring	X		X	X	X	X				X		X			X		
MARYLAND																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Medicaid Waiver for Older Adults	X		X	X	X					X		X			X		
SC	Respite for Caregivers of Adults with Functional Disabilities	X		X	X	X	X				X		X			X		
MASSACHUSETTS																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Home and Community-Based Waiver	X		X	X	X	X				X			X				X
SC	Home Care Program	X		X	X	X	X				X			X				X

Attachment F Continued

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs.	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
MICHIGAN																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	MI Choice	X		X	X	X					X			X				X
SC	State / Escheat Respite	X		X	X	X	X				X			X				X
SC	Caregiver Respite Program	X		X	X	X	X				X			X				X
MINNESOTA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Elderly Waiver	X		X	X	X		Out of home care provided by neighbor, friend, or family			X			X				X
SC	Alternative Care Program	X		X	X	X		Out of home care provided by neighbor, friend, or family			X			X				X
MISSISSIPPI																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X			X		
MC	Elderly and Disabled Waiver	X		X	X	X				X			X			X		
MISSOURI																		
FC	Family Caregiver Support Program	X		X	X		X				X		X				X	
MC	Aged and Disabled Waiver	X		X	X	X						X		X				X
MONTANA																		
FC	Family Caregiving Support	X		X	X	X				X				X				X
MC	Home and Community-Based Services Program for Elderly and Physically Disabled	X		X	X	X	X				X			X				X
NEBRASKA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Aged and Disabled Waiver	X		X	X	X	X	Individualized services		X				X				X
SC	Respite Subsidy Program Across the Lifespan	X		X	X	X	X			X			X			X		
NEVADA																		
FC	Family Caregiver Support Program	X			X						X			X				X
MC	Community Home-Based Initiatives Program	X		X	X	X	X				X			X				X
SC	Independent Living Grant	X		X	X	X	X				X			X				X
SC	Community-Based Care Caregiving Training		X						X			X			X			X

Attachment F Continued

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs.	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
NEW HAMPSHIRE																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X			X		
MC	Elderly and Chronically Ill Waiver	X		X	X	X	X				X		X			X		
NEW JERSEY																		
FC	Family Caregiver Support Program	X		X	X						X			X				X
MC	Community Care Program for the Elderly and Disabled	X		X	X	X	X	Assisted living			X		X			X		
MC	Enhanced Community Options (ECO)	X		X	X	X	X	Assisted living			X		X			X		
SC	New Jersey Statewide Respite Care Program (SRCP)	X		X	X	X	X				X		X			X		
SC	Adult Day Services Program for Persons with Alzheimer's Disease or Related Dementias	X		X						X			X			X		
SC	Jersey Assistance for Community Caregiving	X		X	X	X	X	Assisted living			X		X			X		
NEW MEXICO																		
FC	Family Caregiver Support Program	X		X	X	X					X			X				X
MC	Disabled and Elderly Home and Community-Based Services Waiver	X			X					X			X			X		
NEW YORK																		
FC	Eldercare Family Support Program (EFSP)	X		X	X	X					X			X				X
SC	Respite Program	X		X	X	X	X				X		X			X		
NORTH CAROLINA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Community Alternatives Program for Disabled Adults (CAP/DA)	X		X	X	X	X				X		X			X		
SC	Respite Care Program	X		X	X						X			X				X
NORTH DAKOTA																		
FC	Family Caregiver Support Program	X		X	X	X	X			X			X			X		
MC	Aged & Disabled Waiver	X		X	X	X	X			X			X			X		
SC	Family Home Care	X			X	X	X			X			X			X		
OHIO																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	PASSPORT HCBS Waiver Program	X		X	X						X			X				X
SC	Alzheimer's Respite Program	X		X	X	X	X				X			X				X

Attachment F Continued

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs.	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
OKLAHOMA																		
FC	Family Caregiver Support Program	X		X	X	X					X		X				X	
MC	Advantage Program	X			X	X				NR	NR	NR		X				X
SC	Respite Resource Network	X		X	X	X	X				X		X			X		
OREGON																		
FC	Family Caregiver Support Program	X		X	X	X	X			NR	NR	NR	X				X	
MC	Medicaid Waiver / In-Home Care	X		X	X	X						X		X				X
SC	Lifespan Respite Care Networks	X		X	X	X	X				X			X				X
PENNSYLVANIA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	PA Department of Aging 60+ Medicaid Waiver	X		X	X	X	X				X			X				X
SC	PA Family Caregiver Support Program	X		X	X	X	X			X				X				X
SC	OPTIONS	X		X	X	X	X				X			X				X
SC	BRIDGE	X		X	X	X	X				X			X				X
RHODE ISLAND																		
FC	Partners in CaRing	X		X	X	X					X		X			X		
MC	Home and Community-Based Waiver		X						X			X			X			X
SOUTH CAROLINA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Elderly / Disabled Home and Community-Based Waiver	X		X		X		Companion services			X		X			X		
SOUTH DAKOTA																		
FC	Caregiver Program	X		X	X	X	X	Weekly stay in a facility		X			X			X		
MC	Home and Community-Based Elderly Waiver	X		X								X		X				X
TENNESSEE																		
FC	Family Caregiver Support Program	X		X	X	X	X					X	X				X	
SC	Home and Community-Based Long-Term Care for Non-Medicaid Elderly and Adults with Disabilities		X						X			X			X			X
TEXAS																		
FC	Family Caregiver Support Program	X		X	X	X					X			X				X
MC	Community-Based Alternatives	X			X	X					X		X			X		
SC	Respite Care Program	X		X	X	X				X			X			X		
SC	In-Home and Family Support Program	X		X	X	X				X				X				X

Attachment F Continued

Program		Provide Respite		Types of Respite Care Offered						CG Must Live with CR to Receive Respite			Respite Cap			Respite Cap Uniform across Program Sites		
Type	Name	Yes	No	Adult Day Svcs.	In-home	Overnight	Weekend/ Camp	Other Respite	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
UTAH																		
FC	Caregiver Support Program	X		X	X	X	X				X		X			X		
MC	Medicaid Aging Waiver	X		X	X	X					X			X				X
SC	Home and Community-Based Alternatives	X		X	X	X	X				X		NR	NR	NR			X
VERMONT																		
FC	Family Caregiver Support Program	X		X	X	X	X				X		X				X	
MC	Home-Based Medicaid Waiver	X		X	X	X				NR	NR	NR	X			X		
VIRGINIA																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Elderly and Disabled Waiver	X		X	X	X	X			X			X			X		
SC	Caregiver Grant Program		X						X			X			X			X
SC	Respite Care Initiative Grant	X		X	X			Companion services; Hospice		X			X			X		
SC	Respite Care Grant Program 2003	X		X				Transportation to adult day care			X			X				X
WASHINGTON																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Community Options Program Entry System (COPES)		X						X			X			X			X
SC	WA Family Caregiver Support Program	X		X	X	X	X				X			X				X
SC	Respite Care Services	X		X	X	X	X				X			X				X
WEST VIRGINIA																		
FC	Family Caregiver Support	X		X	X		X				X			X				X
MC	Medicaid Aged and Disabled Waiver		X						X			X			X			X
WISCONSIN																		
FC	Family Caregiver Support Program	X		X	X	X	X			X			X			X		
MC	Community Options Program Waiver (COP-W)	X		X	X	X	X			X				X				X
SC	Alzheimer's Family & Caregiver Support Program	X		X	X	X	X				X			X				X
WYOMING																		
FC	Family Caregiver Support Program	X		X	X	X	X				X			X				X
MC	Home and Community-Based Services Waiver for Elderly and Physically Disabled	X		X	X							X		X				X
SC	Community Based In-Home Services Program (CBIHS)	X		X	X			Chore services; Hospice			X			X				X

NORTH CAROLINA STUDY COMMISSION ON AGING PUBLIC HEARING
Thursday, April 24, 2008
10:00 AM
Jamestown, North Carolina

MINUTES

The North Carolina Study Commission on Aging met Thursday, April 24 2008 in Jamestown, North Carolina for a Public Hearing. The following members were present: Co-Chair Senator Vernon Malone, Senator Stan Bingham, Senator Katie Dorsett, Representative Joe Boylan, Representative Garland Pierce, Public Members Anthony Peace, Karen Gottovi, Jackie Sheppard, Theresa Matula, Shawn Parker, Ben Popkin, and Commission Clerk Bonnie McNeil.

After brief comments, a welcome and instructions on the format of the hearing, Co-Chair Senator Malone called the meeting to order at 10 am. Attachments 1-38 are paper versions of the presentations distributed by those presenters who offered them. The presenters were as follows:

1. Jean Small, Director, Elizabeth and Tab Williams Adult Day Center
2. Eileen McGuiness-Vaillancourt, Program Manager, Triad Office, Western Carolina Chapter of Alzheimer's Association
3. Catherine Sutherland, Regional Long Term Care Ombudsman, Piedmont Triad Council of Governments Area Agency on Aging
4. Laura Hunt, Director of Marketing, Hospice and Palliative Care of Greensboro
5. Lori Lafferty, Adult Services Supervisor, Alamance County DSS
6. Brenda Porter, Program Director, Alamance ElderCare, Inc.
7. Felissa Ferrell, Program Manager for Adult, Prevention and Human Services , Rockingham County Department of Social Services
8. Dick Hatch, Coordinator, AARP North Carolina State Advocacy Team
9. Guilford County Department of Social Services
10. Kathleen Sneed, Caregiver, Charlotte
11. Renee Dutcher, Adult Social Work Services Manager, Mecklenburg County Department of Social Services
12. Doris Sturdivant, Caregiver
13. Isabell Patton, Caregiver
14. Teresa McKeon, Director of Outreach and Coordinator of the Access Dental Program, The Arc of High Point
15. Dale Metz, Executive Director, After Gateway, Inc.
16. Alva Cromartie, Executive Director, Adult Center for Enrichment, Inc.
17. Amanda Hartness, Program Director, Adult Life Programs, Inc.,
18. Nate Huggins, Chairperson, Mecklenburg County Adult Day Care Association
19. Mary Lou Blakeney, Senior Tar Heel Legislature Alternate
20. Guy Pierce, Owner/Operator Heritage Care of Elizabeth City
21. Kim Kethum, Member, Guilford County Community Advisory Committee
22. Phil Cooley, Member, Homewatch CareGivers, Mecklenburg County

23. Robert G. Wallace, Supervisor, Adult Protective Services, Durham County DSS
24. Roxann Sizemore SWS III, Buncombe County DSS
25. Kate Brockett, Council on Aging of Bundcombe County, Inc.
26. North Carolina Association on Aging, Raleigh
27. Mark E. Kirstner, AICP Transportation Director, Guilford County Transportation and Mobility Services
28. E. Venice Preston, Executive Director, Emmanuel Senior Enrichment Center, High Point
29. Cleveland County DSS
30. Calvin Vaughn, Chairperson, North Carolina Alliance of Seniors Centers and Director, Culler Senior Center
31. Susan Morris, Assisted Living Administrator, Rowan County
32. Venice Preston, Executive Director, Emmanuel Senior Enrichment Center, High Point, NC
33. Calvin Vaughn, Director, Roy B. Culler Senior Center , High Point, NC
34. Cleveland County DSS
35. Hank Kennedy, Adult Protective Services Senior Social Work Supervisor, Forsyth County Department of Social Services
36. Debora Sparks, Executive Director, Charlotte-Mecklenburg Council on Aging
37. Kim Dawkins Berry, Director, Piedmont Triad Council of Governments Area Agency on Aging.

Fifty-one speakers offered comments. Nineteen of the fifty-one speakers did not offer written versions of their comments.

There being no further comments the Chair thanked those present, and adjourned the meeting at 12:00 pm.

Respectfully Submitted,

Senator Vernon Malone, Presiding

Bonnie McNeil, Commission Assistant

Agenda

North Carolina Study Commission on Aging

PUBLIC HEARING

Thursday, April 24, 2008
10:00 a.m.-12:00 p.m.
Town Hall
301 E. Main Street
Jamestown, NC

I. Welcome and Introduction of Commission Members

Senator Vernon Malone, Cochair
Representative Jean Farmer-Butterfield, Cochair

II. Greetings from any Elected Officials in Attendance

III. Brief Remarks by Members of the Public to the Commission

Note: Members of the public will have a sign-up sheet if they wish to speak to the Commission. Names on the list will be called by the chair and each individual will have two - three minutes to address the Commission.

Due to the time limit on presentations, please remind speakers to give hard copies of their remarks to the Commission staff so that we have complete information on their issues.

IV. Closing Remarks

Appreciation to Kim Dawkins Berry, Area Agency on Aging Director, for her help in arranging the facility and the hospitality she has shown to all.

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SENIOR SERVICES
Elizabeth and Tab Williams Adult Day Center

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The Study Commission on Aging
Comments from The Elizabeth and Tab Williams Adult Day Center
April 24, 2008
Presenter: Jean Small, Director

My involvement with Project C.A.R.E. began early in the pilot phase. I heard Mrs. Wilhelmenia Pledger speak at a Forsyth Aging Planning Services meeting. She told us about Project C.A.R.E. and the way the money would be used to provide respite for Caregivers. She told us the criteria and it was a fit with our mission to help frail, elderly live at home as long as possible. The Caregivers are providing care 24/7 for persons with Alzheimer's Disease or some type of dementia. Mrs. Pledger did not have an office, so we offered to rent her some office space at the Adult Day Center. As she began to meet with Caregivers, many chose to use the funding for Adult Day services. Some came into our program and others into the Mt. Zion Senior Care program.
This was in February and the funding was to be used by June 30. This put us all into fast track, but, it was worth the extra work to see how the Caregivers gained renewed hope and strength.
The Elizabeth and Tab Williams Adult Day Center has provided Project C.A.R.E. respite to 114 Caregivers since the program began.
The diagnosis of Alzheimer's or a related dementia increases every year. The cost of care is increasing as demand increases, so the need for financial assistance is more critical every year. Families who have day care respite, keep their loved one at home an average of 2 years longer. This results in a tremendous saving to the state Medicaid budget. Project C.A.R.E. scholarships, education, and counseling, changes the lives of Caregivers and those they care for.
Accompaning me today are two Caregivers who received Project C.A.R.E. funds. They want to affirm how the program helped them with counseling and funds, to get much needed respite without placing their loved ones in expensive institutional care.
Please ask that this program continue to be funded.
Thank you for this time and for your interest and evaluation of this very valuable funding.

Ladies and Gentlemen of the Study Commission,

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My name is Eileen McGuinness-Vaillancourt, and I am the Program Manager for the Triad area office of the Western Carolina Chapter of the Alzheimer's Association. I am here today to tell you about the success of a critically acclaimed program called Project C.A.R.E., and what it means to caregivers of individuals diagnosed with dementing illnesses, such as Alzheimer's disease. Project C.A.R.E. is a respite program that pays for itself in Medicare dollars, by delaying or preventing the cost of long-term care.

In my day-to day work for the Alzheimer's Association, I see and hear first-hand, how daunting the caregiving tasks can be to caregivers who are responsible for their loved ones. I receive the telephone calls from broken, crying, desperate individuals who don't know where to turn or who to call. I am the person caregivers scream and holler at when they don't have any other outlet or place to turn to. I am the end of the road, the last hurrah, the person they unload their anguish upon as they have had no satisfaction, and only despair, until now. They want to know who will pay their bills, who will take care of their grandmother, mother, father? Who will keep food on the table now that the breadwinner is sick and can no longer work? They don't mean any harm, they are upset, frightened, and worn out. Caregivers are young, middle-aged, and old. Some are not quite ready for the work-force, and some are well-beyond the ability. Some are working, caring for their own children, and their parents, as well. I am the person who is willing to listen quietly while they let it all out, as I have done on countless occasions. I know all too well what is ailing them for there is no cure and no end in sight. As a matter of fact, I know it is only going to get worse and I will soon be talking to them again. Before it's over, we will develop a relationship that is based forever upon sadness and grief. Many don't have a clue what is coming and this knowledge haunts me through the call.

Some of these phone calls end with a little salvation. When the individual lives in Forsyth, Surry, or Stokes counties, I can refer them to my colleague Wilhelmenia Pledger at the Alzheimer's Association who is a Caregiver Specialist for Project C.A.R.E.. My face lights as I know I will be able to lift the burden a little for the caller because I know that some relief is on the way and it is spelled P–R-O-J-E-C-T C.-A.-R.-E.. Project C.A.R.E. allows overburdened caregivers to get respite so that they do not deteriorate completely in the course of their caregiving responsibilities. Study after study reveals that caregivers are more in danger of dying than the people they care for, as a result of cardiovascular disease and other life threatening illnesses which stem from these tremendous burdens. Project CA.R.E. is an award winning program, and demonstrates a WIN-WIN situation for all and should not only be continued, it should be expanded throughout the entire state of North Carolina.

Families in the other eight counties I provide services to are not as lucky as are the families in Forsyth, Stokes, and Surry counties in the Triad area. I hope that someday soon, they will be. Their needs are no less important than those of the families receiving services through Project C.A.R.E..

I understand the plight of these families so very well because I lived in their shoes for over eleven years with my own father who was diagnosed with early-onset Alzheimer's disease. I remember the desperation and anger, the alienation, the loss of friends. I am a compassionate listener and I hope you will be too. We need your help in a very BIG way. Your brothers and sisters in North Carolina need your support now. Please don't fail them. Alzheimer's disease is preparing to rock our national budget, Medicare, Medicaid, and Social Security and an additional ten million baby boomer families nationwide, at a minimum. We must be proactive at some point and it may as well be today. Thank you for listening to me. It

is my sincere hope that none of you are in the group of 10 million who will be diagnosed in the near future.

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April 24, 2008

The Honorable Vernon Malone
The Honorable Jean Farmer-Butterfield
Co-Chairs, N.C. Study Commission on Aging
N.C. General Assembly
16 West Jones St.
Raleigh, N.C. 27603

Dear Senator Malone, Representative Farmer-Butterfield, and Fellow Members of the NC Study Commission on Aging:

Thank you for the opportunity to address the Study Commission on Aging today. My name is Catharine Sutherland and I'm representing the N.C. Regional Long Term Care Ombudsman Association. I am speaking in support of the proposed star rating system for adult care homes.

I recently bought a new car – the first new car I'd bought in 14 years. Of course, I did a lot of research before I made my final purchase: I went online and looked at photo galleries and price tags. I carefully compared the performance and safety ratings of various makes and models. I studied *Consumer Reports* and talked to family and friends about their experiences with different dealerships and auto manufacturers. I test drove eight different models, some more than once! I spent over a month collecting information from a wide array of sources before ultimately making my selection and driving off the lot.

All of this energy went toward buying a *car* – an investment of less than $25,000 for a piece of property that I will drive for the next five or ten years.

When it comes to making decisions about placing loved ones in adult care homes in North Carolina – an investment of tens of thousands of dollars in a new home for parents, siblings, children, or even themselves – consumers have an appalling lack of information at their fingertips. They are often forced to make placement decisions in a

crisis when they have days, not months, to find an adult care home that not only meets their care needs but satisfies their desire for high-quality care.

Even when consumers take the time to phone a Regional Long Term Care Ombudsman for information about local assisted living facilities and family care homes, Ombudsman do not always have access to the most current facility reports; we are also often out in the field investigating complaints and may not be available to inform a last-minute decision. It would be far preferable to have information available to consumers via the Internet and other direct avenues.

In short, implementing the star rating system for North Carolina's adult care homes will benefit consumers, residents, and administrators of the state's long term care facilities. The star rating system in place for child care centers has resulted in improved care for children; adult care homes could experience an equally impressive boost in quality of resident care as a result of the new star rating system.

The rating system does not require any additional work by adult care homes, it does not change the State's standards for adult care homes, and it will not put adult care homes out of business. What the rating system *will* do is provide public information that will honor consumers' rights to make well-informed decisions about long term care placement for themselves and their loved ones.

This type of information is available for nursing homes and child day care centers in North Carolina – why not adult care homes?

I urge you to support the rules for the star rating system for adult care homes as adopted by the N.C. Medical Care Commission.

Respectfully Submitted,

Catharine Sutherland
Regional Long Term Care Ombudsman
Piedmont Triad Council of Governments Area Agency on Aging
2216 W. Meadowview Rd., Ste. 201, Greensboro, NC 27407

HOSPICE *and* PALLIATIVE CARE
of GREENSBORO

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

April 24, 2008

For more than 28 years Hospice and Palliative Care of Greensboro (HPCG) has offered high quality end of life care in the Greater Greensboro area and Guilford County. We offer support through hospice and palliative care for adults and children from our campus location in Greensboro. Effective medical treatment advances have resulted in a substantial increase in life expectancy. For many of us our aging will most likely bring with it a course of dealing with serious chronic illness that will follow a trajectory of periods of remission and sickness that will eventually lead to our death. The potential for suffering as we "dwindle" is great: physical disability, dependency and social isolation. Most of us will die in hospitals or nursing homes attended by strangers – many without loved ones who can speak for us – voiceless and vulnerable.

Our latest statistics on hospice care through HPCG show our patient population increasing. In 2006-07 patients served increased by 4%, resulting in 1230 patients served. 78% of HPCG patients were 65 and older. 22.3% of HPCG admissions are minority patients. HPCG percentage of minority patients is higher than state or national hospices' % of minority patients. HPCG patient deaths were divided 50-50. 50% of HPCG deaths in 06-07 were with cancer diagnoses, and 50% died from non-cancer diagnoses.

Hospice and Palliative Care of Greensboro urges The Study Commission on Aging to consider providing resources to facilitate a concerted effort – A Task Force for Quality End of Life Care in North Carolina -- to examine end of life care in North Carolina and to provide comprehensive recommendations to address the needs of an aging population.

Issues that are critical and must be considered in the work of the Study Commission on Aging:

- Removal of barriers to referrals for hospice care:
    1. Hospice care in Guilford County and North Carolina is still underutilized (50% of the states in the US use hospice more often than we do).
    2. We must overcome late referrals and the variability of hospice care.
    3. Hospice care must be an expectation of consumers and the health care system just like trauma centers

- Continued emphasis on the promotion of planning for care as we age – Advance Care Planning:

    1. We must hold the gains that we achieved in this area this past legislative year.
    2. We need to emphasize the importance of designating surrogates and then training surrogates about the importance of their job as a surrogate
    3. Examine and improve the NC guardianship laws
    4. Provide support for the Secretary of State's Advance Directive Registry
    5. Encourage ethics-driven decision making for health care providers to this population – consider establishing a network of regional ethics committees that would augment the current ethics work in hospitals and nursing homes
    6. Work to ensure that patients are protected from overuse of unwanted life-sustaining technology just as hard as we must work to ensure that their wishes for care at the end of life are honored.

- HPCG offers palliative care on hospital campuses to in-patients. We also currently offer palliative care in LTC facility settings. HPCG supports increased accessibility of palliative care and pain management in out-patient or clinic-settings for patients struggling with enormous discomfort. (such projects will likely reveal, as they have in other states, cost effectiveness and an increase in quality of care of this group)We ask for your help.

    1. Encourage reimbursement changes that would allow for new continuing care models based on palliative care
    2. Require medical schools to have palliative care curricula to teach pain and symptom management and medical ethics related to aging and end of life care.

The agenda is a challenging one. Thank you for this opportunity to share it.

Submitted by:

Laura H. Hunt
Director of Marketing
Hospice and Palliative Care of Greensboro
2500 Summit Avenue
Greensboro, NC 27405
336.621.2500
lhunt@hospicegso.org

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4-24-08

Ladies and Gentlemen of the Commission,

Every 2.7 minutes, about the same time allowed for each speaker today, an elderly person is abused, neglected or exploited in the United States. Think about your mother or grandfather. Imagine her or him lying on the floor unable to reach the phone for hours. When he or she does not respond to their lifeline call, an emergency crew is dispatched to the home. Upon their arrival they find your relative lying on the floor in filthy conditions. Your mother or grandfather is transported to the hospital and after stabilization is transferred to a rehabilitation facility. Two months later, you then receive a registered letter from the facility that they are going to send your relative home because your sibling has not paid any bills and there is an outstanding bill of over 10,000. This is just one example of mistreatment of older adults. Exploitation cases now out number abuse cases. Mistreatment happens in homes and not just facilities.

Nationally we are on the verge of a tremendous population shift with the growing number of elderly individuals. Between 2000 - 2020 in Alamance County, our 60 year old+ population is projected to increase by 43%; our 85 year old+ population, where most of us typically might expect to begin needing increasing help, is expected to grow by almost 57%.

In Alamance County, over the last 5 years, Adult Protective Services reports have increased by 122% and the number of reports accepted for investigation has more than doubled. With the aging population in our county growing and the number expected to skyrocket in coming years, we anticipate that the percentage of reports will continue to rise. Another consideration is that the complexity of cases has greatly impacted the amount of time required with each case. Our exploitation cases have doubled over the last six months showing a trend with older adults at risk of discharge from facilities with bills in excess of $30,000 - potentially leaving them without care. Due to the complexity of these cases and the investigative skills required often forensic accounting experience is necessary which our staff so not have. While our numbers have risen sharply our staffing and training have remained the same. We have unsuccessfully requested additional staffing for the last 3 years.

It is the vision of the Alamance County Department of Social Services to partner with individuals and families to achieve safety and prosperity. The APS Pilot would provide additional staff and services to help protect our disabled adults of Alamance County thus allowing us to support our most vulnerable citizens and allowing us to do the critical outreach and response in areas that we are presently not able to do so.

Thank you for this opportunity to request your support of the APS pilot program in North Carolina.

Lori Lafferty, Adult Services Supervisor, Alamance County DSS

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NC Study Commission on Aging
April 24, 2008

I would like to talk today about access to services and long term care. Not just the kind of long term care that occurs in facilities like nursing homes...but the long term care that is happening just around the corner, just down the street from where you and I live...in our communities.

- Most people – nearly 79% who need long term care live at home or in community settings, not in institutions. (Agency for Healthcare Research and Quality, 2000 as cited by Family Caregiver Alliance).

- Only 18.2% of long term care expenditures for the elderly are for community-based care. (US Office of Disability, Aging and Long-Term Care Policy, 2000 as cited by Family Caregiver Alliance).

- The estimated value for the informal, non-paid caregiving provided in the community is $ 257 billion nationally. This non-paid assistance is valued at more than twice the costs that are associated with home health care and nursing home care which are $ 124 billion. (Family Caregiver Alliance). Most of this non-paid assistance for those who need long term care in the community is provided by family, friends and neighbors.

- 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 that will help these caregivers and their older loved ones. 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 such 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 – from the very "well" to the very "frail" senior. These access services are provided to people having a wide range of needs and resources who 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.

- These services as well as additional family caregiver services and supports need to be available in sufficient numbers to meet both the current and rapidly growing need for them. Having sufficient numbers of Care Managers on staff is vital to providing these important access and caregiver services. These services are individual in nature and are designed to help meet the challenges that virtually all of us will encounter as we age. These services 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

(9)

April 24, 2008
Public Hearing on Aging-Jamestown, NC

Dear Senator Malone and Representative Farmer-Butterfield:

I am here today to discuss with you the growing need in our community concerning the vulnerable and elderly adults. There are three specific areas of concern that I would like to share with you today:

1. The need to strengthen and enhance the Adult Protective Services in North Carolina through changes in the NC 108A statute and support for the APS Clearinghouse Pilot.
2. Having a public funding source to support consumers who are adjudicated incompetent and become wards to the state.
3. Support for the 5 Star Rating System for Adult Care Homes.

Since March 2007 through March 2008, the Adult Protective Services unit at Rockingham County Dept. of Social Services has had a 53% increase in reports concerning abuse, neglect and exploitation of vulnerable and elderly adults. With this increase, APS social workers are substantiating more cases which require service interventions to stop the abuse, neglect and/or exploitation. Currently, it is not uncommon for an APS social worker to handle 14-16 investigations in a month plus continue to have 10-12 treatment cases open for services to assist this population. One of the more recent cases involved our agency substantiating financial exploitation on 3 disabled adults by a paid caregiver of a home health agency. This case has required more than 150 man hours and we still continue to work with these adults because the perpetrator has attempted to interfere with our services. You can only imagine how time-limited these social workers have to spend on these cases due to the increase in the volume of calls. Furthermore, due to the increase in calls, it becomes more difficult to meet the statutory time requirements when responding to a report. The changes recommended by the North Carolina Social Services Consortium which supports the APS Clearinghouse Pilot, would allow our agencies to begin implementing more prevention based programs and have a true "system of protection" to support this growing population by providing needed funding and changes in statute and rule.

We also support the North Carolina Social Services Consortium and the House Study Committee on State Guardianship Laws committee concerning needed funding for a public guardianship model. Our agency is also beginning to see an increase in guardianship appointments from our Clerk of Court because many times, there are no family members or appropriate persons to appoint when an incapacitated adult is found to be incompetent. As our agency tries to engage best practices in person centered choices and having the adult remain in their home or community, we lack the appropriate social worker resources and funding mechanisms to provide the needed supports for these worthwhile persons.

Finally, I am pleased to see a star rating system for Adult Care Homes in NC. But please do not pass this bill without the needed funding to support this endeavor. Keep in mind

that it is likely the local departments of social services who will be responsible for the additional monitoring and reporting to the Division of Health Services Regulation and another unfunded mandate will only continue to stress our already limited resources. Most Departments are already stretched with trying to meet the mandates set forth by the Division in monitoring, reporting and responding to complaint investigations. Furthermore, I respectfully remind the co-chairs to please carefully look at the practices of placing the mentally ill consumers with the frail, elderly adults in our adult care homes in NC. In our county this year alone, we have had two serious, criminally-founded incidents where frail elderly persons were seriously harmed due to combative or aggressive behaviors from persons who had a mental health disorder or developmental disability. Staff in these facilities had received little or no specialized training in caring for consumers with mental health, substance abuse or developmental disabilities. It is imperative that rules are developed and implemented quickly to address these concerns so there is support for both the elderly and consumers who have mental illness or developmental disabilities.

Please keep in mind that the Adult Services programs at the local Department of Social Services have not had any type of increased funding in over 20 years. Though some policy changes have occurred, no funding mechanisms were identified to support these changes. It is necessary now to begin to implement policy changes and funding mechanisms to support the needed supports and services for the vulnerable and elderly, particularly since this population is expected to grow considerably in the near future. Let's be proactive to the needs of our citizens now, instead of reactive when negative incidents occur and people are hurt.

Thank you for your time and consideration,

Felissa Ferrell

Felissa Ferrell, MSW, LCSW, CSW-G
Program Manager for Adult, Prevention and Human Services
Rockingham County Department of Social Services
Wentworth, NC 27375
(336) 342-1394 ext. 3126

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April 24, 2008

The Honorable Vernon Malone
The Honorable Jean Farmer-Butterfield
Co-Chairs, N.C. Study Commission on Aging
N.C. General Assembly
16 West Jones Street
Raleigh, N.C. 27603

Dear Senator Malone and Representative Farmer-Butterfield:

We, the undersigned groups, appreciate the opportunity to provide comments to the Study Commission on Aging today in support of the proposed star rating system for adult care homes.

First of all, we want to publicly thank the Study Commission on Aging for the leadership it took in supporting a rating system for adult care homes. The Commission heard from consumers and advocates about the need for the citizens of our state to have information about the quality of care provided by adult care homes so they can make informed decisions about placement in homes. You responded to this need by recommending legislation in the 2007 legislative session to give the N.C. Medical Care Commission the authority to adopt rules for the issuance of rated certificates for homes. We celebrate along with you the fact that this legislation passed last year.

As you may be aware, the Medical Care Commission adopted rules earlier this year for a star rating system for adult care homes. These rules were later adopted by the N.C. Rules Review Commission; however, at least ten letters objecting to the rules were submitted to the Commission which sends the issue back to the General Assembly for consideration in the Short Session. We come before you today as a unified voice of support for the implementation of the star rating system for adult care homes as recommended per the rules adopted by the Medical Care Commission and the Rules Review Commission. We ask the Study Commission to stand firm in its commitment to the star rating system and to use its influence to ensure that no action is taken to modify the implementation of the star rating system as proposed.

It is our understanding that some of you have heard arguments against a rating system. We provide the following key facts about the proposed rating system:

- Adult care homes' ratings are to be based on meeting minimum State licensure standards (what homes should be doing). This is determined by regular inspections of homes conducted by the State. Areas addressed in the standards include: admission and discharge procedures; medication management; physical plant; resident care and services, including food service, resident activities programs, and safety measures;

resident rights; sanitation grade; special care units; and use of physical restraints and alternatives.

- The rating system does not require any additional work by the adult care home nor does it place any additional regulation on the home. A home's rating is based on their regular inspection which is already required by law.

- The rating system does not change the State's standards for adult care homes.

- A rating system will not put homes out of business; however, if a home is not meeting minimum State standards, its rating will reflect that. If consumers have choices about placement options, a home's rating may be a factor in the decision of which home a consumer chooses.

- North Carolina has had a rating system in place for child care centers for many years. This has resulted in a better quality of child care throughout the entire state. We believe a rating system for adult care homes will likewise elevate the care provided by homes across the state.

- In the rating system proposed, every adult care home starts with 100 points for meeting minimum standards. Points are deducted for citations of noncompliance with statutes and rules, including citations of Type A and Type B violations. Points are added for correcting citations and violations as well as for participating in quality improvement programs, having a generator, and having an automatic sprinkler system.

  A **Type A violation** 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. Examples of Type A violations are: (1) A confused resident who is not properly supervised wanders away from a home and as a result suffers serious harm or death. (2) The wrong medication is given to a resident and he/she suffers strong adverse affects.

  A **Type B violation** is an identified condition which impacts the quality of care of the residents in an adult care home. Examples of Type B violations are: (1) Criminal background checks are not done on staff. (2) Residents do not receive medication as ordered. (3) Personal care staff are not tested for tuberculosis. (4) Staff do not have CPR training. (5) Staff can not effectively execute procedures in response to a fire drill.

- Consumers need the rating system to help them make more informed decisions about placement in a home either for themselves or a relative. Consumers do not have public information readily available about the quality of adult care homes as is already available about nursing homes, home health agencies, and hospitals which is provided by the federal government. Consumers often have to made quick decisions about placement in adult care homes and without some basis for evaluating homes, they do not have a starting point for making an informed decision.

Again, we appreciate this opportunity to address the Commission today, and we thank the Commission for your leadership in ensuring our State has a rating system in place for adult care homes.

Sincerely,

Bob Jackson, State Director
AARP North Carolina

Bob Konrad, Chair of Public Policy Committee
Friends of Residents in Long-Term Care

Jill Passmore, Legislative Advocacy Chair
NC Regional Long-Term Care Ombudsman Association

Gayla Woody, Chair
NC Association of Area Agencies on Aging

Rick Eldridge, President
NC Association on Aging

Margaret Kirkman, President
NC Adult Foster Care Association

Teresa Johnson, Executive Director
NC Adult Day Services Association

Kathy Boyd, Director
NASW – NC Chapter

John Tote, Executive Director
Mental Health Association in NC, Inc.

Abby Carter Emanuelson, Director of Public Policy
National Multiple Sclerosis Society, NC Chapter

Bill Clark, Commander
AMVETS

Shana Becker, Staff Attorney
NC Public Interest Research Group

Al Ripley, Consumer Action Network Director
NC Justice Center

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Inspection Results of Adult Care Facilities, by type of facility 07/01/07-12/31/07			
Deficiency Status	Both Types	FCH	ACH+7
Some Deficiencies	31%	30%	29%
Type B	25%	13%	37%
Type A	2%	1%	4%
Total	100%	100%	100%

Source:Percentages based on numbers provided by NC-DHSR .

BASED ON 479 ANNUAL SURVEYS

(11)

STATEMENT BY RICHARD C. HATCH AT PUBLIC HEARING OF NC STUDY COMMINSSION ON AGING JAMESTOWN, NC APRIL 24, 2008

Thank you Madam/Mr. Chairman and members of the Commission. I am Dick Hatch, Coordinator of AARP North Carolina's State Advocacy Team. I am also an Alternate Delegate to the North Carolina Senior Tar Heel Legislature and a Delegate to the North Carolina Coalition on Aging.

Shortly before Christmas 2006 I was in Durham Regional Hospital with a 99-year old lady, a world legend in ladies golf, who had fallen and broken her arm. For several years I had been paying her bills and balancing her checkbook, since she was legally blind. A doctor attending her announced, "She will have to go to a home". I was told we had 20 minutes to select one. When I asked for help in finding one, a hospital social worker handed me a list with about 50 names and addresses on it. When I asked for guidance in finding which ones on the list were good and which ones were not so good, the social worker said "I'm not permitted to give that information".

I was pleased when the Study Commission on Aging recommended, and the 2007 General Assembly passed Senate Bill 56 authorizing the establishment of a rating system for Adult Care Homes in our state. The Medical Care Commission has adopted rules establishing a star rating system. At last, consumers will have simple, clear guidance in selecting an Adult Care Home for their loved ones. Such a rating system would have been very valuable to me when I had to make a decision quickly about the placement of my friend in 2006.

The star rating system doesn't impose any additional burden on Adult Care Homes. A home's star rating is based only on the results of state inspections, which are already required by law, nor does it change the state's standards in inspecting Adult Care Homes.

Consumers need the rating system. I ask the General Assembly to avoid doing anything in the forthcoming short session to change the star rating rules adopted by the Medical Care Commission and approved by the Rules Review Commission.

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GUILFORD COUNTY
DEPARTMENT OF SOCIAL SERVICES

April 24, 2008

The Honorable Vernon Malone
The Honorable Jean Farmer-Butterfield
Co-Chairs, N.C. Study Commission on Aging
16 West Jones Street
Raleigh, NC 27603

Dear Senator Malone and Representative Farmer-Butterfield:

Guilford County Department of Social Services (DSS) – Aging and Adult Services Division (AASD) would like to thank the N.C. Study Commission on Aging for providing us with the opportunity to publicly present recommendations about issues involving older adults in North Carolina.

The life expectancy of older adults in North Carolina and within this nation is increasing and it is up to government agencies such as us to adapt to the changing needs and interests of our aging and disabled citizens. North Carolina has become one of the fastest "graying" states in the nation and with the increase in the number of baby boomers; the Guilford County Department of Social Services - AASD is working toward enhancement of our services for aging and disabled adults in North Carolina.

Therefore, we come before you today for support of the following recommendations:

RECOMMENDATION 1: Adult Protective Services (APS) Clearinghouse Model

Guilford County DSS – AASD recommends that the Study Commission on Aging supports the initiation of the APS Clearinghouse Model. APS Law has had no substantive changes in the past 30 years and there is a need for it to be updated. According to the National Elder Abuse Incidence Study (1998), it is estimated that for every one case of elder abuse, neglect, exploitation, or self neglect reported to the authorities about five more go unreported. Thus, support of the initiation of the APS Clearinghouse Model will allow the provision of APS services in those cases where abuse, neglect, and exploitation may be prevented among aging and disabled adults.

RECOMMENDATION 2: Star Rating System for Adult Care Homes

Guilford County DSS-AASD recommends the implementation of the star rating system for Adult Care Homes. Aging and disabled adults and their families do not have public

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information readily available about the quality of care provided in Adult Care Home's in Guilford County. The rating system will allow aging and disabled adults and their families to make informed decisions about placement at an Adult Care Home. We believe a star rating system for Adult Care Home's will elevate the quality of care provided by Adult Care Home's across the state of North Carolina.

RECOMMENDATION 3: Additional Funds for Home and Community Care Block Grant (HCCBG)

Guilford County DSS-AASD recommends additional funding for the HCCBG. Currently, the Guilford County DSS-AASD has a waiting list for In Home Aide Services of over 100 people and we continue to receive daily requests for services. As the aging and disabled population in North Carolina continues to increase, so will our need for more community based services that allow aging and disabled adults to remain in their home environment. Funding of community based services through the HCCBG will save state funds allocated for Adult Care Home and Skilled Nursing Home placements.

RECOMMENDATION 4: Certified Nursing Assistants

Guilford County DSS-AASD recommends an increase in the funding for the recruitment, training, and retention of certified nursing assistants. There is a significant shortage of certified nursing assistants in the home health care field and the adult care home field. If funding is increased, then certified nursing assistants will be able to provide quality services for aging and disabled adults in North Carolina.

RECOMMENDATION 5: Additional Funds for Social Services Block Grant (SSBG)

Guilford County DSS-AASD recommends additional funding for the SSBG. Due to the mental health reform in North Carolina, aging and disabled adults – particularly those with mental illness are requiring greater access to services that will assist them with management of their daily affairs. Over the last year, we (Guilford County DSS-AASD) have experienced an increase in the provision of guardianship services for aging and disabled adults with mental illness who have been determined by the Clerk of Court to be incompetent and unable to manage their daily affairs. Additional funds will create guardianship positions and increase access to services that will ensure the health, safety, and welfare of our aging and disabled adult in Guilford County.

Again, we thank you for this opportunity to address the N.C. Study Commission on Aging today, and we appreciate your leadership and commitment to the aging and disabled citizens of North Carolina.

GUILFORD COUNTY
DEPARTMENT OF SOCIAL SERVICES

Respectfully Submitted,

Robert Williams
Guilford County DSS Director

Jenise Davis
Aging and Adult Services Director

Rick Hall
Adult Protective Services Supervisor

Cheryl Millmore
In Home Aide Supervisor

NeSonya Parker
Adult Foster Care Supervisor

Bill Horne
Adult Medicaid Supervisor

Cheri Neal
Services Intake Supervisor

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(14)

Project C.A.R.E. 2008

Project C.A.R.E. and Respite are so very important to me and all the other Caregivers who are currently caring for love ones. My name is Kathleen Sneed, and I am the Caregiver to my father, Ray Morrison, age 77 who is an Alzheimer's patient. He was diagnosed in August of 2004 and along with him, I was jointly caring for my mother who was diagnosed again with cancer in 2000. My parents lived in China Grove, NC which is approximately 30 miles north of Charlotte where I currently live. However, in March of 2006, my mother died from complications of cancer and I became the primary Caregiver to my father who came to live with my husband and I in May of 2006.

I was diagnosed in January 2005 with Polymyositis which affects the muscles in my entire body and have been on Medical Leave since February 2005 and still under Doctor's care and taking infusions every eight weeks.

It is very demanding caring for my father as he also has severe glaucoma that affects his eye sight. I along with my wonderful husband, have to do everything for him from running his bath water, assisting with his getting dressed, his dental hygiene, all doctor/dentist appointments, medications, shaving and handling his financial needs. I must admit, that all of this along with dealing with my own physical illness is also very stressful.

The lives of my husband and I have been changed dramatically. We can no longer make spontaneous decisions to go out to eat or take in a movie. Every decision we now make must include my father and his care. We have limited time to spend alone with each other as he works during the day and by the time he comes home, we have dinner and I usually spend the next couple of hours with daddy preparing him for bed

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and for the next day.

I can only say that the need for Project C.A.R.E. and Respite is real and desperately needed for the mental and physical health of the Caregivers and the well being of the Care Recipient. During the last couple of years, the Department of Social Services has sponsored workshops for Caregivers and special events to let Caregivers know just how important and special we are, which I've had the opportunity to attend. Project C.A.R.E. has been a life saver for me and a life simulator for my Dad. Daddy currently attends the University Adult Daycare, which allows me the time for my own doctor appointments plus other responsibilities and gives him the opportunity to spend time with other people in his age group and participate in various activities. He looks forward to going and enjoys the independence it gives him as he travels there by special transportation. **Without** the **funding of Project C.A.R.E**, none of this would be possible. **With Project C.A.R.E.**, more families are able to keep their ailing/aging parents at home rather than having to place them in Nursing Home/Assisted Living facilities. This gives our love ones a better quality of life and let's us know that we, the Caregiver is appreciated.

Thank you!

(15)

Comments for the Study Commission on Aging, April 24, 2008

I am Renee Dutcher, 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 the continued need 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 7 years. We receive calls from caregivers every day asking for help. In any given month we have nearly 200 calls asking for some sort of support. Many of these caregivers are asking for help in caring for their loved one with Alzheimer's disease/Dementia.

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 gives caregivers that break. They have a few hours a day for a couple of months to be able to tend to their own personal needs with the assurance of knowing that their loved one is being taken care of. These services often take the form of having an IHA come to the home or the person attending a local Adult Day Care center.

We hear regularly from caregivers who say without these services, they wouldn't have the strength or emotional energy to continue providing care. We must take care of those who care for others, so they may continue.

As the population ages and the rise in diagnosed Alzheimer's/Dementia occurs, Project CARE services needs to continue to be an option. If 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.

(16)

Study Commission on Aging, April 24, 2008

My name is Doris Sturdivant. I am Caregiver for my father, Solomon Sturdivant who is 97. In 1994 the doctor said he had dementia. He has Alzheimer's and he has gone back to the time when he was a sharecropper working on the farm.

My mother died on June 10, 1999 and that was devastating to him. I began to watch him closely because of all the changes that were going on that I did not understand. He often talks about the mules that he had to take care of and that is so real to him.

I went back to work and placed my father in an Adult Day Care. I am thankful for Project CARE that helped me to pay for that for a while. It helped me and I know it helped many others.

I had to take early retirement (10 years early) because it became difficult for me to work and take care of my father. The stress and pressure of trying to get to work on time were very difficult. I often had to leave work to respond to my father's needs at the center- insisting that I take him home.

I recognize that sometimes even your looks change when you are a caregiver. I've been cussed out and then have a frown on my face and don't even know it. It's difficult to have appointments to get my hair done and then my father won't leave the house and the appointments have to be canceled.

I am glad for the Project CARE program which has given me excellent results.
It needs to be continued to help the many caregivers who are struggling like I did.

Thank you for the opportunity to share my story.

"Caregivers in Need" 4-22-08

(17)

Project Care

HelP!!!

My name is Isabell Patton, I am the caregiver for both of my Parents. Willie Parker and Louise Parker. My father is a wonderer... (which means he like to go). My Mother is more calm, she likes to sit and watch, escially outside. I'm grateful for the progran because it gives me a change to rest, and do things that I need to do. I myself have lupus. I'm also a caregiver to a four year old. The program provides care for my porents twice a week, becaus it to of them, and it's only good for three months. When it's time for my Parents to get help again. I will take my Mother out so my father can go more. When he goes he thinks he's been to work. When he don't go he tries to leave walking to catch a bus or ask someone for a ride. So Please help me and my parents, and others

Isabell

My Name is Teresa McKeon; I am the Director of Outreach and Coordinator of the Access Dental program with The Arc of High Point. We support people with a developmental disability, some who currently reside in group homes thanks to deinstitutionalization. Once monthly, Access Dental Mobile Clinic arrives at The Arc to provide dental services for people who cannot find a dental provider, either because the provider will not accept Medicaid, or is not comfortable or equipped to see an individual with a developmental disability.

Last year, at our site alone, Access Dental provided care for 165 people who were not able to be seen by a traditional dental practice. 23 were new patients. In the first quarter of 2008, (which encompasses only 3 mobile clinic dates) we have already seen 9 new patients, an increase over last year's first quarter. Frequently people are scheduled months out for an appointment. Can you imagine any of us with dental insurance expecting to wait 5 months to have a filling, or a toothache, or an extraction?

As we all enjoy the benefits of a longer life, so do people with developmental disabilities. They experience the same aging issues we all do-loved ones and caregivers pass away, incidents of dementia increase. More of the people we support will be transitioning into intermediate care or skilled nursing care facilities, presenting a greater population with more complex needs.

Thank you for your attention to the provision of dental care for the people with developmental disabilities whom we support, and thanks to Access Dental for providing an invaluable service for some of most vulnerable members of our community.

(20)

We Are ALL Aging

In is now 2008 in the USA. There are 641,000 people age 60 or older with developmental disabilities in this country.

It will be 2030, just 22 years from now. In 2030 there will be 1,242,794 people age 60 or older with developmental disabilities in the USA.

We are ALL aging.
Individuals with traumatic brain injury are aging.
Individuals with cerebral palsy are aging.
Individuals with autism are aging.
Individuals with Down Syndrome are aging.
Individuals with epilepsy are aging.
Individuals with severe and profound mental retardation are aging.

We are ALL aging and now is the time to recognize the situation is real.
And now, not 2030, is the time to begin to develop strategies, as a community, and as a state and nation so that we will be prepared for 2030.

Let's look at just one developmental disabilities in particular, Down Syndrome. Although there has been a decrease in Down Syndrome births, it remains the most prevalent cause of mental retardation in the human race.

In the 1920s a child with Down syndrome could expect a life span of 9-12 year of age. When I was a child in the 1950s if a person with Down syndrome lived to be 30 it was cause for great celebration. By the early 1990s the longevity of such a person was 65. In 2008 it is 72 years of age. Just short of a normal lifespan for an American male.

The sadness in this amazing longevity for a person with Down syndrome is that we have recently discovered that 50%, one-half of those people who live to be 55 or older will develop Alzheimer's Disease or some form of dementia. 25% of that group will develop dementia as early as 35 years of age.

Do you see my concerns?
Do you see why we must begin a dialogue in earnest?
I have worked with individuals with developmental disabilities for 40 years. And after speding all these years with them in the public schools and not to have viable alternative programs for them as they age is not recozignizing their worth as human beings in the USA.

I do not mean to paint such a grim picture, but we must, as a caring community opening face and talk about this impending crisis.

(1)Existing elder day care programs recognize the need for developmentally disabled people to be part of their client population.

(2)More hard research being done to study how people with DD age differently and how they age the same. Cerebral Palsy Differences: eating and swallowing; gastrointestinal reflux; osteoporosis and fractures; urologic concerns....in some areas we will share some of these problems with the individual with CP, but in many cases the DD person will have unique needs as well.
Down syndrome: heart ailments; upper respiratory problems
We will have more answers are geriatric studies begin to include the DD population.

(3)Third and perhaps most exciting: NC Care Links and ADRC's

Aging and Disabilities Resource Connections-explain

New and exciting project to provide families with a member with DD a number of resources at their fingertips.

We know what needs to be done. Now we need your help as well as each of our communities to develop the resources needed to met the challenges.

Now lets get busy and DO THE RIGHT THING

Dale J. Metz
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After Gateway Inc/
An adult day health program
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501 South Mendenhall St.
Greensboro, NC 27403

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Study Commission on Aging
Public Hearing
Jamestown, NC
April 24, 2008

Alva "Chip" Cromartie

Executive Director, Adult Center for Enrichment, Inc.
President-Elect, North Carolina Adult Day Services Association
Chair, Guilford County Adult Care Home Advisory Board

Contact Information:
6410 Woodmont Road
Jamestown, NC 27282
(336) 601-0464 or chip@acecare.org

- I would like to thank the members of Study Commission on Aging for the opportunity to speak today and I'd also like to thank the members for their past support of adult day services in NC.
- Continued support is needed for adult day service providers in NC. Almost half of the Counties in NC do not have an adult day center due in large part to the fact that reimbursement rates fall far short of the true cost to provide the actual service. Adult day centers lose anywhere from $13 to more than $20 per day per participant by serving publicly funded clients. HCCBG adult day care funds for example pay $33.00 per day while HCCBG adult day health funds provide $40.00 per day. Adult day centers in NC are open on average 10 hours per day with costs well above $53.00 per day.
- The demand for adult day centers continues to increase while centers are closing across the state. There are 101 adult day centers open in NC today, which are less than there were even in 2007.
- Based on the Weiler Demand Model which was used in a 2001-2002 national adult day services gap analysis study conducted by Partners In Caregiving out of the Wake Forest School of Medicine there will be a projected need for more than 250 new adult day centers in NC by 2010. In 2030 the projected need jumps to more than 550 new adult day centers needed in NC.
- Therefore the North Carolina Adult Day Services Association (NCADSA) asks the Study Commission on Aging to support an appropriation of funds to reimburse adult day services an additional $5.00 per day.
- The NCADSA also asks the Study Commission to support an appropriation for an additional $7 million for Home and Community Care Block Grant Funding. This would help reduce the waiting lists, get people basic supports that they need and provide these supports in the way they want – at home, in the community.
- Also, as Chair of the Guilford County Adult Care Home Advisory Board I support the current rules for the Star Rating System as adopted by the Medical Care Commission. The Star Rating System will provide consumers with needed information about how well adult care homes are providing quality care so that they can make informed decisions about placement in these homes.
- In closing I would like to again thank the Study Commission on Aging for their continued support of older adults in our community.

April 24, 2008

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I am here today not just because I work for an Adult Day Care Program. I am here because Adult Day Care is my passion and I want to see programs thrive across the state of North Carolina.

Improvements can be made in the delivery of services to older adults by simply by putting monies into adult day care programs in North Carolina. There are many reasons why adult day care is a viable option for older adults.

1. A home and community based service such as Adult Day Care allows older adults to remain with their families in their communities for as long as possible. At risk older adults in need of socialization and/or supervision during the day can utilize adult day care while their family members work, run errands or just spend some time for themselves. Adult Day Care Programs also offer support, respite and education to caregivers who often have a burdensome task.
2. Adult Day Care offers a safe environment while allowing older adults to maintain their independence for as long as possible. Coming to adult day care gives individuals meaning by giving them a purpose to get out of bed every morning.
3. Adult Day Care is much more financially viable than institutional placement. Nursing homes can easily exceed $3,000/month; whereas the average cost for a day of care at an adult day care program is around $60.00/day.
4. Coming to adult day care offers socialization to those who may otherwise be socially isolated. Adult Day Care offers the opportunity to develop friendships and activities for individuals to get involved in.
5. Adult Day Care offers nutritious meals and snacks. Often times, if left alone and not supervised older adults do not get their adequate daily nutrition intake.
6. Adult Day Care offers a pro-active approach to ensure older adults well-being. Medications are administered by trained staff. Older adults if left at home alone may skip their medications or take to much or too little. Vital signs are tracked monthly by trained staff, and caregivers are made aware of any changes in their loved one.

These are only a few reasons why Adult Day Care Programs are a viable option for older adults in North Carolina. Monies are needed in Adult Day Care where there are often low-income, at risk individuals needing this valuable service. Most Adult Day Care Programs are non-profit and in my own program, Adult Life Programs, we never turn anyone away because of their inability to pay for the service. I speak for myself and I'm sure other Adult Day Care providers across the state, we are not in this to make money, we have a genuine interest in the well-being of older adults in North Carolina.

Respectfully submitted,

Amanda Hartness, BA, QP
Program Director
Adult Life Programs, Inc.
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alpamanda@charterinernet.com

4/24/08

(25)

Nate Huggins, Blessedadultcare@juno.com
Chairperson, Mecklenburg County Adult Day Care Association
704-576-4754

Concern: 1. Daily cost of Adult Day Care is $61 → NC only reimburses $40/day through the Home Care and Community Block Grant.

Solution: 1. Request you support a $5/day increase in the NC Adult Day Care reimbursement through the Home Care and Community Block Grant program

Concern: 2. Medicaid through the Community Alternative Program Reimbursement is $41.51/day.

Solution: 2. Request you support at $5/day increase in The Adult Day Care Reimbursement.

Concern: 3. NC Caregiver Support program is providing life sustaining services to thousands of older adults and their Caregivers; literally saving lives. It is a temporary program that is appropriated annually.

Solution: Please pass Legislation to continue this program indefinitely.

Senior Tar Heel Legislature

Fact Sheet

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

The Senior Tar Heel Legislature was created to:

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

There is one delegate to the Senior Tar Heel Legislature from each of the 100 counties in the state. Most counties also have an alternate delegate. Delegates and alternates must be age 60 or older. The North Carolina Division of Aging and Adult Services provides staff support for the Senior Tar Heel Legislature in cooperation with the 17 Area Agencies on Aging who are responsible for conducting the selection of delegates and alternates.

Current officers of the Senior Tar Heel Legislature are:

1. Charles Dickens, Speaker (Buncombe)
2. Edwin Deaver, Speaker Pro Tempore (Cumberland)
3. Betty Hunt, Deputy Speaker Pro Tempore (Randolph)
4. Clara Fountain, Secretary (Surry)

2008 Legislative Priorities

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. There are over 11,000 people on the waiting list for Home and Community Care Block Grant services.

Increase funding for senior centers by $634,684 for a total of $2 million per year. There are 163 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 $1,365,316. With limited funding, many senior centers are short-staffed and unable to grow their services, activities, space and operating hours, at the time expectations for senior centers have grown (e.g., participation in Medicare Part D education and counseling).

Appropriate an additional $15,000 in Recurring Funds for the operation of the Senior Tar Heel Legislature. The Senior Tar Heel Legislature currently receives $3,000 per year to cover the expenses of the Senior Tar Heel Legislature. However, the costs of the meeting space, breaks, mailings, and a meal are approximately $6,000 per meeting or $18,000 per year. The Senior Tar Heel Legislature requests an additional $15,000 be appropriated from the General Fund to the Division of Aging and Adult Services to cover the costs of the Senior Tar Heel Legislature's three scheduled meetings per year.

Provide Dental Care for Older Adults with Special Needs and in Rural Areas. The Senior Tar Heel Legislature recommends that $1.35 million be allocated to the Office of Rural Health and Community Care to recruit dentists for underserved areas in North Carolina including dentists that would focus on providing care in long-term care facilities. The Division of Public Health and the

Office of Rural Health and Community Care would use the model of existing mobile dental clinics to provide access to care for residents residing in long-term care facilities, as well as seniors and the disabled living at home.

Provide funding to sustain Project C.A.R.E. (Caregiver Alternatives to Running on Empty). The Senior Tar Heel Legislature recommends that $500,000 in recurring funds be appropriated from the General Fund to the Division of Aging and Adult Services to sustain Project C.A.R.E., which currently serves 14 counties, and to expand it into other counties.

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COUNTY OF DURHAM
DEPARTMENT OF SOCIAL SERVICES

DSS Board
Attorney Pamela Stanback-Glean, Chair
Mr. Thomas Niemann, Vice Chair
Dr. Iris Carlton-LaNey
Commissioner Michael D. Page
Mrs. Gladys Dunston

DSS Director
Sammy R. Haithcock

To members of the NC Study Commission on Aging, thank you for the opportunity to speak before you today. I have been in the field of Adult Protective Services since 1989, and am currently the supervisor of Adult Protective Services in Durham County. Over the years I have seen first hand how the mistreatment of North Carolina's seniors has both impacted the senior's themselves, and the families that care for them. Unfortunately, sometimes it is the very family members that claim to care for seniors that are committing the mistreatment. In the past nearly twenty years, I have been witness to terrible physical abuse and neglect, and financial exploitation totaling hundreds of thousands of dollars. These acts are not always committed by family members, but perhaps, except for some cases of asset exploitation, are often perpetrated by people that seniors have come to trust. In the case of exploitation of a senior's assets, I have seen a rising escalation of mistreatment in the arena of scams. Even these circumstances are acts perpetrated by individuals that attempt to ingratiate themselves with seniors, and pray on their vulnerability and genuine sense of trust.

N.C. G.S 108A needs to be strengthened so that it gives counties departments of social services sufficient tools to provide protection to seniors that have been abused, neglected, or exploited. The primary weakness in the law, however, is that it does an inadequate job of providing protection to those many seniors that are vulnerable to mistreatment and "at risk" for being abused, neglected, or exploited. In other words, waiting until a senior has been mistreated is a woefully inadequate response, and one that the citizens of North Carolina can ill afford. We do not have to wait until our children have been abused to act. We should give our North Carolina senior citizens the same respect for their vulnerability.

The Adult Protective Services Clearinghouse model can provide better tools for engaging with N.C. seniors who not only have been mistreated but those who are also at risk for mistreatment. I urge you to recommend to the General Assembly funding for an Adult Protective Services Clearinghouse pilot. Thank you.

Robert G. Wallace, Supervisor
Adult Protective Services
Durham County DSS
919/560-8622

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Bethamy Center
909 N. Salisbury Avenue
Spencer, NC 28159
704-633-1985

April 24, 2008

Good Morning Madam Chairman and Committee Members:

My name is Susan Morris and I have been an Assisted Living Administrator in Rowan County for 34 years. My facility is licensed for 43 beds and I work in that facility 5 and 6 days each week. I work as the administrator, transportation person, cook, medical technician, activity director and personal care aide on 1st, 2nd and sometimes 3rd shifts. There are some weeks that I put in as many as 60 hours. If there is money at the end of the month I get paid, if there is not, I don't.

I have always made it my responsibility to take care of the personal needs of each of my residents because I personally feel that the State of North Carolina has pushed them aside and does not care about them or their needs. I have paid for their medications and medical equipment, medical bills, provided clothing and shoes, transportation, beyond what is required, hair care, eyeglasses and even paid for their funerals.

I have done all of this while keeping up a first class facility that recieved a State Inspection and a Veteran Administration Inspection last year that was demerit free. It is my absolute fear that this will be the last demerit free year for my facility. My Medicaid occupany is 80% and I recieve about $59.00 a day to provide housing and 24 hours of care from the state. I have used the depreciation of my facility and the money from my private pay residents in the past to keep services up to standard in our facility. I can no longer shoulder the responsibility for NC Medicaid residents that should belong to the State of North Carolina.

Food cost is up 17%, gas is $3.49 per gallon, and we transported clients to medical appointments 115 times in March. Utilities are up

17%, our health insurance is up 23% and the federal government as well as the state is telling me I must increase my wages by .80 cents an hour in July, 2008. The wage increase alone will cost another $2021.98 per month.

I feel that the State of North Carolina has neglected Medicaid eligible clients living in Assisted Living Centers long enough. Will it take the bankruptcy of my facility and others to get the message across? Is that what the General Assembly is waiting to hear before they respond to this Crisis? I pray this is not so.

I appeal to each of you to take these factors into consideration and support my residnents with a rate increase in Special Assistance and Medicaid PCS. Please give them the opportunity to have the best quality of life in the years that they have left.

Thank you for listening.

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NC Study Commission on Aging
April 24, 2008

Thank you to the Study Commission for scheduling this second listening session, and thank you for the opportunity to speak before the commission. My name is Phil Cooley, and I work with Homewatch CareGivers in Mecklenburg County, an agency that contracts with the Mecklenburg County Department of Social Services to provide much needed home care services to low and moderate income seniors and disabled adults in our county. I am here today to speak in support of continued funding for the Project C.A.R.E. program.

Project C.A.R.E. stands for "Caregiver Alternatives to Running on Empty" and is a North Carolina Alzheimer's Demonstration Program that has received several national awards and recognitions. Funding for the program in the past has come through a variety of federal, state and local funding sources, some of which will be ending in June 2008.

Project C.A.R.E. focuses on providing supportive services to caregivers of persons with Alzheimer's disease and related disorders. The goal is to provide relief and respite services to the caregiver. A Family Consultant carefully assesses all referrals to the program to determine the need of the caregiver and income eligibility, to access available resources where possible and to provide respite care for the caregiver where needed.

Recently, Homewatch CareGivers took a referral from Mecklenburg County DSS to provide respite care for a wife whose husband was exhibiting marked signs of Alzheimer's. We provide the wife with only four hours of respite care for her husband a week. Still, she was thrilled to get the help.

The wife told our Nurse: I need to go out and buy groceries, but I am afraid to leave him alone. He might wander off while I am gone. I need to pay my bills, but if I am gone too long, he might turn on the stove and walk away forgetting that he ever turned it on. I need to pick up his medicines, but if he hurts himself while I am away, he would not know what to do. Anytime I do go out without him, I am in a panic to hurry and get home as quickly as possible to check on him.

As our Nurse relayed to our office her experience visiting with this family, she underscored the love and devotion that this wife demonstrated toward her long-time husband. But it is a love and devotion that tragically comes with a price, sometimes a steep price.

Family caregivers often literally work themselves to death caring for their loved ones. And family caregivers of Alzheimer's patients are at an even higher risk. These caregivers suffer from fatigue and stress. The stress can be financial or physical, but it is always emotional as the family caregiver struggles with changes in their loved one's physical decline, loss of cognitive ability [no one can fully appreciate the heartbreak of having a lifelong spouse forget your name], and behavioral demeanor [such as aggressive or combative behavior].

As a result of coping with the ravages of Alzheimer's disease in a loved one, the family caregiver literally exhausts all of their personal resources. The stress can become overwhelming. Caregivers are twice as likely to suffer from depression as the general population. The caregivers themselves become more susceptible to aggravated health problems. Sometimes shame prevents them from reaching out to talk about their struggles with others. Many in today's older generation grew with a fierce sense of self-

reliance. And the end result is often loneliness and isolation. Their life-long best friend has now become a total stranger.

The Alzheimer's Association has been warning us of a coming explosion in the incidence of Alzheimer's disease in this country. Project C.A.R.E. cannot stop the coming tide of the disease. But it can reach out to those citizens who have the least support and the least resources to help themselves and give to those caregivers a lifeline.

Four hours of respite for our client Sally out of 168 hours a week is not much in one respect. Our aide does a few chores around the house to help relieve Sally's work load and watches over her husband. However, four hours is peace of mind that her loved one is looked after while she does important family business. Four hours says to Sally that she is not alone in dealing with the progression of her husband's Alzheimer's. Four hours tells Sally that somebody is going to help take care of her so that she can better take care of her husband.

Without continued state funding, Project C.A.R.E. will be unable to continue serving some of the most vulnerable and most valiant of our citizens past June, or at least will have to curtail services dramatically. From our working with the Project C.A.R.E. program through our contract relationship with the Mecklenburg County DSS, Project C.A.R.E. is one of the programs in the state that takes a small amount of money, manages it well, focuses keenly of a clearly defined need in the community, stretches the dollars as far as they will go, and makes a critical impact in the lives of its customers.

I urge the study commission to give priority consideration to the continued funding of Project C.A.R.E.

Phillip A. Cooley, Homewatch CareGivers
Mecklenburg County

Recommendation to Support the Adult Protective Service Clearing House Model

- **Weaknesses of current statute 108A**

Restrictive Screening Criteria
Not a preventative service
No mandated training for Social Workers or Supervisors
No mandated caseload size
No ratio of supervisor to social worker
Statute has not changed since 1975
Inconsistency in screening practices between counties
Little funding to support program

- **Strengths of proposed Adult Protective Clearing House Model pilot**

Expanded screening options, which would allow us to have earlier intervention, and outreach options; thereby reaching more of our most vulnerable adults who are being abused, neglected, exploited or at substantial risk.
Mandated training for Social Workers and Supervisors
Mandated caseload sizes
Ratio of supervisor to Social Worker
Increased training would eliminate inconsistencies between counties screening practises
Increased funding

I've worked in the field of Adult Protective Service since the early eighties. Adult Protective Service workers are involved with adults who are as vulnerable; as the children in our community; but this issue often gets unnoticed. We have to do a better job as a profession of educating the public of this growing issue. Buncombe County has seen a growth of 89% in the number of APS reports since 2005, we on average receive anywhere from 60-80 new reports a month. We are working with individuals who are dependent; and vulnerable, often being victimized by the very people who they believe love them. As our economy worsens, so does issues of victimization. You have families and adult children moving in with their aged and disabled parents, which is stressful in and of itself, couple that often times with mental illnesses and substance abuse issues; and you have a very volatile situation.

I would love to see this growing issue get the attention it needs to enable social workers and communities to do a better job of protecting our vulnerable adults. The greatest resource our state has is the dedicated staff of local DSS's, and supportive community agencies who tirelessly work to enhance the quality of life that our vulnerable adults have. Thank you for your time.

Respectfully submitted 4/24/2008

By: Roxann Sizemore SWS III
Buncombe County DSS

Dental Care for North Carolina's Special Care Populations

Thanks to the NC Aging Study Commission!

Study Commission initiated legislation to create a new special care dental program in Durham/Orange/Chatham Counties passes in 2008.

What is needed next?

- Support the NC Senior Tar Heel Legislature, NC Governor's Advisory Council on Aging and NC Association of Retired Persons request to appropriate money for new and existing special care dental programs.
- Direct the NC Division of Medical Assistance to study a dental Medicaid behavior reimbursement code for special care patients.
- Study the funding of a special care residency program to train future dental providers.
- Include dental care reimbursement for the NC Money Follows the Person (MFP) Program administered by the NC Division of Medical Assistance.
- Follow up on the Study Commission's proposed Governor's Scholarship for a UNC School of Dentistry student. [Section 9.5.(a), Chapter 116-40.10]

Who Are These Special Care Citizens?

- There is no consistent access to dental care for the more than 200,000 North Carolinians who are homebound or live in nursing homes or group homes.
- These are individuals of all ages, and they have a variety of complicated intellectual and physical disabilities such as profound retardation, autism, cerebral palsy, dementia, cerebral vascular disorders (stroke), head injuries, multiple sclerosis, and muscular dystrophy.

What Are The Problems?

- North Carolina has no statewide oral health system to serve patients with special care needs.
- Nursing home facilities and group homes have few qualified community dentists to care for their residents.
- State deinstitutionalization policies have put people with mental disabilities into communities ill-equipped to treat their dental needs.
- Local dental providers are reluctant to treat the medical and behavior needs of patients with special care needs. Nursing home facilities and group homes are challenged to meet each resident's daily oral hygiene needs.
- There are no specialty training programs for providers wanting to serve this population.
- Uncontrolled oral infections result in more costly infections such as aspiration pneumonia, uncontrolled diabetes and endocarditis.
- Medicaid rates do not keep up with inflation.
- The two non-profit programs that serve these individuals (Access Dental Care/Carolinas Mobile Dentistry) are stretched to the financial breaking point. These organizations provide comprehensive care to 7400 residents in 16 piedmont counties with an 80% Medicaid/20% Private Pay mix.

In-Home Senior Care:
How government funding can support quality of life for elderly citizens and save taxpayer dollars

The Issue: Subsidized In Home Aide Services

Home and Community Care Block Grant (HCCBG) funding for In Home Aide services through Title 3 of the Older Americans Act needs to be increased to support older adults in maintaining their independence and remaining at home.

Level I services provide home management assistance including housekeeping, meal preparation, transportation to and assistance during medical appointments, essential shopping and errands, and bill paying. **Level 2** services assist with all of these tasks, as well as personal care which includes bathing and dressing.

Services are designed to prevent or ameliorate conditions of abuse, neglect, exploitation and dependency, prevent deterioration of functional capacity, and avoid premature and unnecessary out of home placement. Individuals in need of In Home Aide services are at increased risk for the likelihood of injury from falls, poor nutrition, isolation, depression, unsafe living conditions, eviction from housing and disconnection from utilities. One or more of these developments can lead to premature placement into a long-term care facility.

Providing care in the home is a more cost-effective approach to supporting frail elderly in their own homes: The average monthly cost of HCCBG In Home Aide services in Buncombe County (9.68 hours/week at the current rate of $12.90) is approximately **$500 per month**. By contrast, monthly rates for Adult Care Homes range from **$1,400-$4,000 per month** and skilled nursing care ranges from **$3,700 - $6,000 per month** (2006 Nursing Home and Adult Care Home Guide – LOS AAA).

The Problem: A Lack of Funding

As of April 17 of this year, there are 252 Buncombe county residents age 60 and over waiting for In Home Aide services. Year-to-date, The Council on Aging of Buncombe County (COA) has served 72 Level 1 clients. CarePartners Health Services is currently serving 40 Level 2 clients, and Advantage Home and Community Care, Inc is serving 18 Level 2 clients. (The Council on Aging also provides In Home Aide services for an additional 30 clients through another funding stream.)

Currently, 252 frail elderly in Buncombe County are on the COA's waiting list for In Home Aide services; with only 121 HCCBG funded spots available, they face a waiting period of several years to receive needed services. Unless a senior qualifies for Medicaid or is a Veteran, there is no subsidized In Home Aide services program available to him or her. Most people on this waiting list are not able to pay the private rate of $16-22 per hour.

While they are waiting for services, many will face premature institutionalization due to the lack of available assistance and their inability to pay privately for this care. We can spend those tax dollars helping people stay at home, or we can spend almost 12 times as much to support their stay in skilled nursing facilities. HCCBG funding must be increased to prevent this unnecessary spending.

To assure continued provider participation, the reimbursement rate for Level 1 In Home services must be increased without eliminating services currently provided. The 2007-2008 reimbursement rate for In Home Aide services through the Council on Aging is currently $12.90

per hour, which is $3-6 an hour under the provider agencies' usual rate. The In Home Aide agencies currently providing these services have indicated they may have to withdraw from the program due to the low reimbursement rate. (Since August, two providers have dropped out, leaving only five providers.) Some providers have indicated they may need to discontinue serving clients in the most rural areas. COA has informally approached other service providers; all have declined to participate at $12.90 per hour. Level 1 service reimbursements across the state range from $11.90 per hour (Caldwell County) to $16.50 per hour (Mecklenburg County). Without an increase in HCCBG funds, the Council on Aging will have to reduce and/or eliminate services to some existing clients in order to maintain provider participation.

What needs to be done

- At the state and local levels, legislation to increase Home and Community Care Block grant funding must be supported, including Recommendation 2 from the Study Commission on Aging's April 10, 2008 meeting (see handout).
- At a federal level, legislation to increase Older American's Act funding must be supported.

Whom to contact for more information

Kate Brockett, In Home Aide Program Manager, Council on Aging of Buncombe County, Inc.
Wendy Marsh, Executive Director, Council on Aging of Buncombe County, Inc.
828-277-8288
Roxann Sizemore, Social Work Supervisor III
Department of Social Services of Buncombe County
828-250-5500

Aging Study of Buncombe County*
Demographics of Aging

NC Department of Health and Human Services
Division of Aging and Adult Services
April 1, 2008

POPULATION	Buncombe	North Carolina
Total population, 2006	221,320	8,860,341
Projected total population, 2020	262,838	10,850,228
Population age 60+, 2006	**44,992**	**1,469,689**
Population age 85+, 2006	**4,769**	**132,412**
Baby boomers (as % of total population), 2006	31.7%	29.7%
Rural population for all ages (as % of total population), 2000	29.2%	39.8%

	Ages 50-64		Ages 65-84		Ages 85+	
Distribution by Age	**Buncombe**	**NC**	**Buncombe**	**NC**	**Buncombe**	**NC**
Age groups, 2006	19.6%	17.4%	12.9%	10.5%	2.2%	1.5%
Projection for 2030	18.7%	17.2%	18.6%	15.5%	2.9%	2.1%
Growth, 2006-2030	**24.7%**	**37.4%**	**88.6%**	**105.1%**	**73.7%**	**96.1%**

Healthy Aging

	Buncombe	North Carolina
Persons age 65+ in community with 0 disabilities* (as % of age group), 2000	58.5%	54.3%
Persons age 65+ in community with 1 disability* (as % of age group), 2000	19.1%	20.6%
Persons age 65+ in community with 2 or more disabilities* (as % of age group), 2000	22.4%	25.1%

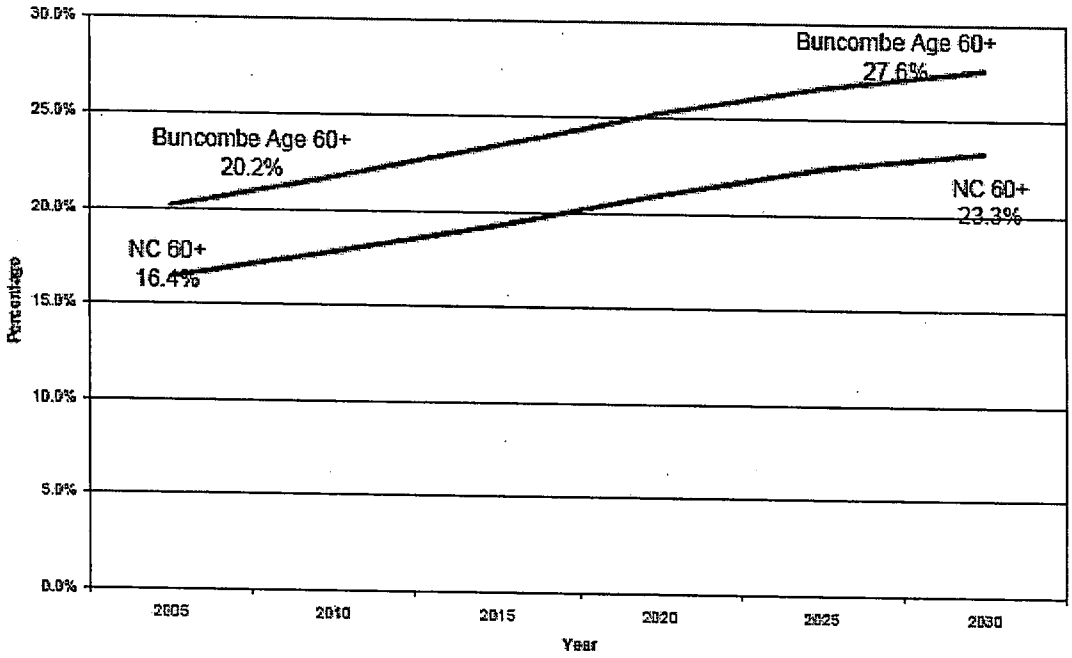
* The US Census Bureau defines disability as "a long-lasting physical, mental, or emotional condition. This condition can make it difficult for persons to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering."

Long-term and In Home Care and Aging

	Buncombe	North Carolina
Persons age 65+ in nursing homes per 1000, 1999	**51.7**	**42.2**
Persons age 65+ in adult care homes per 1000, 1999	**42.0**	**36.5**
CAP/DA clients age 18+ per 1000 Medicaid eligibles, 1999	23.9	36.0
PCS clients age 18+ per 1000 Medicaid eligibles, 1999	17.8	57.7
Adult day care/health clients age 60+ served per 1000, 1999	1.3	1.0
In-home aides clients, age 60+ per 1000, 1999	**5.5**	**9.9**
Total Medicaid expenditures for persons age 65+, 2007	**$40,759,968**	**$1,418,991,691**
Per Capita Medicaid expenditures for persons age 65+, 2007	**$8,394**	**$7,879**
The amount Medicaid spent on home-based care (CAP/DA, CAP/MR, home health, and PCS) for every $100 spent in Nursing homes for clients age 60+, 2006	$24.5	$46.9
Special Assistance (SA) expenditures for persons age 60+ in adult care homes, 2006	$1,449,328	$70,999,119
Number of clients 60+ receiving SA in adult care homes, 2006	398	18,056
Per Capita SA expenditures for 60+ in adult care homes, 2006	$3,642	$3,932

* Adapted from its original format

Buncombe County and State Population Projections 60+



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Dedicated to Assisting and Linking Senior Adults and Their Families with Information, Opportunities and Services that Promote and Enhance Quality of Life.

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Advocating for additional funding targeted for Community Transportation Systems

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In this county independent mobility, being the able to care for ones self, is a basic human need and I would say part of the American Dream. For older adults, losing that independence is devastating. Urban sprawl and growth in traditionally rural areas has led to an increase in the number of persons living in areas without public transit. This is probably not a surprise to most. But here is something you may not have thought of: medical services and shopping have moved out of urban areas leaving persons – including older adults – *stranded* because traditional fixed route public transit does not serve rural small communities. Instead of family members or caregivers having to drive in from the suburbs to pick up a relative who can no longer drive in order to baby-sit for the weekend, why is public transit not available to eliminate the need for assistance? Why is public transit not available in these areas to allow these residents to keep their independence?

One solution is adequate funding for community transportation systems. Having public transit available to all persons and for all purposes, results in the ability to operate an efficient public transit system. Operating a transit vehicle half full is costly compared to when it is full. The cost of transportation is rising, due to gas prices, wage rates and technology investments, while state and federal funding remain relatively flat. Transitioning from institutional care to in-home care can only work if transportation is not a barrier.

Some older adults will not drive after dark, when it is raining, outside their normal territory or "fixed routes" (ex: to see a new doctor or visit family), or when it involves traveling on highways or interstates (ex; to get to a hospital). The stats below indicate how many folks have vehicles; however, it does not say how many are not willing to use them. Then there are those individuals, including older adults, with low fixed incomes who cannot afford gas, insurance, taxes or maintenance to be able to operate a vehicle.

According to the NC Office of Budget & Management, State Demographer the projections of adults 60+ in 2005 in Guilford County are 69,568 and for 2010 is 79,360 and for 2020 is 103,540.

	Guilford County - Total	Greensboro	High Point	Balance of Guilford Co.
Population age 60+	64,942	33,695	13,149	**18,098**
No vehicle available (age 65+)	2,027	998	502	**527**
In Poverty (age 65+)	4,663	2,651	1,091	**921**
Disabled (age 65+)	19,965	10,541	4,303	**5,121**

Source: 2000 Census of Population & Housing.

To: North Carolina Study Commission on Aging . April 24, 2008 . Jamestown, North Carolina

My name is Venice Preston. I'm the executive director of Emmanuel Senior Enrichment Center, non-profit, fully certified adult day care/day health center that has been In operation since 1986 in High Point, NC, the furniture capital of the world.

I have had the pleasure of working in adult day services since 1991. I have seen many changes in our industry...I've observed and experienced revisions in the standards by which our industry is governed, the development of best practices and predictors for success, and I've observed the insurance companies' responses to the explosion of the baby boomer population with the proliferation of long-term care insurance policies. I've also seen the changes in types of adult daycare participant whose caregivers need our support.

I'm talking about participants requiring assistance with two or more activities of daily living (59%), participants who have some type of cognitive impairment (50%), and require nursing services at least weekly (33%).

When I began my work in this industry, the adult day care reimbursement rate for Home and Community Block Grant and State Adult Day Care Fund was $18 dollars per day—the reimbursement rate is now nearly twice that at 33.07/day. But the cost to provide the service is now, according to MetLife's Mature Market Institute (2007), on average $61/day.... approaching or beyond twice the amount of the reimbursement rate, depending on the market location. By contrast, a home health visit to the same type of participant that we serve is an average of $19 per hour and our $33.07 reimbursement for an average of a seven-hour day.

To the commission--- I must say that I sense that the single greatest change that has materialized during my tenure, however, is that I've heard the North Carolina Study Commission on Aging's **VOICE** in a material response to the need for increased reimbursement rates. Mind you, these rates are complementary to the actual cost of care for Home and Community Care Block Grant and State Adult Day Care Fund consumers .

I want to say thank you because your **VOICE** has, indeed, made a difference in our ability to continue to extend a high level of service to a community that may otherwise be overlooked or denied access to needed services. Your **VOICE** that contributed to the financial stability of adult day services providers that want to prevent premature institutional placement among impaired adults.

Emmanuel Senior Enrichment Center, and I'm sure that I speak for my colleagues, as well ...needs to hear your **VOICE** again.

Respectfully submitted by:

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NC Alliance of Senior Centers
Chair person

(44)

My name is Calvin Vaughn, I am the Director of the Roy B. Culler Senior Center in High Point North Carolina. There are approximately 11,000 seniors in the High Point area. At the High Point Senior Center over 1,818 unduplicated seniors participate in our programs. This does not count our outreach programs to High Point communities. (Our outreach programs would increase the number of seniors we serve by 100s. Our local statistics would be similar to many communities across the State.

In response to the North Carolina Division of Aging and Adult Services (NCDAAS) Senior Center certification program many of the 160 Senior Centers across the State have increased and expanded programs and services making the Senior Center "A One Stop Shopping" for seniors to link to community programs and services. "One Stop Shopping Approach" identifies one location in the community where seniors can learn about and connect to needed services. A senior friendly "One Stop Shopping Approach" has proven to be an easy access for seniors to navigate through the maze of existing services. Senior Centers that exist in every county/city across the State is a natural place for one stop shopping. The One Stop Shopping Approach can reduce duplication and make better use of limited funding. In addition to Senior Centers being the ideal place to connect to services they are the natural place for seniors to engage in social, educational and physical activity that has been proven to maintain and even increase independence.

The NCDAAS certification program certifies Senior Centers as Centers of Excellence or Centers of Merit that further provides opportunities for senior's independence. Certified Centers have improved both quality and quantity of services being provided by the certified Senior Centers and their community partners. This enhanced "One Stop Shopping" approach for seniors has proven to be effective and efficient. In order to continue to meet the need of the large number of existing seniors in NC and the increasing number of boomers in NC who are becoming of senior age the need for increase Senior Center funding should become a priority.

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North Carolina Study Commission on Aging
By Cleveland County DSS
April 24, 2008

Thank you for allowing me the opportunity to speak today. I would like to start by exploring the question of what each of us individually consider life's greatest potential loss? Of course all our answers would differ somewhat; but most of us would include our loss of loved ones and loss of health as two of the greatest losses. Another loss at the top of most of our lists would be loss of independence. Social Workers serving the older and disabled population can testify to the tenacity that most adults hold on to their independence. Those same workers can serve as witnesses to the severe decline those people generally exhibit when independence is lost. Adult Services' staff at County Departments of Social Services value helping adults stay both physically and emotionally well and offering support to caregivers as they meet day to day needs. For those who are interested in people, concepts like dignity, health and quality of life are foremost. For those also with the difficult tasks of identifying and allocating available monies, helping to prevent deterioration is the most cost effective as well. We would like to mention several of the most urgent issues that face the Departments of Social Services as well as the adults we serve:

(1) It is time for change in the Adult Protective Services Law and time for funding to better protect our disabled citizens. Children's Services began a concept called Multiple Response System or MRS back in 2002 in pilot counties and because of the positive experience for families this was made statewide in 2006. The system has changed the way children are protected and families served. Very positive outcomes have emerged from offering up front services to families to help, assist and support before a crisis occurs. It is time we offer this same service to our disabled and older adults by funding and offering Adult Protective Services to families who need help. Why would we fail to assist an overstressed caregiver early as opposed to waiting until that same caregiver has neglected or abused an adult in their care? Our agency receives calls for up front services before abuse and neglect have occurred at 5 times the rate of Adult Protective Services as it is defined in the current law. This is an appeal for help that should be answered and we desire the resources to meet these needs. The Adult Protective Services Clearinghouse Model outlines what we believe to be a valuable service and the benefits have already been tested and proven in children's services. Our disabled adults are no less in need and no less important.

(2) The need for additional funds in the Home and Community Care Block Grant has never been greater. Our agency manages just one of the valuable services funded by the grant. We operate the in home aide program-perhaps one of the most valued programs aimed toward helping our clients maintain independence and dignity. With just a few hours of in home aide services performing chores and minimal personal care in the home setting, our clients have lived lives of dignity and safety in their homes for many years-some for over 10 years. They have been healthier, happier and their deterioration has been prevented or delayed due to quality care. Due to funding, our ability to offer these services has decreased dramatically in the last 10 years and we are now able to serve only about 15 adults-down from 45 to 50 in the past. We can offer this service for a fraction of the cost of a long term care facility placement to appropriate clients. We stress the importance of increasing funding for this valuable service. We realize that legislators have increased funding to some degree; but all counties have not realized the increase due to the funding formulas used for allocations.

(3) The need for appropriate care for the younger mentally ill. Services for the mentally ill have been greatly impacted by mental health reform. This is a well known issue and we certainly advocate for needed changes. However, we want to focus on the need for appropriate out of home placements for the mentally ill when living in their own homes is no longer an option. The idea behind keeping the mentally ill out of institutions is so they could be served in their own communities. This cannot be done when the service is inadequate or does not exist at all. We are continuing to ignore the needs of the mentally

ill by swiftly shifting them from the eyes of society to the most willing and least expensive places-many to our adult care homes. Many adult care homes do excellent work and try very hard; but the rules governing their operations do not focus on the needs of the mentally ill and were never designed to serve the population. Many individuals are being poorly and inadequately served and serious consequences have emerged in the way of deaths, accidents and injuries to staff and residents. The need is clear and we encourage efforts to continue advancement for this needy and much overlooked population.

(4) County Departments of Social Services have very limited funds for offering guardianship services. This service is vital to those people who have no one else to speak for them. Very often a social worker who has multiple other duties must manage and serve these very deserving clients. The individuals in the care of an agency who are not fortunate enough to have a caring or able family member should not receive less advocacy. Who will speak to the Dr. to identify needs, hold caretakers accountable and ensure rights and full protection if the guardian does not? To briefly illustrate how important advocacy is for our guardianship cases, our agency Director was appointed guardian for a deaf man advanced in years and discovered that he had been committed to a mental hospital for over 6 decades and had never had a mental health diagnoses. His years could not be restored; but his last years were full because of the advocacy of a guardian doing what a guardian should do. We would encourage a close look at best ways to serve this most vulnerable population who need a voice of care.

There are many needs and as our older population grows, it is very apparent that we cannot continue business as usual. Finances alone push us toward change. If we do not seek change, there is no way that Medicaid and other services can be maintained and continue for these large numbers. A more dramatic shift in focus to helping people continue independent living with their caregivers supported is not only the right thing to do; but it is a necessity.

(50)

4/24/2008

Public Hearing on Aging
Town Hall
Jamestown, NC

Comments supporting the APS Clearinghouse model and monies for Guardianship case management services.

I currently work for the Department of Social Services in Forsyth County. I started work there in July of 2004 as a social worker in the In Home Services Unit. I then moved to the Adult Protective Services Unit as a social worker and then as the APS Supervisor. From my work with Adult Services at DSS, I have come to realize the importance we have in helping to protect and serve the elderly and disabled population.

Our current APS statute was state of the art when it was originally formulated in 1973; however there have been little to no changes since. We need to be proactive and hopefully prevent maltreatment of our elderly and disabled before it ever occurs! I have been fortunate to have been able to be a part of the state APS Task Force that helped to formulate the Clearinghouse Model being proposed to the legislature. The Forsyth County Department of Social Services fully supports the proposed legislation for the APS Clearinghouse model and pilot and changes to the APS statute.

During my work with DSS I have also had the opportunity to work with Guardianship Services and even cover the unit as a supervisor when the position was vacant for a few months. At Forsyth DSS the APS unit and Guardianship unit also works very closely together and thus I have continued exposure and experience with guardianship services as well. As the population ages and families don't always stay in contact with one another, we often find ourselves in the place of having to serve as guardian for someone who may no longer be able to care for themselves or make decisions about their lives and there is no family to assist either. While I feel we provide comprehensive and professional quality services to the wards we serve, there is only so much we can do due to limitations with funding and resources. The Forsyth County Department of Social Services fully supports the proposed legislation for the development of funding for guardianship case management services.

Hank N. Kennedy, MSW
Adult Protective Services Senior Social Work Supervisor
Forsyth County Department of Social Services

Hank N Kennedy MSW

NC Social Services Consortium

NC Assoc. of County Directors of Social Services
NC Assoc. of County Boards of Social Services
NC Social Services Association

Build on North Carolina's History of protection for elder citizens

Our state was a pioneer in enacting the first Elder Abuse Law in 1973, but the statute has not been updated in more than 30 years. We need to revise our elder abuse statute and launch a pilot Adult Protective Services (APS) program that will help protect our elder citizens and put our state in the forefront of national efforts to prevent the abuse, neglect and exploitation of older adults. In 2005, The NC Division of Aging and Adult Services (NCDAAS) was directed by the General Assembly (Session Law 2005-23), to identify ways to improve adult protective services, and we presented recommendations to the 2007 Aging Study Commission to broaden and strengthen North Carolina's APS program. NCDAAS outlined the basic components of a proposed system of protection for vulnerable adults, "Adult Protective Services Clearinghouse Model"—with proposed changes in services, staffing, training and rules. The Study Commission's recommendation led to bills in the House (H198) and Senate (S108) for a pilot project in 9 counties to be supported by $1,492,000 in FY 2007-08 and $1,930,000 in FY 2008-09. Support for this project did not make it into the Budget Bill. *(This item relates to Objective#24 of the 2007-2011 State Aging Services Plan).*

(01) **The APS Clearinghouse pilot** would enable county departments of social services to provide three levels of "protective services" to vulnerable and elder adults who've been abused, neglected or exploited – or who are at risk:

(a) *Information & Referral* for those who consent to be served and do not need outreach services or intervention services,

(b) *Outreach* would include the planning and arrangements for services for a client who consents to receive those services, or

(c) *Intervention* for clients who have no responsible caregiver to arrange or provide needed services. Intervention services could be provided with the client's consent or involuntarily – if the client lacks the ability to comply with a court order and lacks a caregiver who is willing and able to arrange services.

(02) **Statutory Change:** To make the pilot program effective, we must also 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* to support a broader system of protection for vulnerable and older adults who have been abused, neglected or exploited – or who are at risk.

(a) Current state law limits Adult Protective Services (APS) to *disabled persons* aged 18 and older. The focus of protective services should be changed from disabled adults to vulnerable and elder adults, and the definition of "vulnerable adult" should be based on the adult's functional strengths and limitations.

(b) Like Florida, Virginia, Louisiana and other states, North Carolina should use age 60 or older as a benchmark for defining elders eligible for APS.

(c) The definition of "abuse" should be broadened by deleting the intentionality requirement and replacing the term "caretaker" with "caregiver." These changes would put our state in line with the current thinking about best practice for vulnerable elder adults.

(d) The definition of "essential services" should include those steps necessary to safeguard vulnerable adults' rights and resources.

(e) The term "substantial risk" should be added to support the provision of services to elder adults at risk of abuse, neglect or exploitation.

(f) "Protective Services" should be redefined to permit the array of service options described above as the Adult Protective Services Clearinghouse pilot.

Estimated Cost: $1.9 million for a one-year, nine county pilot program

NC Social Services Consortium

NC Assoc. of County Directors of Social Services
NC Assoc. of County Boards of Social Services
NC Social Services Association

Protect our state's most vulnerable elder citizens

The Problem: Elder citizens who are unable to care for themselves or handle their own affairs are often judged incompetent, and if they lack private resources, they become wards of the state. Today, more than 70 % of these North Carolinians – almost 3,000 elder citizens – are under the guardianship of their county department of social services (local DSS). That number will certainly grow. By 2030 the number of persons in our state aged 60 or older will double. By then, 75 counties will have more residents over age 60 than age 17 or younger.*

During the 2007 Session of the NC General Assembly, House Bill 795 was introduced to appropriate funds for guardianship services ($5,121,783). This had been a recommendation of the House Study Committee on State Guardianship Laws, endorsed by the 2007 Aging Study Commission. Related funding did not get included in the Budget Bill. There is no specific funding for public agent guardianships to support the mandate for local human services agencies to provide guardianship services.**

Local social service departments often use Social Services Block Grant (SSBG) funds to provide guardianship services, but that pool of money is already heavily stressed, and as the years go by, less is available for adult services.** The system is under-funded. Additional needy clients are coming. The system and those it serves face a crisis. Without more public services, this population will be at a significantly greater risk of abuse, neglect or exploitation.

The Best Response: Guardianship services can be both extensive and expensive, and given the vulnerability of the typical client, they must be performed with great care. Under the oversight of the local Clerk of Court, a multi-disciplinary evaluation (MDE) team should evaluate the needs of the client and recommend arrangements for care, which then must be approved by the Clerk of Court. Guardianships should be established only as a last resort, and public agencies – most often the county department of social services – should assume guardianship responsibilities only when there is no other appropriate individual or corporation available to serve.

Most local departments of social services restrict their involvement to serving as a "guardian of the person" – one who assumes responsibility for the ward's care, comfort and maintenance and for the ward's personal property. Generally, an attorney will be appointed as a "guardian of the estate" – assuming responsibility for managing the ward's estate, which might include receiving assets due to the ward, performing contracts entered into by the ward, buying or selling property and paying the ward's debts. A "general guardian" might do all of these things, and *in cases where the ward has no property or assets, that role usually falls to the local DSS.* The guardian of the estate or general guardian is responsible for filing annual accountings with the Clerk of Court.

The large volume of work needed to care for these wards is blatantly obvious. Anyone who has assumed responsibility for an aging parent who is ill or frail can appreciate the burden involved. With caseloads growing, no specific funding allocated for guardianships, and *ad hoc* funding sources shrinking, we are headed for a crisis that can only be addressed through increased funding for these services.

Estimated Cost: $5.1 million

*Division of Aging & Adult Services, NC DHHS, 2008 report
** House Study Committee on State Guardianship Laws, 2007 report

Senior-Friendly Mecklenburg

COUNCIL on AGING

YOUR SOURCE AND VOICE ON SENIOR ISSUES

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Remarks of Debora Sparks
Executive Director

Charlotte-Mecklenburg Council on Aging

Before the

North Carolina Study Commission on Aging

Public Hearing on Issues
Involving Older Adults

Jamestown, NC

Thursday, April 24, 2008

Thank you for this opportunity to appear before the North Carolina Study Commission on Aging. My name is Debora Sparks. I am the Executive Director of the new Charlotte-Mecklenburg Council on Aging.

Council on Aging's mission is to transform Charlotte-Mecklenburg into a *"senior-friendly"* community through education and advocacy. Currently, the efforts of the agency are focused on transportation, housing, caregiving and development of an Aging and Disability Resource Connection (or ADRC.) Council on Aging is the co-convener of the Home and Community Care Block Grant process in the County and has established itself as the "source and voice" for issues affecting older adults in Mecklenburg.

This is a very important mission for a very small agency but our County is blessed with a number of dedicated, experienced activists and professionals from varied backgrounds who share a passion for the well-being of older adults, of ensuring them an exceptional quality-of-life, in part, by extending their ability to "age-in-place."

Not only are we convinced by the studies and statistics that this is the best approach to successful aging, it is what the older adults tell us that they want and need. As it turns out, aging-in-place is the cost-effective way to address aging issues because the prohibitive costs associated with premature placement in long-term care settings are avoided or, at least, deferred. More importantly, the individual senior maximizes the time that he or she enjoys making their own schedule, pursuing their own interests, visiting with their own friends, surrounded by their own things, in their own place.

The key to making "aging-in-place" a standard, rather than an exception, is availability and easy access to information and choices about support services, for people who are not experts in aging. That is a principle that Council on Aging is applying to each of the areas that we have targeted for tangible progress in the next 18 months, the issues that become "advocacy" alerts, as well as in the process that we are developing for our ADRC.

So what does any of this mean for the North Carolina Study Commission on Aging?

Right now, Mecklenburg County has a population of adults, age 60 and better, that numbers over 100,000. In four years, that number should exceed 125,000. By 2030, we expect to have over 250,000 older adults living in Mecklenburg County.

Even as we meet today, there are waitlists for services in the areas of adult day care, adult day health care, transportation, congregate meals and other HCCBG service categories. More dollars are needed at the local level to provide support services.

"Gentrification" of established neighborhoods that results in the displacement of older adults due to their inability to pay ever-increasing property taxes does not allow them to "age-in-place." Council on Aging urges that you be receptive to creative proposals that would "cap" or defer property taxes on homes belonging to seniors meeting certain length of residence, age, income or alternative qualifying criteria. If the Homestead Exemption is the proper vehicle, then maintain it as an "evergreen" statute that is reviewed and updated regularly—no less frequently than every two years.

Finally, Council on Aging is a source and voice within Mecklenburg County and for those outside the county—even outside the State. Because of the size and diversity of the aging population we have now, the influx of older adults relocating to our area who are attracted by the amenities, energy and possibilities in Mecklenburg, as well as the aging of the boomers in our midst, there is both challenge and opportunity in abundance.

Those of us committed to older adults embrace these challenges and view the work as a responsibility and a privilege. We look to change the present so that it recognizes and responds in a proactive way to enhancing the well-being of family members, neighbors and friends in our community. Moreover, we welcome collaboration and partnership so that best practices can be shared and the future will be more welcoming for older adults still "under construction."

Charlotte-Mecklenburg's Council on Aging is a neutral forum, a Petri dish, a test track, a pilot program on steroids—

So, when this Commission wants ideas, feedback, collaboration or partnership, I hope you will consider tapping the unique resource that is Mecklenburg County.

My contact information through Council on Aging is provided in the copy of my remarks should you have any comments, questions or suggestions. Thank you for your time and attention.

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Comments to the Legislative Study Commission on Aging
April 24, 2008

Honorable Senators and Representatives, Members of the Legislative Study Commission:

My name is Kim Dawkins Berry, and I am the Director of the Piedmont Triad Council of Governments Area Agency on Aging. Thank you for visiting Piedmont NC to hear our thoughts and concerns as it affects our work with an aging population.

Area Agencies on Aging in NC are responsible for administering and monitoring in excess of 66 million dollars for local services. The services which you are familiar with include in-home care for the frail, transportation to essential services, senior center certification, meals programs and family caregiver supports. Over the last few years our focus has been expanding to provide more health and wellness initiatives. Our plan is to partner with researchers in the field of health to provide specific education, training, activities and evaluation measures. Our goal is to promote healthier lifestyles and offer preventive measures to combat many of the chronic issues currently associated with aging.

Another major role of the Area Agency on Aging staff is that of regional long term care ombudsman. We provide information and mediation as well as investigate grievances for those NC residents and their families in long term care facilities.

A few of the things which our 17 North Carolina Area Agencies on Aging are involved:

- Facilitation of Local Planning in each county, inclusive of strategic processes to determine needs and formalizing operational plans
- Convene the many local agencies participating in the NC CareLink and Aging and Disable Connections (ADRC) initiatives
- Serve as a resource for public benefits, the most recent Medicare Part D
- Operate Medication Assistance Programs
- Write grants to support program expansion
- Plan, recruit sponsors, and hold Health and Wellness Fairs, Appreciation Days for Certified Nursing Assistants, sponsor Elder Rights and Scam Jams, Volunteer Appreciation activities and conduct support groups ranging from Alzheimer's Groups to Grandparents raising Grandchildren
- Work with Legal Services to offer support to grandparents attempting to adopt their grandchildren
- Conduct workshops on Advance Directives, participate in many local community activities with all providers of service for older adults
- Coordinate with developers/HUD to support new housing for seniors
- Provide counseling for Reverse Mortgages

- Facilitate training and provide administrative assistance to the NC Senior Tar Heel Legislature
- Promote and organize Senior Games
- Serve on many gerontology advisory groups with our state colleges and universities

As the front line of defense we are ready for any new issues which come along such as the Medicare Part D changes last year. For many of us that was a full time staff person. This year we faced the challenge of informing our older adults of the Digital T V changes and the Economic Stimulus Package. We have a strong aging network in North Carolina and I credit a lot of that to the leadership offered by the area agencies on aging.

I remind you of this today so that you might Restore Area Agency on Aging Administrative Support Funding to the 2001 level. At that time we each received $57,900 in administrative support funding. Today we receive $45,424. Our necessary initiatives take time and money. We are seeking legislative action for this increase in the amount of $212,000 and that it is recurring. I thank you for your time today and welcome you to the Piedmont.

The North Carolina Joint Study Commission on Aging
Representative Jean Farmer-Butterfield, Co-Chair
Senator Vernon Malone, Co-Chair

May 12, 2008
10:00 AM
Room 544 LOB

The Joint Study Commission on Aging met on Monday, May 12, 2008, in Room 544 of the Legislative Office Building.

The following commission members were present: Senator Vernon Malone, Co-Chair; Rep. Jean Farmer-Butterfield Co-Chair; Sen. Stan Bingham; Rep. Alice Bordsen; Sen. Katie Dorsett; Rep. Joe Boylan; Sen. James Forrester; Rep. Bob England; Mr. Anthony Peace; Honorable Karen Gottovi; Mr. David Lowa; Ms. Jean Reaves; Honorable Edd Nye; and Mr. Jackie Sheppard, Ex-officio member. Also in attendance were Research staff Theresa Matula, Shawn Parker and Ben Popkin, and commission clerks Ruth Merkle and Bonnie McNeil.

Senator Vernon Malone chaired the meeting. He recognized the Sergeants-at Arms for their service to the commission. He then asked for a motion to approve the Minutes from the previous meeting.

Representative England motioned to approve the April 10 minutes. Commission member Jean Reaves seconded. The motion was adopted.

Senator Malone recognized Co-Chair Representative Jean Farmer-Butterfield for any comments. She deferred her comments until later.

Staff member Shawn Parker was recognized to present three new recommendations for consideration by the commission. A copy of these recommendations is attached.

Following Mr. Parker's presentation, Mr. Lowa was recognized for a question and asked if there had been a proposal in the past on the special assistance income disregard. Theresa Matula responded that she was fairly certain that it is not currently stated in the law. She added that the new recommendation looks at individuals who get cost-of-living adjustments (COLAS) that put them over the limit and make them ineligible for Medicaid benefits. Mr. Lowa followed by asking whether retired state workers could be added to the benefits criteria. Representative England commented that income disregards was looked at in 2004 by the department of health and human services (DHHS). He added that he supports adding retired state employees to the same study.

Representative Farmer-Butterfield commented that she supported incorporating state employees into the same study.

Ms. Reaves was recognized and commented that it is her understanding that the income disregard study only looks at those individuals who are already approved for Medicaid and lose their eligibility because of a COLA adjustment. Theresa Matula replied that to be eligible in this study people in adult care homes must currently be receiving Medicaid benefits or other special assistance.

The Chair recognized Rep. Bordsen, who commented that the inclusion of state employees is a separate issue. She then recommended that at the appropriate time that the new recommendations be adopted.

Mr. Lowa was recognized for a follow-up. He requested that state workers be included in any future income disregard study.

Sen. Malone asked Rep. England for a motion that the three new recommendations be included in the final report. Rep. England made a motion, Mr. Peace seconded, and the motion was adopted.

Ms. Matula was then recognized to present the draft report of the North Carolina Study Commission on Aging, with an additional recommendation to replace recommendation 6, which was approved by the Commission on April 10. This change was needed due to recent developments regarding the Medical uniform Screening Tool (MUST). A copy of the draft report and additional recommendations are included with these minutes.

Rep. Boylan was recognized for a question to staff, regarding whether the matching funds for Project CARE are recurring. Dennis Streets of the Division of Aging and Adult Services responded that only 25% of the funds are matching funds. Mr. Lowa asked whether the $500,000 for Project CARE is for programs already in place. Mr. Streets responded that that is the projected amount that is needed for sustaining the program in the 14 counties where it currently operates.

Ms. Reaves was recognized and asked whether the $2.5 million for home and community care are recurring funds. Ms. Matula replied that the commission expressed interest in making the funds recurring.

Ms. Reaves also asked for clarification from Ms Matula as to whether line 6 of recommendation 4 should read "and" or "or". Mr. Streets responded that the division prefers "or". The Chair stated that if there was no objection from the commission that the word "and" be stricken and that the word "or" be added.

Mr. Lowa asked if a client receives a PASAAR II screening and they have a mental illness will that mean they cannot be placed in an adult care home. He followed with a question whether PASAAR level II clients will be separated from frail elderly patients. Ms. Matula referred the question to Mr. Jeff Horton of the Division of Health Services Regulation. He stated that there is currently a mental health unit category, but it currently is voluntary and there is no funding attached to it. Mr. Lowa commented why there is no funding available for adult care homes that house mentally ill patients. He followed with a concern about training mandates and how they pose additional burdens on adult care home operators, especially when there is high turnover and no additional funding to pay for training.

Representative Farmer-Butterfield asked Ms. Matula if transitional residential treatment programs will become another resource. She replied that it will and that it can be utilized by people in the community and in adult care homes.

There being no further discussion on the recommended changes, Senator Malone asked for a motion to amend section 6 of the draft report and replace it with the changes. The motion was adopted.

Following Ms. Matula's presentation on the draft recommendations, staff member Ben Popkin presented three draft bills for consideration by the Commission. A copy of these bills is located on pages 81 – 85 of the draft report.

Staff member Shawn Parker continued with a report on four additional bills for adoption into the final report. A copy of these bills is located on pages 86 – 91 of the draft report. Two of the bills recommended statutory changes to their title: "Raise Ceiling on Personal Property Sale/Guardian" and "No Auto Revoke/Driv.Lic./Incompetent Person". A motion was made to each bill to adopt the recommended changes. Both motions were seconded and adopted.

Three additional recommendations were presented for adoption in the final report:

- Recommendation 14 – Increase Long Term Care Insurance Tax Credit
- Recommendation 15 – Establish MAHS Registration Fee/Penalty for Failing to Register
- Recommendation 16 – Special Assistance Income Disregard Study

Following the staff's presentation of recommendations 14, 15, and 16, the Chair asked if there were any questions or comments from the commission members. Ms. Reaves asked the body to consider an additional bill to the report to authorize an increase of $5.00 a day for adult day services.

Rep. Bordsen asked why this recommendation was not brought up sooner. Ms. Reaves followed that she was under the assumption that it would be included since it came up numerous times.

Senator Malone asked if there was a motion to add Ms. Reaves' recommendation to the report. No motion came forward. The Chair then asked for a motion to adopt the report as written with the recommended changes. A motion was made and seconded and was adopted.

Rep. Farmer-Butterfield thanked the commission members and staff, and commented that she received much positive feedback about the commission's work from her constituents and aging advocates across the state. She also thanked her colleagues in the General Assembly who supported the commission. Mr. Sheppard also thanked the commission and staff for their work, and Senator Malone expressed his appreciation to the commission members and staff.

There being no further business, the meeting was adjourned at 11:38 am.

Senator Vernon Malone
Co-Chair

Ruth Merkle
Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY

STATE LEGISLATIVE BUILDING
16 W. Jones Street
Raleigh, North Carolina 27601-1030

April 28, 2008

MEMORANDUM

TO: Members of the North Carolina Study Commission on Aging

FROM: Representative Jean Farmer-Butterfield, Co-Chair
Senator Vernon Malone, Co-Chair

SUBJECT: Meeting Notice

There will be a meeting of the North Carolina Study Commission on Aging:

DAY:	Monday	TIME:	10:00 am
DATE:	May 12, 2008		
LOCATION:	Room 544 Legislative Office Building		

Commission members, please advise Ruth Merkle, Commission Assistant at 733-5898 or e-mail butterfieldla@ncleg.net, or Bonnie McNeil, Commission Assistant, at 733-5880, or e-mail malonela@ncleg.net if you are unable to attend.

Posted:

cc: Committee
Record
Interested Parties

Agenda

North Carolina Study Commission on Aging

Monday, May 12, 2008
10:00 a.m.
Legislative Office Building
Room 544

I. Welcome

Senator Vernon Malone, Cochair
Representative Jean Farmer-Butterfield, Cochair

II. Approval of Minutes

Meetings:
January 24, 2008
February 28, 2008
March 28, 2008
April 10, 2008

Public Hearings:
March 6, 2008
April 24, 2008

III. Presentation of Additional Recommendations

Shawn Parker, Commission Staff, Research Division, NCGA

Discussion and Vote on Additional Recommendations

IV. Presentation of Draft Study Commission on Aging Report

Theresa Matula, Commission Staff, Research Division, NCGA
Shawn Parker, Commission Staff, Research Division, NCGA

Discussion and Vote on the Report

V. Meeting Adjourned

ATTENDANCE

North Carolina Study Commission on Aging

(Name of Committee)

DATES	January 22	February 28	March 6	March 20	April 10	May 12									
Sen. Vernon Malone, Co-Chair						✓									
Rep. Jean Farmer-Butterfield, Co-Chair						✓									
Sen. Stan Bingham						✓									
Rep. Alice Bordsen						✓									
Sen. Katie Dorsett						✓									
Rep. Joe Boylan						✓									
Sen. James Forrester						✓									
Rep. Bob England						✓									
Sen. A.B. Swindell, IV															
Rep. Garland Pierce															
Mr. Anthony Peace						✓									
Honorable Karen Gottovi						✓									
Ms. Judy Pelt															
Mr. David Lowa						✓									
Ms. Jean Reaves						✓									
Honorable Edd Nye						✓									
Mr. Jackie Sheppard, Ex-Officio						✓									
Theresa Matula, Research Staff						✓									
Shawn Parker, Research Staff						✓									
Ben Popkin, Counsel						✓									
Bonnie McNeil, Commission Clerk						✓									
Ruth Merkle, Commission Clerk						✓									

VISITOR REGISTRATION SHEET

Aging — 5/12/08

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TRACY COLVARD	Association for Home & Hospice Care
Polly Williams	NC Justice Center
Mary Bates	AANP - NC
Mary Edwards	DAAS
Steve Freedman	DAAS
Kris McLaughlin	MHANC
Jean Rose	MHA/NC
Jeff Horton	DHSR
Dennis Streets	DHHS - DAAS
Dick Hatch	AARP, NCCOA, STHL
Teresa Johnson	NC Adult Day Services Assn

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — 5/12/2008

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Suzanne Merrill	DHHS/DAAS
Karisa Derence	DAAS
Roxanne Ray-Cook	NC Coalition on Aging
Abby Emanuelson	Franklin Co Dept of Aging
CHARLES JACKSON	NMSS - NC Chapters
JIM BREWER	OHA/DMA
Paula Wolf	AHHC
	FORETC

VISITOR REGISTRATION SHEET

Aging
Name of Committee

5/14/08
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andie Carson	FORLTC
Lauren Akers	NCCPPR

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — 5/12/2008

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sue Williamson	NCANPHA 3700 National Dr, 218 Raleigh 27612 swilliamson@ncanpha.org
DAVID BARNES	Poyner + Spruill
Jovey Logan	NCACA
Evelyn Hawthorne	NCACA
Neal Petersen	Citizen - NCACA
Judy Brunger	The Carolinas Center for Hospice & End of Life Care
Jeff Mobley	NC Services for Deaf & Hard of Hearing 2301 MSC Raleigh, NC 27699-2301 Jeff.Mobley@ncmail.net
Larry Nash	DMA
Roger Bone	Bone + Assoc
Lon Walker	NCALTCF
Barbara Canada	BSOR

VISITOR REGISTRATION SHEET

North Carolina Study Commission on Aging — 5/12/2008

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joan Pellettier	NC Ass Area Agencies on Aging

Draft Replacement for Recommendation 6

April 22, 2008

Recommendation 6: Adult Care Home Residents

Recommendation 6a: Adult Care Home Admission Screening Process

The Study Commission on Aging recommends that the General Assembly appropriate $1,764,000 for FY 08-09 to the Department of Health and Human Services, Division of Medical Assistance, to design, develop, and implement on a pilot basis, a screening process for mental health and developmental disability conditions as part of the adult care home admission process. The process shall duplicate the nursing facility admission process and shall consist of an automated screening tool and where indicated a face-to-face assessment by a mental health or developmental disabilities professional. The Division of Medical Assistance shall report on the design, development, and piloting of the screening process for mental health and developmental disability conditions as part of the adult care home admission process on or before October 15, 2008.

Recommendation 6b: Transitional Residential Treatment Program Pilot Sites

The Study Commission on Aging recommends that the General Assembly appropriate $567,084 for FY 08-09 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to fund three (3) geographically diverse Transitional Residential Treatment Program pilot sites, which shall begin in January 2009.

Recommendation 6c: Care of Individuals with Mental Illness Training for Direct Care Workers in Adult Care Homes

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Health Service Regulation, Division of Medical Assistance, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to work with adult care home providers to build on recent studies to determine the most appropriate and cost effective way to provide training on the care of individuals with mental illness to direct care workers in adult care homes by tailoring the training to resident assessment results and utilizing web-based formats as appropriate, and to provide an interim report to the Study Commission on Aging by November 1, 2008, and a final report by November 1, 2009.

Recommendation 6d. Assessment and Service Plan Development for Adult Care Home Residents

The Study Commission on Aging recommends that the General Assembly appropriate $580,000 for FY 08-09 to the Department of Health and Human Services, Division of Medical Assistance to support assessment and service plan development for adult care home residents and to provide an interim report by November 1, 2008, and a final report by November 1, 2009.

Background: Adult Care Home Residents

S.L. 2007-156 (SB 164) directed 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 adult care homes to provide appropriate care to residents with mental illness.

On March 28, 2008, the Commission heard a presentation of the report prepared in response to S.L. 2007-156. The report provides an overview of how eight (8) other states handle placement of mentally ill individuals in assisted living/adult care home facilities; information on the limited use of adult care home special care units for residents with mental health disorders; revisions to staffing rules; recommendations and cost figures on the screening, assessment, and the provision of services to mentally ill individuals in adult care homes; and proposed training recommendations and associated costs.

The report indicates the percentage of residents with mental illness as compared to the total number of residents. The report indicates that family care homes (facilities with six or fewer beds) had in the following years, the percentage of adults with mental illness: 2002 = 38.1%, 2003 = 52.7%, 2004 = 60%, 2005 = 44.4%, 2006 = 45.5%, and 2007 = 46.3%. Adult care homes (seven or greater beds) had in the following years, the percentage of adults with mental illness: 2002 = 18.2%, 2003 = 27.7%, 2004 = 30.8%,

2005 = 20.2%, 2006 = 20.2%, and 2007 = 19%.

The report provides a process to assess and provide care to meet the needs of adult care home residents, especially mentally ill residents. The key first step to providing care is to assess the type of care needed through the implementation of screening and assessment programs. Currently a physician designates the appropriate level of care for a potential resident using the FL-2 form. The Department has developed the Medicaid Uniform Screening Tool (MUST, Level I) which is anticipated to replace the FL-2 form in September 2008. If the MUST screening determines that additional mental health assessment is needed, the individual would be referred for the PASARR, Level 2 Assessment. The PASARR Level 2 Assessment will determine whether the individual needs a specialized mental health service. According to the report, if a PASARR Level 2 assessment indicates that specialized mental health services are needed, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) will be notified and service needs will be communicated to the Local Management Entity (LME). The LME will then contact the individual. The Department estimates the PASARR Level II costs for FY '08-09 as $1,764,000 and $281,840 on a recurring basis.

The report outlines the need for $580,000 to develop and automate a comprehensive assessment and care plan system for residents in adult care homes. This assessment, care planning, and training system is being developed through VieBridge, Inc. with funding from the North Carolina Association Long Term Care Facilities (NCALTCF). The NCALTCF and the Department of Health and Human Services, Divisions of Health Service Regulation and Medical Assistance, have worked in a collaborative arrangement on this system. The funding would be used to support the assessment and care planning system for adult care home residents and statewide implementation is anticipated January 1, 2009.

The report provides information on development of Transitional Residential Treatment Programs. This new type of 6-bed residential facility would provide 24-hour residential treatment and rehabilitation of adults who have a pattern of difficult behaviors related to mental illness which exceed the capabilities of traditional community residential settings. The Department would like to pilot three (3) sites at an annual cost of $378,056/site and anticipates being able to utilize funds beginning in January 2009. This would require an appropriation of $567,084 for FY 2008-2009 ($378,056 x 3 = $1,134,168 / 2= $567,084.)

The report outlines three layers of training: Two (2) hours of Basic Orientation training for all facility staff; Twelve (12) hours of Specialized (Phase Two) Training for aides and direct supervisors of all facilities serving one or more persons with mental illness; and four (4) hours of Annual Training for aides and direct supervisors of all facilities serving one or more persons with mental illness. An annual cost of $4,500,00 was provided for the training.

The report also suggests the following to take place after screening and assessment: $334,000 for PASAAR Level II assessments to determine specialized mental health care needs and $14,860,000 to develop capacity to care for adult care home residents needing mental health services.

After the April 10, 2008 meeting and approval of the Commission's initial recommendation on this topic, the Department of Health and Human Services decided to scale back implementation of the Medicaid Uniform Screening Tool (MUST), which was the basis for the recommendation to develop and implement PASARR, Level II screening prior to adult care home admission. Although MUST will not be ready for Statewide implementation, the Department anticipates that it will have a screening tool in place in by fall 2008, and that this initial screening tool will be able to identify those residents that will need a face-to-face mental health evaluation. Therefore, the Commission is recommending that the General Assembly appropriate $1,764,000 for FY 08-09 to the Department of Health and Human Services, Division of Medical Assistance, to design, develop, and implement on a pilot basis, a screening process, for mental health and developmental disability conditions as part of the adult care home admission process. It is anticipated that the process will duplicate the nursing facility admission process and will consist of an automated screening tool and where indicated a follow-up face-to-face assessment by a Mental Health or Developmental Disabilities professional.

In it's report to the Commission, the Department provided that after a mental health assessment is completed, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) staff would make the final determination about whether the individual needed specialized mental health screening, contact the LME to arrange for services, and follow-up to be sure services are provided. The report requested $334,000 for five additional positions to provide this function. For the pilot implementation of the mental health evaluation contained in this recommendation, it is anticipated that

DMH/DD/SAS will absorb this function.

This revised recommendation also requires the Division of Medical Assistance, Division of Health Service Regulation, and DMH/DD/SAS to report on the design, development, and piloting of the screening process for mental health and developmental disability conditions as part of the adult care home admission process an interim report by October 15, 2008, with a final report due October 15, 2009. The Division's report must contain findings and recommendations to include: results on how many individuals were received initial screening prior to admission, how many needed an additional mental health evaluation, and how many of those screened were admitted to an adult care home; a process chart of the screening for adult care home admissions, who performs the screening, and turnaround times for each step in the process; whether there are delays due to pre-admission screening and how these are handled; whether the process should be expanded to all adult care home admissions on a Statewide basis; whether statutory or policy changes are needed for Statewide implementation; and costs associated with Statewide implementation.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-31 [v.2] (04/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/1/2008 10:28:35 AM

Short Title: Improve Adult Care Home Screening and Care. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR AN ADULT CARE HOME SCREENING PROCESS FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITY CONDITIONS, APPROPRIATE FUNDS FOR TRANSITIONAL RESIDENTIAL TREATMENT PROGRAM PILOT SITES, APPROPRIATE FUNDS TO SUPPORT ASSESSMENT AND SERVICE PLAN DEVELOPMENT IN ADULT CARE HOMES, AND TO STUDY SUITABLE METHODS TO PROVIDE DIRECT CARE WORKERS WITH TARGETED AND COST EFFECTIVE TRAINING ON THE CARE OF INDIVIDUALS WITH MENTAL ILLNESS, AS RECOMMENDED BY THE 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 Medical Assistance, the sum of one million seven hundred sixty-four thousand dollars ($1,764,000) for the 2008-2009 fiscal year to be used to design, develop, and implement on a pilot basis, a screening process for mental health and developmental disability conditions as part of the adult care home admission process. This process shall duplicate the nursing facility admission process and shall consist of an automated screening tool, and where indicated, a face-to-face assessment by a mental health or developmental disabilities professional.

SECTION 1. (b) The Department of Health and Human Services, Division of Medical Assistance, Division of Health Service Regulation, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall provide an interim report by October 15, 2008, and a final report by October 15, 2009, to the North Carolina Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and the House of Representatives Appropriations Subcommittee on Health and Human Services, on the design, development, and piloting of the

screening process provided in this section. The report must contain the following information:

(1) The number of individuals that received initial screening prior to adult care home admission as a result of the pilot.

(2) The number of individuals that needed and received an additional mental health evaluation as a result of the pilot.

(3) Of the individuals screened, the number admitted to an adult care home.

(4) Of the individuals screened, the number for which adult care home placement was not deemed appropriate.

(5) A process chart of the screening process for adult care home admissions, depicting who performs the screening, and turnaround times for each step in the process.

(6) Information on whether pre-admission screening resulted in adult care home admission delays and how these are handled.

(7) A recommendation on whether the screening process should be expanded Statewide to include all individuals prior to adult care home admission.

(8) A recommendation on statutory or policy changes that are needed for Statewide implementation

(9) A breakdown of costs associated with Statewide implementation of a screening process.

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of five hundred sixty-seven thousand eighty-four dollars ($567,084) for the 2008-2009 fiscal year to be used to fund three Transitional Residential Treatment Program pilot sites which shall be located in geographically diverse regions and shall begin operation in January 2009.

SECTION 3. (a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, the sum of five hundred eighty thousand dollars ($580,000) to support assessment and service plan development for adult care home residents.

SECTION 3. (b) The Department of Health and Human Services, Division of Medical Assistance, and the Division of Health Service Regulation, shall provide an interim report to the North Carolina Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and the House of Representatives Appropriations Subcommittee on Health and Human Services, by November 1, 2008, and a final report by November 1, 2009, on assessment and service plan development for adult care home residents and the use of funding appropriated in this section.

SECTION 4. The Department of Health and Human Services, Division of Medical Assistance, Division of Health Service Regulation, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall work with adult care home providers and build on recent studies to determine the most appropriate

and cost effective way to provide training on the care of individuals with mental illness to direct care workers in adult care homes by tailoring the training to resident assessment results and utilizing web-based formats as appropriate. The Department of Health and Human Services, Division of Medical Assistance, and the Division of Health Service Regulation, shall provide an interim report to the North Carolina Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and the House of Representatives Appropriations Subcommittee on Health and Human Services, by November 1, 2008, and a final report by November 1, 2009, on findings and recommendations for training of direct care workers.

SECTION 5. This act becomes effective July 1, 2008.

Three Additional Recommendations for Commission on Aging Consideration

Offered by Representative England

April 22, 2008

Recommendation 14: Increase Long Term Care Insurance Tax Credit

Recommendation 14: Increase Long Term Care Insurance Tax Credit

The Study Commission on Aging recommends that the General Assembly increase the Long-Term Care Insurance Tax Credit to 75% of the premiums paid by the purchaser up to a maximum of $1000.

Background: Increase Long Term Care Insurance Tax Credit

In 1997, the North Carolina Study Commission on Aging recommended that the 1997 General Assembly enact a 15% tax credit, up to a maximum of $350, on the premiums paid by the purchaser of long-term care insurance policies. According to the 1997 Commission report, the Office of State Budget and Management estimated that a 15% tax credit up to a maximum of $350 may result in a revenue loss of $17 million. The report further stated that, the average premium was $1,600, thus a 15% credit would be equal to $240. The report acknowledged that it was difficult to estimate the offsetting benefits of the tax credit in terms of reduced Medicaid payments, but that the cost of a year's stay in a North Carolina nursing home was $40,000. The Commission recommended this tax credit again in 1998, and the credit became G.S. 105-151.28.

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.

2003 and 2004, the Commission recommended repealing the sunset. The Commission's report to the 005 General Assembly, the North Carolina Study Commission on Aging recommended that the General Assembly re-enact the Long-Term Care Insurance Tax Credit.

In 2007, S.L. 2007-273 reinstated the tax credit in an amount of 15% of the premium paid each year on a long-term care insurance policy with the stipulation that the credit could not exceed $350 for each policy for which the credit is claimed. The credit amount is the same as originally enacted in 1998.

The current credit differs from the former credit in that, to be eligible to claim it, a taxpayer's adjusted gross income must not exceed the following: Married filing jointly $100,000; Head of Household 80,000; Single 60,000; Married filing separately 50,000. The current credit is effective for taxable years beginning on or after January 1, 2007, and expires for taxable years beginning on or after January 1, 2013.
The tax credit will currently sunset on January 1, 2013.

The North Carolina Study Commission on Aging has supported the long-term care insurance tax credit since its inception recommends increasing the Long-Term Care Insurance Tax Credit.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SQfz-14 [v.2] (04/28)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/30/2008 2:36:36 PM

Short Title: Increase Long Term Care Insurance Tax Credit. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE LONG TERM CARE INSURANCE TAX CREDIT AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 105-151.28 reads as rewritten:

"**§ 105-151.28. (Repealed for taxable years beginning on or after January 1, 2013) Credit for premiums paid on long-term care insurance.**

(a) Credit. – A taxpayer whose adjusted gross income (AGI), as calculated under the Code, is less than the amount listed in this section is allowed, as a credit against the tax imposed by this Part, an amount equal to ~~fifteen percent (15%)~~seventy-five percent (75%) of the premium costs the taxpayer paid during the taxable year on a qualified long-term care insurance contract that offers coverage to either the taxpayer, the taxpayer's spouse, or a dependent for whom the taxpayer was allowed to deduct a personal exemption under section 151(c) of the Code for the taxable year. The credit allowed by this section may not exceed ~~three hundred fifty dollars ($350.00)~~one thousand dollars ($1000.00) for each qualified long-term care insurance contract for which a credit is claimed. The credit allowed under this section may not exceed the amount of tax imposed by this Part for the taxable year reduced by the sum of all credits allowed, except payments of tax made by or on behalf of the taxpayer. A nonresident or part-year resident who claims the credit allowed by this subsection shall reduce the amount of the credit by multiplying it by the fraction calculated under G.S. 105-134.5(b) or (c), as appropriate.

Filing Status	**AGI**
Married, filing jointly	$100,000
Head of Household	80,000
Single	60,000
Married, filing separately	50,000

(b) No Double Benefit. – No credit is allowed for payments that are deducted from, or not included in, the taxpayer's gross income for the taxable year. If the taxpayer claimed a deduction for health insurance costs of self-employed individuals under section 162(l) of the Code for the taxable year, the amount of credit otherwise allowed the taxpayer under this section is reduced by the applicable percentage provided in section 162(l) of the Code. If the taxpayer claimed a deduction for medical care expenses under section 213 of the Code for the taxable year, the taxpayer is not allowed a credit under this section. A taxpayer who claims the credit allowed by this section must provide any information required by the Secretary to demonstrate that the amount paid for premiums for which the credit is claimed was not excluded from the taxpayer's gross income for the taxable year.

(c) Definition. – For purposes of this section, the term "qualified long-term care insurance contract" has the same meaning as defined in section 7702B of the Code.

(d) Sunset. – This section is repealed for taxable years beginning on or after January 1, 2013.".

SECTION 2. This act is effective taxable years beginning on or after January 1, 2009.

Regulation. The Department shall charge each registered multiunit assisted housing with services program a nonrefundable annual registration fee of three hundred and fifty dollars ($350.00). Any individual or corporation that establishes, conducts, manages, or operates a multiunit housing with services program, subject to registration under this section, that fails to register is guilty of a Class 3 misdemeanor, and upon conviction shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense. Multiunit assisted housing with services programs are required to provide a disclosure statement to the Division of Health Service Regulation. The disclosure statement is required to be a part of the annual rental contract that includes a description of the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, are exempt from the regulatory requirements for multiunit assisted housing with services programs."

SECTION 2. This act becomes effective January 1, 2010.

Recommendation 15: Establish MAHS Registration Fee/Penalty for Failing to Register

ecommendation 15: Establish MAHS Registration Fee/Penalty for Failing to Register

The Study Commission on Aging recommends that the General Assembly enact legislation to require facilities meeting the definition of multiunit assisted housing with services (MAHS) register annually with the Division of Health Services Regulation, authorize the Division to charge a fee of up to $350 per registration, and make it a Class 3 misdemeanor punishable only by fine for failing to register.

Background 15: Establish MAHS Registration Fee/Penalty for Failing to Register

Effective July 1,1996, Session Law 1995-535 established a third type assisted living residence termed multiunit assisted housing with services (MAHS). G.S. 131D-2(a)(7a) defines multiunit assisted housing with services as an assisted living residence in which hands-on personal care services and nursing services are arranged by housing management and are provided by a licensed home care or hospice agency, through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not need 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's established plan of care. MAHS programs are required to register with the Division of Health Service Regulation and to provide a disclosure statement. The disclosure statement is required to be part of the annual rental contract that includes a description requirements further specified in the law. MAHS programs are regulated by North Carolina Building Codes for senior apartment construction, Medicaid, Medicare, and licensure of Home Care agencies by the Division of Health Services Regulation. These cilities do not have to complete the Certificate of Need process.

ession Law 2000-67, Section 11.11, directed the North Carolina Study Commission on Aging to study the following in regard to MAHS: (1) What strategies may be employed at the State and local level to ensure registration of MAHS facilities with the Department of Health and Human Services, as required under G.S. 131D-2(a)(7a); (2) Whether persons requesting access to MAHS facilities should be included in the assessment process that is part of the uniform portal of entry system; and (3) Whether an advocacy and oversight system for MAHS facilities should be developed that is comparable to the advocacy and oversight system in place for adult care homes. In response to the above requirement, on August 8, 2000, the Commission heard the following presentations: an overview of the differences between assisted living and MAHS; the regulatory structure; independent housing; housing for the elderly, and assisted living. Minutes from the meeting indicate that the Director of the Division of Facility Services at that time indicated that there were 12 MAHS facilities currently registered. Minutes indicated that Members wanted to know if the Division finds a facility in operation that has not been registered are there any fines. The Division of Facility Services Director stated that there is nothing the Division can do because there are no fines for not registering. The Director suggested this might be something the Commission could discuss in the future as possible legislation. The Study Commission on Aging's Report to the Governor and the 2001 Session of the 2001 General Assembly indicates that the Commission once again addressed MAHS on November 21, 2000. The following excerpt is from the Commission proceedings from November 21, 1000.

> "As a follow-up to the August 8, 2000 discussion, the Commission discussed Multiunit Assisted Housing with Services (MAHS). The Commission was directed by S.L. 2000-67 (HB 1840), Section 11.11 to study this issue. Following much discussion, the Commission determined that this is an evolving issue and clear direction for the 2001 General Assembly is not readily apparent. Thus, the north Carolina Study commission on Aging voted to make no recommendation to the 2001 General Assembly concerning the current statutory framework for the Multiunit Assisted Housing with Services. The Commission also voted to continue to monitor the development and the need for any statutory changes for Multiunit Assisted Housing with Services."

On February 28, 2008, during the presentations by organizations that represent older adults, the Commission heard concerns that there was limited oversight to the required registration and that enforcement measures were currently inadequate to determine an accurate count of multiunit assisted housing operating in the State.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SQfz-15 [v.5] (04/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/29/2008 2:20:48 PM

Short Title: Multiunit Asst. Housing Svs. Regis. Fee. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE MULTIUNIT ASSISTED HOUSING WITH SERVICES (MAHS) PROGRAMS TO REGISTER ANNUALLY WITH THE DIVISION OF HEALTH SERVICE REGULATION AND TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH CERTAIN FEES, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2(a)(7a) reads as rewritten:

" (7a) Effective July 1, 1996, "multiunit assisted housing with services" means an assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency, through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's established plan of care. Multiunit assisted housing with services programs are required to ~~register~~register annually with the Division of Health Service ~~Regulation and to provide a disclosure statement.~~

Recommendation 16: Special Assistance Income Disregard Study

Recommendation 16: Special Assistance Income Disregard Study

The Study Commission on Aging recommends the Department of Health and Human Services, Division of Aging and Adult Services, and Division of Medical Assistance, study whether North Carolina can implement an income disregard policy for current Special Assistance and Medicaid recipients who are adversely impacted due to cost of living or other income increases.

Background 16: Special Assistance Income Disregard Study

State/County Special Assistance (SA) is a Supplemental Security Income (SSI) state supplement that pays cash benefits to eligible recipients residing in licensed facilities that are authorized to receive SA payments. State/County Special Assistance is 50% county dollars and 50% State dollars.

State/County Special Assistance recipients that live in an adult care home are automatically eligible for Medicaid. Medicaid provides coverage for personal care services and other services provided by Medicaid.

Department of Social Services caseworkers work with individuals to determine eligibility. According to the Department of Health and Human Services, Special Assistance/Adult Care Home (SA/ACH) is available to otherwise eligible applicants with a monthly income of $1,218.50 or less and who have savings and assets worth less than $2,000. Countable income includes wages, Social Security and SSI, retirement income and Veteran's Administration income. Assets that are considered include: property, cash, savings, checking accounts, stocks, bonds, annuities, some IRAs, and the case value of life insurance policies.

Special Assistance payments are tied to the maximum rate adult care homes can charge SA recipients for room and board. Effective October 1, 2007, the maximum rate set by the General Assembly is $1,173.

The SA rate for an individual is determined by taking the maximum adult care home rate, adding a personal needs allowance of $36 dollars to allow for clothes and other essentials each month, and subtracting out net countable monthly income. The resulting amount is payment to the adult care home for room and board.

On occasion, individuals receive cost of living increases to their source of income and may no longer be eligible for SA, even though they could be only slightly above the threshold.

Because SA/ACH recipients are automatically eligible for Medicaid, North Carolina must explore implications of such a policy change with the Centers for Medicare & Medicaid Services, through the Division of Medical Assistance, and with the Social Security Administration.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-30 [v.3] (04/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/29/2008 3:50:22 PM

Short Title: Special Asst. Income Disregard Study. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF AGING AND ADULT SERVICES, AND DIVISION OF MEDICAL ASSISTANCE, TO STUDY IMPLEMENTATION OF AN INCOME DISREGARD POLICY FOR CURRENT STATE/COUNTY SPECIAL ASSISTANCE AND MEDICAID RECIPIENTS WHO ARE ADVERSELY IMPACTED DUE TO COST OF LIVING OR OTHER INCOME INCREASES, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. (a) The Department of Health and Human Services, Division of Aging and Adult Services, and Division of Medical Assistance shall study implementation of an income disregard policy for current State/County Special Assistance and Medicaid residents who are adversely impacted due to cost of living or other income increases.

SECTION 1.(b) The Department of Health and Human Service, Division of Aging and Adult Services, and Division of Medical Assistance, shall report the findings and recommendations of the study contained in this section to the Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and the House of Representatives Appropriations Subcommittee on Health and Human Services, on or before October 1, 2009.

SECTION 2. This act is effective when it becomes law.

North Carolina
Study Commission on Aging

May 1, 2008

To: Members of the North Carolina Study Commission on Aging

Enclosed for your review is the draft North Carolina Study Commission on Aging Report to the Governor and the 2008 Regular Session of the 2007 General Assembly. The draft report includes the recommendations approved by the Commission on April 10, 2008.

In addition to the draft report, additional draft recommendations have been included for your review. These will be discussed and voted on during the next Commission meeting. These draft recommendations include:

- A draft recommendation to replace recommendation 6 which was approved by the Commission on April 10. This change was needed due recent developments regarding the Medicaid Uniform Screening Tool (MUST). Essentially only the underlined language in this replacement draft recommendation is new.
- Three draft recommendations being proposed by Representative Bob England in response to his request to offer them during the April 10th meeting.

The Commission will hold its final meeting of the interim on Monday, May 12, 2008 at 10:00 a.m. in Room 544 of the Legislative Office Building.

Enclosures

NORTH CAROLINA

STUDY COMMISSION ON AGING

DRAFT

REPORT TO THE GOVERNOR AND THE 2008 REGULAR SESSION OF THE 2007 GENERAL ASSEMBLY

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North Carolina
Study Commission On Aging

May 12, 2008

To: Governor Michael Easley
Lieutenant Governor Beverly Perdue, President of the North Carolina Senate
Senator Marc Basnight, President Pro Tempore of the North Carolina Senate
Representative Joe Hackney, Speaker of the North Carolina House of Representatives
Members of the 2008 Regular Session of the 2007 General Assembly

Attached is a report from the North Carolina Study Commission on Aging submitted pursuant to North Carolina General Statute §120-187. The report contains recommendations and proposed legislation from the North Carolina Study Commission on Aging based on study conducted after the adjournment of the 2007 Regular Session of the General Assembly.

Respectfully submitted,

Senator Vernon Malone
Co-Chair

Representative Jean Farmer-Butterfield
Co-Chair

North Carolina Study Commission On Aging

2007-2008 Membership List

President Pro Tempore's Appointments

Senator Vernon Malone, Co-Chair

Senator Stan Bingham

Senator Katie Dorsett

Senator James Forrester

Senator A.B. Swindell, IV

Mr. Anthony Peace

Mr. Judy Pelt

Ms. Jean Reaves

Speakers' Appointments

Representative Jean Farmer-Butterfield, Co-Chair

Representative Alice Bordsen

Representative Joe Boylan

Representative Bob F. England, MD

Representative Garland Pierce

Ms. Karen Gottovi

Mr. David Lowa

Mr. Edd Nye

Ex Officio:
Mr. Jackie Sheppard, Assistant Secretary,
Long Term Care and Family Services,
Department of Health and Human Services

Clerks:
Bonnie McNeil
919/733-5880

Ruth Merkle
919/733-5898

Staff:
Theresa Matula,
Shawn Parker,
Ben Popkin
Research Division
919/733-2578

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2007-SHZ-23 AN ACT TO APPROPRIATE ADDITIONAL FUNDS TO THE SENIOR CENTER GENERAL PURPOSE FUND, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2007-SHZ-24 AN ACT TO APPROPRIATE ADDITIONAL FUNDS FOR THE HOME AND COMMUNITY CARE BLOCK GRANT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2007-SHZ-25 AN ACT TO APPROPRIATE FUNDS FOR PROJECT C.A.R.E. (CAREGIVER ALTERNATIVES TO RUNNING ON EMPTY) WHICH PROVIDES CONSUMER-DIRECTED RESPITE CARE AND COMPREHENSIVE SUPPORT TO DEMENTIA CAREGIVERS WITH A GOAL OF INCREASING RESPITE AND SUPPORT SERVICES TO LOW-INCOME RURAL AND MINORITY CAREGIVERS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2007-SHZ-26 AN ACT TO APPROPRIATE FUNDS TO ENACT A PILOT PROGRAM TO ASSESS CHANGES PROPOSED BY THE ADULT PROTECTIVE SERVICES TASKFORCE WITH A GOAL OF IMPROVING NORTH CAROLINA'S SYSTEM OF RESPONDING TO ALLEGATIONS OF ABUSE, NEGLECT, EXPLOITATION, OR SUBSTANTIAL RISK OF VULNERABLE AND ELDER ADULTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2007-SHZ-29 AN ACT TO PROVIDE A COMPREHENSIVE FIVE-YEAR STATEWIDE STUDY OF THE STATE'S READINESS TO RESPOND TO THE COMING WAVE OF OLDER ADULTS BY ESTABLISHING A STEERING COMMITTEE FOR THE STUDY, APPROPRIATING FUNDS TO PROVIDE STAFF TO SUPPORT THE COMMITTEE, AND APPROPRIATING FUNDS FOR THE FIRST YEAR OF THE STUDY, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

2007-SQZ-11 AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATING TO RESPITE CARE AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

2007-SQZ-12 AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATING TO HEARING LOSS IN OLDER ADULTS IN NORTH CAROLINA AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

2007-RDZ-26 AN ACT TO AUTHORIZE THE NORTH CAROLINA STATE BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS TO OBTAIN CRIMINAL HISTORY RECORD CHECKS OF APPLICANTS FOR LICENSURE AS NURSING HOME ADMINISTRATORS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2007-SHZ-27 AN ACT TO RAISE THE CEILING ON THE TOTAL AMOUNT OF PERSONAL PROPERTY A GUARDIAN IS ALLOWED TO SELL WITHOUT A COURT ORDER UNDER THE LAWS PERTAINING TO GUARDIANSHIP, AS RECOMMENDED BY THE HOUSE STUDY COMMITTEE ON STATE GUARDIANSHIP LAWS AND SUPPORTED BY THE STUDY COMMISSION ON AGING.

2007-SHZ-28 AN ACT AUTHORIZING THE DIVISION OF MOTOR VEHICLES TO CONSIDER RECOMMENDATIONS FROM THE CLERK OF COURT IN DETERMINING WHETHER TO REVOKE THE DRIVERS LICENSE OF A PERSON ADJUDICATED INCOMPETENT UNDER THE GUARDIANSHIP LAWS, AS RECOMMENDED BY THE HOUSE STUDY COMMITTEE ON STATE GUARDIANSHIP LAWS AND SUPPORTED BY THE STUDY COMMISSION ON AGING.

HB 93 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.

HB 92 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.

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. 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 2007-2008 interim. The Commission met on five occasions and held public hearings in Wilson and Jamestown. During a meeting on February 28, 2008, the Commission heard brief presentations on issues of interest or concern to organizations that represent older adults. The public hearings, conducted in March and April, provided citizens with an opportunity to speak to Commission members about programs and services for older adults. Based on reports received by the Commission, input from organizations that represent older adults, and comments expressed by citizens, the Study Commission on Aging presents the recommendations contained in this report.

EXECUTIVE SUMMARY

The North Carolina Study Commission on Aging met five times and conducted two public hearings during the 2007-2008 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 2008 Session of the 2007 General Assembly:

Recommendation 1: Senior Center Funds

The Study Commission on Aging recommends that the General Assembly appropriate an additional $500,000 for the 2008-2009 fiscal year to the Senior Center General Purpose Fund with the intent that it shall become part of the continuation budget.

Recommendation 2: Additional HCCBG Funds

The Study Commission on Aging recommends that the General Assembly appropriate an additional $2,500,000 to the Department of Health and Human Services for the 2008-2009 fiscal year for the Home and Community Care Block Grant (HCCBG).

Recommendation 3: Funds for 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 the 2008-2009 fiscal year to fund Project C.A.R.E. (Caregiver Alternatives to Running on Empty) which provides support to individuals with dementia and their caregivers.

Recommendation 4: Adult Protective Services Pilot Program

The Study Commission on Aging recommends that the General Assembly appropriate $1,497,087 to the Department of Health and Human Services, Division of Aging and Adult Services, for the 2008-2009 fiscal year to enact the first year of a two-year pilot program to assess proposed changes to the adult protective services statutes and to report to the Study Commission on Aging on the evaluation of the pilot by March 1, 2010.

Recommendation 5: Statewide Aging Study

The Study Commission on Aging recommends support for a comprehensive, five-year statewide study of the older adult population and the State's readiness to respond to the coming wave of older adults by recommending that the General Assembly take the following steps: establish an appointment process for a steering committee; appropriate $175,000 to the Department of Health and Human Services, Division of Aging and Adult Services, for the establishment of two positions to support the work of the study; appropriate $3,820,000 to the Division of Aging and Adult Services for the 2008-2009 fiscal year, to fund the first year of the study; and direct the Department of Health and Human Services, Division of Aging and Adult Services, to make annual reports to the General Assembly on the status of the study.

Recommendation 6: Adult Care Home Residents (SEE REPLACEMENT IN MAILING)

The Study Commission on Aging recommends that the General Assembly appropriate $1,764,000 for FY 08-09 to the Department of Health and Human Services, Division of Medical Assistance, for development of the PASARR Level II assessment which is a face-to-face mental health evaluation for adult care home residents, or potential residents, that are referred for this level of evaluation; to

appropriate $580,000 to support assessment and service plan development for each resident; and to appropriate $567,084 for FY 08-09 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to fund three (3) geographically diverse Transitional Residential Treatment Program pilot sites, which shall begin in January 2009. Additionally, the Department of Health and Human Services, Division of Health Service Regulation, Division of Medical Assistance, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall work with adult care home providers to build on recent studies to determine the most appropriate and cost effective way to provide training to adult care home employees by tailoring the training to resident assessment results and utilizing web-based formats as appropriate, and to provide an interim report to the Study Commission on Aging by November 1, 2008, and a final report by November 1, 2009.

Recommendation 7: Support for a Reward System for Adult Care Homes with High Ratings

The Study Commission on Aging expresses support for the creation of a reward system for adult care homes that achieve high ratings and at the appropriate time, the Commission anticipates supporting the concepts outlined in the Department's report on S.L. 2007-544, Section 3(d).

Recommendation 8: Support for Respite Care

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Aging and Adult Services, to study the adequacy of service standards and funding for group respite services, and whether opportunities exist to streamline and enhance the provision of respite services; direct the Division of Medical Assistance, Department of Health and Human Services, to study the feasibility of providing respite care as a State Plan Service, and provide a report on both issues to the Commission on Aging by November 1, 2009.

Recommendation 9: Study Older Adult Hearing Loss

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to study the current and anticipated impact of hearing loss on North Carolina's older adult population and the availability and access to qualified professionals for treatment and hearing aid purchase assistance for low income individuals; to develop an inventory of the technology available to assist individuals; and to evaluate resources and programs available in other states, with a report to the Study Commission on Aging by November 1, 2008.

Recommendation 10: Criminal Background Checks for Nursing Home Administrators

The Study Commission on Aging recommends that the General Assembly enact legislation to give the North Carolina Board of Nursing Home Administrators the authority to require a criminal history record check for nursing home administrator license applicants.

Recommendation 11: Support Guardianship Study Recommendations

The Study Commission on Aging recommends that the General Assembly enact legislation to authorize the Division of Motor Vehicles to consider recommendations from the clerk of court in determining drivers license revocation of an incompetent individual, and to raise the ceiling on the amount of personal property a guardian is allowed to sell without court order, which are both based on recommendations from the House Study Committee on State Guardianship Laws to the 2007 General Assembly.

Recommendation 12: Study Safe Transport of Passengers in Wheelchairs

The Study Commission on Aging recommends that the General Assembly enact House Bill 93, Transport of Individuals in Wheelchairs Study, as it directs the Department of Transportation to study appropriate methods of transporting passengers seated in wheelchairs, to develop guidelines for the installation and use of wheelchair tie-down systems, and to report findings and recommendations to the Study Commission on Aging and the Joint Legislative Transportation Oversight Committee. (House Bill 93 is currently in the Senate Committee on Transportation and was a recommendation to the 2007 General Assembly from the Study Commission on Aging.)

Recommendation 13: Study Medically Needy Income Standard

The Study Commission on Aging recommends that the General Assembly enact House Bill 92, Medicaid Income Limits Level Study, as it requires 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. (House Bill 92 is currently in Senate Appropriations and was a recommendation to the 2007 General Assembly from the Study Commission on Aging.)

Aging North Carolina: The 2008 Profile

Prepared by the Department of Health and Human Services, Division of Aging and Adult Services

North Carolina's Demographic Shift

North Carolina remains in the midst of a significant demographic change as the state's 2.3 million baby boomers (those born between 1946 and 1964) are beginning 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. The Baby Boomer Milestones table 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, and as of January of this year, some of the oldest boomers began receiving their first Social Security payments.

Table: Baby Boomer Milestones

	Year when oldest boomers become eligible						
Programs	2006	2007	2008	2009	2010	2011	2012
NC Senior Games participation (55)							
Older Americans Act services (60)							
Social Security at a reduced rate (62)							
Medicare benefits (65)							
Medicaid assistance for the Aged (65)							
Full Social Security (66)							

Figure A: Growth of Older North Carolinians Age 65+ (2000-2030)

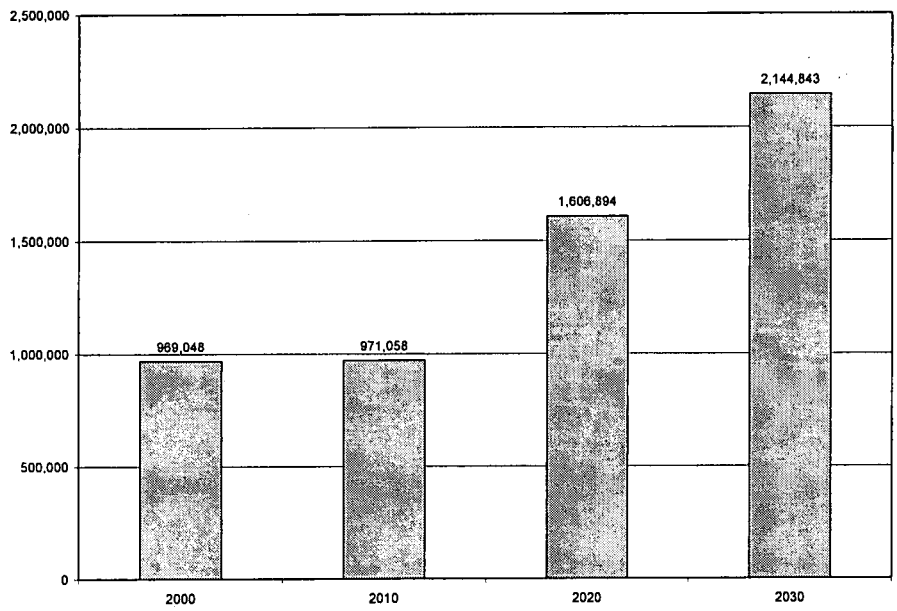
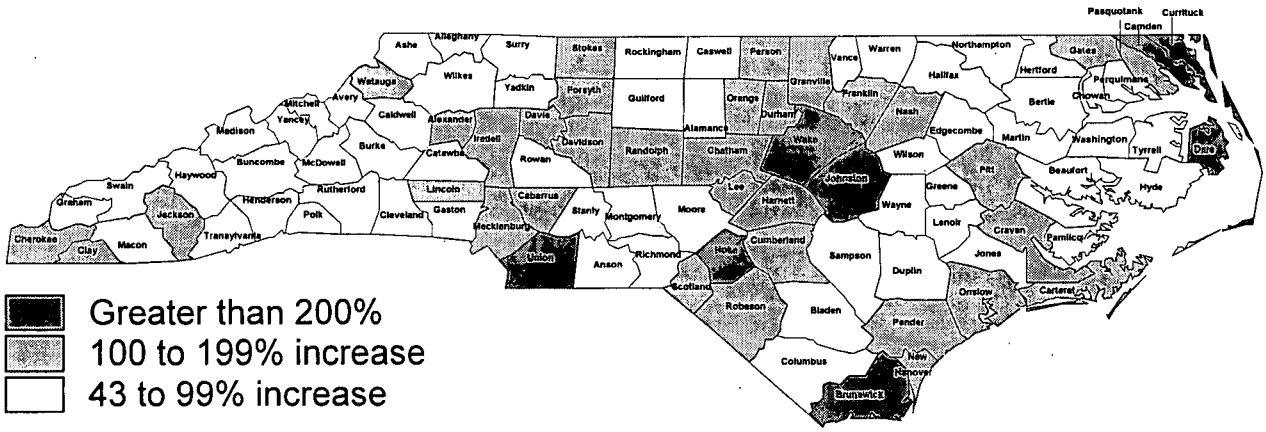


Figure A indicates the projected growth of North Carolinians age 65+ from the year 2010 to the year 2030. [1] The impact of the aging baby boomers is clearly indicated. As the ar graph shows, there is little expected growth in the older population between 2000 and 2010. This is because the Great Depression 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. However, due to 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 is expected to grow 144 percent. [1]

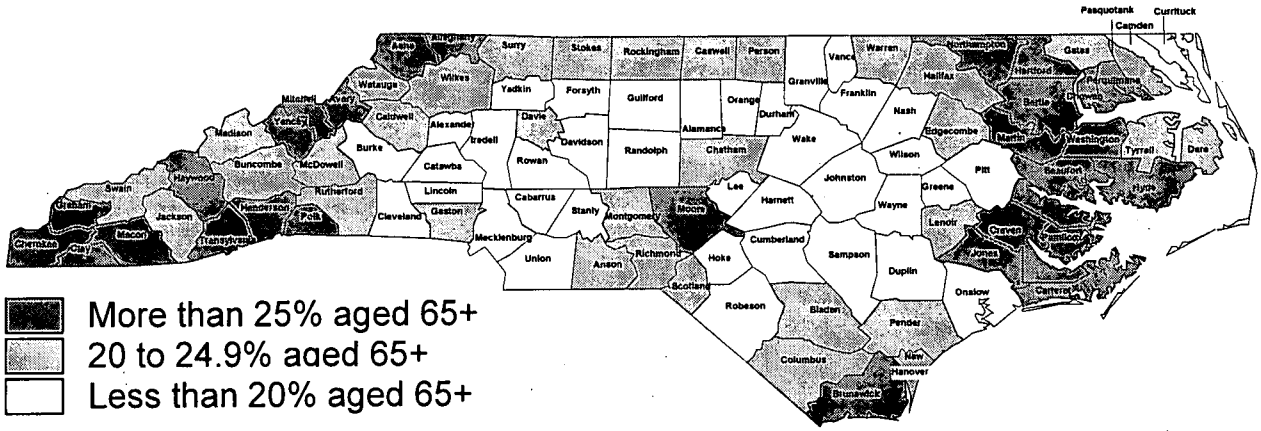
The eight counties with more than 200 percent growth can be divided into two very different categories. Union, Wake, Johnston, and Hoke counties are experiencing rapid growth in their overall population as expanding parts of metropolitan areas, and they will remain relatively "young" (the proportion 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

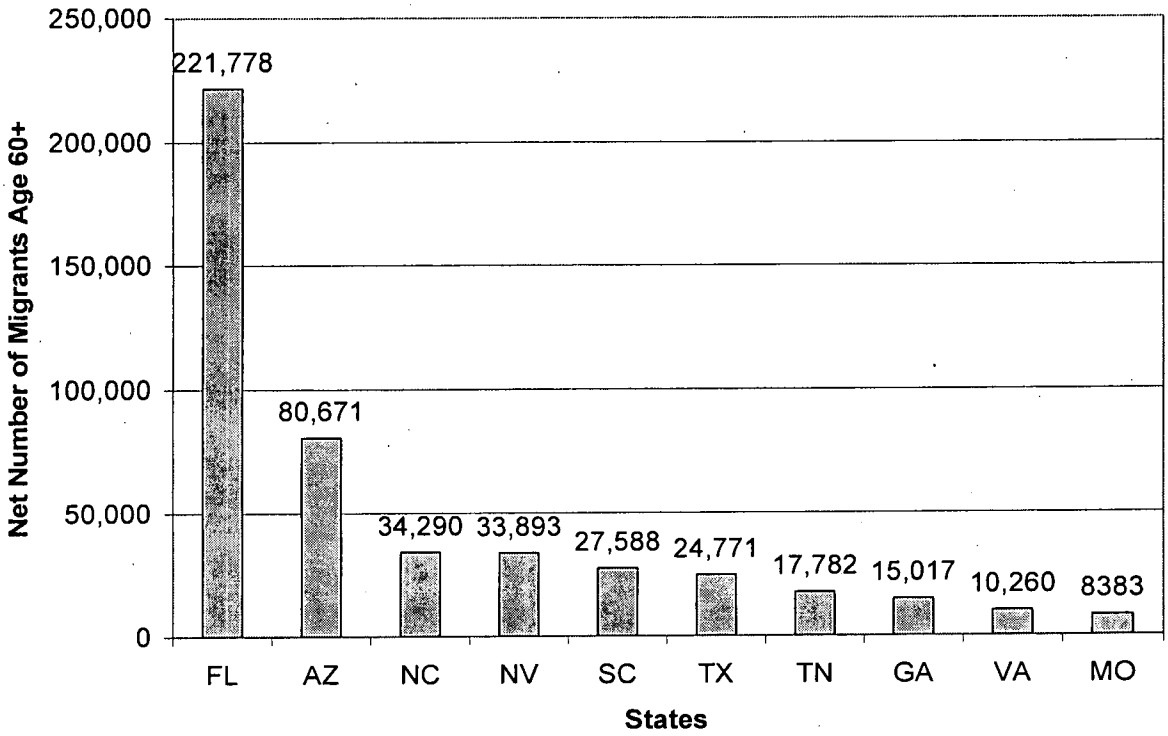
Figure C shows the counties that will have the largest concentration of older adults in 2030. All are in areas attractive to retirees, but many are also counties that will continue to lose younger residents because of modest economic opportunities.

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. The following factors contribute to the different rates of aging in the state's 100 counties [2]:

- 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.
- 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, as well as other select counties with attractions to specific groups of older adults (e.g., golf courses).

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 estimate is that 30,491 older adults (60+) relocated to North Carolina from other states and abroad, in just one year, between 2005 and 2006 [4]. That means that in 2006, two percent of people age 60 and older currently residing in North Carolina had been living in another state the previous year.

Figure D: Top Ten States with Net Number of Migrants Age 60+ (1995-2000)



According to the most recent life tables from the North Carolina 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 Division of Aging and Adult Services, Department of Health and Human Services, introduced a new initiative–Livable and Senior-Friendly Communities–to raise awareness of the aging of our population. The initiative was also designed to encourage North Carolina's communities to become more senior-friendly, and livable for all people, through collaboration among citizens, agencies, organizations, and programs, in both the public and private arenas. This initiative formed the core around which the 2007–2011 State Aging Services Plan was 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, 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 good 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 tenth 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: 1,059,551 (12.0 percent of total population)
- Estimated NC population age 85+ in 2006: 132,412 (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.

- Gender: Older women represent 59.8 percent of the 65+ age group and 72.4 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 2005, 89% of married couples and 88% of nonmarried persons aged 65 or older received Social Security benefits. Social Security was the major source of income (providing at least 50% of total income) for 54% of aged beneficiary couples and 72% of aged nonmarried beneficiaries. It was 90% or more of income for 22% of aged beneficiary couples and 42% of aged nonmarried beneficiaries. [11]

Percent of Unmarried Individuals 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 (15.6 percent in NC compared to 8.3 percent nationally) and a smaller proportion of Latinos (1.2 percent in NC compared to 6.4 percent nationally). American Indians, Asian Americans, and other ethnic groups account for 2.0 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	5.0	8.5	17.6	23.5
Age Group 75+	6.5	12.6	21.9	35.0
Data from 2006 American Community Survey reflecting poverty in 2005.				

- Residence: The 2000 Census showed that in North Carolina, 81.4 percent of householders age 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, 42.0 percent of the non-institutionalized civilian population ages 65 and older reported having one or more disabilities by the US Census definition—45.5 percent of women and 40.7 percent of men, according to the 2006 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 stroke, 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 lifestyle 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 66 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 2006 American Community there were 85,358 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 1.6 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 773,861 veterans living in North Carolina in 2007, over 263,755, or 34 percent, were age 65 and older. Another 260,811 (33 percent) were age 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 earlier 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.

Summary

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 issues, but also new attitudes, new challenges, new opportunities, and new resources.

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[23] US Census Bureau (2008). *2006 American Community Survey.* Table B10050.

[24] AARP (2006). *A State Fact Sheet for Grandparents and Other Relatives Raising Children.*

[25] US Department of Veterans' Affairs *VetPop2006 Version 1.0 State and National Tables (yearly projections)* http://www1.va.gov/vetdata/docs/11.xls

[26] US Department of Veterans' Affairs (2002) *VA History in Brief http://webpages.charter.net/wisconsinlegion-7thdistrict/VA_History.htm#Vietnam_War*

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

January 24, 2008

The North Carolina Study Commission on Aging met on Thursday, January 24, 2008, at 10:00 a.m.. in Room 643 of the Legislative Office Building. Senator Vernon Malone presided. Following introductions, Theresa Matula, Commission staff, presented an overview of the Commission's responsibilities and statutory authority, the tentative meeting schedule for the interim, and the Commission's budget. The Commission approved the budget.

Next the Commission heard from Shawn Parker, Commission staff, who presented a status report of the Study Commission on Aging's recommendations to the Governor and the 2007 General Assembly. A copy of the 2007 Recommendation Status Report is included in Appendix A. Ben Popkin, Commission staff, then presented a document containing summaries of substantive legislation related to older adults that was enacted during the 2007 Session. The Summary of Substantive Legislation Related to Aging is included in Appendix A. Mr. Popkin was followed by Melanie Bush of the Fiscal Research Division who provided an overview of 2007-2009 legislative budget actions and special provisions which are also provided in Appendix A.

The next presentation was an overview of older adults in North Carolina provided by Ms. Matula. Her presentation focused on: who they are, how many there are, where they live, and what types of programs and services are available for older adults in North Carolina. The presentation included data on changes in the North Carolina population which depict the probability of significant growth in the older adult population. The presentation included a brief summary of the range of services provided in the State which include: Senior Games, Senior Centers, Adult Day Care and Adult Day Health Care, State/County Special Assistance, the State/County Special Assistance In-Home Program, the services provided by Home and Community Care Block Grant funds, the Community Alternatives Program for Disabled Adults (CAP/DA), assisted living, Multiunit Assisted Housing with Services, Adult Care Homes, Nursing Homes, and Continuing Care Retirement Communities. Ms. Matula ended her presentation by mentioning additional information and resources including the Area Agencies on Aging and various divisions within the Department of Health and Human Services that serve older adults.

The last presentation for this meeting was a report required by S.L. 2007-355, Section 2. In response to the growth projections for the age 60+ population, the Division of Aging and Adult Services, Department of Health and Human Services, was required to make recommendations on a study to include all counties in North Carolina. The legislation required that the recommendation specify the criteria that should be included in a study and an appropriate funding level for such a study. Dennis Streets, Director, Division of Aging and Adult Services, reported that of the states surveyed, 15 states indicated that they had undertaken a comprehensive statewide study in the past five years. The reported costs ranged from $20,000 to $500,000 for the survey, but the states emphasized that the important work does not end in a study. In fact, the study is just the beginning. In response to these findings, the Division recommended the following: the State create a strategic steering team; assess consumer needs, assets, and expectations; assess State and local awareness and preparedness; conduct special studies; support State and local planning; and create an aging data warehouse. The Division estimated a cost of $175,000 for the establishment of two positions to support the work of the study, and $3,820,000 to fund the first year of the study. Of the $3,820,000, $1,470,000 would be used to strengthen the capacity of Area Agencies on Aging (AAA) for support of regional and local planning (including $270,000 to restore AAA State support reduced in 2001, and $1,200,000 to add a position at each AAA to facilitate regional and community planning for

aging). The remaining $2,000,000 would provide $20,000 to each county to aid the work of citizen-driven local aging leadership planning teams.

For a period of time, the agenda and handouts for this meeting are available on the internet at: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38. (Look under 2007-08 Interim Committee Meetings, 1-24-08 Meeting.)

February 28, 2008

The North Carolina Study Commission on Aging met on February 28, 2008, at 1:00 p.m. in Room 544 of the Legislative Office Building. Representative Jean Farmer-Butterfield was the presiding Co-Chair.

During this meeting, the Commission heard brief presentations from 21 associations and organizations that represent older adults. Each organization presented their legislative priorities and or issues of concern to the Commission. For summary purposes, the issues mentioned with the greatest frequency were: Increase Home and Community Care Block Grant Funds, Increase Senior Center Funds, Provide Funding for Project C.A.R.E., Support for Adult Protective Services/Enact and Fund the Adult Protective Services Clearinghouse Model Pilot, and Increase Funds for New and Existing Special Care Dental Programs (Care in Underserved Areas, Long-term Care, Disabled Seniors at Home). A Summary of Issues Most Frequently Mentioned by Organizations Representing Older Adults is located in Appendix B.

The Commission also heard a report on Project C.A.R.E. (Caregiver Alternatives to Running on Empty). Steve Freedman, Service Operations Section Chief, Division of Aging and Adult Services, Department of Health and Human Services; Dr. Charles Dickens, Speaker, Senior Tar Heel Legislature; and Lisa Gwyther, Family Support Program Director, Duke Center for the Study of Aging and Human Development; provided information about Project C.A.R.E. The goal of Project C.A.R.E is to increase quality, access, choice, and use of respite and support services to low-income rural and minority families caring for a person with dementia at home or within a hospital setting. The program currently has three pilot sites that serve 14 counties and is administered through the Division of Aging and Adult Services. The Division receives consultation and technical assistance from the Duke Aging Center Family Support Program and is currently based within the Mecklenburg County Department of Social Services, and two area offices of the Western Carolina Alzheimer's Chapter. Project C.A.R.E. has received national recognition by numerous organizations as a best practice model. Funding thus far has been provided by the U.S. Administration on Aging's Alzheimer's Disease Demonstration Grants, leveraged through grants provided by private foundations, and supplemented by Family Caregiver Support Programs. However, grant funding is no longer an option for this particular program and State funding is needed to continue the program. It was reported that the Department of Health and Human Services, Division of Aging and Adult Services, would need $500,000 to sustain Project C.A.R.E. activities in 14 western and piedmont counties.

For a period of time, the agenda and handouts for this meeting are available on the internet at: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38. (Look under 2007-08 Interim Committee Meetings, 2-28-08 Meeting.)

March 6, 2008

The North Carolina Study Commission on Aging conducted the first of two public hearings this interim on March 6, 2008, at 10:00 a.m. in the Upper Coastal Plain business Development Center, Wilson, North Carolina. Representative Jean Farmer-Butterfield was the presiding Co-Chair. At this hearing, forty-two (42) people spoke to Commission members about a number of concerns

including: Increase Funding/Continue 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 Home and Community Care Block Grant (HCCBG), Resolve Issues Related to Mentally Ill in Long-Term Care Facilities, Increase Funding/Support for Senior Friendly Housing. Appendix C contains a summary of the public hearing comments.

March 28, 2008

The North Carolina Study Commission on Aging met on Friday, March 28, 2008, at 10:00 a.m. in Room 544 of the Legislative Office Building. Senator Vernon Malone was the presiding Co-Chair. At this meeting, the Commission received a summary of the issues most frequently mentioned during organization presentations and public hearings; heard a presentation from Dr. Victor Marshall, Director, UNC Institute on Aging; and received reports on Respite Care, Mentally Ill in Adult Care Homes, and a Reward System for Adult Care Homes with High Ratings.

Theresa Matula, Commission staff, presented summaries of the issues most frequently mentioned on February 28, 2008, by organizations representing older adults, and a summary of the issues most frequently mentioned during the public hearing on March 6, 2008. These summaries are located in Appendix B and Appendix C.

Next, Victor Marshall, Director, UNC Institute on Aging, provided the Commission with information about UNC Institute on Aging and the projects and programs that it supports. Dr. Marshall also expressed: recommendations for a statewide aging study; the importance of addressing public health issues of older adults; support for the Win A Step Up program; and concerns related to aging workforce initiatives, specifically mentioning the Forum on North Carolina's Aging Workforce, a two-day conference scheduled for September 23-24, 2008.

In response to S.L. 2007-39, Larry Nason, Chief, Facility and Community Care Section, Division of Medical Assistance, Department of Health and Human Services (DHHS), provided a report on respite care. The report included information on the availability of respite care in North Carolina, respite care in other states, and outlined four model programs. The respite care study group made the following findings: separate statutory language for respite care is not needed; the existing licensure and certification systems used by the Division of Health Service Regulation and the Division of Aging and Adult Services allow for appropriate regulation of all levels and types of respite care; consistent and predictable State funding for current respite care models is needed; currently NC Medicaid only provides respite care as a billable service under its waiver programs and as such, respite care is not provided as a "regular Medicaid" benefit under the State Plan. The study group recommended that the North Carolina General Assembly provide an appropriation for Project C.A.R.E., increase the State Adult Day Care Fund, and expand the Aging and Disability Resource Connections to increase information and access on respite care services. The study group also recommended that the Division of Aging and Adult Services study the place of group respite programs in the long-term care continuum and assess the adequacy of service standards and funding, and that the Division of Medical Assistance continue to study the potential of respite as a State Plan Service.

S.L. 2007-156 required 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 adult care homes to provide appropriate care to residents with mental illness. Jackie Sheppard, Assistant Secretary, Long Term Care and Family Services, DHHS, and Bonnie Morrell, Best Practice & Community Innovations Team Leader, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, DHHS presented the report. The report includes: an

overview of how eight other states handle placement of mentally ill individuals in assisted living/adult care home facilities; information on the limited use of adult care home special care units for residents with mental health disorders; revisions to staffing rules; recommendations and cost figures on the screening, assessment, and the provision of services to mentally ill individuals in adult care homes; and proposed training recommendations and associated costs.

The report recommended six items at a cost of $20.9 million dollars in recurring funds and approximately $1.8 million in nonrecurring funds. The recommended system includes: developing and automating a comprehensive assessment and care plan system for residents in adult care homes; expanding required minimum training levels; requiring Preadmission Screening and Annual Resident Review (PASARR) Level II assessments of adult care home residents or potential residents who are referred for this level of evaluation; determination of specialized mental health care needs based on PASARR Level II assessments; development of additional capacity to serve residents in adult care homes who need mental health services; and the implementation of a pilot to develop a residential program for people with mental illness currently in adult care homes but who require a different residential setting. The report included a flow chart depicting the steps for an individual with a history of mental illness. The first step included screening adult care home residents using the Medicaid Uniform Screening Tool (MUST) which would identify the need for a face to face mental health evaluation. If the mental health assessment was needed, a professional assessment would be given using PASARR Level II. For those individuals that need specialized mental health services, care would be provided either in a mental health residential setting, or the person would live in the adult care home and mental health care would be provided by community mental health services. The key to implementation of most, if not all, of these changes seem to hinge on screening and assessment of adult care home residents to determine individual needs.

The final report for this meeting presented by Jeff Horton, Chief Operating Officer, Division of Health Service Regulation, DHHS, was on a reward system for adult care homes with high ratings. The report, developed pursuant to S.L. 2007-544, Section 3d., recommended a system modeled after a nursing home program that has been successful in making facilities better places for residents to live and better places for employees to work. The report recommends that adult care homes achieving a four star rating (100 points or higher on two consecutive annual surveys by the Division of Health Service Regulation), under the Star Rating System, are deemed to have received a high rating and are therefore eligible for the reward.

The nursing home program is funded with civil monetary penalties. However, under North Carolina law, fines collected from adult care homes are transferred to local education agencies. As such the General Assembly would have to appropriate funds for the reward system for adult care homes. The Star Rating System is effective January 2009, thus January 2010 would be the first time facilities might be eligible for rewards, assuming a score of 100 points during the 2009 cycle and during the 2010 cycle.

For a period of time, the agenda and handouts for this meeting are available on the internet at: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38. (Look under 2007-08 Interim Committee Meetings, 3-28-08 Meeting.)

April 10, 2008

The North Carolina Study Commission on Aging met at 10:00 a.m. on April 10, 2008, in Room 421 of the Legislative Office Building. Representative Jean Farmer-Butterfield presided. Presentation topics included: criminal background checks for nursing home administrators, guardianship issues, hearing challenges for older adults, and a report on the aging service levels and needs study.

Jane Baker, Executive Director, North Carolina State Board of Examiners for Nursing Home

Administrators, and Steve Fleming, Chair, North Carolina State Board of Examiners for Nursing Home Administrators, presented information on a statutory amendment that would grant the Board the authority to conduct criminal history record checks. Information presented to the Commission indicated that the Board desires the authority to require criminal history record checks on: applicants from North Carolina, applicants seeking licensure by reciprocity, and persons renewing their licenses.

Pamela W. Best, Deputy Legal Counsel, Administrative Office of the Courts, gave the Commission an overview of guardianship in North Carolina. Her presentation focused on the determination of incompetency, the appointment of a guardian, and the powers and responsibilities of guardians. Representative Melanie Goodwin followed the presentation with information on two recommendations from the House Study Committee on State Guardianship Laws to the 2007 General Assembly. The Study Committee on State Guardianship Laws found that guardians currently have the authority to sell up to $1,500 worth of personal property without a court order in order to meet the monetary needs of the ward, but determined that this amount was outdated and insufficient, and recommended that the total amount of personal property allowed to be sold without a court order be increased to $15,000. In response to the findings, House Bill 794 was introduced but did not crossover to the Senate and is not eligible for consideration during the 2008 Session. During the course of their work, the Committee on State Guardianship Laws also found it unnecessary for the Division of Motor Vehicles to automatically revoke the drivers license of an individual who has been declared incompetent. In response, the Committee recommended that the Division of Motor Vehicles be authorized to not automatically revoke the drivers license of an incompetent if the clerk of superior court recommends the incompetent be allowed to retain the drivers license. House Bill 796 was introduced during the 2007 Session, but did not crossover to the Senate and is not eligible for consideration during the 2008 Session.

Dennis Streets, Director, Division of Aging and Adult Services, Department of Health and Human Services presented a report in response to S.L. 2007-355, Section 1. The law directed the Division of Aging and Adult Services, to work with the Division of Health Service Regulation; Division of Medical Assistance; Division of Public Health; and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; to study programs and services for older adults in Brunswick, Buncombe, Gaston, Henderson, Moore, and New Hanover Counties which currently have, or are projected by 2030 to have, the largest numbers of individuals age 60+ when compared to individuals age 17 and younger. In conducting the study, the Division was directed to utilize existing data and resources, to include the Area Agencies on Aging serving each county studied, and to report to the Study Commission on Aging and to the board of county commissioners of each county studied. The study included the following elements: a profile of the current older adult population; a profile of the projected growth for the older adult population; an assessment of the anticipated impact on programs and services that address the needs of the older adult population; identification of programs and services that are currently in place; identification of programs and services that are needed to meet the growth projections; current funding sources for programs and services serving the older adult population; anticipated funding needs for programs and services serving the older adult population; and a delineation of the programs and services that are shared or offered jointly with another county. Mr. Streets outlined the approach taken, the products provided to each of the six counties, and highlighted particular findings for the Commission. The presentation also listed the top areas of concern identified by the survey.

Next, Theresa Matula, Commission staff, presented draft recommendations for the Commission's consideration. The draft recommendations represented a range of programs and issues heard by the Commission during the interim. Ms. Matula presented 13 recommendations with background information for each and explained that once the Commission approved recommendations, they would be compiled in a report, including bill drafts as applicable, for the Governor and the 2008

General Assembly. During this meeting, the Commission approved 13 recommendations contained in this report and agreed to consider several additional recommendations presented by a Commission member at the final meeting on May 12, 2008.

For a period of time, the agenda and handouts for this meeting are available on the internet at: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38. (Look under 2007-08 Interim Committee Meetings, 4-10-08 Meeting.)

April 24, 2008

The North Carolina Study Commission on Aging conducted a second public hearing this interim at 10:00 a.m. on April 24, 2008 at the Town Hall in Jamestown, North Carolina. The Commission heard from fifty-two (52) individuals during this hearing. The issues mentioned with greatest frequency during the Jamestown hearing were: Funding for Project C.A.R.E., Continued Support for the Star Rating System, Support for the Adult Protective Services Pilot Program, Increased Funding for the Home and Community Care Block Grant (HCCBG), Support for Access Dental Care and Mobile Dental Units, Support for Adult Day Care, and Support for Senior Centers. Appendix C contains a summary of the public hearings and information on which topics were mentioned most frequently at both hearings.

May 12, 2008

The North Carolina Study Commission on Aging met on May 12, 1008, at 10:00 a.m. in Room 544 of the Legislative Office Building. Senator Malone was the presiding Co-Chair. During the meeting, staff reviewed the Commission's draft report to the Governor and the 2008 Regular Session of the 2007 General Assembly.

COMMISSION RECOMMENDATIONS

The North Carolina Study Commission on Aging makes the recommendations presented in this report to the Governor and the 2008 Session of the 2007 General Assembly. Each recommendation is followed by background information, and corresponding legislative proposals, if applicable, appear Appendix D of this report.

Recommendation 1: Senior Center Funds

The Study Commission on Aging recommends that the General Assembly appropriate an additional $500,000 for the 2008-2009 fiscal year to the Senior Center General Purpose Fund with the intent that it shall become part of the continuation budget.

Background 1: Senior Center Funds

During 2007, the Study Commission on Aging recommended that the General Assembly appropriate an additional $500,000 for the 2007-2008 Fiscal Year (FY) and $500,000 for the 2008-2009 FY, to the Senior Center General Purpose Fund to provide additional support for Senior Centers. The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contained $200,000 in non-recurring funding for the 2007-2008 FY for the Senior Center General Purpose Fund.

Increasing senior center funds generally, or specifically making the 2007-2008 FY increase recurring, were the most frequently mentioned items during the Wilson public hearing on March 6, 2008 and was mentioned often during the public hearing in Jamestown. Increasing senior center funding was the second most frequently mentioned item during the February 28, presentations to the Commission by organizations representing older adults. It was listed as a priority by the Governor's Advisory Council on Aging, and the Senior Tar Heel Legislature, among others.

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 of Aging and Adult Services reports that there are currently 164 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.

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 2007-2008 FY is $1,465,316 for the Senior Center General Purpose Fund and $100,000 for Senior Center Outreach. An additional 25% local cash or in-kind match is required for receipt of State funds. For FY 2007-08, Senior Centers received a $200,000 increase in General Purpose funds on a non-recurring basis.

Senior Centers receive funding in "shares" – one share for Uncertified Centers (108 centers), two shares for Centers of Merit (8 centers), and three shares for Centers of Excellence (48 centers). The

State allocation distribution for the 2007-2008 FY is: $5,467 for Uncertified Centers, $10,936 for Centers of Merit, and $16,404 for Centers of Excellence.

The Study Commission on Aging recognizes the importance of senior centers and supports enactment of 2007-SHz-23 to provide additional funding for the 2008-2009 fiscal year.

Recommendation 2: Additional HCCBG Funds

The Study Commission on Aging recommends that the General Assembly appropriate an additional $2,500,000 to the Department of Health and Human Services for the 2008-2009 fiscal year for the Home and Community Care Block Grant (HCCBG).

Background 2: Additional HCCBG Funds

Increasing Home and Community Care Block Grant (HCCBG) Funds was the issue mentioned most frequently during the February 28, presentations to the Commission by organizations representing older adults, the second most frequently mentioned item at the public hearing in Wilson and one of the most frequently mentioned items at the Jamestown public hearing. Eight of the 21 organizations that spoke on February 28, supported increasing HCCBG Funds including the Governor's Advisory Council on Aging and the Senior Tar Heel Legislature.

In 2007, the Study Commission on Aging recommended the General Assembly appropriate an additional $5,000,000 to the Department of Health and Human Services for the 2007-2008 fiscal year and $5,000,000 for the 2008-2009 fiscal year for the Home and Community Care Block Grant (HCCBG). The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contained $536,000 in recurring funding for the 2007-2008 fiscal year and the 2008-2009 fiscal year.

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 the services to be provided, the funding levels for these services, and the community service agencies to provide the 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 decide 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), a funding source in the HCCBG, gives priority to serving the "socially and economically needy" and focuses particular attention on the low income minority elderly and on 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 that are 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 the services provided through the Home and Community Care Block Grant and supports increased funding through enactment of 2007-SHz-24.

Recommendation 3: Funds for 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 the 2008-2009 fiscal year to fund Project C.A.R.E. (Caregiver Alternatives to Running on Empty) which provides support to individuals with dementia and their caregivers.

Background 3: Support Project C.A.R.E.

Providing funding for Project C.A.R.E. (Caregiver Alternatives to Running on Empty) was the most frequently mentioned item during the public hearing in Jamestown and the third most frequently mentioned item during the presentations to the Commission by organizations representing older adults. The Governor's Advisory Council and the Senior Tar Heel Legislature both mentioned this item as a legislative priority for their organizations.

In 2007, the Study Commission on Aging recommended that the General Assembly appropriate $500,000 to the Department of Health and Human Services, Division of Aging and Adult Services, for the 2007-2008 fiscal year, and $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. In response to this recommendation, SB 165 and HB 96 were introduced during the 2007 Session and referred to Appropriation Committees, but did not receive further action.

A statistical abstract, "2008 Alzheimer's Disease Facts & Figures," of US data on Alzheimer's disease published by the Alzheimer's Association recently reported that it is anticipated that between 2000 and 2010, North Carolina will experience a 31% increase in the number of people age 65+ with Alzheimer's disease. According to the report, in 2007, there were 311,578 Alzheimer/dementia caregivers providing 268,953,971 hours of unpaid care per year with an economic value of $2,845,533,016. The report notes that in 2005, Alzheimer's disease was the seventh-leading cause of death for people of all ages and the fifth-leading cause of death for people age 65 and over.

The Commission heard a presentation on Project C.A.R.E. during the meeting on February 28, 2008. The goal of Project C.A.R.E. is to increase quality, access, choice, and use of respite and support services to low-income rural and minority families caring for a person with dementia at home or within a hospital setting. The program is administered through the Division of Aging and Adult Services with assistance from the Duke Aging Center Family Support Program. A Project C.A.R.E. in-home visit: assesses the family care environment; identifies the needs and preferences of both the caregiver and the person with dementia; facilitates discussion and mutual understanding among family members; connects the family with community resources; and ensures the provision of quality respite care and support services.

Project C.A.R.E. began with the Alzheimer's Association, Western Chapter, in 2001. Funding thus far has been provided by the U.S. Administration on Aging's Alzheimer's Disease Demonstration Grants, leveraged through grants provided by private foundations, and supplemented by Family Caregiver Support Programs. Initially, the program served six (6) counties. There are currently

three (3) Project C.A.R.E. pilot sites set up to serve 14 counties: Charlotte (Mecklenburg County); Winston-Salem (Forsyth, Surry, and Stokes); and Asheville (Polk, Henderson, Transylvania, Rutherford, Madison, McDowell, Buncombe, Haywood, Jackson, and Swain). The program received national recognition as a model and best practice in 2004 and 2005. Grant funding is no longer an option for this particular program and State funding is needed to continue the program.

The total budget for the program is $433,333, which includes a 25% local match. The federal funding portion of that total is $325,000 and will end June 30, 2008. 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 14 western and piedmont 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 14-county area will yield sufficient funding to meet matching requirements. A possible advantage to this appropriation is that if the State funds the existing program infrastructure and service capacity, North Carolina may be eligible to receive grants to replicate Project C.A.R.E. in Eastern North Carolina, moving toward the ultimate goal of statewide expansion.

The Study Commission on Aging appreciates caregivers, recognizes the importance of respite, supports State funding for Project C.A.R.E., and therefore encourages enactment of 2007-SHz-25.

Recommendation 4: Adult Protective Services Pilot Program

The Study Commission on Aging recommends that the General Assembly appropriate $1,497,087 to the Department of Health and Human Services, Division of Aging and Adult Services, for the 2008-2009 fiscal year to enact the first year of a two-year pilot program to assess proposed changes to the adult protective services statutes and to report to the Study Commission on Aging on the evaluation of the pilot by March 1, 2010.

Background 4: Adult Protective Services Pilot Program

Support for Adult Protective Services/Enact and Fund the Adult Protective Services (APS) Clearinghouse Model Pilot was the fourth most frequently mentioned item during the organization presentations on February 28, and was among the most frequently mentioned items during the public hearings in Wilson and Jamestown.

In 2007, the Study Commission on Aging recommended that the General Assembly appropriate $1,492,000 to the Department of Health and Human Services, Division of Aging and Adult Services, for the 2007-2008 fiscal year and $1,930,000 for the 2008-2009 fiscal year 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. In response to this recommendation, HB 198 and SB 108 were introduced and referred to Appropriations Committees, but no further action was taken.

S.L. 2005-23 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 goals of the APS Clearinghouse Model are to: increase North Carolina's ability to reach out to citizens to offer voluntary services; enable North Carolina 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.

Exploring feasibility of the APS Clearinghouse Model requires implementation of a pilot. The pilot will require funding for staff in county departments of social services to carry out the pilot, and funding for three (3) staff positions in the Division of Aging and Adult Services (DAAS) to plan and conduct the pilot. The total budget for the APS Pilot in the 2008-2009 fiscal year is $1,497,087, broken down as follows: $1,212,805 for county staff (24.103 FTEs for 9-months), $159,532 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. An additional $1,930,107 is needed for the 2009-2010 fiscal year which would be utilized for the following: $1,617,308 for county staff, $188,049 for DAAS staff, $18,000 for public education, and $6,750 for essential services, and $100,000 for evaluation of the pilot.

The Study Commission on Aging realizes the vital importance of safeguarding our older adults and supports the enactment of 2007-SHz-26.

Recommendation 5: Statewide Aging Study

The Study Commission on Aging recommends support for a comprehensive, five-year statewide study of the older adult population and the State's readiness to respond to the coming wave of older adults by recommending that the General Assembly take the following steps: establish an appointment process for a steering committee; appropriate $175,000 to the Department of Health and Human Services, Division of Aging and Adult Services, for the establishment of two positions to support the work of the study; appropriate $3,820,000 to the Division of Aging and Adult Services for the 2008-2009 fiscal year, to fund the first year of the study; and direct the Department of Health and Human Services, Division of Aging and Adult Services, to make annual reports to the General Assembly on the status of the study.

Background 5: Statewide Aging Study

S.L. 2007-355, Section 1, required several Divisions within the Department of Health and Human Services to study programs and services for older adults in Brunswick, Buncombe, Gaston, Henderson, Moore, and New Hanover Counties. These counties currently have, or are projected by 2030 to have, the largest numbers of individuals age 60+ when compared to individuals age 17 and younger.

Since growth projections for the age 60+ population are anticipated to increase overall in North Carolina, S.L. 2007-355, Section 2, required the Division of Aging and Adult Services to make a recommendation on a study to include all counties in North Carolina. The Division was required to evaluate similar studies conducted by other states and to make recommendations on the criteria that should be included and an appropriate funding level for a study to include all North Carolina counties. On January 24, 2008, the Division made a report to the Commission on a statewide study.

The report recommends the establishment of a steering committee to: oversee the design and implementation of a consumer needs assessment and an expectations assessment; oversee the design and implementation of a State and local awareness and preparedness assessment; identify the need for and to obtain additional studies to supplement the information needed for comprehensive planning; produce reports for the Governor and General Assembly to guide policy and program development based on the findings of the assessments and studies; and to identify action needed to ready North Carolina for its growing older adult population. The Committee would be appointed by the General Assembly and the Governor.

The report recommends two positions to support the steering committee: a Human Services Planner/Evaluator IV (pay grade 74), and an Administrative Assistant III (pay grade 67). The cost for these positions is $175,000.

Use of a consumer survey is recommended in years one and four of the statewide study, for design, implementation, analysis, and reporting associated with conducting a survey of consumer needs, assets, and expectations. The anticipated cost is $200,000 for the 2008-2009 fiscal year and $175,000 for the 2011-2012 fiscal year. (It is anticipated that there would be some savings in survey design the second year.) The report recommends funds for design, implementation, analysis and reporting associated with conducting a survey of state and local governments at a cost of $75,000 in the 2008-2009 fiscal year, 2010-2011 fiscal year, and 2012-2013 fiscal year. Additionally, the report recommends $75,000 per year to secure the services of consultants to conduct special studies and otherwise support the work of the steering committee.

With regard to support for program services, the report recommends:

- $1,470,000 per year to strengthen the capacity of Area Agencies on Aging (AAA) for support of regional and local planning (this includes restoring the $270,000 in recurring AAA State support reduced in 2001, and adding a position at each AAA to facilitate regional and community planning for aging at a cost of $1,200,000 million per year (which would total $1.6 million with a 25% match participation rate)).
- Awarding $20,000 to each county to aid the work of citizen-driven local aging leadership planning teams for a total cost of $2,000,000 per year.

The Study Commission on Aging believes that it is necessary for the State to make preparations now to care for the anticipated increase in the older adult population and supports a statewide study of the State's readiness to respond through the enactment of 2007-SHz-29.

Recommendation 6: Adult Care Home Residents (SEE REPLACEMENT IN MAILING)

The Study Commission on Aging recommends that the General Assembly appropriate $1,764,000 for FY 08-09 to the Department of Health and Human Services, Division of Medical Assistance, for development of the PASARR Level II assessment which is a face-to-face mental health evaluation for adult care home residents, or potential residents, that are referred for this level of evaluation; to appropriate $580,000 to support assessment and service plan development for each resident; and to appropriate $567,084 for FY 08-09 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to fund three (3) geographically diverse Transitional Residential Treatment Program pilot sites, which shall begin in January 2009. Additionally, the Department of Health and Human Services, Division of Health Service Regulation, Division of Medical Assistance, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall work with adult care home providers to build on recent studies to determine the most appropriate and cost effective way to provide training to adult care home employees by tailoring the training to resident assessment results and utilizing web-based formats as appropriate, and to provide an interim report to the Study Commission on Aging by November 1, 2008, and a final report by November 1, 2009.

Background 6: Adult Care Home Residents (SEE REPLACEMENT IN MAILING)

S.L. 2007-156 (SB 164) directed 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 adult care homes to provide appropriate care to residents with mental illness.

On March 28, 2008, the Commission heard a presentation of the report prepared in response to S.L.

2007-156. The report provides an overview of how eight (8) other states handle placement of mentally ill individuals in assisted living/adult care home facilities; information on the limited use of adult care home special care units for residents with mental health disorders; revisions to staffing rules; recommendations and cost figures on the screening, assessment, and the provision of services to mentally ill individuals in adult care homes; and proposed training recommendations and associated costs.

The report indicates the percentage of residents with mental illness as compared to the total number of residents. The report indicates that family care homes (facilities with six or fewer beds) had in the following years, the percentage of adults with mental illness: 2002 = 38.1%, 2003 = 52.7%, 2004 = 60%, 2005 = 44.4%, 2006 = 45.5%, and 2007 = 46.3%. Adult care homes (seven or greater beds) had in the following years, the percentage of adults with mental illness: 2002 = 18.2%, 2003 = 27.7%, 2004 = 30.8%, 2005 = 20.2%, 2006 = 20.2%, and 2007 = 19%.

The report provides a process to assess and provide care to meet the needs of adult care home residents, especially mentally ill residents. The key first step to providing care is to assess the type of care needed through the implementation of screening and assessment programs. Currently a physician designates the appropriate level of care for a potential resident using the FL-2 form. The Department has developed the Medicaid Uniform Screening Tool (MUST, Level I) which is anticipated to replace the FL-2 form in September 2008. If the MUST screening determines that additional mental health assessment is needed, the individual would be referred for the PASARR, Level 2 Assessment. The PASARR Level 2 Assessment will determine whether the individual needs a specialized mental health service. According to the report, if a PASARR Level 2 assessment indicates that specialized mental health services are needed, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) will be notified and service needs will be communicated to the Local Management Entity (LME). The LME will then contact the individual. The Department estimates the PASARR Level II costs for FY '08-09 as $1,764,000 and $281,840 on a recurring basis.

The report outlines the need for $580,000 to develop and automate a comprehensive assessment and care plan system for residents in adult care homes. This assessment, care planning, and training system is being developed through VieBridge, Inc. with funding from the North Carolina Association Long Term Care Facilities (NCALTCF). The NCALTCF and the Department of Health and Human Services, Divisions of Health Service Regulation and Medical Assistance, have worked in a collaborative arrangement on this system. The funding would be used to support the assessment and care planning system for adult care home residents and statewide implementation is anticipated January 1, 2009.

The report provides information on development of Transitional Residential Treatment Programs. This new type of 6-bed residential facility would provide 24-hour residential treatment and rehabilitation of adults who have a pattern of difficult behaviors related to mental illness which exceed the capabilities of traditional community residential settings. The Department would like to pilot three (3) sites at an annual cost of $378,056/site and anticipates being able to utilize funds beginning in January 2009. This would require an appropriation of $567,084 for FY 2008-2009 ($378,056 x 3 = $1,134,168 / 2= $567,084.)

The report outlines three layers of training: Two (2) hours of Basic Orientation training for all facility staff; Twelve (12) hours of Specialized (Phase Two) Training for aides and direct supervisors of all facilities serving one or more persons with mental illness; and four (4) hours of Annual Training for aides and direct supervisors of all facilities serving one or more persons with mental illness. An annual cost of $4,500,00 was provided for the training.

The report also suggests the following to take place after screening and assessment: $334,000 for

PASAAR Level II assessments to determine specialized mental health care needs and $14,860,000 to develop capacity to care for adult care home residents needing mental health services.

In an effort to begin to address the issue of mixed populations in adult care homes, the Study Commission on Aging supports enactment of 2007-SHz-xx.

Recommendation 7: Support for a Reward System for Adult Care Homes with High Ratings

The Study Commission on Aging expresses support for the creation of a reward system for adult care homes that achieve high ratings and at the appropriate time, the Commission anticipates supporting the concepts outlined in the Department's report on S.L. 2007-544, Section 3(d).

Background 7: Support for a Reward System for Adult Care Homes with High Ratings

In response to recommendations from the Study Commission on Aging, S.L. 2007-544 was enacted and Section 3 contained provisions related to a rating system for adult care homes. Section 3(d) required the Department of Health and Human Services to study the structure and cost of a system to reward adult care homes that receive high ratings and to report findings and recommendations to the Study Commission on Aging no later than March 1, 2008.

On March 28, 2008, the Commission heard the report on the structure and cost of a system to reward adult care homes receiving high ratings. The report recommended a system modeled after the grant program for nursing homes that is funded on civil monetary penalties. According to the report, the program for nursing homes, which was started in 1996, has been a highly successful, cooperative effort among regulators, providers, advocates, and others to make facilities better places for residents to live and better places for employees to work. Under North Carolina law, fines collected from adult care homes are transferred to local education agencies and therefore, the General Assembly would have to appropriate funds for the reward system for adult care homes.

The report recommends that an adult care homes that achieves a 4 Star Rating (100 points or higher on two consecutive annual surveys by the Division of Health Service Regulation) would receive a high rating and therefore eligible for the reward. The Star Rating System is effective January 2009, thus January 2010 would be the first time facilities might be eligible for rewards, assuming a score of 100 points during the 2009 cycle and during the 2010 cycle. The Department also requested an administrative officer position at a cost of $50,000, to coordinate and administer the grants in response to decisions made by a Grant Committee, which consists of adult care home stakeholders including provider representatives, advocates, Division of Health Service Regulation staff, and others. As such, the estimated costs for this reward system are $300,000 for FY 2009-2010 ($250,000 for rewards and $50,000 for the position) and $550,000 for the 2010-2011 fiscal year.

The Study Commission on Aging supports rewarding adult care homes with high ratings.

Recommendation 8: Support for Respite Care

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services, Division of Aging and Adult Services, to study the adequacy of service standards and funding for group respite services, and whether opportunities exist to streamline and enhance the provision of respite services; direct the Division of Medical Assistance, Department of Health and Human Services, to study the feasibility of providing respite care as a State Plan Service, and provide a report on both issues to the Commission on Aging by November 1, 2009.

Background 8: Support for Respite Care

S.L. 2007-39 directed the Department of Health and Human Services to study the availability and delivery of respite care. On March 28, 2008, the Commission heard a presentation on the Department's report. The Department reported that there is a need for respite care and that the provision of respite care is important for the State from an economic perspective. The report provided an overview of the various respite programs available in North Carolina as well as information on programs in other states. One of the issues noted was the fragmentation of services both in North Carolina and other states. The fragmentation is due to varying eligibility criteria, target client populations, regulatory requirements, programs, and funding streams. The report suggested that, "While the fragmentation makes respite care more difficult to administer, it does provide for the needs of a diverse population." Four model programs for respite care are defined in the report: Project C.A.R.E, Jackson County Family Resource Center, A Small Miracle, Inc. and Senior Companion Respite Program.

The report indicated that the study group did not see a need for separate statutory language for respite care, but believed that consistent state funding was needed under the existing systems. The study group agreed that respite care delivery could be enhanced if Medicaid included respite as a State Plan Service. The report stated that, a respite service, defined as an Optional Medicaid State Plan Service, should be offered to all who qualify, regardless of where the recipient lives or the recipient's diagnosis, and should be based on needs. Further, the report suggested the State may limit the definition, duration, and scope, and that an assessment of caregiver capability was integral to the process. The report indicated that the Division of Medical Assistance would pursue an internal review of this option. Additionally, the report supported study by the Division of Aging and Adult Services, Department of Health and Human Services, on the place of group respite programs in the long-term care continuum and the adequacy of service standards and funding.

The Commission supports caregivers and the provision of respite services and therefore recommends the enactment of 2007-SQz-11 to require the Department of Health and Human Services continue to study ways to make respite care more accessible.

Recommendation 9: Study Older Adult Hearing Loss

The Study Commission on Aging recommends that the General Assembly direct the Department of Health and Human Services to study the current and anticipated impact of hearing loss on North Carolina's older adult population and the availability and access to qualified professionals for treatment and hearing aid purchase assistance for low income individuals; to develop an inventory of the technology available to assist individuals; and to evaluate resources and programs available in other states, with a report to the Study Commission on Aging by November 1, 2008.

Background 9: Study Older Adult Hearing Loss

On April 10, 2008, the Commission heard a presentation from the Department of Health and Human Services on hearing loss for older adults. Based on NC demographic information, the Department of Health and Human Services, Division of Services for the Deaf and the Hard of Hearing, estimated "the current hearing loss population among senior adults to be 166,420 for ages 65-74 with a projected increase in 2030 to 342,897. For senior adults ages 75 and up, current numbers indicate 207,483 persons with hearing loss and a projected increase to 438,801 for the year 2030." Although hearing loss occurs at all ages, the Department shared that the National Institute on Deafness and Other Communication Disorders (NIDCD) reports that one (1) out of every three persons by age 65 has some form of hearing loss. The Department's report highlighted a lack of readily-available and accurate information on the impact, treatment, and adaptive

technology options for individuals with hearing loss. The lack of information is compounded by the often gradual loss of hearing.

The Department pointed out the following issues faced by older adults with hearing loss:

- "Hearing Aids and Limited Insurance Coverage- One of the first challenges that the hard of hearing person faces is the cost of hearing aids. These devices can often cost several thousand dollars and are rarely covered by any insurance. Generally neither Medicare nor NC Medicaid offer hearing aid coverage for adults. North Carolina along with bordering states of Virginia, Kentucky, South Carolina, Georgia, and Tennessee are in the list of 16 states that do not provide this coverage. In addition, there is virtually no insurance coverage for hearing aids in North Carolina.
- Many people report difficulty finding a trustworthy professional to assist them with hearing aids. The lack of a 30-day mandated trial period for hearing aids in North Carolina, one of 14 states without such a policy, instills in some individuals this lower level of trust toward the hearing health care professional.
- A myriad of emotional responses resulting from difficulties in communicating often lead to increased mental health concerns for senior adults. Better Hearing Institute reports that hearing loss, particularly in older individuals not using hearing aid or assistive devices, has been directly linked to short-term memory loss, fatigue, anxiety and depression.
- Among senior adults, hearing loss is one of the most prevalent and chronic, but treatable, disabling condition[s]. Hearing loss is ranked third, only behind arthritis and hypertension. Hearing loss has also been linked to lower incomes—on average, those with hearing loss but do not wear hearing aids earn up to $12,000 per year less than peers using hearing aids."

The Study Commission on Aging recognizes the challenges that hearing loss presents and recommends the enactment of 2007-SQz-12 to require the Department of Health and Human Services study this issue and explore ways to provide assistance to individuals with hearing loss.

Recommendation 10: Criminal Background Checks for Nursing Home Administrators

The Study Commission on Aging recommends that the General Assembly enact legislation to give the North Carolina Board of Nursing Home Administrators the authority to require a criminal history record check for nursing home administrator license applicants.

Background 10: Criminal Background Checks for Nursing Home Administrators

G.S. 131E-265 provides that an offer of employment by a nursing home to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant.

G.S. 90-278 gives the NC State Board of Examiners for Nursing Home Administrators the authority to issue licenses to qualified persons as nursing home administrators. Therefore, a criminal record background check is not required for nursing home administrators because they have an occupational license.

On April 10, 2008, the Commission heard a presentation on this issue by the North Carolina State Board of Examiners for Nursing Home Administrators who requested the ability to perform criminal history record checks for nursing home administrator license applicants.

The Study Commission on Aging believes that it is imperative to provide safe and secure environments in the State's long-term care facilities and supports allowing the North Carolina State Board of Examiners for Nursing Home Administrators to require criminal history record checks for

nursing home administrator applicants through the enactment of 2007-RDz-26.

Recommendation 11: Support Guardianship Study Recommendations

The Study Commission on Aging recommends that the General Assembly enact legislation to authorize the Division of Motor Vehicles to consider recommendations from the clerk of court in determining drivers license revocation of an incompetent individual, and to raise the ceiling on the amount of personal property a guardian is allowed to sell without court order, which are both based on recommendations from the House Study Committee on State Guardianship Laws to the 2007 General Assembly.

Background 11: Support Guardianship Study Recommendations

The House Study Committee on State Guardianship Laws was established by the Speaker of the House on February 17, 2006. The Committee was directed to submit a final report on the results of its study on or before December 31, 2006.

In the final report, Finding 6 indicates that the Committee found that guardians currently have the authority to sell up to $1,500 worth of personal property without a court order in order to meet the monetary needs of the ward. The Committee further found that the amount of a ward's personal property that guardians are allowed to sell is outdated and insufficient. As a result, the House Study Committee on State Guardianship recommended that the total amount of personal property that can be sold without a court order be increased to $15,000. In response to this recommendation, House Bill 794 was introduced. A Committee Substitute for House Bill 794 received a favorable report in the House Committee on Aging and was referred to House Judiciary II. It was not heard in House Judiciary II and House Bill 794 is not eligible for consideration during the 2008 Session.

In the final report, Finding 7 indicates that the Committee on State Guardianship Laws found it unnecessary for the Division of Motor Vehicles to automatically revoke the drivers license of an individual who has been declared incompetent. The Committee recommended that the Division of Motor Vehicles be authorized to not automatically revoke the drivers license of an incompetent if the clerk of superior court recommends the incompetent be allowed to retain the drivers license. In response to this recommendation, House Bill 796 was introduced. House Bill 796 received a favorable report in the House Committee on Aging and was referred to House Judiciary II. It was not heard in House Judiciary II and House Bill 796 is not eligible for consideration during the 2008 Session.

On April 10, the Commission heard a presentation on guardianship and on the issues surrounding an increase in the amount of a ward's personal property that a guardian can sell, and on the automatic revocation of the driver license of an incompetent.

The Study Commission on Aging supports the work of the House Study Committee on State Guardianship Laws and recommends the enactment of 2007-SHz-27 to address drivers license revocation of an incompetent individual, and enactment of 2007-SHz-28 to raise the ceiling on the amount of personal property a guardian is allowed to sell without court order.

Recommendation 12: Study Safe Transport of Passengers in Wheelchairs

The Study Commission on Aging recommends that the General Assembly enact House Bill 93, Transport of Individuals in Wheelchairs Study, as it directs the Department of Transportation to study appropriate methods of transporting passengers seated in wheelchairs, to develop guidelines for the installation and use of wheelchair tie-down systems, and to report findings and recommendations to the Study Commission on Aging and the Joint Legislative Transportation

Oversight Committee. (House Bill 93 is currently in the Senate Committee on Transportation and was a recommendation to the 2007 General Assembly from the Study Commission on Aging.)

Background 12: Study Safe Transport of Passengers in Wheelchairs

The Study Commission on Aging recommended that the 2007 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. House Bill 93 and Senate Bill 57 were introduced. House Bill 93 was referred to the Senate Committee on Transportation on March 13, 2007 and is still eligible for consideration during the 2008 Session.

This recommendation to the 2007 Session was based on a wheelchair transportation safety restraints presentation made to the Commission on November 15, 2006. 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 without 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: problems occur despite well-intentioned efforts to secure the chairs and apply restraints; 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; 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.

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.

The Study Commission on Aging continues to support House Bill 93, a recommendation to the 2007 Session of the General Assembly, which requires a study of appropriate methods of transporting passengers seated in wheelchairs.

Recommendation 13: Study Medically Needy Income Standard

The Study Commission on Aging recommends that the General Assembly enact House Bill 92, Medicaid Income Limits Level Study, as it requires 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. (House Bill 92 is currently in Senate Appropriations and was a recommendation to the 2007 General Assembly from the Study Commission on Aging.)

Background 13: Study Medically Needy Income Standard

The Study Commission on Aging recommended that the 2007 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. House Bill 92 and Senate Bill 110 were introduced. House Bill 92 was referred to the Senate Committee on Appropriations on 3/14/2007 and is still eligible for consideration during the 2008 Session.

This recommendation to the 2007 Session was based on presentations to the Commission 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 12/13/06, 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). The Department reported that there was consensus among stakeholders that while this 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.

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.

The Study Commission on Aging continues to support House Bill 92, a recommendation to the 2007 Session of the General Assembly, which requires a study of the medically needy income standard to determine the best method of increasing the standard while providing improved consistency across long-term care settings.

APPENDICES

APPENDIX A

2007 Recommendation Status Report

North Carolina Study Commission on Aging
Recommendations
to the
2007 Regular Session

Prepared by Staff for the
North Carolina Study Commission on Aging

January 24, 2008

2007 RECOMMENDATION STATUS REPORT

RECOMMENDATION	RESULT
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.	In response to this recommendation, HB 195 and SB 53 were introduced and both were referred to House and Senate Appropriations Committees. • The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473), contains $200,000 in non-recurring funding for FY 07-08 for the Senior Center General Purpose Fund.
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.	In response to this recommendation, HB 201 and SB 52 were introduced. • A Committee Substitute for HB 201 received a favorable report in House Aging and was referred to Appropriations. SB 52 was referred to Senate Appropriations. The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473), provides $200,000 in non-recurring funding for FY 07-08 for a mobile dental provider to deliver services to the frail elderly and persons with disabilities in unserved areas. • S.L. 2007-323, Section 9.5, enacts G.S. 116-40.10 Board of Governors' Dental Scholarship Loan Program. The program provides a four-year scholarship loan of relevant tuition and fees, mandatory medical insurance, required laptop computers to any first-year students, required dental equipment, and an annual stipend of $5,000 per year to any student who has been accepted for admission to the School of Dentistry at the University of North Carolina at Chapel Hill. The Board of Governors adopts the standards for awarding the scholarship loans. The recommendation by the Commission on Aging is not included in this provision.

RECOMMENDATION	RESULT
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.	In response to this recommendation, HB 95 and SB 109 were introduced. • The statutory changes included in these bills is contained in Section 2 of S.L. 2007-544 (SB 56). • The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contains $583,000 in recurring funding and $40,274 in non-recurring funding for FY 07-08. For FY 08-09, $803,000 in recurring funding and $2,750 in non-recurring funding is provided.
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.	In response to this recommendation, SB 165 and HB 96 were introduced and referred to Appropriation Committees.
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).	In response to this recommendation HB 98 and SB 59 were introduced and referred to Appropriations Committees. • The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contains $536,000 in recurring funding for FY 07-08 and FY 08-09.
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.	In response to this recommendation HB 94 and SB 56 were introduced. • S.L. 2007-544 (SB 56) was enacted and Section 1 contains the changes to 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.	In response to this recommendation, HB 93 and SB 57 were introduced. • HB 93 received a favorable report in House Aging, passed 2nd and 3rd reading in the House and crossed over to the Senate where it was referred to the Senate Committee on Transportation. • SB 57 was referred to the Senate Committee on Transportation.

RECOMMENDATION	RESULT
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.	In response to this recommendation, HB 198 and SB 108 were introduced and referred to Appropriations Committees.
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.	In response to this recommendation, HB 92 and SB 110 were introduced and referred to Appropriations Committees. • HB 92 received a favorable report in House Aging Committee, passed 2nd and 3rd reading in the House, and was referred to the Appropriations Committee in the Senate. • SB 110 received a favorable report in Senate Health and was referred to the Appropriations Committee.
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.	No bills were introduced in response to this recommendation. • The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contains $250,000 in non-recurring funding for FY 07-08 to provide grants-in-aid to community organizations to assist seniors in enrolling in NC Rx and Medicare Part D.

RECOMMENDATION	RESULT
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 disabilities, particularly for those individuals that are transitioning out of State psychiatric hospitals and those that are transitioning out of long-term care facilities.	In response to this recommendation, HB 199 and SB 51 were introduced. • HB 199 was referred to the House Committee on Mental Health Reform, and if favorable, to the Committee on Appropriations. SB 51 was referred to the Committee on Appropriations. The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contains $7,500,000 in non-recurring funding to the North Carolina Housing Trust Fund for the financing of additional independent and supporting living apartments for people with disabilities. The apartments shall be affordable to those with incomes at the Supplemental Security Income (SSI) level.
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.	In response to this recommendation, HB 196 and SB 164 were introduced. • S.L. 2007-156 (SB 164) enacted.

RECOMMENDATION	RESULT
<u>Recommendation 13:</u> 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.	In response to this recommendation, HB 197 and SB 58 were introduced. • S.L. 2007-323, Sec. 10.14 (HB 1473, Sec. 10.14) amends Part 3 of Article 2 of Chapter 108A of the General Statutes to add a new section pertaining to Special Assistance in-home payments. The section provides that the Department of Health and Human Services may use funds from the existing State-County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. The payments may be made for up to 15% of the caseload for all State-County Special Assistance for Adults. The standard monthly payment to individuals enrolled in the 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, unless a lesser payment amount is appropriate for the individual as determined by the local case manager. The Department is required to implement Special Assistance in-home eligibility policies and procedures to assure that in-home program participants are those individuals who need and, but for the in-home program would seek, placement in an adult care home facility. The policies and procedures must also include the use of a functional assessment. The Department must make this in-home option available to all counties on a voluntary basis and, to the maximum extent possible, must consider geographic balance in the dispersion of the payments to individuals across the State. The provision requires that for State fiscal year 2007-08, qualified individuals must not receive payments at rates less than they would have been eligible to receive in State fiscal year 2006-07.

RECOMMENDATION	RESULT
<u>Recommendation 14:</u> 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.	No bills were introduced in response to this recommendation.
<u>Recommendation 15:</u> 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.	In response to this recommendation, HB 248 and SB 752 were introduced. • S.L. 2007-544 (SB56) was enacted and Section 3 contains the provisions related to this recommendation. The act requires that the certificates issued to adult care homes contain a rating based, at a minimum, on inspections and substantiated complaint investigations conducted by the Department of Health and Human Services to determine compliance with licensing statutes and rules. Specific areas to be reviewed are listed in the act. • The Health and Human Services Conference Report for S.L. 2007-323 (HB 1473) contains $500,000 non-recurring funding in FY 08-09 to assist adult care homes with the implementation of the adult care home rated certificate program.

RECOMMENDATION	RESULT
<u>Recommendation 16</u>: 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.	In response to this recommendation, HB 97 and SB 99 were introduced and referred to the Appropriations Committees.
<u>Recommendation 17:</u> 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.	This recommendation expresses support for recommendations from the House Study Committee on State Guardianship Laws.

Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

2007 Session

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

January 24, 2008

Enacted Legislation

Extend Restriction on Home Care Licenses

S.L. 2007-125 (SB 748) extends the restriction on the Department of Health and Human Services from issuing licenses to new home care agencies that intend to offer in-home aide services. The initial restriction began on January 1, 2007 and was scheduled to expire December 31, 2007. The restriction is extended to give the Department time to assure compliance with newly adopted home care rules and will expire at the end of the 2008 calendar year. The act specifies that extending the restriction will give the Department additional time to work with existing home care agencies to assure compliance with the newly adopted home care rules. As with the earlier law, this act does not prevent the Department from issuing licenses to certified home health agencies that intend to offer in-home aide services or to agencies that need a new license due to the acquisition of an existing home care agency.

This act became effective June 27, 2007. (SP)

Senior Center Outreach

S.L. 2007-323, Sec. 10.11 (HB 1473, Sec. 10.11) requires that of the funds appropriated for the 2007-009 fiscal biennium, the Department of Health and Human Services, Division of Aging and Adult Services, must enhance senior center programs:

- 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 prevents State funding from exceeding seventy-five percent (75%) of reimbursable costs.

This section became effective July 1, 2007. (TM)

Quality Improvement Consultation Program for Adult Care Homes

S.L. 2007-323, Sec. 10.12 (HB 1473, Sec. 10.12) requires the Division of Aging and Adult Services, Department of Health and Human Services, 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 based on a timetable for statewide implementation.

The Program must address these 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 Health Service Regulation 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 of Aging and Adult Services is required conduct a pilot of the Program. Pursuant to the section, no more than four county departments of social services are allowed to 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. Recommendations regarding expansion of the pilot to other counties, or statewide implementation 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.

This section became effective July 1, 2007. (TM)

State-County Special Assistance

S.L. 2007-323, Sec. 10.13 (HB 1473, Sec. 10.13) provides that effective January 1, 2007, the maximum monthly rate for residents in adult care home facilities is $1,148 per month per resident, unless adjusted by the Department of Health and Human Services, and effective October 1, 2007, the maximum monthly rate for residents in adult care home facilities increases to $1,173, unless adjusted by the 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. Effective July 1, 2007, the Department must recommend rates for State-County Special Assistance and for Adult Care Home Personal Care Services. The Department may recommend rates based on appropriate cost methodology and cost reports submitted by adult care homes that receive Special Assistance funds and must ensure that cost reporting is done for Special Assistance and Adult Care Home Personal Care Services to the same standards as apply to other residential service providers.

This section became effective July 1, 2007. (TM)

Special Assistance In-Home

S.L. 2007-323, Sec. 10.14 (HB 1473, Sec. 10.14) amends Part 3 of Article 2 of Chapter 108A of the General Statutes to add a new section pertaining to Special Assistance in-home payments. The section provides that the Department of Health and Human Services may use funds from the existing State-County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. The payments may be made for up to 15% of the caseload for all State-County Special Assistance for Adults. The standard monthly payment to individuals enrolled in the 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, unless a lesser payment amount is appropriate for the individual as determined by the local case manager. The Department is required to implement Special Assistance in-home eligibility policies and procedures to assure that in-home program participants are those individuals who need and, but for the in-home program would seek, placement in an adult care home facility. The policies and procedures must also include the use of a functional assessment. The Department must make this in-home option available to all counties on a voluntary basis and, to the maximum extent possible, must consider geographic balance in the dispersion of the payments to individuals across the State. The provision requires that for State fiscal year 2007-08, qualified individuals must not receive payments at rates less than they would have been eligible to receive in State fiscal year 2006-07.

This section became effective July 1, 2007. (TM)

Reenact Long-Term Care Credit

S.L. 2007-323, Sec. 31.5 (HB 1473, Sec. 31.5). Long-term care insurance is designed to protect individuals against the high costs of long-term care. The General Assembly enacted a long-term care insurance tax credit in 1998. It expired in 2004. This section of the act reenacts the individual income tax credit for premiums paid on long-term care insurance. The credit amount is equal to 15% of the premium paid each year on a long-term care insurance policy. The credit may not exceed $350 for each policy for which the credit is claimed. The credit differs from the former credit in that, to be eligible to claim it, a taxpayer's adjusted gross income must not exceed a stated amount. For married taxpayers filing jointly, the income limitation is $100,000.

This section becomes effective for taxable years beginning on or after January 1, 2007, and expires for taxable years beginning on or after January 1, 2013. (CA)

Medicaid Hardship/Estate Recovery/Data Share

S.L. 2007-442 (HB 1537) amends the Medicaid estate recovery provisions to allow the Department of Health and Human Services to continue as a fifth class creditor; amends the law regarding required data sharing by health insurers and the Department of Health and Human Services; and codifies the provisions setting forth the Medicaid hardship waiver process.

Medicaid Estate Recovery Plan. – This portion of the act amends S.L. 2005-276, Section 10.21C, which allowed the Department of Health and Human Services to impose liens against real property for Medicaid estate recovery. The act repeals the following four sections: 1) G.S. 108A-70.6 which pertained to the postponement of estate recovery in cases of undue hardship, 2) G.S. 108A-70.7 which provided direction when estate recovery is not cost effective, 3) G.S. 108A-70.8 which added a notice of estate recovery, and 4) G.S. 108A-70.9 which required county departments of social services to provide information and assistance. This portion of the act further amends the Medicaid Estate Recovery Plan to allow the Department to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid for the recipient. This section of the act also amends medical care services listed under the definition of "medical assistance," to specify that medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient if the recipient is 55 years of age or older, no longer include Medicare premiums, private duty nursing, home health aide services, home health therapy, speech pathology services, but now include prescription drugs (replacing the requirement that prescription drugs must be related to nursing facility services or home and community-based services). This portion of the act also grants the Department the authority to adopt rules to waive whole or partial recovery when the recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective.

Data Sharing. – This portion of the act amends the requirements of insurers to provide certain information to the Department of Health and Human Services. It adds the following definitions:

- "Subscriber" – means the policyholder or covered person of the insurance.
- "Applicant" – means an applicant or former applicant of medical assistance benefits.
- "Recipient" – means a present or former recipient of medical assistance benefits.
- "Request" – means any inquiry by the Department or Division for the purpose of determining the existence of insurance where the Department or Division may have expended public assistance benefits.

This portion of the act also allows information to be provided to the Division or its authorized contractor, to determine what period the individual or the individual's spouse or dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer.

Medicaid Hardship. – This final portion of the act amends the Medicaid laws by adding a new section regarding a waiver of the transfer of assets penalty due to hardship. The act makes the following changes:

- *Notice of the Right to Request a Waiver* - Prior to the imposition of a period of ineligibility for long-term care services because of an asset transfer (penalty period), the county Department of Social Services (DSS) must notify the individual of their right to request a waiver of the penalty period because it will cause an undue hardship.
- *Process for Medicaid Applicant* - The determination of whether to waive the penalty period must be processed as part of the Medicaid application and subject to application processing standards set

forth in the administrative rules when a waiver of penalty period due to undue hardship is requested by a Medicaid applicant requesting Medicaid pay for institutional care.

- *Process for Medicaid Recipient* - When an ongoing Medicaid recipient applies for institutional care, or is receiving Medicaid payment for institutional care, receives notice of the right to request a waiver of the penalty period because it will cause and undue hardship, the recipient has 12 calendar days from the date of the notice to request a waiver. The process for the waiver request is as follows:
  - 5 work days from receipt of a request for waiver, the county DSS must notify the individual in writing of the information and documentation necessary for approving the waiver.
  - 12 calendar days from the date of the notice above, the individual must provide the necessary information and documentation to establish the undue hardship.
  - At the end of the first 12 calendar day period, if the necessary information and documentation has not been received by the county DSS, the DSS must notify the individual of the necessary information and documentation and the individual will be given an additional 12 calendar days to provide information.
  - If the individual fails to request a waiver within 12 calendar days, the county DSS must impose the transfer of assets penalty in accordance with G.S. 108A-79.
  - By the end of the second 12 calendar day notice, if the necessary information and documentation has not been received by the county DSS, the DSS will deny the request for waiver and notify the individual of the denial in accordance with G.S. 108A-79.
  - The county DSS shall make a determination of whether the imposition of the penalty period would cause an undue hardship to the individual if the DSS receives the necessary information and documentation within the specified time frames. The county DSS must complete the determination and notify the individual, pursuant to G.S. 108A-58.2(g), that: 1) an undue hardship exists the waiver is approved, or 2) an undue hardship does not exist and the request for a waiver has been denied. During the determination process, if the county DSS identifies the need for additional information and documentation, the individual must be notified in writing given a new period of time to provide the information.
- Under the changes a facility in which an institutionalized individual is residing may request an undue hardship waiver on behalf of the individual with the written consent of the individual or the personal representative of the individual.
- This portion of the act also provides that while the determination on a request for a waiver is pending, Medicaid is prevented from making payments for nursing facility services or intermediate care facility for the mentally retarded services to hold a bed for the individual. If an individual is institutionalized and receiving Medicaid payment for services, Medicaid will maintain the same level of services until the last day of the month after the later of the expiration of the ten day workday period following the notice required by law, or the date the decision of a local appeal hearing described in the law is issued if the individual requests an appeal, whichever comes later.
- *Undue hardship* – This portion of the act provides that undue hardship exists if the imposition of the penalty period would deprive the individual of medical care, such that health or life would be endangered, or of food, clothing, shelter, or other necessities of life. The individual must provide the information and documentation necessary to demonstrate to the Director of the county DSS, or designee, that:
  - The individual currently does has not alternative source of income or resources available to provide the medical care or food, clothing, shelter or other necessities of life that the individual would be deprived of due to the imposition of the penalty; and
  - The individual or person acting on their behalf, is making a good faith effort to pursue all reasonable means to recover the transferred asset, or the fair market value of it, which may include seeking the advice of an attorney and pursuing legal remedies and cooperating with any attempt to recover the transferred asset or the fair market value.

With regard to undue hardship the following definitions apply:

- "health or life would be endangered" – means a medical doctor with knowledge of the individual's medical condition certifies in writing that in his or her professional opinion, the individual will be in danger of death or the individual's health will suffer irreparable harm if a penalty period is imposed.

- "other necessities of life" – includes basic, life sustaining utilities, including water, heat, electricity, phone, and other items or activities that without which the individual's health or life would be endangered.
- "income" – means all income of the individual and to the community spouse less an amount for the community spouse equal to the minimum monthly maintenance needs allowance as determined under 42 U.S.C. 1396r-5(d)(3)(A)(ii) without regard to any adjustment that would be made under 42 U.S.C. 1396r-5(e3) plus fifty percent (50%) of other income in excess of the minimum monthly maintenance needs allowance as described in this section.
- "resources" – means all resources of the individual and of the community spouse except for the excluded home, the equity of a motor vehicle up to $30,000, other personal property, and an amount of other resources for the community spouse equal to sixty percent (60%) of the community spouse resource allowance as determined under 42 U.S.C. 1396r-5(f)(2)(A) which is not less than the amount specified in 42 U.S.C. 1396r-5(f)(2)(A)(i) or greater than sixty percent (60%) of the amount specified in 42 U.S.C. 1396r-5(f)(2)(A)(ii).

➢ Other changes relative to this provision include:
- The specification that an undue hardship does not exist when the application of a transfer of assets penalty merely causes the individual an inconvenience or restricts his or her lifestyle.
- A requirement that during a penalty period that has been waived due to undue hardship, an acquisition by the individual of new or increased income or resources will be treated as a change in situation and evaluated pursuant to rules adopted by the Department of Health and Human Services.
- The disapproval of 10A NCAC 21B.0314, adopted by the Department of Health and Human Services on January 19, 2007 and approved by the Rules Review Commission on March 15, 2007.
- Uncodified language that provides that unless require by federal law, the Department of Health and Human Services, Division of Medical Assistance must limit notification of estate recovery to the application process for Medicaid, and to following the death of the recipient.

Reporting Requirement. - The act requires the Department of Health and Human Services to report by April 15, 2008, to the chairs of the Senate and House of Representatives appropriations Committees and the chairs of the Senate and House of Representatives appropriations Subcommittees on Health and Human Services. The report must include the following information:

➢ For the previous twenty four months, the total expenditure for personal care services for each year, and the total expenditure for each setting in which personal care services were provided.
➢ For the period beginning October 1, 2007, the total number of deceased recipients that received personal care services, the average expenditure for personal care services for those recipients, and the average value of the estate of those recipients.
➢ For the period beginning October 1, 2007, for each estate against which recovery is sought for the provision of personal care services, the total amount of personal care services provided, and the value of the estate.
➢ Recommendations, if any, by the Department for a threshold to begin recovery from the estate of a deceased recipient of personal care services.

This act became effective August 23, 2007. (TM)

Licensure Changes relating to Hospitals, Adult Care Homes, and Mental Health Facilities

S.L. 2007-444 (HB 772) makes a number of changes relating to the laws regulating the licenses of hospitals, adult care homes, and persons employed in mental health facilities or as medication aides as follows:

Licensed Hospitals- The act authorizes the Secretary of the Department of Health and Human Services to suspend admissions in a hospital or a particular service or unit of a hospital where conditions are considered dangerous to the health and safety of its patients after considering the following factors:

➢ The character and degree of impact the conditions would have on a patient's health and safety;
➢ The character and degree of impact the suspension would have on the functionality of the hospital and its ability to serve current patients and the community;
➢ If all other reasonable means for correcting the problem have been exhausted.

The section further provides that the facility may contest any adverse action on its license within 20 days after the Department mails notice. The section directs the Department to provide consultation to assist the hospital in correcting any conditions that led to a suspension of admissions or specific services in an effort to lift the suspension as soon as the Secretary is satisfied that the condition has improved.

The act authorizes the Division of Health Service Regulation (Formerly Division of Facility Services) to temporarily waive rules pertaining to hospitals during times of emergencies declared in accordance to the laws of the North Carolina Emergency Management Act or upon request of an emergency management agency defined in G.S. 166A-4 to the extent necessary to allow the facility to provide temporary shelter and services. The section provides the Division the authority to identify which rules and to what extent they may be waived in advance of an emergency.

Licensed Mental Health Facilities- The act amends G.S. 122C-80 to allow private entities to conduct the required State criminal history check for potential employees of licensed mental health facilities.

Medication Aides- The act makes technical corrections relating to Medication Aides and the Health Care Personnel Registry.

Licensed Adult Care Homes- The act prohibits a new license from being issued due to a change of ownership of an adult care home if outstanding fees, fines, or penalties imposed by the State against the home have not been paid. The section requires investigations of violations at an adult care home must be completed within 60 days.

This act became effective August 23, 2007. (SP)

Smoking Prohibited Inside Long Term Care Facilities

S.L. 2007-459 (HB 1294) prohibits smoking inside long-term care facilities, including adult care homes, nursing homes, skilled nursing facilities, State psychiatric hospitals, and other licensed facilities that provide long-term care services. The act requires owners, managers, or operators of a long-term care facility to:

- conspicuously post a sign stating that smoking is prohibited;
- direct any person smoking inside the facility to extinguish any lighted tobacco product; and
- provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

The act directs home care agencies to prohibit their employees from smoking while providing services in an individual's home. The home care agency is required to inform its clients about the prohibition. Any owner, manager, or operator of facilities or home care agency not complying with the act can be fined by the Department of Health and Human Services an administrative penalty of up $200 per violation.

The provision relating to State psychiatric hospitals becomes effective January 1, 2008 the remainder of the act became effective October 1, 2007. (SP)

Silver Alert System/Missing Persons Alert

S.L. 2007-469 (HB 38) establishes the Silver Alert System and exempts emergency medical services personnel locating missing persons from the private protective services act.

The Silver Alert System will provide a statewide system for the rapid dissemination of information regarding a missing person who is believed to be suffering from dementia or other cognitive impairment. The System will be established within the North Carolina Center for Missing Persons. The Center is required to make every effort to disseminate the information as quickly as possible when the missing person is 18 years of age or older, and the person's status as missing has been reported to a law enforcement agency. A missing person report may be submitted by a parent, spouse, guardian, legal custodian, or person responsible for the supervision of the missing individual. The Center is required to adopt guidelines and develop procedures for issuing an alert for a person believed to be suffering from dementia or other cognitive impairment, to provide education and training to encourage broadcaster participation, and to ensure that specific health information about the missing person is not made public through the alert or otherwise. Additionally, the Center must work with the Department of Transportation to develop a procedure for the use of overhead permanent changeable message signs to provide information on the missing adult.

The act also amends the definition of private protective services to specify that it does not prevent credentialed emergency medical services personnel from engaging in search and rescue activities at the request of either the

State, a political subdivision of the State, or one of following types of facilities: adult care home, health care facility, or facility licensed to offer mental health, developmental disabilities, or substance abuse services. For purposes of these changes, search and rescue is defined as the activities and documents relating to efforts to locate an individual following the individual's disappearance. However, the exemption from the definition of private protective services does not apply if the emergency medical service provider provides services beyond emergency search and rescue and if the activities meet the definition of private protective services.

The act became effective August 29, 2007. (TM)

Adult Care Home or Nursing Home/Expedited Certificate of Need

S.L. 2007-473 (HB 1685) requires the Department of Health and Human Services, Division of Health Service Regulation, to develop an expedited certificate of need review process for a current holder of a certificate of need for an adult care home or a nursing home, allowing the relocation from one licensed facility or campus to another. The expedited certificate of need review process will be available only to a facility that meets the following criteria:

- The facility currently holds a certificate of need for an adult care home or nursing home.
- The facility proposes to move from one licensed facility or campus to another licensed facility or campus.
- Both the current and the proposed facilities or campuses are located within the same county.
- The relocation of the adult care home or nursing home would not result in an increase in the total number of adult care home beds or nursing home beds for that facility or campus.

The Division is required to implement the expedited certificate of need review process no later than October 1, 2007. On or before May 1, 2008, the Department must define the minimum review criteria necessary to determine the need for relocation of a facility by the circumstances required under this act and report to the General Assembly.

This act became effective August 29, 2007, and applies to certificate of need applications for relocation of adult care homes and adult care home beds or nursing homes and nursing home beds within the same county filed on or after the date of implementation of the expedited review process by the Department of Health and Human Services, Division of Health Service Regulation. (TM)

Penalty Review/Long-Term Care Changes

S.L. 2007-544 (SB 56) amends the Penalty Review Committee, expands the Health Care Personnel Registry, and authorizes the Medical Care Commission to adopt rules for the issuance of rated certificates to adult care homes.

Penalty Review Committee. –

- The act amends the Penalty Review Committee, established within the Department of Health and Human Services, to require that the Committee meet as often as needed, but no less frequently than once each quarter of the year to review administrative penalties assessed to adult care homes and nursing homes. The act also makes changes to the notice requirements for Committee meetings to:
  - Require that public notice of Committee meetings be made via Web site.
  - Require that direct notice of the Committee meetings be made to the licensed provider, who must post the notice of the scheduled Penalty Review Committee meeting in a conspicuous place available to residents, family members, and the public.
  - Require that direct notice be provided to the local department of social services that is responsible for oversight of the facility involved and to the residents affected.
  - Replace the requirement of providing direct notice to "families or guardians of the residents affected" with a requirement that direct notice be provided to those individuals lawfully designated by the affected resident to make health care decisions for the resident.
- Changes to the Penalty Review Committee regarding notification to families and training of Committee members represent a return to statutory language that was in place prior to S.L. 2005-276 because the prior language allowed the process to function more efficiently and effectively.

Health Care Personnel Registry. –

- The act expands the Health Care Personnel Registry, maintained by the Department of Health and Human Services, which contains the names of all health care personnel working in health care facilities that have been subject to findings of neglect, abuse, diversion of drugs, fraud, or misappropriation of property. Individuals ("health care personnel") and entities ("health care facilities") subject to the provisions of the Health Care Personnel Registry are defined by law. This act adds the following entities to the list of defined health care facilities:
  - Licensable Facilities – those that provide services for one or more minors, or for two or more adults, who are mentally ill, developmentally disabled, or substance abusers as defined by G.S. 122C-3(14)b.
  - Multiunit Assisted Housing with Services as defined in G.S. 131D-2.
  - 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.
  - Agencies providing in-home aide services funded through the Home and Community Care Block Grant in accordance with G.S. 143B-181.1(a)11.
- The act also expands the definition and coverage of "health care personnel" to include any unlicensed health care facility staff 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.

Issuance of Rated Certificates to Adult Care Homes. –

- Section 10.41, S.L. 2005-276 (SB 622) required the Department of Health and Human Services to develop a plan for implementing a rating system for adult care homes. The report from this requirement indicated that the Medical Care Commission needed authority to adopt rules for the issuance of certificates. This act gives the Medical Care Commission the authority to adopt rules for the issuance of rated certificates to adult care homes.
- The act requires that the certificates issued to adult care homes contain a rating based, at a minimum, on inspections and substantiated complaint investigations conducted by the Department of Health and Human Services to determine compliance with licensing statutes and rules. Specific areas to be reviewed include:
  - Admission and discharge procedures.
  - Medication management.
  - Physical plant.
  - Resident care and services, including food services, resident activities programs, and safety measures.
  - Residents' rights.
  - Sanitation grade.
  - Special Care Units.
  - Use of physical restraints and alternatives.
- The act requires that initial ratings awarded to a facility must be based on inspections, penalties imposed, and investigations of substantiated complaints that revealed noncompliance with statutes and rules, that occurred on or after the act becomes law.
- The act also specifies that Type A penalties will affect a facility's rating for 24 months from the date the penalty is assessed and Type B penalties will affect the rating for 12 months from the date the penalty is assessed.
- Adult care homes are required to display the rating certificate in a location visible to the public. Certificates must include the Web site address for the Department of Health and Human Services, which can be accessed for specific information regarding the basis for the facility rating. For access by the public on request, adult care homes must also maintain on-site a copy of information provided by the Department regarding the basis of the facility rating. The Web site and the on-site materials must provide information on quality improvement efforts undertaken by the facility including: participation in any quality improvement programs approved by the Department and the facility's attainment of the NC NOVA (New Organizational Vision Award) special licensure designation.
- With regard to adult care home rated certificates the act also includes:
  - A requirement that the Department of Health and Human Services provide to the North Carolina Study Commission on Aging a copy of emergency, temporary, and permanent rules adopted.

- The written intent of the General Assembly to provide funding for technical assistance to adult care homes for the 2008-2009 fiscal year. (This funding is provided in Section 10.54, S.L. 2007-323.)
- A requirement that the Department of Health and Human Services, Divisions of Health Service Regulation, Aging and Adult Services, and Medical Assistance, study the structure and cost of a system to reward adult care homes which receive high ratings and to report to the North Carolina Study Commission on Aging not later than March 1, 2008.
- A requirement that the Divisions of Health Service Regulation and Aging and Adult Services study expanding the rated certificate system to other facilities and services licensed and certified by the Department and report to the NC Study Commission on Aging by October 1, 2009.
- A requirement that the Division of Health Service Regulation make and interim report on the implementation of the rated certificate system to the NC Study Commission on Aging not later than October 1, 2009, and a final report to the Commission not later than October 1, 2010.

The portion of the act pertaining to the Penalty Review Committee becomes effective October 1, 2007; the changes to the Health Care Personnel Registry become effective January 1, 2008; the rated certificates authorized by the act must be issued beginning January 1, 2009; and the remainder of the act became effective August 31, 2007. (TM)

Studies

Study Respite Care

S.L. 2007-39 (HB 424) requires the Department of Health and Human Services, Division of Health Service Regulation, Division of Medical Assistance, and the Division of Aging and Adult Services, to study the availability and delivery of respite care which provides temporary relief for family members and others who care for individuals with disabilities, chronic or terminal illnesses, dementia, or the elderly. The Department is required to examine the following issues:

- The need and availability of respite care in North Carolina.
- The delivery and licensing of respite care in other states and possible models for North Carolina.
- The application process for a grant under the Lifespan Respite Care Act of 2006, 42 U.S.C.
- The need for separate statutory language pertaining to respite care.
- The need, proposed structure, and development timeline for a separate licensure category for respite care.
- The development of a Medicaid waiver covering a proposed new licensure category for respite care.

The Department is required to present findings and recommendations, including any proposed statutory changes and new licensure categories, to the North Carolina Study Commission on Aging on or before March 1, 2008.

This act became effective May 11, 2007. (TM)

Study Housing/Training Mentally Ill in Adult Care Homes

S.L. 2007-156 (SB 164) directs the Department of Health and Human Services (Department) to study:

- The rules and regulations relating to the housing of individuals with mental illness in adult care homes that also house individuals without mental illness;
- The need for training direct care workers in long-term care facilities to provide appropriate care to residents with or without mental illness;
- The fiscal impact that the implementation of the training requirements would have on adult care homes; and
- The amount of funding necessary to support a successful training model.

The act requires the Department to present its findings and recommendations, including any statutory or rule changes, to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before March 1, 2008.

This act became effective June 29, 2007. (SP)

Study Older Adult Programs/Various Counties

S.L. 2007-355 (SB 448) requires the Department of Health and Human Services to conduct a study in select counties of older adult programs, services, and populations, and to provide recommendations on the structure of a similar study to include all North Carolina counties.

- The Department of Health and Human Services, Division of Aging and Adult Services, to work with the Division of Health Service Regulation; Division of Medical Assistance; Division of Public Health; and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to study programs and services for older adults in Brunswick, Buncombe, Gaston, Henderson, Moore, and New Hanover Counties which currently have, or are projected by 2030 to have, the largest numbers of individuals age 60+ when compared to individuals age 17 and younger. The Division is required to make an interim status report on the study to the North Carolina Study Commission on Aging on or before November 1, 2007. On or before April 1, 2008, the Division must make a final report of its findings and recommendations to the 2008 Regular Session of the 2007 General Assembly, the North Carolina Study Commission on Aging, and to the board of county commissioners of each county studied. In conducting the study, the Division shall utilize existing data and resources and shall include the Area Agencies on Aging serving each county studied. The study must include the following for each county studied:
  1. A profile of the current older adult population.
  2. A profile of the projected growth for the older adult population.
  3. An assessment of the anticipated impact on programs and services that address the needs of the older adult population.
  4. Identification of programs and services that are currently in place.
  5. Identification of programs and services that are needed to meet the growth projections.
  6. Current funding sources for programs and services serving the older adult population.
  7. Anticipated funding needs for programs and services serving the older adult population.
  8. A delineation of the programs and services that are shared or offered jointly with another county.
- Additionally, in response to growth projections for the age 60+ population, the Division of Aging and Adult Services is required to make recommendations on a study to include all counties in North Carolina. In conducting the study, the Division must evaluate similar studies conducted in other states. On or before January 1, 2008, the Division is required to make recommendations on the appropriate funding level and criteria to be included in a study to be conducted of all counties in North Carolina. The findings and recommendations on a statewide study must be presented to the North Carolina Study Commission on Aging.

This act became effective August 17, 2007. (TM)

Penalty Review/Long-Term Care Changes-Studies Related to Rated Certificates

S.L. 2007-544 (SB 56). See Enacted Legislation this document.

SIGNIFICANT LEGISLATIVE BUDGET ACTIONS

DIVISION OF AGING AND ADULT SERVICES

Pilot for Adult Care Home Quality Improvement
- Additional $264,000 in nonrecurring funds in each year of the FY 2007-09 biennium;
- To improve independence, dignity, and choice for residents in 4 counties: Alamance, Buncombe, Nash, and Rutherford.

Area Agencies on Aging
- Additional $300,000 in recurring funds for the FY 2007-09 biennium;
- Distributed to the 17 Area Agencies on Aging for services and planning activities statewide.

Senior Center General Purpose Fund
- Additional $200,000 in nonrecurring funds in FY 2007-08;
- To provide additional funding for senior centers.

Home and Community Care Block Grant
- Additional $536,000 in recurring funds in each year of the FY 2007-09 biennium;
- To develop and enhance community-based services and protections for older adults.

OFFICE OF THE SECRETARY

NC Rx Program
- Additional $250,000 in nonrecurring funds in FY 2007-08;
- For the Seniors Health Insurance Information Program to assist seniors enrolling in NC Rx and Medicare Part D.

DIVISION OF HEALTH SERVICE REGULATION

Regulatory and Complaint Staff
- Additional $261,665 in recurring funds FY 2007-08 and $288,887 in recurring funds in FY 2008-09;
- To increase staff and oversight in acute health care facilities' regulation and complaint investigations.

Health Care Personnel Registry and Rating System for Adult Care Homes
- Additional $583,000 in recurring funds and $40,274 in nonrecurring funds in FY 2007-08 and $805,750 in recurring funds in FY 2008-09;
- 14 positions and costs to expand the Health Care Personnel Registry to include all unlicensed staff of a health care facility who have direct access to residents, clients, or their property;
- To implement a Rating System for adult care homes.

Technical Assistance for Adult Care Homes
- Additional $500,000 in nonrecurring funds for FY 2008-09;
- For technical assistance to assist adult care homes with implementation of the adult care home rating program.

SIGNIFICANT SPECIAL PROVISIONS

DIVISION OF AGING AND ADULT SERVICES

Section 10.11 SENIOR CENTER OUTREACH

- Directs the Division to use funds appropriated to:
  - Expand outreach capacity of senior centers to reach unserved or underserved areas and provide start-up funds for new senior centers;
  - Requires county commissioners in counties receiving start-up funds for a new center to endorse the need and commit local funds to support operations.

Section 10.12 QUALITY IMPROVEMENT CONSULTATION PROGRAM FOR ADULT CARE HOMES

- Directs the Division to develop and conduct a pilot quality improvement consultation program for adult care homes to promote better care and improve quality of life for residents of adult care homes.

Section 10.13 STATE-COUNTY SPECIAL ASSISTANCE

Effective October 1, 2007:

- Increases the maximum monthly rate for residents in adult care facilities from $1,148 per month to $1,173 per month;
- Continues the separate maximum monthly rate for residents of special care units at $1,515 per month;
- Allows adjustments to the Special Assistance rate in order to shift some costs to the Medicaid Program. The provision also allows a limited income disregard (subject to federal approval) for individuals whose countable income would exceed the Special Assistance rate once costs are shifted to Medicaid.

Section 10.14 SPECIAL ASSISTANCE IN-HOME

- Codifies authorization language for the Special Assistance In-Home Program;
- Allows up to 15% of the total caseload for the Special Assistance Program to be allocated to the Special Assistance In-Home Program;
- Sets the maximum monthly payment for in-home assistance at 75% of the rate paid for individuals living in an adult care home.

DIVISION OF MEDICAL ASSISTANCE

Section 10.39A SKILLED NURSING FACILITY REIMBURSEMENT RATE

- Directs the Division of Medical Assistance to rebase the rates for the case-mix reimbursement system for skilled nursing facilities:
  - Effective January 1, 2008, one-half of the rate rebasing shall be implemented using 2005 audited cost data;
  - Effective October 1, 2008, the remaining half of the rate rebasing shall be implemented using 2006 audited cost data.
- Requires that inflationary increases for skilled nursing facilities for the 2007-2009 biennium include the rebasing of rates for the case-mix reimbursement system.
- Increases the provider assessment fee by $2.00 over the biennium to reduce State appropriations needed to rebase the rates.

Section 10.40F PILOT PROGRAM/MEDICAID DUAL ELIGIBLES SPECIAL NEEDS PLAN

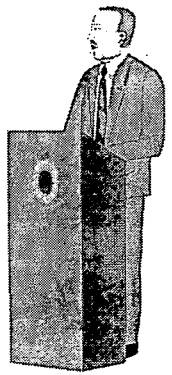
- Directs DHHS to evaluate and establish a pilot program in at least two regions of the State;
- Pilot to offer nursing facility certifiable, dual-eligible Medicaid recipients services through a Special Needs Plan (SNP) that will work with the Community Care of North Carolina Program (CCNC).

Section 10.46 CONTINUE EFFORTS TO EXPAND COMMUNITY CARE OF NORTH CAROLINA AND IMPROVE QUALITY OF CARE FOR AGED, BLIND, AND DISABLED MEDICAID RECIPIENTS

- Directs DHHS to continue to expand the Community Care of North Carolina (CCNC) care management model to Medicare and Medicaid dually eligible persons, focusing on aged, blind, and disabled persons;
- Will manage access and utilization of:
  - personal care services,
  - private duty nursing,
  - home health,
  - durable medical equipment,
  - specialty care,
  - residential services,
  - home infusion therapy,
  - pharmacy, etc

APPENDIX B

Summary of Issues Most Frequently Mentioned On February 28, 2008 By Organizations Representing Older Adults



March 28, 2008

Prepared by Staff for the

North Carolina Study Commission on Aging

Organizations Making Presentations on February 28, 2008

Governor's Advisory Council on Aging
Ann Johnson
NC Association of County Directors of Social Services
John Eller
Alzheimer's Association, Western NC Chapter
Jackie Rivers
Direct Care Workers Association of NC
Tonya Jones
NC Assisted Living Association
Evelyn Hawthorne
NC Dental Society, Committee on Aging
Bill Milner
NC Coalition on Aging
Roxanne Bragg-Cash
NC Retired Governmental Employees Association
Ed Regan
NC Senior Center Alliance
Stacie Nelson
Senior Tar Heel Legislature
Charles Dickens
NC Association Long Term Care Facilities
Lou Wilson

NC Guardianship Association
Gale Kirk
Alzheimer's Association, Eastern NC Chapter
Peggy Smith
Association for Home & Hospice Care
Tracy Colvard
NC Adult Day Services Association
Teresa Johnson
NC Association of Area Agencies on Aging
Joan Pellettier
NC Association on Aging
Alan Winstead
Future Care of NC
Gordon DeFriese
NC Retired School Personnel
Lacy Presnell
The Carolinas Center for Hospice and End of Life Care
Judith Brunger
AARP, NC Chapter
Dee Hatch

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: Funding/Funding Related, Not Directly Related to Funding

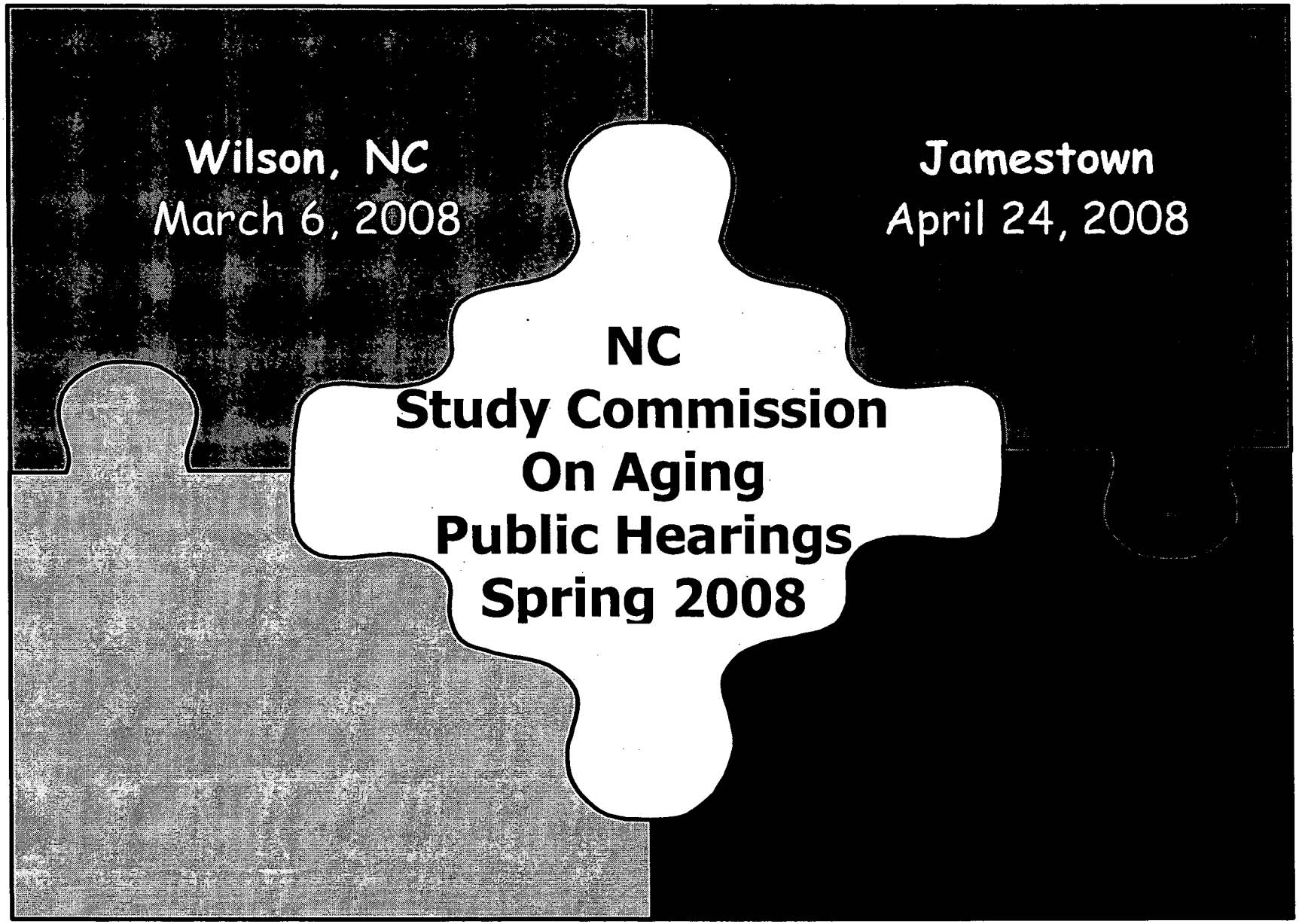
For Summary Purposes, the issues with the highest frequency were:

- **Increase Home and Community Care Block Grant (HCCBG) Funds** *(8)*
- **Increase Senior Center Funds** *(7)*
- **Provide Funding for Project C.A.R.E.** *(6)*
- **Support for Adult Protective Services/Enact & Fund APS Clearinghouse Model Pilot** *(4)*
- **Increase Funds for New & Existing Special Care Dental Programs (Care in Underserved Areas, LTC, Disabled Seniors at Home)** *(4)*

	Governor's Adv. Council on Aging	NC Guardianship Association	NC Assoc.County Directors Social Svs.	Alzheimer's Assoc. Eastern Chapter	Alzheimer's Assoc. Western Chapter	Assoc. for Home & Hospice Care	Direct Care Workers Assoc.	NC Adult Day Services Assoc.	NC Assisted Living Assoc.	NC Assoc. of Area Agencies on Aging	NC Dental Society, Com. On Aging	NC Assoc. on Aging	NC Coalition on Aging	Future Care of NC	NC Retired Gov. Employees Assoc.	NC Retired School Personnel	NC Senior Center Alliance	Carolinas Centr. for Hospice & EndCare	Senior Tar Heel Legislature	AARP, NC	NC Assoc. LTC Facilities
FUNDING/FUNDING RELATED																					
Increase HCCBG Funds *(8)*	x							x		x		x	x				x		x	x	
Increase Senior Center Funds *(7)*	x									x		x	x				x		x	x	
Increase Funds-Alzheimer's Chapters*(1)*				x																	
Increase Funds-Adult Day Reimbursement*(1)*								x													
Increase Funds-Area Agencies on Aging*(1)*										x											
Provide Funds-Additional NC Prescription Drug Assistance to Those Not Qualifying for Medicare Part D Federal Asst. *(1)*										x											
Provide Funding for Project C.A.R.E. *(6)*	x				x			x				x							x	x	
Increase LTC Insurance Tax Credit*(1)*									x												
Increase Asset Limit for Medicaid- Aged, Blind and Disabled*(2)*	x												x								
Provide Funds to Division of Public Health for Indoor Plumbing for Older Adults*(1)*	x																				
Support for Adult Protective Services/ Enact & Fund APS Clearinghouse Model Pilot*(4)*			x					x				x								x	
Increase Funds for New & Existing Special Care Dental Programs (Care in Underserved Areas, LTC, Disabled Seniors at Home) *(4)*	x										x								x	x	
Support/Fund Older Adult Pop. Study*(1)*												x									
Increase Funds-Guardianship Services*(2)*			x									x									
Increase Funds-Senior Tar Heel Legislature*(1)*																			x		
Increase Funds- Housing Trust Fund*(1)*																				x	
Increase Medicaid Nursing Homes Residents Personal Needs Allowance*(1)*										x											
Require DHHS to Adopt Special Assistance & Medicaid Income Disregard Policy*(1)*									x												
Retirement Contribution Rates for Government Employees, Health Plan Benefit*(2)*															x	x					
Collaboration to Streamline Guardianship Efforts (including training) and Funding*(2)*		x																		x	
Include Dental Care Reimbursement for NC Money Follows Person Program - Medicaid*(1)*											x										

[redacted]	Governor's Adv. Council on Aging	NC Guardianship Association	NC Assoc.County Directors Social Svs	Alzheimer's Assoc. Eastern Chapter	Alzheimer's Assoc. Western Chapter	[redacted] for Home & [redacted]ce Care	Direct Care Workers Assoc	NC Adult Day Services Assoc	NC Assisted Living Assoc.	NC Assoc. of Area Agencies on Aging	NC Dental Society, Com. On Aging	NC Assoc. on Aging	NC Coalition on Aging	Future Care of NC	NC Retired Gov. Employees Assoc.	NC Retired School Personnel	NC Senior Center Alliance	[redacted]nas Centr. for Hospice & EndCare	Senior Tar Heel Legislature	AARP, NC	NC Assoc. LTC Facilities
NOT DIRECTLY RELATED TO FUNDING																					
Pursue Rules for S.L. 2005-66 (ACH Licensure Category for Elderly Only) *(1)*									x												
Review Evaluations that Determine Incompetency *(1)*		x																			
Promote Limited Guardianship as Readily Accepted Option*(1)*		x																			
Increased Training for Guardianship*(1)*			x																		
Address Mentally Ill Mixed with Frail Elderly*(1)*																				x	
Continue Support for Information on LTC Providers*(1)*																x					
Require Registration of Multiunit Assisted Housing w/ Services (MAHS) *(1)*									x												
Develop State Alzheimer's Plan*(1)*					x																
Enact Legislation to Study Safe Transport of Passengers in Wheelchairs*(1)*								x													
Require Study on Dedication of Bd. Of Gvnors' Dental Scholarship-Loan Program Slots for Providers Serving Special Populations*(1)*											x										
Direct DHHS-Medical Assistance – to study dental Medicaid behavior reimbursement code for Special Care Patients*(1)*											x										
Study Funding of Special Care Residency Program to Train Future Dental Providers*(1)*											x										
Info. on Direct Care Workers Assn. *(1)*							x														
Info. on PCS Restructuring*(1)*						x															
Info. on Future Care of NC*(1)*														x							
Create Task Force- Quality End of Life Care *(1)*																		x			
Remove Barriers- Referrals for Hospice Care*(1)*																		x			
Continue Emphasis-Advance Care Planning*(1)*																		x			
Increase Availability of Palliative Care & Pain Management in Hospitals& Nursing Homes*(1)*																		x			
ACH/DHHS Partnership for Improved Care of Residents & Web-based System for Resident Assessment, Care Planning, Monitoring, Staff Development, and Peer Support*(1)*																					x

APPENDIX C


Wilson, NC
March 6, 2008
Jamestown
April 24, 2008
NC
Study Commission
On Aging
Public Hearings
Spring 2008

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)

2008 Public Hearings

Date	Location	Number of Speakers
March 6, 2008	Wilson, NC	42
April 24, 2008	Jamestown, NC	52

The issues mentioned with the greatest frequency at both public hearings were:

- **Increase Home and Community Care Block Grant Funds (21)**
- **Increase Funding/Continue Support for Senior Centers/Make 2007-2008 Increase Recurring (21)**
- **Provide Funding for Project C.A.R.E. (15)**
- **Support for Adult Protective Services/Enact & Fund APS Clearinghouse Model Pilot (14)**
- **Increase Funds for Adult Day Reimbursement/Support Adult Day (13)**
- **Increase Funds for New & Existing Special Care Dental Programs (12)**
- **Support for the Star Rating System (11)**
- **Increase Funds/Continue Study For Guardianship Services (7)**
- **Increase Funds (Restore to 2001 Level) for Area Agencies on Aging (6)**

Frequency of Issues Expressed by Speakers

	WILSON	JAMESTOWN	TOTAL
ISSUES	FREQUENCY	FREQUENCY	FREQUENCY
Increase HCCBG Funds	13	8	21
Increase Senior Center Funds/Make 2007-08 Increase Recurring	15	6	21
Increase Funds for Adult Day Reimbursement/Support Adult Day	6	7	13
Increase Funds (Restore to 2001 level) for Area Agencies on Aging	5	1	6
Provide Funding for Project C.A.R.E.	3	12	15
Increase Asset Limit for Medicaid- Aged, Blind and Disabled	1	0	1
Support for Adult Protective Services/ Enact & Fund APS Clearinghouse Model Pilot	5	9	14
Increase Funds for New & Existing Special Care Dental Programs	4	8	12
Support/Fund Older Adult Pop. Growth Study	2	0	2
Increase Funds/ Continue Study for Guardianship Services	3	4	7
Increase Funds for Housing Trust Fund/Recurring Funding	3	0	3
Increase Medicaid Reimbursement Rate for Dental Care	1	1	2
Need Transportation Funding for Seniors	4	1	5
Increase CAP/DA and PCS Rates to Maintain Qualified Workers	1	0	1
Support for Home & Hospice Care	2	1	3
Continue Moratorium on New Home Care Agencies	1	0	1
Prohibit Home Care From Giving to Clients	1	0	1
Extend Grace Period to Resolve Medicaid Issues Prior to Patient Transfer	1	0	1
Medicare Advantage Plans – Concern for Aggressive and Misleading Sales Tactics	3	0	3
Support for Respite Services/Support for Family Caregivers	2	0	2
Advance Directives/Leave Decision in Hands of Health Care Providers	1	0	1
Support for the Star Rating System	1	10	11
Increase Monitoring of Family Care Homes	1	0	1
Expand NC Support for Prescription Drug Coverage	1	0	1
Support for HB 1711 Establish Paid Sick Days	1	0	1
Increase Funds for In-Home Services to Reduce Waiting Lists	1	0	1
Increase Licensed Hospice Beds	1	0	1
Concern Over Reverse Mortgages – Require Face to Face Counseling	1	0	1
Support HR 1279 (Federal) – Increase Direct Care Worker Wages	0	1	1
Address Issues Related to Mentally Ill in Adult Care Homes	2	2	4
Support Task Force on End of Life Care	1	1	2
Address the Needs of Developmentally Disabled Older Adults	2	1	3
Funding for Senior Tarheel Legislature	0	1	1
Support for Senior Games	5	0	5
Support for Community Alternatives Program (CAP)	1	0	1

APPENDIX D

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-23 [v.1] (04/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/4/2008 12:11:22 PM

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 2008-2009 fiscal year to be used as additional funding for Senior Centers. It is the intent of the General Assembly that funding for this purpose shall be part of the continuation budget.

SECTION 2. This act becomes effective July 1, 2008.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-24 [v.2] (04/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/29/2008 11:57:36 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 two million five hundred thousand dollars ($2,500,000) 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, 2008.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-25 [v.2] (04/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/29/2008 11:58:10 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 FOR PROJECT C.A.R.E. (CAREGIVER ALTERNATIVES TO RUNNING ON EMPTY) WHICH PROVIDES CONSUMER-DIRECTED RESPITE CARE AND COMPREHENSIVE SUPPORT TO DEMENTIA CAREGIVERS WITH A GOAL OF INCREASING RESPITE AND SUPPORT SERVICES TO LOW-INCOME RURAL AND MINORITY 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 2008-2009 fiscal year to fund Project C.A.R.E. (Caregiver Alternatives to Running on Empty), which provides respite care and support to families caring for a person with dementia. The goal of the program is to increase quality, access, choice, and use of respite and support services to low-income rural and minority caregivers.

SECTION 2. This act becomes effective July 1, 2008.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-26 [v.1] (04/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/4/2008 1:00:36 PM

Short Title: Adult Protective Services Pilot Funds. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO ENACT A PILOT PROGRAM TO ASSESS CHANGES PROPOSED BY THE ADULT PROTECTIVE SERVICES TASKFORCE WITH A GOAL OF IMPROVING NORTH CAROLINA'S SYSTEM OF RESPONDING TO ALLEGATIONS OF ABUSE, NEGLECT, EXPLOITATION, OR SUBSTANTIAL RISK OF VULNERABLE AND ELDER ADULTS, 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-seven thousand and eighty-seven dollars ($1,497,087) for the 2008-2009 fiscal year to design and implement the first year of a two year pilot program to assess proposed changes to the adult protective services system. The proposed changes include the implementation of an Adult Protective Services Clearinghouse Model intended to enhance the capacity of county departments of social services when responding to the needs of all abused, neglected, or exploited adults. The Department shall evaluate the pilot and report to the North Carolina Study Commission on Aging on or before March 1, 2010.

SECTION 2. This act becomes effective July 1, 2008.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-29 [v.4] (04/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/30/2008 12:22:58 PM

Short Title: Statewide Aging Study. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE A COMPREHENSIVE FIVE-YEAR STATEWIDE STUDY OF THE STATE'S READINESS TO RESPOND TO THE COMING WAVE OF OLDER ADULTS BY ESTABLISHING A STEERING COMMITTEE FOR THE STUDY, APPROPRIATING FUNDS TO PROVIDE STAFF TO SUPPORT THE COMMITTEE, AND APPROPRIATING FUNDS FOR THE FIRST YEAR OF THE STUDY, AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

Whereas, the anticipated increases in the older adult population are due to aging members of the baby boom generation, North Carolina's attractiveness as a retirement destination, and increased longevity; and

Whereas, it is projected that by 2030, 75 of North Carolina's counties will have more persons age 60 and older than age 17 and younger; and

Whereas, according to information from the Demographic Unit, Office of State Budget and Management, between 2000 and 2030, population growth for the state as a whole is projected at 52.5%, while the population 65 and older is expected to grow 123% and the population 85 and older is expected to increase 146%; and

Whereas, these demographic shifts will likely impact workforce supply and demand, tax receipts, economic development, health and human services, and a number of other issues effecting State and local government; and

Whereas, the United States' Administration on Aging has elected to provide assistance to the North Carolina Department of Health and Human Services, Division of Aging and Adult Services and Area Agencies on Aging in developing a comprehensive planning model for aging;

Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.1. Committee Established. – There is established the NC FACT (NC Facing Aging Communities Together) Steering Committee to guide the work of a five-year study to assess the State's readiness to respond increasing numbers of older adults residing in North Carolina; to inform and guide future policy and program development; and to increase State, regional, and local capacity for planning for an aging population.

SECTION 1.2. Membership. – The Steering Committee shall consist of 21 members appointed as follows:

(1) Two members with knowledge of and an interest in aging issues who are recommended by the North Carolina League of Municipalities and appointed by the Speaker of the House of Representatives.

(2) Two members with knowledge of and an interest in aging issues who are recommended by the North Carolina Association of County Commissioners and appointed by the President Pro Tempore of the Senate.

(3) Two members who are directors of Area Agencies on Aging, one appointed by the Speaker of the House of Representatives and one appointed by the President Pro Tempore of the Senate.

(4) Three members who are directors of local public or private non-profit aging services providers, including at least one director of a Department of Social Services, appointed by the Governor

(5) Two members of the Governor's Cabinet, appointed by the Governor.

(6) One member who is a State Office of Budget and Management employee experienced with health and human services or demographic and economic analysis, appointed by the Governor

(7) Two members of the Senior Tar Heel Legislature, one appointed by the Speaker of the House of Representatives and one appointed by the President Pro Tempore of the Senate.

(8) One member of the General Assembly appointed by the Speaker of the House of Representatives.

(9) One member of the General Assembly appointed by the President Pro Tempore of the Senate.

(10) One member of the public appointed by the Speaker of the House of Representatives.

(11) One member of the public appointed by the President Pro Tempore of the Senate.

(12) The chair of the Governor's Advisory Council on Aging, or designee.

(13) The Director of the University of North Carolina Institute on Aging, or designee.

(14) The President of the North Carolina Chamber of commerce, or designee.

SECTION 1.3. Notices to Departments. – The Committee shall invite the Secretary of the Department of Health and Human Services to attend each meeting of the Committee and encourage the participation of representatives from the various

departmental divisions that serve older adults. The Committee shall also inform Secretaries of other Departments represented on the Governor's Cabinet of each meeting and encourage appropriate participation.

SECTION 1.4. Cochairs. – The Committee shall have two cochairs, one designated by the President Pro Tempore of the Senate and one designated by the Speaker of the House of Representatives from among their respective appointees.

SECTION 1.5. Duties of the Committee – The Committee shall perform the following duties:

(1) Identify information and resources to provide needs assessment, planning, and delivery of services and programs to current and future older adults.

(2) Oversee the design and implementation of a Consumer Needs, Assets, and Expectations Assessment.

(3) Oversee the design and implementation of a State and Local Awareness and Preparedness Assessment.

(4) Identify and secure studies of related issues, such as retirement migration patterns, that impact the planning process for North Carolina's older adult population.

(5) Oversee design and implementation of a process to strengthen State and local planning.

(6) Use the findings of assessments, studies, and additional research, to produce reports for the Governor and the General Assembly that will inform and guide policy and program development.

(7) Periodically evaluate the effectiveness of the study and recommend to the Governor and the General Assembly any changes to the Committee's mission.

SECTION 1.6. Vacancies. –Any vacancy on the Committee shall be filled by the original appointing authority.

SECTION 1.7. Expenses of the Committee Members. – Members of the Committee shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate.

SECTION 1.8. Cooperation. – The Committee may call upon any department, agency, institution or officer of the State or any political subdivision thereof for facilities, data, or other assistance.

SECTION 1.9. Consultants. – The Committee may hire consultants to assist with the study or to provide studies of issues impacting the planning and delivery of services to the older adult population and needed public policies.

SECTION 1.10. Meetings. – The Committee shall meet upon the call of the cochairs. The Secretary of the Department of Health and Human Services and the Legislative Services Commission shall grant adequate meeting space for the Committee.

SECTION 1.11. Report. – The Committee shall make an annual report in January of each year to the Governor, the North Carolina Study Commission on Aging, the Senate Appropriations Committee on Health and Human Services, and the House of Representatives Appropriations Subcommittee on Health and Human Services. The

Committee shall make its final report in January 2013, and shall expire upon submitting that report.

SECTION 2.0. 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 hundred seventy five thousand dollars ($175,000) for the 2008-2009 fiscal year, to be used to establish positions to support the CACE (Communities and Aging Carolinians – on Edge) Steering Committee.

SECTION 3.0. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging and Adult Services, the sum of three million eight hundred twenty thousand dollars ($3,820,000) for the 2008-2009 fiscal year to provide funds for design, implementation, analysis and reporting for a survey of consumer needs, assets and expectations; funds for design, implementation, analysis, and reporting for a survey of state and local governments; funds to strengthen the capacity of Area Agencies on Aging for support of regional and local planning; funds to each county to aid the work of citizen-driven local aging leadership planning; and funds for additional studies and consultants.

SECTION 4.0. Sections 2 and 3 of this act become effective July 1, 2008, the remainder of the act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SQz-11 [v.1] (04/21)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/21/2008 11:46:20 AM

Short Title: DHHS Study Group Respite. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATING TO RESPITE CARE AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of Aging and Adult Services shall study the adequacy of service standards and funding for group respite services. The study shall include determining whether opportunities exist to streamline and enhance the provision of respite services.

SECTION 1.(b) The Department of Health and Human Services, Division of Medical Assistance shall study including respite services as part of the Medicaid State Plan.

SECTION 1.(c) The Department shall report findings and recommendations to the North Carolina Study Commission on Aging on or before November 1, 2009.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SQz-12 [v.2] (04/21)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/30/2008 12:46:21 PM

Short Title: DHHS to Study Older Adult Hearing Loss. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATING TO HEARING LOSS IN OLDER ADULTS IN NORTH CAROLINA AS RECOMMENDED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of Services for the Deaf and Hard of Hearing, shall study the impact of hearing loss on North Carolina's older adult population. The study shall examine the following:

(1) The availability of and access to qualified professionals for diagnosis and treatment.

(2) The availability of and access to hearing aid purchase assistance programs for low income individuals.

(3) Developing an inventory of adaptive technology options available to assist older adults with hearing loss.

(3) Resources and programs available in other states.

SECTION 1.(b) In response to the study authorized in this section, the Department of Health and Human Services shall present findings and recommendations to the Study Commission on Aging on or before November 1, 2009.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-RDz-26 [v.2] (04/19)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/29/2008 5:23:03 PM

Short Title: Nursing Home Administrators Criminal History. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE NORTH CAROLINA STATE BOARD OF EXAMINERS FOR NURSING HOME ADMINISTRATORS TO OBTAIN CRIMINAL HISTORY RECORD CHECKS OF APPLICANTS FOR LICENSURE AS NURSING HOME ADMINISTRATORS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 90 of the General Statutes is amended by adding a new section 90-288.01 to read:

"**§90-288.01. Criminal history record checks of applicants for licensure.**

(a) The following definitions apply in this section:

(1) Applicant. – A person applying for initial licensure pursuant to either G.S. 90-278 or G.S. 90-287 or applying for renewal of licensure pursuant to G.S. 90-286.

(2) Criminal History. – A history of conviction of a State crime, whether a misdemeanor or felony, that bears on an applicant's fitness for licensure as a nursing home administrator. The crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Devise or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20,

Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act in Article 5 of Chapter 90 of the General Statutes and alcohol-related offenses including sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(b) Criminal History Record Check. – The Board may require a criminal history record check of an applicant. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure to an applicant. The Board may require the applicants to obtain criminal history record checks from one or more reporting services designed by the Board to provide criminal history record checks. Each applicant is required to pay the designated service for the cost of the criminal history record check. In the alternative, the Board may provide to the North Carolina Department of Justice the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential. The Board shall collect any fees required by the Department of Justice and shall remit the fees to the Department of Justice for expenses associated with conducting the criminal history record check.

(c) Convictions. – If the applicant's criminal history check reveals one or more convictions listed under subsection (a)(2) of this section, the conviction shall not automatically bar licensure. The Board shall consider all of the following factors regarding the conviction:

(1) The level of seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The person's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.
(7) The subsequent commission by the person of a crime listed in subsection (a) of this section.

(d) Denial of Licensure. – If the Board refuses to issue or renew a license based on information obtained in a criminal history record check, the Board must disclose to the person the information contained in the criminal history record check that is relevant to the Board's actions. The Board shall not provide a copy of the

criminal history record check to the person. A person has the right to appear before the Board to appeal the Board's decision. An appearance before the Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(e) Limited Immunity. – The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for its actions based on information provided in an applicant's criminal history record check."

SECTION 2. Chapter 114 of the General Statutes is amended by adding a new section 114-19.24 to read:

"**§ 114-19.11. Criminal record checks of applicants for licensure as nursing home administrators.**

The Department of Justice may provide to the North Carolina State Board of Examiners for Nursing Home Administrators from the State and National Repositories of Criminal Histories the criminal history of any applicant for licensure as a nursing home administrator under Article 20 of Chapter 90 of the General Statutes. Along with the request, the Board shall provide to the Department of Justice the fingerprints of the applicant, a form signed by the applicant consenting to the criminal record check and use of fingerprints and other identifying information required by the State and National Repositories, and any additional information required by the Department of Justice. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a national criminal history record check. The Board shall keep all information obtained pursuant to this section confidential. The Department of Justice may charge a fee to offset the cost incurred by it to conduct a criminal record check under this section. The fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information."

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-27 [v.2] (04/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/29/2008 4:01:11 PM

Short Title: Raise Ceiling on Personal Prop. Sale/Guardian. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO RAISE THE CEILING ON THE TOTAL AMOUNT OF PERSONAL PROPERTY A GUARDIAN IS ALLOWED TO SELL WITHOUT A COURT ORDER UNDER THE LAWS PERTAINING TO GUARDIANSHIP, AS RECOMMENDED BY THE HOUSE STUDY COMMITTEE ON STATE GUARDIANSHIP LAWS AND SUPPORTED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 35A-1251(17)a. reads as rewritten:

"In the case of an incompetent ward, a general guardian or guardian of the estate has the power to perform in a reasonable and prudent manner every act that a reasonable and prudent person would perform incident to the collection, preservation, management, and use of the ward's estate to accomplish the desired result of administering the ward's estate legally and in the ward's best interest, including but not limited to the following specific powers:

...

(17)a. Without a court order to lease any of the ward's real estate for a term of not more than three years, or to sell, lease or exchange any of the ward's personal property including securities, provided that the aggregate value of all items of the ward's tangible personal property sold without court order ~~over the duration of the estate shall not exceed one thousand five hundred dollars ($1,500).~~shall not exceed five thousand dollars ($5,000) per accounting period, and shall not exceed the total aggregate amount of fifteen thousand dollars ($15,000) over the duration of the estate. When any item of the ward's tangible personal property has a value which when increased by the value of all

other tangible personal property previously sold in the estate without a court order would exceed ~~one thousand five hundred dollars ($1,500),~~ five thousand dollars ($5,000) in the current accounting period, or the total aggregate amount of fifteen thousand dollars ($15,000) over the duration of the estate, a guardian may sell the item only as provided in subdivision (17)b.

...."

SECTION 2. G.S. 35A-1252(14)a. reads as rewritten:

"In the case of a minor ward, a general guardian or guardian of the estate has the power to perform in a reasonable and prudent manner every act that a reasonable and prudent person would perform incident to the collection, preservation, management, and use of the ward's estate to accomplish the desired result of administering the ward's estate legally and in the ward's best interest, including but not limited to the following specific powers:

...

(14)a. Without a court order to lease any of the ward's real estate for a term of not more than three years, or to sell, lease or exchange any of the ward's personal property including securities, provided that the aggregate value of all items of the ward's tangible personal property sold without court order ~~over the duration of the estate shall not exceed one thousand five hundred dollars ($1,500).~~shall not exceed five thousand dollars ($5,000) per accounting period, and shall not exceed the total aggregate amount of fifteen thousand dollars ($15,000) over the duration of the estate. When any item of the ward's tangible personal property has a value which when increased by the value of all other tangible personal property previously sold in the estate without a court order would exceed ~~one thousand five hundred dollars ($1,500),~~five thousand dollars ($5,000) in the current accounting period, or the total aggregate amount of fifteen thousand dollars ($15,000) over the duration of the estate, a guardian may sell the item only as provided in subdivision (14)b.

...."

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U D

BILL DRAFT 2007-SHz-28 [v.2] (04/10)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/29/2008 4:01:54 PM

Short Title: No Auto. Revoke/Driv. Lic./Incompetent Person. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE DIVISION OF MOTOR VEHICLES TO CONSIDER RECOMMENDATIONS FROM THE CLERK OF COURT IN DETERMINING WHETHER TO REVOKE THE DRIVERS LICENSE OF A PERSON ADJUDICATED INCOMPETENT UNDER THE GUARDIANSHIP LAWS, AS RECOMMENDED BY THE HOUSE STUDY COMMITTEE ON STATE GUARDIANSHIP LAWS AND SUPPORTED BY THE STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-17.1(a) reads as rewritten:

"(a) The Commissioner, upon receipt of notice that any person has been legally adjudicated incompetent or has been involuntarily committed to an institution for the treatment of alcoholism or drug addiction, shall forthwith make inquiry into the facts for the purpose of determining whether such person is competent to operate a motor vehicle. If a person has been adjudicated incompetent pursuant to the guardianship laws under Chapter 35A of the General Statutes, in making an inquiry into the facts, the Commissioner shall consider the clerk of court's recommendation regarding whether the incompetent person should be allowed to retain his or her driving privilege. Unless the Commissioner is satisfied that such person is competent to operate a motor vehicle with safety to persons and property, he shall revoke such person's driving privilege. Provided that if such person requests, in writing, a hearing, he shall retain his license until after the hearing, and if the revocation is sustained after such hearing, the person whose driving privilege has been revoked under the provisions of this section, shall have the right to a review by the review board as provided in G.S. 20-9(g)(4) upon written request filed with the Division."

SECTION 2. This act is effective when it becomes law and applies to persons adjudicated incompetent under Chapter 35A of the General Statutes on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 1

HOUSE BILL 93*

Short Title:	Transport of Indiv. in Wheelchair Study.	(Public)
Sponsors:	Representatives Weiss, Earle, England (Primary Sponsors); Adams, Alexander, Bordsen, Carney, Clary, Coates, Coleman, Farmer-Butterfield, Fisher, Gibson, Glazier, Harrison, Jeffus, Lucas, Luebke, Martin, Mobley, Wainwright, Womble, and Wray.	
Referred to:	Rules, Calendar, and Operations of the House.	

February 8, 2007

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 tie-down systems. The Department shall report its findings and any recommendations to the North Carolina Study Commission on Aging and the Joint Legislative Transportation Oversight Committee not later than February 1, 2008.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

H 1

HOUSE BILL 92*

Short Title:	Medicaid Income Limits Level Study.	(Public)
Sponsors:	Representatives Weiss, Earle, Bordsen, England (Primary Sponsors); Alexander, Carney, Clary, Coates, Coleman, Faison, Farmer-Butterfield, Fisher, Gibson, Glazier, Goforth, Harrison, Insko, Jeffus, Lucas, Luebke, Martin, Mobley, Saunders, Wainwright, E. Warren, Womble, and Wray.	
Referred to:	Rules, Calendar, and Operations of the House.	

February 8, 2007

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.