JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

INTERIM
1997-1998

October 21-23, 1997
November 18-20, 1997
January 20-22, 1998
February 17-19, 1998
March 17-19, 1998
April 20-21, 1998

Extra Session
March 25, 1998

ATTENDANCE

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCE

INTERIM

1997 - 1998 (Name of Committee)

DATES	10-21	10-22	10-28		11-18	11-19	11-20		1-20	1-21	1-22		2-17	2-18	2-19
Charlotte Gardner, Co-Chair	✓	✓	✓		✓	✓	✓		✓	✓	✓		✓	✓	✓
Lanier Cansler, Co-Chair	✓	✓	✓		✓	✓	✓		✓	✓	✓		✓	✓	✓
Debbie Clary, Co-Chair	✓	✓	al		al	✓	✓		✓	✓	al		✓	✓	✓
Alma Adams	✓	✓	✓		✓	✓	✓		✓	✓	✓		✓	✓	✓
M.W. "Henry" Aldridge	al	✓	✓		✓	✓	✓		✓	✓	✓		✓	✓	✓
Martha Alexander	✓	✓	✓		✓	✓	✓		✓	✓	al		✓	✓	✓
J.W. Hurley	✓	✓	✓		✓	✓	✓		✓	✓	✓		✓	al	✓
Edd Nye, Ranking Minority Member	✓	✓	✓		✓	✓	✓		✓	al	✓		✓	✓	✓
Cindy Watson	✓	✓	✓		✓	✓	✓		✓	✓	✓		✓	✓	✓
Rep. Leo Daughtry, Majority Leader															
Rep. Steve Wood, Pro Temp															
Theresa Esposito, Appro.,Co-Chair						✓			✓	✓	✓		✓	al	al
Rep. Julia Howard, Majority Whip	✓	al	al		al	✓			✓	✓	✓		✓	✓	✓
Rep. Cherie Berry													✓	al	
Rep. Beverly Earle, Capital & Budget	✓	al	al		al	✓	✓		al	✓	✓		✓	✓	✓

ATTENDANCE

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCE

INTERIM

(Name of Committee)

DATES	3-17	3-18	3-19	5/25 (5th Session)			4/20						
Charlotte Gardner, Co-Chair	✓	✓	✓	✓			✓						
Lanier Cansler, Co-Chair	✓	✓	✓	✓			✓						
Debbie Clary, Co-Chair	✓	✓	✓	✓									
Alma Adams	✓	✓	✓										
M.W. "Henry" Aldridge	✓	✓	✓	✓									
Martha Alexander	✓	✓	✓	✓									
J.W. Hurley	✓	✓	✓										
Edd Nye, Ranking Minority Member	✓	✓	✓	✓			✓						
Cindy Watson	✓	✓	✓	✓									
Rep. Leo Daughtry, Majority Leader				✓									
Rep. Steve Wood, Pro Temp													
Theresa Esposito, Appro.,Co-Chair				✓			✓						
Rep. Julia Howard, Majority Whip	✓	✓	✓	✓									
Rep. Cherie Berry	✓	✓	✓	✓									
Rep. Beverly Earle, Capital & Budget	✓	✓	✓	✓									
Rep. Billy Creech appro. co-chair				✓									
Rep. George Holmes appro co-chair				✓									

10-21-97

Reporting Requirements, Senate Bill 352

SECTION XI. Department of Human Resources

Section	Topic	Committee	Due Date
11.2	Reorganization Plan	Appropriations	Ongoing
11.4	IVA-EA Funding	Appropriations	May 1998
11.5	Proposed Health Care Standards	General Assembly	4/1/98
11.5	Children's Health Insurance Plan	General Assembly	May 1998
11.6	Human Services Grants	Jt. Gov. Ops.	Prior to Award
11.7	Provider Reimbursement Rate Study	Appns./FRD	
	Status Report		2/1/98
	Final Report		2/1/99
11.10	Medicaid Growth Reduction Plan	Appropriations	
	Report on intended actions affecting 1998-99		9/1/97
	Plan through 2001		4/1/98
11.21	Adult Care Homes Annual Report	Jt. Gov. Ops./FRD	10/1/97
11.27	Caring Program for Children Annual Report	Jt. Gov. Ops.	5/1/98
11.28	Quarterly IRMC Review of ACTS	Appns./FRD	9/30/97
11.34	Carolina Alternatives Progress Rpt.	Gen'l Assembly/FRD	5/1/98
11.35	Willie M. Reports	FRD	Periodic
11.36	Thomas S. Progress Report	General Assembly	4/1/98
11.37	Thomas S. Cost Containment Measures	Appns./FRD	12/1/97 & 5/1/98
11.40	Special Alzheimer's Units Reports	Appns./FRD	3/1/98
11.42	Study of Substance Abuse Treatment Programs	Jt. Gov. Ops.	Unspecified

11.44	Efficiency Study of Psychiatric Hospitals	Appns./FRD	4/1/98
11.47	Whitaker School Replacement Facility Status Report	Appns./FRD	5/1/98
11.49	Study Downsizing of MR Centers	Appns./FRD	3/2/98
11.51	Annual Reports on Wilderness, Coach Mentor Training, and Gov.'s 1-on-1 Programs	Jt. Gov. Ops.	10/1/97
✓11.55	Smart Start Progress Reports	Jt. Gov. Ops.	Quarterly
11.57	State Child Fatality Review Team		
	Activity Report	Appns./FRD	Quarterly
	Final Report	General Assembly	5/18/98
✓11.60	ABC's Plan for DHR Schools	Jt. Leg. Ed. Oversight	
	✓Interim Report		10/1/97
	Final Report		4/1/98
11.61	Div. of Svcs. for the Blind Performance Audit	Appns.	1/1/98
11.69	Study of Adult Care Home Bed Vacancy Rates	Appns.	2/1/98
11.71	Adult Day Health Care Medicaid Study	Appns.	5/1/98
11.71	Comparison of Medicaid Eligibility Requirements for In-home and Institutional Care Services	Appns./Aging Comm.	3/1/98
11.73	Study of Alt. Living Arrangements	Appns./ Aging Comm./FRD	5/1/98

PART V. DHR Block Grant Provisions

Report on Special Children Adoption Fund	Appropriations	5/1/98
Report on Use of TANF and SSBG Funds for Substance Abuse Services and Reduction in Out-of-Wedlock Births	Appropriations	1/1/98

10-21-97

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

October 10, 1997

The Honorable Leslie Jane Winner, Co-Chairman
Joint Legislative Education Oversight Committee

The Honorable Jean Rouse Preston, Co-Chairman
Joint Legislative Education Oversight Committee

Legislative Office Building
300 North Salisbury Street
Raleigh, NC 27603

Dear Senator Winner and Representative Preston:

Enclosed is the required interim report on the Department of Health and Human Services plan to implement the State Board of Education's ABC Plan for its residential schools as stated in Senate Bill 352, Section 11.60. This report highlights the joint efforts of the State Board of Education and the Department of Health and Human Services on their progress toward the implementation of the ABC's plan in DHHS residential schools.

Sincerely,

H. David Bruton, M.D.

Michael E. Ward

Enclosures

cc: Stephanie Bass
Peter Leousis
Lynne Perrin

Status of ABC's Plan for DHHS Residential Schools

October 1, 1997

The 1997 General Assembly included a special provision in SB 352, Section 11.60, which directs the Department of Health and Human Services (DHHS) to implement the State Board of Education's ABC plan for its residential schools.

The special provision covers a broad spectrum of issues which have been of concern to DHHS for several years. During that period, DHHS placed renewed emphasis upon its educational programs and institutions and will continue to improve the educational quality of its schools.

The DHHS has high expectations for the children and school staff of the schools. Many child-centered improvements have been made and additional improvements are being planned. The challenging issues of special education are being addressed through strategic planning, such as called for in the ABC Plan.

DHHS programs fall into two basic categories:

1. Traditional schools which have K-12 programs, follow the Standard Course of Study, and whose students are in attendance for a full academic year. The students are placed in these schools primarily for educational purposes.

2. Treatment Programs and Training Schools, most of whose students are in attendance for less than a full academic year. Students are placed in these programs for non-educational reasons.

DHHS has adopted the philosophy of the ABC planning process for the residential schools under the Division of Youth Services, the Division of Services for the Blind and the Division of Services for the Deaf and Hard of Hearing. The students in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) educational programs are served for an average of less than 120 days and are admitted to DMHDDSAS facilities due to serious emotional disturbance or mental illness. Since psychiatric treatment needs must be met before educational programs can be addressed, the appropriateness of the ABC Plan for these programs is under review

Members of the Educational Advisory Committee in DHHS and staff of the Exceptional Children Division in DPI have worked closely over the last year in reviewing the State Board's ABC Plan and discussing how DHHS residential schools can be included. Those meetings have been helpful and productive. Below are examples of activities:

1. Representatives from the DHHS residential schools have met with the Accountability Services Division in DPI to receive information about testing and the ABC model. They discussed how the DHHS schools will be a part of the ABC model.

2. Representatives from the DHHS residential schools have met with DPI's Division of School Improvement to review information about the Assistance Teams and how the DHHS schools will receive assistance.

3. The DHHS is represented on the Exceptional Children Advisory Council. Through this Council DHHS has been kept up-to-date on the planning and implementation of the ABC model.

4. In August, 1997, the Exceptional Children Division invited DHHS representatives to attend their annual State Conference on Exceptional Children. At that meeting there was much discussion related to the ABC results and plans.

5. Lowell Harris and Martha Downing from the Exceptional Children Division were invited to visit the Eastern NC School for the Deaf in Wilson on September 16, 1997 to observe the classes and to discuss issues related to the ABC's Plan with the faculty and the management team.

In October, Peter Leousis of DHHS, Dr. Henry Johnson of DPI, and key staff members from each department will meet to discuss the next steps in this joint effort. Included will be the study of methods of alternative testing and other issues that will enable DHHS schools to further address accountability for providing quality education to students.

Educational issues are complex; all DHHS children are special education students with Individualized Education Plans. The processes which are underway will result in a higher quality education for DHHS special needs children.

10-21-97

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

October 7, 1997

TO: Mary Ellen Sylvester
Fiscal Research Division

FROM: Lee Kittredge, Director
Division of Budget and Analysis

SUBJECT: Response to Your Request Regarding Status of Title IV-A Emergency Assistance Claims

The status of the above referenced appeal has changed since our last correspondence. The appeal has been heard and some decisions remain. The action and status as described below has occurred.

The appeal has been heard before the Departmental Appeal Board in Washington, D.C. and a decision rendered on September 19, 1997. There were four points on which the appeal was based and we succeeded in three of the four in contention. The Board ruled in favor of the State on secure facility, the cost allocation plan, and the issue regarding Deloitte and Touch's role. The Board ruled in favor of the Agency for Children and Family on the application/prior eligibility determination issue.

The State has thirty days from the date of the decision to document its expenditures for services which were provided to children after they were determined to be eligible for EA in order to receive a portion of the federal funds the State has claimed. The Division of Youth Services is currently documenting such and the Department will meet this deadline. We do not yet know the dollar amount the State will receive as a result of this documentation. Because the State won on three of the four points, we are now eligible to receive some portion of these funds once we complete the documentation.

A last option is for the State to take this case into U.S. District Court to further pursue the prior eligibility determination issue. A decision has not yet been made to pursue this avenue; however, we are researching and discussing this with the attorneys

who represented the Department at the Board and also with counsel from the Office of the Attorney General. We will know in the next few weeks what our action will be.

If you have further questions please let me hear from you.

BA/sb

cc: James B. Edgerton
Nina Yeager

10-21-97

North Carolina Department of Human Resources

Division of Medical Assistance

P.O. Box 29529 • 1985 Umstead Drive • Raleigh, N. C. 27626-0529

Courier Service 56-20-06

James B. Hunt Jr., Governor
H. David Bruton,M.D., Secretary

Paul R. Perruzzi, Director
(919) 733-2060

August 26, 1997

The Honorable Lanier M. Cansler
The Honorable Charlotte A. Gardner
The Honorable Debbie A. Clary
The Honorable William N. Martin
North Carolina General Assembly
Legislative Building
Raleigh, North Carolina 27601

Dear Appropriations Chairs:

In accordance with the instructions in the Appropriations Act under "Medicaid Growth Reduction," this report sets out DMA's plan for action to meet the budget targets specified by the legislature.

It takes time before program changes or cuts impact the budget. Implementing changes requires studies and analysis, changes in the State Plan, APA, notification to providers, changes in the claims processing system, etc. If there are challenges to the changes, even more time could be lost. Finally, after changes are implemented, it takes several months for the changes to flow through the system and actually result in savings.

To meet the budget targets and ensure a smooth transition from our existing growth in state appropriations to the limit of 8% in SFY 2000-01 we will begin in SFY 97-98 to achieve a reduction in the program's rate of growth by instituting cost containment actions.

Attached is a list of cost containment options. DMA will estimate the cost savings and implications, then meet with appropriate provider associations to get their input and suggestions. After considering provider input, and Medical Care Advisory Committee input, DMA will take the most prudent actions. We intend to take actions to reduce expenditures by an annualized 1.5%. Since these actions will occur at different times this fiscal year the impact on the

97-98 budget may only be in the 1% range. We will be planning for an additional 1.5% reduction that will be implemented in stages during the end of this fiscal year and the beginning of 98-99.

If you have any questions, please contact me.

Sincerely,

Paul R. Perruzzi

PRP/sl
Attachment

cc: H. David Bruton, M.D., Secretary
Jim Edgerton
Nina Yeager
Carol Shaw
Jim Bernstein
Daphne Lyon

Cost Containment Options

Hospital Inpatient-Rebase DRG, reduce DRG payment rate, reduce inflation payment, contract certain services

Hospital Outpatient-Change reimbursement method to a prospective system, reduce inflation rate, change ER reimbursement

Nursing Facilities-Rebase rates, reduce inflation payment, ROE, limit bed coverage, revise admission criteria

Drugs-Change reimbursement rate to AWP-15%, limit reimbursement to the lowest rate offered to any third party payor, prior approval, days supply limit.

In-home Services-Reduce some rates based on cost report data, tighten up medical necessity criteria, introduce controls such as assessment, reassessment and prior approval, reduce inflation payment, require Medicare billing, competitive bid where feasible

CAP Services-Hold to reasonable budgetary limit, adjust rates, limit inflation increase

Public Provider Services-Hold to reasonable budgetary limit.

ACH-Personal Care-Hold inflation payment.

Physician Services-limit crossover payments based on Medicaid rates, reduce rates that exceed Medicare payment rates

Durable Medical Equipment-reduce rates, limit inflation increase, competitive bid

ICF/MR-Reduce inflation increase

Edits-Improve edits in the claim processing system to fail inappropriate claims.

ACCESS-Expand statewide as quickly as possible. Begin ACCESS II demos as quickly as possible.

HMOs-Permit HMOs to compete in select counties

Transfer of Assests-Propose legislation to prevent the transfer of assets to become eligible for Medicaid

8/18/97

10-21-97

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

SUMMARY OF SIGNIFICANT DHHS LAWSUITS

October 21, 1997

***Thomas S. v. Bruton,* C-C-82-0418-M (W.D.N.C)**

Mentally retarded adults who received treatment in state psychiatric hospitals.

***Willie M. v. Hunt, et al.,* C-C-79-294-M (W.D.N.C.)**

Children under 18 who suffer from emotional, mental, or neurological handicaps accompanied by violent or assaultive behavior.

***Adam, Burke, and Caleb v. State of North Carolina, et al,* 5:96-CV-554-BR (E.D.N.C)**

Children in Division of Youth Services custody alleging non-compliance with IDEA educational requirements.

***Alexander, et al v. Bruton, et al.,* C-C-74-183-M (W.D.N.C.)**

AFDC and Medicaid recipients regarding timely processing of claims by Departments of Social Services.

Cases under the *"Gammons"* theory.

Tort claims against State for alleged negligence of local Child Protective Service Workers.

10-21-97

North Carolina Child Support Enforcement

ACTS

Automated Collection and Tracking System

ACTS Implementation

- Statewide implementation completed 9/15/97
- 413,000+ cases
- $25-30+ Million per month in disbursements
- Responding to 750+ calls to ACTS Help Desk
- Full functionality based on 1988 FSA
- Current with all 1997 PRWORA requirements
- Request for Certification Review sent 9/17/97
- Collections Jan - Aug 1997 up 9.5% over 1996

ACTS Implementation

- Pilot Operations (Wilson & Duplin) - Aug 95
- Two stage implementation
  - Data conversion/clean up (2-3 months)
  - Full cutover
- Rollout 1 - Nov 96 Feb 97 (14 offices)
- Rollout 2 - Jan 97 April 97 (14 offices)
- Rollout 3 - Mar 97 June 97 (16 offices)
- Rollout 4 - May 97 Aug 97 (13 offices)
- Rollout 5 - July 97 Sept 97 (25 offices)

ACTS Implementation

Actual Costs Thru 7/31/97

Total Cost	$59.7 M
Planning	.4 M
Personnel	19.7 M
Contract Labor & Hardware	31.6 M
SIPS etc.	7.4 M
Other Misc	.6 M
Federal Share	$49.7 M **
State Share	$10.0 M **

(** Retro 80% match -> Fed = $50.5, State = $9.2M)

ACTS Implementation

Estimated Costs Thru 9/30/97

Total Cost	$62.8 M
Planning	.4 M
Personnel	20.8 M
Contract Labor & Hardware	32.7 M
SIPS etc.	8.3 M
Other Misc	.6 M
Federal Share	$52.9 M
State Share	$ 9.9 M

Section 11.2. (a) The Department of Health and Human Services shall, using the report of KPMG Peat Marwick, L.L.P. to the General Assembly dated March 20, 1997, develop and begin implementing a plan to reorganize the Department of Human Resources. The reorganization plan shall be designed:

(1) To structure planning, management, and service delivery around a strategic shared mission and long-range vision for the Department;

(2) To better achieve a consolidated family-center services orientation that facilitates identification of gaps in services, improvement of efficient and effective access to services, and reduces fragmentation of leadership, management, and service delivery;

(3) To facilitate a system of incentives within the Department and within local agencies that will reinforce personnel efforts at integrated services delivery; and

(4) To enable assessment of program performance in terms of actual client outcomes, effective and efficient service delivery, and the impact services and departmental functions are having in the lives of clients, rather than in terms of process measures.

(b) With funds from within the Department, and in consultation with the House and Senate Appropriations Subcommittees on Human Resources, the Department of Health and Human Services shall engage an entity with proven expertise to provide the Department leadership and management with the knowledge and tools needed to ensure a change in departmental culture that creates an environment:

(1) Where there is an understanding and appreciation for a departmental mission and primary goals that portray a coordinated system of services, rather than a group of independently operating group of services;

(2) Where, although the Department delivers few direct services, a client needing multiple services can have them delivered in a coordinated manner through local governing entities and by local service providers;

(3) Where counties have the opportunity, where practicable, to develop approaches to service delivery that work best for them;

(4) Where the Department can restructure around functions rather than programs; and

(5) Where the Department can develop an internal management capacity for strategic planning, program planning and evaluation, and formal senior management reviews, on a regular basis, of client needs, program performance, and issues related to resource allocation and risk assessment.

(c) The Department of Health and Human Services shall give very strong consideration to establishing the following service delivery functions: services, regulation, institutional management, education, and health care financing.

(d) The Department of Human Resources shall give very strong consideration to establishing the following coordination and infrastructure functions: information services and performance services.

KPMG Peat Marwick LLP

Report to the Commission on the Reorganization of the Department of Human Resources

Key Points & Recommendations

1. DHR must fundamentally change its role as a regulatory and program management agency.

2. Counties should be allowed to fashion a human services delivery structure that meets local needs and conditions.

3. DHR must reorganize itself in ways that promote integrated program policy, partnerships with local service deliverers, and an outcomes-based approach to
measuring results.

4. Develop a focused mission that is clearly understood by all players in North Carolina's human services delivery system.

5. Coordinate services internally to model an integrated approach to service delivery.

6. Remove program silos by restructuring around functions, rather than programs.

7. Align related services along functional lines through creation of five divisions.

8. Create a local services coordination unit that provides a "single face" of DHR to the state's service providers.

Key Points & Recommendations (continued)

9. Develop an information technology infrastructure that supports that state's entire human services delivery system.

10. Create a DHR "to-be" Organizational Model that reflects the principles and structures incorporated in the recommendations in this report.

Specifically KPMG recommended five service delivery functions:

- ***Division of Services:*** To develop program policy, deliver services and coordinate the delivery of services by local providers directly to the citizens of North Carolina.

- ***Division of Regulatory Services:*** To provide regulatory guidelines, licensing services, and program integrity assurance.

- ***Division of Institutional Management:*** To coordinate the management of DHR institutions, especially with regard to common functions, such as building, maintenance, and food.

- ***Division of Education Services:*** To provide program policy and manage the blind and deaf schools and the educational components at the training schools and mental health institutions.

- ***Division of Health Care Financing Services:*** To carry out administrative and regulatory tasks associated with the North Carolina Medicaid program.

KPMG Peat Marwick LLP

Report to the Commission on the Reorganization of the Department of Human Resources

Key Points & Recommendations (continued)

In addition, KPMG recommended the establishment of two coordination and regulatory functions:

- ***Information Services:*** To develop the information technology infrastructure necessary to support program service delivery.

- ***Performance Services:*** To evaluate program performance and identify opportunities for improvements.

Fiscal Research Division
October 21, 1997

10-21-97

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Status of

KPMG Peat Marwick Recommendations

October 21, 1997

Status of
KPMG Peat Marwick Recommendations

RECOMMENDATION	STATUS
• DHR should implement an ongoing, comprehensive planning process clearly understood by all who are involved in the human services delivery system.	DHHS has established a planning function within the Division of Budget, Analysis and Planning. We are currently restructuring and continuing to integrate our planning processes.
• DHR should consider legislation that would rename DHR to the Department of Human Services (DHS).	Department was renamed Department of Health and Human Services (DHHS).
• DHR's executive staff should be structured with an orientation toward strategic issues and high-level decision making.	We have established an executive management team made up of all direct reports to the Secretary. This is the team that the Secretary uses for strategic issues and high-level decision making. This is also the mechanism for achieving enterprise-wide integrated decision-making.

RECOMMENDATION	STATUS
• DHR should create an executive management team that includes the Secretary, an Assistant Secretary for Administration and Finance, and a new Assistant Secretary for Operations.	Same as above.
• Establish a single Services Division for service policy development and delivery coordination.	Extra level not needed - service delivery and policy development coordinated at Executive Committee level
• Consolidate North Carolina's economic programs into an Economic Services Section to promote a holistic approach to delivering financial support services.	Assistant Secretary for Human Services and Education Policy (Peter Leousis) will be responsible for coordinating these functions which are located within the Divisions under him.

RECOMMENDATION	STATUS
• Combine the program planning and policy component of Children's Services and the front-end Youth Services to create a Child and Youth Services Section.	Same as above. The Governor has appointed a Juvenile Crime Commission that will be looking at these issues.
• Combine the Division of Aging and DSS's Adult Services section to form an Adult and Aging Services Section	Study currently being conducted to determine the appropriate way and time to implement.
• DHR must fundamentally change the nature of its internal and external relationships, moving from a role as a regulator and program manager.	We are currently working to implement these recommendations through the new organization structure. We also plan to delegate more service to the local levels.

RECOMMENDATION	STATUS
• DHR must establish a new role that focuses on policy development, leadership, and collaboration to create an integrated system that facilitates service delivery through outcomes-based performance.	The Department is currently reviewing and improving its outcome measures, and we will begin a management reporting process in November. With the devolution of responsibilities, we plan to use outcome measures to measure performance. This is exactly the direction of our reorganization.
• DHR should create a Policy Coordination and Service Delivery Section to coordinate DHR policy across Service Domains and provide a single face of DHR.	The Department will use the Assistant Secretaries and the Executive Management Committee to coordinate DHR policy across Service Domains. No new bureaucracy needed.
• DHR should use regional teams of consultants to represent DHR to local service deliverers in assigned regions which are consistent across programs.	The Department is just beginning to look at its regional structure now that the public health programs and the former DHR Divisions have been combined into a new DHHS.

RECOMMENDATION	STATUS
• Counties should be allowed to fashion a human services delivery structure that meets local needs and conditions.	We will support any human services delivery structure the counties fashion. We will encourage coordination and integration.
• The population minimum law set by the General Assembly for service delivery redesign should be rescinded.	We will encourage combining services where that makes geographic and economic sense.
• DHR should deliver state-administered services through a regional approach that facilitates coordination of services in groups of counties which are the same across all programs.	Under study.
• Create a local educational agency (LEA) under a DHR Division of Education Services to administer DHR schools.	Education policy will be the responsibility of the Assistant Secretary for Human Services and Education Policy. A cross-Department education management team has been established to assist him.

RECOMMENDATION	STATUS
• DHR should build on recent funding and budgeting changes within and external to DHR by institutionalizing information system policy and priority-setting mechanisms that address cross-Division system issues and supporting service delivery consistent with the Guiding Principles.	Currently being implemented based upon Automation Plan that was presented to the 1997 General Assembly. We are taking an enterprise-wide view of automation. Probably the most important effort underway in DHHS.
• DHR should begin planning a DHR systems infrastructure and application systems that build on common core business needs and support the entire human service delivery structure.	Currently being implemented. High-level steering team has been established which includes members from the Executive Management Committee, County Commissioners' Association Division, and local DHHS Directors.

RECOMMENDATION	STATUS
• DHR should implement system support for an integrated services delivery strategy through an "adaptive" systems approach that breaks large projects into multiple smaller ones within an overall project vision. These "adaptive" project components should be funded separately.	Currently under implementation. This is how we are developing future automation.
• DHR should implement a management plan for obtaining and maintaining needed information technology resources and skills.	Currently being developed.

file: kpmgrec.doc

Reinventing How We Serve the Citizens

Future



SEAMLESS DELIVERY



Employment



Housing



Child Care



Nutrition



Mental Health



Volunteers



Faith Community



Public Health



Referrals/
Placements



Smart Start

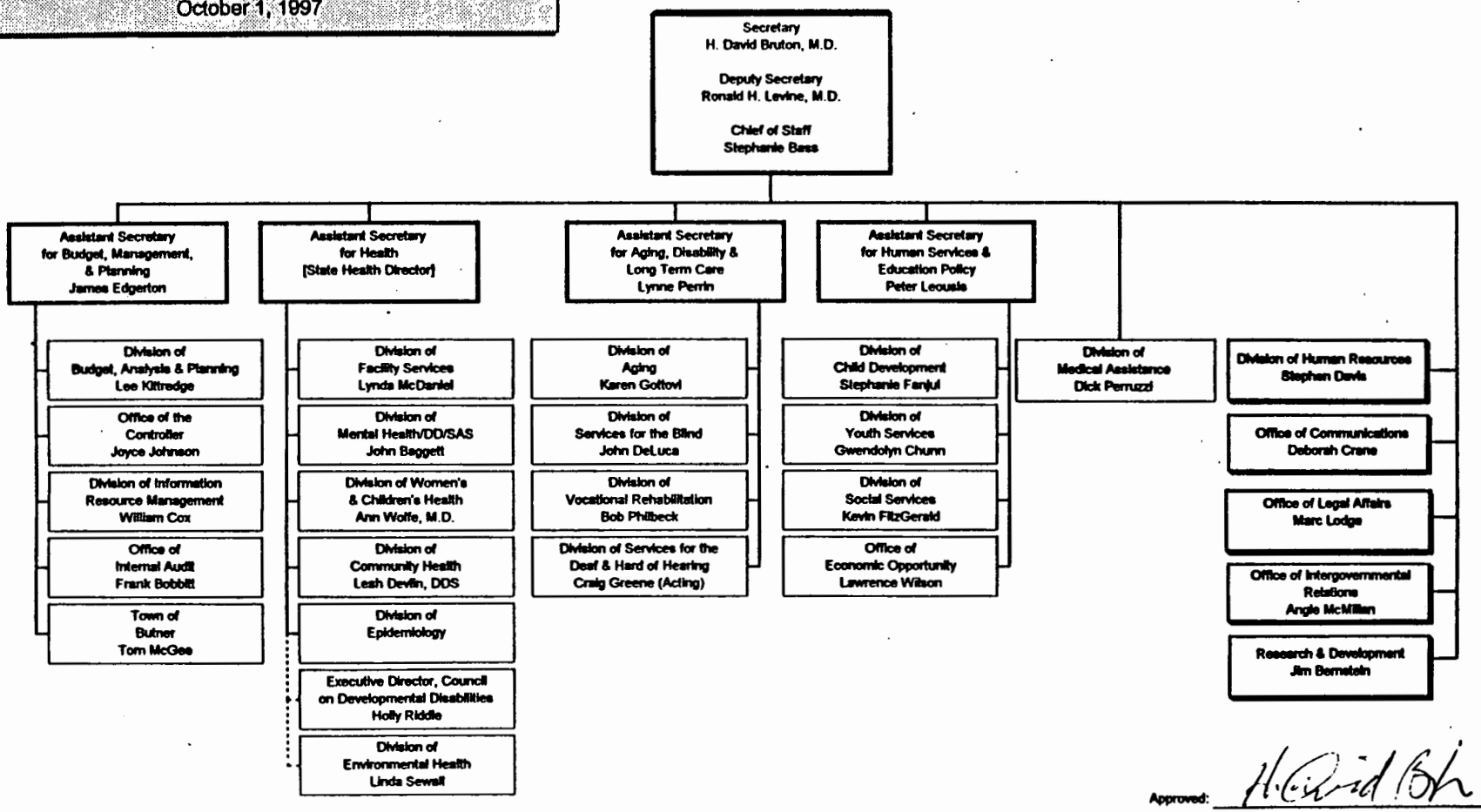


Medical Assistance

Technology Integrated
Service Delivery

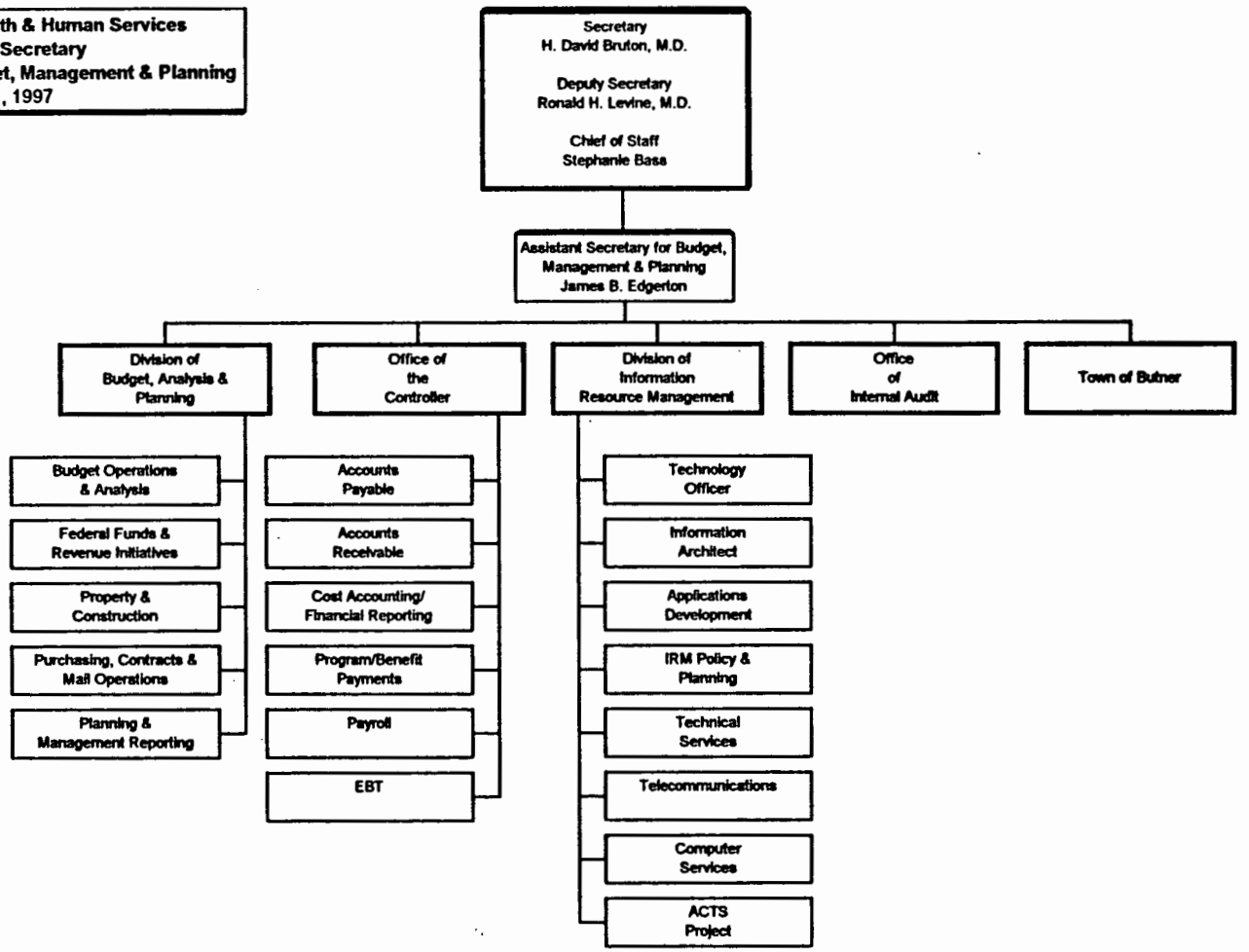
10-21-97

N.C. Department of Health and Human Services
October 1, 1997

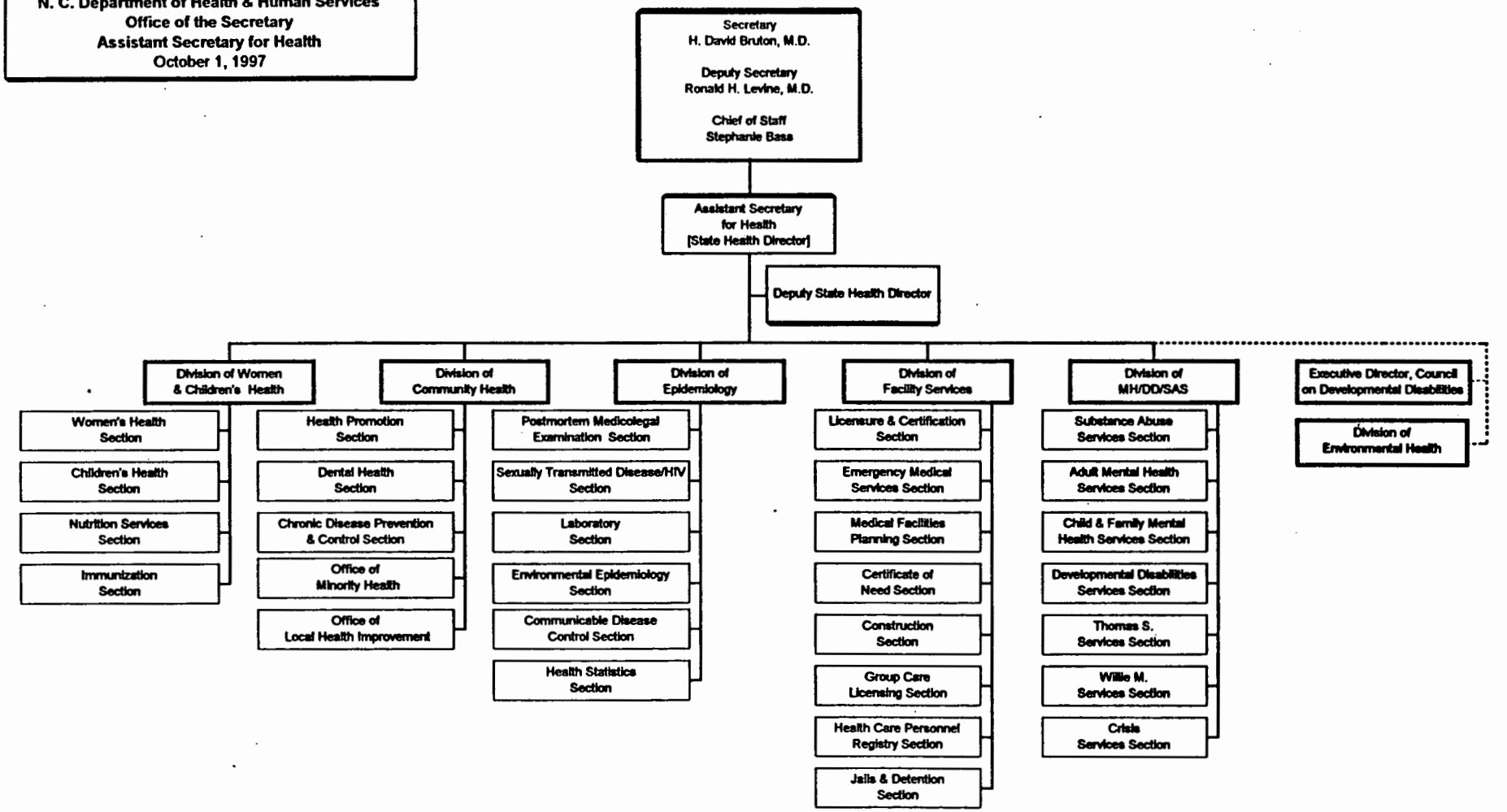


Approved: H. David Bruton

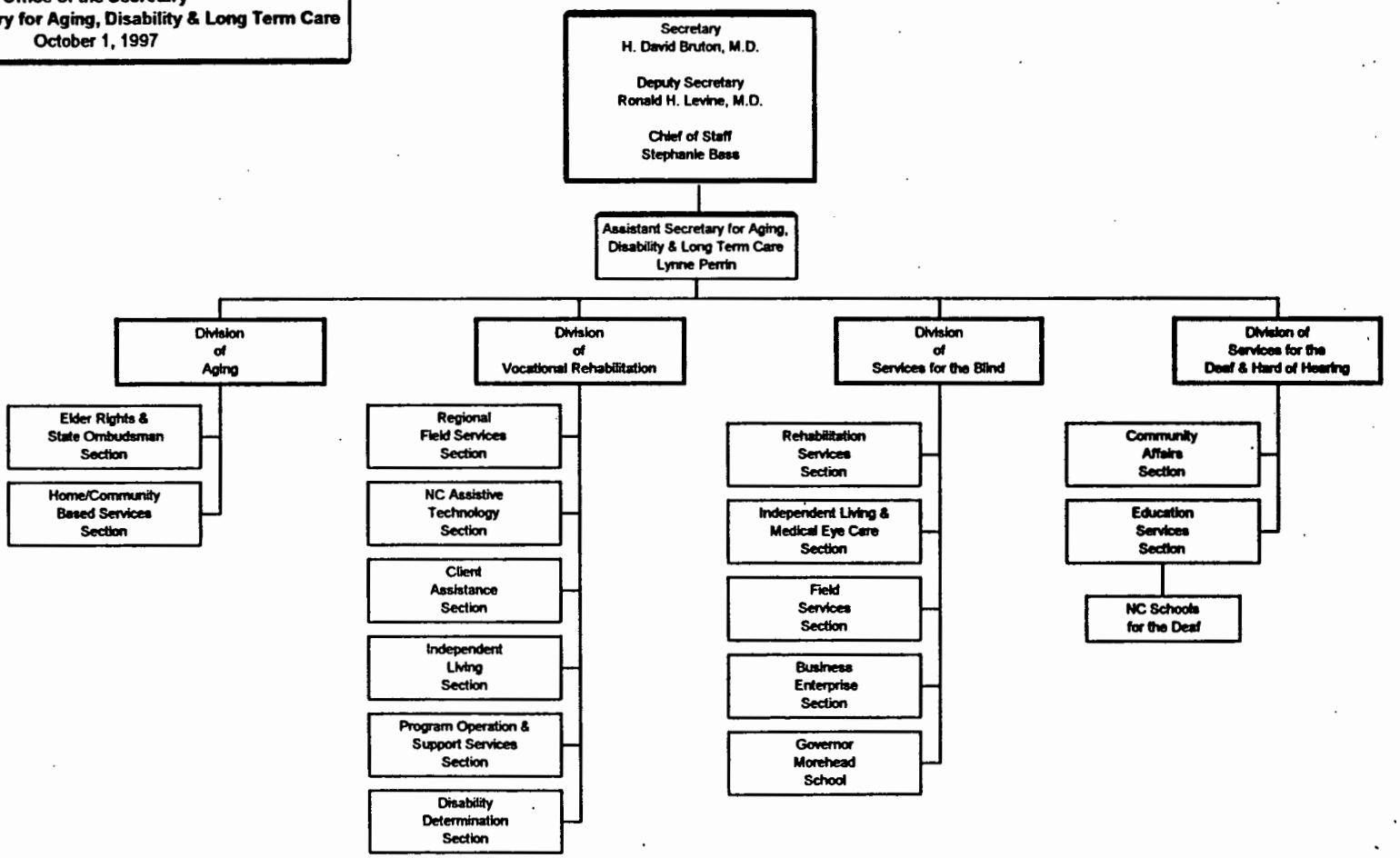
N.C. Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Budget, Management & Planning
October 1, 1997



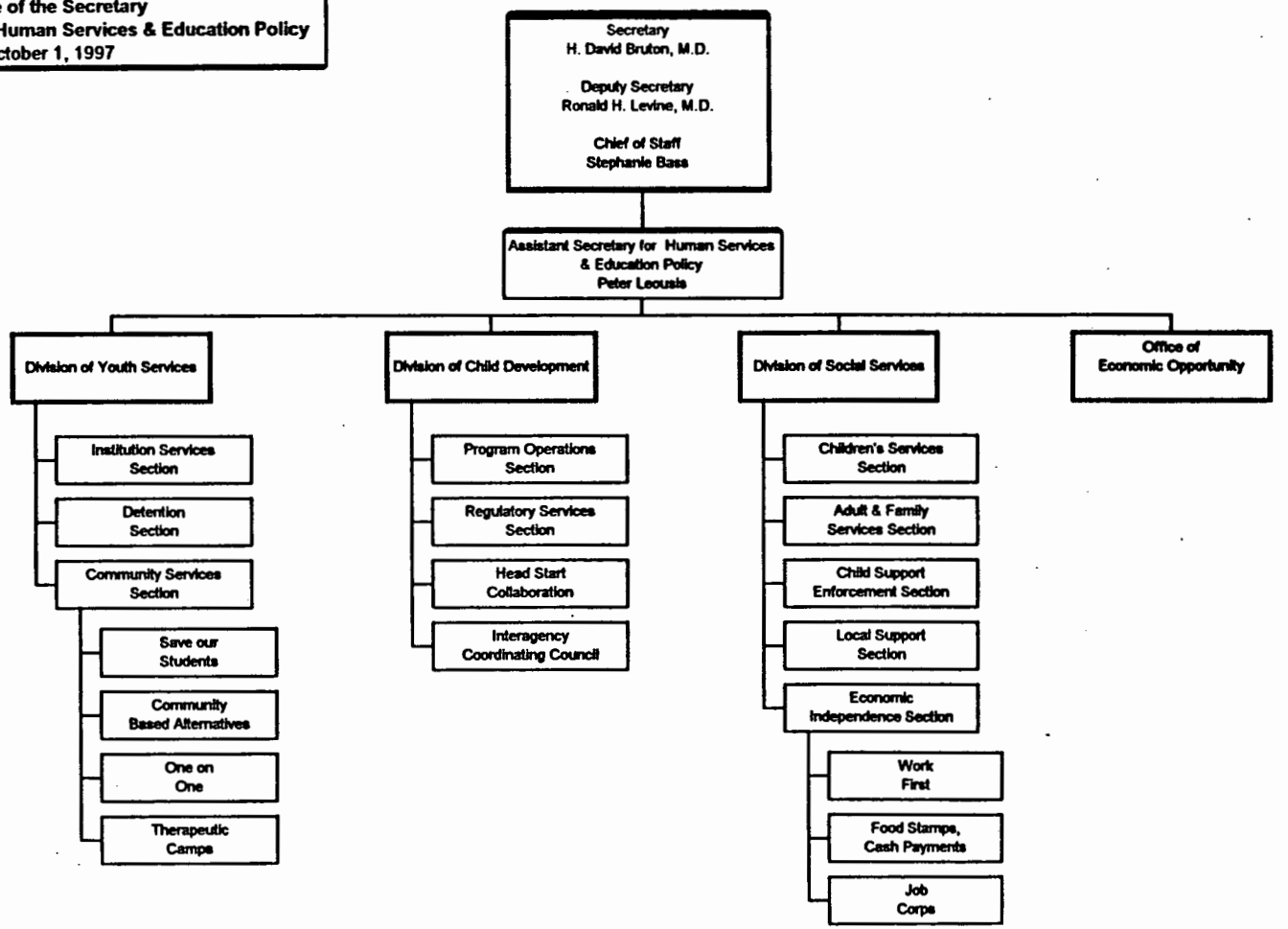
N. C. Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Health
October 1, 1997



Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Aging, Disability & Long Term Care
October 1, 1997



Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Human Services & Education Policy
October 1, 1997



10-24-97

DIVISION OF SOCIAL SERVICES
CHILD WELFARE SYSTEM IMPROVEMENTS
UPDATE - OCTOBER, 1997

1. Meet minimum staffing standards (CPS, Foster Care, Adoptions) in every county

Progress to Date: The Division of Social Services has surveyed all 100 county Departments of Social Services to identify staffing needs and has distributed the results. We are currently finalizing the schedule of county staff allocations.

The Division has also submitted a formal revision to our Title IV-E State Plan to expand the definition of activities that are reimbursable by the federal government under Title IV-E (Foster Care and Adoption Assistance) of the Social Security Act. With approval of the amended State Plan, we can begin claiming additional federal reimbursement for allowable child protective services activities that are meant to prevent foster care placement.

Next Steps: (1) Finalize the staff allocation by county; (2) Obtain federal approval of the amended IV-E State Plan; (3) Train county staff on changes in reporting their time. *Projected Implementation:* December 1, 1997.

2. Develop Comprehensive Training System for Children's Services Staff

Progress to Date: The Division of Social Services has informed all county DSS agencies of mandatory pre-service and in-service training for children's services social workers and supervisors effective January 1, 1998. It is planned that four regional training centers will be developed in Greenville, Greensboro, Charlotte and Asheville. Division staff have met with various University, Community College and AHEC Staff to determine the availability of space and to develop critical partnerships. Job descriptions for the new trainer positions have been written and we expect the positions to be posted in the very near future.

Next Steps: (1) Finalize the location and key partners for the 4 training centers; (2) Hire and train staff for the training centers. *Projected Implementation:* Jan. 1, 1998

3. Implement the Special Needs Adoption Fund

Progress to date: A committee composed of representatives from the North Carolina Association of County Directors of Social Services, six private adoption agencies, and the Division of Social Services met on October 9th to define guidelines for use of the Special Adoption Fund. The group was able to reach consensus on the critical issues: definition of "special needs," rate of payment, and methodology to establish a baseline for each county DSS and private adoption agency. Dr. Lynn Usher from UNC-CH, who was present at the meeting, will analyze data to help establish the baseline.

Next Steps: (1) Establish baselines for all 100 counties and participating private adoption agencies; (2) Inform all agencies of how the Fund will operate and of the number of Decrees of Adoption required to meet their baseline; (3) Finalize methodology for payment system; (4) Closely monitor payments to assure that funds are used as intended; (5) Provide regular reports to agencies and legislators on use of funds; (6) Evaluate the impact of the Special Adoption Fund. *Projected Implementation:* Payments to begin by Jan. 1, 1998.

4. Implement Comprehensive Child Fatality Review Process

Progress to date: The Division of Social Services has implemented a comprehensive child fatality review process using a multi-disciplinary team approach. The reviews are conducted following the fatality of a child who received child protective services from a county DSS agency within 12 months preceding the death. Job descriptions have been completed for the 2 new staff positions who will develop particular expertise in this area of work.

Next steps: (1) Hire and train fatality review specialists. *Projected Implementation:* December 1, 1997.

5. Competitive Grant Program for Community Child Protection Teams

Progress to date: The Division has finalized plans to administer the grant program. A CCPT can apply for a grant not to exceed $50,000 annually.
There will be a two year limit on funding, with the second year extension contingent on the evaluation of the program for the first year.

Next steps: Submit RFPs. *Projected Implementation:* July 1, 1998.

6. Ensure Professional Liability Insurance

Progress to date: Division staff have met with representatives of the Attorney General's Office and the Dept. of Insurance to identify alternative approaches to this issue.

Next Steps: Continue to identify and compare alternative strategies. *Projected Implementation:* July 1, 1998.

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Grounds for Termination of Parental Rights (HB 896) Changes to NCGS: 7A-289.32(3), (7)	• Amends ground for TPR so that the required efforts within 12 months of child's placement are focused on parents' efforts rather than DSS efforts. • Amends ground for TPR based on parental incapability to include substance abuse. • Changes time frame for TPR for incapability from "child's minority" to "the foreseeable future."	• Facilitates termination of parental rights in cases in which parents are not making progress toward reunification, are habitual substance abusers, or are otherwise incapable of providing a safe, nurturing environment for the child. Continues requirement that poverty is not ground for termination. • *Agencies should re-evaluate children who have been in foster care for more than 12 months to determine if termination of parental rights would be appropriate to meet the child's need for a safe, permanent home.*
Reasonable Efforts and Safety (HB 896) Changes to NCGS: 7A-517 (25a), (25b) 7A-577 7A-657	• Defines "reasonable efforts" as the diligent use of preventive or reunification services when a juvenile's remaining home or returning home is consistent with achieving a safe, permanent home for the juvenile within a reasonable length of time. • Defines "safe home" as one in which a child is not at substantial risk of abuse or neglect. • Allows court to discontinue reunification efforts at any hearing if reunification would be futile or is inconsistent with juvenile's safety.	• Facilitates safe, permanent placement for children when agency reunification efforts are inconsistent with the best interests of the child. • *The child's safety is primary in considering continued efforts toward reunification. It is appropriate to recommend to the court at any hearing that reunification efforts be discontinued when these efforts have been futile or are inconsistent with the child's safety.*
Timely Court Reviews (HB 896) Changes to NCGS: 7A-657	• Establishes two new required court hearings: 1) 2nd custody review six months following 1st custody review; and 2) permanency planning hearing within twelve months of placement. • Requires court to provide notification of the hearing and, if the child is not returned home, to enter an order as to the best plan of care to achieve a safe, permanent home for the juvenile within a reasonable period of time.	• Provides for more timely court reviews during a child's critical first year of foster placement. • *Agencies should be considering options for permanent placements for children removed from their homes throughout agency involvement with family, and be prepared to make recommendations at the permanency planning hearing which is held within 12 months of placement.*
Missing Parent (HB 896) Changes to NCGS: 7A-577	• Requires court to inquire about parent missing from hearings at every nonsecure custody hearing; authorizes judge to require specific efforts to locate missing parents.	• Should result in increased participation by parents in nonsecure hearings; • Places increased responsibility on DSS to ensure parental involvement in hearings. • *The judge may order specific efforts on the part of DSS to locate the parents.*

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Relative Placement (HB 896) Changes to NCGS: 7A-576 7A-577 131D-10.6A	• Requires judge, at every non-secure custody hearing, to consider and give priority to placement with a relative who is willing and able to provide proper care and supervision in a "safe home". • Allows review hearings to be waived if child is in stable relative or kinship placement for one year and relative/kin has been designated custodian or guardian of the person of the juvenile. • Allows provisional foster care licensure for six months for persons who have not completed training requirements.	• Should result in increased placement of children with relatives when appropriate care and supervision will be provided. • *Relatives should be given priority as potential placement resources for children in care when suitable.* • *Relatives may be approved for provisional licensure as foster parents prior to completing mandated training.* • *Reviews may be waived in stable, legally secure, permanent placements with relatives or other kin in which the relative/kin has been designated custodian or guardian of the person of the juvenile.*
Investigations of All Children in Home (HB 896) Changes to NCGS: 7A-544	• Requires DSS to ascertain immediately after a report is received whether other children live in the reported child's home and, if so, initiate an investigation on all children in the home. • Requires judge to inquire about status of other children remaining in home at every nonsecure custody hearing.	• Requires more immediate assessment of all children in home and will help to ensure that other victim children are identified earlier in the investigative process; • Ensures that the needs of all children in a household are addressed in court. • *All children living in the same household (including group homes and multi-family households) with the alleged victim child at the time of the report must be opened for a CPS investigation. Investigations on "other children living in the home" must be initiated within 24 hours for reports of abuse, or within 72 hours for reports of neglect or dependency. Children who come into or are born into the home during an open investigation must be evaluated as victim children.* • *If a report is investigated in a residential facility with more than one living unit, only those children exposed to possible maltreatment by the alleged perpetrator/caretaker should be opened for investigation.*
Neglected Juvenile Definition (HB 896) Changes to NCGS: 7A-517	• Amends the definition of "neglected juvenile" to state that in determining whether or not a juvenile is neglected, it is relevant whether he or she lives in a home in which another juvenile in the home has been subjected to abuse or neglect.	• Provides the legal basis for including other children in the home in a neglect petition. • Should result in more children being assessed for their need for protective services.

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Guardian of the Person (HB 896) Changes to NCGS: 7A-585 7A-657	• Defines rights and responsibilities of a juvenile's guardian of the person appointed by the juvenile court. • Clarifies that appointment of guardian of the person of the juvenile is also an option for judges at the conclusion of review hearings.	• Clarifies guardianship as an option for legal permanence for children in foster care and specifies the legal rights that guardianship of the person of the juvenile entails. • Specifically authorizes persons so named to sign for a child to marry, to enlist in the armed forces, to enroll in school, and to receive needed remedial, psychological, medical or surgical treatment • *This law will increase options for permanence for children*
State Authority to Intervene in County DSS Service Delivery (HB 896) Changes to NCGS: 108A-74	• Establishes procedures through which the State can intervene in child welfare services in counties that do not provide those services in accordance with State law and applicable rules. If such circumstances pose a substantial threat to the safety and welfare of children in the county, the State may assume control and provide child welfare services through contract or direct operation.	• Provides safeguards for children by providing immediate state-level assistance and oversight to struggling county child welfare programs. • *If the Secretary of DHHS determines that a county agency is not providing Children's Services in accordance with law and rule, or fails to demonstrate reasonable efforts to do so, he/she may institute corrective action, withhold Federal and State funding, and/or assume control of the agency*
Legislative Study Commission on Children and Youth (HB 896) Changes to NCGS: 120-208 to 120-210	• Creates legislative study commission to study and evaluate the system of delivery of services to children and youth and to make recommendations to improve service delivery.	• Resulting recommendations could affect requirements for services.
Dependent Juvenile Definition (HB 153) Changes to NCGS: 7A-517(21)	• Amends definition of dependent juvenile by deleting reference to "physical or mental incapacity" as the cause of the parent's inability to provide for a child; applies to adjudications of dependency made on or after October 1, 1997.	• Broadens the legal basis for declaring a child dependent.

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Disclosure of Information After Fatalities or Near Fatalities (HB 949) Changes to NCGS: 7A-675.1	• Requires public agencies, upon request and under certain conditions, to provide a written summary of findings and information following a child fatality or near fatality resulting from suspected abuse, neglect, or maltreatment. • Sets parameters for disclosure of information.	• Allows agencies to disclose information to the public following a child fatality or near fatality when a person is criminally charged. • Agencies can disclose a written summary of actions taken by the agency regarding that child, the results of the Child Fatality Review, confirmation of prior reports regarding the victim child, a description of the conduct of the most recent investigation and services rendered, and a statement of the basis for the department's decision. • Agencies are not required to disclose information if disclosure would cause danger or harm to a child in the deceased or injured child's household; would jeopardize the State's ability to prosecute the defendant; would jeopardize the defendant's right to a fair trial; would undermine a criminal investigation; or is not authorized by federal law. • Persons requesting disclosure may apply to superior court for an order compelling disclosure if the agency has refused to provide the information.
Interagency Sharing of Information (HB 949) Changes to NCGS: 7A-675(h)	• Requires chief district court judge to issue an administrative order naming the agencies designated to share information relevant to cases in which abuse, neglect, or dependency petition was filed.	• Facilitates more sharing of information among service providers. • *Should result in more consistent, relevant services to the child and family and should reduce inappropriate duplication of services.* • *This law does not apply to information in which confidentiality is protected by federal law.*
Criminal Records Checks (SB 207) Changes to NCGS: 131D-10.2 131D-10.3A 114-19.4	• Narrows definition of foster parents to only those adults licensed as foster parents; • Requires criminal records checks of all persons over 18 who reside in the family foster home; • Requires criminal record check for in-home care aides; forbids change of current employee from out-of-home position to in-home position if they refuse a criminal history check.	• Clarifies existing requirements for foster family homes. • 18 year olds must have a criminal record check if they are residing in the home at the time of the license. • Closes potential legal loophole for in-home caregivers who were on staff in another capacity.

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Waivers on Licensed Facilities (SB 1023) Changes to NCGS: 131D-10.6	• Requires form to request waiver of Commission licensing rules. • Requires waiver decision within 10 business days. • Requires study re: procedures for granting or denying licensure or waivers to Commission rules.	• Formalizes and expedites waiver request process. • Requires study of waiver/denial actions and report to General Assembly on or before 5/1/98. • *DSS staff will need to inform prospective foster parents of waiver procedures and provide a form to request a waiver.*
Changes to Adoption Laws (SB 162) Changes to NCGS: 48-2-502 48-2-503 48-2-604 48-3-702 48-9-102 48-9-303 48-2-601 48-3-603 48-3-201 48-3-602 48-1-101(8) 48-2-501 48-2-206 48-3-302 130A-108	• Information in adoption report to the court in an agency adoption must not lead to identification of former parent or family member; existing records should be screened and revised.. • Specifies when court can dismiss petition to adopt a child at any point between filing of petition and final order. Requires formal notice of dismissal. • Requires agency to give written acceptance of relinquishment of parental rights. • Extends confidentiality to the special proceedings index. • Removes "parent for whose child a guardian has been appointed" from list of those not requiring consent to adopt and adds Standby Guardians to guardian definition. • Allows waiver of court reports in stepparent adoptions in some situations. • After six months gestation, allows mother of unborn child, adoptive parents, or the agency to initiate a special proceeding to determine whether or not the consent of the biological father of the fetus is required to consent to adoption. Procedures outlined. • County DSS must prepare preplacement assessment if prospective adoptive parent has identified child they wish to adopt and cannot afford the cost of a preplacement assessment. • Provides that relinquishment shall become void if before placement with a prospective adoptive parent occurs, the agency and person agree to rescind the relinquishment. • Provides that the signing of a relinquishment no longer terminates the duty to support a child.	• Conforms statute to existing administrative rule. Report is required to be given to adoptive parent. • Adds procedures for dismissal of petition. • Written vs. oral acceptance • Makes clear that the final decree and the index are confidential. • Achieves consistency with new standby guardian statute. • Could lessen number of required reports to court. • Expected to be used primarily in private, independent adoptions. *However, this could impact DSS adoptions of very young children.* • Self-explanatory. • Clarifies that "unable to obtain" includes financial constraints. *Allows more time for prospective adoptive parents to be approved for a specific child Could increase # of preplacement assessments by DSS.* • Provides a mechanism to void a relinquishment similar to present provision to void consent. *No longer needs to be added to relinquishment form to be used.* • Returns to past position on support: duty to support only ends upon entry of *final decree of adoption.*

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Allocation to Add Additional Child Welfare Staff (Special Provision)	• Additional appropriation to county DSS's to hire or contract for additional CPS, foster care, and adoption workers • Requires no local funding match for SSBG allocation	• Will ensure that every NC county will have enough children's services staff positions to meet national and state caseload standards.
Special Children Adoption Fund (Special Provision)	• Establishes a fund to provide additional money for participating licensed and private adoption agencies.	• Ensures that more funds are available to support children in adoptive placements.
State Child Fatality Review Team (Special Provision)	• Provides funding for two fiscal years to establish and maintain a multidisciplinary state child fatality review team to review deaths of children recently involved with DSS.	• State level, in depth reviews of child fatalities will lead to recommendations of improved coordination of services and reduction of the number of child deaths. • *There will be more comprehensive reviews of child fatalities by the State multidisciplinary review team.*
Required Pre-Service Training for Child Welfare Staff (Special Provision)	• Establishes pre-service training requirements for all child welfare staff hired on or after 1/1/98.	• Requires all new DSS children's services workers and supervisors to receive training prior to service delivery and annually thereafter. • *Agencies will need to plan for coverage until staff is trained and ready to assume duties.*
Professional Liability Insurance for Child Welfare Staff	• Allocates funds to purchase liability insurance for county child welfare staff.	• Will help to attract and retain qualified staff.
Grants to Community Child Protection Teams	• Allocates funds to increase the outreach capacity of the Community Child Protection Teams.	• Provides funds for CCPT's to establish creative outreach services in the community that will reduce risk to children. • *There is now a state coordinator for CCPT's in the Division of Social Services.*

10-21-97

North Carolina
Department of Health and Human Services

101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt, Jr., Governor

H. David Bruton, M.D., Secretary

September 30, 1997

The Honorable Harold Brubaker, Speaker
North Carolina House of Representatives

RECEIVED
OCT 17 1997
DIVISION OF FACILITY SERVICES

The Honorable Marc Basnight, President Pro Tempore
North Carolina Senate
Legislative Building
Raleigh, North Carolina

Dear Representative Brubaker and Senator Basnight:

In accordance with Section 11.21 A of Chapter 443 of the 1997 Session Laws, I am submitting the enclosed annual adult care homes report. This report describes the status of the following: (1) rate-setting and financing of adult care homes; (2) quality assurance and enhancement of adult care homes; and (3) the process for the evaluation of the Adult Care Home Financing and Quality Assurance Program.

Questions regarding rate-setting and financing and the process for the evaluation of adult care home financing are to be addressed to James B. Edgerton, Assistant Secretary for Budget and Management. Questions regarding the remaining portions of the report are to be addressed to Lynne M. Perrin, Assistant Secretary for Aging and Special Needs.

Sincerely,

H. David Bruton, M.D.

HDB:db

cc: Tom Covington
Karen Hammonds-Blake
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ADULT CARE HOMES REPORT

FOR SFY 1996-97

PRESENTED TO

JOINT LEGISLATIVE COMMISSION ON GOVERNMENTAL OPERATIONS AND FISCAL RESEARCH

PREPARED BY THE
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
October, 1997

INTRODUCTION

Section 11.21 A of Chapter 443 of the 1997 Session Laws (Senate Bill 352) requires the Secretary of the Department of Health and Human Services to report annually to the Joint Legislative Commission on Governmental Operations and the Fiscal Research Division of the Legislative Services Office on the planning and status of the following:

1. Rate setting and financing for adult care homes, including the use of Medicaid funds for personal care services;

2. Quality assurance and enhancement of adult care, including case management for residents with special care needs, monitoring of adult care facilities and specialized training of direct care staff; and

3. The process for the evaluation of the Adult Care Financing and Quality Assurance Program.

This report provides a summary of the progress for the state fiscal year of July 1, 1996, to June 30, 1997. Below are highlights of the year's activities, followed by sections addressing the areas noted above.

HIGHLIGHTS FOR SFY 1996-97

- Adult care homes submitted cost reports for the period of October 1, 1995 to September 30, 1996. As of June 30, 1997, 76 facilities failed to submit cost reports or request an exemption. These facilities were sent warning letters. Letters of intent to revoke licenses were sent to facilities that still failed to submit reports. (As of September 30, 1997, 28 facilities had not submitted cost reports and action on their licenses is pending.)

- The Adult Care Home Chart of Accounts for the period of October 1, 1996 to September 30, 1997, was revised with input from adult care home providers, advocates, the Fiscal Research Division and selected members of the General Assembly.

- The Department selected a sample of 110 cost reports of facilities that were licensed for six or fewer beds to perform agreed upon procedures for the period ending September 30, 1995. The Department selected a sample of 20 cost reports of facilities that were licensed for six beds or fewer to perform agreed upon procedures for the period ending September 30, 1996.

- The Department also reviewed a sample of 69 Agreed Upon Procedures Reports submitted by independent accountants and CPAs for the period ending September 30, 1995. Of these 69 reports, 15 were selected for a review of the independent accountant's or CPA's work papers which supported the findings in their reports. As a result of this review, all accountants who perform agreed-upon procedures engagements must participate in a peer review program for the 1998 cost reporting period.

- The agreed-upon procedures for the 1996 cost report audits were developed and distributed in October, 1996.

- The Department reviewed and approved applications from individuals, agencies, and organizations across the state to provide the required adult care home personal care training and/or competency training in addition to the training provided by community colleges.

- Adult care home licensure consultants conducted 522 annual surveys of adult care homes and 233 follow-up or expanded surveys, utilizing the staff pharmacists, dietitians and nurse for follow-up surveys and consultation with facilities experiencing compliance problems in particular licensure areas.

- Heavy care residents received case management services from county departments of social services and area mental health programs in 89 counties. 96% of the heavy care residents received case management services from the county departments of social services at expenditures of $2,255,533, and the rest from area mental health programs.

- A total of 132 case managers provided case management services in 82 county departments of social services with reported results of improved continence, nutrition, performance of activities of daily living, socialization and stimulation, and continuity of care.

- Total Medicaid expenditures for basic and enhanced personal care services was $61,383,798 and the monthly average number of residents receiving Medicaid reimbursable personal care services was 18,026 residents.

- The Division of Medical Assistance began a post-payment review regarding facility compliance with Medicaid policies for receiving enhanced personal care payments and developed "prior approval" procedures for case managers authorizing enhanced personal care payments and facilities billing for enhanced care payments.

I. COST REPORTING AND RATE SETTING

A. Cost Reporting and Audit Requirements

G.S. 131D-4.1-4.3 requires all adult care homes, including mental health group homes, which receive funds through State/County Special Assistance for Adults Program (S/C SA) to submit annual cost reports to the Department of Health and Human Services. Those homes which do not receive funds through S/C SA are exempt from the cost reporting requirements. The law also places audit requirements on adult care facilities which are required to submit annual cost reports.

Below is a summary of the adult care cost reporting and audit requirements established by G.S. 131D-4.1-4.3.

Licensed Bed Capacity	Annual Cost Report Required	Cost Report Required to be Audited
21 or more beds	Yes	Annually
7 to 20 beds	Yes	EveryTwo Years
6 or fewer beds	Yes	Not Required *

* To ensure quality of data, the Department has the authority to conduct audits (G.S. 131D-4.2(f)) and has implemented a process where samples of adult care facilities' ($\leq$ 6 beds) cost reports are selected for review by Department personnel.

In order to meet the audit requirements of G.S. 131D-4.1-3, while at the same time contain the cost incurred by the facilities, the Department developed agreed-upon procedures to be performed by independent accountants and Certified Public Accountants (CPAs). The procedures should be performed in accordance with Statement on Auditing Standards (SAS) No. 75; *Engagements to Apply Agreed-Upon Procedures to Specified Elements, Accounts, or Items of a Financial Statement.* In layman's terms, "agreed-upon procedures" describe specific analytical procedures to be performed by the independent accountant/CPA on an agency's accounting records for verifying the accuracy and validity of reported costs and revenues.

Responsibility for the Cost Reports, Chart of Accounts, and rate-setting has been delegated to the Department's Controller's Office. Responsibility for developing the agreed-upon procedures to be performed by all independent accountants and CPAs in verifying the accuracy and validity of reported costs and revenues has been delegated to the Department's Office of the Internal Auditor. The Department's Office of the Internal Auditor and the Controller's Office have coordinated the adult care facilities' cost report audits.

B. Cost Reports and Chart of Accounts

The Adult Care Home Chart of Accounts and Cost Report, with instructions, were developed for the twelve month period October 1, 1995, through September 30, 1996, with input from industry providers and advocates. The chart of accounts was mailed to providers in February, 1996, and the Cost Report format with instructions were mailed to providers in October 1996. Fiscal Research and selected members of the General Assembly also

provided input on the Cost Report and its instructions. Training sessions for providers were held.

Cost Reports for October 1, 1995-September 30, 1996 Reporting Period
Status as of June 30, 1997

2,159	Adult Care Home (ACH) facilities as of September 30, 1995
307	ACH facilities exempt from reporting
78	ACH facilities not required to report because facility closed or sold
1,774	ACH facilities required to submit cost reports
3	ACH facilities submitted unacceptable cost reports
76	Facilities failed to submit cost reports or exemption request

(Note: The facilities which failed to submit a cost report or submitted an unacceptable cost report were sent warning letters. Subsequently, 51 facilities submitted reports. As of September 30, 1997, 28 facilities had not reported and were being sent notices of intent to revoke their licenses.)

The Adult Care Home Chart of Accounts for the period October 1, 1996 through September 30, 1997, was revised with input from industry providers, advocates, Fiscal Research and selected members of the General Assembly. The updated Adult Care Home Chart of Accounts was mailed to providers in October 1996.

C. Rate Setting

The Department's Controller's Office drafted rules establishing a methodology for determining annual rates for homes which serve State/County Special Assistance residents. The Department shared the rate setting methodology with industry groups and has started the rule-making process. The rules are expected to become permanent in August 1998.

During March, 1997, the Research Triangle Institute, under contract with the Division of Facility Services, conducted a study in 92 adult care homes to learn more about the types of residents who have "heavy" care needs and require considerable staff time. This information, along with cost report data, will be used to evaluate the current payment to adult care homes, including Medicaid payment for personal care. The results of the study will be available in October, 1997.

D. Cost Report Audits

1. 1995 Cost Report Audits

The agreed-upon procedures (consistent with Statement on Auditing Standards (SAS) No. 75: *Engagements to Apply Agreed-Upon Procedures to Specified Elements, Accounts, or Items of a Financial Statement)* for use in the facility 1995 cost report audits were mailed to all adult care facilities with a licensed bed capacity of greater than six beds on January 31, 1996. These procedures were utilized by the accountants/CPA's in the performance of the agreed-upon procedures engagements

for those facilities. ("Engagements" are contractual arrangments between an independent accountant or CPA and a facility to perform services.) The Office of the Internal Auditor provided technical assistance to the accountants/CPA's performing the 1995 agreed-upon procedures engagements throughout the year.

As of January 1, 1996, there were 926 adult care facilities that were licensed for six or fewer beds. The Office of the Internal Auditor selected a sample of Cost and Revenue Reports submitted by one hundred and ten (110) adult care facilities for the nine month period ending September 30, 1995 to perform agreed-upon procedures. The Office of the Internal Auditor completed agreed-upon procedures engagements on seventy (70) facilities for the nine month period ending September 30, 1995. The Office of the Internal Auditor was unable to perform agreed-upon procedures on the remaining forty (40) facilities for the following reasons:

a) The facility did not maintain an adequate accounting system to track revenues and expenses;

b) The facility did not maintain any worksheets, schedules and/or calculator tapes that recapped the detail transactions which supported the reported amounts on the Cost and Revenue Report;

c) Invoices were not maintained by the facility to support/document the costs that were reported; or

d) The facility did not maintain an adequate filing system for its invoices.

The Office of the Internal Auditor reviewed a sample (10%) of the Agreed-Upon Procedures Reports that were submitted by independent accountants/ CPA's for the nine month period ended September 30, 1995. As of July 31, 1996 there were seven hundred and seven (707) adult care facilities that were required to have Agreed-Upon Procedures Reports. Seventy one (71) adult care facilities were selected and a review was completed on sixty nine (69) of the Agreed-Upon Procedures Reports submitted for the nine month period ended September 30, 1995. Two facilities were exempted from having to obtain agreed-upon procedures reports.

Of the 69 reports, a sample of fifteen (15) Agreed-Upon Procedures Reports that were submitted by independent accountants/CPA's were also selected for a review of the independent accountant's/CPA's workpapers which supported the findings in their reports. The review revealed that the Agreed-Upon Procedures Reports submitted by seven out of nine accountants should be deemed unacceptable for various reasons. As a result of the review, the Department will require all accountants who perform agreed-upon procedures engagements to participate in a peer review program for the 1998 cost reporting period. The North Carolina Society of Accountants has agreed to implement a peer review program for all of its members who perform agreed-upon procedures engagements.

2. 1996 Cost Report Audits

The Office of the Internal Auditor developed the agreed-upon procedures for use in the facility 1996 cost report audits. These procedures were mailed to all adult care facilities with a licensed bed capacity of greater than six beds on October 25, 1996

and were utilized by the accountants/CPA's in the performance of the agreed-upon engagements on those facilities.

The Office of the Internal Auditor has provided technical assistance to the accountants/CPA's performing the 1996 agreed-upon procedures engagements throughout the year. In addition, the Office of the Internal Auditor participated in workshops held throughout the State to help educate accountants/CPA's in the performance of agreed-upon procedures.

The Office of the Internal Auditor and the managment of two sixty bed adult care facilities entered into a mutual agreement for the Office of the Internal Auditor to prepare the facility's 1996 Cost and Revenue Report and to perform an agreed-upon procedures engagement. The Office of the Internal Auditor has completed the engagements and issued Agreed-Upon Procedures Reports on both facilities.

The Office of the Internal Auditor, in accordance with a request from DHR Management, selected a sample of family care homes' 1996 Cost and Revenue Reports which had been received by the Department as of January 1, 1997 to perform agreed-upon procedures engagements. In order to comply with DHR Management's request that the fieldwork be completed by February 28, 1997, the Office of the Internal Auditor selected a sample of twenty (20) 1996 Cost and Revenue Reports. The Office of the Internal Auditor has completed the fieldwork on all twenty facilities and issued Agreed-Upon Procedures Reports to the facilities and the Department.

II. QUALITY ASSURANCE AND CARE ENHANCEMENT

A. Licensure Rules

Adult care home licensure rules on staff training and competency, resident assessments and care plans, licensed health professional support, and case management cooperation, that had been adopted as temporary rules as mandated by Chapter 449 of the 1995 Session Laws, were adopted in October, 1997, as permanent rules by the Social Services Commission with some changes. Most of the changes were of a technical nature for clarification purposes. The more substantive changes were the addition of the requirement that the resident care plan be signed and dated by the resident's physician within 15 days of completion of the assessment and the exclusion of over-the-counter medications in the more than 10 medications administered to a resident that would require quarterly review by a registered nurse. An objection by the Rules Review Commission to the rule on training and competency content and approval was met by inclusion of standards the Department uses to approve training and competency programs. The effective date for the permanent rules was May 1, 1997.

B. Staff Training and Competency Evaluation

Training for adult care home personal care aides and those directly supervising them is provided through two sources: community colleges and individuals, organizations or agencies who are approved as training providers by the Division of Facility Services according to standards established in licensure rules.

1. Training through Community Colleges

The 58 community colleges were sent curriculum guidelines for the 20-, 40- and 75-hour training developed through the collaborative effort of the Division of Facility Services and the Department of Community Colleges for implementation under their continuing education departments.

The following data pertains to community college training based on a survey conducted by the Department of Community Colleges in July, 1997, that covers a five-quarter period from the spring of 1996 when community colleges could first offer the adult care home staff training.

20-Hour Training
17 community colleges have offered the training
36 courses scheduled
18 courses taught
142 students completed course

40-Hour Training
35 community colleges have offered the training
107 courses scheduled
75 courses taught
589 students completed course

75-Hour Training
15 community colleges have offered the training
59 courses scheduled
48 courses taught
570 students completed course

The Nurse Aide I program has been used to meet the training requirement but data is not available regarding numbers of adult care home staff so trained.

The difference between the number of courses scheduled and actually taught reflects that each community college requires there to be a certain number of students enrolled before the class can be taught. The availability of students for these training programs depends on a variety of factors including use of private providers of training, i.e., contracting with a registered nurse approved to provide training; numbers of staff who are eligible, based on experience, for competency evaluation for training exemption; and staff turnover rates (this is a one-time training requirement but staff are to be trained within six months of hire).

2. Training and Competency Evaluation through State-Approved Private Providers

Many facilities have arranged to get a state-approved training or competency evaluation program to be provided "in-house", either through a nurse on staff or on a contractual basis. Curriculum guidelines for each training program and applications for training approval have been distributed upon request to prospective applicants.

The same applies to those interested in providing the competency evaluation for exemption from the training for staff meeting the 12-months experience requirement established in rule. (Note: Community colleges do not provide competency evaluation only because there is no training component involved.) Many of the approved competency evaluators do, however, offer refresher training prior to the competency evaluation. The Division of Facility Services approves training program and competency evaluation providers.

Following is information on the numbers of state-approved training and competency evaluation providers.

Training

Total number of approved providers of one or more of the training programs (20, 40 or 75 hours) - 90

Total number of approved training providers according to training program:

20-hour training - 42
40-hour training - 79
75-hour training - 42

Competency Evaluation for Exemption Purposes

Total number of approved providers of the competency evaluation for exemption from one or more of the training programs (20, 40 or 75 hours) - 66

Total number of approved competency evaluators according to exemption:

20-hour exemption - 23
40-hour exemption - 31
75-hour exemption - 41

It is the responsibility of the adult homes specialists of the county departments of social services to monitor for facility compliance with the training and competency requirements and issue plans of correction when staff have not been trained and no extension has been granted by the Department. When a plan of correction is required, the administrator must specify on the plan of correction a specific time frame for completion of training and the plan must be approved by the adult homes specialist.

C. Monitoring

During SFY 1996/97, the Division of Facility Services continued to utilize licensure consultants and specialized staff to carry out its mandated monitoring functions in adult care homes. Specialized staff are dietary, pharmacy, and nursing professionals. Through the utilization of these staff, in addition to the regular licensure consultants, and the implementation of an adult care home survey protocol, the section has increased its efficiency and effectiveness in the surveying, consultation and investigation. The current coordinated efforts within the Division enabled the agency to take a lead role in ensuring at least an annual survey in all homes of seven or more beds, or other homes when assessed as seriously non-compliant, and to follow annual visits with additional expanded surveys with staff teams, as needed. Division staff completed 522 annual facility surveys during the year. During the same period, 233 expanded or follow-up (team) surveys were conducted utilizing specialized staff.

Survey staff now have a better opportunity to identify key indicators of compliance (within the selected areas of building safety, staffing and supervision, personal services, health care, and food service), to review care and service outcomes for identified residents, and to address needs for establishing plans to correct significant areas of violations with facilities in timely and effective ways. Where training and consultation needs have been identified as compliance factors, the survey staff has readily responded to assist the facilities with their resources. Staff have issued 263 plans of correction to facilities based on surveys during SFY 1996-97. During the year staff completed 79 provider consultations in the areas of medications, food services, and health services. Where the violations have been of a serious nature that directly affected the health, safety, or welfare of the residents, the Division has taken appropriate regulatory action. Administrative sanctions imposed by the Division during SFY 1996-97 include 2 license revocations, 18 suspension of admissions, 27 provisional licenses, and 1 summary suspension of a license.

The Division continued to provide direction to the county department of social services staff in an effort to improve monitoring skills and an attempt to bring more uniformity to the local monitoring process. Emphasis will be given to reviewing county departments of social services' monitoring activity to ensure quality as well as consistency during the coming year.

III. ADULT CARE HOME CASE MANAGEMENT

Heavy care residents in adult care homes are eligible for Medicaid adult care home case management services. A heavy care resident is an individual who, according to Medicaid criteria, needs extensive assistance or is totally dependent on another person for eating, toileting or both. Case management services facilitate residents' access to Medicaid-covered services, such as skilled nursing services, physical therapy, speech therapy, physician services, medical supplies, durable medical equipment and mental health services; promote appropriate and cost-effective utilization of services; and help assure the quality of care provided to residents.

A. Program Implementation

- For SFY96-97, adult care home case management was provided to residents in 89 of North Carolina's counties by the county departments of social services or area mental health programs. The other 11 counties either have no facilities or have no heavy care residents living in the facilities in their county.
- County departments of social services expended $2,255,533 in support of adult care home case management ($593,584 in state funds, $534,175 in county funds and $1,127,773 in federal funds). Area mental health programs are reimbursed for case management by Medicaid, but the reimbursement made for these case management

activities are not separately identified from reimbursement for other kinds of mental health case management services.

- Today 96% of the heavy care residents are receiving case management from the county departments of social services and 4% are receiving the service from the area mental health programs.
- The Department is working with two demonstration projects to learn about the benefits and barriers to county departments of social services providing case management to heavy care residents in adult care homes on a multi-county basis. These projects began in December, 1996, and involve Alexander/Burke/Caldwell and Catawba counties in the west and Camden/Chowan/Currituck /Pasquotank and Perquimans counties in the east. These projects are planned to continue until June, 1998.

B. Staffing and Caseloads for Case Management

The following data is for July through December, 1996, for the 82 county departments of social services providing case management directly.

- 82 county departments are providing case management with a total of 132 case managers representing 48.5 full-time equivalent positions (FTE).
- 15 county departments have designated a full time position to provide case management.
- 67 county departments are using staff to provide case management who also provide other adult services. The average FTE for case management in the 67 counties with part-time staff providing case management is right at a half-time position (.48 FTE).
- For staff who provide case management, in addition to other duties, the most common other assignments include guardianship, representative payee, adult placement services, adult protective services, adult home specialist, intake, and in-home services.
- The number of heavy care residents per county varies widely, ranging from 1 resident up to 166 residents. The median number of heavy care residents in a county is 26 residents.
- The average FTE caseload is 64 heavy care residents per case manager. Each resident is receiving an average of 1 hour 12 minutes per month of case management service. These minutes do not include time not directly attributable to a resident, such as time spent in training, supervisory conferences, travel to see the resident, completing paperwork, etc. The recommended caseload is 40 heavy care residents per case manager. This caseload size allows each resident to receive 3 hours of case management per month.

In all 41 area mental health programs, the case management responsibilities regarding heavy care residents have been met by existing case managers in addition to their regular duties. In a sample survey of area mental health programs representing Wake, Anson, Hoke, Montgomery, Richmond, Moore, Randolph, Cabarrus, Stanly and Union Counties, counties with heavy care residents averaged three per county.

C. Heavy Care Resident Characteristics

Data for SFY96-97 show the following about heavy care residents in adult care homes in the 82 counties in which the county departments of social services are providing case management directly.

- About two-thirds of the heavy care residents need extensive or total assistance with toileting; slightly less than one third need assistance with both toileting and eating; and about two percent need assistance with eating only.
- Heavy care residents are primarily elderly, 88% being over the age of 60. The median age is 81. The mentally ill and developmentally disabled residents who meet the heavy care criteria are somewhat younger with their median age being 67.
- 70% of heavy care residents are female.
- 56% of heavy care residents are white; 30% are African-American; and 14% are Native American and other minorities.

D. Conditions, Services, and Outcomes

The following data describes the types of health conditions that heavy care residents have and some of the care and services they are receiving in adult care homes. Counties providing this information include Buncombe, Cabarrus, Cleveland, Craven, Cumberland, Durham, Franklin, Gaston, McDowell, Mecklenburg, Onslow, Pasquotank and Wayne.

- Primary diagnosis for residents in the sample varies extensively. Common problems include arthritis, diabetes, pulmonary disease, and cardio-vascular problems (stroke and heart disease).
- Mild to severe dementia is noted for *almost all* these residents.
- Virtually all residents receive physician and pharmacy services, in addition to enhanced personal care.
- More than 75% receive nursing services through home health agencies.
- 50% receive physical therapy or occupational therapy.
- Over 50% receive assistance in the form of medical supplies and durable medical equipment.
- Other Medicaid-funded services being provided include hospital care (both inpatient and outpatient), dental care, ophthalmology care, mental health services, and medical transportation.
- Other county department-funded services being provided are placement services, guardianship, representative payee, health support services, and adult protective services.

Case managers have reported the following outcomes, which are expected for additional residents as more case management time is provided to current and future heavy care residents:

- improved assessment and health and medical care
- improved continence
- improved nutrition
- better use of residents' funds
- improved communication between residents, families, facility staff and community providers
- improved performance in activities of daily living
- improved socialization and stimulation
- improved continuity of care
- improved services to other residents

IV. MEDICAID REIMBURSEMENT FOR PERSONAL CARE

When Medicaid's adult care home personal care (ACH/PC) coverage began in August, 1995, the Division of Medical Assistance began to develop and install system controls for claims processing. These controls validate the accuracy of adult care homes' billings. The Division also reviews providers' claims to identify inappropriate billings and modifies billing procedures and claims processing system controls to prevent these. The Division's quality control efforts during SFY 1996-97 are described below.

A category of adult care home residents identified as "disenfranchised" was created when the General Assembly reduced the maximum payment level for Special Assistance (SA) to $844 per month, effective August 1, 1995. "Disenfranchised" residents are individuals whose income was between the old and new eligibility limits. These residents were "grandfathered" for continued coverage under SA and Medicaid, but are ineligible for Medicaid's ACH/PC and case management (ACH/CMS) coverage. In September, 1996, the Division installed a system control to prevent adult care homes from being paid for providing ACH/PC to "disenfranchised" residents. In January, 1997, the Division completed a post-payment review of adult care homes' ACH/PC billings to date for "disenfranchised" residents and identified $575,000 paid in error. As of September 22, 1997, $506,000 has been recovered through voluntary repayments and systematic recoupments.

In September, 1996, the Division began a post-payment review focusing on adult care homes' compliance with Medicaid polices for receiving Enhanced ACH/PC payments. With input from industry representatives and adult care home case managers, the Division has made necessary changes in billing procedures and system controls to better assure compliance. The Division developed "prior approval" procedures for ACH case managers authorizing Enhanced ACH/PC coverage for heavy care residents and adult care homes billing for Enhanced ACH/PC payments. These procedures were implemented on a "pilot" basis in 11 counties on June 1, 1997. An ACH/CMS case

manager must authorize Enhanced ACH/PC payments in the claims processing data base before the adult care home can receive Enhanced ACH/PC payments. Statewide implementation is tentatively set for November 1, 1997. Currently, all Enhanced ACH/PC claims paid to date are being subjected to the new system controls for prior approval. All identified overpayments or underpayments will be adjusted.

The Division of Medical Assistance continued its provider education efforts during SFY 1996-97. Division staff made 40 presentations to adult care homes and ACH case managers at regional and local meetings. The Division also continued ongoing site visits to adult care homes to review service documentation for compliance with Medicaid policies. Individualized follow-up letters were sent to identify areas of non-compliance and recommend corrective actions.

V. EVALUATION

The Division of Facility Services developed a plan for the evaluation of the effects of Senate Bill 864. That bill requires the evaluation to be completed by June 30, 1999. The evaluation of the training, case management and monitoring components of the bill will be based on an evaluation working paper drafted by the Division specifying the process and outcome measures to support the evaluation. The working paper calls for a description of each process and the roles and responsibilities of key players. It also presents a series of evaluation questions about major aspects of each process with evaluation designs for answering these questions. Staff with responsibilities in the various areas targeted for evaluation are in the process of gathering information to respond to the questions. The Division will be contracting for this evaluation to be conducted.

TOTAL MEDICAID ACH/PC EXPENDITURES FOR SFY 96-97:

Medicaid ACH/PC Payment Rate Category of Service	Medicaid ACH/PC PerDiem Rates	Expenditures for Category of Service SFY 96-97	Monthly Average of Recipients Receiving Service In SFY 96-97
Basic ACH/PC	$ 8.07	$ 47,554,538	15,264
Enhanced ACH/PC (extra assistance with eating)	$ 16.00	$ 243,413	42
Enhanced ACH/PC (extra assistance with toileting)	$ 10.87	$ 7,632,780	1,871
Enhanced ACH/PC (extra assistance with eating and toileting)	$ 18.08	$ 5,953,067	849
Total ACH/PC Expenditures SFY 96-97		$ 61,383,798	18,026

*Data from N.C. Division of Medical Assistance Program Expenditure Report (PER)

Exhibit 14. Comparisons Between NC Domiciliary Care Residents and Residents in the ASPE 10-State B&C Home Study: Physical Functioning, Continence, Cognitive Status, and Age

AREA OF FUNCTIONING	ASPE B&C (1993)	NC DOM (1994)
Physical Functioning in ADLs		
Received *any* help from a person in dressing	21%	39%
Received *any* help from a person in locomotion/getting around inside	9%	26%
Received *any* help from a person in cutting food, buttering bread, opening cartons	8%	13%
Received *any* help from a person in eating**	5%	11%
Received *any* help from a person in transferring (e.g., from bed to chair)	8%	23%
Received *any* help from a person in toileting	12%	24%
Received *any* help from a person in bathing	45%**	66%
Received "hands-on"/physical help in one or more of Five ADLs*		
0 ADLs	78%	59%
1-2 ADLs	15%	21%
3-5 ADLs	7%	20%
Incontinence		
Bladder	23%	39%
Bowel	13%	23%
Moderately To Severely Cognitively Impaired	39%	64%
Bedfast/Chairfast (in room in bed or chair 22+ hours per day because of health problem)	7%	12%
Age:		
18-64	22%	30%
65-84	44%	46%
85+	34%	24%

* *Defined as including "hands-on" assistance with any of the following ADLs (excluding supervision/cueing): dressing, locomotion, toileting, transferring, or eating [but not merely cutting food or bathing].*

** *The data presented here are estimates, based on samples of homes and residents. In Appendix A, the estimates for each item are presented with the standard errors for the estimate.*

Exhibit 15. Comparisons Between NC Domiciliary Care Residents and Residents in the ASPE 10-State B&C Home Study: Selected Health Conditions and Assistive Devices**

Health Condition	*ASPE B&C 10-State Study (1993)*	*NC DOM CARE (1994)*
Self-reported "Mental, emotional or nervous condition"	33%	51%
Mental retardation/developmental disabilities*	11%	23%
Diabetes	11%	14%
Arthritis or rheumatism	42%	41%
Hypertension/high blood pressure	28%	26%
Asthma, emphysema or COPD	11%	12%
Multiple Sclerosis	1%	0.4%
Parkinson's	3%	3%
Cancer	7%	6%
Stroke last 12 months	6%	5%
Heart attack last 12 months	3%	2%
Fell during last 12 months	32%	34%
Use of Assistive Devices		
Cane	19%	13%
Walker	23%	14%
Wheelchair	15%	28%
Continence pads/briefs	15%	25%
Pressure relieving devices	6%	14%
Pureed diet/mechanically altered diet	0.6%	5%

* *ASPE and NC DOM Care sample of homes excludes homes licensed by Divisions of Mental Health or Developmental Disabilities; thus it does not include group homes for persons with MR/DD or homes specifically licensed for persons with mental illness.*

** *The data presented here are estimates, based on samples of homes and residents. In Appendix A, the estimates for each item are presented with the standard errors for the estimate.*

10-21-97

ADULT CARE BED VACANCY REPORT AS OF 10/20/97

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals							
COUNTY	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	BEDS IN PIPELINE	APPROVED EXEMPTIONS	TOTAL BEDS AVAILABLE	TOTAL BEDS OCCUPIED	VACANCY RATE
ALAMANCE	780	774	565	4	4	1	29	221	1028	566	44.94%
ALEXANDER	66	66	63	0	0	0	3	0	69	63	8.70%
ALLEGHANY	104	104	59	22	22	14	0	0	126	73	42.06%
ANSON	0	0	0	53	47	39	0	60	107	39	63.55%
ASHE	76	76	45	30	30	29	0	0	106	74	30.19%
AVERY	46	46	43	0	0	0	0	0	46	43	6.52%
BEAUFORT	183	181	169	10	10	10	0	6	197	179	9.14%
BERTIE	75	70	65	38	36	33	0	0	106	98	7.55%
BLADEN	259	259	219	30	29	28	18	6	312	247	20.83%
BRUNSWICK	86	86	63	92	92	74	66	60	304	137	54.93%
BUNCOMBE	1082	1067	872	413	413	333	54	22	1556	1205	22.56%
BURKE	379	354	331	60	60	59	0	86	500	390	22.00%
CABARRUS	623	611	496	54	54	40	253	0	918	536	41.61%
CALDWELL	298	289	268	20	17	14	0	108	414	282	31.88%
CAMDEN	6	6	4	0	0	0	0	0	6	4	33.33%
CARTERET	112	112	44	13	12	5	0	76	200	49	75.50%
CASWELL	252	252	218	0	0	0	12	0	264	218	17.42%
CATAWBA	363	348	313	74	74	73	128	106	656	386	41.16%
CHATHAM	194	194	162	120	113	78	0	0	307	240	21.82%
CHEROKEE	48	48	44	20	20	12	6	12	86	56	34.88%
CHOWAN	60	60	59	30	30	29	0	0	90	88	2.22%
CLAY	12	12	7	20	19	18		0	31	25	19.35%
CLEVELAND	438	412	396	0	0	0	87	42	541	396	26.80%
COLUMBUS	183	183	178	25	25	22	0	0	208	200	3.85%
CRAVEN	466	466	404	33	31	27	0	102	599	431	28.05%
CUMBERLAND	777	762	691	194	174	126	110	103	1149	817	28.89%
CURRITUCK	0	0	0	10	8	8	0	0	8	8	0.00%
DARE	0	0	0	18	18	17	0	0	18	17	5.56%
DAVIDSON	318	318	255	198	186	162	144	6	654	417	36.24%
DAVIE	105	101	83	64	64	56	0	0	165	139	15.76%
DUPLIN	325	325	271	62	52	46	0	72	449	317	29.40%
DURHAM	933	890	772	167	167	138	20	101	1178	910	22.75%
EDGECOMBE	281	280	277	65	59	48	66	0	405	325	19.75%
FORSYTH	1489	1424	1158	253	165	144	126	136	1851	1302	29.66%
FRANKLIN	270	269	225	10	10	10	0	0	279	235	15.77%

ADULT CARE BED VACANCY REPORT AS OF 10/20/97

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals							
COUNTY	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	BEDS IN PIPELINE	APPROVED EXEMPTIONS	TOTAL BEDS AVAILABLE	TOTAL BEDS OCCUPIED	VACANCY RATE
GASTON	531	524	503	214	194	168	0	88	806	671	16.75%
GATES	0	0	0	10	10	4	0	0	10	4	60.00%
GRAHAM	30	30	21	23	23	20	0	3	56	41	26.79%
GRANVILLE	197	190	163	40	40	36	0	0	230	199	13.48%
GREENE	46	46	41	17	17	11	6	0	69	52	24.64%
GUILFORD	1103	1029	862	480	456	417	577	300	2362	1279	45.85%
HALIFAX	172	156	126	45	40	35	0	0	196	161	17.86%
HARNETT	483	465	426	114	57	51	0	0	522	477	8.62%
HAYWOOD	311	311	252	30	30	30	0	18	359	282	21.45%
HENDERSON	358	358	328	40	40	37	0	132	530	365	31.13%
HERTFORD	187	187	173	0	0	0	2	0	189	173	8.47%
HOKE	75	71	58	10	10	9	5	0	86	67	22.09%
HYDE	0	0	0	0	0	0	0	0	0	0	0
IREDELL	583	583	473	170	170	151	81	100	934	624	33.19%
JACKSON	143	143	102	20	20	14	0	0	163	116	28.83%
JOHNSTON	474	471	415	30	28	26	84	0	583	441	24.36%
JONES	6	6	6	20	20	15	6	0	32	21	34.38%
LEE	310	310	253	0	0	0	3	0	313	253	19.17%
LENOIR	286	284	255	0	0	0	6	0	290	255	12.07%
LINCOLN	140	138	138	63	63	55	0	0	201	193	3.98%
MACON	52	52	46	30	23	23	0	0	75	69	8.00%
MADISON	54	54	46	20	20	17	0	0	74	63	14.86%
MARTIN	165	157	147	0	0	0	0	0	157	147	6.37%
MCDOWELL	419	412	346	15	15	13	0	0	427	359	15.93%
MECKLENBURG	940	940	704	628	562	448	467	259	2228	1152	48.29%
MITCHELL	35	35	30	10	10	7	0	0	45	37	17.78%
MONTGOMERY	167	166	154	10	10	10	36	0	212	164	22.64%
MOORE	275	257	239	86	85	72	116	192	650	311	52.15%
NASH	235	233	223	149	143	130	0	48	424	353	16.75%
NEW HANOVER	661	660	526	170	50	31	78	20	808	557	31.06%
NORTHAMPTON	211	211	176	0	0	0	19	6	236	176	25.42%
ONSLOW	391	391	312	8	8	8	4	0	403	320	20.60%
ORANGE	196	195	158	127	127	120	86	0	408	278	31.86%
PAMILICO	0	0	0	8	8	8	40	0	48	8	83.33%
PASQUOTANK	190	190	177	0	0	0	0	76	266	177	33.46%

Division of Facility Services
Adult Care Bed Vacancy Survey
10/21/97 1:36 PM

ADULT CARE BED VACANCY REPORT AS OF 10/20/97

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals							
COUNTY	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	BEDS IN PIPELINE	APPROVED EXEMPTIONS	TOTAL BEDS AVAILABLE	TOTAL BEDS OCCUPIED	VACANCY RATE
PENDER	103	103	57	23	23	20	0	0	126	77	38.89%
PERQUIMANS	64	64	53	0	0	0	0	0	64	53	17.19%
PERSON	73	73	61	5	5	5	0	0	78	66	15.38%
PITT	494	491	362	50	50	42	84	68	693	404	41.70%
POLK	38	35	30	74	74	54	0	0	109	84	22.94%
RANDOLPH	315	315	293	68	67	53	268	0	650	346	46.77%
RICHMOND	287	287	178	10	10	10	0	0	297	188	36.70%
ROBESON	631	629	527	47	25	24	36	30	720	551	23.47%
ROCKINGHAM	359	359	295	39	39	37	76	80	554	332	40.07%
ROWAN	510	504	456	207	207	175	84	118	913	631	30.89%
RUTHERFORD	515	506	455	100	100	97	0	76	682	552	19.06%
SAMPSON	173	160	138	60	59	56	53	0	272	194	28.68%
SCOTLAND	158	153	135	20	20	20	0	0	173	155	10.40%
STANLY	55	55	52	52	52	51	6	0	113	103	8.85%
STOKES	123	123	121	58	48	44	0	0	171	165	3.51%
SURRY	404	404	371	71	71	62	0	0	475	433	8.84%
SWAIN	50	50	43	0	0	0	0	0	50	43	14.00%
TRANSYLVANIA	32	31	27	30	30	23	98	0	159	50	68.55%
TYRRELL	0	0	0	0	0	0	0	0	0	0	0
UNION	289	274	232	67	40	36	122	0	436	268	38.53%
VANCE	204	198	146	77	73	64	6	0	277	210	24.19%
WAKE	COUNTY HAS NOT PROVIDED INFORMATION			229	210	184	106	311			
WARREN	189	169	124	20	20	20	0	0	189	144	23.81%
WASHINGTON	0	0	0	9	9	8	40	0	49	8	83.67%
WATAUGA	102	100	97	0	0	0	0	0	100	97	3.00%
WAYNE	537	536	481	32	32	29	187	42	797	510	36.01%
WILKES	161	158	138	19	19	17	0	0	177	155	12.43%
WILSON	445	428	389	69	69	33	50	0	547	422	22.85%
YADKIN	169	169	156	20	20	19	0	0	189	175	7.41%
YANCEY	29	29	29	0	0	0	0	0	29	29	0.00%
TOTALS	**26,643**	**26,122**	**22,159**	**6,245**	**5,692**	**4,842**	**3,954**	**3,292**	**38,433**	**26,817**	**30.22%**

Division of Facility Services
Adult Care Bed Vacancy Survey
10/21/97 1:36 PM

CARING PROGRAM FOR CHILDREN
1997 BOARD OF DIRECTORS

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CARING PROGRAM FOR CHILDREN
1997 BOARD OF DIRECTORS
PAGE 2

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10-27-97

Caring Program for Children

A Partnership of:

The North Carolina General Assembly, The North Carolina Council of Churches and Blue Cross and Blue Shield of North Carolina



MISSION

TO IMPROVE THE HEALTH STATUS OF NC CHILDREN BY OFFERING FREE HEALTH INSURANCE THAT COVERS PRIMARY AND PREVENTATIVE CARE

LIGIBLE CHILDREN

CHILDREN FROM WORKING FAMILIES THAT MEET THE FOLLOWING GUIDELINES:

- **NC RESIDENT**
- **UP TO 18 YEARS OLD**
- **INELIGIBLE FOR MEDICAID**
- **NO PRIVATE INSURANCE**
- **IN SCHOOL (IF SCHOOL AGE)**
- **NOT MARRIED**
- **INCOME BELOW 185% FPL**

OVERED BENEFITS

- PRESCRIPTION DRUGS
- 24 - HOUR NURSE LINE
- WELL-CHILD CHECK UPS
- SICK-CHILD CHECK UPS
- EMERGENCY ROOM VISITS

  (MEDICAL EMERGENCY ONLY)
- DIAGNOSTIC TESTING
- OUTPATIENT SURGERY (LESS THAN 24 HRS)

HILDREN ENROLLED

YEAR-END	ENROLLMENT
1988	125
1989	382
1990	534
1991	808
1992	1216
1993	1678
1994	3553
1995	3812
1996	5727

1997 CURRENTLY = 7,891

UNDING SOURCES

- NC GENERAL ASSEMBLY
- BLUE CROSS BLUE SHIELD NC
- COUNTIES
- SMART START PARTNERSHIPS
- CHURCHES
- BUSINESS/CORPORATIONS
- INDIVIDUALS
- FOUNDATIONS

PROVIDERS

- 4,191 Participating Doctors
- 80 Participating Hospitals

PPROACHES TO PARENTS

- Medicaid offices
- School/lunch programs
- Smart Start Initiatives
- Health Departments
- Child Care Centers
- Hospitals, clinics
- Physician offices
- Pharmacies

CARING PROGRAM COUNCILS

- A LOCAL INITIATIVE ESTABLISHED TO AID IN
  - **PUBLICIZING, ENROLLING AND FUND RAISING**
  - **INCREASING THE BENEFIT FOR COUNTY CHILDREN**

OUTREACH AND PROMOTION

- **STRONGER SYSTEMS LINKAGE: Medicaid, School lunch programs, Health Departments, DSS Offices**
- **4-H CLUBS, SMART START, CHURCHES, CIVIC CLUBS and ORGANIZATIONS SERVING THE NEEDS OF CHILDREN**
- **SCHOOL-BASED CLINICS COLLABORATION, SCHOOL HEALTH NURSES**
- **SUPPORT OF THE CARING PROGRAM COUNCILS**
- **CHILD CARE REFERAL CENTERS**

EEDS AND OPPORTUNITIES

- **FUND RAISING EXPANSION**
- **EXPANSION OF FEDERAL DOLLARS FOR CHILDREN'S HEALTH INSURANCE**
- **ROBERT WOOD JOHNSON 'HEALTHY KIDS' REPLICATION INITIATIVE**

10-21-97

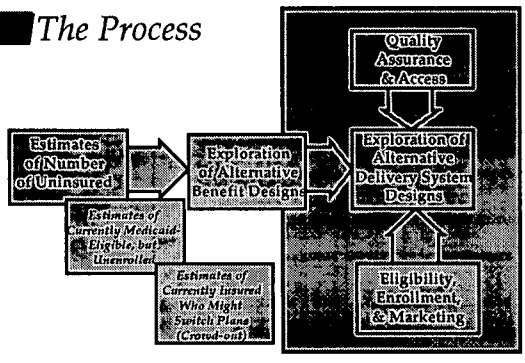
North Carolina Child Health Insurance Task Force

Gordon H. DeFriese, Ph.D.
President, NC Institute of Medicine
Director, Cecil G. Sheps Center for
Health Services Research, UNC-CH
Chair

NC Child Health Insurance Task Force

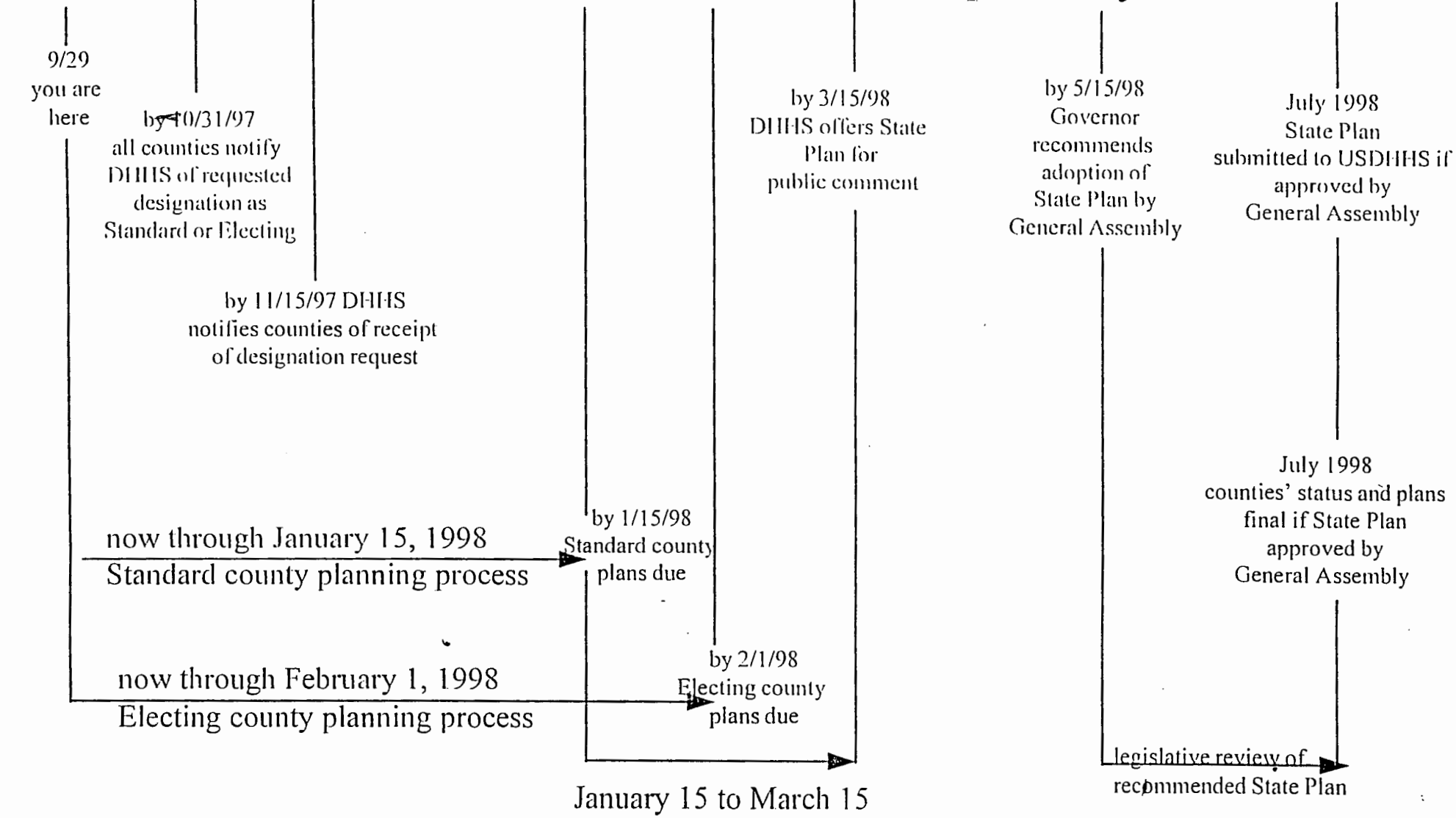
- Five meetings since July 17
- Multiple constituencies represented
  - Insurance industry
  - Health care providers
  - Governmental agencies
  - Family and child advocates
  - Academic institutions
- Open discussions of key issues
- Clear delineation of issues
- Multiple, feasible options

The Process



10-2297

1997-1998 Welfare Reform Time Line



NCDSS 9/24/97

10-22-97

WELFARE REFORM PROVISIONS
COMPARISON OF STANDARD AND ELECTING COUNTIES

Provision	Standard County	Electing County
Determination of County Status		
Notification to NCDHHS - Division of Social Services	County by 10/31/97 must submit notification of desired status, documented by 3/5 vote of Board of County Commissioners	Same as Standard County
Notification of receipt of preference	NCDHHS must notify counties by 11/15/97	Same as Standard County
NCDHHS approval of requested status	Automatic	Dependent upon review by NCDHHS; Electing counties' may total no more than 15.5% of October 1 caseload
Final Notification of Status	NCDHHS by 11/15/97	After review of NCDHHS determination by Joint Legislative Public Assistance Commission, after June 1998
Limitation on number of counties	None	Limited to 15.5% of caseload at 10/1 of each year
Redetermination of county status	Automatic, unless county requests change	Automatic, unless county requests change, or loss of Electing status
Responsible Party		
Program Supervision	NCDHHS - Division of Social Services	Board of County Commissioners
Program Administration	County Department of Social Services	Determined by Board of Commissioners
Work First Program Components - Required Benefits/Services		
Work First Family Assistance (Cash Benefits) • Eligibility Criteria • Payment levels • Time Limit on Assistance • Payments made by	 Determined by NCDHHS Determined by NCDHHS 24 months, extensions under prescribed situations NCDHHS	 Determined by Board of Commissioners * Determined by Board of Commissioners * Determined by Board of Commissioners; may not exceed federal limit of 60 month lifetime benefit* County

Provision	Standard County	Electing County
• Copy of recipient check register to county auditor supplied by	NCDHHS	County
• Required information for federal reporting supplied by	NCDHHS	County
• Applicant appeals	NCDHHS - DSS Hearings & Appeals	County must develop appeal process which is "substantially equivalent" to state process
• Use of Mutual Responsibility Agreement	Determined by NCDHHS	Determined by Board of Commissioners
• Assignment of child support	Required	Same as Standard County ** If different from Standard program, county must explain reason for changes.*
Work First Diversion Assistance (short-term cash payment designed to prevent need for Work First Family Assistance)		
• Eligibility Criteria	NCDHHS	Board of Commissioners
• Payment level	NCDHHS	Board of Commissioners
• Payment made by	NCDHHS	County
Work First Services		
• Core Services	Determined by NCDHHS	Determined by Board of Commissioners - must be consistent w/goals and objectives of Work First and meet federal requirements
• Community Service Work	Optional at County discretion	Required if participant cannot find employment
• Other	Completely flexible, must be outlined in County plan	Same as Standard County
First Stop Employment Assistance (ESC)		
• Registration by all applicants	Required by legislation	Same as Standard County
Work First Program Components - Optional Benefits/Services		
First Stop Employment Assistance (ESC)		
• services other than registration	County option; county contracts with ESC must be paid from County Block Grant funding	Same as Standard County

Provision	Standard County	Electing County
Emergency Assistance cash benefit	County option	Same as Standard County
• Other services consistent with goals & objectives of Work First	County option	Same as Standard County
County Plans		
Required	Yes - must be consistent with goals and objectives of Work First	Same as Standard County
Due date	By January 15, 1998	By February 1, 1998
Responsible for development	County DSS - with assistance from committee comprised of representatives of area mental health authority, health board, school system, businesses, community-based organizations, and other county representatives	Board of Commissioners - with assistance from committee comprised of representatives of area mental health authority, health board, school system, businesses, community-based organizations, and other county representatives
Public comment prior to submission	Yes - County required to provide opportunity	Same as Standard County
Format developed by	NCDHHS	Same as Standard County
Required Components: • Work First Family Assistance • Work First Services • Funding • Outcome goals • Use of public & private resources	 N/A (not in County Plan) Complete description of services offered Detail use of State, Federal, and County Funds Developed in consultation with NCDHHS Plan must outline	 Detail all policies Same as Standard County Same as Standard County Developed by Board of Commissioners Same as Standard County
Reporting & Monitoring		
County performance monitored by, against	NCDHHS, jointly agreed upon outcome measures	NCDHHS, county developed outcome measures
Impact of Work First on Children	Responsibility of NCDHHS & County	Same as Standard County
Monthly progress reports	Submitted by County DSS; format prescribed by NCDHHS	Submitted by entity designated by Board of Commissioners; format prescribed by NCDHHS
Cash Benefit Recipients	N/A (State receives information via EIS)	County must report in detail, if not using EIS
Use of county block grant funds	County DSS	Entity designated by Board of Commissioners

Provision	Standard County	Electing County
Funding		
Work First Family Assistance	Federal, held at State level for benefit payment	Federal, included in county block grant
Work First Diversion Assistance	Federal, held at State level for payment	Federal, included in county block grant
Work First Services	Federal, State and County	Same as Standard County
First Stop Employment Services • Registration • Other Services	 Free to county If used, county must pay proportionate amount of county block grant	 Same as Standard County Same as Standard County
County Funding (Maintenance of Effort)	Proportionate to state, for 1997-98 100% of 1996-97 budgeted level for covered programs (AFDC, AFDC Administration, Emergency Assistance, JOBS)	1st year - no less than 90% of 1996-97 budgeted level for covered programs If 100% of goals and objectives met in 1st year, may go to no less than 80% of 1996-97 budgeted level If county reduces funding, must explain use of funds reduced in county block grant plan
Allocation of State & Federal Funds	Per law, based upon each county's percent of total expenditures by category in SFY 1995-96	Same as Standard County
Payment of Funds • Federal • State	 Paid after expenditure to allow for federal draw in accordance with federal cash management policies Paid as county reports expenditures; unearned funds revert	 Same as Standard County 1/4 of allocation paid at beginning of each quarter; unearned funds do not revert
Corrective Action		
When County fails to meet goals	Develop corrective action plan for NCDHHS approval	Same as Standard County
When County fails to meet goals for 2 years or fails to comply with corrective action plan	Possible State assumption of Work First program	Loss of Electing County status if federal government imposes penalty on State as result of county not meeting goals

WELFARE REFORM:
--COUNTY FUNDING

1. What Has Changed:

	Pre-Welfare Reform	SFY 97-98 All Counties	Additional Changes SFY 98-99 Electing Counties Only
Allocations	Funds allocated in discreet categories: 1. Work First Administration 2. Work First Cash Assistance 3. Work First Employment Services 4. Emergency Assistance Cash 5. Emergency Assistance Services	Funds allocated in only two categories: 1. Work First Cash Assistance 2. Work First County Block Grants	Electing Counties have proportionate share of Cash Assistance Funding included in Work First County Block Grant
Use of Funds	1. Funds had to be used in discreet categories of allocation 2. "Hard" allocation of Work First Employment, Emergency Assistance Services, Work First Administration funding. 3. Work First Cash Assistance paid as needed based upon caseload	1. Work First Cash Assistance paid as needed based upon caseload. 2. "Hard" allocation of Work First County Block Grant - however, county has complete flexibility over use of funds within that category, eg. County determines how much of block grant to spend on Administration, Employment Services, "EA" type services, whether or not to fund an "EA" type cash assistance program.	For Electing Counties, county also has flexibility over use of funds included in block grant for cash assistance.
Reporting and Payment	1. Counties reported cost under each separate funding source. 2. State made interim payments, month-end reconciliation. 3. Funds which county did not earn were not paid	1. Counties will report cost under one funding source - Work First Services. 2. Interim payment and month-end reconciliation unchanged 3. Funds which county does not earn will not be paid.	1. Federal funds will be paid through interim payment with month-end reconciliation 2. State funds will be paid quarterly, in advance, will not revert

FEDERAL AND STATE LAW REQUIREMENTS TO ASSIST IN THE DECISION MAKING PROCESS

To assist counties in the evaluation process, we have listed *most* of the federal and State legislative provisions that will continue to govern both the Standard and Electing Programs. Remember, these are programmatic provisions regarding eligibility criteria. The State and counties are still required to comply with other federal laws such as meeting participation rates and reporting requirements. Federal requirements are generally from P.L. 104-193 unless otherwise noted.

In addition to the list of requirements, County Departments of Social Services will continue to be required to administer the Medicaid and the Food Stamp Programs according to federal and state law and regulation. Decisions made regarding changes to eligibility criteria in Electing Counties could potentially require that the eligibility determination for Medicaid and Food Stamps be separated from the Work First eligibility determination.

- Assistance can only be provided for families where a minor child lives with an adult caretaker relative. [federal - Sec. 406 (a) (1)]
- Sanction must be applied for non-cooperation with child support. [federal - Sec. 406 (a) (2)]
- Adults must assign rights to child support to the State (currently, NC law already assumes the assignment is made when the Work First application is signed). [federal - Sec. 406 (a) (3)]
- Teen parents must attend school and live with parents or in other adult-supervised setting. [federal - Sec. 406 (a) (4) and (5)]
- Lifetime time limit on assistance cannot exceed 5 years, with possible hardship extensions. [federal - Sec. 406 (a) (7)]
- Individual is ineligible for assistance for 10 years if he is found to have fraudulently misrepresented his residence in order to get assistance in 2 or more states. [federal - Sec. 406 (a) (8)]
- Individuals who are fugitive felons and probation and parole violators are not eligible for assistance; certain information must be shared upon request from law enforcement officials. [federal - Sec. 406 (a) (9)]
- Children who are absent from the home for more than 30 but less than 180 days (# days optional) are not eligible for assistance unless they have good cause for being absent. The caretaker relative who fails to notify the agency of the child's absence within 5 days is not eligible for assistance. [federal - Sec. 406 (a) (10)]
- All family members must have a social security number or apply for one. [federal - 42 U.S.C. 1320 (a)(1)]
- Class H or I drug felons are eligible for assistance, others are not. [State - 108A-25.2.]
- All adults must register for employment with the Employment Security Commission. [State - 108A-29.]
- Individuals found to be addicted to alcohol or drugs and to be in need of professional substance abuse treatment services are required to do so as a condition of eligibility. [State - 108A-29.1]

GLOSSARY

- ***Biometrics*** – a system for identifying public assistance applicants and recipients, including those in Work First, using digitized images of the individuals' physical features, such as fingerprints
- ***Child only case*** – a Work First case where the only recipient is a child; not subject to requirements and restrictions such as work requirements and time limits
- ***Community service work*** – unpaid work performed in exchange for Work First assistance by recipients who are unable to find employment
- ***Cooperation with child support*** – unless it has good cause, families must cooperate with the child support unit on issues such as paternity establishment and efforts to collect child support payments from the non-custodial parent
- ***Electing County*** – a pilot county under the Work First program which may adopt eligibility criteria for benefits and payment standards other than those specified under the Standard Work First program; may adopt services not specified in the Standard program as long as in compliance with federal law
- ***Family cap*** – unless there is good cause, if a child is born 10 or more months after a family begins receiving Work First assistance, that family will not receive additional cash assistance for the additional child
- ***First Stop Employment Assistance*** – a program established to provide employment services to Work First applicants, reapplicants, and recipients; administered by the Department of Commerce and the Employment Security Commission
- ***Individual Development Accounts*** – accounts funded jointly by a family and outside resources to assist families with developing assets in areas such as homeownership, business development, and education
- ***Inspector General*** – office established in the Department of Justice to address the detection, prosecution, and prevention of fraud, abuse, and waste in means-tested public assistance programs including Work First, food stamps, and Medicaid
- ***Job Service Employer Committee*** – committee required in every county to oversee operation of the First Stop Employment Assistance Program
- ***Joint Legislative Public Assistance Commission*** – established to monitor implementation of the state's Work First program including the receipt and review of reports from the state; commission consists of 10 legislators from the Senate and 10 from the House of Representatives
- ***Lifetime benefit*** - per federal Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (welfare reform law), only 60 months of cash assistance may be paid to any recipient not qualifying as a "hardship" case
- ***Maintenance of effort*** -- required minimum funding levels by counties and the state for the Work First program
- ***Mutual Responsibility Agreement*** – an agreement between the Work First recipient/family and a county; it describes the recipient's responsibilities in order to receive Work First assistance, and how the county will assist the recipient with carrying out such responsibilities

10-22-97

Fact Sheet

U.S. Department of Labor
Washington, DC

WELFARE-TO-WORK GRANTS

Background

In August 1996, the Personal Responsibility and Work Opportunity Reconciliation Act reformed the nation's welfare laws. A new system of block grants to the States for Temporary Assistance for Needy Families (TANF) was created, changing the nature and provision of welfare benefits in America.

Moving people from welfare-to-work is now one of the primary goals of federal welfare policy. The new Balanced Budget Act of 1997, signed by the President on August 5, helps to achieve that goal by authorizing the U.S. Department of Labor to provide Welfare-to-Work Grants to States and local communities to create additional job opportunities for the hardest-to-employ recipients of TANF. These grants will provide many welfare recipients with the job placement services, transitional employment, and other support services they need to make the successful progression into long-term unsubsidized employment.

Summary of Welfare-to-Work Grants

FUNDING: The grants total $3 billion: $1.5 billion to be awarded in fiscal year 1998 and $1.5 billion in fiscal year 1999. There will be two kinds of grants: (1) Formula Grants to States and (2) Competitive Grants to local communities. A small amount of the total grant money will also be set aside for special purposes: 1 percent for Indian tribes; 0.8 percent for evaluation; and $100 million for performance bonuses to successful States. Grantees will have up to three years to spend the funds.

FORMULA GRANTS TO STATES: After reserving the special purpose funds described above, 75 percent of the grant funds will be allocated to States based on a formula that equally considers States' shares of the national number of poor individuals and adult recipients of assistance under TANF. States will be required to pass through 85 percent of the money to local Private Industry Councils (known as workforce development boards in some areas), which oversee and guide job training programs in geographical jurisdictions called service delivery areas. A State is allowed to retain 15 percent of the money for welfare-to-work projects of its choice. States must provide one dollar of non-federal funding match for every two dollars of federal funding provided under the formula.

Substate Allocations: Half of the funds distributed by formula to local areas must be based on a service delivery area's residents who are poor, i.e., the number of poor individuals in excess of 7.5 percent of the total population. Not more than half may be distributed based on two additional factors: (1) the number of adults receiving TANF assistance for 30 months or more and (2) the number of unemployed in the service delivery area.

State Plan and Administration: In order to receive formula funds, the State must submit a plan for the administration of the Welfare-to-Work grant. The Secretary of Labor must determine that the plan meets the statutory requirements. Governors are responsible for administering formula funds and for assuring that they are coordinated with funds spent under the TANF block grant.

welfare to work

10-22-97
Baggett

Appropriations Committee on Health and Human Services

Division of Mental Health/Developmental Disabilities/Substance Abuse Services

Area Mental Health Program Performance Reviews and Future Plans

October 22, 1997

Background

- For many years, North Carolina did not seek Medicaid funding for human services as aggressively as many other states
- Late eighties and early nineties, MHSC developed 5 Age Disability Plans
  - Adult Mental Health, Child Mental Health, Adult Substance Abuse, Child Substance Abuse and Developmental Disabilities
  - Cost of implementation estimated at over 600 million additional dollars (today $900 million)

Growth in Federal Funding

- State Policy to increase Medicaid revenues to address the disability plans
- Medicaid growth in Area Programs since 1992 is 776%
- CAP-MR has grown from around 800 clients in 1990-91 to over 4000 this year
- State funds to Area Programs reduced in anticipation of Medicaid growth

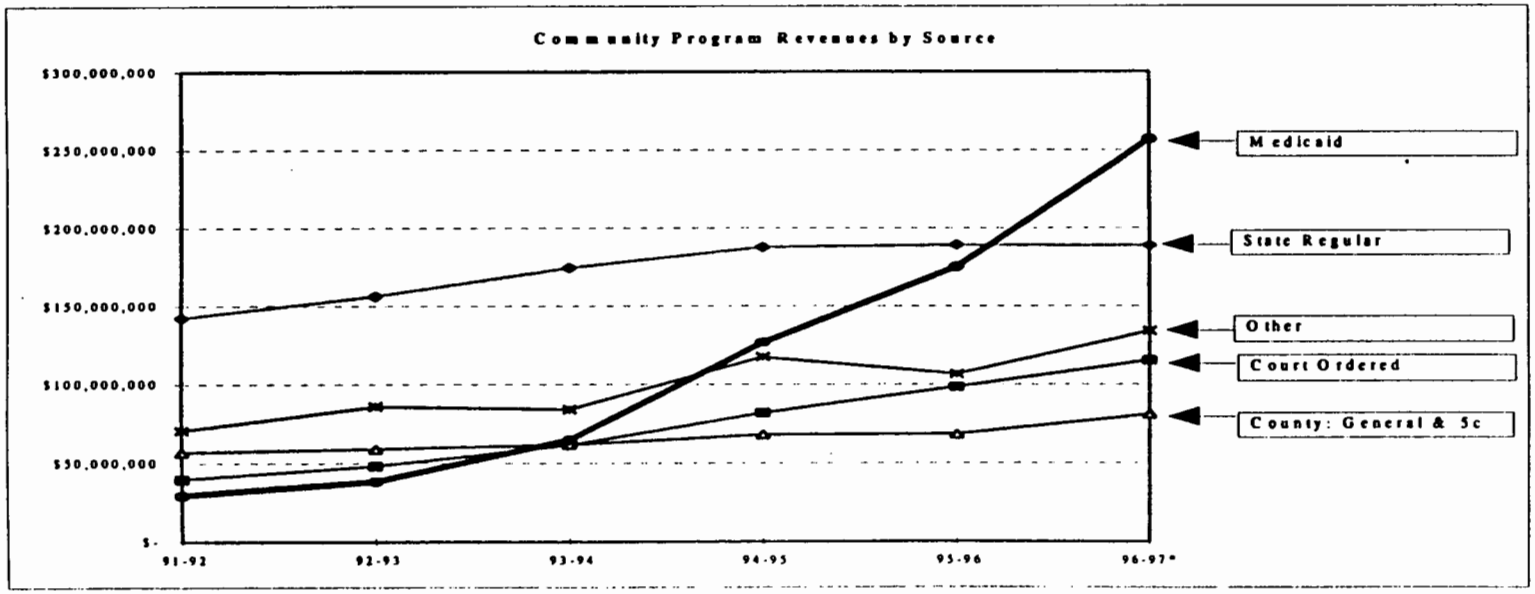
Incentives to Bill Medicaid

- Provide more services and improve quality of care. New service definitions help make that possible
- Maintain current levels of services
- Division policies mandated maximizing Medicaid to limit growth of state funds for Willie M. and Thomas S. Services

DHR - MH/DD/SA SERVICES
FY 1991-92 through FY 1996-97
Community Program Revenues by Source

(Millions of Dollars) TYPE OF REVENUE	FY 91-92	FY 92-93	FY 93-94	FY 94-95	FY 95-96	FY 96-97*	% chg FY92-FY97
STATE REGULAR	$ 142.2	$ 156.0	$ 174.3	$ 187.4	$ 188.9	$ 188.6	33%
COURT ORDERED	$ 39.6	$ 47.9	$ 61.3	$ 81.8	$ 98.4	$ 115.3	191%
COUNTY:GENERAL & 5c	$ 56.8	$ 58.8	$ 61.6	$ 68.0	$ 68.2	$ 80.9	42%
MEDICAID	$ 29.3	$ 38.1	$ 64.6	$ 126.4	$ 175.0	$ 256.8	776%
OTHER	$ 70.6	$ 86.0	$ 84.0	$ 117.3	$ 106.5	$ 134.0	90%
TOTAL RECEIPTS	$ 338.5	$ 386.8	$ 445.8	$ 581.0	$ 637.0	$ 775.6	129%

(Percent of FY Total) TYPE OF REVENUE	FY 91-92	FY 92-93	FY 93-94	FY 94-95	FY 95-96	FY 96-97*
STATE REGULAR	42.0 %	40.3 %	39.1 %	32.3 %	29.7 %	24.3 %
COURT ORDERED	11.7 %	12.4 %	13.8 %	14.1 %	15.4 %	14.9 %
COUNTY:GENERAL & 5c	16.8 %	15.2 %	13.8 %	11.7 %	10.7 %	10.4 %
MEDICAID	8.7 %	9.9 %	14.5 %	21.7 %	27.5 %	33.1 %
OTHER	20.9 %	22.2 %	18.8 %	20.2 %	16.7 %	17.3 %
TOTAL RECEIPTS	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %



Carolina Alternatives (CA)

- Federal 1915(b) Medicaid waiver program
- Currently in 10 area programs serving Medicaid eligible children (ages 0-17) with MH/SA diagnosis
- Current waiver granted an extension through March, 1998. An extension will be requested to extend through June, 1998.
- Area programs authorize services, manage care, and pay providers
- Successful in reducing hospitalization and greatly increased access and quality of outpatient care

Carolina Alternatives Status

- Scheduled last year to begin to expand state-wide for children and adults for MH/SA
- Cost effectiveness challenged by HCFA. Waiver expansion held up
- Provider complaint in TREND Area Program results in audit of CAP program which raises additional concerns about CA

Carolina Alternatives Expansion

- Waiver submission scheduled by December, 1997
- Expand state-wide to all 40 area programs
- Medicaid eligible children (0-17) and adults (18-64)
- Major Changes:
  - Alternative Services for Children and Adults - including inpatient for free standing psychiatric hospitals
  - Levels of Care Criteria for Children and Adults
  - Client Choice Policy enhanced
  - Appeals and Grievances Procedure
  - Consumer Brochure
- Rate Determination
  - Contract agency of DMA examining rates
  - Final rates by January

Carolina Alternatives Expansion (cont.)

- Area Program Readiness Reviews and results of audits will determine order of area program participation.
- New program participation will begin July 1, 1998.
- Additional programs added quarterly based upon readiness and rates established.
- State-wide area program participation by July 1, 1999.

CAP-MR/DD

Community Alternatives Program for People with MR/DD

- Federal 1915(c) Medicaid waiver program
- Targets people with mental retardation, no age limits
- All 40 area programs operate CAP-MR/DD services
- More than 300 providers state-wide
- Consumer must meet ICF-MR level of care criteria in addition to other requirements.
- Currently serves 4100 people

CAP-MR/DD Waiver Changes

- **DD Managed Care Work Group is recommending changes to the waiver in order to accomplish the following:**
  - **Reduce the programmatic inefficiencies of the waiver**
  - **Examine the cost structure and payment methodology**
  - **Increase accountability of providers and area programs**
  - **Serve more people on the waiting lists**
  - **Address the goals and objectives of the 10 year plan**
  - **Enhance consumer choice**
  - **Meet the Governor's Medicaid budget**

Medicaid Compliance

- Increase focus on Medicaid compliance over last 2 years.
- Carolina Alternatives Readiness Reviews have been conducted
- CAP-MR/DD reviews every annually- Findings:
  - Documentation: services were provided but notes and other required documentation components to bill for services did not meet the minimum requirements
  - Client choice restricted
  - Provider network limited
  - Services provided as ordered in the plan and within the acceptable time frame

Medicaid Compliance (cont.)

- **DMH/DD/SAS Medicaid Technical Assistance Team**
  - 21 area programs visited
- **Trend**
  - original complaint from 2 foster families
  - both DMH and DMA reviewed
  - problems/deficiencies noted
  - final report not released
- **Tri-County**
  - DMH/DD/SAS staff assigned to Tri-County
  - Initiated internal record audit
  - 80% non-compliance rating

Plan to Assure Area Program Compliance to Medicaid and DMH/DD/SAS Requirements

- **The Plan assures:**
  - Area Programs are operating in compliance with basic Medicaid requirements
  - Provides reassurance that the area programs are managing effectively
  - Area Programs demonstrate a readiness for full implementation of Carolina Alternatives
- 3 Prong approach to examining compliance to and developing of action plans to correct areas not in compliance.
  - System-wide Compliance with Medicaid
  - Intensive Area Program Review
  - Program Specific Reviews and Interventions

System-wide Compliance with Medicaid Requirements

- **Goals to Identify**
  - **Area Programs that operate with 95% compliance for Medicaid documentation and medical necessity.**
  - **Area Programs that do not meet 95% compliance must submit an improvement plan within 30 days (@70-95%); technical assistance provided based on need; second on-site validation review may be required.**
  - **Area Programs that do not meet 95% compliance must submit a plan of correction within 30 days to be followed by a second on-site validations review (@ less than 70%); technical assistance required.**

Medicaid Compliance Plan

- Selection of 200 random sample Medicaid paid claims for July - August, 1997
- On-Site review of all 40 area programs to examine documentation to:
  - 1)Support medical necessity - treatment plan, diagnosis, service order
  - 2)Verify event billed has documentation to support billing
- Results analyzed and reports distributed
- Follow up visits scheduled by Division or other area programs who have demonstrated excellence.

Strategy and Timeline

- **Review Team**
  - Coordinated by Division Staff
  - Each Institution has provided staff for team participation
  - Each team has been trained in specific requirements
- **Timeline**
  - Reviews began October 20, 1997
  - All area programs will be completed by December 15, 1997
  - Comprehensive Summary report by January 15, 1998
  - Second on-site visits begin January, 1998

Intensive Area Program Reviews

- **Goals:**
  - Complete 3 area program comprehensive/fiscal review to reduce area program failure
  - Identify improvements needed and to monitor improvements
- **Plan**
  - Area Programs selected
  - Review Team selected and trained
  - Review conducted
  - Report distributed
- **Timelines**
  - Pitt Area Program - November 3-5, 1997
  - Onslow Area Program - November 12-14, 1997
  - Wayne Area Program - December 3-5, 1997
  - Follow up visits February, 1998

Program Specific Reviews and Interventions

- Goals
  - Focus limited resources to targeted improvements in service delivery
  - Provide concentrated technical assistance to meet improvement strategies and outcome expectations
  - Plan:
    - » Selection of an area program by each DMH/DD/SAS Section
    - » Each section utilizes standard monitoring tool to review area program
    - » Each section co-ordinates review with area program
    - » Visits completed December 5, 1997
    - » Improvement plans submitted and approved by January, 1998
    - » Second on-site reviews March-June, 1998

Program Selection

- Child and Family Services: Lee Harnett Area Program
- Crisis Services: Southeastern Regional Area Program
- Developmental Disabilities: Durham Area Program
- CAP-MR/DD: Cleveland Center
- Mental Health: Rockingham Area Program
- Substance Abuse Services: Johnston Area Program
- Thomas S Services: Mecklenburg Area Program
- Willie M. Services: CrossRoads Behavioral Health

Future Plans

- Carolina Alternatives Waiver Expansion beginning July 1, 1998 with full implementation July 1, 1999
- CAP-MR waiver modifications with changes effective December 1, 1997 and July 1, 1998
- DMH/DD/SAS Medicaid monitoring, intensive area program reviews and disability reviews completed and correction plans implemented and monitored by July 1, 1998
- Revised area program performance evaluation

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES
Minutes
November 18, 1997

The Joint Appropriations Subcommittee on Human Resources took a field trip organized by the Department of Health and Human Resources on Tuesday, November 18, 1997. The members traveled by bus to C.A. Dillon School and to Henderson to the Vance, Granville, Franklin, Warren Area Program. Six Senators attended. The following House members took part in the trip:

Representative Charlotte Gardner	Representative Lanier Cansler
Representative Alma Adams	Representative Martha Alexander
Representative M.W. Aldridge	Representative J.W. Hurley
Representative Edd Nye	Representative Cindy Watson

Staff members Karen Hammonds-Blanks, Mary Ellen Sylvester, Carol Shaw, Gann Watson and Dianna Jessup were present.

Gwen Chunn, Director of the Division of Youth Services, offered information on the state youth facilities (See handouts) and introduced the staff taking part in the tour of C. A. Dillon. Cathy Borras, Program Manager at the facility, explained the goals of the program (see handout). Ms. Borras said that they have a new residential substance abuse treatment program that has 10 members and are expecting its membership to grow.

The committee was divided into 5 groups headed by a student and unit coordinator for the tour. After the tour, the five students answered member's questions.

The next stop on the field trip was the Adult Day Care Program for the persistently mentally ill in Henderson. Supervisor John Rice explained the program while the members were served lunch in the house that is used as a money making source. The clients work there helping with the catering service for which the house is used. They also run a thrift shop in downtown Henderson.

Tom McBride, Director Area of the Mental Health, Developmental Disabilities and Substance program for Vance Warren, Granville, and Franklin counties, split the committee into 2 groups to visit the Thrift Shop, Child Development Center and the Scott Parker School for child day treatment. Dr. Peter Horner, Director of Children and Family Services for the Area Program, and Jerry Fritzo, Director of the facility, explained the nature and goals of the program. Funding sources for this program is Carolina Alternative and Willie M.

The tour ended at 4:00 p.m., and the bus returned the members to the LOB in Raleigh.

Barbara R. Hocutt
Barbara R. Hocutt, Clerk

Charlotte A. Gardner
Representative Charlotte A. Gardner, Co-Chair

11-18-97

TOWN OF BUTNER

The Unincorporated Town of Butner is State administered. The Secretary of the Department of Health and Human Services is responsible for the operation of the town. Since 1964 the Butner Planning Commission has been in existence. This seven member commission is appointed by the Granville County Commissioners and the Secretary of Health and Human Services. The function is to advise the Secretary on matters relating to Butner involving water and sewer, zoning, water/sewer rates and any other municipal matters.

Town Population - 5,000
Total Institution Population in Butner - over 5,000 including all expansions

The town has 35 miles of paved streets that are State roads and 12.84 paved streets that are Powell Bill roads. The town Water Plant is valued at over 16 million dollars. We provide water to the town and two Sanitary Districts outside the town limits that include the Industrial area. The rated capacity is 3.9 million gallons per day. 2.5 mgd average daily use.

Our Wastewater Treatment Plant is valued at over 24 million dollars. We provide sewer service to the Town of Creedmoor and two Sanitary Districts that include the Industrial area. The design plant flow is 3.9 million gallons per day. Can only use 20% or 3.5 mgd - average daily use 2.1 mgd (includes 300,000 gallons daily for Creedmoor).

Raw Water Storage

Lake Holt	2.2 billion gallons
Reservoir	(behind water plant - 10.8 million gallons)

Finished Water Storage

1 Clearwell - 2 million gallons
1 Elevated Tank - 1 million gallons
1 Elevated Tank - 300,000 gallons

Butner Jurisdiction - Acreage (number of acres)

N.C. Department of Agriculture	4140
Corps of Engineers	2174
Department of Correction	256
Federal Government	770
North Carolina National Guard	4748
North Carolina State University	1300
Department of Health and Human Services	4848

VII. BUTNER COMMUNITY

1. Approximately 1,300 single family dwellings

2. Four (4) mobile home parks (220 spaces)

3. One hundred-eighty (180) apartments and duplex dwellings.

VIII. TOWN OF BUTNER REVENUES/EXPENDITURES FISCAL 1997

Revenue:	Water Plant	$ 1,000,853
	Wastewater Plant	$ 1,146,707
	Town Operations	$ 153,846
Expenditures:	Water Plant	$ 857,123
	Wastewater Plant	$ 1,039,034
	Town Operations	$ 184,670

STATE AND FEDERAL FACILITIES IN THE BUTNER JURISDICTION

NAME OF FACILITY	SQUARE FOOTAGE ACREAGE	EMPLOYEES	PATIENTS INMATES STUDENTS	OPERATING BUDGET
JOHN UMSTEAD HOSPITAL	987,000	1461	625	57,176,459
MURDOCH CENTER	600,000	1628	711	53,021,005 (1993-1994)
UMSTEAD CORRECTIONAL CENTER	78,408	40	150	1,500,000
Polk Youth Center			750	
ALCOHOL DRUG ABUSE TREATMENT CENTER	45,000	91	78	3,900,000
C A DILLON SCHOOL	100,014	143	97	4,600,000 (1993-1994)
STATE UNIVERSITY BEEF CATTLE RESEARCH UNIT	1276 ACRES	14	4	
NC NATIONAL GUARD RANGE	4800 ACRES	5	N/A	
UMSTEAD FARM UNIT	4800 ACRES	18	N/A	900,000
NC DEPT OF AGRICULTURE FOOD WAREHOUSE	80,085	30	N/A	2,674,728
FEDERAL CORRECTIONAL INSTITUTE	769 ACRES	412	785	
FEDERAL CORRECTIONAL INSTITUTE-FEDERAL PRISON CAMP	SEE ABOVE	50	326	
NCNG ARMORY & OMS HOP	47,962	10 FULL-TIME 90 PART-TIME	N/A	

11-18-97

MURDOCH CENTER

Murdoch Center, which is totally ICF/MR certified, is one of North Carolina's five Regional Mental Retardation Centers operated by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Murdoch Center provides comprehensive residential care for profoundly, severely or moderately mentally retarded residents from 16 counties in the State's North Central Region. The facility has 676, including 29 certified infirmary beds, Certified ICF/MR beds.

Approximately 1,594 Murdoch Center employees provide around-the-clock activities and supervision for the residents on the campus. These activities include training, therapeutic and habilitative services Residents are grouped into divisions according to their age, training needs, and medical or physical disabilities.

The facility runs an extensive Community Service Outreach Program. The Center is the basic pivotal point for coordinating Developmental Disability and Mental Retardation Services in the North Central Region.

1997-1998 FACT SHEET

Certified Budget for FY 1997-98*	***Requirements:***	***Receipts***:	***Appropriations***
	$57,202,480	$55,153,892	$ 2,048,588

Current ICF/MR Full Cost Rate (per bed)	***Daily***	***Annual***
	$239	$87,235

*The budget figures are based on the 11/12/97 Certified Budget that does not include SFY 97 Legislative Increase or SFY 98 Legislative Increase as these items have not been approved by the Office of State Budget and Management.

JOHN UMSTEAD HOSPITAL

(including ADATC Unit)

John Umstead Hospital (JUH) is the regional hospital serving the 16 counties in the North Central Region. The hospital has 593 beds, and occupies 50 building that total approximately one million square feet on a 200-acre campus. The original buildings were constructed in 1942 as a W.W.II convalescent hospital. JUH has occupied the buildings since 1947. The physical layout of most of the patient care buildings makes optimum staffing coverage difficult to achieve due to inefficient ward size.

The hospital has a staff of 1351 and provides inpatient care to children (beginning at age 5) and adults. In addition to serving the short-term stabilization needs of acute patients, it also offers longer-term rehabilitation services. The hospital also has a 30-bed nursing facility that serves primarily patients suffering from dementia and which has an affiliation with Duke University. A recent census showed that Umstead had 24 forensic patients among its average daily population of 527 (including ADATC patients). Seven of the 24 had either committed or been charged with murder.

The Butner ADATC was administratively merged with the hospital in 1996.

1997-1998 FACT SHEET

Certified Budget for FY 1997-98*	***Requirements:***	***Receipts:***	***Appropriations***
	$58,807,626	$13,267,778	$45,539,848
Current Cost Per Bed	**Type of Bed**	***Daily***	***Annual***
	Psychiatric	$209	$109,135
	ICF	$209	$ 76,285

*The budget figures are based on the 11/12/97 Certified Budget that does not include SFY 97 Legislative Increase or SFY 98 Legislative Increase as these items have not been approved by the Office of State Budget and Management.

WHITAKER SCHOOL

Whitaker School was opened on October 1, 1980. The School's mandate is to provide psychoeducational treatment in a secure 24 bed residential setting to severely emotionally disturbed adolescents. The program employs 48 individuals and is administered by the North Carolina Department of Health and Human Services. It is known as the the North Carolina Adolescent Re-education Program.

1997-1998 FACT SHEET

Certified Budget for FY 1997-98*	***Requirements:***	***Receipts***:	***Appropriations***
	$2,090,104	$994,000	$1,096,104
Current Cost Per Bed	***Daily***	***Annual***	
	$238.60	$87,087	

*The budget figures are based on the 11/12/97 Certified Budget that does not include SFY 97 Legislative Increase or SFY 98 Legislative Increase as these items have not been approved by the Office of State Budget and Management.

• *BUTNER ADOLESCENT TREATMENT CENTER* •

The Butner Adolescent Treatment Center is composed of two facilities: BATC, a 12 bed locked residential treatment facility, and Oakview Residential Treatment Program, a 12 bed non-secure apartment facility, both located on John Umstead Hospital campus in Butner, North Carolina. Forty-five employees at BATC serve 12 male Willie M. clients ages 13-17 and 39.5 employees at Oakview serve 12 male Willie M. clients ages 13-17.

BATC provides a structured setting with a focus on stabilizing behavior so the client may learn to function in a less restrictive environment. Oakview provides a more intensive focus on independent living skills. BATC and Oakview have a twofold goal for each client: a decrease in behaviors that prevent him from functioning in a community setting, and, through growth in knowledge, skills, and self esteem, an increase in behaviors that allow him to function effectively in more normal settings.

PROGRAM HIGHLIGHTS:

- **Treatment Goal: Competence and Confidence: the qualities that survivors of high-risk backgrounds are shown to possess.** Competencies include: problem-solving skills, ability to get along with others, avoiding negative influences, coping with anger, mending relationships, vocational skills, educational skills, and recreational skills.
- **Positive Discipline.** Clients are given personal responsibility for making limited choices and solving his own problems, rather than imposing external controls. Positive Discipline stresses consequences for behavior that are logical, reasonable, respectful of the client, and related to the violation.
- **Formal clinical services on an individualized basis.** Each client has an individual therapist, whom he sees on a weekly or biweekly basis. Specialized treatment is provided for clients with histories of sexual aggression. Psychoeducational groups are also provided, as are substance abuse assessments. A consulting psychiatrist evaluates clients, assists in treatment planning, and prescribes medications as needed. Other clinical services are provided by staff nurses and clinical social workers. All clinical services are coordinated by the Clinical Director.
- **Education Services:** Winmore School is the school for all BATC, and some Oakview, clients. It is an accredited school in which students can work towards a high school diploma. Emphasis is on maintaining the student's participation, and preventing drop-out or failure, since remaining in school has been a significant predictor of better long-term outcome for at-risk adolescents. Clients at Oakview have three educational options: (1) Vance Granville Community College (VGCC) General Equivalency Diploma or Adult Basic Education program, (2) VGCC High School Diploma Program, and (3) Winmore School at BATC. Significant vocational training and employment opportunities are also provided for clients approaching adulthood or otherwise needing a vocational emphasis.

- **Recreation Services.** The goals are to: (a) evaluate and identify behavior patterns through observation, (b) develop peer interaction skills, (c) increase self-esteem and social, and (d) expose clients to a variety of leisure experiences. These may include sports, music, art, self-help skill building, and other leisure activities.

1997-1998 FACT SHEET

Certified Budget for FY 1997-98*	***Requirements:***	***Receipts***:	***Appropriations***
	$2,935,390	$3,700	$2,931,690
Current Cost Per Bed	***Facility***	***Daily***	***Annual***
	BATC	$416.48	$152,017
	Oakview	$304.93	$111,298

*The budget figures are based on the 11/12/97 Certified Budget that does not include SFY 97 Legislative Increase or SFY 98 Legislative Increase as these items have not been approved by the Office of State Budget and Management.

11-17-97
Cathy Banas
Program Mgr

DYS
TREATMENT PROGRAM

Behavioral Management
(Ensure safety & security; provide order & structure; teach appropriate, lawful behaviors)

Code of Conduct

Choices

Inappropriate behavior

Hold Status

Other Sanctions (privilege suspension, room isolation, charges)

Appropriate behavior

Earn Successful Days

Competencies
(Behaviors, skills to improve life in community)

Individual
Accepting Responsibility, Academic, Work, Victim Empathy, Social Skills, Anger Management & Conflict Resolution, Problem Solving, Reality Therapy, Self-Care, Relapse Prevention Plan, Community Plan, Campus or Community Service Project

Group
Anger Management & Conflict Resolution, Self-Care, Reality Therapy, Social Skills, Moral Reasoning, Victim Empathy, Problem Solving, Relapse Prevention, Victim Awareness

Level Progression

Eligible for Release Consideration

H-18-97

NC Department of Health and Human Services
Division of Youth Services
Facility Description: C.A. Dillon School

The Division of Youth Services operates five Training Schools: the oldest is Stonewall Jackson built in 1909, and the newest is C. A. Dillon School, built in 1968. Training schools provide treatment, education, and rehabilitation services for juveniles ages 10 through 15 who are committed to the Division of Youth Services by the Court. Youth may be committed until age 18.

C. A. Dillon School is a high management secure facility with 121 beds located in Butner, a small town in Granville County approximately thirty-five miles north of Raleigh. Originally established in 1968 as a facility for both males and females, the school now houses males only.

The facility is completely encircled with a fence fifteen feet high which was erected in 1993 using Prison Bond funds. The Dillon property comprises 88 acres. Staff and visitors enter the campus through the administration building which houses the administrative offices of the facility director, program manager, business officer, personnel officer, and the medical clinic. The facility is well landscaped with paved sidewalks providing access to all buildings. The physical plant includes four living units, a cafeteria, maintenance shop, an academic building, gymnasium, swimming pool, vocational classrooms, and a chapel/multipurpose facility. In addition to the fence, recent construction at the facility (enabled through Prison Bond funding) includes a 20-bed self-contained unit, a vocational classroom building, and a chapel/multipurpose facility.

Staffing at C.A. Dillon consists of 204 permanent full-time positions including 122 campus life positions; 27 educational positions; 18 clinical positions (psychologists and social workers); 25 support positions (food services, office support, and maintenance); 5 recreation staff; 4 facility administration positions (director, program manager, business officer, and personnel officer); 2 nurses; and 1 chaplain.

The juvenile population at C.A. Dillon is comprised of the highest classification of offenders who have committed serious crimes against persons. Each student is assigned a social worker and a Treatment Team consisting of Clinical, Educational, and Cottage Life staff. Individualized treatment plans and education plans are prepared for each student. Two specialized treatment programs are offered at C.A. Dillon School: the serious offender program and sex offender treatment program. Currently 36 beds are allocated for the sex offender program with the remainder of the beds at the facility allocated for other serious offenders.

C.A. Dillon Training School
1997-98 Budget Information
November 14, 1997

1997-98 Budget	*Total Requirements*	*Receipts*	*Appropriations*
	$7,660,495	$258,757	$7,401,738
Number of Employees:	204		
Average Daily Budget Per Bed	$171.40		
Number of Beds	121		
Average Daily Enrollment	124		

Note: This information was obtained from the following sources:

- 1997-98 Certified Budget
- October 1, 1997 PMIS Position Printout

Dr. Greene introduced the Superintendents of the Schools for the Deaf and Hard of Hearing: Steve Whitchey, Wilson; Gary Mowl, Morganton; Susan Sien, Greensboro. They made brief introductory statements of their philosophy and goals for their schools. (See attachments #3, #4, #5 and #6.)

Senator Martin requested the division to investigate the influence of brain development and early intervention and for the Deaf and Hard of Hearing Services to join with Public Health for the early identification of and intervention in dealing with this disability

Representative Earle recommended a newborn test to detect deafness which would not require a large cost to implement since the average age for diagnoses of these children is about 2 years of age. The members expressed some of the same concerns for deaf and hard of hearing children that were expressed for the blind: not performing at grade level, lack of coordination with LEAs, and lack of outcome data. Representative Gardner said the Frank Porter Graham School at UNCG was developing a longitudinal study (10 years) following children's development and focusing on language development.

Representative Aldridge requested time to discuss the field trip the members took on Tuesday, November 18, particularly the C.A. Dillon School.

DHHR REORGANIZATION

Dr. Bruton introduced Stephanie Bass who is the Change Agent for reorganization planning and is responsible for keeping the department focused on the reorganization task. It was pointed out that the organization chart to which she was referring was handed out at the October 21st committee meeting (See attachment # 7). She covered the ways the reorganization study the department is conducting dovetails with the KPMG Peat Marwick Recommendations (See attachment #8). The mission statement was presented (see attachment #9). Members had questions about the department contracting with a consulting firm to study reorganization especially since the Legislature had just done that and recommended the resulting KMPG Peat Marwick report to the department by special provision in the Budget. Also, neither the members nor the staff had seen any information on the scope of the DHHR study.

Representative Nye noted that one of the problems in "seamless service delivery" was that some of the providers identify clients and bill Medicaid directly. Also, the Mental Health audit said they don't have to report to the Secretary. He was told that Dick Peruzzi, Director of Medical Assistance, would address that in his presentation. Members had questions about the functioning of a regional organization. Representative Gardner wanted to know how much money South Carolina spent on its EBT system compared to North Carolina which was in a compact with 8 other states to bring an EBT system online.

DHHR AUDIT REPORT

Stan Wesner of the Office of the State Auditor presented the Comprehensive Annual Financial Report (CAFER) and single audit report for the Department of Health and Human Resources conducted for the year ending June 30, 1996. (See Attachment # 10.) There were 30 audit findings from 6 divisions which are the Divisions of Social Services Medical Assistance, Child Development, Mental Health, Youth Services and Blind . Of these 30 findings, 5 findings are considered to be significant; 3 of the 5 are in Social Services, 1 is in Child Development, and 1 is at Medical Assistance.

The most significant finding is at the Division of Medical Assistance and in the report is # 15, Enhance Controls to Prevent Payment of Incorrect Claims, dealing with Medicaid payments. The auditors examined 283 cases statistically and randomly chosen out of 70 million claims. The division through its contractor, EDS, lacks batch control on data entry. In Finding #15, An error $447.50 was paid as $ 4,475,047.50. The item was not "kicked out" for manual review through some mysterious truncating error. The batch control amount at which an item is "kicked out" for review is set at $500,00. $22,000 in interest was lost to the State. The provider reported the error and had the money for 5 weeks. Representative Cansler said that the division needs to find out how to discover error. DMA did not know the answer to several questions regarding the process of payment such as whether the overpayment went to the provider's bank account, how much interest the provider earned on the overpayment and why the batch control amount is set so high. Mr. Wesner stated that the State Auditor's office does not audit EDS; they audit the results. EDS is not a state agency. The audit report recommends that an audit of EDS by an independent CPA should be an integral part of the audit, and Representative Howard recommended the audit. According to Mr. Wesner, Blue Cross Blue Shield does this kind of audit. She also asked the department to look into seeing that EDS takes responsibility for the error and for repaying the $22,000 in interest lost to the state. Representative Gardner expressed concern about the lack of a policy for addressing errors and assurances of the corrections of these mistakes. She would like the auditor to return for a more thorough discussion. Representative Howard asked Dr. Bruton if there was a policy for recovery of money lost in this way, who is responsible for knowing policy and who pursues the aggressive recovery of lost state money. Mr. Peruzzi, Director of the Division of Medical Assistance, said no one thought of recovering the money from EDS but that it would be done. Senator Martin recommended coming up with a policy or process to identify errors and recoup losses connected with these errors on a time schedule. He wanted to know if there was anything in the State audit that EDS was not able to comply with, and Dr. Peruzzi said he would find out where the department stood with EDS on corrective action recommended by the audit.

In answer to Senator Phillips' question about discovering claim errors, Dr. Peruzzi explained the control system they have in place. He said the purpose of the Claims Processing Assessment System is to find out if any claims are processing inappropriately and make systems corrections which, unfortunately, failed in this instance.

Representative Aldridge wanted to know how many other cases of this type there are where restitution was indicated but not pursued. Allen Gambill, Assistant Director Finance Operations, assured the members that measures to address the occurrence of these errors have been instituted. In answer to Representative Gardner's question about recovering overpayments to providers, Mr. Edgerton explained the State cash management policy that guides the department.

Senator Martin asked Mr. Wesner to identify the other 4 significant audit findings besides #15, Enhance Controls to Prevent Payment of Incorrect Claims, which has been discussed. The members can read the report on the others. Mr. Wesner said they are: # 1, Initiate Appropriate Enforcement in Child Enforcement Cases; #2, Division of Social Services, Prepare Annual Financial Statement in Accordance with Generally Accepted Accounting Principles; #3, Claim Federal Financial Participation on Only Eligible AFCD-EA Costs and #19, Claim Submitted for Foster Care Maximization Reimbursement Should be Revised to Eliminate Errors, but he cannot tell the committee if these audit findings have been corrected. The auditors are looking into that. Senator Martin asked the department if there are any that have not been complied with. Mr. Edgerton needs more time to find out where the department is on #1, child support cases. On #2, Social Services, the department is in compliance. On #3, AFDC and 4AEA revenue maximization, the department is appealing certain aspects of the Federal decisions on these programs. Child Day Care, #19, is a disallowed claim by the Federal government, and it has been appealed. The documentation on the disallowance has been gathered, and the department expects to prevail.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Allen Gambill, Assistant Director of Financial Operations for the Division of Medical Assistance, gave the report on Disproportionate Share Hospital Payments (See attachment # 11). DSH payments are made to hospitals that serve either a large number of Medicaid or uninsured patients. Hospitals may qualify for a DSH payment either because of a Federal minimum standard or by determination of the State. The State psychiatric hospitals are designated as Disproportionate Share facilities but there was be a cap placed on money available by the 1997 Federal budget. The Federal government has tightened the program, and the amount has dropped. Presently the money is secure and will be available, but by 2003 the state is going to have a declining availability of money plus a decline in the percentage of money the State can use toward the psychiatric hospitals.

With regard to identifying patients with estates having enough value to collect payments on, the Attorney General's office said we were not aggressively pursuing the recovery these assets, according to Senator Phillips, and he wanted to know how many claims were actually settled in the last 18 months and the dollar value recovered for patients discharged and returned for treatment. The department will get that figure for Senator Phillips. Mr. Edgerton explained the write-offs in payments.

MEDICAID BUDGETING

Daphne Lyons, Assistant Director of Administrations and Regulatory Affairs for the Division of Medical Assistance, gave the report on Budgeting for Medicaid (See attachment #12). The subject is not just cost containment but how we get control of the rate of growth in cost in the Medicaid program. Carolina Access, the State's managed care program for Medicaid, is the cornerstone of that plan. 66 counties are now taking part, and the number is growing. Each client has a doctor either chosen by the client or assigned by the division. The doctor is in charge of coordinating that person's care, and this strategy is helping to cut overuse of emergency room.

Senator Martin asked about emergency room reduction for non-access counties, and Ms. Lyons said that figure was available. She said there is a significant difference in the two with Carolina Access experiencing the largest reduction.

Representative Gardner wanted clarification on the possibility of Carolina Access being an unfunded mandate on the counties. Also, she wanted to know what the Medicaid errors were in 1994-95 that resulted in a refund of $93,000 to the counties. The Public Health departments are seeing that they will lose clients and money. Representative Gardner wants to understand the change in policy. Starting in July, 1998 Public Health departments need to formalize relationships with primary care physicians, and they will be reimbursed for the care the physician refers to them. According to Ms. Lyons, Carolina Access is not a part of the Medicaid reduction package. Public Health can be the primary care provider for clients; they must provide treatment as well as screening. Rep. Gardner is concerned about explaining to her county what is happening. Ms. Lyons offered to meet with Representative Gardner to discuss the program in more detail.

Senator Martin asked Ms. Lyons to summarize the key difference between Carolina Access and Carolina Access II. The key difference is community health planning with all interested parties on budget questions, service delivery and measure of success in saving money to put back in the community. In October, they began HMO as a choice of clients in Gaston County. They are just offering the program in the Triangle area and expect to begin enrollment in 1998. Senator Phillips asked what incentive there is to choose the HMO, and Ms. Lyon said that was probably a good thing to include in the satisfaction survey.

Representative Gardner didn't get an answer to the question of the millions of dollars that were going to have to be paid back to the counties. Dr. Peruzzi explained that Public Health is reimbursed at an interim rate. Then the State reimburses the difference between what Medicaid paid what their costs are. Mr. Edgerton said that total reimbursed to counties was about $9 million.

Senator Martin declared the meeting adjourned.

Barbara R. Hocutt, Clerk

Senator Martin, Senate Chair

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES N 20
NOVEMBER 18, 19 AND 20, 1997

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John DeLuca	Blind Services
John Wagner	DSO
Heather Gail	OSA
Joyce Flowers	OSA
Roland Gaddy	OSA
Joyce Johnson	DHR
Barbara Matula	NCMS Foundation
Evelyn Hawthorne	NCHA
Annette Ethridge	Office of the Governor
Lou Wilson	N.C.A.L.T.C.F.
John Bourdeau	Zeb Alley P.A.
Jan Kimpton	NCANA

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Name of Committee | Date

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NAME	FIRM OR AGENCY AND ADDRESS
David Simmons	ZDA, PA
[signature]	Villages
Roslyn Sawtt	NC Child Care Coalition
John B DeLuca	DSB
Harlell Bernard	GMS
Craig Greene	DSD/HH
Angie McMillan	DHHS
Brenda Fruenkel	DSDHH (CNCSD)
Susan Stein	DSDHH (CNCSD)
Rachael Ragin	DSDHH
Mary Greene	OSBM
Byron K. Harris	OSBM
Stacy Flannery	NCANPHA
S. Lynne Hamlet	Senator Kinnaird - Intern
Melvin Lee	DSD/HH

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
LEN ARON	DSDHH - Raleigh central office
GARY E. MOWL	DSDHH - NCSD - Morganton
Megan Saylor	Easter Seals - Cwtchan 2001
Marian Hartman	DD Council
NELS ROSELAND	STATE BUDGET OFFICE
C L Cochran	UCP - Coal, 2001
DAVE RICHARD	The Arc - Coal 2001
Jared Sumner	NC ARF - Coal 2001
Tom Worth	carolina Mountain Support

Attachment #1

Proposed ABCs Workplan for DHHS Schools

Tasks	Staff	Deadline
Clarify legislative intent of the special provision	Assistant secretary of DHHS, education representatives from divisions with education programs, legislative staff	November 21, 1997
Determine baseline data by facility 1. Students present for 106 days 2. Students present for 106 days at time of end-of year tests in applicable grades 3. Students needing alternative testing based on IEPs	Base line data collected by all school programs for 96-97	December 15, 1997
Collaborate with DPI on development of alternative testing administration expectations, protocols and instruments	Three representatives from Divisions of Services for the Blind, Deaf and Hard of Hearing, and Mental Health	Ongoing
Determine department's hardware, software, and training needs to access the Student Information Management System (SIMS)	School MIS staff working with DPI	December 15, 1997
Develop budget format to show education costs separate from related services, therapeutic and housing costs Determine educational costs at each school	Department Budget & Analysis staff and school budget officers Budget officers and school administrators at each institution and division budget offices and Budget & Analysis	December 15, 1997
Review curriculum to ensure conformity with Standard Course of Study	School staff	January 1998
Begin school-based planning and assess training needs	School and division staff	Jan.- March 1998

11-19-97

11-19-97
Attachment #2

The Governor Morehead School for the Blind

Current Status of ABC Plan Implementation

The three North Carolina Schools for the Deaf, and The Governor Morehead School for the Blind, have already begun implementation of the ABC's Plan by taking the following actions:

- **All are now included in DPI teams addressing ABC Plan issues, as well as, in a number of other educational teams.**

- **All have established site-based "School Improvement Teams,"**

- **All have initiated on-site strategic planning processes which follow and build upon the ABC's Planning Model**

- **All have developed strong child-centered mission and/or vision statements which aim at repositioning the schools for the 21st century**

- **All are establishing accountability standards and measures which exceed the minimum required of an LEA.** (See attachments)

The Challenges of Visual Impairments Education:

- **The average age of identification of the child who is not totally blind is about 2 yrs. of age. Therefore, the first two years of concept and psycho-motor development, of which 85% is dependent upon visual cues, is severely impacted and attenuated.**

- **For the child who is visually impaired, language is acquired auditorily but concept development is arrested without early intervention. Therefore, optimally, the child with visual impairments comprehends 15 % of the language presentations experienced by the typically developing child.**

- **Two-thirds of the parents of children with visual impairments are not visually impaired and have limited capabilities or no means of promoting true comprehension of phenomena above verbalization when interacting with their visually impaired child during the first few years of life.**

- **Most non-multi-handicapped children with visual impairment arrive in the educational setting with conceptual delays of 1-2 years. When the multi-handicapped with visual impairments as the primary challenge are added, that deficit is difficult to overcome and typically increases over time.**

- **Though the student with only visual impairment can be near, at or even above grade level expectation when taught with the proper reading medium, it is striking to note that one-third of the entire Visually Impaired student population is non-reading.**

• additional disabilities.

- **Two thirds of the deaf children in North Carolina attend local public schools.**

- **Only 10% total visually impaired student population are Braille readers. Visual readers constitute 26%, auditory readers 8% and pre-readers are 24%. The availability of the proper assessment and instruction in the appropriate reading medium is a major problem with students across the state. Instruction in the tactile codes in math is even more problematic.**

- **School psychologists, social workers, and regular education teachers are expected to adapt materials they use to evaluate sighted students without the benefit of any additional training for assessing students with visual impairments.**

- **North Carolina is typical of the states on average with 8% at the residential school (the majority of whom are multi-handicapped), 8 % are in either rehabilitation or multi-handicapped centers, and approximately 84% are enrolled in local school districts. Too few there are receiving proper appraisal and vision-specific curricula.**

- **Involvement of parents of students in the state residential school is minimal due to factors of distance and the incidence of poverty as indicated by an 84% level of eligibility for free or reduced priced lunch.**

- **Self-esteem and self-advocacy tend to be lower in students with visual impairments than would be the case with their typically developing age peers.**

- **The number of professional preparation programs in visual impairments education is diminishing nationwide while the visual impairments student population is increasing with the rise in general school enrollment.**

- **Only 26 % of working-age people with severe functional limitation in seeing print are employed.**

What Must Be Done? Full Implementation of National Agenda Goals in North Carolina Birth Through Age 21

- **Students and their families will be referred to an appropriate education program within 30 days of identification of a suspected visual impairment.**

- **All parents will be ensured the right to full participation and equal partnership in the education process.**

- **Universities will prepare a sufficient number of visual impairments educators.**

- **Ongoing professional development will be provided for all teachers and orientation and mobility instructors and reasonable caseloads will be maintained.**

- **North Carolina will ensure that all students with visual impairments have access to a full array of placement options.**

- **Assessment of students will be conducted, in collaboration with parents, by personnel having expertise in the education of students with visual impairments.**

- **Access to developmental and educational services will include an assurance that instructional materials are available to every student with visual impairments statewide in the appropriate media and at the same time as their sighted peers.**

- **Educational and developmental goals, including instruction, will reflect the assessed needs of each student in all areas of academic and disability-specific curricula.**

In addition to the National Agenda, we in North Carolina must also:

- **Provide for a meaningful transition from school to work / higher education.**

- **Make a long-term commitment to maintaining facilities which are safe, pleasant, conducive to learning, and which contribute to the development of high self-esteem.**

- **Develop the schools as outreach, resource, and research centers which will serve students with visual impairments, their parents and the professionals who serve them in all educational settings.**

- **Establish The Governor Morehead School as the technology and distance learning center in Visual Impairments Education in North Carolina.**

What Is Being Done in 1997-98 at GMS?

- **Installed new leadership which is committed to the goals stated above.**

- **Engaging in *GMS 2001: A School Improvement Initiative* which encompasses the DPI School Improvement Model and the Correlates of More Effective Schools**

- **Entered into a formal partnership agreement with North Carolina Central University for the pre-service preparation of teachers of students with visual impairments and the development of a professional development center on-campus.**

- **Is a full participant in the implementation of the ABCs in Residential Schools special provision; thus we look forward to the development of alternative assessments in reading and math with DPI, raising standards and holding students, faculty, and administration accountable for success or failure.**

- **Successfully competed with 95 North Carolina school districts to join 44 recipients of theTechnology Literacy Challenge Fund Grant to install a distance learning facility and develop a vision-specific technology competencies curriculum for staff and students.**

- **Designed and adopted a three year technology plan, 1997-2000.**

- **Conducted a first-time, concurrent statewide Visually Impaired teacher conference for public school and Governor Morehead staff.**
- **Substantially expanded the enrollment goal for the Specific Skills program targeted at visually impaired public school populations of elementary and middle school ages.**

- **Accepted 20 new full-time students on campus this year to date and are gearing up for a substantial increase in infants and toddlers in the preschool program beginnning this spring.**

- **Joined with the adult program of the Division of Services for the Blind to offer a joint program of continuing education credits through an international/national accrediting agency.**

- **In accordance with the ABCs Plan Guidelines, The Governor Morehead School Improvement Team has reviewed the following DHHS and DSB Mission Statements:**

The Mission of the Department of Health and Human Services is to "*Serve the people of North Carolina by enabling individuals, families, and communities to be healthy, and secure, and achieve social and economic well-being.*"

The Mission of the Division of Services for the Blind is "*To empower individuals who are blind or visually impaired to achieve their maximum potential through services provided by competent and caring professionals.*"

The Governor Morehead School Improvement Team now has under consideration the following Mission and Vision statements:

"To successfully educate North Carolina's children and youth with visual impairments to be productive, independent, confident citizens and life-long learners."

"The vision of The Governor Morehead School is to become an exemplary school and resource center, known for excellence in the field of visual impairments. The School will advocate the ideals expressed in the National Agenda for the Education of Visually Impaired Youths and will initiate, implement and support these broadly approved educational

principles for all North Carolina students with visual impairments from birth through age 21, their parents, and the professional who serve them.

This repositioned state school for the blind will:

- *provide the right resource for the right student at the right time*
- *educate the total child through a full array of service delivery models including satellites, public school settings, logn and short-term on-campus placements, and those promoted electronically by the North Carolina Information Highway*
- *partner with North Carolina Central University to improve the professional development center in providing pre-service personnel in the vision field*
- *utilize modern distance education classroom and state of the art, vision-specific technology*
- *serve as a readily available child-advocate to parents and professionals*
- *provide scholars a setting for research in the field of visual impairments education*

11-19-97
Attachment #3

The North Carolina Schools for the Deaf

- ABC Plan Status
- Challenges for Deaf Education
- What Must Be Done
- What Is Being Done
- Mission / Vision
- Current Initiatives

Current Status of ABC Plan Implementation

The three North Carolina Schools for the Deaf, and the Governor Morehead School for the Blind, have already begun implementation of the ABC's Plan by taking the following actions:

- **All are now included in DPI teams addressing ABC Plan issues, and also, in a number of other educational teams.**

- **All have established site-based "School Improvement Teams"**

- **All have initiated on-site strategic planning processes which follow and build upon the ABC's Planning Model**

- **All have developed strong child-centered mission statements**

- **All are establishing accountability standards and measures which exceed the minimum required of an LEA** (See attachments)

The Challenges of Deaf Education:

- The 1988 Presidential Commission on Education of the Deaf stated that "the present status of education for persons who are deaf in the United States is unsatisfactory. Unacceptably so." It went on to reveal that deaf education had been more "reaction than action," and more "remediation than prevention." The challenges that this Commission outlined are similar to those we face in North Carolina.

- **The average age of identification is about 2 yrs. of age. Therefore, the two most important years for normal language development is lost or severely attenuated.**

- **For the deaf child, language is usually experienced through senses other than hearing. Therefore, optimally, the deaf child experiences about 1/8 of the language presentations experienced by hearing children.**

- **95% of the parents of deaf children are hearing and have little or no means of communicating with their deaf child during the first few years of life.**

- **Most deaf children arrive in the educational setting with a language delay of 2-4 years. That deficit is difficult to overcome and often increases over time.**

- **The average deaf high school graduate in America leaves school with a reading level of 4th grade.**

- **30% to 40% of students attending the residential schools for deaf children have diagnosed or strongly suspected additional disabilities.**

- **More than two thirds of the deaf children in North Carolina attend local public schools.**

- **Among our graduating seniors, the average length of stay in the NC Schools for the Deaf has been five years. There is an illusive answer to the question , . . . "What was the quality of the educational experience before arriving at one of our schools?**

- **Involvement of parents is minimal for most deaf students because meaningful communication can be minimal or non-existent.**

- **Self-esteem and self-advocacy tend to be at low levels among deaf youth.**

- **Deaf education in America has been paternalistic since it's inception. As a result, these challenges have often become excuses for accepting low achievement.**

- **All of the above are unacceptable and must be changed.**

What Must Be Done?

- Develop and improve early identification and intervention programs.
- Provide increased parent education and support.
- Improve communication between students and their parents and between parents and the school.
- Establish comprehensive and continuous assessment of student performance, level of functioning, and program effectiveness.
- Make a renewed and articulated commitment to individualized education.
- Raise standards and expectations for student and staff performance.
- Place increased emphasis on building effective communication skills and literacy development.
- Make an increased commitment to staff development and training which is targeted to meeting assessed individual needs.
- Make an increased commitment to technology in learning.
- Develop alternative education programs.

- **Provide for a meaningful transition from school to work / higher education.**

- **Make a renewed commitment to maintaining facilities which are safe, pleasant, conducive to learning, and which contribute to the development of high self-esteem among students and staff.**

- **Develop the schools as outreach, resource, and research centers which will serve deaf and hard of hearing children and families in all educational settings.**

What Is Being Done ?

- **New leadership, committed to the goals stated above, has been installed at all three schools**

- **The three schools and the Central Office now function as a single educational unit, rather than as totally separate entities. Planning and shared expertise is improving every facet of the schools.**

- **A requirement for sign communication skill levels for all staff has been formalized by DSD/HH. This is improving the quality of instruction, raising literacy levels, and improving self-esteem.**

- **The schools have embraced the ABC's of Education Plan and will apply it to our students in precisely the same manner as DPI, thus raising standards and holding students, faculty, and administration accountable for success or failure.**

The North Carolina Schools for the Deaf have jointly developed the following mission statement:

" All deaf and hard of hearing children have unlimited potential. Given that belief, the North Carolina Schools for the Deaf provide a challenging learning environment which prepares each child for a meaningful and productive life in a changing world. "

The following initiatives are among many others now underway at the three schools:

- **IEP Driven Educational Organization - The needs of the children will drive every dimension of the schools. (see diagram)**

- **Early Intervention - A 1997 appropriation has allowed the schools to address the needs of the youngest deaf and hard of hearing children and their parents.**

- **Interagency Cooperation- DSD/HH teams with other agencies to provide the most comprehensive education and service possible.**

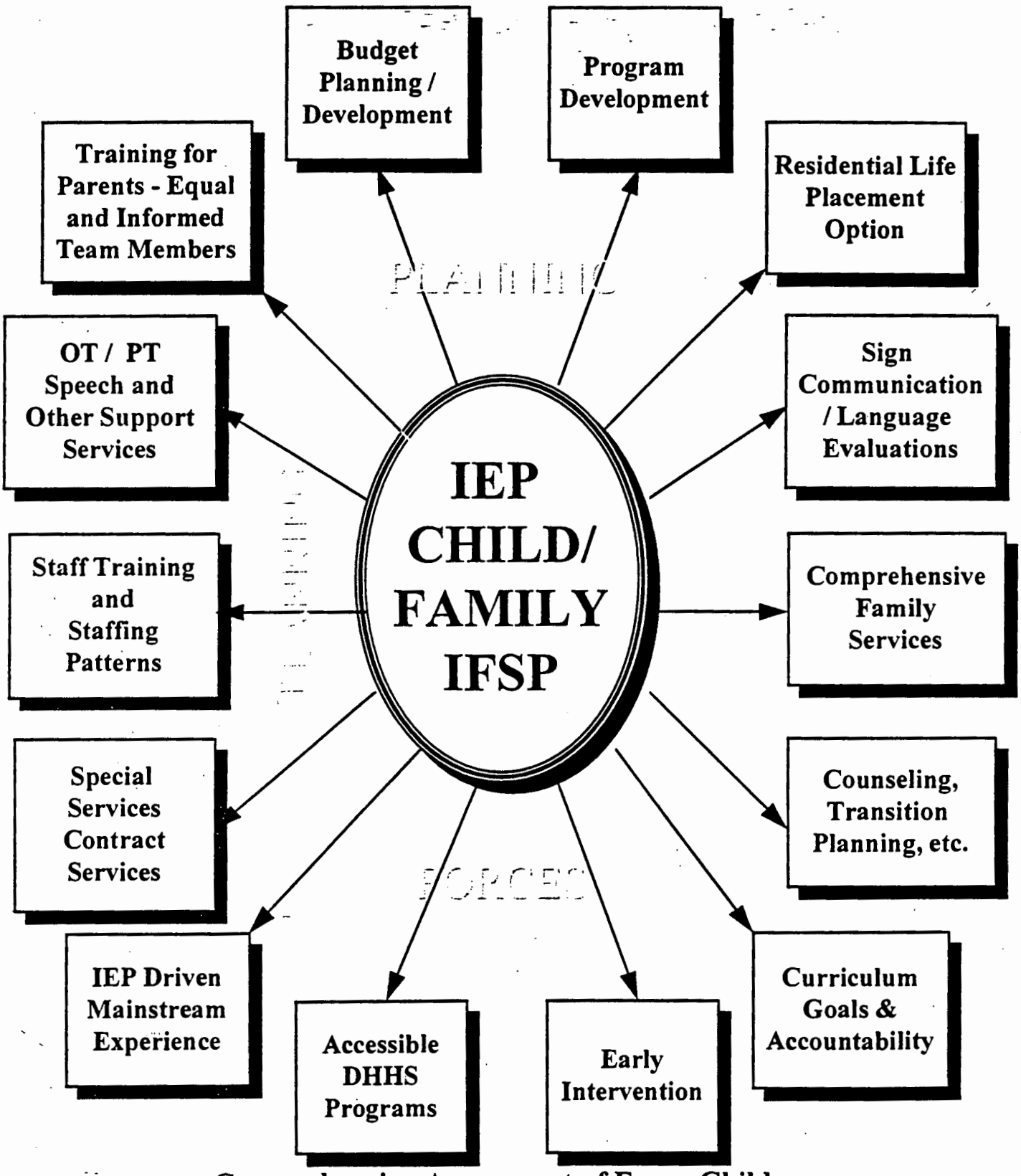
- **Communication and Literacy Development (English / Sign Communication / etc...) - The top priority in our curriculum. Sign Communication skill is now a requirement of employment.**

- **Curriculum and Assessment Team (NCSD's "Report Card", alternative testing, curriculum development). We now have baseline data on student performance and program effectiveness. This allows us to respond to real needs of individual children.**

- **School Improvement (ABC) Planning Process (Mission Statement, School Improvement Teams, Focus on meeting individual needs- We now have the same accountability and performance standards (for teachers and students) as do all public schools in North Carolina. We are striving to exceed minimum requirements.**

DSD/HH CHILD CENTERED MODEL;

IEP / IFSP DRIVEN ORGANIZATION



Comprehensive Assessment of Every Child Supports a Quality Process

- **Residential Education Program (Comprehensive Structured Learning Environment) - Learning goes far beyond the classroom. We have a special curriculum for training our residential staff. We also have a structured learning program for the "after school" hours.**

- **BEH Program (Opens Fall 1998 in Morganton)- This program will serve those deaf children who have severe and disruptive behavior problems.**

- **Technology in Schools- These schools are now becoming state of the art in computer technology. Every classroom will soon be connected to the internet, and distance learning is a reality. The dormitories are also being connected.**

- **Transition Program- The two high school programs have transition programs and are developing model independent living programs. This will begin to reduce SSI dependency.**

- **Support to public school programs through interpreter training and evaluation, sign language evaluation, etc...**

- **Summer Leadership program for deaf and hard of hearing children in North Carolina.**

- **Comprehensive summer programs for deaf and hard of hearing children in North Carolina.**

- **Gallaudet and NTID Collaboration- We have developed an agreement with these two universities for the deaf, to collaborate on a variety of programs, projects, and research.**

11-19-97
attachment #4



Early Intervention . . . . building the future !!!

EARLY INTERVENTION PLANNING COMMITTEE

For Children who are Deaf or Hard of Hearing

Report to the NC Legislature
and the
Division of Services for the Deaf and Hard of Hearing

1997

This report is dedicated to

Dr. Frank Turk

for his care and commitment to families and children who are Deaf or hard-of-hearing in the state of North Carolina

State of North Carolina
Department of Human Resources
Division of Services for the Deaf and Hard of Hearing

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Raleigh, North Carolina 27603

James B. Hunt, Jr..
Governor

H. David Bruton, M.D.
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(919) 773-2966 (TDD)
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May 5, 1997

It is with a deep sense of pride and anticipation that I present the Report of the Early Intervention Planning Committee. The Division of Services for the Deaf and Hard of Hearing established the Early Intervention Planning Committee in response to recommendations from the 1992 Task Force on Quality Assurance for the Deaf and Hard of Hearing, and a subsequent mandate from the 1995 General Assembly. It's mission was to address the early intervention needs of deaf and hard of hearing children, their families, and the professionals who serve them. This effort may be the most significant development in North Carolina history for improving the quality of life for the generations of deaf and hard of hearing individuals who will follow.

The work of this Planning Committee was begun in 1996 under the direction of Ms. Tambrey Oettinger, who served, from August, 1995 through December, 1996, as the first Early Intervention Coordinator for DSD/HH. The Planning Committee work was completed under the direction of Ms. Rachael Ragin. The planning Committee is comprised of over 40 individuals with unique expertise and experience with our youngest deaf and hard of hearing children. They encompass the full spectrum of interests and approaches to addressing the comprehensive needs of these children and their families. The recommendations from this "inclusive" group, reflect the most current research findings and best practices found in America, along with innovations that should establish North Carolina as the leader in addressing the comprehensive needs of deaf and hard of hearing children and their families.

If we are to make dramatic improvements in the academic achievement and quality of life after graduation from school, which is so desired by our deaf and hard of hearing citizens, we must establish a commitment to early intervention services. DSD/HH will take the lead by making early intervention as it's top priority in the development of budget requests, staffing requests, and programs. DSD/HH will be a statewide resource to assist with any and all early intervention needs when they arise. These recommendations are already being woven into the strategic planning efforts of the Division of Services for the Deaf and Hard of Hearing.

I congratulate the members of the Early Intervention Planning Committee for the Deaf and Hard of Hearing for a job well done. With this letter, I am also requesting that it's member continue to serve on this Committee. DSD/HH will use it as an advisory body for the five year implementation period which began with the submission of this Report.

Sincerely,

J. Craig Greene, Ed.D.

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April, 1997

The Early Intervention Planning Committee Report of 1997 is a model of strong interagency collaboration. It has identified the strengths and weaknesses in existing services for children who are deaf or hard of hearing, birth to five. The Early Intervention Planning Committee began this ambitious endeavor one year ago in January of 1996 by bringing all interested parties to the table. It is in the spirit of this partnership that recommendations are made which could dramatically improve the services North Carolina provides to these children and their families.

The committee has responded with enthusiasm to the 1995 Legislative charge to examine early intervention services in conjunction with other agencies. It wholeheartedly supports a collaborative interagency effort to streamline those services to effectively serve our families. This report represents, not the end of this group's efforts, but the beginning. Collaboration must continue to be the focus, as teamwork will only expedite our journey.

As a representative of the Division of Services for the Deaf and Hard of Hearing, I commend those people who have dedicated their time and their hearts to this effort. Their work will benefit many families and children across our state.

Sincerely,

Rachael Ragin

Rachael Ragin
Early Intervention Coordinator
DSDHH

North Carolina Schools for the Deaf
Early Intervention Planning Committee Report

Executive Summary

In 1992, the Task Force Report, Assuring Access to a Quality American Life for North Carolina's Deaf and Hard of Hearing Citizens, was released. Many of the Task Force recommendations in the area of education and early intervention are seen unfolding within the framework of this report The 1995 General Assembly directed the Division of Services for the Deaf and Hard of Hearing (DSDHH) to develop a comprehensive plan for early intervention for children who are deaf and hard of hearing. Recommendations for a comprehensive early intervention model were developed by an interagency committee with input from families.

Broad themes emerged with respect to needs and gaps in services in evaluation, referral, education, related services, parent support and training. Child and family centered programs, developmentally appropriate curricula, and interagency collaboration and coordination of services were noted as critical components of quality early intervention services. The Early Intervention Planning Committee emphasized collaboration of state government divisions/departments to support the delivery of services to these children. The overall focus of this plan is not to create a separate service system for children with hearing loss but to strengthen existing early intervention, childcare and preschool networks through collaboration, planning and the provision of specialized support to these networks.

As we move to a more seamless array of services through interagency collaboration, all efforts to improve services to this population will become more effective. North Carolina has a wealth of resources in the area of early intervention. Resources can be best utilized through this kind of collaboration. The Early Intervention Planning Committee has been an excellent example of how multi-agency collaboration with the parents can begin to identify ways to meet the needs and fill the gaps identified in this report. This is the beginning of a much needed process to develop an implementation plan that is inclusive and collaborative for deaf and hard of hearing infants, toddlers and preschoolers and their families.

The Early Intervention Planning Committee has set forth recommendations to meet the needs and gaps identified in this report. This is the beginning of a process to develop an implementation plan that is inclusive and collaborative for deaf and hard of hearing infants, toddlers, and preschoolers and their families. This committee wishes to extend its

appreciation to the 1995 North Carolina General Assembly and all involved state agencies for their support in the development of this family friendly model. Below are the areas identified that are critical to improving the quality of services provided to infants, toddlers and preschoolers who are deaf or hard of hearing and their families.

Identification and child find process

- Implement universal birth screening process
- Improve identification and tracking

Assessment and evaluation process

- Improve access to audiological evaluations
- Provide comprehensive functional assessments

Referral process

- Improve multi-agency referral processes

Early education development

- Implement 0-2 early education programs in compliance with IDEA, Part H statutes
- Provide family centered services
- Provide flexible personnel system to respond to changing demographics
- Improve recruitment process for educational personnel
- Improve service delivery of home and center based instructional programs
- Provide technological access
- Provide developmentally appropriate early education programs
- Increase outreach services to Local Education Area programs and child care programs
- Establish an implementation and evaluative process for report recommendations

Parent education and support

- Expand parent education and support programs
- Provide communication support to families in all modalities (sign language, cued speech, auditory/verbal, etc. ...)

Professional development

- Provide support to teachers through mentoring programs
- Improve access to statewide training opportunities in early education
- Improve quality of communication modalities used by educational staff

NORTH CAROLINA SCHOOLS FOR THE DEAF

Mission Statement

ALL DEAF AND HARD OF HEARING CHILDREN HAVE UNLIMITED POTENTIAL. GIVEN THAT BELIEF, THE NORTH CAROLINA SCHOOLS FOR THE DEAF PROVIDE A CHALLENGING LEARNING ENVIRONMENT WHICH PREPARES EACH CHILD FOR A MEANINGFUL AND PRODUCTIVE LIFE IN A CHANGING WORLD.

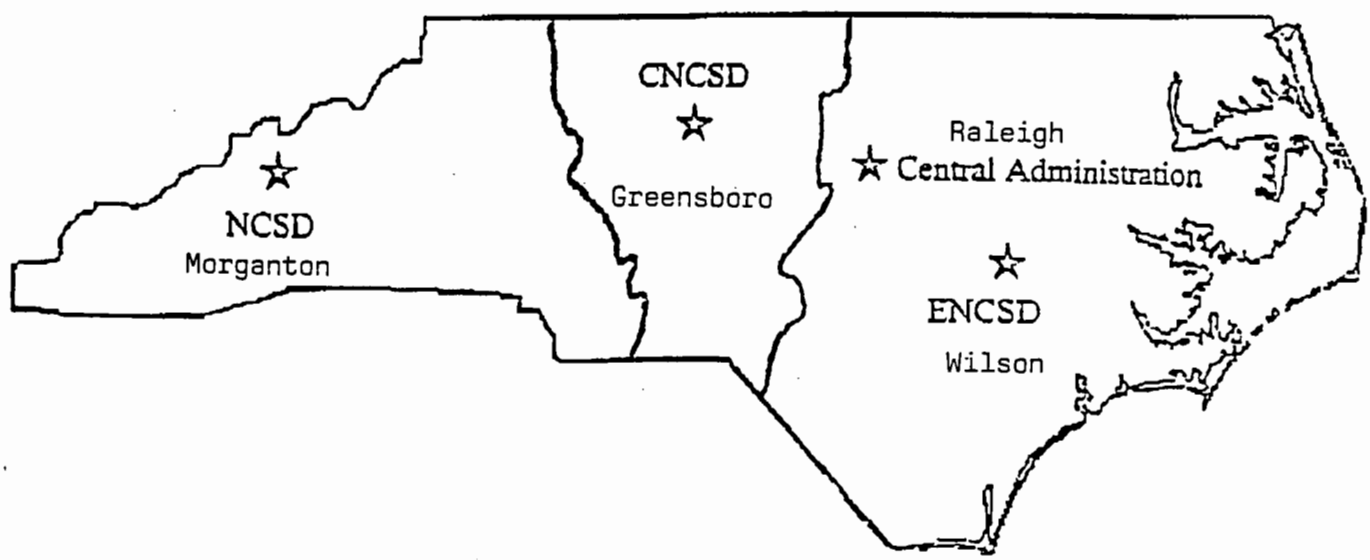


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ACKNOWLEDGMENTS

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Jan Withers, Burke Mental Health Center

Special thanks to Dee Miller and Brenda Jackson for their secretarial support of this committee.

INTRODUCTION

In 1992, the Task Force Report, Assuring Access to a Quality American Life for North Carolina's Deaf and Hard of Hearing Citizens, was released. Many of the Task Force recommendations in the area of education and early intervention are seen unfolding within the framework of this report. The 1995 General Assembly directed the Division of Services for the Deaf and Hard of Hearing (DSDHH) to develop a comprehensive plan for early intervention for children who are deaf and hard of hearing. Recommendations for a comprehensive early intervention model for children who are deaf or hard of hearing and their families were developed by an interagency committee with input from families. The majority of interagency committee members have extensive first-hand experiences, either professionally, personally or both with services for children who are deaf or hard of hearing.

The committee researched state and national programs for the best practices in early intervention for children who are deaf or hard of hearing. Broad themes emerged with respect to needs and gaps in services in evaluation, referral, education, related services, parent support and training. Child and family-centered programs, developmentally appropriate curricula, and interagency collaboration and coordination of services were noted as critical components of quality early intervention services. The Early Intervention Planning Committee emphasized collaboration of state government divisions/departments to support the delivery of services to these children. The overall focus of this plan is not to create a separate service system for children with hearing loss, but to strengthen existing early intervention, childcare and preschool networks through collaboration, planning and the provision of specialized support to these networks. In many cases recommendations brought forward by the committee dovetail with initiatives or services of these divisions. The major initiatives recommend improvement in:

- identification and child find process
- assessment and evaluation process
- referral process
- parent education and support
- early intervention/education development
- professional development
- policies and collaboration

The first five years of life are the most crucial years for development of language in children (Johnson, R.E., Liddell, S.K. Erting, C.J., 1989). Early identification of hearing loss is critical in order to provide intervention for communication, language, cognitive, social and emotional development to minimize the effects of hearing loss on the total development of children with hearing loss. In addition, professionals outside the field of deafness may be insufficiently trained to understand the symptoms, effects and implications of hearing loss (Johnson, et al, 1989). Consequently, many children are not identified until critical periods for language and auditory

skills development have passed. Some children experience hearing loss later in childhood and frequently go undiagnosed or misdiagnosed, missing critical intervention time. Often, delays in language development caused by late identification are never overcome.

Local consortia/Local Interagency Coordinating Councils (LICC) bring multiple agencies together to facilitate evaluation and placement of special needs children in appropriate settings . To comply with state mandated procedures, newly identified children with, or at risk for having, a disability should receive prompt referral to their local consortia to determine eligibility, initiate required and necessary evaluations, develop an IFSP/IEP and begin services. However, some consortia do not have the expertise needed to identify and place children with hearing loss. Providing consistent education and support to local consortia would assure early identification and more timely placement, help parents receive more consistent and complete information about all program options and assist them in making appropriate and informed intervention/educational decisions for their child.

Standardized assessments in a clinic-based setting often do not capture the complete range of a child's abilities. Assessment for intervention planning needs to go beyond standardized tests that are used to establish eligibility for services. Comprehensive evaluation should include judgment-based and routines-based assessment along with identification of family concerns, priorities and resources. Consistent and comprehensive assessment procedures are needed to ensure that all of a child's/family's strengths and needs are recognized, and that these strengths/needs drive the Individual Family Support Plan/Individual Education Plan (IFSP/IEP) process. Functional multidisciplinary assessment for both the child and family through transdisciplinary collaboration of professionals are the driving principles for establishment of a strong family centered IFSP/IEP.

Children exhibiting developmental and/or language delays may have some degree of permanent or fluctuating hearing loss. This hearing loss may significantly affect evaluation results, causing a misdiagnosis and therefore, inappropriate intervention recommendations. In addition, initial evaluations at an early age may not completely identify specific needs that emerge as the child grows older. Development, progress and/or needs may change rapidly. Thus more frequent and effective evaluations would better determine the child's on-going needs to continually provide appropriate intervention strategies.

When a child has been diagnosed with a hearing loss, the family should be provided options for immediate support. Strong support systems are needed to guide families through the grief process. Families need access to complete and balanced information to guide their decision on a communication mode and intervention strategies. Currently, they obtain information from a variety of sources, often with incomplete or even erroneous information, creating stress and confusion for families as they make critical educational decisions for their child. Families continually report that they are unaware of services and options that available to them in their community. Service providers are also frequently unaware of the wealth of services and resources available for children with hearing loss and their families.

Once a parent has completed the referral process, parent support should continue to be a major component of family-centered services. Complex choices for families in the area of communication exist within the framework of services for children who are deaf or hard-of-hearing. The inability to communicate with their child can result in severe deprivation in psycho-social/emotional needs. Parent education is critical in communication, providing an environment for their child that nurtures their psycho-social/emotional needs and building understanding of the unique needs of their child. Training for educational and support staff is necessary to provide parents with complete information about available options and family support. Support to families includes effective grief counseling, transformation in the parent's concept of hearing loss and the child, training staff in basic theory of family systems, providing parents tools for parenting deaf children and establishing a parent-to-parent support network .

The child may receive services through home or inclusive center-based settings. Classrooms and all educational services should promote a developmentally appropriate learning environment. Staff of preschool programs serving deaf and hard of hearing children need training in implementing developmentally appropriate curricula. Educational programs should facilitate communication between the family and their child and provide an enriched, developmentally appropriate environment. Early intervention is essential to the social, physical, intellectual, cognitive and emotional growth of all children. In many parts of the state, this support is not available to meet the existing needs for services.

A mentor program is needed to provide ongoing training for educational and support staff. Mentor support could be provided through interagency collaboration and establishment of peer tutoring programs. In-state and out-of-state experts in diverse areas of instruction, as well as developmentally appropriate, family-centered programming should be brought in to provide the support and expertise that educators and related services staff need. Recruitment efforts to secure qualified staff must also be improved. Shortages continue to exist in trained educational and support staff, particularly in areas requiring dual certification or multiple qualifications.

As we move to a more nearly seamless array of services through interagency collaboration, all efforts to improve services to this population will become more effective. North Carolina has a wealth of resources in the area of early intervention. Resources can be best utilized through this kind of collaboration. The Early Intervention Planning Committee has been an excellent example of how multi-agency collaboration with the parents can begin to identify ways to meet the needs and fill the gaps identified in this report.

The Early Intervention Planning Committee has set forth recommendations to meet the needs and gaps identified in this report. This is the beginning of a process to develop an implementation plan that is inclusive and collaborative for deaf and hard of hearing infants, toddlers, and preschoolers and their families. This committee wishes to extend its appreciation to the 1995 North Carolina General Assembly and all involved state agencies for their support in the development of this family friendly model.

Section A: Identification and Child-Find Process	
Recommendation	**System Level**
1. Support implementation of current legislation requiring that all newborns in North Carolina be screened for hearing loss prior to leaving the hospital. Attention must be given to the funding of this screening process (i.e. third-party reimbursement, Medicaid, legislative funding, medical surcharge). Attention should also be given to implementation of similar legislation in other states.	DEHNR, DSDHH, other agencies, i.e., BEGINNINGS
2. Develop and implement a process to identify children with various types of hearing loss: congenital, early, delayed or progressive; and establish mechanisms for follow up with all Local Interagency Coordinating Councils.	Local Consortia, Preschool programs, DSDHH, other agencies, i.e., BEGINNINGS
3. Expand existing statewide databases and tracking systems to include identification and services provided for at-risk infants, toddlers and preschoolers identified as having a hearing loss.	DMH/SAS/DD, DEHNR, DSDHH
4. Continue development of a multi-agency, on-going statewide plan using existing resources to inform the public and service providers about available early intervention services for children who are deaf or hard-of-hearing.	FSN, Exceptional Children's Assistance Center, DSDHH, other agencies, i.e., BEGINNINGS
5. Provide support for dissemination of multi-media information (brochures, videos, ...) targeted to the medical profession, and continue training for health professionals to increase knowledge in recognizing symptoms of hearing loss and the needs of young children who are deaf or hard-of-hearing.	DEHNR, DSDHH, Physicians, Audiologists, other agencies, i.e., BEGINNINGS, Cued Speech Center

Section B: Assessment and Evaluation Process	
Recommendation	**System Level**
1. Work with early intervention programs, public schools and Developmental Evaluation Centers to (a) develop procedures to rule out hearing loss (using more than a screening procedure when necessary) prior to conducting other evaluations for all children exhibiting developmental delays, and (b) disseminate a list of available places where audiological evaluations are performed for free or on a sliding-scale fee basis.	DEHNR, DSDHH, other organizations, i.e., BEGINNINGS
2. Develop a multi-agency process for obtaining parental consent to release initial intake and assessment information (including families' concerns, priorities and resources) to other professionals working with the child/family.	DMH/DD/SAS, DEHNR, DSDHH, Local Consortia or LICC
3. Evaluate developmental needs of infants, toddlers and preschoolers who are deaf or hard-of-hearing annually for educational and related services.	DEHNR, DSDHH, Public Schools
4. Use judgment-based (subjective clinical judgment) and routines-based assessments with standardized evaluations to determine overall functional assessment of deaf and hard-of-hearing children, including objective language assessment, to ensure optimal placement.	DEHNR, DSDHH, Public Schools

Section C: Referral Process	
Recommendation	**System Level**
1. Develop public awareness strategies and identify resources to promote the referral of children who are deaf or hard-of-hearing upon initial identification of the hearing loss.	DSDHH, Local Consortia, Pediatricians, Audiologists, Public Schools, other organizations, i.e., BEGINNINGS
2. Develop an intake/referral form (4 copy NCR) and process so that all referrals of newly identified children with hearing loss received by BEGINNINGS will be referred simultaneously to the Local Consortia, Schools for the Deaf and Local Education Agencies as appropriate within two (2) days of referral to BEGINNINGS.	State (multi-agency) DSDHH, Local Consortia, other organizations, i.e., BEGINNINGS

Section D: Early Intervention and Education Development	
Recommendation	**System Level**
1. Establish a special fund for DHR education and early intervention programs through legislative action to provide new teacher and teacher assistant positions in response to: increases in numbers of infants, toddlers and preschoolers receiving and/or needing services; increase in complexity of child(ren)'s disabilities; and/or the distance of child's residence with respect to currently available services.	DHR, Legislature
2. Establish interagency multidisciplinary committees to study and make recommendations to improve recruitment, salary levels and the hiring process for teachers, teacher assistants and related service staff with emphasis on an expeditious hiring process.	DHR, OSP, Legislature
3. Establish an interagency multidisciplinary committee, including teachers of each language and methodology, to study and recommend caseloads for teachers, teacher assistants, related service staff and those providing consultation to other agencies in recognition of issues and needs presented by different methodologies used in educating infants, toddlers and preschoolers who are deaf or hard-of-hearing.	DMH/DD/SAS, DPI, DSDHH, NC Schools for the Deaf, Public Schools
4. Provide access to assistive and educational technologies for preschool programs and provide training for staff to support use of technologies.	DEHNR, DMH/DD/SAS, DSDHH, NC Schools for the Deaf, other agencies, i.e., BEGINNINGS
5. Support developmentally appropriate environments in early intervention programs and preschools in which serve infants, toddlers and preschoolers who are deaf or hard-of-hearing.	DEHNR, DMH/DD/SAS, DSDHH, NC Schools for the Deaf
6. Provide appropriate services and placement for mainstreamed children who are deaf or hard-of-hearing. Provide mainstream teachers or caregivers with training and support.	DSDHH, DCD, NC Schools for the Deaf, Public Schools, other agencies, i.e., BEGINNINGS
7. Establish a mentor program to provide support and train teachers, teacher assistants and related services staff who work with children who are deaf or hard-of-hearing knowledge and skills in developing language and English literacy through different communication philosophies	DSDHH, NC Schools for the Deaf
8. Establish guidelines and administer a state quality assurance evaluation for Cued Speech transliterators.	DSDHH, other organizations, i.e., Cued Speech Center
9. Increase awareness of needs of children with cochlear implants.	DSDHH, NC Schools for the Deaf, Public Schools, other agencies i.e. BEGINNINGS
10. Increase consultation services to LEA's and daycare providers to increase success levels of children who are hard-of- hearing.	DSDHH, DPI, NC Schools for the Deaf, Public Schools, other agencies i.e. BEGINNINGS
11. Review and expand year-round, complete services for birth-	DSDHH, NC Schools for the

two population and preschoolers as required by IDEA, Part H statutes.	Deaf, Local Childcare Facilities
12. Coordinate wrap-around services to families in part-time educational programs.	DMH/DD/SAS, DCD, DSDHH, Preschool Programs, Local Childcare Facilities
13. Support training of quality day care providers by professionals in the area of deaf and hard of hearing education.	DSDHH, Preschool Programs Local Childcare Facilities
14. Establish state-wide resources for support, outreach and technical assistance using regional teams of specialists in early childhood development and deafness to provide technical assistance and support regarding assessment, referral, educational recommendations, professional development, child service coordination, family support and mentoring to professionals serving children who are deaf or hard of hearing.	DSDHH, Legislature, NC Schools for the Deaf
15. Require teachers of children who are deaf or hard of hearing, 0-2 years old, to have the infant toddler personnel certificate	DSDHH, NC Schools for the Deaf
16. Establish procedures for a national search to fill vacancies to develop a diverse staff with a variety of educational and experiential backgrounds.	DSDHH, OSP
17. Amend local interagency agreements to include assessment and documentation of needs and to identify methods for addressing specific needs via the IEP.	DPI, DSDHH, Local Interagency Councils, Local Consortia, Public Schools, NC Schools for the Deaf
18. Support efforts to provide supplements for DHR teachers.	Legislature, DHR, OSP, DSDHH
19. Establish an implementation committee to carry forth the recommendations.	DMH/DD/SAS, DPI, DSDHH, DEHNR, NC Schools for the Deaf, Public Schools
20. Plan and implement an outcome based systems evaluation regarding approaches to service delivery for children who are deaf or hard of hearing.	DMH/DD/SAS, DSDHH

Section E: Enhance Parent Education and Support	
Recommendation	**System Level**
1. Expand parent education and support programs to provide consistent support to parents.	DSDHH, Schools for the Deaf, other organizations, i.e., BEGINNINGS, Cued Speech Center
2. Develop a consistent child service coordination program in the Schools for the Deaf Preschool Programs.	DEHNR, DSDHH, Schools for the Deaf, other organizations, i.e., BEGINNINGS, Cued Speech Center
3. Provide training to parents of children enrolled in the DSDHH infant toddler and preschool programs in the communication mode of their choice to ensure consistency of support the use of the chosen language or methodology, i.e., American Sign Language, Auditory/Oral, Auditory/Verbal, Cued Speech, and Oral.	DSDHH
4. Establish resources to provide in-home training to parents specific to the chosen communication mode/language for parents unable to attend classes away from home.	DSDHH, NC Schools for the Deaf
5. Encourage use of a family support network	DPI, DSDHH, FSN, NC Schools for the Deaf
6. Provide consultation to child care centers who serve children who are deaf or hard-of-hearing.	DSDHH, NC Schools for the Deaf, other agencies, i.e., BEGINNINGS
7. Provide quality audiological services to maximize use of residual hearing of children who are deaf or hard-of-hearing.	DSDHH, NC Schools for the Deaf, other agencies, i.e., BEGINNINGS
8. Provide counseling to families of children who are deaf and hard-of-hearing.	DMH/DD/SAS, DSDHH, Schools for the Deaf, other agencies, i.e., BEGINNINGS
9. Continue parent involvement on advisory boards and committees for DSDHH and LEAs.	DSDHH, NC Schools for the Deaf, Public Schools
10. Develop an interagency list of resources available for English and non-English speaking citizens, such as information brochures, lists of interpreters, translators and transliterators for all languages or communication methods represented in North Carolina.	DSDHH, other organizations, i.e., BEGINNINGS and other organizations
11. Support production of a simple brochure (3rd-5th grade reading level) in languages needed by families to access the elements of each communication philosophy/methodology with emphasis on the importance of beginning some form of consistent communication immediately.	DSDHH, other organizations, i.e., BEGINNINGS

Section F: Professional Development	
Recommendation	**System Level**
1. Provide training opportunities for educational and support staff (social work, child care, educational psychology, audiology) to develop skills needed to evaluate, teach and support children who are deaf or hard-of-hearing and their families.	DSDHH, NC Schools for the Deaf, other agencies, i.e., BEGINNINGS
2. Provide training opportunities in areas of deafness and deaf culture sensitivity.	DSDHH, NC Schools for the Deaf
3. Expand and improve collaborative pre-service mentoring programs between teacher training programs and LEAs, infant/ toddler agencies, and/or Schools for the Deaf for training teachers in early intervention/education, birth-to-five population.	DPI, DSDHH, NC Schools for the Deaf, Public Schools, Teacher Training Programs
4. Provide on-going professional development including on-site mentoring and field experiences at in-state exemplary sites with emphasis on developmentally appropriate practice, play-based curriculum, teaching within the child's environment, incidental learning and naturalistic language.	DPI, DSDHH, NC Schools for the Deaf, Public Schools, Child Care Facilities
5. Develop policies and strategies to enhance and facilitate statewide training opportunities for direct and indirect services personnel associated with early intervention and education of children birth-to-five, who are deaf or hard-of-hearing.	DEHNR, DMH/DD/SAS, DSDHH, DMCH, DEC's, NC Schools for the Deaf, Public Schools
7. Promote a family-centered approach throughout the process of identification, referral, early intervention planning and service delivery.	DEHNR, DMH/DD/SAS, DSDHH, NC Schools for the Deaf, Public Schools, other agencies, i.e., BEGINNINGS
8. Provide a statewide personnel preparation program through interagency collaboration .he use of the chosen language or methodology, i.e., American Sign Language, Auditory/Oral, Auditory/Verbal, Cued Speech, and Oral.	DHR, DPI, DSDHH

GLOSSARY OF ACRONYMS

COED	**Council on Education of the Deaf**
DAP	**Developmentally Appropriate Practices**
DCD	**Division of Child Development**
DEC	**Developmental Evaluation Center**
DEHNR	**Division of Environmental Health and Natural Resources**
DPI	**Department of Public Instruction**
DHR	**Department of Human Resources**
DMCH	**Division of Maternal Child Health**
DMH/SAS/DD	**Division of Metal Health/Substance Abuse/Developmentally Delayed**
DSDHH	**Division of Services for the Deaf and Hard of Hearing**
EIPC	**Early Intervention Planning Committee**
FSN	**Family Support Network**
IFSP	**Individual Family Support Plan**
IEP	**Individual Education Plan**
LEA	**Local Education Agency**
LICC	**Local Interagency Coordinating Council**
OSP	**Office of State Personnel**
UNC-CH	**University of North Carolina at Chapel Hill**

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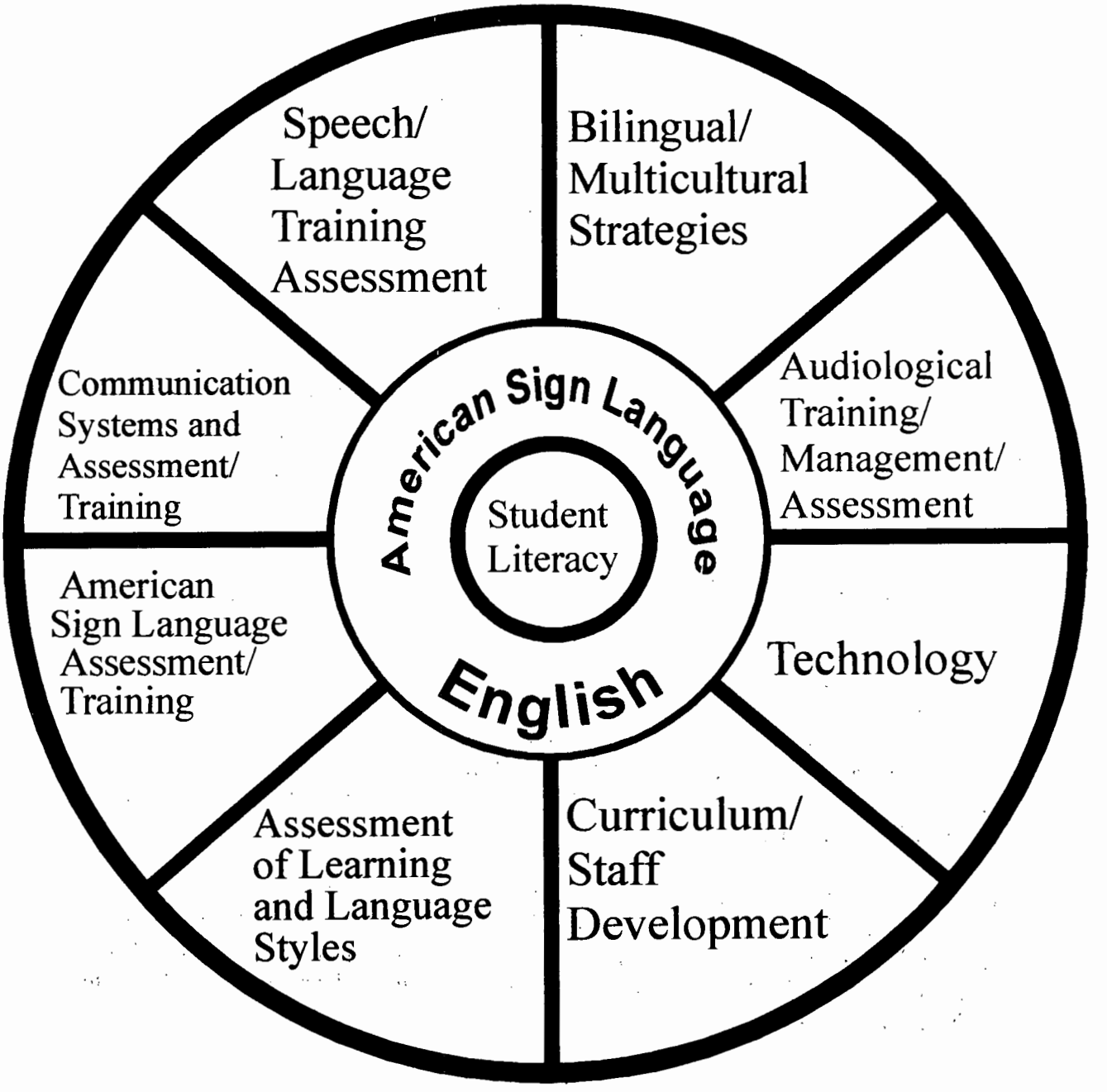
ENCSD Strategic Plan:

. . . Zoned for Learning 1997-2002

Eastern North Carolina School for the Deaf
Wilson, North Carolina
July 1997

Statement of Philosophy:

The primary mission of the Eastern North Carolina School for the Deaf (ENCSD) is to educationally address each enrolled student's social, physical, intellectual, cognitive, and emotional needs. The mission includes prevocational and vocational education, and transitional employment/living services. The mission is carried out through cooperation with state and local education agencies.



Clientele:

The Eastern North Carolina School for the Deaf provides a day/residential program for students, birth to eighth grade, who are deaf and hard of hearing and live in 48 of the most eastern counties of the state. ENCSD expands to a 54 county area to serve students 9th - 12th grades. ENCSD, like the other two schools for the deaf in North Carolina, has a primary and secondary clientele.

Primary Clientele

Referrals of children from birth to three years of age originate with the audiologists, early intervention professionals, health care professionals or parents and are channeled through consortiums. All school-age referrals must originate from the Local Education Areas (LEAs), and all school placements continue to be tracked for individual appropriateness by the LEA.

Current trends indicate that roughly one-third of the K-12 students are day students and two-thirds are residential students. On the ENCSD campus, students may attend preschool through the twelfth grade. Off campus, ENCSD has ten Preschool Satellite classes.

Preschool students constitute roughly one third of the total ENCSD enrollment. Integral components of the preschool program are the itinerant teachers who serve children and parents through contacts at home or day care centers. They network with audiologists, health care professionals and early intervention programs across the eastern counties of North Carolina.

Preschool parents and children are equally significant consumers of services. Goals on the IFSP and IEP address both the needs of parents or other family members and the child him/herself. Home visits and/or sign language classes for parents are regularly scheduled by preschool staff.

Students with multiple disabilities are served campus-wide. Students who are deaf or hard of hearing with visual problems or legal blindness, brain damage, attention deficit/hyperactivity disorder, emotional/behavioral disturbance, epilepsy, orthopedic disability, cerebral palsy and other disabilities are served.

Inclusion opportunities with children who are hearing are facilitated through mainstreaming in Wilson County Public Schools, the Wilson Technical Community College, and the Wilson Recreational Center. Discussion and planning is presently taking place to establish a collaborative arrangement with Wilson's charter school, the Sally B. Howard School.

Secondary Clientele

Parents/Guardians
LEAs
Parent-Staff Organization at ENCSD
Educational Organizations (i.e. NAEYC, CEASD, SACS)
Community Advocacy Organizations
Developmental Evaluation Centers
Pediatricians
Health Department
Wilson County Schools
Barton College
Duke University
Eastern Carolina University
Lenoir-Rhyne College
University of North Carolina - Greensboro
Current and Potential Employers
The Deaf Community
ENCSD Alumni

Administrative Overview:

ENCSD is one of three schools for the deaf in the NC Division of Services for the Deaf and Hard of Hearing, which is a division of the NC Department of Human Resources (DHR). Each school has a Superintendent.

At the Eastern North Carolina School for the Deaf the administration consists of three teams. The Administrative Management Team (AMT) consists of the Personnel Manager, Director of Development, Director of Curriculum / Instruction, Director of Student Services, Director of Student Life, Business Manager, Director of the ENCSD Foundation, and the Superintendent. The Instructional Management Team (IMT) consists of program principals, lead teachers, the Director of Curriculum / Instruction, the Director of Student Life, and the Superintendent. The Joint Supervisory Team (JST) consists of approximately 20 program managers campus wide.

The school budget for fiscal year 1996-97 was $9.6 million of state appropriations of which approximately 86.48% was salaries. ENCSD employs 272 staff to provide Sunday evening through Friday afternoon programming and care for its 315 students.

Preparation for Strategic Planning:

ENCSD's strategic plan is a result of several years of evolution which basically began with the publication of The Task Force on Quality Assurance for the Deaf and Hard of Hearing Report in 1992. It was this report that identified the framework for the Strategic Plan. Following this report two defining factors directly related to programming at the Eastern North Carolina School for the Deaf took place during the 1993-94 school year. During this time, ENCSD conducted an intense self-study in preparation for the accreditation visits by the Conference of Educational Administrators Serving the Deaf and the Southern Association of Colleges and Schools. Also, the Central Office in the Division of Services for the Deaf and Hard of Hearing conducted a Program Audit of each of the three schools. The results of these studies further defined the direction and program development at ENCSD.

In the two following school years, 1994-95 and 1995-96, the school community analyzed and assessed the findings and recommendations of the above mentioned studies and reports resulted in the identification and formulation of a vision, mission statement, common beliefs and values, and the goals set forth in this 'ENCSD Strategic Plan: . . . Zoned for Learning 1997 - 2002' document.

Distribution Plan:

The 'ENCSD Strategic Plan: . . . Zoned for Learning 1997 - 2002' will be distributed to the staff at the opening of the 1997-98 school year along with an overview. The ENCSD Strategic Plan will also be shared with the following:

CNCSD
DHHS Deputy Secretary
DHHS Secretary
DPI Consultant for DHH
DSDHH Central Office
Eastern Catchment Area LEAs
ENCSD Foundation Board
ENCSD Parents
ENCSD PSO Officers
Future ENCSD Employees
Local Legislators
NCSD
NCSsD School Board

Annual reviews of ENCSD's progress as related to the strategic plan will be shared at the close of each school year with the ENCSD staff, parents, and Central Office community.

Recognition of Contributors:

The 'ENCSD Strategic Plan: . . . Zoned for Learning 1997 - 2002' is the culmination of 3-4 years of work. Documents critical to the development of the Strategic Plan such as the reports of the CEASD Accreditation Self-Study, the Southern Association of Colleges and Schools Self-Study, the ENCSD Five Year Technology Plan, the ENCSD Strategic Planning Sequence, and many other documents listed as Resources for Strategic Planning provided the parameters for the plan.

It is impossible to recognize all who were involved in the strategic process at ENCSD at one time or another. These persons include staff, parents, and community members. Key personnel who lead the process include: Dr. Lillian Blakesley, Director of Curriculum and Instruction; Mr. Gary Farmer, Director of Student Life; Mrs. Brenda Farmer, HS Principal; Mrs. Judy Hansley, Business Manager; Mrs. Bonnie Pike, K-8 Principal; Mrs. Diane Pope, Preschool Director; Ms. Roanne Rowan, Lead Teacher for Technology and Instructional Support Services; Mr. Bill Sharpe, Director of Development; Mr. Hal Wright, Principal-Student Support Services.

Vision:

Working together to promote excellence
and quality for all

A place where everyone comes together to promote learning
(Spring 1995).

Mission:

The Eastern North Carolina School for the Deaf affirms that all children who are deaf and hard of hearing have unlimited potential. Given that belief, the Eastern North Carolina School for the Deaf provides a challenging learning environment which prepares each child for a meaningful and productive life in a changing world (Spring 1996).

Beliefs and Values:

- All children can learn and are expected to learn given the appropriate individualized educational environment.
- Access to free and appropriate education is the birth right of all children.
- High levels of knowledge and skills are necessary for the jobs of the future.
- Learning is continuous and needs to be in a collaborative environment.
- All children who are deaf or hard of hearing are entitled to a communication learning environment.
- Family and community play an integral role in the development of children who are deaf or hard of hearing (Spring 1996).

Challenges:

- 70-80% of the adults who are deaf and hard of hearing in this country and in North Carolina are on SSI.

- Statistics show the average reading level for persons who are deaf and hard of hearing at a 3rd - 4th grade level.

- On the average ENCSD students are performing below the national average of students who are deaf or hard of hearing according to 1994 SAT-HI demographics.

- The world of work for the children of our future is not what it was for our parents nor as it is now for you and me. There are basic assumptions: no longer will a high school diploma assure a well paying job...no longer will employment assure permanent job security or re-employability...no longer will workers be able to get by without literacy and basic computer skills.

- The approach to "Deaf Education" at ENCSD, as has been the general practice across the United States, hasn't been the answer to educating children who are deaf or hard of hearing to levels commensurate with their intellectual abilities (Spring 1996).

Keys to Success:

- Early identification of the hearing loss
- Successful involvement of the family with the child's life and education
- Early and *effective* communication environment
- Belief in the child's ability to achieve, and to do so independently
- High Self-esteem
- Successful implementation of a team approach (including family) in the child's education
- Responsiveness of the child's individualized education program to the changing and immediate needs of the child
- Successful transition from the school/family environment [dependence] to the world outside the school environment [independence] (Summer 1996).

General Program Goals:

- All students having equal opportunity to learn and succeed.
- High expectations and achievements for all students.
- A coherent curriculum stressing literacy as the first and most essential goal.
- An environment conducive to learning:
  - commitment
  - resources
  - health/safety
  - nutrition
  - accessibility
  - facilities
- A commitment to character development:
  - honesty
  - respect
  - responsibility
  - compassion
  - self-discipline
  - perseverance
  - giving

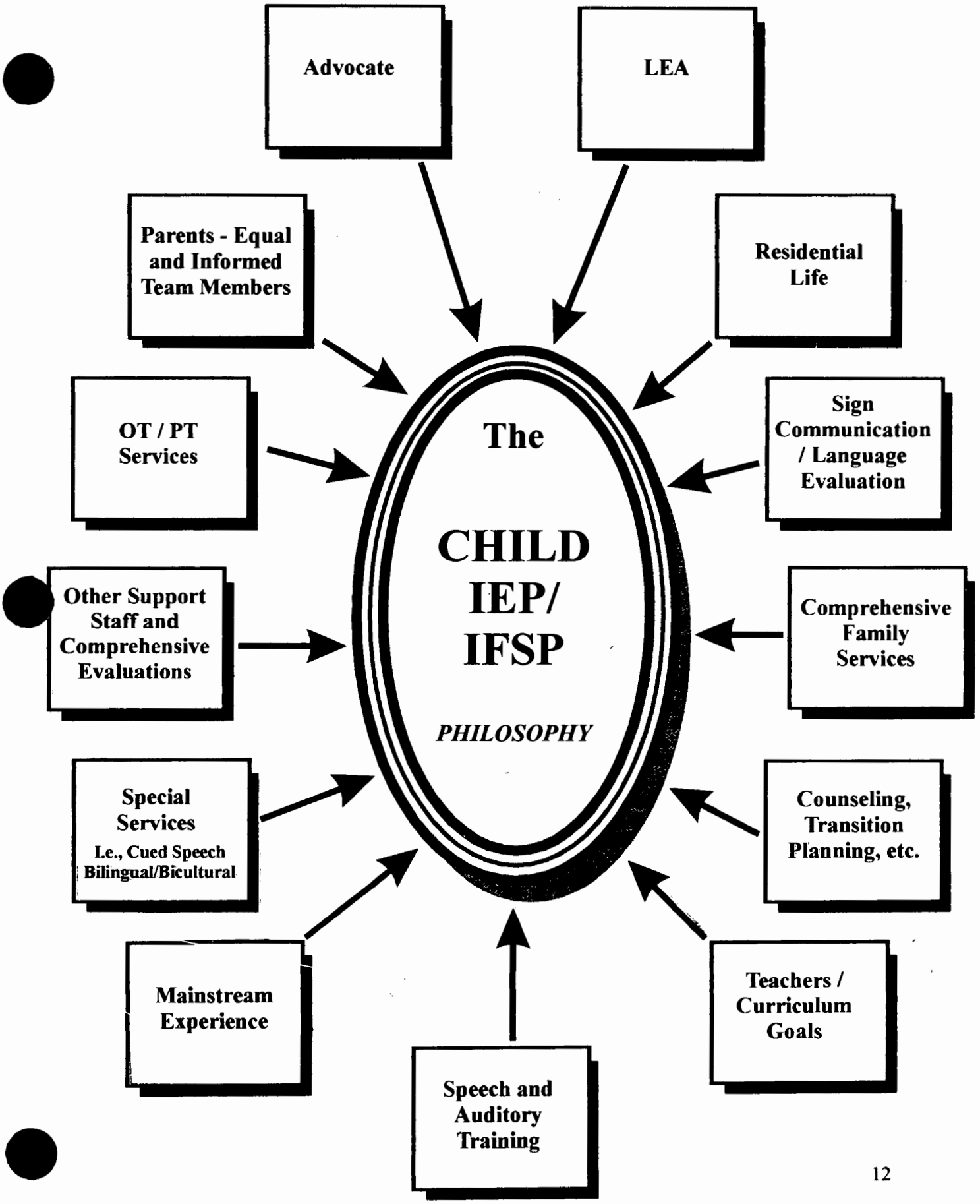
Educational Goals for All Students:

- To communicate effectively
- To acquire a core of knowledge
- To be a motivated learner
- To feel a sense of well being
- To live responsibly

Through the core academic and residential curriculum students graduating from the Eastern North Carolina School for the Deaf will effectively demonstrate the ability to:

- Read with comprehension
- Communicate, write, and comprehend
- Use basic mathematics skills
- Solve problems
- Think critically
- Apply a knowledge of science and social studies
- Use social and interpersonal skills
- Use technology
- Use independent living skills
- Apply study skills
- Apply leisure/recreational living skills

Process


Advocate
LEA
Parents - Equal and Informed Team Members
Residential Life
OT / PT Services
Sign Communication / Language Evaluation
The
CHILD IEP/ IFSP
PHILOSOPHY
Other Support Staff and Comprehensive Evaluations
Comprehensive Family Services
Special Services
I.e., Cued Speech Bilingual/Bicultural
Counseling, Transition Planning, etc.
Mainstream Experience
Teachers / Curriculum Goals
Speech and Auditory Training

Strategic Objectives:

- High Student Performance
- Quality Instructional, Residential and Support Staff
- A Safe and Orderly Environment
- Efficient and Effective Organization
- Outreach - Serving as a Resource
- Communication Modalities
- After School and Residential Development
- Value Technology - Campus Wide

Eastern North Carolina School for the Deaf
July 1997

PRIORITIES

GOALS

PLANS

ASSESSMENTS

Eastern North Carolina School for the Deaf Strategic Plan

July 1997 - June 2002

Priority	Goals	Plans	Assessment
High Student Performance	I. Increase language learning opportunities to assure student readiness for academic instruction. II. Student centered instruction leading each student to master essential skills for literacy and general knowledge. III. The development and implementation of rigorous and relevant curriculums and instructional approaches that include: a. academic standards b. learning styles c. high levels of thinking/problem solving skills d. independent living, leisure and social skills e. the arts f. informal and formal assessments	Provide comprehensive and language rich environments in all areas of school programming with ongoing formal and informal assessments. Provide ongoing staff development for educational and residential staff promoting effective teaching and bringing students to literacy. Implement an integrated curriculum K-12, as appropriate, which includes current technology and the use of "best practices" in education. Use of a variety of informal and formal assessments to include but not be limited to portfolios, standardized testing, student projects, video taping, informal and formal observations.	Documentation of staff development in areas such as learning styles, integrated curriculum, language development, literacy, social skills, and sign language, etc. Documented changes in staff interactions with students in structured, as well as, unstructured situations. Student schedules that reflect an integrated curriculum and individual needs. A portfolio of assessments for each student. An average increase of one year's growth for one year of programming.

Eastern North Carolina School for the Deaf Strategic Plan

July 1997 - June 2002

Priority	Goals	Plans	Assessment
Quality Instructional, Residential, and Support Staff	I. Develop a system to recruit and retain quality educational, residential and support staff. II. Support a system of continuous learning to ensure quality performance. III. Support a system of continuous learning to ensure all employees are sensitive to diversity. IV. Establish high educational, ethical and professional standards for all employees.	Local, state and national recruiting via vacancy announcements, professional publications, minority publications and the internet. Educational assistance for employees based on annual priorities. Diversity and sensitivity training. Develop employee handbooks for each major department within the school. Performance Management tools to address ethical and professional standards.	Documentation of recruiting efforts. Increase in the number of employees who are minorities. Employee handbooks for each major department within the school. Documentation of educational assistance provided to employees. Documentation of Diversity / Sensitivity training opportunities, sign language competencies and a marked improvement in the organizational climate.

Eastern North Carolina School for the Deaf Strategic Plan

July 1997 - June 2002

Priority	Goals	Plans	Assessment
A Safe and Orderly School	I. Create a wholesome learning environment that supports all students achieving high standards. II. Ensure that facilities are esthetically pleasing, safe, and meet at least minimal state and federal standards. III. Establish discipline needed for mutual respect of employees, students and parents. IV. Create a school environment free of drugs and harmful behaviors.	Scheduling that accommodates student learning. Use the F-CAP as a guide for addressing safety and major maintenance issues. Employees to submit workorders as needed. Revise the school Code of Conduct and Discipline Policy as frequently as needed. Provide educational and residential staff with Cooperative Discipline training. Develop policy and procedures for dealing with violent / aggressive students and/or staff.	School climate surveys, documentation of schedules, feedback, observations. Facility improvements. ENCSD Code of Conduct and Discipline Policy - documentation of disciplinary actions. Documentation of staff development in the area of student management and discipline. Policy and procedure document for dealing with violent and aggressive students and/or staff.

Eastern North Carolina School for the Deaf Strategic Plan

July 1997 - June 2002

Priority	Goals	Plans	Assessment
Efficient and Effective Operation	I. Create a unified system that aligns all efforts to achieve high performance. II. Establish control and decision making at all levels. III. Establish an appropriate system of funding that aligns resources with needs and goals. IV. Develop internal and external partnerships to support bringing students to literacy and high performance. V. Develop accountability and information systems capable of reporting strategic/operational results sufficient to monitor and improve programming	Develop/create multi-dept. work groups to facilitate communication and decision making. Set up a multi-approach to increase effective communication program wide. Move responsibility of budget expenditures to department levels. Promote student activity in the community - develop partnerships with local industry schools, parents and alumni. Establish technological support for accountability and information systems - train appropriate staff.	Documentation of work groups. Organizational Climate survey. Documentation of effective communication mediums. Department based budgets. Collaborative opportunities with the community, local schools, industry, parents and alumni. Verification of technological support and staff training for accountability and information systems. Accountability and information data reports.

Eastern North Carolina School for the Deaf Strategic Plan

July 1997 - June 2002

Priority	Goals	Plans	Assessment
Outreach: Serving as a Resource	I. Educational programming to be accomplished through cooperative and reciprocal planning between sections within DPI and the divisions within DHR. II. ENCSD to establish model demonstration programs. III. ENCSD to serve as a resource for LEAs in the eastern region of NC. IV. To provide comprehensive diagnostic evaluations, prescriptive programming alternatives, direct and indirect services, and evaluative referral services to DHH children free of bias.	Set up multi-disciplinary meetings to address special circumstances. Loan and borrow specialized staff on an as needed basis. Create a model a. preschool/day care program b. K-12 program c. Independent living program d. K-12 residential program Commitment of staff, time and financial support to provide external evaluations and LEA support. Training of staff for the purpose of being unbiased.	Documentation of collaborative efforts between agencies including the sharing of staff. Information dissemination about model programs - documentation of observations, information requests and presentations. A 50% increase in external evaluations over the five year period of time. Documentation of staff development opportunities that demonstrate knowledge of all communication / philosophical approaches. An increase in the number of referrals during the 5 yr. period.

Eastern North Carolina School for the Deaf Strategic Plan

July 1997 - June 2002

Priority	Goals	Plans	Assessment
Communication Modalities	I. Eighty to 85% of the staff working in programming with students who use sign language shall have sign language proficiency levels equal to or better than the level identified for their position in the SCPI policy. II. Sign classes and other communication modes of various levels will be provided. III. Ninety to 95% of the staff working in programming with students who use other modes of communication shall be proficient in the mode of communication of the students. IV. ENCSD shall be a communication learning environment.	ENCSD to work with DSDHH in identifying a support system to conduct SCPI evaluations on a regular basis. ENCSD to collaborate with WTCC and other resources to provide appropriate level sign language, cued speech and auditory verbal classes to staff. Sensitivity training for all employees related to communication needs of staff and students. Create incentive program to promote signing in the presence of the D/HH on campus. Identify/adopt an evaluation system for modes of communication other than sign language.	Documentation on the number of staff at or above their expected level of proficiency. Adoption of other evaluative tools for assessment of Cued Speech and Auditory Verbal communication modes. Documentation of sensitivity and communication training for all staff. Improvement in organizational climate as it relates to signed communication on campus. Documentation of incentives and success or lack of success rate.

Eastern North Carolina School for the Deaf Strategic Plan

July 1997 - June 2002

Priority	Goals	Plans	Assessment
Providing for the Total Development of the Students in the After-School and Residential Living Programming	I. Enhance Student Development as it relates to the student's individual level of maturity and ability. II. Enhance communication avenues and skills between students, staff, parents and administration. III. Enhance peer interaction to assist students with their daily social, emotional and development skills. IV. Enhance Staff Development in the growth of professional and paraprofessional training as it relates to student contact and programming. V. Enhance Extra-Curricular activities for the development of more well-rounded students.	Use Student Development Curriculum with added emphasis on consumerism, communication, humanities, character education and student involvement. Establish student council, advisory groups, town meetings, sign lanugage classes, newsletters, etc. Utilize and expose students and staff to technology throughout the after school / residential program. Provide staff with in-service training in Core and Student Development Curriculums. Set up a variety of after-school opportunities for students - clubs, sports, special interest activities, IM, outdoor education etc.	Comparison of student activity schedules in a five year period. Feedback from students, parents and staff. Documentation of communication efforts and enhancements. Fifty to 60 percent of staff and students proficient in use of computer technology according to their level of ability and maturity. Documentation of staff development opportunities. Decrease in the need for discipline measures during the after-school / residential programming.

Eastern North Carolina School for the Deaf Strategic Plan

July 1997 - June 2002

Priority	Goals	Plans	Assessment
Value Technology: Program Wide	I. All staff, as needed, proficient in the use of computer and other technology. II. All students graduating with a diploma or occupational preparation diploma passing the state mandated Computer Literacy Test. III. Establish the Library as the hub of technology on campus. IV. Complete and continue to update the ENCSD LAN system. V. Installation of video technology campus wide to enhance student programming. VI. To comply with the State Technology Plan.	Provide opportunities for computer classes to staff. Require computer competencies on DPI licensed staff. Implement computer literacy throughout the curriculum. Administrative commitment via the budget to continued growth in computer technology throughout the school program. Hire a LAN manager and continue with a Lead Teacher of Computer Technology/ Library-media. Seek partnerships with business to enhance the program's technology.	Documentation of staff development opportunities related to computer/technology. Success rate on performance evaluations as the work task applies to the use of computers / technology. Budget support of computer / technology during a five year period. Employment of LAN manager and Lead Teacher. Evidence and documentation of partnerships that enhance computer/technology.

Resources for Strategic Planning:

- DHR/DSDHH Task Force Report (1992)
- Self-Study Report for Joint Accreditation [Judgment & Recommendations] (1994)
- Program Audit of the North Carolina Schools for the Deaf - Statewide Summary (1994)
- ENCSD Program Audit (1994)
- ENCSD Needs Assessment - CEASD/SACS Recommendations (1994)
- ENCSD Five Year Technology Plan (1995)
- Six Year Capital Improvement Schedule (1996)
- NC State Facility Condition Assessment Program Document (1996)
- Reserve for Repairs and Renovations - Priority List of Requested Projects for ENCSD (1996)
- ENCSD Strategic Planning Sequence (1994-96)
- School Technology Users Task Force Report - NC Department of Public Instruction (1995)
- Learning Connections: Guidelines for Media and Technology Programs, Division of Media and Technology Services, NC Department of Public Instruction

NOTES

11-19-97
attachment #6

Strategic Plan:

An Agenda for Action

North Carolina School for the Deaf
Morganton, NC
1996

A Document Prepared by the
Strategic Planning Committee of the
North Carolina School for the Deaf at Morganton

Committee Members:

Jimmy Autrey
Terri Barret
Mary Bryant
Doug Caraway
Sandra Clark
Sandy Heffinger
Marilyn Lingerfelt
Andrew Massengill
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NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES

NORTH CAROLINA SCHOOL FOR THE DEAF

AT MORGANTON

517 WEST FLEMING DRIVE · MORGANTON, N.C. 28655

(704) 433-2951 (VOICE/TDD)

JAMES B. HUNT, JR., GOVERNOR
C. ROBIN BRITT, SR., SECRETARY

GARY E. MOWL, M.S.
SUPERINTENDENT

May 10, 1996

Dear NCSD Staff,

I am extremely pleased to present to you the NCSD Strategic Plan. This strategic planning document is a collaboratively developed plan that will guide NCSD into the future.

I would like to express sincere appreciation for the tremendous effort and outstanding service to the development of this plan by the members of the Strategic Planning Committee. In addition, I would like to thank the members of our staff and the NCSD community for contributing ideas, suggestions and feedback to the committee as the plan was in the developmental stages.

NCSD has had a very proud and rich history. The implementation of this Strategic Plan will continue to raise our commitment to excellence in the education of deaf and hard-of-hearing students even further. I am very excited about the plan and am looking forward to acting upon the recommendations. I trust that the staff along with the support of our students and their parents and our many friends from the NCSD community will enthusiastically embrace and implement the Strategic Plan.

I look forward to working with you as we boldly begin facing the future.

Sincerely yours,

Gary E Mowl

Gary E. Mowl, M.S.
Superintendent

ACKNOWLEDGMENTS

The Strategic Planning Committee recognizes that its work would not have been possible without the hard work and generous contributions of numerous individuals and organizations. The Strategic Planning Committee, in soliciting feedback from various aspects of the NCSD campus, has been very pleasantly surprised by the quality of input from individuals and groups. Input has been provided either in written form or via verbal communication and always with the sincere interest of NCSD students foremost in mind. The committee wishes it could name all the individuals and campus organizations that contributed to the development of the Strategic Plan, but this page cannot possibly contain such a long list!

However, to be commended in particular is Kim Collins, who assisted the committee with various tasks such as distributing memoranda among committee members, copying NCSD and committee documents and coordinating communication between committee members and with NCSD staff. Despite a tremendous workload, Kim has always managed to comply with committee requests for assistance with a warm smile.

The committee also wishes to acknowledge the contribution of two institutions which came in the form of their excellent examples of strategic planning. The committee has assiduously studied their printed plans for strategic change and gleaned many valuable ideas from their pages. One institution is a well-respected NCSD neighbor, Western Carolina Center. The other one is the National Technical Institute for the Deaf (NTID) in Rochester, New York.

The committee would like to highlight in particular the fact that it has adapted numerous ideas and specific sections from NTID's own Agenda for Action. Without their splendid example, NCSD's Strategic Planning Committee would most likely still be in the infancy of its Strategic Plan development at this time of printing!

INTRODUCTION

NCSD's Agenda for Action is the brainchild of superintendent Gary E. Mowl, who saw a need for NCSD to develop a strategic plan to meet the challenges of educating and developing Deaf and Hard of Hearing children and adolescents in preparation for the 21st century. Simply put, any organization, such as NCSD, that boasts a wide disparity in staff, programming and services is in need of a strategic plan that enables the organization to function as a cohesive unit with a single vision. Such cohesion and focus of purpose will carry NCSD a long way toward achieving its goal of excellence in the education and development of its students.

Procedure for the Development of the Strategic Plan

The Strategic Planning Committee met once a week, beginning in October 1995. These weekly meetings often involved spirited discussions about various aspects of NCSD, but focus was continually maintained on the student. Much of the committee's work entailed soliciting input from the entire NCSD community and familiarizing itself with the contents of critical documents such as reports from Southern Association of Colleges and Schools (SACS) and Conference of Educational Administrators Serving the Deaf (CEASD) accreditation committees and the Department of Human Resources Audit. Consensus was often the rule in the development of recommendations.

Committee Membership

The Strategic Planning Committee is composed of nine members who represent a broad cross-section of the NCSD community and selected in a largely democratic manner. The composition of the committee is as follows:

1. four NCSD staff representatives selected by the Administrative Management Team and the Instructional Management Team (AMT/IMT) based on nominations received;
2. one AMT/IMT representative selected by the AMT/IMT based on nominations received;
3. one student representative selected by the Student Body Government;
4. one parent representative selected by the Parent Staff Organization;
5. one alumni representative selected by the NCSD Alumni Association;
6. one community-wide representative selected by the Superintendent.

About Agenda for Action

Agenda for Action is designed to be used as a working document and as the central guide in the functioning of NCSD. It is by no means intended to supplant the recommendations of accrediting bodies; rather, it is to expand upon those recommendations and reach for the highest ideal of excellence in the education and development of all NCSD students.

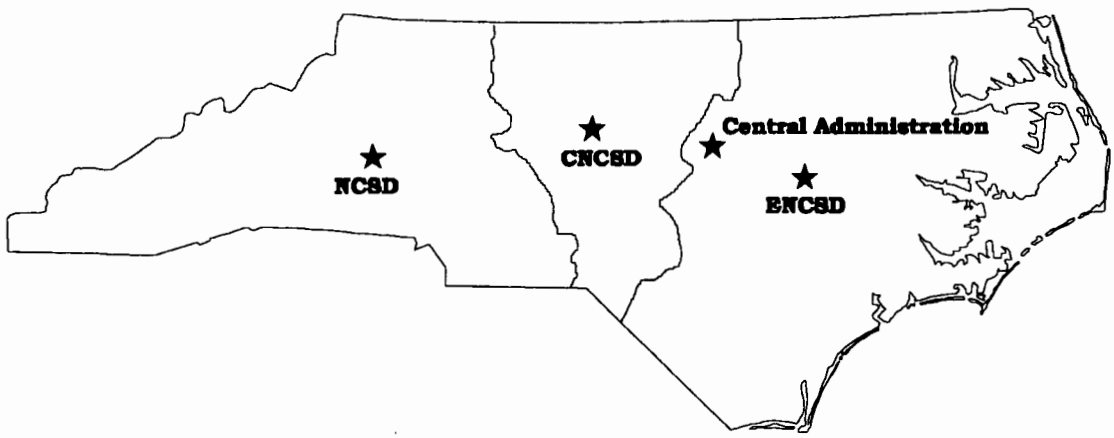
Department of Human Resources

DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING

NORTH CAROLINA SCHOOLS FOR THE DEAF

Mission Statement

ALL DEAF AND HARD OF HEARING CHILDREN HAVE UNLIMITED POTENTIAL. GIVEN THAT BELIEF, THE NORTH CAROLINA SCHOOLS FOR THE DEAF PROVIDE A CHALLENGING LEARNING ENVIRONMENT WHICH PREPARES EACH CHILD FOR A MEANINGFUL AND PRODUCTIVE LIFE IN A CHANGING WORLD.



MISSION STATEMENT ELABORATION WITH OPERATIONAL GOALS AND PRIORITIES

NCSD will provide an outstanding, progressive and inclusive public education with a boarding option, appropriate for deaf and hard-of-hearing students from birth to 21. The educational opportunities available through various programs and services at NCSD will prepare students to be self-sufficient and productive citizens. NCSD's educational endeavors will involve an active and on-going partnership with parents and collaboration with the community.

The educational experience provided for the deaf or hard-of-hearing students at NCSD will be the most appropriate and enriching in the least restrictive environment possible. NCSD will strive to maintain the highest quality professional staff along with the best ancillary services available specifically suited to meet the needs of each individual student attending. Programs and services available at NCSD will adopt a basic tenet that *all* children can and will learn.

- NCSD will strive for inclusion of each student's family in his or her educational experience. Outreach programs specifically designed for the families of NCSD students will be made available.

- Academic programs at NCSD will offer students programs for transition into either higher education or into vocational careers upon completion of studies.

- NCSD will provide full communication access to all Deaf and Hard of Hearing students with respect for the individual student's and parent's preferences and with an unbiased respect for the integrity of languages and learning modalities.

- Positive self-esteem for students shall be developed and fostered through exposure to positive role models in both the Deaf and hearing communities. Students will be encouraged to fulfill their maximum potentials.

- Student development will include programs and activities which aid in the development of a well-rounded, responsible individual. Attention to the cognitive, affective, psychomotor, perceptual and physical domains is included.

- State of the art technologies will be used to improve the lives of students at NCSD. Technologies will be used to enhance instruction, global communications, and administrative functions which, in turn, will aid in the enrichment of student life at NCSD.

- The staff of NCSD is committed to fostering institutional, programmatic, and professional excellence, integrity and credibility.

- Staff development programs at NCSD will promote personal and professional growth while meeting the changing needs of the clientele served.

- The overall environment at NCSD will be one that provides students with a love of learning which will follow them into the future.

CLIENTELE

Strategic planning for the North Carolina School for the Deaf programs proceeds with a description of the primary and secondary audiences which are served.

NCSD is committed to tracking the characteristics of its clientele in order to ensure that the needs of individual students are being met. Current educational opportunities will be expanded or modified by the addition of services for special needs within the population of Deaf and Hard of Hearing students.

PRIMARY AUDIENCES

- Referrals of children from birth to age three years originate with audiologists, early intervention professionals, health care professionals or parents. All school-age referrals must originate from the Local Educational Areas (LEAs), and all school placements are to be tracked for individual appropriateness by the LEA. These groups are, therefore, considered to be the primary audiences.

- Current trends indicate that roughly one-third of the students are day students and two-thirds are residential students. The flexibility to accommodate more students and the possible changing proportion of day/residential students is present. On the NCSD campus, students attend preschool, elementary school, middle school and high school. Off campus are students in Preschool Satellite Program.

- Preschool Satellite Program students constitute roughly a third of the total NCSD population. There are four Preschool Satellite classes in Charlotte, two in Salisbury, one in Elkin, one in Shelby, two in Asheville and two in Morganton. Also included in the Preschool Satellite Program are itinerant teachers who serve children and parents through contacts at home or day care centers and by networking with audiologists, health care professionals and early intervention programs across the western counties of North Carolina.

- Parents and children are equally significant consumers of services at the pre-K level and goals on the IFSP and IEP are as likely to address the needs of the parent or other family members as of the child himself/herself. Home visits and/or sign language classes for parents are regularly scheduled by preschool teachers.

- Multiply-disabled students are served campus-wide; they include students with visual problems or legal blindness, brain damage, heart disorders, attention deficit/hyperactivity disorder, emotional/behavioral disturbance, epilepsy, orthopedic disability, cerebral palsy and other disabilities.

- NCSD will develop a formal procedure for identification of students who are learning disabled or academically gifted. Identifying and serving such special needs are now priority commitments.

- Cooperative programming with the Burke County LEA includes high school students from public schools who come to the NCSD campus for classes. NCSD students attend NCSD for part of the day and a public school for the balance of each day. Several high school students attend classes at Western Piedmont Community College. Some students have job placements for employment training as part of their school day.

SECONDARY AUDIENCES

The following constitute those who do not directly receive services from NCSD but actively collaborate with NCSD in the provision of services to Deaf and Hard of Hearing children and their families throughout North Carolina.

- Parent-Staff Organization at NCSD
- Educational organizations (i.e., NAEYC, CEASD, SACS)
- Community advocacy organizations (i.e., BEGINNINGS, SPEAK)
- Developmental Evaluation Centers, pediatricians, health departments
- Burke County Schools involved in mainstreaming
- Vocational Rehabilitation agencies and Community Services
- Lenoir-Rhyne College teacher education program
- Educational and community interpreters
- Current and potential employers of students
- Colleges and universities
- Day care centers involved in mainstreaming/inclusion
- NCSD Alumni

COMPARATIVE ADVANTAGES

To highlight the advantages of NCSD as an educational and residential setting for students, a statement of comparative advantage is developed. The statement presents NCSD from many perspectives, none of which describe it completely. However, seen as a whole, NCSD presents itself as a dynamic and innovative experience for Deaf and Hard of Hearing children in Western North Carolina.

A. **Location...**NCSD is an attractive and accessible campus with several historic buildings and is convenient to downtown Morganton.

B. **Educational Access...**Within NCSD, innovative instruction is conducted by staff in an inclusive and accessible manner. There is a low student/staff ratio. Within public schools and colleges, there are excellent support resources in classes where Deaf and Hard of Hearing students are educated with hearing peers. High quality programming and a variety of options exist for accessing educational information. The options in the other educational settings involve interpreting, notetaking, tutoring and advising.

C. **Career Preparation/Placement...**High quality programs and services are available to maximize students' preparation for entering the workforce. Continual efforts are made to remain current with state-of-the-art technology and the needs and requirements of the state's employers as students make the transition from school to work.

D. **Student Satisfaction and Sense of Support and Inclusion...**Students find NCSD to be a highly supportive environment as evidenced by the extremely low dropout and teen pregnancy rates. Students report that their self-esteem and critical social skills are enhanced by their daily experience of being fully included in a wide variety of activities.

E. **Cooperative Educational Affiliation with Burke County Public Schools and Western Piedmont Community College...**Many unique, challenging, high quality career choices are available in an educational setting. There are opportunities for educational and social interaction among deaf and hearing students. Work experience in student areas of interest provide strong links with business, industry and government. Such links strengthen the educational experience, enhance employment opportunities, and establish sources of funding and equipment for the benefit of students.

F. **Technology...**NCSD recognizes that deaf students learning is significantly enhanced through the use of technology. There is an on-going commitment in this area demonstrated by continual funding and support from the North Carolina Legislature, Department of Human Resources and the Central Office of the NC Division of Services for the Deaf and Hard of Hearing.

G. **Employer Satisfaction...**Employers view NCSD as a source of highly competent graduates. NCSD with additional resources such as Vocational Rehabilitation provides services to employers during the employee selection process and after the individual is hired.

H. **Unique and Highly Qualified Staff...**Diverse backgrounds, technical skills and expertise and communication capabilities of the staff contribute significantly to the quality of educational opportunities.

I. **Communication Enhancement Services...**Sign language courses, linguistics, communication skills classes and other opportunities are available for individual improvement. Media services include closed captioning of TV programming and campus-wide telecommunications.

J. **Research Focus...**NCSD is willing to participate in research endeavors to enhance education and career opportunities for Deaf and Hard of Hearing students. Recent cooperative efforts include affiliations with projects conducted from several outstanding universities.

K. **Willingness to Grow...**NCSD demonstrates a willingness and ability to adapt in accordance with the needs of students in response to the challenges of a changing world.

L. **Accreditation...**NCSD is accredited by the Southern Association of Colleges and Schools (SACS) and the Conference of Educational Administrators Serving the Deaf (CEASD).

STRATEGIC OBJECTIVES

A mission statement articulates a vision, and the development of objectives enables an organization to move to the realization of the vision as defined in the mission statement.

These strategic objectives are derived from the documentation and community dialogue that was so integral to the strategic planning process. More specifically, these objectives were developed from written suggestions, open discussions, recommendations from other committees and organizations such as the Facility Planning Committee and CEASD's and SAC's accreditation committees, and other sources.

Following are categories which affect all aspects of NCSD and especially the quality of the students' educational and developmental experiences at NCSD. Central to each category is the continual emphasis on excellence, professionalism, and a student-centered focus.

I. Partnership with Parents
II. Access
III. Human Resources
IV. Leadership and Teamwork
V. Curriculum and Instruction
VI. Student Development/Residential Education
VII. Student Resources
VIII. Technology and Instruction al Support Services
IX. Outreach/Diagnostics/Medical
X. Facilities/Support Services
XI. Community Relations
XII. Budget
XIII. Behaviorally-Emotionally Handicapped Students

I. PARTNERSHIP WITH PARENTS

NCSD is committed to having an on going partnership with parents. This collaboration will strengthen our ability to provide individualized educational opportunities for the students we serve. NCSD will reflect this partnership through decision making, program planning, resource sharing, support services, curricular, and classroom practices. To assist in facilitating this partnership, there are considerable support staff who are accessible to parents. Frequent and effective communication between parents and staff is always encouraged.

In meeting these goals for partnership, NCSD will:

A. provide parents with workshops, based on parent interest. These workshops will be offered in various locations in addition to the NCSD campus. These workshops are to be available to NCSD parents and staff as well as parents of mainstream students and professionals who work in the mainstream setting, in order to build interagency relationships.

B. continue to provide mandated IEP conferences and any additional parent/staff conferences necessary to provide quality educational services. Contact for these conferences will be made by parents visiting the classroom, phone calls, and in special situations, staff making home visits. If transportation is a problem, NCSD will provide transportation when possible.

C. offer "OPEN HOUSE" so parents will have the opportunity to visit the classroom, as well as the residential facility. Here, the parents will have the opportunity to discuss their child(ren)'s progress in a positive atmosphere for both parents and staff.

D. assist in establishing a "parent/professional retreat" in cooperation with the Parents Staff Organization and the Alumni Association. The "retreat" will be available to parents, professionals and other interested parties who work with Deaf and Hard of Hearing children.

E. continue to provide, through its preschool program, daily parent contact , as well as home visits, daycare visits and any other contact necessary to promote parents/staff collaboration to ensure appropriate educational services for children ages birth to 5.

F. provide interpreters for parents, as needed, in order to facilitate effective communication between parents and staff.

G. develop a procedure to ensure frequent, even weekly, communication to parents regarding highlights of their child(ren)'s previous week or two in the dormitory and upcoming events special to the child(ren).

II. ACCESS

NCSD will be accessible to all students, staff and external audiences. NCSD will challenge all students, regardless of ability, to meet their potential. In order to ensure academic and developmental success, all students will have full access to programs, services, curricula and the total NCSD environment. Access refers to access to information via communication in its various guises, whether direct or via interpreting services, and to all facilities on campus.

To achieve full accessibility, NCSD will:

A. establish an *ad hoc* committee to develop a campus-wide communications policy. This communication policy is to recognize and highlight the following:

1. a full understanding of the meaning of inclusion for all students (which also incorporates reference to the "unwritten curriculum," or "incidental learning,")*
2. English and American Sign Language are of equal worth and used for different purposes,
3. the unique and individual needs and characteristics of each deaf or hard of hearing child,
4. many Deaf and Hard of Hearing children benefit from auditory and speech training,
5. the spirit of the policy is to be reflected in the daily interactions of all people on the NCSD campus, and
6. orientation and training will be provided to all staff and parents in order to enable them to effectively communicate with NCSD students.

B. professionalize interpreting services by providing appropriate support, training and funding. A committee will be established to address the issue of professionalization of interpreting services as well as the issue of support and consultation as needed to the Burke County LEA.

C. establish a procedure to ensure that NCSD is in compliance with ADA, OSERS, SEC. 504 and other regulations governing access.

D. establish a procedure which enables NCSD staff to periodically assess the students' access to academic, vocational, student development and counseling curricula.

E. expand the use of emerging technologies which facilitate communication access, such as telecommunication equipment, interactive video, electronic mail and electronic conferencing, in collaboration with existing community resources toward a goal of enhancing accessibility by Deaf students.

F. provide communication support, through the use of communication specialists and other selected staff, to all staff and students with the goal of encouraging the widespread practice of easy and effective communication at all times.

* **Inclusion** is defined as the child's ability to access all information through signed and/or spoken communication in all situations and throughout the day and evening with the ease that the hearing child expects in a hearing environment. **Inclusion** is also defined as the child's sense of being fully included in all activities on campus as a hearing child is included in a hearing environment, whether in school or at home.

III. HUMAN RESOURCES

NCSD recognizes its human resources as the driving force in providing quality education and services to its Deaf and Hard of Hearing students. Thus, NCSD will promote the development and maintenance of programming which enhances professionalism and professional development among all staff members and maximizes efficiency and effectiveness of delivery of services to students and their parents. NCSD will also create an environment that seeks, nourishes and sustains diversity and pluralism, respecting the dignity and worth of every individual, including staff, students and parents.

To demonstrate its commitment to the ideals of a student-centered, collaborative workforce, NCSD will:

A. develop procedures and structures that create greater democratic and collaborative relationships among staff throughout NCSD.

B. continue NCSD's commitment to include a broad representation on committees and in leadership positions regardless of rank, paying particular attention to representation of minorities, women, Deaf and Hard of Hearing individuals, students and parents.

C. find innovative and creative ways to consistently and equitably recognize contributions made by all staff who demonstrate optimal focus on students and excellence in leadership, teaching and service.

D. ensure the compatibility of policies, procedures and practices with the goals of a student-centered environment.

E. develop innovative strategies to enhance professional development opportunities for staff.

F. develop educational and developmental programming that fosters greater understanding of the nature and dynamics of individual differences for students, staff and parents.

G. promote an environment that is celebratory of diversity among staff, students and their parents.encourage staff to recognize the students' need for nurturing and attention from caring adults. All staff members are encouraged to be open to informal and supportive discussions with students. Such sharing enriches both staff and students.

H. develop, with the active participation of students, a bill of rights and responsibilities for students.

I. provide formal orientation to each new staff member at the onset of their employment. Orientation is to include a packet of information that not only highlights basic requirements and rights of personnel but also introduces NCSD's history, vision, goals and basic student-centered philosophy as outlined in NCSD's Agenda for Action and other pertinent materials.

IV. LEADERSHIP AND TEAMWORK

The leaders of the North Carolina School for the Deaf are committed to provide access and equitable opportunities for Deaf and Hard of Hearing students in Western North Carolina. This will continue to be accomplished through direct and indirect services and through integration, collaboration, partnership and reciprocity with all appropriate educational cooperatives, local education agencies, colleges and universities. Although the administrative staff will be the authority in the areas of education, employment and human services, accessibility, staff development, parent/public awareness and advocacy, the input of all staff, students and parents is critical.

More specifically, NCSD will:

A. select and support leaders who demonstrate the ability to communicate effectively and facilitate collaboration.

B. continue to have leaders who respect individuality and student-centered goals for Deaf and Hard of Hearing students as they prepare for independence as adults.

C. provide leadership that will add vitality and knowledge to the support structure of the school staff.

D. provide opportunities for growth potential for colleagues to also become leaders throughout the educational setting.

E. continue to be team-oriented and recognize the importance of working in groups to achieve meaningful improvements.

F. be familiar with educational trends affecting programming needs, methods of analyzing information and decision-making methods.

G. define clearly the roles and responsibilities of supervisors to include emphasis on leadership, facilitating collaboration, supporting the teaching and learning process, and cultural diversity.

V. CURRICULUM AND INSTRUCTION

NCSD will provide a coherent curriculum emphasizing literacy and critical thinking skills with respect for diversity and innovation. Outcomes will be documented and measured according to minimum standards required by North Carolina law. NCSD will maintain a comprehensive array of curricula and programs which respond to the individual needs of students.

In addressing the critical area of curriculum, NCSD will:

A. renew its commitment to excellence, enhanced by state of the art technology and current research and trends in regular education as well as Deaf education.

B. define its programs and progress in response to the review of the division-wide testing\curriculum committee. The North Carolina Standard Course of Study outlines the required minimum standards. Graduation requirements for North Carolina schools seem subject to change; therefore, the school must keep in step with the changes. The Essential Skills Curriculum benchmarks provide for documentation and diagnosis of skills for students unable to meet the minimum diploma standards.

C. review textbook options from the state and make choices through campus-wide teams for specific content areas. Those which follow more closely the NC Standard Course of Study are carefully scrutinized.

D. define its preschool program according to the guidelines developed by the North Carolina Department of Public Instruction, in the Circle of Childhood curriculum , the Parent Infant Communication Curriculum, auditory and language skills curricula, and by guidelines established in the Child Service Coordination Program of North Carolina.

E. re-emphasize NCSD's connection with current educational techniques that are used by professionals in education in public school programs and in innovative Deaf programs. In-service training is provided for staff on a regular basis.

F. define its programs so that students demonstrate competence in skills relevant to written English with a focus on reading for meaning throughout the elementary grades, with a commitment to scheduling significant blocks of school time with this objective. A coordinated approach to writing skills will focus of specific types of writing at each grade level, i.e., 2nd grade focus on recounting, 3rd grade focus on instruction, 4th grade focus on narrative, etc.

G. strive for a collaborative definition of graduation expectations, and standards for each program area and certificate level. In addition, it is expected that performance outcomes regarding students living and working in a rapidly changing global community and enhancing lifelong learning will be developed, articulated and measured. These outcomes will be a measure of NCSD's success in achieving its mission.. Each program will take responsibility for developing criteria relevant to its area of responsibility within the framework of established curricula.

H. extend NCSD's commitment to diversity, pluralism and multi-cultural education within the NCSD curriculum. Curriculum, activities and materials will reflect a broad based awareness of the skills and sensitivity needed to function in the community.

I. recruit and employ those people who are appropriately licensed to provide quality programming and leadership according to standards of other educational institutions across the state.

J. support and expand existing cooperative programming with Burke County Public Schools and Western Piedmont Community College.

K. incorporate a structured thinking skills curriculum from kindergarten through high school, such as Cognet or Instrumental Enrichment, and provide all teachers with ample opportunities for training in this area.

L. plan and implement a complete arts program including drama, dance, visual arts and music.

M. plan for smooth transitioning between programs (home based to preschool, preschool to elementary, elementary to middle school, middle to high school, and high school to college/work).

N. recognize that residential and student support services share responsibility in implementing curriculum with valuable opportunities to generalize and support skills introduced at school.

O. make available supplemental materials including manipulatives, lab equipment, computers, periodicals, and so forth, to supplement curricular objectives.

P. accommodate programming to individual needs of students . Students with learning problems, behavioral problems, multiple handicaps, students who rely on hearing for optimal learning, accelerated academic students and academically gifted students need to have the curriculum content presented in such a way as to allow them to develop to their greatest potential.

Q. integrate vocational opportunities with reading, language and math. Allow for development of skills which would give students entering the work world the best advantage for success in a job while continuing to progress in academic skills including on the job training opportunities and a functional life skills curriculum.

R. foster interagency exchanges with Preschool Interagency Councils, Vocational Rehabilitation, Foothills Mental Health, Broughton Hospital and Foothills Mental Health. Explore how mainstream students might be involved in extended school year programs by cooperative programming with Local Education Agencies

S. include drug awareness, AIDS awareness, suicide prevention, sex education and crime prevention/safety programs where appropriate in the curriculum.

VI. STUDENT DEVELOPMENT/RESIDENTIAL EDUCATION

Because NCSD believes in the total development of each student, a strong and active student development/residential education program is critical. In order for the student to be "ready to learn", the student's social and interpersonal skills need to be developmentally appropriate. Further, NCSD strives to maintain an environment in which each student achieves a sense of connectedness with peers and adults and a measure of independence so vital to the student's preparation to become a healthy, well-rounded and capable individual with a lifelong zest for learning.

To promote the total development of the student, NCSD will:

A. encourage all students to participate in student development/residential education activities wherever and whenever appropriate and desirable.

B. make the Student Development curriculum the centerpiece of the Student Development/Residential Education unit and establish a formal procedure to review on an annual basis the curriculum content and application. Recommendations will be made for modifications of the curriculum as needed.

C. provide a formal and thorough orientation to all staff in this unit at the onset of employment. The orientation is to include the mission of NCSD, expectations for professional conduct and growth, and proper understanding of the students' developmental needs.

D. provide training to all staff in the application of the Student Development curriculum and in the areas of child/adolescent development, behavior analysis and management, and parenting/nurturing skills, among others.

E. develop a procedure to ensure maximum daily coordination between the academic, counseling and Residential Education staff on behalf of students.

F. develop a standard procedure to handle varied emergencies and communication with parents and provide training to all staff in these areas.

G. implement optimal programming for recreational and leisure-time activities within the guidelines of individualized education plans. NCSD will also provide opportunities either on campus or in the community which promote the physical fitness of students.

H. establish a full athletics program with a variety of individual and team sports available to students in K - 12 in the fall, winter and spring.

I. establish an active, campus-wide Big Brother/Big Sister program which encourages meaningful interactions between students, including tutoring and skills development.

The program will also be used to assist in the transition of students from elementary school to middle school to high school and of transfer students from mainstream programs.

J. maintain a Peer Advisor program to assist students with their daily socio-emotional concerns and to encourage the development of nurturing and conflict-resolution skills.

K. maintain a Judicial Board composed of students to address cases involving minor infractions of established rules and conflicts between peers.

L. encourage the ongoing operation of the "Bear Center," a student-operated store which puts profits back into the store for future expansion or to assist with student development/residential education planning.

M. offer life management skills training to developmentally delayed students weekly.

N. establish a fully-functioning independent living skills program to assist students in becoming self-sufficient adults.

O. provide tutoring daily to students in need of assistance with homework assignments or to those desiring improved study habits.

VII. STUDENT RESOURCES

NCSD believes that one of the most effective ways to achieve optimal student development is to empower the students to use their mental, social, and physical attributes to the fullest. To encourage the students to use such attributes, full and optimal use of student resources, among other things, on the NCSD campus and in the surrounding area is necessary and desirable. Student resources can be considered to include the following: facilities and equipment for athletic, recreational and leisure time.

To promote full and optimal use of student resources, NCSD will:

A. make student resources available throughout the day and evening.

B. ensure that student resources are kept current and in good condition.

C. ensure that students are kept well aware of the resources available to them on campus and in the surrounding community.

D. promote easy and appropriate access to resources available, including transportation.

E. utilize student resources to the maximum potential to enhance the learning environment.

VIII. TECHNOLOGY AND INSTRUCTIONAL SUPPORT SERVICES

NCSD will be responsive to technological change and its societal implications by ensuring its curriculum and services are relevant to such change, by acquiring and integrating new technologies and instructional materials into academic programs and by ensuring that the staff maintain the necessary technical skills to achieve excellence in teaching, research and services. Additionally, NCSD will escape its physical boundaries and further its national impact through technology.

In meeting these goals, NCSD will:

A. develop programs to solicit funding from the federal government and private sources for equipment purchasing and for technology related staff development.

B. develop strategies to enhance opportunities for staff to acquire and maintain current technological competencies.

C. provide student access to technology in and out of the classroom. This will be accomplished by locating technology in every classroom and by establishing lab facilities, supervised by technologically competent staff, available to students after class hours.

D. support efforts to establish cooperative and innovative educational projects with local schools, organizations and the private sector.

E. assist staff in the utilization and selection of effective instructional materials. When appropriate materials are not commercially available, assist staff with the development and production of those materials.

F. provide students with current library books, periodicals and other materials which support school curriculum as well as provide students with information on a wide variety of topics of interest.

G. establish an active and centralized professional library and keep professional materials current.

IX. OUTREACH/DIAGNOSTICS/MEDICAL

NCSD's outreach, diagnostic and medical services are critical in supporting the students' readiness to learn. As current practice indicates, essential to the effective delivery of these services is the team approach which promotes quick and efficient coordination among staff members. In addition, the team approach enhances the holistic focus on the student.

To maximize efficient and effective provision of outreach, diagnostic and medical services, NCSD will:

A. ensure that outreach and diagnostic services are readily available and known to parents of NCSD students and students and professionals from other LEAs and other organizations.

B. actively educate and familiarize all NCSD students and staff with these services and with the referral process.

C. provide periodic training to NCSD staff in maintenance of student health, management of student behavior and in other areas as needed.

D. promote and maintain collaborative work relationships between all aspects of the NCSD campus and personnel providing outreach, diagnostic and medical services.

E. adhere to and promote among NCSD staff the principle of confidentiality at all times.

F. assist NCSD staff and parents in understanding the implications of diagnostic findings and in developing and applying appropriate intervention tools as dictated by the diagnostic results.

G. develop and implement a K-12 counseling/guidance curriculum which can either be taught separately in counseling/guidance groups or integrated into the academic and student development curricula.

H. establish support teams for identified at-risk students, as need dictates. These support teams will include teachers, residential education staff and other staff who interact with the identified students on a daily basis.

I. actively seek to utilize community resources through various means available, such as writing grant proposals and developing professional partnerships.

J. develop and implement an active, year-round Outdoor/Experiential Education program which is available to NCSD students, staff and parents as well as members of the community.

K. utilize a computer network to assist in the rapid response and active coordination of the outreach, diagnostic and medical team.

L. establish permanent and clearly identified counseling offices/classrooms in the elementary school, middle school and high school. These offices/classrooms are to be sufficiently equipped to assist in counseling and guidance activities. Each school is to have a counselor, and counselors will have clearly established hours in those offices/classrooms and spend the bulk of their time in their respective offices. For the purpose of teamwork, counseling services as well as outreach, diagnostic and medical services will continue to be housed in a central and easily accessible location on campus. Further, this central location will continue to have space for individual and group counseling sessions as needed.

M. ensure the smooth transitioning of students transferring to NCSD from other schools or vice versa.

N. establish a task force to develop and implement a procedure for the management of student behavior, student discipline and staff training specific to each school and residential facility. NCSD's counseling team and key community resources will be critical to the task force's work.

O. provide training on an annual basis to staff on recognizing signs of sexual abuse and to students on preventing sexual abuse.

P. centralize support services, including audiology, medical services, diagnostic/prescriptive services, occupational/physical therapy services, parent outreach services, psychological services, counseling services and any other support services, to promote effective teamwork and to ensure privacy and confidentiality.

X. FACILITIES/SUPPORT SERVICES

NCSD's facilities and support services (Dietary, Housekeeping, Laundry and Maintenance) are critical to the daily functioning of the entire campus and in establishing a positive environment for its primary and secondary audiences.

To ensure optimal functioning of NCSD's facilities and support services, NCSD will:

A. comply with recommendations developed by SACS, CEASD and NCSD's Facility Planning Committee and maximize the use of all facilities and grounds for the benefit of all students.

B. ensure that safety is a top priority and that NCSD is in compliance with all federal, state and local laws and regulations.

C. establish a Media and Technology Center which is housed in a central location on campus and available to all students and staff all day and in the evenings. The three libraries will be consolidated and housed in this center. The Center will also include a computer laboratory, a professional library and a film/video library. Major consideration will be given to the proper supervision of students in the Center and to the full accessibility of the Center's resources to all students and staff.

XI. COMMUNITY RELATIONS

NCSD's community possesses a wealth of resources which potentially enhance the educational and developmental experiences of its students. NCSD's ability to effectively meet the needs of its students is closely connected to the quality of its relationships with its community. NCSD's community is considered to include, but not limited to, the following: Parent-Staff Organization, NCSD Alumni Association, Burke County LEA and LEAs in 37 other counties in western North Carolina, local businesses, Western Piedmont Community College, Western Carolina Center, Outward Bound, Foothills Area Program, local and state legislators, Lenoir-Rhyne College and other colleges and universities, and other area/civic organizations.

To attain optimal relations with members of its community, NCSD will:

A. ensure that all visitors are made to feel welcome and instrumental in NCSD's educational/developmental endeavors.

B. encourage frequent and meaningful student interaction with various aspects of its community throughout the academic year.

C. strive for effective and collaborative partnerships which are student-focused.

D. actively seek community resources which contribute to NCSD's educational and developmental goals on either a one-time or on-going basis.

E. establish a procedure to ensure that all units within NCSD are in coordination in its relations with the community.

XII. BUDGET

Proper management of financial resources is essential to the operation of NCSD. In this age of tightening belts creative means to find and develop financial resources is critical.

To maximize NCSD's financial resources, NCSD will:

A. actively seek funding through grants and designate a person to attend to this need.

B. maintain an active endowment.

C. award each unit at NCSD the capability to make decisions with regard to budgetary needs within its own unit and provide each unit the technology to ensure efficient and effective management of its budget.

D. actively include state and local legislators in NCSD's events and encourage these legislators to become more aware of NCSD's programs and services.

E. educate the NCSD community about the budget and budgeting process.

XIII. BEHAVIORALLY-EMOTIONALLY DISTURBED STUDENTS

NCSD has received funding for the development and implementation of a program for behaviorally-emotionally disturbed Deaf and Hard of Hearing youths from throughout North Carolina. The program will be operated 24-hours a day, seven days a week and 12 months a year. Additional staff will be hired to operate this program. The program will be self-contained and integrated with NCSD's regular activities, based on the individual student's progress.

To ensure the smooth operation and integration of this program, NCSD will:

A. establish an advisory board which will be responsible for selecting a name for the program, developing a philosophy and mission statement, and providing support in the search for a coordinator of the program.

B. educate the NCSD community on the purpose and function of the program

C. notify all North Carolina LEAs of the availability of the program for their students.

D. provide training to regular NCSD staff on the proper integration of program students into regular classes and activities when deemed appropriate.

E. provide support to the program coordinator and staff in the implementation and operation of the program.

PROGRAM/SERVICE RECOMMENDATIONS

The development of strategic objectives necessarily calls for the determination of an ideal program/service mix at NCSD which is able to effectively and efficiently implement these objectives. This section, which lists recommendations for an ideal program/service mix at NCSD, addresses broad areas of programming, services and staff makeup within the institution. These recommendations do not, by any means, address the issue of organizational structure which will follow this section. Although these recommendations are broad, more specific recommendations which comply with the spirit and intent of each of the following recommendations and which best implement the strategic objectives are to be developed in accordance with directives from the office of NCSD's superintendent.

Curriculum and Instruction:

* The makeup of NCSD's staff is to reflect the most efficient and effective way to **ensure** continued compliance with federal and state regulations governing curriculum and instruction and to **maintain** current knowledge of developments in instructional techniques and technologies.

* **Maximum flexibility** in the staff-student ratio to meet the needs of all individual students throughout the campus for the duration of the academic year is a critical necessity.

* **Increase** emphasis on the development of reading comprehension and effective writing skills. Strong consideration is to be given to the **addition** of an itinerant reading specialist to NCSD staff to work with both teachers and students across campus.

* To address the growing need for attention to the issue of learning disability among NCSD students, strong consideration is to be given to the **addition** to NCSD staff a specialist in learning disabilities for the purpose of developing intervention strategies in the classroom.

* **Add** to NCSD staff an itinerant teacher who specializes in working with students who are academically gifted.

* **Establish** a full and active Fine Arts program, including drama, studio art, dance and music, for the entire campus.

* **Maximize** utilization of outside resources (person-power) through contractual arrangements to meet specific areas of need in delivery of educational and other services to NCSD students.

* **Enhance** the physical education and fitness of students in Grades 10-12 by offering electives.

Student Development:

* **Establish** an active independent living skills program in conjunction with legal requirements for transitioning to the world of work.

*__Enhance__ the athletics program for competition with other schools and to promote fitness; a component of this athletics program is to be weekly intramurals activities.

Human Resources:

* **Establish** a fully-functioning staff development office that focuses exclusively on the orientation and training of all staff, and all units on campus will work closely with this office to promote optimal training of their respective staff members.

* **Enhance** the communications specialist staff for the purpose of maximizing the ease and effectiveness with which all students, staff and parents can communicate and the development of literacy in English and American Sign Language.

Technology and Instructional Support Services:

* **Establish** for the library and technology each a separate budget line item for the purpose of enhancing decision-making related to budgetary concerns.

* **Maintain** current staff and **ensure** support for keeping knowledge, equipment and training current.

Outreach/Diagnostics/Medical:

* **Expand** the number of Guidance Counselors on campus from two to three so that Hoey Hall, Jeter Hall and Rankin Hall each will have a full-time counselor.

* **Maintain** the position of full-time director of Student Support Services.

Facilities/Support Services:

* **Establish**, in a central location on campus, a Media and Technology Center, including consolidation of three libraries into one central library, establishment of a professional library and a computer laboratory available to all staff and students.

* **Maintain** current staffing for the library. However, **ensure** that the Media and Technology Center is open not only during school hours but also in the afternoons and evenings each day and that there is **sufficient** staff for purposes of supervision and tutoring.

Program for Behaviorally-Emotionally Disturbed Students:

* The program is to be implemented in January of 1997. A Coordinator will be hired to develop and implement the program. **Ensure** that there is sufficient staffing and programming support to optimize delivery of services to these at-risk students and to promote efficient and effective coordination with teachers, parents and other professionals.

ORGANIZATION

PRINCIPLES OF ORGANIZATION

A major intent of the reorganization is to create a structure that enables members of different parts of the NCSD community to easily and consistently work closely with each other regardless of the unit to which they belong. The structure is designed with the recognition that much of everyone's work will be involved with other units and that all NCSD staff members share in the common responsibility to provide excellence in programs and services for students. However, the success of the strategic plan will not be measured by the change in the structure alone; while necessary, reorganization will be insufficient without a concurrent change in the culture of the organization.

The following seven principles will facilitate organizational changes that will influence both structure and culture. The structure itself:

1. supports NCSD's strategic plan and objectives by clustering responsibilities and activities across units (through differentiation) while facilitating interdependence and collaboration (through linkages);
2. is functionally driven;
3. enhances delivery of services to students and parents and reduces duplication of services;
4. moves toward a flatter organization so that increased responsibility will be delegated and more important decisions will be made across the organization to facilitate more direct access and reporting to superintendent by staff;
5. facilitates meeting the critical organizational objectives of collaboration, joint decision making and programmatic integration;
6. promotes interdisciplinary work and the creation of project teams to accomplish stated institutional priorities and strategic objectives;
7. organizes the administrative level to provide clear decision-making.

RECOMMENDATION REGARDING REORGANIZATION

Because resources at NCSD are by no means unlimited, it is imperative that NCSD make wise use of resources on campus and that the organizational structure reflect this wise use. Decisions regarding the organizational structure of NCSD will be made by NCSD's superintendent, and input from NCSD's Administrative Management Team and Instructional Management Team is strongly encouraged as part of this decision-making process. These decisions are to reflect at all times the strategic plan and the seven principles outlined above.

STRATEGIC PLANNING - THE NEXT STEPS

The strategic plan sets a vision and objectives for moving NCSD toward the future - a future in which NCSD will be better positioned to respond to a rapidly changing world and one in which the experiences of the past and the difficulties of the present can be used as a solid base for building success in the future. Throughout this document, a variety of changes have been recommended that will require effective leadership in decision-making and action in order to bring about necessary shifts in the community's intellectual climate and educational processes. In responding to this leadership challenge, the movement into the stage of actual implementation of the strategic plan will be guided by the proposed major shifts in spirit and commitment to values and the financial implications embedded in the plan.

MAJOR SHIFTS

During this period of preparation and decision-making leading into the implementation stage, it is of vital importance that the community, especially the leadership, be responsive to significant changes in the community's values and structure that have been identified and recommended and will serve as foundations for NCSD's mission. These include:

- Organizational Culture: A modified organizational arrangement is integral to promoting the fundamental institutional values shared by all members of NCSD and which include collaboration, open communication, shared governance, staff development opportunities and commitment to excellence and ongoing change.
- Language and Culture: The understanding and appreciation of the Deaf community and Deaf culture and the recognition, study and use of English and American Sign Language as languages of the educational community are commitments of NCSD. Further, NCSD emphasizes the vital importance of promoting at all times easy and effective communication and the respect for individual choices in communication approaches.
- Pluralism: A commitment, recognition, appreciation and integration of pluralism within the NCSD community goes well beyond intellectual statements of intent. Objectives regarding the development of an understanding and appreciation of students of diverse backgrounds, and students requiring special services; the recruitment, retention and career advancement of deaf, hard of hearing, minority staff and staff with disabilities will require definitive action.
- Student Centeredness: A focus on student centeredness encourages students' participation and decision-making in their educational and developmental process. It also requires NCSD to provide clear access to programs and services.
- Strengthening of Curriculum: A call for the examination and evaluation of all curricula within NCSD, giving specific attention to substance, academic

requirements, and a balanced distribution of vocational and general education credits is underscored as a priority activity.

FINANCIAL IMPLICATIONS OF THE PLAN

The Strategic Plan was developed with the understanding that there is no additional funding to permit expansion of programming and services at NCSD. However, to account for inflation, possible expansion of the student population and NCSD's continual striving for excellence, a critical feature of the Strategic Plan is NCSD's readiness to both take immediate and prudent action to respond to a changing fiscal picture and establish a long-range fiscal vision. Such readiness will enable NCSD to prepare its students for a changing world.

To ensure NCSD's readiness, it is recommended that NCSD maintain a vigorous foundation, be ever vigilant in taking advantage of opportunities for expansions in funding and to develop new funding sources through a variety of means, including writing grant proposals.

STRATEGIC PLAN IMPLEMENTATION AND OVERSIGHT

Evidently, proper implementation and oversight of the Strategic Plan is essential to ensuring its success in meeting the goal of optimizing NCSD's preparation of its students for the 21st century. To promote proper implementation and oversight, an Agenda for Action Advisory Committee is to be established immediately following completion of the Strategic Plan. The Advisory Committee is to be composed of members with representation not unlike that seen in the Strategic Planning Committee which developed this Strategic Plan. In order to ensure continuity of the process, it is desirable that the Advisory Committee include at least two or three active representatives from the original Strategic Planning Committee. The process used to select members of the current Strategic Planning Committee is to be used to select members for the Advisory Committee, and the superintendent of NCSD is to assist in this process.

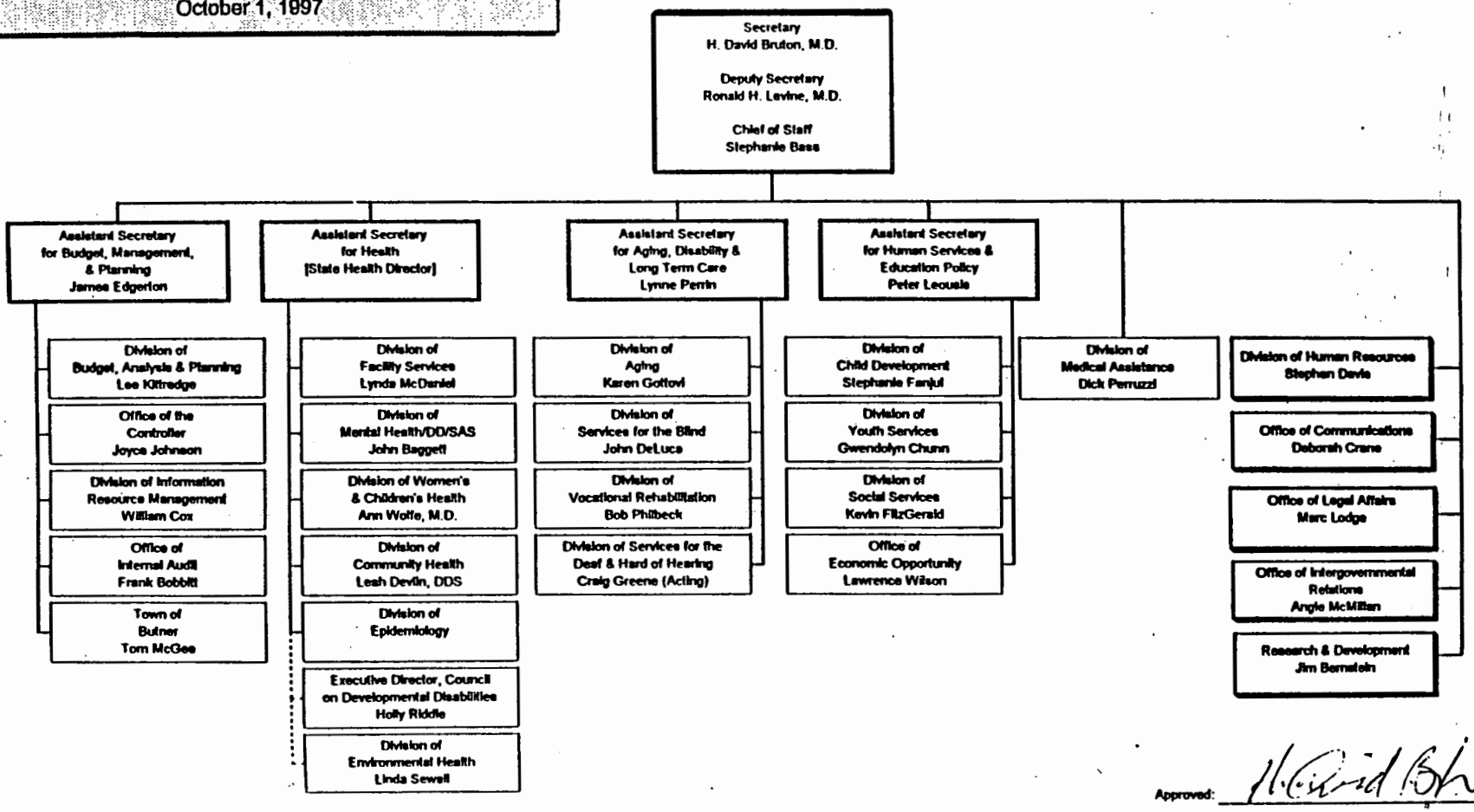
The Agenda for Action Advisory Committee will be charged with encouraging timely implementation of the recommendations set forth in the Strategic Plan and with oversight. Oversight is to include ensuring that the recommendations are being followed to the letter and spirit and, when necessary, calling for the establishment of a new strategic planning committee to make recommendations for still more changes further down the road. The responsibility for the actual implementation of recommendations lies with NCSD's superintendent. The process as outlined is designed to ensure continuity of NCSD's mission and to enable NCSD to make adaptations as needed to maintain excellence in the education of its Deaf and Hard of Hearing students. Finally, the Advisory Committee is to inform as much as possible the entire NCSD community of progress in the implementation of the Strategic Plan.

Before implementation of specific recommendations is to begin, the superintendent's office is to orient the entire NCSD community as soon as possible to the Strategic Plan as set forth in the Agenda for Action. NCSD is to ensure easy access to copies of Agenda for Action throughout the entire campus. Additionally, orientation for all new employees is to include Agenda for Action as its centerpiece, and it is strongly recommended that all current employees become familiar with the Strategic Plan in its entirety.

Attachment # 1

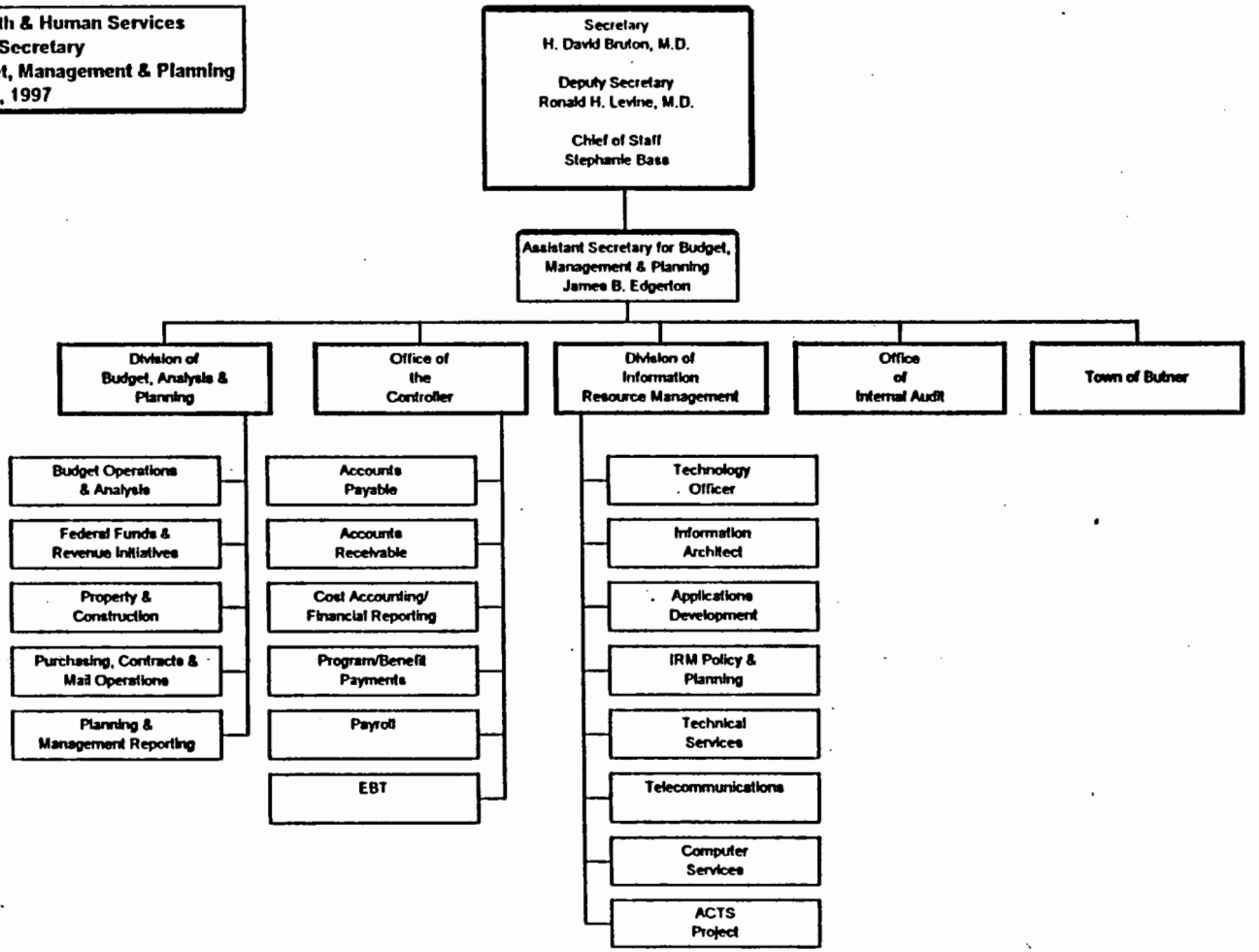
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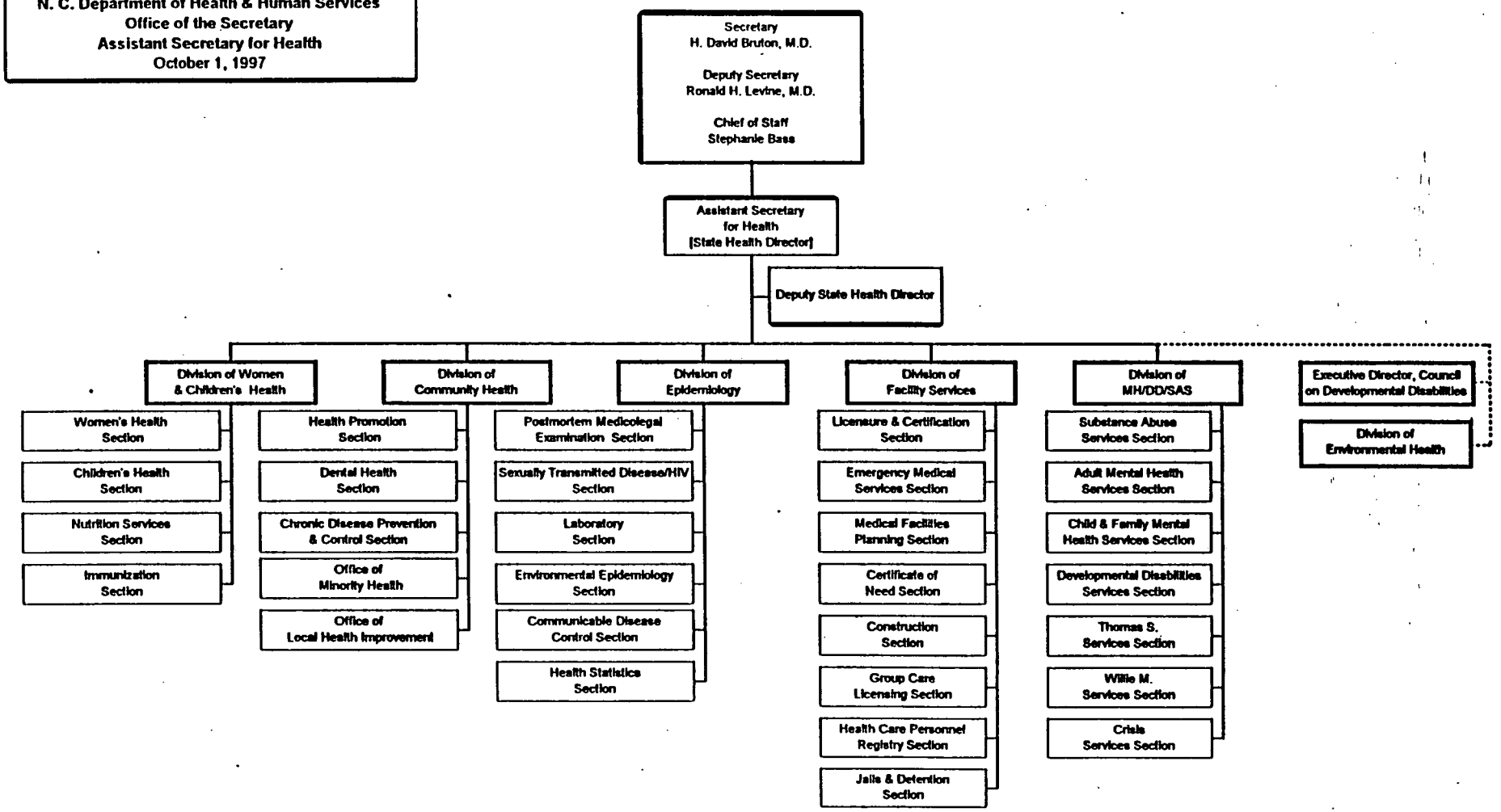


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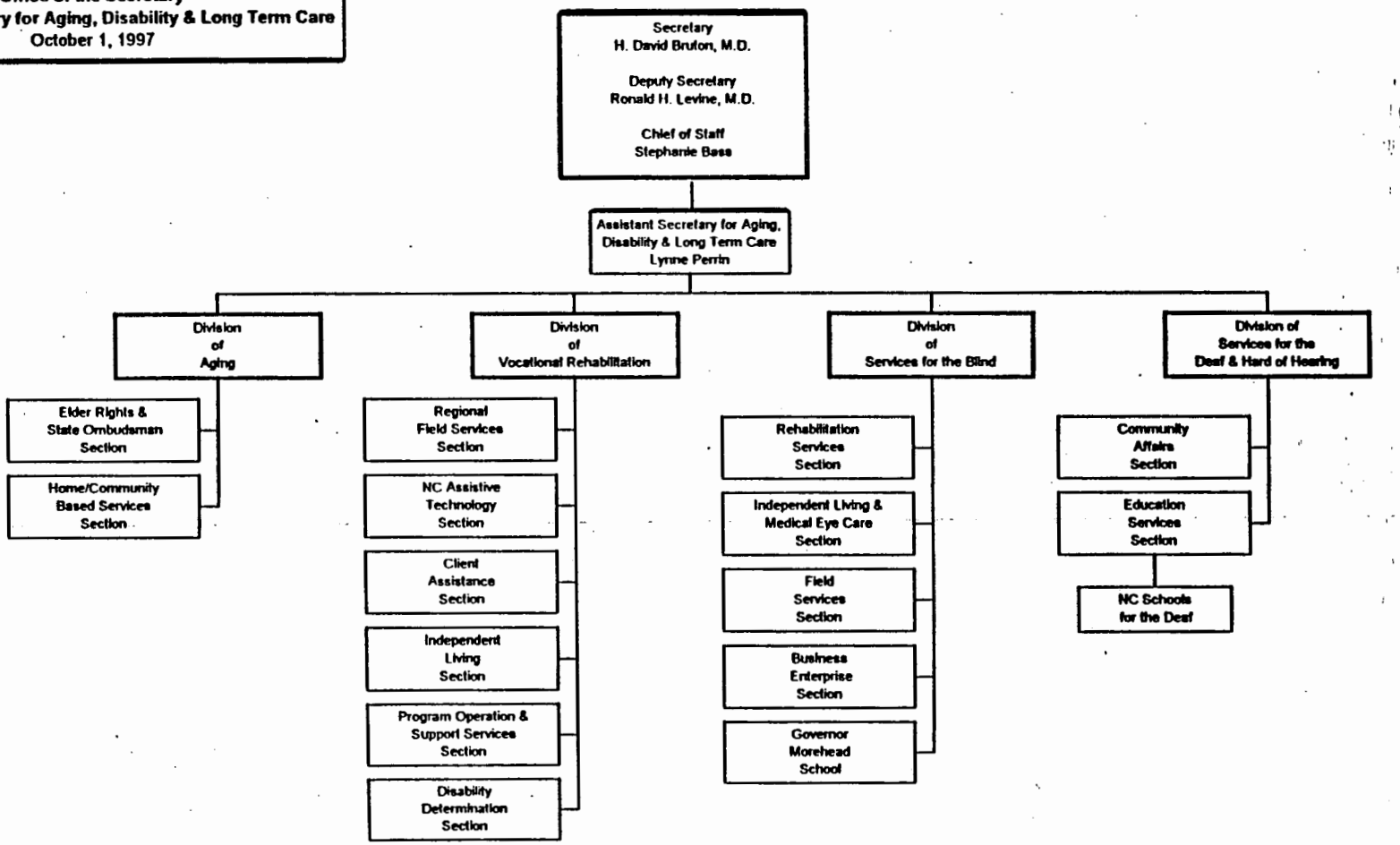
N.C. Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Budget, Management & Planning
October 1, 1997



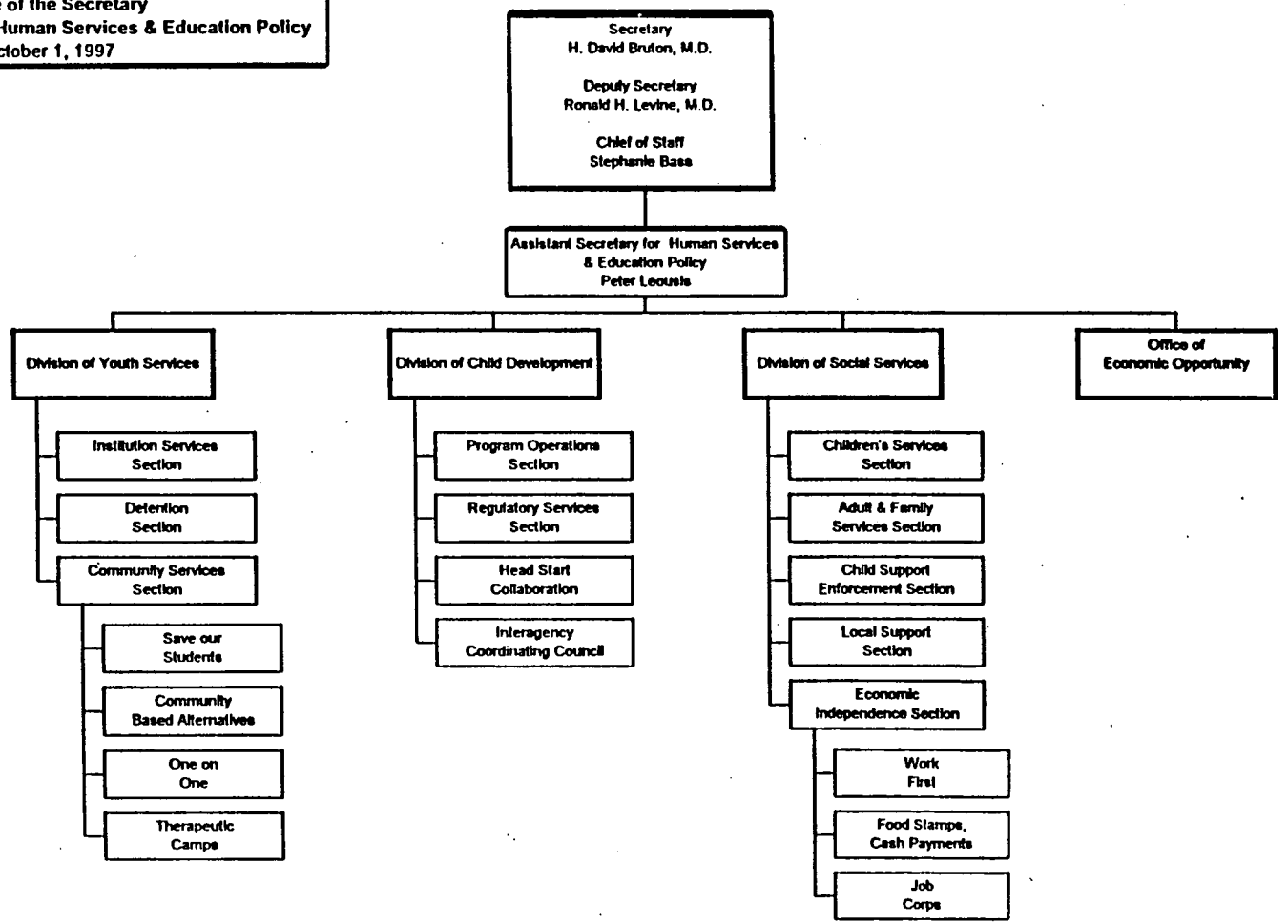
N. C. Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Health
October 1, 1997



Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Aging, Disability & Long Term Care
October 1, 1997



Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Human Services & Education Policy
October 1, 1997



Attachment #8

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Status of

KPMG Peat Marwick Recommendations

October 21, 1997

Status of
KPMG Peat Marwick Recommendations

RECOMMENDATION	STATUS
• DHR should implement an ongoing, comprehensive planning process clearly understood by all who are involved in the human services delivery system.	DHHS has established a planning function within the Division of Budget, Analysis and Planning. We are currently restructuring and continuing to integrate our planning processes.
• DHR should consider legislation that would rename DHR to the Department of Human Services (DHS).	Department was renamed Department of Health and Human Services (DHHS).
• DHR's executive staff should be structured with an orientation toward strategic issues and high-level decision making.	We have established an executive management team made up of all direct reports to the Secretary. This is the team that the Secretary uses for strategic issues and high-level decision making. This is also the mechanism for achieving enterprise-wide integrated decision-making.

RECOMMENDATION	STATUS
• DHR should create an executive management team that includes the Secretary, an Assistant Secretary for Administration and Finance, and a new Assistant Secretary for Operations.	Same as above.
• Establish a single Services Division for service policy development and delivery coordination.	Extra level not needed - service delivery and policy development coordinated at Executive Committee level
• Consolidate North Carolina's economic programs into an Economic Services Section to promote a holistic approach to delivering financial support services.	Assistant Secretary for Human Services and Education Policy (Peter Leousis) will be responsible for coordinating these functions which are located within the Divisions under him.

RECOMMENDATION	STATUS
• Combine the program planning and policy component of Children's Services and the front-end Youth Services to create a Child and Youth Services Section.	Same as above. The Governor has appointed a Juvenile Crime Commission that will be looking at these issues.
• Combine the Division of Aging and DSS's Adult Services section to form an Adult and Aging Services Section	Study currently being conducted to determine the appropriate way and time to implement.
• DHR must fundamentally change the nature of its internal and external relationships, moving from a role as a regulator and program manager.	We are currently working to implement these recommendations through the new organization structure. We also plan to delegate more service to the local levels.

RECOMMENDATION	STATUS
• DHR must establish a new role that focuses on policy development, leadership, and collaboration to create an integrated system that facilitates service delivery through outcomes-based performance.	The Department is currently reviewing and improving its outcome measures, and we will begin a management reporting process in November. With the devolution of responsibilities, we plan to use outcome measures to measure performance. This is exactly the direction of our reorganization.
• DHR should create a Policy Coordination and Service Delivery Section to coordinate DHR policy across Service Domains and provide a single face of DHR.	The Department will use the Assistant Secretaries and the Executive Management Committee to coordinate DHR policy across Service Domains. No new bureaucracy needed.
• DHR should use regional teams of consultants to represent DHR to local service deliverers in assigned regions which are consistent across programs.	The Department is just beginning to look at its regional structure now that the public health programs and the former DHR Divisions have been combined into a new DHHS.

RECOMMENDATION	STATUS
• Counties should be allowed to fashion a human services delivery structure that meets local needs and conditions.	We will support any human services delivery structure the counties fashion. We will encourage coordination and integration.
• The population minimum law set by the General Assembly for service delivery redesign should be rescinded.	We will encourage combining services where that makes geographic and economic sense.
• DHR should deliver state-administered services through a regional approach that facilitates coordination of services in groups of counties which are the same across all programs.	Under study.
• Create a local educational agency (LEA) under a DHR Division of Education Services to administer DHR schools.	Education policy will be the responsibility of the Assistant Secretary for Human Services and Education Policy. A cross-Department education management team has been established to assist him.

RECOMMENDATION	STATUS
• DHR should build on recent funding and budgeting changes within and external to DHR by institutionalizing information system policy and priority-setting mechanisms that address cross-Division system issues and supporting service delivery consistent with the Guiding Principles.	Currently being implemented based upon Automation Plan that was presented to the 1997 General Assembly. We are taking an enterprise-wide view of automation. Probably the most important effort underway in DHHS.
• DHR should begin planning a DHR systems infrastructure and application systems that build on common core business needs and support the entire human service delivery structure.	Currently being implemented. High-level steering team has been established which includes members from the Executive Management Committee, County Commissioners' Association Division, and local DHHS Directors.

RECOMMENDATION	STATUS
• DHR should implement system support for an integrated services delivery strategy through an "adaptive" systems approach that breaks large projects into multiple smaller ones within an overall project vision. These "adaptive" project components should be funded separately.	Currently under implementation. This is how we are developing future automation.
• DHR should implement a management plan for obtaining and maintaining needed information technology resources and skills.	Currently being developed.

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11-19-97
Attachment #9

The Mission of the Department of Health and Human Services is:

> To serve the people of North Carolina by enabling individuals, families, and communities to be healthy and secure, and to achieve social and economic well-being.

To achieve this mission, the Department will:

- provide comprehensive and coordinated services for
    - prevention
    - intervention
    - assistance
    - education
    - empowerment
- assure equal access to services,
- be accountable for achieving meaningful results,
- continuously improve service delivery by involving citizens, and
- support and develop employees as diverse, invaluable resources.

Adopted November 10, 1997

11-19-97

Attachment # 16

STATE OF NORTH CAROLINA

AUDIT FINDINGS AND RECOMMENDATIONS

RESULTING FROM CAFR AND SINGLE AUDIT PROCEDURES

DEPARTMENT OF HUMAN RESOURCES

FOR THE YEAR ENDED JUNE 30, 1996

OFFICE OF THE STATE AUDITOR

RALPH CAMPBELL, JR.

STATE AUDITOR

STATE OF NORTH CAROLINA
Office of the State Auditor

RALPH CAMPBELL, JR.
STATE AUDITOR

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October 10, 1997

The Honorable James B. Hunt, Jr., Governor
Members of the North Carolina General Assembly
Dr. H. David Bruton, Secretary
North Carolina Department of Human Resources

We have completed certain audit procedures at the Department of Human Resources related to the State's *Comprehensive Annual Financial Report (CAFR)* and the State's *Single Audit Report,* for the year ended June 30, 1996. Our audit was made by authority of Article 5A of *North Carolina General Statute § 147.*

The results of these procedures, as described below, yielded audit findings and recommendations for the Department related to the State's general-purpose financial statements and the State's federal financial assistance programs which may require disclosure in the aforementioned reports. The findings noted above are included in the findings and recommendations section contained herein. Our recommendations for improvement and management's response follow each finding.

We noted several internal control weaknesses and instances of noncompliance with State and federal regulations at the Division of Social Services. These deficiencies pertained to the allowability of costs chargeable to federal programs, timely cash management to minimize the use of federal and state funds, and whether the financial management system met federal standards. We also noted several errors in the preparation of the Division's financial statements. Findings 1 through 14 describe these and other conditions.

The system for paying Medicaid claims at the Division of Medical Assistance contained significant weaknesses which resulted in large overpayments of several claims. Also, the Division maintained excessively large positive and negative cash balances throughout the year in the Medicaid program. Findings 15 through 18 describe these conditions.

The Foster Care claim filed by the Division of Child Development with the U.S. Department of Health and Human Services, as part of a revenue maximization effort, contained numerous errors and had to be re-filed. The Division failed to promptly

draw down federal funds resulting in the loss of interest to the State that could have been earned on these funds. These conditions are described in findings 19 through 21.

We noted several internal control weaknesses at the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. The disbursing account statement was not properly reconciled. Invoices were not canceled in a manner to prevent their payment a second time. Findings 22 through 25 describe these conditions.

The Division of Youth Services needs to improve its documentation of student eligibility at its training schools, improve the accuracy of documentation in support of payment to students, and needs to better comply with the State Cash Management Plan. These conditions are described in findings 26 through 28.

The Division of Services for the Blind should establish better control over its equipment and should process its payments in accordance with State and federal laws. Findings 29 and 30 describe these conditions.

The accounts and operations of the Department of Human Resources are an integral part of the State's reporting entity represented in the *CAFR* and the *Single Audit Report*. In the *CAFR*, the State Auditor expresses an opinion on the State's financial statements. In the *Single Audit Report*, the State Auditor also presents the results of tests on the State's internal control and on the State's compliance with laws, regulations, contracts, and grants applicable to the State's financial statements and to its federal financial assistance programs. The audit procedures were conducted in accordance with generally accepted auditing standards, *Government Auditing Standards* issued by the Comptroller General of the United States, and Office of Management and Budget Circular A-128.

As part of the work necessary for issuance of the *CAFR* and the *Single Audit Report*, the following individual funds and federal programs of the State were subjected to audit procedures at the Department of Human Resources as we considered necessary:

Funds for the *Comprehensive Annual Financial Report*:

Division of Social Services:

General Fund

Special Revenue Fund (Budget/Actual) - Disability Determination

Division of Medical Assistance:

General Fund

Federal Programs for the *Single Audit Report*:

Major:

Division of Social Services:

Food Stamps

State Administrative Matching Grants for Food Stamp Program

Family Support Payments to States - Assistance Payments

Job Opportunities and Basic Skills Training

Child Support Enforcement

Foster Care - Title IV-E

Social Services Block Grant

Social Security - Disability Insurance

Medical Assistance Program

Division of Medical Assistance:

Medical Assistance Program

Division of Child Development:

Child Care and Development Block Grant

Foster Care - Title IV-E

Social Services Block Grant

Family Support Payments to States - Assistance Payments

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

Block Grant for Prevention and Treatment of Substance Abuse

Family Support Payments to States - Assistance Payments

Social Services Block Grant

Division of Youth Services:

Family Support Payments to States - Assistance Payments

Division of Services for the Blind:

Rehabilitation Services - Vocational Rehabilitation Grants to States

Social Services Block Grant

Division of Aging:

Food Distribution

Division of Vocational Rehabilitation Services:

Rehabilitation Services - Vocational Rehabilitation Grants to States

Nonmajor:

Understanding of Internal Control Related to Nonmajor Programs:

Division of Child Development

Understanding of Internal Control Related to New Nonmajor Programs:

Division of Social Services

Division of Medical Assistance

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Division of Youth Services

Division of Services for the Blind

Division of Central Administration

Division of Aging

Division of Vocational Rehabilitation Services

Compliance with Requirements for Transactions Selected as Part of CAFR or Other Single Audit, Entity-Wide Tests:

Division of Social Services

Division of Medical Assistance

Compliance with Requirements for Transactions Selected as Part of Other Single Audit, Entity-Wide Tests:

Division of Child Development

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Division of Youth Services

Division of Services for the Blind

Division of Central Administration

Division of Aging

Division of Vocational Rehabilitation Services

The individual funds and federal programs subjected to audit at the Department of Human Resources are substantially less in scope than would be necessary to report on the general-purpose financial statements that relate solely to the Department or the administration of federal programs by the Department. Therefore, we do not express such conclusions.

This document is intended for the use and information of management and appropriate governmental bodies. However, this document is a matter of public record and its distribution is not limited.

Respectfully submitted,

Ralph Campbell, Jr.
State Auditor

Material Finding and Recommendation from Prior Audits - The following presents the status of a material finding and recommendation presented in the prior year *Single Audit Report* that affected the current year audit objectives.

DIVISION OF SOCIAL SERVICES

1. INITIATE APPROPRIATE ENFORCEMENT ACTION IN CHILD SUPPORT CASES

The prior year audit of the Child Support Enforcement program disclosed cases in which the Division had not taken appropriate or timely enforcement action to ensure that absent parents complied with court orders related to the payment of child support. Based on information contained in the case files, appropriate enforcement action was lacking for periods ranging anywhere from several months to two - three years. Wage withholdings were not initiated even for more readily enforceable cases such as those related to military personnel. Federal regulations require the local IV-D agencies to maintain an effective system of monitoring compliance with support obligations. The appropriate enforcement action must be taken within thirty days of identifying noncompliance.

This finding remains unresolved. Our current audit revealed six cases, out of a sample of thirty, in which the Division had not taken appropriate or timely enforcement action to ensure that absent parents complied with court orders related to the payment of child support. Appropriate enforcement action was lacking for periods ranging anywhere from several months to two years. As of August 1996, the six cases owed $18,175 for Aid to Families with Dependent Children (AFDC) arrearages and $22,157 for non-AFDC arrearages.

Recommendation: The local IV-D offices should adhere to prescribed procedures to monitor cases in default and to initiate appropriate action according to Federal guidelines. The local child support offices should increase their use of the parent locator services.

Agency Response: The Division does not dispute the audit finding; however, it should be noted that the State's only standard for audits is 100% compliance. Further, it should be noted that the federal government's standard for all Child Support Enforcement audit issues is a finding of 75% compliance. An audit score of 80% by the federal government is considered substantial compliance and the enforcement finding in the State's audit is in fact a score of 80%.

Auditor's Note: All noncompliance detected by us, whether material or otherwise, is required by federal regulations to be reported. The most important reason for the disclosure of this finding, however, is the presence of the material internal control weakness which caused the noncompliance to have occurred in the first place. Although not material in the current year, it should be noted that in the prior year, the agency did not meet the minimum 75% compliance requirement of the federal government.

Findings and Recommendations from Current Audit - The following presents findings and recommendations, determined during the current audit, which represent significant deficiencies in internal control. Also presented are findings and recommendations regarding noncompliance with either laws, regulations, contracts, or grants.

DIVISION OF SOCIAL SERVICES

2. PREPARE ANNUAL FINANCIAL STATEMENTS IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES

The Division's financial statements had to be adjusted for errors made in the implementation of Governmental Accounting Standards Board Statement number 24 (GASB 24), *Accounting and Financial Reporting for Certain Grants and Other Financial Assistance,* and for errors made during the implementation of the North Carolina Accounting System (NCAS):

- Revenues and expenditures associated with the Food Stamp program were not recorded on the financial statements as required by GASB 24. The omission caused revenues and expenditures to be each understated by $493 million.

- During the conversion to NCAS, one revenue account was inadvertently classified as a liability account. This error caused liabilities to be overstated by $28 million and revenues to be understated by an equal amount.

- A number of revenues were misclassified due to NCAS revenues combining differently from the way they were accumulated under the former Departmental Accounting System (DAS). Staff mistakenly assumed the way revenues were accumulated under NCAS was the same as under DAS. Adjusting entries totaling $50 million were needed to correct these classification errors.

Recommendation: The financial statements have been adjusted for the errors noted. The Division should consult with the Office of the State Controller regarding new GASBs that will affect its financial statements. The Division should ensure that amounts reported on the financial statements are prepared in accordance with generally accepted accounting principles.

Agency Response: The Division concurs with the finding and recommendation. In addition to the adjustments made, the Division has also made the appropriate changes to the chart of accounts so that revenues will roll up correctly on future financial statements. Also, appropriate staff will consult with the Office of the State Controller regarding new GASBs that would have an impact on financial statements.

3. CLAIM FEDERAL FINANCIAL PARTICIPATION ON ONLY ELIGIBLE AFDC - EA COSTS

The Division did not comply with all Federal regulations when it filed claims for reimbursement from the Aid to Families with Dependent Children - Emergency Assistance (AFDC - EA) program:

A. Division of Youth Services

The Division of Social Services filed claims during the fiscal year for $35,028,708 ($17,514,354 Federal share) in AFDC - EA costs for services provided by the Division of Youth Services (DYS). These services were provided from January 1, 1995 through December 31, 1995. In July of 1996, the federal Department of Health and Human Services (HHS) denied one of these claims. The denied claim of $30,366,362 ($15,183,181 Federal share) represented the total AFDC-EA payments and related administrative costs for services provided by DYS for the period January 1, 1995 through September 30, 1995. HHS denied the claim because of noncompliance with one or more of the following regulations:

- AFDC-EA services were provided to youth in "secure" facilities. The Division was notified January 1995 by HHS that Federal financial participation (FFP) was not available for any situation in which a youth had been placed in a secure facility. The Administration for Children and Families Section (ACF) of HHS asked the State to confirm that the State had not claimed FFP for costs associated with a youth placed in a secure facility. ACF also requested assurance that FFP would not be claimed in future placements. HHS informed the State again in April 1995 that "FFP is not available under the AFDC-EA program for children in secure facilities." Despite the instructions from HHS, the Division submitted claims for the prohibited services.

- DYS did not submit a cost allocation plan. Instead, a computed per diem rate was charged for AFDC-EA services provided by DYS. OMB Circular A-87 requires grantees to develop, document, and implement a cost allocation plan subject to approval by the Federal Government.

- The Department of Human Resources (DHR) contracted with an outside firm to determine AFDC-EA eligibility and to prepare claims for reimbursement of AFDC-EA services. Federal regulation 45 CFR 205.100 requires that State agencies not delegate to other than its own officials its authority for exercising administrative discretion over the State Plan. ACF has taken the position that determination of eligibility and authorization of payments and/or services are administrative functions that may not be delegated.

- AFDC-EA eligibility was determined retroactively and subsequent requests for reimbursement for services were made retroactively. In a July 1996 letter to DHR, ACF stated that retroactive FFP claims were not permissible when State procedures did not comply with application, eligibility determination, and authorization procedures. The letter stated that an applicant family was required to apply and be determined eligible for emergency assistance under the State Plan, and that such assistance was required to be authorized prior to making an expenditure reimbursable with Federal funds. The letter also stated that

assistance provided for prior emergency needs must clearly relate to the current crisis for which an application has been made. The ACF July 1996 letter also stated that when the State attempted to document its claim by establishing retroactive eligibility, there was no emergency for which services were required. The services that were required (placement in an institution in order to avoid destitution) to alleviate the emergency had already been provided.

B. Division of Mental Health, Developmental Disabilities and Substance Abuse

The Division of Social Services claimed $32,786,310 (Federal share $16,393,155) in AFDC - EA costs for emergency services provided by the Division of Mental Health, Developmental Disabilities and Substance Abuse (DMH). These services were provided from January 1, 1995, through June 30, 1996. Over 80% of these costs were claimed by area mental health centers, subrecipients of DMH. The services provided were not in compliance with one or more of the following regulations:

- DMH did not submit a cost allocation plan. Instead, DMH used a per diem rate or a rate determined by the "Pioneer System" to charge for AFDC-EA services. As stated above, agencies are required to develop cost allocation plans subject to approval by the Federal Government.

- Many of the claims contained costs for prior periods. During our audit of DMH, our tests for eligibility revealed that twenty (representing costs of $131,586) of the seventy-five students tested had received retroactive approval. When the State filed its claims for retroactive eligibility, there was no emergency for which services were required. As stated above, retroactive FFP claims are not permissible if State procedures do not comply with application, eligibility determination, and authorization procedures.

We are questioning $33,907,509 ($17,514,354 for the Division of Youth Services and $16,393,155 for the Division of Mental Health) representing the Federal share of costs claimed for AFDC-EA services provided by the Department, as described above.

Recommendation: The Division should claim FFP on only eligible AFDC-EA costs in accordance with required application, eligibility determination, and authorization procedures. The Division should correct the claims filed for AFDC - EA services.

Agency Response: As stated above, the findings by the Office of the State Auditor are consistent with the reasons given by the Region IV Office of the Department of Health and Human Services, Agency for Children and Families, as the basis for their denying payment of AFDC-EA claims submitted by the Division of Social Services on behalf of the Division of Youth Services and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services. These Divisions, the Department of Human Resources, and Deloitte and Touche, the firm with which the Department has a contract

to maximize federal funds and who prepared some of these claims, strongly disagree with the Region IV interpretations of applicable federal law, regulations and policies. Based upon knowledge of how the AFDC-Emergency Assistance Program operated in other states and other federal regions during the period of time in question, and on the advice of outside legal counsel, the Department has appealed the ACF decision. The appeal is now scheduled to go before the federal Grant Appeals Board in May 1997.

4. SYSTEM EDITS SHOULD BE IMPLEMENTED TO PREVENT PAYMENT OF UNALLOWABLE CHILD CARING CHARGES

The Division reimbursed a child caring institution (CCI) and a substantial number of counties from Foster Care and Aid to Families with Dependent Children - Emergency Assistance (AFDC - EA) funds at rates that exceeded the established monthly rate. The Division also reimbursed these counties for charges that were not allowable:

- The Division reimbursed a number of counties for costs of child caring facilities at rates which exceeded the standard board rate. The child caring facilities had not been approved to receive the excess rates. This resulted in overpayments of $389,674 in Foster Care funds and $69,998 in AFDC - EA funds. These overpayments were deducted from subsequent reimbursements prior to the end of the fiscal year.

- The Division reimbursed several counties $95,685 for payments made to for-profit child caring facilities. For-profit facilities do not meet the definition of foster family homes, as stated in Public Law 96-272, and are not eligible for Federal reimbursement. This amount is being questioned.

- One CCI's rate was incorrectly changed in the computer system to the previous fiscal year's rate. The $6,727 overpayment of Foster Care funds and $882 overpayment of AFDC - EA funds were deducted from a subsequent reimbursement prior to the end of the fiscal year.

- The Division reimbursed a county the costs for two Foster Care children at a rate which exceeded the facility approved rate. This resulted in an overpayment of $536. This amount is being questioned.

The overpayments occurred because the Division did not have procedures in place to compare the amount paid for each facility to the approved rate or to determine that facilities which received excess payments were approved to receive them. No edits were in place to prevent payments to for-profit facilities. OMB Circular A-87 states that cost that exceed established limitations are not allowable.

Recommendation: Edits should be established to ensure that amounts paid do not exceed the maximum rate allowed. System edits should also be implemented to prevent reimbursement to counties for payments to for-profit facilities.

Agency Response: The Division concurs with the finding and recommendation. Edits were put in place effective 7/1/96.

5. SEEK REIMBURSEMENT FROM COUNTIES AND CORRECT ERRORS MADE WHEN FOSTER CARE PAYMENTS WERE RECLASSIFIED

The Division determined during the current fiscal year that $352,841 of prior year federal expenditures charged to the Foster Care program were unallowable. The unallowable costs represented amounts paid to counties for contracts the counties entered into with for-profit foster care facilities. Payments to for-profit facilities are not eligible for reimbursement with Foster Care funds.

The Division reclassified these unallowable Federal expenditures to State expenditures prior to the end of the fiscal year. Because it believed the Federal policy on the use of for-profit facilities was unclear, the Division decided not to seek reimbursement from the counties which were overpaid. The Foster Care State Plan and the Family Services Manual, however, listed the type of services which could be paid with Foster Care funds. For-profit facilities were not included in the listing of eligible providers.

The reclassification from Federal to State expenditures also resulted in the Division's paying counties more State funds per child than the amount allowed by the standard board rate established in the 1995 Appropriation Act. The standard board rate represents the maximum amount the State will match with local departments of Social Services for foster care assistance. Child caring institutions can expend State funds in excess of the standard board rate only if the institutions have been approved by the General Assembly. These child caring institutions paid by the counties did not meet the criteria for receiving excess State funds.

In addition, when the Division made these adjustments, the adjustments overstated the reduction of charges to Federal funds by $11,676. Some of the payments classified as having been made to for-profit facilities were actually made to non-profit facilities. Making payments to non-profit facilities is allowable under Federal regulations. The adjustments were made without proper review. The risk of errors increases when adjusting entries are processed without proper review.

Recommendation: The Division should seek reimbursement of the $352,841 overpaid to the counties. The amounts received from the counties should revert to the State's General Fund. The Division should correct the errors made to reclassify Federal expenditures to State expenditures. All future adjusting entries should be reviewed and approved for accuracy.

Agency Response: The Division disagrees that these funds should be reimbursed by the counties. The policy on this wasn't clear and counties, in good faith, entered into contracts with these providers to provide services to children. To recover these funds now would be punitive to Counties. A temporary employee performed the reclassifications and was given adequate instructions; however, time did not allow for proper review of his product. Appropriate entries were made during September 1996 to correct the adjustments.

6. DRAW DOWN FUNDS IN ACCORDANCE WITH FEDERAL REGULATIONS

The Division held excess funds of more than $12 million for five months for eight non-major programs. The Federal programs involved were: Family Preservation and Support Services, Refugee and Entrant Assistance-State Administered Programs, Unanticipated Arrivals and Targeted Assistance, Rural/Urban Enterprise, Refugee Citizenship, Child Abuse and Neglect State Grants, Family Violence Prevention and Services-Grants to States and Indian Tribes, and Independent Living.

The Division was instructed November 1995 by the Office of State Budget and Management (OSBM) to draw down all Federal funds available. OSBM issued these instructions in response to a possible Federal Government shutdown and the prospect that sufficient Federal funds would not be available to operate Federal programs. Federal regulation 45 CFR 92.20 requires drawdowns to be made as close as possible to the time of making disbursements.

Recommendation: The Division should draw down funds in accordance with Federal regulations.

Agency Response: The Division concurs with the finding and recommendation. The Division operated on specific instructions/direction from both the Office of State Budget and Management and the Office of the State Controller.

7. TRACKING SYSTEM FOR SUBRECIPIENT AUDIT REPORTS SHOULD BE UTILIZED

The Division did not determine whether five of its subrecipients which had received $25,000 or more in Federal funds spent those funds in accordance with applicable laws and regulations. The Division relied on subrecipient audit reports to determine whether subrecipient expenditures were in accordance with Federal regulations. However, the Division was unaware that the audit reports for five of its subrecipients had not been submitted. OMB Circular A-128 requires recipients that provide $25,000 or more in Federal financial assistance to a subrecipient to determine whether the subrecipient spent the Federal funds in accordance with applicable laws and regulations.

We are questioning $564,117 of costs associated with the five subrecipients. This amount represents Federal funds drawn down and provided to the five subrecipients during the fiscal year ended June 30, 1995.

Recommendation: The Division should better use the tracking system in place to monitor compliance with Federal audit requirements.

Agency Response: The Division concurs with the finding and recommendation. In the future, we will ensure that we are in compliance with applicable OMB Circulars as well as DHR Directives. Also, two of the five audits cited have been received and the remaining three are in process and should be received soon.

8. IMPLEMENT MONITORING PROCEDURES IN THE SPECIAL ASSISTANCE PROGRAM AND RECONSIDER POLICY ON RECOUPING OVERPAYMENTS

The Division had no quality review procedures in place to monitor participant eligibility in the Special Assistance to Adults Program (SA), a program whose benefits exceeded $90 million during the fiscal year. Prior to April 1995, the Division of Medical Assistance included the SA program in its Medicaid sampling plan. Effective April 1995, the Division of Medical Assistance changed the Medicaid sampling plan and excluded SA cases from quality review procedures.

The Division has a policy which does not require counties to report overpayments caused by the counties. Also, the Division does not require that these overpayments be recouped and remitted to the State. Lack of monitoring coupled with a lack of reporting of overpayments, and no requirement that overpayments be recouped and remitted to the State, creates an unnecessarily high risk for error in this program. This could permit the improper expenditure of State funds in the Special Assistance Program.

Recommendation: The Division should implement monitoring procedures for the Special Assistance Program. Procedures should include verification of eligibility and procedures to detect overpayments and underpayments. Management should consider revising its policy of not requiring counties to recoup overpayments in the SA Program.

Agency Response: The Division concurs with the finding and recommendation. The Division has made arrangements with the Division of Medical Assistance to resume the inclusion of Special Assistance cases in the sampling of cases to be monitored for eligibility. The Division will review and consider revising the current policy of not recouping Special Assistance benefits that occur as a result of eligibility errors made by county departments of social services.

9. STRENGTHEN CONTROLS OVER ELECTRONIC DATA PROCESSING

Our review of the Division's electronic data processing general controls revealed weaknesses in access controls:

- Four terminated employees continued to have screen access.
- One terminated employee was deleted without the authority or knowledge of the security administrator.
- A number of employees had access to more functions than necessary for their jobs.

The design of the security request form utilized by the Division granted more security access for some accounting functions than was needed.

Recommendation: The Division should strengthen controls to limit access to the accounting system. An access control system should authenticate each computer user and restrict access to only necessary functions. Terminated employees should be removed promptly from the system.

Agency Response: The Division concurs with the finding and recommendation. Terminated employees have been removed from the system. Since the Controller's Office has been consolidated, it is now necessary for employees to have a wider span of security and access among NCAS Companies.

10. VERIFY CREDENTIALS OF NEW EMPLOYEES BEFORE COMMITTING TO PAY MOVING EXPENSES

The Division did not verify the credentials of a new employee before committing to pay his moving expenses. Within four months of his employment, the employee was released for misrepresentations in his employment application. The Division expended $11,373 in moving expenses for the employee. Good business practices dictate that the Division verify credentials before committing funds to relocate new employees.

Recommendation: Employee credentials should be verified before entering into any agreement to reimburse moving expenses. The Division should confer with the Attorney General's Office to pursue the recovery of the moving expenses.

Agency Response: The Division agrees with this recommendation. The Division very rarely reimburses moving expense; however, if we do so in the future, we will only reimburse after the employee's credentials have been verified. The Division has written to staff in the Attorney General's office to determine if it is possible to recover the funds paid in this instance.

11. MAINTAIN SUPPORTING DOCUMENTATION FOR THE SOCIAL SERVICES BLOCK GRANT (SSBG) REPORT

Reconciliations between the SSBG Annual Report of Services Funded and the accounting records could not be located for 37% of the SSBG expenditures. Documentation was also unavailable for the number of recipients served for eight of the twenty-nine categories in the report. Good internal controls require that adequate documentation be maintained to support the amounts shown on Federal reports.

Recommendation: The Division should maintain supporting documentation for all reports. Reports should be reviewed for accuracy and the reports should be reconciled to the accounting records.

Agency Response: The Division agrees with this recommendation. The staff responsible for preparing the reports have been instructed to maintain all documentation to substantiate the report and to ensure that the reports agree to the official financial records maintained by the Controller's Office.

12. EXPENDITURES SHOULD NOT BE CHARGED AS BOTH DIRECT AND INDIRECT COSTS

The Division overcharged the Social Security Administration grant $8,950 by reporting rent expenditures as both direct and indirect costs. OMB Circular A-87 requires that each item of cost be treated consistently, either as a direct or an indirect cost. The Division was informed by the Department of Human Resources that the correction would be made on the 1996-97 Fixed Statewide and Department Cost Schedule. We are questioning this $8,950.

Recommendation: The Division should make the appropriate adjustments to the accounting records.

Agency Response: The Division concurs with the finding and recommendation. The Division received instructions from the Department to allow the credit to DDS (Social Security Administration grant) to process through the SFY 1996-97 Fixed Statewide and Departmental Cost Allocation Plan. The plan submitted to DHHS for SFY 1996-97 for approval included the credit adjustment against the SSA grant for the previous overcharge. This method of adjustment is consistent with the way in which the Department has made adjustments in previous years. No further action is required relative to this finding.

13. DISBURSING ACCOUNT STATEMENTS SHOULD BE RECONCILED PROMPTLY

Disbursing account statements for the trust account used for child support collections were not reconciled for the last seven months of the fiscal year. An outside vendor, contracted to help develop a tracking system related to child support collections, made program errors that prevented the Division from producing the reports necessary to perform the monthly reconciliations. Errors in cash balances could remain undetected if disbursing account reconciliations are not performed. The North Carolina Administrative Code requires each entity to reconcile its statements within fifteen days of receipt.

Recommendation: The Division should reconcile monthly disbursing account statements promptly. Changes to computer programs should be sufficiently tested prior to their implementation.

Agency Response: The Division concurs with the finding and recommendation. The bank reconciliation reports from ACTS had reported problems soon after implementation in Wilson and Duplin counties (pilot counties) during August 1996. Due to contract issues with the vendor, the problems could not be addressed until after March 1996. The inability to immediately resolve the reporting issues caused a delay in getting the required data to DSS/CSE Accounting until June 1996 for these two counties. This information is now being provided monthly to accounting and the Division is in the process of bringing the reconciled statements up-to-date.

14. VERIFY THAT ALL EXPENDITURES ARE CODED TO THE CORRECT FEDERAL PROGRAM

The Division overstated expenditures in the following Federal programs:

93.560	AFDC	$42
93.561	JOBS	$67
93.645	Child Welfare	$37
93.667	SSBG	$34

The errors resulted from the Division's failure to code the transactions to the Federal program receiving the benefits. OMB Circular A-87 requires that a cost be allocable to a particular cost objective to the extent of benefits received by such objective. We are questioning the $180 in coding errors.

Recommendation: The Division should verify that all expenditures are coded to the Federal program receiving the benefits.

Agency Response: The Division concurs with the finding and recommendation. Consolidation of the Controller's Office and formation of the Accounts Payable Section should eliminate these types of problems in the future. By consolidating the accounts payable functions in one section within the Controller's Office, there will be tighter internal controls. The adjustments cited in the audit were made in the accounting records of DSS during the month of February 1997. No further action is required relative to this finding.

DIVISION OF MEDICAL ASSISTANCE

15. ENHANCE CONTROLS TO PREVENT PAYMENT OF INCORRECT CLAIMS

In our examination of 283 Medicaid claims we noted a number of errors caused by control weaknesses. The Division overpaid several claims and underpaid one claim:

- The Division does not have an effective system to control the correct data input of claim amounts. Due to a keying error, a $447.50 claim was paid as $4,475,047.50. The Division does not utilize a batch control system to control input of amounts. Also, the system is supposed to reject any payment over $500,000 for manual review; however, the system failed to reject this claim. The $4,474,600 overpayment was refunded approximately five weeks after the claim was paid. We were unable to determine whether the provider or the Division was first to identify the overpayment. Because the refund was received and credited back to the program before the fiscal year end, there are no questioned costs associated with this error.

- Two claims were overpaid because the payment system improperly added credits to payments rather than deducting them. Because the overpayments of $31,464 were recouped before year end, there are no questioned costs associated with this error.

- Two claims were overpaid due to keying an excessive number of units into the system. The error in one of these claims was caused by keying 17 days as 5,000,017 days, resulting in an overpayment of $350,000. This amount was recouped before year end. The error in the second claim was caused by keying 31 days as 5,000,031 days, resulting in an overpayment of $350,000. This amount was not recouped until after fiscal year end and is being questioned.

- A procedure billed at an excessive amount on an electronically submitted claim was accepted and paid by the system. The payment system does not contain sufficient edits to determine if claimed amounts are reasonable for the procedure involved. The excessive amount paid of $549,738 is being questioned.

- A disproportionate share hospital was underpaid on a claim because the rate on the payment system differed from the rate established by the Division's rate setting section. The underpayment of $849 was corrected before year end.

OMB Circular A-87 states that to be allowable under a grant program, costs must be necessary and reasonable for proper and efficient administration of grant programs and must not exceed established limitations.

Recommendation: The Division should require its claims processor, through modification of its contract if necessary, to implement and modify edits to prevent these types of errors from occurring. A system of batch controls should be implemented. Claims over a certain amount should be rejected and flagged for manual review. The system problem of adding credits rather than deducting them should be corrected.

Agency Response: The Division of Medical Assistance and the Department of Human Resources concur with the findings and agree that cost effective enhancements should and will be implemented to minimize the potential for payment errors. The Division has worked in the past and will continue to identify any weakness in the claims processing system and implement corrective actions. Steps have been taken to modify the payment system to prevent the inadvertent bypassing of edits and audits, improve the accuracy of data input from paper claims and to assure review of payment rate files for accuracy against rate setting instruction. The Division is reviewing the possibility of utilizing optical scanning systems to reduce the potential for keying errors. Identified overpayments and underpayments have been corrected.

16. DRAW FEDERAL FUNDS IN ACCORDANCE WITH THE AGREEMENT WITH THE U.S. DEPARTMENT OF THE TREASURY

The Division did not comply with the agreement between the U.S. Department of the Treasury and North Carolina which implemented the provisions of the federal Cash Management Improvement Act of 1990. The Division continuously maintained large positive and negative cash balances throughout the year in the Medicaid program.

For example, on March 11, 1996, the Division ended the day with a federal funds balance of $79 million. This balance rose as high as $132 million and went as low as $66 million before finally being substantially eliminated on April 8. In another example, on July 17, 1995, the Division began with a federal funds balance of $5 million. This balance rose as high as $43 million before it was substantially eliminated on July 26. Although not as numerous, there were cases in which there was a deficit federal funds balance. In these situations, State funds were required to cover federal expenditures. For example, on April 8, 1996, there was a deficit funds balance of $30 million. This balance rose as high as $40 million before being eliminated with federal funds on April 12.

The agreement prohibits the State from drawing funds more than two business days prior to the day corresponding disbursements are made. The agreement requires that the request for funds be for no more than the amount the State expects to disburse.

Recommendation: The Division should draw funds in accordance with the agreement with the U.S. Department of the Treasury.

Agency Response: The Division concurs with the recommendation. The Division and the DHR Controller's Office will work to ensure that the federal cash draw is in accordance with the agreement with the U. S. Department of the Treasury.

17. CONTROLS OVER THE RECEIPT AND DELIVERY OF GOODS NEED IMPROVEMENT

Internal control weaknesses were noted over the receipt of supplies and property:

- Signatures documenting the receipt of goods were not present for three items appearing in our sample of thirty items.
- The receiving area was not properly secured and was easily available to anyone coming into or leaving the building.
- Signatures were not required for items picked up or delivered from the receiving area.

The Division's policy manual and good internal control require documentation indicating the receipt and delivery of supplies and property.

Recommendation: The Division's policy manual should be followed. Additional policies should be developed to strengthen controls over physical access to assets.

Agency Response: The Division of Medical Assistance and the Department of Human Resources concur with the finding and agree with the recommendations. To strengthen the oversight and compliance with policy, the Mail Room which includes the receiving area has been transferred to the Assistant Director of Financial Operation, effective July 1, 1997. As an assignment of responsibility the policies and practices will be reviewed and action taken to assure compliance with policy.

18. PREPARE THE SCHEDULE OF FEDERAL FINANCIAL ASSISTANCE IN ACCORDANCE WITH GUIDELINES

The Division incorrectly reported Medicaid program expenditures on the Schedule of Federal Financial Assistance (SFFA). The amount reported reflected the activity in the federal funds budget code, rather than the activity in the operating code. The federal funds budget code did not correctly account for the actual expenditures in this program.

OMB Circular A-128 and Office of the State Controller instructions require that expenditures for each federal program be reported in the SFFA.

Recommendation: The Division should accurately report program expenditures on the SFFA.

Agency Response: With the consolidation of the DHR Controller's Office, the Division no longer has a Federal Fund Budget Code; therefore, this should not represent a problem in the future.

DIVISION OF CHILD DEVELOPMENT

19. CLAIM SUBMITTED FOR FOSTER CARE MAXIMIZATION REIMBURSEMENT SHOULD BE REVISED TO ELIMINATE ERRORS

The Foster Care claim filed with the U.S. Department of Health and Human Services, as part of the Department of Human Resources' revenue maximization effort, contained amounts for ineligible children and amounts in excess of actual costs. The claim for $5,015,341 ($3,257,167 federal share) represented the amount paid with state funds for day care services for children who the Division claimed were eligible for Foster Care during the period October 1, 1993 through June 1995. The Department of Human Resources contracted with an outside organization to determine the amount of the claim. This claim was filed through the Division of Social Services and at the time of our audit, no federal funds had been received as reimbursement for this claim. Our review of a sample of the documentation supporting this claim disclosed errors totaling $17,208 as described below:

- From a sample of ninety-two children, four were found not eligible for Foster Care during any of the periods claimed. An additional twelve children were found to be ineligible for at least one period claimed. The procedures used by the contractor to identify day care recipients as Foster Care eligible did not account for possible breaks in Foster Care eligibility nor did the contractor consider that the same identification number was used for different children. Foster Care payments are allowable for federal reimbursement only if the children meet the requirements in 45 CFR 1356.60(a)(i) and Public Law 96-272.

- We uncovered fourteen erroneous payments in a sample of 106 payments. The contractor failed to eliminate three duplicate payments from the Foster Care claim. The Division was unable to reconcile the amounts claimed to the amounts paid for eleven other payments. OMB Circular A-87 states that costs must be adequately documented to be allowable under federal awards.

We are questioning the $17,208 in errors uncovered in our sample. We believe, however, that likely questioned costs are material to the program administered at the Division of Child Development.

Recommendation: The Foster Care claim for reimbursement should be revised. The Division should only claim reimbursement for those children who are Foster Care eligible. Eligibility of children with duplicate identification numbers should be researched in order to eliminate those who are not eligible. The Division should request reimbursement for only actual amounts paid for day care services and should eliminate duplicate payments before submitting the claim.

Agency Response: Deloitte and Touche has taken several actions to eliminate identified errors and is preparing a revised claim:

Duplicate client IDs identified on the Day Care Reimbursement file were researched and made unique. A revised claim report has been produced which eliminates the overpayments and underpayments which had previously occurred because of cases in which several children share the same ID. Additionally, ineligible children appearing on the earlier report due to their sharing a client ID with an eligible child, have been identified, given a new ID, eliminated from the claim documentation report, and the cost of the child day care they have received will not be included in the revised claim. To assure absolute accuracy of the claim, a final step has been added to the selection methodology. In this step, prior to the production of the claim documentation report, the system does a final verification of eligibility dates including recognizing and accounting for breaks in foster care eligibility.

Deloitte and Touche asserts that all issues with regard to the claim submitted for Foster Care maximization reimbursement have been addressed and all errors have been eliminated. They contend that the methodology they have used ensures accurate eligibility selection and that no duplication occurs in the revised claim or will appear in future claims. The revised claim and supporting documentation report are now ready for review and acceptance by the Department of Human Resources.

20. THE COST ALLOCATION PLAN SHOULD BE AMENDED FOR CHANGES IN THE ALLOCATION BASIS

The Division failed to prepare an amendment to its cost allocation plan to include a new cost center. Federal regulation 45 CFR 95.509 requires that the cost allocation plan be amended if the allocation basis is changed. The Division claimed $9,990 from federal programs for amounts charged to the cost center not included in the cost allocation plan. We are questioning this amount as follows: Aid to Families with Dependent Children (93.560) - $5,360; Child Care and Development Block Grant (93.575) - $4,630.

Recommendation: The Division should strengthen procedures to ensure that its cost allocation plan is amended promptly when changes are made.

Agency Response: In response to this audit finding, the charges to RCC 1148 were made due to a Legislative mandate effective January 1996. We find that there was an oversight and an amendment was not executed for the charges to RCC 1148. The Division will submit a retroactive amendment for RCC 1148. With the centralization of the DHR Accounting Sections, there will be a new section responsible for the Cost Allocation process. This will result in better monitoring of the amendments and charges to newly established RCCs.

21. FEDERAL FUNDS SHOULD BE DRAWN DOWN IN A TIMELY MANNER

The Division failed to promptly draw down $2,386,995 in federal funds in the Child Care Assistance program in compliance with the agreement between the State of North Carolina and the United States Department of the Treasury implementing the Cash Management Improvement Act of 1990. Because state funds were temporarily used in place of federal funds, the State lost approximately $31,000 in interest that could have been earned on these funds.

The Treasury-State agreement requires that direct program expenditures and direct administrative costs other than payroll be reimbursed on a pre-issuance basis. The State's Cash Management Plan requires agencies to schedule their requests for federal funds so that the receipt of those funds occurs as close as practical to their disbursement. The State is at risk of losing interest when it fails to collect the federal share of its costs in a timely manner.

Recommendation: The Division should more closely monitor its cash requirements. The Division should comply with the Treasury-State agreement implementing the requirements of the federal Cash Management Improvement Act of 1990 and the State's Cash Management Plan.

Agency Response: We concur that we were not in compliance with the Cash Management Improvement Act for August 1995. Due to changes in staff and preparation of the financial statements, funds were not drawn down in August. The CMIA directive has been discussed with staff and made fully aware they are not to use state funds for federal funds.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

22. DISBURSING ACCOUNT STATEMENTS SHOULD BE PROPERLY RECONCILED

Our examination of disbursing account statements disclosed unreconciled differences between the balance on the disbursing account statement and the balance on the general ledger. At June 30, 1996, there was an unreconciled difference of $22,823 between the book and the disbursing account balances.

Recommendation: The Division should strengthen its internal controls by requiring disbursing account statements to be properly reconciled.

Agency Response: The DHR Controller's Office concurs with this finding. During SFY 1994, the bank reconciliations for the Division were not kept current. Two temporaries were brought in to complete the reconciliation. Due to lack of all necessary information, the amount which they could not reconcile was $22,824.81. The Division currently reconciles back to this amount on a monthly basis. Since we were unable to determine the reason for the $22,824.81, we asked the auditors what to do; however, no response has been received. We are again asking for assistance in what to do. Also, we have contacted the Office of the State Controller for any assistance they may be able to provide.

23. INVOICES SHOULD BE CANCELED AT THE TIME THEY ARE ENTERED INTO THE ACCOUNTING SYSTEM

We noted that eight disbursements, out of thirty-eight tested, included invoices which were not canceled. This condition occurred because the Division failed to require the proper cancellation of invoices. The risk of duplicate payments increases when invoices are not canceled.

Recommendation: The Division should strengthen controls by requiring that invoices be canceled at the time they are entered into the North Carolina Accounting System.

Agency Response: The DHR Controller's Office does not concur with this issue. The period covered by this audit is July 1995 through June 1996 which is the first year of NCAS. Under the new account system, invoices are paid based on the payment terms of the vendor. Therefore, when the invoice is keyed into NCAS, it may not be paid for up to 30 days. Canceling the invoice paid does not mean that the invoice was paid when keyed in. There is no feasible way of determining payment except on an invoice by invoice basis which is very time consuming. There are safeguards built into NCAS which deter duplicate payments. NCAS will not allow the same invoice number for a vendor to be keyed in/paid twice and therefore a duplicate payment cannot be made. However, since NCAS was implemented by the Division the Office of the State Controller has issued Memorandum No. NCAS 97-0039 which gives instructions on how to cancel invoices. The DHR Controller's Accounts Payable Unit will implement the necessary action to comply with this Memorandum.

24. MONITOR REIMBURSEMENTS TO INSTITUTIONS MORE CLOSELY

The Wright and Whitaker Schools submitted invoices to the Division which contained clerical errors in five of the six months sampled. These invoices were for reimbursement of the Aid to Families with Dependent Children - Emergency Assistance program. The miscalculation of days to be reimbursed caused Wright School to be underpaid by $7,050 and Whitaker School to be overpaid by $7,650. OMB Circular A-87 requires that costs be allocable to federal awards and be adequately documented. We are questioning the net overpayment of $600.

Recommendation: The Schools should make the necessary corrections for the above-noted errors. Also, the Division should consider requesting supporting documentation from the Schools prior to making payments. The Wright and Whitaker Schools should implement procedures to ensure the clerical accuracy of invoices.

Agency Response: We agree with this finding and the related questioned cost of $600. As recommended by the State Auditor, the Division has implemented a procedure through which census and utilization data will be submitted along with billing to document the charges which were reported.

25. DETERMINE ELIGIBILITY BEFORE PAYING BENEFITS

From a sample of seventy-five students reviewed at the Wright and Whitaker Schools, we noted that the Whitaker School incurred costs in the Aid to Families with Dependent Children - Emergency Assistance program for four students whose applications were not completed as required. The Whitaker School did not complete an application for two students and it failed to obtain the answer to a required eligibility question for two other students.

Federal regulation 45 CFR Section 234.120 (f) requires that an applicant's eligibility be adequately documented. School personnel responsible for determining eligibility did not demonstrate a complete understanding of all the eligibility requirements. We question $16,065 in costs related to these four students.

Recommendation: Eligibility should be adequately documented in the application process.

Agency Response: We disagree with this finding and the questioned cost of $16,065. All eligibility information has been completed on the two EA applications that were noted to be incomplete. All of the relevant eligibility information utilized to complete the two EA applications was contained and had previously been documented in the client service record. The Operations Manager in the Child and Family Services Section has consulted with the directors of Wright and Whitaker Schools to ensure that all applications will be fully completed. The directors will personally review each application to ensure completeness.

In addition, the audit referenced two children for whom no applications were made. It was appropriate that no applications were completed, as it was intended that no claims be filed on their behalf. These cases were not related to the questioned amount of $16,065. Further, procedures have been established which fully integrate EA eligibility determination into the admission process.

Auditor Comments: We questioned costs for the two students whose applications were incomplete at the time of our audit on July 17, 1996. The applications required the Whitaker School to declare whether the students were eligible. This was not done. As for the two students for whom there were no applications, claims were in fact filed. The claims filed were for retroactive pay for the month of February 1995, and totaled $14,280. Since this amount was questioned in the Division of Social Services section of this report as part of finding 3B, they are not again questioned herein.

DIVISION OF YOUTH SERVICES

26. VERIFY ACCURACY OF DOCUMENTATION IN SUPPORT OF PAYMENTS

The Dobbs School submitted to the Division attendance logs which contained clerical errors. The attendance logs were used to support reimbursement from the Aid to Families with Dependent Children - Emergency Assistance program. The School miscalculated the number of days reimbursed resulting in overpayments of $821 for June 1995 and $137 for August 1995. Also, a student was listed twice for August 1995 causing an additional overpayment of $2,875. OMB Circular A-87 requires that costs be adequately documented. We question the overpayments totaling $3,833.

Recommendation: The Division and the Dobbs School should implement procedures to verify the clerical accuracy of the attendance logs and summaries submitted for reimbursement.

Agency Response: The Division agrees with the recommendation. If the EA program continues, we will have the EA specialist supervisors check the accuracy of the monthly sheets. The log sheets will be checked again upon receipt in the State's EA coordinator's office in Raleigh.

27. ELIGIBILITY SHOULD BE ADEQUATELY DOCUMENTED

From a sample of eighty-seven students reviewed at the Division's five training schools, we noted that the schools billed and received funds for four ineligible students in the Aid to Families with Dependent Children - Emergency Assistance program. Eligibility questions on the applications for assistance for three students were not properly answered. Federal regulation 45 CFR Section 234.120(f) requires that an applicant's eligibility be adequately documented. Another student received authorization for emergency assistance more than one time during a period of twelve consecutive months, in violation of Federal regulation 45 CFR 233.120(b)(3). This regulation limits

authorization for assistance to one time during twelve consecutive months. School personnel responsible for determining eligibility did not demonstrate a complete understanding of all the eligibility requirements. We question $12,045 in costs related to these four students.

Recommendation: Eligibility should be adequately documented in the application process. Also, the Division should comply with the time limits defined in the eligibility requirements.

Agency Response: The Division concurs that errors were made in the completion of the applications in 3 of the cases cited. The errors were failure to correctly ***document*** eligibility. In all of these 3 cases the clients were correctly determined eligible during the application process, but the workers failed to document the clients' eligibility by correctly and completely answering all questions in the records.

In the fourth case, the worker states that she checked the automated EA Eligibility system to determine if the client had been determined eligible by another agency or by another worker within the agency. She found that the client had been determined eligible and was within the 12 months period of eligibility. However, she failed to note that the client had been determined eligible for *cash only* and had not been determined eligible for *services*. The error was not an incorrect or duplicate determination of eligibility within a 12 month period, but rather the provision of a benefit for which the client had not been determined eligible during the 30 day prescribed period of eligibility determination.

If the EA program continues, we will have supervisors of our EA specialists at the facilities monitor for accuracy, in addition to a regular monitoring once the application reaches the EA coordinator in the Central Office.

28. THE DIVISION SHOULD COMPLY WITH THE STATE CASH MANAGEMENT PLAN

The Division regularly failed to promptly request reimbursement for Social Services Block Grant (SSBG) and Aid to Families with Dependent Children - Emergency Assistance (AFDC-EA) expenditures. The State Cash Management Plan requires agencies to promptly bill other governmental agencies for amounts due. This finding is similar to one noted during our prior year audit.

Because State funds were used in lieu of federal funds, the State lost $88,000 in interest as a result of not drawing federal funds in a timely manner on the AFDC-EA program. We were unable to calculate the interest lost from the SSBG program because the transactions for several months were lumped together on the detail transaction ledger, making a correct calculation impossible.

Recommendation: The Division should comply with the State Cash Management Plan and request reimbursement for federal expenditures in a timely manner.

Agency Response: The Division agrees with the recommendation. The consolidated DHR Controller's Office has developed procedures to draw down federal funds for each applicable check write. In addition, the Federal Funds Unit will monitor, on a monthly basis, the draw down of Federal funds. Also, the Budget Officer within the Division will review the monthly BD-701 report to ensure that receipts are drawn monthly and properly recorded.

DIVISION OF SERVICES FOR THE BLIND

29. REHABILITATION EQUIPMENT SHOULD BE PROPERLY CONTROLLED

The Division has not developed appropriate procedures to account for and monitor the status and location of equipment purchased for the rehabilitation of its clients. The Division purchased $389,000 of rehabilitation equipment during the fiscal year for the use of clients, yet none of it was recorded in an inventory control system. In the absence of appropriate controls over its use and custody, the equipment cannot be safeguarded or monitored against accidental or intentional misuse or neglect.

Forty-five CFR 92.20(b)(2) states that grantees must maintain records which adequately identify the source and application of funds provided for financial-assisted activities. Good internal control requires that equipment be controlled with records which identify its use and disposition.

Recommendation: The Division should develop and maintain appropriate records to assist in the management and control of its rehabilitation equipment.

Agency Response: The Division will work with the Division of Information Resource Management (DIRM) to develop a standard and more centralized system which will aid in tracking equipment purchased by the Division for blind consumers. Currently documentation of purchase of equipment is maintained in each client's case file rather than in a single database. The centralized system should track equipment from time of purchase until it is released to the consumer. To the extent possible, the system will build upon the Division's existing client database versus development of a new system. The Division does wish to avoid development of a costly system or one which is highly labor intensive to maintain. The Division recognizes the potential benefit of the development of a system which is user friendly and reliable.

30. PROCESS PAYMENTS IN COMPLIANCE WITH STATE AND FEDERAL REGULATIONS

Controls over invoice payments have failed to prevent premature payments. In our tests of controls over cash disbursements, we noted four instances in which invoices were paid before their due dates. Because of the premature payment of the Division's obligations, the State Treasurer loses the opportunity to invest and earn interest income on the funds which have been disbursed prematurely.

The State Cash Management Plan and G.S. 147-86.11 state that billings to the State for goods received and services rendered shall be paid neither early nor late but on the discount date or due date to the extent practicable. Forty-five CFR 92.20(a) states that a state must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds.

Recommendation: The Division should comply with the Cash Management Plan and governing federal regulations.

Agency Response: We agree four invoices were paid prior to the due date. With the consolidation of accounts payable into one operational unit within the newly centralized DHR Controller's Office as well as accounts payable personnel now having a year's experience with the new State Accounting System (NCAS) instances such as these should be at a minimum.

OTHER DEPARTMENTAL DIVISIONS

The results of our tests disclosed no instances of noncompliance and no material weaknesses in internal control which require disclosure under *Government Auditing Standards* for the Division of Central Administration, the Division of Aging, or the Division of Vocational Rehabilitation Services.

DISTRIBUTION OF AUDIT FINDINGS AND RECOMMENDATIONS

In accordance with G.S. § 147-64.5 and G.S. § 147-64.6(c)(14), copies of this document have been distributed to the public officials listed below. Additional copies are provided to other legislators, state officials, the press, and the general public upon request.

EXECUTIVE BRANCH

The Honorable James B. Hunt, Jr.	Governor of North Carolina
The Honorable Dennis A. Wicker	Lieutenant Governor of North Carolina
The Honorable Harlan E. Boyles	State Treasurer
The Honorable Michael F. Easley	Attorney General
Mr. Marvin K. Dorman, Jr.	State Budget Officer
Mr. Edward Renfrow	State Controller
Dr. H. David Bruton	Secretary, Department of Human Resources

LEGISLATIVE BRANCH

Appointees of the Joint Legislative Commission on Governmental Operations

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Senator Robert G. Shaw	Representative Stephen W. Wood
Senator Ed N. Warren	
Senator Allen H. Wellons	

Other Legislative Officials

Representative James B. Black	Minority Leader of the N.C. House of Representatives
Mr. Thomas L. Covington	Director, Fiscal Research Division

October 10, 1997

ORDERING INFORMATION

Copies of this document may be obtained by contacting the:

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JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

MINUTES
NOVEMBER 19, 1997

The Joint Appropriations Subcommittee on Human Resources was called to order by Senator William N. Martin on Wednesday, November 19, 1997 at 9:00 a.m. in Room 414 LOB. Six Senators attended. The following House members were present:

Representative Charlotte Gardner	Representative Lanier Cansler
Representative Debbie Clary	Representative Alma Adams
Representative M.W. Aldridge	Representative Martha Alexander
Representative J.W. Hurley	Representative Edd Nye
Representative Julia Howard	Representative Beverly Earle
Representative Theresa Esposito	

Staff members present were: Karen Hammonds-Blanks, Carol Shaw, Mary Ellen Sylvester, Dianna Jessup, and Gann Watson.

ABC WORKPLAN

Peter Leousis, DHHR Assistant Secretary of Children, Youth and Family, presented the Proposed ABC Workplan for the Division of the Deaf and Hard of Hearing Schools (See attachment #1). The goal of this plan is to fulfill the requirement of the Special Provision in the 1997-98 Budget to meet the expectations of the ABC Plan in the schools supervised by the division. The members questioned Mr. Leousis about collaboration with the Department of Public Instruction in making these plans with particular concern about the testing requirements.

Mr. John DeLuca, Director of the Division of Services for the Blind, and Dr. John Bernardo, Superintendent of the Governor Morehead School for the Blind, presented the plans for implementing the ABC Plan for blind students(See attachment #2). Members were concerned with the level of achievement of blind students particularly those that have been "mainstreamed". Staff will get more information on the relationship of the LEAs (Local Area Administrations), blind students, institutions and constituent groups for the members of the committee. They also wanted to know the historical context of "mainstreaming".

Dr. Craig Green, Director of the Services for the Deaf and Hard of Hearing, presented the report on this department's efforts to meet the needs of the students. His focus was on the opportunity offered by the special provision in the Budget requiring the deaf schools to meet ABC requirements since students were not now functioning at grade level academically.

11-19-97
attachment 18

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

DSH payments are payments made to hospitals that serve either a large number of Medicaid or uninsured patients. Hospitals may qualify for a DSH payment either because of a federal minimum standard or by determination of the state. DSH payments are permitted, and to a certain extent required, by federal law governing Medicaid.

Federal law requires the DSH payment to hospitals that serve Medicaid and uninsured patients at a level equal to or above a "low income utilization rate" or "Medicaid utilization rate", both determined by calculating the ratio of Medicaid and/or uninsured charges against total charges. The "low income utilization rate" is set by law at 25%, the "Medicaid utilization rate" is set at one standard deviation above the state average, at present that is 28%. North Carolina also has determined that hospitals with an overall Medicaid and bad debt ratio of 20% of revenues as being eligible for DSH along with the hospitals that provide the top 50% of Medicaid inpatient days. These payments are made from the regular program budget as an add-on to the inpatient hospital payments. Traditionally these payments amount to about 2% of total inpatient hospital services ($15 million).

Federal law also permits the state to qualify other hospitals as DSH so long as the hospital has a Medicaid utilization rate of at least 1% and the state has defined the DSH hospital in a manner that is uniform and applied equally. Based upon changes in the federal law over time the State has since SFY 92-93 determined that the State owned hospitals are DSH eligible and since SFY 95-96 the other non-state public hospitals are DSH eligible.

The most notable changes to DSH are noted below:

1991 Federal restrictions are placed on provider taxes and donations. intergovernmental transfer are protected. Limits on DSH expenditures are set by introduction of state specific and national level limits.

1993 Hospital upperlimits implemented between 1994 and 1995. A specific hospital could not be paid more than their cost for Medicaid and uninsured patients.

1997 Beginning in FFY 1998 the state allotment for DSH is reduced over a period of time and the amount of DSH paid to an Institution for Mental Disease is implemented. HCFA has not determined the level of funds available for the IMD, an interpretation is expected prior to January 1, 1998. Based upon analysis of options for SFY 98-99. the $83 million budgeted as a non-tax revenue is expected to be covered.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS (DSH)

Divison of Medical Assistance
History of Transactions

State Owned Hospital (State Psych Hospitals and UNC)

Year	(000,000's) Paid	Gain
91-92	$ 56	$ 37
92-93	$ 255	$ 159
93-94	$ 467	$ 303
94-95	$ 168	$ 96
95-96	$ 164	$ 78
96-97	$ 159	$ 101
97-98	$ 158	$ 97
Total	$ 1,426	$ 870
Reverted or Transfer to State as Non Tax Revenue		$ 787
DMA Retained per 97-98 budget		$ 83

DSH and Supplemental Payments to Non-State Hospitals

Year	(000,000's) Paid	State Gain	Hospital Gain
95-96	$ 195	$ 50	$ 88
96-97	$ 295	$ 35	$ 174
97-98	$ 292	$ 40	$ 166
Total	$ 782	$ 125 *	$ 428

* All payments are subject to cost settlement, estimated value of funds in trust is $110 million

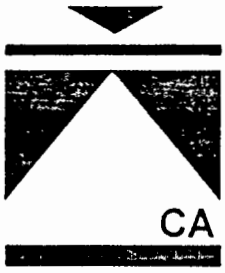
Summary		
State Hospitals		$ 870
Non-State		$ 428
DMA Trust		$ 110
	Total	$ 1,408

CAROLINA ACCESS

57	Counties participating
330,438	Medicaid eligibles enrolled

Advantages:

- Your own personal doctor
- Coordinated Care
- Referral to specialists
- An alternative to the ER
- More choices for health care
- Accountability

Carolina  ACCESS

Counties as of November 1, 1997

Alamance
Alexander
Anson
Beaufort
Bladen
Buncombe
Burke
Cabarrus
Caldwell
Camden
Caswell
Catawba
Chatham
Cherokee
Cleveland
Craven
Currituck
Davidson
Duplin
Durham
Edgecombe
Forsyth
Gaston
Granville
Greene
Guilford
Halifax
Harnett
Haywood
Henderson
Iredell
Jackson
Johnston
Lee
Lenoir
Lincoln
Macon
Madison
Moore
Nash
Northampton
Onslow
Orange
Pasquotank
Pender
Person
Pitt
Rockingham
Sampson
Scotland
Stokes
Surry
Transylvania
Wake
Warren
Wayne
Wilson

CAROLINA ACCESS

Outcomes

Our state Medicaid program saw:

- ER costs decreased in ACCESS counties by 31% for children, 39% for disabled , and 45% for other adults
- Primary Care Providers increased by 7%
- Hospital inpatient cost **decreased** by 3.5%
- Hospital outpatient costs at **zero** growth
- County-based plan representatives
- Provider training
- Physician-controlled care management
- ER physicians have an opportunity to refer

ACCESS II

- Builds on Carolina ACCESS
- Provider focused
- Incentives to hold down cost
- Tools to hold down cost
- Maintains physician control
- Encourages integration & cooperation among health care providers

Sites

Comprehensive Community Care Plan:

- Cabarrus County
- Pitt County

Enhanced Program:

- Buncombe County Health Center
- Cleco, Cleveland County
- Durham Network
- Gaston Family Health Services
- Health Serve Medical Center, Guilford County
- Surry County Health System

Medicaid HMO

Mecklenburg HMO's:

- Atlantic Health Plans
- Kaiser
- Maxicare
- Optimum Choice
- Wellness

Mecklenburg County HMO Enrollment 28,168

Gaston County HMO's

- Maxicare
- Optimum Choice
- Wellness

Gaston County HMO Enrollment 43

Triangle Area HMO Applicants
(Wake, Durham, Orange, Person,
Chatham, and Harnett Counties)

- Optimum Choice
- Community Health Care of NC (FQHC)
- Maxicare
- Generations Health Plan
- United Health Care

Triangle Area Target Enrollment January 1998

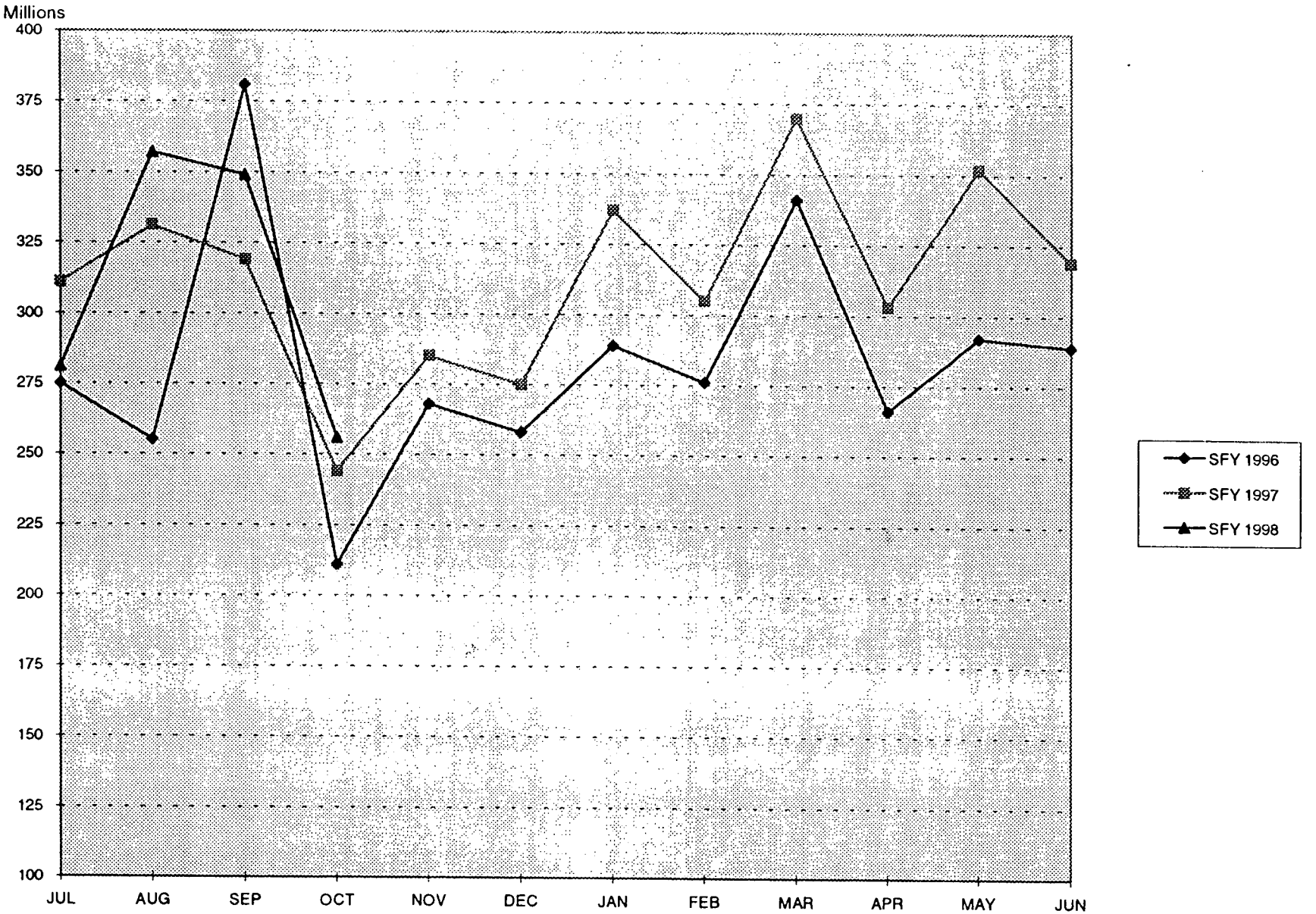
Health Care Connection

Satisfaction Indicators ?

A satisfaction survey is being completed by UNC-Charlotte. Meanwhile some indicators that may be relevant are:

- 139 complaints or .5% of enrollments. All resolved
- 89% recipient selection; 11% auto assigned
- 7% turnover among plans; generally evenly divided; range 13% to 20%

North Carolina Medicaid
Expenditures per Month



11-19-97
Attachement #12

Budgeting for Medicaid

Because of the uncertainty of expenditures patterns, it is difficult to predict the Medicaid expenditures compared to budget in a given 12 month period and nearly impossible to make adjustments in provider payments to reduce expenditures if it appears the budget will be exceeded. A 1% change in the Medicaid budget amounts to $42 million in requirements and $12.6 million in appropriations.

Why is it difficult to take actions to control the budget in the budget year? First, actions need to be taken in the beginning of the year if they are to impact the current year expenditures. For example, actions that affect rates for hospitals or nursing facilities must be taken in October which is the month new rates are implemented. It then takes time before the new rates are billed. For example, a hospital discharge made in October may not be billed for one to six months after discharge. This means the impact of a rate action may be felt for only a part of the year. Another problem is that providers are able to make up for some revenue loss so any reduction taken usually is less than projected.

Over this two year biennium, we expect we will have to make a reduction of about $64 million next year to stay within the 9% appropriation limit. This is a reduction of about 1 1/2%. Rather than take all the cuts next year and to be sure we don't overrun this year's budget, thereby making the $64 million hole bigger, we have elected to take an annualized reduction of about of 1% this year and a reduction of 1/2% for next year. As the year progresses, we will assess the need to take further actions.

Because of the timing of this year's reduction (October 1) and the time it will take for the reduction to flow through the system, the impact this year is expected to be less than 1/2 of 1%. However, if the legislature rebases 98-99 reflecting the reduction we took in 97-98, we will be confronted with the same $64 million reduction for next year.

To prevent this we need to take a longer view of the Medicaid budget, perhaps as long as four years.

Health care insurance companies have the same problem. However, they set up a reserve which can be used to smooth out year to year differences so that over a period of time they are able to stay within their budgets.

Cost Containment Options

Hospital Inpatient: Action taken to hold Medicaid increase to that of Medicare. Medicare did not raise hospital rates for FFY 97-98. SFY 97-98 savings $12.5 million requirements. Annual savings $25 million. Hospital budget $737.1 million.

Hospital Outpatient: Currently, hospitals are reimbursed at 80% of outpatient and ER costs. Both Medicare and Medicaid are looking at getting away from cost based reimbursement to a prospective method. Several projects are underway nationally using flat rates based on diagnosis and other variables. This method could be two years out. Interim actions could include reducing the percent of outpatient costs or changing the method of reimbursement to more closely align with similar services. Hospital outpatient and ER $199.9 million.

Nursing Facilities: Action taken to limit inflation to approximately 2.0% effective October 1. SFY 97-98 savings $7.6 million requirements. Annual savings $15 million. Budget $807.1 million.

Drugs: Currently reimbursing at $5.60 dispensing fee set by the legislature and AWP-10%. N.C.'s dispensing fee is one of the highest in the country. 15 states use AWP discount greater that 10%, 18 use 10% and 8 use less than AWP-10%. Options include reducing the dispensing fee, increasing the AWP discount to higher than 10%, and reimposing the requirement that pharmacies bill the lower of the Medicaid rate or the lowest rate paid by the general public. Each 1% reduction in AWP would save $2.3 million in requirements. Each 1% reduction in dispensing fee would save $470,000 in requirements.

We are working with the Pharmaceutical Association on options and are also beginning work with the Association and Medical Society to look at how providers can be more cost conscious in the prescribing of drugs. Budget $448.8 million.

In-home Services: Reduce some rates based on better cost report data, tighten up medical necessity criteria, introduce controls such as assessment, reassessment and prior approval, reduce inflation amount and require Medicare billing before billing Medicaid. Working with the Association on all of these options.

CAP Services: Hold to reasonable budget limits. CAP services are budgeted each year based on use estimates. CAP/MR actions taken in October, which are not related to budget reductions, but to payment rates that are excessive, should permit us to serve significantly more recipients with the same amount of money. We are continuing to review all reimbursement rates for reasonableness and are working with advocates, providers, area programs and Mental Health to tighten up the program. CAP/MR budget $119.8 million. CAP/DA budget $126.4 million.

Public Provider Services: Public health, mental health, state hospitals, state ICFs/MR - Hold to reasonable budget targets and make off-budget adjustments when appropriate. Off-budget adjustments include supplemental payments to cost.

FQHC and Rural Health: Hold to reasonable costs but permit expenditures for primary and preventive care to expand.

ACH-Personal Care: Hold inflation increases pending cost report data and RTI report that supports existing rate structure as per HCFA interim approval for this service.

Physician Services: Limit payment to the lower of Medicaid or Medicare. Reduce inflation rate.

Durable Medical Equipment: Tighten up enrollment criteria. Reduce rates based on more current cost data. Competitive bid.

Implement Modifier Enhancement to MMIS: This enhancement will permit more stringent pricing by unbundling some services which now must be paid at the aggregate level. Submitting APD for federal approval and expect 12 months implementation.

Implement Detail Crossover Enhancement to MMIS: This will permit detail processing of Medicare crossover claims and permit edit and audit checks for duplicate services. Will follow implementation of Modifiers.

Implement Table Driven Edit System in MMIS: This enhancement will permit quicker implementation of edits which are designed to insure claims that are paid are in conformance with Medicaid policy. Current practice requires too much systems engineering time to implement audits for services. This change will greatly reduce both the cost and time to implement edits.

Disease Management: Undertake demonstration projects to test whether disease management can provide higher quality and lower cost services. Will require up-front investment to test whether diabetes, asthma, cancer and other chronic illnesses can be managed in a cost-effective manner.

Expand and Improve Managed Care: Includes expanding ACCESS statewide, ACCESS II demonstrations, LTC demonstrations and selective expansion of HMOs services in ACCESS counties.

Transfer of Assets: Propose legislation to tighten up transfer of assets law.

Balanced Budget Act of 1997

These are the major provisions of the Balanced Budget Act which could have an impact on North Carolina.

* **Continuous eligibility for MIC children under 19 for up to 12 months without regard to income status.** Current policy permits continuous eligibility if there is no change in income, family composition or living arrangement.

***Presumptive eligibility for children under 19 including AFDC and MIC.** Presumptive eligibility could be determined by authorized entities. Eligibility would be good for the month in which it is determined and the following month. If an application is not filed, eligibility ceases.

***Disabled children losing SSI.** Medicaid must be continued for children under 18 who were receiving SSI and who were/are terminated because they no longer can meet the new children's disability criteria. Eligibility continues until the child no longer meets the financial eligibility criteria for SSI.

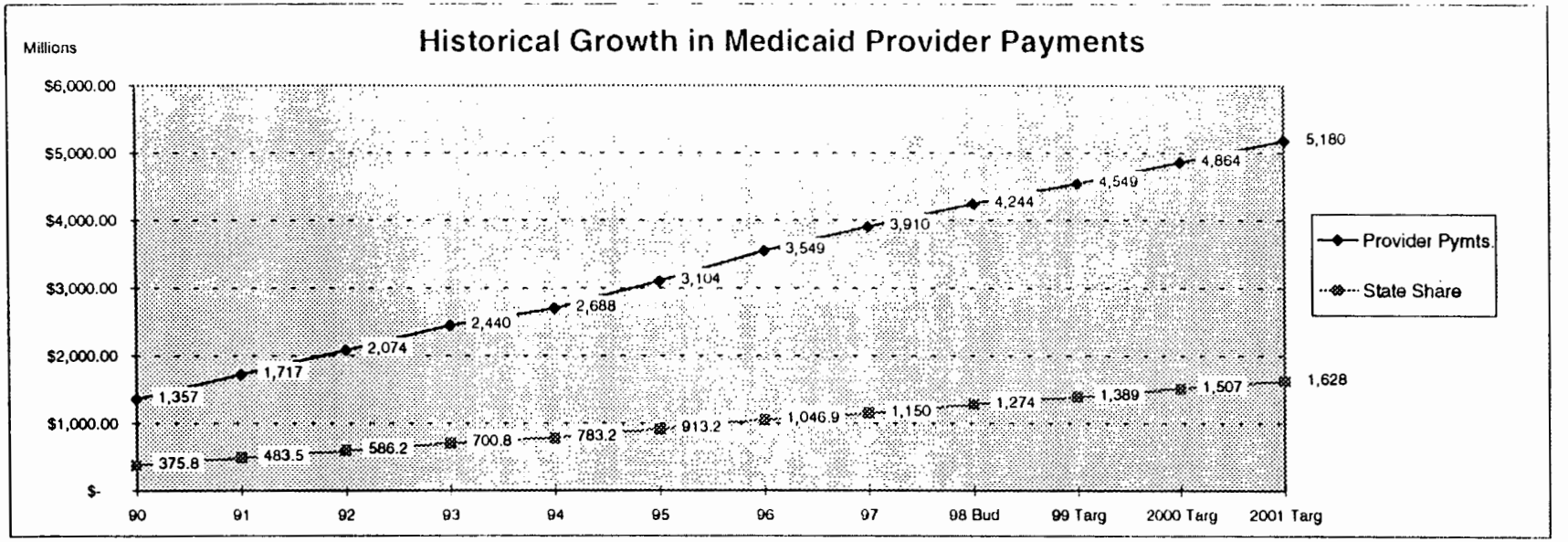
***New Children's Health Insurance Program**

***Qualifying Individuals (QIs) for payment of Part B Premium.** Creates two new eligibility groups. Medicare recipients whose income is between 121% and 135% will have their Part B premium paid for by the Federal Government up to the amount of the state grants. Those whose income is between 136% and 175% of the FPL may have the increase in their premium attributable to the shift of Home Health from Part A to Part B, paid for by the Federal Government up to the amount of the state allotment. This will be on a first come first serve basis. The amount that must be paid out for the second category is $1.07 per month. State must put up 50% of the cost of administering this new benefit.

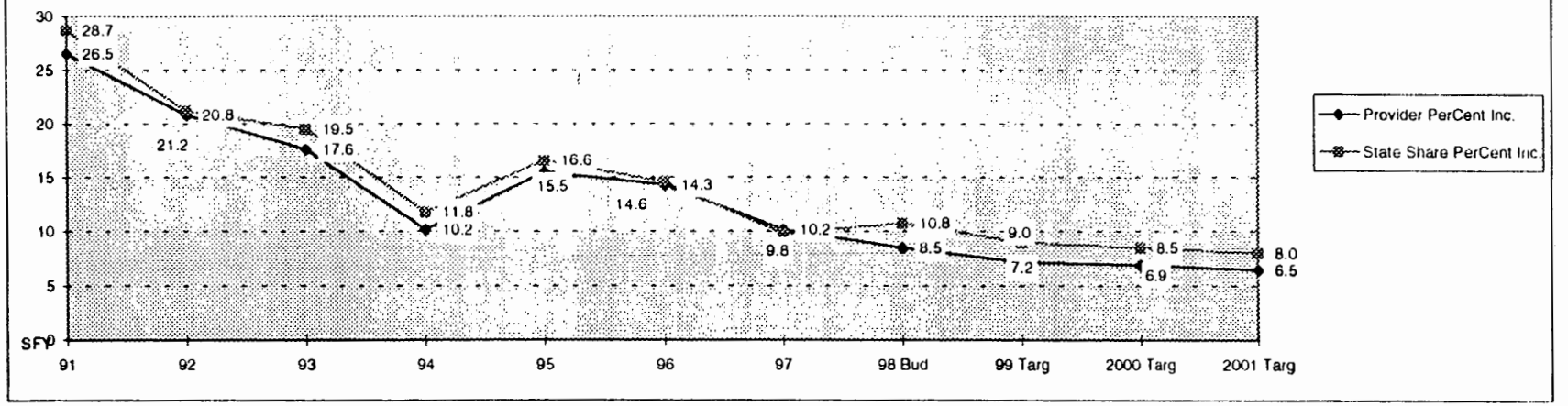
Medicaid buy-in for disabled up to 250% of FPL. This provision permits the states to cover persons who meet the federal disability provisions except for income. Upon payment of a premium, these persons would qualify for all Medicaid covered services.

Medicare Home Health-There are many important changes to the Medicare program. One particular one could have a significant impact on Medicaid. Effective February 5, visits solely for drawing blood will not qualify for coverage under the Medicare home health benefit. The Association for Home Care estimates that 20-44% of their membership's daily patient census may have venipuncture as the qualifying skilled service.

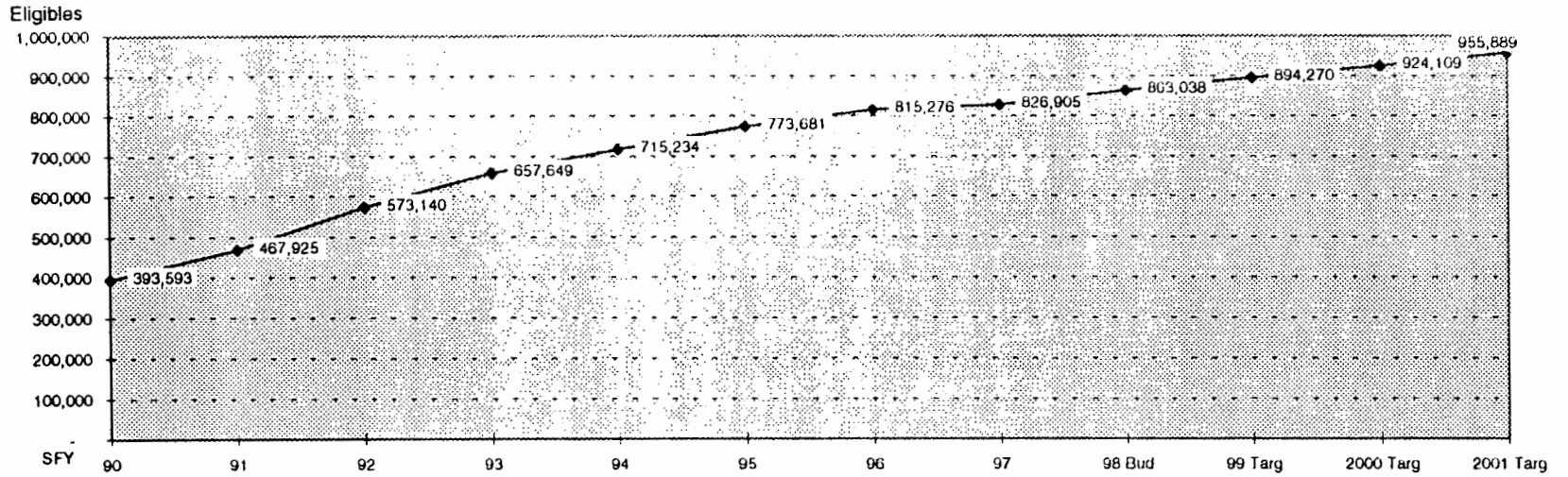
Historical Growth in Medicaid Provider Payments



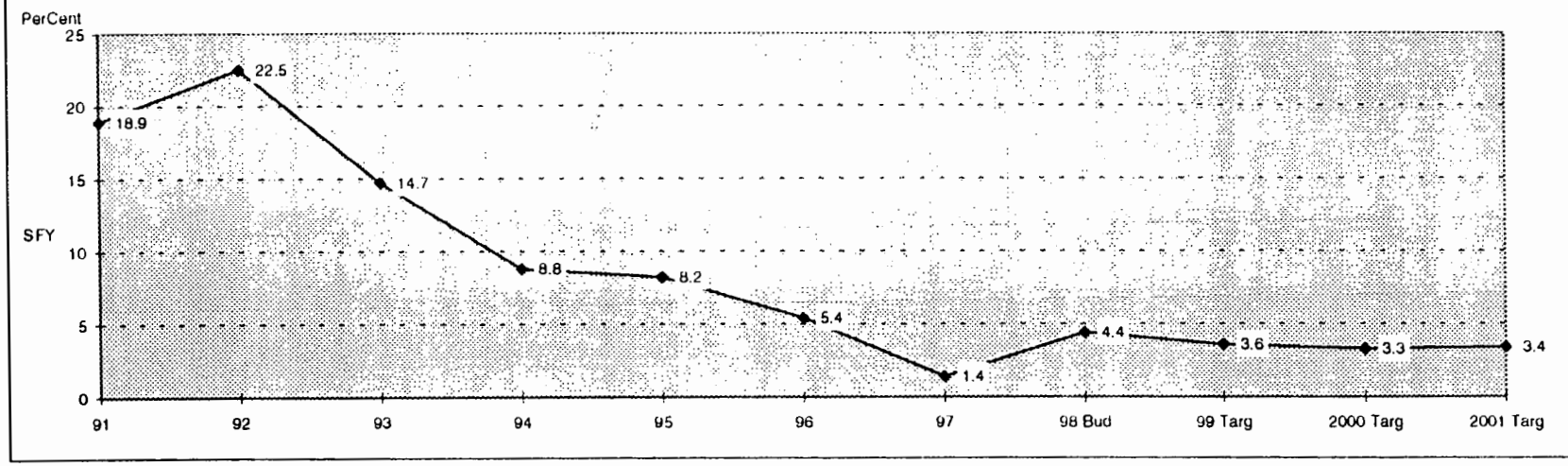
Historical Growth in Medicaid Provider Payments by Percentage



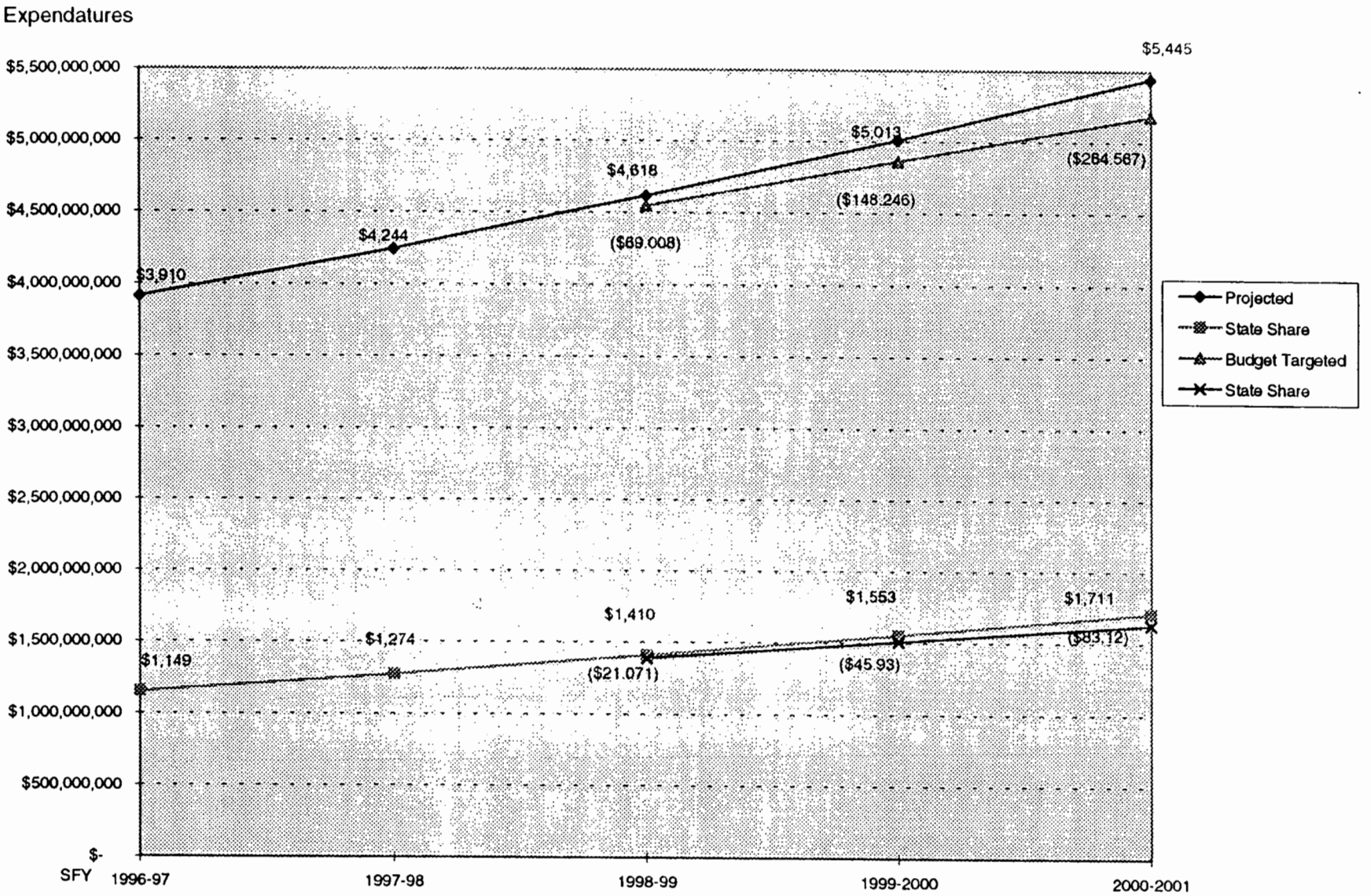
Historical Growth in Medicaid Eligibles



Historical Growth in Medicaid Eligibles by Percentage



Projected Medicaid Expendatures v.s. Budget Target



JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Minutes
November 20, 1997

The meeting of the Joint Appropriations Subcommittee on Human Resources was called to order by Representative Lanier Cansler on Thursday, November 20, 1997 in Room 414 LOB. Five Senators were present and the following House members:

Representative Charlotte Gardner	Representative Lanier Cansler
Representative Debbie Clary	Representative Alma Adams
Representative M.W. Aldridge	Representative Martha Alexander
Representative Bill Hurley	Representative Edd Nye
Representative Beverly Earle	Representative Cindy Watson

Staff members present were: Karen Hammonds-Blanks, Mary Ellen Sylvester, and Dianna Jessup.

Agenda

Chairman Cansler announced that the Medicaid Growth Reduction Plan update is on the agenda again today since there was not sufficient time to hear it yesterday. Senator Martin reminded the chairman that one of the members wanted time to discuss the trip to the C.A. Dillon School.

Wake County Human Services Department

Maria Spaulding, Director of the Wake County Human Services Department, explained the reorganization plan that was implemented in Wake County in 1996. The plan was the result of an ordinance passed by the Wake County Board of County Commissioners and approved by the legislature. The governing concept is to consolidate and integrate services from traditional departments of public health, mental health, developmental disabilities and social services. All separate boards were abolished, and one policy setting board with 25 members that reports to the Board of County Commissioners was established. The authorizing legislation requires representation from a number of professional organizations as well as at-large citizen appointments. The human services agency represents functions and services such as community revitalization and housing Child Support is a stand-alone agency There are 1400 -1600 employees. The positions of Mental Health Director, Public Health Director and Social Services Director were abolished. The director reports to the County Manager and the Human Services Board which allows for better accountability. There are 7 major outcome areas of services designed around special populations and results the department wants to achieve rather than the previous territorial structure of agencies:

1. Family and Youth Success activities
2. Community Health - responsible for prevention awareness, education with the caveat to move from treatment to prevention and intervention.

3. Economic Self-Sufficiency emphasizes redesigning eligibility positions to function from the total perspective of client needs. These include the former entitlement programs.
4. Emergency and Adult Services handles adult services such the Women's Center, 24-Hour Crisis Center, and alcoholic treatment.
5. Adult Community Support Services deals with the populations that will never be self-sufficient from services.

The members' questions about the functioning of the Board, funding relationships, political realities and savings with this system were addressed by Ms. Spaulding. There was $1.4 million in savings last year, and the County Commissioners returned that to the agency. She gave the following statistical information about the clients served: During the first 26 months of the Work First program, services to 2,346 adults in Wake County have been terminated due to employment status. However, there is an increase in the population because there are more cases coming in than are terminating. In response to Senator Phillips' questions about the caseload in Wake County, Ms. Spaulding said that was dependent on the area being served, and she will get that information for the Senator. According to Ms. Spaulding, there are 8,442 on AFDC, 23,836 receiving Food Stamps and 35,533 Medicare recipients out of a population of 525,000.

Senator Martin asked about the families on Work First and if there is anything to address their getting and keeping jobs. Ms. Spaulding said she thought there are about 100 families who have about a year on Work First, and the new Job Link Center will be a permanent resource for clients needing job information.

Representative Nye asked why Wake County has the largest waiting list for developmental disabilities in the State, 839 made up of half children and half adults, and whether some of the savings could be put in this program. Ms. Spaulding said this was not a priority this year, but she planned to ask the county commissioners to appropriate some money for this program and suggested the legislators do the same to serve these people.

Senator Dannelly asked, of the remaining cases each month not getting jobs, whether that group is growing. Ms. Spaulding said she had not captured that information yet. Her fear is that those people who are going off Work First will move into the homeless group and dollars will just shift around.

Work First/Women's Health Initiative

Bruce Handley, Director of Missions Outreach for the Mission St. Joseph's Hospitals, presented information on the partnership to produce a Work First program. (See attachment #1). The other members of this partnership are the Asheville Housing Authority and the Department of Social Services. The outgrowth of this partnership is the In-home Aide Training Initiative which produces Certified Nurse Assistants. The program received a $50,000 Fannie Mae Foundation grant. The presentations that followed explained how the Work First program is structured, how each group contributes to the program and the results. Spike Gram from the Asheville Housing

Authority, Carolyn Colvarde of the Buncombe County Department of Social Services and Kay Clark, a R.N. at Mission St. Joseph's, explained each agency's role in the program.

Follow-up on Yesterday's Questions on Medicaid Accounting Procedures and Update on Medicaid Cost Reductions

Dick Peruzzi, Director of Medical Assistance, brought members up-to-date on the corrective measures taken as a result of the audit (See 11-19-97 Minutes). He said the overpayment was made on August 7,1996, and the provider notified DMA and EDS of the error on August 10, 1996. September 1, DMA picked up the error because they reviewed the August claims. On September 28, 1996, the provider sent a return check. He explained the corrective measures the division has taken:

- The Auditor suggested they have upper limits depending on the type of claim and they have installed this system on September 25, 1996 They have different 100 levels depending on the provider type and specialty type. Whenever one exceeds the appropriate level for that particular service it "kicks out".
- EDS is required to a 100% review on any "kick outs".
- DMA does a sample of EDS review quarterly to satisfy themselves that they are done correctly. The division's review is extremely comprehensive looking at eligibility, provider enrollment and all of edits and audits required for that system
- A third review is done quarterly as part of their surveillance and utilization review system where they routinely look at exceptions to peer averages.

The members had some questions about the length of time before the money was returned and what can be done about it. Mr. Peruzzi said there needed to be this kind of critical independent review, and the department benefits from having issues like these identified. The question of why the division's fiscal agent wasn't timely in getting the overpayment returned will be addressed, according to Mr. Peruzzi. Senator Martin asked if it had been determined that the provider received interest on the overpayment while it was in their account for 5 weeks and would the state get that money back? It was Mr. Perruzzi's expectation that they did since it was electronically transferred to the provider's bank account, and he said the interest would be recovered. Mr. Peruzzi agreed with Senator Dannelly that we need to react cautiously in recovering interest from providers since sometimes the turn-around on payment is 30-45 days. He explained this is almost a paperless process, and the division does the edits and audits to monitor the system.

Mr. Peruzzi gave an overview of Medicaid program which covers 1.2 million people in North Carolina and represents an expenditure of about $4 billion (See Attachment #2). The administrative costs are about 3.1% which about 24% below the national average. The cost to the recipient is about $4,016. In North Carolina 1 in 7 receive Medicaid which is 14% of the population but 1 in 7 North Carolinians are uninsured which is 14% of the population. 44% of babies born in North Carolina are served by Medicaid. 82% of nursing home patients receive some Medicaid assistance which includes co-insurance and deductibles the division pays for Medicare patients. 100% of Children to age 19 who live in poverty (family of 4 with an income of $15,000) are eligible for Medicaid. There are

over 48,800 providers, and DMA pays over 70 million claims. $1.1 billion is spent on 805,000 mothers and children. $1.5 billion on 175,000 disabled. $1.3 billion is spent on 169,000 elderly. The funding mix is 63.9% federal, 30.7% state, and 5.4% county (96-97 figures). Mr. Peruzzi said he would get the committee the latest update on these figures. He told the committee the impact of changes in the program on the budget: A 1% increase in the Medicaid budget represents $12.7 million in state appropriations and $42 million in provider payments. The 4 main elements that drive the Medicaid Budget are the number of eligibles, cost per unit of service, the number of units, and the Medicare costs. To limit the growth of Medicaid is difficult because the state does not have control of all the variables; only our own payment rates and utilization of services can be controlled to some extent. The principle way is try to reduce the rate of use of service and engage the physicians to use the Carolina Access program. Strategies being emphasized are preventive care, outpatient care and overall patient management to reduce in-hospital care and emergency room use. He feels these are working and are reflected in the figures. Dr. Peruzzi suggested because of the unpredictability of variables that affect Medicaid the division be allowed to hold on to any reductions as reserves against variations in eligibility and utilization of programs from year to year.

Rep. Aldridge wanted to know if the death rate was adjusting the growth rate? Dr. Peruzzi explained how they extrapolate the information to know the increase in the eligibles, and he wonders if client's income is such they can't qualify for programs. Senator Phillips wanted to know what is being done to deal with people who can't afford medicines and as a result end up in the hospital where the expense is greater than the cost of the medication to prevent a worsening of their illness. According to Dr. Peruzzi, a drug task force looked at this problem, and found it would require a great deal of money. He said he would ask the Division of Aging to send Senator Phillips a copy of the report. In answer to Rep. Aldridge's question about using savings from reductions in Medicare for prescriptions, Dr. Peruzzi said it had been tried. It was determined Medicare cannot recognize savings across two programs. There are no savings from Medicaid.

Representative Gardner suggested we add dental care if there are any savings anywhere that can be used. Representative Cansler said he perceived the growth in Medicaid was the result in expansion of eligibles, and Dr. Peruzzi agreed. Representative Cansler asked if we focus on uninsured children in expanding the Medicaid program, what is the projection in the growth in eligibles? Dr. Peruzzi predicts there are about 70,000 children and they will be low cost. Preventive care would be more cost effective and wouldn't have a major budgetary impact. Representative Gardner said that if we have a responsibility for these children in Medicaid, why doesn't Medicaid take preventive dental care into consideration. She also wanted to know when are we going to hear about the children's health insurance program Secretary Bruton said he would appreciate having some time to talk with the committee about this topic. Representative Cansler said he would like to see these items put on the next agenda since there isn't sufficient time to discuss them fully today. Representative Gardner commented that she didn't believe they had heard a full discussion of Medicaid growth reduction, and

Representative Nye agreed. He said we're supposed to get a report by April of 1998, and maybe the committee will hear then.

Regional Public Health Department

Chris Hoke, Deputy State Public Health Director spoke to the committee about regionalization of Public Health agencies. He asked Danny Staley who is a district health director to give the committee a view of how it operates. Mr. Staley said his board listed the advantages to regionalism as:

1. Availability to resources small counties wouldn't have
2. Larger population base
3. Reduced bureaucracy
4. Savings to counties
5. Program and staffing flexibility
6. Build infrastructure to meet changing needs
7. Addressing programs that single counties might not want or can afford
8. Consolidation of supervisory functions
9. Economies of scale for the use of equipment
10. Stability in manpower and ability to attract a quality workforce

In answer to Representative Nye's question about Smart Start, Mr. Staley said they are a provider and worked with the program to provide services they need. He also asked if Carolina Access would have detrimental effects on Public Health in his district. Mr. Staley said Carolina Access was a concern. His experience was that even though clients are rostered with a physician they're still going to show up where it is convenient and attention is timely. In answer to Representative Nye's question about his region being a primary health service provider, he thought 24 hour access was a difficulty. Senator Phillips asked about availability of health clinics to rural people and was told that serving this population base was being accomplished.

Butner Field Trip

Senator Martin led the discussion on the Butner field trip. Representative Aldridge was concerned that the short time the inmates are assigned to C.A. Dillon wasn't adequate to impact the behavior of the inmate and suggested a study committee to look into this issue. He said there was not follow-up on these inmates. Senator Martin pointed out the split jurisdiction of these young people because the Department of Health and Human Services runs the training school but when the inmates are released they are under the jurisdiction of the Administrative Office of the Courts. Gwen Chunn, Director of the Division of Youth Services, explained the legal aspects of the sentencing of the young people over which Youth Services has no control. The inmates cannot be incarcerated any longer than an adult would be who is guilty of a similar offense. Aftercare and accountability are issues that will be addressed by the Governor's Commission on Juvenile Crime. Youth Services would like to be able to give the committee clearer evidence of success of their programs, according to Ms. Chunn. Senator Martin asked about follow-up by the Administrative Office of the Courts. Ms. Chunn may keep up with those who have met their goals at the training schools and "paroled" early. Dr. Bruton wants to change

philosophy to prevention and treatment so that the student's problem can be unlinked from punishment and incarceration. Representative Aldridge asked if Youth Services have input into the report to the Governor's Commission and was assured that was being done. Senator Phillips asked about long range plans to address the problems of juveniles returning to training schools. Ms. Chunn said her experience tells her that early intervention and a coordinated continuum of involvement in the child's treatment is more effective in preventing recidivism. She would like more front end community-based support of families and the children to try to prevent the need for the more expensive incarceration programs.

Representative Gardner referred to the day treatment program the committee visited and said she found it appalling that a child is having to be taught to adapt to the dysfunctional behavior of his parent. The director mentioned some change in the law, and she wants to understand to understand what he means. She requested more information at the next meeting.

Representative Watson is concerned about the quality of personnel and their conditions of work. She also mentioned the lack of protein and the amount of starch she observed in the inmates' diet. She would like to see more job training, vocational rehabilitation and suggested their learning to grow a garden for their food or learning horticulture for future employment. Ms. Chunn said they are moving in the direction Representative Watson mentioned. She said the problem with vocational rehabilitation is the money and the DPI accreditation requirements. Violence is a big problem also. She contacted a registered dietitian who looks at the dietary needs, and the diet is recommended by a child nutrition expert. Representative Adams pointed out this was a maximum security training school environment. In answer to her question about the division's willingness to expend the money to get qualified personnel, Ms. Chunn pointed out that prison guards make more that some of their personnel. Representative Gardner asked about the training requirements for employees. Ms. Chunn said they are required to complete 167 hours of basic training by the Department of Justice before that can work with children. 40 hours of in-service a year are required by the Department of Justice. Representative Watson asked about the amount of supervision and wants more "hands on" people. Ms. Chunn will follow-up on the use of nurses requested by Senator Dannelly. Ms. Chunn said the Youth Services vocational teachers meet DPI certification and get the same salary as teachers in public schools.

The meeting was adjourned.

Barbara R. Hocutt, Clerk

Representative Lanier Cansler, Co-Chairman

Attachments

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES N 20
NOVEMBER 18, 19 AND 20, 1997

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bowdish	Zeb Alley P.A.
Polly Williams	NC Equity
Carmen Hooker Buell	Carolinas Health Care System
Evelyn Howe Thorne	NCHA
S. Lynne Hamlet	Intern - Senator Kinnaird
S Radson	DSS
Roz Sawyer	NC Child Care Coalition
Lee D. Kitchings	DHHS Budget Analysis OSBM
Angie McMillan	DHHS
DAVE BRUTON	DHHS
Jim Edgerton	DHHS
Kay M. Clark	Mission St. Joseph's Asheville
SPIKE GRAM	Housing Authority City of Asheville
BRUCE HANDLEY	Mission St. Joseph's, Asheville
Patricia Yancey	AIPCNC
Tommy Watts	Carolina HealthCare Syst
David Simmons	ZDA, PA.
Deborah Ross	ACLU
Stacy Bathe	ACLU
[illegible]	DHHS
Danny Staley	Appalachian District Health Dept.
James Bowden	DHHS / DYS
[illegible]	DHHS / DYS
Richard Rideout	DHHS / DYS

Attachment #1 11-20-97

N E W S R E L E A S E

MISSION St. JOSEPH'S
HEALTH SYSTEM

October 14, 1997

FOR IMMEDIATE RELEASE

For more information call Merrell Gregory

704/258-6536
704/257-1202 (pager
704/254-0351 (home)

Work First Training Idea Wins Grant

Success with its innovative Work First In-Home Aide Training Program has earned the Mission+St. Joseph's Health System a $50,000 Fannie Mae Women's Health grant from the Fannie Mae Foundation to expand the service. The program trains mothers on welfare to be chore workers for the frail elderly who live in Asheville Housing Authority complexes.

The program helps the elderly, mostly women, remain independent in their own homes and teaches in-demand job skills to single mothers receiving public assistance. Robert Burgin, president and CEO of the Mission+St. Joseph's Health System, announced receipt of the grant.

Graduates of the Work First Initiative program are prepared to further train as Certified Nursing Assistants (CNAs) to meet a growing demand in nursing homes, home health services, etc., and thus become self-supporting. CNA training is offered at Asheville-Buncombe Technical Community College.

The Asheville program which serves two groups of women in need was chosen to receive one of only 5 such grants awarded nationally through the Fannie Mae Foundation Women's Health Grant Program. A site visit by the Fannie Mae Foundation team was made August 26th.

"Linking the Work First Initiative with services to the elderly in public housing has the potential to be a national model which can be replicated across the country" said Fred Wacker, Regional Manager of the Fannie Mae Foundation.

In North Carolina, welfare reform, called Work First, requires that able-bodied recipients of public assistance go to work. The grant application states that many of the Work First participants are women and many have small children. "Nevertheless," the grant application said, "they are required to find work or serve a not-for-profit organization for 35 hours a week."

Women had the idea of linking the job needs of mothers on welfare and the elderly's need of housekeeping services. Kay Clark, gerontological nurse practioner with the Community Outreach Program of Mission+St. Joseph's Health System, Margery "Spike" Gram, service coordinator for the elderly at the Housing Authority, and Carolyn Colvard of the Department of Social Services, developed the in-home aide training program.

The Work First Initiative, a partnership effort of Mission+St. Joseph's and Asheville Housing Authority, in cooperation with the Department of Social Services, graduated its first class of in-home aides this summer. All graduates planned to enroll in further training and enter the job market. During their training, Work First Initiative participants received child day-care vouchers from the Department of Social Services.

Residents of AHA's Aston Park Towers were among the first to receive services from Work First Initiative enrollees.

The Fannie Mae Foundation, a private foundation, supports national and local non-profit organizations working to provide decent and affordable housing, and otherwise improve the quality of life, in communities throughout the United States. To promote home ownership, the Foundation also sponsors public service outreach efforts, including consumer education and home buying fairs, and conducts housing and policy research. The Foundation's sole source of support is Fannie Mae. The Foundation is headquartered in Washington, DC and has regional offices in Atlanta, Chicago, Dallas, Pasadena, and Philadelphia.

N E W S R E L E A S E

MISSION ST. JOSEPH'S
HEALTH SYSTEM

October 14, 1997

FOR IMMEDIATE RELEASE

For more information call Merrell Gregory 704/258-6536
704/257-1202 (pager

"We Are Pioneers"
Work First Graduates Make the Leap From Receiving Welfare to Giving Care to Elderly

by Nancy Marlowe

SPECIAL TO THE CITIZEN-TIMES

Their alarm clocks went off as early as 5:00 a.m. They coaxed sleepy children through breakfast and into clothes. They drove borrowed clunkers and pumped grocery money away at gas stations. They put in hours in class and hours on the job. Afterward, they picked up their kids at day care and prayed the big, old cars home again. After dinner and baths, they collapsed at last only to hear, "Mommy, have you done your homework yet?"

These are the pioneering women graduated July 11 as the first class in a unique Work First program aimed at getting people off the welfare rolls and into jobs. The young mothers trained to be in-home aides who do housekeeping chores and provide companionship to the elderly. Their need to quickly learn a marketable skill and the need of old and chronically ill people for a little help around the house is a match made in heaven - with the help of several Asheville community resources including Mission+St. Joseph's Health System, Asheville Housing Authority and the Department of Social Services.

Each of the three graduates of the pilot program said she had dreamed of doing nursing care at some level. Although qualified for jobs as in-home aides at the completion of the Work First program, each graduate plans to enroll for training as a Certified Nursing Assistant at Asheville-Buncombe Technical Community College this summer. Jobs at nursing homes and rehabilitation hospitals are waiting. The need for nursing assistants is at crisis level in an aging population.

Although there was a will to work, there was no way for these mothers to find jobs until Work First stepped in. "Making changes in your life on a very limited income is almost impossible," said Tamam Newman, mother of a 3-year-old son.

Newman, a proud graduate, said "When you are living on 'the system,' the stigma is there. If you've only been on welfare for six months, people assume you've been on it for generations. This Work First program made me so happy. I felt empowered to know that within a few short weeks, the whole DSS (Department of Social Services) would be out of my life. Nobody I've ever met has said, 'Yea! I'm on welfare.' All of us were among the 'haves' of this world before we slipped into the 'have nots.'"

Newman said her training as an in-home aide allows her to use "all my people skills." Caring for her young son and her elderly clients is similar in many ways, she said. "When you are a caregiver, it doesn't matter who you are giving care to. Most of the people I worked with were angels and easy to care for."

Melody Gosnell, mother of three children ages 3, 4 and 6-years-old, said that when she heard of the training to be offered, she said, "Sign me up. I want this." She was surprised to learn that since job training was mandatory, she must wait to be contacted before she could enroll. "I've always thought I'd like to be a nurse or do something in health care," she said.

Gosnell said being away from her children for hours each day was difficult for her and the children. "I'd never been separated from them before." Gosnell had only two days' notice in which to find day care for her children. "We had to do the leg work," she said, "and that's as it should be. We wanted to choose for ourselves, but DSS provided vouchers to pay for day care."

"I was eager to sign up," Kathy Hamilton said. "I was excited about Work First from the moment I heard about it. I thought, 'This will help me do what I've wanted to do and haven't because of my income.' Nursing appealed to me because I had worked as a nurse's aide at the Black Mountain Center." Hamilton has a son and daughter.

Five women were enrolled in the in-home aide training program. Three finished the course and received certificates in ceremonies complete with congratulatory speeches, certificates and applause.

The graduates said they found the training an easy-to-assimilate mix of textbook and classroom work and hands-on experience in the homes of the residents of Aston Park Towers and Garden Apartments, a facility of the Asheville Housing Authority. They formed friendships with the residents, most of whom attended the graduation and exchanged flowers and hugs with their aides.

Tamam Newman said she and her classmates have become friends for life and consider themselves pioneers in the advancement of women from welfare recipients to providers of essential services. "It is something rare and wonderful to ride the crest of a wave," she said.

Aide training program receives grant

Fannie Mae Foundation aids Work First assistance program

By Tim Reid
STAFF WRITER

An innovative program that helps single mothers get off welfare while performing badly needed chores for the elderly received a boost Tuesday.

The Fannie Mae Foundation awarded a $50,000 grant for the Work First In-Home Aide Training Program of the Mission+St. Joseph's Health System.

"We're better than just a place to live. We are community oriented people," Beth Lee of the St. Joseph's Hospital Foundation said during a luncheon at Celine and Co. to announce the grant.

The program was one of five in the nation selected for funding from 64 applications.

"This is a great program and a wonderful collaborative effort. We're looking at making this a national model," said Dawn Butler, the Fannie Mae Foundation's regional program director.

Under the seven-week program, women on public assistance receive job training while performing daily chores for elderly residents of Aston Park Tower and other facilities of the Asheville Housing Authority.

"They provide housekeeping and socialization to help older people age in place. They become like family," said Spike Gram, the Housing Authority's service coordinator for the elderly.

Carolyn Colvard of Social Services and Kay Clark, a gerontological nurse for Mission+St. Joseph's, designed the program to meet the needs of both groups it serves.

Participants train to be in-home aides who do housekeeping chores and provide companionship to the elderly. When they graduate from the seven-week program, they can enroll for Certified Nursing Assistant training at A-B Tech.

"What I like is that it puts them on a career track where they can get a good job and there is opportunity to grow," said Buncombe County Social Services Director Calvin Underwood.

Every public entity and every private entity has a stake in the effort to help welfare recipients perform productive work, said Housing Authority Director David Jones.

"As dollars dwindle, we've got to do more of these collaborative things," he said.

Participants in the program have been a godsend to the elderly, said Mary Robertson, president of the Resident's Association, Aston Park Tower and Garden Apartments.

"These young people are so welcomed by the tenants in my building, many of whom are separated from family and very fragile," Robertson said. "Having young people around has been an inspiration. We like to see them succeed."

Two of the first graduates of the program attended the luncheon to add their personal testimony.

"It's very exciting to help old people," Kathy Smith said. "You're doing something for someone who really appreciates it and needs you."

"It's great. I especially love working with Alzheimer's patients," said Melody Gosnell, who became a Certified Nursing Assistant after finishing the in-home training and now works at Aston Park Tower.

Gosnell said the program turned her life around: "I get to work hard for my money and I can be proud of who I am."

"These young people are so welcomed by the tenants in my building, many of whom are separated from family and very fragile. Having young people around has been an inspiration. We like to see them succeed."

MARY ROBERTSON
ASTON PARK TOWER AND GARDEN APARTMENTS

"We're better than just a place to live. We are community oriented people."

BETH LEE
ST. JOSEPH'S HOSPITAL FOUNDATION



DEBBIE CHASE-JENNINGS/CITIZEN-TIMES

Mary Robertson, left, president of the tenants' association at Aston Park Tower, chats with Kathy Smith, who helped Aston Park residents while completing Work First In-Home Aide training.

Oct 21, 1997

SENIOR SCENE

She helps keep the elderly on their feet

If the way to a man's heart is through his stomach, the way to elder health care might be through the feet.

That's the successful route taken by Kay Mantiply Clark, gerontological nurse practitioner, who specializes in treating the foot ailments to oldsters in public housing.

A large part of health care, a large part of what Clark does, is gather information which leads to bringing the oldster together with the health provider and helping them age in place.

To age in place, that is avoid nursing homes, a person usually must be able to walk. That's why many seniors place foot care as their number one need and why Clark's work is so important.

Clark, who is on the payroll of Mission+St. Joseph's Health System, points out that the fastest growing segment of the population is 85 and older.

"You don't reach that age sitting around. Most reach that age with one or more chronic diseases. Some can't reach their feet."

The list of things that can go wrong with your feet is as long as your arm. They include:

Callus, corn, blister, ingrown toenail, hammertoe, bunion, arthritis, warts, fungus, cracked heel, allergies, burning soles and cold feet, damaged ligaments and tendons.

Lower back pain is often caused by naughty feet. As an aside, Clarke said the big clunky sports shoes that youngsters wear have resulted in cruel cases of athlete's foot because the shoes never really dry.



Doug Walker

Because it took many of her charges 80 years to get to their present state, one cannot expect an overnight turnaround. Her motto is, "Start low and go slow."

To reach the elderly-poor, most of them women, Mission+St. Joseph's has a Care Van which Clark uses at public housing sites on Wednesdays and Thursdays. Foot care is a big draw and it's used to spot other ailments.

Clark also works in concert with her office mate, Spike Gram, elderly coordinator for the Asheville Housing Authority. If a Meals-On-Wheels volunteer spots an oldster who looks unwell, Spike is called.

In turn, Clark might go to see them and take them to a doctor. Diabetes and hypertension are common ailments among elderly women.

If you are a senior concerned about your feet, call Clark at 258-1222. For other senior problems, call Spike Gram at the same number.

Like a good mechanic, Clark has a wonderful tool box. To get the job done, she believes you need the right tools. She can nip ingrown toenails and trim those heavy "rams horn" nails.

For starters she will check the circulation in the feet with a Doppler.

Fungus, either common athlete's foot, or growing under the nails, is often treated by soaking the feet in a cup of white vinegar to four cups of water.

After drying the feet, a topical remedy can be applied. Fungus doesn't like the vinegar, which also removes odors.

Finally, here's a bit of hot doggerel: When your dogs begin to bark, don't delay, just visit Clark.

Doug Walker's Senior Scene column appears on Tuesdays in the Lifestyle section. Write him with your comments and ideas c/o Features Department, Asheville Citizen-Times, P.O. Box 2090, Asheville, N.C. 28802.

ASHEVILLE CITIZEN-TIMES

Monday Oct 13, 1997

Asheville Citizens Times

LIFESTYLE

FOCUS ON: HEALTH

Wanted: CNAs

Health industry struggles from lack of certified nursing assistants

By John Boyle
STAFF WRITER

High turnover, low pay and morale, lack of authority and respect.

These problems plague the nursing home industry and certified nursing assistants, the workhorses of most long-term care facilities.

Seeking answers to the CNA conundrum, GreenTree Ridge and the Baptist Retirement Homes of North Carolina are collaborating on a comprehensive CNA program study designed to slow the turnover rate. Throughout the industry, the rate reaches as high as 400 percent and often exceeds 75 percent. In 1996, it averaged more than 100 percent nationwide.

At GreenTree Ridge, it hovers between 30 and 40 percent. At the Baptist Home, the rate was more than 50 percent last year.

A turnover rate of 150 percent would mean three people have held the same position in one year.

Dr. Margaret Noel, a geriatrician with Thoms Rehabilitation Hospital and the medical director at GreenTree Ridge, will direct the 18-month study. It will examine the reasons behind the high turnover and employ strategies to stem that rate locally.

The study will have a three-pronged approach: reduce patient-to-CNA ratios, give CNAs more training and mentoring, and allow them more participation and input in decision making on the resident care team. It will involve a 51-bed unit at the Baptist Home, a 60-bed unit at GreenTree Ridge.

The $321,300 study is being funding through grants from the Duke Endowment and the Thoms Health Services Foundation.

Ronnie Metcalf, the study project coordinator, suggests that reducing turnover rates makes sense economically and from a quality of care perspective. In short, facilities can decrease administrative costs while improving care. Nursing Management magazine puts the cost of training and processing each new CNA at $2,200.

Low pay for CNAs undoubtedly contributes to the high turnover.

"I think both the industry itself and a larger group of people will have to ask some hard questions about what the job is worth," Noel said.

According to a 1996 article in Provider Magazine, the average annual salary for a nursing home assistant was less than $15,000. Metcalf maintains that GreenTree Ridge's scale meets the industry average.

"The people who pay more are the people who can't get CNAs at all," he said, adding that those jobs usually come with much higher patient-to-CNA ratios.

Simply boosting CNA pay isn't as easy at it sounds. According to the N.C. Health Care Facilities Association, the average industry operating profit margins have been less than 5 percent of revenues. Also, nursing facilities rely on Medicaid reimbursement, which limits their ability to raise prices.

Metcalf points out that if a facility raises CNA pay, it likely will have to increase pay for licensed practical nurses and registered nurses. "You've got to be careful that you're not paying a CNA what you would pay an LPN," he said.

CNAs typically complete a six-week program, while LPN status requires an associate's degree, RN status a four-year degree.

Those in the industry

❖ See CNA on page C6



PHOTOS BY EWART BALL/CITIZEN-TIMES

To CNA Charlsie Sweat, the occasional hallway stroll with a patient is just part of the job. She and patient Willie Hensley frequently walk together in GreenTree Ridge Nursing Home.


The work day of a CNA exhausting but fulfilling

By John Boyle

▼ Full Story on page C6



EWART BALL/CITIZEN-TIMES

"Every little thing we would do for ourselves, we do for them," says CNA Charlsie Sweat while combing the hair of a GreenTree Ridge resident. A certified nursing assistant with 24 years experience, Sweat says the work is hard, but is worth it because she likes to help those in need.

Work

❖ *Continued from page* **C1**

puts hair gel on an elderly man's scalp and brushes his hair, then wheels him into the hall for a change of scenery.

Another patient, 84-year-old Willie Hensley, resplendent in a neat shirt and cabbie's cap, walks into the room. His eyes are bright when he talks about Sweat, his regular care giver.

"That's sugar, my honey," he says, pointing at her. "I tell you one thing – she's a good person."

She walks hand-in-hand with him down the hall, chatting amiably. Then she heads into another patient's room to change all the bed linen.

"It's a lot of work to make them comfortable," says Sweat, 45.

With seven children – all grown and out of the house now – her work day didn't end at the nursing home for much of her career. Now the domestic load is lighter, but she works a lot of overtime, sometimes until 10:30 p.m. That's after coming in at 7 a.m.

It's a grueling schedule in a backbreaking profession, but Sweat has no plans to quit. She's a beacon of positive attitude. She's also an anomaly in a profession plagued with unusually high turnover.

"I enjoy working with people. I like to see people happy and to be doing something for them, especially when they're less fortunate," she says. "I think that's what's kept me in this business for so long."

It's certainly not the money. After eight years at GreenTree Ridge, Sweat makes $8.44 an hour – about $17,500 a year, not counting overtime. It's better than minimum wage but still far short of what nurses make. She started out at GreenTree Ridge making $5 an hour.

Nursing assistants are the backbone of most nursing homes – they provide 90 percent of the hands-on care to the elderly and disabled.

To get a feel for what CNAs like Sweat go through, Dr. Margaret Noel, a geriatrician with Thoms Rehabilitation Hospital and the medical director at GreenTree Ridge, worked one-hour stints as a CNA.

"I was exhausted and I had only a couple of patients," she says. "The work is physically and psychologically demanding. The pay scale is a problem and the respect issue that anybody that works in long-term care faces is a problem as well."

Noel said she will "never forget the fear in one resident's eyes" when she went to lift her out of bed, a common task for CNA's but one Noel wasn't accustomed to.

"I just have the greatest admiration and respect for what they do," Noel says. "It's a job that requires tremendous physical and emotional exertion."

For Sweat, the exertion has its rare dedication and a genuine love of helping those in need, she finds great satisfaction in her work.

"To be honest, I haven't thought of doing another job," Sweat said. "This is my life."

CNA

❖ *Continued from page* **C1**

attribute the high turnover rate to lack of appropriate training, low pay and inadequate recognition of the crucial role CNAs play. Also, CNAs frequently now deal with much sicker patients because of the health industry trend of discharging patients earlier from hospitals.

In many facilities statewide, CNA-patient ratios are as high as 15 to 1, with most facilities averaging 12-to-1 ratio.

"You can be motivated out of your heart, but even those people who are truly there with a love of caring – given too many people – just can't do it," Noel says.

After discussing the challenges, grueling schedule and low pay, Noel offered a common lament – one you won't hear from too many health officials.

"You almost end up asking yourself, 'Why does anybody do this job?'" she said.

CNAs NEEDED

▼ With the aging of the baby-boom generation, some researchers predict that by the year 2000 the U.S. will need an additional 500,000 CNA's.

▼ By 2040, seniors over age 80 will make up more than 25 percent of the population.

▼ Fifty percent of the population currently over 65 will spend some time in a nursing home before they die, according to industry journals.

▼ Nationwide in 1996, average annual salary for a nursing home assistant was $14,830; the average hourly wage $7.13.

▼ Buncombe County is licensed for 1,681 nursing home beds, the state 40,139.

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Budgeting for Medicaid

Because of the uncertainty of expenditures patterns, it is difficult to predict the Medicaid expenditures compared to budget in a given 12 month period and nearly impossible to make adjustments in provider payments to reduce expenditures if it appears the budget will be exceeded. A 1% change in the Medicaid budget amounts to $42 million in requirements and $12.6 million in appropriations.

Why is it difficult to take actions to control the budget in the budget year? First, actions need to be taken in the beginning of the year if they are to impact the current year expenditures. For example, actions that affect rates for hospitals or nursing facilities must be taken in October which is the month new rates are implemented. It then takes time before the new rates are billed. For example, a hospital discharge made in October may not be billed for one to six months after discharge. This means the impact of a rate action may be felt for only a part of the year. Another problem is that providers are able to make up for some revenue loss so any reduction taken usually is less than projected.

Over this two year biennium, we expect we will have to make a reduction of about $64 million next year to stay within the 9% appropriation limit. This is a reduction of about 1 1/2%. Rather than take all the cuts next year and to be sure we don't overrun this year's budget, thereby making the $64 million hole bigger, we have elected to take an annualized reduction of about of 1% this year and a reduction of 1/2% for next year. As the year progresses, we will assess the need to take further actions.

Because of the timing of this year's reduction (October 1) and the time it will take for the reduction to flow through the system, the impact this year is expected to be less than 1/2 of 1%. However, if the legislature rebases 98-99 reflecting the reduction we took in 97-98, we will be confronted with the same $64 million reduction for next year.

To prevent this we need to take a longer view of the Medicaid budget, perhaps as long as four years.

Health care insurance companies have the same problem. However, they set up a reserve which can be used to smooth out year to year differences so that over a period of time they are able to stay within their budgets.

Cost Containment Options

Hospital Inpatient: Action taken to hold Medicaid increase to that of Medicare. Medicare did not raise hospital rates for FFY 97-98. SFY 97-98 savings $12.5 million requirements. Annual savings $25 million. Hospital budget $737.1 million.

Hospital Outpatient: Currently, hospitals are reimbursed at 80% of outpatient and ER costs. Both Medicare and Medicaid are looking at getting away from cost based reimbursement to a prospective method. Several projects are underway nationally using flat rates based on diagnosis and other variables. This method could be two years out. Interim actions could include reducing the percent of outpatient costs or changing the method of reimbursement to more closely align with similar services. Hospital outpatient and ER $199.9 million.

Nursing Facilities: Action taken to limit inflation to approximately 2.0% effective October 1. SFY 97-98 savings $7.6 million requirements. Annual savings $15 million. Budget $807.1 million.

Drugs: Currently reimbursing at $5.60 dispensing fee set by the legislature and AWP-10%. N.C.'s dispensing fee is one of the highest in the country. 15 states use AWP discount greater that 10%, 18 use 10% and 8 use less than AWP-10%. Options include reducing the dispensing fee, increasing the AWP discount to higher than 10%, and reimposing the requirement that pharmacies bill the lower of the Medicaid rate or the lowest rate paid by the general public. Each 1% reduction in AWP would save $2.3 million in requirements. Each 1% reduction in dispensing fee would save $470,000 in requirements.

We are working with the Pharmaceutical Association on options and are also beginning work with the Association and Medical Society to look at how providers can be more cost conscious in the prescribing of drugs. Budget $448.8 million.

In-home Services: Reduce some rates based on better cost report data, tighten up medical necessity criteria, introduce controls such as assessment, reassessment and prior approval, reduce inflation amount and require Medicare billing before billing Medicaid. Working with the Association on all of these options.

CAP Services: Hold to reasonable budget limits. CAP services are budgeted each year based on use estimates. CAP/MR actions taken in October, which are not related to budget reductions, but to payment rates that are excessive, should permit us to serve significantly more recipients with the same amount of money. We are continuing to review all reimbursement rates for reasonableness and are working with advocates, providers, area programs and Mental Health to tighten up the program. CAP/MR budget $119.8 million. CAP/DA budget $126.4 million.

Public Provider Services: Public health, mental health, state hospitals, state ICFs/MR - Hold to reasonable budget targets and make off-budget adjustments when appropriate. Off-budget adjustments include supplemental payments to cost.

FQHC and Rural Health: Hold to reasonable costs but permit expenditures for primary and preventive care to expand.

ACH-Personal Care: Hold inflation increases pending cost report data and RTI report that supports existing rate structure as per HCFA interim approval for this service.

Physician Services: Limit payment to the lower of Medicaid or Medicare. Reduce inflation rate.

Durable Medical Equipment: Tighten up enrollment criteria. Reduce rates based on more current cost data. Competitive bid.

Implement Modifier Enhancement to MMIS: This enhancement will permit more stringent pricing by unbundling some services which now must be paid at the aggregate level. Submitting APD for federal approval and expect 12 months implementation.

Implement Detail Crossover Enhancement to MMIS: This will permit detail processing of Medicare crossover claims and permit edit and audit checks for duplicate services. Will follow implementation of Modifiers.

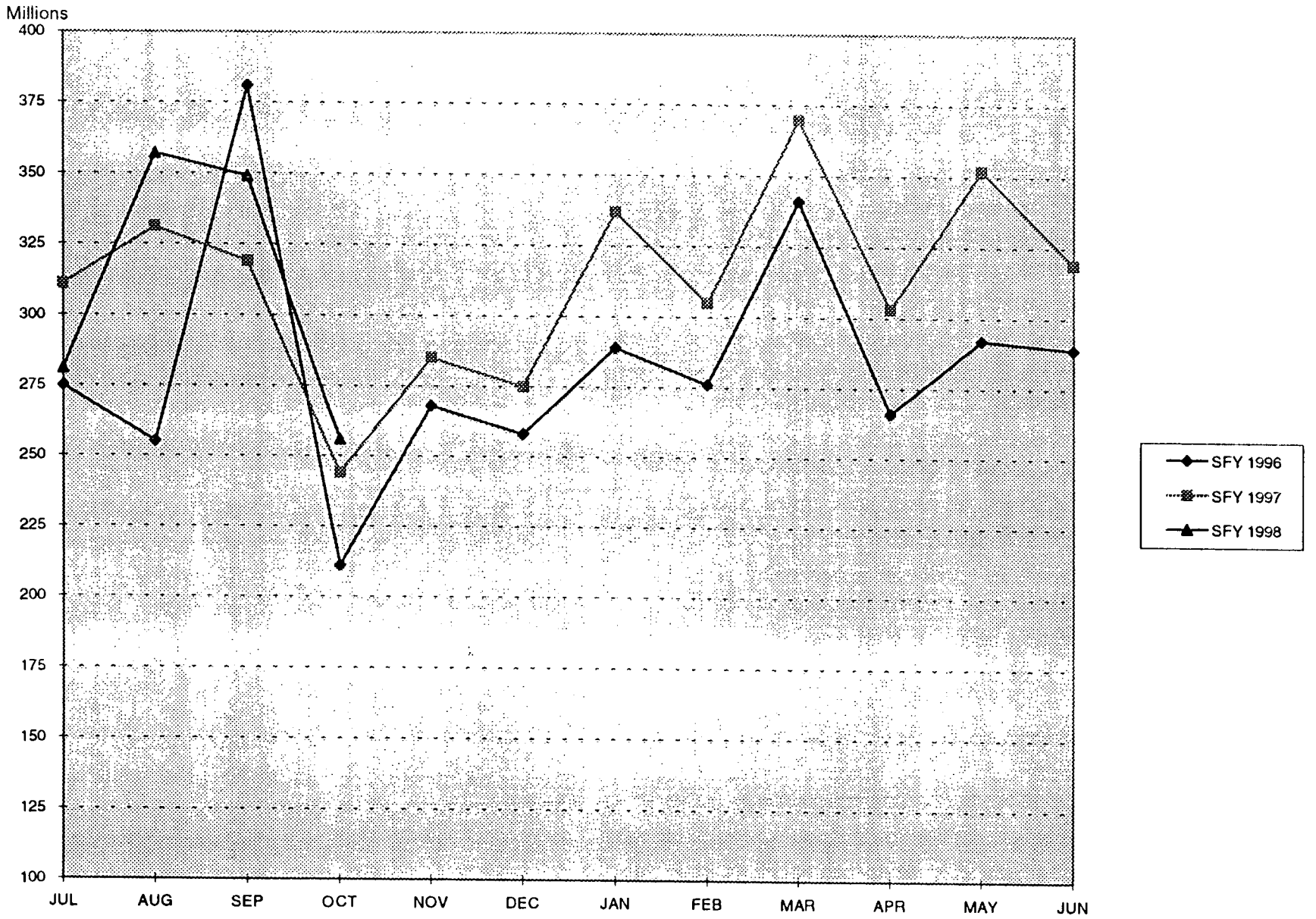
Implement Table Driven Edit System in MMIS: This enhancement will permit quicker implementation of edits which are designed to insure claims that are paid are in conformance with Medicaid policy. Current practice requires too much systems engineering time to implement audits for services. This change will greatly reduce both the cost and time to implement edits.

Disease Management: Undertake demonstration projects to test whether disease management can provide higher quality and lower cost services. Will require up-front investment to test whether diabetes, asthma, cancer and other chronic illnesses can be managed in a cost-effective manner.

Expand and Improve Managed Care: Includes expanding ACCESS statewide, ACCESS II demonstrations, LTC demonstrations and selective expansion of HMOs services in ACCESS counties.

Transfer of Assets: Propose legislation to tighten up transfer of assets law.

North Carolina Medicaid
Expenditures per Month



Balanced Budget Act of 1997

These are the major provisions of the Balanced Budget Act which could have an impact on North Carolina.

* **Continuous eligibility for MIC children under 19 for up to 12 months without regard to income status.** Current policy permits continuous eligibility if there is no change in income, family composition or living arrangement.

***Presumptive eligibility for children under 19 including AFDC and MIC.** Presumptive eligibility could be determined by authorized entities. Eligibility would be good for the month in which it is determined and the following month. If an application is not filed, eligibility ceases.

***Disabled children losing SSI.** Medicaid must be continued for children under 18 who were receiving SSI and who were/are terminated because they no longer can meet the new children's disability criteria. Eligibility continues until the child no longer meets the financial eligibility criteria for SSI.

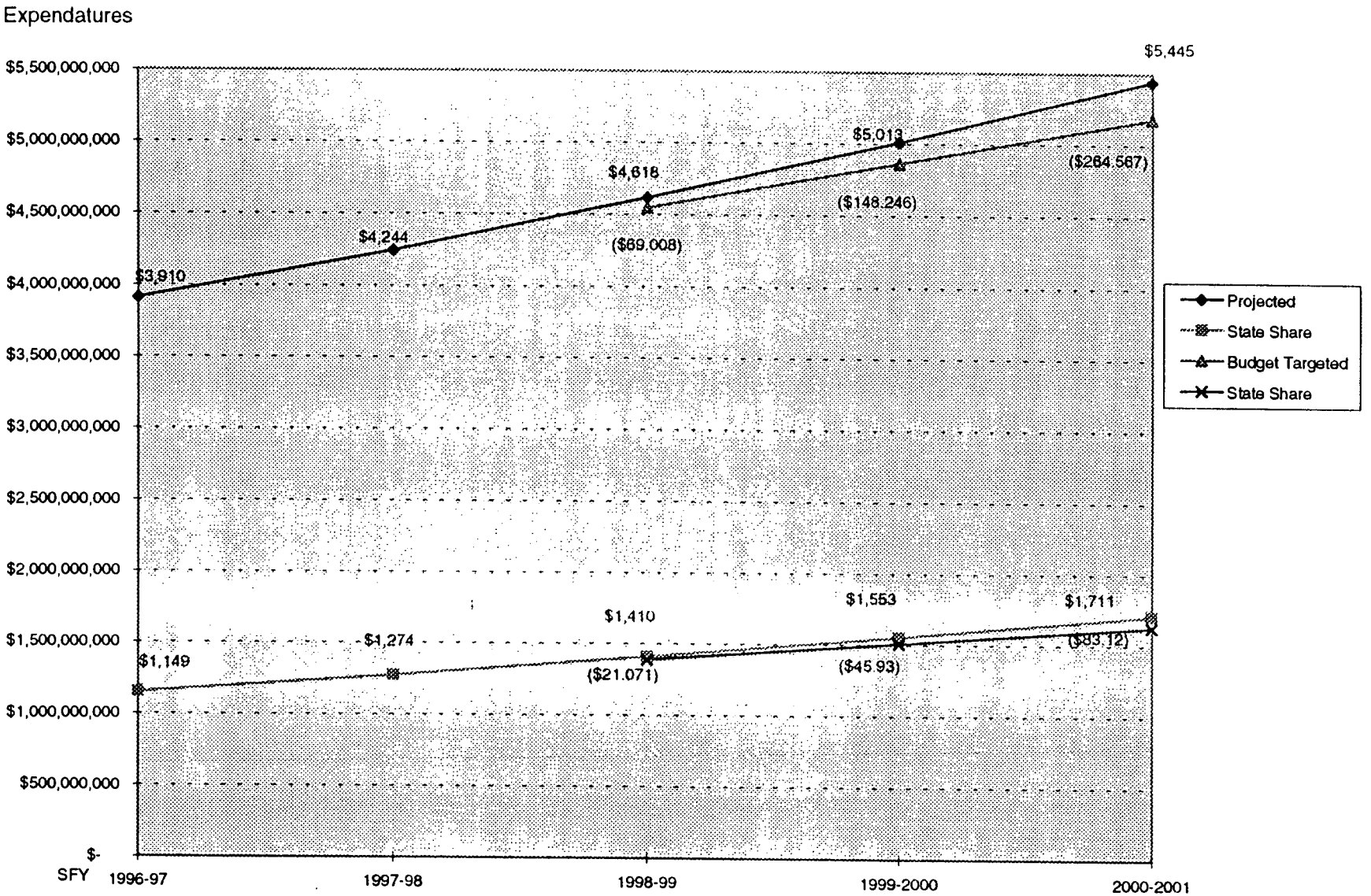
***New Children's Health Insurance Program**

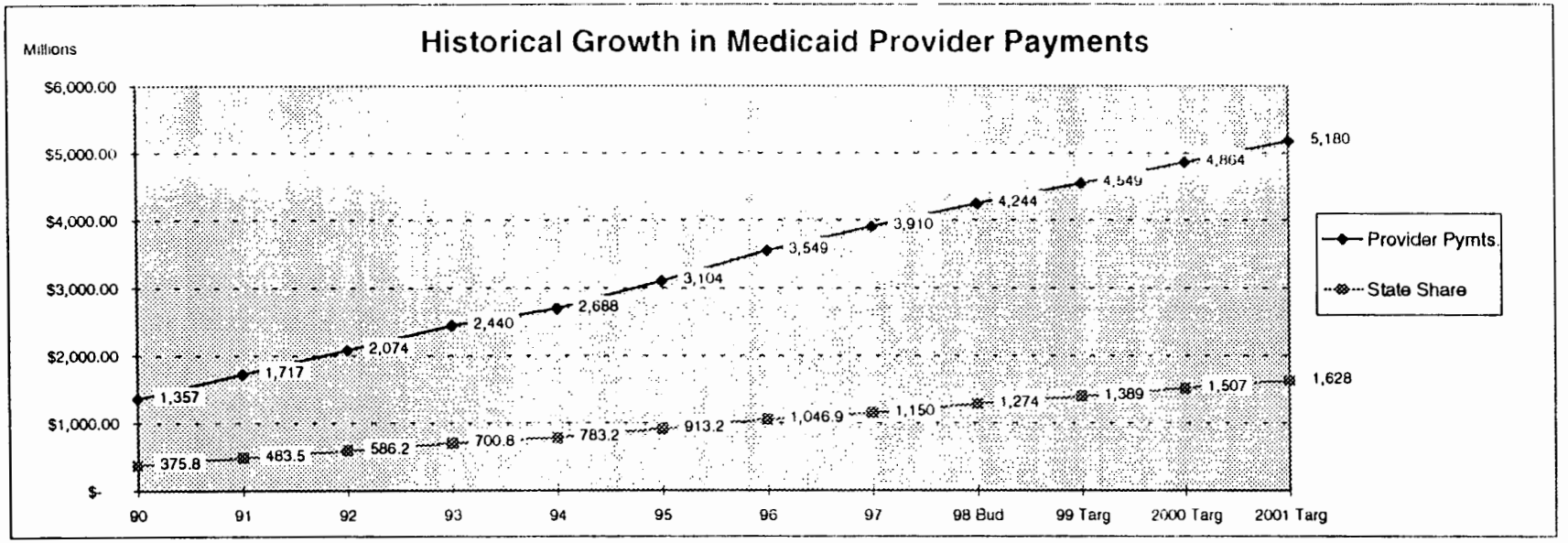
***Qualifying Individuals (QIs) for payment of Part B Premium.** Creates two new eligibility groups. Medicare recipients whose income is between 121% and 135% will have their Part B premium paid for by the Federal Government up to the amount of the state grants. Those whose income is between 136% and 175% of the FPL may have the increase in their premium attributable to the shift of Home Health from Part A to Part B, paid for by the Federal Government up to the amount of the state allotment. This will be on a first come first serve basis. The amount that must be paid out for the second category is $1.07 per month. State must put up 50% of the cost of administering this new benefit.

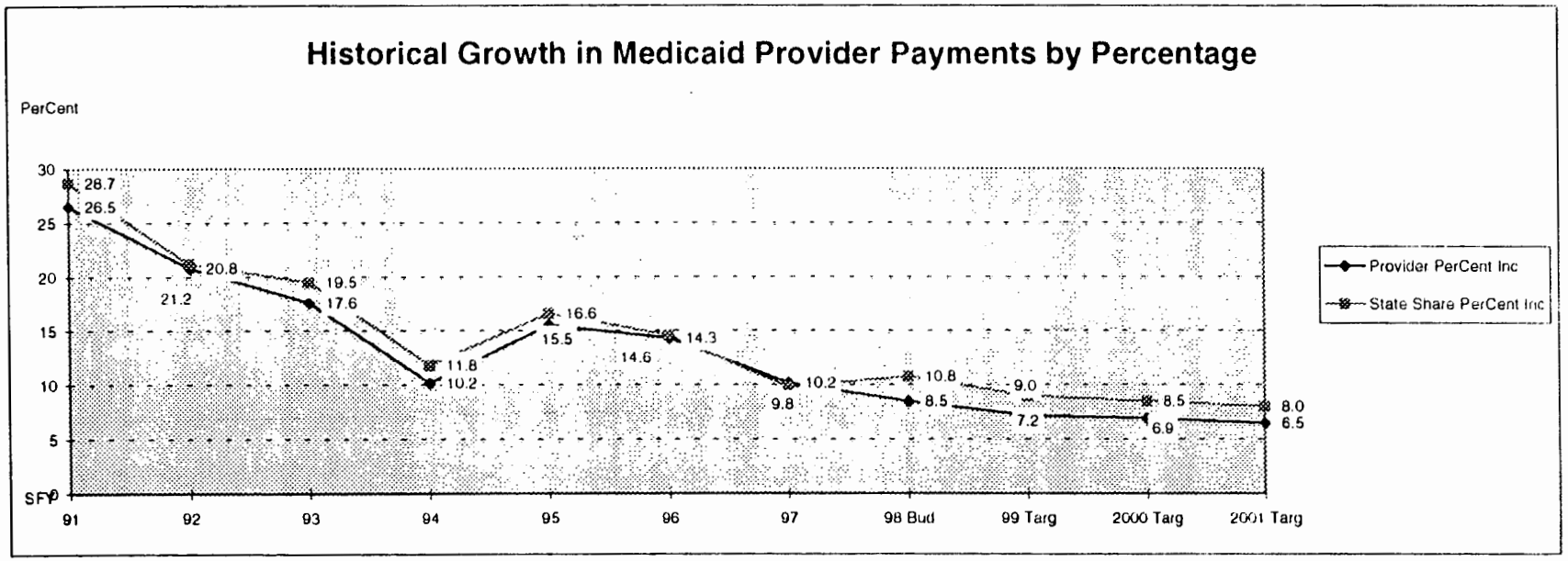
Medicaid buy-in for disabled up to 250% of FPL. This provision permits the states to cover persons who meet the federal disability provisions except for income. Upon payment of a premium, these persons would qualify for all Medicaid covered services.

Medicare Home Health-There are many important changes to the Medicare program. One particular one could have a significant impact on Medicaid. Effective February 5, visits solely for drawing blood will not qualify for coverage under the Medicare home health benefit. The Association for Home Care estimates that 20-44% of their membership's daily patient census may have venipuncture as the qualifying skilled service.

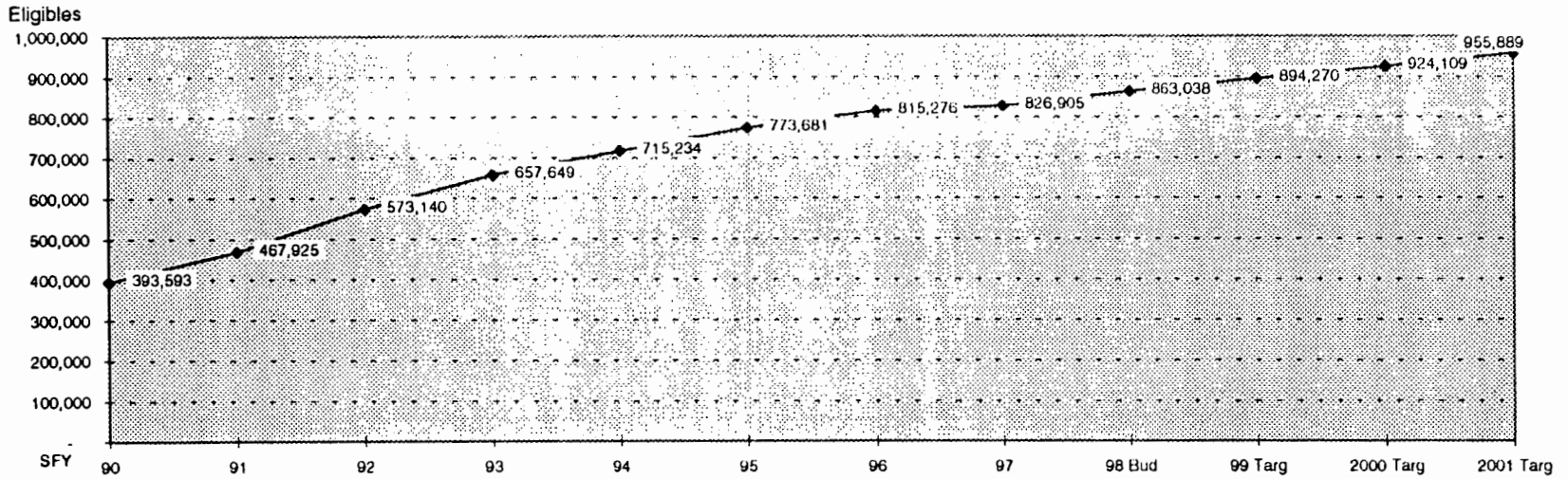
Projected Medicaid Expendatures v.s. Budget Target



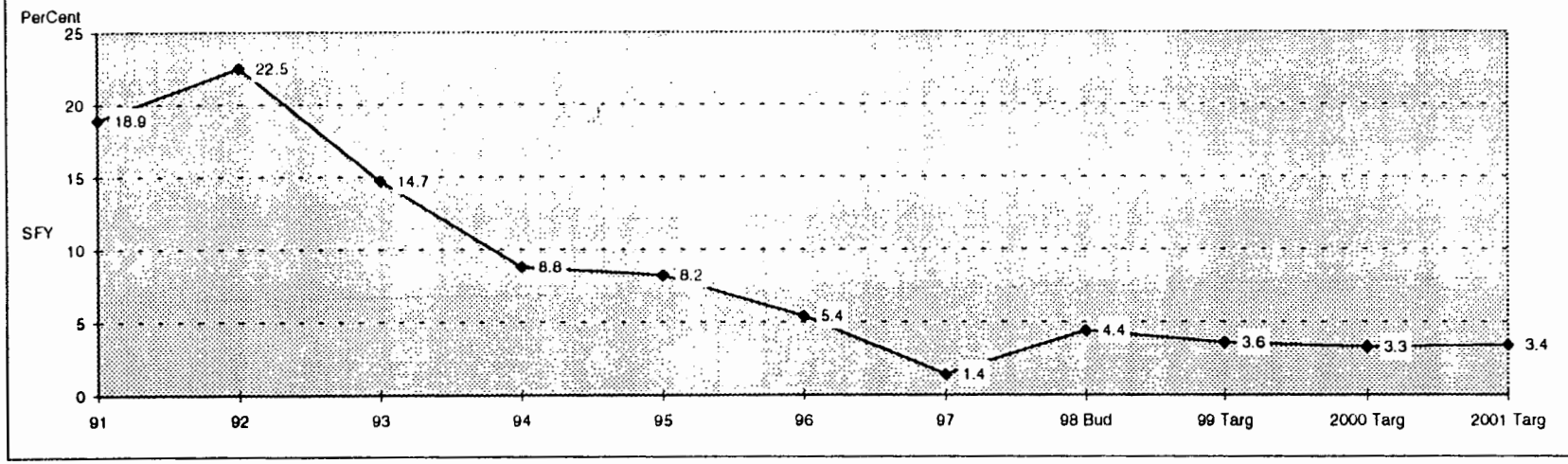

Historical Growth in Medicaid Provider Payments
Millions
$6,000.00
$5,000.00
$4,000.00
$3,000.00
$2,000.00
$1,000.00
$-
1,357
1,717
2,074
2,440
2,688
3,104
3,549
3,910
4,244
4,549
4,864
5,180
375.8
483.5
586.2
700.8
783.2
913.2
1,046.9
1,150
1,274
1,389
1,507
1,628
90
91
92
93
94
95
96
97
98 Bud
99 Targ
2000 Targ
2001 Targ
Provider Pymts.
State Share


Historical Growth in Medicaid Provider Payments by Percentage
PerCent
30
25
20
15
10
5
0
SFY
28.7
26.5
20.8
21.2
19.5
17.6
11.8
10.2
16.6
15.5
14.6
14.3
10.2
9.8
10.8
8.5
9.0
7.2
8.5
6.9
8.0
6.5
91
92
93
94
95
96
97
98 Bud
99 Targ
2000 Targ
2001 Targ
Provider PerCent Inc
State Share PerCent Inc

Historical Growth in Medicaid Eligibles



Historical Growth in Medicaid Eligibles by Percentage



MEDICAID IN A MINUTE - SFY 96-97

DATA

- 1.2 million Medicaid eligibles
- 4.0 billion dollars for services
- Administrative costs are 3.12% (1.8% County; 1.3% State) of total expenditures. Administrative costs are approximately 24% below national average.
- Cost per recipient is $3,446 in SFY 1997.

- One in 6 North Carolinians receives Medicaid (16% population).
- One in 7 North Carolinians is uninsured (14% population).
- Medicaid increases in eligibility reduce the numbers of uninsured and reduce cost-shifting to private payers.

- 43.8% of babies born in North Carolina are covered by Medicaid.
- 82% of nursing home patients receive some help from Medicaid.
- 100% of children to age 19 living in poverty (family of 4 = $15,000) are eligible for Medicaid.

- 48,800 providers of care are enrolled in Medicaid.
- Over 70 million claims for services are processed annually.
- 15% of the Medicaid budget is paid to public (state and local) providers of care (public hospitals, state mental hospitals, ICF's/MR, health departments, mental health clinics, and school-based programs).

- $1.1 billion is spent on 805,000 mothers and children; average cost per recipient is $1,411.
- $1.5 billion is spent on 176,000 disabled; average cost per recipient is $8,759.
- $1.3 billion is spent on 170,000 elderly; average cost for full benefits is $7,691; average cost for Medicare - QMB only is $1,526.

- 30% of the recipients spend 70% of service dollars.

- 40% of expenditures are for LONG TERM CARE (SNF,ICF,ICF/MR,CAP and others).
- 19% of expenditures are for INPATIENT HOSPITAL CARE.
- 23% of expenditures are for OUTPATIENT CARE (Outpatient Hosp.,Clinics, Physician).
- 18% are for drugs, dental, Medicare premiums, etc.

FEDERAL FUNDS

- 1996-97 Medicaid services federal matching rate is:
  63.9% federal
  30.7% state
  5.4% county

- Federal matching formula is based on state's per capita income. Federal match decreases each year as NC's personal income increases.

- 1/2 of 1% reduction in federal matching rate for a $4 billion program can require $17.0 million in additional state funds and $3.2 million in additional county funds.

- State Medicaid matching formula also applies to AFDC payment match rate.

MAXIMIZING FEDERAL FUNDS

- The state's decision to maximize federal funds increases the Medicaid budget, while decreasing state and local budgets in other areas.

- Examples of maximization include:

  * decreasing State/County Special Assistance funds, while increasing Medicaid coverage of personal care services in Rest Homes.

  * offsetting costs of uncompensated care in public hospitals through DSH payments while decreasing state and local payments.

  * paying public providers at cost to reduce need for state and local subsidies.

BUDGETING FOR MEDICAID

- Budget is driven by numbers and types of eligibles, cost per service (inflation), and intensity or use of services.

- 1% increase in the Medicaid budget equals $12.7 million in state appropriations.

- A change in number of eligibles can have a major impact on the budget depending on the type of eligibles.

  * The average cost per recipient for the Aged is $7,691.

  * The average cost per recipient for the Disabled is $8,759.

  * The average cost per recipient for Mothers and Children is $1,411.

  The number of AFDC adult eligibles is declining. On an average cost/monthly eligible it would take a decline of three AFDC adult eligibles to offset the cost of an increase in one disabled eligible.

- Eligibility increases may be mandated by Congress, enacted by the General Assembly, result from economic downturns or from NC's growing aged population.

- Since 1988, eligibles have increased from 480,000 to 1.2 million annually. Eligibility increases account for 2/3 of Medicaid's annual growth.

- In Federal Financial Year 1996, average cost/recipient was 15% below the national average.

CONTROLLING USE OF SERVICES

- Traditional strategies include: annual limits on outpatient visits; monthly prescription drug limits; prior aproval for certain services; diagnosis related reimbursement for inpatient hospital care; selected case management services for special populations; emphasis on prevention.

- Managed care strategies include:

  * Carolina ACCESS (physician as case manager) to reduce specialist, hospital and ER use and ACCESS II.

  * Carolina ALTERNATIVES (mental health capitated services plan) to reduce inpatient use.

  * Voluntary HMO enrollment (Kaiser)

  * Mandatory HMO enrollment (Mecklenburg)

  * Baby Love care coordination to reduce need for neo-natal intensive care units.

- Long Term Care strategies include: delaying or preventing nursing home placement by substituting home and community based services where appropriate; supporting additional personal care services in Domicilliary Care Facilities (rest homes); holding down growth of new beds.

ADMINISTRATIVE RECOVERIES

- Drug Rebates
- Third Party Insurance Collections
- Fraud, abuse and auditing activities

11/14/97

North Carolina General Assembly
House of Representatives
State Legislative Building
Raleigh 27601-1096

REPRESENTATIVE CHARLOTTE A. GARDNER
35TH DISTRICT

OFFICE ADDRESS: 417B LOB
RALEIGH, N.C. 27601-1096
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January 12, 1998

COMMITTEES:

APPROPRIATIONS
CHAIRMAN: HUMAN RESOURCES
ENVIRONMENT
HUMAN RESOURCES: AGING
INSURANCE
JUDICIARY II
WELFARE REFORM

STUDY COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE: CO-CHAIRMAN
STUDY COMMISSION ON DHR REORGANIZATION: CO-CHAIRMAN

MEMORANDUM

TO: **House Appropriations Subcommittee on Human Resources Members**

FROM: **Representative Charlotte A. Gardner**
Representative Debbie Clary
Representative Lanier Cansler

SUBJECT: **Joint meetings, January 20, 21 and 22, 1998**

JOINT APPROPRIATIONS/SUBCOMMITTEE ON HUMAN RESOURCES MEETING*

DATES: **Tuesday, January 20, 1998 - 10 a.m. to 4 p.m.**
Wednesday, January 21, 1998 - 9 a.m. to 4 p.m.
***Thursday, January 22, 1998* - 9 a.m. to 1 p.m.**
Joint meeting with Natural & Econ. Resources

PLACE: **Room 414 LOB on Tuesday & Wednesday, January 20 & 21**
Room 643 LOB on Thursday, January 22

If you have any questions about these meetings contact Fiscal Staff: Karen Hammonds-Blanks and Mary Ellen Sylvester. (919-733-4910)

*According to the memo sent by Senator Plyler and Representative Holmes, the subcommittee is to meet jointly with the Senate members the third week of the month on Tuesdays, Wednesdays and Thursdays beginning October, 1997 and continuing through April, 1998.

Barbara R. Hocutt, Committee Clerk
919-715-3017 (Thursdays)

Joint Appropriations Subcommittee on Health & Human Services

Wednesday, January 21st, 9:00 a.m. - 4:00 p.m.
Room 414 - Legislative Office Building

9:00	Status of Children's Health in NC	Tom Vitaglione, Chief Children's Health Section, DHHS
11:00	Food Bank Presentation	TBD
11:30	Impact of Budget Cuts on Psychiatric Hospitals	Gladys Fisher, Parent of Consumer

LUNCH

1:00	Welfare Reform ■ 5-Year Business Plan/Reinvestment Strategy ■ Status of 1997-98 Funding	Jim Edgerton, Assistant Secretary for Budget, Management, & Planning *and* Peter Leousis, Assistant Secretary for Human Services and Education Policy, DHHS
	■ Initiatives to Reduce Out-of-Wedlock Births	Ann Wolfe, Director Women's and Children's Health, DHHS
3:00	Progress Report on Thomas S. Cost Containment	Susan White, Chief Thomas S. Services Section

Thursday, January 22nd, 9:00 a.m. - 12:00 p.m.

Joint Meeting with NER Subcommittee - Room 643, Legislative Office Building

9:00	Administrative Costs Associated with Transferring Health Functions to DHHS	Carol Shaw, Analyst Fiscal Research Division
9:45	Administration of Environmental Health Programs	Mona Moon, Analyst Fiscal Research Division
10:45	Welfare-to-Work Status	Dept. of Commerce Division of Social Services

ADJOURN

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Tuesday, January 20th, 10:00 a.m. - 4:30 p.m.
Room 414 - Legislative Office Building

10:00	Performance Audit Results on the Division of Services for the Blind	Ralph Campbell, Jr. State Auditor Janet Hayes, Performance Audit Manager Office of the State Auditor John De Luca, Director Division of Services for the Blind, DHHS

LUNCH

1:00	School-Based Health Centers	Denise Stallings, Director Cleveland County Public Health Dept.
2:00	AIDS Program	Steve Martin, Deputy Director Division of Epidemiology, DHHS
3:00	Updates: Forensic Unit	Don Willis, Chief Mental Health Services, DHHS
	Efficiency Study of Psychiatric Hospitals	Don Willis, DHHS
	Early Intervention Funding	Duncan Munn, Child/Adolescent Services, Developmental Disabilities Section, DHHS
	Child Care Subsidy	Peter Leousis, Assistant Secretary for Human Services & Education Policy, DHHS
	County Commissioners' Letter on Medicaid Cost-Sharing	Carol Shaw, Analyst Fiscal Research Division

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

MINUTES
JANUARY 20, 1998

The Joint meeting of the House and Senate Appropriations Subcommittees on Human Resources was convened by Co-Chair, Representative Charlotte Gardner, at 10:00 a.m. on Tuesday, January 20, 1998. Six Senators were present. The following House members were in attendance:

Representative Charlotte Gardner	Representative Lanier Cansler
Representative Debbie Clary	Representative Edd Nye
Representative Alma Adams	Representative Henry Aldridge
Representative Martha Alexander	Representative Esposito
Representative Julia Howard	Representative Bill Hurley
Representative Cynthia Watson	

Staff members present were: Gann Watson, Attorney; Dianna Jessup, Attorney; Mary Ellen Sylvester, Karen Hammonds-Blanks and Carol Shaw, Fiscal Staff and Wanda Kay, Clerk.

Performance Audit of the Division of the Blind

State Auditor Ralph Campbell introduced Janice Hayes, Performance Audit Manager, who explained the Performance Report for the Division of Services for the Blind of the Department of Health and Human Resources (See Handouts # 1 and 2.) Several of the members expressed concern over the income inequity in vending contracts held by the blind clients and that many of the issues cited in the performance audit are the same that were mentioned in the last audit.

John DeLucca, Director of the Division of Services for the Blind in the Department of Health and Human Resources, presented an overview of plans to address the recommendations of the Performance Audit. He introduced Debbie Jackson, Assistant Director, and Glen Cutler, Chief of the Business Enterprises Program who answered questions about the division's response to the Audit.

Representative Alma Adams asked for information on or a chart outlining the total number of operators, locations, who has been removed, license revoked, etc. Mr. Cutler said they could get that information together for the committee. Representative Gardner asked the fiscal staff to look into the issues raised by the members about the organization and operation of the division. She wants to know what the committee needs to be concerned about.

Senator Phillips asked about a uniform system of accounting for the division, and Edgerton, Assistant Secretary for Budget and Management, said the controllers would be

the best ones to answer the accounting questions. Representative Gardner asked the staff to look into the audit by the Business Enterprises Program counselors showing the allowable expenditures by the vendors of food service. She also told Mr. DeLucca that the committee might want him to come back with a response to the Performance audit.

The meeting recessed for lunch.

Expansion of School Health Services

Ms. Denise Stallings, Director of the Cleveland County Public Health Department, gave a presentation showing the comprehensive health care plan operating in Cleveland County. (See Handout #3.) Representative Clary whose district includes Cleveland County passed out a picture of the desk drawer of a secretary of a school in another county showing the pitiable state of medical assistance in public schools. (See Handout #4)

Representative Watson wanted figures comparing the adolescent pregnancy rate in other counties with the rate in Cleveland County during the 10 years Cleveland County's school-based nursing program has been in effect, and Ms. Stallings said she would get that information for Ms. Watson. Representative Gardner asked staff to follow-up with that information for the committee.

HIV-AIDS PROGRAM

Evelyn Foust, Section Chief of the HIV/STD Prevention and Care Program in the Division of Epidemiology, gave a presentation on HIV/STD program. (See Handout # 5.) In reference to questioning by the members on the source of funding for this program and on projections of funding needs, Dr. Ron Levine, State Health Director, will come back to the committee with specific money amounts for the program.

Forensic Unit

The Chief of Mental Health Services, Don Willis, gave an update on the Forensic Unit at Dorothea Dix Hospital. (See Handout #6.) Bob Hargett answered legal questions about the Wendell Williamson and Michael Hayes cases raised by Representative Gardner who shared with the committee a letter sent to her by Mr. R.B. Nicholson on the disposition of these cases. Mr. Hargett gave the legal reasons for Williamson being assigned to Broughton hospital instead of the Forensic Unit at Dix. The treatment team decides the appropriate treatment and, therefore, the disposition of the prisoner. Mr. Hargett pointed out that if a person is adjudged not guilty by reason of insanity (NGRI) then he is treated like any other mentally ill person. Representative Gardner asked for language to remedy that in statute and will introduce that bill. Mr. Hargett said there have been discussions about changing the statute.

Representative Cansler asked if members could ask questions of the team doing the review on the Hospital Efficiency Plan which is due April 1, 1998. Mr. Willis said he would set up whatever kind of meeting the committee members wanted.

Early Intervention Funding

The Early Intervention Funding presentation was given by Duncan Munn of Child/Adolescent Services of the Developmental Disabilities Section. (See Handout # 7.)

Child Care Subsidy

Peter Leousis, Assistant Secretary for Human Service and Education Policy, addressed the child care waiting list. Representative Gardner asked why these people are on the waiting list and wanted a breakdown on these numbers reflecting the reasons they are not being served, and Mr. Leousis said he would look into getting these figures. She said Senator Martin suggested a sampling of urban and rural counties to get an idea of the need for after hours day care for shift workers, sick children, etc. would be sufficient.

The request for the $10.8 million transfer of TANF money into the child care block grant will be presented to the Gov. Ops. Committee in February, but the committee can hear the content of the request prior to that presentation.

Representative Howard said that the figures in her survey do not match the numbers of Work First children by counties on the waiting list shown by the department figures. She also wanted to know how those being served by TANF will get their money. Mr. Leousis said that he and Mr. Edgerton will present that information at tomorrow's meeting.

The meeting was adjourned.

Barbara R. Hocutt, Clerk

Representative Charlotte Gardner, Co-Chair

VISITOR REGISTRATION SHEET

Joint Appropriations Subcommittee on Health & Human Services 1/20-22/98

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Don McCorquodale	NC Retail Merchants Association.
Wayne Williams	OSBM
Ed Cochrane-Brown	BMA DHHS
Jimmy Benson	OSA
Byron K. Harris	OSBM
Steven L. Hicks	Making The Grade
Patricia Young	APPCNC / SCSL
Pax Kilpatrick	DHHS Budget & Analysis
Suzanne Williams	Bme & Assoc.
John Rustin	NC Family Policy Council
[illegible]	DMH/DD/SAS

VISITOR REGISTRATION SHEET

Joint Appropriations Subcommittee on Health & Human Services 1/20-22/98

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Hargett	Justice
Marc Cadge	DHHS
Don Jennie	DHHS
Don Willis	DMHDDSAS
Steve Johnson	"
Lyn Agnew	DHHS- DSS
CL Cochran	UCP-NC - Coalition
Dave Richard	Arc/NC —
Peggy Ball	DHHS-DCD
Ruth Francis	DHHS

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Tuesday, January 20th, 10:00 a.m.
Room 414 - Legislative Office Building

10:00	Performance Audit Results on the Division of Services for the Blind	Ralph Campbell, Jr. State Auditor Janet Hayes, Performance Audit Manager Office of the State Auditor John De Luca, Director Division of Services for the Blind DHHS

LUNCH

1:00	Expansion of School Health Services	Denise Stallings, Director Cleveland County Public Health Dept.
2:00	AIDS Program	Evelyn Foust, Section Chief Division of Epidemiology DHHS
3:00	Updates: Forensic Unit	Don Willis, Chief Mental Health Services DHHS
	Efficiency Study of Psychiatric Hospitals	Don Willis, DHHS
	Early Intervention Funding	Duncan Munn, Child/Adolescent Services, Developmental Disabilities Section DHHS
	Child Care Subsidy	Peter Leousis, Assistant Secretary for Human Services & Education Policy DHHS
	County Commissioners' Letter on Medicaid Cost-Sharing	Carol Shaw, Analyst Fiscal Research Division

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Wednesday, January 21st, 9:00 a.m.
Room 414 - Legislative Office Building

9:00	Status of Children's Health in NC	Ann Wolfe, Director Women's and Children's Health, DHHS
11:00	Medicaid Growth Reduction Plan Update Proposed Changes in Staffing	Dick Perruzzi, Director Division of Medical Assistance DHHS
11:30	Impact of Budget Cuts on Psychiatric Hospitals	Gladys Fisher Parent of Consumer

LUNCH

1:00	Welfare Reform ■ 5-Year Business Plan/Reinvestment Strategy ■ Status of 1997-98 Funding	Jim Edgerton, Assistant Secretary Budget, Management & Planning DHHS Peter Leousis, Assistant Secretary Human Services and Education Policy DHHS
	■ Initiatives to Reduce Out-of-Wedlock Births	Ann Wolfe, Director Women's and Children's Health, DHHS
2:30	Child Welfare Expansion Update	Kevin Fitzgerald, Director Division of Social Services Leza Aycock, Assistant Director Division of Social Services
3:15	Progress Report on Thomas S. Cost Containment	Susan White, Chief Thomas S. Services Section DHHS

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Thursday, January 22nd, 9:00 a.m.

Joint Meeting with NER Subcommittee - Room 643, Legislative Office Building

9:00 Welfare-to-Work Status	Rick Carlisle, Acting Secretary Department of Commerce Pheon Beal, Chief of Economic Independence Division of Social Services DHHS
9:45 Administrative Cost Associated with Transferring Health Functions to DHHS	Carol Shaw, Analyst Fiscal Research Division
10:45 Administration of Environmental Health Programs	Mona Moon, Analyst Fiscal Research Division

Ralph Campbell #1

STATE OF NORTH CAROLINA

Performance Audit
of the
Department of Health and Human Services
Division of Services for the Blind

a presentation to the

Joint Appropriations Subcommittee on Human Resources

JANUARY 20, 1998

OFFICE OF THE STATE AUDITOR
RALPH CAMPBELL, JR.
State Auditor

Performance Audit

of the

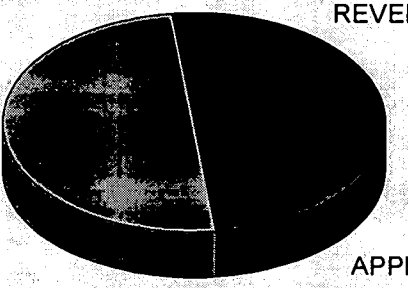
Department of Health and Human Services,

Division of Services for the Blind

AUDIT OBJECTIVES

- DETERMINE AGENCY'S MISSION
- DETERMINE GOALS OF MAJOR PROGRAMS
- DETERMINE TARGET POPULATIONS
- DETERMINE "CLIENTS"; HOW COUNTED
- EXAMINE ORGANIZATIONAL STRUCTURE
- REVIEW FINANCIAL MANAGEMENT OF GOVERNOR MOREHEAD SCHOOL

DSB Revenues, Expenditures and Appropriations for FY96-97



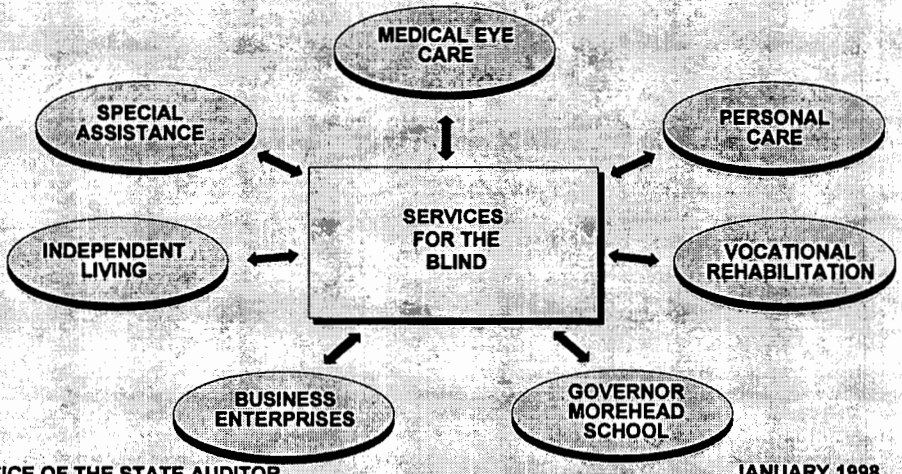
Amounts Shown in Millions

MISSIONS AND GOALS

- **DHHS MISSION**: PROVIDE PROGRAMS AND SERVICES TO BLIND AND VISUALLY IMPAIRED
- **DSB GOAL:** OFFER SERVICES TO EMPOWER BLIND OR VISUALLY IMPAIRED INDIVIDUALS TO ACHIEVE MAXIMUM POTENTIAL
- STATUTES VAGUELY WRITTEN
  - FEDERAL
  - STATE
- OPEN TO INTERPRETATION
- POLICIES AND PROCEDURES NOT CURRENT
- NO COMPREHENSIVE TRAINING PROGRAM FOR STAFF

TARGET POPULATIONS

- PERSONS "...TOTALLY BLIND OR WHOSE VISION WITH GLASSES IS SO DEFECTIVE AS TO PREVENT PERFORMANCE OF ORDINARY ACTIVITY"
- 7 MAJOR PROGRAMS

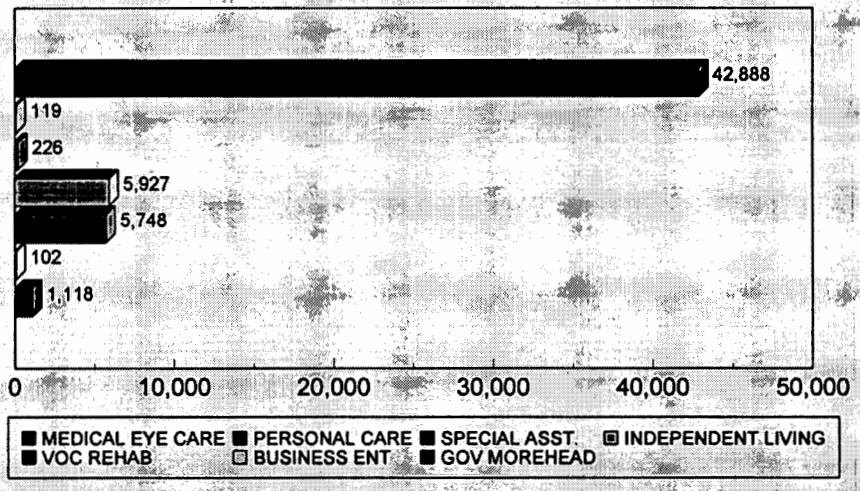


OFFICE OF THE STATE AUDITOR

JANUARY 1998

NUMBER OF CLIENTS

- DSB SERVED APPROXIMATELY 56,000 CLIENTS FOR FY 96-97



OFFICE OF THE STATE AUDITOR

JANUARY 1998

CLIENT ACCOUNTING

- NO CENTRALIZED DATABASE FOR ALL PROGRAMS
- EACH PROGRAM ACCOUNTS FOR ITS CLIENTS
- CLIENTS CAN, AND DO, RECEIVE SERVICES FROM MORE THAN ONE PROGRAM
- ACTUAL NUMBER OF INDIVIDUAL CLIENTS SERVED BY DSB CANNOT BE DETERMINED
- NUMBER CLIENTS REPORTED BY PROGRAM ACCURATE

ORGANIZATIONAL ISSUES

- COMMISSION MEMBERS AVERAGE ATTENDING ONLY 77% OF MEETINGS
- ORGANIZATIONAL LINES OF AUTHORITY UNCLEAR
- NEED TO CONDUCT WORKLOAD STUDY

OPERATIONAL ISSUES

- BUDGET INFORMATION NOT TIMELY
- QUESTIONABLE EMPLOYMENT SERVICES PROVIDED
- UNABLE TO OBTAIN FINANCIAL DATA BY VENDING FACILITY
- SET-ASIDE STRUCTURE NEEDS TO BE RE-EVALUATED
- PROCEDURES RESTRICT NUMBER OF HIGHWAY VENDING OPERATORS
- ONLY MINOR PROBLEMS WITH GOV. MOREHEAD SCHOOL FINANCIAL MANAGEMENT

Ralph Campbell #2

STATE OF NORTH CAROLINA

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND

DECEMBER 1997

OFFICE OF THE STATE AUDITOR
RALPH CAMPBELL, JR.
State Auditor

STATE OF NORTH CAROLINA
Office of the State Auditor

RALPH CAMPBELL, JR.
STATE AUDITOR

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PRESS RELEASE

For Immediate Release: December 31, 1997

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STATE AUDITOR RALPH CAMPBELL, JR. RELEASES REPORT ON THE DIVISION OF SERVICES FOR THE BLIND

The Division of Services for the Blind (DSB), located within the Department of Health and Human Services, has responsibility for the operation of all programs associated with the blind and visually impaired citizens of the State. As defined in GS §111, a visually handicapped person is one who is ". . . totally blind or whose vision with glasses is so defective as to prevent the performance of ordinary activity for which eyesight is essential." The North Carolina Department of Health and Human Services is authorized under the federal Barden-Rehabilitation Act to make the necessary rules and regulations for delivery of services to the blind. The Commission for the Blind directs the State's program and adopts rules governing the conduct of the State's rehabilitative programs for the blind. DSB as the administrative agency provides services to approximately 56,000 clients annually with a budget of $32 million.

According to State Auditor Ralph Campbell, Jr., "This performance audit, as mandated by the 1997 General Assembly, focused on:

- questions concerning the agency's mission,
- the goals and purposes of the major programs at DSB,
- a determination of the target populations,
- what constitutes a "client" and how clients are accounted for, as well as participation requirements, and
- an examination of the agency's organizational structure."

"Of major concern was the way by which DSB accounts for its clients and reports that information to the public and the General Assembly," Auditor Campbell said. "We found that DSB does not have a centralized database which captures client information for all programs." "Rather," Mr. Campbell continued, "each program director accounts for clients within their respective programs. Since each client can, and frequently does, receive multiple services, the actual number of individual clients served by DSB cannot be accurately determined. However,

OVER

we are of the opinion that the data for the number of clients served by each program is reasonably accurate."

"The second major recommendation in our report pertains to the need for statutory clarification of the authority and responsibilities of DSB," Auditor Campbell noted. "We found that the State statutes are based in part on the federal legislation for the blind. The legislation at both the federal and State level is vaguely written and is open to interpretation. Therefore, DSB sometimes approves requests for services that may not meet its current policies. To eliminate this confusion, the Department and DSB management should recommend necessary statutory changes to the North Carolina General Assembly for consideration.

"The lack of substantive operational policies and procedures for the DSB is a third area of concern," continued Auditor Campbell. "The current lack of strict procedures resulted in the Division of Services for the Blind spending over $23,000 in travel for one client to interview all over the United States and in at least one foreign country. In another example, current policy allows clients to purchase cars for traveling to work and have the down payment and first six months' insurance paid by DSB. There are no guidelines as to the amount of the down payment or when or if any of the money must be repaid. In the vending operations the repayment of money received as start-up grants is not adequately defined."

State Auditor Campbell noted, "Some other areas of concern included in the report are:

- The confusion for staff at various levels of DSB over reporting relationships and the need to reexamine job duties for several classifications;
- The need for more timely and detailed budget reporting for management purposes;
- The need to update and distribute DSB policies and procedures timely and to limit exceptions to those policies;
- The need to examine the current policies and procedures in the Business Enterprises' program affecting vendor facilities, particularly those which affect highway vending sites; and,
- The need to more fully utilize the rehabilitation training facility."

State Auditor Campbell concluded by saying, "Overall, the Division of Services for the Blind has done a good job of administering very diverse and difficult programs. The Department of Health and Human Services and the Division are to be commended for the excellent programs and services offered to the blind and visually impaired citizens of North Carolina."

Copies of the report including the response from the Secretary of the Department of Health and Human Services are available by contacting the Office of the State Auditor at the address above or by electronic mail (**reports @aud.osa.state.nc.us.**) The executive summary will also be available on the OSA Internet home page, **http://www.osa.state.nc.us**.

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PERFORMANCE AUDIT
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND

DECEMBER 1997

STATE OF NORTH CAROLINA
Office of the State Auditor

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AUDITOR'S TRANSMITTAL

December 31, 1997

The Honorable James B. Hunt, Jr., Governor
Senator Marc Basnight, President Pro Tempore
North Carolina Senate
Representative Harold J. Brubaker, Speaker
North Carolina House of Representatives
Dr. H. David Bruton, Secretary
Department of Health and Human Services
Members of the North Carolina General Assembly

Ladies and Gentlemen:

We are pleased to submit this performance audit of the *Department of Health and Human Services, Division of Services for the Blind* as mandated by the 1997 General Assembly in Senate Bill 352, Section 11.61. The objectives of the audit were to identify areas where the effectiveness and efficiency of program operations could be improved in the areas of operating policies, practices, control activities, and current organizational structure and staffing.

This report consists of an executive summary, program overview, and operational findings and recommendations. Management of the Department and the Division have reviewed a draft copy of this report and their written comments are included.

We wish to express our appreciation to the Secretary and his staff for the courtesy, cooperation, and assistance provided us during this effort.

Respectfully submitted,

Ralph Campbell, Jr.

Ralph Campbell, Jr.
State Auditor

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EXECUTIVE SUMMARY

We have conducted a performance audit of the Division of Services to the Blind (DSB), within the Department of Health and Human Services (Department). The audit was mandated by the 1997 General Assembly in Senate Bill 352, Section 11.61. The Department has been given statutory responsibility under Chapter 111 of the General Statutes for the operation of all programs associated with the blind and visually impaired citizens of the State. This responsibility has been delegated to the Division of Services for the Blind. DSB provides services to all legally blind and visually impaired North Carolinians. As defined in GS §111, a visually handicapped person is one who is ". . .totally blind or whose vision with glasses is so defective as to prevent the performance of ordinary activity for which eyesight is essential."

DSB has divided the State into four general areas in which there are located seven district offices, offering services in local communities. A rehabilitation center for the blind in Raleigh provides direct training to clients. Other direct training is provided through the purchase of service agreements with Industries for the Blind organizations located throughout the State. Services are also purchased from community colleges, universities, and other private service providers. The scope of the audit encompassed all aspects of the operation of the Division of Services for the Blind.

The draft report was reviewed by Department and DSB management. Their response is included as Appendix A, page 42.

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AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

North Carolina GS §147-64 empowers the State Auditor with authority to conduct performance audits of any state agency or program. Performance audits are reviews of activities and operations to determine whether resources are being used economically, efficiently, and effectively.

This performance audit of the Division of Services for the Blind (DSB), within the Department of Health and Human Services, was mandated by the 1997 General Assembly in Senate Bill 352, Section 11.61. The State Auditor was directed to conduct a performance audit to address, but not be limited to, the financial management of the Division, to include the Governor Morehead School.

Given this mandate, our specific objectives were to:

- determine the mission, goals and purposes of the major programs at DSB to determine target populations;
- examine the organizational structure at DSB and how it relates to the major programs;
- examine the accounting and reporting systems, specifically to understand what constitutes a "client;" and
- examine the educational and vocational rehabilitation programs, specifically to determine requirements for participation.

The scope of the audit encompassed all aspects of the operation of the Division of Services for the Blind, with particular emphasis on the major programs of Medical Eye Care, Independent Living Services, Education and Business Enterprises/Employment. Additionally, the Department of Health and Human Services' Controller's Office and Personnel Office were included to the extent necessary to conduct our review of DSB's operations.

During the period September 23, 1997, through October 31, 1997, we conducted the on-site fieldwork for the audit of DSB. In order to achieve our objectives, we employed various auditing techniques which adhere to the generally accepted auditing standards as promulgated in *Government Auditing Standards* issued by the Comptroller General of the United States. These techniques included:

- review of existing General Statutes and North Carolina Administrative Code as they relate to DSB;
- on-site, in-depth interviews with 42 members of staff;
- site visits to 5 area and district offices and interviews with field staff;
- interviews with all current members of the Commission for the Blind;
- identification and review of internal control procedures for DSB sections relative to accounting and reporting functions, and analysis of financial data;
- review of existing planning documents, organizational charts, policies and procedures, contractual arrangements, and financial data;
- sample of data contained in DSB databases to test validity;
- examination of staffing levels, workloads, and time records;
- review of various other studies and reports on DSB operations; and
- review of data from other states for comparative purposes.

This report contains the results of the audit as well as specific recommendations aimed at improving the operations of DSB in terms of economy, efficiency, and effectiveness. Because of the test nature and other inherent limitations of an audit, together with the inherent limitations of any system of internal and management controls, this audit would not necessarily disclose all weaknesses in the system or lack of compliance. Also, projection of any of the results contained in this report to future periods is subject to the risk that procedures may become inadequate because of changes in conditions and/or personnel, or that the effectiveness of the design and operation of policies and procedures may deteriorate.

BACKGROUND INFORMATION

FEDERAL AUTHORITY

Barden-Rehabilitation Act:

The Barden-Rehabilitation Act is the federal act authorizing the North Carolina Department of Health and Human Services (Department) to make the necessary rules and regulations for delivery of services to the blind. The Department is empowered to assist the blind in becoming self-supporting through rehabilitation and through assistance in obtaining employment, including employment in business enterprises operated by the Department.

Randolph-Sheppard Bill (H.R. 4688):

The Randolph-Sheppard Act[1] was enacted to promote uniformity of treatment of blind vendors by all federal agencies, establish consistent guidelines for all state licensing agencies, ensure fair treatment of blind vendors, increase economic opportunities for the blind, stimulate the blind to greater efforts in striving to make themselves self-supporting, and give authority to the blind to operate vending facilities on any federal property.

STATE STATUTORY AUTHORITY

Commission for the Blind:

The Commission for the Blind was created by GS §143B-157 through 160. The statutes give the Commission the power and duty to adopt rules governing the conduct of the State's rehabilitative programs for the blind necessary to carry out the provisions and purposes of the statute. The Commission consists of eleven members appointed by the Governor for terms of six years. The Commission meets at least once each quarter. Specifically, the overall function, purpose, and duty of the Commission is to:

- adopt rules that are necessary and desirable for the programs administered by the Department of Health and Human Services;
- adopt rules that are required by the federal government for grants-in-aid for rehabilitative purposes for the blind that may be made available to the State, in order that the State and its citizens may benefit from such grants-in-aid;
- review, analyze, and advise the Department regarding the performance of its responsibilities under the federal rehabilitation program as it relates to the services to the blind;
- advise the Department regarding preparation of applications, the State Plan, the strategic plan, amendments to these plans, the State needs assessments, and the evaluations required by the federal rehabilitation program;
- conduct a review and analysis of the effectiveness of, and consumer satisfaction with, the functions performed by the Department and other public and private entities responsible for performing functions for individuals who are blind or visually impaired, including vocational rehabilitation services;
- prepare and submit an annual report to the Governor, the Secretary, and the federal rehabilitation program; and

[1] Authority found in the United States Code Service Title 20, Chapter 6A, Section 107.

- coordinate with other councils within the State who have direct impact upon services to the blind and visually impaired.

Professional Advisory Committee:

GS §143B-161 creates the Professional Advisory Committee to advise the Commission for the Blind on matters concerning or pertaining to the procurement, utilization, and rendering of professional services to the beneficiaries of the Commission's aid and services. The Committee is composed of nine members appointed by the Governor for three year terms. There are three members representing licensed physicians whose practice is limited to ophthalmology, three optometrists, and three opticians. All members are nominated by their respective state professional associations.

Consumer and Advocacy Advisory Committee for the Blind:

GS §143B-163 creates the Consumer and Advocacy Advisory Committee for the Blind consisting of fourteen members representing various groups and associations for blind and visually impaired persons. This Committee's responsibility is to make a continuing study of the entire range of problems and needs of the blind and visually impaired population of the State and make specific recommendations to the Department as to how these may be solved or alleviated through legislative action. The Committee examines national trends and programs of other states, as well as programs and priorities in North Carolina and makes recommendations concerning methods of preventing blindness and restoring vision. All entities which supervise, administer, or control any program for or affecting citizens who are now or will become visually handicapped or impaired must inform the Consumer and Advocacy Advisory Committee of any proposed change in policy, program, budget, rule, or regulation in order that the Committee might review and comment on those changes.

Governor Morehead School Board of Directors:

The Governor Morehead School (GMS) Board was created by GS §143B-176.1 with the power and duty to adopt rules and establish standards to be followed in the conduct of the GMS operations and the professional care of children enrolled to the School. The statute further charges the school to be as nearly self-supporting as consistent with the purposes of its creation. The GMS Board of Directors consists of eleven members, each appointed by the governor for a six year term.

Department of Health and Human Services:

The Department of Health and Human Services (Department) has been given statutory responsibility under Chapter 111 of the General Statutes for the operation of all programs associated with the blind and visually impaired citizens of the State. Specifically, it is the Department's responsibility to:

- maintain a complete register of the blind in North Carolina describing the condition, cause of blindness, capacity for education and industrial training of each, among other pertinent facts;

- maintain bureaus of information and industrial aid to assist the blind in finding employment and to teach them trades and occupations, and to assist them in disposing of products from their home industry;
- establish training schools and workshops for the blind, to employ suitable blind persons in the schools and workshops, and to devise means for the sale and distribution of the products created;
- aid individual blind persons or groups of blind persons to become self-supporting by furnishing material or equipment to them and assisting them in the sale of their products;
- give direct money payments to the needy blind, with approval of the Commission of the Blind;
- establish and operate a rehabilitation center for the blind to assist them in mental, emotional, physical, and economic adjustment to blindness;
- receive grants-in-aid from the federal government under the Barden-Rehabilitation Act;
- conduct promotion visits with blind citizens and teach them in their homes;
- continue to make inquiries concerning the cause of blindness, to learn how many cases are preventable, and to take action on these findings;
- arrange for the examination of the eyes of blind or partially blind persons and secure and pay for medical and surgical treatment; and
- carry on activities to promote the rehabilitation and employment of blind through the operation of various business enterprises suitable for the employment of or operation by the blind.

The Department has established the Division of Services for the Blind to administer the various responsibilities as outlined in the General Statutes.

Division of Services for the Blind:

The Division of Services for the Blind (DSB) offers a variety of services to empower individuals who are blind or visually impaired to achieve their maximum potential. DSB provides services to all legally blind and visually impaired North Carolinians. As defined in GS §111, a visually handicapped person is one who is ". . .totally blind or whose vision with glasses is so defective as to prevent the performance of ordinary activity for which eyesight is essential."

ORGANIZATIONAL STRUCTURE AND STAFFING

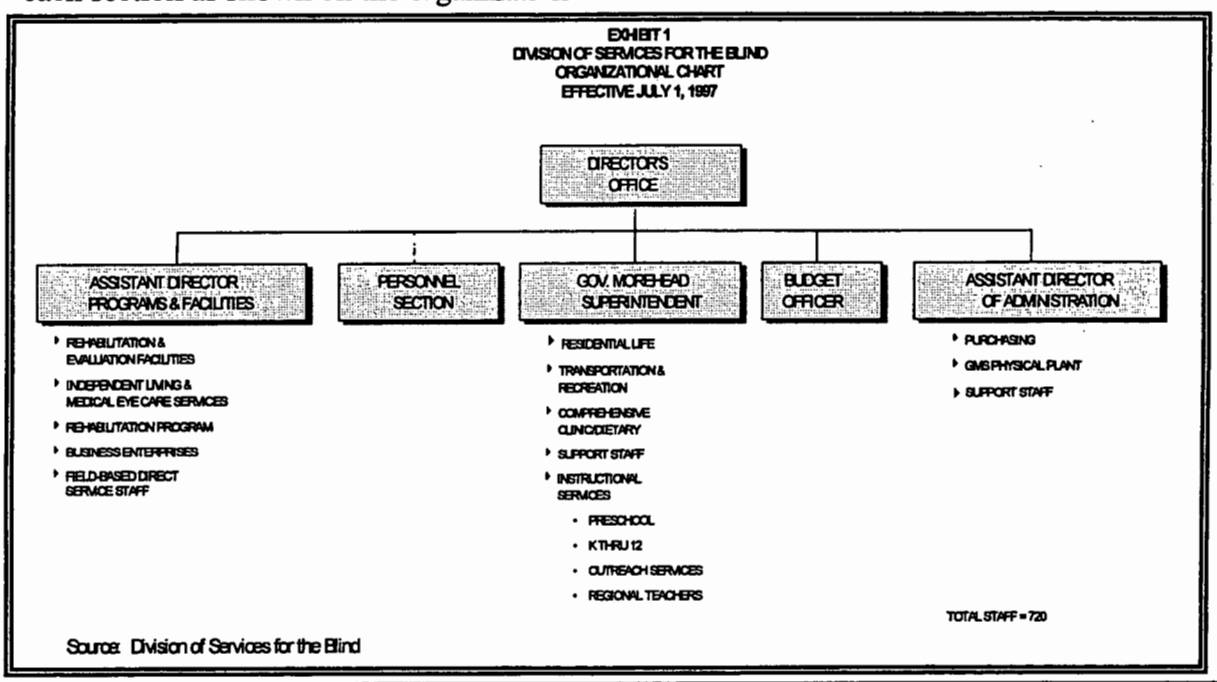
Total staff for DSB consists of 720 positions located throughout the State. Of these, 194 are assigned to the Governor Morehead School. There are 127 management and support staff in the division offices, including maintenance and dietary staff. There are 399 staff located in the area, district, and county social services offices, of which 211 permanent part-time positions are for personal care services. DSB has divided the State into four general areas in which there are located seven district offices. Although the organizational structures vary among the four areas, the following services are offered in each:

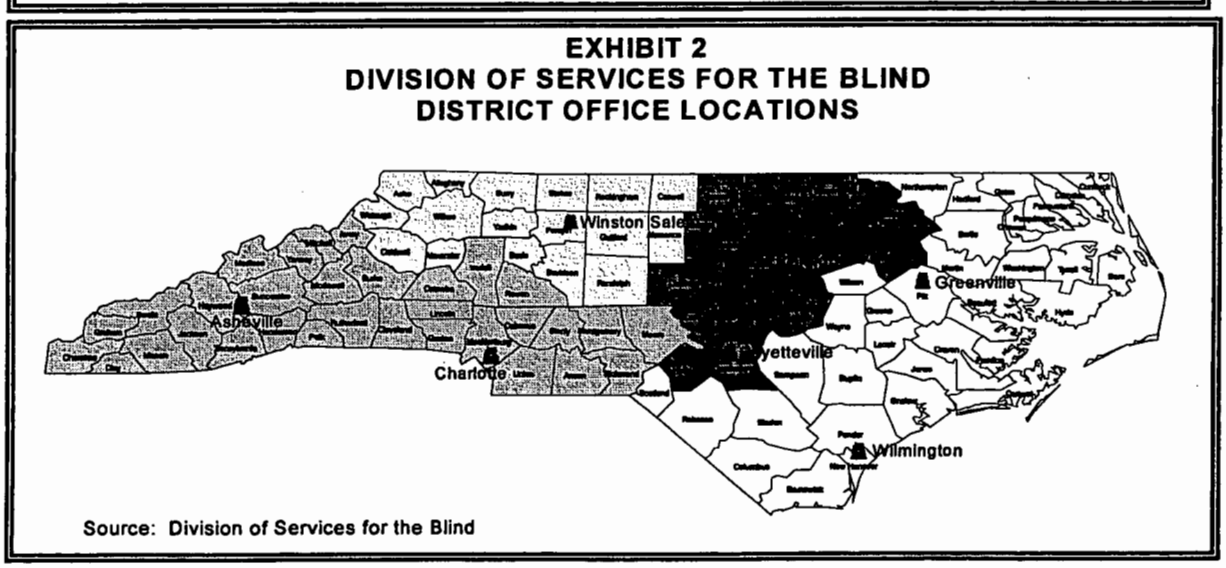
- Social Services (Independent Living Services)
- Rehabilitation Services (Counseling and Placement)
- Medical Services

- Orientation and Mobility Services
- Children's Program Services
- Business Enterprises (Employment)

The seven district offices offer services in local communities, while a rehabilitation center for the blind in Raleigh provides direct training to clients. Other direct training is provided through the purchase of service agreements with Industries for the Blind organizations located throughout the state. Services are also purchased from community colleges, universities, and other private service providers.

Exhibit 1 depicts the organizational structure in place during the audit. This organization features the administrative headquarters located in Raleigh and seven area office locations as shown in Exhibit 2. On the following pages we briefly describe the major functions of each section as shown on the organizational chart.





The **Administrative Services** Section of DSB, headed by an Assistant Director, provides overall management support services at the State and regional level, as well as those for the Governor Morehead School. Services provided include accounting, fiscal operation, and policy making to insure uniformity in the implementation and provision of services offered by DSB. Included in this section are the Business Office, the Purchasing Office and the Physical Plant operations for the Governor Morehead School Campus.

The **Programs and Facilities** Section of DSB is also headed by an Assistant Director. Included in this section are programs for business enterprises, rehabilitation, independent living and medical eye care services. These programs are designed to provide services which promote sight conservation, independent living skills, and employment to the clients served by DSB.

PROGRAM OVERVIEW

DSB provides services to approximately 56,000 clients annually. The major service programs provided by DSB are shown in Table 1.

TABLE 1
DIVISION OF SERVICES FOR THE BLIND
CLIENTS SERVED AND EMPLOYEES
BY PROGRAM AREA FOR FY96-97

PROGRAM AREA	CLIENTS SERVED	DSB EMPLOYEES
Medical Eye Care	42,888	11
Personal Care Services	119	211
Special Assistance for the Blind	226	1
Independent Living Services	5,927	71
Vocational Rehabilitation	5,748	93
Business Enterprises	102	12
Governor Morehead School	1,118	194
Management & Support		127
TOTALS	56,128	720

Source: Division of Services for the Blind

Medical Eye Care :

Blindness often results from retinal disorders, cataracts, or glaucoma. The Medical Eye Care program was established to help **prevent** blindness, and where possible, to restore vision in qualified low-income individuals who have suffered loss of sight. Preventive and corrective services under this program include:

- Eye examinations, treatment, and surgery
- Glaucoma screenings
- Children's vision screening
- Low-vision evaluations
- Correction of limited vision with low-vision aids or glasses
- Eye care education

DSB records show that last fiscal year, approximately 13,000 people were screened for glaucoma and approximately 11,000 children received vision screenings from DSB nurses. (See Table 4, page 21.)

Personal Care Services:

The Personal Care Services program is a component of the Medical Eye Care Section. The program provides personal in-home care to Medicaid eligible blind or visually

impaired persons with medical needs. Without these personal services, the individual would likely require institutionalization, which would require more state and federal funding. As of July 1, 1997, there are 76[2] permanent part-time positions providing personal services to approximately 120 clients.

Special Assistance for the Blind:

The Special Assistance for the Blind program has no service requirements. Rather, it assists blind persons living in rest homes to meet their minimum financial needs. Monthly financial assistance payments are made to all eligible recipients in rest homes at the current legislatively authorized rates. Additionally, funding is provided for non-Medicaid covered expenses of eligible individuals. For FY97-98, 226 clients are receiving payments from the program. The program's expenditures for FY96-97 were $1.1 million.

Independent Living Services:

The Independent Living Service program provides opportunities to persons of all ages who are blind or visually impaired to learn daily living skills and obtain the assistance they need to become self-sufficient. Much of the instruction is provided in the person's home. Independent Living Services include:

- Adjustment Services - counseling, personal care skills, and training in home management
- In-home Aide Services - assisting with meal preparation, home cleaning, and errands
- Health Support Services - counseling on health, nutrition, and diet
- Family Adjustment Services - providing information and support to help family members adjust to the changes necessary to support the individual's independence
- Children's Services - working with children, parents, teachers, and others to help the child develop independent living skills
- Safe Travel Skills - teaching individuals to use sighted guide, white canes and safety techniques to travel independently

Vocational Rehabilitation:

The Vocational Rehabilitation program assists the blind and visually impaired in maintaining, returning to, or securing competitive employment in activities which allow them to become productive members of society. To accomplish this responsibility, the program:

- Provides evaluation, vocational training, physical restoration, maintenance, transportation, and job placement;
- Prepares clients to take advantage of vocational training, higher education, and/or employment by providing adjustment to blindness services and training services at DSB's rehabilitation center; and
- Seeks client involvement through client satisfaction surveys for the rehabilitation program.

[2] There were 211 permanent, part-time positions assigned to the Personal Care services program at the time of the audit; however, 135 of these positions were vacant.

A variety of programs is offered by DSB to provide rehabilitative services for individuals who are blind or visually impaired. Rehabilitation counselors work one-on-one with participants to determine which rehabilitation programs they need to become self-sufficient. These programs and services may include:

- Rehabilitation Guidance and Counseling
- Vocational Evaluations
- Work Adjustment Program
- Supported Employment Services
- Adjustment to Blindness
- Independent Living Rehabilitation Services
- Business Enterprises Program
- Adaptive Technology Services
- Rehabilitation Engineering Services
- Job Placement and Follow-up Services

Specialized Employment Services:

Supported Employment Services help persons who are blind, visually impaired or multi-handicapped find and maintain employment in competitive, integrated work settings. Individuals qualifying for these special services are the most severely disabled who need multiple services and long term follow-up to become successfully employed and maintain employment. DSB typically uses the job/coach model which provides a person to work with the blind individual on a one-on-one basis until they can work independently. After training, follow-along services are provided to ensure continued success.

The Business Enterprises (BE) Program is one type of employment service offered by DSB. The BE Program is designed to identify and train blind or visually impaired individuals in the operation of vending facilities located primarily on state and federal properties.

Education:

The Governor Morehead School (GMS) is the only state supported residential school designed to serve children with severe visual impairments. It is located in Raleigh on a 75-acre campus much like that of a small college. Education services are divided into preschool, standard elementary and secondary programs, and modified curriculum emphasizing communication, self-help, vocational, and living skills for students with developmental disabilities. The goal of the GMS preschool program is to help children with visual impairments gain skills and self confidence. The *preschool* program serves visually impaired children from birth through age four, it being critical to begin contact with these children as early as possible. The preschool services are community based and teachers visit the children in their homes or in their community based day care centers. Parents also receive training and support so they can take an active role in their child's growth and progress. The *secondary education* program serves both college-bound students and those who will continue to require support in vocational and living skills throughout adulthood. The *outreach* program focuses on coordinating efforts which link

the Governor Morehead School with local education agencies serving children who are blind or visually impaired, providing liaison between GMS and community agencies, and coordinating school staff providing diagnostic services, consultative, educational evaluation, and technical assistance to visually impaired students in local school systems.

The Comprehensive Clinic provides medical and therapeutic services to the GMS students. Services include occupational therapy, speech-language therapy, and psychological evaluations. Social work and health/medical services provide support to the various school components. The clinic also supervises the Dietary Department responsible for providing daily meals to the GMS students and faculty, and maintains the Record Center for current and past students.

Management and Support Services:

This element of DSB provides management and administrative support services for the components of the division including the Governor Morehead School. These services include budget/accounting service, LAN/information systems support, policy development, implementation and interpretation of policies and procedures, and maintenance of the statewide Blind Register.

BUDGETARY DATA

Table 2, page 13, summarizes the financial data for General Fund Revenues for DSB for fiscal years 1992-93 through 1996-97. A review of the budgetary data reveals that there has been little change in program expenditures and revenues in the past five years. Revenues, averaging approximately $17.4 million per year, are primarily from four sources: Rehabilitation Service Basic Support Grant, county funds, Personal Care Services, and DHHS Social Service Block Grant funds. The Rehabilitation Service Basic Support Grant provides approximately 50% of revenues each fiscal year. The transfer of funds from the Department of Health and Human Services for the Social Services Block Grant reimbursements makes up 19% of revenues. County funds have decreased over the past five years as a result of a decrease in clients served. Revenues for Personal Care Services have decreased due to greater availability of private providers who can meet the needs of clients. In addition to these revenues, approximately $15 million of State appropriations are required to support a $32 million annual budget which has remained relatively constant during the past five years. Beginning on page 16, we briefly discuss the funding sources for each of the programs in DSB. Exhibit 3, page 15, shows the source of funds for FY 96-97, and Exhibit 4 shows funding by purpose for the same period.

TABLE 2
DIVISION OF SERVICES FOR THE BLIND
STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCE
FOR GENERAL FUNDS

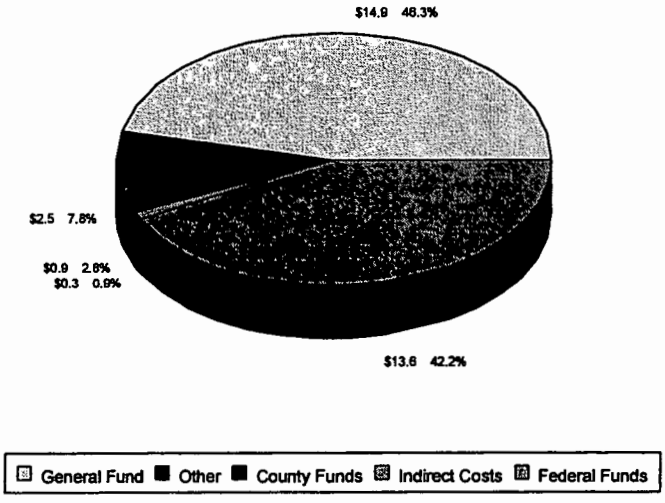
	FYE 6/30/93	FYE 6/30/94	FYE 6/30/95	FYE 6/30/96	FYE 6/30/97
REVENUES					
Rehabilitation Service Basic Support	$ 8,667,096.00	$ 8,002,717.00	$ 9,395,906.00	$ 8,158,843.00	$9,626,072.75
Rehabilitation Training	44,876.00	37,710.00	22,654.00	161,829.00	153,587.50
Rehabilitation Services-Severely Disabled	39,051.00	0.00	(103.00)	0.00	0.00
Supported Employment	158,368.00	150,239.00	46,306.00	242,127.00	173,673.28
Social Security Funds	0.00	386,755.00	0.00	0.00	0.00
Independent Living	77,803.00	60,820.00	4,006.00	82,905.00	64,069.01
Older Blind Grant	127,126.00	0.00	41,213.00	150,849.00	266,847.87
County Funds	1,122,528.44	1,222,972.15	1,177,559.23	1,069,871.76	945,939.09
Interagency Transfers	0.00	0.00	46,231.61	228,254.00	71,990.73
DPI-Remediation	2,775.00	2,876.00	2,445.00	2,270.00	2,270.00
DHR-Social Service Block Grant Reimbursement	3,202,145.00	3,390,989.00	3,159,479.39	3,205,808.73	3,358,466.05
Interagency Grants/Allocation	0.00	350,000.00	0.00	0.00	0.00
Transfer from Social Services Critical Needs	0.00	0.00	0.00	416,750.00	0.00
D D Council Funds	48,731.84	86,316.14	19,620.00	0.00	0.00
Child Nutrition and Supp	29,420.40	38,704.15	33,779.92	37,926.09	43,633.22
NETP Mini Grant	0.00	1,000.00	0.00	0.00	0.00
Cultural Resources-Library	2,366.09	7,233.91	1,576.51	4,013.90	0.00
ESEA Chapter 1H	0.00	0.00	0.00	8,163.00	0.00
Beg For Parents of Hearing	999.46	820.45	0.00	0.00	0.00
Space- Develop Disability	16,865.00	18,629.00	13,547.75	27,076.52	9,163.00
Space-Office of Rural Health	55,765.00	52,713.75	51,558.00	70,936.55	25,279.15
Space-Penland	0.00	0.00	0.00	9,258.32	1,851.66
Space-Division of Services for the Blind	351,133.00	435,170.33	103,824.77	601,853.13	183,928.05
Space-Developmental Evaluation Center	32,797.00	5,893.56	0.00	0.00	0.00
Space-Deaf and Hard Hearing	0.00	0.00	0.00	7,651.53	2,777.49
Transfer Federal Indirect Reserve	126,657.00	404,102.00	222,246.00	0.00	0.00
Non-Fed Share-Rent	24,409.08	15,652.63	0.00	73,232.00	0.00
Non-Fed Share of Meals	11,728.00	16,045.20	0.00	0.00	0.00
GMS Cottage Bedding	0.00	8,533.84	0.00	0.00	0.00
Prior Fiscal Year Transfer	947,344.00	445,680.00	637,343.00	133,678.00	578,330.00
Vocational Education	0.00	0.00	0.00	0.00	5,629.00
Imprest Cash	13,545.00	14,200.00	14,060.00	14,060.00	8,281.15
Cafeteria	72,058.54	119,098.15	56,993.29	0.00	0.00
Food and Vending	0.00	0.00	0.00	113,261.13	71,535.15
Sale-Vocational Products	88,997.19	115,519.06	32,545.16	(173.39)	0.00
Set-Aside	0.00	0.00	0.00	0.00	0.00
Clinic Reimb - Medicaid	1,327.03	1,585.83	1,195.49	306.25	0.00
Clinic Reimb -Rehabilitation	467.74	0.00	0.00	15.00	0.00
Clinic Reimb-Co Payments	1,225.00	1,390.00	1,060.00	32,730.82	478,888.70
Personal Care Services Fund	1,480,755.41	1,319,206.43	1,017,840.89	745,722.27	207,718.08
Community Action Program	0.00	106.54	(213.08)	220.00	295.00
Third Party - Revenues	0.00	208.14	0.00	0.00	0.00
Lions Contribution	2,257.91	3,848.00	3,014.00	6,768.00	5,998.00
Sale of Equipment	5,000.42	2,849.39	9,824.16	9,714.74	1,810.00
Hospital Medical Benefit	6,029.38	454.22	(3,670.52)	0.00	0.00
Business Enterprises	141,920.31	324,413.61	273,930.70	0.00	124,660.51
Utilities-Employee Housing	10.00	0.00	0.00	0.00	0.00
Miscellaneous	65,223.22	151,521.75	182,157.00	443,406.20	581,053.84
Indirect Cost	464,009.17	1,301,942.26	820,437.79	292,746.56	292,509.00
Other Income	5,906.94	138.06	(689.81)	0.00	0.00
Escheats Payable	0.00	0.00	0.00	351.34	0.00
Payroll Interface Clearing	0.00	0.00	0.00	(195.46)	0.00
Accr-Sales Tax Payable	0.00	0.00	0.00	0.00	(930.93)
TOTAL REVENUES	$17,438,717.57	$18,498,054.55	$17,387,678.25	$16,352,229.99	$17,285,326.35

TABLE 2 (concluded)
DIVISION OF SERVICES FOR THE BLIND
STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCE
FOR GENERAL FUNDS

	FYE 6/30/93	FYE 6/30/94	FYE 6/30/95	FYE 6/30/96	FYE 6/30/97
EXPENDITURES					
Salaries, Overtime, Longevity	$12,632,399.07	$13,983,679.37	$13,794,832.48	$14,243,373.21	$14,341,388.10
Stu Temp Wages	183,899.21	197,306.43	243,343.13	113,301.92	98,301.81
Awards to Emp, Med Benefits, Disability	268,385.97	193,801.09	114,585.73	103,155.21	331,948.64
Compensation to Bd Members	855.00	1,335.00	1,695.00	1,425.00	1,950.00
Retiremnt, SS, Staff Bene.,Hsp Contrib.	2,980,110.94	3,252,302.95	3,270,375.15	3,364,510.01	3,356,815.90
Contractual Services	289,486.57	358,582.11	385,817.18	674,487.04	918,047.44
Other Material & Supplies	41,319.11	35,203.12	75,143.70	119,717.69	98,565.61
Food- Institutional Use	250,633.66	187,845.07	111,277.77	0.00	
Educational, Drug, & Food Supplies	8,267.59	135,978.12	129,117.84	246,176.56	231,945.23
Maint & Repair Supplies	52,969.82	71,294.86	53,963.21	0.00	
Motor Vehicle Supplies	23,111.87	27,300.64	27,531.74	23,164.02	16,983.33
Office Supplies and Materials	54,856.35	77,695.81	108,333.30	126,001.49	86,818.87
Purchases for Resale	10,539.85	11,478.73	11,986.56	17,769.86	11,975.10
Heating & Utility Supplies	20,403.72	14,681.74	27,849.19	0.00	
Transportation Expenses	629,845.95	689,022.98	769,894.76	786,919.40	966,521.97
Telephone and Postage	205,817.83	228,125.61	247,746.23	0.00	
Utilities	342,374.39	376,388.00	330,699.47	374,176.40	314,630.93
Printing	47,182.31	48,265.82	30,184.13	0.00	
Repairs & Maintenance	91,496.80	147,201.60	228,107.32	130,001.05	236,074.29
Freight	3,102.52	2,940.72	3,216.06	0.00	
Advertising	783.16	518.17	532.63	0.00	
Data Processing	331,112.86	353,543.80	154,147.60	0.00	
Advertising, Emp Edu, and Other Svc.	179,924.27	168,937.06	189,736.79	150,590.48	136,066.97
Rent of Offices	490,801.81	578,465.52	229,453.86	1,068,887.65	699,624.58
Postage & Xerox Rental	3,147.46	5,522.62	4,179.76	0.00	
Service & Maint Contracts	37,884.15	34,583.70	42,590.18	47,426.63	41,126.44
Insurance Bonding	12,847.25	14,971.64	13,414.97	0.00	
Indirect Cost	463,105.00	1,301,403.00	820,101.00	292,509.00	292,509.00
Dues, Sub, & Other Admin	47,584.21	51,833.93	70,904.70	340,924.54	353,810.39
Office Furniture & Equip	46,169.17	109,358.35	260,854.69	847,404.06	474,736.20
Data Processing Equip	48,853.30	181,157.69	388,598.97	0.00	0.00
Educational Equipment	54,307.14	94,143.85	350,114.02	0.00	0.00
Trucks	0.00	0.00	58,017.25	0.00	13,690.50
Other Equipment	36,851.66	15,897.22	232,944.04	25,455.76	0.00
Books	39,876.60	85,230.67	82,622.09	0.00	37,782.03
Air Conditioning Contract	1,441.94	38,890.03	0.00	0.00	0.00
State Aid to Blind, County Equalization	12,000.00	12,000.00	12,000.00	12,000.00	0.00
Grants, State Aid	8,835,387.85	8,686,383.13	8,902,549.11	7,959,890.00	8,239,555.35
Non-Fed Sh-Rent & Transfer	1,137,138.08	731,177.67	512,830.00	0.00	566,256.56
Transfers	(52.94)	35,753.21	49,775.20	277,204.36	0.00
Reserve for Indirect Cost	0.00	390,027.00	222,246.00	0.00	0.00
Reserve for Imprest Cash	13,545.00	14,200.00	14,060.00	0.00	0.00
Agency Carry Forward	0.00	0.00	0.00	262,730.00	310,544.00
TOTAL EXPENDITURES	$29,929,766.50	$32,944,428.03	$32,577,372.81	$31,609,201.34	$32,177,669.24
TOTAL APPROPRIATION	$12,491,048.93	$14,446,373.48	$15,189,694.56	$15,256,971.35	$14,892,342.89

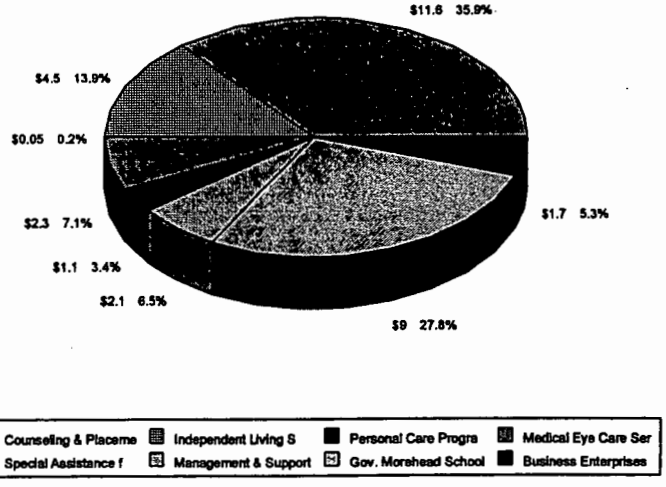
Source: Division of Services for the Blind

EXHIBIT 3
DIVISION OF SERVICES FOR THE BLIND
SOURCE OF FUNDS
FOR THE YEAR 1996-97
(in millions)



Source: Division of Services for the Blind

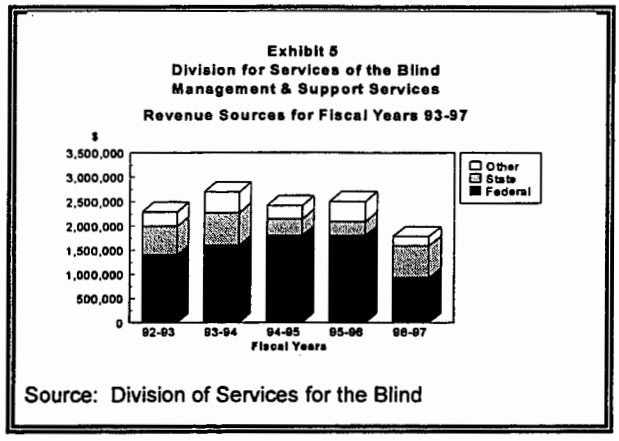
EXHIBIT 4
DIVISION OF SERVICES FOR THE BLIND
FUNDING BY PURPOSE
FOR THE YEAR 1996-97
(in millions)



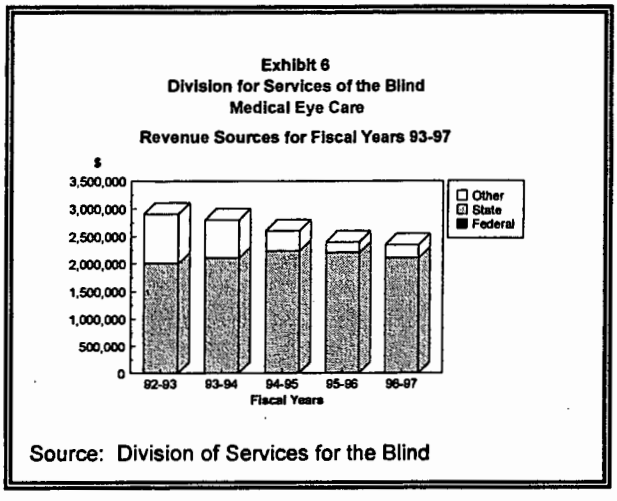
Source: Division of Services for the Blind

Management and Support Services:

Federal funds make up 60% of revenues averaging $1.5 million each year. Other revenues include 23% State appropriations and 17% prior year transfers.



Source: Division of Services for the Blind



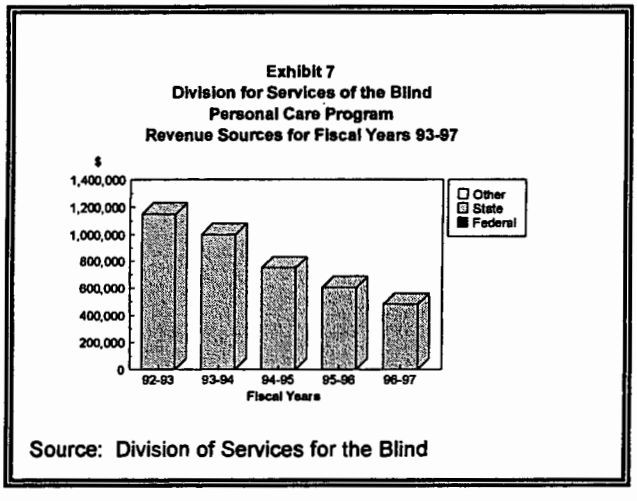
Source: Division of Services for the Blind

Medical Eye Care Services:

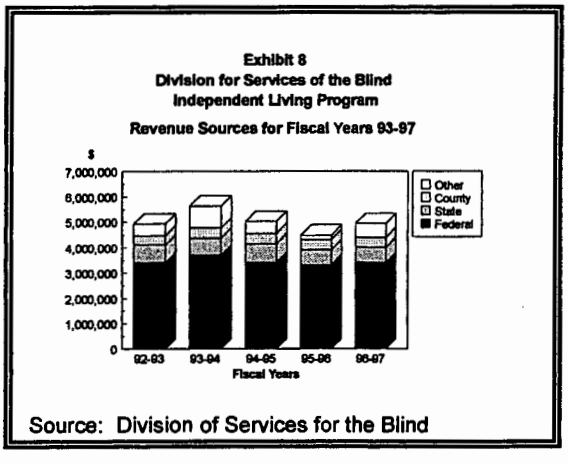
Medical Eye Care Service revenues are comprised of 82% state appropriations and 18% personal care service funds (Medicaid).

Personal Care Services:

Personal Care Service revenues primarily consist of Medicaid funds which are billed to Electronic Data Services (EDS), a Medicaid contractor, by the Division of Services for the Blind.



Source: Division of Services for the Blind



Source: Division of Services for the Blind

Independent Living Services:

Federal funds make up 75% of revenues averaging $3.4 million each year. Other revenues consist of 14% State appropriations, 9% County funds, and 2% transfers.

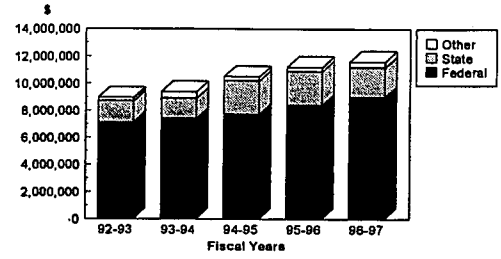
Counseling and Placement (Vocational Rehabilitation):

Funding sources include 78% Federal funds, 19% State appropriations, and 3% miscellaneous revenues. Federal funds average $8 million each year.

Business Enterprises:

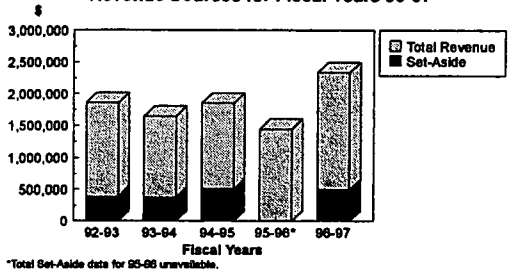
Funding sources consist primarily of Federal funds and the set-aside revenues within the General Fund and Special Revenue fund. Since fiscal year 1993, federal funds have made up approximately 62.25% of total revenues, averaging $920,399 per year. Over the same period, the set-aside funds comprised approximately 29.77%, averaging $437,275. The set-aside revenues are profits from the operations of business enterprises.

Exhibit 9
Division for Services of the Blind
Counseling and Placement
Revenue Sources for Fiscal Years 93-97



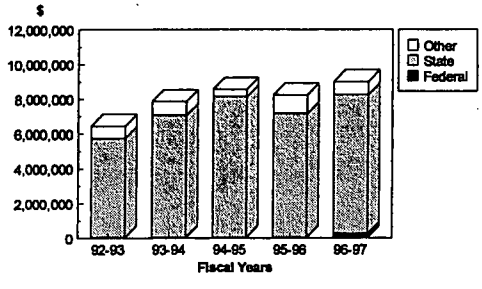
Source: Division of Services for the Blind

Exhibit 10
Division for Services of the Blind
Business Enterprises
Revenue Sources for Fiscal Years 93-97



Source: Division of Services for the Blind

Exhibit 11
Division for Services of the Blind
Governor Morehead School
Revenue Sources for Fiscal Years 93-97



Source: Division of Services for the Blind

Governor Morehead School:

Funding sources are primarily State appropriations, 89%. Other revenues consists of rental of office space.

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FINDINGS AND RECOMMENDATIONS

This section of the report contains findings and recommendations for improvements. We have organized them into organizational issues which affect all programs, or specific programs as identified, and operational issues for specific programs.

ORGANIZATIONAL ISSUES

THE COMMISSION FOR THE BLIND DOES NOT HAVE OPERATIONAL POLICES AND PROCEDURES.

As prescribed in GS §143B-158, the Commission for the Blind consists of eleven members, appointed by the Governor, who serve staggered six year terms. The Governor designates the Chairman who serves at the pleasure of the Governor. By statute, the Commission meets at least once in each quarter and may hold special meetings at any time and place within the State at the call of the Chairman or upon the written request of at least five members. The functions of the Commission include adopting rules governing the conduct of the State's rehabilitative programs for the blind.

During the field work, we found that not all commission members attend meetings on a regular basis. Over the last seven fiscal years, Commission members averaged attending 77% of the meetings. While most Commissioners attended regularly, one member attended only 21% of the meetings during the period examined. (See Table 3). We were unable, however, to find written policies and procedures for the Commission outlining the expectation for attendance. In our opinion, for the Commission to be effective, members need to attend meetings. Failure to attend meetings prevents the Commissioners from doing the job for which they were appointed. The statutes give the Governor the power to remove any member of the Commission from office.

TABLE 3
COMMISSION FOR THE BLIND
ATTENDANCE AT COMMISSION MEETINGS
FOR THE PERIOD FY90 THROUGH FY97

MEMBER	# OF MEETINGS	# NOT ATTENDED	MEETINGS ATTENDED	PERCENT ATTENDANCE
A	28	0	28	100%
B	13	4	9	69%
C	28	7	21	75%
D	13	1	12	92%
E	21	4	17	81%
F	8	2	6	75%
G	28	3	25	89%
H	28	9	19	68%
I	13	0	13	100%
J	28	22	6	21%
K	16	5	11	69%
L	19	1	18	95%
M	15	5	10	67%
N	15	0	15	100%
O	15	1	14	93%
P	6	4	2	33%
Q	6	0	6	100%

Source: Division of Services for the Blind

RECOMMENDATION

The Commission should establish written policies and procedures for its operations. One policy should specifically address meeting attendance by members and spell out the remedies for excessive absences from meetings. Names of members with excessive absences, as defined in the policy, should be reported by the Chairman and Secretary to the Governor for action. Further, a consideration and item for discussion with any prospective Commission member should be the commitment to regular attendance of meetings.

ORGANIZATIONAL LINES OF AUTHORITY IN SOME AREAS ARE NOT CLEARLY DEFINED.

DSB recently combined the area and district offices in one area in an effort to streamline the reporting structure and save money on office rent. However, this situation has led to some confusion over the lines of authority and responsibilities. The area social services supervisor is of the opinion that she is reporting to the area rehabilitation supervisor, even though they are the same pay grade and have a horizontal reporting relationship per the agency's organizational chart. Staff who formerly reported to the area social services supervisor are uncertain to whom they should report since the area rehabilitation supervisor has been designated "office manager."

Historically, the area offices have been supervised by an area supervisor and district offices have been supervised by counselors-in-charge. Since the two offices were combined, the counselors in the district offices are uncertain as to whom they report. Some counselors stated they report to the area supervisor even though the organizational chart shows they should report to the counselor-in-charge. We discovered that the area supervisor has been conducting the performance evaluations for these counselors. This leads us to question what the real reporting relationships are and whether the job descriptions for the area supervisors and the counselors-in-charge need to be reviewed.

RECOMMENDATION

DSB should review the lines of reporting authority within each region. Appropriate lines of authority should be determined and clearly communicated to management and staff. Performance evaluations should be conducted by each employee's immediate supervisor. Where district offices have been combined with area offices, the need for counselor-in-charge positions should be evaluated. All job descriptions and pay grades should be re-evaluated to properly reflect actual duties and responsibilities.

WORKLOADS AMONG HEADQUARTERS STAFF AND FIELD PERSONNEL ARE NOT EQUITABLE.

As part of the audit, we reviewed job descriptions and other data supplied by DSB relating to the various functions within the division. We compared this data with the information gained through interviews with personnel at all levels of DSB. We noted that the job descriptions for a number of different positions (see discussion above) did not contain the duties the personnel in the positions said they perform. This appears to be the result of reorganization, shifting of personnel from one area to another, and combining of positions. Specific issues identified included:

- lack of workload indicators for the different functions within DSB;
- several positions were moved from DSB to the Department level without identification of the effect these moves had on DSB operations; and
- the number of staff and the organization is different from region to region, does not appear to take into account the number of clients currently served, nor differences in staffing needs based on recent reorganizations.

RECOMMENDATION

DSB should initiate a workload study and examine all job descriptions for accuracy of the duties currently performed by staff. To this end, DSB should ask for assistance from the Office of State Personnel.

BUSINESS ENTERPRISES COUNSELORS DO NOT REPORT DIRECTLY TO THE CHIEF OF BUSINESS ENTERPRISES.

The purpose of the Business Enterprises (BE) program is to assist DSB clients in the establishment and operation of food service facilities. The BE program is the responsibility of the Chief of Business Enterprises, located in Raleigh. Seven business enterprises counselors, assigned to district offices across the State, are employed to implement the program at the local level. The majority of the counselors' duties revolve around the monitoring of food service facilities in their territories. Currently, these counselors report directly to the Area or District Rehabilitation Supervisor rather than the Chief of Business Enterprises. Thus, the Chief of Business Enterprises must communicate through the Area or District Rehabilitation Supervisor to coordinate work to be performed by the counselors. While an informal reporting relationship already exists between the counselors and the Chief, the official reporting structure results in the restriction of the Chief's ability to administer the BE program in an efficient and effective manner.

We believe this reporting structure is the result of funding decisions and does not reflect functional reporting needs. Based on a projection provided by DSB for a departmental internal audit, there would be a $61,000 shortage in funds available to

support the district management positions without the funding from the BE program.[3] Because the role of the counselors is essential to the operation of the Business Enterprises program, we believe that a direct technical reporting relationship should exist between the BE counselors and the Chief of the program. However, if the day-to-day administrative reporting lines are through the Area or District Rehabilitation supervisors, we are of the opinion that the current funding structure could be justified.

RECOMMENDATION

The Business Enterprises counselors should be placed under the direct technical supervision of the Chief of the Business Enterprises Program. This move will improve communication between the program head and the staff charged with local implementation of the program.

THE NURSES IN THE MEDICAL EYE CARE SERVICES SECTION ARE NOT BEING USED EFFECTIVELY.

Currently, there are eleven eye care nurses located in the district offices. When the program first started, their duties included eye exams, screening for glaucoma, delivering optical aids, and providing glasses to clients in areas of the State where these services were not available. Table 4 contains a breakdown of the number of clients by type of service offered through the medical eye care program. As the program has developed and medical eye care services have become more available at the local level, the nurses' primary function has changed to performing vision screening for children and adults. Vision screening consists of having the client read from the standard eye chart and noting at what level the person is able to read; i.e., 20-20, 20-30, etc. During the audit, we learned that in many area and district offices, the vision screenings are actually given by secretarial staff. We could find little support for the need of the nurse positions as originally established since the same services under this program are offered by staff from county health departments, Smart Start, Head Start, the Society for the Prevention of Blindness and interested Lions clubs.

TABLE 4
NUMBER OF MEDICAL EYE CARE CLIENTS BY SERVICE
FYE 6/30/97

Eye Exams	7,035
Eye Glasses	3,218
Surgery/Treatments	4,243
Clinics	248
Low Vision Evaluations	3,333
Children Screening	11,376
Glaucoma Screenings	13,435
TOTAL	42,888

Source: Division of Services for the Blind

[3] Funding for the area management positions now comes from three sources: Vocational Rehabilitation Basic Support Grant, the BE Program, and state appropriations. If supervision of the BE counselors was reassigned from the district office to the BE Program, supervision costs might have to be reallocated between the two remaining funding sources (Social Services Block Grant and Vocational Rehabilitation Basic Support Grant).

RECOMMENDATION

DSB should either abolish the medical eye care nurse positions or redesign the positions to be trainers of field staff performing the eye exams. Further, DSB should actively work with local entities to make sure all eye care screenings are being done on a timely basis. DSB should also work with private organizations in the various counties to place the individuals in the medical eye care program who are receiving personal care services through the program.

THE INDEPENDENT LIVING REHABILITATION COUNSELORS ARE PERFORMING DUTIES BEYOND THEIR JOB DESCRIPTIONS.

DSB currently has ten independent living counselors located across the state. The major responsibility of these counselors is to provide services to blind and visually impaired individuals and their families, community-based independent living skills training, one-on-one in-home instruction, and information/referral services. Funding for these counselors is provided by 90% federal funds and 10% state funds. During the audit we learned that many of these counselors are performing some regular social worker duties in addition to the specialized independent living counselor functions for which they were hired. Additionally, because of limited funding, these counselors do not have adequate funds to purchase the specialized equipment necessary to assist clients to attain an independent living status. With improved technology for the blind, program staff could be more effective with additional funds for the purchase of specialized equipment.

RECOMMENDATION

DSB should re-evaluate the current role of the independent living counselors and clarify their role as it relates to the duties of a social worker. Additionally, DSB should determine the level of funding needed to allow the purchase of specialized equipment needed to make the program more effective.

OPERATIONAL ISSUES

Global Issues:

THE STATUTORY AUTHORITY AND RESPONSIBILITIES FOR DSB ARE VAGUE AND OPEN TO INTERPRETATION.

The various programs offered by DSB are authorized under Chapters 111 and 143B of the General Statutes of the State of North Carolina. The responsibilities as outlined in these statutes are based in part on federal regulations adopted to implement in the Barden-Rehabilitation Act and the Randolph-Sheppard Bill. During the audit, we learned that the legislation, both at the federal and state level, is written in very vague terms and is open to interpretation. This situation has been recognized by the North Carolina Attorney General's Office in a memo to DSB which indicated that the rules and regulations governing DSB are too vague to offer enough support in court. Therefore, DSB is left in the position of having to approve requests for services which do not meet its stated policies if the policies are challenged, or are likely to be challenged, by a client. For example:

- Equipment is being purchased for a client who does not meet the criteria for receiving adaptive equipment because the client has filed a number of appeals on DSB decisions not to provide equipment or services. This client is also receiving more than twice the maximum amount of hours allowed for reader services.

- A client has twice been paid the actual cost for lodging at a rate more than the state rate. The first overpayment was because of an error by the rehabilitation counselor. The second overpayment was made because the client "has been given to expect reimbursement of actual costs."

RECOMMENDATION

DSB and the Department should undertake an immediate review of all statutes, rules, and regulations relating to all programs offering services to the blind. This review should result in recommendations for needed changes to be presented to the General Assembly for action. The General Assembly should review the recommendations in detail for the purpose of further clarifying the intent of the programs for the blind and further strengthening and better defining the responsibilities of DSB, within the federal framework.

THE DSB CENTRALIZED DATABASE DOES NOT CONTAIN STATISTICS FOR ALL PROGRAMS.

DSB has a computer system which tracks client data for the Rehabilitation Services, the Independent Living Services, and the Independent Living Rehabilitation programs. Other DSB programs not tracked by this system are the Special Assistance for the Blind, Personal Care Services, Business Enterprises, and the Governor Morehead School. Data for these programs are tracked by the individual program manager. Since programs count their respective number of clients served, a problem of double counting occurs when a client receives services from more than one program. Therefore, the information provided to the General Assembly, the Commission for the Blind, and any other agency requesting information on total number of clients served by DSB is overstated and does not represent an unduplicated number of individual clients served. The numbers reported by program, however, appear to be accurate. We were unable to determine the exact number of individual clients served by DSB because of this method of record-keeping.

RECOMMENDATION

DSB should modify its database system to include records for all DSB programs. The system should accommodate both program requirements and provide an accurate count of individuals receiving one or more program services. Additionally, when the agency is reporting data to the General Assembly, the public or other agencies, an unduplicated count should be used for individuals served, while continuing to provide the number of clients receiving services through each program. DSB should identify costs associated with this database change and request funds from the General Assembly, if needed, for this purpose.

SOME POLICIES AND PROCEDURES ARE NOT CURRENT AND ARE NOT BEING CONSISTENTLY FOLLOWED.

During the audit, we learned that DSB policies and procedures as contained in the *Rehabilitation Manual* were not being followed. Additionally, the *Performance Standards Manual* used by the Business Enterprises Program was outdated and management had instructed staff to ignore many portions of the manual. Some of the policies and procedures in place are at least 10 years old. For this reason, many are not accurate as to the current practice and, therefore, are ignored by the staff. For instance:

- Adaptive equipment is being purchased for individuals who are not in training or who do not have a job in which they need the equipment. Per policy, adaptive equipment should only be purchased for

individuals who are in training or are employed and require the adaptive equipment to perform their job function.

- Reader services are being provided for up to 100 hours per month when policy states that the maximum allowed is 40 hours per month.

- Lodging expenses are being reimbursed at cost instead of the state rate as provided by the current policies.

RECOMMENDATION

DSB should immediately update its policies and procedures. All policies and procedures should be clearly defined. A system for periodic update and distribution of the policies and procedures should be established. Changes should be communicated to management and staff in a timely manner. All decisions concerning client authorizations for any facet of the program should be based on DSB policy and should be implemented following DSB procedures. Any deviations should have the appropriate DSB/Department approval and have adequate supporting documentation.

DSB DOES NOT HAVE A COMPREHENSIVE TRAINING PROGRAM FOR STAFF.

As we conducted interviews with staff, a need consistently identified was for a comprehensive, on-going training program. We heard this from administrative staff, field staff in all program areas, as well as teachers and social service personnel. Currently, DSB does offer staff the opportunity of taking various courses and workshops. However, these courses and workshops, while relevant, are not presented in a comprehensive training program. This makes the courses less effective than they could be. The absence of a comprehensive training program for each specialty area does not give DSB any method of assuring that its staff have knowledge of current and adequate methods of service delivery. We learned during the audit that DSB does not have sufficient training funds to develop and implement a comprehensive training program.

RECOMMENDATION

DSB should establish a task force to determine the generic and specialized courses necessary to develop a comprehensive training program for staff. A plan of study should be developed for each specialized area. Each staff member's experience and existing competencies should be determined and a training plan developed for each person depending on his/her needs. This program should be on-going and updated as methods change.

In our opinion, each staff member should receive continuing education each year, combining generic courses with courses in the staff member's area of specialty. Further, DSB should determine the amount of funding necessary to develop and implement the training program. These funds should be requested from the General Assembly.

Financial Issues:

BUDGET INFORMATION IS NOT DISSEMINATED TO PROGRAM MANAGERS ON A TIMELY BASIS.

In 1996 DSB converted to the North Carolina Accounting System (NCAS). Since that time, program managers report that budget information has not been readily available to them since DSB staff were in the process of defining the various reports available from NCAS. Administration instructed the managers to use FY95-96 expenditures as their guide for current year program expenditures until all reports could be defined and equipment could be installed. This step was taken because DSB's conversion to NCAS has taken time and the data contained in NCAS for the various programs might not be accurate or reliable since it was still being defined. DSB is in the process of installing all equipment necessary to fully convert to NCAS. However, at the time of the audit, computers were not available to all program managers, nor had training been given to all managers.

RECOMMENDATION

DSB should continue its efforts to complete the conversion to NCAS and take steps to assure that the data contained therein is accurate and reliable. As soon as possible, computer equipment should be made available to all program managers, and they should be provided with appropriate training. Once the system is fully operational and reliable, the various program managers should be granted authority and held responsible for managing their respective programs.

DSB HAS NOT DESIGNED NCAS REPORTS SHOWING FINANCIAL DATA BY VENDING FACILITIES.

The Business Enterprises program is currently able to accumulate revenues and expenditures by vendors only on an individual vendor basis by calendar year. This allows DSB to provide the vendors with the data necessary to file their personal income tax forms. During the audit, we learned that DSB has not designed NCAS reports to provide BE program management with data on revenues and expenses for a given vending location. The only way management can obtain this information is if the same vendor has been at the same location for the entire

calendar year. Management's inability to obtain revenue and expense data by location inhibits its ability to monitor profitability of individual sites. This further complicates management recommendations on sites which might be divided to increase the opportunities for client participation in the program. (See discussion on page 36.)

RECOMMENDATION

DSB should request assistance from Department accounting staff in making the necessary modifications to capture financial data by vending location. Once this data is available, it should be used to more closely monitor the earnings potential of each site and manage the BE program to offer the maximum number of opportunities for client participation.

THE GOVERNOR MOREHEAD SCHOOL IS USING SUBSTITUTE FUNDS IN A QUESTIONABLE MANNER.

The Governor Morehead School (GMS) staffing budget provides for substitutes for teachers and educational development aides when they are absent from work. At the time of the audit, GMS had a vacant permanent teacher position and a vacant permanent educational development aide position. The substitute teacher filling the vacant permanent position was being paid from substitute teacher funds. The vacant aide position was filled by a substitute being paid from substitute aide funds. This situation reduces the number of potential substitutes that can be hired on a day-to-day basis based on need. Additionally, it creates "lapsed salary" funds which DSB has transferred at a later date to cover contractual services which has traditionally been underfunded. These actions shortchange the students of the Governor Morehead School and demonstrate management's need to develop a budget which more accurately portrays its operational needs. Substitutes filling vacant permanent positions should be paid from the budgeted salaries for those positions, not substitute funds.

RECOMMENDATION

DSB management should closely examine the practice of using its full-time and substitute funds in this manner and consider the consequences of this action. The number of substitutes on a given day should be determined by the need and the availability of substitute funds. Further, DSB should develop a continuation budget which more accurately reflects its actual operational needs. If more funds are needed in the contractual services line item, DSB should document this need to the Department and work with Department accounting to find ways to adequately fund the need.

FOLLOW-UP OF PRIOR FINANCIAL RELATED AUDIT

As a part of our review, we followed-up on a financial related audit on DSB performed by the Office of the State Auditor for the period of July 1, 1996, through January 31, 1997. That audit was limited to assessing certain DSB internal controls for selected financial activities not included in the audit work of the State's *Comprehensive Annual Financial Report* (CAFR) or *Single Audit Report.* During this audit, the financial team found: 1) records were not maintained to document eye examinations; and 2) expenditures needed to be monitored for the Supported Employment Extended Service Program.

DSB has sent out memorandums to its staff to reinforce GS §111-8 and Section T10:19H.206 of the North Carolina Administrative Code which requires an eye examination to be completed by physicians before medical or surgical treatment can be given to blind or partially blind clients. For the Supported Employment Extended Service Program, procedures have been implemented that require the programs to submit invoices to program managers by the seventh day of the month following the month in which services were provided. The invoices will also be submitted to DSB accounting by the twelfth day of the month for review. Additionally, DSB now requires the budget officer to review expenditure coding.

RECOMMENDATION

DSB should modify written operational procedures to reinforce the requirement that eye exam reports be a part of the files in which treatment/surgery is provided or required for blind or partially blind clients. In addition, DSB should continue its efforts in monitoring the propriety and timeliness of expenditures.

Employment/Business Enterprises Issues:

DSB HAS PROVIDED QUESTIONABLE EMPLOYMENT SERVICES TO A CLIENT.

One of the responsibilities of DSB is to assist clients in obtaining employment. DSB uses a variety of methods to fulfill this responsibility including paying for clients to attend conferences and go to job interviews, both in-state and out-of-state. During the audit, we found documentation showing that DSB had paid for a number of conference trips for the same individual. These conferences, held in Boston, San Diego, San Francisco, and New York, were for the purpose of "networking" in hopes of landing a job interview. After the first conference the client indicated that all the potential positions had been either filled, were on hold, or no longer existed. Additionally, this same individual was sent to several other cities for job interviews, including a trip to Greece. According to DSB staff, the client turned down the job in Greece when it was offered, but stayed in Greece for

a week at the State's expense. Yet, these trips continued to be approved even though the client's Individual Written Rehabilitation Plan stated that trips would only be approved when there was documentation showing that a vacancy existed for which the client qualified and that a formal interview had been scheduled.

DSB has also paid for a guide to accompany this client on trips. The guide was necessary because the client refused to take the mobility and orientation training offered by DSB which would enable him to travel independently. This refusal was despite the fact that the client agreed to participate in the training in an earlier settlement agreement with DSB. While it is ultimately the client's choice whether or not to take mobility and orientation training, the State should not bear the costs associated with his non-participation since he had previously agreed to take the training. Providing guide services has doubled the cost of the trips taken. Overall, the State has paid $47,585 for questionable services to this one client, including $23,205 for the trips alone. Because of the condition of the records at DSB, we were unable to determine whether this was an isolated instance or a standard practice.

RECOMMENDATION

DSB should examine its regulations and procedures regarding approval of and reimbursement for employment related travel for clients. The guidelines for client travel as established by DSB should be adhered to. Trips should only be approved when it can be documented that a vacancy exists for which the client is qualified and a formal interview has been scheduled for the client. The duration of the trips should be limited to a reasonable amount of time necessary to attend the interview, in our opinion no more than three days. Guide and reader services should only be provided in unusual circumstances. When a client has refused to take mobility and orientation training, DSB should consider making the client responsible for providing guide and/or reader services.

THE POLICY ALLOWING DSB TO PURCHASE VEHICLES FOR CLIENTS IS OPEN ENDED.

Current policy allows DSB to make the down payment and pay the first six months of insurance on vehicles for clients if it is determined that the client needs a vehicle to perform his/her job. The policy does not address such crucial issues as:

- who will negotiate the price to be paid for the vehicle;
- the maximum allowable amount of down payment;
- the amount of time a client must have been in the program to qualify;

- the amount of time a client must remain in the program after receiving the vehicle;
- whether, and when, the client must repay the down payment and insurance paid by the program; and
- what remedies are available to DSB if the client does not meet his/her obligations.

While our fieldwork did not reveal any instances of this policy being abused, the potential for abuse does exist.

RECOMMENDATION

DSB should rewrite its vehicle purchase policy to lessen the potential for abuse. The policy should allow DSB to have input in negotiating the purchase price of the vehicle. The policy should also establish a dollar limit or a maximum percentage of the purchase price that is allowed for the down payment. Time limits for participation by the client before and after the purchase of the vehicle need to be established, as does a set time for the client to repay the program for the down payment and insurance. Consequences of not meeting the requirements set forth in the policy should be established and clearly communicated to clients accessing this service.

CURRENT SET-ASIDE STRUCTURE MAY NOT BE ACCOMPLISHING THE OBJECTIVES INTENDED BY THE LEGISLATURE.

The Randolph-Sheppard Act of 1936 provides authority for DSB to assess a fee against the net proceeds[4] of each vending facility operated under the Business Enterprises Program. Per federal regulations[5], these funds may be set-aside for the purposes of:

- maintenance and replacement of equipment;
- purchase of new equipment;
- management services;
- assuring a fair minimum return to vendors; or

[4] The code of federal regulations (34 CFR Part 395.1 (k)) defines net proceeds (income) as follows: "*Net Proceeds* means the amount remaining from the sale of articles or services of vending facilities, and any vending machine or other income accruing to blind vendors after deducting the cost of such sale and other expenses (excluding set-aside charges required to be paid by such blind vendors)."

[5] Determination of the set-aside fee must be in compliance with the federal requirements as described in 34 CFR Part 395 as administered by the US Department of Education, Office of Special Education and Rehabilitation Services.

- establishment and maintenance of retirement or pension funds, health insurance contributions, and provision for paid sick leave and vacation time.

The federal regulations further allow the state agency to determine the amount to be charged for each of the above purposes. Prior to 1992, DSB could set-aside no more than twenty percent (20%) of the funds from the net proceeds of each vending facility. However, as a result of a legislative study of the highway vending program conducted in 1992, GS §111-50 revised the method of calculating set-asides. It appears the anticipated effect of the legislative change was to shift the burden of financial support of the set-aside fund to the higher income producing facilities. Now profits are based upon operator net income and determined as follows:

- seventeen percent (17%) set-aside on operator net income up to two and one-half times the average operator income for the previous State fiscal year;
- fifty percent (50%) set-aside on operator net income between two and one-half and three and one-half times the average operator income for the previous State fiscal year; or
- sixty-five percent (65%) on all operator net income over three and one-half times the average operator income for the previous State fiscal year.

DSB adopted these rates for non-highway vendors as well as for highway vendors. (See page 36). With this system, vendors pay a set-aside fee beginning with the first dollar of profit. However, based upon the guaranteed minimum return[6] of $700 per month, some vendors receive a refund of the set-aside dollars in the same month they pay set-aside dollars.

We believe the current set-aside structure is not accomplishing the objective intended by the legislature. As indicated above, the set-aside rate is 17% for all operator net income up to two and one-half times the average net income for the preceding State fiscal year. However, the rates increase dramatically for net income levels exceeding this amount. Based upon the average operator net income for FY1995-96, an operator would have to earn in excess of $89,898 net income from operations to be charged a set-aside rate at the 50% level. Only six of 94[7] operators were charged 50% for calendar year 1996 and no operator has ever reached the maximum 65% rate. Furthermore, the set-aside rates charged to each vendor do not reflect the level of management services provided by DSB (see

[6] The guaranteed minimum return is authorized by the legislature in NCAC (.0701 (a)) and established by DSB.

[7] The actual number of operators varies and could not be determined from DSB records. Per DSB staff, the total number of vending facilities for calendar year 1996 was 99 with 104 operators. Some vendors may temporarily operate more than one facility.

discussion below). Therefore, there is no practical graduated scale based upon the level of operator net income.

RECOMMENDATION

DSB should reexamine the current rate structure. In our opinion, a graduated scale of the set-aside fees with a minimum income level should be developed in lieu of the current rate structure. Table 5 below suggests such a scale and shows the effect on 1996 data. This would have the effect of making the set-aside fees more equitable. DSB should petition the legislature to remove the rates from the statutes and for the authority to establish and manage its own set-aside rate structure.

TABLE 5
SCHEDULE OF SUGGESTED SET-ASIDE RATES
BASED ON CALENDAR YEAR 1996
NET INCOME FROM OPERATIONS BY VENDING FACILITY

1996 Individual Stand Net Income From Operations	*Suggested Rates*					Total Suggested Set-Aside	Total 1996 Set-Aside	Difference
	$0-$12,000	$12,001-$24,000	$24,001-$36,000	$36,001-$60,000	Over $60,000			
	-0-	15%	25%	35%	50%			
$111,493	$0	$1,800	$3,000	$8,400	$25,746	$38,945	$26,080	$12,865
110,179	0	1,800	3,000	8,400	25,089	38,288	25,423	12,865
104,971	0	1,800	3,000	8,400	22,485	35,684	22,820	12,865
93,404	0	1,800	3,000	8,400	16,701	29,901	17,036	12,865
90,825	0	1,800	3,000	8,400	15,412	28,611	15,747	12,865
77,621	0	1,800	3,000	8,400	8,810	22,009	13,196	8,814
74,374	0	1,800	3,000	8,400	7,187	20,386	12,644	7,742
73,213	0	1,800	3,000	8,400	6,606	19,805	12,446	7,359
71,107	0	1,800	3,000	8,400	5,553	18,752	12,088	6,664
68,428	0	1,800	3,000	8,400	4,214	17,413	11,633	5,780
66,201	0	1,800	3,000	8,400	3,100	16,299	11,254	5,045
66,100	0	1,800	3,000	8,400	3,050	16,249	11,237	5,012
61,971	0	1,800	3,000	8,400	985	14,184	10,535	3,649
59,776	0	1,800	3,000	8,321	0	13,121	10,162	2,959
58,604	0	1,800	3,000	7,911	0	12,711	9,963	2,748
54,418	0	1,800	3,000	6,446	0	11,246	9,251	1,994
53,733	0	1,800	3,000	6,206	0	11,006	9,135	1,871
52,370	0	1,800	3,000	5,729	0	10,529	8,903	1,626
50,706	0	1,800	3,000	5,147	0	9,946	8,620	1,326
49,605	0	1,800	3,000	4,761	0	9,561	8,433	1,128
45,586	0	1,800	3,000	3,355	0	8,154	7,750	405
45,410	0	1,800	3,000	3,293	0	8,093	7,720	373
42,401	0	1,800	3,000	2,240	0	7,039	7,208	(169)
41,978	0	1,800	3,000	2,092	0	6,892	7,136	(245)
41,282	0	1,800	3,000	1,848	0	6,648	7,018	(370)
39,435	0	1,800	3,000	1,202	0	6,001	6,704	(703)
37,760	0	1,800	3,000	616	0	5,415	6,419	(1,004)
37,481	0	1,800	3,000	518	0	5,318	6,372	(1,054)

TABLE 5 continued

34,179	0	1,800	2,544	0	0	4,344	5,810	(1,466)
34,091	0	1,800	2,522	0	0	4,322	5,795	(1,473)
33,729	0	1,800	2,432	0	0	4,232	5,734	(1,502)
31,405	0	1,800	1,851	0	0	3,651	5,339	(1,688)
30,102	0	1,800	1,525	0	0	3,325	5,117	(1,792)
29,683	0	1,800	1,421	0	0	3,220	5,046	(1,826)
29,366	0	1,800	1,341	0	0	3,141	4,992	(1,851)
29,320	0	1,800	1,330	0	0	3,130	4,984	(1,855)
27,711	0	1,800	928	0	0	2,727	4,711	(1,983)
27,287	0	1,800	821	0	0	2,621	4,639	(2,017)
27,077	0	1,800	769	0	0	2,569	4,603	(2,034)
26,731	0	1,800	682	0	0	2,482	4,544	(2,062)
26,667	0	1,800	667	0	0	2,466	4,533	(2,067)
25,940	0	1,800	485	0	0	2,285	4,410	(2,125)
25,375	0	1,800	344	0	0	2,143	4,314	(2,170)
25,229	0	1,800	307	0	0	2,107	4,289	(2,182)
25,173	0	1,800	293	0	0	2,093	4,279	(2,187)
25,003	0	1,800	250	0	0	2,050	4,250	(2,200)
23,553	0	1,733	0	0	0	1,733	4,004	(2,271)
21,419	0	1,413	0	0	0	1,413	3,641	(2,229)
20,038	0	1,206	0	0	0	1,206	3,407	(2,201)
19,858	0	1,179	0	0	0	1,179	3,376	(2,197)
19,756	0	1,163	0	0	0	1,163	3,359	(2,195)
19,611	0	1,142	0	0	0	1,142	3,334	(2,192)
19,471	0	1,121	0	0	0	1,121	3,310	(2,190)
19,470	0	1,120	0	0	0	1,120	3,310	(2,190)
18,372	0	956	0	0	0	956	3,123	(2,168)
17,015	0	752	0	0	0	752	2,893	(2,140)
15,925	0	589	0	0	0	589	2,707	(2,119)
15,430	0	514	0	0	0	514	2,623	(2,109)
15,351	0	503	0	0	0	503	2,610	(2,107)
14,609	0	391	0	0	0	391	2,484	(2,092)
14,307	0	346	0	0	0	346	2,432	(2,086)
13,686	0	253	0	0	0	253	2,327	(2,074)
13,633	0	245	0	0	0	245	2,318	(2,073)
12,830	0	124	0	0	0	124	2,181	(2,057)
12,068	0	10	0	0	0	10	2,052	(2,042)
12,060	0	9	0	0	0	9	2,050	(2,041)
11,848	0	0	0	0	0	0	2,014	(2,014)
11,816	0	0	0	0	0	0	2,009	(2,009)
11,684	0	0	0	0	0	0	1,986	(1,986)
11,510	0	0	0	0	0	0	1,957	(1,957)
11,234	0	0	0	0	0	0	1,910	(1,910)
10,781	0	0	0	0	0	0	1,833	(1,833)
10,498	0	0	0	0	0	0	1,785	(1,785)
10,411	0	0	0	0	0	0	1,770	(1,770)
9,660	0	0	0	0	0	0	1,642	(1,642)
9,083	0	0	0	0	0	0	1,544	(1,544)
8,826	0	0	0	0	0	0	1,500	(1,500)
8,367	0	0	0	0	0	0	1,422	(1,422)
8,322	0	0	0	0	0	0	1,415	(1,415)
8,174	0	0	0	0	0	0	1,390	(1,390)
7,828	0	0	0	0	0	0	1,331	(1,331)
7,772	0	0	0	0	0	0	1,321	(1,321)
7,378	0	0	0	0	0	0	1,254	(1,254)
7,362	0	0	0	0	0	0	1,251	(1,251)
6,569	0	0	0	0	0	0	1,117	(1,117)
6,114	0	0	0	0	0	0	1,039	(1,039)
6,111	0	0	0	0	0	0	1,039	(1,039)

TABLE 5 continued

	5,832	0	0	0	0	0	0	991	(991)
	5,810	0	0	0	0	0	0	988	(988)
	5,065	0	0	0	0	0	0	861	(861)
	4,280	0	0	0	0	0	0	728	(728)
	4,224	0	0	0	0	0	0	718	(718)
	3,985	0	0	0	0	0	0	677	(677)
	3,929	0	0	0	0	0	0	668	(668)
	3,717	0	0	0	0	0	0	632	(632)
	3,657	0	0	0	0	0	0	622	(622)
	3,537	0	0	0	0	0	0	601	(601)
	3,424	0	0	0	0	0	0	582	(582)
	2,778	0	0	0	0	0	0	472	(472)
	2,497	0	0	0	0	0	0	425	(425)
	2,449	0	0	0	0	0	0	416	(416)
	2,257	0	0	0	0	0	0	384	(384)
	2,162	0	0	0	0	0	0	368	(368)
	2,148	0	0	0	0	0	0	365	(365)
	2,122	0	0	0	0	0	0	361	(361)
	1,951	0	0	0	0	0	0	332	(332)
	1,860	0	0	0	0	0	0	316	(316)
	1,655	0	0	0	0	0	0	281	(281)
	1,434	0	0	0	0	0	0	244	(244)
	1,381	0	0	0	0	0	0	235	(235)
	1,360	0	0	0	0	0	0	231	(231)
	1,357	0	0	0	0	0	0	231	(231)
	1,237	0	0	0	0	0	0	210	(210)
	1,199	0	0	0	0	0	0	204	(204)
	1,115	0	0	0	0	0	0	190	(190)
	1,090	0	0	0	0	0	0	185	(185)
	1,053	0	0	0	0	0	0	179	(179)
	967	0	0	0	0	0	0	164	(164)
	807	0	0	0	0	0	0	137	(137)
	781	0	0	0	0	0	0	133	(133)
	779	0	0	0	0	0	0	132	(132)
	684	0	0	0	0	0	0	116	(116)
	627	0	0	0	0	0	0	107	(107)
	552	0	0	0	0	0	0	94	(94)
	552	0	0	0	0	0	0	94	(94)
	528	0	0	0	0	0	0	90	(90)
	486	0	0	0	0	0	0	83	(83)
	455	0	0	0	0	0	0	77	(77)
	433	0	0	0	0	0	0	74	(74)
	245	0	0	0	0	0	0	42	(42)
	175	0	0	0	0	0	0	30	(30)
Totals	$2,912,945	$0	$97,560	$104,505	$168,880	$144,938	$515,884	$515,458	$426

Source: **Data**--Division of Services for the Blind; **Schedule**--Computed by the Office of the State Auditor

DSB DOES NOT AUDIT VENDOR RECORDS FOR ACCURACY.

DSB currently provides four levels of management services, funded by set-aside and federal monies, depending upon the specific needs of each vendor.

1. The operator may send all invoices, deposit slips, repair bills, and other documents to DSB including overcash[8] according to a schedule established by the Accounting Office; all payroll functions are performed by DSB.
2. The operator may retain sales and deposit documentation and send a summation of purchases for resale and all expenses paid out of the facility to DSB monthly along with overcash; all payroll functions are performed by DSB.
3. The operator may perform all functions in item (2) and perform his own payroll functions.
4. The operator may perform all functions of items (2) and (3) calculate his own profit and loss statement and send only the set-aside due DSB.

Each vendor operation is reviewed quarterly to ensure that projected sales and profit margin criteria are achieved. However, there is no control over the number of family members who may work in the vending operation or the amount of salaries paid to them. It is conceivable that the operator could use high salaries to a family member to keep reportable profits at a low level yet maintain the required profit margin percentages. The BE counselors performing the quarterly reviews are not required to complete a standard financial review program or to specifically check for family member employees. We learned during the audit that each counselor conducts these reviews differently. Therefore, the Chief of the BE program receives inconsistent and incomparable information on vendor operations. Operators who choose option 4 above receive no accounting support from DSB. However, they do receive record keeping reviews twice a year to determine accuracy of records and appropriateness of set-aside remittance.

RECOMMENDATION

DSB should develop and implement a standard financial review program for Business Enterprises counselors to use in the review of a vendor's financial operations. Further, the costs associated with DSB-provided management services should be analyzed and billed separately.

CURRENT PROCEDURES RESTRICT THE NUMBER OF HIGHWAY VENDING FACILITY OPERATORS.

One of the opportunities offered to clients by the Business Enterprises Program is the opportunity to operate vending stands located at rest areas along North Carolina's highways. As of December 31, 1996, a total of 25 highway vending facilities were in operation. (Exhibit 12, page 37) The average net income from operations for the 25 sites was $55,428,

TABLE 6
NET INCOME FROM OPERATIONS FOR HIGHWAY VENDING FACILITIES FOR CALENDAR YEAR 1996

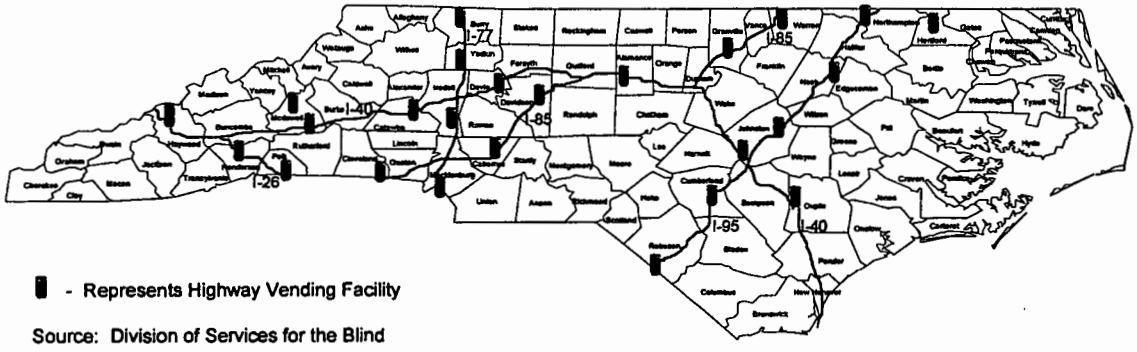
SITE	NET INCOME	SITE	NET INCOME
1	$111,493	14	$ 52,370
2	110,179	15	50,706
3	104,971	16	49,605
4	90,825	17	42,401
5	77,621	18	39,435
6	74,374	19	30,142
7	73,213	20	29,366
8	71,107	21	27,077
9	68,428	22	25,173
10	66,201	23	8,456
11	60,100	24	8,322
12	59,167	25	552
13	54,418	Average	$ 55,428

Source: Division of Services for the Blind

[8] "overcash" is defined by DSB as the daily receipts in excess of change fund

with three sites generating net income from operations in excess of $100,000. (Table 6) Current procedures allow DSB to award highway vending sites on both sides of a divided highway to a single operator. We learned during the audit that DSB had not performed any analysis regarding the income potential of these stands prior to entering into contracts with these vendors. Therefore, a situation was created whereby a single operator could earn high levels of income from locations which could probably support two separate vendors. (See discussion below.) At the time of the audit, there were approximately 20 licensed clients on a waiting list for vendor stands. Since one of the stated goals of the BE program is to offer business opportunities to as many clients as possible, we believe DSB is not taking the appropriate steps to achieve that goal.

EXHIBIT 12
DIVISION OF SERVICES FOR THE BLIND
LOCATIONS OF HIGHWAY VENDING FACILITIES
AS OF OCTOBER 1, 1997



▮ - Represents Highway Vending Facility

Source: Division of Services for the Blind

RECOMMENDATION

DSB should review its goals relative to the Business Enterprises Program. In our opinion, the highway vending locations should be divided among as many vendors as possible. Locations which are high income producers should be divided into two separate locations operated by two different clients. In order to accomplish this, DSB needs to review the income produced at the different locations over a period of time and then determine what level of net income is reasonable for an individual operator.

THE BUSINESS ENTERPRISES CONTRACTUAL AGREEMENTS ARE MISLEADING.

DSB requires each operator of a vending facility to enter into a contractual agreement with DSB. The agreement indicates the period of the contract is two years. However, the agreement allows the operator to continue operations indefinitely unless he violates performance standards relating to profit margin or exhibits "inappropriate behavior." DSB records show that only eight of 131 operators were terminated during the two-year period ending June 30, 1997, due to failure to meet performance standards or for inappropriate behavior. Therefore, operators have come to feel that they have a lifetime right (or franchise) to operate their facilities. DSB staff indicated in interviews that it is their opinion that the BE program was designed to give eligible clients employment for as long as they wanted it. Our review of the federal and state legislation regulating the program indicated that the wording was vague and open to interpretation. However, it is our opinion that the entire training program, of which BE is one component, is intended to teach clients skills which would allow them to obtain jobs in the open market to the extent possible. This interpretation was reinforced by DSB management who stated that the BE Program was designed to rehabilitate clients. Therefore, by providing "lifetime" business opportunities, DSB is not meeting one of its stated goals. Also, the language in the contract as written appears vague in some areas and does not address specific issues that may be applicable in the operation and administration of vending facilities in some buildings. For instance, for a given location, the contract might need to say the vendor cannot use an open cooking grill due to lack of proper ventilation in that building.

RECOMMENDATION

DSB should review its goals and objectives for the Business Enterprises Program and the training program as a whole. Steps should then be taken to modify existing practices and procedures to train and place as many clients as possible. This may require changes to the existing state legislation, which should be presented to the legislature for its consideration. Further, the terms of the vending contracts should be strengthened and expectations for both parties clearly defined. This should include the rights of the agency to examine vending records for reporting accuracy and adapting the contract to the specific types of vending facilities.

VENDING OPERATORS ARE RECEIVING START-UP GRANTS FROM DSB FOR EXTENDED PERIODS OF TIME.

Currently, DSB provides all vending operators with an initial complete stock inventory and a petty cash fund for each vending facility. The amount of inventory and petty cash provided depends on the magnitude of operations at each location.

The more income a facility is capable of producing, the larger the inventory and change fund requirements. As of December 31, 1996, the initial stock inventories varied from $331 to $8,952. Additionally, the change funds provided to the stand operators varied from $100 to $1,230.

Therefore, the higher income producing stand operators get a disproportionate grant from the State. Since vendors are only required to repay these funds when and if the stand closes or the vendor leaves the program, this practice results in a long-term, interest free "loan" to the operators. As of December 31, 1996, DSB's outstanding initial stock inventory totaled $274,853 and the petty cash balance was $49,278. See Table 7. These are funds which could be used to further the goals and objectives of the program if they were repaid with interest in a timely manner.

Table 7
Division of Services for the Blind
Business Enterprises Program
Schedule of Initial Stock and Petty Cash Fund Balances As of 12/31/96

Site Number	Actual Initial Stock	Petty Cash Balance	Site Number	Actual Initial Stock	Petty Cash Balance	Site Number	Actual Initial Stock	Petty Cash Balance
1	$ 8,951.96	$ 1,000.00	34	$ 2,011.35	$ 250.00	67	$ 3,827.05	$ 625.00
2	2,939.59	750.00	35	2,066.02	200.00	68	1,340.11	300.00
3	1,349.87	200.00	36	5,293.78	800.00	69	1,437.77	300.00
4	2,153.26	400.00	37	1,444.51	500.00	70	2,281.87	300.00
5	3,827.25	1,200.00	38	5,305.08	500.00	71	1,516.38	300.00
6	2,403.49	750.00	39	2,282.64	500.00	72	2,939.65	400.00
7	4,416.22	475.00	40	5,172.38	500.00	73	4,078.69	500.00
8	1,424.64	1,230.00	41	2,075.92	500.00	74	4,409.45	500.00
9	5,357.07	1,000.00	42	4,947.24	750.00	75	2,347.62	400.00
10	2,147.84	500.00	43	3,425.72	400.00	76	4,183.00	500.00
11	812.53	1,000.00	44	5,099.54	500.00	77	2,202.62	500.00
12	1,976.66	150.00	45	3,831.72	800.00	78	1,108.47	300.00
13	2,378.26	750.00	46	4,068.69	300.00	79	2,946.38	900.00
14	487.36	500.00	47	5,304.97	500.00	80	1,984.14	700.00
15	1,323.30	250.00	48	1,665.12	100.00	81	3,460.13	500.00
16	1,562.06	750.00	49	1,117.36	300.00	82	5,325.46	500.00
17	977.25	500.00	50	5,081.23	750.00	83	4,316.21	497.65
18	4,260.37	750.00	51	1,142.10	150.00	84	4,119.13	1,000.00
19	1,295.48	750.00	52	3,001.82	500.00	85	1,608.64	500.00
20	1,220.85	500.00	53	2,439.41	500.00	86	2,823.62	400.00
21	8,611.93	500.00	54	3,515.75	1,000.00	87	679.73	400.00
22	1,792.10	500.00	55	5,170.52	300.00	88	2,516.28	500.00
23	3,219.46	600.00	56	0.00	350.00	89	702.15	400.00
24	330.60	0.00	57	1,696.88	200.00	90	2,809.00	400.00
25	5,728.76	200.00	58	1,967.50	1,100.00	91	2,358.51	300.00
26	1,685.51	600.00	59	3,215.88	500.00	92	3,579.84	500.00
27	806.70	200.00	60	1,721.28	200.00	93	1,395.63	150.00
28	5,248.61	1,000.00	61	4,354.42	400.00	94	3,984.49	500.00
29	1,604.61	200.00	62	1,947.36	200.00	95	853.10	500.00
30	3,513.45	750.00	63	713.80	400.00			
31	2,190.89	500.00	64	7,281.39	1,000.00			
32	5,944.27	1,000.00	65	1,922.69	500.00			
33	4,539.70	500.00	66	951.80	250.00	TOTALS	$ 274,852.89	$ 49,227.65

Source: Division of Services for the Blind

RECOMMENDATION

DSB should amend the contract to require each vendor to repay all inventory and petty cash advances, with a reasonable rate of interest. A repayment plan should be implemented within six months of the opening of a stand, with full repayment of all advances within two years (contract period). DSB should develop procedures to assist any vendor who experiences trouble meeting the repayment schedule.

THE REHABILITATION TRAINING FACILITY[9] IS UNDER-UTILIZED.

DSB has a training facility, located on the Governor Morehead School grounds, which has been used primarily to train clients identified for the Business Enterprises Program.[10] The BE program focuses only on individuals identified by the BE counselors as being capable of operating or overseeing an entire stand operation. BE training programs are planned four times a year for six week periods with a class size limited to four to five since the ideal training ratio is 1:3. (See discussion on page 36.) This means that the training facility is not being used in an optimal manner. We were unable to determine the cost to the state of non-optimal use since the school's budget does not break out the facility's costs separately. As the training facility is currently set up, it could be used to train DSB clients in other aspects of food services during the periods when it is not in use for the vendor stand training. Currently, the operation of the training facility is the responsibility of the Director of Facilities, with limited input from the Chief of the Business Enterprises Program in the development of the curriculum. Further, DSB does not actively promote the BE program. As a result, it is possible that many visually impaired individuals may not be aware of the program opportunities.

RECOMMENDATION

DSB should explore the possibilities of expanding the Business Enterprises Program to encompass training and placement of clients in other areas of the food services industry. A cooperative plan for the most effective use of the training facility should be developed with input from the Director of Facilities and the Chief of the BE program. Additionally, DSB should develop methods of enhancing client awareness and the food service industry awareness of the training opportunities offered by DSB.

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[9] The BE Training Facility is located at the Rehabilitation Center for the Blind on the campus of the Governor Morehead School.

[10] DSB began piloting a new training model in Sept. 1997.

OTHER STATES

One of our objectives was to compare the North Carolina Division of Services for the Blind to other states' operations. We learned that each state can have a different definition of what constitutes being "blind." Additionally, each state offers different programs and when the same programs are offered, the interpretation of regulations is different. (See discussion on page 24 of the vagueness of the regulations.) Further complicating this issue of comparability is the fact that there is no central statistical data for programs for services to the blind. Therefore, we were unable to complete this objective for the audit. We did, however, review reports on the various programs for the blind in other states which we were able to locate and did use those in considering the recommendations contained in this report.

APPENDIX A

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

December 23, 1997

The Honorable Ralph Campbell, Jr., State Auditor
Office of the State Auditor
300 N. Salisbury Street
Raleigh, NC 27611

Dear Mr. Campbell:

I am enclosing the response of the Department of Health and Human Services to the draft report of the Performance Audit entitled Department of Health and Human Services, Division of Services for the Blind.

In so doing, I want to acknowledge and express my appreciation to you for the consummate professionalism demonstrated by your staff in conducting this audit. It was clear to us that each member of the audit team made a concerted effort to understand the program and services provided by the Division of Services for the Blind. I am confident that many of the audit recommendations will lead to improved operations in the Division of Services for the Blind. I know that each recommendation evoked serious reflection by our staff on how we do business.

As a bottom line, we feel that our participation in this process has been healthy for us and will lead to further strengthening services to the blind and visually impaired citizens of North Carolina. If you have questions or need additional information, please contact Jim Edgerton at (919) 733-4534.

Sincerely,

H. David Bruton, M. D.

HDB:SA
cc: James B. Edgerton

North Carolina: Host of the 1999 Special Olympics World Summer Games

* The response from the Division of Services for the Blind has been reformatted to conform with the style and format of the rest of the audit report. However, no data has been changed.

THE COMMISSION FOR THE BLIND DOES NOT HAVE OPERATIONAL POLICIES AND PROCEDURES.

DSB concurs with the recommendation that the Commission develop operational policies and procedures which, among other things, address attendance at meetings. While there has, as stated in the report, been only one instance of chronic absenteeism, this recommendation is viewed as a good proactive step. Division staff will begin immediately working with the Commission to develop and implement operational policies and procedures.

ORGANIZATIONAL LINES OF AUTHORITY IN SOME AREAS ARE NOT CLEARLY DEFINED.

By way of explanation as to the locations of DSB field-based offices, DSB has staff located in four area offices--Charlotte, Winston-Salem, Raleigh, and Greenville. Until 1995 there were four district offices administratively connected to each of the four area offices--Asheville, Burlington, Fayetteville, and Wilmington. Because the Burlington Office was in relatively close proximity to the Winston-Salem Office, it was closed in an effort to save rent; and the staff was relocated to Winston-Salem. The Area Social Services Supervisor and the Area Rehabilitation Supervisor were, at that time, as they are now, located in the Winston-Salem Office together. The closing of the Burlington Office had no impact on the placement of either supervisor. A similar structure existed in Greenville where the Area Social Services and Area Rehabilitation Supervisor were located together and in Fayetteville and Asheville the Area Social Services Supervisor and District Rehabilitation Supervisor have been located together for many years.

By way of clarification, in all cases the Area or District Rehabilitation Supervisor has been designated as the "Office Manager." There is not additional pay associated with this designation. The main function of the "office manager" is to handle onsite issues that arise in the day-to-day operation of the office. Maintenance needs, telephone problems, supplies, emergency communications, and workplace disruptions are among the things which might be handled by the office manager. Most of the people in the area or district office are supervised by the Area or District Rehabilitation Supervisor, while the Area Social Services Supervisor supervises Social Workers for the Blind who are dispersed at local Department of Social Services Offices throughout the area. Thus, it is necessary for the Area Social Services Supervisor to be out of the office more than the Area or District Rehabilitation Supervisor. The Division believes that, while there might be some disgruntlement in one location with the designation of the office manager, the designation is consistent with Agency practice in other locations and has proven workable in other locations.

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With respect to confusion among rehabilitation staff regarding to whom they report in a given office location, due to some unique circumstances in one location involving a counselor-in-charge who developed a disabling condition which has ultimately resulted in her retirement and the fact that the Area Rehabilitation Supervisor is relatively new to the job and in need of getting to know the staff and their roles, joint supervision of a number of employees did occur with the support of Division management in Raleigh.

Upon the retirement of the employee mentioned above at the end of October, 1997, the Division did study the need for continuing the counselor-in-charge position and determined that it was appropriate to maintain the position as its elimination would have required that the remaining Area Rehabilitation Supervisor supervise approximately eighteen employees, most of which are direct service providers. That same supervisor would have had to serve as liaison with two community rehabilitation programs, one of which also has a Supported Employment Program. The supervisor would have had to work with at least one third-party cooperative school program at a time when we are pursuing agreements with other school districts. It was our determination that the quality of work in the area and most importantly the services to clients would suffer because the sole supervisor would not have time to devote to individual staff and client needs which arise. It is our belief that the reporting lines will be clearer once a new counselor-in-charge is hired and able to be onsite consistently. If, however, additional clarification is needed by the staff in the one office where this seems to be an issue, Division management can and will provide that clarification.

WORKLOADS AMONG HEADQUARTERS STAFF AND FIELD PERSONNEL ARE NOT EQUITABLE.

The Division concurs with the recommendation that job descriptions be reviewed and updated as appropriate to ensure that the job descriptions accurately reflect the work being done by the employee in the position and that the job functions meet the needs of the client population. In fact, as positions have been vacated they have routinely been reviewed. Additionally some job classes have been reviewed. For example, all clerical support positions were reviewed approximately three years ago as part of a State Personnel review of this group; and, as a result, a number of positions within DSB did move to a higher classification. Currently the Business Enterprises Representative (BE Counselor) positions are being reviewed, a process which began many months ago and is now with State Personnel. Those position descriptions were quite old and, we believed, not reflective of the changes which have occurred within the program thus requiring changes in how the counselor operates in his day-to-day work. The Division will place emphasis on reviewing and, when needed, updating job descriptions.

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In regard to workload distribution inequities between central office and field staff, during the course of discussions with the audit team one example was cited by an auditor which seemed to illustrate this point. In that particular situation the duties of the field-based employee had evolved as other positions had been abolished as part of ongoing required cuts. After several evolutions which have affected that position, it probably is accurate to view the position as having an unwieldy workload; and the Division will review that position to determine if steps can be taken to address the matter. Additionally, the recently updated Span of Control chart will be reviewed to determine if there are other apparent inequities which can be corrected either immediately or as vacancies occur which will create a more natural opportunity for reassignments.

BUSINESS ENTERPRISES COUNSELORS DO NOT REPORT DIRECTLY TO THE CHIEF OF BUSINESS ENTERPRISES.

This is a point which has received extensive discussion over the past several years. In fact, a number of years ago the BE Counselors did, as recommended here, report to the Chief of Business Enterprises. Not surprisingly, there are at least two schools of thought on whether that was a better or worse reporting structure than the existing one.

The audit finding is correct in stating that funding from the BE set-aside monies does help to support the cost of the Area Rehabilitation Supervisors to whom the BE Counselors report. If those supervisors were left with no significant role in managing the BE Program, it would not be appropriate to use BE set-aside money to support these positions. As there are not actually any Social Services monies in these positions as stated in the finding, it would be necessary to fund the supervisors' positions with a combination of State appropriations and Federal rehabilitation money. Thus, State funds would need to be identified to replace the BE set-aside monies. Money is, however, only one part of the consideration from the standpoint of Division management.

The auditors acknowledged that an informal working relationship does exist between the local staff and Chief of Business Enterprises. We have, over the last twelve to eighteen months, tried to strengthen that relationship realizing that the BE Chief does have the greatest amount of knowledge about the law governing the program and other technical aspects related to operation of various food service facilities. A benefit, however, of having strong local involvement on the part of the Area Rehabilitation Supervisor lies in the need for someone onsite to have the authority and responsibility for going to a given vending site when an emergency arises and representing the Division's interests. It is not practical to think that, if a problem arises in Asheville, a Raleigh-based supervisor or management level staff

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person can meet with those onsite at the vending location, be it our blind BE operator, the facility site manager, customers, salespeople, or others. While such occurrences are, fortunately, not daily events, they are not unusual either. Thus, it is important that the Area Rehabilitation Supervisor have enough knowledge of the operation of the program to be able to perform this type intervention when needed. We believe that the more removed the Area Rehabilitation Supervisor is from the program the less able he will be to provide this type assistance locally and the less responsibility he will feel to do so.

As stated before, this is not a new issue for DSB; and we will continue to look at how the reporting, supervision, and management of the BE Program can be most efficiently and effectively handled. We believe that caution should be exercised in setting up a structure where there are essentially two supervisors for the BE Counselor lest that create greater confusion about roles. If we do pursue this model to an extent greater than that now used, it will be necessary to very clearly define those tasks to be performed by the Area Rehabilitation Supervisor and those to be performed by the Chief of the BE Program.

THE NURSES IN THE MEDICAL EYE CARE SERVICES SECTION ARE NOT BEING USED EFFECTIVELY.

In regard to the statement in the finding which indicates that secretarial staff is conducting vision screenings, Division management has not directed secretarial staff to function in this manner; and if they are doing so, steps will be taken to eliminate this practice.

With respect to the functions performed by the nurses, as other groups, both public and private become proficient in providing vision screening services, the Division plans to review, and possibly redefine the role of its nursing staff. This will allow time for the nursing staff to concentrate on providing low vision evaluations for North Carolina's growing elderly population. The nursing staff will also be available to provide in-service training for social workers for the blind, rehabilitation counselors, teachers, etc. The Division views this as a positive recommendation and one which should result in expanded services to clients and the community.

THE INDEPENDENT LIVING REHABILITATION COUNSELORS ARE PERFORMING DUTIES BEYOND THEIR JOB DESCRIPTIONS.

The role of the Independent Living Rehabilitation counselor is one which has evolved over the past several years, and the services provided by that small group of staff benefit a large number of newly blinded adults--many of whom are over 55

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years of age. The community-based group instruction provided by these staff receives some of the most positive feedback of any of the Division's programs. As federal or state money is available, the desire of the Division is to expand this program.

The Division is agreeable to the recommendation that roles of the Independent Living Rehabilitation Counselors and of the Social Workers for the Blind be reviewed and, where necessary, clarified to gain the most efficient use of positions in meeting the needs of DSB clients.

The point made in the audit finding regarding the limited funding available in this program thus limiting the services which can be offered to clients is significant. Funding used to enable elderly and disabled people to remain independent in their homes is, we believe, money more efficiently used than money spent in residential care. With training such as that provided by the Independent Living Rehabilitation Counselors along with other Division staff as well as some technology, many blind people can remain independent in their homes and active members of their communities.

THE STATUTORY AUTHORITY AND RESPONSIBILITIES FOR DSB ARE VAGUE AND OPEN TO INTERPRETATION.

A comprehensive revision of the General Statutes which authorize the programs of Services provided by the Division of Services for the Blind to the blind and visually impaired citizens of North Carolina has not been undertaken since 1973. Thus, we would agree that a thorough statutory review of the kind suggested by the audit would be both appropriate and beneficial.

However, it is unlikely that such a review would result in amendments that purged all vagueness from these Statutes or rendered them immune to multiple interpretations.

Furthermore, to be worthwhile, this review should be meaningful. For the review to be meaningful, there must be time to receive input from clients and advocates as well as departmental and divisional staff.

With respect to the rules which govern the operations of the Division of Services for the Blind, a thorough review was done last in 1989 and resulted in the repeal of many rules in 1990. Additionally rules for the Business Enterprises and Vocational Rehabilitation Programs were amended in January, 1996. The next comprehensive rules review should be conducted only after the process of statutory review and amendment is complete. Otherwise, it is very likely that yet another rules review would be needed following the completion of the statutory review and amendment

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process. We do not believe that delaying the rules review until after the completion of the statutory review process would be problematic given the length of time that it currently takes to navigate the rule-making process.

THE DSB CENTRALIZED DATABASE DOES NOT CONTAIN STATISTICS FOR ALL PROGRAMS.

The Division has a database which serves two purposes--one tracking demographic and service information on blind and visually impaired clients and second serving as an authorization/billing mechanism for the purchase of goods and services for clients served. The programs which have data residing in the database are the Independent Living Services Program (SSBG funded), Medical Eye Care Program, Vocational Rehabilitation Program, and Independent Living Rehabilitation Program (funded through federal rehabilitation and state funds). These are the programs which serve the largest number of individuals and which purchase goods and services during the course of assisting blind and visually impaired individuals in reaching their stated goals.

Based upon preliminary discussion with programming staff at the Division of Information Resource Management (DIRM), it appears likely that an unduplicated count can be obtained from the database for the four programs which reside in the database with little or no modification to the database. Because of the nature of the services provided, these are the four programs which would most likely serve a client on more than one occasion during a year or where a client would be served by more than one program during the year, thus resulting in a duplicate report. This step alone should take care of most of the duplicate counts. At the same time the Division will be able to provide client count by program, a function which the Division believes to be important and which the audit seems to support.

In response to the recommendation that other programs including all Governor Morehead School programs, Business Enterprises, Special Assistance for the Blind and Personal Care Services be added to the database, the Division's Automation Committee will discuss the recommendation and ask for an estimate of time and money required to accomplish this objective. However, our initial reaction is that the limited number of clients served in these programs and the reliability of the figures which each program can currently provide combined with the fact that only limited duplication should occur between the programs leads us to question whether the value of modifying the database would be worth the cost in terms of programming time and required updates to the files.

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SOME POLICIES AND PROCEDURES ARE NOT CURRENT AND ARE NOT BEING CONSISTENTLY FOLLOWED.

The Division acknowledges that update to the Business Enterprises manual is needed. A process of policy review was begun about a year ago with some older and unnecessary policies being deleted and some overlapping policies being combined, but the process was not completed and it should be.

There are also policy manuals for the Independent Living Services Program, Medical Eye Care Program, Personal Care Services Program and Vocational Rehabilitation Program. All of these manuals have undergone review and revisions within the past two years.

Every three to five years Congress reauthorizes the Rehabilitation Act and issues revised regulations governing programs under the Act. State policies are reviewed and revised each time the Act is reauthorized in order to bring policies into compliance. Much of the content of the state policies reflects federal law and regulation. Division policies are reviewed annually by the Rehabilitation Services Administration, the federal agency under the Department of Education which is responsible for monitoring state rehabilitation agencies. The Division's policies have been determined to be in compliance with federal law and regulation.

Because of the federal requirement that clients have some involvement in the choice of goals and services and because absolute caps are not allowed by federal regulation and case law, some flexibility must exist within the Division's Vocational Rehabilitation policies. Policies have been put into place which provide guidance and parameters for the "routine" service situations but also allow for exceptions when they are warranted. It is the practice of the Agency to grant exceptions via approval of administrative staff in Raleigh and to provide written documentation of the decision and justification. To use one example from the audit report, it is common practice to pay lodging for clients at the appropriate in-state or out-of-state rate as set forth by the General Assembly, but it is also possible for clients to request and receive excess lodging just as state employees can request and receive excess lodging under special circumstances. To the extent that the agency has appeared to act outside of stated policy, the client has, we believe, been the beneficiary and the intent has been to do all that can reasonably be done to make the client independent and self-supporting. Division management will, however, reinforce with staff the importance of acting within policy and, when exceptions are appropriate, seeking support from the Central Office in Raleigh prior to taking action.

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DSB DOES NOT HAVE A COMPREHENSIVE TRAINING PROGRAM FOR STAFF.

We concur strongly with the spirit of this finding and recommendation. It is beyond dispute that Division staff would benefit from the kind of intensive and extensive training program envisioned by the audit. However, to be understood fully, some additional points must be made.

First, there are significant inconsistencies in the level of training presently provided to Division staff depending upon the training funds that are available in the program for which they work. For example, the vocational rehabilitation program affords its staff many training opportunities as the result of a significant federal grant which must be used for the training of staff who provide vocational rehabilitation services to vocational rehabilitation clients. An employee committee, the Human Resources Development Advisory Council, has been charged with the responsibility of assessing training needs within this program and arranging training to meet those needs.

Similarly, the Governor Morehead School has a reasonable level for staff training.

On the other hand, the Independent Living Services Program represents an example of the other extreme. The problem of minimal funds for staff training is complicated by additional considerations. These include the number of staff in the program (57 social workers for the blind, 3 area social services supervisors, and 4 children's program consultants) and the distribution of this staff throughout North Carolina. Moreover, due in large part to the fact that these employees frequently travel to the homes of the clients to provide services, travel funds for this program are also perennially in short supply. This is not a desirable situation but one which we have not yet found an optimal way to defeat.

Second, at a time when the budget reduction process has become routine, administrative ranks have shrunk to help fund these reductions; and there is general reluctance to cut funds for direct services, training funds often feel the pinch.

Third, as noted in the audit, additional funds would be required to implement this recommendation. We have not yet identified the required amount, but we would welcome the opportunity to do so.

BUDGET INFORMATION IS NOT DISSEMINATED TO PROGRAM MANAGERS ON A TIMELY BASIS.

DSB acknowledges that it has been more difficult to define and distribute the budget information needed by program managers to monitor their budgets since

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moving from the Departmental Accounting System to the North Carolina Accounting System (NCAS). Reports are not automatically prepared in the format and on the schedule that staff had been accustomed to under the previous system. The migration to the new system has been complicated by the fact that all DSB office locations do not have LAN access so even with training would not be able to access the budget information independently. We now have four of our seven district offices on the LAN and will focus on providing training for those supervisors in addition to the program managers. A system for providing hard copy of the information is being developed for the offices which do not have LAN access. Our long-range goal will be to have LAN access for all district offices but that will be fairly expensive, and we are reluctant to make significant financial investments in office space which is leased.

DSB HAS NOT DESIGNED NCAS REPORTS SHOWING FINANCIAL DATA BY VENDING FACILITIES.

Based upon our discussion with staff of the DHHS Controller's Office relative to this finding and recommendation, we have been advised that it is possible under the current operations system to capture financial data relative to a given location although the Division has rarely seen the need to do so. Information about a location's annual operation can be generated by adding together that data which corresponds to the periods of time when the various vendors operated that location. According to the DHHS Controller's Office, all the data elements are in the NCAS system to provide such an analysis if an existing IE report could be reprogrammed to resort the data by location instead of by vendor. The Division has not requested that such a report be generated. While we have not experienced a problem in monitoring earnings or potential earnings of a given location, if this type problem should arise in the future, it is good for us to know that we can obtain the data discussed in this finding.

THE GOVERNOR MOREHEAD SCHOOL IS USING SUBSTITUTE FUNDS IN A QUESTIONABLE MANNER.

The language in the audit finding regarding the insufficiency of funds initially budgeted for contractual services at the Governor Morehead School is accurate. It is also accurate that lapsed salaries are used to remedy this shortfall. This practice became customary a few years ago, when difficult to fill positions such as those for occupational therapists and physical therapists were eliminated during rounds of position reductions. At the time of elimination, these positions had been vacant for months and we were already contracting for the services. The understanding was that we would give up the positions and use lapsed salaries to pay for the contracts for these services.

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Thus, we concur with the recommendation that this perennial shortfall be addressed through the continuation process.

Regarding the issue noted with vacant teacher and educational development aide positions, it must first be made clear that no such position has been left vacant longer than necessary so as to generate additional lapsed salary funds. The vacant teacher position referenced in the audit finding remained vacant for a period of six weeks and was covered by a substitute teacher. Given the relative scarcity of teachers certified in the field of visual impairment in North Carolina and the various steps in the personnel process, it is not atypical or unacceptable for a teaching vacancy to take that long to fill. It is also our understanding that using someone in a substitute teacher or educational development aide position to cover a vacant permanent teacher or educational development aide position does not violate applicable law or personnel policy.

Even so, after careful consideration, we also concur with that part of the recommendation to the effect that individuals who are filling vacant teacher or educational development aide positions on a temporary basis should be paid from these positions rather than from substitute positions. We believe that this deployment will allow for more effective use of a limited number of substitute positions and will thus implement this measure immediately.

FOLLOW-UP OF PRIOR FINANCIAL RELATED AUDIT.

DSB has taken steps designed to address the issues cited in the most recent Single Audit.

In three of thirty-eight cases reviewed, eye exam reports were not in the file. Staff were provided written reminder of the necessity of having reports in the file as appropriate for either determining eligibility for treatment or prior to paying bills for services rendered. Additionally staff have been asked to make certain that the required reports are in the file when conducting quality assurance reviews.

It is accurate that a number of problems arose related to the payment of invoices for the provision of services under the Supported Employment Program--problems which originated with incorrect coding of invoices, lack of timely submission of invoices both by the provider and by the staff of the Division to the Controller's Office, and problems which arose simply out of the timing of the payment of invoices during end-of-year close-out of the books. Procedures have been implemented which we believe will reduce and hopefully eliminate the problems outlined.

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DSB HAS PROVIDED QUESTIONABLE EMPLOYMENT SERVICES TO A CLIENT.

DSB management wishes to make clear that the seeming excessive assistance cited in the findings and the accompanying recommendations relate to a single client who has, admittedly, presented the Division with a unique challenge from the job placement standpoint. The client has a highly specialized degree. There are very limited opportunities for placement; so in an effort to enable the client to avail himself of every possible opportunity to identify potential openings in the field, the Division has employed means outside those typically needed for clients to achieve their employment goal. For example, the client had, in fact, been employed in Greece some time prior to the Agency-sponsored trip to Greece. Thus it was reasonable to believe that he could obtain employment there again in his specialized area. At the time the job in Greece was turned down, there seemed to be a good possibility of employment in another state--a gamble which the client took and unfortunately lost. The trip to Greece occurred in 1991. To our knowledge no overseas trips had occurred prior to that time, and we are certain that none have occurred since. The audit staff did raise this question and were provided this information. Agency involvement in any trips of this type would be approved by top management within the Division.

The findings raise questions about the travel provided to the same client cited in the example of the overseas trip above. Because of the specialized field in which this client has been seeking employment, the Division has agreed to sponsor his attendance at one conference per year for the purpose of making contact with others in the field, contacts which would hopefully lead to job opportunities. When out-of-state trips were sponsored in association with job interviews, the Division has obtained documentation of the scheduled interview just as it has obtained conference agendas in the case of conference attendance.

The Division understands and accepts the point made regarding independent travel relative to this client (same as in two paragraphs above) and acknowledges that it would have been more acceptable had the client traveled independently rather than with a guide. It is still possible, however, in the case of the client and given the type positions that he would be applying for that a reader would have been required as a reasonable accommodation under the Americans with Disabilities Act (ADA).

Based on the recommendation, the Division will give special attention to future requests for out-of-state travel for clients and will document in the file any approvals of and justifications for such trips. Every effort will be made to make certain that such trips are handled in the most cost effective manner possible. The Division does not want the one client example cited throughout this finding and recommendation to be viewed as the norm--it is clearly an exceptional client situation for which exceptional steps have been taken to try to reach a job goal.

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THE POLICY ALLOWING DSB TO PURCHASE VEHICLES FOR CLIENTS IS OPEN ENDED.

While this service is not frequently provided as part of the Rehabilitation Program, the Division is willing to review the policy to see if some of the points raised in the audit can be addressed in more specificity in the policy.

CURRENT SET-ASIDE STRUCTURE MAY NOT BE ACCOMPLISHING THE OBJECTIVES INTENDED BY THE LEGISLATURE.

The Division has studied carefully the current set-aside rate structure as laid out in G.S. 111-50 to determine if it meets the current needs of the Division. It does. The Division does not accept without qualification the premise that the intent of the General Assembly was simply to have those operators with the highest incomes pay at the higher set-aside rates. We believe that a condition precedent for an operator to pay at a higher rate is to have income that is so high that it reaches certain statutorily specified levels. The Division views the current set-aside structure as fair and equitable in that every vendor pays set-aside on the first dollar of net income and according to the same formula under the same rules as every other vendor. The Division would welcome the ability and authority to establish and manage its own set-aside rate structure in conjunction and partnership with the federal Rehabilitation Services Administration apart from state statutory considerations as was done prior to 1992. This would allow for a more flexible future response to changing fiscal needs within the Business Enterprises Program.

DSB DOES NOT AUDIT VENDOR RECORDS FOR ACCURACY.

The financial records of vendors who operate above the accounting level of "Category A" are audited twice yearly using a standard form, the Record Keeping Review form. Individual counselors might use the form differently or there might be a need for additional training in the proper use of the form, but a standard review mechanism does exist. No vendors at this level are exempt from the review, and it would be less useful to move backwards to a system of random or routine selection for audit when the majority of vendors are already studied each year under the present system to determine the accuracy and reliability of their reports.

The costs associated with DSB-provided management services are known and are properly charged against set-aside collections each year. This is as outlined in the federal regulations which govern this program and which specifically outline and define "management services" citing it as one of the allowable charges against set-

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aside funds. To "bill separately" would be to impose an additional "set-aside" charge against the vendors above and beyond that allowed in statutes and would be in violation of both federal regulations delineating how the program is to be funded as well as state statutes regarding set-aside.

CURRENT PROCEDURES RESTRICT THE NUMBER OF HIGHWAY VENDING FACILITY OPERATORS.

Regarding the establishment of operator-attended highway vending locations along the North Carolina interstates, the audit states that "DSB had not performed any analysis regarding the income potential of these stands prior to entering into contracts with these vendors." The focus of this finding is the two-sided highway vending rest areas where both sides of an interstate rest area were awarded to a single vendor as "one" location from which he would earn an income. Division management does not view this observation as accurate.

In fact, prior to the placement of blind vendors in these locations the highway vending sites were initially contracted to private commercial vending companies with commissions being paid into the Division based on gross sales volumes. Based on the commissions received, a very careful analysis was done to determine the likely income potential of highway vending sites. Estimates turned out to be incorrect. Possible explanations include underpaid commissions or underrepresented gross sales figures.

A secondary factor that has resulted in higher incomes for blind vendors is the public acceptance of these vending efforts along the interstates. Prior to the mid-1980's, rest areas that did exist offered no vending or refreshment service. As we began to offer these services and more rest areas came to exist along new and improved interstates, the public acceptance and utilization of our vending services were exceptional. The traveling public today expects a level of service availability that we could never have anticipated as we began to consider highway vending projects ten years ago. We provide a service that is appreciated and well patronized by citizens traveling in North Carolina. Vendors benefit directly from this patronage to a degree unimagined at the time when critical decisions were made about starting the highway vending program.

The Division has studied the issue of dual-sided highway vending locations being split into separate facilities, and we recognize the merit and appeal of the recommendation. This Division has maintained for some time that, upon a vacancy being created in one of these locations, the Division has the right to split the facility, advertise the availability of two locations, and to accept applications for two operator contracts where only one existed before. We continue to hold this belief. In fact, this action would be very controversial and would only be taken

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after a careful study and determination that the two new facilities could each support an operator and that the potential exists for available operators to be interested.

The splitting of these facilities in the absence of a vacancy would be devastating to the current operator and an act of bad faith as the original awards were made for both sides to be serviced under one contract. Implementation of this recommendation would require additional financial and personnel resources in order to maintain the current level of direct services provided to facility operators.

Current program growth properly accommodates the number of incoming vendors who are newly licensed each year. Reference is made in the audit report to a "waiting list" of approximately 20 clients with the reference implied that these individuals were waiting for opportunities to work in Business Enterprises. In fact, we have a mailing list of individuals who are licensed to work in the program but not currently under contract at any location. Some of these individuals have never applied for any vacancy that has been advertised. It is not the Division's perception that these individuals are "waiting" for an opening to occur in order to seek employment at a vending facility as vacancies are advertised every month in various locations across the State. Others on the mailing list have left the program after working many years and desire to remain on the list for vacancy advertisements in the event that just that perfect opportunity should become available. Finally, others on that list have had their prior contracts terminated for various reasons and yet remain eligible to reapply even as their chances for being put under a new contract are very slim. The Division does not view this list as a "waiting" list but rather as a "mailing" list. Actually, we have already experienced situations where vacancies had to be advertised more than once because no applications were received.

THE BUSINESS ENTERPRISES CONTRACTUAL AGREEMENTS ARE MISLEADING.

The purpose of the Business Enterprises Program is to provide jobs and job opportunities as outlined in the federal legislation which authorizes the program. While operators can and do leave the Program to enter into private employment settings, it is not the stated goal of the program to "transition" blind vendors out of the Program and into some other type of employment. The Business Enterprises program is a jobs outcome program funded from federal rehabilitation funds and program generated profits with a goal of increasing the self-employment opportunities available for blind and visually impaired citizens.

Self-employment as a business enterprises operator is a legitimate outcome of rehabilitation services and is recognized as such by the Rehabilitation Services

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Administration. "Rehabilitation" doesn't necessarily mean working for someone else but includes a broad range of self-employment options. The rehabilitation program of the Division does exist, separate and apart from the business enterprises efforts, to assist blind and visually impaired citizens in North Carolina obtain work in the "open market." It is unclear from the written recommendation just what problems are believed to exist in the Business Enterprises program training or what legislation might require changes.

The Division agrees that the wording of the contractual agreements used with vendors could be clearer and program staff have been asked to work with the Elected Committee of Vendors to make those changes. The Division already has the right, which is recognized by all vendors, to examine all records relative to the operation of a Business Enterprises facility.

VENDING OPERATORS ARE RECEIVING START-UP GRANTS FROM DSB FOR EXTENDED PERIODS OF TIME.

The federal guidelines under which this Division operates the Business Enterprises Program require that assurances be made in the Division's rules and regulations that no individual will be denied the opportunity to become a vendor because of the individual's "unwillingness or inability to purchase facility equipment or initial stocks." Adoption of a policy that would require vendors to "repay" or purchase initial stocks or petty cash could run contrary to federal regulations. The Division's current system for monitoring individual operator performance and adherence to financial standards, as well as our system of transfer and promotion, is based on knowing or being able to know at any given time the inventory level in a particular facility. Should the Division not retain title to this inventory, the question could arise as to what right we have to know about inventory levels apart from the departure of an individual vendor from a facility.

Many operators are not in a financial position to make paybacks of those initial items that are provided for them and which are mandated by regulation as something this Division must do in support of the program. The accounting headaches of tracking the paybacks could become as cumbersome as the current system of tracking inventories.

THE REHABILITATION TRAINING FACILITY IS UNDER-UTILIZED.

The Rehabilitation Center for the Blind is a statewide residential training program for adults who are visually impaired or blind. The training focuses on personal, social and pre-vocational skill development. The major components of the program are: Home Management (cooking, techniques of daily living, client education, sewing); Orientation and Mobility (learning to travel safely within a

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home, school, or work environment, mall travel, residential and business areas); Communication Skills (Braille, adaptive computer technology, keyboarding, handwriting, remedial education, recreation & leisure); and Pre-Vocational (career exploration, medical transcriptionist, Business Enterprises training and Introduction to Food Science).

The Business Enterprises training is one of the various training opportunities available at the Rehabilitation Center. The BE training is cooperatively developed by the chief of the Business Enterprises Program and the teaching staff of the Rehabilitation Center. The BE training is a concentrated 6-week program with the BE students participating in the BE training for 6+ hours per day. The 6-week program is offered four times per year; class size is ideally at a one to four ratio. Size of class can vary to accommodate individual needs.

The Center also offers clients the Introduction to Food Science modules which emphasize other types of job opportunities in food service. Some clients can train as cashiers; others as stock clerks, short order cooks, dishwashers, etc. When not in use specifically for BE training, the classroom setting where that training is provided is used for other types of training which prepares clients for jobs in the food service industry as described above. The Division and the Center are always interested in finding ways to more effectively utilize space and will continue to try to use the existing space in the ways which meet the needs of the greatest number of clients.

To enhance clients'/employers' awareness of the Center and the BE Program, DSB has developed brochures and a handbook which are focused toward clients and business. As funding permits, DSB plans to expand into other media forms.

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In accordance with GS §147-64.5 and GS §147-64.6(c)(14), copies of this report have been distributed to the public officials listed below. Additional copies are provided to other legislators, state officials, the press, and the general public upon request.

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The Honorable Michael F. Easley	Attorney General
Mr. Marvin K. Dorman, Jr.	State Budget Officer
Mr. Edward Renfrow	State Controller
Dr. H. David Bruton	Secretary, Department of Health and Human Services

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Senator Ed N. Warren	

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Representative James B. Black	Minority Leader of the N.C. House of Representatives
Mr. Thomas L. Covington	Director, Fiscal Research Division

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December 31, 1997

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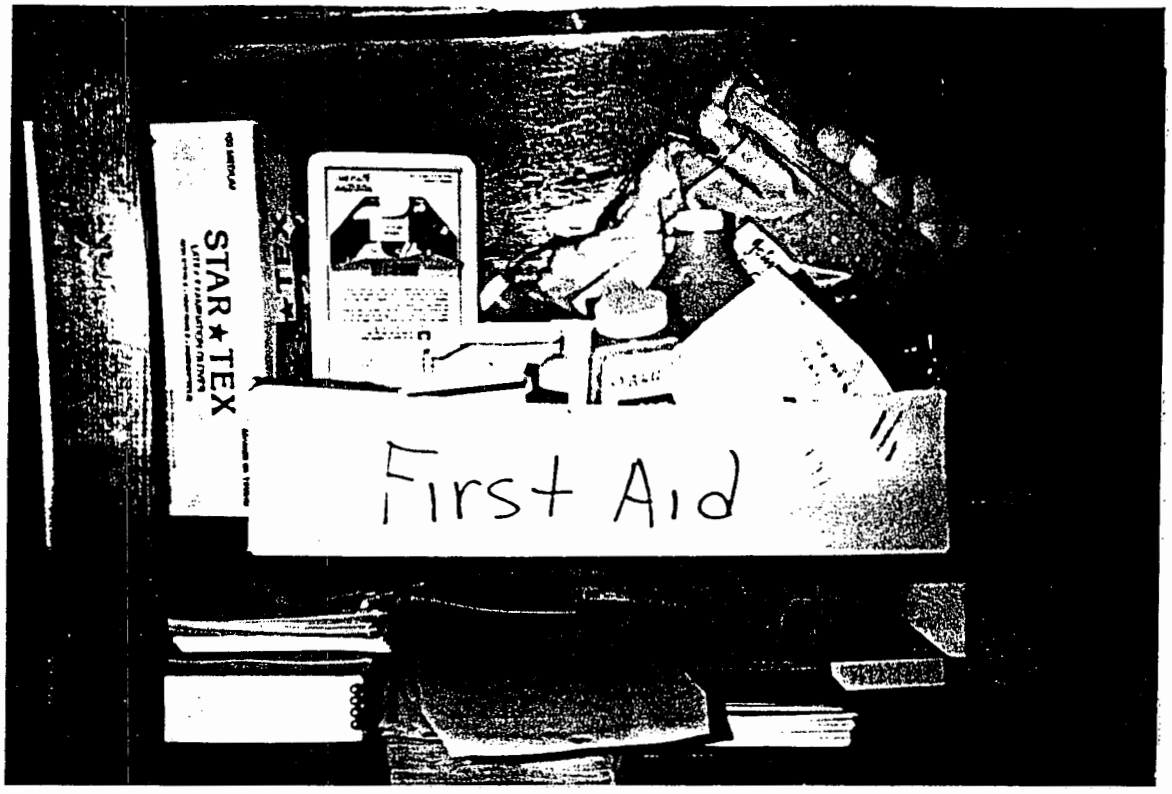
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Rep. Clancy
4





Handout #

TYPES OF DIAGNOSES

1996/1997

Cleveland County Expanded School Health Program

	Burns High School	Crest High School	Kings Mountain High School	Shelby High School
GU/STD/FP	6.6%	8.3%	7.5%	13.7%
EENT	12.6%	17.6%	14.9%	15.3%
RESP.	17.5%	11.8%	6.2%	10.3%
GI	13.9%	9.7%	6.2%	7.7%
SKIN	13.8%	11.1%	13.0%	8.9%
MUS/SKEL	11.2%	11.7%	15.4%	8.8%
HEADACHE	10.0%	15.6%	25.8%	19.3%
PSYCH	3.4%	1.4%	0%	0.3%
CONSULT/EDU	5.4%	7.9%	6.3%	13.2%
OTHER	5.1%	4.3%	4.3%	2.1%
TOTAL NUMBER	2805	2228	1716	2308

#5 Evelyn Lee
1-20-98

Division of Epidemiology
HIV/STD Prevention and Care Section
Key Program Descriptions

[redacted]ion's Mission Statement

The HIV/STD Prevention and Care Section's Mission is to reduce and eventually eliminate morbidity and mortality due to sexually transmitted diseases (syphilis, gonorrhea and chlamydia), Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), and to assure that an up-to-date continuum of care services is available to all HIV-infected individuals residing in North Carolina.

Field Services Branch

The mission of the Field Services Branch is to interview and notify patients diagnosed with syphilis/HIV and notify partners; consult on syphilis/HIV control measures; provide consultation and technical support to HIV/STD laboratories and clinics; coordinate and monitor HIV counseling/testing program; distribute STD drugs, gonorrhea culture plates, condoms, and patients brochures; and act as an HIV/STD training resource for North Carolina.

Prevention and Community Planning Branch

The Prevention and Community Planning Branch is committed to the elimination of HIV and other sexually transmitted diseases through the provisions of technical assistance and consultation, risk reduction education, capacity building, introductions of innovative/creative intervention strategies, and forging partnership between inter/intra departmental agencies, local health departments, and community based organizations, and to ensure participation by affected individuals and communities in planning and development.

Epidemiology and Special Studies

The Epidemiology and Special Studies Branch provides support to the HIV/STD Prevention and Care Section in the form of data collection, analysis, and reporting of disease trends; maintenance of patient registries; and the promotion of reporting of all sexually transmitted infections.

[redacted]n White HIV C.A.R.E. Program ($7,053,271; includes $2,870,201 to be used in the HIV Medications Program. The RW program [redacted]ding] year is April 1 through March 31. These figures represent April 1997 through March 1998 funding .)

The Federal Ryan White Program provides grants to states to "improve the quality, availability and organization of health care and support services for individuals and families with HIV disease." The majority of North Carolina's service funds are allocated to 15 regional HIV care consortia, which plan and arrange for services in all 1 00 counties. Case management, transportation and in-home aide/personal care services are available, at least to some extent, through all consortia and in all counties. Funds are also used to provide HIV medications through a statewide fee-for-service arrangement, and will also soon be used to increase access to and the quality and appropriateness of primary medical and dental care services in selected under served areas of the state. Each consortia may choose to provide other outpatient health and support services, based on their local situation and the availability of financial resources.

Housing Opportunities for Persons with AIDS ($1,707,000. HOPWA program [funding] year is January through December; funds are available for a three-year period. This figure represents January 1997 through December 1997 funding.)
The Federal Housing Opportunities for Person with AIDS Program assists states in devising long-term comprehensive strategies for meeting the housing needs of persons with HIV and AIDS. NC's HOPWA Program supports the following approaches in efforts to achieve its goal: emergency housing, support services, pre-development grants and loans for the creation of housing, rental assistance, small housing repairs, housing information, operational support for specialized housing situations, adult day/health care and the identification and pursuit of additional funding opportunities and resources, at both the state and local levels.

Medicaid HIV Case Management Program (funds for the services provided through this program reside in the DMA/Medicaid budget; a Kate B. Reynolds Foundation grant of $100,000 per year for 3 years, ending June 30, 1998, along with funds provided by DMA, support the administration of the program.)

The purpose of the Medicaid HIV Case Management Program is to assist Medicaid-eligible individuals living with HIV/AIDS to prevent or alleviate health and social crises which may threaten the quality and/or length of their lives. HIV CMS is a client-focused strategy for [redacted]dinating care. It involves assessing a client's need for specific health, psychological and social services and facilitating access to [redacted]ces that will address those needs. Medicaid HIV CMS can only be offered by providers certified by the AIDS Care Branch, and enrolled with the Division of Medical Assistance (Medicaid). All Medicaid-eligible persons diagnosed with HIV disease who live in North Carolina and are not in an institution or general hospital are eligible for HIV CMS. There is no limit on the amount of HIV CMS that an

eligible person may receive. Case management services provided under the Ryan White Program to individuals who are not Medicaid eligible are subject to the same standards, procedures and quality requirements as Medicaid HIV CMS.

Medicaid Community Alternatives Program (CAP/AIDS) (funding is as described above in HIV Case Management Services Program)

The purpose of the Community Alternatives Program for Persons with AIDS is to prevent the institutionalization of Medicaid-eligible HIV-infected individuals who have an AIDS diagnosis through the provision of an expanded package of home and community-based services which cost-effectively address client care needs while maintaining them in home and community settings. CAP/AIDS is offered to eligible clients as an option, providing an alternative to placement in intermediate or skilled care facilities.

HIV Medications Program ($750,000 of state appropriations; $2,870,201 of the Ryan White federal program funds [$2,250,201 of specifically designated funds and $620,000 of regular State Title 11 funds] are also available for this purpose)

The purpose of the HIV Medications Program is to provide life-sustaining medications to low income North Carolinians diagnosed with HIV infection and AIDS. To be eligible for the Program, an individual must be determined by a physician to be infected with HIV, have a net income of less than 1 1 0% of the Federal Poverty Level, and not be Medicaid eligible (or have any other insurance that will pay for their medications).

HIV/STD PREVENTION

AND

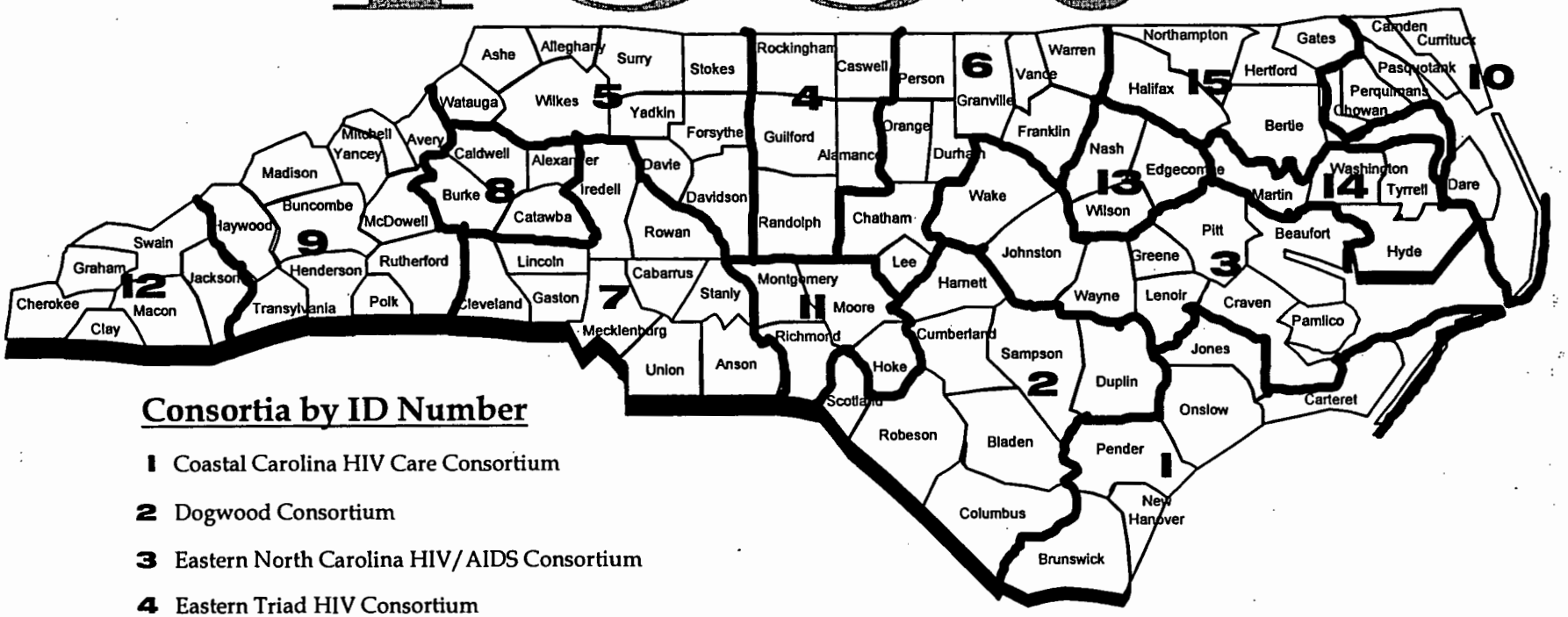
CARE SECTION

FUNDED CARE

AND HOUSING

SERVICES PROVIDED

North Carolina HIV Care CONSORTIA



Consortia by ID Number

1 Coastal Carolina HIV Care Consortium

2 Dogwood Consortium

3 Eastern North Carolina HIV/AIDS Consortium

4 Eastern Triad HIV Consortium

5 Northwest HIV Care Consortium

6 Piedmont HIV Health Care Consortium

7 Regional HIV/AIDS Consortium

8 Ryan White Foothills Consortium

9 Western North Carolina HIV/AIDS Consortium

10 Jeff Jones HIV Care Consortium of the Albemarle

11 South Central HIV Care Consortium

12 Nantahala AIDS Consortium

13 Nash-Edgecombe-Wilson Counties HIV/AIDS Consortium

14 Down East HIV/AIDS Consortium

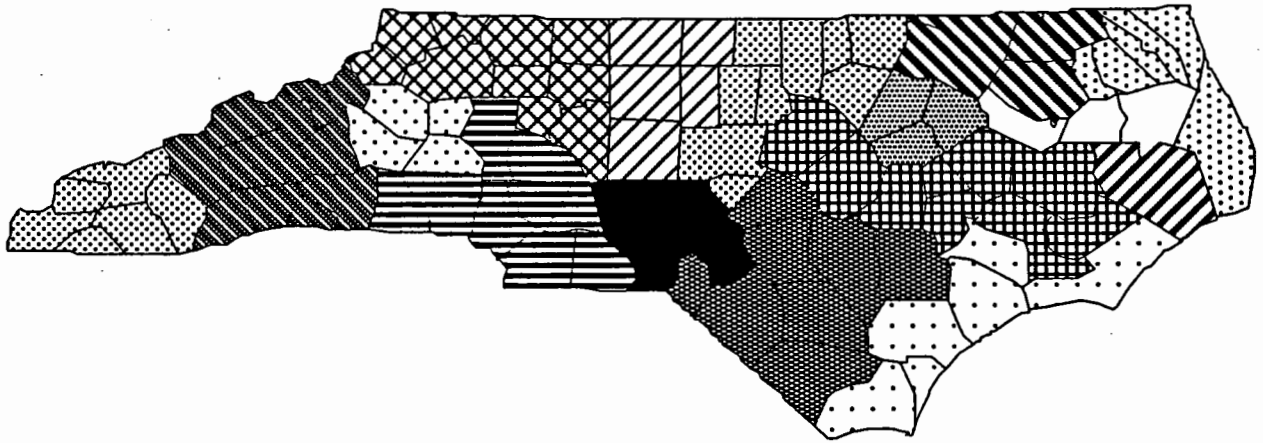
15 Five Area Consortium Team

Care Initiatives: HIV Care Consortia

January 1998

CONSORT

- Coastal
- Dogwood
- Down East
- Eastern
- Eastern Triad
- Five Area
- Jeff Jones
- Nantahala
- Nash–Edgecombe–Wilson
- Northwest
- Piedmont
- Regional
- Foothills
- South Central
- Western
- Split – Down East/Jeff Jones



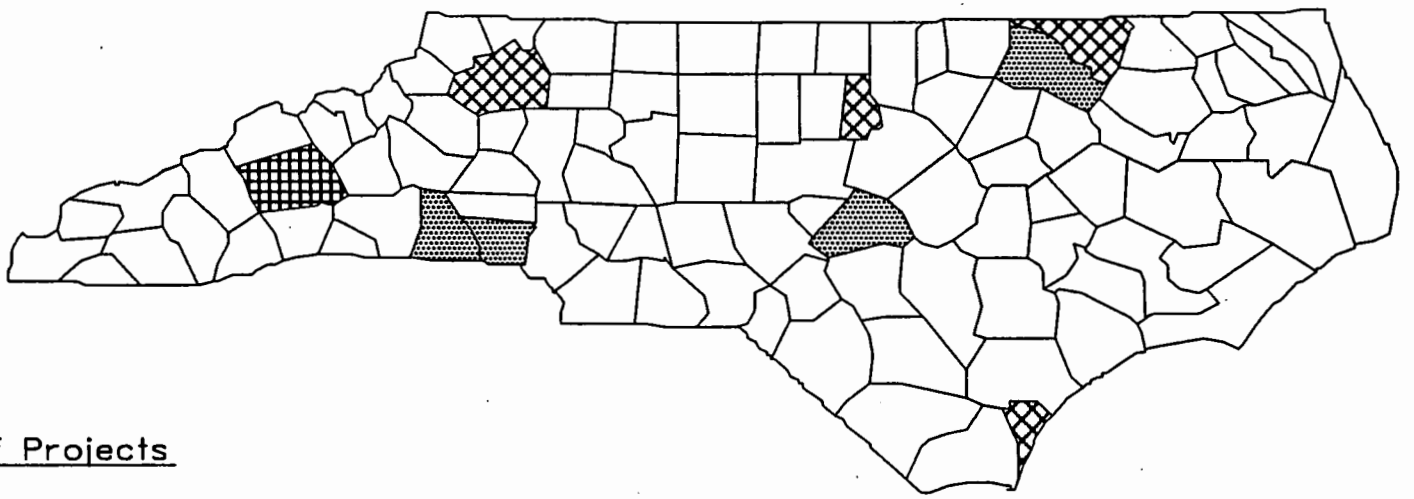
HIV Care Consortia

December 1, 1997

CONSORTIUM	CONTACT	COUNTIES SERVED
Coastal Carolina HIV Care Consortium Onslow County Health Department 612 College Street Jacksonville, NC 28540	Mr. Clinnie Pickett 910-347-2154 910-347-7941 (Fax)	Brunswick, Carteret, Jones, New Hanover, Onslow, Pender
Dogwood Consortium Robeson County Health Department 460 Country Club Road Lumberton, NC 28358	Ms. Sandra Fogleman 910-737-5010 910-737-5011 (Fax)	Bladen, Columbus, Cumberland, Duplin, Harnett, Robeson, Sampson, Scotland
Down East HIV/AIDS Consortium MTW District Health Department 210 West Liberty Street Williamston, NC 27892	Ms. Brenda Mills 919-799-3060 919-799-3098 (Fax)	Hyde, Martin, Tyrrell, Washington
Eastern NC HIV/AIDS Consortium PO Box 30705 Greenville, NC 27833	Ms. Kimberly Scott 919-353-7919/353-6916 919-353-0105 (Fax)	Beaufort, Craven, Greene, Johnston, Lenoir, Pamlico, Pitt, Wake, Wayne
Eastern Triad HIV Consortium 408-B Holly Hill Lane Burlington, NC 27215	Mr. Al Sherman-Huntoon 910-586-0062 910-586-0063 (Fax) ethivc@juno.com (Email)	Alamance, Caswell, Guilford, Randolph, Rockingham
Five Area Consortium Team Northampton County Health Deparment P.O. Box 635 Jackson, NC 27845-0635	Mr. Bob Gosney 919-534-5841 919-534-1045 (Fax)	Bertie, Gates, Halifax, Hertford, Northampton
Jeff Jones HIV Health Care Consortium of the Albemarle PPCC District Health Department P.O. Box 189 Elizabeth City, NC 27907	Ms. Amanda Betts 919-338-4385 919-338-4383 (Fax)	Camden, Chowan, Currituck, Dare, Hyde, Pasquotank, Perquimans
Nantahala AIDS Consortium P.O. Box 61 Franklin, NC 28734-0061	Ms. Nancie Wilson 704-524-9568 704-524-6154 (Fax) nawilson@dnet.net (Email)	Cherokee, Clay, Graham, Jackson, Macon, Swain
Nash-Edgecombe-Wilson Counties HIV/AIDS Consortium P.O. Box 2723 Rocky Mount, NC 27802-2723	Ms. Jo Ann Cook 919-977-1464 919-977-9192 (Fax)	Edgecombe, Nash, Wilson
Northwest Care Consortium United Way of Forsyth County 400 West 4th Street Winston-Salem, NC 27101-7805	Mr. Matt Dyson 910-721-9332 910-724-1045 (Fax) mdyson7411@aol.com (Email)	Alleghany, Ashe, Davidson, Davie, Forsyth, Stokes, Surry, Watauga, Wilkes, Yadkin
Piedmont HIV Health Care Consortium 5th Floor, 331 West Main Street Durham, NC 27701	Ms. Susan Sachs 919-682-3998 919-682-3873 (Fax) piedmonthiv@mindspring.com (Email)	Chatham, Durham, Franklin, Granville, Lee, Orange, Person, Vance, Warren
Regional HIV/AIDS Consortium 229 South Brevard Street Charlotte, NC 28202	Ms. Ellie Perzel 704-371-6342 704-375-7997 (Fax) HIVAIDS13@aol.com (Email)	Anson, Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union
Ryan White Foothills Consortium Grace Health Care System 2201 South Sterling Street Morganton, NC 28655	Ms. Carolyn Sheets 704-438-2000, ext. 2150 704-438-2019 (Fax)	Alexander, Burke, Caldwell, Catawba
South Central HIV Care Consortium Moore County Health Department P.O. Box 279 Carthage, NC 28327-0279	Mr. Bengie Hair 910-947-3300 910-947-1663 (Fax)	Hoke, Montgomery, Moore, Richmond
Western NC HIV/AIDS Consortium P.O. Box 788 Asheville, NC 28802-0788	Ms. Glenda Scofield 704-236-1900 704-236-2005 (Fax) scofield@buncombe.main.nc.us (Email)	Avery, Buncombe, Haywood, Henderson, Madison, McDowell, Mitchell, Polk, Rutherford, Transylvania, Yancey

Care Initiatives: Primary Medical and Dental Care Projects

January 1998



Type of Projects

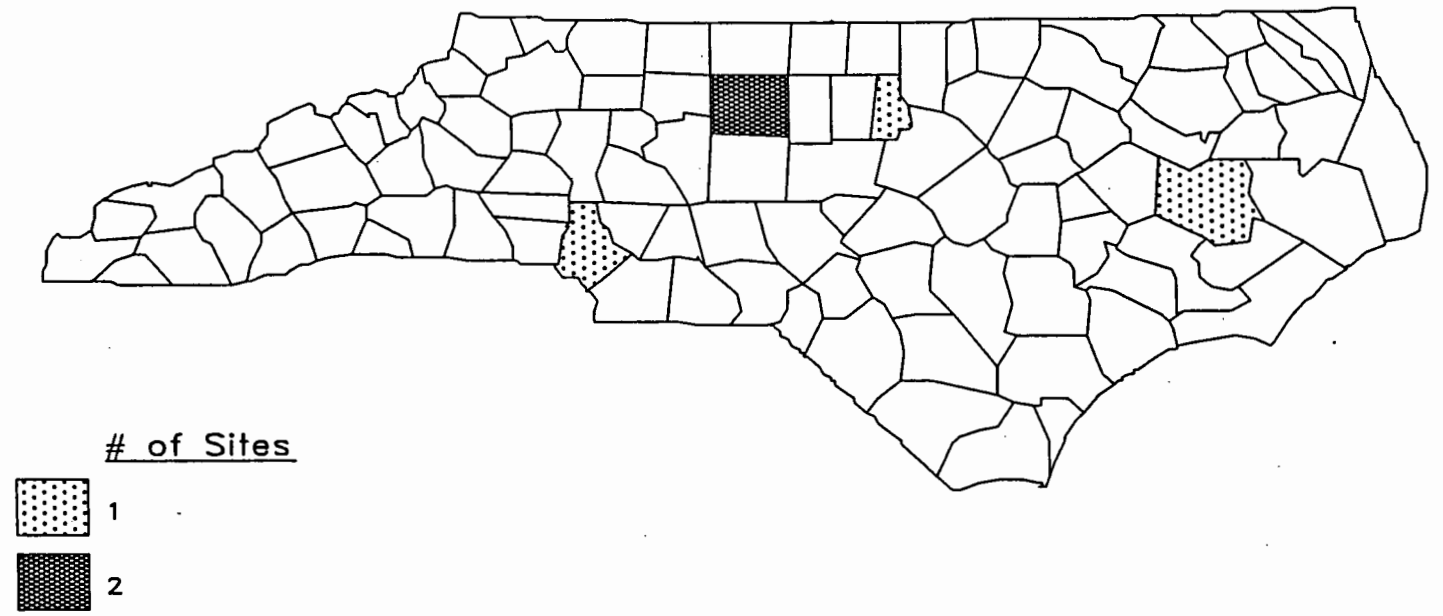
- Mecical Care
- Dental Care
- Both Medical and Dental Care

HIV Primary Medical and Dental Care Projects
1996 & 1997 Ryan White Title II Funds
January 1998

Organization	Contact	PMC/Dental
Cleveland County Health Department 315 East Grover Street Shelby, NC 28150-3998	Beth Moore 704-484-5255 704-484-5220 (Fax)	Both
Gaston Family Health Services, Inc. 991 West Hudson Blvd. Gastonia, NC 28052	Robert E. Spencer 704-853-5261 704-853-5269 (Fax)	Both
Halifax County Health Department PO Box 10 19 Dobbs Street Halifax, NC 27839	Rhonda Hubbard 919-583-5021 919-583-2975 (Fax)	Both
New Hanover Regional Medical Center PO Box 9000 2131 S. 17th Street Wilmington, NC 28402-9000	Fiona Baxter 910-815-5876 910-343-2611 (Fax)	PMC
Piedmont Consortium/Duke Satellite ID Clinic c/o Piedmont Consortium 5th Floor, 331 West Main Street Durham, NC 27701	Susan Sachs 919-682-3998 919-682-3873 (Fax) piedmonthiv@mindspring.com (Email)	PMC
Roanoke Amaranth Community Health Group PO Box 644 1213 N. Church Street Jackson, NC 27845	Bill Remmes 919-534-1024 919-534-2841 (Fax)	PMC
Tri-County Community Health Center PO Box 237 3332 Easy Street Dunn, NC 28334	J. Michael Baker 910-567-5663/6194 910-567-5342 (Fax)	Both
Western NC Community Health Services PO Box 338 (zipcode 28802) 123 Kenilworth Road Asheville, NC 28803	Carlos Gomez 704-285-0622 704-285-9831 (Fax)	Dental
West Wilkes Medical Center 171 West Wilkes Medical Center Dr. Ferguson, NC 28642	Kevin Tebrugge, OD 910-973-7897 910-973-8277	PMC

Care Initiatives: HOPWA Project-based Support Services

January 1998

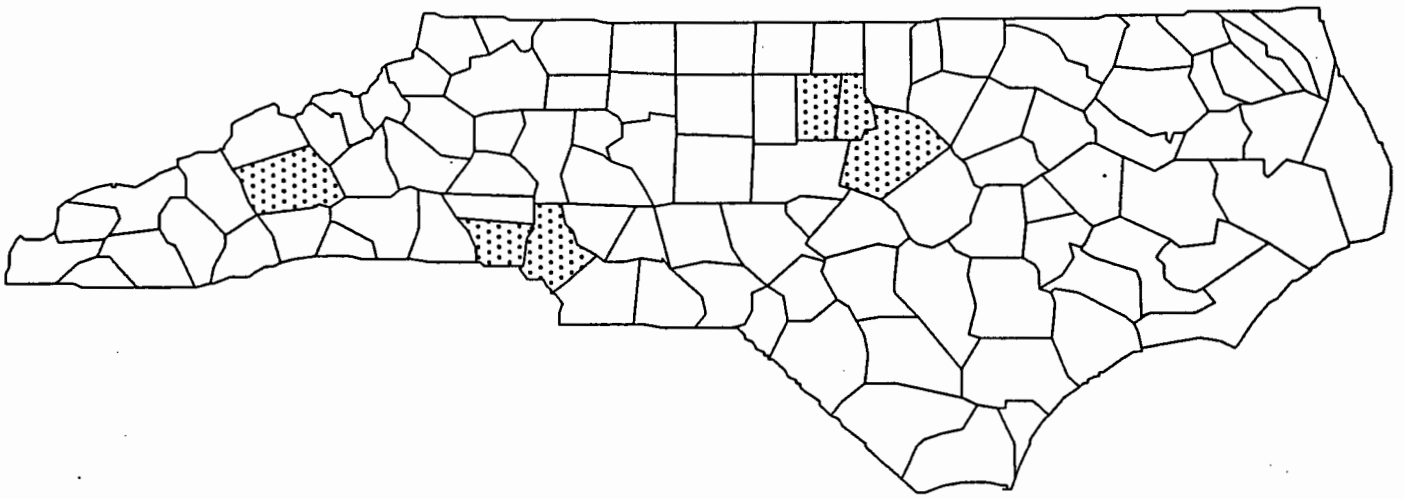


HOPWA RECIPIENTS
PROJECT-BASED SUPPORT SERVICES

ORGANIZATION	CONTACT	NAME OF PROJECT
ACRA PO Box 61854 Durham, NC 27715	Ms. Janice Johnson 919-956-7901 919-956-7718 (fax)	Fitts-Powell Apts. (Note: We also support their family care home)
The Havens Inc. 3115 Creighton Drive Charlotte, NC 28205	Ms. Crystal Patterson 704-531-6753 704-531-7309 (fax)	The Havens Apts.
Triad Health Project 313 South Green Street Greensboro, NC 27401	Mr. Ben McFayden 910-275-1654 910-275-2209	Williams-DeLashmet Apts.
Metropolitan Low Income Housing and CDC, Inc. 102 West Fourth Street PO Box 1706 Washington, NC 27889	Reverend Lynn Bolden 919-946-1668 919-946-8537 (fax)	Metro House Apts. (Note: We also support their adult day health center)
The Servant Center 1312 Lexington Ave. Greensboro, NC 27403	Ms. Gail Haworth 910-275-8585 910-370-1540 (fax)	St. Stephens House (transitional housing)

Care Initiatives: HOPWA Family Care Homes

January 1998



# of Sites

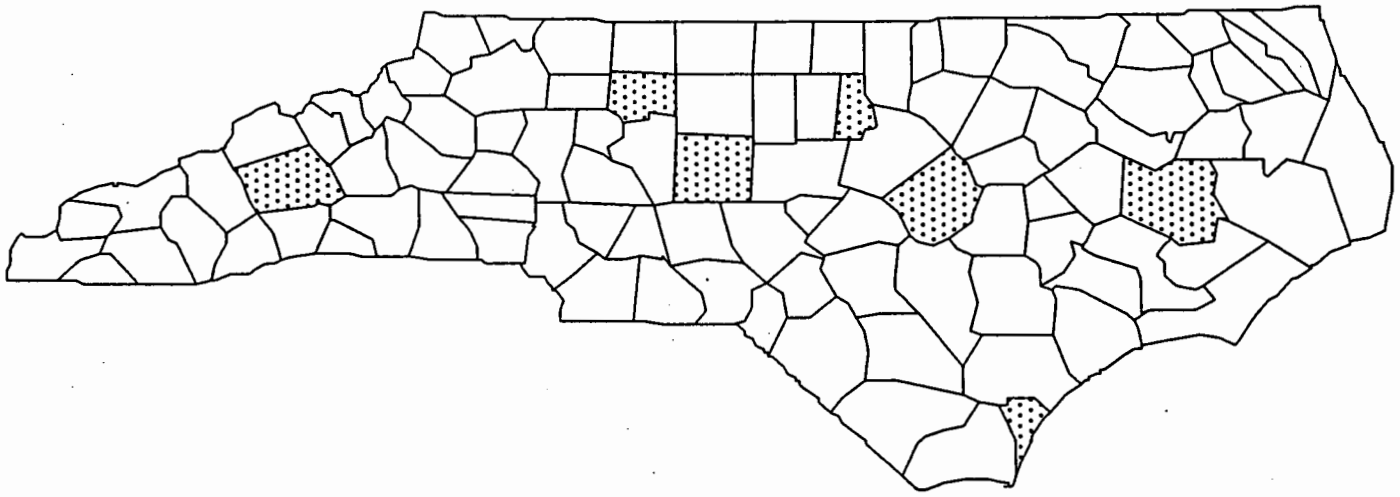
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HOPWA RECIPIENTS
FAMILY CARE HOMES

ORGANIZATION	CONTACT	NAME OF HOME
ACRA PO Box 61854 Durham, NC 27715	Ms. Janice Johnson 919-956-7901 919-956-7718 (fax)	Blevins House (Note: We also support their independent apartment complex
House of Mercy Inc. 701 Mercy Drive PO Box 808 Belmont, NC 28012	Mr. Stan Patterson 704-825-4711 704-825-9976 (fax)	House of Mercy
ASA of Orange County PO Box 16574 Chapel Hill, NC 27516	Ms. Donna Deleno 919-967-0009 fax - same	Orange Community Residence
Taylor Home, Inc. PO Box 36512 Charlotte, NC 28236	Ms. Deb Hirsch 704-365-1194 704-365-1812 (fax)	Taylor Home Inc. (Note: Home has not yet opened, but funds have been encumbered)
ASA of North Carolina PO Box 12583 Raleigh, NC 27605	Ms. Jacqueline Clymore 919-834-2537 919-832-8321 (fax)	Hustead House
Western NC Community Health Services PO Box 338 Asheville, NC 28802	Mr. Carlos Gomez 704-285-0622 704-285-9831 (fax)	Marne Road Group Home (Note: This home is specifically designed for those dually diagnosed with HIV and mental illness. We also support their adult day health center)

Care Initiatives: HOPWA Adult Day Care/Day Health Care Centers

January 1998



# of Sites

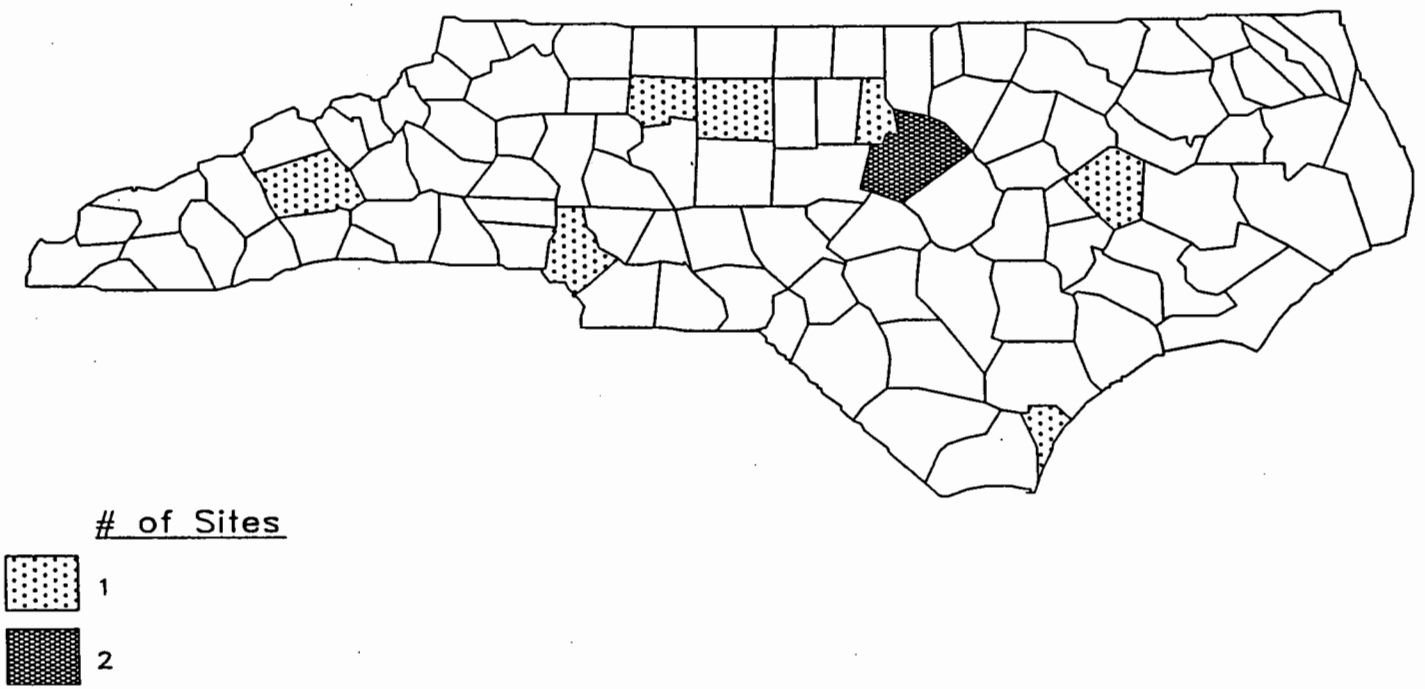
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HOPWA RECIPIENTS
ADULT DAY CARE/DAY HEALTH CARE CENTERS

ORGANIZATION	CONTACT	NAME OF CENTER
Center of Living Home Health and Hospice 416 Vision Drive Asheboro, NC 27203	Mr. Devin Griffith 910-672-9300 ext. 227 fax: 910-672-0868	Enrichment Pointe (day health center)
Western NC Community Health Services PO Box 338 Asheville, NC 28802	Mr. Carlos Gomez 704-285-0622 704-285-9831 (fax)	Kenilworth Wellness Center (day health center) (Note: We also support their family care home for those dually diagnosed with HIV and mental illness)
DAPAA PO Box 2172 Smithfield, NC 27577	Mr. James Wise 919-989-1122 919-989-6617 (fax)	Project Daybreak (day care center)
AIDS Care Service, Inc. PO Box 15401 Winston-Salem, NC 27113	Mr. Larry Roth 910-777-0142 fax: same	AIDS Care Services Adult Day Activities Center (day care center)
HUGGS 114 Lakeshore Drive Durham, NC 27701	Ms. Alice Smith 919-682-8800 fax: 919-956-9800	HUGGS Adult Day Health Center (day health center)
CURE-AIDS of Wilmington 1125 North 4th Street Wilmington, NC 28401	Ms. Belinda Blue 910-251-0744 910-251-8299 (fax)	Covington House (day health center)
Metropolitan Low Income Housing and CDC, Inc. 102 West Fourth Street PO Box 1706 Washington, NC 27889	Reverend Lynn Bolden 919-946-1668 919-946-8537 (fax)	Agape House (day health center)

Care Initiatives: HOPWA Tenant–based Rental Assistance

January 1998



HOPWA RECIPIENTS
TENANT BASED RENTAL ASSISTANCE

ORGANIZATION	CONTACT	COUNTIES SERVED
Asheville Housing Authority PO Box 1898 Asheville, NC 28802	Ms. Marjorie Scavella 704-285-1222 704-254-2276 (fax)	Buncombe
Charlotte Housing Authority PO Box 36975 Charlotte, NC 28236	Ms. Virginia Statton 704-336-5227 704-336-8484 (fax)	Mecklenburg
Commission Of Indian Affairs 217 West Jones Street Raleigh, NC 27603	Mr. W.C. Groves 919-733-5998 919-733-1207 (fax)	Columbus, Granville, Halifax, Hoke, Person, Sampson and Warren
Durham Housing Authority PO Box 1726 Durham, NC 27702	Ms. Debbie Britt 919-683-1551 ext. 238 919-683-1237 (fax)	Durham
Greensboro Housing Authority PO Box 21287 Greensboro, NC 27702	Ms. Revonda Madison 910-275-8501 910-378-1307	Guilford (except High Point)
Greenville Housing Authority PO Box 1426 Greenville, NC 27834	Ms. Sally Streeter 919-830-4000 919-830-3682 (fax)	Pitt
Raleigh Housing Authority PO Box 28007 Raleigh, NC 27611	Ms. Yvette Byrd 919-831-6620 919-831-6160 (fax)	Wake
Wilmington Housing Authority PO Box 899 Wilmington, NC 28402	Mr. Marc Recko 910-341-7700 910-341-7760 (fax)	New Hanover
Winston-Salem Housing Authority 901 Cleveland Avenue Winston-Salem, NC 27101	Ms. Karen Young 910-727-8500 910-777-8508 (fax)	Forsyth

HOPWA RECIPIENTS
CLIENT-BASED SUPPORT SERVICES

HIV Care Consortia

December 1, 1997

CONSORTIUM	CONTACT	COUNTIES SERVED
Coastal Carolina HIV Care Consortium Onslow County Health Department 612 College Street Jacksonville, NC 28540	Mr. Clinnie Pickett 910-347-2154 910-347-7941 (Fax)	Brunswick, Carteret, Jones, New Hanover, Onslow, Pender
Dogwood Consortium Robeson County Health Department 460 Country Club Road Lumberton, NC 28358	Ms. Sandra Fogleman 910-737-5010 910-737-5011 (Fax)	Bladen, Columbus, Cumberland, Dup Harnett, Robeson, Sampson, Scotland
Down East HIV/AIDS Consortium MTW District Health Department 210 West Liberty Street Williamston, NC 27892	Ms. Brenda Mills 919-799-3060 919-799-3098 (Fax)	Hyde, Martin, Tyrrell, Washington
Eastern NC HIV/AIDS Consortium PO Box 30705 Greenville, NC 27833	Ms. Kimberly Scott 919-353-7919/353-6916 919-353-0105 (Fax)	Beaufort, Craven, Greene, Johnston, Lenoir, Pamlico, Pitt, Wake, Wayne
Eastern Triad HIV Consortium 408-B Holly Hill Lane Burlington, NC 27215	Mr. Al Sherman-Huntoon 910-586-0062 910-586-0063 (Fax) ethivc@juno.com (Email)	Alamance, Caswell, Guilford, Randol Rockingham
Five Area Consortium Team Northampton County Health Deparment P.O. Box 635 Jackson, NC 27845-0635	Mr. Bob Gosney 919-534-5841 919-534-1045 (Fax)	Bertie, Gates, Halifax, Her[redacted] Northampton
Jeff Jones HIV Health Care Consortium of the Albemarle PPCC District Health Department P.O. Box 189 Elizabeth City, NC 27907	Ms. Amanda Betts 919-338-4385 919-338-4383 (Fax)	Camden, Chowan, Currituck, Dare, Hyde, Pasquotank, Perquimans
Nantahala AIDS Consortium P.O. Box 61 Franklin, NC 28734-0061	Ms. Nancie Wilson 704-524-9568 704-524-6154 (Fax) nawilson@dnet.net (Email)	Cherokee, Clay, Graham, Jackson, Macon, Swain
Nash-Edgecombe-Wilson Counties HIV/AIDS Consortium P.O. Box 2723 Rocky Mount, NC 27802-2723	Ms. Jo Ann Cook 919-977-1464 919-977-9192 (Fax)	Edgecombe, Nash, Wilson
Northwest Care Consortium United Way of Forsyth County 400 West 4th Street Winston-Salem, NC 27101-7805	Mr. Matt Dyson 910-721-9332 910-724-1045 (Fax) mdyson7411@aol.com (Email)	Alleghany, Ashe, Davidson, Davie, Forsyth, Stokes, Surry, Watauga, Wil Yadkin
Piedmont HIV Health Care Consortium 5th Floor, 331 West Main Street Durham, NC 27701	Ms. Susan Sachs 919-682-3998 919-682-3873 (Fax) piedmonthiv@mindspring.com (Email)	Chatham, Durham, Franklin, Granvill Lee, Orange, Person, Vance, Warren

CONSORTIUM	CONTACT	COUNTIES SERVED
Regional HIV/AIDS Consortium 229 South Brevard Street Charlotte, NC 28202	Ms. Ellie Perzel 704-371-6342 704-375-7997 (Fax) HIVAIDS13@aol.com (Email)	Anson, Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowa Stanly, Union
Ryan White Foothills Consortium Grace Health Care System 2201 South Sterling Street Morganton, NC 28655	Ms. Carolyn Sheets 704-438-2000, ext. 2150 704-438-2019 (Fax)	Alexander, Burke, Caldwell, Catawba
South Central HIV Care Consortium Moore County Health Department P.O. Box 279 Carthage, NC 28327-0279	Mr. Bengie Hair 910-947-3300 910-947-1663 (Fax)	Hoke, Montgomery, Moore, Richmon
Western NC HIV/AIDS Consortium P.O. Box 788 Asheville, NC 28802-0788	Ms. Glenda Scofield 704-236-1900 704-236-2005 (Fax) scofield@buncombe.main.nc.us (Email)	Avery, Buncombe, Haywood, Hender Madison, McDowell, Mitchell, Polk, Rutherford, Transylvania, Yancey

HIV/STD PREVENTION

AND

CARE SECTION

FUNDED

PREVENTION SERVICES

PROVIDED

HIV/STD Prevention & Care Section Funded
Community Based Organization Initiatives

Organization	Contact	Counties Served
OPERATION SICKLE CELL (Minority AIDS Education Project) 2409 Murchinson Road Fayetteville, NC 28301	Mary Mcallister 910-488-6118 910-733-5706 910-488-6810 (fax)	Cumberland
MOUNT SINAI AIDS EDUCATION PROJECT Post Office Box 1962 Thomasville, NC 27361-1962	Pastor E. L. White 910-475-5801 910-475-5633 (fax)	Davidson
GUILFORD COUNTY HEALTH DEPT. 301 North Eugene Street Greensboro, NC 27401	Harold Gabel, MD 910-373-3203 910-333-6807	Guilford
BEAUFORT COUNTY HEALTH DEPT. (Minority AIDS Education Project) 403 North Harvey Street Post Office Box 579 Washington, NC 27889	Tamara Hower 919-946-1902 919-946-8430 (fax)	Beaufort
CASE MANAGEMENT FOR AIDS AND ADDITION THROUGH REFERRALS AND EDUCATON (CAARE) 400 Crutchfield Post Office Box 15567 Durham, NC 27704	Sharon Elliott-Bynum, RN 919-477-4517 919-477-6366 (fax)	Durham
CURE AIDS OF WILMINGTON 1125 North Fourth Street Wilmington, NC 28401	Belinda Blue 910-251-0744 910-251-8299 (fax)	New Hanover
ASHEVILLE ALUMNAE DELTA HOUSE, INCORPORATED 218 South French Broad Avenue Post Office Box 1672 Asheville, NC 28802-1672	Shirley Whitesides 704-254-6804 704-254-6737	Buncombe
METROLINA AIDS PROJECT 227 East Boulevard Post Office Box 32662 Charlotte, NC 28232	Les Kooyman 704-333-1435 704-376-8794 (fax)	Mecklenburg
AIDS SERVICE AGENCY OF NC 324 South Harrington Street Post Office Box 12583 Raleigh, NC 27603	Bill Brent 919-834-2437 919-834-3404 (fax)	Wake
SOUTHLIGHT, INCORPORATED 2500 Blue Ridge Road, Suite #400 Raleigh, NC 27607	Franklin Ingram 919-787-6131 919-571-2932 (fax)	Wake
TRIAD HEALTH PROJECT 313 South Green Street, Suite #200 Post Office Box 5716 Greensboro, NC 27435	Ben Mcfadyen 910-275-1654 910-275-2209	Guilford

HIV/STD Prevention & Care Section Funded
Community Based Organization Initiatives

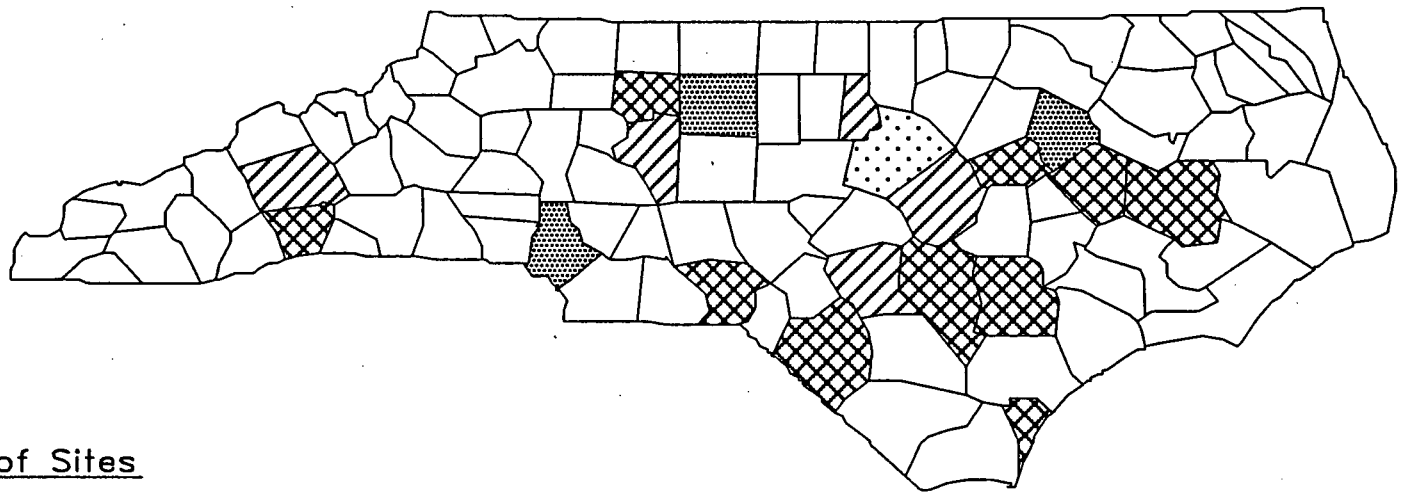
Organization	Contact	Counties Served
DURHAM COUNTY HEALTH DEPT. (Project Straight Talk) 414 East Main Street Durham, NC 27701	Tekola Fisseha 919-560-7760 919-560-7772 (fax)	Durham
BLUE RIDGE COMMUNITY HEALTH US 64 East and Howard Gap Road Post Office Box 5151 Hendersonville, NC 28793	John Dula Interim Executive Director 704-692-4289 704-692-4396 (fax)	Henderson
PRESENT DAY CARES, INCORPORATED 2730 Razzelles Ferry Road Charlotte, NC 28208	Pastor Gwendolyn Curry 704-393-2005 704-336-7587 (fax)	Mecklenburg
SOZO MINISTRIES 1701 Sunset Avenue, Suite #201D Rocky Mount, NC 27804	Rev. Regi Silver 919-985-3614 919-985-2256	Edgecombe
RICHMOND COUNTY HEALTH DEPT. 125 Carolina Street Post Office Box 429 Rockingham, NC 28379	Tommy Jarrell 910-997-8300 910-997-8336 (fax)	Richmond
EDGECOMBE COUNTY HEALTH DEPT. 2909 Main Street Tarboro, NC 27886	James R. Baluss 919-641-7511 919-641-7565 (fax)	Edgecombe
NORTH CAROLINA PWHA COALITION, INCORPORATED 115 Smith Street Post Office Box 1380 Four Oaks, NC 27524	Victor Johnson	Johnson
ROBESON COUNTY HEALTH DEPT. 460 Country Club Road Lumberton, NC 28358	William J. Smith 910-671-3200 910-671-3434 (fax)	Robeson

HIV/STD Prevention & Care Section Funded Non-Traditional Counseling, Testing and Referral Site Initiatives

Organization	Contact	Counties Served
COLUMBUS COUNTY ALCOHOL AND DRUG PREVENTION COALITION(CCADPC) 805 North Franklin Street Post Office Box 1757 Whiteville, NC 28472	Evelyn Troy 910-642-0633 910-642-0712 (fax)	Columbus
DRUGS & AIDS PREVENTION AMONG AFRICAN-AMERICANS, INC. (DAPAA) 612 Raleigh Road Post Office Box 2172 Smithfield, NC 27577	Linda Bell 919-989-1122 919-989-6617 (fax)	Johnson
GUILFORD COUNTY HEALTH DEPT. 301 North Eugene Street Greensboro, NC 27401	Phyllis Stevens, RN 910-373-3202 910-333-6807 (fax)	Guilford
METROLINA AIDS PROJECT (MAP) Post Office Box 32662 Charlotte, NC 28232	Mike Rogers 704-3331435 704-376-8794 (fax)	Mecklenburg
OPPORTUNITIES INDUSTRIALIZATION CENTER, INCORPORATED (OIC) East Virginia Street at Carolina Avenue Post Office Box 2723 Rocky Mount, NC 27802	Willie Powell, Jr. 919-977-3730 919-985-0341 (fax)	Edgecombe
PITT COUNTY HEALTH DEPARTMENT 201 Government Circle Greenville, NC 27834	Dr. John Morrow, MD Health Director 919-413-1305 919-413-1446 (fax)	Pitt
WAKE COUNTY DEPARTMENT OF HEALTH 10 Sunnybrook Road Raleigh, NC 27620	Gibbe Harris Amy Rigney 919-250-4400 919-250-4429 (fax)	Wake
WESTERN NORTH CAROLINA COMMUNITY HEALTH SERVICES (WNCCHS) Post Office Box 338 Asheville, NC 28802	Carlos M. Gomez 704-285-0622 704-285-9831 (fax)	Buncombe
MARTIN-TYRRELL-WASHINGTON DISTRICT HEALTH DEPARTMENT 210 West Liberty Street Williamston, NC 27892	Brenda M. Mills 919-792-7811 919-792-8779 (fax)	Martin
THE ADOLESCENT CONNECTION OUTREACH CENTER Post Office Box 20021 Greensboro, NC 27420	Olivia M. Rowe 910-691-1175 910-691-1807 (fax)	Guilford
WILSON OPPORTUNITIES INDUSTRIALIZATION CENTER, INC. Post Office Box 547 Wilson, NC 27894-0547	Howard Jones 919-291-0038 919-291-7281 (fax)	Wilson

Prevention Initiatives: Community–based Organizations

January 1998



# of Sites

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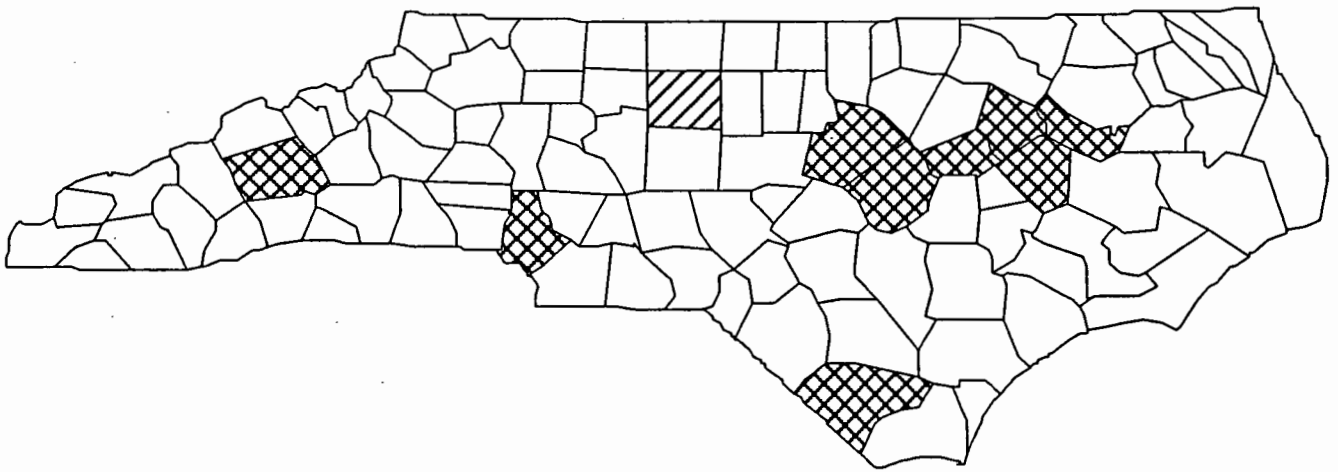
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Prevention Initiatives: Non-Traditional Counseling and Testing Sites

January 1998



# of Sites

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2

HIV/STD PREVENTION AND CARE SECTION
FUNDED
NON-TRADITIONAL COUNSELING, TESTING AND REFERRAL SITE INITIATIVES

COLUMBUS COUNTY ALCOHOL AND DRUG PREVENTION COALITION (CCADPC)
EVELYN TROY
805 NORTH FRANKLIN STREET
POST OFFICE BOX 1757
WHITEVILLE, NORTH CAROLINA 28472
PHONE: (910) 642-0633
FAX: (910) 642-0712

DRUGS & AIDS PREVENTION AMONG AFRICAN-AMERICANS, INCORPORATED (DAPAA)
LINDA BELL
612 RALEIGH ROAD
POST OFFICE BOX 2172
SMITHFIELD, NORTH CAROLINA 27577
PHONE: (919) 989-1122
FAX: (919) 989-6617

GUILFORD COUNTY HEALTH DEPARTMENT
PHYLLIS STEVENS, RN
301 NORTH EUGENE STREET
GREENSBORO, NORTH CAROLINA 27401
PHONE: (910) 373-3202
FAX: (910) 333-6807

METROLINA AIDS PROJECT (MAP)
MIKE RODGERS
POST OFFICE BOX 32662
CHARLOTTE, NORTH CAROLINA 28232
PHONE: (704) 333-1435
FAX: (704) 376-8794

OPPORTUNITIES INDUSTRIALIZATION CENTER, INCORPORATED (OIC)
WILLIE POWELL, JR.
EAST VIRGINIA STREET AT CAROLINA AVENUE
POST OFFICE BOX 2723
ROCKY MOUNT, NORTH CAROLINA 27802
PHONE: (919) 977-3730
FAX: (919) 985-0341

PITT COUNTY HEALTH DEPARTMENT
JOHN MORROW, MD, HEALTH DIRECTOR
201 GOVERNMENT CIRCLE
GREENVILLE, NORTH CAROLINA 27834
PHONE: (919) 413-1300
FAX: (919) 413-1446

WAKE COUNTY DEPARTMENT OF HEALTH
GIBBIE HARRIS
AMY RIGNEY
10 SUNNYBROOK ROAD
RALEIGH, NORTH CAROLINA 27620
PHONE: (919) 250-4400
FAX: (919) 250-4429

WESTERN NORTH CAROLINA COMMUNITY HEALTH SERVICES (WNCCHS)
CARLOS M. GOMEZ
POST OFFICE BOX 338
ASHEVILLE, NORTH CAROLINA 28802
PHONE: (704) 285-0622
FAX: (704) 285-9831

MARTIN-TYRRELL-WASHINGTON DISTRICT HEALTH DEPARTMENT
BRENDA M. MILLS
210 WEST LIBERTY STREET
WILLIAMSTON, NORTH CAROLINA 27892
PHONE: (919) 792-7811
FAX: (919) 792-8779

THE ADOLESCENT CONNECTION OUTREACH CENTER
OLIVIA M. ROWE
POST OFFICE BOX 20021
GREENSBORO, NORTH CAROLINA 27420
PHONE: (910) 691-1175
FAX: (910) 691-1807

WILSON OPPORTUNITIES INDUSTRIALIZATION CENTER, INCORPORATED
HOWARD JONES
POST OFFICE BOX 547
WILSON, NORTH CAROLINA 27894-0547
PHONE: (919) 291-0038
FAX: (919) 291-7281

(HIV/STD)

14

AIDS drug fund is running low

NHO 12/20/97

By Catherine Clabby
STAFF WRITER

AIDS activists are frustrated that state officials haven't replenished a fund that buys life-extending drugs for low-income AIDS patients. If the money runs out, North Carolina could have a new public health threat on its hands, they say.

But health officials vowed on Friday that they will find a way to keep medicine cabinets stocked for patients already dependent on the fund — no matter what.

"Those people already on the drug treatment will not have a lapse," said Bill Furney, a spokesman for the Department of Health and Human Services.

Like several other states, North Carolina was blindsided this year by steep increases in the cost of medication used to slow the development of deadly AIDS in people infected with the HIV virus.

New drug cocktails — mixtures of protease inhibitors and other treatments — help many patients stay healthy and live longer. But they are very costly, as much as $1,500 a month. And the $3.4 million the state set aside to cover drug bills was spent long before the end of the fiscal year.

Health and Human Services officials are appealing a state budget office refusal to free up an account identified as a potential source of extra funding. If that doesn't work, they'll find the money elsewhere, Furney said.

Activists say the funding is essential for many reasons. Most pressing is the expectation that if people stop taking their medication, they are likely to develop drug-resistant strains of the virus. If such strains get spread, they are tough to treat.

Also, the cost of treating a person with full-blown AIDS is higher than the cost of the drugs, they say. And when a life-saving medical technology is available, all people should have a shot at it.

"You hope your government will help you," said Coleman Temple, a 34-year-old Durham resident who has the virus. "If it doesn't, you don't have much security."

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lia. Earlier, President Clinton spoke confidently about trade issues. Page A6.

AIDS Drugs Give Little Hope To Thousands Unable to Pay

By SHERYL GAY STOLBERG

MIAMI — The doctor's chicken scratch is barely legible, but to Luis Figueroa the scribbles on the little white slips of paper are precious. They are prescriptions for powerful new AIDS medications that once miraculously revived Mr. Figueroa, who was so close to death last year that his parents brought in a priest in case he needed last rites.

But there is a problem with the prescriptions. Mr. Figueroa cannot afford to fill them, and the government cannot afford to fill them for him.

The three-drug cocktail costs nearly $12,000 a year — a sum that is beyond the reach of Mr. Figueroa, an unemployed 33-year-old printer who recently moved here from Washington, leaving his health insurance behind. On a recent morning, he went looking for help at a social service agency for people infected with H.I.V., but he found little solace.

There, a counselor told him that the Federal-state partnership that pays for AIDS drugs for the indigent was broke in Florida, as it is in 25 other states. It can pay for two of his antiviral medications, but not for the protease inhibitor, the most powerful drug in his combination.

LEFT BEHIND

The Destitute

"It's a matter of waiting and hoping," the social worker, Gilberto Robledo, said as Mr. Figueroa tapped his feet nervously on the floor. Mr. Robledo told Mr. Figueroa that his name would be placed on a waiting list. He did not tell him that the Florida list had 600 names.

So did Mr. Figueroa fall through the cracks of the AIDS drug revolution, and he is one of many. It has been 18 months since protease inhibitors came into widespread use in this country, helping to transform AIDS from a death sentence to a chronic but treatable disease for many patients, Mr. Figueroa included.

But the new drugs are expensive, and experts say tens of thousands of people who could benefit from state-of-the-art AIDS therapy do not receive it.

The reasons are varied. Some people with H.I.V., the virus that causes AIDS, do not seek treatment. Others have yet to learn of combination therapy. And because the protease-

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Miracle AIDS-Fighting Drugs Elude (

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inhibitor regimen is complex — up to 30 pills a day, some with food, some without — some doctors are purposely withholding the drugs from unstable patients, fearing they will miss their doses and, as a result, help the virus become resistant.

But as H.I.V. continues to spread among the poor, experts say, the main obstacle is increasingly money.

"I call it the therapeutic haves and the therapeutic have-nots," said Dr. Arthur Ammann, president of the American Foundation for AIDS Research. "Anybody who walks into a pharmacy in a poor neighborhood and looks at the line of people who are trying to negotiate which drugs they can or cannot get understands this."

Longer Lives for Some, No Benefits for Others

The problem is generating a host of complex public policy issues as well as anxiety for patients like Mr. Figueroa, who is hoping that his doctor will persuade a drug company to give him the medicine free.

As word of the benefits of the new medications spreads, clinics are jammed with patients who, imbued with a sense of hope, are eager for the drugs. Many are poor, and many have shunned treatment in the past.

At the same time, the fact that protease inhibitors have helped keep so many people alive is depriving others of benefits.

Enrollment in the AIDS Drug Assistance Program, the Federal-state partnership that provides the drugs to the needy, has exploded with the arrival of protease inhibitors. The rosters in some states have climbed as much as 2,000 percent, said Richard Jefferys of the AIDS Data Treatment Network, an advocacy group in New York.

And as patients live longer, there is barely any turnover in the program. In many parts of the country, precious slots are full, and state officials, short of cash, are faced with a wrenching problem: whether to cover all the drugs for some patients or some drugs for all.

"People are not dying as rapidly, so they are not opening up spaces," said Dr. Patricia Hawkins of the Whitman-Walker Clinic in Washington, which treats and counsels people with AIDS. "There is so much hope in these medications, and then you have to tell people they can't get on it yet. It's very frustrating."

The problem is particularly acute in Florida, the state with the third-highest AIDS caseload, after New York and California. As Mr. Figueroa tries to remain calm — "If I worry, I get stressed, and it's no good for me," he said — he knows that the longer he goes without his medicine, the worse his condition is likely to become.

Other patients are growing angry.

"I feel stuck," said Mica Paris, 28, who is also on the Florida waiting list.

Ms. Paris was tested for H.I.V. as part of an outreach program run by the Health Crisis Network, the same agency where Mr. Figueroa sought assistance. Medicaid turned her down, and she says she has no money to fill her prescription.

"The whole purpose of me getting tested was to get treatment and help," Ms. Paris said. "I guess I'm not going to get help until I'm damn near dead."

According to the Federal Centers for Disease Control and Prevention, 750,000 Americans are infected with H.I.V., and fewer than 1 in 5 of them have private health insurance. Roughly half are insured by Medicaid or other government programs, but 29 percent have no insurance at all.



Susan Greenwood for The New York Times

Luis Figueroa, left, who has been trying unsuccessfully for months to get state-of-the-art AIDS therapy, being counseled by his case manager, Gilberto Robledo, at the Health Crisis Network in Miami.

'Greyhound Therapy' And Red Tape's Toll

Access to the drugs varies from state to state and even from county to county, contributing to what one expert called "Greyhound therapy," a tendency of some patients to move to where the drugs are.

If a patient and his doctor are aggressive, experts say, they can generally find a way to get the protease inhibitors through a patchwork of government assistance, clinical trials or, as a last resort, the pharmaceutical industry, which donates drugs through its "compassionate use" programs.

But sometimes the red tape proves overwhelming, and patients give up.

At the same time, drug companies, which say the high prices are necessary to recover millions of dollars that they are spending on research, are themselves feeling squeezed. They are inundated with requests from doctors and even state governments for free medicine.

The North Carolina drug program, for instance, closed to new patients at the beginning of October. And the Colorado program will run out of money in December, three months before the end of its fiscal year; after that, Colorado will ask drug companies to pick up the cost of medications for the 720 patients enrolled.

"We need to bear in mind that there are limits," said Joy Schmitt, a spokesman for Agouron Pharmaceuticals, which makes nelfinavir, a protease inhibitor. Another manufacturer, Hoffmann-La Roche, a subsidiary of Roche Holding Ltd., has closed its compassionate use program to patients in Florida, in an effort to press the state to pay for more.

"The state was zapping so many resources," said a Hoffmann-La Roche spokesman, Jeff Winton, that "some of the other states weren't able to put their patients in."

The Clinton Administration is considering a pilot program to expand Medicaid so that additional people with H.I.V. can get the drugs. Medicaid covers the protease inhibitors, but at present only people who are disabled by AIDS are eligible.

That policy flies in the face of what doctors know about the drug cocktails: that patients benefit the most when they begin taking them in the early stages of the disease.

"You've got to get yourself really sick so you can qualify to be totally disabled so you can get the medicine that might have been able to save you," said Dr. Hawkins, of the Whit-

Grasp of Many Thousands of the Poor

Left Behind

This is the last of three articles that have appeared since Aug. 22 on AIDS patients who have not fully benefited from the discovery of a powerful new class of drugs, protease inhibitors, that has revolutionized the treatment of AIDS.

man-Walker Clinic in Washington. "It's a crazy system."

It was into this bureaucratic netherworld that Mr. Figueroa plunged when he decided over the summer to leave Washington for a warmer region. His predicament illustrates the stresses that uninsured, often desperately ill patients face as they struggle to get medications.

Mr. Figueroa, who was born in Honduras, immigrated to the United States with his parents 11 years ago and worked as a printer. In 1989, he found out that he was H.I.V.-positive. His employer covered his medical care.

But in 1995 he developed AIDS-related pneumonia and had to quit his job. He has no idea whether he is eligible for Medicaid; he says he never realized that he could apply.

Instead, he sought help from a friend who owned a business and who included Mr. Figueroa in the company's insurance plan, as an employee. Looking back, Mr. Figueroa acknowledges that the arrangement was not quite legitimate, and says he was never comfortable with it. But he was desperate.

By February 1996, the normally stocky young man was thin and wasting away. His count of T cells, which are crucial to fighting off infection, had fallen to 7. A normal count is more than 500.

He did not have the strength to rise from his bed to go to the bathroom. Thrush, a yeast infection, coated his throat, making it impossible for him to eat. "Basically," Mr. Figueroa said, "I was dying."

Then indinavir, a new protease inhibitor manufactured by Merck & Company, was approved by the Food and Drug Administration. His doctor prescribed the drug in a cocktail with two other antiretroviral medications, and before long Mr. Figueroa had become another AIDS miracle, one of legions of patients whose health was seemingly restored by protease inhibitors.

His viral load dropped to 4,000 copies per cubic milliliter of blood, from 49,000. But by this summer, after he had spent more than a year on the drug, the numbers had started creeping up again.

It was about this time that Mr. Figueroa decided to move. The decision to give up his health insurance was not easy, but he feared another cold winter in Washington. He knew of patients who were receiving their medicine through government programs, and he thought he could do the same.

Had he moved to New York or California, he might have had an easier time. Those states, with the largest AIDS caseloads in the nation, have vastly increased their contributions to the AIDS Drug Assistance Program to cover all poor patients.

But Florida, which this year received $27 million in Federal money for the program, has not been so generous: the state contributes $2 million, while state health officials estimate the need at $12 million.

As a result, said Thomas Liberti, who runs the AIDS program at the State Health Department, Florida recently capped enrollment. Those who are already receiving the protease inhibitors may continue, but no new patients are being added.

"All you have to do is look at the math," Mr. Liberti said, "to know that we don't have enough money to go around."

That was a surprise to Mr. Figueroa, but it is no surprise to the doctors at the AIDS clinic at South Shore Hospital, the small community hospital in South Beach where he is being treated. About 85 percent of all the patients there lack health insurance. The Federal Government pays their medical bills with money from the Ryan White Care Act.

Most South Shore patients in combination therapies receive their drugs, free from pharmaceutical companies, said Dr. Jose Hernandez, who treats Mr. Figueroa. But getting approval takes time.

"The patient has to go see his case manager," Dr. Hernandez said. "The case manager fills out the report. It comes back to me. I fill out my part, I give it back to the case manager, I'm writing prescriptions that I know are not going to be immediately filled."

Although his doctor is optimistic that he will eventually get the drugs, Mr. Figueroa is growing weary of the wait. It has been nearly a month since he picked up his prescriptions.

When he visited Mr. Robledo at the Health Crisis Network in late September, Mr. Figueroa said, he expected to receive his medication right away. He left three hours later empty-handed, with instructions to ask his doctor for a copy of the test showing his viral load — the H.I.V. level — and a letter explaining the need for the medicine.

"It's a runaround situation," Mr. Robledo acknowledged, "a back-and-forth kind of thing."

Early in October, Mr. Figueroa returned. He came away discouraged. He was not feeling well, he said, and was starting to worry about his health.

"Gilberto tried to help me," Mr. Figueroa said, "but we just filled out more forms. I have a cold, and I can't sleep thinking about all these things."

HIV
Prevention Community Planning Epidemiologic Profile for North Carolina

Epidemiology and Special Studies Branch

HIV/STD Prevention and Care Section

Division of Epidemiology

Post Office Box 29601
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Epidemiologic Profile for HIV Prevention and Community Planning

I. INTRODUCTION

This epidemiologic profile is designed to provide a thorough understanding of the HIV epidemic among the various populations in North Carolina. The majority of the data presented in this profile is drawn from the surveillance systems maintained by the HIV/STD Prevention and Care Section. We have attempted to integrate other appropriate data sources in the analysis and discussion presented.

In developing this profile, we have attempted to answer four key questions:

1. What are the sociodemographic characteristics of the population?
2. What is the impact of HIV/AIDS on the population?
3. What is the risk for becoming infected with HIV?
4. What is the geographic distribution of HIV infection?

In order to produce an accurate profile, it is critical to consider data limitations when evaluating identified trends and patterns. Data collection systems vary in completeness and relevancy. Also caution must be exercised when extrapolating trends from reported cases to the population at large.

Information regarding AIDS and HIV positive cases reported in this profile is from the HARS (HIV/AIDS Reporting System) surveillance system maintained by the Epidemiology and Special Studies Branch, HIV/STD Prevention and Care Section. While AIDS cases reflect the HIV infections that occurred in earlier years, examination of trends in AIDS cases can draw attention to emerging patterns in the HIV epidemic. Traditionally the median time from HIV infection to development of AIDS is approximately 10 years. Some people develop AIDS in as few as three years after infection, thus, emerging patterns may be seen earlier than the commonly cited 10-year lag. However, due to the rapid developments in the field of antiretroviral therapy, we anticipate an increase in the time between which a person learns of their serostatus and the development of the condition we know as AIDS. With these dramatic improvements available, progression to AIDS may ultimately be a surrogate measurement for the lack of appropriate care for HIV-infected individuals.

A significant portion of both AIDS and HIV cases are reported without an identified transmission mode. Many of these cases have been investigated but do not meet the criteria to be reported as one of the CDC-defined risk categories. Amendment of existing categories and/or additional categories are needed to facilitate identification of trends and patterns in North Carolina's epidemic. Historically (nationally) the largest proportion of male cases initially reported as no risk identified were later reclassified male to male sexual contact, followed by injecting drug use and heterosexual contact. Most female cases initially reported as no risk identified are generally reclassified as heterosexual contact followed by injecting drug use. However, anecdotal data from North Carolina indicates those increasing numbers of the AIDS and HIV cases reported with no specified risk may be the result of heterosexual transmission (which includes individuals

who reported multiple heterosexual partners and exchange of sex for drugs and/or money). The extent to which analysis of trends in AIDS/HIV exposure categories is compromised by the large proportion of cases reported with no risk identified depends on the extent to which AIDS/HIV transmission is changing over time.

II. SOCIODEMOGRAPHIC CHARACTERISTICS OF NORTH CAROLINA

Based on the 1990 Federal Census and Census Bureau projections through the year 2000, North Carolina remains the tenth populous state in the United States. For the first time in history, at the time of the 1990 census, over half of the North Carolina population is urban. The Census Bureau defines urban according to specific criteria. Urban population includes all persons living in urbanized areas and all persons living in places of 2,500 or greater population outside of urbanized areas. An urbanized area has a population of 50,000 or more inhabitants and consists of two parts: (1) a central city which is usually the largest incorporated place within the urbanized area, and (2) the surrounding, closely settled, contiguous territory, called the urban fringe (suburbs). The rural population is all those persons who do not live in an area defined as urban. Nationally, a greater percentage of the population is urban. While just over half of the state's population is urban, it is still a very rural state, ranking third behind Pennsylvania and Texas in the number of rural residents and 46th in the percent of urban population.

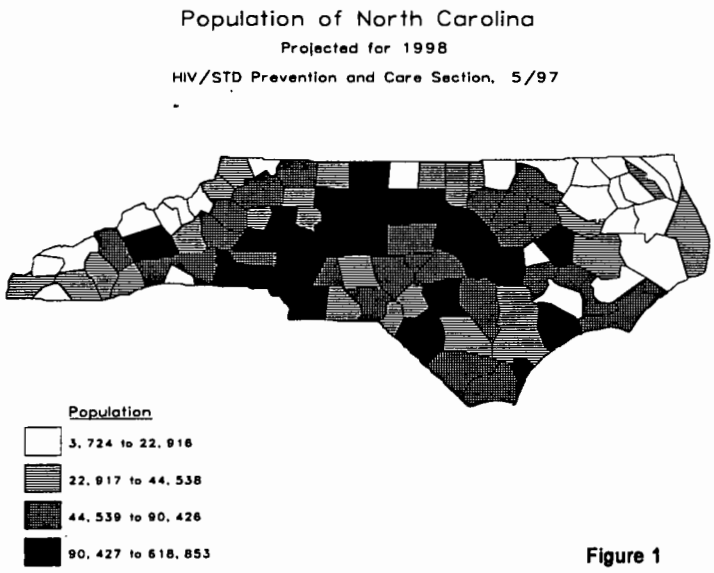


Figure 1

The North Carolina Office of State Planning projects the 1998 population as 7,543,001. Over half of the state's population will live in sixteen of the one hundred counties in North Carolina (Mecklenburg, Wake, Guilford, Cumberland, Forsyth, Durham, Buncombe, Gaston, Onslow, Davidson, New Hanover, Catawba, Pitt, Rowan, Randolph, and Alamance). Eight counties will have a population less than 10,000 (Alleghany, 9,472; Camden, 6,587; Clay, 8,102; Gates, 9,988; Graham, 7,654; Hyde, 4,986; Jones, 9,566; and Tyrrell, 3,724). Figure 1 displays the population distribution among the counties in North Carolina.

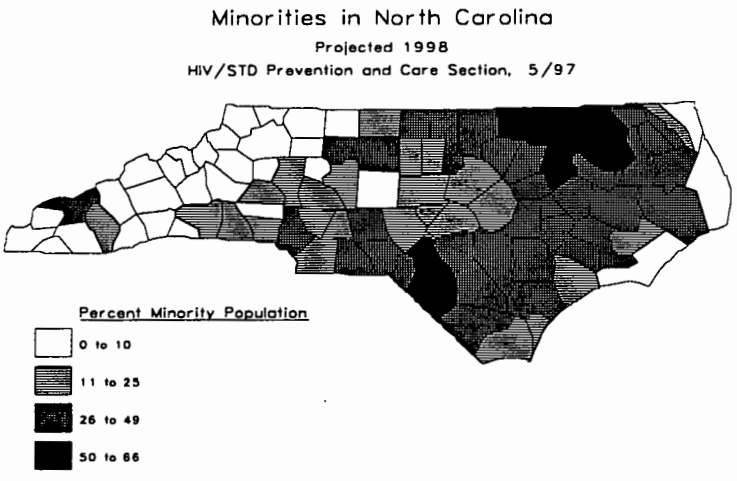


Figure 2

North Carolina has the 7th largest racial/ethnic minority population in the United States. The North Carolina Office of State Planning projects the 1998 racial/ethnic minority population as 1,826,458. According to 1998 projections, eight counties will have a population that is more than 50% racial/ethnic minorities (Bertie, 63.6%; Edgecombe, 60.4%; Halifax, 55.4%; Hertford, 61.7%; Hoke, 57.3%; Northampton, 58.1%; Robeson, 66.2%; Warren, 60.1%). Figure 2 displays each county's racial/ethnic minority population as a percentage of the total population.

North Carolina has both a relatively low per capita income and low unemployment rate. These two statistics suggest that while many citizens are employed in North Carolina, they work at low paying jobs.

In 1994, 14.2% of all persons in N.C. had an income below the poverty level, as compared to 14.5% for the U.S. population. This places North Carolina 18th among all states in percentage of persons with income below poverty level. According to the Bureau of Labor Statistics, the North Carolina unemployment rate was 4.9% in January 1996. Seventy percent of adults aged 25 and above have attained a high school degree (42nd in the U.S.) as compared with 75.2% for the U.S. as a whole.

According to the Bureau of Economic Analysis , the per capita income for 1996 in North Carolina was $22,010, 91% of the national average of $24,231. This places North Carolina 32nd in the U.S. for personal per capita income and represents a 20.5% increase in per capita income since 1992.

III. THE IMPACT OF HIV/AIDS ON THE POPULATION

Demographics and Risk

In most of the subsequent discussions of HIV/AIDS data, HIV infections are counted as those infections that have not progressed to AIDS and are based on the date reported to the HIV/STD Prevention and Care section. However, there are some figures that do indicate HIV cases that

have progressed to AIDS, and cases first reported as AIDS as three distinct entities. These figures will be clearly labeled so the reader is aware of the different treatments of the data.

AIDS became reportable in North Carolina in 1984. As of December 31, 1996, 7,255 cases of AIDS had been reported in North Carolina. The majority of North Carolina's reported AIDS cases were in adults and adolescents as only 104 cases have been reported in infants and children younger than 13. The ethnicity of the AIDS epidemic has shifted from 48% African American among cases reported between 1984 and 1989 to 69% African American among cases reported between 1994 and 1996 (Table 1).

More than 80% of the AIDS cases reported were among males (89% between 1984 and 1989, 83% from 1990 to 1993 and 79% from 1994 to 1996). African American males made up 65% of male AIDS cases reported between 1994 and 1996 and African American females made up 83% of female AIDS cases reported during the same time frame. This represents a significant increase for African American males from 45% in 1984 - 1989 but little change for African American females from 82% in 1984 - 1989. This shift in AIDS reports to African Americans was predicted by the HIV reports which showed 75% of males with HIV reported between 1990 and 1993 were African American and 81% of females reported with HIV from 1990 to 1993 were African American (Table 2). The proportion of HIV infections reported from African Americans have remained fairly stable over time, indicating that the AIDS case distribution will soon stabilize also at approximately the same ratio. For female cases, we predict the ratio will remain steady at about 83% while for males we can expect a short term increase from 65% to 70% African American cases.

Table 3 shows the proportion of male AIDS cases attributed to male to male sexual contact has decreased from 60% of cases reported between 1984 and 1989 to 49% of cases reported from 1990 to 1993 and 41% of cases reported between 1994 and 1996. In addition, in the first time period, 8% of male cases were attributed to both male to male contact and IV drug use whereas in the most recent time period (1994 to 1996) this percentage decreased to 6%. Likewise, the proportion of male cases attributed to IV drug use increased from 17% in the first time period to 22% during the most recent time period. For females, the proportion attributed to IV drug use decreased from 46% in 1984 to 1989 to 31% between 1994 and 1996. For females, the proportion attributed to heterosexual contact increased from 36% between 1984 and 1989 to 39% between 1994 and 1996. The proportion of cases attributed to blood products among both sexes has decreased from 7% in 1984 to 1989 down to 2% in the 1994 to 1996 time period. The proportion of cases for which there is No Identified Risk (NIR) (according to the CDC definition) has remained higher among females than among males in every time period, and for both sexes combined constituted 21% of cases during the 1994 to 1996 time period. Some of these cases are under investigation at this time and may be reclassified to one of the risk groups listed. Investigation of transmission risk of some cases has revealed that while there is no CDC-defined attributed risk, there are behaviors and factors that should be considered for these cases. It is our belief that while it is true that with in depth follow-up interviews and investigation of sexual partners it may be possible to reclassify many cases as heterosexual based on the CDC

guidelines, there is a growing proportion of these cases where the partner may be infected and be unaware of his or her HIV status. We believe that in guiding the planning for HIV Prevention, we must not ignore this behavior or misstate it as risk not identified. It is truly the behavior of experiencing multiple partners or exchanging sex for drugs or money that has put many of the people reported at risk for HIV infection. If we continue to only accept heterosexual transmission as occurring when the index case knows the serostatus of a partner, we will under represent the influence of heterosexual transmission.

Table 1
AIDS in North Carolina
By Race and Ethnicity

	1984 - 1989		1990 - 1993		1994 - 1996	
	Cases	Percent	Cases	Percent	Cases	Percent
Males	1045	89% of total cases	2519	83% of total cases	2419	79% of total cases
White	543	52	1023	41	768	32
African American	474	45	1430	57	1563	65
Hispanic	15	1	40	2	55	2
Asian	3	0	6	0	7	0
Indian	7	0	14	0	21	1
Unknown	3	0	6	0	5	0
Females	130	11% of total cases	500	17% of total cases	642	21% of total cases
White	21	16	73	15	96	15
African American	107	82	417	83	535	83
Hispanic	2	2	3	1	6	1
Asian	0	0	2	0	0	0
Indian	0	0	5	1	5	1
Unknown	0	0	0	0	0	0
Both Sexes	1175	100	3019	100	3061	100
White	557	47	1096	36	864	28
African American	567	48	1847	61	2098	69
Hispanic	16	1	43	1	61	2
Asian	3	0	8	0	7	0
Indian	7	0	19	1	26	1
Unknown	3	0	6	0	5	0

Table 2
HIV (non-AIDS) in North Carolina
By Race and Ethnicity

	1990 - 1993		1994 - 1996	
	Cases	Percent	Cases	Percent
Males	2564	69.3% of total	2146	63.5% of total
White	585	22.8	517	24.1
African American	1912	74.6	1574	73.3
Hispanic	17	0.7	22	1
Asian	6	0.2	6	0.3
Indian	26	1	16	0.7
Unknown	18	0.7	11	0.5
Females	1133	30.6% of total	1232	36.5% of total
White	200	17.7	188	15.3
African American	915	80.8	1020	82.8
Hispanic	0	0	6	0.5
Asian	1	0.1	4	0.3
Indian	13	1.1	10	0.8
Unknown	4	0.4	4	0.3
Both Sexes	3697	100	3378	100
White	785	21.2	705	20.9
African American	2827	76.5	2594	76.8
Hispanic	17	0.5	28	0.8
Asian	7	0.2	10	0.3
Indian	39	1.1	26	0.8
Unknown	22	0.6	15	0.4

Table 3
Adult and Adolescent AIDS Cases in North Carolina
By Risk Groups

	1984 - 1989		1990 - 1993		1994 - 1996	
	Cases	Percent	Cases	Percent	Cases	Percent
Males	1032	89	2494	84	2399	79
MSM	623	60	1222	49	973	41
IDU	173	17	606	24	523	22
MSM + IDU	83	8	180	7	140	6
Heterosexual*	27	3	143	6	256	11
Blood Products	68	6	82	3	45	2
NIR	58	6	261	10	462	19
Females	121	11	469	16	629	21
IDU	56	46	159	34	196	31
Heterosexual*	43	36	211	45	245	39
Blood Products	10	8	27	6	17	2
NIR	12	10	72	15	171	27
Both Sexes	1153	100	2963	100	3028	100
MSM	623	54	1222	41	973	32
IDU	229	20	765	26	719	24
MSM & IDU	83	7	180	6	140	5
Heterosexual*	70	6	354	12	501	17
Blood Products	78	7	109	4	62	2
NIR	70	6	333	11	633	21

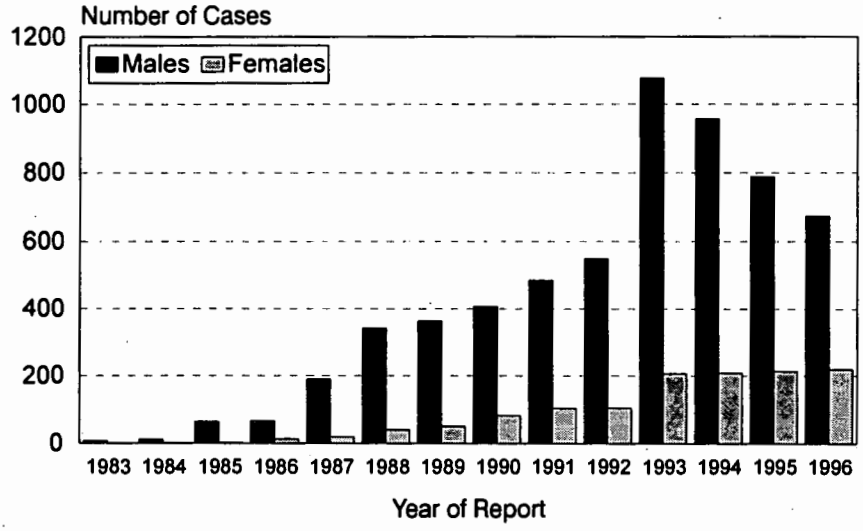
* Includes multiple heterosexual partners, exchange of sex for drugs/money, previous STD diagnosis.

Table 4
Adult and Adolescent HIV (non-AIDS) in North Carolina
By Risk Groups

	1990 - 1993		1994 - 1996	
	Cases	Percent	Cases	Percent
Males	2546	70	2115	64
MSM	708	28	715	33
IDU	493	19	348	16
MSM + IDU	201	8	84	4
Heterosexual*	154	6	585	28
Blood Products	34	1	33	1
NIR	956	38	333	16
Females	1113	30	1233	36
IDU	279	25	181	15
Heterosexual*	248	22	732	59
Blood Products	21	2	40	3
NIR	565	51	260	21
Both Sexes	3659	100	3328	100
MSM	708	19	715	21
IDU	772	21	529	16
MSM & IDU	201	5	84	2
Heterosexual*	402	11	1314	39
Blood Products	55	1	73	2
NIR	1521	42	613	18

* Includes multiple heterosexual partners, exchange of sex for drugs/money, previous STD diagnosis.

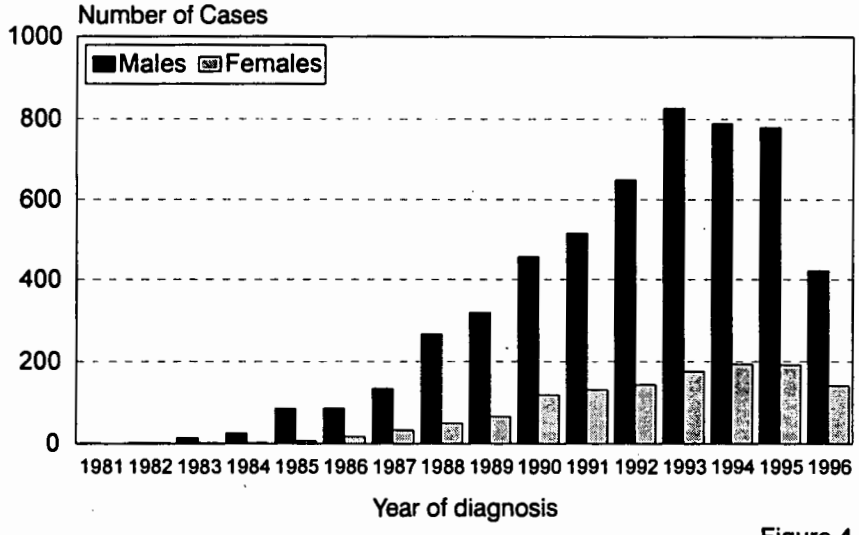
AIDS Cases By Year of Report and Gender



HIV/STD Prevention and Care Section, 6/97

Figure 3

AIDS Cases by Year of Diagnosis and Gender



HIV/STD Prevention and Care Section, 6/97

Figure 4

Figure 3 demonstrates the distribution of AIDS case reports over the past 7 years. There was a change in the case definition of AIDS in 1993 which caused a temporary peak in new AIDS cases reported. However, the number of new AIDS cases reported each year since that time appears to have stabilized and may be dropping. Nationally, new AIDS cases have been decreasing since 1995. This is attributed to the changes in treatment for HIV positive individuals as well as the success of some prevention activities. Figure 4 demonstrates the number of new AIDS cases each year by year of diagnosis, rather than year of report. From an epidemiological point of view, this is a better method to follow the trends in new cases.

However, because of the reporting delay, the newly diagnosed cases are often not reported to the HIV/STD Prevention and Care Section in a timely manner. For instance, For cases reported between 1990 and 1994, 47% were reported within 3 months of diagnosis, and 78% were

reported within 12 months of diagnosis. By comparison, CDC reports nationally 50% of cases are reported to CDC within 3 months and 80% within one year. Therefore, care must be taken in interpreting Figure 4. Delayed reports mean that cases diagnosed during 1995 and 1996 are still coming in, as well as a few from 1994 and before.

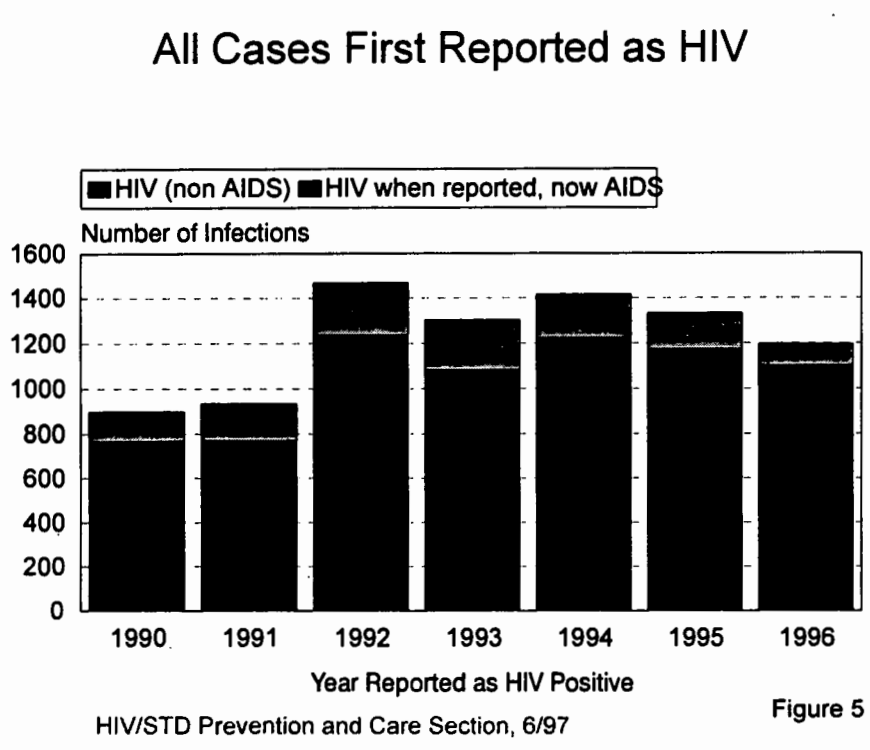


Figure 5

HIV infection was made reportable by name in North Carolina in 1990. Between February 1, 1990 and December 31, 1996, a total of 8,545 HIV infections were reported to the HIV/STD Prevention and Care Section. Of these HIV reports, 1,469 of the individuals originally reported as HIV positive have subsequently been reported with an AIDS-defining condition. Figure 5 shows the number of HIV cases reported by year. This chart includes those cases that have progressed to an AIDS diagnosis. There was a dramatic increase from 1991 to 1992 in the number of cases reported, and the total number of cases reported per year has declined slowly since 1992. An interesting correlation to note is that 1992 was the peak year for HIV seropositivity among women who gave birth in North Carolina (data from the Survey in Childbearing Women) and was also the peak year for syphilis cases reported in North Carolina.

Table 2 details the HIV infections reported by race and sex over three time periods since 1990. Again, the majority of HIV reported remains among African Americans, with 73% of the males reported between 1994 and 1996 and 83% of females reported in that time period being African American. The rates have not changed appreciably since the earlier time period.

HIV cases by risk group are presented in Table 4. The proportion of MSM risks has increased from 19% for the 1990 to 1993 time interval to 21% for the 1994 to 1996 interval. Through this time period, the proportion assigned to "no identified risk" has decreased from 42% to 18%. Additionally, for both males and females, the proportion of cases in the heterosexual risk group has increased significantly, from 6% to 28% for males and from 22% to 59% among females.

The proportion of cases due to blood products has increased slightly from 1% for 1990 to 1993 to 2% for 1994 to 1996.

Tables 5 and 6 show the AIDS and HIV rates by region as well as by race, sex and age. The rates for both HIV and AIDS have been decreasing overall and in some of the regions. Regions 1, 5 and 6 have seen a slight increase in the AIDS rate between 1995 and 1996. Regions 1, 2 and 5 have seen a slight increase in the HIV Infection rate during the same time period while the overall rate has remained fairly constant. Reports stratified by region, race, gender and time period are presented in greater detail as Attachment 1 to this section and are intended for the Regional Community Planning Groups to draw from for their regional planning.

Table 5 AIDS in North Carolina Cases and Rate of AIDS by Regions and Population Subgroups							
		1/94-12/94		1/95-12/95		1/96-12/96	
	1995 Population	Cases	Rate*	Cases	Rate*	Cases	Rate*
REGION							
Region 1	774723	76	10	62	8	75	10
Region 2	1531987	200	13	253	17	177	12
Region 3	1425776	227	16	223	16	130	9
Region 4	1453385	363	25	226	16	234	16
Region 5	785240	120	15	75	10	99	13
Region 6	662161	114	17	109	16	126	19
Region 7	532026	64	12	55	10	53	10
Unknown							
North Carolina Total	7165298	1164	16	1003	14	894	12
AGE GROUPS							
Missing age		0	-	0	-	1	-
Under 14	1469462	4	0	11	1	17	1
15 - 19	474999	7	1	3	1	6	1
20 - 29	1116634	218	20	171	15	146	13
30 - 39	1157270	554	48	462	40	388	34
40 - 49	1036744	289	28	264	25	252	24
50 and over	1910189	92	5	92	5	85	4
RACE							
White	5429701	359	7	284	5	221	4
Other	1735597	805	46	719	41	673	39
SEX							
Male	3470231	956	28	789	23	674	19
Female	3695067	208	6	214	6	220	6
Unknown							

* Cases per 100,000 population

Table 6
HIV in North Carolina

Cases and Rate of HIV by Regions and Population Subgroups

		1/94-12/94		1/95-12/95		1/96-12/96	
	1995 Population	Cases	Rate*	Cases	Rate*	Cases	Rate*
REGION							
Region 1	774723	50	6	46	6	65	8
Region 2	1531987	371	24	278	18	303	20
Region 3	1425776	159	11	180	13	162	11
Region 4	1453385	292	20	287	20	236	16
Region 5	785240	151	19	137	17	153	19
Region 6	662161	125	19	107	16	99	15
Region 7	532026	69	13	61	11	48	9
Unknown							
North Carolina Total	7165298	1217	17	1096	15	1066	15
AGE GROUPS							
Missing age		0	-	0	-	0	-
Under 14	1469462	11	1	27	2	18	1
15 - 19	474999	30	6	45	9	32	7
20 - 29	1116634	405	36	329	29	333	30
30 - 39	1157270	493	43	449	39	404	35
40 - 49	1036744	219	21	177	17	226	22
50 and over	1910189	59	3	69	4	53	3
RACE							
White	5429701	233	4	249	5	223	4
Other	1735597	984	57	847	49	843	49
SEX							
Male	3470231	791	23	699	20	656	19
Female	3695067	426	12	397	11	409	11
Unknown		0	-	0	-	1	-

*Cases per 100,000 population

HIV/AIDS-related deaths

Unlike chronic diseases with high death rates such as cancer or cardiovascular diseases, AIDS is a killer of the young and middle-aged. The case fatality rate for the cumulative AIDS reports is 63%, however for those cases diagnosed and reported before 1990, that rate is 87%. Unfortunately, there are several cases where we only learn of the diagnosis at the time the person dies.

The data reported in this section of the profile were collected by the North Carolina Center for Health Statistics. Mortality data are coded from death certificates collected by the State's registrars. Reporting is nearly 100% complete, as death certificates are required for every death in North Carolina. However, the causes of death are based on information recorded by the certifying physician and may be inaccurate or incomplete. Due to under-reporting of certain causes of death, the number of HIV-related deaths and the spectrum of related conditions will be underestimated to some extent. AIDS has increased in ranking as a cause of death among 15-44 year-olds in North Carolina in recent years (Figure 6).

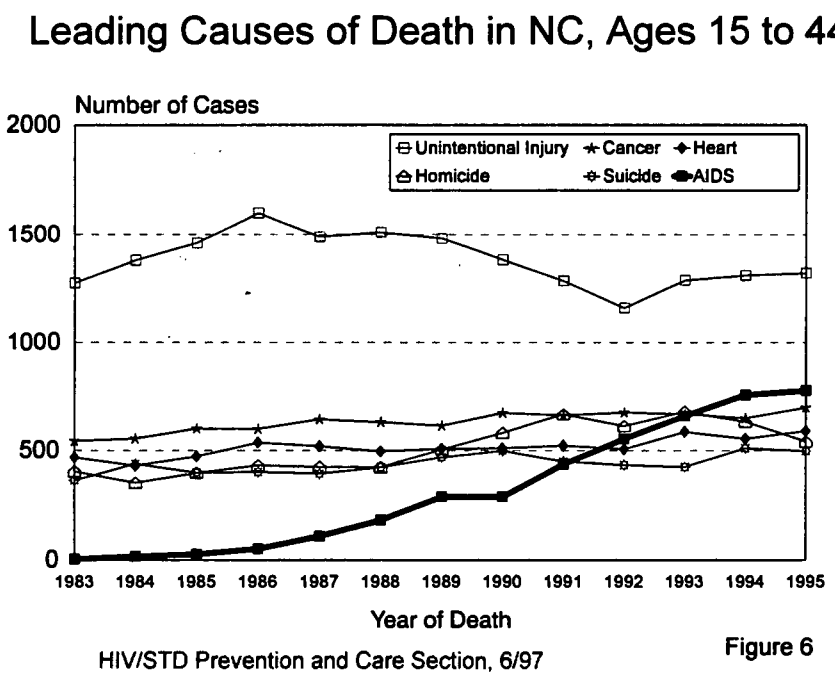


Figure 6

In North Carolina in 1995, for all persons aged 15 to 44, unintentional injury was the leading cause of death (1,322 of 6,126 deaths); AIDS was the second leading cause of death (776 deaths); cancer was the third leading cause of death (698 deaths) and homicide was the fourth leading cause of death (541 deaths). However, AIDS was the leading cause of death in 15 to 44-year-olds in Durham, Forsyth, Guilford, Mecklenburg, New Hanover, Wake and Wilson counties.

Among males aged 15 to 44, AIDS was the second leading cause of death (639 of 3,894 deaths) for the state. Unintentional injury was the leading cause of death for all males in this age group. However, AIDS was the leading cause of death for 15 to 44-year-old males in Durham, Forsyth, Guilford, Mecklenburg, New Hanover, and Wake and was tied with unintentional injuries in Gaston county.

AIDS was the third leading cause of death for the state and was the leading cause of death in Vance and Wilson counties for 15 to 44-year-old women. Among 15 to 44-year-old African-Americans, AIDS was the leading cause of death for the state (500 of 2,304 deaths) and in Durham, Forsyth, Gaston, Guilford, Mecklenburg, New Hanover, Pitt, Wake and Wilson counties. AIDS was tied with two other causes of death as the leading cause for African Americans in Vance and Wayne counties.

Among persons aged 15 to 44, AIDS was the leading cause of death for African-American males, the second leading cause of death for African-American females, the fourth leading cause of death for white males, and the sixth leading cause of death for white females in North Carolina.

HIV Seroprevalence in North Carolina

Crude estimates of HIV prevalence (number of persons living with HIV) among adults and adolescents have been calculated for North Carolina using the CDC methods in appendix D -- Simple Methods for Estimating HIV Prevalence in the Suggested Guidelines for Developing an Epidemiologic Profile for HIV Prevention Community Planning, June 1995, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention. These estimates include all persons living with HIV, including those diagnosed with AIDS. The seroprevalence estimates do not include HIV-infected persons who have died.

A - Extrapolation from the Survey of Childbearing Women (SCBW)

The most recent year in which data were collected for the SCBW was 1994. The Survey was suspended by the Centers for Disease Control in 1995 and technical difficulties made it impossible to test the specimens that were actually collected during that year. The suspension of the Survey has had a substantial negative impact on our ability to monitor and respond to the HIV epidemic in our state. As a result of the suspension, these data are out of date and it would be inappropriate to continue to extrapolate from it. Therefore, we have not utilized these data to estimate HIV seroprevalence.

B - Extrapolation from National Projections of HIV infection

National projections available from the Centers for Disease Control and Prevention indicate 110,000 to 155,000 women and 525,000 to 750,000 men were HIV-infected in 1996. Using the 1996 CDC HIV/AIDS Surveillance Report and averaging over 1995 and 1996, North Carolina had 1.32% of the total cases in the U.S. Among females for the U.S., there were 13,682 AIDS reports in 1995 and 13,820 reported in 1996. Also, for the U.S. as a whole, there were 59,285 males reported with AIDS in 1995 and 54,653 males reported with AIDS in 1996. In North Carolina, in 1995, there were 789 males and 314 females reported with AIDS and in 1996, there were 674 males reported with AIDS and 220 females.

These data indicate approximately 1.28% of the males and 1.94% of the females in the U.S. were reported in N.C. during 1995-1996. Using the projected national ranges listed above, we would estimate that between 2,134 and 3,007 females and between 6,720 and 9,600 males in North Carolina are HIV positive for a total prevalence of from 8,854 to 12,607 people in North Carolina who are currently HIV positive.

C - Other

HIV/AIDS Reporting System (HARS):

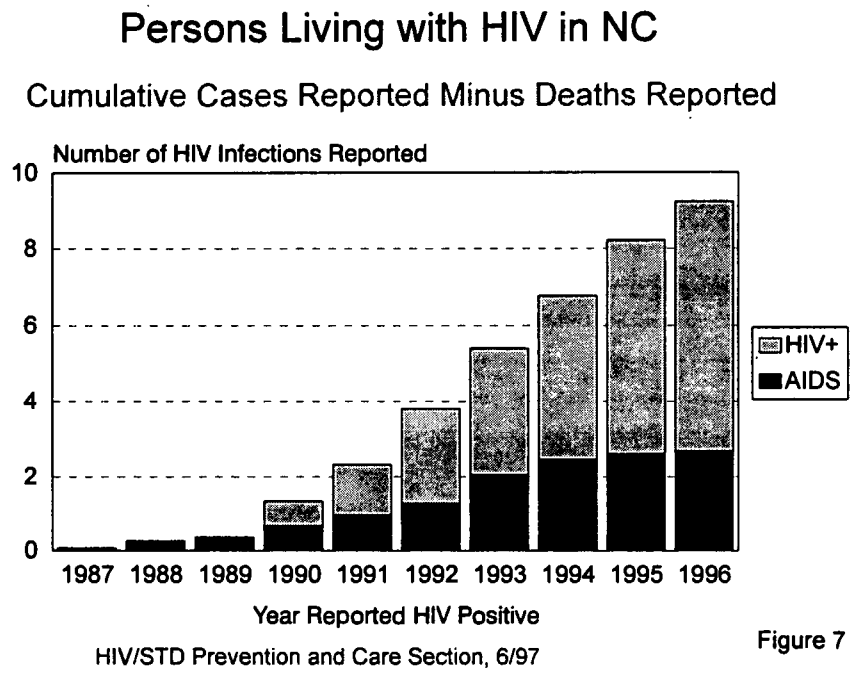


Figure 7

The cumulative number of HIV cases reported through December 31, 1996 was 7,076, of whom 524 had died. The cumulative number of AIDS cases reported through December 31, 1996 was 7,255 of whom 4,571 had died. Therefore, total number of persons living with HIV reported to the HIV/STD Prevention and Care Section is 9,236. Figure 7 indicates the prevalence of HIV (including AIDS cases) by year for 1987-1996. The data are stratified as HIV and AIDS reports.

Military Recruits:

Since October 1985, all persons applying for active duty or reserve military service, the service academies, and the Reserve Officer training Corps (ROTC) have been screened for HIV infection as part of their entrance medical evaluation. The Department of Defense shares the resulting statistical data with CDC for HIV surveillance purposes.

Military applicants are interviewed by recruiting officials about drug use and homosexual activity (both of which are grounds for exclusion from entry into military service) before referral for medical evaluation. Potential applicants are informed that they will be screened for HIV antibody. It is expected, therefore, that IV drug users and homosexual men are underrepresented among military applicants who are medically evaluated.

On July 19, 1993, President Clinton authorized a new policy in which military applicants would not be asked about homosexual activity. This "don't ask, don't tell" policy was instituted in military recruitment stations shortly after July 19, 1993.

The data from 1993 through 1996 were used to determine the number of new HIV positive tests which were found between January 1, 1994 and December 31, 1996. These have been compiled into two tables and are presented as Attachment 2. Since the testing of military recruits constitutes a biased sample, it is difficult to draw general conclusions from the results. However, we note that in this sample the seroprevalence of African American recruits is over three times as great as that for white recruits. This difference is consistent with that found in Tables 1 and 2.

In addition, the seroprevalence of HIV was found to increase with increasing age at recruitment. This trend is consistent with the trend found in the HARS data which are further detailed in Section 6, Adolescents. Seroprevalence in male military recruits is higher than that of female military recruits, again consistent with the HARS data.

Seroprevalence Summary:

According to extrapolation from National Estimates, between 8,854 and 12,607 people in North Carolina are living with HIV. According to the HARS data, 9,236 people are living with HIV. From these two data sources, we have estimated our prevalence at between 8,854 and 12,607 HIV-infected persons living in North Carolina.

IV. Who is at risk for becoming infected with HIV?

The persons most likely to become infected with HIV are those who engage in high-risk behavior with persons in communities with a high prevalence of HIV infection.

HIV infection in NC disproportionately affects certain groups in the population, particularly men who have sex with men and racial and ethnic minority communities.

1. Men who have sex with men

The relative proportion of AIDS cases attributed to verified risk factors have changed over the course of the epidemic (Table 3). In the beginning of the AIDS epidemic, from 1984 through 1989, men who had sex with men (MSM) made up the majority of AIDS cases, both among males (60%) and among all cases (54%). However, the trend in the past seven years, has been for a smaller percentage of total cases to be attributed to men having sex with men. In the most recent time period, from 1994 through 1996, less than half of the male cases (41%) have been attributed to men having sex with men. Likewise, the proportion of cases attributed to men who both use IV drugs and have sex with men has decreased from 8% of male cases between 1984 and 1989 to 6% of male cases in the 1994 to 1996 time period.

Table 4 presents HIV infections by risk factors over two time periods. HIV risk factors may tell more about recent HIV infection than AIDS risk factors. These percentages differ from the AIDS percentages over the same time period. However, while the percentage of AIDS cases attributed to MSM has decreased from the 1990 to 1993 time period to the 1994 to 1996 time period, the percentage of HIV reports attributed to the same risk has increased from 28 to 33 percent.

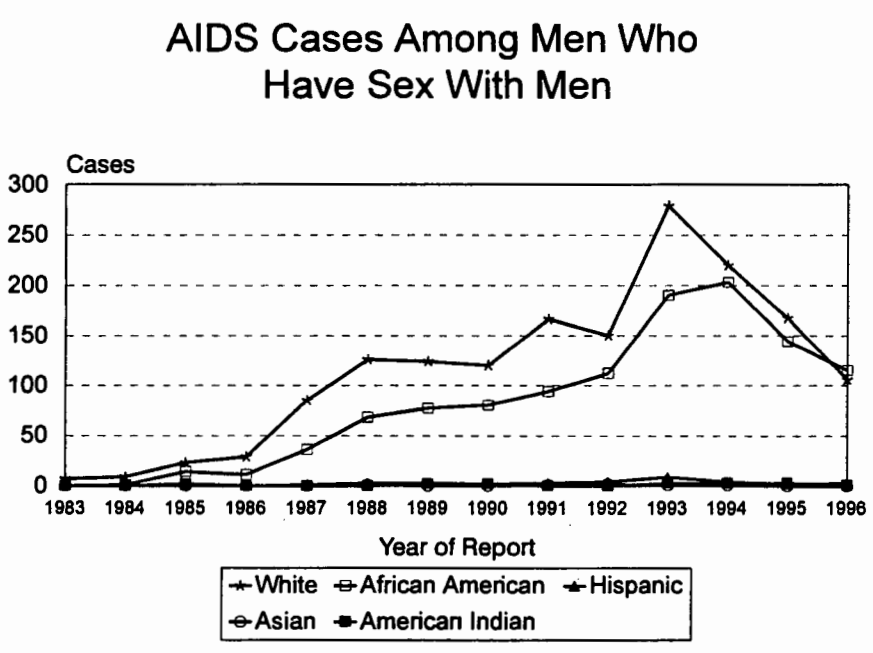
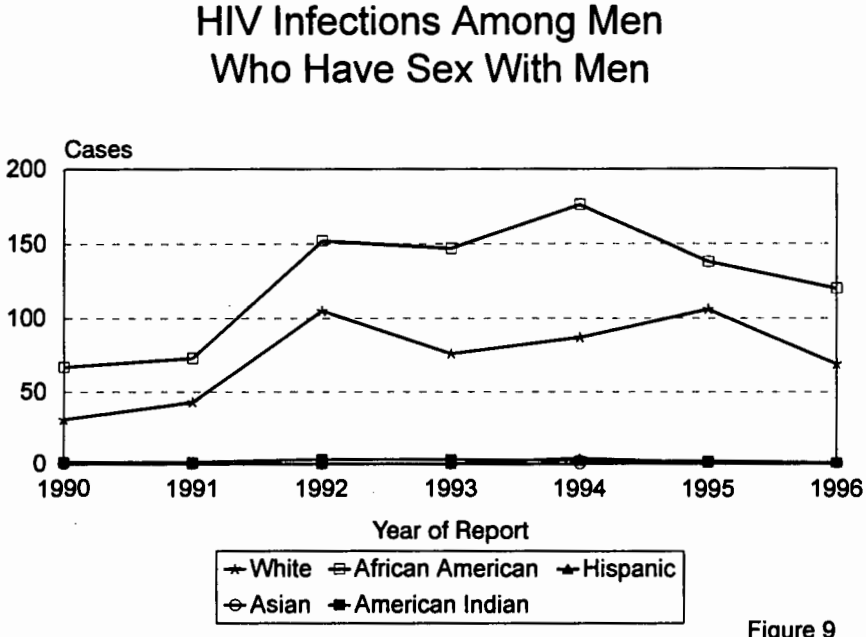


Figure 8

It should be noted that while the proportion of AIDS cases reported for MSM and MSM/IDU has declined through time, the average number of cases reported per year has increased slightly. The changes in proportions reflect the second wave of the HIV epidemic as we see a greater number of cases reported with heterosexual contact as a risk.



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Figure 9

The increase noted in MSM and MSM/IDU risk for recent HIV infection reports suggests that the efforts to minimize risk in the gay community should continue.

Until 1996, whites have been reported with greater frequency than African Americans among MSM (Figure 8). For the first time, in 1996, there were more cases of AIDS among African American MSM (115) than there were among white MSM (106). However, for HIV infections, among MSM, African Americans have been continuously reported with greater frequency than whites (Figure 9).

2. Injecting drug users

Table 3 presents the change in percentage of AIDS cases attributed to injecting drug use over the course of the AIDS epidemic in North Carolina. In the early period, from 1984 through 1989, 17% of male AIDS cases and 46% of female AIDS cases were attributed to injecting drug use. In addition, 8% of male cases were attributed to both males having sex with males and injecting drug use. The percentage of cases attributed to IV drug use has decreased for females. However, for males, the proportion of cases associated with injecting drug use remains higher than the initial time period, though slightly lower than the 1990 to 1993 time period. Also, the combined risks for injecting drug use remains about 25% of all AIDS cases since 1990.

Table 4 presents the change in percentage of HIV infections since 1990. This percentage has decreased for both sexes, and for the combined group now represents 16% of all HIV cases reported between 1994 and 1996. In addition, between 4 and 8 percent of HIV infections reported since 1990 have been attributed to both males having sex with males and IV drug use.

The impact of drug use as a risk factor for HIV/AIDS extends beyond the IDU patient reported or documented heterosexual contact with an infected partner. Table 7 indicates some of the documented as well as projected cases of drug involvement. The reader will notice there are some transmission mechanisms, such as "sex with a person with HIV/AIDS" that may not specify drug involvement. These are included because while there was no evidence of either injecting or non-injecting drug use, there were no other risk factors known. We offer these data

as "informed suggestions" of the extent to which drug use, both actual use as well as behavioral association, may impact the Prevention Planning process.

Table 7
Potentially Drug Related Cases

	Year of Report						
	1990	1991	1992	1993	1994	1995	1996
AIDS							
IDU	136	150	146	333	315	220	184
MSM & IDU	31	34	40	75	57	34	49
Heterosexual Contact with IDU	34	47	39	61	75	67	56
Sex for Drugs or Money	NA	NA	NA	NA	9	17	26
Sex with Person with HIV/AIDS	9	19	34	70	77	76	81
Pediatric, Mother is IDU	6	0	9	0	1	1	4
Pediatric, Mother had sex with IDU	1	0	6	3	0	2	2
Pediatric, Mother had sex with person with HIV-AIDS	2	0	6	1	0	3	6
Pediatric, Mother had HIV-AIDS	0	2	7	1	0	4	3
Total	219	252	287	544	525	419	412
HIV							
IDU	130	182	273	187	185	171	173
MSM & IDU	55	85	35	26	33	22	29
Heterosexual Contact with IDU	9	17	63	70	88	80	55
Sex for Drugs or Money	NA	NA	NA	NA	67	57	40
Sex with Person with HIV/AIDS	5	18	61	85	179	61	140
Pediatric, Mother is IDU	0	0	1	1	1	4	2
Pediatric, Mother had sex with IDU	0	0	0	1	0	2	5
Pediatric, Mother had sex with person with HIV-AIDS	0	0	0	0	0	9	2
Pediatric, Mother had HIV-AIDS	2	2	1	14	4	7	6
Total	201	304	443	384	640	575	454

3. Persons exposed to HIV through heterosexual contact

Table 3 presents the change in the percentage of AIDS cases attributed to heterosexual contact for AIDS cases reported through December 31, 1996. While only 3% of male AIDS cases were attributed to heterosexual contact during the 1984 to 1989 time period, this percentage had increased to 11 percent between 1994 and 1996. For females, however, the percentage of cases attributed to heterosexual contact increased from 36% in 1984 to 1989 to 39% in 1994 to 1996. The risk for heterosexual transmission for both sexes combined rose from 6% in 1984 to 1989 to 17% in the 1994 to 1996 time period.

Table 4 presents the change in percentage of HIV infections attributed to heterosexual contact since 1990. For males, 6% of reports in the 1990 to 1993 interval were attributed to heterosexual contact while for females that number stood at 22%. By the 1994 to 1996 time period, that percentage for males had increased to 28% and for females had increased to 59%. For both sexes combined, the percentage of heterosexual reports increased from 11% to 39%, an increase of 355%.

4. Women

Tables 1 and 3 and Figures 3 and 4 show the numbers and percentages of AIDS cases in women. In the 1980's, women made up just 11 percent of the AIDS cases reported. That increased to 21% of AIDS cases reported during the 1994 to 1996 time period. Among women, over 80% of the cases have been among African Americans during the entire AIDS epidemic. While the percentages have stayed the same, the number of women diagnosed with AIDS has increased each year since 1990.

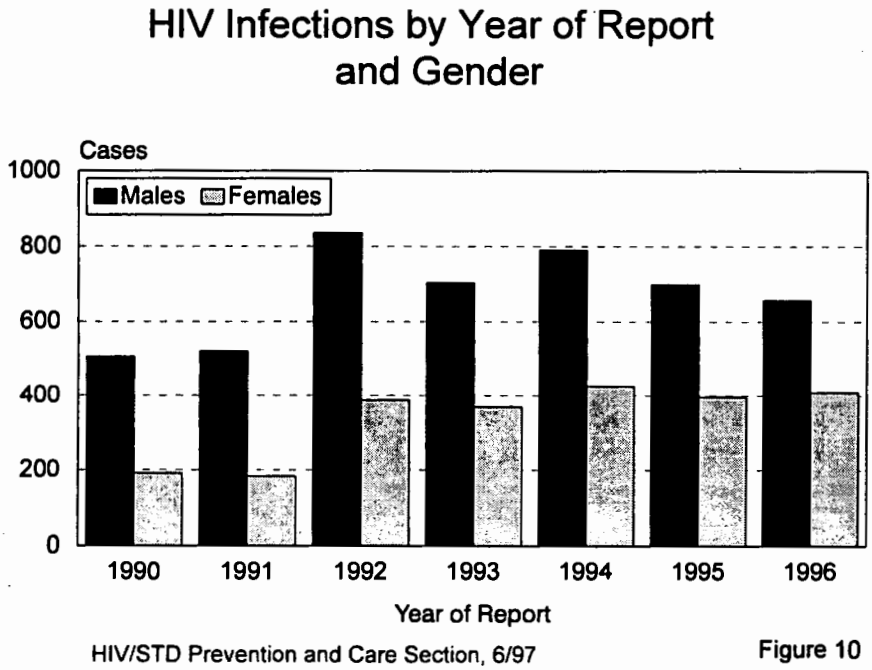


Figure 10

Table 3 presents the risk factors during the entire epidemic. While the percentage of female cases attributed to injecting drug use has decreased from 46% in the 1980's to just under a third in the 1990's, the risk from blood products has decreased from 8% of cases in the earlier time periods to 2% during the most recent time period. The percentage of cases attributed to heterosexual contact has hovered between 36 and

45% without a discernable trend.

Tables 2 and 4 and Figure 10 show the numbers and percentages of HIV infections in women during the 1990s. As for AIDS, African American women make up 80 percent or more of all female HIV infections. A decreasing percentage of female HIV infections have no identified risk attributed to them, from 51% in 1990 to 1993 to 21% of cases reported from 1994 to 1996. This is due, in part, to the use of the CDC definitions for risk factors, and the redistribution of NIR cases using the local North Carolina risk modes. The percentage of female cases attributed to injecting drug use has decreased from 25% in 1990 to 1993 to 15% in the 1994 to 1996 time period. The percentage of female cases attributed to blood products increased slightly from 1 to 2% between the two time periods.

Data from the Survey of Childbearing Women (SCBW) have been collected and analyzed through most of 1994, but not in 1995 and 1996 due to funding and technical difficulties. This population-based survey provided data representative of all women giving birth to live infants. Consistent with other data presented earlier, nonwhite women had higher seroprevalence rates than white women (about 20-fold higher) in all regions. Because of the lack of recent seroprevalence data, we are unable to analyze this further or to update trends.

5. Children less than 13 years of age

Table 8
Adolescent HIV/AIDS cases by exposure category by year of report
Ages 13 through 19

Exposure Category	HIV		AIDS	
	1990 - 93	1994 - 96	1990 - 93	1994 - 96
MSM	23	19	4	2
IV Drug Use	6	6	3	0
Adult Hemophilia	1	0	3	1
Pediatric Hemophilia	0	0	3	4
MSM & IDU	4	0	0	0
Heterosexual Contact	12	37	7	6
Transfusion/transplant	1	0	1	1
Risk Not Specified*	80	53	6	5
Total	127	115	27	19

* Includes cases that were reported but not fully investigated for risk ascertainment.

Through 1996, 96 pediatric HIV infections have been reported (not including cases which have progressed to AIDS.) In addition, 111 pediatric cases of AIDS have been reported, for a total of 207 infected children aged 12 and below.

Table 9
Pediatric Cases of HIV and AIDS

Reporting Period	1981 - 1989		1990 - 1993		1994-1996		Total
	Males	Females	Males	Females	Males	Females	
AIDS	13	9	22	31	16	14	105
HIV	0	0	18	20	31	19	88
Total	13	19	40	51	47	33	193

As the number of HIV infected women continued to grow, the number of HIV infected infants also grew. However, now that physicians are aware that AZT can reduce vertical transmission during pregnancy, we anticipate that the numbers of new cases of HIV in infants will continue to decrease from the peak years of 1990 to 1993.

Table 10 details pediatric AIDS cases by exposure category and race/ethnicity by year of report. The proportion of pediatric cases among African Americans is significantly higher for those with an exposure category of "Mother with/at risk for HIV infection," while most of the pediatric cases with hemophilia/coagulation disorder are among whites. Equal numbers of cases with a risk of transfusion/transplant are found among both whites and African Americans. The proportion of pediatric cases reported since 1991 has increased for the exposure group "mother with/at risk for HIV infection" from 68% to 92%, while the proportion with a risk of hemophilia/coagulation disorder or transfusion/transplant have decreased from 29% in 1981 to 1990 to 2% in 1991 to 1995.

Table 10 Pediatric AIDS cases by exposure category and race/ethnicity by year of report								
Exposure Category	White		African American		Other		All Races Combined	
	1981 - 90	1991 - 96	1981 - 90	1991 - 96	1981 - 90	1991 - 96	1981-90	1991-96
Hemophilia/coagulation disorder	4	6	0	2	0	1	4	9
Mother with/at risk for HIV infection	4	8	17	58	1	1	22	67
Transfusion/ Transplant	3	0	3	0	0	0	6	0
Other	0	1	1	1	0	0	1	2
Total	11	15	21	61	1	2	33	78

6. Adolescents (Ages 13 through 19)

The tables below (Tables 11 and 12) indicate the percentage of AIDS cases and HIV infections by age group and year of report. While only 1 percent of AIDS cases are found among teenagers aged 13 to 19, an additional 20% are found among those in their twenties who may have acquired their infections while they were in their teens. Likewise, 3% of HIV infections are among teenagers, but an additional 34% are found among those in their twenties. The number of adolescent HIV reports far exceeds the number of adolescent AIDS cases. This indicates a growing problem among teens.

Table 11 AIDS Cases by Age and Time Interval									
AGE	1995 Population	1985-1989		1990 - 1993		1994 - 1996		Cumulative	
		Cases	Percent	Cases	Percent	Cases	Percent	Total	Percent
< 13	1,430,147	22	1	53	1	29	1	104	1
13 - 19	514,314	11	1	27	1	19	1	57	1
20 - 29	1,116,634	284	24	618	20	535	17	1437	20
30 - 39	1,157,270	520	44	1447	48	1404	46	3371	46
40 - 49	1,036,744	225	19	650	22	805	26	1680	23
50+	1,910,189	113	10	224	7	268	9	605	8
Total	7,165,298	1175	100	3019	100	3061	100	7255	100

Table 12 HIV Infections by Age and Time Interval							
AGE	1995 Population	1990 - 1993		1994 - 1996		Cumulative	
		Cases	Percent	Cases	Percent	Total	Percent
< 13	1,430,147	38	1.0	50	1.5	88	1.2
13 - 19	514,314	121	3.3	113	3.3	234	3.3
20 - 29	1,116,634	1350	36.5	1067	31.6	2417	34.2
30 - 39	1,157,270	1536	41.5	1346	39.8	2882	40.7
40 - 49	1,036,744	504	13.6	622	18.4	1126	15.9
50+	1,910,189	148	4.0	181	5.4	329	4.7
Total	7,165,298	3697	100.0	3379	100.0	7076	100.0

The proportion of adolescent HIV infections attributed to heterosexual contact has increased from 9% in 1990 - 1993 to 37% in the most recent 3-year period, while the proportion of adolescent AIDS cases attributed to heterosexual contact has increased slightly from 26% to 31%. However, the high proportion of HIV reports with unspecified risk make it difficult to draw conclusions about changing risk factors among teens. Many of these individuals have not been interviewed to collect risk information.

As a surrogate for behaviors that place persons at risk for HIV infection as a result of heterosexual activity, we utilized pregnancy rates. Data from the State Center for Health Statistics, "North Carolina Reported Pregnancies, 1995", indicated the pregnancy rate for North

Carolina was 80.1 per 1,000 females aged 15 to 44. This includes a rate of 72.5 pregnancies per 1,000 for white females and 99.6 per 1,000 for nonwhite females. This is the lowest rate in the past ten years. The pregnancy rate is defined as pregnancies per 1,000 females ages 15 to 44.

There were 732 pregnancies among young girls aged 10 to 14, 238 of which were among white girls and 491 among nonwhite girls. In addition, of 21,530 teens aged 15 to 19 who were pregnant, 11,899 were white and 9,542 were nonwhite. Of the 132,316 pregnancies in 1995, 50,459 were among nonmarried women. Of these, 22,498 were white and 27,792 were nonwhite.

Pregnancy alone is not a risk factor for HIV. However, STD rates among teens (see section 8 and Figures 13 through 15) also indicate that much of the sexual activity of teens puts them at risk for sexually transmitted diseases such as gonorrhea and chlamydia where the rates are highest for 15 to 19 year olds. Thus, both the sexual activity, and the concomitant STDs put teens at risk for acquiring HIV infection as well.

Table 13 North Carolina Pregnancies 1995				
	Induced Abortions	Live births	Fetal Deaths	Total
Total, All Ages	29,938	101,555	823	132,316
Total Whites	15,881	71,330	418	87,629
Total Nonwhites	13,474	30,225	405	44,104
Ages 10 to 14	305	424	3	732
Whites, 10 to 14	133	105	0	238
Nonwhites, 10-14	169	319	3	491
Ages 15 to 19	6,350	15,042	138	21,530
Whites, 15 to 19	3,574	8,267	58	11,899
Nonwhites, 15 to 19	2,687	6,775	80	9,542
Nonmarried Total	18,165	31,903	391	50,459
Nonmarried, white	9,503	12,973	122	22,498
Unmarried, Nonwhite	8,493	19,030	269	27,792

As an additional indicator of adolescent risk, the **1995 Youth Risk Behavior Surveys** supplies state-specific numbers on specific high risk behaviors of high school students. While the increase in adolescent AIDS cases is not as dramatic in North Carolina as in some other areas of the country, these surveys indicate North Carolina adolescents are engaging in behaviors that may place them at risk for HIV exposure. In North Carolina, 57.3% of high school students reported that they had ever had sexual intercourse, including 57.6% of high school females and 57.2% of high school males. A total of 12.5% of high school students reported having first intercourse before age 13, including 18.9% of high school males and 6.3% of high school females. A total of 23.8% of high school students reported having four or more sex partners during their lifetime, including 27.9% of high school males and 19.8% of high school females. Currently 41% of high school students are sexually active (having sex in the last 3 months), including 38.3% of high school males and 43.7% of high school females. Among students who had sex during their lifetime, 28.2% were currently abstinent (no sex in the last 3 months) including 23.9% of high school females and 32.8% of high school males.

In North Carolina, 54.2% of high school students reported having used a condom during their last sexual intercourse. This includes 44.8% of females and 65.4% of males. Also, 18.2% of students reported having used alcohol or drugs at last sexual intercourse (16.1% of females and 20.6% of males).

7. Racial/ethnic minorities

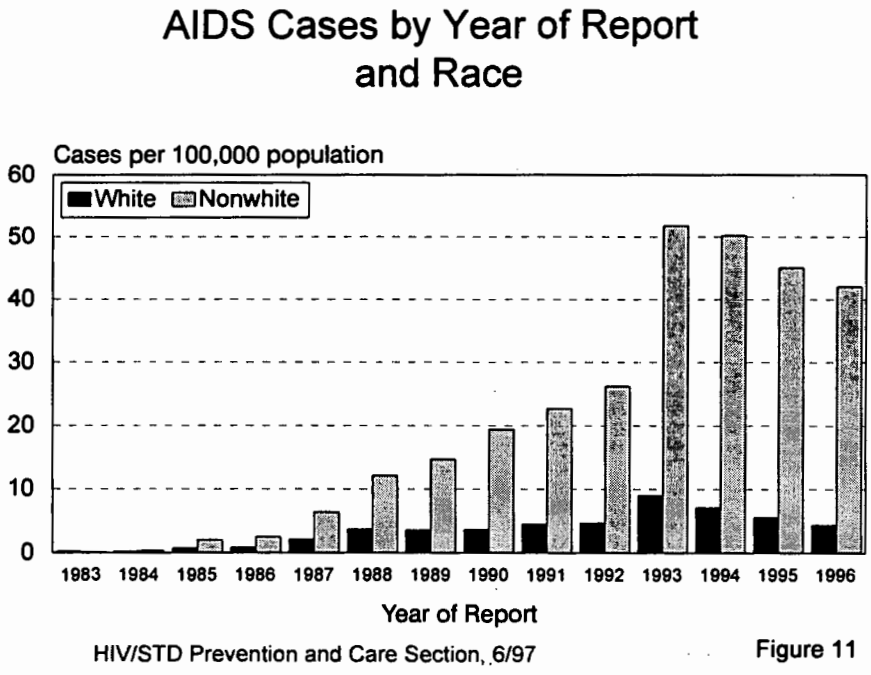


Figure 11

About one quarter of North Carolina's population are racial/ethnic minorities. However, the proportion of AIDS cases among minorities has increased from just over 50% in the earliest time period to over two thirds in the most recent time period (Table 1) and remains stable at about three quarters of the HIV infections. This indicates that HIV/AIDS has a disproportionate effect on minorities in North Carolina compared with the rest of the population.

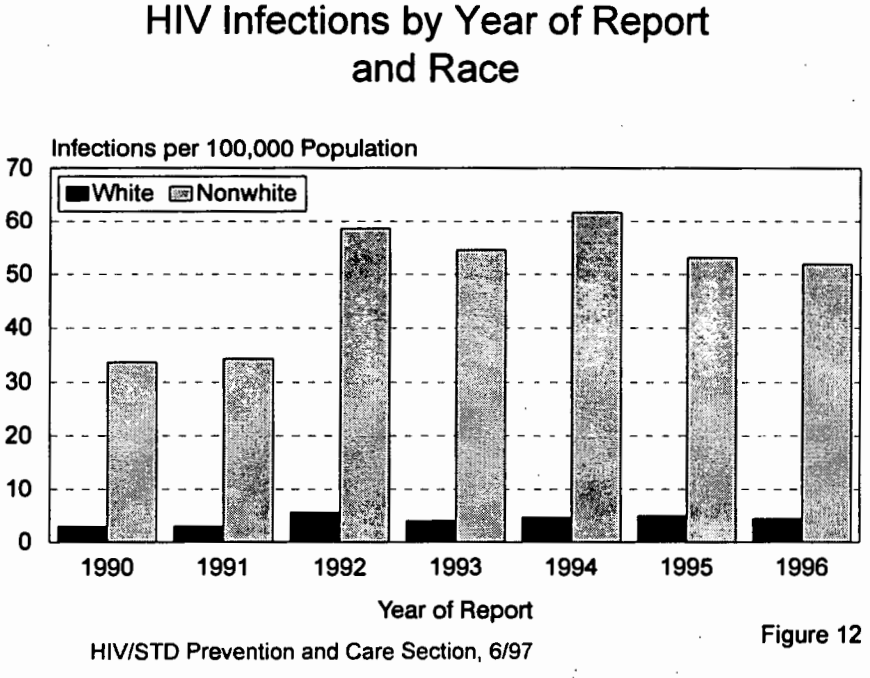


Figure 12

Considering the *rates* of AIDS and HIV infection, we can only compare whites to nonwhites because the population projections for specific minorities are not available between census years. Figures 11 and 12 demonstrate the continued disparity between the AIDS and HIV rates of whites and nonwhites across the years. While the majority of nonwhite cases reported have been among African-Americans, an increase in the proportion of reports

from other racial/ethnic communities, especially the Hispanic community, has been noted. We predict an increasing number of cases from the Hispanic community, given the rapid increase in the Hispanic population in North Carolina.

Figure 2 details the distribution of minorities across the state of North Carolina. Comparing this to the following maps showing the AIDS and HIV and syphilis distribution, it is apparent that some of the areas of greatest AIDS and HIV rates are also counties with a high proportion of minorities.

North Carolina collects data on syphilis, gonorrhea and chlamydia. The case rates for racial/ethnic minorities are significantly higher than the statewide case rate for all 3 STDs. In 1996, *90% of the syphilis cases, 87% of the gonorrhea cases and 69% of the chlamydia cases were reported among African Americans.*

8. Persons with Bacterial Sexually Transmitted Diseases

Persons with bacterial sexually transmitted diseases represent a group of sexually active people who have recently had unprotected intercourse. The extent to which STD rates correspond with HIV risk depends on HIV infection rates within the sexual network of persons practicing unsafe sex. While STD data is an imperfect marker for risk of HIV infection, it does provide a reliable indicator of high-risk behavior. Groups with high incidences of STDs are potentially at increased risk for acquiring HIV. Additionally, considering the relatively short incubation periods for these infections, STD morbidity represents the recent consequences of unsafe sexual behavior and indicates population groups that are practicing unsafe sexual behavior and are at greater risk for acquiring and transmitting HIV infection.

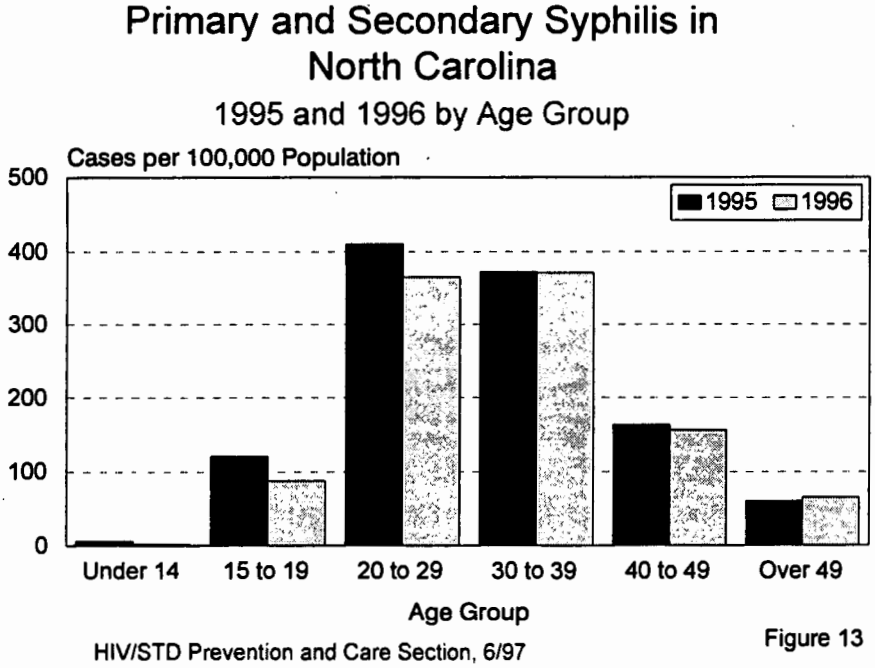
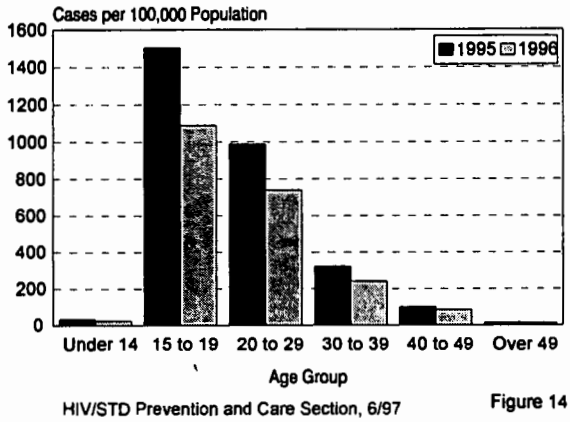


Figure 13

Figures 13, 14, and 15 demonstrate the age distribution for cases of infectious syphilis, gonorrhea and chlamydia in 1995 and 1996. This demonstrates the risky behavior among persons of the age groups with the highest rates. For chlamydia and gonorrhea, the rates are highest among 15 to 19 year olds. For syphilis, the rates are highest among 20 to 29 year olds. These infections

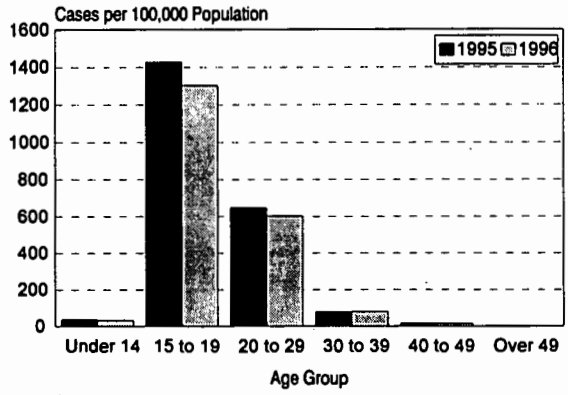
Gonorrhea in North Carolina
1995 and 1996 by Age Group



HIV/STD Prevention and Care Section, 6/97

Figure 14

Chlamydia in North Carolina
1995 and 1996 by Age Group



HIV/STD Prevention and Care Section, 6/97

Figure 15

not only demonstrate the high risk behavior of the populations involved, they also increase the probability of acquiring the HIV infection should the person involved become exposed to the HIV virus while infected with another sexually transmitted disease. Thus, prevention activities aimed toward sexually transmitted diseases will also help reduce the threat of HIV as well.

Figures 16, 17 and 18 display maps of 1994 to 1996 AIDS case rates, 1994 to 1996 HIV infection report rates and 1996 syphilis case rate. These maps indicate a strong connection between HIV and other STDs in North Carolina.

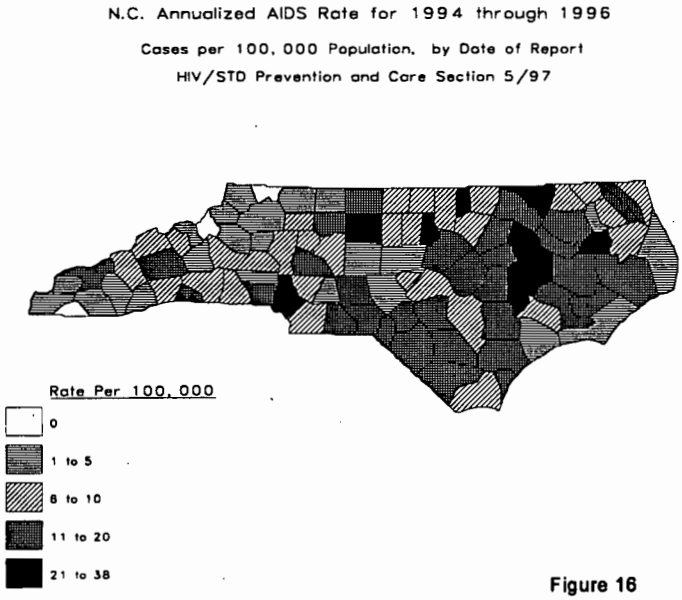


Figure 16

In 1995 North Carolina had the 5th highest primary and secondary syphilis rate, after Mississippi, Louisiana, Arkansas and Tennessee. However, the syphilis rate in North Carolina has dropped from its 25-year peak in 1992 of 36 cases per 100,000 to 14 cases per 100,000 in 1996. The North Carolina gonorrhea rate has decreased from 410 cases per 100,000 population in 1994 to 249 cases per 100,000 in 1996. This decrease could be seen in all regions, age groups, races and both sexes. The

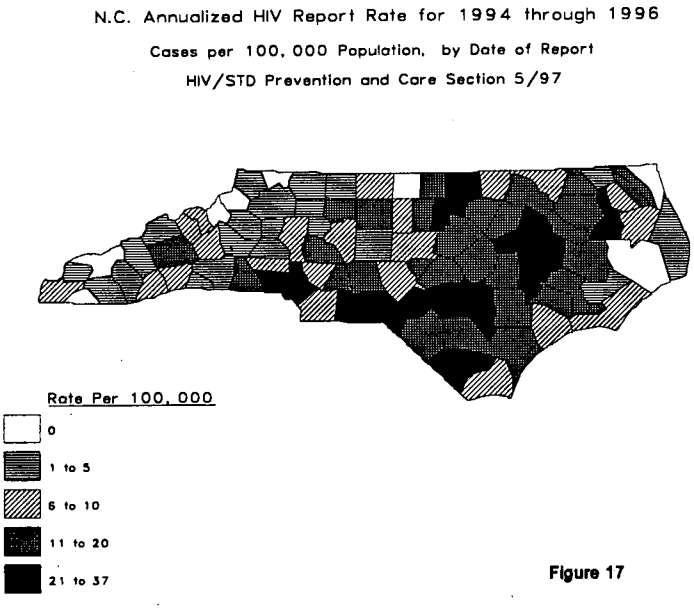


Figure 17

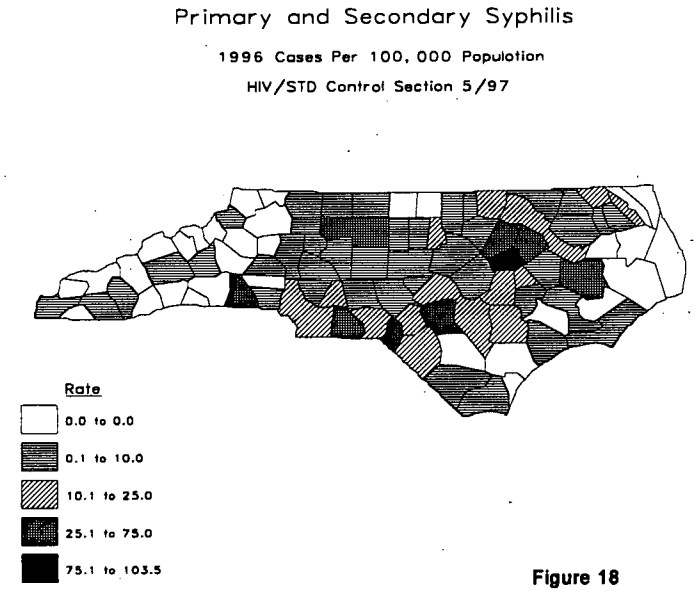


Figure 18

1996 chlamydia rate in N.C. declined from 252 cases per 100,000 in 1994 to 206 per 100,000 in 1996.

Data reported by the STD branch of the National Institute of Allergy and Infections Diseases indicate people who are infected with gonorrhea and chlamydia are three to five times as likely to contract HIV, and those with lesion diseases such as herpes and syphilis have nine times the risk (1996 May, Alive and Kicking Issue 55, by Teresa Tamkins, Medical Tribune News Service). According to Dr. Jean Anderson, in the 1996 July, Johns Hopkins University, Hopkins HIV Vol 8 No 3 -- Women's Issues, the increased risk is believed to relate, at least in part, to the increased numbers of HIV target cells and the increased HIV shedding in the genital tract associated with STDs. Treatment of genital tract infections has been shown to decrease both the presence and magnitude of HIV shedding.

SUMMARY

The following information summarizes the critical elements of the information presented regarding population subgroups. The order of the categories does not indicate a ranking of importance.

Men who have Sex with Men

Male to male sexual contact has been the most frequently cited exposure mode for both AIDS cases and HIV infections. However, in recent years, this trend has changed so that in the most recent time period, 1994 through 1996, less than half of the male cases have been attributed to men having sex with men. Likewise, less than 40% of HIV infections were attributed to men having sex with men in the same time period.

Injecting Drug Use

The majority of cases attributed to injecting drug use are among African Americans. The proportion of cases attributed to this exposure mode remains relatively stable at under 25%.

Heterosexual Contact

Over three quarters of the HIV infections attributed to heterosexual contact have been reported since 1993. Higher numbers of STD cases (which indicate higher levels of unsafe sexual practices) were reported among racial/ethnic minorities and persons aged 15 to 39.

Women

The proportion of AIDS cases reported among women has increased from 11% in 1984 through 1989 to 21% in 1994-1996. Likewise the proportion of HIV infections reported among women has increased from 30% of the total cases to 36% of total cases in 1994 to 1996. A greater proportion of female HIV infections is attributed to heterosexual contact and a decreasing proportion is attributed to intravenous drug use.

Adolescents

Approximately 1/5 of AIDS cases were likely the result of adolescent transmission of HIV. Of the cases where mode of transmission was determined, a greater number of the AIDS cases and HIV infections were attributed to heterosexual contact than to any other mode of transmission.

Racial/Ethnic Minorities

Both HIV infections and AIDS have a disproportionate effect on minorities in North Carolina.

V. What is the geographic distribution of HIV infection?

The distribution of HIV and AIDS cases is uneven across the state as can be seen in Figures 16, 17 and 18. This distribution can be partly explained by the population distribution as the epidemic had been concentrated in urban areas though it now reaches the rural areas as well. The syphilis epidemic preceded the HIV epidemic both because many of the risk factors are the same, and lesion diseases are correlated with increased transmission risk for the virus. While the syphilis epidemic peaked in 1992 and is now decreasing, the evidence for such a decrease in HIV is not yet apparent in North Carolina. STDs remain a marker for high risk activity which predicts the areas of highest HIV rates as well (Fig 18).

While there is a significant amount of in- and out-migration before and after infection with the HIV virus, prevention activities should be concentrated in the areas where the rate or number of cases is the greatest. Elevated HIV/AIDS rates may be due to different high risk behaviors depending on the community and geographic areas of the state. A knowledge of the communities under consideration will be necessary to determine the prevention activities most useful in that area, and the risk groups to which they should be addressed.

VI. Summary and Conclusions

The HIV epidemic continues in North Carolina. Rates of infections continue to grow among adolescents and among women with heterosexual contacts as their primary mode of transmission. The minority population is disproportionally affected by this epidemic in all risk groups. The geographic distribution of cases for HIV, AIDS and bacterial STDs indicate the high correlation of STDs as a predictor of HIV risk.

Attachments

AIDS and HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION 1									
HIV	1990 - 1993	Males	61	42	0	0	0	1	104
		Females	18	10	1	0	0	0	29
		Both	79	52	1	0	0	1	133
	1994 - 1996	Males	82	35	2	0	0	1	120
		Females	27	14	0	3	1	2	41
		Both	109	49	2	3	1	3	161
	All Years	Both	188	101	3	3	1	4	294
AIDS	1981-1990	Males	67	26	1	1	4	0	99
		Females	6	7	0	0	1	0	14
		Both	73	33	1	1	5	0	113
	1991 - 1993	Males	96	25	4	0	0	1	126
		Females	13	9	0	0	0	0	22
		Both	109	34	4	0	0	1	148
	1994 - 1996	Males	109	58	5	2	4	1	179
		Females	18	14	1	0	1	0	34
		Both	127	72	6	2	5	1	213
	All years	Both	309	139	11	3	10	2	474
HIV & AIDS	All years	Both	497	240	14	6	11	6	768

AIDS and HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION II									
HIV	1990 - 1993	Males	180	643	3	0	3	4	833
		Females	79	280	0	0	1	3	363
		Both	259	923	3	0	4	7	1196
	1994 - 1996	Males	139	467	4	2	2	5	619
		Females	54	273	0	3	1	2	333
		Both	193	740	4	5	3	7	952
	All Years	Both	452	1663	7	5	7	14	2148
AIDS	1981-1990	Males	194	151	6	0	0	0	352
		Females	9	30	0	0	0	1	39
		Both	203	181	6	0	0	1	391
	1991 - 1993	Males	190	283	6	0	0	3	484
		Females	13	61	0	0	0	0	74
		Both	203	344	6	0	0	3	558
	1994 - 1996	Males	159	344	8	3	1	1	516
		Females	22	92	0	0	0	0	114
		Both	181	436	8	3	1	1	630
	All years	Both	587	961	20	3	1	5	1579
HIV & AIDS	All years	Both	1039	2624	27	8	8	19	3727

AIDS and HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION III									
HIV	1990 - 1993	Males	88	246	2	2	5	6	349
		Females	23	111	0	0	1	0	135
		Both	111	357	2	2	6	6	484
	1994 - 1996	Males	76	241	0	0	0	1	318
		Females	27	153	2	0	1	0	183
		Both	103	394	2	0	1	1	501
	All Years	Both	214	751	4	2	7	7	985
AIDS	1981-1990	Males	136	127	3	0	0	0	266
		Females	3	23	0	0	0	0	26
		Both	139	150	3	0	0	0	292
	1991 - 1993	Males	152	211	5	2	1	1	372
		Females	6	58	0	0	1	0	65
		Both	158	269	5	2	2	1	437
	1994 - 1996	Males	181	289	5	1	3	0	479
		Females	18	83	0	0	0	0	101
		Both	199	372	5	1	3	0	580
	All years	Both	496	791	13	3	5	1	1309
HIV & AIDS	All years	Both	710	1542	17	5	12	8	2294

AIDS and HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION IV									
HIV	1990 - 1993	Males	134	552	5	3	4	0	698
		Females	33	255	0	0	1	0	289
		Both	167	807	5	3	5	0	987
	1994 - 1996	Males	106	411	4	1	0	2	524
		Females	32	258	0	0	0	1	291
		Both	138	669	4	1	0	3	815
	All Years	Both	305	1476	9	4	5	3	1802
AIDS	1981-1990	Males	196	238	4	0	2	0	441
		Females	8	55	1	0	0	1	64
		Both	204	293	5	0	2	1	505
	1991 - 1993	Males	219	331	8	2	1	0	561
		Females	12	97	1	0	0	0	110
		Both	231	428	9	2	1	0	671
	1994 - 1996	Males	171	448	11	0	0	2	632
		Females	15	176	0	0	0	0	191
		Both	186	624	11	0	0	2	823
	All years	Both	621	1345	25	2	3	3	1999
HIV & AIDS	All years	Both	926	2821	34	6	8	6	3801

AIDS and HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION V									
HIV	1990 - 1993	Males	58	202	4	1	14	7	286
		Females	23	128	0	0	10	1	162
		Both	81	330	4	1	24	8	448
	1994 - 1996	Males	43	198	10	3	13	2	269
		Females	26	134	2	1	7	1	171
		Both[1]	69	333	12	4	20	3	440
	All Years	Both	150	663	16	5	44	11	888
AIDS	1981-1990	Males	36	41	2	2	4	2	87
		Females	3	20	0	1	0	0	24
		Both	39	61	2	3	4	2	111
	1991 - 1993	Males	72	123	5	0	7	0	207
		Females	4	36	1	1	3	0	45
		Both	76	159	6	1	10	0	252
	1994 - 1996	Males	47	166	11	0	12	0	236
		Females	6	47	0	1	4	0	58
		Both	53	213	11	1	16	0	294
	All years	Both	168	433	19	5	30	2	657
HIV & AIDS	All years	Both	318	1096	35	10	74	13	1545

AIDS and HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION VI									
HIV	1990 - 1993	Males	22	134	1	0	0	0	157
		Females	13	88	0	0	0	0	101
		Both	35	222	1	0	0	0	258
	1994 - 1996	Males	35	147	2	0	0	0	184
		Females	13	132	1	0	1	0	147
		Both	48	279	3	0	1	0	331
	All Years	Both	83	501	4	0	1	0	589
AIDS	1981-1990	Males	43	86	0	0	0	0	129
		Females	3	27	0	0	0	0	30
		Both	46	113	0	0	0	0	159
	1991 - 1993	Males	60	154	5	2	0	0	221
		Females	6	55	0	0	0	0	61
		Both	66	209	5	2	0	0	282
	1994 - 1996	Males	59	187	8	0	0	1	255
		Females	7	86	1	0	0	0	94
		Both	66	273	9	0	0	1	349
	All years	Both	178	595	14	2	0	1	790
HIV & AIDS	All years	Both	261	1096	18	2	1	1	1379

AIDS and HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION VII									
HIV	1990 - 1993	Males	42	93	2	0	0	0	137
		Females	11	43	0	0	0	0	54
		Both	53	136	2	0	0	0	191
	1994 - 1996	Males	36	75	0	0	1	0	112
		Females	9	56	1	0	0	0	66
		Both	45	131	1	0	1	0	178
	All Years	Both	98	267	3	0	1	0	369
AIDS	1981-1990	Males	38	38	3	0	0	0	79
		Females	2	11	2	0	0	0	15
		Both	40	49	5	0	0	0	94
	1991 - 1993	Males	67	70	3	0	0	0	140
		Females	6	35	0	0	0	0	41
		Both	73	105	3	0	0	0	181
	1994 - 1996	Males	42	71	7	1	1	0	122
		Females	10	37	3	0	0	0	50
		Both	52	108	10	1	1	0	172
	All years	Both	165	262	18	1	1	0	447
HIV & AIDS	All years	Both	263	529	21	1	2	0	816

1. Region V has 1 African-American, sex unknown, with HIV reported 1994 - 1996.

AIDS by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION I									
AIDS	1981-1990	Males	67	26	1	1	4	0	99
		Females	6	7	0	0	1	0	14
		Both	73	33	1	1	5	0	113
	1991 - 1993	Males	96	25	4	0	0	1	126
		Females	13	9	0	0	0	0	22
		Both	109	34	4	0	0	1	148
	1994 - 1996	Males	109	58	5	2	4	1	179
		Females	18	14	1	0	1	0	34
		Both	127	72	6	2	5	1	213
	All years	Both	309	139	11	3	10	2	474
REGION II									
AIDS	1981-1990	Males	194	151	6	0	0	0	352
		Females	9	30	0	0	0	1	39
		Both	203	181	6	0	0	1	391
	1991 - 1993	Males	190	283	6	0	0	3	484
		Females	13	61	0	0	0	0	74
		Both	203	344	6	0	0	3	558
	1994 - 1996	Males	159	344	8	3	1	1	516
		Females	22	92	0	0	0	0	114

AIDS by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
		Both	181	436	8	3	1	1	630
	All years	Both	587	961	20	3	1	5	1579
REGION III									
AIDS	1981-1990	Males	136	127	3	0	0	0	266
		Females	3	23	0	0	0	0	26
		Both	139	150	3	0	0	0	292
	1991 - 1993	Males	152	211	5	2	1	1	372
		Females	6	58	0	0	1	0	65
		Both	158	269	5	2	2	1	437
	1994 - 1996	Males	181	289	5	1	3	0	479
		Females	18	83	0	0	0	0	101
		Both	199	372	5	1	3	0	580
	All years	Both	496	791	13	3	5	1	1309
REGION IV									
AIDS	1981-1990	Males	196	238	4	0	2	0	441
		Females	8	55	1	0	0	1	64
		Both	204	293	5	0	2	1	505
	1991 - 1993	Males	219	331	8	2	1	0	561
		Females	12	97	1	0	0	0	110
		Both	231	428	9	2	1	0	671

AIDS by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
	1994 - 1996	Males	171	448	11	0	0	2	632
		Females	15	176	0	0	0	0	191
		Both	186	624	11	0	0	2	823
	All years	Both	621	1345	25	2	3	3	1999
REGION V									
AIDS	1981-1990	Males	36	41	2	2	4	2	87
		Females	3	20	0	1	0	0	24
		Both	39	61	2	3	4	2	111
	1991 - 1993	Males	72	123	5	0	7	0	207
		Females	4	36	1	1	3	0	45
		Both	76	159	6	1	10	0	252
	1994 - 1996	Males	47	166	11	0	12	0	236
		Females	6	47	0	1	4	0	58
		Both	53	213	11	1	16	0	294
	All years	Both	168	433	19	5	30	2	657
REGION VI									
AIDS	1981-1990	Males	43	86	0	0	0	0	129
		Females	3	27	0	0	0	0	30
		Both	46	113	0	0	0	0	159
	1991 - 1993	Males	60	154	5	2	0	0	221

AIDS by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
		Females	6	55	0	0	0	0	61
		Both	66	209	5	2	0	0	282
	1994 - 1996	Males	59	187	8	0	0	1	255
		Females	7	86	1	0	0	0	94
		Both	66	273	9	0	0	1	349
	All years	Both	178	595	14	2	0	1	790
REGION VII									
AIDS	1981-1990	Males	38	38	3	0	0	0	79
		Females	2	11	2	0	0	0	15
		Both	40	49	5	0	0	0	94
	1991 - 1993	Males	67	70	3	0	0	0	140
		Females	6	35	0	0	0	0	41
		Both	73	105	3	0	0	0	181
	1994 - 1996	Males	42	71	7	1	1	0	122
		Females	10	37	3	0	0	0	50
		Both	52	108	10	1	1	0	172
	All years	Both	165	262	18	1	1	0	447

HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION 1									
HIV	1990 - 1993	Males	61	42	0	0	0	1	104
		Females	18	10	1	0	0	0	29
		Both	79	52	1	0	0	1	133
	1994 - 1996	Males	82	35	2	0	0	1	120
		Females	27	14	0	3	1	2	41
		Both	109	49	2	3	1	3	161
	All Years	Both	188	101	3	3	1	4	294
REGION II									
HIV	1990 - 1993	Males	180	643	3	0	3	4	833
		Females	79	280	0	0	1	3	363
		Both	259	923	3	0	4	7	1196
	1994 - 1996	Males	139	467	4	2	2	5	619
		Females	54	273	0	3	1	2	333
		Both	193	740	4	5	3	7	952
	All Years	Both	452	1663	7	5	7	14	2148

HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION III									
HIV	1990 - 1993	Males	88	246	2	2	5	6	349
		Females	23	111	0	0	1	0	135
		Both	111	357	2	2	6	6	484
	1994 - 1996	Males	76	241	0	0	0	1	318
		Females	27	153	2	0	1	0	183
		Both	103	394	2	0	1	1	501
	All Years	Both	214	751	4	2	7	7	985
REGION IV									
HIV	1990 - 1993	Males	134	552	5	3	4	0	698
		Females	33	255	0	0	1	0	289
		Both	167	807	5	3	5	0	987
	1994 - 1996	Males	106	411	4	1	0	2	524
		Females	32	258	0	0	0	1	291
		Both	138	669	4	1	0	3	815
	All Years	Both	305	1476	9	4	5	3	1802

HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION V									
HIV	1990 - 1993	Males	58	202	4	1	14	7	286
		Females	23	128	0	0	10	1	162
		Both	81	330	4	1	24	8	448
	1994 - 1996	Males	43	198	10	3	13	2	269
		Females	26	134	2	1	7	1	171
		Both[1]	69	333	12	4	20	3	440
	All Years	Both	150	663	16	5	44	11	888
REGION VI									
HIV	1990 - 1993	Males	22	134	1	0	0	0	157
		Females	13	88	0	0	0	0	101
		Both	35	222	1	0	0	0	258
	1994 - 1996	Males	35	147	2	0	0	0	184
		Females	13	132	1	0	1	0	147
		Both	48	279	3	0	1	0	331
	All Years	Both	83	501	4	0	1	0	589

HIV by Region, Sex and Race									
	Time Period	Sex	White	African American	Hispanic	Asian	Indian	Other/ Unk	Total
REGION VII									
HIV	1990 - 1993	Males	42	93	2	0	0	0	137
		Females	11	43	0	0	0	0	54
		Both	53	136	2	0	0	0	191
	1994 - 1996	Males	36	75	0	0	1	0	112
		Females	9	56	1	0	0	0	66
		Both	45	131	1	0	1	0	178
	All Years	Both	98	267	3	0	1	0	369

1. Region 1 has 1 black person, sex unknown, with HIV reported 1994 - 1996.

Prevalence of HIV Among Military Recruits by Age Using Data from 12/93 and 12/96										
	Total		Age 17 - 19		Age 20 - 24		Age 25 - 29		Over Age 30	
	# Pos	Total tests	# Pos	Total tests	# Pos	Total tests	# Pos	Total tests	# Pos	Total tests
All tested as of 12/96	116	140360	22	79115	41	42122	34	11776	19	7347
All tested as of 12/93	103	110336	20	62451	35	32946	31	9105	17	5834
Tested 1/94 - 12/96	13	30024	2	16664	6	9176	3	2671	2	1513
Three year rate	0.04		0.01		0.07		0.11		0.13	
Annualized Rate '94-96'	0.01		0.00		0.02		0.04		0.04	
Males tested as of 12/96	106	115486	16	66221	40	33893	32	9339	18	6033
Males tested as of 12/93	94	92143	14	53252	34	26128	29	7258	17	4508
Males tested 1/94 - 12/96	12	23343	2	12969	6	7765	3	2081	1	1525
Three year rate - males	0.05		0.02		0.08		0.14		0.07	
Annualized rate - males	0.02		0.01		0.03		0.05		0.02	
Females tested as of 12/96	10	24874	6	12894	1	8229	2	2437	1	1314
Females tested as of 12/93	9	18193	6	9199	1	6118	2	1847	0	1029
Females tested 1/94 - 12/96	1	6681	0	3695	0	2111	0	590	1	285
Three year rate - females	0.02		0.00		0.00		0.00		0.35	
Annualized rate - females	0.00		0.00		0.00		0.00		0.12	

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Prevalence of HIV Among Military Recruits by Race
Using Data from 12/93 and 12/96

	Total		White		African American		Hispanic		Other	
	# Pos	Total tested	# Pos	total tested	# Pos	Total tested	# Pos	Total tested	# Pos	Total tested
All tested as of 12/96	116	140360	32	85258	80	50844	3	1178	0	2438
All tested as of 12/93	103	110336	29	67544	70	39857	3	784	0	1796
Tested 1/94 - 12/96	13	30024	3	17714	10	10987	0	394	0	642
Three year rate	0.04		0.02		0.09		0.00		0.00	
Annualized rate '94-96	0.01		0.01		0.03		0.00		0.00	
Males tested as of 12/96	106	115486	30	73036	72	39142	3	875	0	1970
Males tested as of 12/93	94	92143	27	58515	63	31295	3	593	0	1466
Males tested 1/94 - 12/96	12	23343	3	14521	9	7847	0	282	0	504
Three year rate - males	0.05		0.02		0.11		0.00		0.00	
Annualized rate - males	0.02		0.01		0.04		0.00		0.00	
Females tested as of 12/96	10	28874	2	12222	8	11702	0	303	0	493
Females tested as of 12/93	9	18193	2	9029	7	8562	0	191	0	330
Females tested 1/94 - 12/96	1	10681	0	3193	1	3140	0	112	0	163
Three year rate - females	0.01		0.00		0.03		0.00		0.00	
Annualized rate - females	0.00		0.00		0.01		0.00		0.00	

NC HIV/STD Epidemiology & Special Studies Branch
N. C. Cumulative HIV Infections (non-AIDS) through 12/31/97
HIV/AIDS Surveillance Report - 01/06/98

Disease Category	Adult/Adolescent * Cases (%)	Adult/Adolescent * Deaths (%)	Pediatric * Cases (%)	Pediatric * Deaths (%)	Total Cases (%)	Total Deaths (%)
PCP	0 (0)	0 (.)	0 (0)	0 (.)	0 (0)	0 (.)
Other Disease w/o PCP	0 (0)	0 (.)	1 (1)	0 (0)	1 (0)	0 (0)
KS Alone	0 (0)	0 (.)	0 (0)	0 (.)	0 (0)	0 (.)
No Diseases Listed	7821 (100)	593 (8)	97 (99)	7 (7)	7918 (100)	600 (8)
Total	7821 (100)	593 (8)	98 (100)	7 (7)	7919 (100)	600 (8)

Age *	Cases (%)
Under 5	79 (1)
5-12	19 (0)
13-19	269 (3)
20-29	2636 (33)
30-39	3196 (40)
40-49	1316 (17)
Over 49	404 (5)
Unknown	0 (0)
Total	7919 (100)

3. Race/Ethnicity	Adult/Adolescent * Cases (%)	Pediatric * Cases (%)	Total Cases (%)
White, Not Hispanic	1675 (21)	14 (14)	1689 (21)
Black, Not Hispanic	5957 (76)	78 (80)	6035 (76)
Hispanic	54 (1)	3 (3)	57 (1)
Asian/Pacific Is.	18 (0)	0 (0)	18 (0)
Am. Indian/Alaska Native	72 (1)	1 (1)	73 (1)
Unknown	45 (1)	2 (2)	47 (1)
Total	7821 (100)	98 (100)	7919 (100)

Exposure Category	Adult/Adolescent Transmission Modes** Males (%)	Females (%)	Total (%)
Men who have sex with men	1624 (31)	0 (0)	1624 (21)
Injecting drug use	929 (18)	500 (19)	1429 (18)
Men who have sex with men and inject drugs	338 (7)	0 (0)	338 (4)
Hemophilia/coagulation disorder	17 (0)	3 (0)	20 (0)
Heterosexual contact	471 (9)	869 (33)	1340 (17)
Receipt of blood, components, or tissue	56 (1)	66 (3)	122 (2)
Risk not reported/Other	1762 (34)	1184 (45)	2946 (38)
Total	5197 (100)	2622 (100)	7819 (100)

	Pediatric Transmission Modes Males (%)	Females (%)	Total (%)
Hemophilia/coagulation disorder	1 (2)	0 (0)	1 (1)
Mother with/at risk for HIV infection	45 (82)	38 (86)	83 (84)
Receipt of blood, components, or tissue	0 (0)	1 (2)	1 (1)
Risk not reported/Other	9 (16)	5 (11)	14 (14)
Total	55 (100)	44 (100)	99 (100)

* Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).
** patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children. They are counted as adults/adolescent cases in tables 1, 2, and 3;and as pediatric cases in table 4.

NC HIV/STD Epidemiology & Special Studies Branch

N. C. Cumulative AIDS Cases Through December 31, 1997

HIV/AIDS Surveillance Report - 01/06/98

1. Disease Category	Adult/Adolescent * Cases (%)	Adult/Adolescent * Deaths (%)	Pediatric * Cases (%)	Pediatric * Deaths (%)	Total Cases (%)	Total Deaths (%)
PCP	2584 (32)	1901 (74)	37 (33)	26 (70)	2621 (32)	1927 (74)
Other Disease w/o PCP	3255 (41)	2272 (70)	74 (67)	32 (43)	3329 (41)	2304 (69)
KS Alone	130 (2)	88 (68)	0 (0)	0 (.)	130 (2)	88 (68)
No Diseases Listed	2013 (25)	581 (29)	0 (0)	0 (.)	2013 (25)	581 (29)
Total	7982 (100)	4842 (61)	111 (100)	58 (52)	8093 (100)	4900 (61)

2. Age *	Cases (%)
Under 5	91 (1)
5-12	20 (0)
13-19	61 (1)
20-29	1568 (19)
30-39	3757 (46)
40-49	1906 (24)
Over 49	690 (9)
Unknown	0 (0)
Total	8093 (100)

3. Race/Ethnicity	Adult/Adolescent * Cases (%)	Pediatric * Cases (%)	Total Cases (%)
White, Not Hispanic	2701 (34)	21 (19)	2722 (34)
Black, Not Hispanic	5042 (63)	88 (79)	5130 (63)
Hispanic	150 (2)	1 (1)	151 (2)
Asian/Pacific Is.	19 (0)	0 (0)	19 (0)
Am. Indian/Alaska Native	56 (1)	1 (1)	57 (1)
Unknown	14 (0)	0 (0)	14 (0)
Total	7982 (100)	111 (100)	8093 (100)

4. Exposure Category

Adult/Adolescent Transmission Modes**

	Males (%)	Females (%)	Total (%)
Men who have sex with men	3038 (46)	0 (0)	3038 (38)
Injecting drug use	1455 (22)	476 (33)	1931 (24)
Men who have sex with men and inject drugs	442 (7)	0 (0)	442 (6)
Hemophilia/coagulation disorder	98 (1)	8 (1)	106 (1)
Heterosexual contact	466 (7)	579 (40)	1045 (13)
Receipt of blood, components, or tissue	106 (2)	57 (4)	163 (2)
Risk not reported/Other	936 (14)	314 (22)	1250 (16)
Total	6541 (100)	1434 (100)	7975 (100)

Pediatric Transmission Modes

	Males (%)	Females (%)	Total (%)
Hemophilia/coagulation disorder	13 (21)	0 (0)	13 (11)
Mother with/at risk for HIV infection	44 (72)	52 (91)	96 (81)
Receipt of blood, components, or tissue	4 (7)	2 (4)	6 (5)
Risk not reported/Other	0 (0)	3 (5)	3 (3)
Total	61 (100)	57 (100)	118 (100)

* Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).

**7 patients were diagnosed with AIDS as adults but have evidence of being HIV infected as children. They are counted as adults/adolescent cases in tables 1, 2, and 3; and as pediatric cases in table 4.



1997 World AIDS Day

INFORMATION PACKET

THE WHITE HOUSE

WASHINGTON

August 15, 1997

Greetings to all those around the world observing the tenth annual World AIDS Day. On this day each year, we are called to unite in memory of those whose lives have been claimed by HIV/AIDS, and in support of all those who are courageously fighting this disease every day.

We have come a long way in our struggle to overcome this epidemic, but we still have a tough road ahead. New treatments and heightened awareness contributed to a 19 percent decline in AIDS deaths last year. However, the battle is not over. Recent years have seen a significant shift in the demographics of this epidemic, with new infections in children rising dramatically. We must recognize these changes as we renew our efforts in the fight.

This year's World AIDS Day theme, "Give Children Hope in a World with AIDS," challenges us, as Americans and as citizens of the world, to consider the long-term repercussions of this epidemic. In 1996 alone, 400,000 children under the age of 15 became infected with HIV. Furthermore, over 40 percent of the more than 23 million people living with HIV are women; and in some countries, as many as 40 percent of women visiting antenatal clinics in urban areas are HIV-positive. These numbers are alarming not only because of their direct implications for those women, but also because they signify a great danger of mother-child transmission of HIV.

As this disease infects our children, it strikes at the future of our nation and our world. We must ensure that those already infected are fully cared for and educate those not infected so that they may protect themselves. I remain fully committed to the battle against this epidemic. The strides we make today will translate into a better life for our children tomorrow.

Hillary joins me in sending best wishes for a successful World AIDS Day.

Bill Clinton

WORLD AIDS DAY OVERVIEW

What is World AIDS Day?

World AIDS Day was observed for the first time on December 1, 1988, after a summit of health ministers from around the world called for a spirit of social tolerance and a greater exchange of information on HIV/AIDS. World AIDS Day, observed annually on December 1, serves to strengthen the global effort to face the challenges of the AIDS pandemic, which continues to spread in all regions of the world. This organized effort is designed to encourage public support for programs to prevent the spread of HIV infection and to provide education and awareness of issues surrounding HIV/AIDS.

World AIDS Day 1997: *"Give Children Hope in a World with AIDS"*

The 1997 World AIDS Day theme, "Give Children Hope in a World with AIDS," challenges people around the world to contemplate the long-term repercussions of the AIDS pandemic, without losing sight that AIDS affects everyone. The theme was adapted from the Joint United Nations Programme on HIV/AIDS (UNAIDS) designated theme, "Children Living in a World with AIDS," to incorporate a message of hope. It focuses on young people under the age of 18, based on the United Nations Convention on the Rights of the Child definition of children.

Children are not helpless in a world with AIDS. They are humankind's most precious resources for change.

Overall Aim of World AIDS Day 1997

UNAIDS defines the overall aim of this year's World AIDS Day initiative as "increased understanding of the magnitude of the HIV/AIDS epidemic and its global dimensions, with an emphasis on promoting action and sound policies to prevent HIV transmission and to minimize the epidemic's impact on children, their families and their communities."

In a World with AIDS, Give Children Hope for...

- Better understanding of the magnitude and diversity of the impact of HIV/AIDS on children, their families and their communities.
- Stronger commitment, improved policies and increased action for preventing HIV infection and minimizing the epidemic's impact on children, their families and their communities.
- Increased and improved access to quality education and relevant information on the prevention and care of HIV/AIDS for children, their families and their communities.
- Greater understanding of the interaction between children's rights, human rights and HIV/AIDS.

Who Organizes World AIDS Day?

In recognition of the growing complexities of the HIV/AIDS pandemic, the United Nations created a partnership of six UN agencies in 1996. Called the Joint United Nations Programme on HIV/AIDS (UNAIDS), the program brings together the United Nations Children's Fund, the United Nations Development Programme, the United Nations Population Fund, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization and the World Bank as cosponsors of this joint effort. Through joint planning and the sharing of resources and costs, this strategic partnership permits more powerful advocacy for global action and greater support for national HIV/AIDS programs.

Formerly the World Health Organization (WHO) was the sole sponsor of the international World AIDS Day. This year UNAIDS is continuing in its second year as international sponsor of World AIDS Day.

UNAIDS Goals

UNAIDS is dedicated to achieving the following: support of a long-term response to HIV/AIDS; improvements in the quality of response by ensuring technically sound programs; a focus on the most vulnerable population groups; advocating supportive rather than coercive prevention tactics; an emphasis on human rights, regardless of HIV status; building and/or working through partnerships; assurance of national autonomy; and a desire to complement existing efforts rather than duplicating them.

While the new joint program is headquartered in Geneva, Switzerland, its staff includes Country Program Advisers and Inter-country Technical Advisers strategically located around the globe. In addition, for the first time, the UN has invited non-governmental organizations (NGOs) and people living with HIV/AIDS to sit on the Program Coordinating Board.

By providing assistance to countries and ensuring "international best practice," UNAIDS supports research and works with existing programs to lead an expanded and more powerful international response to HIV/AIDS.

American Association for World Health

The American Association for World Health (AAWH), located in Washington, DC, serves as the U.S. Committee to WHO and the Pan American Health Organization (PAHO). In cooperation with the U.S. Department of Health and Human Services, PAHO and the Centers for Disease Control and Prevention (CDC), AAWH coordinates efforts for World AIDS Day in the United States.

FACT SHEET

10 Things to Know about HIV/AIDS

1. The AIDS pandemic has left no continent untouched. As of December 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that 22.6 million men, women and children worldwide were living with HIV/AIDS and over 6.4 million people had already died as a result of the infection.

2. AIDS (acquired immunodeficiency syndrome) results from the late stage of infection with HIV (human immunodeficiency virus). In some adults, AIDS can take more than 10 years to develop. Thus, a person infected with HIV may look and feel healthy for many years, but he or she can still transmit the virus to someone else, which is why it is very important for individuals to get tested.

3. HIV is found in the following types of fluid:
   - semen (and pre-ejaculate fluid)
   - vaginal secretion
   - blood
   - breast milk

4. To protect yourself and your partner, get tested! 1 out of 3 Americans have been tested for HIV.

5. Sexual transmission of HIV can be prevented. Sexual intercourse, whether heterosexual or homosexual, is the major route of transmission of HIV.

   You can prevent sexual transmission of the virus by:
   - abstaining from sexual intercourse (this is the only 100% safe and effective way to avoid HIV infection.)
   - practicing mutual monogamy (having sex with only one partner who has sex only with you) with an uninfected partner

   You can significantly reduce the risk of spreading HIV through sexual intercourse by:
   - using latex condoms correctly from start to finish with each act of vaginal or anal intercourse and with each act of oral sex on a man
   - using a condom cut open, dental dam, or household non-microwavable plastic wrap while performing each act of oral sex on a woman
   - engaging in safer sex practices that involve no penetration such as dry kissing, massaging, hugging, touching, body-rubbing, and masturbation.

6. HIV does not survive long outside the body, and therefore can only be transmitted when certain types of body fluid (see above) of an infected individual enter an uninfected individual.

   Examples include:
   - having unprotected sex (vaginal, anal or oral) with someone infected with HIV
   - sharing needles to inject illegal and other drugs including steroids, or for body piercing or tattooing, with someone infected with HIV (HIV-infected blood is passed directly into your blood from needles or syringes)
   - from an infected mother to her child during pregnancy or delivery, or in infancy through breastfeeding.

7. Infection through blood can be stopped. Blood for transfusion is tested for HIV infection and discarded if contaminated. Needles, syringes, and other skin-piercing instruments should be sterilized or discarded after each use and should never be shared because if other people use the same instrument, they could be shooting HIV directly into their bloodstream.

8. You do not get HIV from:
   - donating blood
   - mosquito bites and other bug bites
   - sharing cups and utensils
   - sneezes or coughs
   - hugging, touching, or dry kissing a person with HIV
   - sharing telephones, computers or coffee pots
   - going to any public place with HIV infected people (pools, movies, etc.)
   - drinking fountains or toilet seats

9. Discrimination against people with HIV/AIDS—or those thought to be at risk of infection—violates individual human rights and endangers public health. It gives people outside the stigmatized group a sense that the threat of infection, and thus the need for personal precautions, has been removed.

10. "HIV/AIDS is a disease of the young." –UNAIDS. As of December 1996, 2.6 million children were infected with HIV worldwide. UNAIDS estimated that more than 9 million children under age 15 had lost their mothers to AIDS, and that one in three children orphaned by HIV/AIDS is younger than 5 years old.

1997 • American Association for World Health • 1825 K St. NW, Ste 1208 • Washington, DC 20006 • www.aawhworldhealth.org

HIV/AIDS Prevention

Prevention Works!

CDC—Centers for Disease Control and Prevention—is optimistic about the progress made in curbing the spread of HIV in the United States. The number of new AIDS diagnoses has leveled off to the current rate of 3-5% increase in new cases each year, compared to more than 85% increase per year at the beginning of the epidemic.

Message to Young Adults

The 15-24 age group now comprises the majority of new adult HIV infections. Between 1990 and 1995, AIDS incidence among young heterosexual men and women aged 13-25 rose more than 130%. A balance of prevention messages is important for young adults:

- Total abstinence from sexual activity is the only sure way to prevent sexual transmission of HIV infection.
- For those who choose to participate in sexual activity, consistent and correct use of latex condoms is highly effective in preventing the transmission of HIV and other sexually transmitted diseases (STDs).

Consistent and Correct Use of Condoms

What does "consistently and correctly" mean?

Consistently means using a latex condom from start to finish each time you have anal, oral or vaginal sex.

Correctly means following these steps:

1. Use a new condom for each act of intercourse.
2. Put the condom on after the penis is erect and before any genital contact (vaginal, anal or oral). If the penis is uncircumcised, pull the foreskin back before putting on the condom.
3. Hold the tip of the condom and unroll it onto the erect penis, pinching the tip of the condom to ensure that no air is trapped in the condom's tip.
4. Withdrawal should occur immediately after ejaculation, holding the condom firmly to keep it from slipping off.
5. If the condom breaks or slips during sex, stop and put on a new condom.

Other tips for condom use

- Use latex condoms. Look for the words "latex" or "For Disease Protection" on the package. Lambskin and natural membrane condoms are not an effective form of disease prevention because the pores in the material have been shown to allow the passage of viruses.
- Only use water-based lubricants, such as glycerin or lubricating jelly. NEVER use an oil-based lubricant, such as petroleum jelly, cold cream, hand lotion or baby oil.
- Store condoms properly in a cool, dry place out of direct sunlight. If you want to keep one with you, put it in a loose pocket, wallet or purse for no longer than a few hours at a time.
- Do not use expired condoms. Check the date.
- Do not use a condom if it is sticky or torn.

If your sexual behavior places you at risk for HIV infection, using latex condoms correctly every time you have sex can greatly reduce, but not totally eliminate, your risk. For more information, contact the CDC National AIDS Clearinghouse at 1-800-458-5231 or the CDC National AIDS Hotline at 1-800-342-2437.

The Female Condom

Reality®, the female condom, is the only disposable barrier device designed for women to protect themselves from STDs, including HIV. The female condom is most beneficial for women whose sex partners do not use latex male condoms.

- Made of a polyurethane sheath, the condom is unlikely to rip or tear, comes prelubricated, and is meant to be used for only one sex act.
- The condom is inserted manually into the vagina before intercourse. It can be placed up to several hours before sexual activity.
- The female condom does not have to be immediately removed after ejaculation. Neither removal nor insertion requires an erect penis.
- The Food and Drug Administration (FDA) advises couples NOT to use both the female and male condoms at the same time.
- Female condoms do not cause allergic reaction.
- No special storage conditions are required. Polyurethane is resistant to adverse temperature and humidity conditions.
- You do not need to see a health care professional to purchase the female condom, but counseling prior to initial use is recommended.

For more information, contact The Female Health Company at 1-800-274-6601.

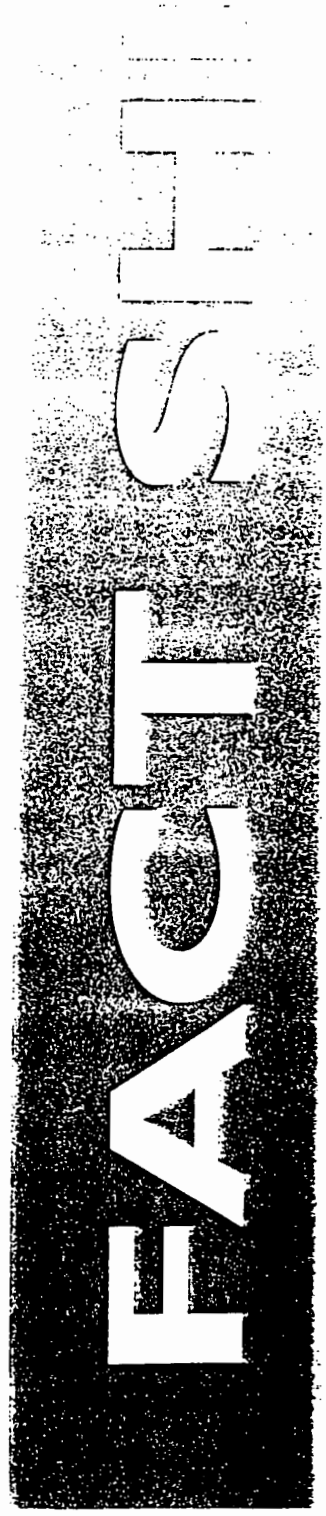
Message to HIV-Positive Pregnant Women

In 1996, 92% of reported pediatric HIV infection cases in the United States resulted from vertical transmission (mother-to-child), according to CDC. Research has concluded that the antiviral drug AZT (zidovudine) reduces the rate of vertical transmission of HIV by 68% when administered to HIV-positive women in pregnancy and to their newborns. Mother-to-child transmission rate was 25.5% without AZT, and 8.3% with AZT.

- Early prenatal care is essential. Women who are unsure of their HIV status should get tested to safeguard the health of their baby.
- AZT treatment requires pregnant women to take antiviral drugs early in their pregnancy and for an intravenous infusion during delivery.

Prevention for ALL Populations

According to the Center for AIDS Prevention Studies at the University of California San



FACT SHEET

HIV/AIDS & STDs

Sexually transmitted diseases (STDs) are infections contracted through sexual contact—vaginal, oral or anal—with an infected person. The bacteria or viruses that cause STDs are transmitted through bodily fluids such as blood, semen and vaginal secretions.

- Among adults, there are 333 million new cases of gonorrhea, chlamydial infection, syphilis, chancroid, and trichomoniasis worldwide each year.
- The United States has the highest rates of STDs in the industrialized world, with rates that are 50-100 times higher than other industrialized nations.
- There are an estimated 12 million new cases of STDs in the United States each year. Of these, 3 million occur among teenagers, 13 to 19 years old.
- At least 40 million Americans have evidence of a past STD, or 1 in every 6 Americans.
- There are more than 25 STDs, including HIV.

Relationship between HIV infection and STDs

- HIV transmission is at least twofold to fivefold higher when other STDs are present. Genital sores and breaks in the skin caused by STDs permit HIV to enter the bloodstream more easily.
- Like other STDs, HIV infection can be prevented by the consistent and proper use of latex condoms.

STD Prevention

- The only 100% safe and effective way to prevent getting an STD through sexual intercourse is abstinence (if always practiced).
- Mutual monogamy (having sex with only one person who only has sex with you) with an uninfected partner can also prevent you from getting an STD.
- Latex condoms do not ensure 100% protection from STDs, but are the next best method for avoiding infection when used properly and consistently. (See Fact Sheet on Prevention.)

Symptoms of STDs

There are often no symptoms of STD infection. However, indicators of STD infection include sores, bumps or blisters near genitals or mouth and burning or pain during urination. Women may experience vaginal discharge, irregular bleeding, or lower abdominal pain. Men may notice drip or discharge from the penis or pain in the testicles. Only your doctor can tell you if you have an STD.

Dangers of STDs

If STDs are untreated, both men and women can become sterile. Infections in men also usually cause mild to moderate genital or urinary tract problems. In women, STDs may lead to cervical cancer, inflammation of the uterus and ectopic (tubal) pregnancies. STDs can be passed from an infected mother to her baby during pregnancy or delivery, causing disease or death in the fetus or newborn. STDs also facilitate the transmission of HIV.

Can STDs be cured?

- There is no cure for herpes, genital warts or HIV, but most STDs can be cured using antibiotics if treated early.
- Herpes can be treated to reduce frequency of outbreaks, and genital warts can be removed.
- CDC and other health officials strongly recommend vaccination against the Hepatitis B virus.

HIV/AIDS & Tuberculosis

Tuberculosis (TB) is an airborne infectious disease that spreads when a person with active TB coughs, laughs, sneezes or talks. TB is not spread through contact with objects, such as dishes or clothing. Once infected with TB, individuals will remain infected for the rest of their lives. In most infected people, the TB germ remains dormant and does not cause sickness. A person with inactive TB cannot spread the disease to others.

- One third or more of the world's population is infected with TB.
- The symptoms of TB can include prolonged cough, chest pain, fevers, chills, loss of appetite, weight loss, fatigue or night sweats. If left untreated, TB can affect the brain and spinal cord or be fatal.
- TB disease can be prevented. Patients infected with TB need to complete the treatment to prevent the development of drug-resistant bacteria.
- People with active TB should cover their mouths and noses when they cough, sneeze or laugh.

Relationship between HIV/AIDS & TB

- Because HIV infection weakens the immune system, the progression from TB infection to TB disease in HIV-positive individuals is more rapid and 30 times more likely to occur.
- The presence of HIV can make the diagnosis of TB more difficult.
- More HIV-positive individuals die from TB than from any other cause.

For more information on TB, contact your local or state health department.

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ACTIVITY IDEAS

☆ indicates activity may involve persons under the age of 18

IN THE CLASSROOM

IN THE CLASSROOM support comprehensive school health education:

☆ Set aside class time for a special lesson on HIV/AIDS.

☆ Hand out and discuss the 10 Things You Need to Know About HIV/AIDS found on page 20 of this booklet.

☆ Start a peer education program where students educate other students about HIV/AIDS.

☆ Have older students from the local high school trained on HIV/AIDS talk to younger junior high or elementary school students.

☆ Invite a young adult with HIV/AIDS as a guest speaker to your class.

☆ Form a youth theater group or club that performs plays addressing HIV/AIDS and other adolescent health issues.

☆ Show videos in which other teens talk about their personal experiences with HIV/AIDS. Some possible videos include:

"In Our Own Words: Teens & AIDS" (Media Works, 1-800-600-5779)

"Teen: AIDS in Focus" (San Francisco Study Center, 415-626-1650)

"AIDS Not Us" (HIV Center for Clinical & Behavioral Studies, New York State Psychiatric Institute 212-543-5788)

"Sex, Drugs and HIV" (ODN Productions, Inc., 1-800-707-MEDIA)

"Don't Forget Sherrie" (Call you local American Red Cross chapter)

An additional listing of movies/films/videos is available under "Colleges and Universities."

☆ Subscribe to Straight Talk: A Magazine for Teens, a series of topical magazine-style publications for adolescents about important health topics and lifestyle issues. (Call The Learning Partnership, 1-800-551-7672, for more information.)

☆ Make adolescents aware of the free AIDS hotlines staffed by trained students available to them:

TEENS TAP (Teens Teaching AIDS Prevention)

1-800-234-TEEN, Monday-Friday 5 pm to 9 pm EST

The Teen AIDS Hotline

1-800-440-TEEN, Fridays and Saturdays 6 pm-12 am EST

Check your phone book's *Human Services* section for other local hotlines.

☆ Have students in class form small groups and discuss their ideas and questions about HIV/AIDS. (The Harvard Pilgrim Health Care Foundation's AIDS Prevention Project has designed a FIRST AIDS KIT to help facilitate discussion among young adults, 1-800-4-AIDS-KIT.)

☆ Prepare a current events bulletin board for students to fill with newspaper or magazine articles about HIV/AIDS; have students present and discuss the articles.

☆ Create a special HIV/AIDS writing assignment due on December 1 (or any day): essay, poem, book report, or research report about the responsibility we all share in addressing the HIV/AIDS pandemic. (See Creative Crayons and Composition Competition on pp. 34-35.)

☆ Have students locate statistics and articles about HIV/AIDS from different regions of the world and different age/sex groups to illustrate that no one is immune to HIV/AIDS.

☆ Sponsor a poster, T-shirt or bumper sticker design contest for the "Give Children Hope in a World with AIDS" theme.

☆ Role play to make students aware of instances of discrimination associated with HIV/AIDS.

☆ Create a board game/quiz on HIV/AIDS facts.

☆ Invite a health practitioner who works with HIV/AIDS patients to come and talk to students.

☆ Prepare a lesson that addresses how drug and alcohol use impair judgment and therefore increase risk of HIV infection.

☆ Write a letter or article for the school newspaper about HIV/AIDS.

☆ Air public service announcements about HIV/AIDS over the school public address system. (See Public Service Announcements box on p. 39.)

☆ After completion of a lesson/project on HIV/AIDS, have students create informational brochures about HIV/AIDS to educate adults.

☆ Plan a special session for the parents to learn about talking with their children about HIV/AIDS. (See Talking about HIV/AIDS: Tips for Parents on page 14.)

☆ Obtain or create a video for teaching parents the facts about HIV/AIDS.

☆ Bring the AIDS Memorial Quilt to your high school. Contact the National High School Quilt Program at the NAMES Project Foundation, (415) 882-5500.

☆ Call the CDC National AIDS *Classroom Calls* hotline in your class at 1-800-342-AIDS.

AT COLLEGES & UNIVERSITIES

AT COLLEGES AND UNIVERSITIES work with university administrators, faculty, staff and students:

- Organize a lecture or panel discussion on HIV/AIDS. Invite speakers to your school from local hospitals, AIDS clinics or AIDS Service Organizations (ASOs).
- Arrange special service projects by university, civic, religious and social clubs.
- Organize HIV/AIDS discussion workshops or an open house with student educators in informal settings such as the student center or in dormitory lounges. Distribute information on HIV testing and prevention (see Testing and Prevention Fact Sheets).
- Sponsor a benefit theater production or music concert, from which proceeds go to a local HIV/AIDS organization.
- Encourage the varsity athletic department to sponsor a benefit football (basketball, hockey, etc.) game on December 1, from which proceeds go towards HIV/AIDS prevention and education centers.
- Participate in National Condom Week in February and hand out free condoms on Valentine's Day.
- Sponsor a T-shirt/button/pencil sale or walk/run to benefit an HIV/AIDS program in your area.
- Distribute keyrings containing condoms and an HIV/AIDS awareness message.
- Create tabletop displays (table tents) with World AIDS Day messages and place on cafeteria tables.
- Collect photographs, posters, articles and drawings reflecting that people of all ethnicities, ages, genders and sexual orientations can be infected with and affected by HIV; ask different student groups to submit a piece and create a mural display for campus.
- Hold a film festival featuring films about or that deal with HIV/AIDS. Suggestions include:

Jeffrey (R)	And the Band Played On (PG-13)
It's My Party (R)	A Mother's Prayer (PG-13)
Peter's Friends (R)	Boys on the Side (R)
Common Threads (NR)	Philadelphia (PG-13)
Longtime Companion (R)	Wigstock (R)

- Write an article or letter to the editor of the school paper; include statistics about the prevalence of HIV infection and AIDS in your school and/or your community.
- Coordinate with local bars and restaurants to give out free condoms; pass out literature focusing on the high correlation of HIV transmission and alcohol consumption.
- Invite a local HIV testing center/clinic to your campus on December 1 for students who would like to be tested or receive counseling.
- Create an HIV/AIDS Awareness Committee to educate your campus about HIV/AIDS and host seminars on HIV/AIDS prevention.
- Photocopy and distribute 10 Things You Need to Know about HIV/AIDS and HIV Prevention Fact Sheets on World AIDS Day.
- Support long-term HIV/AIDS prevention education at your college/university.

IN THE COMMUNITY

IN THE COMMUNITY work with your state and local health departments:

- ☆ Mobilize groups of which you or your children are a member to participate in World AIDS Day 1997.
- Organize the presentation of a World AIDS Day proclamation from a town/community official.
- ☆ Participate in and/or organize an HIV/AIDS fundraising event or community program.
- ☆ Create a way to include a World AIDS Day observance as part of your favorite spectator sport.
- ☆ Decorate trees, buildings and lampposts with red ribbons.
- Write a letter or op-ed article to your local newspaper demonstrating support for World AIDS Day 1997. (See Media Outreach Guide, pp. 36-39.)
- ☆ Show a video or film that deals with HIV/AIDS at your local library and hold a discussion after its showing. Arrange for a representative from a local AIDS service organization to be present to answer questions after the film and to moderate the discussion. (See listing of film/video suggestions under Colleges and Universities.)
- Contact the NAMES Project and bring The AIDS Memorial Quilt to your community, (415) 882-5500.
- ☆ Sew squares for the AIDS Memorial Quilt and present them to the NAMES Project. Contact local children's and teen groups such as Brownies, Cub Scouts, Girl Scouts, Boy Scouts, little leagues and cheerleading and ask that the children draw a square for the quilt; choose the best drawings and use them as a guide when sewing. Provide community recognition for the submissions.
- ☆ Coordinate with a local medical school to start the STATS project in your area. STATS—Students Teaching AIDS to Students—prepares medical students to visit schools and other youth community centers in order to teach young people about HIV infection and AIDS. For more information, contact the American Medical Student Association (AMSA) at (703) 620-6600 ext. 454.
- Deliver pamphlets on HIV/AIDS testing for pregnant women to local physicians.

- ☆ Set up a special display of books and resource materials about HIV/AIDS at your local library.
- Volunteer—become a trained Red Cross HIV/AIDS instructor or a member of a support group for those affected by HIV/AIDS.
- ☆ Organize performances by musicians and artists to raise money and awareness.
- Celebrate "DAY WITHOUT ART" to inspire meaningful discussions about HIV/AIDS and increase awareness. (For information on planning "DAY WITHOUT ART," please contact Visual AIDS, (212) 627-9855; 526 W 26th Street, Room 510, New York, NY 10001.)
- ☆ Ask local AIDS groups to participate in or sponsor special events. They can provide prevention information or show videotapes at community functions. A group could sponsor an educational display at a school, place of worship, library or workplace.

IN YOUR FAITH COMMUNITY

IN YOUR FAITH COMMUNITY encourage long-term commitment to HIV/AIDS:

- Hold a candlelight service of remembrance for those affected by HIV/AIDS; contact your local AIDS ministry program and coordinate with them. Plan to participate in the International AIDS Candlelight Memorial on May 17, 1998. (For more information, see box on page 46.)
- Support World AIDS Day call to action by joining with other congregations in the "17 Bells" project: Ring your steeple bell 17 times at 2:00 pm on December 1 signifying the 17 years of the epidemic. (For more details, contact the AIDS National Interfaith Network, (202) 842-0010.)
- Encourage your religious leader to speak about HIV/AIDS in sermons and invite an individual living with HIV/AIDS to share his or her story.
- ☆ Observe a moment of silence during services for those who have died of AIDS.
- ☆ Focus on the impact of HIV/AIDS during religious education programs; invite people living with HIV/AIDS to speak; coordinate with local AIDS ministry or community-based AIDS organizations.
- Contact the national office of your religious affiliation or one of the religious organizations listed on pages 41-43 and ask for information about what is happening within your national religious organization with regard to HIV/AIDS programs and policies.
- Start an AIDS ministry within your congregation or with others in your community.
- ☆ Start a service program: members of your congregation can work with a local AIDS group to provide meals, transportation, shelter, companionship or other services to people living with HIV/AIDS.
- ☆ Bring the AIDS Memorial Quilt to your congregation. Contact the National Interfaith Quilt Program, (415) 882-5500.

GOVERNMENT

GOVERNMENT can also participate in World AIDS Day:

- Adopt a proclamation (see Sample Proclamation, page 28) urging citizens to take part in World AIDS Day activities and observances designed to increase awareness and understanding of HIV/AIDS, its impact on children, and that the epidemic continues despite new hope in treatment.
- Encourage your communities to join the White House in dimming their lights as a visual demonstration expressing the worldwide commitment to stop the spread of HIV/AIDS, from 7:45 pm to 8:00 pm on December 1.
- Perform HIV/AIDS needs assessment in your community and develop policies that address unmet needs, especially those of traditionally underserved populations including individuals and families living in rural communities, adolescents, Native Americans, homeless individuals and families, hemophiliacs, and incarcerated individuals.
- Hold an open Town Meeting to discuss HIV prevention, education and treatment needs in your community.
- Provide your community with statistics on HIV infection rates in your area and use these numbers as a call to action.

IN HEALTH CARE SETTINGS

IN HEALTH CARE SETTINGS work with staff to improve HIV/AIDS prevention and care:

- Organize a workshop to educate health professionals on the ethical issues surrounding HIV/AIDS.
- Contact AIDS service organizations serving various ethnic and racial groups and ask that they make a presentation to your staff regarding cultural sensitivity and HIV.
- Mobilize the communications department in your institution to develop World AIDS Day messages to be distributed throughout the institution as well as surrounding communities.
- Offer routine HIV prevention services and be persistent in prevention efforts.
- Develop a questionnaire for taking an HIV risk history.
- ☆ Visit a local school on World AIDS Day or any day to teach students and educators about HIV/AIDS.

AT WORK

AT WORK launch your Business Responds to AIDS (BRTA) program or Labor Responds to AIDS (LRTA) program. Obtain BRTA/LRTA materials from the CDC National AIDS Clearinghouse, 1-800-458-5231 or other workplace material from the National AIDS Fund Workplace Resource Center at (202) 408-4848:

- Distribute World AIDS Day information.
- Ask your employer to help establish December 1 as a day to address the issue of HIV/AIDS in your workplace.
- Submit a proclamation to your employer stating that your organization recognizes World AIDS Day.
- Organize a meeting to establish or clarify office policy concerning HIV/AIDS education and awareness.
- Educate employees on the protection of people with HIV/AIDS and on non-discrimination laws.
- Donate products and services to HIV/AIDS programs.
- Initiate a program to have World AIDS Day messages inserted in paycheck envelopes and printed on bags and cartons.
- Develop and distribute tray liners for the cafeterias reminding people about the importance of HIV/AIDS awareness.

☆ Organize an HIV/AIDS fundraising event (run, walk, bike) and invite the community.

- Develop cards with the World AIDS Day logo, your business logo, and the national and local AIDS hotline numbers.
- Make a long-term commitment for comprehensive HIV/AIDS prevention education to include policy development, training managers, supervisors and executives in that policy, employee and family education, and the development of corporate/community service and volunteerism. Your local AIDS service organization, Red Cross or AFL-CIO can provide workplace education materials, including training manuals, videos and brochures.
- Encourage your office to display posters, flyers or brochures about HIV/AIDS.

☆ Emphasize family awareness and encourage employees and co-workers to educate their families about HIV/AIDS prevention.

Program in Action: LABOR*cares*

Labor Cares! is a coalition of labor organizations responding to the challenges presented in the workplace by the HIV/AIDS epidemic. Its goals include:

- to provide visibility for the labor movement regarding HIV/AIDS issues
- to prepare trade unionists and unions to respond to HIV/AIDS issues, such as civil rights, insurance and benefits
- to provide outreach, resources and information to workers affected by HIV/AIDS
- to act as a bridge to the Labor Responds to AIDS initiative of the Centers for Disease Control and Prevention.

For more information about Labor Cares! contact the HIV/AIDS Workplace Education Project at (301) 431-5453.

INDIVIDUALS

ONE PERSON can make a difference; as an individual you can:

☆ Talk to your friends and family about HIV/AIDS testing and prevention. (See Fact Sheets on Talking about HIV/AIDS: Tips for Parents, HIV Prevention and HIV Testing.)

☆ Discuss HIV infection openly with your sex partner.

☆ Get tested if you have been put at risk.

☆ Correct misinformation about HIV and AIDS. Speak up when family and friends do not know the facts.

☆ Call your state's AIDS Hotline to find out how you can help in your community.

☆ Distribute to others and/or wear a red ribbon as a symbol of hope.

☆ Write to your congresspersons and encourage them to take responsibility and encourage an active response to the HIV/AIDS needs in your community.

☆ Contact your local school board. Urge them to make a long-term commitment to develop and support HIV prevention education within comprehensive school health education.

☆ Read a book or watch a movie/film about HIV/AIDS issues (see listing of videos under "Colleges and Universities").

☆ Attend lectures, seminars and classes about HIV/AIDS.

☆ Make a donation to local community HIV/AIDS programs.

☆ Visit someone who has AIDS who is homebound or in the hospital.

☆ Volunteer at a local AIDS service organization.

☆ Write letters to the editor of your local newspaper; emphasize that accurate AIDS education and prevention information are important.

☆ Express appreciation to news media when they accurately report on HIV/AIDS issues as well as when television and radio stations air public service announcements regarding HIV/AIDS.

SUGGESTED PRESS RELEASE

FOR IMMEDIATE RELEASE
DATE:_____

CONTACT:_____

WORLD AIDS DAY TO BE OBSERVED DECEMBER 1st

December 1st will be the tenth annual observance of World AIDS Day. Over 190 countries around the world, including the United States, have designated this day to draw attention to the HIV pandemic. World AIDS Day originates with the World Health Organization (WHO), a specialized health agency of the United Nations, and is sponsored in the United States by the American Association for World Health. This year the Joint United Nations Programme on HIV/AIDS (UNAIDS) is continuing in its second year as international sponsor of World AIDS Day.

This year's theme for World AIDS Day is "Give Children Hope in a World with AIDS." The aim of this theme is to emphasize that even persons under the age of 18 years are affected--directly and indirectly--by HIV/AIDS. WORLD AIDS Day this year aims to increase understanding of the magnitude of the HIV/AIDS epidemic, its global dimensions and that it continues despite new hope in treatment. It emphasizes promoting action and sound policies to prevent HIV transmission and to minimize the epidemic's impact on children, their families and their communities.

Locally, (your agency) will be sponsoring several activities during World AIDS Day to spread the message of HIV prevention in __(county)__. Local activities planned for World AIDS Day will include __(activity, date, time, place)__.

"The recognition of World AIDS Day will give us the opportunity to focus attention on this devastating pandemic that affects us all." __(agency director)__ said. "More than 21 million people worldwide are currently living with HIV/AIDS. Children under the age of 15 years account for 830,000 of the 21.8 million living with the disease. It is important for everyone in (your county) to understand how they can protect themselves from HIV and how they can

help those who are infected," _(he/she)_ said.

For more information about HIV and how you can help, contact ___(your agency)___ at __(phone)__.

###

North Carolina

- In 1994, HIV/AIDS was the leading cause of death among African Americans aged 15-44 living in North Carolina. Because the median time from infection to AIDS is 10 years, this indicates that many AIDS cases were infected while they were teens.

- As of September 30, 1997, North Carolina had 7946 cumulative reported AIDS cases: 6495 in adult/adolescent males; 1451 in adult/adolescent females, and 117 cases in children under 13.

- During the first nine months of 1997, 690 new cases of AIDS were reported in North Carolina, including 511 adult/adolescent males, 179 adult/adolescent females and 6 cases aged 12 and under.

- In North Carolina in 1996, 457 of the newly reported adult/adolescent AIDS cases were among African Americans. Also, 183 of the newly reported female AIDS cases were among African Americans.

- As of September 30, 1997, North Carolina had 7779 cumulative reported HIV cases, 74% of those were in the 20 to 39 year age group.

- During the first 9 months of 1997, 926 new HIV infections were reported in North Carolina, including 604 among adult/adolescent males, 313 among adult/adolescent females, and 7 among children aged 12 and under.

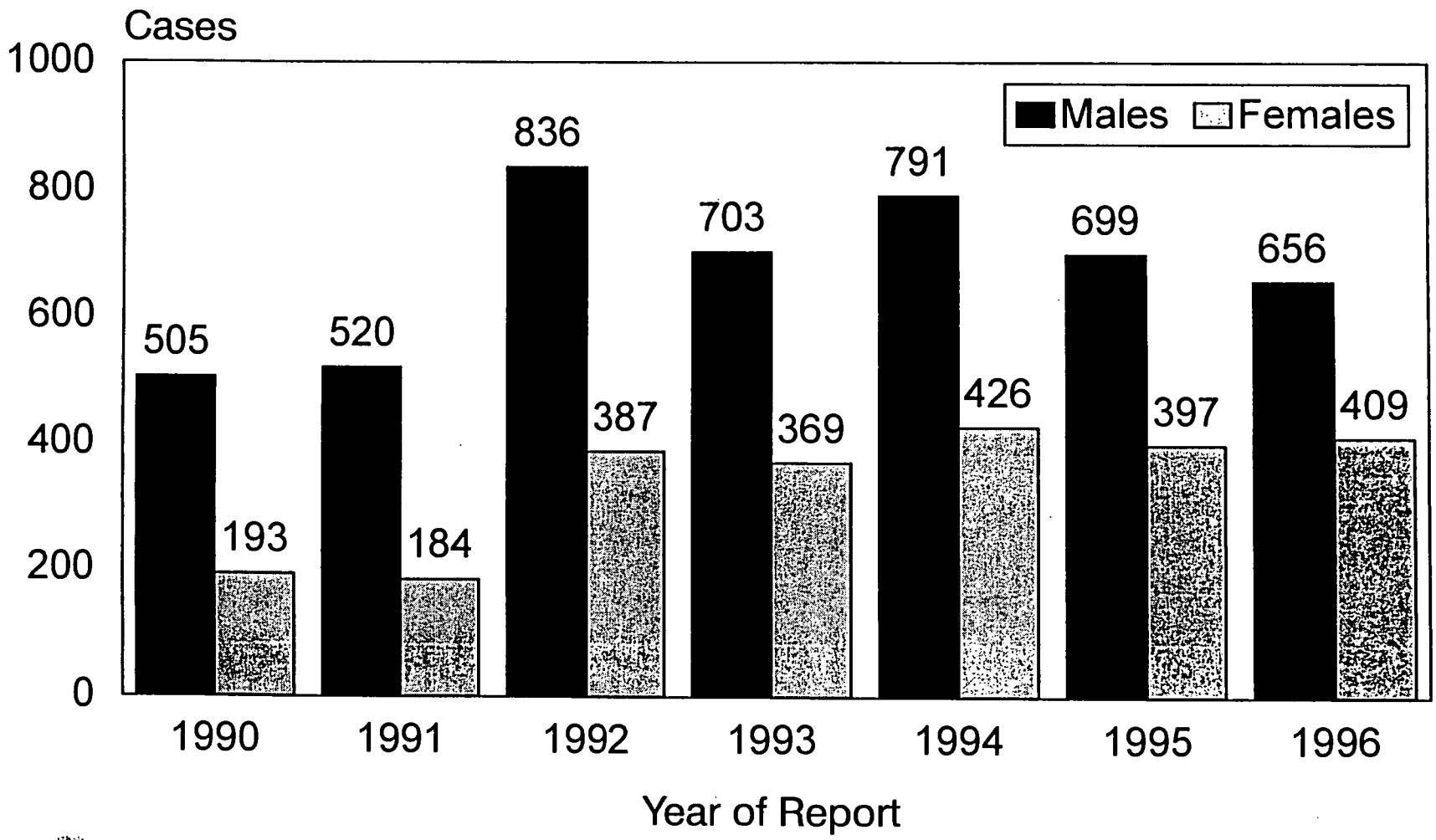
- As of September 30, 1997, North Carolina had 263 cumulative reported HIV cases among adolescents aged 13 to 19.

- During the first 9 months of 1997, there were 12,767 reported cases of gonorrhea in North Carolina, 3869 of which were among adolescents aged 13 to 19 years.

- As of September 30, 1997, 1266 cases of syphilis had been reported in North Carolina, 105 of which were among adolescents aged 13 to 19 years.

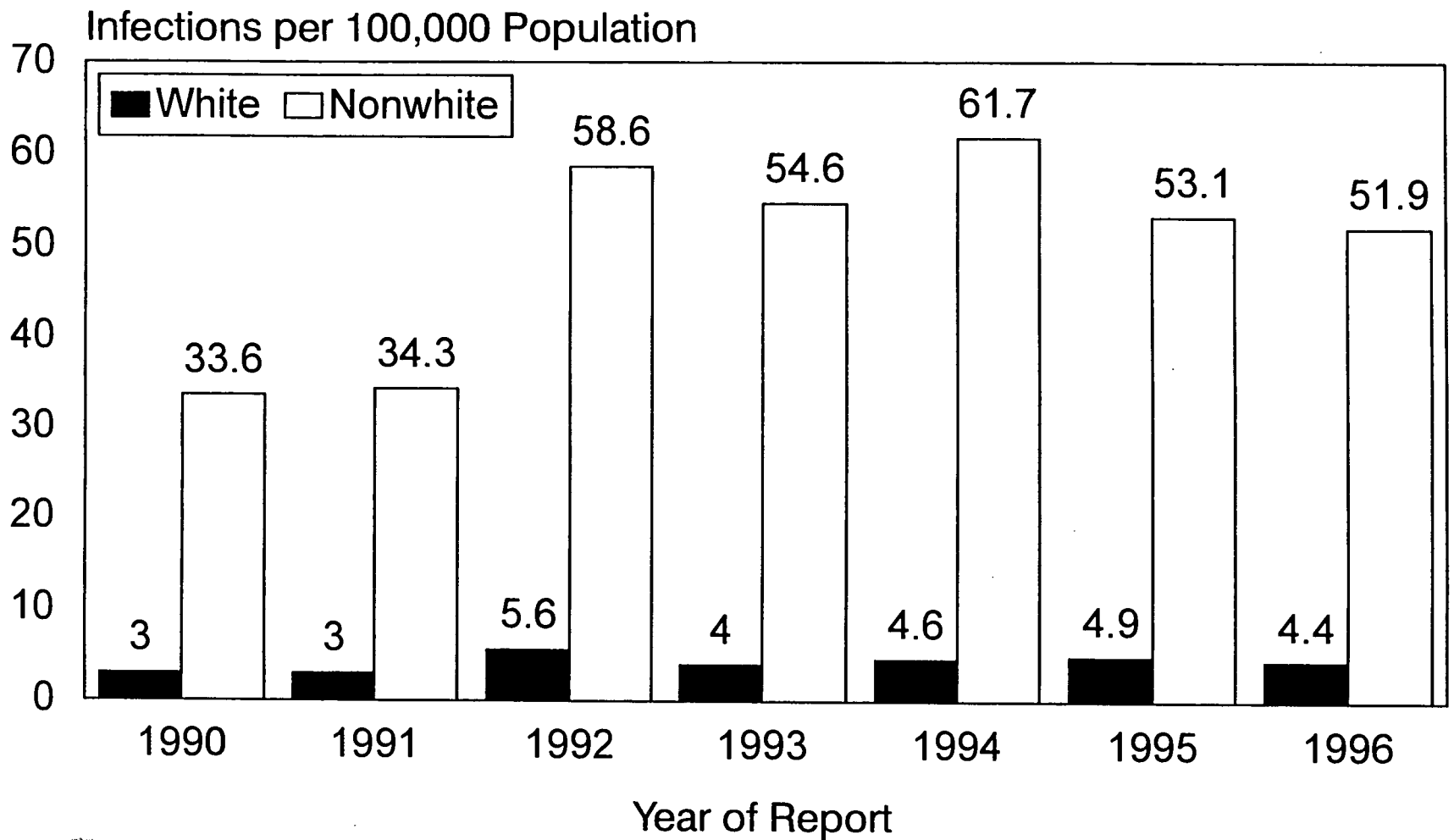
HIV/STD Control Section, Epidemiology and Special Studies Branch, 11/97

HIV Infections by Year of Report and Gender



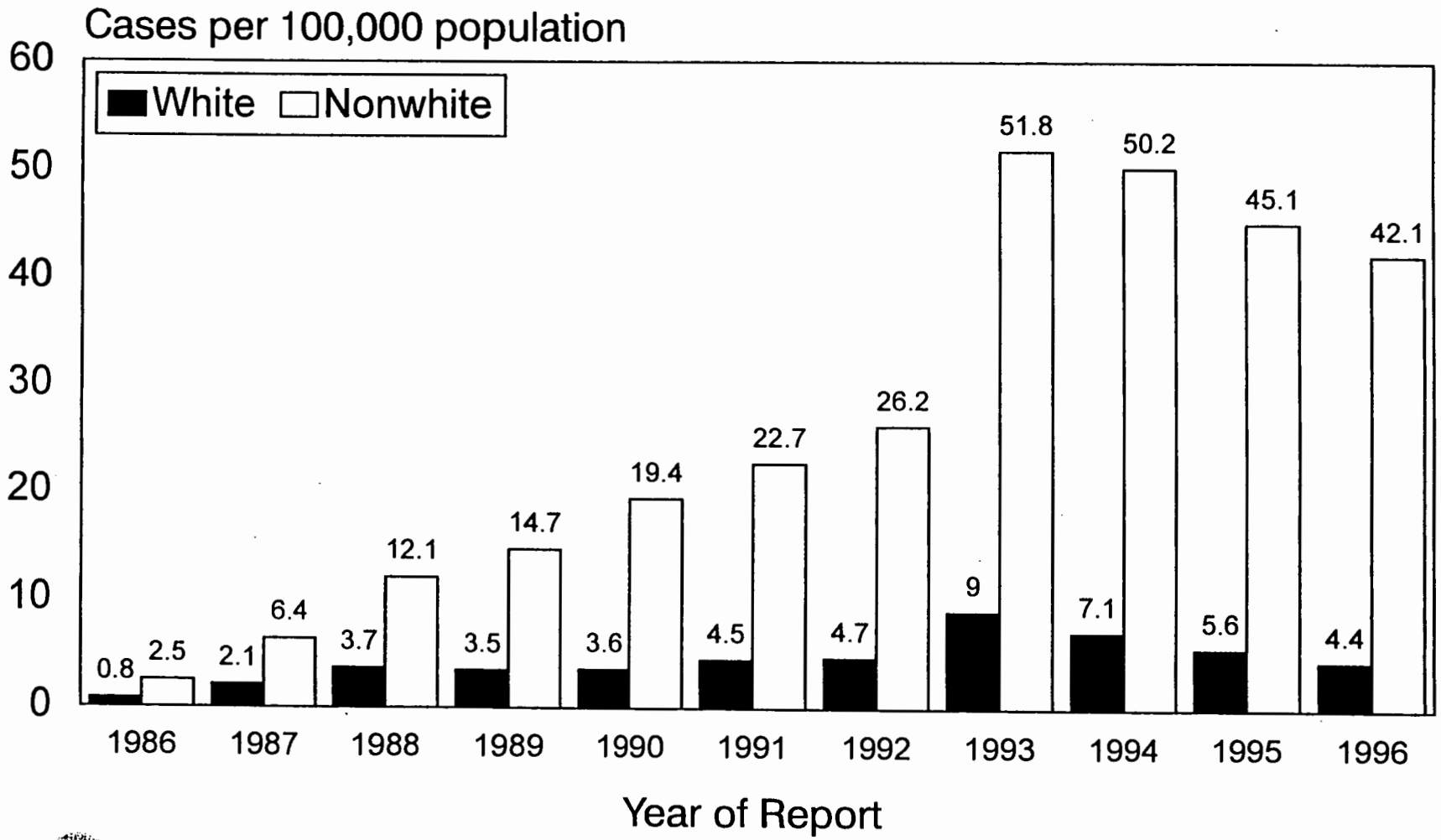
HIV/STD Prevention and Care Section, 6/97

HIV Infections by Year of Report and Race



HIV/STD Prevention and Care Section, 6/97

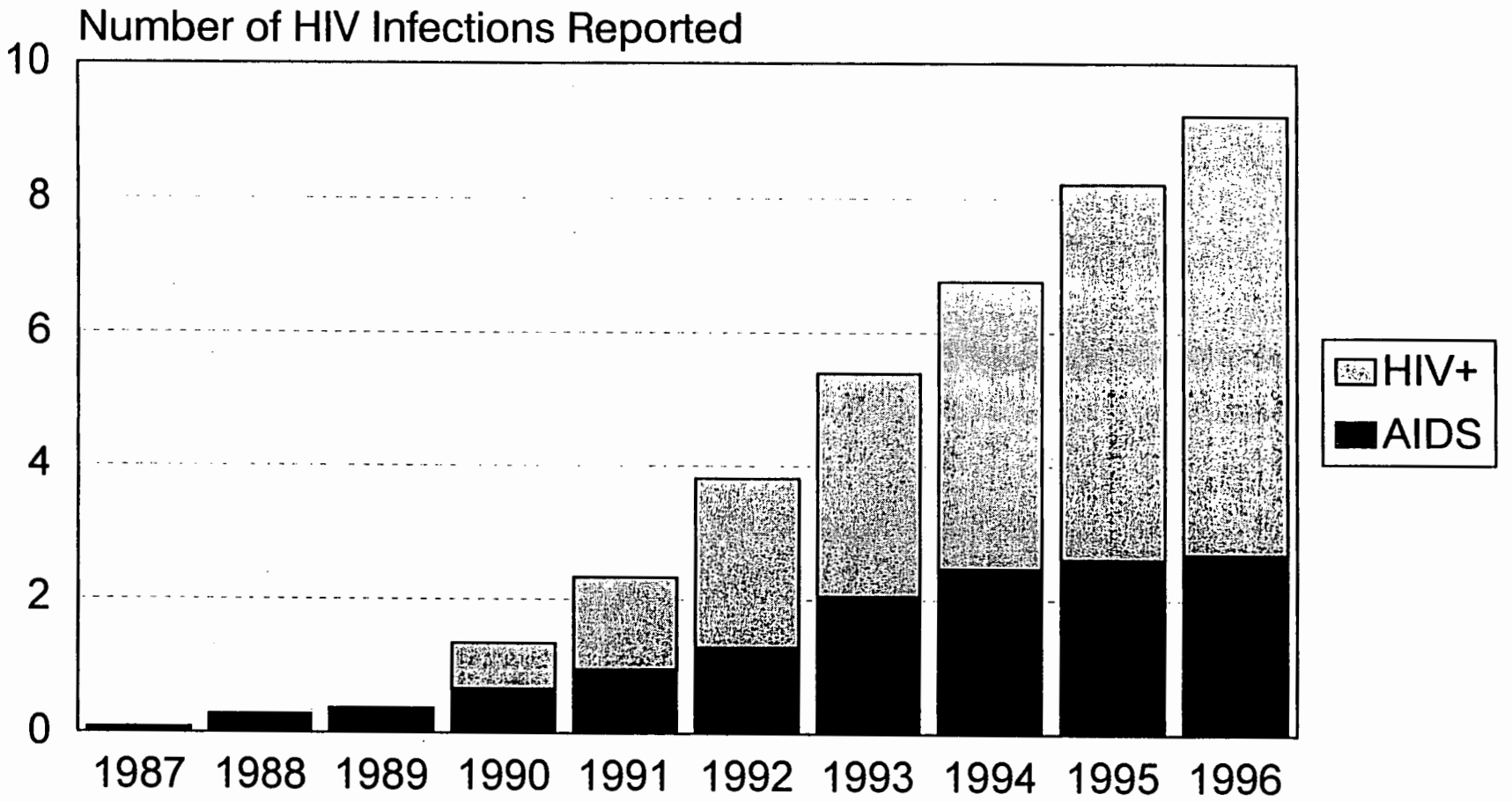
AIDS Cases by Year of Report and Race



HIV/STD Prevention and Care Section, 6/97

Persons Living with HIV in NC

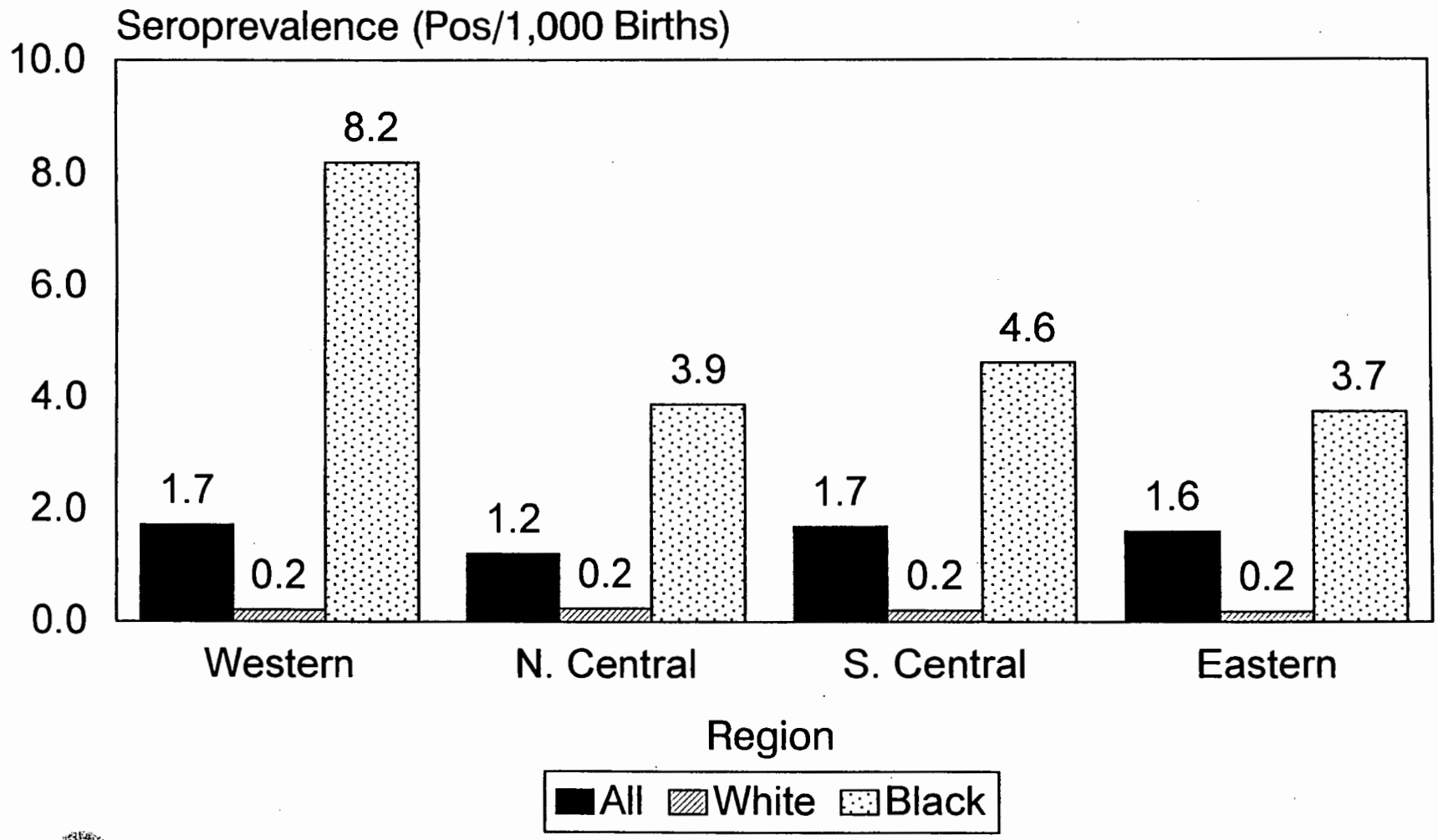
Cumulative Cases Reported Minus Deaths Reported



HIV/STD Prevention and Care Section, 6/97

HIV Seroprevalence Among Childbearing Women

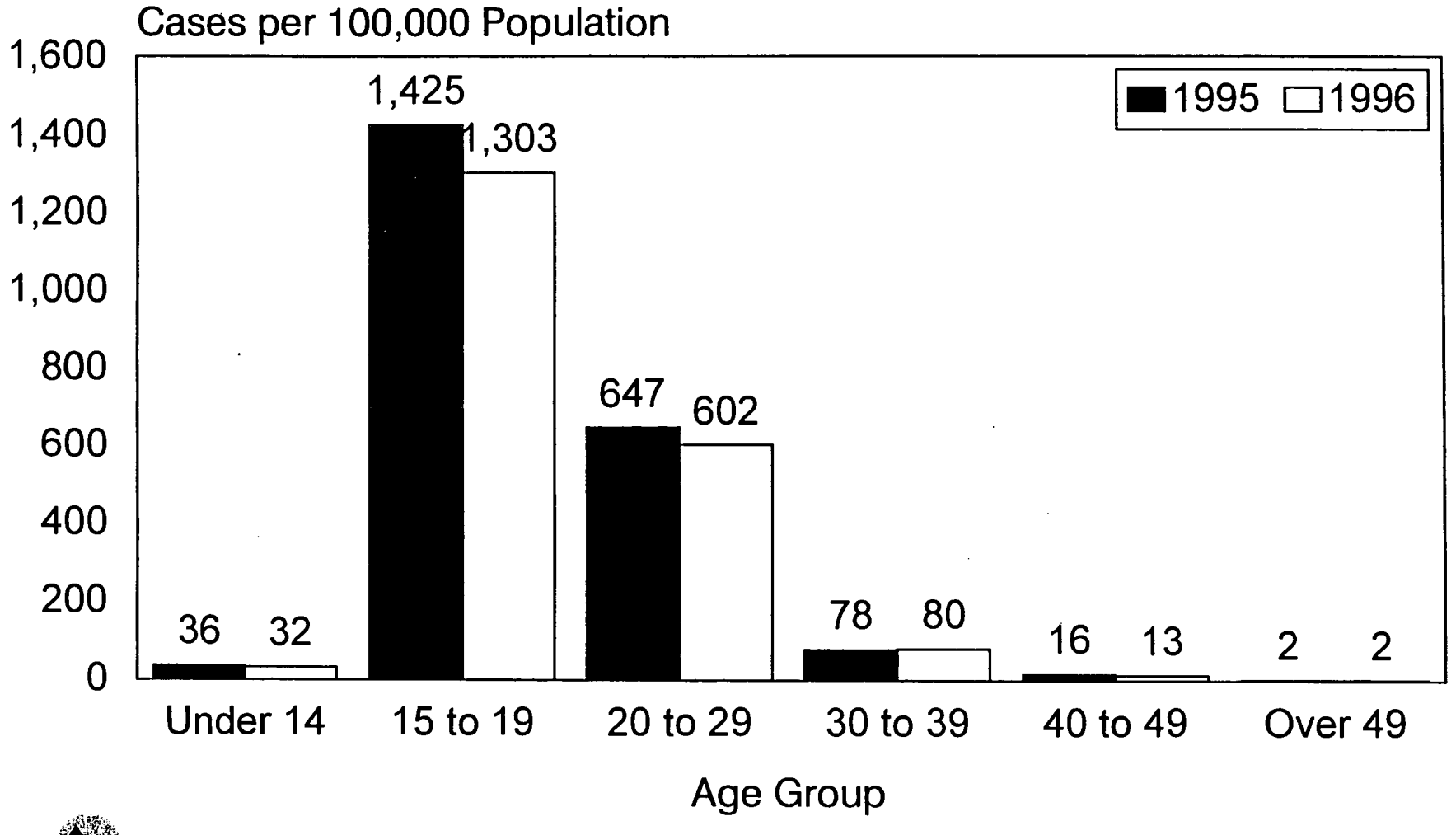
By Race and Region in North Carolina in 1994



HIV/STD Prevention and Care Section, 6/97

Chlamydia in North Carolina

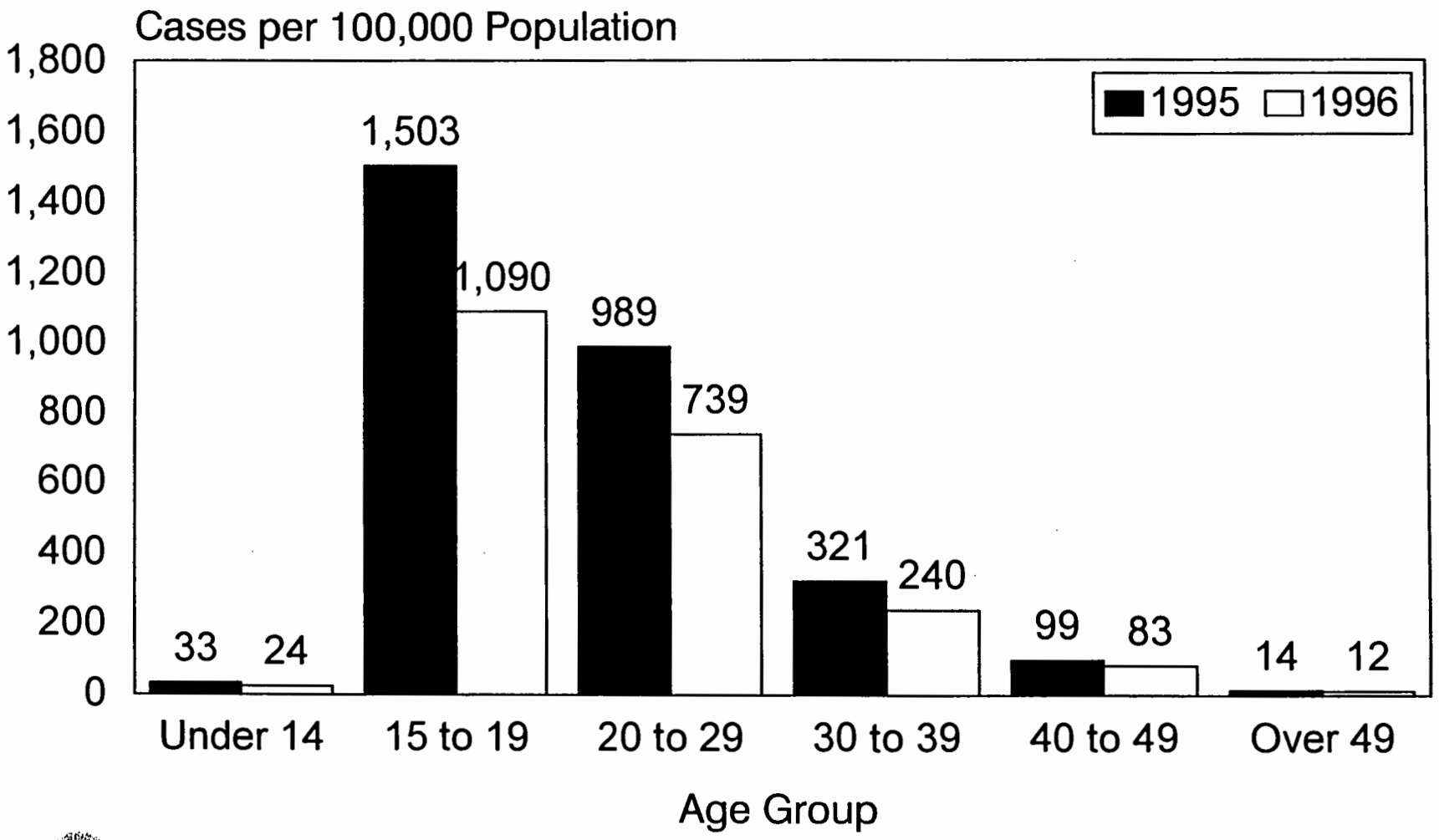
1995 and 1996 by Age Group



HIV/STD Prevention and Care Section, 6/97

Gonorrhea in North Carolina

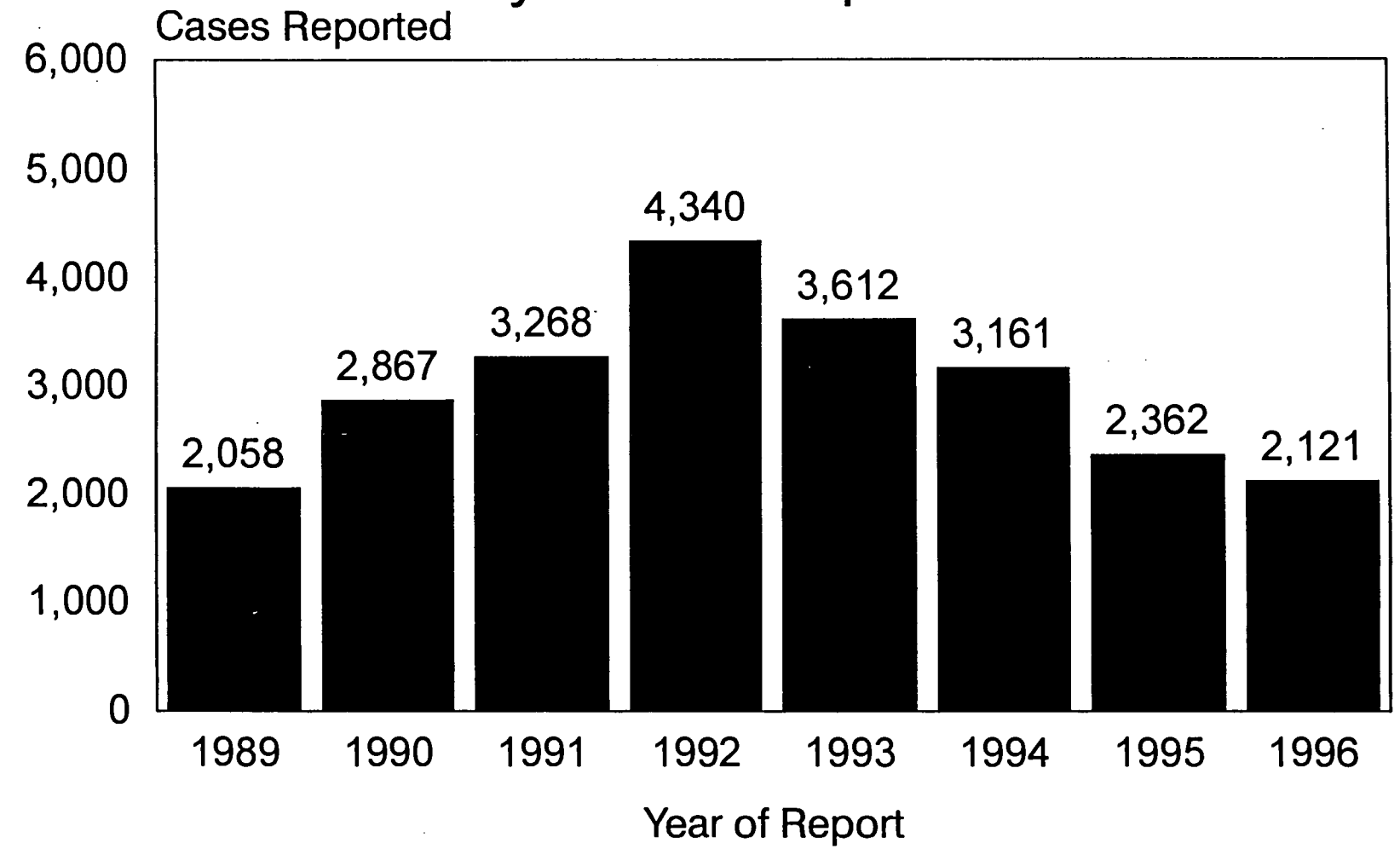
1995 and 1996 by Age Group



HIV/STD Prevention and Care Section, 6/97

North Carolina Primary, Secondary and Early Latent Syphilis Cases

by Year of Report



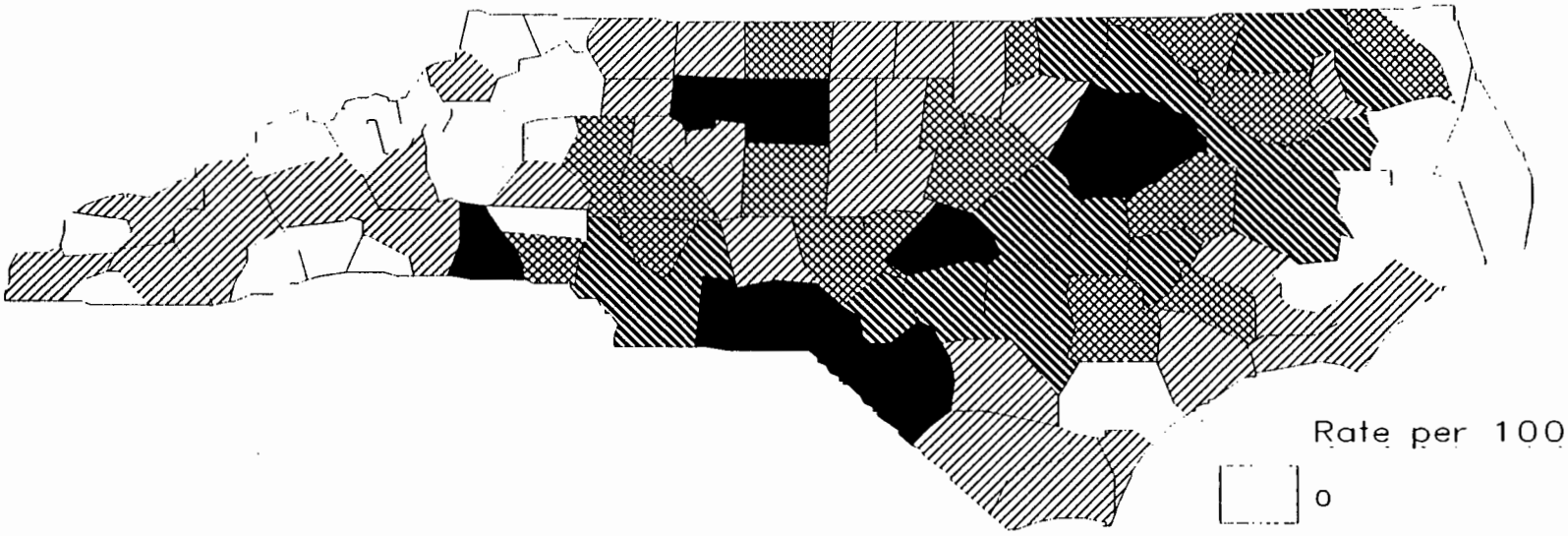
HIV/STD Prevention and Care Section, 6/97

North Carolina

Primary, Secondary and Early Latent Syphilis

Rate per 100,000 Population

1996



Rate per 100,000

- 0
- 1 to 10
- 10.1 to 25
- 25.1 to 50
- 50.1 to 185

HIV/STD Prevention and Care Section

State of North Carolina



JAMES B. HUNT JR.
GOVERNOR

WORLD AIDS DAY

1997

BY THE GOVERNOR OF THE STATE OF NORTH CAROLINA

A PROCLAMATION

WHEREAS, the global spread of HIV infection and AIDS necessitates a worldwide effort to increase communication, education and action to stop the spread of HIV/AIDS; and

WHEREAS, the Joint United Nations Programme on HIV/AIDS (UNAIDS) observes December 1 of each year as World AIDS Day, a day to expand and strengthen the worldwide effort to stop the spread of HIV/AIDS; and

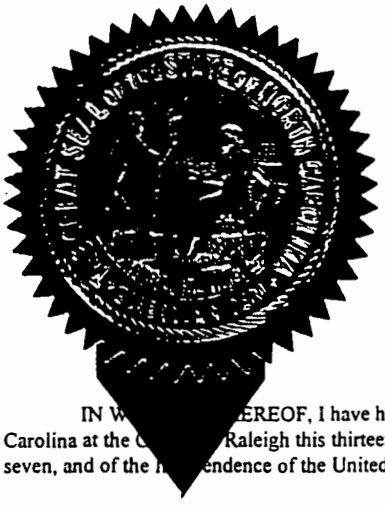
WHEREAS, UNAIDS estimates that 21.8 million people are currently living with HIV/AIDS, with children under the age of 15 years accounting for 830,000 of the cases; and

WHEREAS, the American Association for World Health is encouraging a better understanding of the challenge of HIV/AIDS nationally as it recognizes that the number of people diagnosed with HIV and AIDS in the United States continues to increase, with 581,429 AIDS cases reported (as of December 31, 1996); and

WHEREAS, World AIDS Day provides an opportunity to focus on HIV infection and AIDS, caring for people with HIV infection and AIDS, and learning about HIV/AIDS; and

WHEREAS, the 1997 World AIDS Day theme "Give Children Hope in a World with AIDS" a) urges the world to contemplate long-term repercussions of the AIDS pandemic, b) recognizes that everyone can do something about the pandemic through prevention, education and compassion, and c) emphasizes the hope of finding the means to prevent and cure HIV/AIDS in the ultimate prospect of minimizing the impact of the epidemic on children, their families and their communities;

NOW, THEREFORE, I, JAMES B. HUNT JR., Governor of the State of North Carolina, do hereby proclaim December 1, 1997, as "**WORLD AIDS DAY**," in North Carolina, and urge all citizens to take part in activities and observances designed to increase awareness and understanding of HIV/AIDS as a global challenge, to take part in HIV/AIDS prevention activities and programs, and to join the global effort to prevent the further spread of HIV/AIDS.



JAMES B. HUNT JR.

IN W EREOF, I have hereunto set my hand and affixed the Great Seal of the State of North Carolina at the C Raleigh this thirteenth day of November in the year of our Lord nineteen hundred and ninety-seven, and of the I endence of the United States of America the two hundred and twenty-first.

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

February 28, 1997 / Vol. 46 / No. 8

MMWR™
MORBIDITY AND MORTALITY WEEKLY REPORT

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Update: Trends in AIDS Incidence, Deaths, and Prevalence — United States, 1996

The national acquired immunodeficiency syndrome (AIDS) surveillance system is used to describe the impact of HIV-related morbidity and death in the United States. This report presents trends in AIDS incidence during 1996 and describes recent declines in deaths among persons reported with AIDS (AIDS deaths) and increases in AIDS prevalence.*

Cumulative AIDS cases among persons aged ≥13 years reported to CDC based on the 1993 expanded surveillance case definition from the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories were analyzed by year of report, race/ethnicity, and mode of risk/exposure (*1*). Estimates of AIDS incidence and deaths were adjusted for the effects of delays in reporting. For analyses by mode of risk/exposure, estimates were adjusted for the anticipated reclassification of cases initially reported without an HIV risk/exposure (*1*). To adjust for the expansion of the reporting criteria in 1993, estimates of the incidence of AIDS-opportunistic illnesses (OIs) were calculated from the sum of cases diagnosed with an AIDS-OI and the estimated dates of an AIDS-OI diagnosis for cases reported based on immunologic criteria† (*1*). AIDS-OI incidence was estimated quarterly through June 1996, the most recent period for which reliable estimates were available. Estimates of AIDS-OI incidence rates per 100,000 population were based on 1995 population estimates from the Bureau of the Census. Deaths among persons with AIDS were identified by review of medical records and death certificates and include both deaths from AIDS and from other causes. AIDS prevalence was estimated from cumulative AIDS incidence minus cumulative deaths.

Reported AIDS Cases

From 1981 through 1996, a total of 573,800 persons aged ≥13 years with AIDS were reported to CDC by state and local health departments (Table 1). The expansion of the AIDS surveillance case definition in 1993 resulted in a large increase in reported cases

*Single copies of this report will be available until February 28, 1998, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231 or (301) 217-0023.

†The immunologic criteria that were added to the AIDS case definition in 1993 were CD4+ T-lymphocyte count <200 cells/μL or CD4+ T-lymphocyte percentage of total lymphocytes of <14.

TABLE 1. Number and percentage of persons aged ≥13 years reported with AIDS, by sex and race/ethnicity — United States, 1981–1996

Characteristic	Year of report											
	1992		1993*		1994		1995		1996		1981–1996	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Sex												
Male	40,330	(86)	87,945	(84)	64,730	(82)	59,285	(81)	54,653	(80)	488,300	(85)
Female	6,307	(14)	16,671	(16)	13,830	(18)	13,682	(19)	13,820	(20)	85,500	(15)
Race/Ethnicity												
White, non-Hispanic	22,320	(48)	47,468	(45)	32,677	(42)	29,402	(40)	26,229	(38)	267,487	(47)
Black, non-Hispanic	15,576	(33)	37,523	(36)	30,373	(39)	28,729	(39)	28,346	(41)	198,780	(35)
Hispanic	8,223	(18)	18,410	(18)	14,612	(19)	13,961	(19)	12,966	(19)	101,253	(18)
Asian/Pacific Islander	334	(<1)	761	(<1)	573	(<1)	558	(<1)	561	(<1)	4,090	(<1)
American Indian/ Alaskan Native	121	(<1)	369	(<1)	246	(<1)	237	(<1)	207	(<1)	1,544	(<1)
Total†	**46,637**	**(100)**	**104,616**	**(100)**	**78,560**	**(100)**	**72,967**	**(100)**	**68,473**	**(100)**	**573,800**	**(100)**

*Year the expanded AIDS surveillance case definition was implemented.
†Totals inlcude persons with unknown or missing race/ethnicity.

AIDS — Continued

during 1993 followed by declines in numbers of AIDS cases reported each year from 1994 through 1996. The 68,473 AIDS cases reported during 1996 was substantially higher (47%) than the number reported during 1992.

From 1992 through 1996, non-Hispanic blacks, Hispanics, and women accounted for increasing proportions of persons reported with AIDS. In 1996, non-Hispanic blacks accounted for 41% of adults reported with AIDS, exceeding for the first time the proportion who were non-Hispanic white, and women accounted for an all-time high of 20% of adults reported with AIDS.

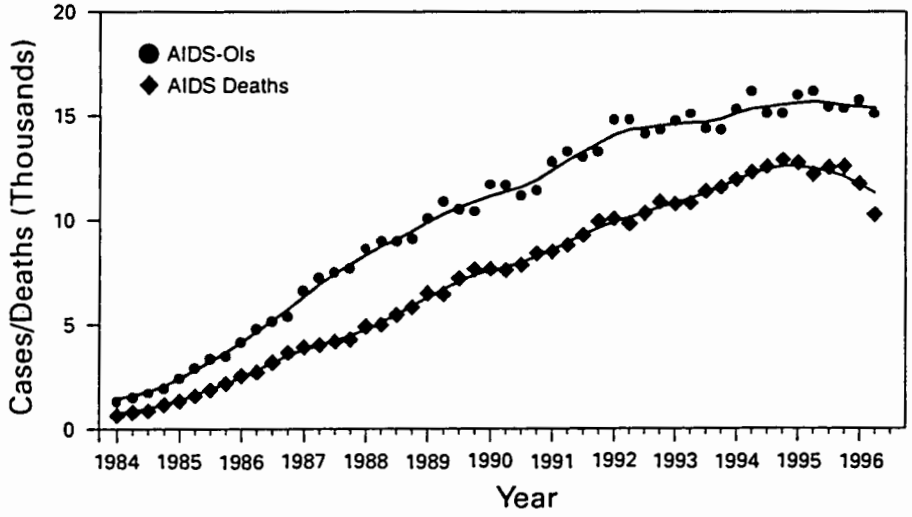
AIDS-OI Incidence

In 1995, AIDS-OIs were diagnosed in an estimated 62,200 persons, an increase of 2% over the estimate for 1994 (61,200) (Figure 1). From January 1994 through June 1996, the quarterly incidence of AIDS-OIs was stable (mean: 15,200 cases per quarter).

During 1995, estimated AIDS-OI incidence rates per 100,000 population were approximately sevenfold higher among non-Hispanic blacks (99) and threefold higher among Hispanics (50) than among non-Hispanic whites (15). Estimated rates were lowest among American Indians/Alaskan Natives (14) and Asians/Pacific Islanders (6) and were nearly five-fold greater among men (48) than among women (10).

From 1994 through 1995, estimated AIDS-OI incidence was approximately constant (a decrease of 2%) among men who have sex with men (MSM) (Figure 2) and among heterosexual injecting-drug users (IDUs) (an increase of 2%) (Figure 3), but increased substantially among persons infected through heterosexual contact (17%) (Figure 4).

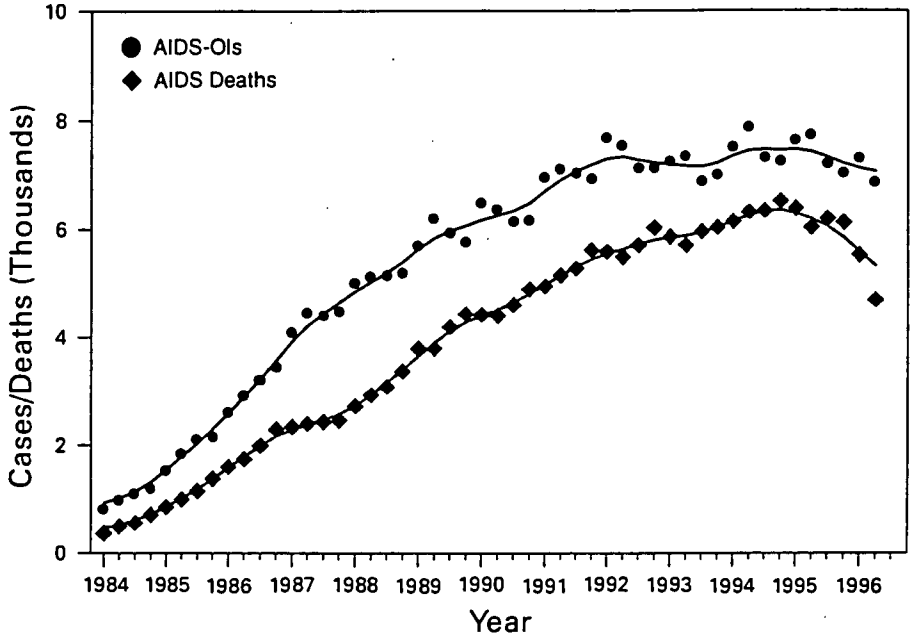
FIGURE 1. Estimated AIDS-opportunistic illness (OI) incidence and estimated deaths among persons with AIDS (AIDS deaths)*, adjusted for delays in reporting, by quarter and year of diagnosis/death — United States, 1984–June 1996†



*Estimates include persons aged <13 years.
†Points represent quarterly incidence; lines represent "smoothed" incidence. Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.

AIDS — Continued

FIGURE 2. Estimated AIDS-opportunistic illness (OI) incidence and estimated deaths among persons aged ≥13 years with AIDS (AIDS deaths), by exposure category (men who have sex with men), adjusted for delays in reporting, by quarter year of diagnosis/death — United States, 1984–June 1996*



*Points represent quarterly incidence; lines represent "smoothed" incidence. Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.

Of the 30,100 persons in whom AIDS-OIs were diagnosed during January–June 1996, 46% were MSM, 29% were IDUs, and 17% were infected through heterosexual contact.

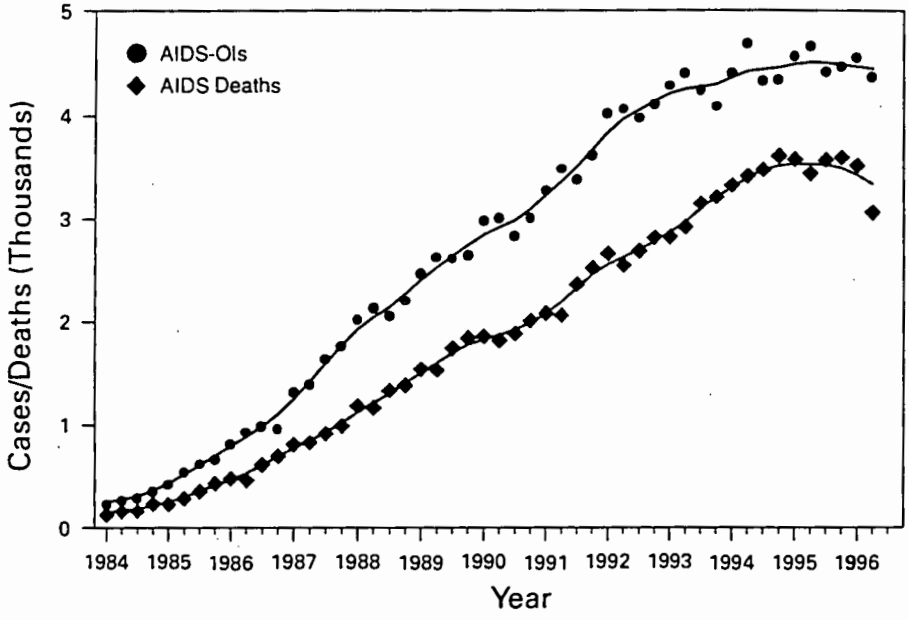
Deaths Among Persons Reported with AIDS

The estimated number of deaths among persons reported with AIDS increased steadily through 1994 (approximately 49,600 deaths among persons with AIDS during 1994) (Figure 1) but increased only slightly in 1995 (approximately 50,000 deaths). During January–June 1996, the estimated number of AIDS deaths (22,000) was 13% less than that estimated during January–June 1995 (24,900), and the number of deaths declined in each of the four regions of the United States (Northeast [15%], South [8%], Midwest [11%], and West [16%])[§]. The number of AIDS deaths also declined among all racial/ethnic groups (non-Hispanic whites [21%], non-Hispanic blacks [2%], Hispanics [10%], Asians/Pacific Islanders [6%], and American Indians/Alaskan Natives [32%])

[§]Northeast=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and West=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

AIDS — Continued

FIGURE 3. Estimated AIDS-opportunistic illness (OI) incidence and estimated deaths among persons aged ≥13 years with AIDS (AIDS deaths), by exposure category (injecting-drug use), adjusted for delays in reporting, by quarter year of diagnosis/death — United States, 1984–June 1996*



*Points represent quarterly incidence; lines represent "smoothed" incidence. Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.

and among men (15%) but increased 3% among women. By risk/exposure category, deaths declined 18% among MSM (Figure 2) and 6% among IDUs (Figure 3) but increased 3% among persons infected through heterosexual contact (Figure 4), the only risk/exposure group with large increases in AIDS-OI incidence during 1995.

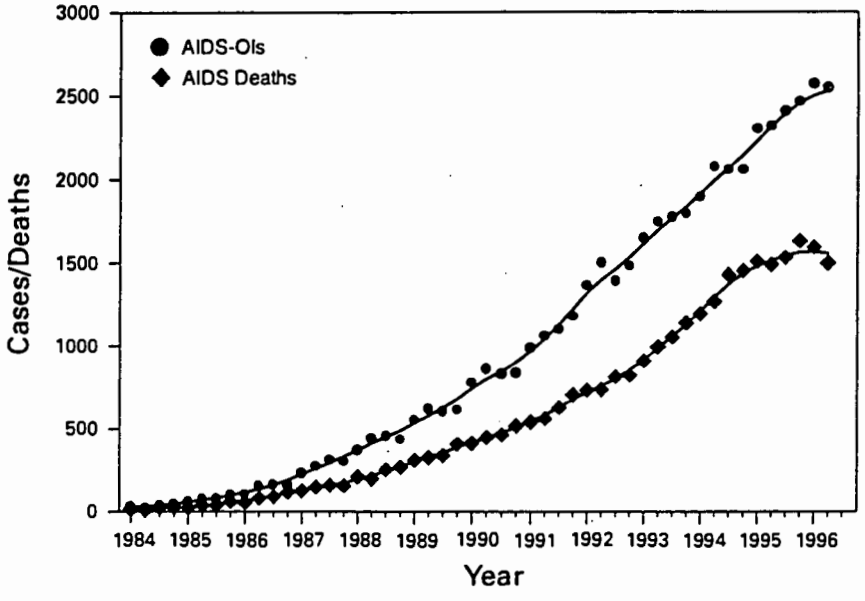
AIDS Prevalence

As of June 1996, the estimated prevalence of AIDS was 223,000 U.S. residents aged ≥13 years (Figure 5), representing increases of 10% and 65% since mid-1995 and January 1993, respectively. Of prevalent cases of AIDS, 82% were among men; 43%, non-Hispanic whites; 38%, non-Hispanic blacks; and 19%, Hispanics. By risk/exposure category, MSM accounted for the largest number of prevalent cases of AIDS (44%), followed by IDUs (26%) and persons infected through heterosexual contact (12%); all other risk/exposure groups[¶] combined accounted for 18% of prevalent cases of AIDS. The largest proportionate increase in AIDS prevalence from June 1995 through June 1996 occurred among persons infected through heterosexual contact (19%) while the largest absolute increase occurred among MSM (5100).

[¶]Includes men who reported both having sex with men and injecting-drug use, persons with hemophilia/coagulation disorders, transfusion recipients, and persons with other or no risks reported.

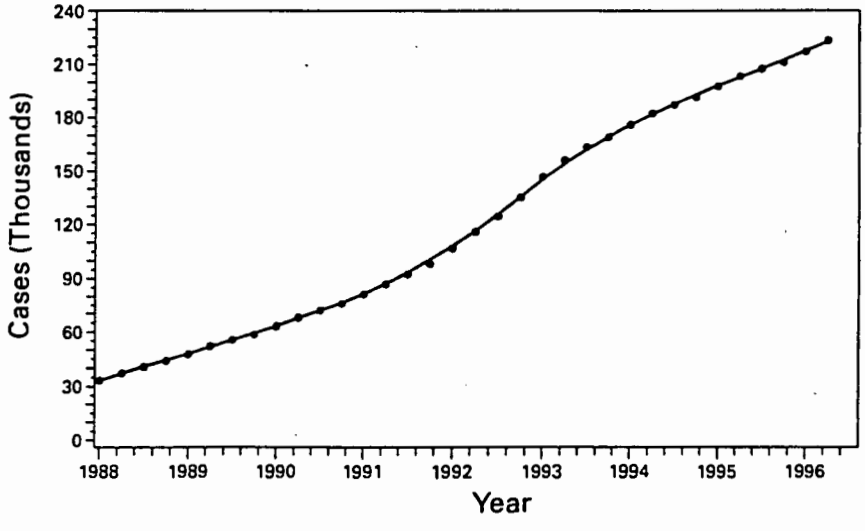
AIDS — Continued

FIGURE 4. Estimated AIDS-opportunistic illness (OI) incidence and estimated deaths among persons aged ≥13 years with AIDS (AIDS deaths), by exposure category (HIV infection acquired through heterosexual contact), adjusted for delays in reporting, by quarter year of diagnosis/death — United States, 1984–June 1996*



*Points represent quarterly incidence; lines represent "smoothed" incidence. Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.

FIGURE 5. Number of prevalent AIDS cases among persons aged ≥13 years, adjusted for delays in reporting, by quarter year — United States, 1988–June 1996*



*Points represent quarterly prevalence; the line represents "smoothed" prevalence. Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases or AIDS deaths.

AIDS — Continued

Reported by: State and local health depts. Div of HIV/AIDS Prevention—Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, CDC.

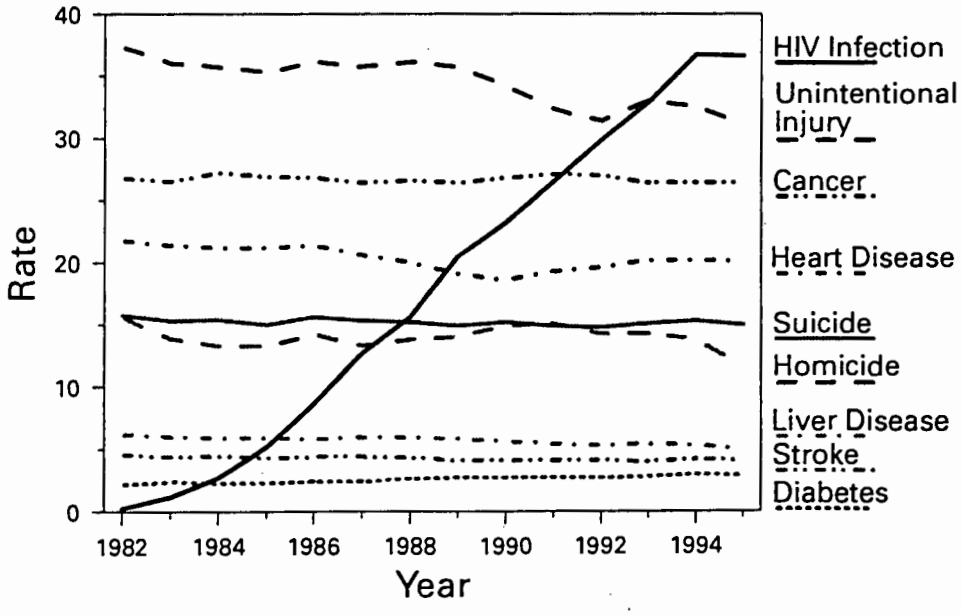
Editorial Note: The findings in this report document a substantial increase in AIDS prevalence in the United States. Prevalence is a function of both the rate of new infections and the duration of illness. The increase in AIDS prevalence reflects declines in AIDS deaths and stable AIDS incidence. The increased prevalence of AIDS indicates the need for medical and other services for persons with HIV infection and for prevention programs to reduce the number of persons becoming infected with HIV.

The leveling of AIDS-OI incidence nationally in 1995 was preceded by a gradual deceleration in the rate of increase of new AIDS diagnoses during previous years (*1*). Similar trends have been documented among MSM and IDUs in clinic-based HIV-seroprevalence surveys (*2*). However, the incidence of cases associated with heterosexual contact has continued to increase, primarily reflecting transmission from the large population of IDUs with HIV/AIDS to their heterosexual partners.

For the first time, deaths among persons with AIDS have decreased substantially. This finding is consistent with recent reports, based on death-certificate data, of declines in deaths from HIV infection in New York City (*3*) and nationally (*4*). Despite these trends, during 1995 HIV infection remained the leading cause of death among persons aged 25–44 years (Figure 6), accounting for 19% of deaths from all causes in this age group.

The decrease in AIDS deaths reflects both the leveling of AIDS-OI incidence and improved survival among persons with AIDS. Increased survival reflects recent im-

URE 6. Death rates* for leading causes of death among persons aged 25–44 years, year — United States, 1982–1995†



*Per 100,000 population.
†Based on underlying cause of death reported on death certificates, using final data for 1982–1994 and preliminary data for 1995.

AIDS — Continued

provements in medical care, the use of combination therapy with antiretroviral agents, and increasing use of prophylactic drugs to prevent secondary AIDS-OIs (*5*). In addition, the widespread availability of protease inhibitors, approved by the Food and Drug Administration in 1996, may further improve survival (*6*).

The higher AIDS-OI incidence rates among non-Hispanic blacks and Hispanics than among non-Hispanic whites may reflect reduced access to health care associated with disadvantaged socioeconomic status, cultural or language barriers that may limit access to prevention information, and differences in HIV risk behaviors (*7*). The number of AIDS deaths did not decrease among women or persons infected through heterosexual contact, reflecting, in part, continued increases in AIDS incidence and differences in access to treatment, which may vary by sex, region, race/ethnicity, and risk/exposure. To assist prevention efforts and treatment services, surveillance systems are being developed to assess access to counseling, testing, and care.

Monitoring AIDS prevalence will help direct resources to persons most in need of treatment for severe HIV disease. However, because the clinical status of most HIV-infected persons has not yet progressed to AIDS (*8*), AIDS prevalence underestimates the total number of HIV-infected persons in need of related services. Advances in treatment and improved survival also will affect efforts to monitor the HIV epidemic based on the current AIDS surveillance definition and, therefore, will require surveillance systems that are less sensitive to changes in the progression of HIV disease. Among the 26 states that conducted surveillance for cases of both HIV infection and AIDS in 1996, prevalence of HIV and AIDS among reported cases (126,491) was 2.5-fold higher than the prevalence of AIDS (51,217) (*1*). However, this represents a minimum estimate of HIV prevalence in these states because not all HIV-infected persons seek testing and some persons are tested anonymously.

The Council of State and Territorial Epidemiologists has recommended that all states consider implementing surveillance for HIV infection and AIDS (*9*). Population-based surveillance for both HIV and AIDS provides a more complete measure of the number of HIV-infected persons and a more timely measure to detect emerging patterns of HIV transmission than does AIDS surveillance alone. CDC provides technical assistance and funding to areas that conduct both HIV and AIDS case surveillance. CDC also supports research to develop optimal surveillance methods that meet the need for important behavioral, biomedical, and treatment data for persons with HIV and AIDS and that address public health and community concerns about factors that may influence decision-making regarding testing or treatment.

Future trends in the HIV/AIDS epidemic in the United States will reflect the effectiveness of programs to prevent new HIV infections, to promote timely diagnosis, and to continue improving clinical management. CDC has established as a primary prevention strategy efforts to involve affected communities in planning and evaluating HIV-prevention programs (*10*). To continue to provide data for planning, directing, and evaluating HIV prevention and care services at the federal, state, and local levels, HIV/AIDS surveillance systems must adapt to changes in the diagnosis and clinical management of HIV and AIDS.

AIDS — Continued

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Update: Influenza Activity — United States, 1996–97 Season

Influenza activity in the United States has continued to decline since mid-January 1997. The predominant viruses have been influenza type A (H3N2), although the proportion of influenza B isolates has increased since the week ending January 18. This report summarizes influenza activity in the United States from September 29, 1996, through the week ending February 15, 1997.

The proportion of patients who visited 120 U.S. sentinel physicians for influenza-like illness (ILI) peaked at 7% from mid-December through the first week of January and was 3% of total visits by the week ending February 15, 1997. The proportion of visits for ILI had remained at or below the baseline level of 3% since the week ending January 25, 1997; however, the proportion of ILI visits had not yet reached baseline levels in the West South Central and Pacific regions through the week ending February 15, 1997.

Influenza activity* has decreased since the week ending December 28, 1996, when state and territorial epidemiologists in 38 states reported either widespread or regional activity. For the week ending February 15, 1997, either widespread or regional influenza activity was reported in 21 states and sporadic activity was reported in 25 states and the District of Columbia (Figure 1). None of the states in the East North Central region reported regional or widespread activity for the week ending February 15.

*Levels of activity are 1) *no activity*; 2) *sporadic*—sporadically occurring ILI or culture-confirmed influenza with no outbreaks detected; 3) *regional*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of <50% of the state's total population; and 4) *widespread*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of ≥50% of the state's total population.

Chlamydia Screening Practices of Primary-Care Providers — Wake County, North Carolina, 1996

Genital chlamydial infection is the most commonly reported infectious disease in the United States (*1*), and the prevalence of *Chlamydia trachomatis* genital infections in sexually active adolescents is 5%–15%, regardless of socioeconomic status (*2–4*). Although chlamydial infections frequently are asymptomatic in women, untreated infections can cause extensive inflammation and scarring of the female reproductive tract (*5*). In addition, chlamydial infections may facilitate human immunodeficiency virus transmission (*6*). Because of the risks and complications associated with this infection, CDC and the U.S. Preventive Services Task Force have recommended that all sexually active adolescent women undergoing a pelvic examination receive routine screening for chlamydia (*7,8*). To characterize the chlamydia screening practices of primary-care providers in Wake County, North Carolina, a county with high reported rates of chlamydial genital infection, the Wake County Human Services Public Health Center conducted a survey of primary-care providers during August–October 1996. This report summarizes the results of that survey, which document missed opportunities for the detection of chlamydia infection by health-care providers in both public and private practices.

A list of all primary-care practices in Wake County (1995 population: 512,944) was compiled using the county telephone directory and the physician registry from the North Carolina Medical Society. Primary-care practices included private physician offices, urgent-care centers, local health department clinics, hospital emergency departments and outpatient clinics, university health centers, community health centers, health maintenance organization (HMO) clinics, and nonprofit clinics (e.g., Planned Parenthood). Managed care was defined as a either a free-standing HMO clinic (e.g., Kaiser Permanente) or a practice participating in a preferred provider organization (PPO). A questionnaire was mailed to a total of 159 primary-care practices in Wake County, of which 127 (80%) responded; of these, 117 (92%) practices reported serving adolescent patients (aged 12–19 years). Routine chlamydia screening was defined as the performance of chlamydia testing during all or annual pelvic examinations.

Of the 117 responding practices that served adolescents, 94 (80%) reported that they performed chlamydia testing, and 34 (29%) reported that they routinely screened adolescent women. Practices that described their financial charter as private-for-profit were less likely to screen routinely than other practices (e.g., private nonprofit, health department, community health services, and university health centers) (15% versus 77%; prevalence ratio [PR]=0.2; 95% confidence interval [CI]=0.1–0.3) (Table 1). Practices with any patients insured through managed care were less likely to screen than those without managed-care patients (20% versus 58%; PR=0.3; 95% CI=0.2–0.6) or if they served patients with fee-for-service private insurance (20% versus 65%; PR=0.3; 95% CI=0.2–0.5). Practices were less likely to screen routinely if they reported lower proportions of non-Hispanic blacks (19% versus 39%; PR=0.5; 95% CI=0.2–0.9) or Hispanics (14% versus 41%; PR=0.3; 95% CI=0.2–0.8). Practices without written protocols for chlamydia testing were less likely to test routinely than practices with written protocols (17% versus 59%; PR=0.4; 95% CI=0.2–0.7). The proportion of practices conducting routine screening were similar in urban and rural (outside of the two main metropolitan areas, Raleigh and Cary) locations, by number of patient visits per year,

Chlamydia Screening Practices — Continued

TABLE 1. Number of primary-care providers serving adolescents and performing routine chlamydia testing, by selected characteristics — Wake County, North Carolina, 1996

Characteristic	No. providers (n=117)	Performing routine screening (n=34) No.	(%)
Financial charter			
Private, for profit	91	14	(15)
Private, non-profit	9	8	(89)
Health department	9	7	(78)
Community health clinic	2	2	(100)
University health center	6	3	(50)
Type of medical specialty			
Family practice	26	4	(15)
Obstetrics/gynecology	27	6	(22)
Pediatrics	20	5	(25)
Internal medicine	10	1	(10)
Infectious disease	1	0	(0)
Combined specialties	6	1	(17)
Health department clinic	9	7	(78)
General medical or emergency care	18	10	(56)
Participates in managed care*			
Yes	82	16	(20)
No	24	14	(58)
Accepts fee-for-service private insurance*			
Yes	86	17	(20)
No	20	13	(65)
Accepts Medicaid*			
Yes	59	16	(27)
No	47	14	(30)
Racial/ethnic† distribution of providers' patient populations§			
White, non-Hispanic			
Median proportion or higher (≥68%)¶	50	7	(14)
Less than median (<68%)	49	22	(45)
Black, non-Hispanic			
Median proportion or higher (≥25%)	51	20	(39)
Less than median (<25%)	48	9	(19)
Hispanic			
Median proportion or higher (≥2%)	56	23	(41)
Less than median (<2%)	43	6	(14)
Written protocol for chlamydia testing			
Yes	29	17	(59)
No	82	14	(17)
Unknown	6	4	(67)
Location of practice			
Urban	102	30	(29)
Rural	15	4	(27)

*Information from 11 offices missing.
†Numbers for races other than black and white were too small for meaningful analysis.
§Information from 18 offices missing.
¶Proportions used to make dichotomous variables for the racial/ethnic distributions of the providers' clientele are based on the medians of patients of those racial/ethnic groups examined by all offices.

Chlamydia Screening Practices — Continued

or by medical specialty. A multivariate logistic regression model was constructed using backward elimination beginning with the variables identified as significant on univariate analysis. Based on the multivariate analysis, the only characteristics significantly associated with lack of routine screening were private-for-profit financial charter (odds ratio [OR]=0.1; 95% CI=0.02–0.17) and a low proportion of Hispanic patients (OR=0.3; 95% CI=0.1–0.9).

Of the 60 practices that provided chlamydia testing but did not provide routine testing of adolescents during all or annual pelvic examinations, all reported testing for chlamydia if signs and symptoms of infection were present; 58 (97%) if the patient reported that his/her partner had a chlamydial infection; 12 (20%) if the patient reported a new sex partner; and 18 (30%) if the adolescent reported multiple sex partners.

Approximately one fourth (23%) of practices serving adolescents reported that any of their clinicians had received any kind of continuing medical education that addressed genital chlamydial infections or pelvic inflammatory disease (PID) during the preceding year. Thirty-five percent expressed interest in obtaining continuing medical education in chlamydia or PID.

Reported by: PA Leone, MD, L Fiscus, Wake County STD Clinic, Raleigh; D Williams, PhD, EM Foust, MPH, JM Moser, MD, State Epidemiologist, North Carolina Dept of Health and Human Svcs. Epidemiology and Surveillance Br, Div of STD Prevention, National Center for HIV, STD, and TB Prevention, CDC.

Editorial Note: In November 1996, in a report documenting the high prevalence of sexually transmitted diseases (STDs) among adolescents in the United States, the Institute of Medicine recommended improving clinical STD services for this population, especially within the private sector (*9*). Screening and treatment programs are effective in decreasing chlamydia prevalence in adolescent women (*3,4*) and in decreasing the incidence of PID (*10*).

This report documents low rates of routine chlamydia screening of sexually active adolescent women in an area with known high reported rates of infection. In Wake County, during 1996–1997, the prevalence of chlamydia infection in female adolescents attending family-planning clinics or STD clinics was 10% and 17%, respectively (North Carolina Chlamydia Prevention Program, unpublished data, 1997). Routine chlamydia screening was associated with the clinics' financial charters and with patients' insurance, race, and ethnicity. Some third-party payers in the county (e.g., Medicaid, Kaiser Permanente, some Blue Cross/Blue Shield plans, and some PPOs) already reimburse for chlamydia testing during annual pelvic examinations. Clinicians may have believed that they could predict their patients' risk for chlamydial infection based on their insurance status, race, and ethnicity. However, among sexually active adolescent women, there is a high prevalence of chlamydial infection independent of their demographic factors (*2–4*).

Local health departments in North Carolina in areas with high prevalences of STDs are informing private physicians of the problem and encouraging additional testing, treatment, and reporting. In addition, plans are under way to assess specific barriers to chlamydia screening of adolescents.

Coordinated efforts between the private and public sectors are necessary to implement recommendations of the Institute of Medicine for STD services for adolescents. Managed-care organizations are beginning to address the importance of routine

Chlamydia Screening Practices — Continued

chlamydia testing for adolescent women: beginning in 1997, a new clinical performance measurement of the Health Employer Data Information Set has been implemented to assess the ability of managed-care organizations to perform and monitor chlamydia tests annually for enrolled women aged <25 years. For those settings in which pelvic examinations for adolescent women are not feasible, new diagnostic techniques, such as urine chlamydia testing using DNA amplification, may increase the availability of services. Primary-care providers serving adolescent women need to be educated about the risk for chlamydial infection in this population and need to be encouraged to perform routine screening for all sexually active adolescent women, regardless of symptoms or risk factors.

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Don White 116

Update on the Forensic Unit

- On any given day there are approximately 160 legal status patients in the four state psychiatric hospitals, i.e. not guilty by reason of insanity (SB43), persons who are not capable of proceeding to trial (HB95), and persons who were sent to the state hospital with a legal detainer.
- During the '97 Session the General Assembly appropriated $3.5 million, $1.1 million for FY '98 and $2.5 million for FY '99, to establish a 72 bed forensic treatment unit at Dix Hospital.
- Thirty-six beds are to be established during FY '98 and 36 additional beds to be established during FY '99.
- The initial 36 beds which are located in the Spruill Building on the Dix Campus became operational, as planned, on January 1, 1998.
- Division has established a set of priorities for admission to the unit.
- All patients who have been found not guilty by reason of insanity (NGRI) excluding those who are in a certified nursing bed or medical bed, or who committed a non-violent crime, will be transferred to the unit.
- There are currently 20 NGRI's in the four hospitals.
- Each of these NGRI patients is eligible for transfer to the unit.
- Five NGRI patients have been transferred to the unit thus far. All NGRI transfers are to be completed by the end of January '98 or as soon as possible thereafter.
- Beds remaining after the initial transfer of NGRI's will be filled by patients who are incapable of proceeding to trial.

Not Guilty By Reason of Insanity (NGRI)

- Each hospital will be given equal access to these remaining beds
- The hospitals will send those HB95 patients who present the greatest risk of violence. The transfer of HB95 patients is to begin in February.
- The initial 36 beds should be filled by mid to late March '98.
- When the additional 36 beds open in July '98 all beds will be utilized according to the following priorities:

  1. NGRI patients
  2. HB95, detainers and others in accordance with the level of dangerousness

7 Duncan Munn

Early Intervention Expansion Funds

Status Report 1/20/97

Contact: Duncan E. Munn
Developmental Disabilities Section
Division of Mental Health, Developmental Disabilities
and Substance Abuse Services
(919) 733-3654

Federal Early Intervention Funds: 1997-98

A. Profile By Agency

Agency	Amount	Fund Utilization
1. Division of MH/DD/SAS	5,601,631	early intervention direct services, administration, staff development
2. Division of Women's and Children's Health	966,535	evaluation direct services, technical assistance
3. Division of Services for the Blind	128,163	early intervention direct services
4. Division of Services for the Deaf and Hard of Hearing	148,408	early intervention direct services
5. Division of Child Development	144,768	ICC support
6. Private/Other	666,032	contracts for training, information and referral services
Total	**7,655,537**	

B. Profile By Types of Fund Utilization

Fund Use	Percentage
1. Local Direct Service Delivery	86.8
2. Local Staff Development	9.4
3. ICC Support (staff, parent expenses)	1.8
4. Information and Referral	1.4
5. Lead Agency Administration	.6

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Tuesday, January 20th, 10:00 a.m.
Room 414 - Legislative Office Building

10:00	Performance Audit Results on the Division of Services for the Blind	Ralph Campbell, Jr. State Auditor Janet Hayes, Performance Audit Manager Office of the State Auditor John De Luca, Director Division of Services for the Blind DHHS

LUNCH

1:00	Expansion of School Health Services	Denise Stallings, Director Cleveland County Public Health Dept.
2:00	AIDS Program	Evelyn Foust, Section Chief Division of Epidemiology DHHS
3:00	Updates: Forensic Unit	Don Willis, Chief Mental Health Services DHHS
	Efficiency Study of Psychiatric Hospitals	Don Willis, DHHS
	Early Intervention Funding	Duncan Munn, Child/Adolescent Services, Developmental Disabilities Section DHHS
	Child Care Subsidy	Peter Leousis, Assistant Secretary for Human Services & Education Policy DHHS
	County Commissioners' Letter on Medicaid Cost-Sharing	Carol Shaw, Analyst Fiscal Research Division

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Wednesday, January 21st, 9:00 a.m.
Room 414 - Legislative Office Building

9:00	Status of Children's Health in NC	Ann Wolfe, Director Women's and Children's Health, DHHS
11:00	Medicaid Growth Reduction Plan Update Proposed Changes in Staffing	Dick Perruzzi, Director Division of Medical Assistance DHHS
11:30	Impact of Budget Cuts on Psychiatric Hospitals	Gladys Fisher Parent of Consumer

LUNCH

1:00	Welfare Reform ■ 5-Year Business Plan/Reinvestment Strategy ■ Status of 1997-98 Funding	Jim Edgerton, Assistant Secretary Budget, Management & Planning DHHS Peter Leousis, Assistant Secretary Human Services and Education Policy DHHS
	■ Initiatives to Reduce Out-of-Wedlock Births	Ann Wolfe, Director Women's and Children's Health, DHHS
2:30	Child Welfare Expansion Update	Kevin Fitzgerald, Director Division of Social Services Leza Aycock, Assistant Director Division of Social Services
3:15	Progress Report on Thomas S. Cost Containment	Susan White, Chief Thomas S. Services Section DHHS

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Thursday, January 22nd, 9:00 a.m.

Joint Meeting with NER Subcommittee - Room 643, Legislative Office Building

9:00 Welfare-to-Work Status	Rick Carlisle, Acting Secretary Department of Commerce Pheon Beal, Chief of Economic Independence Division of Social Services DHHS
9:45 Administrative Cost Associated with Transferring Health Functions to DHHS	Carol Shaw, Analyst Fiscal Research Division
10:45 Administration of Environmental Health Programs	Mona Moon, Analyst Fiscal Research Division

JOINT APPROPRIATIONS HUMAN RESOURCES SUBCOMMITTEE

January 21, 1998
Minutes

The meeting of the Joint Appropriations Human Resources Subcommittee was held on January 21, 1998 in Room 414 LOB at 9:00 a.m. Senator Bill Martin presided. There were six Senators present and the following House members:

Representative Charlotte Gardner
Representative Alma Adams
Representative Beverly Earle
Representative Bill Hurley
Representative Cindy Watson
Representative Debbie Clary
Representative Henry Aldridge
Representative Martha Alexander
Representative Theresa Esposito
Representative Julia Howard
Representative Lanier Cansler

Staff members present were Karen Hammonds-Blanks, Mary Ellen Sylvester and Carol Shaw of Fiscal staff, Staff Attorneys Dianna Jessup and Gann Watson and Wanda Kay, Senate Committee Clerk.

Medicaid Cost-Sharing

Carol Shaw presented the County Commissioners Association letter on Medicaid cost-sharing. (See Handout #1.) The cost of Medicaid to counties including administrative costs is $276 million. The counties are concerned about increased costs that could come to them if the child health program is converted to a Medicaid program. Also, outreach programs for the child health program could increase the number of children enrolled in Medicaid resulting in $7 million in additional costs to the counties. It is difficult for the counties to come up with funds in the middle of a budget year, according to Representative Gardner.

In answer to Representative Forrester's question about advising the counties of the possibility that if Dr. Bruton's child health program is not approved by the Feds, it could come back to the counties as a Medicaid program that would require counties to pick up the 5% cost-sharing, Dr. Bruton said that was true, and the budget letter of instruction is being prepared February 15 to send to the counties to detail this.

Representative Howard asked if there was a representative of the County Commissioners Association present that could share some suggestions about this issue. Patrice Roesler came forward to say that the Commissioners supports the child health program as a way to help with welfare reform. Planning notice is most critical for the commissioners enabling them to handle the cost over a longer period of time, according to Ms. Roseler. Senator Martin asked what the impact will be on individual counties, and Ms. Roesler said she did not have this information.

Status of Children's Health in NC

The Director of the Maternal and Children Health Division, Ann Wolfe, gave an overview of the status of Children's Health in North Carolina. (See Handouts #2, NC Child Health Report Card.) She introduced section chiefs who gave a more detailed presentation: Kevin Ryan, Chief of the Women's Health Section; Barbara Sterritt, Chief of Immunization Section; Tom Vitaglione, Chief of Children and Youth Section, and Dr. Steven Klein of the Division of Community Health.

Kevin Ryan, Chief of the Women's Health Section, gave a presentation on the status of infant mortality. (See handout # 3, Infant Deaths and Rates.) Senator Martin would like a comparison of outcomes for those people who take part in programs like WIC and those who don't. Senator Dannelly wanted an explanation of the relationship of the alphabetical grade compared to the numerical score on the Report Card (Handout #2). Mr. Vitaglione said these scores are a mixture of objective and subjective evaluations. Representative Aldridge asked for documentation explaining our differences with other states in infant mortality rates relating to Dr. Ryan's assertion that the best states are more aggressive in family planning and access to health care. Dr. Wolfe, in answer to Representative Adam's request for data on comparisons with other states on several indicators of infant mortality, said they would get this information to her.

Dr. Bruton replied to Representative Howard's question about the number of uninsured children by pointing out on Page 4 of the Task Force Report that 223,000 is the total number. He said the 71,342 figure represents children of families whose income is up to 200% of poverty. There are 71,000 Medicaid eligible children being served and approximately 70,000 currently eligible for Medicaid that are not signed up. Representative Howard said the Report Card (#2) seems to show we are doing best in mandated programs and asked what policy this information indicates.

Barbara Sterritt, Chief of the Immunization Section, gave an explanation of the immunization program and will fax members a sheet that shows the results of 3 surveys of immunization data which should help members understand why the immunization figures show fluctuation. Representative Esposito asked for the North Carolina statistics on meningitis immunization, and Ms. Sterritt said she would get her that information. On her question about TB, Ms. Sterritt said that information would have to come from epidemiology.

Representative Gardner said Ms. Sterritt had not addressed her earlier question about Dr. Katz's assertion of the poor effectiveness of universal immunization. Ms. Sterritt said the fact sheet will answer some of the questions. She will provide a list of the 15 universal immunization states and their status. Representative Gardner asked how we compare with non-universal immunization states, and if Ms. Sterritt disagrees with Dr. Katz's evaluation. Both Ms. Sterritt and Dr. Wolfe voiced their disagreement. saying that North Carolina's immunization rate nationwide is very high. In answer to Representative Gardner question about whether the drop in immunization rate is accurate, Dr. Wolfe said the groups who did the survey disagreed. Representative Gardner wants more information about how much we've spent in comparison with other states. Senator Martin suggested a meeting with Dr. Wolfe and Dr. Katz to pinpoint whether there are differences and what they are. Dr. Wolfe agreed.

Representative Watson talked about the rapid change in population in Duplin county due to the influx of Hispanics and asked if we have enough money to immunize these people and to mandate newborns being immunized. There are organizations that have been very helpful in local areas to insure these people get immunizations, according to Ms. Sterritt who will her get a list of those organizations. Senator Dannelly wanted to know about mandates and parental rights. Dr. Ron Levine, State Public Health Director, said the only exemptions from universal immunization are religious grounds and allergic reaction. He said the universal immunization program is one of North Carolina's great successes, and he will provide the latest survey which shows the state's immunization rate to be 84% and among the highest in the nation.

Representative Alexander asked about Hepatitis B vaccine, and Ms. Sterritt told the committee that with state money and matching funds this vaccine is available to children ages 0-18 years.

Steve Klien, Chief of the Dental Health Section in the Division of Community Health, spoke on the objectives of the oral health program and the strategies to reach the objectives. (See Handouts # 4,5, & 6.) Representative Gardner asked if a rate increase was being proposed to address the problem of finding dentists to serve Medicaid recipients and was told by Mr. Klein that a task force was studying that and will make recommendations. She said her information indicates there are other factors affecting the lack of Medicaid dental service such as patients keeping appointments.

Don Vitaglione, Chief of Women's and Children's Health, reviewed programs that are addressing child fatality and child abuse, neglect and dependency problems. (See Handouts #7, 1996 Child Deaths in North Carolina and #8, Central Registry Reports of Child Abuse, Neglect and Dependency.) He continued with an overview of the status of child health efforts. (See Handouts # 9, School Health Nurses ; #10, North Carolina School Based-Health Centers and #11; 1996 Health Check Data: State Rate 50.9%.)

Representative Esposito pointed out that the Report Card (#2) implies that child health insurance will effect all areas surveyed in the brochure and asked Mr. Vitaglione to respond.

Jennifer Tally, Director of Prevent Child Abuse North Carolina, answered Representative Esposito's questions about the nature of child abuse. Representative Clary asked what is being done to address the possibility that the perpetrator of sexual abuse is still in the home, and Kevin Fitzgerald described the protection plan for children.

Mr. Vitaglione responded to Representative Clary's concern about private physicians being unable to deliver services proposed under the new child health plan by saying they were addressing the problem of waiting lists for health checks. Dr. Bruton, Secretary of DHHS, told Representative Clary that her concern over Public Health not being able to bill Medicaid directly and the pediatrician not being able to serve the population is not what is happening. He said the doctors and public health are required to work together after July, 1998. Public Health centers can be the primary caregiver if they furnish 24 hour service. He wants to have an integrated child health care system rather than piecemeal delivery of services. Representative Clary said the Cleveland County Public Health Service is losing $250,000 because the primary caregiver is getting the $2.50 per child, and the request for services is coming back to the Public Health departments. There is a 3 to 4 months wait for health checks. Dr. Bruton said a waiting list should not happen because Medicaid does not pay unless child is seen in a timely fashion. Representative Gardner asked where the truth lies because she is getting the same information from Rowan County as Representative Clary is from Cleveland County. The lead time to accomplish this policy change is too short, and she wants to know how to respond to these complaints in her local area. Senator Martin agreed with Representative Gardner that the committee should hear from the Association of County Commissioners and the Association of Public Health Directors about this problem and suggested a preliminary discussion with a few people on this. He said the topic will be on the agenda for the next series of committee meetings, but there will not be time for a special committee meeting on the child health program before then.

<u>Impact of Budget Cuts on Psychiatric Hospital</u>

Ms. Gladys Fisher, the parent of a patient at Dorothea Dix, brought her view of the inadequacy of the patient facilities and the impact of budget cuts on the psychiatric hospitals. (See Handout #12.) Mr. Edgerton, Assistant Secretary of Budget and Management of DHHS, answered Rep.

Gardner's question about cuts in the psychiatric hospital's budget when there were no budget cuts made by the General Assembly in the last budget. She asked members if they had ever heard Mr. Pedneau say there was not enough money in the budget to provide good care because she had not heard that being said to the committee. She also asked if there was a request for a new hospital, but Mr. Edgerton couldn't respond to that issue. He said a long range capital budget plan which never reached the committee called for 4 small psychiatric hospitals. It proposed building a new 255 bed hospital on the Dix campus costing $41 million and using the old Dix hospital for an department office complex, according to Mr. Edgerton. Senator Martin said a number of members have had concerns about the funding for the psychiatric hospital, and the committee will be looking into this issue. Representative Clary asked staff about the cost per resident in the psychiatric hospitals, and Karen said she didn't have that but the cost would depend on the services. She will get that information for Representative Clary. Ms. Fisher said the cost per resident is $325 per day. Representative Clary asked why we can't provide quality care for these patients at $100,000 per patient per year which is the figure she recalls from previous discussions. Adult home care costs are much less, and they have patients with some of these same problems. Mr. Stelle, former director of Dorothea Dix, said that factors contributing to the problems are age of the facility, inappropriateness of the buildings and accreditation standards. Dr. Stelle said to look at the line items that are not related to supporting staff and the items that furnish these facilities. The source of these funds are donations from other state facilities and vending machine sales.

Representative Nye asked Ms. Fisher what her son needs to improve care. She said exercise, more staff and more technician training. Mr. Stelle said he finds it hard to understand why Mrs. Fisher is having to provide therapy for her son. Representative Gardner asked if other patients were receiving therapy. Representative Cansler pointed out there is an efficiency study to reveal where the money is going that will report prior to the short session. Senator Martin asked that the information revealed at this meeting be provided to the contractors doing the efficiency study. Representative Watson said she recommended visiting the mental institutions to help us prioritize and change policy on spending. Senator Martin requested a copy of the portion of the tape with Mrs. Fisher's comments on it be given to the department to pass on to the consultants doing the efficiency study.

The committee recessed for lunch.

Medicaid Growth Reduction Plan Update

Allen Gamble of the Division of Medical Assistance detailed the need for an increase in the administrative staff of the division. (See Handout # 13.) He pointed out that only the approval of the state budget office is necessary to effect the staffing increase. He offered to the members a survey of the staffing patterns over the past 10 years

Representative Gardner questioned the policy decisions involved in bypassing the health departments in the child health plan. She asked about the negotiations with the private providers on the CAP slots and what the effect will be on the public health departments and area mental health programs. Mr. Gamble said CAP/MR allows private provider to directly enroll Medicaid clients, if elected by the patient. The agreement by the work group was that the Area Mental Health program is the case manager responsible for seeing the services ae rendered, and service delivery would be by freedom of choice. The Area Mental Health can continue to provide the service if there is no other provider available. The work group included a broad base of interested parties including DMA, DMH, several area programs, ARC of North Carolina, DD

Council, NC Association of Rehabilitation Facilities, ICFR Facilities Association, the NC Community Support Provider Council and some private providers.

Representative Nye asked what the Area Mental Health Programs were doing with the $23 million that will now result as savings resulting from the new rate structure which Mr. Gamble said reflected actual costs. Mr. Gamble said he did not have a definitive answer. He said appropriate referral have been made to the integrity unit. Previously, the area mental health programs were paid an hourly rate. They will have a payment for overhead cost amounting to $509 per CAP recipient.

5-Year Business Plan/Reinvestment Strategy

Mr. Jim Edgerton, Assistant Secretary for Budget, Management and Planning, summarized the 5-year Business Plan/Reinvestment Strategy to respond to the changes in federal welfare which did away with entitlements. As projected over a 5-year period, there will be a surplus of to the amount $569.9 million. The legislature has approved reinvestment of $422.4 million. The department wants to transfer $10.8 million from TANF for child care, and there will still be a surplus. (See Handouts # 14,#15, and #16.) Representative Cansler wanted to know how costs would be covered in an economic downturn. Since the federal government has capped the funds and there would be no more federal money, the legislature would have to appropriate additional money for eligibles, according to Mr. Edgerton. Representative Gardner pointed out we didn't know there wasn't enough money when we promised the counties money for child protective workers and now the legislature has to come up the money. She wanted to know where the children's health Insurance money coming from. The department is neither proposing to take money out of its funds nor the $50 million reserve; The money will need to be appropriated by the Legislature to assist the hard-core welfare recipients get off welfare, according to Mr. Edgerton.

Status of 1997-98 Funding

Peter Leousis, Assistant Secretary for Human Services and Education Policy, gave the Status of 1997 Funding. (See Handouts #17 and 18.) Representative Gardner questioned the number of children coming into the program staying constant. In response to Representative Howard question about using up the reserves for day care, Mr. Leousis said that if the funds aren't transferred into child care, the welfare rolls will increase. He said they were taking into account the resources needed to assist the hard-care welfare recipients He said Congress had given the states authority to transfer of 30% of the TANF funds to child care. Several states have transferred 26% of their TANF block grant to child care.

Initiative to Reduce Out-of-Wedlock Births

Anne Wolfe, Director of Woman's and Children's Health, introduced Dr. Kevin Ryan who would be talking about the $1.6 million of TANF funds the legislature transferred from the DSS to this division and what is being done with the money. He said the money is being used to reduce out of wedlock births in cooperation with county social service targeting TANF families and others at risk. Their plans are reviewed by the division. Representative Adams asked specifically what is being done to prevent pregnancy and wants another conversation with Dr. Ryan.

Child Welfare Expansion Update

Kevin Fitzgerald, Director of the Division of Social Service updated the committee on the status of child welfare expansion. (See Handout #19.) He said that in response to the committee

recommendation, the Adolescent Parenting Program has been transferred to the Woman's and Children's Health Division from the Social Services Division. The goal is to have a more integrated program, according to Mr. Fitzgerald. Although the Senate members had to leave early, the committee decided to continue with Mr. Fitzgerald's presentation until that time. The division and the counties have been putting into place the changes the legislature made last session to protect children. The North Carolina legislation was the precursor to the federal legislation called to the Adoption and Safe Families Act, and the division is working on the changes needed to be in compliance.

Mr. Fitzgerald said because the federal government approved the use of only 38% of the request for 4EA funds for the 314 child protection positions needed, the division is proposing to up the county block grant for services with $5.1 million of TANF funds which would include $2.1 for the expansion of the Families for Kids program. They are appealing the federal decision.

Representative Gardner said there is a grant available from the National Conference of State Legislatures (NCSL). To obtain their services the leadership needs to write a letter of request. She moved that the committee asked the leadership of the House and Senate to support a request for the NCSL grant to help in the change in statewide protocol for child protective services. The motion passed. Representative Gardner expressed her displeasure at learning through other channels that there is a funding shortfall and speculated there would be a shortfall this year due to counties hiring the child protective workers so promptly.

Senator Martin announced that the committee will meet with NER in Room 643 at 9:00 a.m. The meeting was adjourned.

Barbara R. Hocutt

Barbara R. Hocutt, Clerk

Senator Bill Martin, Co-Chairman

WJM:brh
attachments

VISITOR REGISTRATION SHEET

Legislative Study Commission on Mental Health, Developmental Disabilities and Substance Abuse Services — **January 8, 1998**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Evelyn Hendrickson	NCHA PO Box 80428, Raleigh 27623-0428
Jim Lowry	NCALTCF 4010 Barrett Dr. Ste 102 Raleigh 27609
Charles Franklin	P.O. Box 326, Elizabeth City, N.C. 27909
John Boggett	MH/DD/SAS
Marci White	AMH/DD/SAS
S. Lynn Hamlet	Senator Ellie Kinnaird
Sparkie Clark	DMH/DD/SAS
Charles S. Mathews	A.M.I. 4104 Huckleberry Dr. Raleigh NC 27612
Doris Jeter	1321 Williamson Dr. Raleigh 27608
Marian Hartman	DD Council 1508 Western Blvd Ral. 27606
Byron K. Harris	OSBM 116 W. Jones St. Raleigh
Christine Heinberg	Carolina Legal Assistance 224 S. Dawson Ral
Charles Li	Howell Centers, P.O. Box 607 LaGrange NC 28551
Mr Tate	MHA/NC - C200,
Larry Swabe	DD Council 852-5655
Ellen Russell	The Arc of NC Po Box 20545 Raleigh 27619
Susan Reed	The Arc of Wake County 401 Oberlin Rd.
Louise G Fisher	NCMHA 2502 Mayview Rd. Raleigh, NC Suite 225 Raleigh 27607 27605
PAUL Meyer	NCACC Box 1488 - Raleigh, 27602

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bowdish	Zeb Alley, P.A.
Myra Mills	NASW-NC
Carolyn Busse	Sheps Center, UNC-CH
John Rustin	NC Family Policy Council
Stephanie Hendricks	NASW-NC
Cheryl Waller	DHHS/DMCH
Kevin Ryan	DHHS/DMCH

Carol Shaw
Handout #1
1-21-98

NORTH CAROLINA ASSOCIATION OF COUNTY COMMISSIONERS

ALBERT COATES LOCAL GOVERNMENT CENTER • 215 NORTH DAWSON STREET • P.O. BOX 1488
RALEIGH, NORTH CAROLINA 27602-1488 • TELEPHONE 919/715-2893 • FAX 919/733-1065

December 19, 1997

The Honorable Charlotte A. Gardner
1500 W. Colonial Dr.
Salisbury, N.C. 28144

Dear Representative Gardner:

I understand from our Assistant Executive Director Ed Regan that you wished to be informed as soon as possible regarding our Board of Directors' action pertaining to the proposed Child Health Initiative.

The Board of Directors on December 17th and discussed the proposal. Concerns were expressed regarding the possible implementation of this program as an add-on to the State Medicaid program if this strategy should require additional county expenditures. The Board discussed the proposal for the State to pay all of the non-federal share of the Medicaid program costs for the new child enrollees, and expressed great appreciation for this approach. The Board members understand that by enrolling the children who would qualify for the new program, we would also reach children who would qualify for the regular Medicaid program. While this is not an unworthy objective, the estimated costs to counties for this group of children are estimated at $8 million.

The Board of Directors concluded that the counties are hardly in a position to absorb such increased costs. It is certainly not possible to find this amount of money in mid-year. Additional concerns were expressed about the capped federal program becoming an "entitlement" if it is implemented through an expansion of the Medicaid program. While our commissioners are not unsympathetic to the need for medical care for the uninsured children of North Carolina, the conversion of a capped program to entitlement status raised many concerns about Medicaid budget increases we could experience in future years. It was pointed out that Congress could discontinue the funding , leaving the State and counties with a huge funding gap.

We certainly appreciate the concerns raised by the members of the Appropriation Sub-committee on Human Resources. We want to be supportive in implementing the Child Health Initiative and know that it will benefit many children in our state. For a program of this magnitude, a conservative implementation strategy would be more cost-neutral to the counties. We would be pleased to discuss these issues with you further. Should you have any questions, please do not hesitate to call.

Yours truly,

C. Ronald Aycock
Executive Director

cc: Senate & House Appropriations on Human Resources

VISITOR REGISTRATION SHEET

Joint Appropriations Subcommittee on Health & Human Services 1/20-22/98

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Angie McMillan	DHHS
Patricia Reuben	NCACC
Paula A. Hoey	Covenant w/ NC's Children
AL DEITCH	DOA/YAIO
TOM VITAGLIONE	DHHS - WCH
Ann Woolfe	DHHS - WCH
Betsy Sykes/Joe Fiorda	WRAL-TV
Danielle Dardashti	NBC-17
[signature]	DHHS - DWCH - Imm.
Doral Patock	DHHS - DWCH - Nutrition
Wendy Mills	SEANC

#2 Wolfe
1-21-98

1997

NORTH CAROLINA
Child Health Report Card



Grade: still C-

The health of North Carolina's children is not as good as it could or should be. However, all of these health problems can be overcome.

NORTH CAROLINA INSTITUTE OF MEDICINE

Citizens dedicated to improving the health of North Carolinians

IN COLLABORATION WITH:

Division of Women's and Children's Health,
North Carolina Department of Health and Human Services
North Carolina Area Health Education Centers Program
North Carolina Child Advocacy Institute
Wellness Council of North Carolina
North Carolina Child Fatality Task Force

HEALTH INDICATOR:	N.C. DATA	CHANGE FROM PREVIOUS YEAR	GRADE
Insurance (1997):[1]			
Number of uninsured children:			
All	222,913		D
Under age 1	7,321	(data	D
Age 1-5	57,595	unavailable)	D
Age 6-18	157,997		D
Access to Preventive Care (1996):[2]			
% of Medicaid-enrolled children (ages 0-18) receiving preventive care	47.8	(from 44.0)	C
Infant Mortality (1996):[3]			
Number of deaths per 1,000 live births:			
All	9.2	no change	C
White	7.1	(from 6.8)	B
Non-white	14.3	(from 15)	[illegible]
Low Birth-Weight Infants (1996):[4]			
% of infants born weighing 5.5 lbs. or less:			
All	8.7	no change	C
White	6.8	no change	B
Non-white	13.3	(from 13.2)	D
Prenatal Care (1996):[5]			
% of mothers receiving prenatal care during first and second trimesters:			
All	83.4	(from 83)	B
White	87.7	(from 88)	B
Non-white	71.9	(from 71)	B
Immunization Rates (1996):[6]			
% of children with appropriate immunizations:			
At age 2	78	(from 84)	C
At school entry	98	no change	A
Communicable Diseases (1996):[7]			
Number of newly reported cases (ages 0-19):			
Syphilis, Gonorrhea, Chlamydia	12, 634	(from 15,178)	[illegible]
AIDS	24	(from 8)	
Tuberculosis	34	(from 19)	D

HEALTH INDICATOR:	N.C. DATA	CHANGE FROM PREVIOUS YEAR	GRADE
Vaccine-Preventable Communicable Disease (1996):			
Number of cases:			
Measles	2	(from 0)	B
Mumps	17	(from 28)	B
Rubella	9	(from 0)	B
Diphtheria	0	no change	A
Pertussis	128	(from 115)	C
Tetanus	0	no change	A
Polio	0	no change	A
Environmental Health (1996):[8]			
% of children (age 12-24 months):			
Screened for lead levels	34.2	(from 31.2)	C
Screened having elevated blood lead	5.8	(from 6.7)	C
Dental Health (1996):			
children:			
With one or more sealants, grades 5 and 6	28	(from 25)	C
With fluoridated water systems	89	(from 87)	B
Developmental Health (1996):[9]			
Number of children (age 0-3) enrolled in early intervention services to reduce effects of developmental delay, emotional disturbance and/of chronic illness	8,454	(from 7,593)	B
Child Abuse, Neglect and Dependency (1996-97)[10]			
	FY 96-97	**FY 95-96**	
Number of reports	60,687	(from 57,907)	D
Number of substantiated reports	19,512	(from 18,241)	D
Number of children affected in reports	102,168	(from 96,175)	D
Number of children affected in substantiated reports	33,133	(from 30,812)	D
	CY 96	**CY 95**	
Number of confirmed child deaths due to abuse	45	(from 18)	F
Childhood Fatality (1996):[11]			
ber of deaths (ages 0-18) per 100,000 children	90.7	(from 89)	C

Notes

1 Insurance: The number of uninsured children in NC was derived from an average of 1995 and 1996 Current Population Survey data which was adjusted to reflect true Medicaid enrollment and extrapolated to 1997 NC Population Projections. The number of uninsured children in low-income families (families below 200% of the Federal Poverty Guidelines) accounts for 62% of all uninsured children. The 1997 Balanced Budget Act included a provision to develop a Child Health Insurance Program designed to cover uninsured children under the age of 19 in low-income families. The NC Child Health Insurance Task Force, under charge by the Secretary of the NC DHHS, has prepared a proposal to the General Assembly that would cover uninsured, low-income children in NC under this new federal block grant matching program.

2 Access to Preventive Care: The percentage of Medicaid-enrolled children (ages 0-18) receiving preventive care increased 9% in 1996 for a three-year improvement of 50%. This increase can be attributed to the outreach efforts of the Health Check Initiative. The increase is even more significant because 150,000 more children have been enrolled in Medicaid over the past three years due to these efforts and the actions of the General Assembly.

3 Infant Mortality: While the total number of deaths per 1,000 live births has remained constant since 1995, it remains the lowest number ever reported in NC. It is still short, however, of the NC goal of 7.4 in the year 2000. In addition, while the number of non-white deaths has *decreased* slightly, the number of white deaths has *increased* slightly.

4 Low Birth-Weight Infants: Low birth-weight is often associated with increased risk of infant mortality. The percent of infants born weighing less than 5.5 lbs. has not changed in the past three years and remains a serious problem.

5 Prenatal Care: Infants whose mothers seek prenatal care in the first trimester (first 13 weeks) of pregnancy are less likely to be low birth-weight and are less likely to fall victim to infant mortality.

6 Immunization Rates: According to the American Academy of Pediatrics, the recommended schedule of immunizations for a child under age two includes: three doses of Hepatitis B, three doses of Diphtheria, Tetanus and Pertussis (DTP), three doses of H influenzae type b, two doses of Polio, one dose of Measles, Mumps and Rubella (MMR) and one dose of Varicella. Though NC showed significant improvement in 1995 of 29%, in 1996 it experienced a decline of 7%.

7 Communicable Diseases: The number of newly reported cases of Syphilis, Gonorrhea and Chlamydia decreased 17% in 1996 after increasing 13% in 1995. The number of reported new cases of AIDS increased an alarming 200% in 1996. Finally, the resurgence in newly reported Tuberculosis cases increased a dramatic 79% after experiencing a decline of 44% in 1995.

8 Environmental Health: Current policy recommends that all children between the ages of 12-24 months be screened for elevated lead levels [elevated defined as 10 micrograms/deciliter (Δ µg/dl) or higher]. The percentage of preschool children age 12-24 months that have been screened for elevated lead levels has increased steadily since 1994 by 34%. Education and intervention programs designed to heighten awareness of the effects of high lead levels on the physical and intellectual development of children has led to a decline in the number of reported cases of elevated lead levels by 13% in 1996.

9 Developmental Health: The number of children (age 0-3) enrolled in early intervention services has increased 11% in 1996 and 38% between 1994 and 1996.

10 Child Abuse, Neglect and Dependency: Data was provided by the NC Central Registry's Reports of Child Abuse, Neglect and Dependency and the NC Medical Examiner's Office. The number of substantiated reports are those investigated and confirmed. However, not all reports are investigated. Also, a single report often involves more than one child, therefore, the total number of children affected each year is significant--almost twice the number of actual reports. Finally, the number of confirmed deaths due to child abuse alone (not including deaths due to neglect) has increased an alarming 150% between calendar year 1995 and 1996.

11 Childhood Fatality: Between 1988 and 1995, childhood fatalities decreased dramatically by 25%. However, in 1996, childhood fatalities increased slightly by 2%. The NC Child Fatality Task Force was established by the General Assembly in an effort to study and make recommendations on ways to prevent childhood fatalities in the future.

12 Deaths Due to Injuries: In 1996, the rates of all unintentional deaths due to injuries increased significantly, with the exception of drownings and motor vehicle-related deaths. For intentional deaths, the number of homicides increased 44%, while the number of suicides remained constant. In 1996, the number of *unintentional* deaths due to firearms *increased* 22%. However, over the four-year period of 1993 to 1996, the number of unintentional deaths by firearms *decreased* 23%.

13 Alcohol, Tobacco and Substance Abuse: The 1995 data were derived from the biennial Youth Risk Behavior Survey conducted by the NC Department of Public Instruction in cooperation with the Centers for Disease Control and Prevention. The percentage of 9th-12th graders who report having used smokeless tobacco and beer in the past 30 days declined 17% and 9%, respectively, between 1993 and 1995. However, the percentage of 9th-12th graders who reported using cigarettes increased 7% and the marijuana increased 47%. While the increase in marijuana use nificant, it pales in comparison to the 100% increase reported nationally. The reported use of cocaine by the same group in the same time period remained the same.

Physical Fitness: The percentage of 9th-12th graders who report exercising at least 20 minutes per day, for a minimum of 3 days per week has increased only slightly to 61.3% in 1996.

14 Nutrition: The children represented by these data are those who receive services in a local health department sponsored clinic and may not be representative of the state as a whole. Overweight is conservatively defined as a weight for height (2-4 years old) or a body mass index (5-18 years old) greater than or equal to the 95th percentile. Concern about overweight prevalence occurs when it exceeds 5%. This data shows that for these children, NC has three times the expected number of overweight preschoolers, more than three times the expected number of overweight school-age children and more than four times the expected number of overweight teens.

15 Teen Pregnancy: Overall, the number of pregnancies per 1,000 girls (ages 15-17) dropped 6% in 1996 after a three-year increase between 1993 and 1995 of 11% and is nearing the NC goal of 63. However, the number of nonwhite pregnancies (101.3/1,000) is 107% higher than the number of white pregnancies (49.0/1,000), remaining a cause for concern as it is far from the NC goal of 86.7.

Grading Method: While not statistically derived, letter grades were determined as follows:

A = >25% improvement or current status remains very good

B = <25% improvement or current status remains satisfactor

C = no significant change or current status remains mediocr

D = <25% worse or current status remains unsatisfactory

F = >25% worse or current status remains very bad

HEALTH INDICATOR:	N.C. DATA	CHANGE FROM PREVIOUS YEAR	GRADE
Deaths Due to Injuries (1996):[12]			
Number of deaths (ages 0-18):			
Unintentional			
Motor vehicle-related	182	(from 180)	C
Drowning	35	no change	C
Fire/Burns	33	(from 23)	D
Firearm	11	(from 9)	D
Bicycle	18	(from 10)	D
Intentional			
Suicide	37	no change	D
Homicide	69	(from 48)	F
Alcohol, Tobacco and Substance Abuse (1995):[13]			
% students (grades 9-12) who used the following in the past 30 days:			
Cigarettes	31.3	(from 29.3)	D
Smokeless Tobacco	9.2	(from 11.1)	
Marijuana	21.7	(from 14.8)	
Alcohol (beer)	39.7	(from 43.7)	D
Cocaine	2.2	no change	D
Physical Fitness (1995):[13]			
% (grades 9-12) who exercised at least 20 minutes per day for at least 3 days in the past week	61.3	(from 59.1)	C
Nutrition (1996):[14]			
% of low-income children who are overweight:			
Age 0-4	15.0	(from 10.7)	D
Age 5-11	16.5	(from 14.0)	D
Age 12-18 (1988-96)	21.7	(data unavailable)	C
Teen Pregnancies (1995):[15]			
Number of pregnancies per 1,000 girls (ages 15-17):			
All	65.0	(from 69.1)	C
White	49.0	(from 50.7)	C
Non-White	101.3	(from 111.7)	D

THE 1997 NORTH CAROLINA CHILD HEALTH REPORT CARD was developed by the North Carolina Institute of Medicine. Data were compiled by Thomas Vitaglione, MPH, with the Division of Women's and Children's Health at the NC Department of Health and Human Services (DHHS). Data sources include the health divisions of NCDHHS and the State Center for Health and Environmental Statistics. Graphic design was by Carolyn Busse, Communications Coordinator at the Cecil G. Sheps Center for Health Services Research of the University of North Carolina at Chapel Hill.

INFANT DEATHS AND RATES
BY REGION AND COUNTY OF RESIDENCE
NORTH CAROLINA, 1995, 1996, AND 1992-1996

#2 Revised 1-21-98 Ryan

	1995		1996		1992-1996	
	INFANT DEATHS	RATE	INFANT DEATHS	RATE	INFANT DEATHS	RATE
NORTH CAROLINA	935	9.2	962	9.2	5024	9.8
DEHNR I	81	9.0	95	10.1	432	9.4
DEHNR II	161	7.3	156	6.8	935	8.4
DEHNR III	188	9.9	188	9.7	926	9.8
DEHNR IV	208	9.9	212	9.8	1082	10.3
DEHNR V	134	10.2	149	11.1	758	11.3
DEHNR VI	89	9.8	102	10.9	530	11.3
DEHNR VII	74	9.0	60	7.2	361	8.7
PCR I	59	8.6	72	10.1	317	9.0
PCR II	241	9.8	230	9.3	1172	9.6
PCR III	120	6.9	127	6.9	744	8.5
PCR IV	176	9.5	167	8.7	875	9.4
PCR V	164	9.9	166	9.9	886	10.5
PCR VI	175	9.9	200	11.1	1030	11.3
ALAMANCE	10	7.0	11	7.0	64	8.7
ALEXANDER	4	11.0	4	10.2	16	8.6
ALLEGHANY	0	0.0	0	0.0	0	0.0
ANSON	3	10.1	5	14.8	21	11.9
ASHE	2	9.6	3	11.5	12	10.3
AVERY	1	5.7	2	12.9	14	14.8
BEAUFORT	9	15.2	7	13.0	31	10.8
BERTIE	4	14.5	3	10.2	15	10.4
BLADEN	4	11.0	5	11.9	30	14.6
BRUNSWICK	7	10.1	1	1.4	25	6.8
BUNCOMBE	18	8.1	19	8.1	90	7.8
BURKE	10	9.4	10	8.8	56	10.7
CABARRUS	13	8.6	2	1.3	48	6.5
CALDWELL	11	11.6	11	11.5	45	9.2
CAMDEN	0	0.0	1	18.2	4	12.2
CARTERET	6	9.9	5	8.5	29	9.1
CASWELL	3	13.8	4	16.9	17	13.9
CATAWBA	7	4.0	9	5.4	59	6.8
CHATHAM	4	7.5	13	22.1	25	9.0
CHEROKEE	1	4.2	3	12.5	11	9.1
CHOWAN	0	0.0	1	4.8	6	6.1
CLAY	0	0.0	0	0.0	1	3.1
CLEVELAND	9	7.2	10	7.7	64	9.9
COLUMBUS	12	16.3	7	9.7	48	13.2
CRAVEN	10	6.8	7	4.7	69	9.0
CUMBERLAND	53	9.2	58	10.3	316	10.8
CURRITUCK	3	18.2	4	21.5	17	19.0
DARE	1	3.1	1	3.5	7	4.7
DAVIDSON	14	8.1	10	5.4	70	7.9
DAVIE	2	5.4	2	5.9	18	10.4
DUPLIN	7	10.5	8	11.2	48	14.7

Note: Rates based on fewer than 10 deaths are unstable and should be interpreted with caution.

INFANT DEATHS AND RATES
BY REGION AND COUNTY OF RESIDENCE
NORTH CAROLINA, 1995, 1996, AND 1992-1996

	1995		1996		1992-1996	
	INFANT DEATHS	RATE	INFANT DEATHS	RATE	INFANT DEATHS	RATE
DURHAM	34	11.5	23	7.6	153	10.1
EDGECOMBE	6	6.8	10	11.8	58	12.9
FORSYTH	55	13.4	48	12.0	243	12.3
FRANKLIN	8	15.0	3	5.5	33	12.4
GASTON	21	8.9	19	7.5	119	9.4
GATES	1	9.1	1	12.0	4	7.2
GRAHAM	0	0.0	0	0.0	3	6.5
GRANVILLE	9	16.8	4	7.5	35	12.9
GREENE	5	26.2	2	8.5	18	17.9
GUILFORD	53	10.2	60	11.5	263	10.2
HALIFAX	17	21.2	8	10.9	69	16.4
HARNETT	13	10.4	12	8.7	61	9.4
HAYWOOD	6	11.1	8	15.7	21	7.9
HENDERSON	8	11.0	13	14.8	34	8.3
HERTFORD	4	12.7	5	17.8	27	17.4
HOKE	9	17.9	6	11.0	38	15.6
HYDE	1	15.9	2	35.1	3	9.8
IREDELL	16	11.2	10	6.9	64	9.0
JACKSON	5	16.3	3	9.4	14	9.1
JOHNSTON	12	7.7	15	9.5	62	8.5
JONES	4	44.0	1	9.8	5	8.8
LEE	9	12.2	11	15.7	48	13.7
LENOIR	8	9.3	11	12.2	56	12.8
LINCOLN	5	6.6	7	8.7	34	9.2
MCDOWELL	2	4.4	5	10.5	18	7.8
MACON	2	7.4	5	17.8	17	13.0
MADISON	1	5.2	2	9.2	8	8.1
MARTIN	4	12.8	4	13.4	21	12.4
MECKLENBURG	55	6.2	60	6.4	363	8.1
MITCHELL	3	18.3	0	0.0	7	8.8
MONTGOMERY	1	2.6	4	11.2	20	11.0
MOORE	7	8.6	10	12.5	44	11.0
NASH	8	6.9	21	17.3	79	13.1
NEW HANOVER	12	6.5	13	7.1	66	7.3
NORTHAMPTON	4	15.4	9	36.3	21	15.5
ONSLOW	28	8.7	25	7.6	135	8.2
ORANGE	10	9.2	11	9.8	45	8.0
PAMLICO	1	10.2	0	0.0	4	7.0
PASQUOTANK	4	10.1	5	11.8	34	15.3
PENDER	2	4.4	1	2.5	10	4.6
PERQUIMANS	1	8.6	1	8.7	8	13.3
PERSON	4	8.9	3	7.2	20	9.4
PITT	18	10.7	30	16.6	118	13.7
POLK	2	12.6	3	17.4	10	12.4
RANDOLPH	10	6.4	15	9.1	58	7.4
RICHMOND	12	17.8	12	18.0	42	12.4
ROBESON	17	9.4	28	14.2	111	11.5
ROCKINGHAM	14	12.9	12	10.4	61	10.7

Note: Rates based on fewer than 10 deaths are unstable and should be interpreted with caution.

INFANT DEATHS AND RATES
BY REGION AND COUNTY OF RESIDENCE
NORTH CAROLINA, 1995, 1996, AND 1992-1996

	1995		1996		1992-1996	
	INFANT DEATHS	RATE	INFANT DEATHS	RATE	INFANT DEATHS	RATE
ROWAN	17	11.5	11	7.3	73	9.8
RUTHERFORD	7	9.0	7	8.9	50	12.6
SAMPSON	12	16.2	4	5.0	37	10.2
SCOTLAND	3	5.6	5	8.7	38	13.6
STANLY	2	2.9	10	13.9	29	8.3
STOKES	4	8.0	3	6.2	25	10.2
SURRY	5	5.9	4	4.5	29	6.9
SWAIN	2	13.0	0	0.0	12	14.3
TRANSYLVANIA	1	3.7	4	12.9	15	10.3
TYRRELL	0	0.0	2	55.6	3	14.9
UNION	12	7.6	14	8.4	66	8.5
VANCE	8	12.9	8	12.4	34	10.5
WAKE	64	8.2	61	7.5	327	8.6
WARREN	1	5.3	0	0.0	12	11.7
WASHINGTON	1	5.1	5	24.0	12	12.1
WATAUGA	4	11.3	5	13.2	16	8.9
[illegible]YNE	10	6.4	9	5.5	68	8.5
[illegible]KES	7	8.4	8	9.9	33	8.4
WILSON	10	10.4	12	11.6	61	12.3
YADKIN	5	11.0	3	6.4	17	7.9
YANCEY	1	6.1	0	0.0	6	6.7

Note: Rates based on fewer than 10 deaths are unstable and should be interpreted with caution.

#4 Steve Klein
1-21-98

DENTAL HEALTH SECTION

North Carolina Department of Health and Human Services

Division of Community Health

January 1998

Mission Statement

To promote conditions in which all North Carolina citizens can achieve optimal oral health.

Program Description

Prevention is the key to improved oral health. All too many citizens and in particular children, still experience debilitating and preventable oral diseases. The goal of the state dental public health program is to reduce the impact of tooth decay, periodontal disease, cancer, and injuries for all citizens. The long-term goal is generations of North Carolina children who are decay-free.

To achieve these goals, the Section's programs and services are organized into four broad categories: **(1) Education/Promotion, (2) Prevention, (3) Oral Health Surveillance, and (4) Access to Care**. The services provided include dental health education, dental sealant promotion, water fluoridation, fluoride mouthrinse, oral screenings/referral/follow-up, dental assessment and surveillance, oral epidemiological surveys, and professional dental care.

Outcome Objectives

1. **Increase the percentage of population served by community water systems with optimally fluoridated water**. Approximately 89% of NC citizens served by community water systems are receiving fluoridated water. This exceeds the National Year 2000 Objective of 75%. However, because NC is still a rural state with a significant number of private wells, 36% of the population is not receiving an adequate level of fluoride in their drinking water.
2. **Increase the proportion of children with dental sealants to 50% by the Year 2000**. Approximately 28% of NC school children have at least one dental sealant in a permanent molar. This is an increase from 12% in 1986-87.
3. **Increase the percentage of children who are caries-free**. The baseline number as reported in the 1986-87 Statewide School Survey is 43%. The goal is to have 75% of 12 year olds caries-free by the Year 2000.
4. **Decrease the percentage of children with unmet dental treatment needs**. This measure will give us an indication of the access to care issues facing NC children. Obviously there are many factors that contribute to dental disease going untreated.

Strategies

1) **Education/Promotion** - All of the Section's activities include a dental health education and promotion component. These are the traditional public health interventions of classroom education, teacher training, individual instruction on dental care, sealant promotion, use of fluoride, plaque control, etc. Last year the Section provided direct educational services for over 300,000 individuals, distributed more than 600,000 educational materials, and reached over 62,000 people with point-of-contact dental health exhibits.

2) **Prevention** - Fluoride, especially community water fluoridation, continues to be the single most effective tool we have in preventing dental disease. It is important to keep the progress we have made as a state with **fluoridated water supplies**. We are also looking for opportunities to expand our fluoridation efforts as new areas consolidate water systems. The Section works with dentists and other health professionals to encourage the proper use of **fluoride supplements**. School-based **fluoride mouthrinse** is also a cost-effective preventive methodology particularly for targeted schools with high-risk children. Approximately 300,000 school children participated in the fluoride mouthrinse program last year in 77 counties across the state. **Dental sealants** are underutilized in North Carolina. The Section has a five-part strategy to promote dental sealants – public awareness, provider education, sealant demonstration projects, media promotion, and partnering with provider groups. ***Seal the State in '98*** is an intensive effort to collaborate with privately practicing dentists to provide free dental sealants to high-risk children statewide.

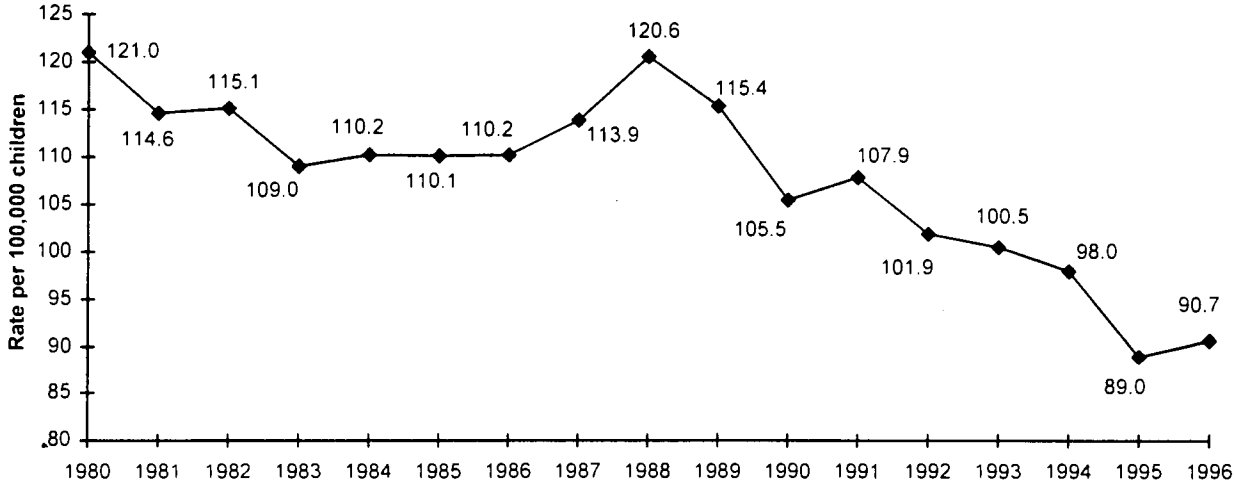
3) **Oral Health Disease Surveillance** - North Carolina is the only state in the nation with a series of oral epidemiological surveys dating back to the early 1960's. These periodic statewide surveys provide us with important epidemiological data on which to base dental health programs and policies. These surveys are resource intensive therefore they are only done every 10-15 years. The next survey is planned for the year 2001 to measure our success in reaching the state and national Year 2000 Health Objectives. In an effort to gather more timely information for local program planning, dental public health staff have been trained in a new **Dental Assessment** technique. This new technique is a modification of the dental screening effort already performed by dental public health staff across the state. Last year approximately 270,000 school children were screened for dental decay. The improved "Assessment" will measure the number of decayed and filled teeth, which will provide the percentage of kindergarten, and fifth grade children who are free from caries and the percentage who are in need of dental care. Sealant presence will also be recorded. This statistically valid data can be used to make comparisons county to county and statewide.

4) **Access to Care** - Public Health has the responsibility and the obligation to assure that there are adequate resources to respond to the dental treatment needs of its citizens. The Dental Health Section collects information on dental disease prevalence and the unmet treatment needs to evaluate access to care. Where additional clinical resources are needed, the Section works to assist the community in building local capacity for dental care.

#7 Vitaglione
1-21-98

1996 CHILD DEATHS IN *NORTH CAROLINA*

TREND IN RATE OF CHILD DEATHS 1980-1996
AGES BIRTH THROUGH 17



Child Deaths By Cause in North Carolina Ages Birth through 17			
Cause of Death	Average Annual Number 1992-1995	Number in 1996	Percent Change
Birth defects	233	237	2%
Other birth-related conditions	531	471	-11%
Sudden infant death syndrome	120	101	-16%
Illnesses	309	327	6%
Unintentional injuries	306	329	7%
motor vehicle injuries	*176*	*182*	*3%*
bicycle injuries	*9*	*18*	*95%*
injuries caused by fire	*30*	*33*	*9%*
drowning	*30*	*35*	*19%*
other unintentional injuries	*61*	*61*	*0%*
Homicide	67	69	3%
Suicide	40	37	-8%
All other	43	35	-18%
TOTAL	1649	1606	-3%

Child Deaths by Age			
	Average 1992-95	Number in 1996	Percent Change
Infant	1016	962	-5%
1-4	187	168	-10%
5-9	105	129	23%
10-14	128	126	-1%
15-17	215	221	3%

POPULATION		
	1990 Census	1996 Estimate
Total	6,628,637	7,323,085
Children age 0-17	1,606,149	1,771,041

Charts reflect state residents only.

Produced by the Division of Maternal and Child Health in conjunction with the State Center for Health Statistics

Sep-97

Notes on 1996 Child Death Data

1. In 1996, 1,606 North Carolina resident children birth through 17 died.

2. This represents a child death rate of 90.7 per 100,000 children, a slight increase over 1995, when 1,548 children died for a rate of 89.0 per 100,000.

3. Even with this slight increase, the child death rate has decreased 25% since 1988.

4. While comparable 1996 data are not available from other states, it is likely that North Carolina ranks in the mid-forties among the states with regard to its child death rate.

5. In 1996, there were 58 more child deaths than in 1995, accounting for the increase in the death rate. When compared by age categories, there were substantial increases in deaths to infants (27) and to those ages 5 through 9 (36). There were small decreases in deaths to children ages 1 through 4 (-10) and 10 through 14 (-3), and a slight increase in ages 15 through 17 (8).

6. To provide a more accurate indication of the trends in child deaths by age and cause, the 1996 data are compared to the average number of deaths in the four-year period 1992-95. Using this comparative method, there was a 5% decrease in infant deaths in 1996, and a significant 10% decrease in children ages 1 through 4. There was a significant 25% increase in deaths to children ages 5 through 9. Changes in the categories 10 through 14 and 15 through 17 were small.

7. Using this same comparison for child deaths by cause, there were increases in birth defects (2%), illnesses (6%), unintentional injuries (7%) and homicide (3%). There were more significant decreases in other birth-related conditions, such as prematurity and respiratory distress (-11%), sudden infant death syndrome (-16%) and suicide (-8%).

8. Though the numbers are small, the substantial increases in bicycle injuries and drownings are particularly troublesome.

9. Similar numerical comparisons are available for each county. Because the numbers for each county are small, death rates are not appropriate.

10. North Carolina benefits from a state-supported three-pronged focus on child deaths. Local Child Fatality Review Teams are available in each county to study resident child deaths with the aim of developing recommendations to change policies and procedures (usually local) to prevent future child deaths. A State Child Fatality Review Team reviews statewide child death data and the reports of the Local Teams, and makes recommendations for statewide policy/procedure/legislative changes. The Child Fatality Task Force essentially functions as a legislative study commission, receiving reports from State and Local Teams, and offering a legislative agenda to prevent child deaths in North Carolina.

Contacts:	Child Death Data	Tom Vitaglione	715-3808
		Eleanor Howell	715-4472
	Child Fatality Task Force	Tom Bennett	715-3294
		Ilene Nelson	662-3591
	State Child Fatality Team	Dr. Marcia Herman-Giddens	966-2253
	Local Child Fatality Teams	Michael Sanderson	715-3296

1996 Child Deaths: Age and Cause of Death

North Carolina Residents Ages Birth through 17

	Birth defects	Other birth-related conditions	Sudden infant death syndrome	Illnesses	Motor vehicle injuries	Bicycle injuries	Injuries caused by fire	Drowning	Other unintentional injuries	Homicide	Suicide	All other	Total
Infants (less than 1 year old)	201	469	101	130	12	0	3	2	13	16	0	15	962
1-4	16	2	0	60	25	0	17	12	8	16	0	12	168
5-9	8	0	0	48	27	11	8	7	12	7	0	1	129
10-14	9	0	0	38	33	6	5	5	12	7	7	4	126
15-17	3	0	0	51	85	1	0	9	16	23	30	3	221
TOTAL	237	471	101	327	182	18	33	35	61	69	37	35	1606

Produced by the Division of Maternal and Child Health
in conjunction with the State Center for Health Statistics

September 1997

1996 Infant and Child Deaths in North Carolina

	Total	CAUSE OF DEATH												AGE					RACE			
		Birth defects	Other birth-related conditions	SIDS	Illnesses	Motor vehicle injuries	Bicycle injuries	Fire injuries	Drowning	Other preventable injuries	Homicide	Suicide	All other	Infant	1-4	5-9	10-14	15-17	White	African American	Native American	Other
North Carolina 1992-95 Average	1649	232 75	531	120	309 25	176 25	9 25	30 25	29 5	61	66 75	40 25	42 75	1015 5	187	104 5	127.5	214.5	896	706 25	31 25	15 5
[illegible]	[illegible]	237	471	101	327	182	18	33	35	61	69	37	35	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Alamance 1992-95 Average	20.25	2	8 5	1 5	4	2 25	0	0	0 25	0 5	0 5	0	0 75	13 25	2 25	1 25	1 5	2	11 75	8 5	0	0
[illegible]	[illegible]	[illegible]	6	[illegible]	[illegible]	2	1	0	0	2	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Alexander 1992-95 Average	6.50	1	1 75	0 5	1 5	0 75	0	0	0 25	0 25	0 5	0	0	3	1 75	0 75	0	1	6 25	0 25	0	0
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0	3	0	1	0	1	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Alleghany 1992-95 Average	1.75	0	0	0	0 75	0 75	0	0	0	0	0	0 25	0	0	0 25	0 5	0.25	0.75	1.75	0	0	0
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Anson 1992-95 Average	5.75	0 75	2 5	0 5	0 5	1	0	0	0	0	0 25	0 25	0	4	0 25	0 5	0	1	1 5	4.25	0	0
[illegible]	[illegible]	[illegible]	2	[illegible]	[illegible]	4	0	0	0	0	1	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Ashe 1992-95 Average	4	0 75	1 5	0	0	0 75	0 25	0	0	0	0 5	0 25	0	2 25	0 5	0 5	0 5	0 25	3 25	0 5	0	0 25
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Avery 1992-95 Average	3.75	0 5	1 25	0 75	1	0 25	0	0	0	0	0	0	0	3	0 25	0 25	0 25	0	3.75	0	0	0
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Beaufort 1992-95 Average	10.25	1 5	3 25	0 5	1 25	1 5	0	0	0 5	1 25	0	0 25	0 25	6	1 25	0 75	0 75	1 5	3 5	6.75	0	0
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	3	0	1	0	0	1	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Bertie 1991-94 Average	5.5	0 5	2 25	0 25	0 75	0 5	0	0	0	0	0 75	0	0 5	3	0 75	0 5	0.25	1	0 5	5	0	0
[illegible]	[illegible]	0	2	0	1	2	0	0	0	1	0	0	1	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Bladen 1992-95 Average	10	1 25	4 25	0 75	1	1 25	0	1	0	0 25	0 25	0	0	6 25	0 75	1 25	0 75	1	3 75	6 25	0	0
[illegible]	[illegible]	2	1	1	2	1	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Brunswick 1992-95 Average	9.5	1	3 5	0 75	1 5	0 75	0	0 75	0 5	0	0 25	0 25	0 25	6	0 25	1.25	1 25	0 75	6.75	2.75	0	0
[illegible]	[illegible]	2	0	0	1	1	0	0	0	1	1	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Buncombe 1992-95 Average	32.25	6 5	7 5	1	7	3 25	0	1 5	0 5	1 5	0 75	2 5	0 25	17.75	4 5	3 5	2	4 5	27 5	4.5	0	0 25
[illegible]	[illegible]	4	10	1	10	7	0	0	0	1	2	2	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Burke 1992-95 Average	15.75	3 25	6	1.75	1 75	1 5	0	0 25	0	0 5	0 25	0 25	0 25	11.5	0 75	0 75	1.5	1.25	12.75	2	0	1
[illegible]	[illegible]	[illegible]	[illegible]	1	2	[illegible]	0	2	0	1	1	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Cabarrus 1992-95 Average	17	2 5	6	2	1 75	2 25	0	0 25	0 25	1	0 25	0	0 75	11.5	1 75	1	2	0 75	12.5	4.5	0	0
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Caldwell 1992-95 Average	15.75	3 5	4	1	2 25	1 75	0	0 75	0 25	0 5	0 75	0 75	0 25	8 5	2 75	0 5	0.75	3 25	14	1 75	0	0
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Camden 1992-95 Average	2	0	0 75	0	0 75	0	0	0	0	0	0	0	0	0 75	0	0 25	0 5	0	0.75	0 75	0	0
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Carteret 1992-95 Average	10.25	1	2 75	1 25	1 75	1 75	0 25	0 25	0 5	0 5	0	0	0 25	6	0 75	0 5	1.5	1 5	8 75	1 25	0	0 25
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Produced by the Division of Maternal and Child Health in conjunction with the State Center for Health Statistics

Data reflects deaths of county residents

September 1997

1996 Infant and Child Deaths in North Carolina	Total	CAUSE OF DEATH											AGE					RACE			
		Birth defects	Other birth-related conditions	SIDS	Illnesses	Motor vehicle injuries	Bicycle injuries	Fire injuries	Drowning	Other unintentional injuries	Homicide	Suicide	All other	Infant	1-4	5-9	10-14	15-17	White	African American	Native American	Other
Caswell 1992-95 Average	5.25	1	1 5	0 5	0 75	1	0	0	0 25	0	0 25	0	0	3 25	0 5	1	0.5	0	2.75	2.5	0	0
Caswell 1996	**6**	**1**	**3**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**	**2**	**0**	**0**	**1**	**5**	**0**	**0**
Catawba 1992-95 Average	23	3	4 75	2 5	4 75	3 5	0 25	0 5	0 25	1	1 25	0 75	0 5	12.5	3 75	1.75	2	3	18 5	4	0	0.5
Catawba 1996	**23**	**0**	**5**	**2**	**6**	**6**	**0**	**0**	**0**	**0**	**2**	**0**	**2**	**9**	**3**	**0**	**[illegible]**	**[illegible]**	**16**	**6**	**[illegible]**	**[illegible]**
Chatham 1992-95 Average	6.75	0 75	1	0 5	1 25	1 25	0	1	0	0	0 25	0 5	0 25	3	1 5	1	0 25	1	3 75	3	0	0
Chatham 1996	**17**	**3**	**8**	**1**	**0**	**3**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**[illegible]**	**0**	**1**	**[illegible]**	**[illegible]**	**12**	**[illegible]**	**[illegible]**	**[illegible]**
Cherokee 1992 95 Average	3	0 25	1	0 25	1 25	0	0	0	0	0 25	0	0	0	2	0 25	0	0.5	0 25	2.75	0 25	0	0
Cherokee 1996	**3**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**[illegible]**	**0**	**0**	**[illegible]**	**[illegible]**	**3**	**[illegible]**	**[illegible]**	**0**
Chowan 1992-95 Average	3	0	1	0	0 5	1	0	0	0	0 25	0	0	0 25	1.25	0.25	1	0.25	0.25	1.25	1.75	0	0
Chowan 1996	**2**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**[illegible]**	**0**	**0**	**[illegible]**	**[illegible]**	**0**	**[illegible]**	**[illegible]**	**[illegible]**
Clay 1992-95 Average	0.75	0	0	0	0 5	0	0	0	0	0	0	0	0 25	0.25	0	0.25	0	0.25	0.5	0	0 25	0
Clay 1996	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**[illegible]**	**1**	**0**	**[illegible]**	**[illegible]**	**1**	**[illegible]**	**[illegible]**	**[illegible]**
Cleveland 1992-95 Average	23.75	3	7	1 75	6	2 75	0	0	0 5	1 25	1	0 25	0 25	13.5	4	0 75	2	3.5	13	10.5	0	0 25
Cleveland 1996	**22**	**0**	**7**	**1**	**6**	**5**	**0**	**1**	**0**	**1**	**0**	**0**	**1**	**[illegible]**	**3**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**
Columbus 1992-95 Average	16.25	1	5 5	2	4 25	1 5	0	0	0 25	0	1	0 5	0 25	10.25	1.5	0.5	1.75	2.25	8.75	7.5	0	0
Columbus 1996	**15**	**1**	**5**	**1**	**4**	**3**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**[illegible]**	**2**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**
Craven 1992-95 Average	22.5	3 25	7 25	2	4	2 5	0	0 75	0 25	0 25	1	0 5	0 75	15.5	3	0.25	1	2.75	12 25	10.25	0	0
Craven 1996	**19**	**1**	**4**	**1**	**3**	**2**	**0**	**3**	**2**	**1**	**0**	**2**	**0**	**[illegible]**	**0**	**[illegible]**	**[illegible]**	**[illegible]**	**8**	**[illegible]**	**[illegible]**	**[illegible]**
Cumberland 1992 95 Average	93.5	15	35 5	7 5	14 5	6 5	0	1 5	1 5	2	4 25	3	2 25	64 5	10 25	5	4	9.75	41 25	49.75	1 5	1
Cumberland 1996	**95**	**12**	**30**	**8**	**16**	**7**	**1**	**3**	**3**	**4**	**8**	**2**	**1**	**58**	**14**	**5**	**[illegible]**	**[illegible]**	**49**	**[illegible]**	**[illegible]**	**[illegible]**
Currituck 1992-95 Average	4.5	0 5	2	0 25	0 75	0 5	0	0	0 25	0	0	0	0 25	3 25	0	0 5	0 5	0 25	3 5	0 75	0 25	0
Currituck 1996	**7**	**1**	**3**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**	**0**	**[illegible]**	**[illegible]**	**5**	**[illegible]**	**[illegible]**	**[illegible]**
Dare 1992-95 Average	4.25	0 5	0 5	0 25	1	1 25	0	0	0	0 25	0	0 25	0 25	1 5	0 75	0 5	0.5	1	4 25	0	0	0
Dare 1996	**2**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**[illegible]**	**0**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**
Davidson 1992-95 Average	26	3	7 5	2 25	3 25	5	0	0	1	1	1	0 5	1 5	15	3 5	1 5	2 5	3 5	22 5	3 5	0	0
Davidson 1996	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**
Davie 1992-95 Average	6.75	1 75	1.75	0 5	1	0 75	0	0	0 25	0 5	0 25	0	0	4	0.5	0.75	0 5	1	5.5	1.25	0	0
Davie 1996	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**
Duplin 1992-95 Average	13.75	1.75	6	0 75	2 5	0 75	0	0 5	0 25	0	0 5	0 25	0.5	10	1.25	0.75	1.25	0 5	6 5	7.25	0	0
Duplin 1996	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**
Durham 1992-95 Average	48.5	6 25	14.5	3 75	13 25	2 25	0	1	0 75	2	2 75	1	1	32 5	4.5	2.75	2	6.75	16 75	31.25	0.5	0
Durham 1996	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**
Edgecombe 1992-95 Average	19.5	3 75	5 5	1	3 25	2 5	0	0 5	0 25	0 5	1 5	0	0 75	12	2 5	0 75	0.5	3 75	5.5	13 5	0 5	0
Edgecombe 1996	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**

[illegible]ed by the Division of Maternal and Child Health in [illegible]iction with the State Center for Health Statistics

Data reflec[illegible]s of county residents

[illegible]ptember 1997

1996 Infant and Child Deaths in North Carolina

	Total	CAUSE OF DEATH												AGE					RACE			
		Birth defects	Other birth-related conditions	SIDS	Illnesses	Motor vehicle injuries	Bicycle injuries	Fire injuries	Drowning	Other unintentional injuries	Homicide	Suicide	All other	Infant	1-4	5-9	10-14	15-17	White	African American	Native American	Other
Forsyth 1992-95 Average	74.75	7	30.5	5	14	7.5	0.25	1.5	1	2	2.5	3	0.5	48.75	7.75	4.5	4.5	9.25	34.25	40.5	0	0
Forsyth 1996	**70**	**16**	**21**	**7**	**13**	**7**	**1**	**1**	**0**	**3**	**3**	**1**	**3**	**48**	**6**	**4**	**4**	**8**	**37**	**33**	**0**	**0**
Franklin 1992-95 Average	12.25	1.25	4.5	0.75	2.5	2	0	0.25	0	0	0.25	0.75	0	7.5	1	0.5	0.5	2.75	7.25	5	0	0
Franklin 1996	**15**	**1**	**2**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**5**	**0**	**1**	**0**	**1**				
Gaston 1992-95 Average	39.5	4.25	13.75	3.75	6	3.25	0	1.25	1.25	2.75	2	0.5	0.75	25	3.25	3.25	3	5	27.25	11.75	0	0.5
Gaston 1996	**35**	**8**	**10**	**3**	**3**	**2**	**2**	**0**	**1**	**1**	**2**	**1**	**2**	**19**	**0**	**2**			**21**			
Gates 1992-95 Average	2	0.25	0.25	0	1	0.5	0	0	0	0	0	0	0	0.75	0.5	0.25	0	0.5	1	1	0	0
Gates 1996	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**			**0**	**0**		
Graham 1992-95 Average	1.25	0.5	0.5	0	0.25	0	0	0	0	0	0	0	0	0.75	0.25	0	0	0.25	1.25	0	0	0
Graham 1996	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**2**	**0**	**0**	**1**	**0**			**3**			
Granville 1992-95 Average	9.75	1.75	3.5	1.25	2	0.25	0.25	0	0	0	0	0.25	0.5	7.75	0.25	0.5	1.25	0	4.25	5.5	0	0
Granville 1996	**8**	**0**	**2**	**0**	**2**	**3**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**1**	**3**	**0**			**6**			
Greene 1992-95 Average	6.75	0.25	2.25	0.5	2.25	1	0	0	0.25	0	0	0.25	0	4	0.5	0.25	1	1	2	4.75	0	0
Greene 1996	**5**	**0**	**1**	**0**	**1**	**3**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**0**			**4**			
Guilford 1992-95 Average	85	8.75	30.25	6.75	17.5	8.25	0.5	0.75	1.25	2.5	2.5	3.5	2.5	50.75	9.75	5	7.5	12	39.5	42.25	0.75	2.5
Guilford 1996	**87**	**10**	**35**	**6**	**16**	**5**	**2**	**0**	**2**	**2**	**4**	**2**	**3**	**60**	**4**	**3**			**56**			
Halifax 1992-95 Average	21.75	4	9	0.5	3	2.5	0	0	0.25	0.75	1	0.25	0.5	15.25	1.75	0.25	1.5	3	4.5	15.75	1.5	0
Halifax 1996	**16**	**3**	**6**	**0**	**4**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**15**	**2**	**2**	**2**	**1**	**2**	**12**		
Harnett 1992-95 Average	19	2.25	7	1.25	3.75	1.75	0.25	0	0.5	1.25	0.25	0.25	0.5	12.25	1.75	0.75	2	2.25	13	5.75	0.25	0
Harnett 1996	**17**	**4**	**4**	**2**	**1**	**1**	**0**	**0**	**1**	**0**	**3**	**1**	**0**	**12**	**1**	**2**	**1**	**1**	**10**	**7**		**0**
Haywood 1992-95 Average	6.5	1	1.75	0.5	1.25	0.5	0	0	0.5	0.75	0	0	0.25	3.25	0.75	0.75	1.25	0.5	6	0.5	0	0
Haywood 1996	**10**	**0**	**1**	**2**	**2**	**1**	**0**	**0**	**1**	**0**	**1**	**0**	**2**	**6**	**0**	**0**	**0**	**2**	**10**	**0**	**0**	**0**
Henderson 1992-95 Average	10.5	2	2.5	0	2	2	0.5	0	0.25	0.5	0.5	0.25	0	5.25	0.5	1.5	1	2.25	9	1	0.25	0.25
Henderson 1996	**21**	**3**	**5**	**2**	**7**	**1**	**0**	**1**	**2**	**0**	**0**	**0**	**0**	**15**	**5**	**1**	**1**	**1**	**19**	**2**	**0**	**0**
Hertford 1992-95 Average	7.75	1.75	3	0	0.75	0.75	0	1.25	0	0	0	0	0.25	5.5	0.5	0	0.5	1.25	0.75	7	0	0
Hertford 1996	**6**	**2**	**4**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**3**	**2**	**0**			**1**			
Hoke 1992-95 Average	13.5	2.25	3.75	0.75	2.75	2	0	0.25	0	0.5	0.5	0	0.75	8	2	1.25	1	1.25	4	8.5	1	0
Hoke 1996	**21**	**2**	**1**	**1**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**0**	**0**			**3**			
Hyde 1992-95 Average	1.75	0.25	0	0	0.25	1	0	0	0	0	0.25	0	0	0.25	0	0	0	1.5	0.5	1.25	0	0
Hyde 1996	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**			**0**			
Iredell 1992-95 Average	19.25	1.5	6.75	1.5	4.75	0.75	0	0	0.25	1	1	0.75	1	13.5	1	1.5	1.25	2	11.5	7.75	0	0
Iredell 1996	**22**	**2**	**4**	**0**	**7**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**10**	**0**	**0**			**16**			
Jackson 1992-95 Average	3.75	1	1	0.25	0.5	0.25	0	0	0	0.25	0	0.25	0.25	2.75	0.25	0.25	0	0.5	3.25	0	0.5	0
Jackson 1996	**3**	**2**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**0**			**2**			

*Produced by the Division of Maternal and Child Health in conjunction with the State Center for Health Statistics

Data reflects deaths of county residents.

September 1997

1996 Infant and Child Deaths in North Carolina	Total	CAUSE OF DEATH											AGE					RACE			
		Birth defects	Other birth-related conditions	SIDS	Illnesses	Motor vehicle injuries	Bicycle injuries	Fire injuries	Drowning	Other unintentional injuries	Homicide	Suicide	All other	Infant	1-4	5-9	10-14	15-17	White	African American	Native American	Other
Johnston 1992-95 Average	18.75	2	7	1.25	3.25	1.75	0	1.25	0.75	0.75	0.25	0.5	0	11.75	1.5	1.25	1.25	3	11.75	7	0	0
Johnston 1996	**24**	**5**	**8**	**1**	**3**	**4**	**0**	**0**	**0**	**2**	**1**	**0**	**0**	**15**	**0**	**0**	**1**	**8**	**13**	**11**	**0**	**0**
Jones 1992-95 Average	1	0.5	0	0.5	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0.5	0.5	0	0
Jones 1996	**2**	**1**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**1**	**1**	**0**	**0**
Lee 1992-95 Average	15.75	2.75	5.75	1.25	1.25	1.75	0	0	0	0.25	1	1.25	0.5	9.25	0.5	1.75	1.25	3	10	5.75	0	0
Lee 1996	**6**	**5**	**1**	**0**	**3**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**1**	**1**	**1**	**2**	**10**	**0**	**0**	**0**
Lenoir 1992-95 Average	16.75	2	5.5	1.75	4.5	0.75	0	0	0	0.75	0.75	0.25	0.5	11.25	2	0.5	0.75	2.25	6.5	10.25	0	0
Lenoir 1996	**12**	**3**	**6**	**0**	**4**	**1**	**0**	**0**	**1**	**3**	**0**	**0**	**0**	**1**	**2**	**2**	**1**	**6**	**12**	**0**	**0**	**0**
Lincoln 1992-95 Average	10	1.5	2.75	1.5	1.25	1.75	0	0	0.25	0.25	0.25	0.25	0.25	6.75	0.75	0.75	0.5	1.25	9	1	0	0
Lincoln 1996	**5**	**3**	**3**	**0**	**0**	**3**	**0**	**1**	**0**	**4**	**1**	**0**	**0**	**5**	**4**	**0**	**1**	**3**	**10**	**0**	**0**	**0**
McDowell 1992-95 Average	6.5	0.75	1	0.75	1.25	1.75	0	0.25	0	0.5	0	0	0.25	3.25	1	1	0.25	1	6.25	0.25	0	0
McDowell 1996	**3**	**2**	**2**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**1**	**3**	**0**	**0**	**0**
Macon 1992-95 Average	4	1	1	0.75	0.25	0.75	0	0	0	0.25	0	0	0	3	0.25	0.25	0	0.5	3.75	0	0	0.25
Macon 1996	**5**	**1**	**1**	**0**	**4**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**3**	**1**	**0**	**1**	**0**	**5**	**0**	**0**	**0**
Madison 1992-95 Average	3.5	0.5	0.75	0	0.5	1.75	0	0	0	0	0	0	0	1.5	0.75	0.25	0.75	0.25	3.5	0	0	0
Madison 1996	**2**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**1**	**0**	**0**	**2**	**0**	**0**	**0**
Martin 1992-95 Average	8.25	1.25	2	0.75	1.25	1.75	0	1	0	0	0.25	0	0	4.25	1.5	1	1	0.5	2.75	5.5	0	0
Martin 1996	**4**	**0**	**3**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**1**	**0**	**2**	**0**	**1**	**4**	**0**	**0**	**0**
Mecklenburg 1992-95 Average	128.25	19	39.75	7.5	25.5	10.75	0.25	1.75	1.25	4.25	10.75	2.25	5.25	75.75	15.75	7.75	10.25	18.75	54.25	71	0.5	2.5
Mecklenburg 1996	**99**	**17**	**25**	**12**	**20**	**10**	**0**	**0**	**1**	**0**	**8**	**2**	**4**	**60**	**12**	**11**	**6**	**10**	**44**	**53**	**1**	**1**
Mitchell 1992-95 Average	3	0.25	1	0	0.75	0.25	0	0	0	0.5	0	0	0.25	1.75	0.25	0.25	0.5	0.25	3	0	0	0
Mitchell 1996	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**
Montgomery 1992-95 Average	7.75	0.25	1.75	0.5	1.75	1.25	0	1	0.25	1	0	0	0	4	1.75	1	0	1	4.75	3	0	0
Montgomery 1996	**11**	**0**	**1**	**0**	**2**	**4**	**0**	**1**	**0**	**1**	**1**	**1**	**0**	**4**	**1**	**2**	**1**	**3**	**6**	**4**	**1**	**0**
Moore 1992-95 Average	14.25	2.25	4	1.75	1.25	1.75	0	0.5	0.5	1.5	0.5	0.25	0	8.5	1.5	1	1.25	2	8.25	6	0	0
Moore 1996	**16**	**3**	**5**	**1**	**7**	**2**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**1**	**2**	**1**	**1**	**4**	**15**	**1**	**0**	**0**
Nash 1992-95 Average	22	3.25	7.25	0.5	5.25	2	0.25	1	0.5	0.5	0.25	0.5	0.75	14.5	3	0.75	2.25	1.6	8.25	13.5	0	0.25
Nash 1996	**22**	**3**	**10**	**0**	**6**	**4**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**2**	**1**	**1**	**1**	**1**	**17**	**4**	**0**	**0**
New Hanover 1992-95 Average	22	3.75	3.75	2.75	5.75	1.75	0.25	0	0.75	1	0.75	0.75	0.75	13.25	3.25	1.25	1.25	3	13	9	0	0
New Hanover 1996	**15**	**1**	**1**	**1**	**2**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**13**	**2**	**0**	**0**
Northampton 1992-95 Average	5	1	1.25	0.5	1.25	0.5	0	0	0	0.25	0	0	0.25	3	1	0	0.25	0.75	1	4	0	0
Northampton 1996	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**
Onslow 1992-95 Average	38.25	7.5	11.25	3	7.5	4	0.25	0	0.25	2	1.25	0	1.25	27.5	4.75	2.5	0.75	2.75	26.25	11.25	0	0.75
Onslow 1996	**26**	**4**	**10**	**1**	**5**	**2**	**0**	**0**	**1**	**1**	**0**	**0**	**2**	**2**	**0**	**2**	**0**	**2**	**20**	**4**	**0**	**2**

[redacted]ed by the Division of Maternal and Child Health in [redacted]ction with the State Center for Health Statistics

Data reflec[redacted]s of county residents

[redacted]ptember 1[redacted]97

1996 Infant and Child Deaths in North Carolina

	Total	CAUSE OF DEATH												AGE					RACE			
		Birth defects	Other birth-related conditions	SIDS	Illnesses	Motor vehicle injuries	Bicycle injuries	Fire injuries	Drowning	Other unintentional injuries	Homicide	Suicide	All other	Infant	1-4	5-9	10-14	15-17	White	African American	Native American	Other
Orange 1992-95 Average	14.25	2.5	5.5	0.5	2.5	1.25	0.25	0	0	0.5	0.25	1	0	8.5	1.25	1	1.5	2	8.25	5.25	0.25	0.5
[redacted]	18	1	8	0	0	1	0	1	0	2	0	1	1	11	0	2	0	2	17	[redacted]		
Pamlico 1992-95 Average	2.75	1	0.25	0	0.5	0.25	0.25	0.5	0	0	0	0	0	1	0.5	0.25	0.5	0.5	1.5	1.25	0	0
[redacted]	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	[redacted]			
Pasquotank 1992-95 Average	10.75	0.75	5.25	0.25	1	1.25	0.25	0	0.25	1.25	0.5	0	0	7.25	1.25	1.5	0	0.75	2.75	8	0	0
[redacted]	5	1	4	0	2	0	1	0	0	0	0	0	0	5	0	1	1	0	[redacted]			
Pender 1992-95 Average	5.25	1.25	0.5	0.75	1.25	0.5	0	0.25	0	0.25	0	0.5	0	2.25	1.25	0.75	0.25	0.75	2.5	2.75	0	0
[redacted]	4	0	0	0	1	1	0	1	0	0	0	1	0	1	1	0	1	1	[redacted]			
Perquimans 1992-95 Average	2.75	0.25	0.75	0.25	0.5	0.5	0	0	0.25	0	0.25	0	0	1.75	0.25	0.25	0	0.5	1.75	1	0	0
[redacted]	3	0	1	0	2	0	0	0	0	0	0	0	0	1	2	0	0	0	[redacted]			
Person 1992-95 Average	9	1	2.25	0.25	1.25	1.25	0	0.75	0.25	1.25	0.25	0	0.5	4.25	2	0.75	1.25	0.75	3.75	5.25	0	0
[redacted]	8	2	0	1	2	0	0	0	1	0	0	0	3	0	1	1	3	[redacted]				
Pitt 1992-95 Average	31.75	6	12	1.75	5.25	1.25	0	0.75	0.5	1.5	1.75	0.75	0.25	22	3.25	1	3	2.5	11.5	19.75	0	0.5
[redacted]	42	18	2	5	3	0	4	0	2	0	1	0	30	3	1	3	4	[redacted]				
Polk 1992-95 Average	4	0.25	0.5	0.25	1.25	0.25	0	0.5	0	0.25	0.25	0.5	0	1.75	0.25	0.25	0.75	1	3	1	0	0
[redacted]	5	2	0	0	1	1	0	0	0	0	1	0	0	3	0	0	1	1	[redacted]			
Randolph 1992-95 Average	21.5	2.5	4.5	3	3.5	2.75	0	0	0.75	1.75	1	1.25	0.5	10.75	4	0	3.25	3.5	18.5	2.75	0	0.25
[redacted]	23	9	4	0	7	3	0	0	0	0	0	0	0	15	1	2	5	[redacted]				
Richmond 1992-95 Average	11	2	4.5	0.5	1	1.25	0	0	0	0.5	0.5	0.25	0.5	7.5	1.75	0.5	0.75	0.5	6	5	0	0
[redacted]	15	1	4	2	2	2	0	0	1	2	1	0	0	12	0	1	0	2	[redacted]			
Robeson 1992-95 Average	37.25	4.5	11.25	2.25	5.25	5.5	1	0.25	1.75	2.25	1.75	0.5	1	20.75	4.25	3.25	3.25	5.75	5.75	13	18.5	0
[redacted]	41	5	13	4	9	4	0	0	1	1	2	1	1	28	1	3	4	5	[redacted]			
Rockingham 1992-95 Average	19.5	2.5	7.25	1.25	3.25	2	0.5	0.25	0	0	1.5	0.75	0.25	12.25	1.75	1.25	2.25	2	11.25	8	0.25	0
[redacted]	21	2	7	1	4	3	0	0	0	3	1	0	0	12	2	3	2	2	[redacted]			
Rowan 1992-95 Average	26	5	6.5	2.75	5	3.25	0.25	0	0.75	1	0.25	0.25	1	15.5	3.5	1.5	1.5	4	14.75	10.5	0.5	0.25
[redacted]	28	8	11	8	0	1	0	1	1	0	0	4	11	5	1	0	11	[redacted]				
Rutherford 1992-95 Average	18.75	2.75	4	2.25	4	1	0.5	0	0.5	1	1	0.75	1	10.75	1	0	3	4	13.25	5.5	0	0
[redacted]	15	2	0	5	0	0	0	0	0	0	0	0	8	0	0	0	7	[redacted]				
Sampson 1992-95 Average	14.25	2	4	1.25	1.5	3	0.75	0	0	0.25	1	0.25	0.25	8.25	0.75	0.5	3	1.75	6.75	7.25	0.25	0
[redacted]	10	0	0	0	0	0	0	0	1	0	0	0	9	0	0	0	1	[redacted]				
Scotland 1992-95 Average	12.25	1.25	5.5	0.75	1.75	0.75	0.25	0	0.25	1	0.5	0	0.25	8.25	1.25	0.5	1.25	1	3.5	7.5	1.25	0
[redacted]	6	0	0	3	0	0	0	0	0	0	0	0	3	1	0	0	1	[redacted]				
Stanly 1992-95 Average	8.75	1.25	2.5	0.25	1.5	1.25	0	0	0	0.5	0.75	0	0.75	4.75	2.25	0.25	0.25	1.25	6	2.25	0	0.5
[redacted]	11	0	0	0	0	0	0	0	0	0	0	0	11	0	0	0	1	[redacted]				

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September 1997

1996 Infant and Child Deaths in North Carolina	Total	CAUSE OF DEATH											AGE					RACE			
		Birth defects	Other birth-related conditions	SIDS	Illnesses	Motor vehicle injuries	Bicycle injuries	Fire injuries	Drowning	Other unintentional injuries	Homicide	Suicide	All other	Infant	1-4	5-9	10-14	15-17	White	African American	Native American	Other
Stokes 1992-95 Average	9.5	1	2 25	1 25	2	1	0	0 5	0 25	0 25	0 25	0 75	0	5 5	1 25	0 75	0 75	1 25	8 5	1	0	0
Stokes 1996	5	1	2	0	1	1	0	0	0	0	0	0	0	3	1	0	0	1	5	0	0	0
Surry 1992-95 Average	13	3	2	1	3 75	1 75	0 5	0 25	0 25	0	0	0 5	0	6 25	2 5	0 25	1 75	2 25	12 75	0 25	0	0
Surry 1996	12	2	0	2	3	3	0	0	1	1	0	0	0	4	4	0	2	2	11	1	0	0
Swain 1992-95 Average	4.25	0 5	1 25	0 5	1 25	0 5	0	0	0	0	0	0	0 25	3	0 5	0	0 25	0 5	2 5	0	1 75	0
Swain 1996	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transylvania 1992-95 Average	3.5	0 75	0 5	0 5	1	0	0	0 75	0	0	0	0	0	2 75	0 25	0 5	0	0	3 25	0 25	0	0
Transylvania 1996	4	1	3	0	1	0	0	0	0	0	0	0	0	4	0	0	0	0	3	0	0	0
Tyrrell 1992-95 Average	0.25	0	0 25	0	0	0	0	0	0	0	0	0	0	0 25	0	0	0	0	0	0 25	0	0
Tyrrell 1996	2	1	1	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2	0	0	0
Union 1992-95 Average	23	3 25	5	3 25	2 5	5	0 25	0	0 5	1 25	1 25	0 25	0 5	13	1 75	2	1 5	4 75	12 25	10 25	0	0 5
Union 1996	27	7	0	10	3	0	0	1	0	0	1	1	4	18	2	0	2	5	22	4	0	1
Vance 1992-95 Average	10.5	1 75	3 5	1 25	1 25	0 5	0 25	0 5	0	0 5	0 5	0 25	0 25	6 5	1 25	1 25	0 5	1	2 75	7 75	0	0
Vance 1996	23	2	13	1	6	0	0	0	0	0	2	0	0	6	0	0	0	0	5	18	0	0
Wake 1992-95 Average	105.25	14 5	39 75	3 5	23 75	8 5	0 5	1 25	1 75	2 5	3	2 25	4	66 5	11 25	6 5	8 75	12 25	58 5	44 5	0	2 25
Wake 1996	100	24	24	7	19	6	0	4	2	4	5	13	2	61	13	7	9	10	55	40	0	5
Warren 1992-95 Average	4.25	0 5	2	0 25	1	0 5	0	0	0	0	0	0	0	3	0 25	0	0	1	1 5	2 5	0 25	0
Warren 1996	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington 1992-95 Average	3.5	0 75	1	0	0 5	0 5	0	0	0 5	0	0	0 25	0	1 75	0	0 75	0 25	0 75	1 25	2 25	0	0
Washington 1996	6	1	3	0	1	0	0	0	0	0	0	0	0	5	0	0	0	1	0	5	0	1
Watauga 1992-95 Average	3.5	0 75	1 5	0 25	0 5	0 5	0	0	0	0	0	0	0	2 75	0	0	0 25	0 5	3 5	0	0	0
Watauga 1996	5	1	2	0	2	0	0	0	0	0	0	0	0	5	0	0	0	0	5	0	0	0
Wayne 1992-95 Average	30.5	3	9 25	1 25	7 25	4	0	0 75	1 5	0 75	1 5	0 5	0 75	14 75	5	2 5	2	6 25	14 5	15 75	0 25	0
Wayne 1996	23	3	5	2	2	2	1	2	1	0	4	1	0	9	3	2	4	5	9	14	0	0
Wilkes 1992-95 Average	9.25	2 25	2 25	1	1 5	1 25	0	0	0 25	0 25	0	0 25	0 25	6 25	1 25	0 5	0 25	1	8 5	0 5	0 25	0
Wilkes 1996	14	4	4	0	3	3	0	0	0	0	0	0	0	8	0	0	4	2	10	1	0	0
Wilson 1992-95 Average	19.5	1 75	7 25	1 5	3 25	2 5	0 25	0 5	0 25	0 5	1 5	0	0 25	12 25	2	1	2 25	2	7 25	12 25	0	0
Wilson 1996	21	2	6	2	8	2	0	0	1	0	0	0	0	12	2	0	2	5	12	9	0	0
Yadkin 1992-95 Average	6.5	1 25	1 75	0 25	1 75	0 25	0	0	0 25	0 25	0 5	0 25	0	3 5	1 25	0	0 75	1	5 75	0 5	0	0 25
Yadkin 1996	10	0	1	0	1	0	0	2	0	0	0	0	0	3	0	0	0	0	8	0	0	0
Yancey 1992-95 Average	2.25	0.75	0 5	0	0 5	0 5	0	0	0	0	0	0	0	1 5	0	0 25	0 25	0 25	2 25	0	0	0
Yancey 1996	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
North Carolina 1992-95 Average	1649	232 75	531	120	309 25	176 25	9 25	30 25	29 5	61	66 75	40 25	42 75	1015 5	187	104 5	127 5	214 5	896	706 25	31 25	15 5
NORTH CAROLINA	1605	237	471	101	327	166	18	33	35	61	69	32	55	962	188							

Compiled by the Division of Maternal and Child Health in cooperation with the State Center for Health Statistics

Data reflects [illegible] of county residents

[illegible] September 19[illegible]

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NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES
DIVISION OF SOCIAL SERVICES
CENTRAL REGISTRY REPORTS OF CHILD ABUSE, NEGLECT, & DEPENDENCY
COUNTY-BY-COUNTY DATA
SFY 1995 - 1996

No.	COUNTY	# OF REPORTS	# OF REPORTS SUBSTANTIATED	% OF REPORTS SUBSTANTIATED	# OF CHILDREN REPORTED*	# OF CHILDREN SUBSTANTIATED*	% OF REPORTED CHILDREN SUBSTANTIATED
1	Alamance	625	254	40.64%	890	358	40.22%
2	Alexander	49	31	63.27%	63	41	65.08%
3	Alleghany	68	25	36.76%	101	43	42.57%
4	Anson	96	17	17.71%	152	28	18.42%
5	Ashe	213	48	22.54%	326	81	24.85%
6	Avery	162	33	20.37%	230	41	17.83%
7	Beaufort	391	116	29.67%	599	182	30.38%
8	Bertie	103	35	33.98%	153	49	32.03%
9	Bladen	286	52	18.18%	422	89	21.09%
10	Brunswick	254	90	35.43%	405	142	35.06%
11	Buncombe	2,125	592	27.86%	3,605	1,043	28.93%
12	Burke	490	197	40.20%	748	295	39.44%
13	Cabarrus	990	250	25.25%	1,711	453	26.48%
14	Caldwell	805	219	27.20%	1,220	322	26.39%
15	Camden	27	1	3.70%	33	1	3.03%
16	Carteret	415	157	37.83%	648	253	39.04%
17	Caswell	210	76	36.19%	371	143	38.54%
18	Catawba	1,168	479	41.01%	1,965	787	40.05%
19	Chatham	342	157	45.91%	507	230	45.36%
20	Cherokee	252	77	30.56%	495	152	30.71%
21	Chowan	40	7	17.50%	52	9	17.31%
22	Clay	40	10	25.00%	52	17	32.69%
23	Cleveland	921	266	28.88%	1,736	526	30.30%
24	Columbus	326	39	11.96%	587	72	12.27%
25	[redacted]	769	319	41.48%	1,234	516	41.82%
26	[redacted]land	2,408	860	35.71%	4,095	1,436	35.07%
27	[redacted]k	142	39	27.46%	223	57	25.56%
28	Dare	178	82	46.07%	288	144	50.00%
29	Davidson	1,239	405	32.69%	1,975	670	33.92%
30	Davie	104	41	39.42%	145	55	37.93%
31	Duplin	415	148	35.66%	720	263	36.53%
32	Durham	2,025	678	33.48%	4,187	1,286	30.71%
33	Edgecombe	711	213	29.96%	1,270	385	30.31%
34	Forsyth	1,337	424	31.71%	2,264	697	30.79%
35	Franklin	290	103	35.52%	474	183	38.61%
36	Gaston	1,500	599	39.93%	2,423	995	41.06%
37	Gates	29	4	13.79%	36	6	16.67%
38	Graham	40	20	50.00%	56	26	46.43%
39	Granville	201	60	29.85%	300	85	28.33%
40	Greene	122	35	28.69%	197	56	28.43%
41	Guilford	2,705	909	33.60%	4,186	1,486	35.50%
42	Halifax	534	178	33.33%	965	351	36.37%
43	Harnett	686	236	34.40%	1,209	419	34.66%
44	Haywood	693	178	25.69%	1,011	262	25.91%
45	Henderson	1,077	283	26.28%	1,079	281	26.04%
46	Hertford	119	21	17.65%	185	33	17.84%
47	Hoke	99	27	27.27%	154	46	29.87%
48	Hyde	23	2	8.70%	31	4	12.90%
49	Iredell	681	222	32.60%	1,013	355	35.04%
50	Jackson	279	55	19.71%	396	79	19.95%
51	Johnston	625	198	31.68%	961	310	32.26%
52	Jones	90	39	43.33%	159	72	45.28%
53	Lee	399	67	16.79%	600	96	16.00%
54	Lenoir	519	127	24.47%	827	216	26.12%
55	Lincoln	612	164	26.80%	1,017	277	27.24%
56	Macon	311	45	14.47%	457	66	14.44%
57	Madison	94	17	18.09%	166	26	15.66%
58	Martin	115	34	29.57%	191	63	32.98%
59	[redacted]ell	542	181	33.39%	852	312	36.62%

NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES
DIVISION OF SOCIAL SERVICES
CENTRAL REGISTRY REPORTS OF CHILD ABUSE, NEGLECT, & DEPENDENCY
COUNTY-BY-COUNTY DATA
SFY 1995 - 1996

Co. No.	COUNTY	# OF REPORTS	# OF REPORTS SUBSTANTIATED	% OF REPORTS SUBSTANTIATED	# OF CHILDREN REPORTED*	# OF CHILDREN SUBSTANTIATED*	% OF REPORTED CHILDREN SUBSTANTIATED
60	Mecklenburg	4,227	1,219	28.84%	7,873	2317	29.43%
61	Mitchell	161	33	20.50%	244	50	20.49%
62	Montgomery	219	38	17.35%	423	61	14.42%
63	Moore	219	84	38.36%	303	118	38.94%
64	Nash	599	168	28.05%	1,051	317	30.16%
65	New Hanover	1,543	488	31.63%	2442	752	30.79%
66	Northampton	203	71	34.98%	318	102	32.08%
67	Onslow	1,485	663	44.65%	2550	1,161	45.53%
68	Orange	611	278	45.50%	926	436	47.08%
69	Pamlico	100	33	33.00%	159	48	30.19%
70	Pasquotank	132	34	25.76%	201	54	26.87%
71	Pender	271	36	13.28%	500	69	13.80%
72	Perquimans	49	10	20.41%	67	15	22.39%
73	Person	227	75	33.04%	358	137	38.27%
74	Pitt	856	320	37.38%	1,391	531	38.17%
75	Polk	86	30	34.88%	136	49	36.03%
76	Randolph	1,137	433	38.08%	1,741	663	38.08%
77	Richmond	543	202	37.20%	968	363	37.50%
78	Robeson	1,917	584	30.46%	3.673	1,172	31.91%
79	Rockingham	575	158	27.48%	973	269	27.65%
80	Rowan	1,175	309	26.30%	1,842	499	27.09%
81	Rutherford	717	127	17.71%	1,293	227	17.56%
82	Sampson	239	68	28.45%	403	131	32.51%
83	Scotland	330	86	26.06%	540	148	27.41%
84	Stanly	351	119	33.90%	518	154	29.73%
85	Stokes	373	121	32.44%	566	194	34.28%
86	Surry	585	198	33.85%	870	282	32.41%
87	Swain	79	13	16.46%	126	18	14.29%
88	Transylvania	258	82	31.78%	380	122	32.11%
89	Tyrrell	11	5	45.45%	16	8	50.00%
90	Union	1,153	389	33.74%	2.017	758	37.58%
91	Vance	545	152	27.89%	1,150	328	28.52%
92	Wake	2.066	632	30.59%	3.132	1.026	32.76%
93	Warren	151	68	45.03%	299	122	40.80%
94	Washington	98	21	21.43%	167	39	23.35%
95	Watauga	180	36	20.00%	283	58	20.49%
96	Wayne	991	262	26.44%	1,690	451	26.69%
97	Wilkes	523	109	20.84%	806	167	20.72%
98	Wilson	432	146	33.80%	757	271	35.80%
99	Yadkin	232	58	25.00%	389	91	23.39%
100	Yancey	147	42	28.57%	217	63	29.03%
	TOTAL:	57,907	18,241	31.50%	96,175	30,812	32.04%

*This is not an unduplicated count of children.

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REGISTERED NURSES
SCHOOL HEALTH NURSE/STUDENT RATIO BY COUNTIES/LEAS (1997)

COUNTY		# RN'S	# STUD.	RATIO	COMMENTS
Alamance-Burlington	*	6	18,400	1:3066	
Alexander	NR	1	4,880	1/4:4880	
Alleghany	*	.50	1,489	.5:1489	
Anson	*	2	4,312	1:2156	
Ashe	*	1	3,400	1:3400	
Avery	*	.25	2,328	.25:2328	
Beaufort	*	0	7,341		HD on call
Bertie	*	0	3,826		
Bladen	*	1	5,800	1:5800	
Brunswick	*	4	9,521	1:2380	
Buncombe:	*	8.5FTE	24,075	1:3351	Ratio includes both LEAs
Asheville	*		4,414		
rke	*	3	13,398	1:4466	
Cabarrus:	*	4.5FTE	15,600	1:3120	
Cabarrus County Schools Kannapolis City Schools	*	1FTE	3,922	1:3922	
Caldwell	*	4.5FTE	11,909	1:2646	
Camden +	*	2	1,120	1:560	
Carteret	*	2	8,526	1:4250	
Caswell	*	.5	3,378	.5:3378	
Catawba: Catawba Co. Schools Hickory City Schools Newton Conover Schools	*	5FTE	20,919	1:5976	All 3 are served by same nurses
Chatham	*	3	6,559	1:2186	
erokee	NR	0	3,332		
howan	NR	2	2,500	1:1250	
ay	*	1FTE	1,250	1:1250	
Cleveland: Cleveland Co Schools	*	4	8,465	1:2117	
Shelby City Schools	*	1	3,200	1:3200	
ng Mt. Schools	*	1	3,961	1:3961	

COUNTY		# RN'S	# STUD.	RATIO	COMMENTS
Columbus	*	3	7,390	1:2463	
Craven	*	5	14,609	1:2922	
Cumberland	*	10	49,597	1:4960	
Fort Bragg +	*	9	4,515	1:502	
Currituck +	*	3	2,081	1:694	
Dare	*	5FTE	4,331	1:866	
Davidson: Davidson Co. Schools Lexington Schools Thomasville Schools	*	.365FTE	22,461		
Davie	*	5FTE	4,839	1:940	
Duplin	*	1	8,300	1:8300	
Durham	*	14	29,000	1:2071	
Edgecombe	*	2FTE	7,670	1:3835	
Winston-Salem--Forsyth	*	6.75FTE	42,000	1:6222	
Franklin	*	2	6,793	1:3397	
Gaston	NR	11.5FTE	28,852	1:2509	
Gates	*	1	1,883	1:1883	
Graham	*	1FTE	1,300	1:1300	
Granville	*	1	7,277	1:7277	
Greene	*	1	2,869	1:2869	
Guilford	*	27.375FTE	59,439	1:2172	
Halifax	*	2	6,450	1:3225	
Roanoke Rapids	*	1	3,155	1:3155	
Harnett	*	3	14,701	1:4900	
Haywood	*	2.5FTE	7,500	1:3000	
Henderson	*	3FTE	11,241	1:3747	
Hertford	*	2	4,203	1:2102	
Hoke	*	1	5,814	1:5814	
Hyde	*	0	793		HD on call
Iredell	*	6	13,907	1:2318	
Iredell County Schools Mooresville Schools	NR	1	3,263	1:3263	
Jackson	*	.5FTE	3,700	.5:3700	
Johnston	NR	4	16,197	1:4049	

COUNTY		# RN'S	# STUD.	RATIO	COMMENTS
Jones	*	0	1,511		
[illegible]e	NR	4	7,720	1:1930	
Lenoir	*	3	10,124	1:3375	
Lincoln	*	2FTE	9,351	1:4676	
Macon	NR	0	3,702		HD on call
Madison	*	.75FTE	2,453	.75:2453	HD on call
Martin	*	3	4,873	1:1176	Nurses serve K-8 only
McDowell	*	1.5FTE	6,140	1:4093	
Charlotte-Mecklenburg	NR	45FTE	94,000	1:2088	
Mitchell	NR	0	2,280		HD on call
Montgomery	*	2	4,267	1:2134	
Moore	*	3.5FTE	10,500	1:3000	
Nash	*	8	17,228	1:2154	
New Hanover	*	12	21,650	1:1804	
Northhampton	NR	0	3,752		1 RN PART-TIME
Onslow	*	10	20,350	1:2035	
[illegible]ange /Chapel Hill-Carrboro	*	5FT/2PT	14,000	1:3333	
Pamlico	*	0	2,057		HD ON CALL
Pasquotank	*	2	6,341	1:3170	
Pender	*	1	5,869	1:5869	
Perquimans	*	1	2,000	1:2000	
Person	*	1	5,444	1:5444	
Pitt	*	9	18,542	1:2000	Nurses serve K-8 only
Polk	NR	0	2,108		
Randolph:	*	6	14,882	1:2480	
Randolph County Schools Asheboro City Schools	*	2	3,932	1:1966	
Richmond	*	4	8,728	1:2182	
Robeson	NR	13	23,000	1769	
Rockingham	*	3	13,941	4647	
Rowan-Salisbury Schools	*	5	18,479	1:3696	
Rutherford	*	3	9,700	1:3233	
Sampson:	*	2	7,280	1:3640	
[illegible]mpson County and [illegible]nton City Schools	*	1	2,600	1:2600	

COUNTY		# RN'S	# STUD.	RATIO	COMMENTS
Scotland	NR	5	6,812	1:1362	
Stanly	*	.80(1PT)	8,889	.80:8889	
Stokes	*	1	6,758	1:6758	
Surry: Surry County Schools Elkin Schools Mt. Airy Schools	*	3	7,809 1,082	1:2603	
	*	2	1,965	1:983	
Swain	*	1	1,500	1:1500	
Cherokee Reservation	*	2	1,153	1:5765	
Transylvania	*	1.75FTE	3,960	1:2263	
Tyrrell	*	0	788		HD on call
Union	*	6	18,408	1:3068	
Vance	*	1	7,462	1:7462	
Wake	*	46.5FTE	85,662	1:1842	
Warren	*	1.5FTE	3,450	1:2300	
Washington	*	1	2,587	1:2587	
Watauga	*	1	5,000	1:5000	
Wayne	*	2	18,740	1:18,665	1 RN serves 75 Sp. Ed. only
Wilkes	*	6.5FTE	9,797	1:1507	
Wilson	*	3	12,000	1:4000	
Yadkin	*	2.5FTE	5,428	1:2714	
Yancey	*	1	2,400	1:2400	

* End of Year Report Submitted
NR--End of Year Report Not Submitted---numbers based on 96-97 data
+ Meets NASN recommended ratio of 1:750
HD-Health Department
FT-Full-time/PT-Part-time
FTE-Full time equivalent

504 full-time and part-time school nurses/1,183,335 students in NC Public Schools (118 LEAs)

Data is from '96-'97 School year, assembled last June from 104 of 118 LEAs. (88% response rate!) There are only 504* School Nurses (RN's) serving 1.2 million public school children (Ratios p.6.)

HEALTH COUNSELING:

It is within the scope of school nursing practice to provide health counseling. Students seek the school nurse with health concerns which range from normal growth and developmental issues to serious emotional and mental health concerns requiring referrals to mental health professionals.

12,682 health counseling sessions provided by school nurses. about:

- 916 substance abuse
- 1,130 child abuse
- 3,983 pregnancy information
  Known pregnancies=2,089
  6--elementary students
  220--middle school students
  1,863--high school students
  (509 received homebound services and 170 dropped out of school permanently.)
- 316 suicide
  Known suicide attempts=120
  9--elementary students
  50--middle school students (3 deaths)
  62--high school students (7 deaths, one occurred at school)

HEALTH TEACHING:

School nurses are involved in a variety of health teaching and instruction. This occurs one on one, in small groups and within the classroom. School nurses reported a wide variety of topics taught. A few examples are:

In student classrooms - hygiene, first aid, wellness and fitness promotion, Open Airways for asthma management, AIDS peer education, smoking prevention and cessation, violence prevention, sexuality education, pre-natal and parenting programs.

Training for faculty and staff - medication administration, infection control, OSHA, CPR and first aid, chronic disease management, PTA presentations and Health Fairs.

STUDENTS WITH CHRONIC HEALTH CONDITIONS:

School nurses serve as case managers for students diagnosed with many types of chronic illnesses. In supporting their optimal level of wellness and school participation, the school nurse assists these students, their families and their teachers in achieving academic success.

* 504 this includes 3 both full-time and part time position.

Of the nurses who reported on this section of the survey:

62,220 students with various types of chronic health conditions:

ADD/ADHD	20,183
Allergies (Severe)	4,633
Anorexia/Bulimia	324
Asthma	14,148
Cerebral Palsy	1,271
Cytomegalovirus	28
Cystic Fibrosis	129
Diabetes	1,458
Down's Syndrome	438
Epilepsy	2,173
Genetic Diseases, Other	397
Functional Heart Murmur	929
Congenital/Other Cardiac	674
Hemophilia/Bleeding Disorder	243
Hepatitis B	35
HIV/AIDS	16
Malignant Disease	218
Migraine HA	2,755
Neuromuscular Disease	527
Muscular Dystrophy	110
Multiple Sclerosis	25
Orthopedic Disability	2,706
Psychiatric Disorder	4,799
Renal Disease	311
Rheumatoid Arthritis	469
Sickle Cell Anemia	385
Substance Abuse (known)	1,025
Ulcers	1,811

Most adults who've been "out of school" for awhile have little idea about the serious and complex healthy medical problems that school staff must deal with!

HEALTH CARE PROCEDURES AT SCHOOL:

Students with chronic health conditions, physical handicaps and disabilities require special health care assistance during the school day. These include: catheterizations, suctioning, tracheostomy care, nasogastric or gastrostomy tube feedings, stoma care, blood glucose monitoring, oxygen therapy, and nebulizer treatments.

Once again, not all nurses reported in this category.

Catheterizations	271	Respirator Care	31
Stoma Care	43	Suctioning	73
Tube Feeding	166	Trach Care	30
Other	213		

MEDICATIONS:

From the 104 LEAs reporting in this survey there were:

- **67,073 students who received medications,**
- 38,780 students received long term (more than 3 weeks) daily medication,
- 14,826 students received short term (less than 3 weeks) medication, and
- 13,467 students were given medications on an emergency or as needed basis.

lots of opportunities for error

The administration of medications to students by school personnel is a serious responsibility.

- **42%** of the LEAs reporting provide **formal training programs** for school employees who are designated to administer medications.
- **53%** of the LEAs reporting **conduct audits** of medication administration records.
- Of all the LEAs reporting the **school secretary** was reported most often as being the primary person who administers medications.

HEALTH POLICIES:

Of the 104 LEAs who reported in this survey, the following have written policies for:

Medication	87%	Special Health Care Services*	36%
Injury Reporting	50%	Maintenance of School Health Records	46%
Problem Identification	24%	Prevention & Control of CommunicableDisease	69%
Provision of Emergency Care	56%	Transportation (non-school bus)	25%
Screenings	40%	Referral and Follow-up	32%

*Special Health Care Services, NC State Board Policy #04A 107 which states that "each LEA shall make available a registered nurse for assessment, care planning, and on-going evaluation of students with special health care service needs in the school setting."

STUDENT HEALTH CARE COORDINATION:

The school nurse's role extends beyond the school setting. She serves as liaison with physicians, community agencies and families while supporting and serving the health needs of students. Of the nurses reporting in this section, there were **5,479 home visits** completed to assist families in resolving student health problems and concerns.

EMERGENCY CARE:

Not all LEAs reported in this section, but of those that did:

- **3,898 serious injuries** (requiring EMS calls, or immediate medical care and resulting in ½ day or more loss of school time) occurred at school.

Where did these injuries occur most often?

1,437 (37%) playgrounds
1,093 (28%) P.E. classes
813 (21%) Classrooms

What type of injuries occurred?

861 (22%) Sprains
677 (17%) Lacerations
644 (17%) Fractures
387 injuries required law enforcement intervention
4 injuries resulted in deaths

An additional **168,362 minor school injuries** were reported.

SCHOOL NURSE/STUDENT RATIOS:

School nurses are defined as registered nurses. The national standard for the school nurse to student ratio is 1:750 for general student populations, 1:250 for students with special health needs and 1:125 for students with severe and profound handicapping conditions. This survey reveals a wide range and variation of school nurse staffing within the 118 LEAs in North Carolina.

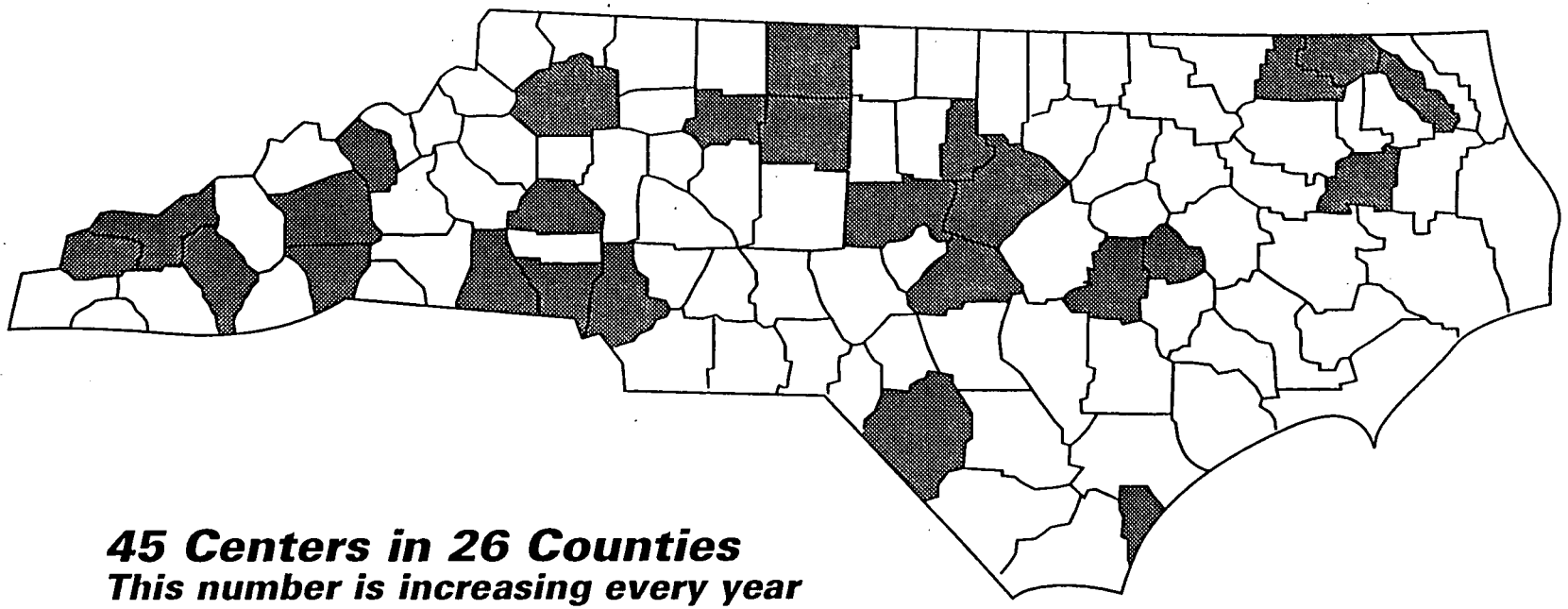
Average state-wide ratio is **1:3,148** about 1:3,000

Actual range of ratios are: 1:768—>1:18,817—>no school nurses in some LEAs

Source: End of Year Report (School Nurse Survey) 1997
Public Schools of North Carolina
NC DEHNR, Division of Maternal and Child Health

#10 Vitaphone

Making the Grade in North Carolina Is Making a Difference



45 Centers in 26 Counties
This number is increasing every year

Centers Bring Good Health Care To Young People Who Had Little Or None Before

#10 Vitaphone 1-21-98

North Carolina School-Based Centers

County	Health Center(s)	Medical Sponsor
Buncombe	Asheville High School* Asheville Middle School*	Buncombe County Health Department Mission-St. Joseph's Health System
Catawba	Catawba Valley High School*	Catawba County Health Department
Chatham	Horton Middle School*	Chatham County Health Department
Cleveland	Shelby Middle School* Shelby High School Kings Mountain Middle School Kings Mountain High School Burns High School* Crest High School Crest Middle School*	Cleveland County Health Department Cleveland Regional Medical Center
Durham	NC School of Math and Science Hillside High School Wellness Ctr. Southern High School Wellness Ctr. Geo. Watts Elem. Sch. Wellness Ctr.	Lakewood Family Practice Lincoln Community Health Center. Duke University School of Nursing Duke University School of Nursing
Eastern Band of Cherokee Indians	Cherokee Elementary School*	Cherokee Health Delivery
Forsyth	Independence High School*	Bowman-Gray Baptist Medical Center
Gates	Gates County High School*	Gates County Medical Center
Greene	Greene Central High School*	Greene County Health Care
Guilford	Grimsley High School* High Point Central High School	Guilford County Health Department High Point Regional Hospital
Harnett	Harnett County School Health Alliance	Harnett County Health Department
Henderson	Apple Valley Middle School	Blue Ridge Community Health Services
Hertford	Hertford County Middle School*	Roanoke-Chowan Alliance
Pasquotank	Northeastern High School* Elizabeth City Middle School*	Pasquotank County Health Department

County	Health Center(s)	Medical Sponsor
Robeson	Purnell Swett High School*	Robeson County Health Department
Rockingham	McMichaelHigh School Morehad High School Reidsville High School Rockingham County High School	Morehead Memorial Hospital
Swain, Jackson & Graham	Robbinsville Middle School* Swain County Middle School* Fairview Middle School*	West Care Health System
Washington	Washington Co. Union Middle Sch.	Washington County Hospital
Wayne	Brogden Middle School* Goldsboro Middle School*	Wayne Memorial Hospital
Wilkes	Central Wilkes High School* East Wilkes High School* North Wilkes High School* West Wilkes High School* (Mobile van unit)	Wilkes County Health Department
Yancey	East Yancey Middle School* Cane River Middle School*	Yancey County Health Department

North Carolina School-Linked Health Centers

County	Health Center	Medical Sponsor
Eastern Band of Cherokee Indians	Cherokee Teen Center *	Cherokee Health Delivery
Gaston	Advocates for Healthy Citizens, Inc.	Private Family Physician
Mecklenburg	Teen Health Connection	Carolinas Medical Center
New Hanover	Wilmington Health Access to Teens	Grants: RWJ & Duke Hospitals/Health Department
Wake	Wake Teen Medical Services	Wake Medical Center

*Health Centers using School-Health On-line data system

SOURCES OF FUNDING FOR SCHOOL-BASED/SCHOOL-LINKED HEALTH CENTERS

State[1]	$ 910,000/annually
The Duke Endowment[2]	$2,345,000 (over three years)
Robert Wood Johnson Foundation[3]	$ 980,000 (over three years)

Please note: Additional funding resources are required for the daily operation of school-based/school-linked health centers. Centers and their community advisory boards use the following sources to supplement the above funds: in-kind contributions (both staff & equipment), fees collected for services, contributions of cash or equipment from community service groups, and other grant-funding resources.

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[1] Fourteen School-Based/School-Linked Comprehensive Adolescent Health Care Projects

[2] Six communities funded (8 School-Based Health Centers)

[3] Two communities funded (4 School-Based Health Centers)

School-Based/School-Linked Health Centers
North Carolina Model

- Services are targeted to the school-age population with a documented need for services and address important health challenges, such as unintentional injuries, violence, too early parenting, alcohol, tobacco and other forms of substance abuse, nutritional problems, and unmet dental needs.

- Centers provide comprehensive services including mental health, prevention health and risk management services, and age-appropriate primary care.

- Services are provided by a multi-disciplinary team of health professionals that meet the needs of the population in a cost-effective manner and are coordinated and integrated with existing school and community services.

- Services are provided at an easily accessible site for the school-age population.

- Centers are overseen by an advisory board composed of parents, community representatives, youth and other appropriate individuals and agencies.

- Centers commit to billing and to the establishment of stable, long-term funding.

- Centers assure appropriate parental/guardian consent for services.

Making the Grade in [redacted]th Carolina
Targeting Criteria 1997-1998

KEY

HPSA: Designated Health Professional Shortage Area ("P"= partial/ "W"=whole)
MUA: Designated Medically Underserved Area ("P"= partial/ "W"=whole)
CAcc: Carolina Alternatives County
CA: Carolina Access County
Healthy Carolinians: County with Healthy Carolinians Program

County Number	County Name	children ages 6-17*	# of uninsured children 6-17**	% of uninsured children	rank by percent of uninsured children	rank by number of uninsured children	HPSA/MUA	CAcc/CA	Non-Profit Hospital	Healthy Carolinians
1	Alamance	16628	1499	9.01%	94	29	P/W	No/Yes	Yes	Yes
2	Alexander	4697	438	9.33%	85	78	W/W	Yes/Yes	Yes	Yes
3	Alleghany	1243	194	15.61%	18	95	No/W	No/No	Yes	Yes
4	Anson	3960	525	13.26%	55	68	W/W	No/Yes	No	Yes
5	Ashe	3085	418	13.55%	49	80	No/W	No/No	Yes	Planning
6	Avery	2177	333	15.30%	22	85	No/P	No/No	Yes	No
7	Beaufort	6919	986	14.25%	37	47	P/W	No/Yes	Yes	No
8	Bertie	3806	542	14.24%	38	66	W/W	No/No	Yes	No
9	Bladen	4908	729	14.85%	29	58	W/W	No/No	Yes	Planning
10	Brunswick	8736	1339	15.33%	21	34	W/W	Yes/No	Yes	No
11	Buncombe	27633	2609	9.44%	81	10	No/P	Yes/Yes	Yes	Planning
12	Burke	12375	1065	8.61%	99	44	No/P	Yes/Yes	Yes	Yes
13	Cabarras	17499	1613	9.22%	87	26	No/P	No/No	Yes	Yes
14	Caldwell	10909	1368	12.54%	69	32	P/W	No/Yes	Yes	Planning
15	Camden	964	185	19.19%	6	96	No/W	No/No	No	No
16	Carteret	8519	1395	16.38%	13	31	P/W	No/No	Yes	No
17	Caswell	3196	495	15.49%	20	71	W/W	No/Yes	No	Planning
18	Catawba	19189	1678	8.74%	97	23	P/P	No/Yes	Yes	Planning
19	Chatham	6185	807	13.05%	60	56	W/W	Yes/Yes	Yes	Inactive
20	Cherokee	3029	453	14.96%	28	76	P/W	Yes/Yes	Yes	Yes
21	Chowan	2369	360	15.20%	24	84	No/P	No/No	Yes	Yes
22	Clay	1096	173	15.78%	16	97	W/W	No/No	No	No
23	Cleveland	13809	1753	12.69%	65	20	P/W	No/Yes	Yes	Yes
24	Columbus	8942	1239	13.86%	44	37	W/W	No/No	Yes	No
25	Craven	14520	2345	16.15%	14	12	No/W	No/Yes	Yes	Planning
26	Cumberland	53511	5962	11.14%	73	3	P/P	No/No	Yes	No
27	Currituck	2614	452	17.29%	9	77	W/W	No/No	No	No
28	Dare	3843	603	15.69%	17	64	P/W	No/No	No	No

*1995 census data

**Estimated numbers based on the March 1995 Current Population Survey. Analysis conducted by the Duke University Center for Health Policy Research and Education

29	Davidson	20830	1962	9.42%	82	16	No/P	No/Yes	Yes	No
30	Davie	4290	391	9.11%	91	83	No/W	No/No	Yes	Yes
31	Duplin	7090	927	13.07%	59	50	P/W	No/Yes	Yes	No
32	Durham	28420	2497	8.79%	96	11	P/P	No/Yes	Yes	No
33	Edgecombe	10240	1359	13.27%	54	33	W/W	No/Yes	No	Inactive
34	Forsyth	42892	3953	9.22%	88	5	No/P	Yes/Yes	Yes	Yes
35	Franklin	6724	719	10.69%	75	59	W/W	Yes/No	No	Yes
36	Gaston	28569	2675	9.36%	83	8	P/P	Yes/Yes	Yes	Yes
37	Gates	1678	305	18.18%	7	88	W/W	No/No	No	No
38	Graham	1112	170	15.29%	23	98	W/W	Yes/No	No	Planning
39	Granville	6414	875	13.64%	47	53	No/W	Yes/No	No	No
40	Greene	2689	396	14.73%	31	82	W/W	Yes/Yes	No	Planning
41	Guilford	54342	4943	9.10%	92	4	P/P	No/Yes	Yes	Yes
42	Halifax	10087	1513	15.00%	27	28	P/W	No/Yes	Yes	Planning
43	Harnett	12642	1839	14.55%	33	17	P/W	No/Yes	Yes	No
44	Haywood	6498	917	14.11%	40	51	No/P	Yes/Yes	Yes	Planning
45	Henderson	9945	1406	14.14%	39	30	P/P	Yes/Yes	Yes	No
46	Hertford	4047	627	15.49%	19	62	P/W	No/No	Yes	Yes
47	Hoke	5249	617	11.75%	72	63	W/W	No/No	No	Yes
48	Hyde	806	164	20.35%	3	99	W/W	No/No	No	Planning
49	Iredell	15869	2020	12.73%	64	14	No/P	No/No	Yes	Planning
50	Jackson	3711	519	13.99%	42	69	No/P	Yes/Yes	Yes	No
51	Johnson	14845	1981	13.34%	53	15	P/W	No/No	Yes	No
52	Jones	1569	238	15.17%	25	94	W/W	No/No	No	Planning
53	Lee	7721	1013	13.12%	57	46	No/P	No/Yes	No	No
54	Lenoir	8796	1191	13.54%	50	38	P/W	No/Yes	Yes	Yes
55	Lincoln	8833	869	9.84%	79	54	No/P	Yes/Yes	Yes	Yes
56	Macon	5505	426	7.74%	100	79	P/W	Yes/Yes	Yes	Yes
57	Madison	3379	310	9.17%	89	87	W/W	Yes/Yes	No	Yes
58	Martin	2448	478	19.53%	4	73	No/W	No/No	No	Planning
59	McDowell	4321	930	21.52%	2	49	No/W	Yes/No	Yes	No
60	Mecklenburg	94416	8409	8.91%	95	1	P/P	No/Yes	Yes	Yes
61	Mitchell	2088	299	14.32%	35	90	No/W	Yes/No	Yes	Yes
62	Montgomery	3903	514	13.17%	56	70	W/W	No/No	Yes	Planning
63	Moore	9671	1332	13.77%	46	35	No/P	No/Yes	Yes	No
64	Nash	13694	1735	12.67%	67	21	P/W	No/Yes	Yes	No
65	New Hanov	20446	2027	9.91%	78	13	P/P	Yes/No	Yes	Planning
66	Northampton	2091	554	26.49%	1	65	W/W	No/Yes	No	Yes
67	Onslow	24685	3132	12.69%	66	6	W/W	No/Yes	No	Planning
68	Orange	13312	1244	9.34%	84	36	No/P	Yes/Yes	No	Planning
69	Pamlico	1754	288	16.42%	12	91	W/W	No/No	No	Yes
70	Pasquotank	5761	951	16.51%	11	48	No/No	No/No	Yes	No

*1995 census data

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7	[redacted]der	5268	793	15.05%	[redacted]	57	W/W	Yes/No	Yes	Yes
7	[redacted]quimans	1727	302	17.49%	[redacted]	89	No/W	No/No	No	Yes
73	Person	4917	644	13.10%	58	61	No/W	Yes/Yes	Yes	Yes
74	Pitt	19076	1815	9.51%	80	18	No/W	No/Yes	Yes	No
75	Polk	1933	285	14.74%	30	92	P/W	No/No	Yes	No
76	Randolph	18088	1634	9.03%	93	24	W/P	No/No	Yes	Planning
77	Richmond	7691	1045	13.59%	48	45	No/W	No/No	Yes	Yes
78	Robeson	21456	2870	13.38%	52	7	W/W	No/No	Yes	No
79	Rockingham	13280	1731	13.03%	61	22	No/W	No/Yes	Yes	No
80	Rowan	19016	1758	9.24%	86	19	No/P	No/No	Yes	Yes
81	Rutherford	9234	1164	12.61%	68	41	No/W	No/No	Yes	Planning
82	Sampson	8417	1165	13.84%	45	40	P/W	No/Yes	No	Yes
83	Scotland	6453	835	12.94%	63	55	P/W	No/Yes	Yes	Yes
84	Stanly	8792	1185	13.48%	51	39	P/P	No/No	Yes	Yes
85	Stokes	6209	670	10.79%	74	60	P/W	Yes/No	Yes	Yes
86	Surry	9327	1151	12.34%	71	42	P/P	No/Yes	Yes	Yes
87	Swain	1916	280	14.61%	32	93	P/P	Yes/No	Yes	No
88	Transylvania	3763	531	14.11%	41	67	No/P	Yes/Yes	Yes	No
89	Tyrrell	709	137	19.32%	5	100	W/W	No/No	No	Yes
90	Union	17369	1587	9.14%	90	27	W/W	No/No	Yes	No
91	Vance	6873	894	13.01%	62	52	No/W	Yes/No	Yes	Planning
92	Wake	79643	6855	8.61%	98	2	No/P	Yes/Yes	Yes	Yes
93	Warren	2941	473	16.08%	15	74	W/W	Yes/No	No	Yes
94	Washington	2394	410	17.13%	10	81	W/W	No/No	No	Planning
95	Watagua	4561	473	10.37%	76	75	No/P	No/No	Yes	Planning
96	Wayne	18416	2648	14.38%	34	9	P/W	Yes/Yes	Yes	Planning
97	Wilkes	9172	1150	12.54%	70	43	No/W	No/No	Yes	No
98	Wilson	11618	1622	13.96%	43	25	P/W	No/Yes	Yes	No
99	Yadkin	4835	483	9.99%	77	72	No/W	No/No	No	Yes
100	Yancey	2207	315	14.27%	36	86	P/W	Yes/No	No	Yes

*1995 census data

**Estimated numbers based on the March 1995 Current Population Survey. Analysis conducted by the Duke University Center for Health Policy Research and Education

11 Utilization 1-21-98

CY=Calendar Year

Calendar Year 1996 (Jan. - Dec) Health Check Data: State Rate 50.9%

* = Counties in Health Districts

County	# of Individuals eligible for Health Check				# Eligibles who should receive screening				# Eligibles receiving one screening				Participation Ratio			
	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96
Alamance	6751	7159	7703	7875	4523	4759	5065	5094	1921	2197	2486	2562	42.5	46.2	49.1	50.3
Alexander	1686	1920	2197	2270	1003	1258	1418	1390	400	508	597	675	39.9	40.4	42.1	48.6
Alleghany*	614	625	675	700	405	398	441	443	231	214	216	223	57.0	53.8	49.0	50.3
Anson	2854	3071	3438	3577	1889	2094	2294	2351	802	907	1123	1218	42.5	43.3	49.0	51.8
Ashe*	1640	1772	1893	2017	1043	1178	1194	1275	525	616	859	991	50.3	52.3	71.9	77.7
Avery*	1149	1293	1335	1346	763	857	863	862	158	369	405	600	20.7	43.1	46.9	69.6
Beaufort	4681	4953	5217	5235	2991	3117	3249	3277	1438	1613	1657	1788	48.1	51.7	51.0	54.6
Bertie	2882	3028	3254	3398	1848	2005	2158	2219	471	601	693	1004	25.5	30.0	32.1	45.2
Bladen	3866	4055	4143	4210	2585	2691	2598	2593	911	1003	1026	1198	35.2	37.3	39.5	46.2
Brunswick	5583	6170	6660	6809	3621	4019	4248	4294	1376	1569	1589	1779	38.0	39.0	37.4	41.4
Buncombe	13274	14463	15457	15825	8856	9427	9954	10102	5173	6196	6191	6330	58.4	65.7	62.2	62.7
Burke	5919	6543	6954	7068	3538	3932	4089	4116	1825	2447	2364	2850	51.6	62.2	57.8	69.2
Cabarrus	6689	7054	7501	7499	4461	4621	4889	4840	2360	2437	2487	2435	52.9	52.7	50.9	50.3
Caldwell	5295	5681	5968	6172	3468	3708	3907	3986	1644	2201	1967	2056	47.4	59.4	50.3	51.6
Camden*	490	513	542	531	305	313	322	322	136	161	196	245	44.6	51.4	60.9	76.1
Carteret	4056	4448	4577	4452	2616	2806	2889	2780	1509	1771	1767	1687	57.7	63.1	61.2	60.7
Caswell	1755	1895	1906	1996	1062	1230	1186	1219	444	544	487	619	41.8	44.2	41.1	50.8

County	# of Individuals eligible for Health Check				# Eligibles who should receive screening				# Eligibles receiving one screening				Participation Ratio			
	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96
Catawba	7970	8608	9615	10160	5220	5646	6159	6621	2562	2889	3214	3797	49.1	51.2	52.2	57.3
Chatham	2468	2524	2630	2791	1657	1708	1756	1810	740	859	853	941	44.7	50.3	48.6	52.0
Cherokee	2074	2237	2307	2434	1314	1355	1418	1527	572	674	685	1153	43.5	49.7	48.3	75.5
Chowan*	1705	1778	1908	1968	1135	1149	1263	1273	406	438	549	568	35.8	38.1	43.5	44.6
Clay	492	609	646	672	288	345	374	372	121	183	207	326	42.0	53.0	55.3	87.6
Cleveland	7980	8457	8731	9313	5300	5571	5657	5915	2134	2341	2162	2483	40.3	42.0	38.2	42.0
Columbus	7425	7953	8322	8438	4650	5173	5516	5528	647	1075	750	798	13.9	20.8	13.6	14.4
Craven	8042	8400	8667	8723	5111	5372	5457	5460	2448	2818	3034	3164	47.9	52.5	55.6	57.9
Cumberland	26355	27559	29200	29925	16932	17660	18479	18739	7485	9692	9908	9733	44.2	54.9	53.6	51.9
Currituck	1380	1460	1489	1398	792	846	849	784	223	272	301	330	28.2	32.2	35.5	42.1
Dare	1380	1503	1562	1622	843	912	934	951	308	342	368	429	36.5	37.5	39.4	45.1
Davidson	9050	9653	10196	10513	6013	6376	6677	6908	3538	3717	3902	4420	58.8	58.3	58.4	64.0
Davie	1550	1663	1676	1713	1029	1081	1116	1110	503	507	527	540	48.9	46.9	47.2	48.6
Duplin	4804	4997	5172	5323	3123	3273	3340	3406	1482	1523	1523	1831	47.5	46.5	45.6	53.8
Durham	14377	15228	16367	17044	9557	10095	11336	11937	2430	3668	3331	4393	25.4	36.3	29.4	36.8
Edgecombe	8514	9001	9702	10208	5737	5998	6601	6870	2255	2798	2990	3295	39.3	46.6	45.3	48.0
Forsythe	20067	20827	21837	22124	13893	14441	15297	14396	5972	6504	6863	7144	43.0	45.0	44.9	49.6
Franklin	3585	3739	3950	4153	2280	2376	2495	2588	1047	1494	1626	1694	45.9	62.9	65.2	65.5
Gaston	15334	15380	15598	15826	10040	10018	9965	9957	3786	3792	3742	4343	37.7	37.9	37.6	43.6

County	# of Individuals eligible for Health Check				# Eligibles who should receive screening				# Eligibles receiving one screening				Participation Ratio			
	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96
Gates*	825	903	953	951	529	571	591	536	177	233	239	352	33.5	40.8	40.4	65.7
Graham*	837	862	899	858	520	536	528	478	246	279	292	393	47.3	52.1	55.3	82.2
Granville*	2702	3053	3375	3527	1801	2014	2174	2266	629	960	1251	1345	34.9	47.7	57.5	59.4
Greene	1707	1794	1931	2081	1108	1197	1192	1283	400	468	452	740	36.1	39.1	37.9	57.7
Guilford	25677	27529	29207	30327	17121	18244	19004	19468	5269	7216	7875	9633	30.8	39.6	41.4	49.5
Halifax	9123	9316	9499	9585	6094	6203	6269	6217	2568	2559	3075	3409	42.1	41.3	49.1	54.8
Harnett	7565	8022	8130	8418	4968	5241	5244	5386	1976	2009	2133	2328	39.8	38.3	40.7	43.2
Haywood	3765	4054	4397	4495	2426	2620	2834	2850	1437	1785	1634	1878	59.2	68.1	57.7	65.9
Henderson	5123	5670	6125	6353	3372	3696	3927	4048	1348	1665	1919	2328	40.0	45.0	48.9	57.5
Hertford*	3501	3679	3871	3925	2357	2456	2560	2547	668	761	902	1368	28.3	31.0	35.2	53.7
Hoke	3770	3860	4202	4315	2359	2430	2665	2638	871	1204	1368	1488	36.9	49.5	51.3	56.4
Hyde	677	654	716	697	458	441	491	463	174	159	192	235	38.0	36.1	39.1	50.8
Iredell	7045	7382	7800	8054	4605	4797	5032	5157	1613	1962	2091	2235	35.0	40.9	41.6	43.3
Jackson	2256	2382	2446	2543	1503	1585	1595	1634	589	691	790	1095	39.2	43.6	49.5	67.0
Johnston	7465	7909	8710	8979	4924	5157	5691	5782	2252	2398	2700	2936	45.7	46.5	47.4	50.8
Jones	1050	1083	1147	1151	718	730	758	721	354	388	435	583	49.3	53.2	57.4	80.9
Lee	4197	4533	4990	5229	2764	3009	3278	3391	1072	1228	1202	1378	38.8	40.8	36.7	40.6
Lenoir	7112	7442	7819	8046	4800	4921	5168	5326	1794	1825	2313	2808	37.4	37.1	44.8	52.7
Lincoln	3703	3908	4110	4264	2411	2460	2626	2749	934	1191	1338	1418	38.7	48.4	51.0	51.6

County	# of Individuals eligible for Health Check				# Eligibles who should receive screening				# Eligibles receiving one screening				Participation Ratio			
	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96
Macon	1852	2052	2217	2354	1119	1291	1354	1513	588	707	736	1025	52.5	54.8	54.4	67.7
Madison	1518	1682	1731	1706	952	1019	1071	1067	406	580	621	710	42.6	56.9	58.0	66.5
Martin*	3086	3212	3313	3393	2070	2148	2242	2167	874	1000	1052	1109	42.2	46.6	46.9	51.2
McDowell*	2552	2817	3002	3152	1713	1888	1978	2072	491	747	893	1055	28.7	39.6	45.1	50.9
Mecklenburg	42002	44088	45562	46177	27619	28788	29301	29410	9504	9501	9311	9183	34.4	33.0	31.8	31.2
Mitchell*	902	992	1014	998	623	663	669	641	320	378	382	373	51.4	57.0	57.1	58.2
Montgomery	2602	2844	3127	3091	1692	1845	2004	1970	689	720	948	990	40.7	39.0	47.3	50.3
Moore	4438	4835	5175	5315	2802	3069	3350	3406	948	1213	1359	1707	33.8	39.5	40.6	50.1
Nash	6969	7437	7872	7956	4578	4860	5051	5038	1811	2385	2580	2869	39.6	49.1	51.1	56.9
New Hanover	11617	12347	13028	12918	7809	8426	8872	8729	2815	3328	3611	3867	36.0	39.5	40.7	44.3
Northampton	3070	3217	3391	3493	2092	2166	2229	2254	955	1158	1349	1414	45.7	53.5	60.5	62.7
Onslow	10204	11145	11676	11597	6402	7171	7017	7358	3718	5176	5063	5273	58.1	72.2	72.2	71.7
Orange	4208	4429	4577	4486	2795	2927	2947	2869	1203	1376	1443	1651	43.0	47.0	49.0	57.5
Pamlico	1114	1173	1180	1169	713	745	732	734	311	356	427	422	43.6	47.8	58.3	57.5
Pasquotank*	4011	4255	4442	4430	2745	2786	2927	2885	1307	1562	1693	2009	47.6	56.1	57.8	69.6
Pender	3476	3744	4038	4191	2266	2400	2544	2620	1012	1222	1639	1706	44.7	50.9	64.4	65.1
Perquimmons*	1325	1417	1506	1462	873	921	927	879	390	440	534	610	44.7	47.8	57.6	69.4
Person	2476	2687	2833	2821	1619	1762	1814	1776	713	834	936	994	44.0	47.3	51.6	56.0
Pitt	11736	12267	12931	13173	8088	8411	8788	8914	3462	3839	4007	4523	42.8	45.6	45.6	50.7

County	# of Individuals eligible for Health Check				# Eligibles who should receive screening				# Eligibles receiving one screening				Participation Ratio			
	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96
Polk*	779	842	967	1046	463	534	625	613	81	135	157	203	17.5	25.3	25.1	33.1
Randolph	6716	7576	8337	8796	4133	4953	5395	5733	1820	2075	2333	2795	44.0	41.9	43.2	48.8
Richmond	5181	5824	6287	6617	3414	3820	4121	4375	1352	1924	1970	2070	39.6	50.4	47.8	47.3
Robeson	17674	18578	19281	19718	11260	12380	13063	12293	5582	6090	6006	6219	49.6	49.2	46.0	50.6
Rockingham	6535	7183	7588	7655	4268	4683	4885	4901	1862	2144	2288	2420	43.6	45.8	46.8	49.4
Rowan	8254	8972	9411	9981	5447	5822	6116	6396	2197	2604	2685	2830	40.3	44.7	43.9	44.2
Rutherford*	4761	4954	5093	5306	2911	3023	3291	3395	361	613	797	894	12.4	20.3	24.2	26.3
Sampson	5643	6109	6369	6532	3628	3891	4090	4208	2103	2519	2562	2650	58.0	64.7	62.6	63.0
Scotland	5340	5548	5725	5867	3558	3713	3852	3941	1452	2044	2126	2145	40.8	55.0	55.2	54.4
Stanly	3830	4172	4629	4837	2464	2726	3067	3170	1264	1583	1607	1958	51.3	58.1	52.4	61.8
Stokes	2401	2600	2688	1382	2801	1620	1724	1744	542	533	689	969	39.2	32.9	40.0	55.6
Surry	3971	4186	4605	4877	2410	2566	2752	3176	975	1189	1296	1877	40.5	46.3	47.1	59.1
Swain*	1501	1609	1682	1655	974	1003	1062	1042	370	431	494	683	38.0	43.0	46.5	65.5
Transylvania	2213	2345	2355	2379	1454	1526	1485	1518	662	637	710	768	45.5	41.7	47.8	50.6
Tyrrell*	548	544	559	535	370	361	360	334	211	207	195	194	57.0	57.3	54.2	58.1
Union	6930	7582	7677	7674	4567	4820	5052	4981	1361	1832	2055	2140	29.8	38.0	40.7	43.0
Vance*	5245	5720	6247	6720	3618	3898	4249	4450	932	1386	1965	2508	25.8	35.6	46.2	56.4
Wake	23365	25315	27693	28177	15917	17135	18441	18586	7898	9470	9980	10653	49.6	55.3	54.1	57.3
Warren	2058	2210	2397	2472	1300	1405	1551	1562	579	699	884	957	44.5	49.8	57.0	61.3

County	# of Individuals eligible for Health Check				# Eligibles who should receive screening				# Eligibles receiving one screening				Participation Ratio			
	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96	CY 93	CY 94	CY 95	CY 96
Washington*	2032	2097	2148	2182	1379	1410	1418	1439	475	461	475	575	34.4	32.7	33.5	40.0
Watauga*	1735	1841	1961	1973	1176	1263	1291	1285	688	827	828	787	58.5	65.5	64.1	61.2
Wayne	10053	10661	11291	11766	6458	6888	7173	7427	3886	4611	4796	4872	60.2	66.9	66.9	65.6
Wilkes	4065	4375	4914	5240	2645	2890	3234	3454	1238	1546	1851	2141	46.8	53.5	57.2	62.0
Wilson	8038	8554	9007	9136	5099	5660	5669	5720	1387	1846	1864	2577	27.2	32.6	32.9	45.1
Yadkin	1900	2044	2248	2237	1231	1314	1423	1411	514	609	643	697	41.8	46.3	45.2	49.4
Yancey*	1204	1327	1370	1392	740	874	871	890	552	639	573	576	74.6	73.1	65.8	64.7
STATE TOTALS	572966	609662	644466	660561	375565	399580	419157	424601	156215	185097	195259	216240	41.6	46.3	46.6	50.9

#12 Gladys Fisher
1-21-98

JAN. 21, 1998

MEMBERS Health and Human Services
And guests:

I am Gladys M. Fisher, my husband Robert and I live in Sanford NC. Our son James has been a patient in Dorothea Dix Hospital since 1985. During the last twelve years James has been moved to different areas of Dorothea Dix, the last from the Lineberger Building to the McBryde Building.

I find the present location, Ward C, Second floor, North Wing, McBryde Building to be inadequate as a Hospital facility to provide care for patients with mental illness.

My husband and I have visited Ward C, on several occasions, the last accompanied with Rep. Don Davis, Mrs. Beth Melcher, director of North Carolina Alliance for the Mentally Ill, Mr. Roy Haddock, Adult Services Director for the Lee Harnett Mental Health Office, family members who have a son in the hospital, and members of the hospital staff. The following is a listing of my comments regarding these visits.

The operation of the hospital facility is not adequately funded to provide decent care for the patients. Cutting the appropriations funds to operate this facility for the past years has reduced the patient care to inadequate and the building proper to a shell of an efficient hospital.

STAFF Most of the staff have a caring attitude toward the patients but are handicapped in the performance of their duties by being understaffed, crowded for space, and a lack of programs or equipment to provide the care needed to prepare patients for possible discharge.

In Ward C, there are 20 patients. Three Technicians during the first shift, three second shift, and two at night. Two nurses are on duty for 54 patients during the first shift. This covers all four sections A,B,C,D. Dr, Wouters covers part of B and C section. My son's Social Worker shares an office with two other Social Workers, previously she had her own office in the Lineberger Building, and there is a Dietician. A Rehab Therapist says my son attends therapy only once a week with a volunteer who I pay $10.00 an hour for her service. If our son is ever to leave this hospital he needs in depth care, frequently. All the staff from the Lineberger Building did not follow the patients to the McBryde Building, and several experienced caring staff are no longer with these patients.

BUILDING The first impression a family member visiting a patient notices is there are two approaches to Ward C. (1) Go to the reception desk in the main lobby and have a Technician come and escort you through the several locked wards. (2) Family members are told to go to the outside entrance of the North Wing to a small dirty entrance door, and walk up the 60 steps to the Ward C door. The locked door required that you pound on it to attract a Technician to unlock it, but recently a loud buzzer was installed to attract attention.

Once inside you can observe the facilities. The lavatory is just inside the entrance, quite some distant from the mens bed

rooms. It is small for 20 men and contains two toilets in one inclosure, and an open shower with a shower curtain. A Technician mentioned that the water is usually cold. The bed rooms are around the corner from this hallway and also small, but they each house four patients. They contain four beds with pull out drawers under the bed. There are no tables or chairs. There are four wooden lockers which were procured used from the university, locks that do not work and no latches or keys. These are for storing personal belongings, and on top of there is a plastic basket for "soiled Laundry" which the patient or a Technician can laundry.

The Laundry room is situated in a dual purpose room, it houses the Conference or Meeting Room, Laundry, and a Computer. It is locked, and meetings and laundry do not co-exist. There are several crowded offices including the main central office for the Technicians to dispense their duties, and the main congregating area which contains chairs, a TV overhead, a ping pong table, and a pool table. It is very crowded for 20 patients. At the other end of the hall is the dining room with 5 or 6 table and chairs. Exit in case of fire is out the door to the steps, or through doors to other hospital wards, all via locked doors. If a patient becomes unruly and needs a quiet room, there is none available on this ward.

COMMENTS In My Opinion the environment on Ward C, second floor is dangerous, understaffed, inefficient, uncomfortable, and not conducive to providing the caring help patients need.

Mr. Pedneau, Hospital Director, in a meeting with me, said there is not enough money in the Mental Health Budget to give good care. Nor is there enough to properly renovate the deteriorating hospitals.

There seems to be enough to remodel the buildings taken from the hospital to make office buildings. This is the fate of the Lineberger Building, fit for offices but not for patients.

Sufficient funds need to be budgeted and appropriated to provide more than just warehousing care for the mentally ill patients in the four state hospitals. The managing staff have robbed Peter to Pay Paul until it hurts. This can't go on forever.

THINGS NEEDED Space for additional toilets, wash basins, and showers. A room for family to visit patients on the ward. Single bedrooms with chair and storage equipment a closet. A pager at the elevator on the ground floor. Most important is the need for additional trained staff, Technicians, nurses, and social workers to provide the programs that can help the patients improve their lives. Sitting idle all day deteriorates both body and mind.

Basically, what is needed is to put out for bids for the New Modern Hospital that was promised, and explained so eagerly to families at a NCAMI Conference two years ago. A modern efficient Hospital which was to replace Dorothea Dix Hospital.

Gladys M. Fisher

Gladys M. Fisher
3019 Bourbon St.
Sanford, NC. 27330

#13 Allen Hamblin
1-21-98

DIVISION OF MEDICAL ASSISTANCE
January 21, 1998

BACKGROUND

- FY 1997/98 operating budget of $4.3 billion.
- Current staffing of 285 positions.
- Since 1987 program expenditures increased by 345%; administrative costs by 85%; staff positions by 67%.
- State administration as % of budget since 1987 decreased from 2.09% to 1% ($38.7); county administration and payments to other state agencies for support (EIS, Facility Services, etc.) raise total administrative cost to 3.1% of budget.
- Each DMA employee on average is responsible for $15.1 million in program funding, a 170% increase over 1987 levels of $5.6 million.
- DMA operates 11th largest Medicaid Program in the nation.
- National average for administrative expenditures is 4.56%; average for 10 largest states is 3.41%.

Administrative Increases for DMA

The Division of Medical Assistance is in need of improvements in its ability to address the responsibility of oversight of a program that is in excess of $4 billion. The current state level administrative budget for DMA is $38.7 million. This represents the budgeted cost for state level staff and contracts that are under the direct control of DMA and is approximately 1% of the total budget. County Administration for eligibility determination and transfers to other state agencies for the EIS and other support services raises the total administrative cost to 3.1% of the budget. The national average for administration is 4.29%. The total increase in recurring administration being recommended represents approximately .1% (1/10th percent) increase in the ratio of admin to program budget.

Managing the Medicaid budget is not only necessary on an annual basis but also includes the need to work with a four to five year planning horizon.

The package of additional staff, the Decision Support System(DSS), and the LAN equipment permits DMA to meet head on the challenge of managing the program in a manner that both assures the provision of appropriate services to the recipient population and to meet the targeted budget requirement. In accordance with Section 11.11 (o) of the Appropriations Act, Medicaid is in the process of completing the necessary budget documents to support the creation of 63 new positions, acquire by contract the DSS, and to install a LAN system, all of which must represent a net savings to the state. The total cost of these actions will be supported from within the Medicaid Budget and must be demonstrated as being capable of producing a net savings.

New Positions

DMA is recommending the addition of 63 new staff positions within the Division. Attachment #1 provides a summary of the positions by organizational unit. While the number of positions represents an increase of 22% over the current staffing, the dynamics of change require this level of support. The recurring cost of the positions is approximately $3 million, which will be supported by approximately $5 million in program savings.

A brief description of benefit and need by section is noted below:

Director - 2 positions- These positions are needed to support the review of innovative policies and action at the national level and in other states, that either have shown savings or have potential. These positions will work with stake holders, DHHS and DMA staff to develop and examine the benefit of changes within the program to assure cost effective and appropriate services.

Information Systems/DSS/LAN - 14 positions - Of absolute necessity in managing the program is access to information about the population served, services used, and payments made. When DMA decided to forego the development of a new MMIS, due to significant cost, the use of a DSS became critical. Once the system is developed, this staff will provide the programming support and also the support for the LAN equipment to permit staff within DMA to access current and accurate data for policy analysis and program monitoring. These resources will be of particular importance in supporting our Program Integrity Unit, Financial Operations, and Medical Policy. These staff will be able to develop reports that meet agency needs, set up production reports, and assist with complex analysis of expenditure history.

Managed Care - 5 positions - As Medicaid prepares to expand the availability of HMOs, as an option to Medicaid recipients, in counties outside of Mecklenburg, the agency will be required to have contracts with more HMO's. Each contract requires monitoring for compliance and evaluation of performance. In addition, DMA is proceeding with state wide implementation of ACCESS and ACCESS II. It is expected that HMO payments will be approximately 7% less than the fee for service before recognizing increased Medicaid administrative costs of approximately 2%. ACCESS II is expected to cost 4-5% less than the fee for service.

Provider/Recipient Services - 5 positions- Additional staff is needed in this area to support the enrollment of new providers and to accommodate changes concerning eligibility and enrollment in various managed care programs. Recent changes in federal laws, such as mandated certifications of insurability, expansion of eligibles for payment of purchase of surety bonds from authorized companies as a condition of Medicaid enrollment. Medicare Part B premium requirements have also placed new demands upon this section.

Financial Operations - 8 Positions- These positions are necessary to permit the further detailed study of provider costs, projections of impact of changes and to aid in the growth in the area of Third Party Recovery. Staffing compliments the support necessary to move into the various managed care models at rates that are a savings to the state. Additional staffing will permit the examination of federal

revenue maximization consistent with agency objectives as noted previously in DSH and hospital supplemental payments.

Program Integrity - 15 Positions- These staff are to permit an increase level of review for inappropriate billings, abuse and review of provider audits.

Medical Policy - 14 Positions- Staff positions are needed to review the basis of policy that is consistent with sound medical practice. Professional staff are needed in disciplines, including Mental Health services, to assure that medical coverage is appropriate, reflective of acceptable standards, and is of cost beneficial nature. Medicine is one of the fastest growing fields, timely review of new procedures, practices and methods are needed to permit development of policy that is current and beneficial.

DECISION SUPPORT SYSTEM (DSS)

The DSS consists of a data warehouse and software for retrieving from the warehouse data used for information reporting. The data warehouse will contain information from the MMIS paid claims and reference files (e.g., Provider Master File, Eligibility File, Diagnosis File, Procedure Code File). Initially the data warehouse will contain 24 months of data. When the warehouse is completely loaded, it will contain 36 months of data. The data warehouse will be updated or refreshed every month.

The information in the data warehouse will be used in different ways. There will be predefined reports that are updated and produced automatically on a routine basis. There will be questions or queries that are predefined, but with the ability to set specific parameters such a time periods, diagnosis codes, type/service procedures codes, etc., for the user's specific needs. These queries are stored in the DSS library for use. Users can create new reports using and modifying these queries, and the new queries may be kept for future use. There also will be access to the data elements in the library for new, complex ad hoc reports. For most reports, you will be able to access the specific data elements used to create the report by use of "drill down" capability.

LOCAL AREA NETWORK (LAN) - The Division of Medical Assistance is in need of adequate computer hardware, available to all staff, and interconnected in a manner that permits detailed analysis of information and rapid transferal of data and analysis sets. The system must connect the two physical locations of the Division. The system places a PC on each staff member desk and utilizes consistent software packages. Depending upon the specific duties of each staff, other software

options are available to meet unique needs. The components and software list have been reviewed by the DHHS Division of Information Management and complies with all applicable state standards.

COST / BENEFIT

Attachment #1 represents the estimated cost for the DSS, LAN and new staff for the period of SFY 97-98 through SFY 02-03. Staff costs are based upon a six month basis. The only additional cost in the years past SFY 98-99 is for required modification and equipment replacement. Those costs will be requested during the preparation of the Continuation Budget for SFY 99-01.

Programmatic savings are anticipated by the addition of additional staff, the information that will be made available by the DSS and the use of the LAN. The Division of Medical Assistance is preparing budget realignments that will reflect the net savings of the added administrative costs.

Savings:

Increase in Managed Care Savings (Savings through difference in fee for service and capitated payment rates)	$ 2,500,000
Financial Operations (Savings through review of rates)	$ 6,000,000
Program Integrity (Savings through improved fraud and abuse detection and audit recoveries)	$ 2,000,000
Medical Policy (Savings through setting of appropriate utilization standards for medical services)	$ 4,000,000
Estimated Annual Program Savings	$14,500,000
Estimated Annual State Share	$ 4,500,000
Estimated State Share for New Administrative Support	$ 1,824,000
Savings to State Appropriations	$ 2,676,000

Summary of Additional Staffing Needs				
	Current	Proposed		
Organizational Unit	# postions	# postions	Level	
Director		2	Professional	
Total	8	2		
DSS/LAN		13	Professional	
		1	Clerical	
Total	22	14		
Managed Care		4	Professional	(one position Qalified Medical)
		1	Clerical	
Total	34	5		
Provider/Receipient Svcs		5	Midlevel	
Total	53	5		
Finanical Operations		4	Professional	
		3	Midlevel	
		1	Clerical	
Total	46	8		
Program Integ.		5	Auditor	
		5	Professional	(three positions Qalified Medical)
		5	Clerical	
Total	73	15		
Medical Policy		11	Professional	(two positions Qalified Medical)
		3	Clerical	
Total	49	14		
Total Division		5	Auditor	
		39	Professional	(six positions Qalified Medical)
		8	Midlevel	
		11	Clerical	
Total	285	63		
New Total		348		
% Increase		22%		
Federal Funding for staff is at 50% except for Qualified Medical which is at 75%				
Federal Funding at 75% is also available for				

Division of Medical Assistance
Preliminary cost estimates

		98	99	00	01	02	03
DSS Implementation		$ 5,745,000	$ 364,000	0	0	0	
	Federal	$ 5,173,200	$ 327,600				
	State	$ 571,800	$ 36,400				
DSS Operations		$ 210,000	$ 1,090,000	$ 1,165,000	$ 1,240,000	$ 1,315,000	$ 545,000
	Federal	$ 157,500	$ 817,500	$ 873,750	$ 930,000	$ 986,250	$ 408,750
	State	$ 52,500	$ 272,500	$ 291,250	$ 310,000	$ 328,750	$ 136,250
Lan - Equipment		$ 3,292,970					
	Federal	$ 532,252					
	State	$ 2,760,718					
Staff - 63 new positions							
	Recurring	$ 1,767,301	$ 3,029,659	$ 3,029,659	$ 3,029,659	$ 3,029,659	$ 3,029,659
	Non recurring	$ 1,052,730	$ -	$ -	$ -	$ -	$ -
	Total	$ 2,820,031	$ 3,029,659	$ 3,029,659	$ 3,029,659	$ 3,029,659	$ 3,029,659
	Federal	$ 1,410,016	$ 1,514,830	$ 1,514,830	$ 1,514,830	$ 1,514,830	$ 1,514,830
	State	$ 1,410,016	$ 1,514,830	$ 1,514,830	$ 1,514,830	$ 1,514,830	$ 1,514,830
Total	Recurring	$ 1,977,301	$ 4,119,659	$ 4,194,659	$ 4,269,659	$ 4,344,659	$ 3,574,659
	Non recurring	$ 10,090,700	$ 364,000	$ -	$ -	$ -	$ -
	Sub total	$ 12,068,001	$ 4,483,659	$ 4,194,659	$ 4,269,659	$ 4,344,659	$ 3,574,659
	Federal	$ 7,272,967	$ 2,659,930	$ 2,388,580	$ 2,444,830	$ 2,501,080	$ 1,923,580
	State	$ 4,795,034	$ 1,823,730	$ 1,806,080	$ 1,824,830	$ 1,843,580	$ 1,651,080

#14 Edgerton
1-21-98

Work First Program

Business Plan and Reinvestment Strategies

Temporary Assistance for Needy Families

State Fiscal Years 1997 - 2002

Summary of Projected Work First Funding and Expenditures
SFY 96-97 through 2001-2002
Based on Estimates of Welfare Reform Impacts and Governor's Goal 2000
Dollars in Millions

PROGRAM AREA	STATE FISCAL YEAR 1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02	TOTAL SFY 1996-2002
Estimated Expenditures:							
A. TANF DIRECT PROGRAM COSTS:							
1. Work First Family Assistance (Cash)	$280.4	$262.7	$232.7	$218.8	$199.0	$193.6	$1,387.3
2. Work First County Block Grant - Total	185.8	181.7	176.0	165.3	157.3	155.3	1021.4
WF County Block Grant Detail							
Employment, Training, Support Services	46.2	46.7	44.7	35.5	28.9	28.3	230.3
EA Services (CPS; etc.)	73.0	73.0	73.0	73.0	73.0	73.0	438.0
EA Cash	8.5	8.5	8.5	8.5	8.5	8.5	51.0
County Eligibility Determination/Case Workers	43.0	39.6	36.9	35.8	34.7	33.7	223.7
County Administration	15.1	13.9	12.9	12.5	12.2	11.8	78.4
3. DMH/DD/SAS Emergency Assistance	23.1	23.1	23.1	23.1	23.1	23.1	138.6
4. State Management	10.4	10.2	10.0	9.8	9.6	9.4	59.4
5. Child Support Enforcement Operations	0.0	0.4	0.4	2.1	2.1	2.1	7.0
6. Automation	0.0	16.9	11.7	14.3	11.8	8.1	62.8
TOTAL Estimated Expenditures:	$499.7	$494.9	$454.0	$433.4	$402.9	$391.5	$3,697.9
B. Available Funds:							
Federal:							
Base TANF Grant	$295.7	$302.2	$302.2	$302.2	$302.2	$302.2	$1,806.9
Supplemental TANF Grant	0.0	6.5	15.4	24.5	26.9	6.7	79.9
Federal Funds Carried Forward	0.0	8.7	0.6	1.0	1.9	10.5	22.6
State	109.0	109.0	109.0	109.0	109.0	109.0	654.0
Local	103.9	103.9	103.9	103.9	103.9	103.9	623.3
TOTAL Available Funds:	$508.6	$530.3	$531.1	$540.6	$543.9	$532.3	$3,186.8
C. TOTA DIFFERENCE:	$8.9	$35.4	$77.1	$107.2	$141.0	$140.8	($511.1)
D. Reinvestment Needs							
Transfer to Division of Child Development							
Increased Subsidy to Accomodate Work First Participants	$0.0	$3.8	$41.8	$71.2	$96.5	$104.5	$317.7
Provide funds for Smart Start Expansion	0.0	22.9	31.5	31.5	31.5	31.5	148.9
Provide funds for other Expansion Priorities	0.0	5.0	0.0	0.0	0.0	0.0	5.0
Maternal Outreach Program	0.0	0.4	0.4	0.4	0.4	0.4	2.0
Substance Abuse Treatment Funds	0.0	1.0	1.0	1.0	1.0	1.0	5.0
Community College Collaboration	0.0	0.5	0.5	0.5	0.5	0.5	2.5
Evaluation	0.0	0.7	0.7	0.7	0.7	0.7	3.5
Staff Development	0.3	0.5	0.3	0.0	0.0	0.0	1.0
Carry-Forward to Subsequent Year	8.7	0.6	1.0	1.9	10.5	0.0	22.6
TOTAL Reinvestment Needs	$8.9	$35.4	$77.1	$107.1	$141.0	$138.6	$508.1
Difference	($0.0)	($0.0)	($0.0)	$0.0	($0.0)	$2.2	$2.2

Summary of Projected Work First Participants and Cost Per Participant SFY 96-97 through 2001-2002

Based on Estimates of Welfare Refom Impacts and Governor's 100% Work Participation Goal

I. Estimated Participants:

PROGRAM AREA	STATE FISCAL YEAR 1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02
Total Work First Participants	104,800	100,192	92,417	89,096	85,572	83,361
Less:Child Only Families & Families with Child Under Age 1	-41,200	-42,820	-39,594	-39,465	-37,866	-36,319
Work First Participants Subject to Work Requirements	63,600	57,372	52,822	49,631	47,706	47,042
Unsubdized Employment	8,000	11,000	17,000	20,000	26,706	26,542
Subsidized Employment	0	500	1,500	2,500	4,000	4,000
Training and Support Services	31,000	31,000	28,500	22,500	17,000	16,500
Not Participating in work or training	24,600	14,872	5,822	4,631	0	0
Work First Diversion	200	1,500	2,000	2,500	3,000	3,500
Child Protective Services, MH/SA Services - Emergency Grants	41,786	41,786	41,786	41,786	41,786	41,786

II. Estimated Annual Cost Per Participant:

PROGRAM AREA	STATE FISCAL YEAR 1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02
Total Work First Participants	$3,115	$3,074	$2,980	$2,826	$2,628	$2,620
Less:Child Only Families & Families with Child Under Age 1	2,772	2,772	2,772	2,772	2,772	2,772
Work First Participants Subject to Work Requirements	3,337	3,329	3,169	2,905	2,551	2,540
Unsubdized Employment	1,488	1,488	1,488	1,488	1,488	1,488
Subsidized Employment	0	2,488	2,488	2,488	2,488	2,488
Training and Support Services	4,262	4,262	4,288	4,239	4,237	4,245
Not Participating in work or training	2,772	2,772	2,772	2,772	0	0
Work First Diversion	1,000	1,000	1,000	1,000	1,000	1,000
Child Protective Services, MH/SA Services - Emergency Grants	2,503	2,503	2,503	2,503	2,503	2,503

NC WORK FIRST / TANF PROGRAM
CASELOAD BREAKDOWN BY STATE FISCAL YEAR

SCHEDULE III

	FFY 1995 Base Year	State Fiscal Year Ending June 30 1997	1998	1999	2000	2001	2002
TOTAL CASELOAD	**125,503**	**104,800**	**100,192**	**92,417**	**89,096**	**85,572**	**83,361**
Single Parent	95,312	73,700	69,278	63,736	60,549	58,127	56,964
Two Parents	3,042	3,100	2,914	2,681	2,547	2,445	2,396
Child Only	27,149	28,000	28,000	26,000	26,000	25,000	24,000
Less Exempts:							
Child Only	27,149	28,000	28,000	26,000	26,000	25,000	24,000
Non-Able-Bodied	3,000	3,000	2,820	2,594	2,465	2,366	2,319
Single with child under 1 yr	15,416	10,200	12,000	11,000	11,000	10,500	10,000
Subject to Requirements	**79,938**	**63,600**	**57,372**	**52,822**	**49,631**	**47,706**	**47,042**
Exempt From Requirements	**45,565**	**41,200**	**42,820**	**39,594**	**39,465**	**37,866**	**36,319**
Entire caseload:							
% Reduction prior year		16%	4%	8%	4%	4%	3%
Non-Exempt caseload							
% drop from prior year		20%	10%	8%	6%	4%	1%
% drop from FFY 1995		20%	28%	34%	38%	40%	41%

1 - Single Parent with child under 1 year of age or disabled.

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Work First Program

Business Plan and Reinvestment Strategies

Temporary Assistance for Needy Families

State Fiscal Years 1998 - 2002

Summary of Projected Work First Funding and Expenditures
SFY 97-98 through 2001-2002

Based on Estimates of Welfare Reform Impacts and Governor's Goal 2000
Dollars in Millions

Estimated Annual Expenditures as of 12-1-97	1998	1999	2000	2001	2002	FIVE YEAR TOTAL
A. TANF DIRECT PROGRAM COSTS						
1. Work First Family Assistance (Cash)	$225.4	$204.5	$182.7	$170.7	$160.9	$944.2
2. Work First County Block Grant - Total	192.7	193.0	193.6	191.6	185.4	956.3
WF County Block Grant Detail:						
Employment, Training, Support Services	57.7	61.6	63.7	63.2	58.4	304.6
EA Services (CPS, etc)	73.0	73.0	73.0	73.0	73.0	365.0
EA Cash	8.5	8.5	8.5	8.5	8.5	42.5
County Eligibility Determination/Case Workers	39.6	36.9	35.8	34.7	33.7	180.7
County Administration	13.9	13.0	12.6	12.2	11.8	63.5
3. DMH/DD/SAS Emergency Assistance	23.1	23.1	23.1	23.1	23.1	115.5
4. State Administration	10.2	10.0	9.8	9.6	9.4	49.0
5. Child Support Enforcement Operations	0.4	0.4	2.1	2.1	2.1	7.0
6. Automation Costs	16.9	11.7	14.3	11.8	8.1	62.8
TOTAL DIRECT TANF PROGRAM COSTS	$468.6	$442.7	$425.5	$408.9	$388.9	$2,134.6
B. AVAILABLE FUNDS:						
Federal:						
Base TANF Grant	$302.2	$302.2	$302.2	$302.2	$302.2	$1,511.0
Supplemental TANF Grant	6.5	15.4	24.5	26.9	6.7	80.0
Federal Funds Carried Forward	27.7	15.4	0.6	0.0	5.2	48.9
State	109.0	109.0	109.0	109.0	109.0	545.1
Local	103.9	103.9	103.9	103.9	103.9	519.4
TOTAL TANF AVAILABLE	$549.3	$545.9	$540.2	$542.0	$527.0	$2,704.5
C. SURPLUS/(DEFICIT)	$80.7	$103.2	$114.7	$133.1	$138.1	$569.9
D. REINVESTMENT NEEDS: (Approved by legislature)						
1. Tfr. to CCDF - Child Care Subsidy	$5.6	$41.8	$71.2	$96.5	$104.2	$319.3
2. Tfr. to CCDF - Community College Child Care	0.5	0.5	0.5	0.5	0.5	2.5
3. Tfr. to DMH/DD/SAS - SA Services	5.3	5.3	5.3	5.3	5.3	26.5
4. Tfr. to MCH - Out-of-Wedlock Births	1.6	1.6	1.6	1.6	1.6	8.0
5. Tfr. to SSBG - Juvenile SA/MAJORS	1.2	1.2	1.2	1.2	1.2	5.9
6. Tfr. to SSBG - Special Needs Adoptions	0.3	0.3	0.3	0.3	0.3	1.5
7. Staff Development	0.5	0.5	0.5	0.5	0.5	2.5
8. Evalutaion	0.4	0.4	0.4	0.4	0.4	2.0
9. Partial Funding for Biometrics	4.0					4.0
10. Tfr. to GA - Joint Legislative Public Assistance	0.03	0.04	0.04	0.04	0.04	0.19
11. TANF Reserve	16.0	20.0	14.0			50.0
TOTAL REINVESTMENT NEEDS	$35.4	$71.6	$95.0	$106.3	$114.0	$422.4
TOTAL EXPENDITURES	**$504.0**	**$514.3**	**$520.5**	**$515.2**	**$502.9**	**$2,557.0**
SURPLUS /(DEFICIT)	**$45.3**	**$31.6**	**$19.7**	**$26.8**	**$24.1**	**$147.5**
PROPOSED USE OF SURPLUS FUNDS						
1. Transfer to Day Care	10.8	26.4	11.0	3.0	19.0	70.2
2. Child Welfare System Improvement		5.1	5.1	5.1	5.1	20.4
3. Carryforward to Subsequent Year	15.4	0.6	0.0	5.2	0.0	21.2
BALANCE OF FUNDS AVAILABLE	$19.1	$0.0	$3.6	$13.5	$0.0	$36.2

Summary of Projected Work First Participants and Cost Per Participant SFY 97-98 through 2001-2002

Based on Estimates of Welfare Refom Impacts and Governor's 100% Work Participation Goal

I. Estimated Participants:

PROGRAM AREA	STATE FISCAL YEAR 1997-98	1998-99	1999-2000	2000-01	2001-02
Total Work First Participants	86,603	77,943	70,148	65,940	61,983
Less:Child Only Families & Families with Child Under Age 1	-41,634	-38,589	-35,282	-33,805	-32,012
Work First Participants Subject to Work Requirements	44,969	39,354	34,867	32,134	29,971
Unsubdized Employment	10,000	10,000	10,000	10,000	9,600
Subsidized Employment	2,000	2,500	3,300	3,500	3,000
Training and Support Services	17,500	18,500	18,800	18,634	17,371
Not Participating in work or training	15,469	8,354	2,767	0	0
Work First Diversion	3,000	8,000	9,000	9,000	9,000
Child Protective Services, MH/SA Services - Emergency Grants	41,786	41,786	41,786	41,786	41,786

II. Estimated Annual Cost Per Participant:

PROGRAM AREA	STATE FISCAL YEAR 1997-98	1998-99	1999-2000	2000-01	2001-02
Total Work First Participants	$3,243	$3,337	$3,416	$3,445	$3,429
Less:Child Only Families & Families with Child Under Age 1	2,772	2,772	2,772	2,772	2,772
Work First Participants Subject to Work Requirements	3,711	3,931	4,110	4,200	4,180
Unsubdized Employment	1,488	1,488	1,488	1,488	1,488
Subsidized Employment	3,288	3,288	3,288	3,288	3,288
Training and Support Services	5,861	5,861	5,846	5,826	5,822
Not Participating in work or training	2,772	2,772	2,772	0	0
Work First Diversion	750	750	750	750	750
Child Protective Services, MH/SA Services - Emergency Grants	2,503	2,503	2,503	2,503	2,503

NC WORK FIRST/TANF PROGRAM
CASELOAD BREAKDOWN BY STATE FISCAL YEAR

Schedule III

	FFY 1995 Base Year	State Fiscal Year Ending June 30 1997	1998	1999	2000	2001	2002
TOTAL CASELOAD	**125,503**	**104,800**	**86,603**	**77,943**	**70,148**	**65,940**	**61,983**
Single Parent	95,312	73,700	56,129	50,516	45,464	42,736	40,172
Two Parents	3,042	3,100	2,200	1,980	1,782	1,675	1,575
Child Only	27,149	28,000	28,274	25,447	22,902	21,528	20,236
Less Exempts:							
Child Only	27,149	28,000	28,274	25,447	22,902	21,528	20,236
Non-Able-Bodied	3,000	3,000	2,826	2,714	2,577	2,475	2,426
Single with child under 1 yr	15,416	10,200	10,534	10,428	9,802	9,802	9,350
Subject to Requirements	**79,938**	**63,600**	**44,969**	**39,354**	**34,867**	**32,134**	**29,971**
Exempt From Requirements	**45,565**	**41,200**	**41,634**	**38,589**	**35,282**	**33,805**	**32,012**
Entire caseload:							
% Reduction prior year		16%	17%	10%	10%	6%	6%
Non-Exempt caseload							
% drop from prior year		20%	29%	12%	11%	8%	7%
% drop from FFY 1995		20%	44%	51%	56%	60%	63%

1 - Single Parent with child under 1 year of age or disabled.

#16
Edgerton

Work First Program

Business Plan and Reinvestment Strategies

Child Care

State Fiscal Years 1997 - 2002

NC Department of Health and Human Services

1/21/98

Summary of Projected Child Care Funding and Expenditures - March 1997 Projection
SFY 96-97 through 2001-2002

Based on Estimates of Welfare Reform Impacts and Governor's Goal 2000

Dollars in Millions

PROGRAM AREA	STATE FISCAL YEAR 1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	SFY 1997-00
Estimated Expenditures							
Work First Related (Incl. Child Only)	$71.1	$83.7	$116.3	$156.0	$189.5	$200.2	$816.8
Welfare Diversion	95.6	110.6	131.6	154.0	177.7	202.9	872.6
Child Protective and Welfare Services	13.6	13.3	13.8	14.3	14.8	15.3	85.2
Quality, Availability, Services Support	13.3	13.3	13.3	13.3	13.3	13.3	79.8
Administration	5.8	5.8	5.9	6.2	6.4	6.6	36.7
TOTAL Estimated Expenditures:	$199.5	$226.8	$281.0	$343.7	$401.8	$438.3	$1,891.1
Available Funds:							
Federal	$124.0	$131.9	$134.4	$138.9	$144.1	$148.2	$821.6
State (Non-Smart Start)	61.7	65.4	65.4	65.4	65.4	65.4	389.0
Smart Start	18.8	21.5	21.5	21.5	21.5	21.5	126.3
Smart Start Expansion	0.0	4.2	17.8	36.1	63.5	75.1	196.7
Transfer from TANF	0.0	3.8	41.8	71.2	96.5	104.5	317.7
TOTAL Available Funds:	$204.6	$226.8	$281.0	$333.1	$391.0	$414.7	$1,851.2
DIFFERENCE:	$5.1	$0.0	$0.0	($10.6)	($10.8)	($23.6)	($39.8)

Notes:

1) Estimated Expenditures include costs to subsidize children currently being served under federal CCDBG, federal Child Care Development Fund and SSBG, as well as children served under state subsidy funds and Smart Start. Anticipated additional demand for care in SFY 1996-97 through SFY 01-02 includes children expected to demand care due to Work First requirements, children eligible for care that are waiting to be served and children anticipated to demand care under new income eligibility limits.

2) Available Federal Funds assume North Carolina receives all mandatory (formerly FSA), matching (new), and discretionary (formerly CCDBG) funds authorized by the welfare reform bill. Additional funds may be reallocated to North Carolina if other states do not fully utilize their matching funds allocations. Also assumes continuation of current SSBG.

3) Available State Funds include $45.0 million in FSA match, $20.4 million in Non-FSA/Non-Welfare Reform and 30% of available Smart Start direct services funds (assumes expansion of Smart Start).

Summary of Projected Child Care Funding and Expenditures - December 1997 Projection
SFY 96-97 through 2001-2002

Based on Estimates of Welfare Reform Impacts and Governor's Goal 2000

Dollars in Millions

PROGRAM AREA	Actual 1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	SFY 1998-00
Estimated Expenditures							
Work First Related (Incl. Child Only)	$58.4	$65.9	$72.8	$80.5	$88.9	$98.3	$406.4
Welfare Diversion	94.6	157.3	192.7	230.0	269.3	310.8	1,160.1
Child Protective and Welfare Services	13.2	14.1	15.1	16.3	17.5	18.8	81.7
Quality, Availability, Services Support	11.2	14.2	16.5	16.7	17.6	17.9	82.9
Administration	1.8	5.2	5.9	6.2	6.4	6.6	30.3
TOTAL Estimated Expenditures:	$179.3	$256.6	$303.1	$349.5	$399.7	$452.4	$1,761.4
Available Funds:							
Federal	$124.0	$151.5	$132.6	$137.1	$142.2	$146.4	$709.8
State (Non-Smart Start)	61.7	62.5	62.5	62.5	62.5	62.5	312.7
Smart Start	18.8	21.5	21.5	21.5	21.5	21.5	107.5
Smart Start Expansion	0.0	4.2	17.8	36.1	63.5	75.1	196.7
Transfer from TANF	0.0	6.1	42.3	71.7	97.0	105.0	322.0
TOTAL Available Funds:	$204.6	$245.8	$276.7	$328.9	$386.7	$410.5	$1,648.7
Federal Funds Carried Forward	22.1						
DIFFERENCE:	$3.2	($10.8)	($26.4)	($20.7)	($13.0)	($41.9)	($112.7)

Notes:

1) Estimated Expenditures include costs to subsidize children currently being served under federal CCDBG, federal Child Care Development Fund and SSBG, as well as children served under state subsidy funds and Smart Start. Anticipated additional demand for care in SFY 1996-97 through SFY 01-02 includes children expected to demand care due to Work First requirements, children eligible for care that are waiting to be served and children anticipated to demand care under new income eligibility limits.

2) Available Federal Funds assume North Carolina receives all mandatory (formerly FSA), matching (new), and discretionary (formerly CCDBG) funds authorized by the welfare reform bill. Additional funds may be reallocated to North Carolina if other states do not fully utilize their matching funds allocations. Also assumes continuation of current SSBG (which was reduced in SFY 1997-98). Of $25.3 million in unspent funds shown in SFY 1996-97, $22 million in federal funds carried forward to SFY 1997-98 and $3.2 million in state funds reverted ($2.5 million of Smart Start and $.7 million in State non-Smart Start funds). TANF transfer amounts for SFY 1997-98 include funds to replace SSBG reduction in funding and $500,000 transfer for community colleges.

3) Available State Funds include $45.0 million in FSA match, $20.4 million in Non-FSA/Non-Welfare Reform and 30% of available Smart Start direct services funds (assumes expansion of Smart Start).

North Carolina Child Care Program
Breakdown of Children Expected to Demand Care

Total Eligible Children Not Currently Served	**209,100**
Number of Children Under 47% State Median Income	124,169
Number of Children Between 47% - 75% State Median Income	84,931
Total Of Eligible Unserved Population Expected to Demand Care	**155,738**
Number of Children Under 47% State Median Income	92,481
Number of Children Between 47% - 75% State Median Income	63,257
Total Current Number of Children Served	165,000
Total Children Expected to Demand Care	**320,738**
Less Children Served through Head Start/Chapter I	**291,791**

NOTES: 1) Assumes that 74.48% of unserved eligible children will demand care. This percentage represents historical propensity to demand child care in the AFDC population.
2) For purposes of estimating costs to serve children through DCD, children served with Head Start and Chapter I funding are removed from totals.

I. Total Expected Demand for Child Care (Assuming Phase-In)

Program Area	STATE FISCAL YEAR 1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
Work First Related	45,698	48,790	52,091	55,616	59,379	63,397
Welfare Diversion	79,962	125,711	148,754	171,558	194,108	216,386
Child Protective and Welfare Services	9,927	10,312	10,713	11,128	11,560	12,008
Total Demand for Care	**135,587**	**184,814**	**211,558**	**238,302**	**265,047**	**291,791**

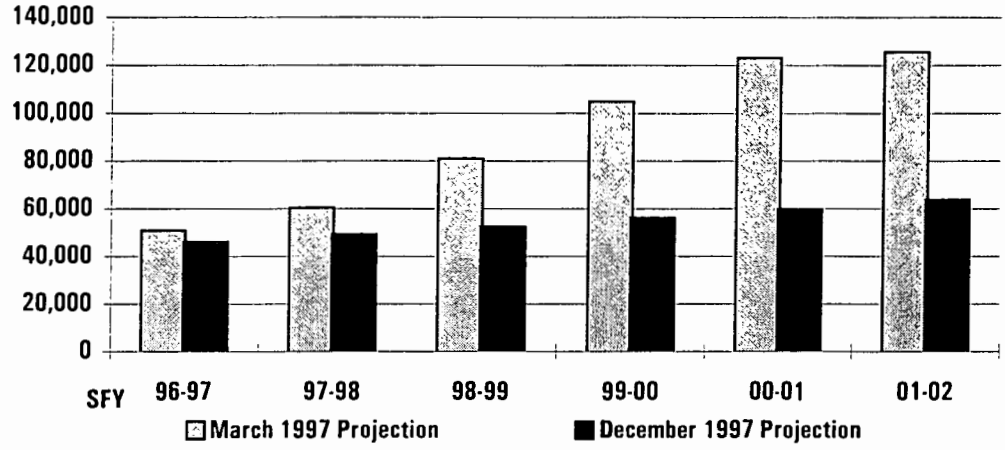
NOTES: 1) Assumes a constant annual increase in the number of children served from current levels of service to reach full demand in SFY 2001-02. This phase in is included to estimate the effects of a gradual influx of new populations into care. Additionally it will take time for child care capacities to grow to accommodate these new levels of demand.

II. Estimated Annual Cost Per Recipient

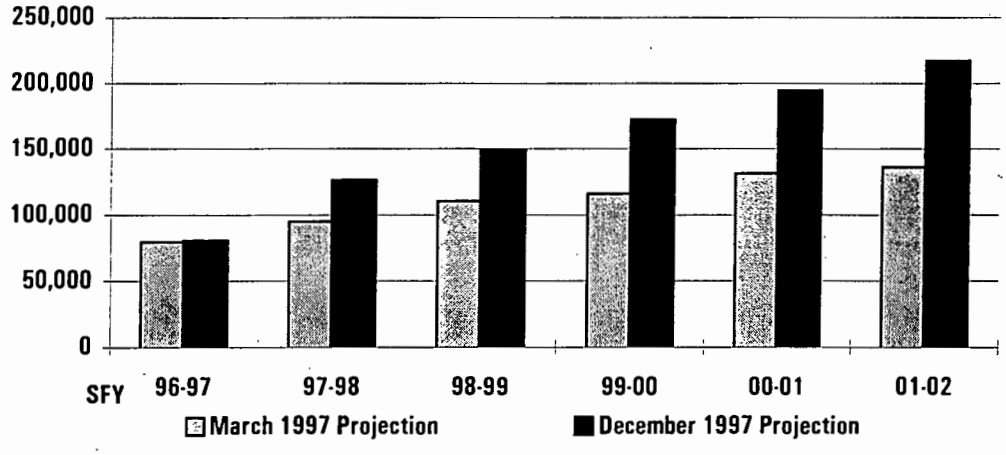
Program Area	STATE FISCAL YEAR 1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
Work First Related	$1,279	$1,351	$1,398	$1,447	$1,498	$1,550
Welfare Diversion	$1,185	$1,252	$1,295	$1,341	$1,388	$1,436
Child Protective and Welfare Services	$1,317	$1,363	$1,411	$1,460	$1,511	$1,564

Number of Children Projected to Demand Subsidized Child Care
March 1997 vs. December 1997 Projections

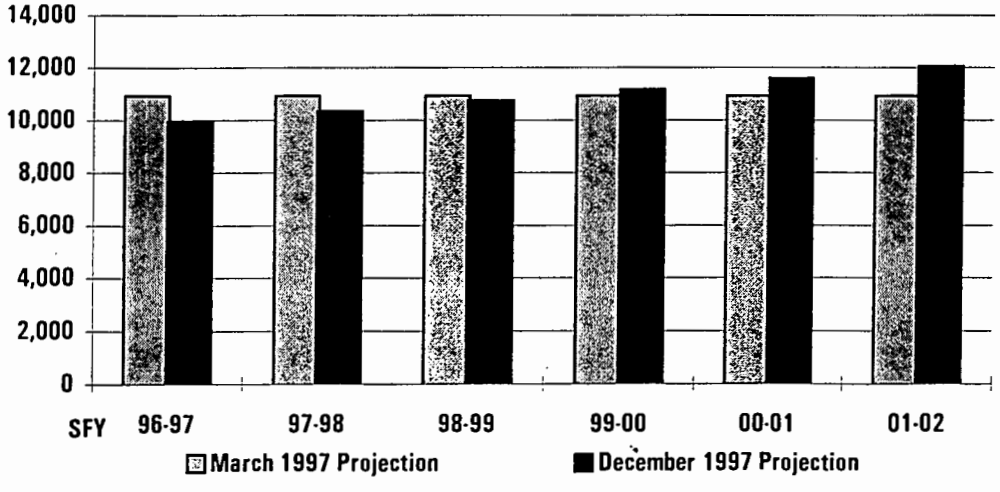
Children in Families Receiving Work First Cash Assistance



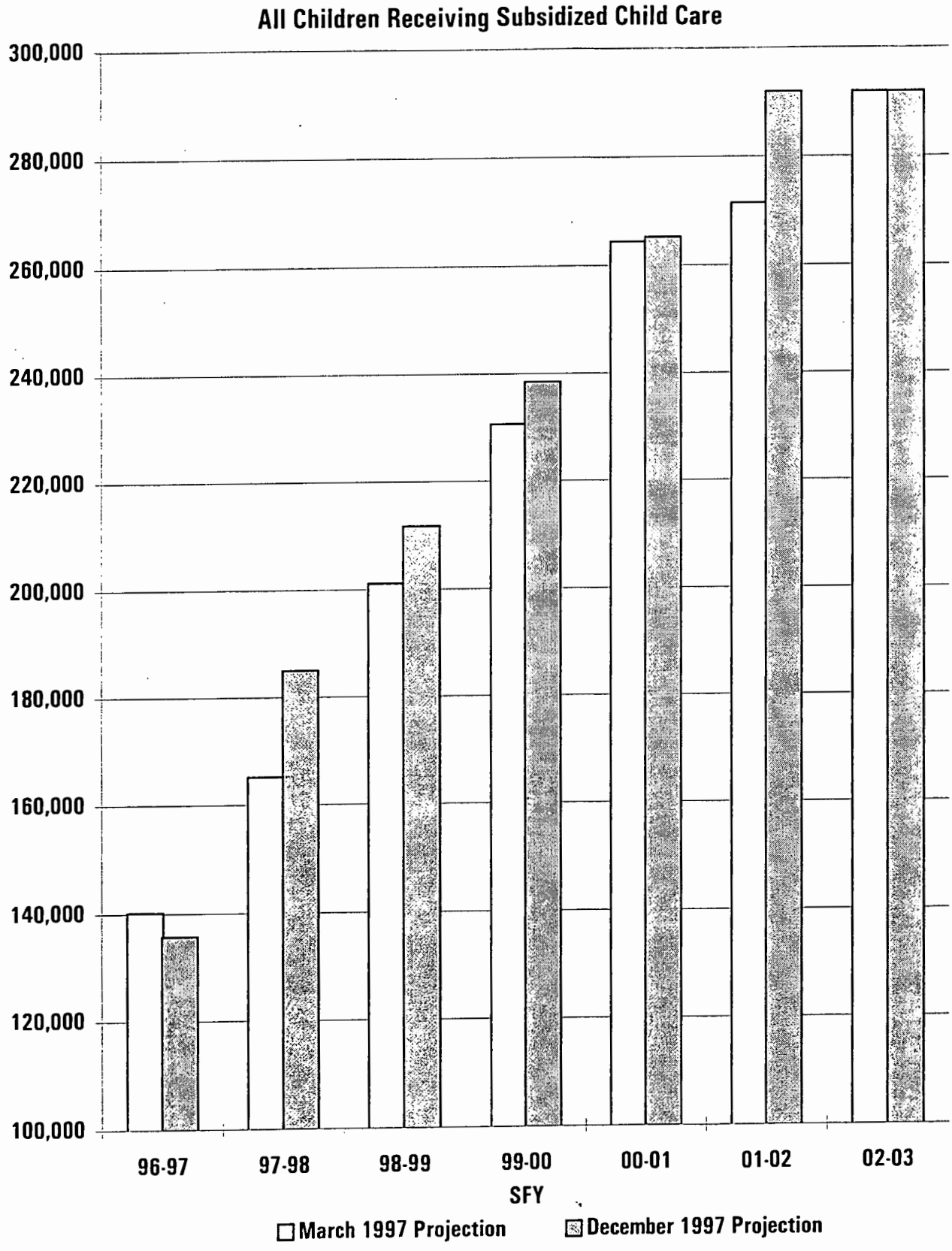
Children in Families Not Receiving Work First Cash Assistance



Children in Families Receiving Child Protective Services



Number of Children Projected to Demand Subsidized Child Care
March 1997 vs. December 1997 Projections



* Includes children served for reasons of Child Protective and Welfare Services.

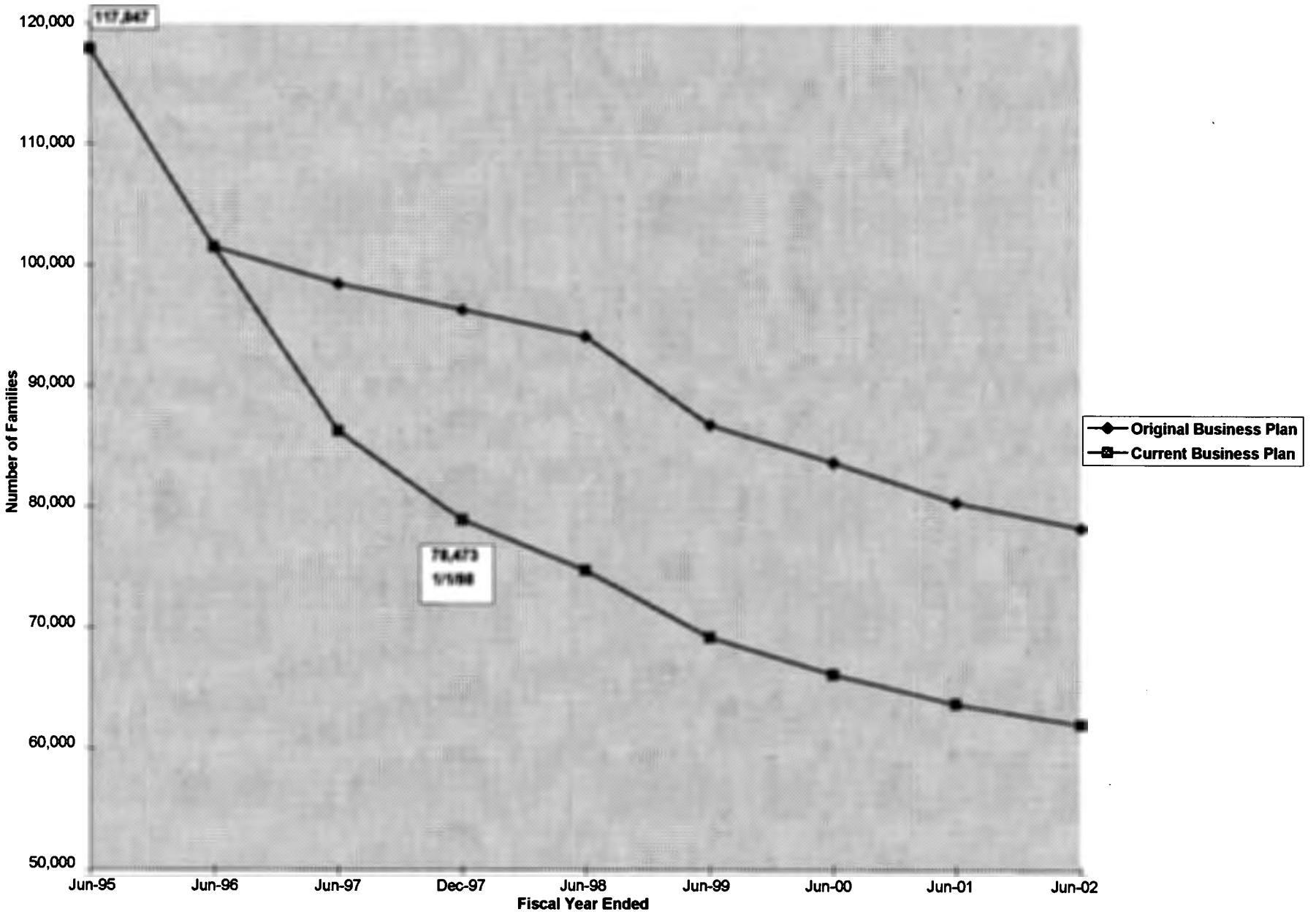
Note: March estimates did not assume serving all children in demand until SFY 2002-03.

1/21/98

DEPARTMENT OF HEA[illegible]AND HUMAN SERVICES
DIVISION OF [illegible]AL SERVICES

#18 Flowers
1-21-98

WORK FIRST CASELOAD:
COMPARISON OF ORIGINAL BUSINESS PLAN PROJECTIONS TO CURRENT ESTIMATES



DSS Budget Office
1/21/98

#19 Fitzgerald
1-21-98

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

CHILD WELFARE SYSTEM IMPROVEMENT INITIATIVES
Items Needed in Addition to Increases Approved by General Assembly in 1997

GOALS:	**Requirements**
NC System should meet worker/caseload standards in CPS and Foster Care/Adoptions	
Standards of 1:12 in CPS, 1:20 Foster Care/Adoptions, 1:5 staff:supervisor	**10,493,850**
To maintain adequate worker:caseload standards, NC system should effect culture change	
Grants to counties to hire time-limited staff (36) to work with DSS and local community to develop system changes designed to reduce length of stayand prevent 'backlog' (child in FC>1 yr.)	**2,137,686**
To attract and retain qualified staff, NC system should offer staff protection from lawsuits	
Professional liability insurance for county child welfare staff	**200,000**
To adequately serve children, NC system should ensure that staff are fully trained	
Training for child welfare staff before they're assigned a caseload	**967,442**
To provide adequate oversight of child welfare services, NC system should ensure intensive assistance when problems identified	
State oversight of corrective measures- Fatality Reviews/poor Biennial Reviews	**508,115**
To adequately protect children, NC system should involve communities	
Strengthen outreach capacity of Community Child Protection Teams	**250,000**
TOTAL FUNDING NEEDED TO ACHIEVE GOALS	**14,557,093**

March Estimate						
Estimated Expenditures	**1997-98**	**1998-99**	**1999-00**	**2000-01**	**2001-02**	
Subsidy	207.7	261.7	324.3	382.0	418.4	1,594.2
Quality, Availability, SS	13.3	13.3	13.3	13.3	13.3	66.5
Administration	5.8	5.9	6.2	6.4	6.6	31.0
TOTAL Estimated Expenditures:	**226.8**	**281.0**	**343.7**	**401.8**	**438.3**	**1,691.6**
Available Funds:						
Federal	131.9	134.4	138.9	144.1	148.2	697.6
State (Non-Smart Start)	65.4	65.4	65.4	65.4	65.4	327.2
Smart Start	21.5	21.5	21.5	21.5	21.5	107.5
Smart Start Expansion	4.2	17.8	36.1	63.5	75.1	196.7
Transfer from TANF	3.8	41.8	71.2	96.5	104.5	317.7
TOTAL Available Funds:	**226.8**	**281.0**	**333.1**	**391.0**	**414.7**	**1,646.6**

December Estimate						
Estimated Expenditures	**1997-98**	**1998-99**	**1999-00**	**2000-01**	**2001-02**	
Subsidy	237.3	280.6	326.7	375.7	427.8	1,648.2
Quality, Availability, SS	14.2	16.5	16.7	17.6	17.9	82.9
Administration	5.2	5.9	6.2	6.4	6.6	30.3
TOTAL Estimated Expenditures:	**256.6**	**303.1**	**349.5**	**399.7**	**452.4**	**1,761.4**
Available Funds:						
Federal	151.5	132.6	137.1	142.2	146.4	709.8
State (Non-Smart Start)	62.5	62.5	62.5	62.5	62.5	312.7
Smart Start	21.5	21.5	21.5	21.5	21.5	107.5
Smart Start Expansion	4.2	17.8	36.1	63.5	75.1	196.7
Transfer from TANF	6.1	42.3	71.7	97.0	105.0	322.0
TOTAL Available Funds:	**245.8**	**276.7**	**328.9**	**386.7**	**410.5**	**1,648.7**

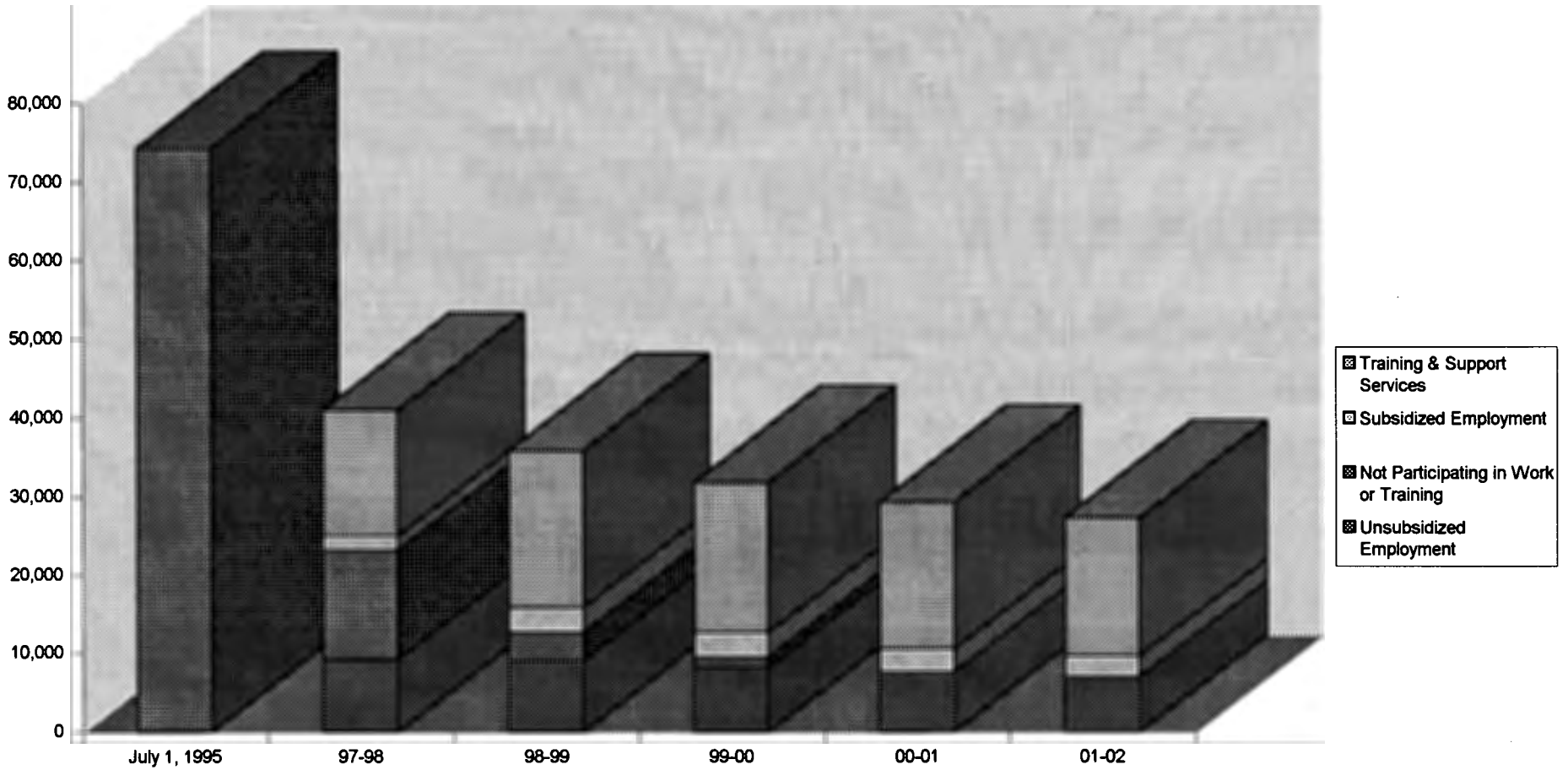
Change						
Estimated Expenditures	**1997-98**	**1998-99**	**1999-00**	**2000-01**	**2001-02**	
Subsidy	29.6	18.9	2.4	-6.3	9.4	54.0
Quality, Availability, SS	0.9	3.2	3.4	4.3	4.7	16.4
Administration	-0.6	0.0	0.0	0.0	0.0	-0.6
TOTAL Estimated Expenditures:	**29.8**	**22.1**	**5.8**	**-2.0**	**14.1**	**69.8**
Available Funds:						
Federal	19.6	-1.8	-1.8	-1.8	-1.8	12.2
State (Non-Smart Start)	-2.9	-2.9	-2.9	-2.9	-2.9	-14.5
Smart Start	0.0	0.0	0.0	0.0	0.0	0.0
Smart Start Expansion	0.0	0.0	0.0	0.0	0.0	0.0
Transfer from TANF	2.3	0.5	0.5	0.5	0.5	4.3
TOTAL Available Funds:	**19.0**	**-4.2**	**-4.2**	**-4.2**	**-4.2**	**2.0**

Total Current Deficit	**-10.8**	**-26.4**	**-20.7**	**-13.0**	**-41.9**	**-112.7**
Previous Deficit	**0.0**	**0.0**	**-10.6**	**-10.8**	**-23.6**	**-44.9**
Total Change	**-10.9**	**-26.4**	**-10.0**	**-2.2**	**-18.3**	**-67.8**
Change Due to						
Increased Subsidies	29.6	18.9	2.4	-6.3	9.4	54.0
Increased Q\A Set Aside Req.	0.9	3.2	3.4	4.3	4.7	16.4
Administration	-0.6	0.0	0.0	0.0	0.0	-0.6
Reduced Funding	-19.0	4.2	4.2	4.2	4.2	-2.0
Total Change	**10.9**	**26.4**	**10.0**	**2.2**	**18.3**	**67.8**

#17 Lewis
1-21-98

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

ACTIVITIES OF WORK FIRST PARTICIPANTS SUBJECT TO WORK REQUIREMENTS

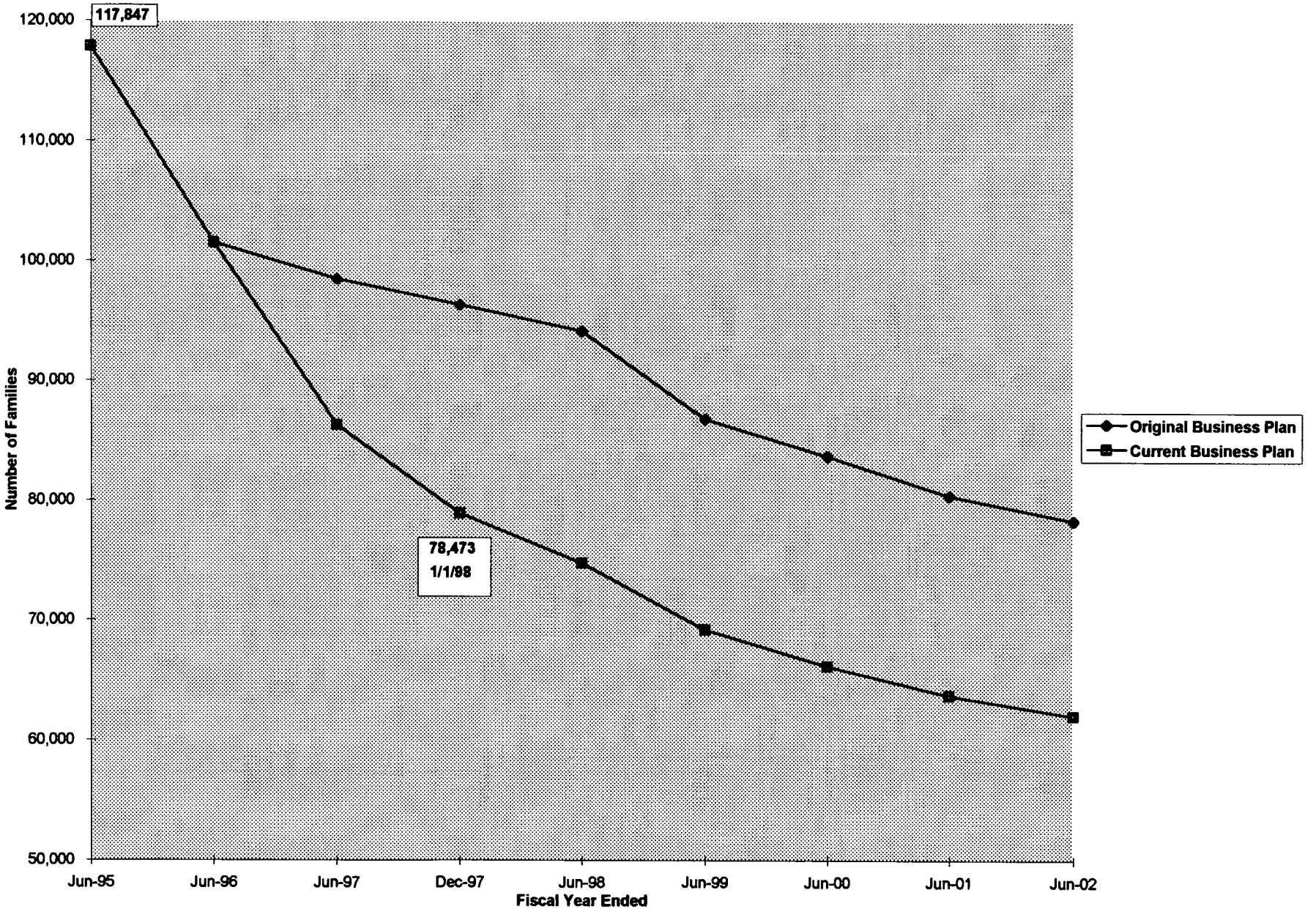


DSS Budget Office
1/21/98

DEPARTMENT OF HEA[redacted]AND HUMAN SERVICES
DIVISION OF[redacted]AL SERVICES

#18 Flowers
1-21-98

WORK FIRST CASELOAD:
COMPARISON OF ORIGINAL BUSINESS PLAN PROJECTIONS TO CURRENT ESTIMATES



DSS Budget Office
1/21/98

#19 Fitzgerald
1-21-98

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

SUMMARY OF PROJECTED CHILD WELFARE SYSTEM IMPROVEMENT FUNDING AND EXPENDITURES
INCLUDES INCREASES APPROPRIATED BY GENERAL ASSEMBLY IN 1997 SESSION
SFY 97-98 through SFY 2001-2002

PROGRAM AREA	STATE FISCAL YEAR 1997-98	1998-99	1999-2000	2000-01	2001-02	TOTAL
Estimated Expenditures:						
Improve County Staffing	10,462,774	19,863,233	19,863,233	19,863,233	19,863,233	89,915,706
Enhance State Oversight & Training	1,206,167	1,475,557	1,475,557	1,475,557	1,475,557	7,108,395
Foster Community Partnerships	250,000	250,000	250,000	250,000	250,000	1,250,000
TOTAL Estimated Expenditures:	11,918,941	21,588,790	21,588,790	21,588,790	21,588,790	98,274,101
Available Funds:						
Social Services Block Grant	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	6,500,000
Title IVE	5,482,755	10,889,623	10,889,623	10,889,623	10,889,623	49,041,247
Title IVE Training	335,921	513,712	513,712	513,712	513,712	2,390,769
County Funds	735,049	1,507,268	1,507,268	1,507,268	1,507,268	6,764,121
Tfr. from TANF		5,108,435	5,108,435	5,108,435	5,108,435	20,433,740
State Appropriations	2,269,752	2,269,752	2,269,752	2,269,752	2,269,752	11,348,760
TOTAL Funds Available:	10,123,477	21,588,790	21,588,790	21,588,790	21,588,790	96,478,637
Difference:	(1,795,465)	0	0	0	0	(1,795,465)

Note: Given 1st year start-up issues, we do not believe that the $1,795,465 shortfall in the first year will actually occur, since that number assumes ALL county staff are hired effective 12/1/97.

6 Steve Klein 1-21-98

Celebrating 80 Years of Dental Public Health in North Carolina



1918 - 1998

SEAL THE STATE in '98

80th ANNIVERSARY

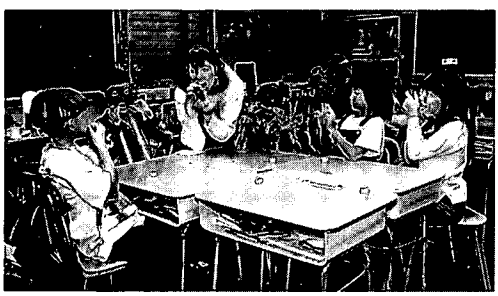
North Carolina
Department of Health and Human Services
Dental Health Section

Public Health in North Carolina -1998

1975 - General Assembly again approved a Preventive Dentistry Bill, adding additional staff for the field.
- Revision of NC public health laws required the state to provide residency training in dental public health.

1976 - **The Kellogg Foundation funded a follow-up epidemiological study of the Fulton-Hughes 60s survey, "Natural History of Dental Disease in North Carolina," to determine progress of the preventive activities.**

1977 - Kellogg study revealed much progress in reduction of dental disease, especially among schoolchildren over 15 years of age. Data also showed increase in reported amount of periodontal disease among some groups.
- General Assembly approved additional funds for dental public health staff.



Plaque Control

1979- Dr. George G. Dudney named Chief of the Dental Health Section.

1980- Preventive dental health workshops were held for Dental Board of Health members by NC Dental Society and dental public health staff.
- First edition of "Framework for Dental Health Education" for use by teachers was published and distributed.

1983 - The first statewide "Children's Dental Health Month Contest," was co-sponsored by the Dental Society, Public Instruction and Dental Public Health.

1984 - All staff dentists were trained in the application of the new occlusal sealants.

1985 - Dental public health was awarded three-year grant from the Kate B. Reynolds Health Care Trust to conduct a statewide oral health survey (the third since the 60s) and to develop 20 videocassettes for use by classroom teachers.

1986 - The General Assembly, with strong support from Dental Society leaders and others, approved a new bill to add positions to the field staff.

1987 - **Statewide School Oral Health Survey completed in May: 6,674 students from 292 schools examined by trained staff.**

1988 - Year-long 70th Anniversary Celebration, "Thanks for the Smiles," to report progress in preventive dentistry, recognize partners and plan ahead. Activities included: Statewide educational exhibits, State Fair exhibit, Pearson Foundation established to honor second director, and NC Symposium recommendations to continue public/private cooperation and recommendations for Division's program planning.

1989 - Dr. C. Jean Spratt named Chief of the Dental Health Section.
- Tooth Surface Index of Fluorosis (TSIF) epidemiological survey in Asheville pediatric dentistry practice found higher than expected levels of mild fluorosis.
- Division developed comprehensive Infection Control and Hazardous Materials manuals.
- American Dental Association selects "NC Super Smiles" as the first place winner of the Samuel D. Harris National Children's Dental Health Month State Program Award.

1990 - 70th Anniversary Symposium findings published in Journal of Public Health Dentistry, Volume 50, Number 2, Special Issue 1990.
- In its 25th year, the Residency Program is fully accredited by the Commission on Dental Accreditation of the American Dental Association.
- National Toxicology Program peer review process of fluorides in Research Triangle Park, NC reaffirms importance of the appropriate use of fluorides



Dear Public Health Friends and Colleagues:

We learn from pausing to examine where we are and how we got here. Dental public health in North Carolina has a rich and varied history that no other state can match either in terms of years of experience or effectiveness. This leads me to ask the question why? Certainly other states have the resources and the desire to improve the dental health of their citizens. To what do we owe 80 years of success for dental public health in North Carolina? I offer these few observations:

- ***United Front***
  From the beginning, improving the dental health of North Carolina citizens, particularly our children, was viewed as a common goal by all. Dentists, physicians, educators, parents, and business leaders worked together to start the dental public health program.
- ***Organizational Leadership***
  The North Carolina Dental Society, itself the first state dental society, and the State Board of Health provided the initial leadership to secure legislative support for an investment in dental public health. The current list of ongoing statewide supporters continues that tradition.
- ***Individual Leadership***
  We have been blessed with strong visionary leaders to guide us through the years. In many cases these state and national advocates for dental public health have come from outside dentistry.
- ***Scientific Basis***
  A strong partnership with our nationally recognized schools of dentistry and public health ensure that our programs and services are founded on the most current scientific evidence.
- ***Education***
  Each of the state's dental professional training programs and community colleges incorporate dental public health into their curriculum, assuring well informed practitioners.
- ***Work Force***
  And above all, North Carolina dental public health has a tremendous work force of committed and energetic state and local staff who make the difference.

We have cause to celebrate our accomplishments; however, our work is not complete. We still have children with preventable dental disease. We still have children with untreated dental problems who do not have access to care. And we still have families who don't benefit from dental sealants or fluoridated drinking water. Fortunately, we also still have the best family of dental public health partners in the world to help us solve these problems.

Thank you to all those people who have helped us get where we are today. I am proud to be a part of dental public health in North Carolina and look forward to continuing the tradition of excellence.



J. Steven Cline, DDS, MPH, State Dental Director

1918 - Celebrating 80 Years of Dental

1960 - **Scientific survey of dental disease in North Carolina, mapped by Drs. John T. Fulton and John T. Hughes was the first comprehensive dental survey in the nation. Data became basis for all future dental health planning.**

- With a US Public Health Service grant, Dr. Pearson employed a trained health educator, Rebekah S. Bowden, to organize 36 statewide oral cancer seminars.

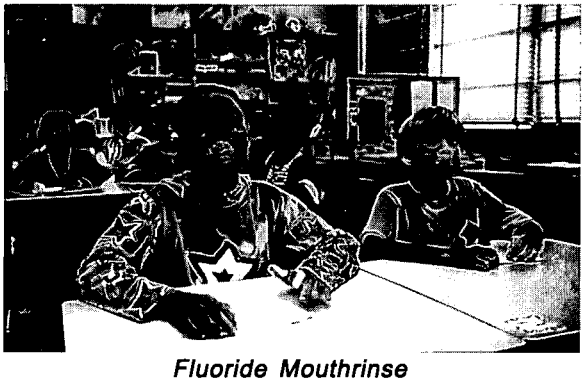
1965 - The Dental Public Health program established a Dental Public Health Residency training program, one of the first in the country.

1966 - Following a national fluoridation conference, North Carolina held its own conference in Greensboro to give momentum to community fluoridation.

1969 - The North Carolina Citizens Committee for Dental Health was established. It lobbied successfully for funds from the Legislature to match local funds to buy fluoridation equipment.
- The rural school water system fluoridation program began.

1971 - Research identified a new, previously unknown enemy of dental health – plaque – and produced methods for combating the problem.
- The NC Dental Society passed resolutions advocating a strong preventive dental program.
- A Task Force for Community Preventive Dental Health Education was established by the Dental Society, with representation from the Society, dental public health, community college training auxiliaries and UNC School of Dentistry.
- All dental public health personnel were trained in plaque control and directed to initiate plaque control programs in health departments.

2 - Preventive dentistry (plaque control) workshops were conducted across the state by the task force for all North Carolina dentists and their auxiliaries.
- Dental public health employed its first four dental hygienists to teach preventive dental health in counties.
- Home Economics Extension agents and club leaders were taught the new preventive techniques in regional sessions.
- First countywide fluoridation program started in Anson County.
- NC Dental Public Health was awarded the American Dental Association's *first* Preventive Dentistry Award.
- First fluoride mouthrinse program started in Robeson County schools.

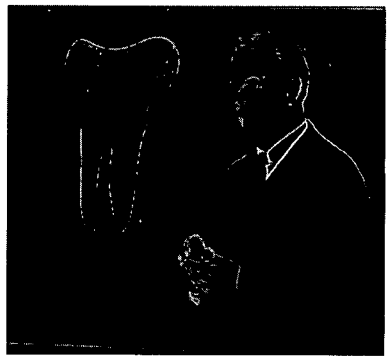


Fluoride Mouthrinse

1973 - A 10-year plan designed to reduce dental disease by specific percentages and using a variety of approaches was launched by the NC Dental Society, dental public health and allied agencies and institutions.
- General Assembly passed a Preventive Dentistry Bill providing extra funds for rural school water fluoridation and employment of more dental hygienists.
- Encouraged by dental society leaders, Public Instruction agreed to a new, much stronger, preventive dental program for the schools. The resulting coalition of dental, educational, and public health formed the Steering Committee for Preventive Dental Education in North Carolina schools.

4 - "A Teacher's Guide to a Preventive Dental Health Program in North Carolina Schools" was developed by dental public health.

Ernest A. Branch, DDS
Director, NC Division of Oral Hygiene (1929-1958)
"Education is putting into practice today what we learned yesterday with hope that it will become a habit tomorrow."

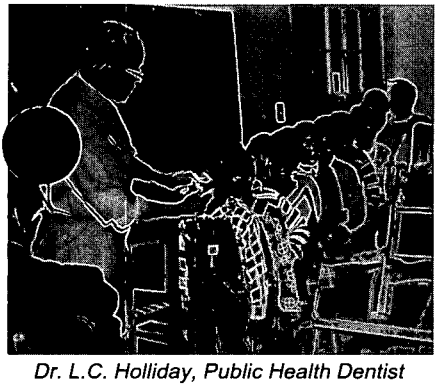

Dr. Ernest A. Branch

[redacted]Pearson Jr., DDS, MPH
[redacted]NC Dental Health Section (1959-1979)
"I am thrilled we were able to convince the Legislature and the NC State Board of Dental Examiners of the importance and the effectiveness of community-based dental public health hygienists."

George G. Dudney, DDS, MPH
Chief, NC Dental Health Section (1979-1988)
"No disease was ever eradicated by a treatment program alone ... prevention, prevention, prevention."

Carle W. "Woody" Mason, DDS
President, NC Dental Society (1996-1997)
Member of the original NC Preventive Dentistry Committee
"The Division of Dental Health has had tremendous impact on the health of the citizens of North Carolina. The North Carolina Dental Society has been a proud partner from the start."

Bruce Warlick, DDS
NC Dental Society Chairman, NC Steering Committee (1977-1991)
"The deeds have been done beautifully by Dental Public Health but the story has not been told sufficiently. Dental Public Health needs to toot it's own horn."


Dr. L.C. Holliday, Public Health Dentist

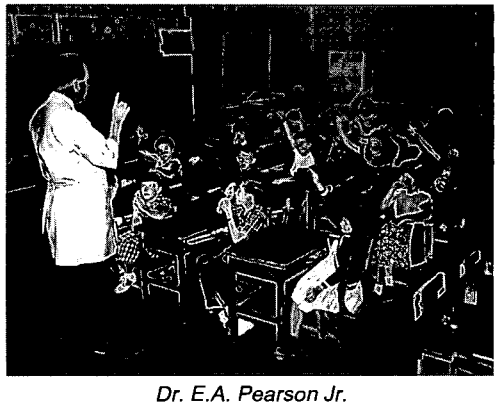
James W. Bawden, DDS, MS, PhD
Alumni Distinguished Professor, UNC Dept. of Pediatric Dentistry (1961-present)
"North Carolina Dental Public Health has made enormous contributions to the health and well being of not just our citizens but populations all over the world. No other state has anything close to the comprehensive long-term knowledge of dental disease patterns in their population."

George Shackelford, MEd
Department of Public Instruction (1964-1989)
Chief Consultant - Health Education
"From the beginning the North Carolina Department of Public Instruction has recognized the importance of our relationship with dental public health. Teachers all across North Carolina depend on dental public health staff to support their work."

Becky S. Bowden, BSPH, MPH
Health Educator, Divison of Dental Health (19 years)
"The secret to the success of Dental Public Health in North Carolina has been the dedication of many persons and a feeling that there is no limit to the good a program can do if those involved don't care who gets the credit."

Lucretia Montgomery
Community Advocate, NC Committee for Dental Health (1984-1993)
"I have always believed in service to my community. As a citizen volunteer, I can say North Carolina Dental Public Health has always delivered on that score."

Jacob Koomen, MD, MPH
Former State Health Director (1966-1978)
"[redacted]my childhood I was taught [redacted]od dental health is an important part of good general health. As state health director I felt privileged to be associated with one of the greatest dental public health programs in the nation."


Dr. E.A. Pearson Jr.

1856 - First state Dental Society in the nation founded in North Carolina.

1877 - North Carolina's State Board of Health established.

1908 - First scientific paper on need for dental education of schoolchildren presented to the North Carolina Dental Society.

1910 - A permanent Oral Hygiene Committee established by the Dental Society.

1918 - Dr. George Cooper, State Board of Health, urged NC Dental Society to action on behalf of acute dental needs among schoolchildren; he also added oral hygiene to the public health agenda.
- Dental society endorsed dental health program for schools and sought special funds from the Legislature.
- Cooper employed six dentists and six nurses to work in the schools.

1919 - First dentist, Dr. E.J. Tucker, appointed to the State Board of Health.



First Public Health Dent

1921 - First dentist employed to work for State Board of Health at state level – Dr. J.C. Johnson (served until 1928).
- Purpose of dental program in the schools was fixed: Relief of pain and suffering and education on good dental health.

1929 - Ernest A. Branch, DDS, became the State Supervisor of Oral Hygiene.

1931 - Division of Oral Hygiene created by the State Board of Health – first in the nation.
- State law passed placing a private dentist on all local boards of health.

1934 - A "Mouth Health Survey" conducted by NC Dental Society. Of those surveyed, 54.3% had never seen a dentist.

1935 - Dr. Branch started the famous Little Jack Puppet Show which for 30 years visited schools all over the state educating students on dental health.



Little Jack Puppet Show

1936 - The Institute of Public Health Dentistry was established in the UNC School of Medicine, another national first, for training dentists working in public health.

1941 - New building for oral hygiene, with equipment to process dental health education materials, built on the State Public Health campus.

1949 - Charlotte, NC was the first city in the state to fluoridate.

1950 - UNC School of Dentistry was established.
- Federal grants made available to match North Carolina funds to employ dentists in more counties.

1959 - Ernest A. Pearson Jr., DDS, MPH, succeeded Dr. Branch as State Dental Director.

1991 - 1986-1987 North Carolina School Oral Health Survey Monograph published and distributed nationally. Major findings included: Caries decline continues; 80% of decay filled; 85% of remaining decay is pit and fissure; sealants underutilized; 80% of remaining decay in 25% of North Carolina children.
- Division clinical resources dedicated entirely to prevention with emphasis on sealant promotion projects available to every county.

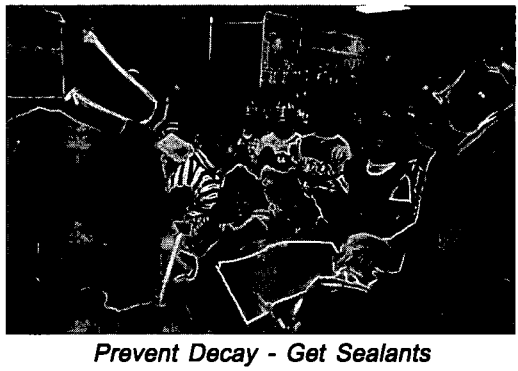
1992 - A series of traveling dental health educational exhibits was developed covering 10 topics. All 10 topics were available in 13 locations across the state.
- Dental objective included in the Healthy Carolinians 2000 Statewide Coalition: "Increase the percentages of children and youth whose permanent teeth are free of dental decay."

1993 - Piloted program to loan division dentists to local public health clinics on a short term basis to assist local programs with their financial viability.
- NC Dental Society Access to Care/Medicaid Liaison Committee was established with division representation.
- Five part sealant initiative began with emphasis on: 1) School-based sealant demonstration projects, 2) Sealant exhibits, 3) Media campaign, 4) Public-private sealant projects, and 5) "Ask Us About Sealants" point of purchase campaign.

1994 - Residency project involved a scientific study to evaluate the effectiveness of the school water fluoridation (SWF) and fluoride mouthrinse (FMR) programs.
- Based on study results, school water fluoridation program discontinued.

1995 - North Carolina held a national symposium on the current issues of fluoride action, effectiveness and utilization.
- Madison County Oral Health Intervention Project, designed to evaluate effectiveness of sealant program in a "real life" public health setting, demonstrated that targeting first and second graders as well as high-risk children increased effectiveness of sealants.
- Standardized dental screening techniques developed to provide statistically valid assessment of decayed and filled teeth within each county.
- Statewide sealant media campaign initiated. Two PSAs produced and all staff trained in using the media.

1996 - Dr. Steve Cline named as State Dental Director.
- Statewide implementation of calibrated K and 5 dental screening assessment.
- Division conducted Community Dentistry Workshop on how to develop local dental clinics.
- Boards of Health workshops on sealant program conducted throughout the state to assist local board of health members, dentists and health directors.
- Statewide task force on Dental Care for Children organized by Division and North Carolina Dental Society.

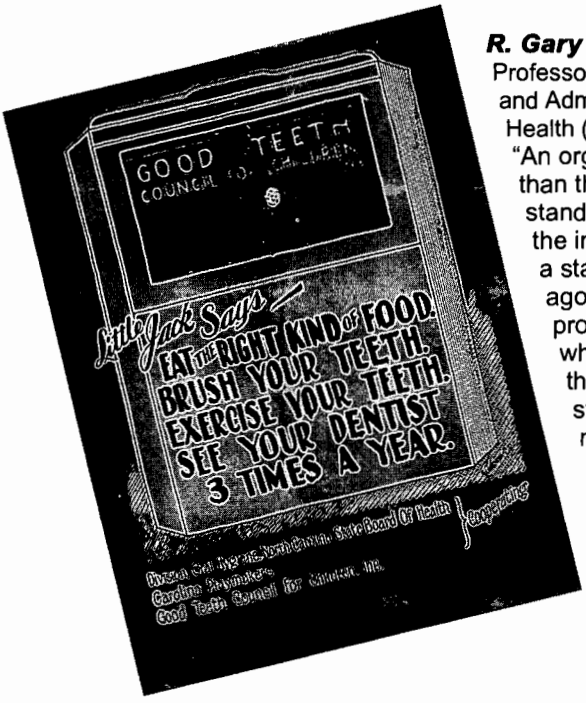


Prevent Decay - Get Sealants

1997 - NC Dental Practice Act amended to allow private not-for-profit health care facilities serving low income populations to operate a dental practice.
- Last major community water system fluoridated in Hendersonville, NC.

1998 - Seal the State in '98: Dental Public Health 80th Anniversary observance is a statewide sealant initiative to prevent decay through increased utilization of dental sealants.
- January 8-9: National "Seal the State in '98" Symposium.
- February 6: Community-based sealant projects conducted in every county of the state.

Annual Dental Public Health Services	
Population drinking fluoridated water	4,009,043
Students participating in fluoride mouthrinse programs (K-6)	279,381
Schools with mouthrinse programs	665
Number of teeth applied with sealants	15,651
Number of schoolchildren screened using K-5 Assessment	152,159
Number of counties served by dental public health dentist and/or hygienist	100
Number of children who received dental educational services	272,447
Number of individuals viewing dental public health exhibits	61,285
Adult Educational Services (educators, health care providers, adult consumers)	36,561
Total number of educational materials distributed	over 600,000



R. Gary Rozier, DDS, MPH

Professor, Department of Health Policy and Administration, UNC School of Public Health (1976-present)

"An organization is not more or less than the people who work in it. We all stand on the very broad shoulders of the individuals who had the vision of a state dental program over 80 years ago when no prototypes for such a program existed in the nation, and who over the years saw to it that through their dedication and steadfast adherence to the mission of improving the health of the public that the North Carolina dental public health program became not only the first program in the nation, but the very best. We all owe a debt of gratitude to these many individuals."

Acknowledgements

Thank you to the many friends and colleagues of North Carolina Dental Public Health who contributed their thoughts and ideas to this publication.

This document was printed in memory of Dr. E.A. Pearson Jr., State Dental Director 1959-79, through a generous contribution from his family.

NC Department of Health and Human Services
Division of Community Health
Dental Health Section



SEAL THE STATE IN '98

It's happening on February 6, 1998.

"My hat goes off to the hundreds of concerned citizens and dental professionals willing to volunteer their time and energy to improve the oral health of North Carolina children."

--Rev. Franklin Graham, Honorary Chair

Seal the State in '98 is a coalition of public and private community volunteers working together to provide 98,000 dental sealants for children in every county across North Carolina.

Who: *Volunteer dentists, dental hygienists, dental assistants, school personnel, community volunteers and child health advocates.*

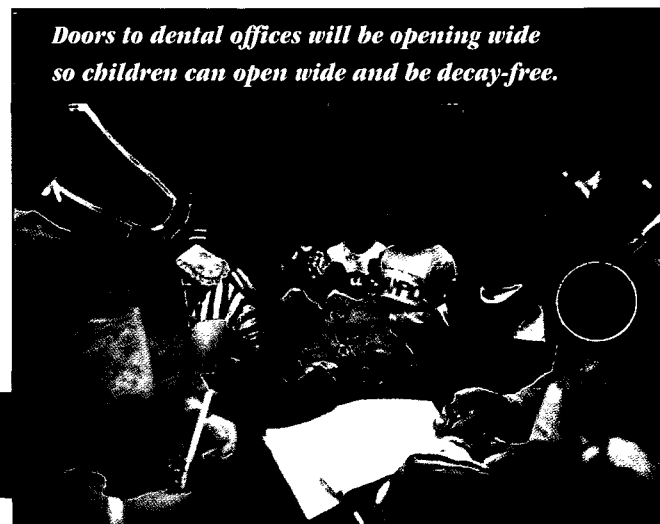
What: *Free dental sealants*

When: *February 6, 1998*

Where: *Participating public and private dental offices in every county of the state*

The impact of ***Seal the State in '98*** will go far beyond February 6, 1998. Many of our children may grow up decay-free because of this day. But equally important, it demonstrates the tremendous impact of dental professionals and community leaders working together to improve oral health.

Doors to dental offices will be opening wide so children can open wide and be decay-free.



The purpose of *Seal the State in '98* is to prevent decay through the increased use of dental sealants. Sealants are thin plastic coatings brushed on the chewing surfaces of teeth. Sealants can prevent more than 80 percent of dental decay in children. Sealants are underutilized in North Carolina. Only an estimated 26 percent of North Carolina children have sealants on their permanent teeth. Approximately 65 percent of school-age children need them.*

**(1986-87 School Oral Health Survey)*

SEAL THE STATE in '98 80th ANNIVERSARY

PREVENT DECAY - GET SEALANTS

Celebrating 80 Years of North Carolina Dental Public Health

In 1998, North Carolina is celebrating the 80th Anniversary of dental public health. We have the oldest state dental public health program in the U.S. Our program began in 1918, at the urging of the North Carolina Dental Society and the North Carolina State Board of Health. The primary purpose then was to provide relief of pain and suffering and provide education on good dental health.

Throughout its history, dental public health has responded to the dental health needs of N.C. citizens by:

- ***conducting surveys, assessments and studies on dental conditions***
- ***providing dental health education to schoolchildren and adults***
- ***providing preventive dental health services to schoolchildren including fluorides***
- ***improving access to dental care***

Today, there are state and local dental public health professionals working in every county in North Carolina. In 1998, we will celebrate the 80th Anniversary with special events throughout the year including:

Celebrating 80 Years: Seal the State in '98 Symposium will be held on January 8-9, 1998 in Greensboro, NC. State and national leaders in dental public health will come together to recognize our accomplishments and plan our strategy for the next decade.

Statewide Sponsoring Organizations for Seal the State in '98 include:

- *Healthy Carolinians*
- *North Carolina Academy of General Dentistry*
- *North Carolina Academy of Pediatric Dentistry*
- *North Carolina Association of Local Health Directors*
- *North Carolina Citizens for Public Health, Inc.*
- *North Carolina Committee for Dental Heal*
- *North Carolina Dental Assistants Associat*
- *North Carolina Dental Health Section*
- *North Carolina Dental Hygiene Association*
- *North Carolina Dental Society*
- *North Carolina Department of Public Instruction*
- *North Carolina Public Health Association*
- *North Carolina Public Health Association, Dental Health Section*
- *North Carolina Society for Public Health Education*
- *Old North State Dental Society*
- *Oral Health America*
- *UNC - School of Dentistry*
- *UNC - School of Public Health*

For more information or to get involved, contact your local health department or :

Seal the State in '98 Headquarte
N.C. Citizens for Public Health
c/o N.C. Dental Health Section
PO Box 29598
Raleigh, NC 27626-0598
Phone (919) 733-3853

#5 Steve Klein 1-21-98

SEAL THE STATE IN '98



It's coming to cities and towns across North Carolina on February 6, 1998

SEAL THE STATE in '98
80th ANNIVERSARY

N.C. Dental Public Health

Joint Appropriation Subcommittee on Human Resources

Minutes
January 22, 1998

The Joint Appropriations Subcommittee on Human Resources met with the Joint Appropriations Subcommittee on Natural and Economic Resources on Thursday, January 22, 1998 in Room 643 LOB at 9:00 a.m. The NER Subcommittee Chairman Rex Baker presided. 4 Senators were present and the following members of the Joint Appropriations Subcommittee on Human Resources were present:

Representative Watson	Representative Aldridge
Representative Earle	Representative Adams
Representative Nye	Representative Hurley
Representative Julia Howard	Representative Esposito
Representative Cansler	Representative Gardner

The Fiscal Staff consisting of Karen Hammonds-Blanks, Carol Shaw, and Mary Ellen Sylvester was present as was the legal staff, Gann Watson and Dianna Jessup.

Welfare to Work Status

Rick Carlisle, Acting Secretary of the Department of Commerce, spoke on the status of the "Welfare to Work" program. He explained the congressional legislation targets the hard to serve among the welfare population who have multiple barrier problems. In North Carolina this population is about 20% of the welfare recipients. The federal guidelines for the "Welfare to Work" program issued in September/October, 1997, provided requirements for structuring applications and for waiver requests. The waiver requests guidelines were:

1. no waiver for any areas smaller that federal service delivery areas for the JTPA program.
2. no statewide or blanket waiver permitted.
3. Workforce Development Boards or Private Industry Councils are the presumptive deliverers of service.

Due to the tension caused by the differences in the special provisions in the budget and the federal guidelines, the department convened the affected parties in November to come up with a compromise. They agreed to develop an application that would set up a local planning and allocation process with the Job Services Employer Councils and the local TANF agency, DSS, as full partners in planning for services at the county level. While abiding by the federal requirements, they submitted a waiver that set up a process at the local level whereby the counties could select the Job Services Employer Councils or another entity of their choice instead of the Workforce Development Boards as deliverers of services. No money can be expended until the General Assembly approves the plan.

Representative Carpenter asked why the waiver requested by the General Assembly was not pursued. He thought the Executive branch was not cooperative. Mr. Carlisle said the Feds were consulted about interpretation of the waiver guidelines, and there was no purpose to sending a waiver request that did not meet those federal guidelines.

Representative Gardner said she didn't know what region or agency is representing her county, and no one has gotten in touch with her. Mr. Carlisle assured her the information would be

forwarded to her. The Workforce Development Board have been asked to submit this information directly to members of the Joint committees and the chairs of the Joint Public Assistance Committee, according to Mr. Carlisle.

Representative Hall asked about accountability in the job training program and how the legislature is to know what progress these people are making. Mr. Carlisle promised a report on the recipients' progress. He said most of the services are post employment services which require the recipient have to get a job to get the services.

Representative Howard asked for an explanation of the JSEC (Job Services Employer Councils) where they are located and their focus. She asked about the difference in the cost of the JSEC program and the Workforce Development Board. Also, she wanted to know which has the highest overhead costs and how much goes to the client. Mr. Carlisle said he did not have that comparison but the way the structure is set up 85% of the funds go directly to service for the client on the local level, 15% retained by the state. 15% can be held back for administration costs.

Representative Weatherly said, according to a past study commission, the Employment Security Commission was charged with the responsibility to monitor the training program and wanted to know the status. Mr. Carlisle said a commission has been working on oversight but is not sure whether it was fully operational.

Representative Aldridge complained that the committee members are told often that presenters don't have the information requested and the information will be forthcoming, but it never happens.

Representative Gardner said she wants to know specifically who the members of COG are in her area. She wants to know how they are chosen in each and everyone, and how many there are. She wants specifics on their accomplishments. Since there are no strings on this money, she expects accountability on their part. Mr. Carlisle assured her she would get this information.

Representative Hall wants a county by county listing of who has taken part in that service, how many completed it and how many are working. He wanted the numbers clarified so the same person isn't being counted more than once for the same service. He said the committee needs to know what they are getting for the money.

Ms. Pheon Beal, Chief of Economic Independence of the Division of Social Services in the Department of Health and Human Services, spoke on the Welfare to Work Status. She delineated the population of those eligible for the Welfare to Work funds.

Representative Carpenter characterized hard core cases as those who don't like to work and asked for a definition of "no fault of their own". Ms. Beal said a client who has cooperated with his counselor, taken a job and complied with the requirements but doesn't have a job is so designated. He wanted to know the statistics on the status of the "hard to place". She said they don't have in their information systems a way to track specifically this population now but are working into the system the information that will allow the division to track them.

Representative Mitchell wanted to know how they can identify drug users. Case managers usually find out after they have been placed in a job, according to Ms. Beal. He wanted to know if benefits could be cut off immediately. She said there is an escalating scale of sanctions. There are plans to change this system under the new program.

Representative Howard said that Ms. Beal has been very responsive to the legislative oversight committee which is concerned that state money can be used to extend benefits beyond the 5-year clock. Although the state has been operating the Work First program under Executive order, the legislature can make changes during the short session, according to Representative Howard.

Senator Clark asked what the amount of funds is that clients are receiving in addition to the $272 a month in the Welfare to Work Program. Ms. Beal said that some of them were receiving child care assistance, food stamps of about $140 a month, about 30% are receiving child support, about 24% are getting a housing subsidy and those with wages are getting the earned income tax credit. Representative Culp asked if seasonal work is considered full employment under the Work First program, and Ms. Beal said, yes, with some conditions.

Senator Horton moved "to resolve that it is the sense of the Subcommittees that the Governor should submit a request for a waiver to the Department of Labor to the end that the Employment Security Commission will handle all Welfare to Work Funds." Representative Baker noted there would not be a formal vote taken because of the nature of the meeting, but the Chair did not object to a sense of the Subcommittee being expressed. The motion was passed by a show of hands, 19 in favor of the motion and 7 against. The Chair noted the sense of the Subcommittees on this issue will be passed on the Department of Commerce

Administrative Cost Associated with Transferring Health Functions to DHHS

Carol Shaw of the Fiscal Staff gave the summary of the results of the negotiations with DENHR and DHR for the positions allocated and how they would be paid for. (See Handout #1, "Results of Negotiations.) The Department of Heath and Human Resources expressed a need for more 14 1/2 positions for administration to the State Budget Office.

Representative Gardner said they were told there would not be any cost to transferring Health divisions to the Department of Human Resources. Representative Cansler asked how many employees were transferred in the beginning when health was put into DEHNR and how many employees were transferred in the present change. Jim Edgerton said they asked for 28 positions back, and they received 14 1/2. (See Handout #2, "Allocation of Administrative Services Fund 1146.) Now they need an additional 14 1/2. Mr. Reel of the State Budget office said that they recommended the departments split the difference, in response to Representative Owen's question. Senator Cochrane asked for these figures in writing, and Mr. Edgerton will get that to the committee. Mr. Edgerton said that not all of the positions had been filled. Senator Forrest said it was wrong of the department to hire the additional people without the approval of the legislature and pledged his support to remove them. Representative Carpenter voiced his support of Senator Forrester's position.

Senator Cochrane asked Carol Shaw about the $500,000 study of DHR and was told the transfer was not a part of that study. Karen Hammonds-Blanks said what the department did in the transfer was not impacted at all by the study.

Representative Baker said that 69 employees were transferred to DEHNR in 1989, 28 were transferred back to DHHR and wanted to know what happened to the 41 employees missing in this equation. Henry Lancaster, Deputy Secretary of the Department of Environment and Natural Resources, said that between 1989 and 1992 there was a significant reduction in the workforce which were taken out of the administrative divisions. The change in the decentralization of the department to centralization affected the number. Mr. Lancaster cannot give the assurance that the 41 are not still employed, and he agreed to take a look at that.

Senator Bob Martin recollected that the cuts that were made in DENHR were in the Forestry Division and asked for a list of the health personnel cuts. Mr. Lancaster said he was referring to a later round of cuts in 1991 and said he would identify for Representative Martin the cuts that were made going back to 1991

Representative Baker asked Ms. Linda Sewell, Director of the Environmental Health Division, for confirmation that Environmental Health was staying in Natural Resources and she explained that the legislation moving the Health services to Human Resources specified that Division of Environmental Health would stay in the Department of Environment and Natural Resources for a year while the Environmental Review Commission (ERC) studied it. The ERC is to make a recommendation at its next meeting as to where these programs will end up. Most of them will likely go to Health, according to Ms. Sewell. Representative Baker wanted to know how many positions were transferred when Environmental Health was moved into DENHR. She did not know, but will get that information for him. The division has expanded a great deal, according to Ms. Sewell. Representative Baker was concerned that the move would incur costs like the Health services. In answer to Representative Baker inquiry, staff replied that the committee was not specifically requested to provide any positions relating to the transfer of the Health divisions to the Department of Human Resources.

Senator Cochrane said it was unacceptable that the State Budget Office would give a department the idea it could go out and to hire 63 people without the approval of the legislature. Mr. Reel of the Office State Budget and Management said he couldn't respond to the 63 positions. However, when the decision was made to put a negative reserve in the budget to accomplish the transfer of Health services, it was not one was that was intended to fly in the face of the General Assembly or to go beyond the authority of the Executive Budget Act. The negative reserve represents a budget neutral action, and, in the end, no more funds will be spent than were appropriated by this body, according to Mr. Reel. The agencies have to go back and find continuing funds to fund to support the action of the transfer.

Nina Yeager said the legislature endorsed a proposal to limit the expenditures of Medicaid to 8% growth rate over the next 4 years. As a consequence of that decision and the tremendous growth in Medicaid expenditures, the SBO has been working with DMA on their needs. They have made a strong case for these 63 positions resulting in cost savings. The Executive Budget Act and Appropriation Bill gives SBO the responsibility and the authority to look at what is an efficient and effective administration of the program. She thinks that the new positions will be approved but will be glad to review this decision with the committee. Senator Cochrane encouraged the chairman of the two subcommittees speak with the House Speaker and the Senate

Pro Temp about the appropriateness of seeing to it that issues such as these come before the Gov. Ops. Committee when the General Assembly is not in session. Senator Bill Martin requested that information about these kind of requests be made available in advance to avoid the type of concerns that have been expressed by the members. Senator Cansler suggested that since the legislature will have to come up with the money to continue to fund these positions, the departments consult with us before they add them. Representative Carpenter asked the Department what it would cost just to put the Health services back in DENHR. Mr. Edgerton assumes the 14 1/2 positions wouldn't be needed in that case.

Joint Appropriations Subcommittee on Human Resources
Senator Bill Martin told the members of the Joint Appropriations Subcommittee on Human Resources that the items left on the its agenda will be addressed at the February meeting.

Administration of Environmental Health Programs
Mona Moon, Analyst in the Fiscal Research Division, gave an explanation of the budgetary impact of the administrative transfer of the Environmental Health Programs. (See Handout #3, "Department of Environment and Natural Resources.)

The meeting was adjourned.

Barbara R. Hocutt, Clerk

Senator Bill Martin, Chairman

WNM/brh

VISITOR REGISTRATION SHEET

H. Approp / Human Resources — 1/22/98

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Linda Sewall	DEH/DENR
Angie McMillan	DHHS
Andy Ellen	NC Farm Bureau
Leslie Boney	NCDOC
Polly Williams	NC Equity
DAVE BEECTON	DHHS
Jim Edgerton	DHHS
Lee Kitchen	DHHS
NEIS ROSELAND	OSBM
Lisa Aycock	DHHS- DSS
Shanese Ransome	DSS

VISITOR REGISTRATION SHEET

Joint Appro./Human Resources — 1/22/98

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
R. Logan	ENR
Curt [redacted] Wms	Gov's [redacted] Office
Clark Kent	Metropolis, USA
Dawn Comeau	NASWAC
W. Travis Porter	Parker & Steel
John Bowdish	Zeb Alley P.A.
David Simmons	ZVA, PA
Richard K. Rowe	Wake Co.
[illegible]	Raleigh NC
Joe McClure	N.C. State [illegible]
Doug Lassiter	" " "

VISITOR REGISTRATION SHEET

Joint Approp. / Human Resources — 1/22/98

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bernie Cope	DHHS
Allyn Duffey	DHHS - BHA
BOB TANNER	D.O.C.
Danny McDuffie	DOC/ITS
CHARLES E. LAWRENCE	CENTER FOR EMPLOYMENT TRAINING 4022 STIRRUP CREEK RD DURHAM 27703
Tom Washburn	DHHS
Mary Greene	OSBM
Byron K. Harris	OSBM
[illegible] Altieri	OSBM
R. Lois Artis-Murray	DENR
[illegible]NE Smith	DENR

VISITOR REGISTRATION SHEET

Joint Approp./Human Resources — 1/22/98

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Beryl R. Wade	GOV
Becki Strut	PPAP
Patricia Feeley	NCACC
Judy Batten	N.C. Assoc. of Directors of Disability Centers
Martha Lee Ellis	NC Assoc of Directors of Dev. Disability Centers
Nancy C Cates	N.C. Assoc. of Director of Dev. Disability Centers
Tom Worth	Carolinas Rehab Co Inc
Johnny Gray	OSBM
Pat James	APPCNC / SCSL
Roslyn Savitt	Lobbyist

VISITOR REGISTRATION SHEET

Joint Approp./Human Resources — 1/22/98

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Roger Nunnery	CCS
Ann Wolfe	DHHS - DWCH
Pamela Silver	DHHS DMOT
Peggy Balak	DHHS MH/DD/SAS
Jim Garrard	DHHS DMH/DD/SAS
Nell Barnes	N.C. ADD

Carol Shaw #1

Results of Negotiations:

Positions were allocated based on stated need as outlined below:

Allocation of DENR Administrative Positions

DENR Fund 1140	DHHS's Stated Need	DENR's Stated Need	Total Need	Total DENR Positions*	Difference
Personnel	5.0	16.5	21.5	19.5	2.0
Controller's Office	11.0	33.2	44.2	38.3	6.0
Budget, Planning & Analysis	1.0	8.0	9.0	9.0	0.0
General Services	18.5	22.0	40.5	35.0	5.5
Purchase of Care	24.0	0.0	24.0	24.0	0.0
Infomation Technology	1.0	24.0	25.0	24.0	1.0
EEO	0.0	2.0	2.0	2.0	0.0
TOTAL	60.5	105.8	166.3	151.8	14.5

* Total Positions for 1997-99 after Legislative Adjustments and Repeat Budget Revisions.

Budgetary Implications:

Each department identified its need for administrative support positions. The combined need exceeded by 14.5 the total number available to allocate from fund 1140.

The combined requirements to support these positions was ~~$644,793~~ 669,793 greater than the amound of appropriation available to support them.

The certified budget for each department reflects the total requirements needed to support administrative support positions and operating cost. As a result, each budget reflects a negative reserve amounting to one-half of the $644,793 appropriations shortfall (or approximately ~~$322,000~~ 332,000).

DENR retained the number of positions it stated as its Need	105.8
DENR transferred to DHHS 46 positions	46.0
DHHS received requirements to establish remaining Need	14.5
TOTAL	166.3

#2 Edgerton

Allocation of Administrative Services Fund 1140

To transition Health Services from then DEHNR to DHR, it was necessary to negotiate allocation of DEHNR Fund 1140, which included departmental administrative support to all divisions of the department in the areas of:

- Personnel;
- Controller;
- Budget, Planning & Analysis;
- General Services (mail operations, purchasing & property);
- Purchase of Medical Care; and
- Information Technology.

DHHS Requirements:

Needs were determined based on thorough analysis, including expenditure data; interviews and surveys to determine processes and percent of time spent on budget, purchase & contracts, and controller functions; workload analyses.

Some Findings:

- 53% of DEHNR's 1996-97 expenditures were for Public Health programs.
- 28.9% , or 1,351, positions of DEHNR total positions are Public Health.
- 75.8% of DEHNR's contracts were attributable to Health Services.
- 25.5% of purchase orders processed were for Health Services.
- 25.0% of mail room services supported Public Health.
- 46.2% of mail locations are Public Health.

Staff converted workload requirements into FTEs and caculated budgetary requirements for each of the departments to support its respective responsibilities.

Staff reviewed transfer of positions in 1989 when Health Services was transitioned from DHR to create the new DEHNR (summary chart on following page).

Administative Positions Transferred with Health in 1989 Compared to DHHS Request in 1997

	1989 Transferred	1997 DHR Request
Personnel	7	5
Controller	25	11
Mail Room	0*	4.5
Purchasing & Contracts	0*	5
Information Systems	17	1
Budget	1	1
Property	1	1
Print Shop	ALL	ALL

* DHR did not transfer purchase and contract positions; however, Health gave DEHNR General Services (to be used for purchase, contracts, & mail room) 12 positions.

- **Personnel** - Health transferred approximately 1,300 positions to DEHNR in 1989, and transferred back approximately 1,351 in 1997.
- **Controller** - Interviews and surveys to determine how accounting and financial reporting was provided to health divisions, DHHS requested 18 Controller's Office positions (excluding Purchase of Medical Care). This was revised to 11 as a compromise. The DHR Controller's Office recently consolidated and reorganized, resulting in the reduction of 68 positions, or 15% of the workforce.
- **Mail Room** - Of the total requested, 2 positions needed to make deliveries & 2 positions needed to work in the mail room to handle health volume and needs.
- **Purchase and Contracts** - Request based on Health's volume of 1,200 - 1,500 P.O.'s per year and the calculation that health is 60% of DEHNR contract volume.
- **Budget** - Request is for 1 of 9 Budget, Planning & Analysis staff in DEHNR.
- **Property** - Health has over 35 leases, 1 capital project, and requires maintenance, security, & parking for Cooper, Cotton & Bath Buildings.
- **Print Shop** - Transferred in entirety in 1989 and recommended in OSBM study to be transferred back to DHR.

ATTACHMENT III

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

October 17, 1997

Mr. Wayne McDevitt, Secretary
N.C. Department of Environment and Natural Resources
512 North Salisbury Street
Raleigh, North Carolina 27611

Dear Secretary McDevitt:

This correspondence is in follow-up to our meeting recently with Franklin Freeman and Marvin Dorman to discuss allocation of administrative staff and support relative to the transfer of the Health Services Division from the Department of Environment and Natural Resources to the Department of Health and Human Services. I am pleased we have reached agreements in this area.

In summary, it is agreed that the each of our certified budgets will reflect the total requirements to support the required level of administrative services. However, the sum of these requirements is $644,793 greater than the amount of appropriation available to fund them, and is 14.5 positions greater than the number currently established. To address this, the certified budgets for each of our departments will reflect a negative reserve amounting to one-half of the appropriations shortfall. DENR will transfer to DHHS 46.5 Administrative Services positions, and DHHS will work with the Office of State Budget and Management to establish the additional 14.5 positions it needs.

To recap our agreements in greater detail:

- The Print Shop will transfer to DHHS (total budget and eight positions). DHHS will provide print shop services to DENR on a billing/reimbursement basis. Print Shop services will be transitioned to DHHS under the supervision of Debbie Crane effective October 20.

- Purchase of Care will transfer to DHHS (total budget and 24 positions).

- One DENR Budget Office position and a pro rata share of support cost will transfer to DHHS. Department budget support responsibilities have already been transferred to DHHS.

- DENR will transfer four positions for mail room service to DHHS. Mail room services will continue to be provided by DENR until December 31, 1997.

- DENR will transfer one position for purchase and contracts to DHHS. Purchase and contract responsibilities will transfer to DHHS December 1.

- DENR will transfer five Controller's Office positions to DHHS. Transfer of controller duties is currently being negotiated to a mutually agreed upon date.

  DENR will transfer three Personnel Management positions to DHHS. Personnel management responsibilities have already been transferred to DHHS.

In other related issues:

- The Center for Geographic Information Systems will transfer to DHHS; however, DENR will retain one existing position.

- DENR will transfer nine appropriation supported positions from the Regional Offices fund to DHHS. Health Services will continue to reside in the regional offices where they are presently located, with continued computer services (LAN) and receptionist support services provided by DENR. These and other operating costs incurred by DENR in support of Health Services will be allocated back to the programs as it has been in the past.

- Positions transferred from DENR to DHHS will include the office furnishings, computer, and equipment associated with each position.

- Fiscal staff of the two departments will take appropriate actions to "buy back" expenditures incurred by DENR for Health Services Divisions through the final transition.

I would like to thank you and your staff for your hard work, and I look forward to continuing our efforts together to ensure a smooth transition.

Sincerely,

H. David Bruton, M.D.

HBD/psk

cc: Marvin Dorman, Office of State Budget and Management
Franklin Freeman, Office of the Governor

epartment of Environment & Natural Resources
ransfer of Health Programs to DHHS
ositions to be Transferred

FTE	Position Number	Section	Classification	Employee Name	Including L.I.	Before L.I	FICA	Retirement	Medical Insurance	Employee Cost
ntrtoller's Office:										
.00	53006	Contracts	Accounting Tech II -- P/G 61	Connie Fowler	$ 26,468	$ 25,409	$ 1,944	$ 2,752	$ 1,736	$ 31,841
.00	53005	Contracts	Accounting Tech II -- P/G 61	Dorenda Dixon	27,530	26,429	2,022	2,862	1,736	33,049
.00	53020	Payroll	Payroll Clerk IV -- P/G 61	Linda Bunn	26,431	25,374	1,941	2,748	1,736	31,799
.00	53011	A/P - Invoices	Accounting Clerk IV -- P/G 59	Glenda Newsome	28,981	27,822	2,128	3,013	1,736	34,699
.00	53017	A/P - Travel	Accounting Clerk IV -- P/G 59	Andria Bridges	28,276	27,145	2,077	2,940	1,736	33,898
.05	53001	Systems	Info Processing Asst II -- P/G 6	Vacant	267	267	20	29	1,736	2,052
.05			Total Accounting Salaries		$ 137,953	$ 132,446	$ 10,132	$ 14,344	$ 10,416	$ 167,338
rsonnel:										
.00	52011	Personnel	Personnel Tech I -- P/G 63	Karen Jarvis	$ 28,598	$ 27,498	$ 2,104	$ 2,978	$ 1,736	$ 34,316
.00	52017	Personnel	Personnel Analyst II -- 72	David Shehun	38,429	36,951	2,827	4,002	1,736	45,516
.00	52019	Personnel	Personnel Analyst II -- 72	Margaret Anderso	37,106	35,678	2,729	3,864	1,736	44,007
.00			Total Personnel Salaries		$ 104,133	$ 100,127	$ 7,660	$ 10,844	$ 5,208	$ 123,839
ieral Services										
00	55006	Purchasing	Dept. Purchasing Agent I -- 65	James Graham	$ 26,018	$ 25,018	$ 1,914	$ 2,709	$ 1,736	$ 31,377
00	55019	Mail Room	Mail Clerk III -- 56	Teresa Howard	19,026	18,294	1,399	1,981	1,736	23,410
00	55023	Mail Room	Mail Clerk III -- 56	Theron Locklear	18,577	17,863	1,367	1,935	1,736	22,901
00	55026	Mail Room	Mail Clerk III -- 56	Robert Wall	17,910	17,222	1,317	1,865	1,736	22,140
00	55022	Mail Room	Mail Clerk III -- 56	Frank Logan	17,402	16,732	1,280	1,812	1,736	21,560
00	55028	Prtng Shop	Printing Unit Super. II -- 65	Legrant Taylor	30,074	28,918	2,212	3,132	1,736	35,998
00	55029	Prtng Shop	Printing Equip Oper III -- 59	Tyrone Bryd	28,967	27,853	2,131	3,016	1,736	34,736
00	55031	Prtng Shop	Printing Equip Oper II -- 57	Jerry Jernigan	18,972	18,242	1,396	1,976	1,736	23,350
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epartment [redacted]vironment & Natural Resources
ransfer of Health Programs to DHHS
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.00	53005	Contracts	Accounting Tech II -- P/G 61	Dorenda Dixon	27,530	26,429	2,022	2,862	1,736	33,049
.00	53020	Payroll	Payroll Clerk IV -- P/G 61	Linda Bunn	26,431	25,374	1,941	2,748	1,736	31,799
.00	53011	A/P - Invoices	Accounting Clerk IV -- P/G 59	Glenda Newsome	28,981	27,822	2,128	3,013	1,736	34,699
.00	53017	A/P - Travel	Accounting Clerk IV -- P/G 59	Andria Bridges	28,276	27,145	2,077	2,940	1,736	33,898
.05	53001	Systems	Info Processing Asst II -- P/G 6	Vacant	267	267	20	29	1,736	2,052
.05			Total Accounting Salaries		$ 137,953	$ 132,446	$ 10,132	$ 14,344	$ 10,416	$ 167,338
rsonnel:										
.00	52011	Personnel	Personnel Tech I -- P/G 63	Karen Jarvis	$ 28,598	$ 27,498	$ 2,104	$ 2,978	$ 1,736	$ 34,316
.00	52017	Personnel	Personnel Analyst II -- 72	David Shehan	38,429	36,951	2,827	4,002	1,736	45,516
.00	52019	Personnel	Personnel Analyst II -- 72	Margaret Anderso	37,106	35,678	2,729	3,864	1,736	44,007
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ATTACHMENT III

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

October 17, 1997

Mr. Wayne McDevitt, Secretary
N.C. Department of Environment and Natural Resources
512 North Salisbury Street
Raleigh, North Carolina 27611

Dear Secretary McDevitt:

This correspondence is in follow-up to our meeting recently with Franklin Freeman and Marvin Dorman to discuss allocation of administrative staff and support relative to the transfer of the Health Services Division from the Department of Environment and Natural Resources to the Department of Health and Human Services. I am pleased we have reached agreements in this area.

In summary, it is agreed that the each of our certified budgets will reflect the total requirements to support the required level of administrative services. However, the sum of these requirements is $644,793 greater than the amount of appropriation available to fund them, and is 14.5 positions greater than the number currently established. To address this, the certified budgets for each of our departments will reflect a negative reserve amounting to one-half of the appropriations shortfall. DENR will transfer to DHHS 46.5 Administrative Services positions, and DHHS will work with the Office of State Budget and Management to establish the additional 14.5 positions it needs.

To recap our agreements in greater detail:

- The Print Shop will transfer to DHHS (total budget and eight positions). DHHS will provide print shop services to DENR on a billing/reimbursement basis. Print Shop services will be transitioned to DHHS under the supervision of Debbie Crane effective October 20.

- Purchase of Care will transfer to DHHS (total budget and 24 positions).

- One DENR Budget Office position and a pro rata share of support cost will transfer to DHHS. Department budget support responsibilities have already been transferred to DHHS.

- DENR will transfer four positions for mail room service to DHHS. Mail room services will continue to be provided by DENR until December 31, 1997.

- DENR will transfer one position for purchase and contracts to DHHS. Purchase and contract responsibilities will transfer to DHHS December 1.

- DENR will transfer five Controller's Office positions to DHHS. Transfer of controller duties is currently being negotiated to a mutually agreed upon date.

  DENR will transfer three Personnel Management positions to DHHS. Personnel management responsibilities have already been transferred to DHHS.

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Results of Negotiations:

Positions were allocated based on stated need as outlined below:

Allocation of DENR Administrative Positions

DENR Fund 1140	DHHS's Stated Need	DENR's Stated Need	Total Need	Total DENR Positions*	Difference
Personnel	5.0	16.5	21.5	19.5	2.0
Controller's Office	11.0	33.2	44.2	38.3	6.0
Budget, Planning & Analysis	1.0	8.0	9.0	9.0	0.0
General Services	18.5	22.0	40.5	35.0	5.5
Purchase of Care	24.0	0.0	24.0	24.0	0.0
Infomation Technology	1.0	24.0	25.0	24.0	1.0
EEO	0.0	2.0	2.0	2.0	0.0
TOTAL	60.5	105.8	166.3	151.8	14.5

* Total Positions for 1997-99 after Legislative Adjustments and Repeat Budget Revisions.

Budgetary Implications:

Each department identified its need for administrative support positions. The combined need exceeded by 14.5 the total number available to allocate from fund 1140.

The combined requirements to support these positions was $644,793 greater than the amound of appropriation available to support them.

The certified budget for each department reflects the total requirements needed to support administrative support positions and operating cost. As a result, each budget reflects a negative reserve amounting to one-half of the $644,793 appropriations shortfall (or approximately $322,000).

DENR retained the number of positions it stated as its Need	105.8
DENR transferred to DHHS 46 positions	46.0
DHHS received requirements to establish remaining Need	14.5
TOTAL	166.3

ATTACHMENT I

ANALYSIS OF FUND 1140 - ADMINISTRATIVE SERVICES DIVISION

	DHHS PROPOSAL					DENR PROPOSAL	
	DHHS		DENR			DHHS	
	Personnel	Support	Personnel	Support	TOTALS	Personnel	Support
REQUIREMENTS							
Personnel	$ 229,674	$ 9,800	$ 930,026	$ 52,331		$ 123,839	$ 8,171
Controller's Office	396,653	185,806	1,024,821	405,450		167,338	185,006
Budget, Plan., & Analysis	60,575	4,559	430,541	28,705		60,575	3,170
General Services	340,111	39,564	813,833	650,560		129,551	476,553
Print Shop	226,948	440,143	-	-		218,785	
Purchase of Care	788,841	373,627	-	-		744,556	373,627
Information Technology	62,109	6,500	1,439,689	220,468		-	-
Total Requirements	$ 2,104,911	$ 1,059,999	$ 4,638,910	$ 1,357,514	$ 9,161,334	$ 1,444,644	$ 1,046,527
				Funds in Budget	8,496,361		
				Requirements in Excess of Budget	$ 664,973		
RECEIPTS							
DMA Admin. Match		$ 43,362			$ 43,362		$ 43,362
DHA Medicaid Title XIX		239,774			239,774		239,774
Reimburse for Printing		470,000			470,000		470,000
DSS Sterilization Fees		300,000			300,000		300,000
Indirect Cost		1,046,382		$ 1,250,237	2,296,619		1,046,382
All Other Revenues				184,223	184,223		-
TOTAL RECEIPTS		$ 2,099,518		$ 1,434,460	$ 3,533,978		$ 2,099,518
APPROPRIATIONS							
			Appropriations Needed for DHHS	$ 1,065,392			
			Appropriations Needed for DENR	$ 4,561,964			
			Total Appropriations Required		$ 5,627,356		
			Appropriations in Budget		4,962,383		
			Appropriations Shortfall		$ 664,973		

4

epartment of Environment & Natural Resources
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3 Mona Moon

Department of Environment and Natural Resources

Division of Environmental Health							
	1994-95 Actual	1995-96 Actual	1996-97 Actual	1997-98 Certified	%Δ	1998-99 Certified	%Δ
Expenditures	11,510,510	12,057,672	15,801,246	13,048,851	-17.4%	12,708,411	-19.6%
Less Receipts	(4,180,804)	(4,662,021)	(8,135,382)	(3,940,627)	-51.6%	(3,940,627)	-51.6%
State Appropriations	*7,329,706*	*7,395,651*	*7,665,864*	*9,108,224*	18.8%	*8,767,784*	14.4%
Positions	164.00	164.00	166.00	185.00		185.00	

%Δ = Percentage change in budget over/under Current Fiscal Year 1996-97 Authorized budget.

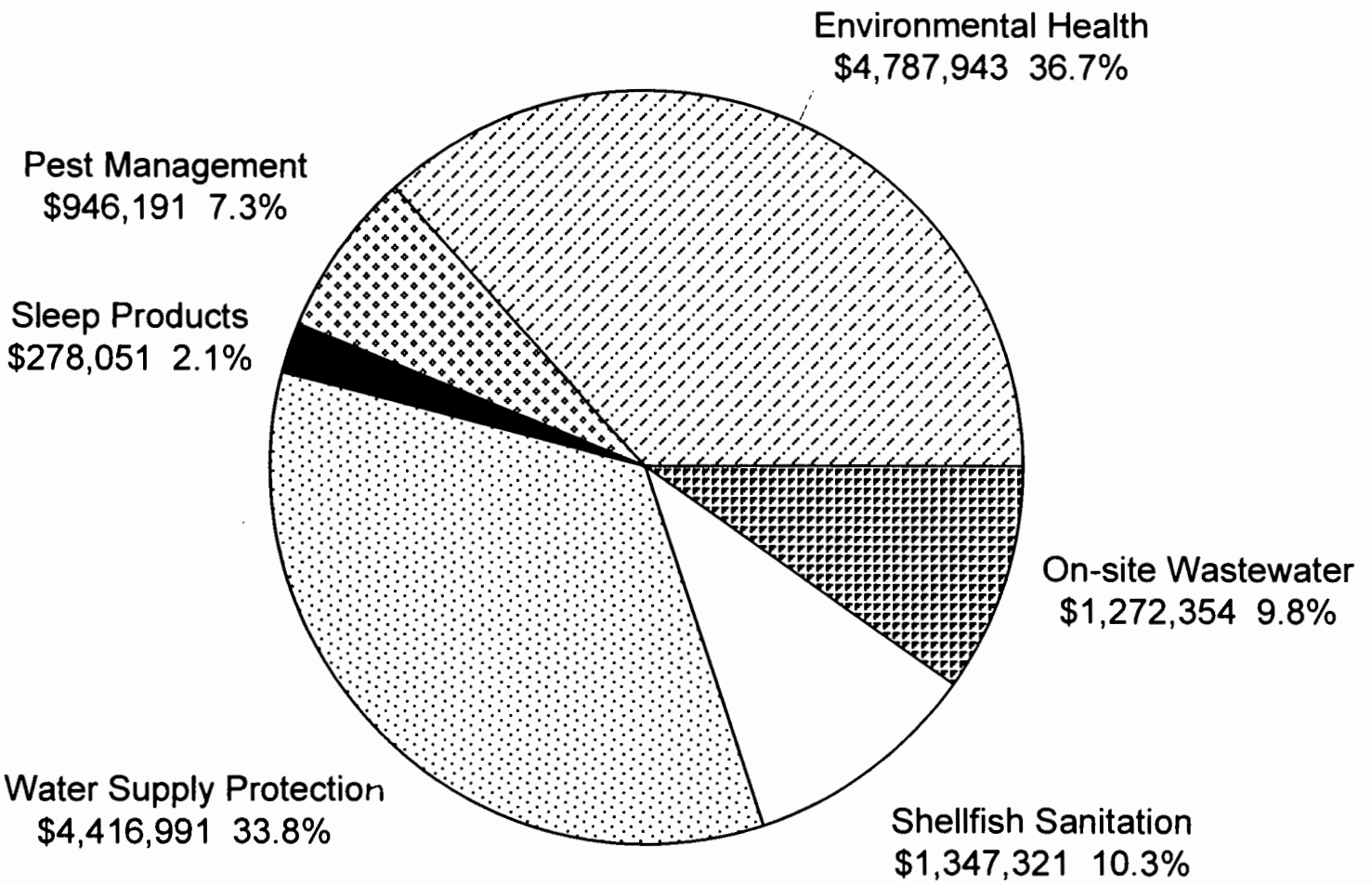
DIVISION PROGRAMS AND ACTIVITIES

- Food, Lodging and Institutional Sanitation
- Shellfish Sanitation
- Milk Supply Sanitation
- Public Swimming Pool Safety and Sanitation
- Childhood Lead Poisoning, Prevention and Abatement
- Sleep Products Sanitation
- Mosquito Control (Fema receipt)
- Public Water Supply Protection
- On-site Wastewater

Division of Environmental Health

Comparison of Program Budgets

FY 1997-98 Certified



Fiscal Research Division -- January 1998

DIVISION OF ENVIRONMENTAL HEALTH
OVERVIEW OF BUDGET ACTIONS

1997 Regular Session

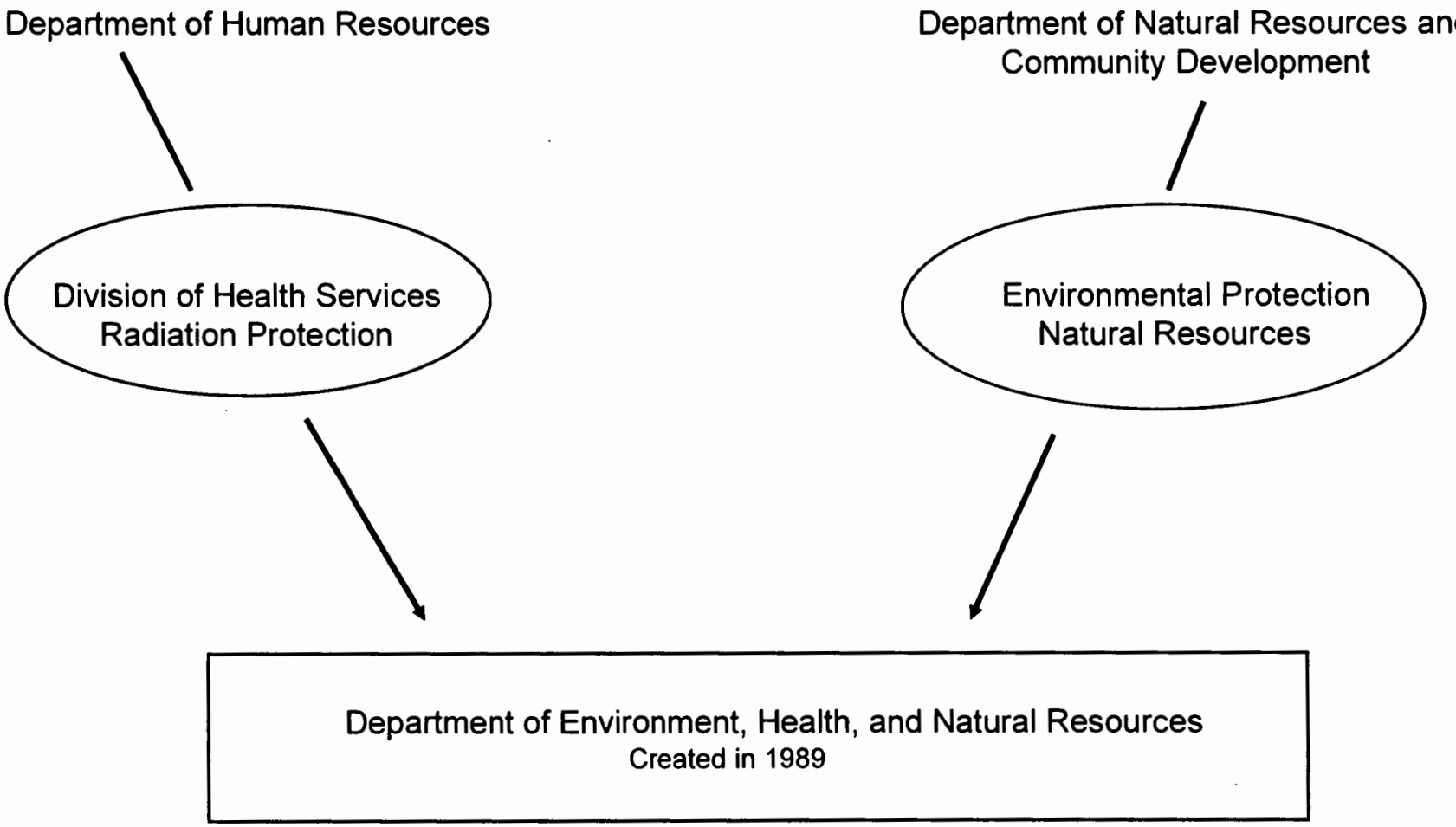
EXPANSION BUDGET ITEMS	FY 1997-98		FY 1998-99	
a. **Childhood Lead Exposure Control** Funds to expand the state's Childhood Lead Poisoning Prevention Program to emphasize compliance with maintenance standards to minimize lead hazards. Funds contingent upon the passage of HB 1007, SB 806, or identical legislation [SB 352, Section 15.30, pp. 307-313].	$210,879 $26,200 3.00	R NR	$210,879 3.00	R
b. **Assistance to Local On-Site Wastewater Programs** Funds to provide additional training, technical assistance and regulatory oversight to local programs in the areas of plan review, septic tank design, manufacture, installation and performance. Funds also to provide additional staff to identify and eliminate straight pipe sewage and wastewater discharges and failing septic systems throughout the state.	$226,212 $23,800 4.00	R NR	$226,212 4.00	R
c. **Evaluation of Septic Problems** Funds to evaluate the condition of septic tanks in the Neuse River Basin [SB 352, Section 15.16, pp. 300-301].	$150,000	NR		
d. **Support for Local Environmental Health Programs** Funds to provide training, continuing education and technical assistance to local environmental health specialists performing food, lodging and institution inspections, and other regulatory activities to ensure the sanitation and safety of swimming pools, spas and tatoo artists [SB 352, Section 15.24, p. 304].	$355,402 6.00	R	$355,402 6.00	R

OVERVIEW OF BUDGET ACTIONS (CONTINUED)

1997 Regular Session

EXPANSION BUDGET ITEMS	FY 1997-98		FY 1998-99	
e. **Food Sanitation Training Funds** Funds to provide training and continuing education to persons who conduct food and lodging inspections for county health departments [SB 352, Section 15.24, p. 304].	$100,000	NR		
f. **Federal Water Supply Assistance Matching Funds** Funds to provide the 20% state match required to receive a federal capitalization grant through US EPA's Drinking Water State Revolving Fund Program. Funds will be used to provide low interest loans to public water systems for capital expenditures associated with drinking water regulations and compliance.	$9,222,820	NR		
g. **Coastal Water Quality Monitoring** Funds to develop and implement a program to monitor coastal area waters, rivers and sounds for contaminants to protect the public health of swimmers and other recreational users of the state's coastal waters [SB 352, Section 15.17, p. 301].	$337,566 $59,500 6.00	R NR	$337,566 6.00	R

Administration of Environmental Health Programs



Effort to Consolidate Environmental Programs

- Solid Waste Management
- Radiation Protection Services
- Regulation of Septic Tanks

Part XIA of Senate Bill 352 (1997Appropriations Act)

Health from DEHNR to DHR/Name Changes

- Transfers the powers and authority of the health divisions and the Commission for Health Services from the Department of Environment, Health, and Natural Resources to the Department of Human Resources,

  except for the authority to regulate:

  1. solid waste
  2. hazardous waste management

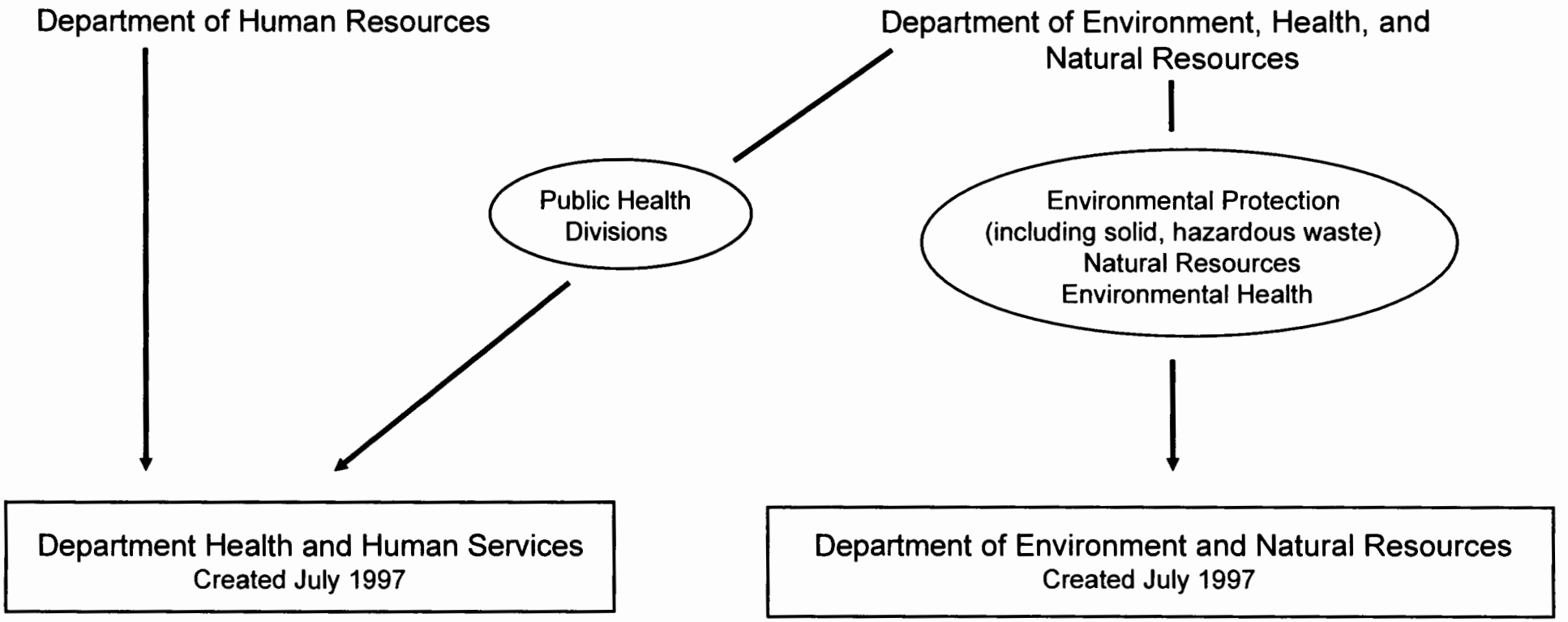
  and to administer:

  3. environmental health programs

- The new Department of Health and Human Services and the new Department of Environment and Natural Resources are required to enter into a Memorandum of Agreement to coordinate functions shared by the departments within 30 days of enactment.

- The new Department of Health and Human Services is required to report to the General Assembly by May 1, 1998 on additional changes needed to implement the reorganization, including any changes requiring legislation.

- The Environmental Review Commission is required to study and report any findings and recommendations to the General Assembly for the 1998 Regular Session with respect to the appropriate roles and financing of state and local agencies in administering environmental health programs and permitting, inspecting and monitoring drinking water wells, surface water supplies and wastewater treatment systems.



Effort to improve coordination and consistency of preventive programs, provision of health care services, financing and regulatory responsibilities.

Effort to maintain coordination of environmental programs.

Administration of Environmental Health Programs
General Issues Regarding Departmental Location

- **Departmental Mission and Organizational Fit**

  Identification of state agency(ies) that appear to have the most suitable mission and program responsibilities relative to environmental health programs and activities.

- **Maintaining Coordination of Effort**

  Primarily with respect to water programs, and the on-site wastewater program in particular, since consolidating programs responsible for the regulation of wastewater systems was one of the primary reasons for creating DEHNR.

- **Impact of Reorganization of Water Programs within DENR**

  In 1995 DEHNR created the Environmental Protection Action Team (EPAT) to examine the organizational structure of the environmental programs and make recommendations to eliminate or reduce overlap, duplication, fragmentation, inconsistencies and poor coordination of programs. Water programs in particular were the subject of many such complaints. An employee of the Division of Environmental Health was a member of the team. DENR is expected to present its plan for reorganization to the Environmental Review Commission this interim.

  Section 11A.127 of Part XIA of Senate Bill 352 prohibits consolidation of on-site wastewater functions and drinking water programs in the Division of Environmental Health with the Division of Water Quality until the Environmental Review Commission has completed its study.

♦ Memorandum of Agreement between DHHS and DENR

G.S. 143-279.2(1b), as amended by Section 11A.5 of Part XIA of Senate Bill 352, states the following as one of the duties of DENR:

> "(1b) To provide for the protection of the environment and public health through the regulation of solid waste and hazardous waste management and the administration of environmental health programs."

G.S. 143-279.3(c)(3), as amended by Section 11A.6 of Part XIA of Senate Bill 352, provides the following with respect to the duties and functions of the Division of Environmental Health:

> "(3) There is created a division within the environmental areas of the Department of Environment and Natural Resources to be named the Division of Environmental Health. All functions, powers, duties and obligations of the Division of Environmental Health of the Department of Environment and Natural Resources are transferred in their entirety to the Division of Environmental Health, Department of Environment and Natural Resources."

The Memorandum of Agreement between DHHS and DENR states that pending the ERC study:

> "... the Division of Environmental Health (DEH) will be organizationally located within DENR but will report for program and policy as directed by the Secretary of DHHS. The responsibility for personnel, budget and other administrative support for DEH will remain under DENR. DEH will follow DENR administrative procedures (both for administrative functions and for review of proposed rules)."

Options and Related Issues to Consider

1. Transfer all of the programs of the Division of Environmental Health to DHHS

   - Emphasizes public health aspect of environmental health programs.
   - Allows DENR to relinquish organizational control and administrative responsibilities for DEH, since the current Memorandum of Agreement already requires the division to report to DHHS on program and policy issues.
   - Potentially dilutes any improvements in the coordination of water related issues and efforts gained from the 1989 reorganization.
   - Provides opportunity to maintain the historical organization and management of environmental health programs; although once transferred, the division may undergo reorganization within DHHS.

2. Maintain the current organizational location of the Division of Environmental Health in DENR

   - Emphasizes both environmental and public health aspects of environmental health programs.
   - Requires a decision as to whether to maintain current reporting responsibility to DHHS, direct DENR to take responsibility for program and policy direction of the division, or formalize through legislation, a more coordinated reporting path including both agencies.
   - Allows DENR to include environmental health programs in the reorganization of water programs or maintain the historical organization and management of environmental health programs.
   - Potentially misplaces some programs which may have a better organizational fit in DHHS.

3. Retain some environmental health programs in DENR and transfer selected programs to other agencies

- ♦ Provides opportunity to manage environmental health programs through new approaches.
- ♦ Requires thorough evaluation of individual program responsibilities and activities to determine appropriate placement.
- ♦ May require additional resources for administrative support and program delivery.
- ♦ May require education of constituent groups to gain support and approval.

Examples for Illustrative and Discussion Purposes

a. Retain Public Water Supply and On-Site Wastewater in DENR.

- ♦ Although both programs address traditional public health core issues, the interventions and activities take place in an environmental setting. Housing in the state's environmental agency may provide the best fit.
- ♦ Programs could remain in an environmental health division or be consolidated with other water programs.
- ♦ May require a new approach to program funding and resource allocation, particularly with the On-site Wastewater Program.

b. Transfer the Milk Sanitation Program to the Department of Agriculture and Consumer Services (NCDACS), Food and Drug Protection Division, which is responsible for assuring that various foods, drugs, pesticides and other products are safe, wholesome and properly labeled.

- ♦ Program seems to be an appropriate fit with NCDACS consumer protection program.

c. Transfer regulatory programs governing sanitation of restaurants, lodging facilities, institutions, swimming pools, and tattoo parlors to DHHS, Division of Facility Services.

- Inspections of these facilities are performed by local health departments and are considered to be important to ensuring clean and safe operations.
- Facility Services already inspects, licenses and certifies physical facilities and operation of hospitals, nursing homes, mental health facilities, adult health care and other health facilities.

d. Transfer the Childhood Lead Poisoning Prevention Program to the Division of Women's and Children's Health in DHHS.

- Lead hazard investigations, abatement of lead hazards and education of home owners and tenants are the primary means of preventing lead poisoning in children and ensuring proper development.

e. Transfer Mosquito Control Program and Public Health Pest Management to the Division of Community Health in DHHS.

- Prior to Hurricane Fran, mosquito control was seen as more of a nuisance concern than a public health risk, but recent threats of mosquito borne diseases have returned the program to its original focus.
- State role is primarily to provide funds to counties to administer local mosquito control programs.
- Maintains mechanism in state's health agency for dealing with other diseases transmitted by pests, such as ticks.

f. Transfer Sleep Products Program to the Department of Agriculture and Consumer Services, Structural Pest Control Division, which regulates persons engaged in pest control to prevent deception and fraud.

- Program's purpose is to ensure sanitation and quality of mattresses, pillows, comforters and bedding products.

g. Shellfish Sanitation

- Transfer to the Division of Facility Services in DHHS, along with the other sanitation programs.
- Transfer to the Department of Agriculture and Consumer Services, Food and Drug Protection Division.
- Combine with the Division of Marine Fisheries, which already has enforcement responsibilities with respect to seafood dealers. More emphasis is being placed on the impact of water quality and habitat protection on fisheries resources.
- Combine with the Division of Water Quality. The section is taking on a new focus related to water quality monitoring with the creation of the Coastal Water Quality program.

North Carolina General Assembly
House of Representatives
State Legislative Building
Raleigh 27601-1096

REPRESENTATIVE CHARLOTTE A. GARDNER
35TH DISTRICT

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SALISBURY, N.C. 28144
(704) 636-5775

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February 3, 1998

COMMITTEES:

APPROPRIATIONS
CHAIRMAN: HUMAN RESOURCES
ENVIRONMENT
HUMAN RESOURCES: AGING
INSURANCE
JUDICIARY II
WELFARE REFORM

STUDY COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE: CO-CHAIRMAN
STUDY COMMISSION ON DHR REORGANIZATION: CO-CHAIRMAN

MEMORANDUM

TO: **House Appropriations Subcommittee on Human Resources Members**

FROM: **Representative Charlotte A. Gardner**
Representative Debbie Clary
Representative Lanier Cansler

SUBJECT: **Joint meetings, February 17, 18 and 19, 1998**

JOINT APPROPRIATIONS/SUBCOMMITTEE ON HUMAN RESOURCES MEETING

DATES: **Tuesday, February 17, 1998 - 10 a.m. to 4 p.m.**
Wednesday, February 18, 1998 - 9 a.m. to 4 p.m.
Thursday, February 19, 1998 - 9 a.m. to 1 p.m.

PLACE: **Room 414 LOB**

If you have any questions about these meetings contact Fiscal Staff: Karen Hammonds-Blanks and Mary Ellen Sylvester. (919-733-4910)

Barbara R. Hocutt, Committee Clerk
919-715-3017 (Thursdays)

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Tuesday, February 17th, 10:00 a.m. - 4:00 p.m.
Room 414 - Legislative Office Building

10:00	Children's Health Insurance Program	Governor's Commission on Uninsured Children

LUNCH

1:00	Discussion of Medicaid Growth Reduction Plan *What is the role of managed care in Medicaid?*	Carol Shaw, Fiscal Analyst Fiscal Research Division

2:00 *Discussion of the Role of Public Delivery Systems in N.C.*

-Who are the players in the local public health/mental health care delivery system?
-What is the impact of recent and proposed changes in Medicaid on local public health/mental care?
-What role will local public health/mental health care programs play in the Children's Health Insurance Program?
-What is the role of public health/mental health in Medicaid managed care?
-How will the issue of access be impacted by changes in Medicaid?
-How is the issue of fragmentation of services impacted by changes in Medicaid?
-How are local public health/mental health budgets impacted by changes in Medicaid?
-What are the anticipated patient/client outcomes within the new public-private relationship in Medicaid?

Role of Public Health Departments	Various Directors of Local Public Health Departments
Role of Area Mental Health Programs	Various Directors of Area Mental Health Programs

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Wednesday, February 18th, 9:00 a.m. - 4:00 p.m.
Room 414 - Legislative Office Building

9:00	Sickle Cell Syndrome Program	Gladys Robinson, Chair Sickle Cell Syndrome & Related Disorders Association
10:00	AIDS/HIV Budget	Karen Hammonds-Blanks, Fiscal Analyst Fiscal Research Division
10:30	Child Welfare Expansion Budget	Leza Aycock, Assistant Director Division of Social Services
10:45	Overview of Public Schools Commission Meeting & Discussion re: Schools for the Deaf	Mary Ellen Sylvester, Fiscal Analyst Fiscal Research Division
11:15	Fund Transfer for Cancer Purchase of Care Program	Ron Levine, Deputy Secretary DHHS
11:30	Food Banks	Jerry Hardesty

LUNCH

1:00	Division of Mental Health Response to 1/21/98 Constituent Comments (Dorothea Dix Hospital)	Don Willis, Chief Mental Health Services Section
1:45	Progress Report on TANF/Substance Abuse Services Initiative	Starlene Scott-Robbins, Women's Services Branch
2:30	Thomas S. Cost Containment Report	Susan White, Chief Thomas S Services Section
	Update on Recent Court Decision in Thomas S & Willie M	Bob Hargett, Attorney General's Office

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Thursday, February 19th, 9:00 a.m.
Room 414 - Legislative Office Building

9:00	Overview & Trends In N.C.'s Aging Population	Karen Gottovi, Director Division on Aging
9:30	Discussion of Needs in the Aging Population	Ann Johnson Senior Citizen Coalition
10:00	Status Report on Adult Day Health Expansion Funds	John Tanner, Chief Adult Services Section Teresa Johnson, Director N.C. Adult Day Services Association
11:00	Pharmaceuticals Assistance for Low Income Elderly	Carol Shaw, Fiscal Analyst Fiscal Research Division
11:45	Adult Care Home Bed Vacancies Report	Lynda McDaniel, Director Division of Facility Services

Committee Discussion of Future Meeting Topics

ADJOURN

George Bond
Buncombe Cty.
Public Health Director

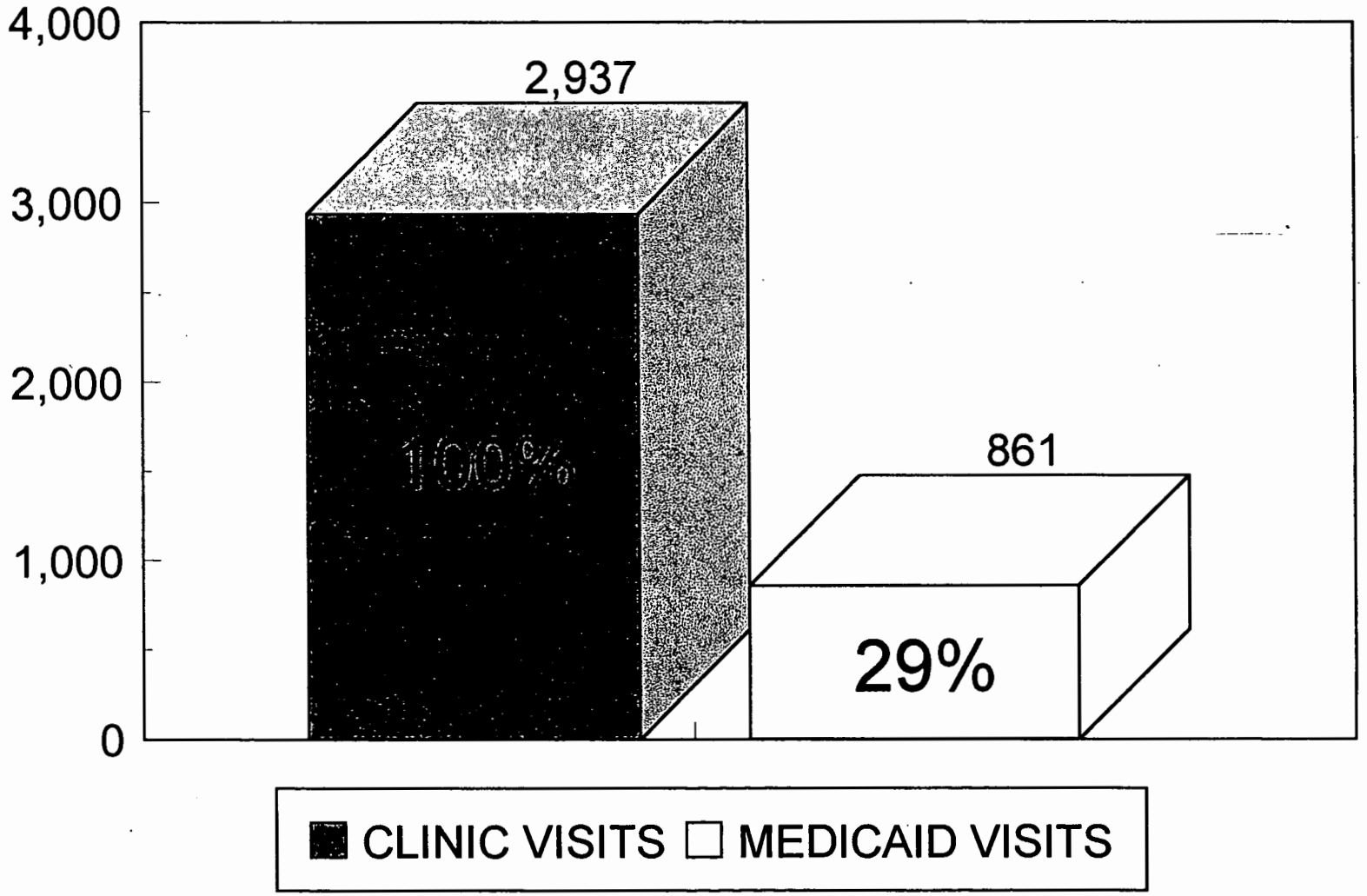
MEDICAID IMPLICATIONS

FOR

LOCAL HEALTH DEPARTMENTS

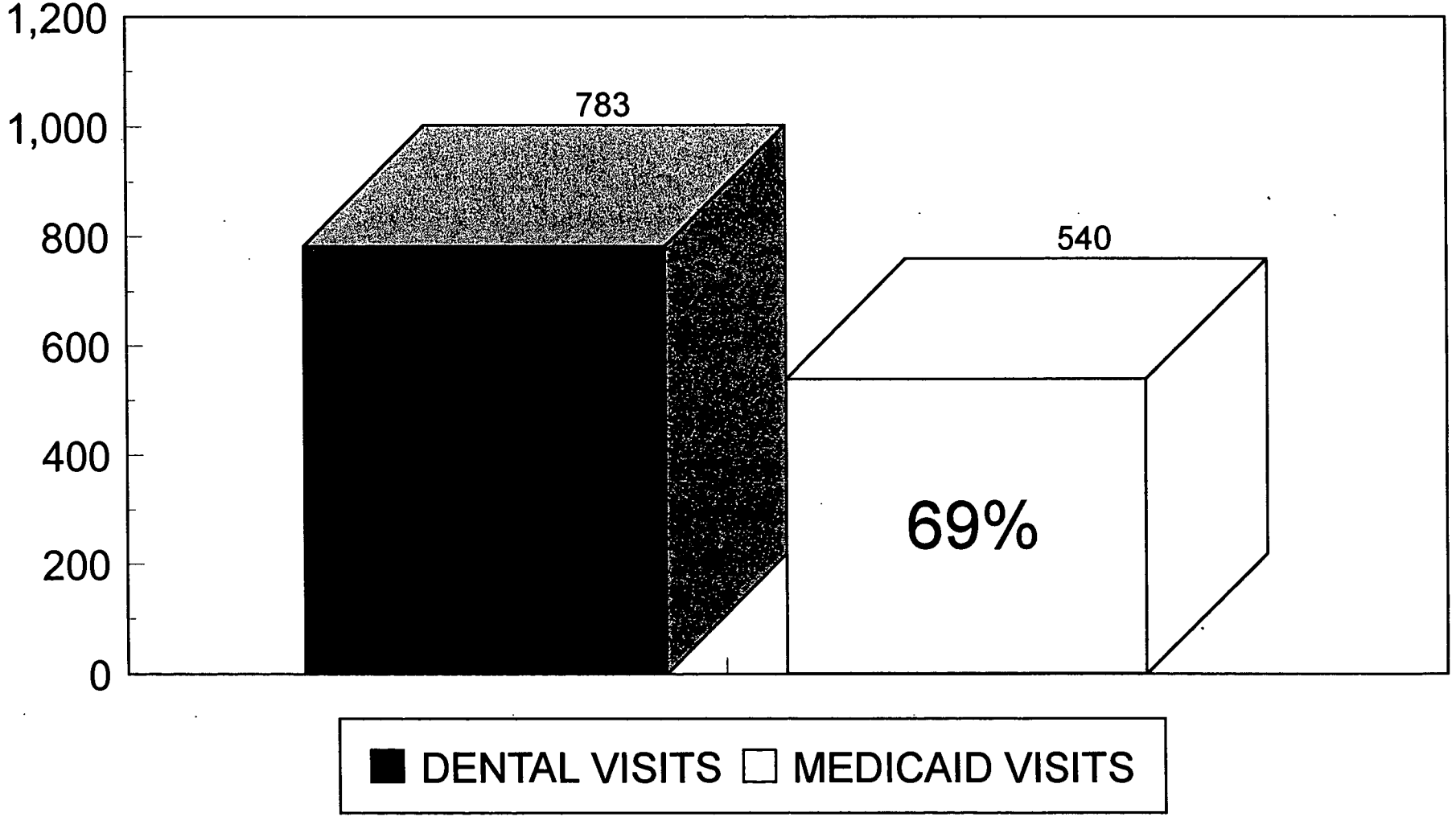
George F. Bond, Jr.
Buncombe County Health Center
Asheville, North Carolina
February 17, 1998

MEDICAID AS A PERCENT OF TOTAL CLINICAL SERVICES JANUARY 1998



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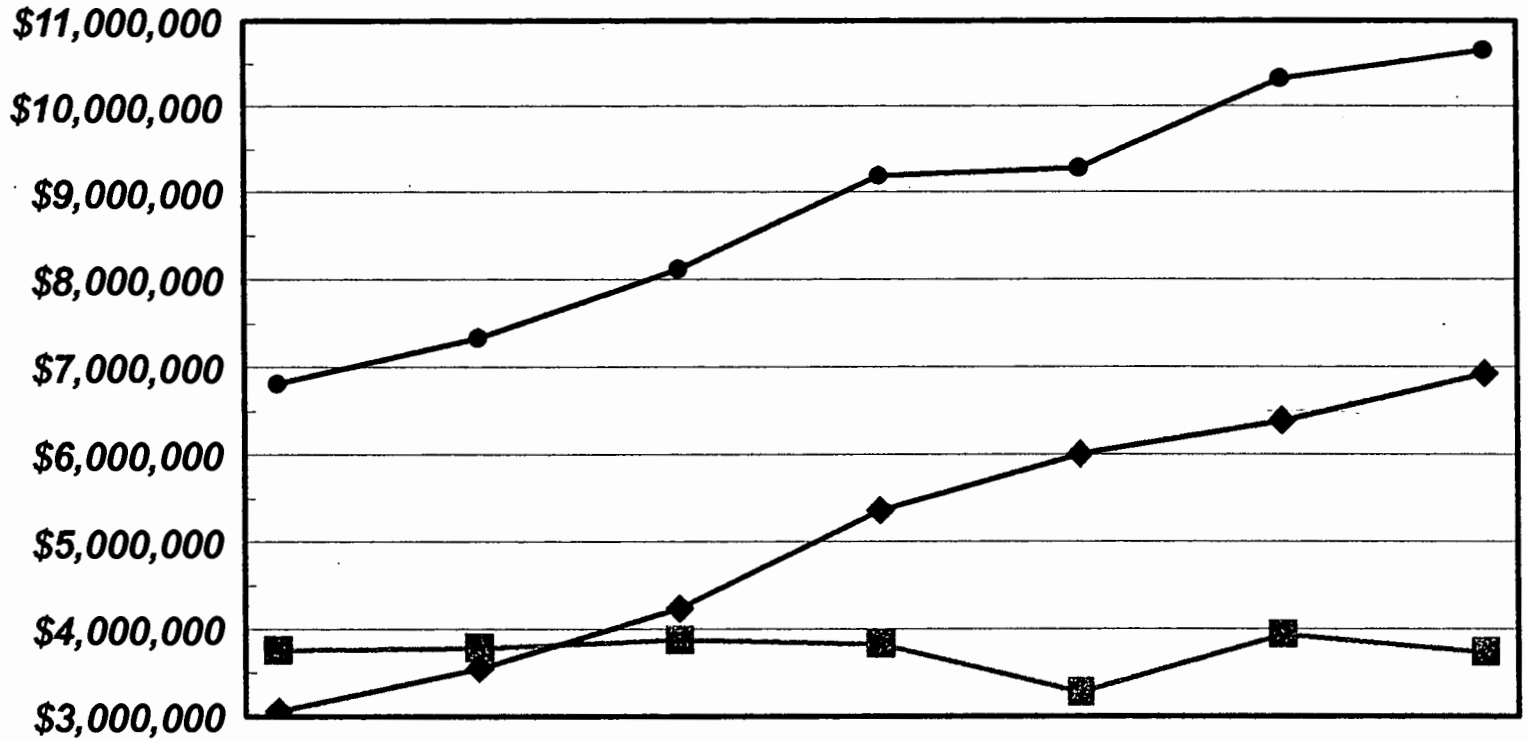
MEDICAID AS A PERCENT OF DENTAL SERVICES JANUARY 1998



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Revenue Source Trends Over Seven Fiscal Years

Buncombe County Health Center Budget



	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
COUNTY	$3,756,998	$3,786,303	$3,877,262	$3,829,176	$3,276,183	$3,939,107	$3,732,760
NON-COUNTY	$3,056,396	$3,549,833	$4,239,774	$5,367,356	$6,008,861	$6,391,573	$6,926,933
FY TOTALS	$6,813,394	$7,336,136	$8,117,036	$9,196,532	$9,285,044	$10,330,680	$10,659,693

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olina ACCESS II

Goal: Improve Access And Outcomes For A Vulnerable Population While Controlling Cost

ACCESS Council (13 Member Board)

- Health Director - Mr. George Bond
- Executive Director Buncombe County Medical Society - Mr. Alan McKenzie
- Executive Director Mountain Healthcare - Ms. Ellen Wells
- 5 Providers -
  - *Dr. Joe Sechler (Asheville Pediatrics)
  - *Dr. Charles Murray (Buncombe County Health Center)
  - *Dr. Harald Kowa (Asheville Children's Medical Center)
  - *Dr. William Brannan (MAHEC Women's Health Center)
  - *Dr. Suzanne Landis (MAHEC Family Health Center)
- Mission ✚ St. Joseph's Health System - Mr. John Graeter
- Board Chair Health Partners - *Dr. Suzanne Landis
- Carolina Access Coordinator - Mr. Marty Phillips
- 2 Consumer Representatives - *Dr. Carol Long (Pediatrician)
  Mr. Curtis Venable (Pisgah Legal Services)

*Denotes Members of Medical Management Committee

What's Different About CA II

- Enhanced Case Management Services (CMS)
  - ✓ Additional $2.50 PM/PM - specifically used for CMS
- Enhanced Disease Management Initiatives
  - ✓ Targeting Both Children and Adults
- Quality Assurance/Improvement Plan
- Standardized Patient Education
- Local Control and Collaboration
- Improved Access
  - ✓ Centralized Call System
  - ✓ 90 Day Initial Patient Assessment
  - ✓ Enhanced Provider Availability Standards

Revenue Which Would Be Lost To Prior Authorization Requirement

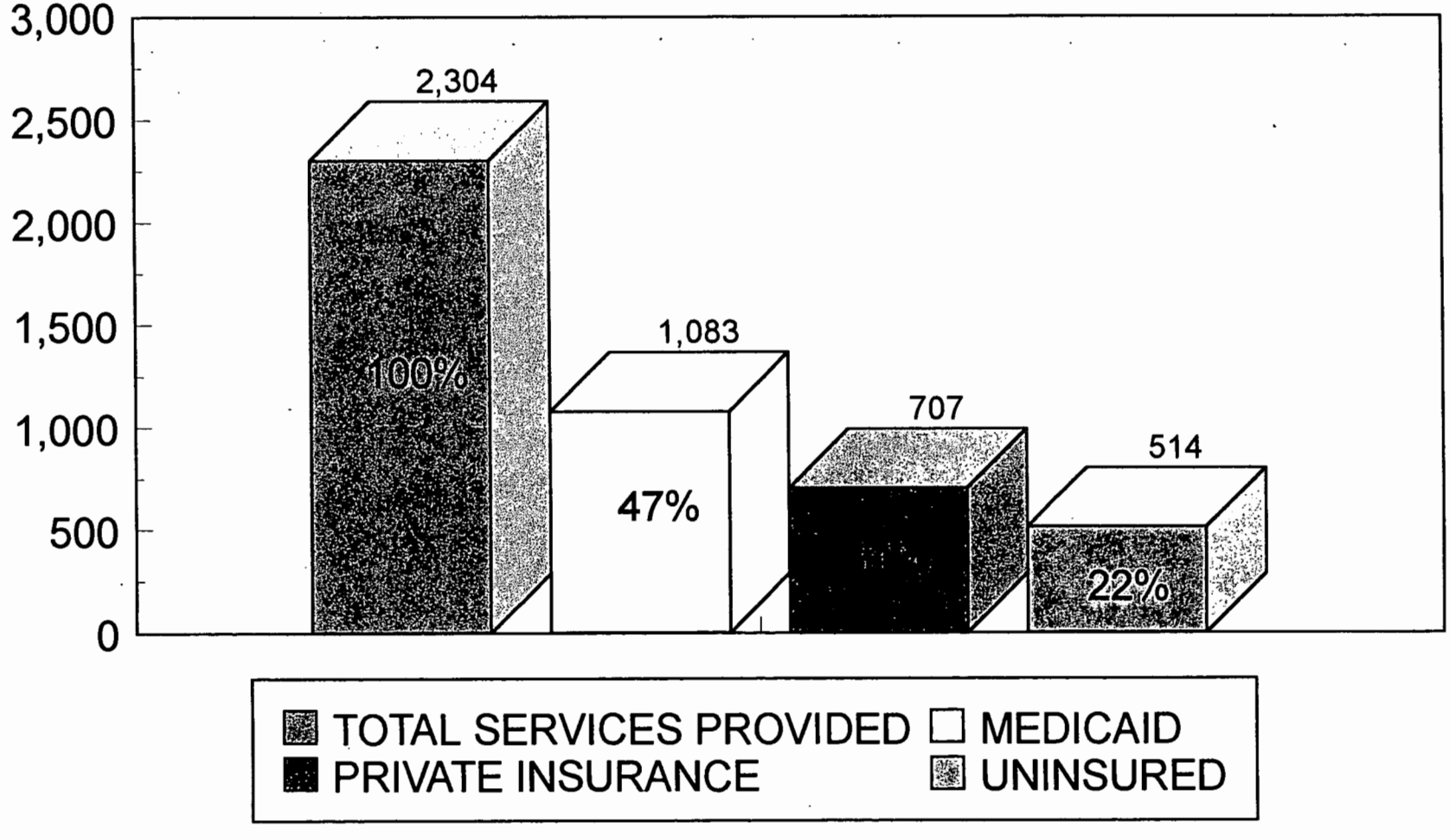
Buncombe County Health Center sample of services provided to children with Medicaid:

64% BCHC Primary Care Provider
36% Other MD Primary Care Provider

Buncombe County Health Center Medicaid revenue is approximately $3,000,000 per year.

The loss of 36% of the revenue is $1,080,000.

STUDENT HEALTH CENTERS:
ASHEVILLE HIGH SCHOOL
ASHEVILLE MIDDLE SCHOOL
October - December 1997 By Payor



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Briefing: NCACC Human Resources Subcommittee
"Medicaid Managed Care - Carolina ACCESS -
Issues of Concern to Local Public Health"

James Baluss, Chair, Health Director
Edgecombe County Health Department

February 11, 1998

I. OUTLINE OF MAJOR POINTS

1. County Governments are major stakeholders in the design, piloting, funding, implementation, and assessment of strategies for Medicaid Managed Care in NC.

2. Muti-Faceted Stakeholder Role:
   1. Appropriations for Local State Medicaid (eg. funding)
   2. Provider Status
   3. Advocacy & "Safety Net" Role

3. In NC, Medicaid Managed Care is:
   * Carolina ACCESS I: 2 models
   * Carolina ACCESS - Mecklinburg HMO Model
   * Carolina ACCESS II: Various models
     1) Community Network (6 pilots)
     2) Horizontal Network
     3) Expanded HMO Models
     4) Expanded Carolina ACCESS "PCP" Gatekeeper

4. Remarkable & Troublesome lack of Local Government input due to:
   1. HCFA Waiver Process
   2. Relative size and economic impact of some decisions.
   3. "Phasing" of Managed Care for Medicaid enrollees.

5. This lack of Local Government input and influence has resulted in:
   1. Precipitous and far reaching decision on removal of "Exempt Status" of Local Health Departments.
   2. Problems with CHIP (eg. Medicaid "Look-a-like"): Problems inherent in Carolina ACCESS will be replicated in CHIP.

6. NCALHD has serious concerns about Medicaid Managed Care
   1. Exempt Status - "Health Check Screening Rates"
   2. Contracting with PCPs
   3. Negative impacts on Local Public Health Revenues/"Infrastructure"

II. RECOMMENDATIONS FOR POSITION BY NCACC

1. Local Health Departments retain "Exempt Status" under Carolina ACCESS for provision of "well care" (eg. immunizations, Health Check Screening & Treatment, Prenatal, Family Planning Services, School Based Clinics, and others as recommended by NCALHD.

2. CHIP as a Medicaid "look-a-like" should be opposed if Health Departments do not retain "Exempt Status" for Carolina ACCESS.

3. DHHS/DMA should allow and State Health Director should promote and facilitate coordination and contracts for comprehensive health care at the local level. Maximum local flexibility for contracts should be a principle of such contracting. If Carolina ACCESS enrollment is mandatory, Medicaid recipients should have the freedom to choose Health Department/Medicaid funded services.

4. DHHS/DMA should assume a more viable and visible "assurance" role in holding PCPs (public, private practice, public health based, etc.) accountable for the full range of preventive and well care services under Carolina ACCESS.

5. Recognizing that there appears to exist a potential negative impact from Carolina ACCESS to local Public Health Departments (and hence County Governments), the following action should be taken by appropriate State officials:

    1) Immediate release of "embargoed/impounded" Medicaid Maximization Funds to local Departments.

    2) Consultation & Technical Assistance from State Health Director's office for development of "provider status" (PCP) for local Departments that seek to become PCPs under Carolina ACCESS.

6. Consider appointing a Medicaid Managed Care Task Force, with representatives from affected Local government operations (eg. Health Directors, Social Services Directors, Senior Services, Etc.) to provide ongoing assessment and recommendations to NCACC. This will enable advocacy to influence State Policy through cohesive, coherent "county government/local human services delivery system" perspectives for Medicaid Managed Care.

Carol Shaw
#2
2-18-9

MEDICAID MANAGED CARE

FISCAL RESEARCH DIVISION

FEBRUARY 1998

MEDICAID MANAGED CARE
INITIATIVES

- CAROLINA ACCESS
- HEALTH CARE CONNECTION
- VOLUNTARY HMOs
- CAROLINA ALTERNATIVES
- CAROLINA ACCESS II

MEDICAID MANAGED CARE
CAROLINA ACCESS

- Coordinates care by linking eligible recipients with a primary care provider who has agreed to act as a gatekeeper and to provide or arrange for health care services.
- By improving access to primary care, the program promotes a continuity of care while helping to reduce inappropriate utilization and controlling costs.
- Implemented April 1991
- Participation is mandatory for all Medicaid eligibles. Special pregnant women and elderly with Medicare coverage participation is optional.
- Current enrollment: Over 350,000 recipients in 65 counties.
- Over 3,500 physicians participate in the program and are paid $2.50/$3.00 per month per enrolled recipient.
- Cost Savings: Not specifically identified, but appears to be reducing the growth of Medicaid by lowering emergency room expenditures and reducing the cost per eligible for children

MEDICAID MANAGED CARE
HEALTH CARE CONNECTION

- A pre-paid capitated risk contract with Health Maintenance Organizations (HMOs) to provide a comprehensive range of medical services to Medicaid recipients residing in Mecklenburg County.
- Implemented July 1996
- Five HMOs and one Federally Qualified Health Center are currently participating in the program.
- Mandatory enrollment for TANF recipients, children, pregnant women, and the disabled - elderly recipients are excluded.
- Current enrollment: 31,749 of 41,167 eligible
- Participating HMOs: Atlantic Health Plan, Kaiser, Maxicare, Optimum Choice, and Wellness Plan.
- Prescription drugs, mental health, and long-term care services are excluded from the capitated rates.
- Cost Savings: Net reduction is 7% below statewide fee for service costs.

withdrawing from Program in March

MEDICAID MANAGED CARE
VOLUNTARY HMO ENROLLMENT

- A pre-paid capitated risk contract with Health Maintenance Organizations (HMOs) to provide a comprehensive range of medical services to Medicaid recipients residing in various counties.
- Implemented January 1998
- Counties: Gaston, Chatham, Durham, Harnett, Orange, Person, and Wake.
- Participating HMOs: Generations, Maxicare, Optimum Choice, and Wellness Plan.
- Recipients can choose between one of the HMOs or Carolina Access.
- Over 74,000 recipients in the following categories have this choice: TANF recipients, children, and the disabled.
- Cost Savings: Similar to Health Care Connections for eligibles who choose the HMO option.

MEDICAID MANAGED CARE
CAROLINA ALTERNATIVES

- A prepaid, capitated managed care program administered by area mental health programs which includes all mental health and substance abuse services (inpatient and outpatient).
- Implemented January 1994
- Established in 10 area programs covering 32 counties: Blue Ridge, Foothills, Forsyth-Stokes, Gaston-Lincoln, OPC, Smokey Mountain, Southeastern, Trend, VGFW, and Wake.
- Mandatory for all Medicaid eligible children age 0-17 living in counties covered by the participating area programs.
- Cost Savings: The cost per eligible has grown more slowly in Carolina Alternatives than in other area programs.

CAROLINA ACCESS II
GENERAL INFORMATION

- ACCESS II is a new demonstration project that is designed to build on Carolina ACCESS by assisting local providers to develop managed care delivery systems that coordinate a continuum of care with processes to influence cost and quality of care.
- The program is sponsored by the Division of Medical Assistance and the NC Foundation for Alternative Health Programs, Inc. and is funded, in part, by the Kate B. Reynolds Health Care Trust.
- HHS is seeking an amendment of its Carolina Access and HMO 1915(b)(1) waiver to implement ACCESS II.
- Approval of the waiver is expected by April 1998.
- Planning for implementation is ongoing with selected sites developing their final proposals.

CAROLINA ACCESS II
GOALS AND OBJECTIVES

- Maximize both physician and patient choice while developing a model emphasizing access, quality, and cost.
- Transition Carolina ACCESS into a program which offers assistance to providers to develop processes for improved care management.
- Maintain the local safety nets that are needed to care for N.C.'s low-income families.
- Provide the state with enhanced cost savings and budget predictability and provide a reference point for other managed care initiatives.
- Keep medical decisions in the hands of local primary care providers.
- Provide access to the full range of Medicaid benefits through community based health care providers for recipients and uninsured low-income children.
- Encourage establishment of community-based and controlled Medicaid service delivery models that will be able to meet the needs of the chronically ill, elderly, and disabled.
- Create physician directed, community based not-for-profit managed care entities focused on improved patient care and cost efficiency.

CAROLINA ACCESS II
OPTIONS FOR PARTICIPATION

- ***OPTION ONE:*** A fee-for-service model with an enhanced management fee that participating providers will receive each month to develop and implement improved care management strategies as a means to meeting annual budget and utilization targets.
  - Seven proposals including one Large Network of Primary Care Groups and six Individual Provider and /or Local Networks.
  - Over 97,000 Medicaid recipients covered by these proposals.
- ***OPTION TWO:*** An integrated community care model where private and public providers collaborate in forming a community network to serve recipients. This entity will also receive the enhanced management fee and will be required to meet annual budget and utilization targets.
  - Two proposals from Pitt and Cabarrus Counties.
  - Over 17,000 Medicaid recipients will be covered by these proposals.

CAROLINA ACCESS II
EXPECTATIONS

- Revised provider contracts that promote improved care management strategies and greater accountability for cost and utilization.
- Development of targeted care management tools and performance measures aimed at improving the health status and outcomes of health care services delivered to recipients.
- Implementation of utilization targets
- Intensified client education, preventive screenings, and outreach efforts.
- Existence of collaborative decision making and care coordination processes between the local health department, physicians, and local hospital.
- Organizational,, management, and financial systems to manage services.
- Capacity to meet the needs of all covered Medicaid recipients in a proposed service area.

CAROLINA ACCESS II
COST EFFECTIVENESS

- Aims to demonstrate that enhanced care management processes and targeting high-risk recipients with chronic conditions will produce greater savings that Carolina ACCESS and will be able to provide budget predictability
- Each ACCESS II plan will be given a "community budget" using a per member per month actuarial rate structure. All claims will continue to be paid on a fee-for-service basis, but the claims will be charged against the "community budget".
- Individual ACCESS II providers will be measured on their ability to remain within their budget. The enhanced management fees will also be charged against the budget.
- The enhanced management fee is $2.50 per enrollee per month.
- The net cost savings for ACCESS II is estimated to be $46 per enrollee per year.
- Annual ACCESS II savings are estimated to be $5.3 million. state share 30%

Roy Wilson
2-17-98

NEUSE CENTER

MISSION STATEMENT

Neuse Center serves consumers facing significant challenges related to substance abuse, mental illness and/or developmental disability. Our commitment is to provide a consumer-driven, family-oriented system of services within available resources that is flexible, accessible, and respects the consumer's freedom of choice. Services are designed to empower consumers to become as independent as possible within the community.

PHILOSOPHY

The philosophy of service delivery at Neuse Center is to provide quality services to all consumers and their families based on the consumer's needs with the ultimate goals of independence, self-autonomy, and fulfilling innate potential. We believe that our consumers are citizens with all the rights and responsibilities that accompany citizenship.

By entering into joint partnership with consumers and families, we focus on a consumer-driven, family-oriented system of services to achieve these goals in the most effective/efficient manner while respecting the consumer's rights.

This philosophy is implemented into daily operations through a comprehensive quality management system.

WORKING PRINCIPLES

Extend beyond what is required by being prompt, innovative, flexible and responsive.

Seek to trust as well as to be trusted. Commit to work together as a group for a common goal.

Try to find a way to say yes. Our physical environment reflects on the quality of our service.

Show favoritism and partiality to all consumers.

Seek out and take advantage of opportunities to move the organization toward excellence.

VALUES

Flexibility - Our system of services is designed to be consumer-driven and responsible to the needs of the individual.

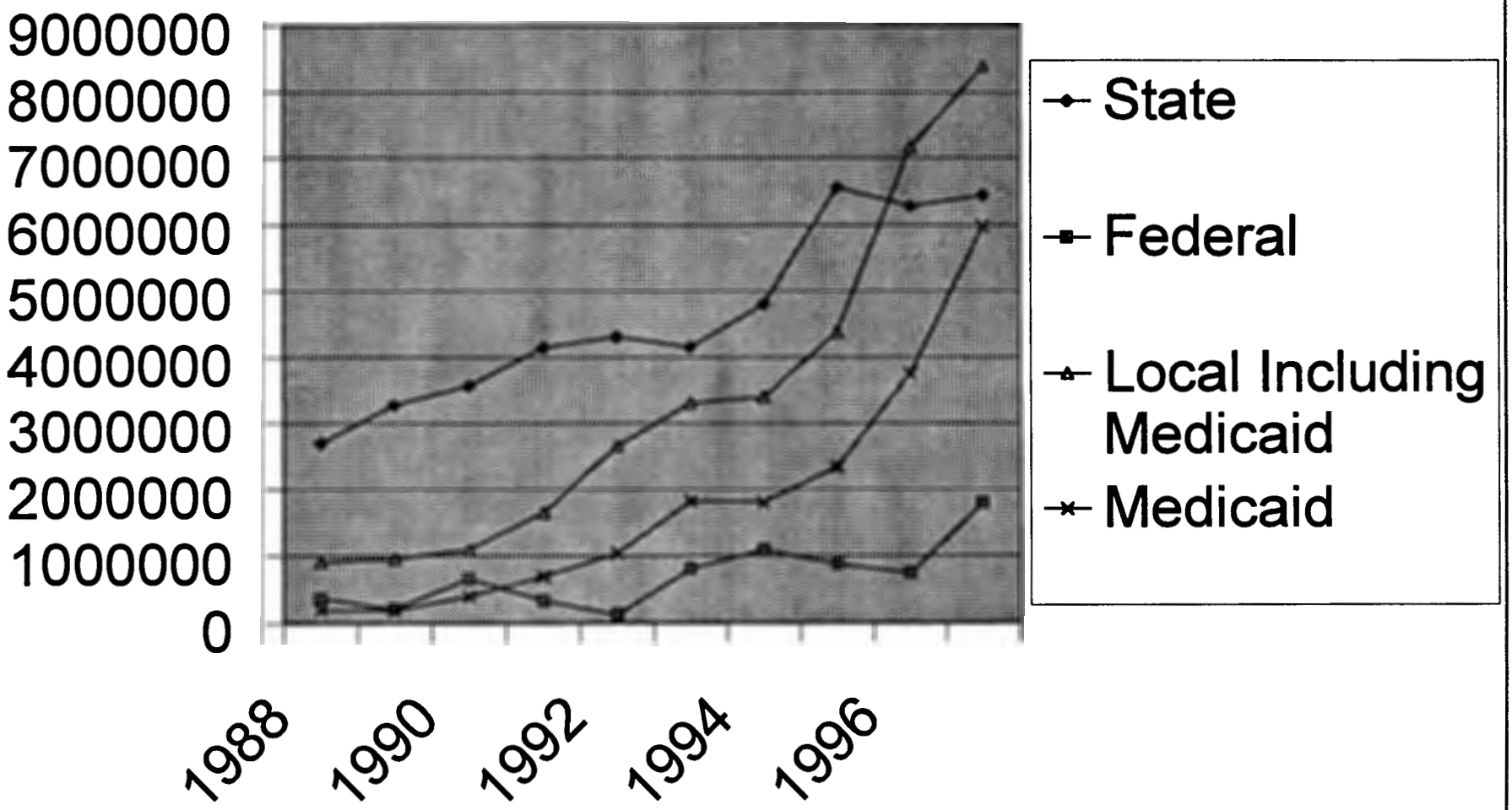
Accessibility - We employer our consumers with the knowledge and skill to use certain organizational and community resources, while simultaneously seeking opportunities to eliminate barriers to services.

Partnership - The therapeutic and/or habilitative process is a working relationship between consumer and staff that requires the trust, honesty and participation of all members.

Excellence - We look for competence at all levels of daily operations, respect for self, consumers and others, and the integrity to maintain high ethical standards.

Self-autonomy - We believe that each of our consumers should be given the freedom of choice, self-direction, and that assistance which may be needed to become independent.

Neuse Center Actual Revenues



Carol Shaw
2-17-98
#2

Briefing Summary

Joint Appropriations Subcommittee on Health and Human Services

February 17, 1998

Agenda Item

Discussion of the role of public health departments in the delivery of health care services for the indigent.

Background Information

The purpose of this agenda item is to facilitate a policy discussion on the impact of current and proposed changes in the state Medicaid program on the role of public health departments in the delivery of health care services for the indigent.

Carolina ACCESS policy has exempted health departments from the requirement to obtain PCP authorization for all Medicaid services that they provide to recipients. Last year, the Division of Medical Assistance proposed requiring that Health Departments get PCP authorization to provide most services for Carolina ACCESS recipients (effective 7/1/98). The exceptions to this proposed requirement were prenatal care services; screening, diagnosis, counseling, or treatment of STDs, TB, and HIV; and "carved-out" services not subject to Carolina ACCESS policy. The new policy allowed PCPs to contract with health departments to provide Health Check screenings which would no longer be exempted under the new health department policy, but the decision to contract was in the control of the PCPs.

Health departments expressed a number of concerns with the new policies: Access to Health Check screenings, impact on school-based clinics, impact on health departments ability to serve the uninsured, and the impact on health departments budgets. HHS has worked with health departments to resolve their concerns. The proposed policy has been discarded and the health department exemption will be continued. In addition, PCPs and health departments are equal partners in meeting Health Check screening targets.

In preparation for this meeting, several health department directors were invited to present their views on the impact of Medicaid Managed Care and the role of public health departments in the delivery of health care services for the indigent.

Issues Impacting Public Health Departments

1) **Role of Public Health Departments under Medicaid Managed Care**: Historically health departments have provided health care services for the poor and uninsured because private providers were reluctant to serve these populations. North Carolina has been successful in encouraging private providers to serve indigents through Medicaid; and Medicaid's payment rates are more competitive with private insurance in today's managed care environment for health care. **What is the impact of these**

changes on health departments traditional role in providing health care services to the poor and uninsured?

2) **Impact of Medicaid on Health Departments' Budgets:** Health departments have been encouraged to seek Medicaid reimbursement to cover the health care and case management services that they have provided to the poor; and health departments have been aggressive in receiving Medicaid funding. Health departments received $65.4 million from Medicaid during 1996-97. Medicaid funding in health departments is described as the "glue" that works with state and local funds to provide many of the health department services for Medicaid recipients and the uninsured. **If Medicaid reimbursement to health departments declines over time, what is the impact on health departments' ability to provide services? How will clients be impacted?**

3) **Future of Health Departments**: Under Carolina ACCESS and ACCESS II, health departments have the option of becoming primary care providers. Currently 18 health departments have chosen to become Carolina ACCESS providers and other departments are considering this option. Being an ACCESS provider locks in Medicaid funding for Health Departments. **What is the impact of health departments focusing on primary care on the core public health functions? What happens to health departments that cannot become primary care providers?**

CAROLINA ACCESS
EXEMPT SERVICES

- Ambulance
- Anesthesiology
- **At Risk Case Management**
- **CAP Services**
- Certified Nurse Anesthetist
- **Child Services Coordination**
- **Developmental Evaluation Centers**
- Certain Eye Care Services
- **Dental**
- **Family Planning**
- **Health Department Services**
- Hearing Aids (.> age 21)
- Hospice
- Independent & Hospital Lab Services
- Optical Supplies/Visual Aids
- Pathology Services
- Pharmacy
- Psychiatric/Mental Health
- Radiology
- **Services provided by Schools and Head Start programs**

CAROLINA ACCESS
HEALTH CHECK

- The Health Check Program provides comprehensive preventive health care for children and teens from birth to age 21.
- Health Check pays for comprehensive child health screenings to detect problems early, and pays for the diagnosis, treatment, and referrals necessary to correct any identified health problems.
- Under Carolina Access, PCPs are required to perform all Health Check responsibilities for children under their care.

CAROLINA ACCESS
PRIMARY CARE PROVIDER REQUIREMENTS

- Operate an office a minimum of 30 hours per week
- Develop patient/physician relationships
- Manage the health care needs of enrollees
- Provide essential preventive services
- Provide 24 hours, 7 day a week access to medical care for enrolled members
- Maintain hospital admitting privileges
- Authorize and arrange referrals when needed

Karen Hammonds-Blanks

Briefing Summary

Joint Appropriations Subcommittee on Health and Human Services

February 17, 1998

Agenda Item

Discussion of the Role of Area Mental Health Programs in N. C.

Background Information

The purpose of this agenda item is to facilitate a policy discussion regarding the role of area mental health programs. The impact of current and proposed changes in the state Medicaid Program; changes in state policy regarding financing of area mental health programs; and implementation of the new Children's Health Insurance Program (CHIP) have forced many area programs to begin questioning their role in the delivery of mental health services across the state.

In preparation for this meeting, several area program directors have been invited to present their views on current and recent state policies regarding financing of area programs including Medicaid and state appropriations. Specifically, directors have been asked to address the impact these items are having on their ability to continue to function in their statutory and traditional role as provider of mental health services for indigents.

Issues Impacting Area Mental Health Programs

1) **Medicaid Growth Reduction Vs. Five Years of Federal Funds Maximization** -- For the last five years the state has forced area programs to increase reliance on federal funds as a source of ongoing revenues to support operation and service expansion. Since FY94/95, the state proposed and the Legislature adopted cuts contingent upon increases in Medicaid and Title IVA-EA reimbursements. Title IVA-EA no longer exists (the funds are capped under the TANF Block Grant) and Medicaid rates are being reduced. ***What is the impact of these changes on area program budgets? How are clients impacted?***

2) **Indigent Care** -- With the elimination of Jordan-Adams funds (previously appropriated inflationary increases for local programs), area programs' funding base has slowly eroded. These, coupled with reduced Medicaid rates, translate into reduced state appropriations for indigent care. ***What is the impact on indigent care? Has the Legislature's policy on the role of area mental health programs changed? What is the future of indigent care for the mentally ill, developmentally disabled or substance abuser in N.C.?***

Fiscal Research Division
February 17, 1998

FINAL REPORT
OF THE
TASK FORCE ON CHILD HEALTH INSURANCE
TO THE
SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

November, 1997

BACKGROUND

In June, 1997, the Secretary of the North Carolina Department of Health and Human Services, the Honorable H. David Bruton, charged the North Carolina Institute of Medicine and the Division of Women's and Children's Health to form a Task Force on Child Health Insurance.[1] The Task Force, chaired by Dr. Gordon H. DeFriese, President of the Institute of Medicine, included representatives of organizations and constituencies around the state having an interest in child health issues (See Appendix A for Task Force listing).[2] The Task Force met six times between the middle of June and the end of October, while subcommittees held additional meetings to deliberate on specific issues.

The work of the Task Force took on more urgency with the passage of the Child Health Insurance Program as part of the Balanced Budget Act of 1997. The number of constituencies represented on the Task Force increased substantially over the course of the meetings, and included representatives of state and local governmental agencies, private health care providers,

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[1] Prior to the Secretary's charge to the N.C. Institute of Medicine, there were two private initiatives to expand health insurance coverage to uninsured children. The N.C. Caring Program, a private-public partnership with Blue Cross Blue Shield, has been operational for ten years. The Caring Program receives approximately $1.0 million each year from the N.C. General Assembly along with private contributions which enables the program to cover approximately 7,000 children with a low-cost limited primary care benefits package. Healthy Kids of North Carolina, Inc. was a separate non-profit initiative aimed at providing low -cost health insurance coverage to children eligible for the free or reduced lunch programs. Healthy Kids, a coalition of consumers, providers and managed care organizations, approached the N.C. Division of Women's and Children's Health to encourage them to apply for a Robert Wood Johnson Foundation grant to replicate the Florida Healthy Kids demonstration program in North Carolina. The group pulled together for the Robert Wood Johnson proposal grew into the Secretary's Task Force.

[2] The Task Force on Child Health Insurance wishes to express its gratitude to Pam Silberman, J.D., Dr.P.H. of the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, and to Tom Vitaglione, MPH, Chief, Children and Youth Section, Division of Women's and Children's Health, North Carolina Department of Health and Human Services, for their staff assistance during the process through which this report was prepared. The Task Force is also grateful to Thomas C. Ricketts, III, Ph.D., Deputy Director for Policy Analysis, and Ms. Ann Howard, Systems Analyst, of the Sheps Center at UNC-Chapel Hill and to Christopher Conover, Ph.D., of the Center for Health Policy, Law and Management at Duke University for their expert and timely analysis of state and federal data pertinent to the number of uninsured children in this state. The Task Force also wishes to thank Aimee Briggs, J.D., Jean Hetherington, J.D., MPH, and Gus Papas, M.D., students at the School of Public Health at UNC-Chapel Hill, for their assistance in providing some of the research used for the Task Force deliberations.

health insurers, managed care organizations, academic health centers, and child advocacy organizations. Although no formal "votes" were cast, genuine efforts were made to ascertain all points of view, to hear about the child health care activities of all public and private agencies and organizations, and to debate the relative merits of all alternative pathways to provide health insurance coverage for North Carolina's uninsured children.

This report presents the major policy choices facing the state in enacting child health insurance coverage. The information provided in this report will enable policy makers to make expeditious and educated decisions on how to implement the provisions of the new Child Health Insurance Program. The Task Force believes that this is the most opportune time in the past 30 years to take such a bold initiative in the interest of North Carolina's children.

PROGRAM GOALS

The Task Force members agreed that the ultimate goal for the new program is to provide children in North Carolina with access to quality, affordable health care. Therefore, the state should define eligible children broadly to reach as many uninsured children as possible. The program should help increase the utilization of preventive health services in order to improve the general health status of children and reduce program costs over the long term. The program should be "seamless" and allow families to participate easily. Adequate information and counseling should be provided so that families understand all their program options, and how to utilize services appropriately. Families should be allowed to enroll all of their children as members of a family unit—therefore, to the extent possible, eligibility and benefits should be consistent for all children in a family and not vary by the age of the child. The program should be built upon the existing state and local infrastructure, so as not to create duplicative administrative structures and higher costs. The new Child Health Insurance Program must include accountability and oversight structures, as well as an evaluation mechanism to assess the effectiveness of the system. Adequate resources should be made available to ensure the success of the program.

OVERVIEW OF THE FEDERAL LEGISLATION

Congress created a new child health insurance block-grant program as part of the Balanced Budget Act of 1997.[3] The program was enacted as Title XXI of the Social Security Act. The federal legislation appropriates $39.6 billion over the next ten years to expand health insurance coverage for uninsured children under age 19 in families with incomes up to 200% of the federal poverty guidelines ($26,600 for a family of three in 1997; this is the equivalent of two workers each earning $6.50/hr.).[4] States are basically given three options: 1) they can

[3] P.L. 105-33.

[4] The legislation authorizes states to cover children up to 200% of the federal poverty guidelines, or 50 percentage points above its current Medicaid income guidelines, whichever is higher. This means that North Carolina could choose to cover infants under age one up to 235% of the federal poverty guidelines (as the state already covers all infants with family incomes up to 185% of the federal poverty guidelines).

expand Medicaid; 2) they can create a new state child health insurance program; or 3) they can implement a combination of both.

Title XXI, like Medicaid, is funded jointly by the federal and state governments. However, states are entitled to an enhanced matching rate under Title XXI to pay for the expanded coverage for children. In North Carolina, the federal government will pay for 74.1% of program costs up to a federal maximum allotment of $79.5 million in FY 1998 (compared to the regular Medicaid matching rate of 63.0%).[5] The state is expected to match the new federal monies.[6] As much as 10% of the federal funds may be used for program administration, outreach efforts, and payment for direct provision of services. If the state chooses to establish a new child health insurance program, it will be limited to the Title XXI federal allotment. However, if the state chooses to expand Medicaid, it may continue to draw down federal monies at the regular Medicaid matching rate if Title XXI enhanced funds are exhausted.

Certain children are ineligible for coverage under the new Title XXI program. States may not use the new money to cover children who presently have private health insurance coverage. Further, states may not use the enhanced federal funds to cover children who are already eligible for Medicaid.[7] In fact, states must screen potential eligibles to determine if they are eligible for Medicaid coverage, and if so, must enroll them in Medicaid. States that choose to establish a new child health insurance program may not use the funds to cover children who are members of a family that is eligible for health benefits coverage under a state health benefits plan, although such limitation does not apply if the state chooses to expand Medicaid coverage.[8]

In order to receive FY 98 federal monies, a state must submit a child health plan to the Secretary of Health and Human Services describing how it will implement the new child health block grant. The plan must describe the state's eligibility standards, the method for delivering services, the benefits package, the outreach plan, and the state's mechanism for monitoring quality and ensuring access. The plan must be approved before September 30, 1998 for the state to receive its 1998 allotment. The state has up to three years to expend each annual allotment of federal funds.

ESTIMATING THE UNINSURED

Low income children, defined as those with family incomes below 200% of the federal poverty guidelines, obtain health insurance coverage through a variety of methods. Some children in North Carolina obtain group health insurance coverage as dependents of working

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[5] The amount of the state's allotment is based on the state's numbers of uninsured children as reported in the Current Population Survey (CPS).

[6] States are expected to match federal Child Health Insurance funds. If the program spent the full $79.5 million in FY 1998, then North Carolina would be expected to provide $27.6 million as the state match. However, the expected expenditures for the first year should be considerably less (see p. 23).

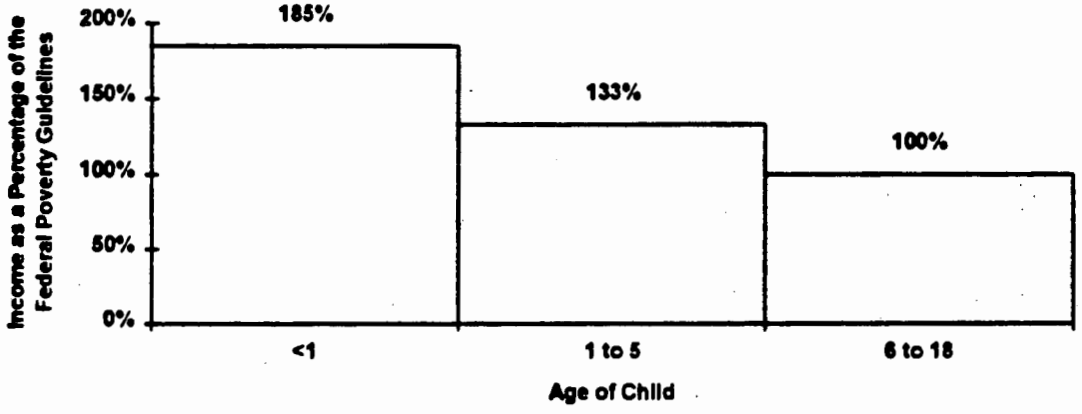
[7] In determining whether the child is eligible for Medicaid, states must use the Medicaid eligibility rules that were in effect in April 5, 1997.

[8] Sec. 2110(b)(2)(B). Children who are inmates of public institutions or patients in mental institutions are also ineligible for coverage.

parents. Some families purchase individual health insurance policies to cover themselves and their children. Other children qualify for publicly-funded programs, like Medicaid or CHAMPUS/VA.

North Carolina's Medicaid program currently covers all infants with family incomes up to 185% of the federal poverty guidelines, children ages one through five with family incomes up to 133% of the federal poverty guidelines, and children ages six through eighteen with family incomes up to 100% of the federal poverty guidelines. (See chart below). This still leaves a large number of uninsured children in families with incomes below 200% of the federal poverty guidelines.

Medicaid Income Guidelines Vary By Age of Child



In North Carolina, there are an estimated 138,743 uninsured children below 200% of the federal poverty guidelines. Of these, 67,401 are estimated to be eligible currently for the Medicaid program and 71,342 would be eligible for the new coverage under Title XXI. There are an estimated 7,800 uninsured children with family incomes below 200% of the federal poverty guidelines who are dependents of state employees.[9]

The basic data source to estimate the numbers of uninsured children in North Carolina is the Current Population Survey (CPS), an annual survey conducted by the U.S. Bureau of the Census. (See next page.) The CPS was chosen as the basic data source because it is the source used by the federal government in determining state allocations under Title XXI. This is the only readily available source of data to estimate the numbers of uninsured children in North Carolina.

[9] The State Health Benefits Office does not collect data on the numbers of uninsured children who are dependents of state employees or teachers, nor does it collect data on total family income (to determine which state employees or teachers have family incomes below 200% of the federal poverty guidelines). Therefore, the Sheps Center for Health Services Research at UNC-CH used 1996 CPS data for the U.S. South to get an estimate of the numbers of state or local employees with family incomes below 200% of the federal poverty guidelines with uninsured children. The Sheps Center applied this percentage to the total number of N.C. state employees and teachers eligible for the state health benefits plan.

Average Daily Health Insurance Coverage, by Poverty Status
North Carolina
(based on 1995-96 Current Population Survey data, adjusted to 1997 NC Population Projections)[10]

Age Category/ Type of Coverage	Total Children	Family Poverty Status (as percent of Federal Poverty Guidelines) <100%	100-124%	125-149%	150-174%	175-199%	200-399%	400%+
				Average Daily Number				
Under 1	98,439	26,303	12,136	5,948	7,740	4,657	23,664	17,992
Group Coverage	38,861	1,509	2,162	662	5,555	1,902	15,347	11,725
Medicare	-	-	-	-	-	-	-	-
Medicaid	43,144	21,627	9,974	4,660	1,559	1,283	*4,041*	-
CHAMPUS/VA	7,683	678	-	626	626	632	4,275	845
Individual Coverage	1,429	-	-	-	-	-	-	1,429
Uninsured	7,321	2,489	-	-	-	840	-	3,992
1 to 5	510,676	139,311	27,174	33,602	28,291	28,584	154,870	98,843
Group Coverage	257,758	9,196	8,960	15,651	12,661	13,275	112,905	85,110
Medicare	-	-	-	-	-	-	-	-
Medicaid	153,381	106,086	10,958	10,365	5,905	7,566	10,874	1,627
CHAMPUSVA	29,648	2,016	1,749	1,784	6,727	4,613	12,139	619
Individual Coverage	12,293	1,275	1,803	-	2,100	-	2,221	4,894
Uninsured	57,595	20,738	3,704	5,803	898	3,129	16,730	6,593
6 to 18	1,290,676	268,871	52,875	67,351	73,853	62,323	479,429	285,975
Group Coverage	766,376	25,896	30,194	22,675	23,523	40,941	368,446	254,701
Medicare	3,863	-	2,630	-	-	1,233	-	-
Medicaid	239,431	185,007	3,623	15,933	13,679	6,638	14,551	-
CHAMPUS/VA	43,676	2,566	2,920	-	8,854	3,274	20,354	5,708
Individual Coverage	79,333	14,932	1,766	9,920	5,425	2,499	31,651	13,139
Uninsured	157,997	40,470	11,742	18,822	22,372	7,736	44,428	12,427
TOTAL CHILDREN	1,899,791	434,485	92,184	106,901	109,884	95,564	657,963	402,810
Group Coverage	1,062,996	36,601	41,316	38,988	41,738	56,118	496,698	351,536
Medicare	3,863	-	2,630	-	-	1,233	-	-
Medicaid	435,957	312,720	24,555	30,958	21,143	15,487	29,467	1,627
CHAMPUS/VA	81,006	5,260	4,669	2,410	16,207	8,520	36,769	7,172
Individual Coverage	93,054	16,207	3,569	9,920	7,525	2,499	33,871	19,462
Uninsured	222,913	63,697	15,446	24,625	23,270	11,705	61,158	23,012

[10] CPS data have some limitations. First, they are based on relatively small sample sizes in each state. Thus, experts at the Sheps Center for Health Services Research (UNC-CH), the Duke Center for Health Policy, Law and Management, and the State Center for Health Statistics combined 1995 and 1996 CPS numbers to gather more reliable estimates. Second, the CPS data were adjusted to reflect the actual number of children in North Carolina in 1997 (as estimated by the North Carolina Office of State Planning). Finally, CPS historically undercounts the number of children receiving Medicaid (thereby overestimating the numbers of uninsured). The Division of Medical Assistance adjusted the CPS numbers to reflect the true numbers of Medicaid enrollees.

PROBLEMS FACED BY UNINSURED CHILDREN

The lack of health insurance is a substantial barrier for low-income families in obtaining timely and appropriate health care. Children with health insurance are more likely to receive regular and preventive health care (GAO, 1996). Children without health insurance have difficulties in obtaining routine services and are less likely to receive childhood immunizations, one of the key preventive measures (Wood, 1990; Oberg,1990; Himmelstein, 1995). These children are more likely to be seen in an emergency room with more severe illnesses and are less likely to get care for injuries (Overpeck, 1995), to see a physician if chronically ill, or to obtain regular dental care (Monheit, 1992).

The lack of appropriate care can affect a child's health status throughout life. The 1987 National Medical Care Expenditure Survey showed that one-third of the uninsured children with recurring ear infections and half of the uninsured children with asthma never saw a doctor (Agency for Health Care Policy and Research, 1987). Children with recurring ear infections may suffer permanent hearing loss, and children with untreated asthma may endure avoidable hospitalizations. Children with undiagnosed vision problems may be unable to see the blackboard, and children in pain or discomfort may have trouble concentrating in school. The lack of health insurance coverage for children has adversely affected North Carolina's children, as is evidenced by these "real-life" examples below:

> Three-year-old Jane developed an earache one night. Since she was not covered by her parents' insurance, the family chose not to take Jane for medical care. After 3 days the earache subsided. Jane experienced five such episodes over the next 18 months. She was diagnosed with a mild hearing loss when she received her kindergarten health assessment.
>
> Paul was diagnosed with mild cerebral palsy soon after discharge from the newborn nursery. His parents' insurance covered basic medical care, but did not cover special therapies or equipment (such as wheelchairs). Because of their limited income, Paul's parents were unable to pay for these services and equipment out-of-pocket. Five years later, Paul entered school in a stroller. He had a curvature of the spine and joint contractures. The school arranged for special therapies and a wheelchair (to be used only at school). The therapists reported that Paul's disability had progressed too far for therapies to have their maximum positive effect.
>
> Mary was thirteen and having trouble adjusting to high school. Her grades began to slip and she seemed depressed. The school counselor recommended that Mary receive mental health services. Mary's parents had no insurance coverage. They were reluctant to seek "free" services in their community, and decided to seek second jobs to save money to get services for Mary. In the meantime, Mary attempted suicide.

OVERVIEW OF THE CHOICES

Each state faces a number of choices in designing its child health insurance program. These choices include:

- •Basic Program Options
  - •Medicaid Expansion
  - •New Insurance Program
  - •Combination of the Two
- •Administration
  - •Eligibility Determination/Enrollment
  - •Outreach
  - •Benefits Education and Advocacy
- •Benefits Package
- •Cost-Sharing
- •Delivery System
- •Access, Quality Assurance, and Consumer Protections
- •Crowd-Out

The Child Health Insurance Task Force considered these choices over a course of six meetings. Task Force members were generally in agreement on a number of these issues (including outreach and enrollment, administration and eligibility determination, benefits education and advocacy, and support services to promote utilization of preventive health services), but reached less consensus on other topics (including delivery system design). Where consensus was reached, only one set of recommendations is presented. Where consensus was not evident, a number of different options are presented along with the advantages and disadvantage of each.

1) Basic Program Options

The state has three options under the Child Health Insurance Program—it can expand Medicaid, create a new child health insurance program, or design a system that combines the two.

a. Medicaid Expansion:

Under this option, the state would expand Medicaid to cover as many uninsured children under 200% of the federal poverty guidelines as funds would permit. Uninsured children who qualify for the program would be guaranteed coverage (i.e., the program would remain an entitlement program).

One of the chief advantages of using the Title XXI funds to expand Medicaid is that the state can build on an existing infrastructure (Weil, 1997). The state already covers approximately 435,000 low income children through the Medicaid program. The state has a network of providers, systems for handling client and provider issues such as enrollment,

education, outreach, appeals, and mechanisms for rate setting, claims payments, and fraud prevention. In addition, the state's administrative costs for Medicaid are quite low—averaging approximately 4 percent. The system is in place and operational, so it would be the easiest option to implement. Due to the size of the program, Medicaid has significant purchasing power. The addition of the newly-covered children would increase its leverage to the benefit of both the new and current eligibles.

Another advantage is that states can use enhanced Title XXI funds through the Medicaid program to cover the dependents of state employees and teachers. This is the only way currently that North Carolina can cover uninsured dependents of state employees and teachers.[11] This is an exception from the general provisions which prohibit states from using Title XXI funds to cover dependents of state employees. In addition, because Medicaid is an entitlement, the state can continue to draw down federal funds at regular Medicaid matching rates to support health insurance coverage for children if Title XXI funds are exhausted.

Expanding Medicaid eligibility would also be easier for many families. Under current Medicaid rules, some children in a family may be eligible for Medicaid and other siblings not, because of the difference in the state's Medicaid income guidelines for children of different ages. If the state expanded Medicaid to cover all children in the family, all the children in a single family would be eligible for the same benefits package and could obtain care from the same set of providers.

One concern raised by some is that, because Medicaid is an entitlement program, the state may be required to appropriate additional funds if the numbers of uninsured exceed the initial budget estimates. However, the General Assembly always has the option of modifying eligibility rules, payment rates, or services covered to decrease program costs. In addition, the current Medicaid eligibility determination process apparently creates barriers for some families, for many eligible families are not enrolled. (Note: The Task Force recommended that a simplified eligibility determination process be used in both the Medicaid and new Title XXI program.)

b. New Child Health Insurance Program

Another option is a separate child health insurance program. The federal law gives the state flexibility in designing this new program, as long as it creates a benefits package that is actuarially equivalent to one of three benchmarked plans (See Section 3 below).

The chief advantage of this approach is that the fiscal liability of the state is limited The state could set eligibility caps and establish waiting lists if the numbers of eligible uninsured children were higher than initial estimates.

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[11] The October 10, 1997 HCFA Question and Answer communication clarifies that states can use enhanced Medicaid funds to cover dependents of state employees if the state chooses to expand Medicaid (Question 34). However, states are still prohibited from using Title XXI funds to cover dependents of state employees if the state chooses to establish a new child health insurance program.

Disadvantages to this option would include higher administrative costs, the possibility that fewer services might be offered, and difficulties in coordination with the Medicaid Program (both in eligibility determination and in service delivery).

Another disadvantage is that the state cannot cover dependents of state employees if it enacts a separate child health insurance program. Also, under a separate insurance program, federal funds available to cover the uninsured are limited. Therefore, if the state does not want to put a limit on the number of children it covers, a separate program will provide less federal assistance than an entitlement program. See chart below:

	For Each $100 in Coverage Until the Allotment is Used Up		For Each $100 in Coverage After the Allotment is Used Up	
	Medicaid Option	Separate State Program	Medicaid Option	Separate State Program
Federal Share	$74.10	$74.10	$63.00	$0
State Share	$25.90	$25.90	$37.00	$100

c. Combination of Medicaid Expansion and New Insurance Program:

The state can expand Medicaid eligibility and create a new block grant program to cover the children above the state's new Medicaid income guidelines. For example, the state can expand Medicaid to 150% of the federal poverty guidelines, and create a new state child health program for children with family incomes between 150%-200% of the FPG. This limits the state's potential fiscal liability while still providing assurances that the lowest income children in the state will be covered. Also, dependents of state employees with family incomes below 150% of the federal poverty guidelines would be covered.

The program may not be as "seamless" for families if the state creates two programs with two delivery systems or benefit packages. However, this problem can be overcome if the state chooses to create a "Medicaid look-alike" program (which would be a non-entitlement program that offers children the Medicaid benefits package and operates through the Medicaid system).[12] Also, if the state does not want to put a limit on the number of children it covers, a block grant program will provide less federal assistance than an entitlement program.

[12] It is important to note that the state cannot cover uninsured dependents of state employees or teachers as part of a Medicaid look-alike program.

2. *Administration (Including Eligibility Determination/Enrollment, Outreach and Marketing, Benefits Education and Advocacy)*

There was a general consensus among members of the Child Health Insurance Task Force that the state should administer the new Child Health Insurance Program (whether it is a Medicaid expansion or a new block grant program). The state should have primary responsibility for the eligibility determination process, outreach and marketing, benefits education and advocacy, data collection and analysis, quality assurance, planning, and evaluation. The state should also be responsible for monitoring the performance of private managed care organizations (MCOs) if the state chooses to contract with private MCOs. The state can use up to 10% of the federal allocation for administration, outreach and marketing costs and direct provision of health services.

The Task Force recommended that the state simplify the application form (for both Medicaid and any new program), decentralize places where applications can be taken through outstationed staff, and allow mail-in applications. The Task Force also recommended that the state explore the role that others (e.g., public health, private providers, schools, Smart Start, day care, etc.) can play in the eligibility determination process. The same application should be used for the Medicaid program and the new child health block grant program, and ideally, should also allow the state to determine the family's eligibility for other public programs through the same process and portals of entry. In addition, the state should utilize the existing eligibility information system to prevent children from being inadvertently enrolled in two programs, provide a consistent source of enrollment data, and avoid the substantive investment required in creating a new computerized information system.

The state should also implement federal options for simplifying the Medicaid enrollment and re-enrollment process, and use these same strategies if the state implements a new child health insurance program. These strategies include presumptive eligibility for children, and 12 month guaranteed eligibility. Reports indicate that presumptive eligibility, simplified application forms, and outreach activities have been successful in enrolling eligible Medicaid recipients (GAO, 1991; Center on Budget and Policy Priorities, 1997).

The Task Force recommended that the state conduct an extensive outreach and marketing campaign in order to reach as many eligible children as possible. There are three possible sources of money for this effort: 1) a portion of the 10% federal Child Health Insurance Program funds spent in the state; 2) the federal funds available to the state for Medicaid outreach as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (90% federal matching rate);[13] or 3) Medicaid funds that are generally available for outreach activities (50% federal matching rate).

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[13] Congress appropriated $500 million to be made available to the states at an enhanced match rate to help pay for administrative activities to ensure that children and families do not lose Medicaid coverage as a result of welfare reform changes. Section 1931(h) of Title XIX of the Social Security Act (Medicaid). North Carolina's share of the allotment is $11,550,703. Federal Register. May 14, 1997. Vol. 62, No. 93.

The Task Force recommended that the state use a single name for both Medicaid and the new child health insurance program to support a simple, seamless marketing approach. (The Task Force recognized that it would be difficult to have a single name if the two programs operated substantially differently). The state should develop a marketing approach that includes the program name, logo, and slogans, through social marketing research with the targeted population. This would be similar to the process used in designing the "Baby Love" campaign, which has been heralded as one of the most successful efforts in the country in reaching out to uninsured pregnant women. The outreach and marketing plan should involve health care providers, consumers and local voluntary organizations with interests in children. Existing resources should be built upon and expanded to support the program, including the First Step Campaign Office, the Health Check Hotline and the system of Health Check Coordinators. The existing telephone hotlines can be used to provide families with program information and referral to community resources.

In addition, the Task Force recommended that the program include health benefits advisors and an Ombuds office. The health benefits advisors would help to educate families about the covered benefits, choice of plans (if any) and provider options. The program should also include a centralized Ombuds office. This office can help advocate on the child's behalf if problems arise in accessing services, can assist in the appeal process and ensure that the program is functioning as intended.

3. Benefits Package

The Medicaid benefits package is the most comprehensive health insurance package currently available for children in North Carolina. Unlike most commercial health insurance plans which are largely designed to meet the needs of commercially-insured adults, the Medicaid benefits package has been fashioned specifically to meet the needs of children, including children with special health care needs. Approximately 10% of the children in this country have special needs.[14] While Task Force members were generally supportive of using the Medicaid benefits package, they recommended that dental reimbursement rates be enhanced (for current Medicaid beneficiaries and for any children covered under Title XXI) to attract sufficient numbers of dentists to participate in the program.

The state can use the Medicaid benefits package in implementing the new child health insurance program (whether or not it chooses to expand Medicaid as an entitlement), or it can design a new benefits package. If the state chooses the latter, the state must create a comprehensive benefits package that is equal to or actuarially equivalent to one of three

[14] National estimates suggest that between 5-10% of children experience some developmental problems sometime during their lives, between 12-15% of children experience behavioral and emotional disorders, and between 3-5% of children have complex physical conditions (such as spina bifida, sickle cell anemia, AIDS, cancer or cystic fibrosis). Fox H, McManus P. Preliminary Analysis of Issues and Options in Serving Children with Chronic Conditions Through Medicaid Managed Care Plans. Maternal and Child Health Policy Research Center, Washington D.C. 1994 Aug.

benchmarked plans listed in the federal legislation: the State Employees Health Plan, the Federal Employees Health Benefit Plan (Blue Cross Blue Shield PPO option), or the most commonly commercially purchased HMO plan in the state. The Child Health Insurance Task Force analyzed the different benefits available under each of the benchmark plans (Medicaid, State Employees Health Plan, BCBS Federal Employees Health Benefits Plan, Healthsource Advantage,[15] and Blue Cross Blue Shield PCP Option 1).[16] Based on this analysis, it chose two plans (with some modifications) for William M. Mercer, Inc. to cost-out: 1) Medicaid; and 2) the State Employees Health Benefits Plan (See Appendix B).

The Task Force considered using the benefits package available to state employees and teachers, because it is one of the three allowable benchmarked plans and is well understood by the general public. Since this plan was largely designed for an adult population, the Task Force recommended the addition of preventive dental services and a biennial comprehensive vision exam to better meet the needs of children. In addition, the State Employees Health Plan also excludes certain services needed by children with special needs. For example, the State Employees Health Plan will pay for special therapies when a child is showing significant progress, but not to help a child maintain functional status. These services are critical to certain children with developmental disabilities and severe chronic illnesses who may need continuing therapies to ensure that the condition does not deteriorate. Therefore, if the state chooses to use the State Employees Health Benefits package, the Task Force would recommend the creation of a "wrap-around" reinsurance pool. This would enable families to obtain the specialized services that their children with special needs require.[17]

The William M. Mercer, Inc. actuarial data showed that the cost of the Medicaid expansion option (using current N.C. Medicaid reimbursement rates) was actually less expensive than a private option (based on the provider reimbursement rates currently paid under the State Employees Health Plan). The costs are described below:

[15] According to data obtained from Healthsource, Healthsource Advantage is the most commonly purchased commercial HMO plan sold in North Carolina.

[16] According to data obtained from Blue Cross Blue Shield of North Carolina, PCP Option 1 is the most commonly purchased commercial POS plan sold in North Carolina.

[17] The North Carolina Pediatric Society has created a task force to explore the idea of creating a reinsurance pool to address the health care needs of special needs children who have commercial insurance or are uninsured.

Comparative Costs of the State Employees Health Plan and Medicaid Benefits Packages[18]
(common utilization assumptions with no cost-sharing)

Age/Gender Bands	Modified State** Employees Health Plan (per member per month)	Medicaid Benefits Package (per member per month)	Variance
<1	$318	$281	13%
1-5	95	85	12%
6-18	74	70	6%
14-18 female	159	154	3%
14-18 males	172	175	2%
Total*	108	104	4%

* Does not include administrative costs.

** Services for children with special needs are somewhat limited. Eyeglasses and hearing aids are excluded. Special therapies and medical equipment are not covered when a child's condition is not improving.

4. Cost-Sharing

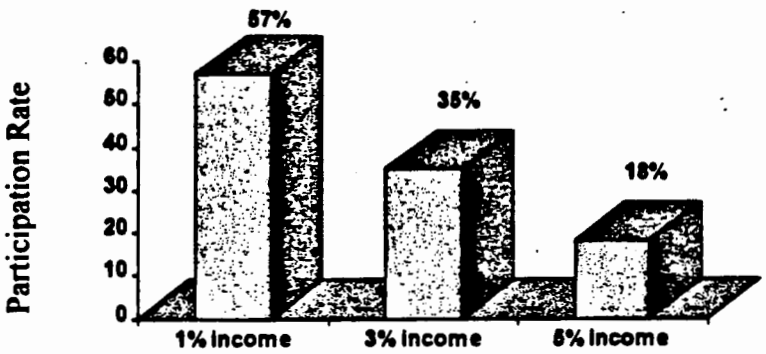
Federal law sets different cost-sharing requirements for families with incomes below 150% of the federal poverty guidelines versus those with incomes at or above 150%. For families below 150% of the federal poverty guidelines, states may impose nominal monthly premiums, but no cost-sharing (i.e., deductibles, copayments, or coinsurance). For families at or above 150% of the federal poverty guidelines, states may impose a premium and/or other cost-sharing, as long as the total out-of-pocket costs do not exceed 5% of the family's income. States may not impose any cost-sharing on preventive services (e.g., well-baby, well-child, or immunizations). Further, states may not use any cost-sharing amounts to finance the state share of the new Title XXI program.

Cost-sharing serves several purposes, such as deterring unnecessary utilization, reducing any potential welfare stigma associated with public programs, and potentially decreasing the possible "crowd-out" effect. However, cost-sharing may deter enrollment and utilization of

[18] William M. Mercer Inc. presentation to the Child Health Insurance Task Force, October 23, 1997. Mercer, Inc. provided actuarial estimates for both the Medicaid benefits package and that of the modified State Employee Health Plan (with dental and vision benefits included). The estimates are based on the reimbursement profiles of each program. Common utilization assumptions were used. The children that will receive coverage under Title XXI, taken as a whole, will be more indigent than the current SEHP child population, and less indigent than the current Medicaid Program child population.

medically necessary services. For example, a recent study from the Urban Institute showed that families are highly sensitive to the cost of health insurance premiums, and that even moderately priced premiums tend to deter significant numbers of low and moderate income families from participating in the publicly subsidized programs. In addition, collecting monthly premiums would be expensive and administratively burdensome.

Participation in Children's Health Programs In Relation To Premium Increases



Premiums as a Percentage of Family Income

(Ku and Coughlin, 1997).

For these reasons, the Task Force identified two policy options for the two income groups defined as targets in the statute: (a) no cost sharing of any kind, or (b) nominal cost sharing (including a one-time annual enrollment fee, and copayments for the higher income families). These options were presented to William M. Mercer, Inc. actuaries to determine the impact of these policies on actuarial costs. In general, the annual enrollment fee reduced the monthly costs by $1 per member. The copayments reduced the monthly costs by approximately $8 per member.

Families with incomes below 150% of the federal poverty guidelines:

Option a: No cost-sharing or premiums of any kind.

A policy of no cost-sharing or premiums would be the easiest to administer, and would eliminate any potential financial barriers which low income families may experience in obtaining needed health services or in participating in the program. However, free programs may carry a "welfare" stigma, and may reduce a family's perceived ownership of the insurance coverage.

Option b: $10 (one child)/$19 (two or more children) annual enrollment fee to be paid one time each year.

The Task Force chose not to recommend a monthly premium since the costs of collecting the premium would exceed any programmatic savings. The experience of some states that imposed monthly premiums in their child health insurance program showed that the premiums were hard to collect, and caused some beneficiaries to drop coverage. For example, approximately 40% of the children enrolled in the Florida Healthy Kids program dropped coverage when premium rates were increased about $15 per month (Shenkman, 1996). Those with the lowest family income were the most likely to drop coverage. Children with the greatest health care needs were the most likely to remain insured, thereby raising the premium costs for the covered children. Initially, Tennessee had great difficulty collecting premiums, and about 40% of the individuals who were required to pay premiums dropped their coverage (Wooldridge, 1996).[19] Because of the difficulties experienced in other states, the Task Force recommended a modest annual enrollment fee instead of a monthly premium.

An enrollment fee helps to reduce program costs and may create more investment in the program by families. However, even this modest annual enrollment fee may reduce program participation, and may be administratively complex to manage. Several members of the Task Force were reluctant to impose any enrollment fee, because of the concerns that this fee might deter program participation.

Families with incomes at or above 150% of the federal poverty guidelines:

Option a: No premium or cost-sharing.

Members of the Child Health Insurance Task Force thought that the same policy reasons for not imposing cost-sharing on the lower-income families also applied to the families with slightly higher incomes. In general, it is easier to design and implement a program without cost-sharing requirements. Without cost-sharing requirements, the state would have no need to monitor a family's out-of-pocket payments to ensure that the cost-sharing did not exceed 5% of the family's income.

Option b: $10/$19 annual enrollment fee. $0/$3 prescription drug copayment (generic/brand name drugs, $3 copayment would be waived if medical reason for brand-name); $3 acute care outpatient visits; $20 for non-"emergency" use of emergency department services.[20]

The combined enrollment fee and copayments reduce the monthly member costs by approximately $9. This would help reduce overall program costs. In addition, the copayments may help deter unnecessary utilization, and may create an investment in the program on the part of program participants and may remove the welfare stigma. However, some of the Task Force members expressed concerns with several aspects of this proposal. First, copayments are

[19] Tennessee's premiums were based on the families' income, and ranged from 20% of the capitation rates for families with incomes between 100-199% of the Federal Poverty Guidelines to 100% of the capitation rate for families with incomes at 400% of the Federal Poverty Guidelines.

[20] The state would use the new definition of emergency contained in SB 455, enacted as part of the 1997 Session.

effectively "taxes" on *providers*. If the recipient is unable to pay the required copayment, the provider is in the position of having to refuse care or to have their reimbursement effectively cut by the cost of the copayment. This may deter provider participation in the program. Second, studies in the past have shown that cost-sharing helps deter both necessary and unnecessary care (Lohr, 1986). Poor children, those with incomes below 200% of the federal poverty guidelines, were most likely to be adversely affected by the imposition of cost-sharing, particularly for acute conditions where highly effective therapies were available. Third, 86% of the parents of uninsured children are also uninsured (National Association of Children's Hospitals, 1997). These families are already likely to be incurring significant out-of-pocket costs to meet the health care needs of the adult family members, and may have few resources available to pay additional health care costs.

5. Delivery System

The Task Force members generally agreed that private managed care organizations (MCOs), including health maintenance organizations, provider sponsored networks or other forms of managed care, should be allowed to participate in the program. However, there was considerable divergence of opinion on how this could best be accomplished. There were generally three proposals discussed during the Task Force meetings: 1) operate the program through the Medicaid system, with the state setting an established premium price, allowing any MCO to participate as long as it met the state's quality, access and benefits standards; 2) contract out the program to the lowest cost bidder or bidders (with the assumption that bids must be less than Medicaid's cost to care for this population); or 3) create a voucher program and allow recipients to choose from competing health care plans

Because there was such diversity of opinion on these issues, the Task Force created a list of criteria for judging these different approaches, including: a) existence of an operational administrative structure; b) choice of plans; c) choice of providers; d) ease of implementation; e) ability to interface with Medicaid; f) cost-effectiveness; g) seamlessness for families; h) ability to track utilization and monitor quality; i) ability to operate the system statewide; j) simplicity of understanding for families.

Medicaid-administered, private plan participation:

The N.C. Division of Medical Assistance (DMA) would administer the program, but would allow any managed care organization to offer coverage as long as the MCO can deliver services for the same cost, quality and access as the state now provides to Medicaid-eligible children. This is similar to the system offered state employees and teachers, who are given a choice of a traditional fee-for-service indemnity plan or can pick from competing HMOs. Under this option, recipients would be given the option to choose any plan operating in their service area (including the Medicaid delivery system), at no additional cost to the family. Plans could compete on the basis of quality and extra services. This program could be operated even if the state chose not to expand Medicaid, by establishing a Medicaid look-alike program (basically a non-entitlement program that operates like a Medicaid program).

In assessing the Medicaid-administered, private plan participation option, the Task Force found the following:

a) *Existing administrative structure:* The Medicaid system is already operational statewide, and includes mechanisms for accountability, oversight and evaluation. The state would not need to create a new administrative structure, although an additional investment would be required to modify and expand existing systems to meet the broader needs and requirements of the Child Health Insurance Program.
b) *Choice of plans:* This system permits any willing MCO that meets the state's price and quality criteria to participate. This also would enable recipients to have a choice of plans.
c) *Choice of providers:* The lack of providers available to treat children is a concern in the Medicaid program. This problem might be ameliorated if more MCOs offer coverage, as MCOs may have a broader network of providers.
d) *Ease of implementation:* This option would be the easiest to implement, as Medicaid is already operational and has had experience with prior program expansions.
e) *Ability to interface with Medicaid:* Since this option would be implemented by the Division of Medical Assistance, it has the best ability to meet the federal requirements of coordination with the Medicaid program.
f) *Cost-effectiveness:* The program is cost-effective, as the Medicaid benefits costs are actually lower than benefits offered under the State Employees Health Plan, and the Medicaid administrative costs are only 4% of the total costs of the system. Further, the actuarial costs of the Medicaid benefits package, using the Medicaid reimbursement rates, are actually lower than other less comprehensive commercially available plans.
g) *Seamlessness for families:* Another advantage is that having the two programs operate in concert would make it easier to meet the federal requirements that the state coordinate coverage for Medicaid and the Children's Health Insurance Program. Also, as family incomes (and eligibility) fluctuate, eligibility for regular Medicaid or the look-alike plan may vary, but benefits and enrollment would be continuous and seamless.
h) *Ability to track utilization and monitor quality:* The state is enhancing its current computer system to be able to analyze managed care organization utilization data to assure access and quality.
i) *Statewide operation:* The Medicaid program is operational statewide, and allows for flexibility in the design of the delivery system to accommodate regional variations in the private market (for example, the Medicaid agency can operate a fee-for-service system, a primary care case management program, and a capitated program, depending on the availability of managed care organizations).
j) *Simplicity of understanding for families:* The Medicaid system already has experience educating low-income families and children about multiple plan options, which it can draw upon in implementing a further expansion.

Contracting with Lowest Cost Bidder(s):

Under this plan, the state would open the program for competitive bids from managed care organizations. The lowest bidder(s) who meets the state quality, access and benefits

requirements can participate in the program, provided the qualifying bids are less than Medicaid costs for serving the same population.

In assessing the lowest cost bidder option, the Task Force found the following:

a) *Existing administrative structure:* The Department of Health and Human Services would have to establish contracting rules to assure cost, access and quality standards are met.
b) *Choice of plans:* This system potentially offers the recipients the fewest choice of plans.
c) *Choice of providers:* Depending on the MCOs participating, plans may offer recipients an extensive or a more limited choice of providers.
d) *Ease of implementation:* Once basic contracting rules are established, the program would be relatively easy for the state to administer as the program would be contracted out to private organizations to deliver services.
e) *Ability to interface with Medicaid:* It would be more difficult to coordinate with Medicaid.
f) *Cost-effectiveness:* The state could save money if a MCO bid at a lower price than the Medicaid costs. However, it is probable that the overall administrative costs associated with developing efficient and effective linkages with Medicaid would be significant.
g) *Seamlessness for families:* This program would be harder to interface with Medicaid. If a family had one child in the Medicaid program, and another child who was receiving services through the private MCO, the family may have to take their children to different providers. Further, continuity of care might be impeded if family circumstances change so that they move from Medicaid to the separate child health insurance program (or the reverse).
h) *Ability to track utilization and monitor quality:* Most of the larger HMOs have experience tracking utilization data for HEDIS-type performance measures, although it is unclear that other MCOs have similar capacity. The state agency would still be charged with collecting and analyzing the data.
i) *Statewide operation:* Although several of the HMOs are licensed statewide, only about 90 of the counties have an HMO option available to them through the State Employees Health Plan.
j) *Simplicity of understanding for families:* A program with a limited choice of MCOs may be easier for families to understand. However, as noted previously, this program would be more difficult for families with other children covered by Medicaid as the family would need to understand two different program rules.

Vouchers:

Under this option, eligible families would be given a voucher to purchase a private health insurance plan that meets mandated cost, quality, access, and benefits requirements. Because there is an insufficient track record with this type of system operating successfully anywhere in the country, the Task Force was reluctant to recommend this option. However, as there were some Task Force members who expressed an interest in this type of approach, an analysis of this

option is reported below. Given the lack of experience with this type of approach, any suggestions on the impact of this program are largely speculative.

In assessing the voucher option, the Task Force found the following:

a) *Existing administrative structure:* The state would need to establish a new structure to administer the program. This would delay program implementation.
b) *Choice of plans:* Theoretically, this system would afford recipients the greatest freedom of choice among plans, assuming that plans were willing to participate at the state's fixed premium level.
c) *Choice of providers:* Depending on the MCOs or insurers chosen, the plan may offer recipients an extensive or a more limited choice of providers.
d) *Ease of implementation:* There is little existing structure in place to administer the program.
e) *Ability to interface with Medicaid:* As with the private contracting option, this program would be more difficult to coordinate with Medicaid.
f) *Cost-effectiveness:* The program would be relatively cost-effective if the state used the Medicaid actuarial costs as the voucher value.
g) *Seamlessness for families:* This program would be harder to interface with Medicaid. If a family had one child in the Medicaid program, and another child who was receiving services through a private MCO, the family may have to take their children to different providers. Further, continuity of care might be impeded if family circumstances change so that they move from Medicaid to the separate child health block grant program (or the reverse).
h) *Ability to track utilization and monitor quality:* With a multiplicity of participating plans, it would be more difficult to adequately track utilization and monitor quality. The state would need to build in strong marketing and consumer protections to prevent the dissemination of misleading information.
i) *Statewide operation:* It is unclear whether this program could successfully operate on a statewide basis, as it has largely been untested.
j) *Simplicity of understanding for families:* Because of the lack of experience with this approach, its understanding for families is difficult to assess. It seems likely, however, that this approach would require an enormous amount of health benefits advisement.

Based on this analysis, the Task Force developed the following chart comparing the three delivery system approaches:

Evaluation Criteria	Medicaid administration and other plans participating	Contracting out to lowest cost bidder(s)	Vouchers
Administrative structure in place	★★★★★	★★★★	★
Choice of plans	★★★	★★	★★★★★
Choice of providers	★★★	★★★★	★★★★
Ease and quickness of implementation	★★★★★	★★★★	★
Ability to interface with Medicaid	★★★★★	★★★	★★★
Cost-effective system of care	★★★★★	★★★★	★★★★
Seamlessness for families	★★★★★	★★★	★★★
Ability to track utilization	★★★	★★★	★
Statewide delivery system	★★★★★	★★★★	★★★
Simplicity of understanding	★★★★★	★★★★★	★
Average ranking:	4.4★	3.6★	2.6★

(Ranking: 1-5★, with 5★ indicating that the delivery option was most likely to meet the criteria established by the Task Force.)

6) Access, Quality Assurance and Consumer Protections

The Task Force believed that the new Child Health Insurance Program should include mechanisms to assist families in accessing health care services on behalf of their children. Families, particularly of low and moderate income, often experience barriers which make it difficult for them to access needed care. For example, some families lack transportation, have difficulty taking time off work to take their children to the doctor, need translation services, or help understanding how to obtain care within a managed care environment. North Carolina,

through Medicaid's Health Check program, has already had success in helping families obtain needed services. The program has coordinators in 53 counties which helps families access care and coordinates available community resources. This can serve as a model for the state's Child Health Insurance Program.

The federal Balanced Budget Act requires the state's Child Health Insurance Program to include performance measures and report on these measures to the U.S. Secretary of Health and Human Services. Performance measures will assist the state with assuring that the program provides accessible, high-quality health care services to North Carolina's children. Both quality assurance and quality improvement measures will be used. The quality assurance measures will focus on structural issues, such as accreditation and credentialing of providers, provider capacity, and geographic accessibility. These measures also will assess processes, for example the percentage of children and adolescents receiving check-ups and immunizations as called for by the American Academy of Pediatrics. By contrast, the quality improvement measures will focus on outcomes; for example, a quality improvement intervention could look at whether the rates of sexually-transmitted diseases in adolescents decreased over time.

While the "science" of performance measurement is still evolving, there are a number of quality assessment tools that already are available or are under development, including measures from the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS), the Health Care Financing Administration's Quality Assurance Reform Initiative (QARI), and Quality Improvement System for Managed Care (QISMC, which will replace QARI and unify Medicare and Medicaid performance measures), and Foundation for Accountability (FACCT), a set of performance measures developed by a nonprofit coalition of public and private purchaser and consumer organizations. These various measures should be explored in depth for potential use by the state Child Health Insurance Program because: (1) they are already in existence through the efforts of public-private development partnerships; (2) many providers, nationwide, already are familiar with them; (3) they tend to be comprehensive, addressing clinical and non-clinical areas, such as effectiveness of care, access to/availability of care, consumer satisfaction with care, health plan stability, utilization of services, cost of care, and consumer services. In addition, whatever measures are designed for use in the new state Child Health Insurance Program should also be used to measure the performance of the Medicaid program.

The Task Force was also concerned that the state build in adequate due process measures, including written notice of any decision to deny or reduce requested services (or to deny eligibility), expedited review of certain medical decisions, and review by an independent hearing officer. The Medicaid program already has a model grievance process in place for the recipients enrolled in MCOs, which could be used as a model for this new program.

7. Crowd-Out

When Congress passed the Child Health Insurance Program, it took steps to ensure that the new federal monies would be used to cover uninsured children rather than to substitute for, or "crowd-out," private coverage. For example, the state cannot create a new child health insurance program which uses Title XXI funds to cover children who already have private health insurance coverage or who are eligible for Medicaid. However, this provision does not prohibit coverage of children who are eligible for, but not actually covered under, an employer plan at the time they apply for child health assistance (with the exception of children eligible for coverage under the State Employees Health Plan). The state plan must describe the procedures the state will use to ensure that the insurance provided under the plan does not substitute for existing coverage (Sec. 2102(b)(3)(c)).

It is impossible to accurately predict how many employees and employers would actually drop dependent coverage in order to enroll dependents in the new public program. Policy experts strongly disagree regarding the amount of crowd-out that states have experienced as a result of the Medicaid expansions for pregnant women and children in the last ten years. Estimates range from virtually no crowd-out effect (Yazici, 1996) to over 50% (Dubay, 1997). Most of the studies were derived from cross-sectional data of different individuals gathered at various points in time.. One study tracked the same poor and near-poor children to monitor the impact of the previous Medicaid expansions on their private insurance coverage and concluded that minimal or no-crowd-out occurred (Yazici, 1996).

It is difficult to ascertain what portion of the drop in private health insurance coverage is directly attributable to the availability of publicly-subsidized health insurance coverage, and what portion of the decline is due to external factors, such as changes in the economy (i.e., recession), the rising cost of health insurance coverage, and/or "changes in the nature of employment and employers' views about the benefits they need to offer to attract workers" (Cutler, 1997; Cutler, 1996; Holahan, 1997). For example, an increasing number of individuals are employed by small businesses which are less likely to offer health insurance coverage (National Association of Children's Hospitals, 1997). The percentage of workers in firms with less than 25 employees increased from 28.8% in 1988 to 31% by 1994. Further, there has been a shift to part-time and temporary employment which are less likely to offer the benefit of insurance coverage. Moreover, there has been a disproportionate increase in premium costs for family coverage as opposed to individual employee coverage. Between 1989 and 1996, cost increases for family premiums were 13-23% higher than for employee-only premiums. (GAO, 1997). Not surprisingly then, the percentage of children with employment-based health insurance coverage nationally declined steadily from 66.7 percent in 1987 to 58.6 percent in 1995 (EBRI, 1997). In North Carolina, there was a 5.2% drop in employer-based health insurance coverage for children between 1990-92 relative to 1988-90 (Holahan, 1995).

In Minnesota, researchers surveyed individual participants in the publicly-subsidized health insurance program to determine the extent of prior health insurance coverage. The study determined that only 7% of the newly eligibles had been previously insured with private

coverage (Call, 1997). "Importantly, there is little evidence that the MinnesotaCare program has resulted in significant erosion from the private market. In fact, most of the uninsured in 1995 reported having no access to insurance through their employer or family members, and those that technically had such access simply found it to be unaffordable" (Call, 1997). The minimal coverage-shifting experienced in Minnesota suggests that extensive precautions against crowd-out may be unjustified.

According to some experts, there are several possible political disadvantages to erecting strict crowd-out policies. First, by restricting the coverage for those children whose parents have had some access to employer-based coverage, the program is penalizing parents for past decisions to obtain coverage. In addition, overly strict policies may ultimately defeat the primary objective of the legislation by preventing coverage of many poor and near-poor uninsured children (Merlis, 1997). In addition to these negative policy implications, severe restrictions would create another serious administrative burden and expense for the new program. Florida's Healthy Kids program dropped its verification of children's previous insurance status largely because of the administrative difficulties in obtaining verification from employers and insurance companies (Gauthier, 1997).

Based on the lack of clear evidence that significant crowd-out will occur, and awareness of the potentially harmful effects that ill-conceived restrictions might have, the Task Force recommends that the state avoid imposing harsh restrictions immediately. As the state plan progresses, the shifts in enrollment should be closely monitored to determine whether any crowd-out is occurring as a result of the expanded coverage. If it appears that a significant percentage of new enrollees have recently dropped private insurance coverage, then the state can design future "firewalls" to avoid this coverage shifting.[21]

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[21] California has completed its proposed state plan and adopted a similar approach. If the federal government requires more restrictive firewalls, it affords the administering agency the discretion to exclude children if they were covered by employer-sponsored insurance within the previous three months. After a "reasonable period" of monitoring or if required by the federal government, the program could extend the exclusion up to six months. California also provides that exceptions will be made for "cases where prior coverage ended [within the previous three or, if applicable, six months] due to reasons unrelated to the availability of the program," and at least under the following conditions: the loss of a job other than as the result of quitting; the unavailability of employer-sponsored coverage; the discontinuation of health benefits for all employees; and the termination of the 18 month COBRA coverage period.

In addition to the construction of firewalls, the California legislation addresses other means of preventing unwanted coverage shifting. It provides for monitoring to ensure that private coverage is not being improperly dropped (sec. 12693.71; 12693.80). Insurance industry personnel who encourage people to terminate their employment-based dependent coverage by referring them to the state plan or arranging for them to apply may be guilty of "unfair competition" for which an employee has a personal cause of action (sec. 12693.81). It is also an unfair labor practice for either insurers or employers to improperly influence enrollment in the state program (sec. 12693.82; 12693.83).

ESTIMATED PROGRAM COSTS

The state's annual allocation of $79.5 million in federal funds, plus the $27.6 million in required state match, appears adequate to cover the entire estimated target of 71,342 uninsured children in families below 200% of the poverty guidelines, using the actuarial estimates presented on p. 13, and assuming 100% participation. The pragmatics of budget estimation for operation of the program for the first several years have been left to the experienced professionals of the Department of Health and Human Services.

In the first year of program operation, it is reasonable to expect less than full participation as the word of the new program and the eligibility requirements are made public. Even in subsequent years, it is unlikely that all eligibles will participate. Experience from the prior Medicaid expansions around the country for children suggest that on average 32-38% of eligible children fail to enroll, and even in the states with the highest penetration between 7-27% of eligibles remain uninsured (Summer, 1997). Therefore, based on past experience, it is reasonable to assume no more than 80% of the program eligibles will participate.

The issue of crowd-out must also be addressed in budget estimates. Given the uncertainty of the level of crowd-out as noted on pages 22 and 23, it seems reasonable to assume (at least initially) a mid-level range of crowd-out between 10% and 30%. Thus, for planning and budgeting purposes, a crowd-out level of 20% is proposed. Since the estimated enrollment of the uninsured is 80%, and the enrollment due to crowd-out is 20%, it seems reasonable to use the original figure of 71,342 uninsured children as the long-term enrollment figure for budget planning purposes.

The Task Force recommends that the outreach, marketing, and health benefits functions be funded as fully as possible. States may use up to 10% of the federal allotment for administration, outreach and direct services.

During the course of its meetings, the Task Force received suggestions regarding the use of the "10 percent money" for direct services. Among those suggestions were: support services for children with special needs; support for school-based health services to enhance access to care by school-age children; support for centers to provide services to traditionally hard-to-reach populations, such as migrants and farmworkers. While the Task Force did not rank these suggestions above the outreach, etc. functions noted above, it seems reasonable to review these suggestions after the initial year of the new program's operation.

Special Note

As noted earlier, an estimated 67,000 children are currently eligible, but not enrolled in the Medicaid Program. As the new program is implemented, its outreach activities will surely lead to the Medicaid enrollment of many of these children. The Task Force did not make specific budget projections in this regard. It was noted that these children are probably relatively

healthier than the children enrolled in Medicaid, and their enrollment will be slow and incremental. DHHS budget planners should use these assumptions in developing budget estimates in this regard.

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APPENDIX A
Child Health Insurance Task Force Participants

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NC Health Alliance Board
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Other Participants
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- Lynne Hamlet
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APPENDIX B
Comparison of Benefits Covered by Medicaid and a Modified State Employees Health Plan

Services	Medicaid	Modified State Employees Health Plan
Mandatory Services		
Hospital Services (inpatient and outpatient)	Covers inpatient and outpatient hospital care, including specialty hospitals (pulmonary and chronic diseases).	Covers if precertified, no day limits. Covers room and board in semi-private accommodations (unless hospital has only private rooms), medically necessary supplies, medications, lab tests, radiological services, operating and recovery rooms, hospital staff. Outpatient surgery covered. The state uses a DRG reimbursement system.
Physician Services	Covers physician services and other professional services; 24 visit limits waived for children who require additional visits as result of EPSDT screenings.	Covers office visits, surgical services and anesthesia services.
Laboratory and x-ray services	Covered.	Covered.
Well-baby and well-child care	Health Check (EPSDT) includes periodic physicals, immunizations, and all the follow-up treatment identified by the provider. The Health Check periodicity schedule is 5 times in first year, 3 times in 2nd year, annually in the 3-6 years, and then one checkup every three years thereafter.	Covers well baby and well-child care. Allows all medically necessary care. No limits on well-child visits up to age 1; 3 visits ages 1-2, and 1 visit ages 2-7. Children older than seven can obtain a check-up once every three years.
Immunizations	Covered.	Covered.
Additional Services		
Prescription drugs	Covers prescription drugs and insulin.	Covers prescription legend drugs and insulin. (Legend drugs must have unrestricted market approval by FDA).
Mental health services	Covers, including treatment in state mental hospitals. 24 visit/year limit waived if care provided through Area Mental Health agency, or needed as result of EPSDT screening. No day or dollar limits, but case managed through Carolina Alternatives, which is a carved-out managed care program covering mental health and substance abuse services for children. Operates out of 10 area MHDDSAS program (32 counties).	Covered. No day/dollar limits. Can obtain 26 visits outpatient visits/year without preauthorization. Most other mental health services require preauthorization (including inpatient mental health, urgent admissions, 23-hour observation bed stays, partial hospitalization treatment, psychiatric residential treatment care, care in intensive outpatient program) More than 26 outpatient visits requires preauthorization.
Vision	Vision screening; corrective lenses, eyeglasses and other visual aids covered (prior approval required for visual aids).	One comprehensive eye exam covered every two years.

Services	Medicaid	Modified State Employees Health Plan
Hearing	Covered.	Surgery/services to correct hearing problems are covered; appliances are not covered.
Other Allowable Services		
Eyeglasses	Covers corrective lenses, eyeglasses and other visual aids covered (prior approval required for visual aids).	Excluded.
Dental services	Most general dental services covered, such as exams, cleanings, fillings, x-rays and dentures, and some additional services (prior approval required for certain services).	Covers preventive, oral evaluations, radiographs, tests and lab exams, palliative treatment, space maintenance, amalgam restorations, silicate restorations, filled or unfilled resin restorations, inlay restorations, extractions, surgical extractions, anesthesia, oral and maxillofacial surgery and dental care related to accidental injury. Not more than once every 6 months.
Dental devices	See below.	Excluded (unless due to accidental injury).
Hearing aids	Covered.	Excluded.
Therapy (physical, occupational, and services for individuals with speech, hearing, and language disorders)	Covers audiologists, occupational therapists, physical therapists, and respiratory therapists. Also covers speech and language pathologists. No day or dollar limits; provided for habilitative as well as rehabilitative care.	Physical, limited occupational, inhalation and speech therapy covered when approved in advance. Requirement that condition expected to show significant improvement.[1]
Inpatient substance abuse	Covered. Substance abuse services part of capitated managed care system for children in 32 counties through Carolina Alternatives. No day or dollar limits, but case managed through Carolina Alternatives.	Covered. No day or dollar limits.
Outpatient substance abuse	Covered. Substance abuse services part of capitated managed care system for children in 32 counties through Carolina Alternatives. No day or dollar limits, but case managed through Carolina Alternatives.	See above.
Clinic services and other ambulatory health care services	Covers services at community health centers, rural health centers, migrant health clinics, county health departments, 24 visit limit waived if additional services needed as result of EPSDT screening.	Covered.

[1] If doctor or therapists thinks the patient will get some benefit, then the state will cover services. The state looks for short-term and long-term objectives; if progress is being made then the state will continue to cover the services. For speech therapy, must be able to show potential for cognitive understanding. (Kyle Howard, Medical Review for State Health Plan, Aug. 29, 1997).

Services	Medicaid	Modified State Employees Health Plan
Prenatal care	Covers.	Covered. Prenatal care for child dependents excluded.
Family planning	Covered. Covers Norplant, IUDs, prescription contraceptives, Depo-Provera.	Covers birth control pills, Norplant and Depo-Provera.
Abortion (limited to when necessary to save the life of the mother or if pregnancy result of act of rape or incest)	Limited to when necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.	Limited to when necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
Durable medical equipment and prosthetic devices, implants, adaptive devices	Prosthetics and orthotics covered.	Covers if reasonable and medically necessary (prior approval required if above $250). Prosthetics and orthotics are covered. Excludes: lifts, blood pressure cuffs and kits, wheelchair accessories, van lifts, ramps, and structural modifications, shoe inserts.
Disposable medical supplies	Under home health, Medicaid pays for medical supplies.	Covers medical supplies designed to serve only a medical purpose.
Over-the-counter medications	Not covered.	Not covered.
Home and community-based services (such as home health nursing, home health aide, personal care, assistance with activities of daily living, chore services, day care services, respite care, training for family members, and minor modification to home)	Covers personal care services such as assistance with dressing, feeding, household tasks, transportation and monitoring self-administered medication. Also covers home health services.	Home care includes private duty nursing, home care aides, skilled nursing visits, hospice care, home IV therapy. Prior approval required. Limited to 60 days, additional day available when approved in advance. To receive services, patient must be homebound, must require skilled services that cannot be provided by or taught to a person with no medical training. Excludes: care provided by family member, care provided by non-skilled or unlicensed caregiver, when patient no longer requires skilled level of care.
Nursing services (nurse practitioner services, nurse midwife services, advanced practice nurses, private duty nursing, pediatric nurse services, and respiratory care services in home, school or other setting	Covers nurse practitioner services, nurse midwifery, private duty nursing in certain instances. Covers home infusion therapy.	Private duty nursing covered when approved in advance.

Services	Medicaid	Modified State Employees Health Plan
Case management services	Covers case management services for pregnant women, children under age of 5 with special needs, mentally ill, chronic substance abusers, and people with HIV. Also provides case management services as part of Carolina Alternatives, Mecklenburg Co. managed care project, and Health Check.	None currently provided.
Care coordination	See above.	None currently provided.
Hospice care	Covered.	Covers.
Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative services (whether in facility, home, school or other setting) if prescribed by physician or other licensed provider, performed under supervision of physician, or furnished by licensed health care facility.	See therapy services above.	Covers up to $650/year in cardiac rehabilitation.
Premiums for private health care coverage	Not covered.	Not covered.
Medical transportation	Covers ambulance services (when other means of transportation would endanger the patient's health).	Covers ambulance services up to 50 miles.
Enabling services (such as transportation, translation, and outreach services) designed to increase accessibility of primary and preventive health services	Covers translation (paid as part of administrative costs or as part of cost-based reimbursement for federally qualified health centers), case management, medically necessary transportation.	None.
Any other health care services allowed by law (see below for examples)	Covers services of podiatrists, osteopaths, chiropractors, and optometrists; 24 visit limitation waived if need identified as part of EPSDT screening.	Covers up to $2000/year chiropractic services, podiatry services.
Other Covered Services by Plan		
Transplants and Dialysis	Covers.	Covers bone marrow for specified diagnoses, corneal, heart, kidney, liver, lung, pancreas and pancreas/ kidney. Requires prior approval. Excludes transplants determined to be experimental or investigational.
Alternative Therapy		Covers acupuncture by American MDs.

Services	Medicaid	Modified State Employees Health Plan
Wellness	Covered under Health Check described above, also covers parenting, childbirth education and other health education services provided as part of an office visit. Smoking cessation not covered (except in Mecklenburg Co. HMO project).	Covers $150 of eligible wellness charges each fiscal year (then covers additional amounts with deductibles/coinsurance). Services include general health check-ups, routine diagnostic exams and tests, x-rays, mammograms, prostate and rectal exams, blood pressure checks, urine tests and tuberculosis tests. There is a periodicity schedule which may be waived if medically necessary.
Other Excluded Services		
Learning disorders	Exclude special education services, but covers health related services.	
Reconstructive Surgery	Not covered if exclusively cosmetic.	Covered, including breast reconstruction following mastectomy. Excluded if purely cosmetic.
Experimental or Investigational Therapies excluded	Excluded if part of a protocol for investigation, not authorized by FDA. (Similar to other plans exclusions).	G.S. 35-40.1(7.1). Similar to other plans' exclusions.
Other exclusions		Cosmetic surgery, radial keratotomy, services to reverse surgical sterilization.
Other unusual provisions		Excludes maternity benefits for dependent children; newborn nursery care when mother not eligible for maternity benefits.
General Provisions		
Medical Necessity defined	Services which are, in the opinion of the treating physician or the DMA consulting physician, reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time the services are rendered. Each service must be sufficient in amount, duration and scope to reasonably achieve its purposes; and the amount, duration or scope may not be arbitrarily denied or reduced solely because of the diagnosis, type of illness or condition.	Acceptable medical diagnoses and treatment of disease, injury or illness.
Emergency room or urgent care (coverage and definition; would be included as part of mandatory hospital care)	Covers care in emergency room. Must be pre-authorized if patient enrolled in Carolina Access or Mecklenburg County HMO project.	Covers with copayment (waived if admitted to hospital or no other care reasonably available).

Services	Medicaid	Modified State Employees Health Plan
Primary Care Providers	To participate as a primary care provider in Carolina Access, the provider must be enrolled as a Medicaid primary care provider for the service area; provide patient care coordination (provide or arrange for care), operate the office a minimum of 30 hours/week, provide essential preventive services, provide after hour coverage that does not automatically refer to the ER, establish and maintain hospital admitting privileges or establish formal arrangements with another practice to manage inpatient care, participate with Carolina ACCESS utilization management and quality assessment programs, and refer potentially eligible enrollees to WIC.	NA
Statewide Coverage		
Currently offered	100 counties	100 counties (HMOs offered in 92 counties). Out-of-state and out-of-country also covered.
Sources of Information	Division of Medical Assistance.	Its Your Choice (1997); Your Health Benefits (1996).

Title XXI with Copays - 200% FPL

Title XXI	SFY98-99	SFY99-00	SFY00-01	SFY01-02	SFY02-03	SFY03-04	SFY04-05	SFY05-06	SFY06-07
Funding (in Millions)									
Federal Appropriation for FFY	$ 4,275.00	$ 4,275.00	$ 4,275.00	$ 4,275.00	$ 3,150.00	$ 3,150.00	$ 3,150.00	$ 4,050.00	$ 4,050.00
NC Allotment	79.91	79.91	79.91	79.91	59.54	59.54	59.54	76.55	76.55
Program Costs	$ 77.31	$ 80.40	$ 83.62	$ 86.97	$ 90.44	$ 94.06	$ 97.82	$ 101.74	$ 105.81
Administration*	$ 7.73	$ 8.04	$ 8.36	$ 8.70	$ 9.04	$ 9.41	$ 9.78	$ 10.17	$ 10.58
Total Program & Admin	$ 85.04	$ 88.44	$ 91.98	$ 95.66	$ 99.49	$ 103.47	$ 107.61	$ 111.91	$ 116.39
Total Fed Match	63.20	65.36	67.64	70.00	72.45	74.98	77.60	80.70	83.93
Total State Match	21.84	23.08	24.34	25.66	27.04	28.49	30.01	31.21	32.46

*Administration is based upon 10% of Program Costs

Note: 10th year not shown; Federal allotment increases to $5 billion.

Children Served: 66,361

1/16/98

Title XIX - Eligible but Unenrolled

Title XIX	SFY98-99	SFY99-00	SFY00-01	SFY01-02	SFY02-03	SFY03-04	SFY04-05	SFY05-06	SFY06-07
Program Costs	$ 46.22	$ 49.03	$ 52.01	$ 55.18	$ 58.53	$ 62.09	$ 65.86	$ 69.87	$ 74.12
Projected Admin Costs	4.45	4.65	4.86	5.07	5.30	5.54	5.79	6.05	6.32
Total Program & Admin	$ 50.67	$ 53.68	$ 56.87	$ 60.25	$ 63.83	$ 67.63	$ 71.65	$ 75.92	$ 80.44
Total Federal Match	31.66	33.25	34.96	36.75	38.63	40.61	42.69	45.24	47.93
Total County Match*	7.86	8.42	9.01	9.64	10.31	11.03	11.80	12.49	13.22
Total State Match	11.15	12.01	12.90	13.86	14.89	15.99	17.16	18.19	19.29

*includes non-Federal share for Area Mental Health costs

Children Served: 34,377

1/16/98

Title XXI with Copays - 150% FPL

Title XXI - 150% FPL	SFY98-99	SFY99-00	SFY00-01	SFY01-02	SFY02-03	SFY03-04	SFY04-05	SFY05-06	SFY06-07
Funding (in Millions)									
Federal Appropriation for FFY	$ 4,275.00	$ 4,275.00	$ 4,275.00	$ 4,275.00	$ 3,150.00	$ 3,150.00	$ 3,150.00	$ 4,050.00	$ 4,050.00
NC Allotment	79.91	79.91	79.91	79.91	59.54	59.54	59.54	76.55	76.55
Program Costs	$ 45.59	$ 47.42	$ 49.31	$ 51.28	$ 53.34	$ 55.47	$ 57.69	$ 60.00	$ 62.40
Administration*	$ 4.56	$ 4.74	$ 4.93	$ 5.13	$ 5.33	$ 5.55	$ 5.77	$ 6.00	$ 6.24
Total Program & Admin	$ 50.15	$ 52.16	$ 54.24	$ 56.41	$ 58.67	$ 61.02	$ 63.46	$ 66.00	$ 68.64
Total Fed Match	37.27	38.54	39.89	41.28	42.72	44.21	45.76	47.59	49.49
Total State Match	12.88	13.61	14.35	15.13	15.95	16.80	17.70	18.41	19.14

*Administration is based upon 10% of Program Costs

Note: 10th year not shown; Federal allotment increases to $5 billion.

Children Served: 37,094

1/16/98

Title XXI with Copays - 185% FPL

Title XXI - 185% FPL	SFY98-99	SFY99-00	SFY00-01	SFY01-02	SFY02-03	SFY03-04	SFY04-05	SFY05-06	SFY06-07
Funding (in Millions)									
Federal Appropriation for FFY	$ 4,275.00	$ 4,275.00	$ 4,275.00	$ 4,275.00	$ 3,150.00	$ 3,150.00	$ 3,150.00	$ 4,050.00	$ 4,050.00
NC Allotment	79.91	79.91	79.91	79.91	59.54	59.54	59.54	76.55	76.55
Program Costs	$ 77.35	$ 80.44	$ 83.66	$ 87.01	$ 90.49	$ 94.11	$ 97.87	$ 101.79	$ 105.86
Administration*	$ 7.74	$ 8.04	$ 8.37	$ 8.70	$ 9.05	$ 9.41	$ 9.79	$ 10.18	$ 10.59
Total Program & Admin	$ 85.09	$ 88.49	$ 92.03	$ 95.71	$ 99.54	$ 103.52	$ 107.66	$ 111.97	$ 116.45
Total Fed Match	63.23	65.39	67.68	70.04	72.48	75.01	77.64	80.74	83.97
Total State Match	21.86	23.09	24.35	25.67	27.06	28.51	30.03	31.23	32.48

*Administration is based upon 10% of Program Costs

Note: 10th year not shown; Federal allotment increases to $5 billion.

Children Served: 64,475

North Carolina's Child Health Insurance Program

Federal Legislation:

In 1997 Congress enacted legislation allowing States to cover uninsured children of working families whose incomes did not exceed 200% of the federal poverty level. (States which had already increased coverage beyond Medicaid limits of 185%, 133% and 100% were allowed to expand 50 percentage points above their higher levels).

Funds were allocated for ten years and must be matched by State funds. North Carolina's allocation is $79.9 million with a matching requirement of $27 million on an annualized basis. This is sufficient to cover an estimated 71,300 uninsured children for the next ten years in spite of fluctuations in the federal allotment in the out years because of the State's ability to roll forward the unspent federal dollars from the first year for the next two years. No County matching funds will be required for the new program.

Federal legislation contains many limitations and restrictions on how the money can be spent, but the most important for North Carolina is the exclusion from covering children of employees of public agencies who are eligible for health benefits coverage under the State Health Benefits Plan and whose family income otherwise qualifies them for the program.

North Carolina does not pay for dependent coverage. We may be allowed to cover dependent children of low income public employees only by enrolling them in the Medicaid Program under a special classification.

The Plan:

1. The Plan will cover uninsured children whose family incomes do not exceed 200% of the Federal Poverty level.
2. Uninsured children of low income public employees will be covered by Medicaid under a special classification up to 200% of the Federal Poverty level.
3. Except for children of public employees, all other eligible children will be in a non-entitlement program, which means that the amount of funds available to serve them will determine how many can be served. Have enough $ to take care eligible
4. The benefits will be comprehensive and tailored to the needs of children - both well children as well as very sick children. They will include vision, hearing and dental care along with well-child and acute care. Mental Health services and therapies for children with special needs also will be covered
5. Cost sharing will include copayments for the following services: Physician visits - $3.00; Hospital Outpatient - $5.00; Brand name drugs - $5.00; Unnecessary emergency room use - $20.00. By federal law, cost sharing is limited to families above 150% poverty. No copays will be charged for preventive well child care.
6. Existing administrative structures and delivery systems will be used, permitting any willing provider to deliver services to eligible children, including traditional providers,

2½% of parents of Medicaid

Health Departments, school-based health centers, Community Care networks, Carolina ACCESS providers, HMO's, insurance plans, etc.

7. Extensive outreach campaigns will be conducted to ensure that eligible children are enrolled and that their health care needs are met. Payment for their care should reduce cost shifting to other payors and improved health outcomes by rendering primary and preventive care in a timely manner, thus reducing the need for costly emergency room and acute care services.

Impact on Medicaid program:

Federal law does not allow States to use the new federal funds to pay for Medicaid eligible children; therefore, applicants for the new program must be screened for Medicaid eligibility. Outreach efforts may result in additional Medicaid eligibles. The number of children who may qualify for Medicaid under current rules, but who have not applied, is estimated to be 68,800, of which approximately 34,000 are expected to enroll.

Very few children of low income working families in North Carolina have adequate health insurance. It is estimated that there are 71,342 children who would be eligible for coverage under the new Title XXI Child Health Insurance Program (CHIP). These are children in families with incomes above current Medicaid eligibility and below 200% of the federal poverty guidelines. ($26,660 for a family of 3)

North Carolina's federal allotment is $79.9 million. This new money requires 26% state match. North Carolina's projected SFY 98-99 match will be $21.84 million. No county match is required. Some county funds may be required to cover Medicaid (Title XIX) children, who are eligible but not currently enrolled.

We propose a non-entitlement program that has the same comprehensive benefit package as Medicaid. The program will be administered by the infrastructure already in place for Medicaid. We plan to expand greatly our outreach efforts for the new program.

Private insurers and HMOs can participate fully in the CHIP program. Where they are willing to deliver the same comprehensive benefits package at our access and quality, they can have all of the business they can earn. This competition should benefit the state's program.

Above 150% of poverty we plan to use some cost sharing and co-pays, especially for unnecessary emergency room visits. Federal rules limit the amounts of co-pays allowed.

In the next few weeks the General Assembly will need to agree on the elements of our initial program to be submitted to HCFA for approval. If HCFA will not approve covering state employees' children with a non-entitlement program, then we will need to expand Medicaid to cover them.

Small businesses, where many of our low income working people are employed, should benefit greatly from this new Child Health Insurance Program. This would allow them to compete with larger businesses, who do sometimes provide health coverage for employees' children. The new money should help all employers and providers with the cost shifting problem. For serious problems these children now receive non-compensated care. The CHIP program would eliminate this non-compensated care for covered children.

Children's Health Insurance Talking Points
1/28/98

Ten million American children have no health insurance. Nine out of ten of those children have working parents. Six out of ten live in two parent families. In 1980, the majority of workers in medium to large companies had employers who paid 100 percent of family health insurance costs. Today, less than 25 percent offer those benefits. The employer-based health insurance system is collapsing around our children.

In 1997, Congress recognized this problem and came up with a plan to help states cover uninsured children. North Carolina's federal allotment is $79.9 million. To get that money, North Carolina must find a 26 percent match. No county match will be required.

We've got to devise a plan and present it to the feds for their approval. Our proposed plan would cover the estimated 71,300 uninsured children – children whose parents make too much to qualify for Medicaid but not enough to pay for health coverage. We would cover children in families with incomes up to 200 percent of the federal poverty guidelines. For a family of four that's just $32,100 or $2,675 a month.

These are the children of working poor. Their families are trying hard, but they still don't earn enough to make sure their children are getting medical care.

In the past couple of months, we've heard from some of these parents. Earlier this month, Lisa Jennings came from North Wilkesboro to speak at the public hearing on this plan. Mrs. Jennings, who works in a small business, and her husband have five children between them. Two are covered by an ex spouse's medical plan. The other three didn't have any health insurance until last year. That's when Mrs. Jennings and her husband scraped together the funds to cover one of the three. Imagine, having to choose which one of your kids to insure.

But that's the kind of choices the working poor must make. With this new plan, we've got a chance to fix this and take care of our children.

Our proposal is a non-entitlement program with the same comprehensive benefits package as Medicaid. Unlike Medicaid, however, it is not an entitlement. Eligible children sign up for the program and they're covered as long as the dollars hold out. Once the dollars are gone, then they would be placed on a waiting list.

But, we've crunched the numbers every way possible and we're certain that we can cover all children whose families are below 200 percent of the federal poverty guidelines.

This comprehensive health care package would include vision care and the cost of durable medical equipment, eyeglasses and hearing aids. It will provide preventative care and it is comprehensive enough to take care of special needs children as well. Patients will be cared for by the physician of their choice.

The program will be administered by our Medical Assistance Division. Private insurers and HMOs can participate fully in the program – as long as they can deliver the same quality comprehensive benefits package at our cost.

Although we will not require premiums, we will use some cost sharing and co-pays above 150 percent of the poverty level, especially for emergency room visits.

We're at a crucial crossroads. Lt. Governor Dennis Wicker is leading a bi-partisan commission which is devising the state plan that will be presented to the legislature for its approval. That commission is due to finish its work by late February.

In order to get this year's funds, the feds must approve our plan before October 1. We've been told that the feds will need a minimum of 90 days to approve state plans and they can stop the clock any time they have a question about the state plan. So, we're working with a real sense of urgency.

Our children's health insurance plan is a win-win. This is a good deal. We can't allow this opportunity to slip through our fingertips. If we don't get this money to help North Carolina's children – then other states, like New York or New Jersey – will get our portion of the federal dollars. That would be unconscionable.

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Wednesday, February 18th, 9:00 a.m. - 4:00 p.m.
Room 414 - Legislative Office Building

9:00	Sickle Cell Syndrome Program	Gladys Robinson, Chair Sickle Cell Syndrome & Related Disorders Association
10:00	Child Welfare Expansion Budget	Leza Aycock, Assistant Director Division of Social Services
10:15	Overview of Public Schools Commission Meeting & Discussion re: Schools for the Deaf	Mary Ellen Sylvester, Fiscal Analyst Fiscal Research Division
10:45	Fund Transfer for Cancer Purchase of Care Program	Ron Levine, Deputy Secretary DHHS
11:15	Food Banks	Representatives of Regional Food Banks

LUNCH

1:00	Division of Mental Health Response to 1/21/98 Constituent Comments (Dorothea Dix Hospital)	Don Willis, Chief Mental Health Services Section
1:45	Progress Report on TANF/Substance Abuse Services Initiative	Starlene Scott-Robbins, Women's Services Branch
2:30	Thomas S. Cost Containment Report	Susan White, Chief Thomas S Services Section
	Update on Recent Court Decision in Thomas S & Willie M	Bob Hargett, Attorney General's Office

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Tuesday, February 17th, 10:00 a.m. - 4:00 p.m.
Room 414 - Legislative Office Building

10:00	Children's Health Insurance Program	Governor's Commission on Uninsured Children

LUNCH

1:00	Discussion of Medicaid Growth Reduction Plan *What is the role of managed care in Medicaid?*	Carol Shaw, Fiscal Analyst Fiscal Research Division

2:00 *Discussion of the Role of Public Delivery Systems in N.C.*

-Who are the players in the local public health/mental health care delivery system?
-What is the impact of recent and proposed changes in Medicaid on local public health/mental care?
-What role will local public health/mental health care programs play in the Children's Health Insurance Program?
-What is the role of public health/mental health in Medicaid managed care?
-How will the issue of access be impacted by changes in Medicaid?
-How is the issue of fragmentation of services impacted by changes in Medicaid?
-How are local public health/mental health budgets impacted by changes in Medicaid?
-What are the anticipated patient/client outcomes within the new public-private relationship in Medicaid?

Role of Public Health Departments	Various Directors of Local Public Health Departments
Role of Area Mental Health Programs	Various Directors of Area Mental Health Programs

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Wednesday, February 18th, 9:00 a.m. - 4:00 p.m.
Room 414 - Legislative Office Building

9:00	Sickle Cell Syndrome Program	Gladys Robinson, Chair Sickle Cell Syndrome & Related Disorders Association
10:00	AIDS/HIV Budget	Karen Hammonds-Blanks, Fiscal Analyst Fiscal Research Division
10:30	Child Welfare Expansion Budget	Leza Aycock, Assistant Director Division of Social Services
10:45	Overview of Public Schools Commission Meeting & Discussion re: Schools for the Deaf	Mary Ellen Sylvester, Fiscal Analyst Fiscal Research Division
11:15	Fund Transfer for Cancer Purchase of Care Program	Ron Levine, Deputy Secretary DHHS
11:30	Food Banks	Jerry Hardesty
	LUNCH	
1:00	Division of Mental Health Response to 1/21/98 Constituent Comments (Dorothea Dix Hospital)	Don Willis, Chief Mental Health Services Section
1:45	Progress Report on TANF/Substance Abuse Services Initiative	Starlene Scott-Robbins, Women's Services Branch
2:30	Thomas S. Cost Containment Report	Susan White, Chief Thomas S Services Section
	Update on Recent Court Decision in Thomas S & Willie M	Bob Hargett, Attorney General's Office

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Thursday, February 19th, 9:00 a.m.
Room 414 - Legislative Office Building

9:00	Overview & Trends In N.C.'s Aging Population	Karen Gottovi, Director Division on Aging
9:30	Discussion of Needs in the Aging Population	Ann Johnson Senior Citizen Coalition
10:00	Status Report on Adult Day Health Expansion Funds	John Tanner, Chief Adult Services Section Teresa Johnson, Director N.C. Adult Day Services Association
11:00	Pharmaceuticals Assistance for Low Income Elderly	Carol Shaw, Fiscal Analyst Fiscal Research Division
11:45	Adult Care Home Bed Vacancies Report	Lynda McDaniel, Director Division of Facility Services

Committee Discussion of Future Meeting Topics

ADJOURN

The North Carolina Sickle Cell Syndrome Program provides services to persons with sickle cell disease, a lifelong red blood cell disorder that is passed from parent to child through genes. Sickle cell disease causes painful episodes, increased susceptibility to infections and damage to vital organs. The Program focuses its efforts on early detection, treatment and maintenance which can prevent many serious health problems that can lead to illness and early death in clients.

who is at risk?

In the United States, sickle cell disease primarily affects African-Americans, American Indians, and Hispanics of Caribbean ancestry. It affects other groups, too, including people of Arabian, Iranian, Italian, Indian, Turkish, and Greek descent. A growing number of Caucasian Americans in North Carolina are being diagnosed with sickle cell trait (carrier state) and other related blood disorders.

providing hop promoting wellness

All newborns in North Carolina receive a hemoglobin test at birth. It is also recommended that couples who are planning to become parents and persons of childbearing age be tested at their local health department or physician's office. Research studies at the Comprehensive Sickle Cell Centers have led to the usage of new drugs and other treatments which help clients live longer, healthier and more productive lives. In addition, several children in North Carolina have received successful bone marrow transplants which enable them to have a future free of sickle cell disease.

helping families in need

The North Carolina Sickle Cell Syndrome Program was established in 1973 to educate, test and counsel individuals with sickle cell disease. Since then, the Program has grown to include comprehensive services for individuals affected by this disease. Research has shown that chronic illnesses such as sickle cell disease affect not only the patient, but family members as well. Financial strain, anxiety, depression, fear, and unfamiliarity with the disease itself can place extreme stress on families. Through a network of health care providers, the Program assists clients and families in need. Services provided include:

SCREENING
- Universal screening of all newborns in North Carolina at no cost
- Screening services at local health departments
- Analysis of blood tests by the state laboratory

EDUCATION
- Patient and family education
- Training for health and human service professionals
- Statewide public education for schools, churches, civic groups, etc.

COUNSELING
- Genetic counseling for those identified with sickle cell disease/ trait or other abnormal hemoglobin

SERVICE COORDINATION
- Follow-up clients with sickle cell disease throughout the life cycle
- Consultation with health and human service professionals
- Referrals to medical centers and other agencies
- Education and employment intervention
- Statewide support groups

PAYMENT PROGRAM
- Reimbursement program which covers inpatient/outpatient visits and medication for eligible patients

MEDICAL CENTERS
- Medical treatment
- Physician training
- Physician-patient consultations
- Psychosocial services
- Community clinics
- Access to national research studies

"Through its regional sickle cell educator/counselors, contracts with major medical center programs and community-based centers, the Program provides in-depth services for clients. This creates a full circle of care that improves their quality of life and provides hope for a brighter future. If you have sickle cell disease, you are not in this by yourself. We are all in this together."

PROGRAM MANAGER
NORTH CAROLINA SICKLE CELL SYNDROME PROGRAM



TIONNE WATKINS (T-BOZ)
the national spokesperson
for the Sickle Cell Disease Association of America
and the lead singer for recording artists TLC,
on living with sickle cell disease.

"WHEN YOU'RE BORN WITH SOMETHING LIKE SICKLE CELL, YOU THINK YOU'RE LIKE EVERYONE ELSE... MY MOTHER MADE ME UNDERSTAND THAT... SOMETIMES I WOULD HAVE TO TAKE IT EASY. BUT WHEN YOU GROW UP WITH THIS DISEASE YOU LEARN THAT IT'S A PART OF YOUR LIFE... SICKLE CELL HASN'T STOPPED ME FROM DOING WHAT I WANT TO IN LIFE.... BY THE GRACE OF GOD, I AM ABLE TO TOUR AND PERFORM. I KNOW THAT THERE ARE TIMES THAT I WILL GET SICK, BUT I...KEEP A POSITIVE OUTLOOK AND KEEP MY SPIRITS UP."*

* excerpted from an interview in the February/March 1997 Issue of *skool pages* magazine.

For more information, contact:
North Carolina Sickle Cell Syndrome Program, Raleigh, NC
Phone: (919) 715-3411 or (800) 737-3028
Fax: (919) 715-9633

REGIONAL OFFICES

ASHEVILLE REGIONAL OFFICE
ASHEVILLE, NC
PHONE: (704) 251-6788

DEVELOPMENTAL EVALUATION CENTER
CONCORD, NC
PHONE: (704) 786-9181

RALEIGH REGIONAL OFFICE
RALEIGH, NC
PHONE: (919) 571-4700

FAYETTEVILLE REGIONAL OFFICE
FAYETTEVILLE, NC
PHONE: (910) 486-1191

WASHINGTON REGIONAL OFFICE
WASHINGTON, NC
PHONE: (919) 946-6481

DEVELOPMENTAL EVALUATION CENTER
WILMINGTON, NC
PHONE: (910) 251-5817

ALBEMARLE EVALUATION & TREATMENT CENTER
ELIZABETH CITY, NC
PHONE: (919) 338-4044

COMMUNITY-BASED CENTERS

Sickle Cell Disease
Association of Southern Piedmont, Inc.
Charlotte, NC
Phone: (800) 435-6004

Sickle Cell Disease
Association of America
Eastern NC Chapter
Jacksonville, NC
Phone: (800)826-1314

Operation Sickle Cell, Inc.
Fayetteville, NC
Phone: (910) 488-6118

Sickle Cell Disease
Association of the Piedmont
Greensboro, NC
Phone: (800)733-8297

MEDICAL CENTERS WITH SICKLE CELL PROGRAMS

Bowman Gray School of Medicine,
Wake Forest University
Winston-Salem, NC
Phone: (910) 716-4324

Carolinas Medical Center
Charlotte, NC
Phone: (704) 355-8189

Duke University Comprehensive Sickle Cell Center
Duke University Medical Center
Durham, NC
Phone: (919) 681-3395 or
(919) 684-3724

ECU School of Medicine
Greenville, NC
Phone: (919) 816-4676

UNC Comprehensive Sickle Cell Center
UNC School of Medicine
Chapel Hill, NC
Phone: (919) 966-1178 or
(919) 966-2467

State of North Carolina - *James B. Hunt, Jr., Governor*
Department of Environment, Health and Natural Resources
Jonathan B. Howes, Secretary
Division of Maternal and Child Health Sickle Cell Syndrome Program

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providing hope for a future

NORTH CAROLINA
SICKLE CELL SYNDROME PROGRAM

2-18-98

PRESENTATION TO

THE JOINT APPROPRIATIONS SUBCOMMITTEE

ON HEALTH AND HUMAN SERVICES

"NC SICKLE CELL SYNDROME PROGRAM"

FEBRUARY 18, 1998

9 a.m.

Legislative Office Building
Raleigh, NC

Presenters:

Mrs. Gladys R. Robinson, Chairperson, NC Council on Sickle Cell Syndrome

Russell Ware, MD, Duke University Comprehensive Sickle Cell Program

Eugene Orringer, MD, UNC Comprehensive Sickle Cell Program

NORTH CAROLINA COUNCIL ON SICKLE CELL SYNDROME AND RELATED GENETIC DISORDERS

Gladys A. Robinson, M.Ed., Chairperson

In 1973, through the adoption and ratification of House Bill 32, the North Carolina Council on Sickle Cell Syndrome and Related Genetic Disorders was established to determine the needs and make recommendations for legislative action with regard to sickle cell syndrome and related disorders. Through appointment by the Governor, the Council has the responsibility for ensuring services to persons with sickle cell syndrome and their families throughout the state and for recommending programs, staff and funds deemed germane to the provision of needed services.

At its beginning, the Sickle Cell Syndrome Program provided services of education, testing, genetic counseling to persons in our state. But in the last 10 years, our comprehensive and collaborative service network has made North Carolina a premiere state in the provision of quality care for persons with sickle cell disease. A brief summary of the services we now provide include newborn screening of all infants born in NC hospitals; confirmatory diagnosis of disease through our state laboratory; genetic counseling for persons/families affected; education of the general public, public schools and health professionals; child service coordination for children ages 0 to 5 years; and annual case assessments of each patient to identify needs and make referrals. Improved medical care is offered by local providers and health departments, who rely on hematology specialists at major medical centers for referrals and consultations. Sickle cell speciality clinics are held at 5 major medical centers and two satellite clinics at community-based centers in Greensboro and Fayetteville. Other services include patient support groups, some psychological services and most important, payment for inpatient/outpatient care and pharmaceuticals for patients who meet the eligibility criteria. Because of the network of sickle cell educator/counselors employed by the state program and contracted services through community-based centers and medical centers, we are proud to say that patients in North Carolina have received a quality of care that remains unduplicated in most other states.

As chair of the Council, I extend our thanks to you as members of the NC General Assembly for supporting us in our efforts for 26 years; efforts which have enabled us to maintain quality services, and to also bridge gaps to meet the critical needs of this patient population. Upon the advice of the Council, you, our legislators, assisted us in increasing our service level from simply education, testing and genetic counseling, to comprehensive case management for over 2,500 persons affected with the disease; upon the advice of the council, which also included medical center directors, you gave us support to institute newborn screening to reduce the infant mortality/morbidity rate for nonwhite infants in North Carolina in 1987 and later for all infants; through the insightfulness of the council, eligibility scales for families with sickle cell were made comparable to other chronic disorders for outpatient and now inpatient care, so that medical care can now be preventive rather than crisis oriented for many persons. The Council has been dutiful

in carefully assessing the needs of the patient population and making careful recommendations to the General Assembly for those for whom we advocate. Now we again need your support.

For the last 15 years, North Carolina has been fortunate to have one of 10 comprehensive sickle cell center research grants from the Sickle Cell Disease Branch of the National, Heart, Lung and Blood Institute (NHLBI) of the National Institutes of Health. Initially, this grant included the Duke University Comprehensive Sickle Cell Center and 2 community-based centers at Sickle Cell Disease Association of the Piedmont in Greensboro and Operation Sickle Cell in Fayetteville. Through our intent to expand the coordination of care for the majority of patients in North Carolina, the grant during the last 5 to 10 years was also expanded to include UNC-Chapel Hill, and East Carolina University. Thus, during the 15 years of the center grant, persons with sickle cell disease in North Carolina have benefited from the collaboration of these and two other medical and community-based centers and the 9 state employed educator/counselors.

Recently, in September of 1997, we were informed that the NHLBI would not award a comprehensive center grant to the Duke-UNC Center in the next funding cycle, which begins on April 1, 1998. This will result in a tremendous loss to the patients and families affected by sickle cell in North Carolina. We have since contacted our congress persons from North Carolina to have them address the issue and have funding restored. We, as citizens, were fortunate to have the support of Congressmen Watt, Price and McIntyre and Senator Faircloth, as we held an issues forum on Capitol Hill in September. However, their efforts have not been fruitful. While we are distressed at the loss of this funding to the 3 medical centers and 2 community-based centers, the Council has taken the opportunity to reassess the need for patient care in North Carolina. It is our position that comprehensive care is preventive in nature. A comprehensive health care system is where each sickle cell patient can rely on major medical centers for specialty care, on pediatric hematologists for the preventive and continuous care of infants and children, where patients are followed up constantly in their own communities by community-based center nurses (coordinating care with private providers and hospitals) and on regional and community-based educator/counselors - who connect patients to local resources to enhance their quality of life; this system is the best prevention for the high cost of medical care often required by the chronically ill. **We are, therefore, not asking simply for renewal of funds that were lost from the NHLBI, but for funding to support comprehensive medical and psychosocial care throughout North Carolina**.

Allow me now to introduce to you, hematologists from two of the major medical centers, where sickle cell patients receive quality care. First, Dr. Russell Ware, pediatric hematologist from Duke Comprehensive Sickle Cell Center, followed by Dr. Eugene Orringer, adult hematologist, UNC-Chapel Hill Comprehensive Sickle Cell Center. Following their presentations, we will be glad to answer any questions you may have. Thank you.

PROVIDING OPTIMAL MEDICAL CARE FOR CHILDREN WITH SICKLE CELL DISEASE IN NORTH CAROLINA: THE ROLE OF THE MEDICAL CENTERS

Russell Ware, M.D.
Duke University Comprehensive Sickle Cell Program

I. OVERVIEW

Sickle cell disease is one of the most common inherited genetic diseases, affecting approximately 75,000 to 100,000 persons in the United States. In the state of North Carolina, it is estimated that over 4,000 persons have sickle cell disease. Each year in our state, over 100 infants with a significant hemoglobin disorder are identified by newborn screening. Half of these infants have sickle cell anemia, the most severe form of sickle cell syndrome. For optimal health care, these infants require early confirmation of their hemoglobin disorder, followed by integration into existing medical care facilities involving both community-based programs and major medical centers. Children with sickle cell disease must be followed closely during the first few years of life, to ensure compliance with penicillin prophylaxis and to receive proper family education regarding the recognition and management of clinical complications. In collaboration with other health providers, the major medical centers in North Carolina help provide state-of-the-art medical care for children with sickle cell disease. The medical centers have superb on-site facilities and also provide staffing for monthly satellite clinics at off-site locations.

II. IDENTIFICATION OF INFANTS WITH SICKLE CELL DISEASE

1. Newborn screening. Analysis of newborn blood samples for hemoglobin disorders began at Duke University in 1986 as a pilot program. Pilot testing was very successful, so the program was transitioned to the State Newborn Screening Laboratory in Raleigh. By 1991, newborn screening for hemoglobin disorders was performed by the State Laboratory on all "non-white" infants born in this state. In 1994, testing for abnormal hemoglobins became universal, so that all newborns were tested. Last year in North Carolina, over 100,000 newborn samples were tested by the State Laboratory and a total of 110 infants with signs of hemoglobin disorder were identified.

2. Notification. After the State Laboratory identifies an infant with an abnormal hemoglobin, a letter is sent to the mother, the hospital of birth, the physician of record, the health department, and the N.C. Sickle Cell Syndrome Program. There are currently 9 regional sickle cell educator/counselors and 4 community-based centers, collectively covering all counties in the state, who contact the family of the infant and arrange for a repeat blood sample to be tested.

3. Repeat testing. A second blood sample must be collected to confirm the abnormal newborn screening result. In North Carolina, repeat testing approaches 100% and is almost always performed at one of the major medical centers. Ideally, the infant is retested within the

first two months of life, to allow early education of family members and the initiation of penicillin prophylaxis. In North Carolina, the average time to second analysis is approximately one month.

III. MEDICAL CARE OF INFANTS WITH SICKLE CELL DISEASE

1. Medical follow-up. It is essential that infants identified on newborn screening with sickle cell disease receive close medical follow-up during the first few years of life. Medical centers provide the optimal education and treatment for these affected infants. In North Carolina, over 75% of infants with sickle cell disease receive medical care under the direction of a medical center.

2. Penicillin prophylaxis. By age 2-3 months, all infants with sickle cell disease should receive penicillin twice a day, to prevent overwhelming bacterial infection. Treatment with penicillin is the single most important intervention to prevent mortality of these infants. For infants with sickle cell anemia, penicillin must be given for at least 5 years.

3. Family education. Visits to the medical centers provide the opportunity to teach family members about sickle cell disease. Families are taught the importance of recognizing fever or pain in these infants, and when to seek immediate medical care for these events. Families also are taught to recognize other serious clinical complications of sickle cell disease, including splenic enlargement, pneumonia, and stroke. Teaching sessions occur at every visit to the medical center, typically every 3 months during the first few years of life. Counseling is given regarding the inheritance of sickle cell disease and the risks for future pregnancies.

4. Additional medical care. Confirmation of the precise hemoglobin diagnosis occasionally requires repeat testing when the infant is 6-12 months old. This testing is best performed at a major medical center. Infants with sickle cell disease receive all of the normal childhood immunizations, but also require a special vaccine to prevent serious bacterial infection.

IV. MEDICAL CARE OF CHILDREN WITH SICKLE CELL DISEASE

1. Medical visits. Older children with sickle cell disease require ongoing medical care. Optimal care would include visits every 6 months. Usually this occurs at one of the major medical centers or their satellite clinics. During these visits, children receive physical examinations, assessment of growth and development, and laboratory studies.

2. Education. As children grow older, education must be provided to the patients themselves. The recognition and management of pain is particularly important, as early intervention can frequently prevent hospitalization. Additional clinical complications including pneumonia, gallstones, and stroke are routinely reviewed.

3. Surgery. Many patients with sickle cell disease require surgery during childhood. Examples include PE tubes in the ears, tonsillectomy, and removal of the spleen or gallbladder. Compared to the normal population, children with sickle cell disease are at high risk for complications resulting from surgery and anesthesia. As a consequence, these children require pre-operative hydration and blood transfusions to reduce the risks of surgery. All patients with sickle cell disease should have surgery performed only at a major medical center under the supervision of experienced pediatric personnel.

4. Counseling. Many children with sickle cell disease benefit from counseling offered by sickle cell educator/counselors or medical centers. Management of anxiety and depression require specialists familiar with these diseases. School and job performance are particularly important issues.

V. SUMMARY

The state of North Carolina has been extremely successful in providing medical care to infants and children with sickle cell disease through the N.C. Sickle Cell Syndrome Program. Also, the newborn screening program is a model of success from the standpoint of universal screening, accurate detection of infants with abnormal results, notification of health care providers, and confirmatory testing. The medical centers play a vital role in the care of these patients, beginning with repeat blood testing, initiation of penicillin prophylaxis, ongoing specialized medical care, education and counseling.

Your financial support of the medical centers will ensure that children with sickle cell disease will continue to receive the best available medical care. Without your support, the medical centers will not have the funding to continue providing the specialized care so essential to reducing mortality and morbidity in those suffering with sickle cell syndrome.

THE ROLE OF THE MEDICAL CENTERS

Eugene P. Orringer, M.D.
Professor of Medicine
Director of the Comprehensive Sickle Cell Program
UNC at Chapel Hill

Just as with infants and children, the care of adults with sickle cell disease requires a thorough understanding of this chronic illness and considerable experience with its many complications. We and many of our colleagues around the country have found that delegation of the care of patients with sickle cell disease to family physicians, primary care providers, and/or managed care organizations often results in unnecessary complications, needlessly prolonged hospitalizations, excessive morbidity, and even mortality.

To emphasize this point, a few examples are cited below:

Acute Chest Syndrome: Acute Chest Syndrome is the leading cause of death in adults with sickle cell disease. This dreaded sickle cell complication typically presents with the rather sudden onset of chest pain. Unfortunately, this pain is often mistaken by those who are not thoroughly knowledgeable about sickle cell disease as a typical "sickle cell crisis." Therefore, instead of an inpatient admission that includes aggressive diagnostic and therapeutic efforts focused at this severe and often life-threatening complication, these unfortunate patients are typically seen in a local emergency room where they are given narcotic analgesics and sent home with instructions to "return if they don't improve in 24 hours." My colleagues and I at the major medical centers are convinced that these 24 hours can mean the difference between life and death. Indeed, we have each received frantic phone calls from patients, their families, and/or patient advocates from the NC State Sickle Cell Syndrome Program or the community-based Sickle Cell Agencies describing a patient who is now gasping for breath and needs desperately to come to one of our institutions. By then, however, it is often too late, as the Acute Chest Syndrome of sickle cell disease has claimed another victim.

Blood Transfusions: While patients with sickle cell disease always have low blood counts, they generally adapt well to this anemic state and rarely require blood transfusions. Therefore, my colleagues at the major medical centers and I have become increasingly cautious about the use of blood transfusions, particularly for patients with sickle cell disease. We do recognize that, as with every patient who receives a transfusion, the use of blood products carries an inherent risk of infectious complications such as hepatitis and AIDS. Furthermore, we are well aware that the repeated administration of blood transfusions, particularly to patients with sickle cell disease, is well-known to produce immunization against foreign red cells. As they become immunized to blood products, sickle cell patients often experience a serious complications that is referred to as a "transfusion reaction." In addition, in the relatively infrequent circumstances when these individuals

really do need to be given a blood transfusion, the immunization that results from their previous transfusions, many of which were unnecessary, often makes it impossible to obtain blood products that are suitable for administration to these unfortunate individuals.

Acute Intrahepatic Cholestasis: Because this relatively infrequent complication of sickle cell disease presents with the same signs and symptoms that characterize acute cholecystitis (i.e., jaundice or yellowing of the eyes, fever, and right-sided abdominal pain), acute intrahepatic cholestasis is often mistaken for an acute attack of gall stones. However, these two disorders are very different from one another both in their underlying cause and in their treatment. Several years ago, a high school student went to his local emergency room complaining of fever and jaundice. There he was seen by an ER physician and by a surgeon. Because of the presence of gall stones, they made the diagnosis of acute cholecystitis and recommended surgery. Unfortunately for this young man, the diagnosis was incorrect. Instead of cholecystitis, he had acute intrahepatic cholestasis and the surgery was not only inappropriate, but ultimately proved to be fatal for this unfortunate young man.

My purpose in citing these three examples has been to emphasize for you just how important it is for sickle cell patients to have access to health care providers who are knowledgeable about all aspects of this relatively common genetic disorder. We here in North Carolina are particularly fortunate to have at our major medical centers a large cadre of individuals with both the commitment to these individuals and the expertise that is essential to provide care of the highest quality to patients with sickle cell disease. Indeed, North Carolina has consistently been identified and singled out as a national leader in the area of sickle cell disease. The North Carolina Sickle Cell effort (and in large part the reasons for our success) include the following:

The North Carolina State Sickle Cell Program: This organization, which plays a vital role in all aspects of sickle cell-related activities, has a central office based in Raleigh and a well-trained and highly committed team of educator/counselors who live and work throughout the entire state. These latter individuals serve as an important interface between the patients and their families in their home towns and the Comprehensive Sickle Cell Programs that are based at the major medical centers.

The Community-based Sickle Cell Agencies: These agencies, which are located in those areas of the State that have the largest number of African-American citizens, serve as an important complement to the State Sickle Cell Program. Much like the State Program, these community-based agencies provide a wide variety of services to patients and their families and create the vital linkages to the major medical centers.

NC State Hemoglobinopathy Screening Laboratory: The State Laboratory of Public Health provides newborn screening for all infants born in this state. Through this mandated effort, the NC Newborn Screening Program each year identifies over 100 infants who are affected with a major sickle hemoglobinopathy. Once these infants have been identified

by the state lab, the NC State Sickle Cell Syndrome Program, through its newborn screening component, provides case management services and directs these infants and their families to the most appropriate major medical center where they receive the comprehensive medical services that are essential to their good health and long-term survival.

The Comprehensive Sickle Cell Programs: These programs, each of which is based at a major medical center, have developed their own institutional programs capable of providing comprehensive medical and psychosocial care to children and adults with sickle cell anemia and the related hemoglobinopathies. Because sickle cell disease can damage nearly every organ system in the body and does so to a variable degree in different patients, it is crucial that the care provided by such diverse medical disciplines as internal medicine, obstetrics, orthopedics, and ophthalmology is coordinated so that the patient receives the necessary types of care and also avoids complications from such care. Thus, the sickle cell patient undergoing hip replacement needs to be followed by the sickle cell team, to receive appropriate pre-operative transfusions and expert post-operative monitoring for potentially life-threatening complications of surgery not seen in other patients. Out-patients likewise often require frequent medical advice regarding the possible causes and appropriate treatment of symptoms they develop at home, as well as help in negotiating difficulties at work and school created by frequent illness. For that reason, each medical center provides both continuing medical care as well as social services and counseling on a longitudinal basis. In addition, the medical centers, in cooperation with the community centers and the state program, have played a major role in the formation of the North Carolina State Consortium for Sickle Cell Disease. Among the primary goals of the consortium is to improve the quality of care for sickle cell patients that is provided by local physicians. This state consortium has produced a set of guidelines for medical care in sickle cell disease and has surveyed physicians statewide regarding both their medical knowledge and continuing education needs as related to the treatment of sickle cell disease. Finally, it is most important to emphasize how much of this effort from the medical centers is carried out without any form of reimbursement whatsoever to our medical centers. All of the hours communicating with patients, families, state educator/counselors, and local physicians are also spent at no cost to those who benefit from our efforts. The lectures and seminars that we give, the meetings that we organize, and the time that we devote simply reflects our absolute commitment to this patient population.

WHERE DO WE GO FROM HERE

Until now, the bulk of the support for each of the components of this statewide sickle cell effort (**EXCEPT FOR THE MAJOR MEDICAL CENTERS**) has come from the State of North Carolina through the NC Sickle Cell Syndrome Program. As shown on the attached pie chart which depicts the $2.5 million budget received by the NC Sickle Cell Syndrome Program in

fiscal year 1997-1998, the medical centers based at UNC, Duke, ECU, Bowman Gray, and Charlotte are this year receiving a cumulative total of $116,371. This amounts to less that 5% of the total budget and less than $25,000/center/year.

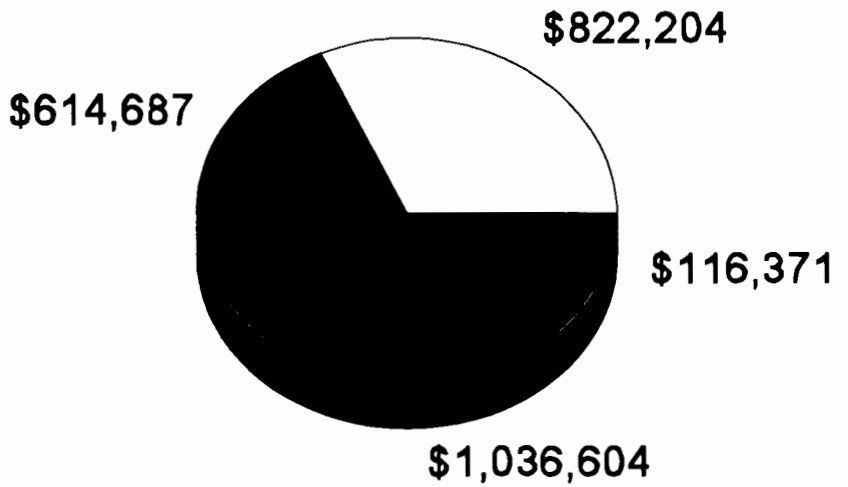
Much of the reason for this inadequate level of funding for the medical centers has been related to the presence of a federal grant to the **Duke-UNC-ECU Comprehensive Sickle Cell Center**. This grant from the National Institutes of Health (NIH), which was originally awarded to us in April, 1983 and has been continuously funded until the present time, has brought more than $2 million/year to the State comprehensive care programs. Unfortunately, our renewal application for this award was not funded, and beginning on April 1, 1998, we will no longer receive any federal support for our sickle cell effort.

WE MUST NOT LET OUR STATEWIDE SICKLE CELL EFFORT DIE!!

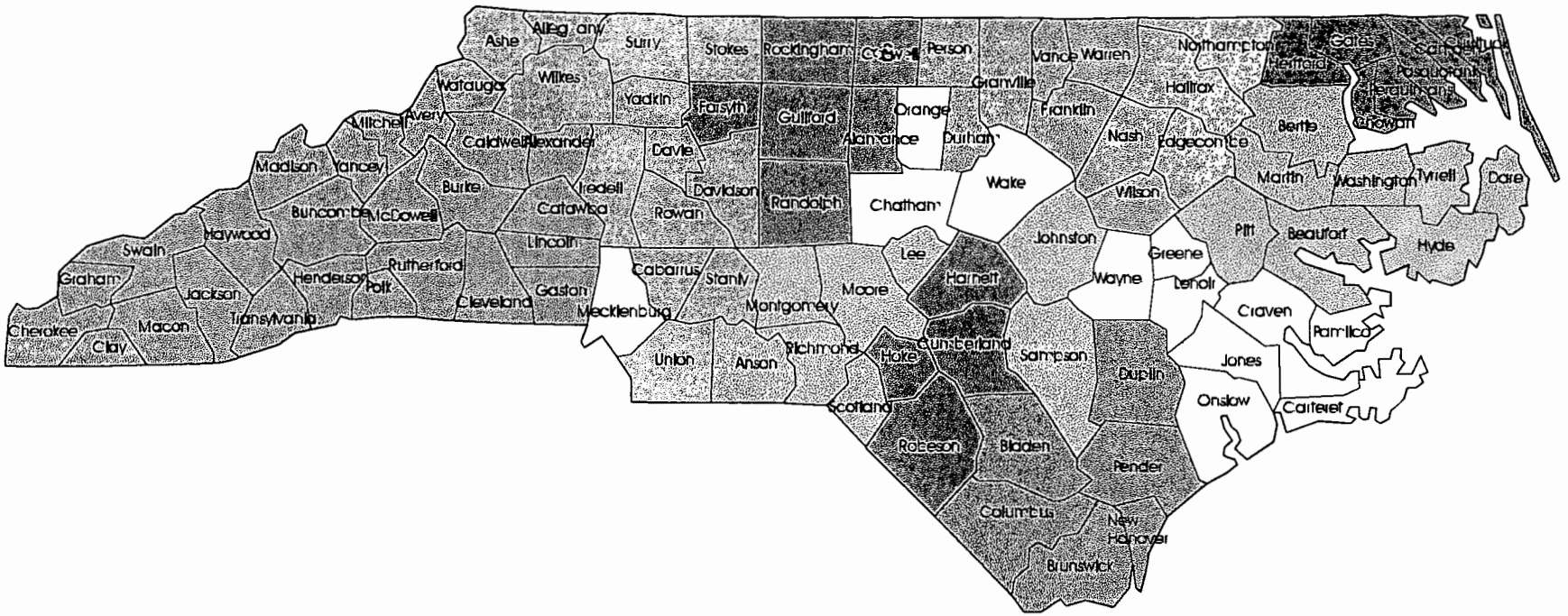
This statewide effort is absolutely vital to our patients and their families. Many other states have long since recognized the importance of their major medical centers to the ongoing health and well-being of their sickle cell patient population. To cite a few examples, the State of Georgia provides $700,000 and $400,000 respectively to each of its two medical centers. The University of Mississippi and the University of Pittsburgh each receive $250,000/year, and Children's Hospital of Philadelphia receives $330,000/year. By contrast, the medical center-based comprehensive sickle cell programs here in North Carolina receive an average of less than $25,000/center/year. In the past, we were able to get by on this modest level of funding because we had the support of the federal government through the Comprehensive Sickle Cell Center grant. However, this year's loss of the center award points out just how insecure this type of grant support actually is. We ask you to help us eliminate the dependence of our patients and their families on the whims of the granting agencies by establishing a much more secure and long-term base of support for our medical center-based comprehensive sickle cell programs.

NC Sickle Cell Syndrome Program Budget FY 97/98

Total Budget - $2,589,866



- Community-based Centers
- Program Salaries/Expenses
- Purchase of Medical Care Services
- Medical Center Programs



SICKLE CELL SYNDROME PROGRAM CATCHMENT AREAS

State Regional Educator/Counselors

Community-Based Centers

Distribution of TANF Funds for Qualified Substance Abuse Professional FTE(s)

2-18-98

Area Program Name	Total Number of Families in AP Catchment Area	Amount of Distribution Based on Work First
Alamance-Caswell	1,081	$ 45,000
Albemarle	1,445	$ 45,000
Blue Ridge	1,996	$ 80,000
Catawba	1,077	$ 45,000
Cleveland	1,299	$ 45,000
Cumberland	4,285	$ 80,000
Davidson	930	$ 45,000
Duplin-Sampson	1,252	$ 45,000
Durham	3,560	$ 80,000
Edgecombe-Nash	2,561	$ 80,000
Foothills	1,539	$ 45,000
Forsyth-Stokes	3,975	$ 80,000
Gaston-Lincoln	2,960	$ 80,000
Guilford	4,416	$ 80,000
Halifax	1,794	$ 45,000
Johnston	926	$ 45,000
Lee-Harnett	1,654	$ 45,000
Lenoir	1,350	$ 45,000
Mecklenburg	6,735	$ 80,000
Neuse	1,673	$ 45,000
New River	1,042	$ 45,000
Onslow	1,149	$ 45,000
OPC	1,052	$ 45,000
Piedmont	2,858	$ 80,000
Pitt	2,150	$ 80,000
Randolph	647	$ 45,000
Roanoke-Chowan	1,716	$ 45,000
Rockingham	1,002	$ 45,000
Rutherford-Polk	750	$ 45,000
Sandhills	3,015	$ 80,000
Smoky Mountain	1,242	$ 45,000
Southeastern Area	2,704	$ 80,000
Southeastern Regional	5,128	$ 80,000
Surry-Yadkin	1,312	$ 45,000
Tideland	1,680	$ 45,000
Trend	838	$ 45,000
V-G-F-W	2,350	$ 80,000
Wake	3,761	$ 80,000
Wayne	1,656	$ 45,000
Wilson-Greene	1,535	$ 45,000
	84,095	$ 2,325,000

October 31, 1997

URINE TOXICOLOGY CONTRACTS

Area Program Name	Total Number of Families in AP Catchment Area	Amount of Distribution Based on Work First
Alamance-Caswell	1,081	$ 9,641
Albemarle	1,445	$ 12,887
Blue Ridge	1,996	$ 17,801
Catawba	1,077	$ 9,605
Cleveland	1,299	$ 11,585
Cumberland	4,285	$ 38,216
Davidson	930	$ 8,294
Duplin-Sampson	1,252	$ 11,166
Durham	3,560	$ 31,750
Edgecombe-Nash	2,561	$ 22,840
Foothills	1,539	$ 13,726
Forsyth-Stokes	3,975	$ 35,451
Gaston-Lincoln	2,960	$ 26,399
Guilford	4,416	$ 39,384
Halifax	1,794	$ 16,000
Johnston	926	$ 8,259
Lee-Harnett	1,654	$ 14,751
Lenoir	1,350	$ 12,040
Mecklenburg	6,735	$ 60,066
Neuse	1,673	$ 14,921
New River	1,042	$ 9,293
Onslow	1,149	$ 10,247
OPC	1,052	$ 9,382
Piedmont	2,858	$ 25,489
Pitt	2,150	$ 19,175
Randolph	647	$ 5,770
Roanoke-Chowan	1,716	$ 15,304
Rockingham	1,002	$ 8,936
Rutherford-Polk	750	$ 6,689
Sandhills	3,015	$ 26,889
Smoky Mountain	1,242	$ 11,077
Southeastern Area	2,704	$ 24,116
Southeastern Regional	5,128	$ 45,734
Surry-Yadkin	1,312	$ 11,701
Tideland	1,680	$ 14,983
Trend	838	$ 7,474
V-G-F-W	2,350	$ 20,958
Wake	3,761	$ 33,542
Wayne	1,656	$ 14,769
Wilson-Greene	1,535	$ 13,690
	84,095	$ 750,000

Distribution of TANF Funds for Non-Medicaid Reimbursable Services

Area Program Name	Total Number of Families in AP Catchment Area	Amount of Distribution Based on Work First
Alamance-Caswell	1,081	$ 15,747
Albemarle	1,445	$ 21,049
Blue Ridge	1,996	$ 29,075
Catawba	1,077	$ 15,689
Cleveland	1,299	$ 18,922
Cumberland	4,285	$ 62,419
Davidson	930	$ 13,547
Duplin-Sampson	1,252	$ 18,238
Durham	3,560	$ 51,858
Edgecombe-Nash	2,561	$ 37,306
Foothills	1,539	$ 22,418
Forsyth-Stokes	3,975	$ 57,903
Gaston-Lincoln	2,960	$ 43,118
Guilford	4,416	$ 64,327
Halifax	1,794	$ 26,133
Johnston	926	$ 13,489
Lee-Harnett	1,654	$ 24,094
Lenoir	1,350	$ 19,665
Mecklenburg	6,735	$ 98,108
Neuse	1,673	$ 24,370
New River	1,042	$ 15,179
Onslow	1,149	$ 16,737
OPC	1,052	$ 15,324
Piedmont	2,858	$ 41,632
Pitt	2,150	$ 31,319
Randolph	647	$ 9,425
Roanoke-Chowan	1,716	$ 24,997
Rockingham	1,002	$ 14,596
Rutherford-Polk	750	$ 10,925
Sandhills	3,015	$ 43,919
Smoky Mountain	1,242	$ 18,092
Southeastern Area	2,704	$ 39,389
Southeastern Regional	5,128	$ 74,699
Surry-Yadkin	1,312	$ 19,112
Tideland	1,680	$ 24,472
Trend	838	$ 12,207
V-G-F-W	2,350	$ 34,232
Wake	3,761	$ 54,786
Wayne	1,656	$ 24,123
Wilson-Greene	1,535	$ 22,360
	84,095	$ 1,225,000

AGENDA

North Carolina Association of Second Harvest Food Banks

Sub Committee for Appropriations for Human Resources
North Carolina General Assembly
Wednesday, February 18, 1999
11:30 AM

Introduction	Jerry Hardesty, Food Solicitor Second Harvest Food Bank of Northwest North Carolina Winston Salem, NC
Second Harvest Food Banks (video)	Anne Register, Executive Director Second Harvest Food Bank of Metrolina President, NCASHFB Charlotte, NC
The Need in North Carolina	Toby Ives, Executive Director MANNA Food Bank Vice President, NCASHFB Asheville, NC
The Results of General Assembly	Nan Holbrook Griswold Executive Director Second Harvest Food Bank of Northwest North Carolina Vice President, NCASHFB Winston Salem, NC
Local Agency	The Reverend T.J. Bland St. Andrew's Episcopal church Greensboro, NC Director, St. Andrew's/ St. Pius Food Pantry
Questions	

Thank you for allowing us to present the needs of the poor in our state to you. We are grateful for your support of Food Banks and emergency assistance agencies and their poor and needy clients through the grant to purchase nearly 2 million pounds of nutritious food to help feed the people of North Carolina.

SNAP RECEIVED - 4TH QTR 1997

PRODUCT	QTY PER CASE	MDI (FBNWNC)	ORDER	# CASES	# CASES NOV/FEB	CASES RECEIVED	DATE	VALUE
VEGETABLE SOUP	24/10.5 OZ.	10.10	8,585.00	850	425	850	12/19/97	8,585.00
CHICKEN NOODLE SOUP	24/10.5 OZ.	11.16	9,486.00	850	425	840	12/9/97	9,374.40
PEANUT BUTTER	12/18 OZ.	12.44	10,574.00	850	425	850	1/27/98	10,574.00
TUNA	48/6.5 OZ.	24.23	15,749.50	650	325	640	1/27/98	15,507.20
CORN	24/15.25 OZ	7.10	5,325.00	750	375	750	12/9/97	5,325.00
PINTO BEANS	12/2 LB.	6.48	5,508.00	850	425	840	12/2/97	5,443.20
BEEF STEW	12/24 OZ.	10.41	12,492.00	1,200	600	1,210	11/25/97	12,596.10
BEEF RAVIOLI	24/15 OZ.	15.40	7,700.00	500	250	500	12/9/97	7,700.00
MACARONI & CHEESE	24/7.25 OZ.	5.26	4,471.00	850	425	854	12/9/97	4,492.04
ORANGE JUICE	12/46 OZ.	12.86	10,931.00	850	425	848	1/27/98	10,905.28
GREEN BEANS	24/14.5 OZ.	7.10	5,325.00	750	375	750	1/27/98	5,325.00
PEARS	24/14.5 OZ.	18.50	14,800.00	800	400	800	1/27/98	14,800.00
RICE	24/1 LB.	7.61	1,689.42	222	111			-
PEACHES	24/15 OZ.	16.22	12,976.00	800	400	800	1/27/98	12,976.00
FRUIT COCKTAIL	24/15 OZ.	16.21	13,778.50	850	425	850	12/17/97	13,778.50
			139,390.42	**11,622**	**5,811**			
#10 CANS								
CORN	6/10 LB.	13.07	3,921.00	300				
GREEN BEANS	6/10 LB.	9.78	2,934.00	300				
FRUIT COCKTAIL	6/10 LB.	25.22	7,566.00	300		300	1/27/98	7,566.00
TOMATOES	6/10 LB.	10.48	1,834.00	175		175	1/27/98	1,834.00
TOMATO SAUCE	6/10 LB.	11.41	1,711.50	150		152	12/19/97	1,734.32
			17,966.50	**1,225**				
						12,009		148,516.04
	TOTALS		**157,356.92**	**12,847**			VALUE/CASE	12.37
	SALES TAX RECEIVABLE 1/98		9,441.42					
	GRAND TOTAL		**166,798.34**					

FOOD BANK OF NORTHWEST NORTH CAROLINA, INC.
3655 REED ST.
WINSTON-SALEM, NC 27107
ERIC YARBROUGH
(910) 784-5770, FAX = (910) 784-7369

NC Second Harvest Food Banks Fact Sheet

Mission: The NC Second Harvest Food Banks seek to reduce hunger and malnutrition throughout our state. They distribute reclaimed usable food to 501(c)(3) agencies and churches feeding those in need.

History: Have operated in NC since 1981. There are 6 regional locations: Asheville, Charlotte, Elizabeth City, Fayetteville, Raleigh and Winston-Salem.

Service Area: All 100 NC Counties.

Facilities: Large warehouses equipped with freezer and cooler capacity.

Distribution: *19,751,619* million pounds of food in 1997.

Agencies: Over 1,658 human care agencies throughout the state:

- Emergency church food pantries and crisis assistance ministries giving food boxes to families
- Shelters assisting the homeless and abused
- Soup Kitchens feeding the poor and homeless
- Kids Cafes feeding children evening meals and providing enriching activities
- Elderly Nutrition Programs providing food for seniors
- Group Homes helping people with disabilities and at-risk children
- Day Care Services (low income) caring for children and adults(low income)
- Substance Abuse Centers and Rescue Missions

NC Donors: Harris Teeter, Lowes Foods, Food Lion, Ingles, Winn-Dixie, Kroger, Hannaford, Lance, Bi-Lo, NC Pork Producers, NC Egg Association, Seneca, Garner Foods, Goodmark Foods, Mt. Olive, Society of St. Andrew.

National Donors: Nabisco, General Mills, Sara Lee, Kraft, General Foods, Coca-Cola Foods, Kellogg's, CPC Best Foods, Proctor & Gamble, Quaker Oats, Campbell's Soup, Ocean Spray, Keebler, Frito Lay, Heinz USA.

State Nutrition Assistance Program (SNAP): The NC General Assembly has provided funding for the food banks to purchase staple items for emergency assistance agencies for two years.

The Emergency Food Assistance Program (TEFAP): The NC Department of Agriculture agreed in 1997 for food banks to distribute these commodities through its network of food pantries rather than mass distribution.

Second Harvest: The largest hunger relief network in the U. S. with 200 food banks providing hundreds of millions of pounds of donated food through more than 50,000 charities.

Location of the Food Pantry

St. Andrew's Episcopal Church
2105 W. Market Street
Greensboro, NC 27403
Phone: 336-275-1651
Located in a 400 square foot building behind the church on the church property.
Managing Director: The Rev. T. J. Bland, Sr.

Staff

The Managing Director, The Rev. T. J. Bland, Sr., is the only paid staff member with a staff of 40 volunteers from St. Andrew's and St. Pius who help purchase and transport food and other items to the Food Pantry. These volunteers also stock shelves at the pantry, box food and other items for the clients to pick up (or have other local community agency personnel pick up food for distribution); break down large packages of rice, crackers, coffee, and other items and repackage them in smaller quantities; pick up bakery products from local supermarkets and bakeries; assist the Director in fund raising activities; serve on the Food Pantry Board of Directors; and perform carpentry work and other skilled labor needed by the Pantry.

Who Qualifies for Assistance

- Hospice Participants
- Battered Women
- AIDS patients
- the Mentally Ill
- Individuals recently laid off from work
- Individuals waiting for Food Stamps or Checks which have been delayed, lost, or stolen
- Recovering Alcoholics
- Narcotic addicts
- Homeless unwed mothers
- Home care affiliates
- Any others who need immediate emergency food assistance on a temporary basis until they can obtain help and guidance from the appropriate agency.

ST. ANDREW'S / ST. PIUS FOOD PANTRY

A Joint Ministry with St. Pius Tenth Roman Catholic Church

Purpose and History

T. J. Bland, a member of St. Andrew's Episcopal Church in Greensboro and an active community volunteer, determined through his activities that a need existed for a source that would provide temporary assistance to persons who "Fell Through the Cracks" in trying to qualify for aid from governmental and local charitable agencies, such as Guilford County Dept. of Social Services and the Greensboro Urban Ministry.

Mr. Bland submitted a proposal to the vestry of St. Andrew's Episcopal Church for the operation of a food pantry located at the church which would fill this need. After approval by the vestry, Mr. Bland started the Food Pantry in March 1992 in the lower level of the church. St. Andrew's contributed space for the food storage area and for the office. They also contributed utilities and some secretarial help.

From the beginning, the St. Andrew's / St. Pius Food Pantry has been open to serve clients five days a week. It is the **only** Food Pantry in Greensboro offering this type of assistance on a full-time basis.

In the Spring of 1995, St. Pius Tenth Catholic Church, one of the few organizations providing food assistance on a part-time basis, lost its director. Rather than close its Food Pantry, the church approached St. Andrew's about a merger of resources of the two pantries. On May 11, 1995, St. Andrew's began operating in the lower level of St. Andrew's Episcopal Church as a joint ministry with St. Pius. St. Pius supplies volunteer help, food obtained in a monthly collection at their church, and a limited amount of funding. Since that time, the two remaining part-time food pantries providing emergency assistance have also closed, leaving St. Andrew's / St. Pius Food Pantry as the only operation of its type in the community.

At St. Andrew's / St. Pius Food Pantry clients receive boxes of canned vegetables, soup, fruit and meat, cereal, peanut butter, rice, coffee, tea, flour, fruit juice, crackers, bread and other bakery products and a limited amount of household and personal care items. Occasional purchases of chicken and hamburger are also provided through donations from local food chains, such as Harris Teeter and Lowe's Foods.

In **March 1992** the St. Andrew's Food Pantry assisted **19 persons.** In **December 1997** the number of persons receiving assistance has reached **1,100 persons per month.** The Food Pantry has also outgrown its small operating space in the lower level of St. Andrew's Episcopal Church and now **operates from a 400 square foot building located behind the church on St. Andrew's Episcopal Church property.**

How It Works

Human service agencies and churches are often the first contact for families and individuals in crisis situations. These are the groups who refer most of the clients to our Food Pantry program. Information on all clients is entered in our record keeping system. If necessary, we verify information with other groups before providing assistance. If a client has not yet sought help from the Urban Ministry Assistance Program, we coordinate our efforts with this agency.

Clients qualifying for assistance from the Food Pantry receive a card with five punches, good for weekly visits over the next 5 weeks. At the end of the five weeks, the cardholder's circumstances are reviewed and a decision is made as to whether or not to continue assistance.

Referring Groups

- Department of Social Services
- Urban Ministries
- Churches
- Triad Health Project
- Greensboro Housing Coalition
- Guilford County Mental Health
- Hospice
- Advanced Home Care of North Carolina
- NC Dept. of Vocational Rehabilitation and Independent Living Program

Sources of Food

- Grocery Purchases are made at a minimal cost from the Food Bank of Northwest North Carolina located in Winston Salem, NC.
- Purchases at a minimal cost from the Greensboro Urban Ministry Food Bank
- Donations from local supermarkets, bakeries, and other local merchants
- Individual donations

How the Food Pantry is Financed

Operation of St. Andrew's / St. Pius Food Pantry is financed by grants and contributions from foundations, churches, and church groups, community organizations, and individuals.

NC Second Harvest Food Banks
Board Members

Albemarle Manna (Elizabeth City)
[redacted]Baker
[redacted]phia Cable

Anna Biggs
Biggs Pontiac

Mark D'Andrea
US Coast Guard

Pat Davis
BB&T

Susan Ellswick, MSW
Pasquotank County Public Schools

The Rev. Charles Foster
Holy Trinity Church

Father Nicholas Iberra
Iglesia Episcopal de San Mateo

Dr. Bishop Patterson
Elizabeth City State University

Joyce Pickrel
At-Large

[redacted]Prentiss
[redacted]thal, Riley, Ellis & Maland

The Rev. Paul Roberts
Christ Episcopal Church

Kathryn Slocumb
Hornthal, Riley, Ellis & Maland

Martha Swain
College of the Albemarle

Dru Thompson
At-Large

Ken Willingham
Retired, US Coast Guard

Food Bank of NC (Raleigh)
Rick Anicetti
Hannaford Brothers

Chris Bubin
First Citizens

Sister Mary Ann Czaja
Tarboro Community Outreach

[redacted]Davenport
Davenport & Sons

Sandra Davis
Community Volunteer

John Gray
First Citizens

Steve Gunn
Associated Foodservices

Ken Hammond
Kroger

The Rev. Haywood Holderness, Jr.
Westminster Presbyterian Church

Harry Kaplan
Attorney, Lobbying & Government Relations

Donna Lindquist
Community Volunteer

Mary Esther Martin
Community Volunteer

Easter Maynard
Community Volunteer

William (Skip) Orser
CP&L

Ashmead Pipkin
Pipkin, Knott & Clark, L.L.P.

Shannon St. John
Triangle Community Foundation

John Stokes
Alliant Food Service

Dr. Rollie Tillman
Community Volunteer

MANNA (Asheville)
Anne Ayala
Community Volunteer

Boyce Baker
Steelcase, Inc.

Sara Bissette
Community Volunteer

Jonathan Blakely
Wilsonart International

Tim Burleson
Billy Graham Training Center

Jane Curran
Mountain Area Hospice

Tim Davey
Ingles Markets, Inc.

John Evans
Blue Ridge Bone and Joint Clinic

Joel Gillespie
Smith Dray Line

Charles D. Hardy, III
First Union National Bank

Sandra Hoskin
Community Volunteer

W. Randolph Jameson (Emeritus)
Thomas and Howard Co.

Stephen Kaser
Velvet Ridge Greenhouses, Inc.

Wayne Kinser
Peppertree Resorts, LTD.

David Lewter
Atlas Food Brokers, Inc.

Fritz Mueller
President, Asheville Rotary Club

Robert Price
Retired, Gerber Products

W. Bradford Searson
VanWinkle Law Firm, P.A.

Peter Sprague
Thomas and Howard Co.

Marjorie Ulin
Community Volunteer

Sandy Worley
The Alpha Group

Second Harvest Food Bank of Metrolina (Charlotte)
Richard H. Barnhardt, Jr.
Carolinas' Division, US FoodService

Mary K. Bartley
Community Volunteer

Phil O. Brooks
Lance, Inc.

Second Harvest Fact Sheet

Organization: Second Harvest is the largest domestic hunger-relief charity in the United States. Second Harvest's mission is to feed hungry people by soliciting and distributing food and grocery products through a nationwide network of certified affiliate food banks and to educate the public about the nature of and solutions to the problem of hunger in America.

Operations: The Second Harvest network of nearly 200 regional food banks serves all 50 states and Puerto Rico by distributing food and grocery products to nearly 50,000 charitable feeding programs, including local food pantries, soup kitchens, homeless shelters, Kids Cafes and other nonprofit agencies. Approximately 99.7 percent of all donations made to Second Harvest go directly to hunger assistance.

Donations: Second Harvest works with more than 400 national grocery and food service company donors to secure surplus food and grocery products. The list, which reads like a "Who's Who" in corporate America, includes such donors as Kraft Foods, General Mills, Nabisco, Quaker Oats, Marriott International, Pillsbury, Proctor & Gamble and hundreds more.

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Stats: It is estimated that there are 30 million hungry people in the United States, including 13 million children and 3 million elderly.

"According to independent research of emergency feeding programs conducted for Second Harvest, 26 million people rely on food pantries or soup kitchens each month," says Christine Vladimiroff, Second Harvest President and CEO. "Hunger in the United States has grown an estimated 50 percent since 1985." 9/97

Second Harvest Food Banks of North Carolina

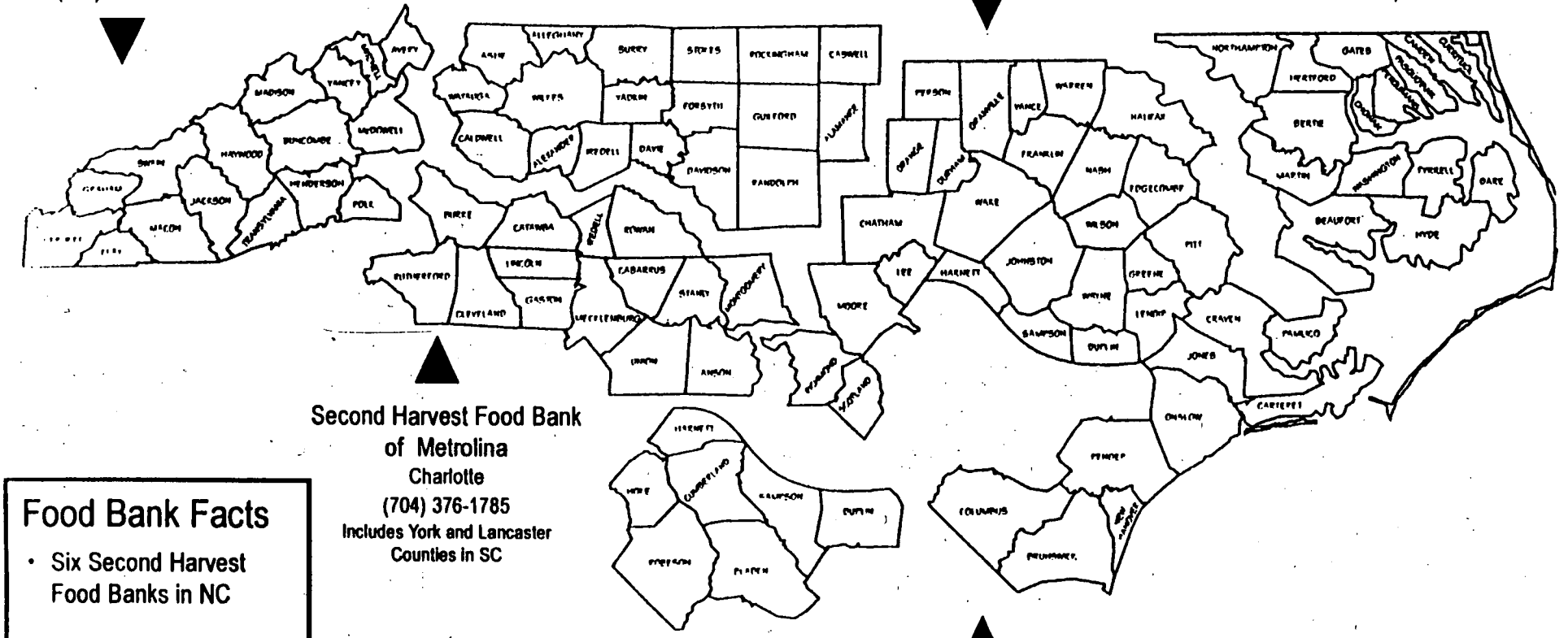
Serving All 100 Counties

Manna Food Bank
Asheville
(704) 299-3663

Second Harvest Food Bank
of NWNC
Winston-Salem
(336) 784-5770

Food Bank of NC
Raleigh
(919) 875-0707

Albemarle Manna
Food Bank
Elizabeth City
(919) 335-4035



Second Harvest Food Bank
of Metrolina
Charlotte
(704) 376-1785
Includes York and Lancaster
Counties in SC

Second Harvest Food Bank
of Southeast NC
Fayetteville
(910) 485-8809

Food Bank Facts

- Six Second Harvest Food Banks in NC
- Alleviating hunger through 1,650 charities
- Distributing more than 19.7 million pounds of products a year

Executive Directors	
Asheville	Toby Ives
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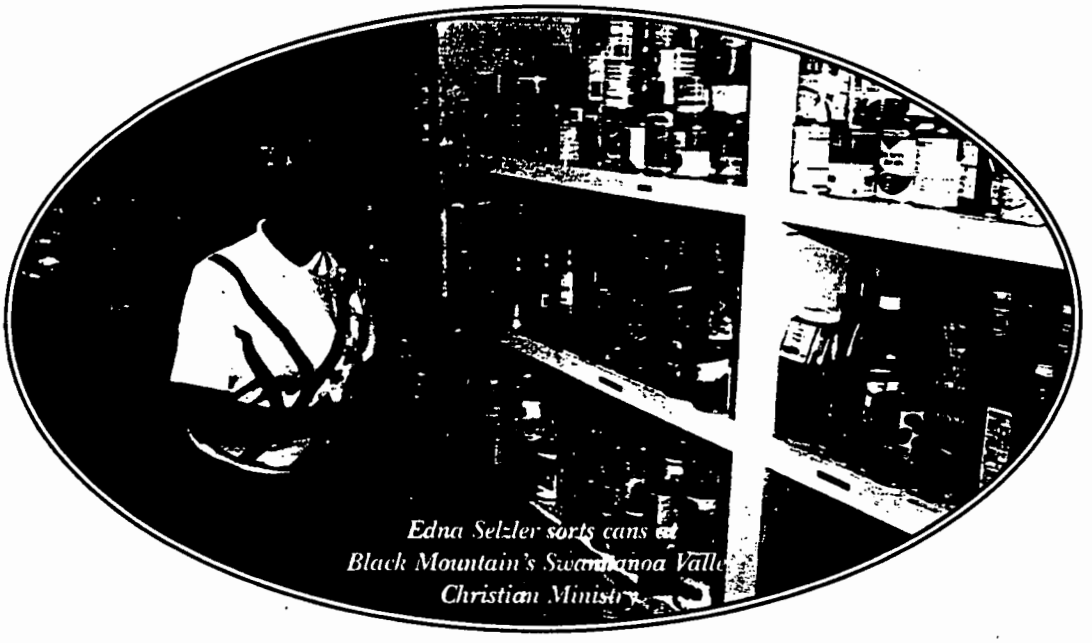
In the Spirit

...e little match girl struck a second match — and before her was a big table — with a glistening white tablecloth — there was a huge roast duck with apples, cake, and warm milk — and she was ...happy because ...e was so terribly hungry. Then just when she was reaching for the roast duck — the match burned out — and then she was colder and more hungry than ever.

from "The Little Match Girl" by Hans Christian Andersen

The story of North Carolina food banks and their success is not about capital fund-raising campaigns or the logistics of redistributing food. It is the story of people, good people, who look beyond their own needs to help those in greater need.

Text and photography by Ralph Grizzle



Edna Selzler sorts cans at Black Mountain's Swannanoa Valley Christian Ministry.

A little west of the Eastern Continental Divide, in a small hamlet that bills itself as the "Front Porch of Western North Carolina," Edna Selzler stacks cans of Del Monte peaches, Laura Lynn green beans, loaves of Merita bread, and boxes of Post cereal. She is one of 60 volunteers who donates a few hours each week to perform a variety of chores at the Swannanoa Valley Christian Ministry, located in Black Mountain.

Outside, retiree Francis Blankenship, who lives just a few doors down from the ministry, harnesses a blower to remove leaves from the parking lot. Like Selzler, he's been coming here to help for a decade or so, not for pay, nor for recognition, but for the feeling he gets from helping others.

"We have a lot of good people here," says Lois Nix, who has served as executive director of the ministry since 1976. "We're like one big family." While she praises her volunteers, a flatbed pick-up truck rolls into the parking lot, loaded with more loaves of Merita bread. Parked in a distant corner, a mother tends to two children, while a couple of ministry volunteers tote boxes of groceries to her old, battered Ford Escort. "Being a Christian is not a requirement for obtaining food here," Nix says. "You just have to be in need."

Each day, in cities and towns throughout North Carolina, food pantries, Christian ministries, and other organizations distribute food to the needy. Most are backed by area churches, corporate entities such as grocery chains, food manufacturers, and a six-region organizational network known as the Food Banks of North Carolina. Annually, the food banks distribute millions of pounds of food to feed the

of the Season

hungry and raise millions of dollars to run their facilities.

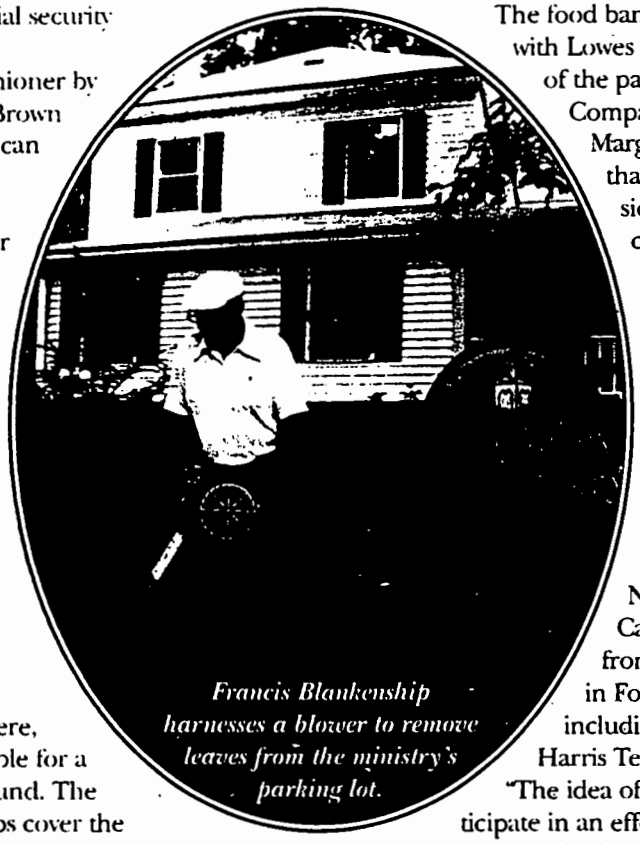
But the story of food banks and their success in North Carolina is not about capital fund-raising campaigns or the logistics of redistributing food. It is the story of people, good people, who look beyond their own needs, beyond the needs of their businesses. It is the story of people like Lois Nix and her volunteers who feed nearly 200 people each month; people like Margaret Urquhart, the forward-thinking president of Lowes Food, whose corporate philosophy extends beyond the bottom line; and a whole host of others whom you'll meet in this story.

Working hand-in-hand

It was mid-summer when Father Stott got the news. Nineteen Mexican parishioners of the Holy Angels Catholic Church in Mt. Airy had suddenly lost their jobs because of a "defect in their social security numbers."

Stott and a parishioner by the name of John Brown knew that the Mexican families would be strapped for food and supplies. "Their income was low to begin with," Stott says. "And because they don't have proper social security numbers, they don't have access to social services."

So Stott and Brown headed down to the Food Bank of Northwest North Carolina in Winston-Salem. There, food is made available for a mere 14 cents a pound. The token payment helps cover the food banks' operating costs. Just think, 10 pounds of food for $1.40. "I've been breaking my arms ever since, bringing food back here," Stott quips. "The food banks really came to our rescue."



Francis Blankenship harnesses a blower to remove leaves from the ministry's parking lot.

Nan Griswold, executive director of the Winston-Salem facility, has watched similar scenarios play out over the 16 years she's been there. "You truly feel like it's a system that works," she says. "My first job was in juvenile court as a probation officer, then I worked in residential care, a runaway home, and directed an inner-city ministry for children. So I had worked with individuals and agencies, and there is a frustration there. But here, I know I'm making a difference."

To many observers, food banks show America working at its best. Most of the food comes from grocery stores that donate items that are either in abundant supply or nearing their expiration dates. The stores and other corporate entities also donate funds and sponsor fund-raising campaigns for the food banks. Griswold says she has been told that there is no better partnership between corporate America and the nonprofit community.

The food banks' relationship with Lowes Food is emblematic of the partnership. Company President Margaret Urquhart says that giving is an extension of Lowes Food's corporate philosophy. "Part of our vision is that we feed people body, mind, and spirit," she says. "And that goes beyond just people who can afford to buy food."

Food Bank of Northwest North Carolina picks up from 34 grocery stores in Forsyth County, including Food Lion, Harris Teeter, and others. "The idea of being able to participate in an effort that helps people who can't afford to buy food or are in a situation where they're not getting the right kinds of foods, it's something that makes us feel good about being in business," Urquhart says.

"Are there no prisons?" asked Scrooge. "... they would rather die," said Scrooge, "they had better do it and decrease the surplus population." Best and happiest of all, the Time before him was his own, to make amends in! ... Scrooge was better than his word. He did it all and infinitely more ... It was said of him that he knew how to keep Christmas well, if any man alive possessed the knowledge."

from "A Christmas Carol" by Charles Dickens

one who cherishes this season, I reluctantly confess to spending a good deal of my life oblivious to its deeper meaning — guilty of not seeing the forest for the Christmas trees. ... But when the candy-coated facade is stripped away, what is it that remains of the season?

It was just such a circumstance that I truly learned of Christmas — in a place where there was no Christmas. ... In this state of heart, I came to

The need in North Carolina

In Forsyth County alone, 27,000 people live in poverty — 9,000 of whom are children, according to a flyer distributed by the food bank. "When I first came on board, one of the things I didn't want was pictures of starving children," Griswold says. "I know that people give out of guilt, but I want them to understand that hunger is solvable. It's a community problem, and the community has to respond to it. It's something that individuals can do

Safe Havens



Smiling faces and full tummies express thanks to Kids Cafe.

When an HIV-related illness claimed her only daughter at the tender age of 23, Maxcine Mann found herself tossed into a sea of despair. Like many others facing desperation, she turned to the church. But Maxcine Mann didn't ask for a helping hand to calm her troubled mind. Instead, she found healing by lending one of her own.

The journey from her daughter's death six years ago to Mann's present station in life has been a long and rewarding one. Here, at Chapel of Christ the King, an Episcopal mission located several blocks away from downtown Charlotte's towering buildings, Mann oversees a program designed to feed and nurture impoverished children ages five to 12. "My daughter was a loving person who really cared for children," says this gentle black woman. "This is my way of living through her, my way of giving back to a few kids who are having hard times."

Mondays through Thursdays, Mann and a group of volunteers welcome any and all neighborhood children to an after-school program called Kids Cafe. It is here that kids receive a warm, nutritious meal, mentoring and tutoring, and perhaps more important, a warm embrace. For some children, showing up at Kids Cafe means not showing up at a home where they are abused or neglected.

"I know this neighborhood and what the children are going through," Mann says. "Some of the parents have gotten themselves into situations that they don't think they can get out of. I can't go in and fix every kid's household, but I can make it good for them while they're here with us. I know they need food. I know they need a smile, and I know that sometimes, they just need a shoulder to cry on. Then they can go home and shut their bedroom door and wait until it's time to go to school the next morning. If I can just make their life better for one hour, then I've succeeded."

Kids Cafe is hosted jointly by the church and Metrolina Food Bank, which solicits corporations for funds and food to feed hungry kids. Metrolina's Becky Van Wie says the organization is constantly looking for agencies willing to host a Kids Cafe and businesses and corporations willing to fund it. "For about $10,000, we can feed 75 children two to four nights a week for a year," she says.

The children of Charlotte aren't unique in their need for these safe havens where they'll be fed and nurtured. The need extends across the state, and six North Carolina-based food banks are working to address those needs. Metrolina Food Bank sponsors two Kids Cafes in Charlotte and one in Gaston County. Winston-Salem also has a Kids Cafe.

For the kids in this neighborhood in downtown Charlotte, the program is making a difference, not only in nutritional substance but also in self-esteem. "It is possible to change," Mann says. "There are some great children in this neighborhood because of this building and this program. If they can get a little kindness every day, it really makes them a better person. It raises their self-esteem. A well-fed child is a happy child."

something about."

People can, for example, volunteer at the local food bank distribution centers located in Asheville, Charlotte, Elizabeth City, Fayetteville, Raleigh, and Winston-Salem. "They can work in the warehouse and know that the food they're getting ready for shipping is going out to help somebody," Griswold says.

Toby Ives, executive director of Asheville's Manna Food Bank, says volunteers logged 2,400 hours in August. Who are the recipients of this goodwill? "Most of our clients are good, hard-working people in difficult straits temporarily," Ives says. "Many have disabilities or are too old or too young to work."

> According to a recent United States Department of Agriculture report and Self magazine, "96 billion pounds of food in supermarkets, restaurants, and homes are tossed in the trash — more than a quarter of all the food produced in the United States annually. Equally shocking, the waste is at a time when 30 million Americans are said to be at risk of hunger."

For every dollar donated, food banks can distribute $7 worth of food. For $10,000 donations from corporations, Metrolina Food Bank in Charlotte says that it can feed as many as 75 children three times a week. "Part of the reason that there are hungry people in this country is the distribution of wealth for one thing," Griswold says, "but the food is there. It's getting the food to the people who need it that is the challenge."

Back in Black Mountain, Lois Nix and her crew continue to load food into boxes that will be picked up during the week by those in need. Her "clients," as she refers to them, run the gamut, from young to old, families to single mothers.

Over the two decades that she's served, she has given a lot. But she says she's gotten a lot back in return. "It makes me feel good to know that we're making a difference in people's lives, to know that when I go to bed at night, there are little children who are warm because we're here, to know that their tummies are full because we were able to provide them with food," she says. "Most of us associate economically, denominationally, and racially with our own kind. You don't see the need until you get involved in something like this."

Ralph Grizzle is a freelance writer living in Asheville.

You can help ...

- For $25, you can sponsor a child's enrollment to Chapel of Christ the King's Kids Cafe for one month. Director Maxcine Mann says she values the program so much that she would pay for all kids if she could. "But I can't do that and take care of them, too," she says. If you'd like to help, contact Mann at (704) 334-3096 between 1 p.m. and 6 p.m. Mondays through Thursdays.
- North Carolina food banks also operate other programs for children and adults. Individuals, corporations, and partner agencies (such as churches or nonprofit organizations) can get involved on a local level. For more information, contact the food bank nearest you.

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Elizabeth City
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Fayetteville
Cape Fear Community Food Bank
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Raleigh
Food Bank of North Carolina
(919) 875-0707

Winston-Salem
Food Bank of Northwest North Carolina
(910) 784-5770

In addition, Greensboro's Urban Ministry collects food to offer to groups and individuals. (910) 271-5959



the realization that it is, perhaps, not as much a question of what Christmas is about as it is what we are about. That is, while we are attempting to define the season, the season, in fact, is far more adept at defining us. For Christmas reveals us as it questions our hearts and intents and asks whether we will hear its call.

from "The First Gift of Christmas" by Richard Paul Evans

Second Harvest Fact Sheet

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Executive Secretary
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APC Building Products

Robert E. Rose
Wake Forest University Medical Center

Shirley Smith
Alex Lee, Inc.

Vernon L. Walters, Jr.
American Children's Home

Andy Watts
A. Watts Construction

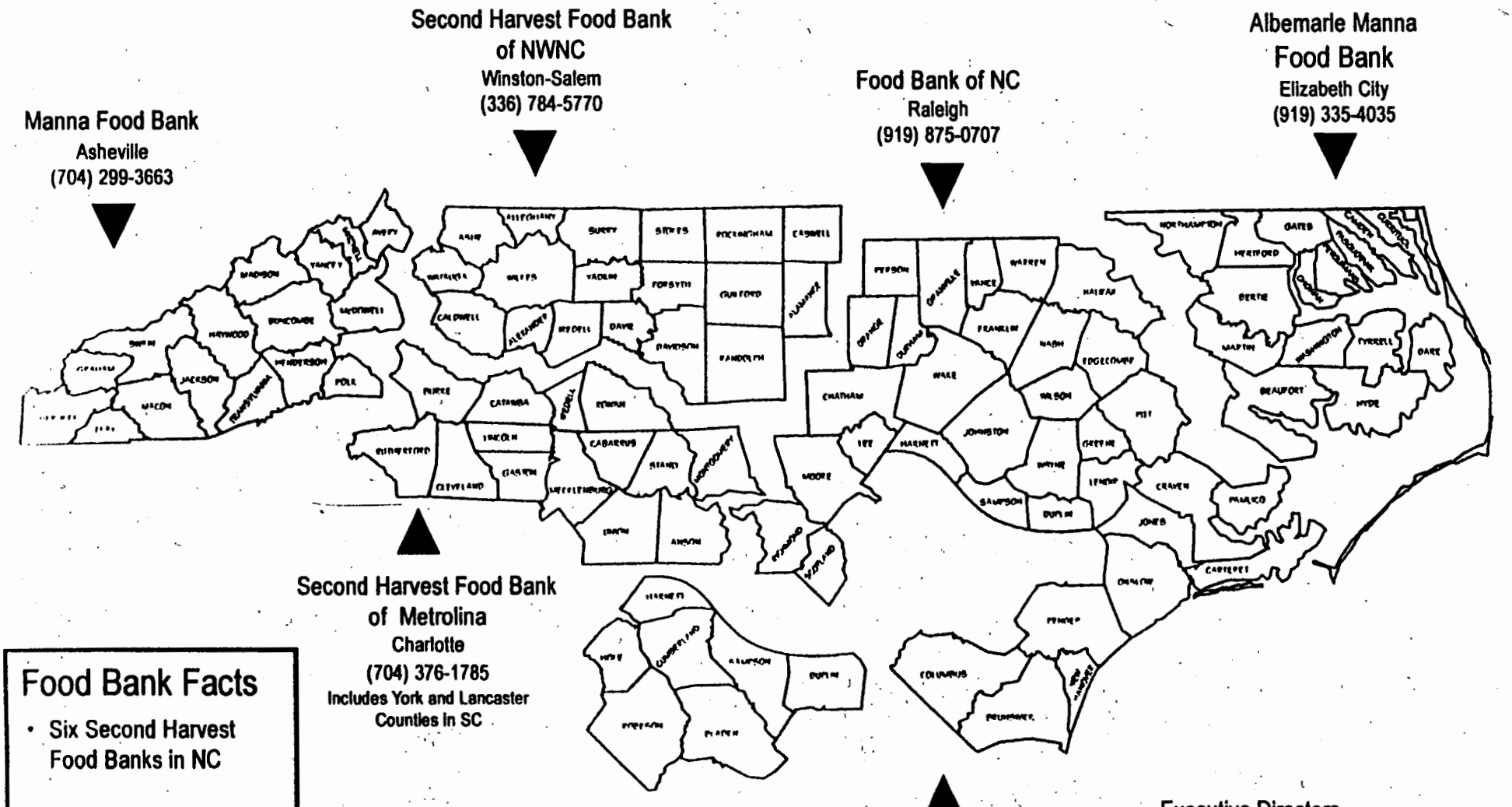
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Food Bank Volunteer

Annette M. Wilson
US Air

Edwin R. Brenegar, Jr. (Emeritus)
Retired, McLean Trucking Company

Second Harvest Food Banks of North Carolina

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SNAP AND TEFAP
STATE NUTRITION ASSISTANCE PROGRAM
THE EMERGENCY FOOD ASSISTANCE PROGRAM

SNAP REQUEST

Two million two hundred thousand dollars ($2,200,000) was requested in 1997 from the NC General Assembly to enable the six North Carolina Second Harvest Food Banks to further alleviate hunger by using $2 million of this appropriation to purchase staple foods from North Carolina companies. Two hundred thousand dollars would be designated for transportation, storage and distribution costs at the Food Bank level. A bill was passed by the Senate and $1,050,000 was allocated to the Food Banks.

TEFAP

Under the new Welfare Reform Law, TEFAP and the Soup Kitchen/Food Bank USDA Commodities have been merged into one program. TEFAP has been administered by the County Commissioners in the state and distributed by the County Departments of Social Services through a mass distribution system to needy people. The six North Carolina Second Harvest Food Banks are working with the North Carolina Department of Agriculture to distribute the food through the six Food Banks' distribution system to emergency assistance agencies for their needy clients. This system would free up the County DSS to work on the new welfare reform programs and is a more dignified and humane way to feed our needy citizens. Over 50% of the counties have agreed to transfer to the Food Bank distribution system for TEFAP.

PROGRAMS PROVIDE NUTRITION

Because Food Banks are dependent on donated food, staples are often unavailable. A State Nutrition Assistance Program would enable Food Banks to purchase high protein foods that are an essential part of a healthy diet. In 1997-98 with the $1,050,000 appropriated from the NC General Assembly, the six Second Harvest Food Banks are purchasing and distributing approximately 2 million pounds of vegetable soup, chicken noodle soup, peanut butter, tuna, corn, pinto beans, beef stew, beef ravioli, macaroni and cheese, orange juice, green beans, pears, rice, peaches, fruit cocktail, tomatoes and tomato sauce. The food goes to emergency assistance agencies. TEFAP product would add nutritious product to the Food Banks' inventory for distribution to the emergency assistance programs. Presently over 50 of the 100 counties in the state have transferred the TEFAP Program to Food Banks.

FOOD BANK FACTS

- *Serve all 100 North Carolina counties through an established distribution system of 1,658 church and nonprofit organizations such as emergency pantries, shelters, soup kitchens, elderly nutrition programs, group homes and adult and child day cares*
- *Located regionally to save duplication of costs: Asheville, Charlotte, Elizabeth City, Fayetteville, Raleigh, and Winston-Salem*
- *1997 Product Distribution over 19 Million Pounds; Estimated Retail Value - $27 million*
- *Food Banks have operated in North Carolina since 1981*
- *NC Donors Include: Harris Teeter, Lowes Foods, Ingles, Winn-Dixie, Food Lion, Lance, Kroger, Bi-Lo, NC Pork Producers, NC Egg Association, Hannaford, Mt. Olive*
- *National Donors Include: Nabisco, General Mills, Sara Lee, Kraft, General Foods, Coca-Cola Foods, Kellogg's, CPC Best Foods, Procter & Gamble, Quaker Oats, Campbell's, Ocean Spray, Keebler, Frito Lay, Heinz USA, Society of St. Andrew*

NORTH CAROLINA POVERTY

- *13% of North Carolinians live in poverty.*
- *20% of children under five live in poverty.*
- *19.5% of older adults live in poverty.*
- *62 counties have poverty populations higher than the state average.*

Lewine
2-18-98

Talking Points on Shortfall for the Cancer Control Program
February 1998

What action is bring requested?

Funds totaling $800,000 are being requested to be moved from another Purchase of Medical Care Program (Children's Special Health Services) into the Cancer Control Program to enable the Cancer Control Program (CCP) to remain open this state year. Over 11% of CCP clients are under 20 years of age. Permission to carry forward $500,000 of these funds to pay for FY98 claims that would be received in FY 99 is also requested.

What is the Cancer Control Program?

The Cancer Control Program was established by the General Assembly in 1945 to reduce cancer-related deaths among North Carolinians. The mandated purpose of the Cancer Control Program is to "establish and administer a program for the prevention and detection of cancer and for the care and treatment of persons with cancer" (G.S. 130A, Sec. 205). The Program's mission includes treatment of cancers for indigent North Carolinians (the "fee-for-service" program administered through Purchase of Medical Care Services), as well as education about the prevention and early detection of cancers. For FY98, $2,261,761 has been provided for the "fee-for-service" program.

Who does the Program serve?

Program services are now provided throughout NC in local physician's offices, hospitals and health departments to patients who are at or below 115% of federal poverty levels. These individuals do not have Medicaid or other insurance and are at low income - 115% of poverty level which for example represents $12,202 in gross income for a family of two.

How extensive is the Program?

In FY97, over 7,700 people in NC received services funded by the Program and almost 700 providers billed the program on behalf of patients, as well as 44 hospitals.

How did this shortfall occur?

A budget shortfall was experienced in FY97 when due to an increase in funding services were covered for people at an eligibility of 200% of poverty. In March of 1997 eligibility was reduced to 115% of federal poverty levels so the people could be served all year and within available budgeted funds. However, claims for the persons approved at the increased eligibility of 200% took 5-6 months to decrease, a factor which had not been anticipated.

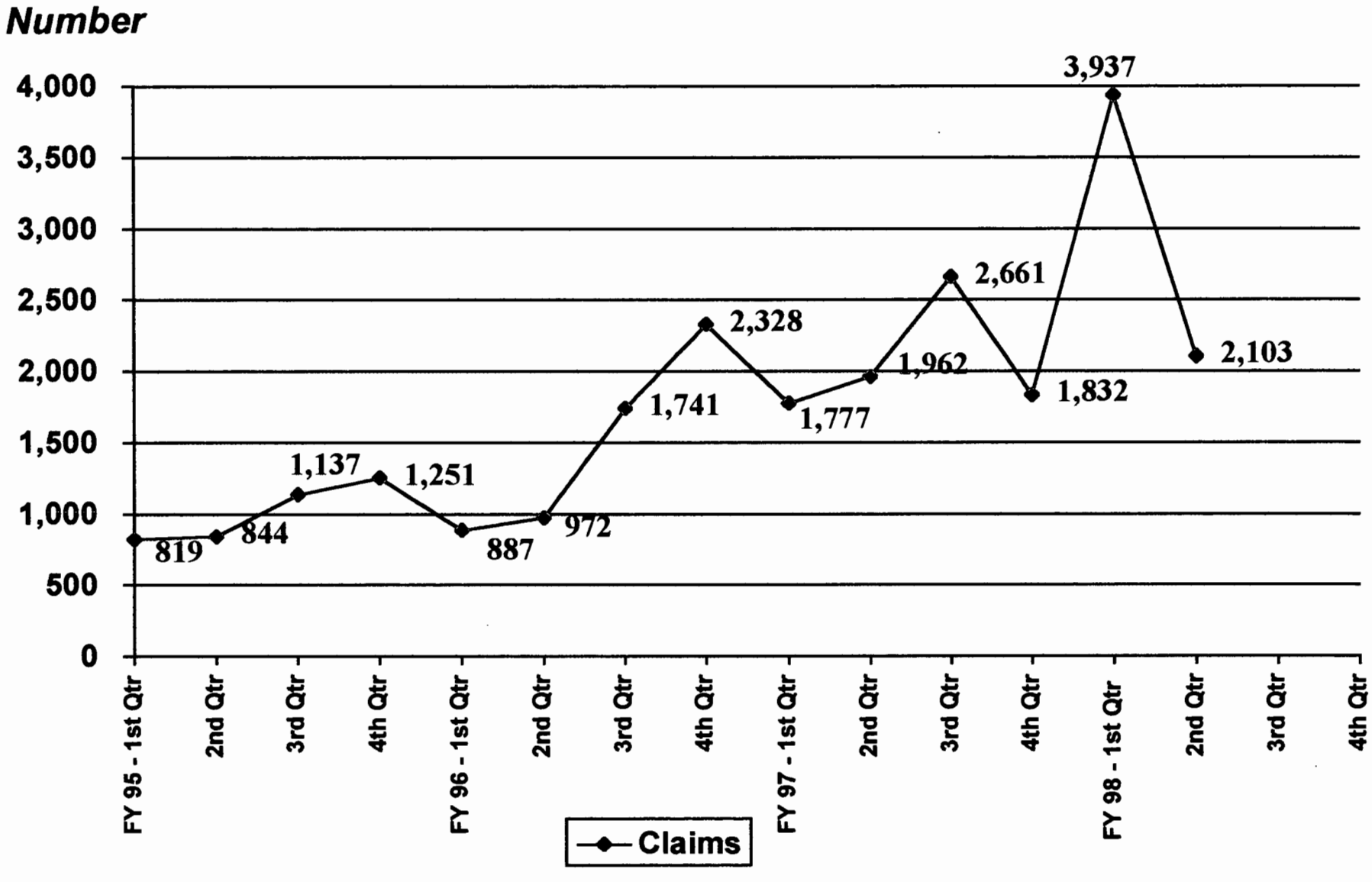
Would this be enough to forestall any problems this year and for the next years?

Monthly Program expenses had fallen to $190,000 per month, an amount that would let the program stay within available funds. Since the Program has committed all of its FY98 funds, new authorizations for services are being held. Because new authorizations are being held currently as of January 1, 1998, receipt of related claims will be delayed and a percentage of the $800,000 will need to be carried forward into FY99. Also, some FY99 funds may be needed to pay the balance of FY98 claims. We are proposing that a similar approach would be needed until the carry forward of claims would not be needed.

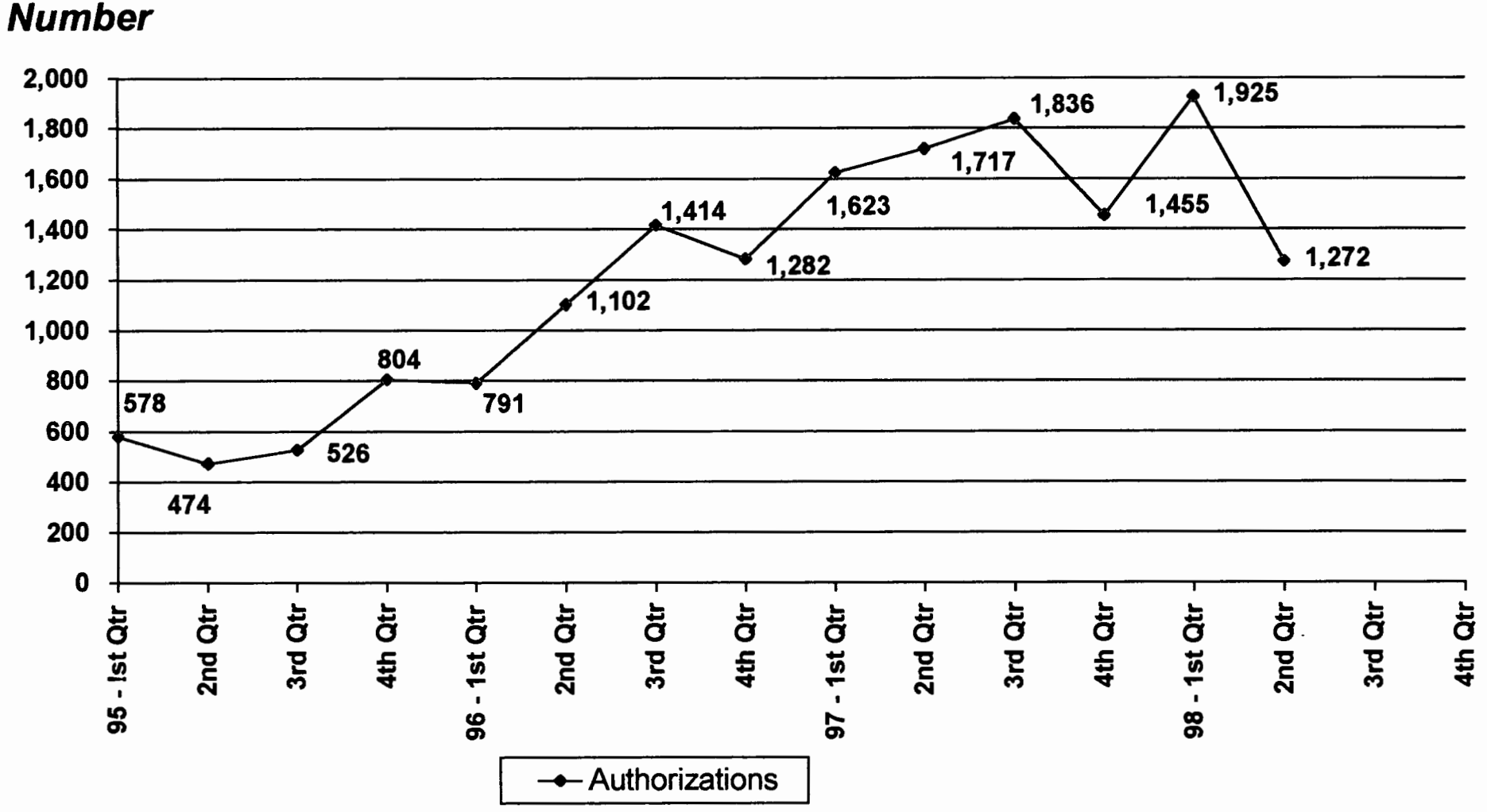
What would happen if the Program closed?

The transfer of this $800,000 and approval to pay up to $500,000 in FY98 claims with FY99 funds will avoid denying early detection and treatment of cancer for approximately 3,400 people who have greater than a 75% success rate of survival.

Number of Claims Paid, Cancer Control Program FY 95, FY 96 FY 97 and FY 98



Number of Authorizations, Cancer Control Program FY 95, FY 96, FY 97 and FY 98



#1
2-18-98

PRESENTATION TO

THE JOINT APPROPRIATIONS SUBCOMMITTEE

ON HEALTH AND HUMAN SERVICES

"NC SICKLE CELL SYNDROME PROGRAM"

FEBRUARY 18, 1998

9 a.m.

Legislative Office Building
Raleigh, NC

Presenters:

#1 **Mrs. Gladys R. Robinson, Chairperson, NC Council on Sickle Cell Syndrome**

Russell Ware, MD, Duke University Comprehensive Sickle Cell Program

Eugene Orringer, MD, UNC Comprehensive Sickle Cell Program

NORTH CAROLINA COUNCIL ON SICKLE CELL SYNDROME AND RELATED GENETIC DISORDERS

Gladys A. Robinson, M.Ed., Chairperson

In 1973, through the adoption and ratification of House Bill 32, the North Carolina Council on Sickle Cell Syndrome and Related Genetic Disorders was established to determine the needs and make recommendations for legislative action with regard to sickle cell syndrome and related disorders. Through appointment by the Governor, the Council has the responsibility for ensuring services to persons with sickle cell syndrome and their families throughout the state and for recommending programs, staff and funds deemed germane to the provision of needed services.

At its beginning, the Sickle Cell Syndrome Program provided services of education, testing, genetic counseling to persons in our state. But in the last 10 years, our comprehensive and collaborative service network has made North Carolina a premiere state in the provision of quality care for persons with sickle cell disease. A brief summary of the services we now provide include newborn screening of all infants born in NC hospitals; confirmatory diagnosis of disease through our state laboratory; genetic counseling for persons/families affected; education of the general public, public schools and health professionals; child service coordination for children ages 0 to 5 years; and annual case assessments of each patient to identify needs and make referrals. Improved medical care is offered by local providers and health departments, who rely on hematology specialists at major medical centers for referrals and consultations. Sickle cell speciality clinics are held at 5 major medical centers and two satellite clinics at community-based centers in Greensboro and Fayetteville. Other services include patient support groups, some psychological services and most important, payment for inpatient/outpatient care and pharmaceuticals for patients who meet the eligibility criteria. Because of the network of sickle cell educator/counselors employed by the state program and contracted services through community-based centers and medical centers, we are proud to say that patients in North Carolina have received a quality of care that remains unduplicated in most other states.

As chair of the Council, I extend our thanks to you as members of the NC General Assembly for supporting us in our efforts for 26 years; efforts which have enabled us to maintain quality services, and to also bridge gaps to meet the critical needs of this patient population. Upon the advice of the Council, you, our legislators, assisted us in increasing our service level from simply education, testing and genetic counseling, to comprehensive case management for over 2,500 persons affected with the disease; upon the advice of the council, which also included medical center directors, you gave us support to institute newborn screening to reduce the infant mortality/morbidity rate for nonwhite infants in North Carolina in 1987 and later for all infants; through the insightfulness of the council, eligibility scales for families with sickle cell were made comparable to other chronic disorders for outpatient and now inpatient care, so that medical care can now be preventive rather than crisis oriented for many persons. The Council has been dutiful

in carefully assessing the needs of the patient population and making careful recommendations to the General Assembly for those for whom we advocate. Now we again need your support.

For the last 15 years, North Carolina has been fortunate to have one of 10 comprehensive sickle cell center research grants from the Sickle Cell Disease Branch of the National, Heart, Lung and Blood Institute (NHLBI) of the National Institutes of Health. Initially, this grant included the Duke University Comprehensive Sickle Cell Center and 2 community-based centers at Sickle Cell Disease Association of the Piedmont in Greensboro and Operation Sickle Cell in Fayetteville. Through our intent to expand the coordination of care for the majority of patients in North Carolina, the grant during the last 5 to 10 years was also expanded to include UNC-Chapel Hill, and East Carolina University. Thus, during the 15 years of the center grant, persons with sickle cell disease in North Carolina have benefited from the collaboration of these and two other medical and community-based centers and the 9 state employed educator/counselors.

Recently, in September of 1997, we were informed that the NHLBI would not award a comprehensive center grant to the Duke-UNC Center in the next funding cycle, which begins on April 1, 1998. This will result in a tremendous loss to the patients and families affected by sickle cell in North Carolina. We have since contacted our congress persons from North Carolina to have them address the issue and have funding restored. We, as citizens, were fortunate to have the support of Congressmen Watt, Price and McIntyre and Senator Faircloth, as we held an issues forum on Capitol Hill in September. However, their efforts have not been fruitful. While we are distressed at the loss of this funding to the 3 medical centers and 2 community-based centers, the Council has taken the opportunity to reassess the need for patient care in North Carolina. It is our position that comprehensive care is preventive in nature. A comprehensive health care system is where each sickle cell patient can rely on major medical centers for specialty care, on pediatric hematologists for the preventive and continuous care of infants and children, where patients are followed up constantly in their own communities by community-based center nurses (coordinating care with private providers and hospitals) and on regional and community-based educator/counselors - who connect patients to local resources to enhance their quality of life; this system is the best prevention for the high cost of medical care often required by the chronically ill. **We are, therefore, not asking simply for renewal of funds that were lost from the NHLBI, but for funding to support comprehensive medical and psychosocial care throughout North Carolina.**

Allow me now to introduce to you, hematologists from two of the major medical centers, where sickle cell patients receive quality care. First, Dr. Russell Ware, pediatric hematologist from Duke Comprehensive Sickle Cell Center, followed by Dr. Eugene Orringer, adult hematologist, UNC-Chapel Hill Comprehensive Sickle Cell Center. Following their presentations, we will be glad to answer any questions you may have. Thank you.

PROVIDING OPTIMAL MEDICAL CARE FOR CHILDREN WITH SICKLE CELL DISEASE IN NORTH CAROLINA: THE ROLE OF THE MEDICAL CENTERS

Russell Ware, M.D.
Duke University Comprehensive Sickle Cell Program

I. OVERVIEW

Sickle cell disease is one of the most common inherited genetic diseases, affecting approximately 75,000 to 100,000 persons in the United States. In the state of North Carolina, it is estimated that over 4,000 persons have sickle cell disease. Each year in our state, over 100 infants with a significant hemoglobin disorder are identified by newborn screening. Half of these infants have sickle cell anemia, the most severe form of sickle cell syndrome. For optimal health care, these infants require early confirmation of their hemoglobin disorder, followed by integration into existing medical care facilities involving both community-based programs and major medical centers. Children with sickle cell disease must be followed closely during the first few years of life, to ensure compliance with penicillin prophylaxis and to receive proper family education regarding the recognition and management of clinical complications. In collaboration with other health providers, the major medical centers in North Carolina help provide state-of-the-art medical care for children with sickle cell disease. The medical centers have superb on-site facilities and also provide staffing for monthly satellite clinics at off-site locations.

II. IDENTIFICATION OF INFANTS WITH SICKLE CELL DISEASE

1. Newborn screening. Analysis of newborn blood samples for hemoglobin disorders began at Duke University in 1986 as a pilot program. Pilot testing was very successful, so the program was transitioned to the State Newborn Screening Laboratory in Raleigh. By 1991, newborn screening for hemoglobin disorders was performed by the State Laboratory on all "non-white" infants born in this state. In 1994, testing for abnormal hemoglobins became universal, so that all newborns were tested. Last year in North Carolina, over 100,000 newborn samples were tested by the State Laboratory and a total of 110 infants with signs of hemoglobin disorder were identified.

2. Notification. After the State Laboratory identifies an infant with an abnormal hemoglobin, a letter is sent to the mother, the hospital of birth, the physician of record, the health department, and the N.C. Sickle Cell Syndrome Program. There are currently 9 regional sickle cell educator/counselors and 4 community-based centers, collectively covering all counties in the state, who contact the family of the infant and arrange for a repeat blood sample to be tested.

3. Repeat testing. A second blood sample must be collected to confirm the abnormal newborn screening result. In North Carolina, repeat testing approaches 100% and is almost always performed at one of the major medical centers. Ideally, the infant is retested within the

first two months of life, to allow early education of family members and the initiation of penicillin prophylaxis. In North Carolina, the average time to second analysis is approximately one month.

III. MEDICAL CARE OF INFANTS WITH SICKLE CELL DISEASE

1. Medical follow-up. It is essential that infants identified on newborn screening with sickle cell disease receive close medical follow-up during the first few years of life. Medical centers provide the optimal education and treatment for these affected infants. In North Carolina, over 75% of infants with sickle cell disease receive medical care under the direction of a medical center.

2. Penicillin prophylaxis. By age 2-3 months, all infants with sickle cell disease should receive penicillin twice a day, to prevent overwhelming bacterial infection. Treatment with penicillin is the single most important intervention to prevent mortality of these infants. For infants with sickle cell anemia, penicillin must be given for at least 5 years.

3. Family education. Visits to the medical centers provide the opportunity to teach family members about sickle cell disease. Families are taught the importance of recognizing fever or pain in these infants, and when to seek immediate medical care for these events. Families also are taught to recognize other serious clinical complications of sickle cell disease, including splenic enlargement, pneumonia, and stroke. Teaching sessions occur at every visit to the medical center, typically every 3 months during the first few years of life. Counseling is given regarding the inheritance of sickle cell disease and the risks for future pregnancies.

4. Additional medical care. Confirmation of the precise hemoglobin diagnosis occasionally requires repeat testing when the infant is 6-12 months old. This testing is best performed at a major medical center. Infants with sickle cell disease receive all of the normal childhood immunizations, but also require a special vaccine to prevent serious bacterial infection.

IV. MEDICAL CARE OF CHILDREN WITH SICKLE CELL DISEASE

1. Medical visits. Older children with sickle cell disease require ongoing medical care. Optimal care would include visits every 6 months. Usually this occurs at one of the major medical centers or their satellite clinics. During these visits, children receive physical examinations, assessment of growth and development, and laboratory studies.

2. Education. As children grow older, education must be provided to the patients themselves. The recognition and management of pain is particularly important, as early intervention can frequently prevent hospitalization. Additional clinical complications including pneumonia, gallstones, and stroke are routinely reviewed.

3. Surgery. Many patients with sickle cell disease require surgery during childhood. Examples include PE tubes in the ears, tonsillectomy, and removal of the spleen or gallbladder. Compared to the normal population, children with sickle cell disease are at high risk for complications resulting from surgery and anesthesia. As a consequence, these children require pre-operative hydration and blood transfusions to reduce the risks of surgery. All patients with sickle cell disease should have surgery performed only at a major medical center under the supervision of experienced pediatric personnel.

4. Counseling. Many children with sickle cell disease benefit from counseling offered by sickle cell educator/counselors or medical centers. Management of anxiety and depression require specialists familiar with these diseases. School and job performance are particularly important issues.

V. SUMMARY

The state of North Carolina has been extremely successful in providing medical care to infants and children with sickle cell disease through the N.C. Sickle Cell Syndrome Program. Also, the newborn screening program is a model of success from the standpoint of universal screening, accurate detection of infants with abnormal results, notification of health care providers, and confirmatory testing. The medical centers play a vital role in the care of these patients, beginning with repeat blood testing, initiation of penicillin prophylaxis, ongoing specialized medical care, education and counseling.

Your financial support of the medical centers will ensure that children with sickle cell disease will continue to receive the best available medical care. Without your support, the medical centers will not have the funding to continue providing the specialized care so essential to reducing mortality and morbidity in those suffering with sickle cell syndrome.

THE ROLE OF THE MEDICAL CENTERS

Eugene P. Orringer, M.D.
Professor of Medicine
Director of the Comprehensive Sickle Cell Program
UNC at Chapel Hill

Just as with infants and children, the care of adults with sickle cell disease requires a thorough understanding of this chronic illness and considerable experience with its many complications. We and many of our colleagues around the country have found that delegation of the care of patients with sickle cell disease to family physicians, primary care providers, and/or managed care organizations often results in unnecessary complications, needlessly prolonged hospitalizations, excessive morbidity, and even mortality.

To emphasize this point, a few examples are cited below:

Acute Chest Syndrome: Acute Chest Syndrome is the leading cause of death in adults with sickle cell disease. This dreaded sickle cell complication typically presents with the rather sudden onset of chest pain. Unfortunately, this pain is often mistaken by those who are not thoroughly knowledgeable about sickle cell disease as a typical "sickle cell crisis." Therefore, instead of an inpatient admission that includes aggressive diagnostic and therapeutic efforts focused at this severe and often life-threatening complication, these unfortunate patients are typically seen in a local emergency room where they are given narcotic analgesics and sent home with instructions to "return if they don't improve in 24 hours." My colleagues and I at the major medical centers are convinced that these 24 hours can mean the difference between life and death. Indeed, we have each received frantic phone calls from patients, their families, and/or patient advocates from the NC State Sickle Cell Syndrome Program or the community-based Sickle Cell Agencies describing a patient who is now gasping for breath and needs desperately to come to one of our institutions. By then, however, it is often too late, as the Acute Chest Syndrome of sickle cell disease has claimed another victim.

Blood Transfusions: While patients with sickle cell disease always have low blood counts, they generally adapt well to this anemic state and rarely require blood transfusions. Therefore, my colleagues at the major medical centers and I have become increasingly cautious about the use of blood transfusions, particularly for patients with sickle cell disease. We do recognize that, as with every patient who receives a transfusion, the use of blood products carries an inherent risk of infectious complications such as hepatitis and AIDS. Furthermore, we are well aware that the repeated administration of blood transfusions, particularly to patients with sickle cell disease, is well-known to produce immunization against foreign red cells. As they become immunized to blood products, sickle cell patients often experience a serious complications that is referred to as a "transfusion reaction." In addition, in the relatively infrequent circumstances when these individuals

really do need to be given a blood transfusion, the immunization that results from their previous transfusions, many of which were unnecessary, often makes it impossible to obtain blood products that are suitable for administration to these unfortunate individuals.

Acute Intrahepatic Cholestasis: Because this relatively infrequent complication of sickle cell disease presents with the same signs and symptoms that characterize acute cholecystitis (i.e., jaundice or yellowing of the eyes, fever, and right-sided abdominal pain), acute intrahepatic cholestasis is often mistaken for an acute attack of gall stones. However, these two disorders are very different from one another both in their underlying cause and in their treatment. Several years ago, a high school student went to his local emergency room complaining of fever and jaundice. There he was seen by an ER physician and by a surgeon. Because of the presence of gall stones, they made the diagnosis of acute cholecystitis and recommended surgery. Unfortunately for this young man, the diagnosis was incorrect. Instead of cholecystitis, he had acute intrahepatic cholestasis and the surgery was not only inappropriate, but ultimately proved to be fatal for this unfortunate young man.

My purpose in citing these three examples has been to emphasize for you just how important it is for sickle cell patients to have access to health care providers who are knowledgeable about all aspects of this relatively common genetic disorder. We here in North Carolina are particularly fortunate to have at our major medical centers a large cadre of individuals with both the commitment to these individuals and the expertise that is essential to provide care of the highest quality to patients with sickle cell disease. Indeed, North Carolina has consistently been identified and singled out as a national leader in the area of sickle cell disease. The North Carolina Sickle Cell effort (and in large part the reasons for our success) include the following:

The North Carolina State Sickle Cell Program: This organization, which plays a vital role in all aspects of sickle cell-related activities, has a central office based in Raleigh and a well-trained and highly committed team of educator/counselors who live and work throughout the entire state. These latter individuals serve as an important interface between the patients and their families in their home towns and the Comprehensive Sickle Cell Programs that are based at the major medical centers.

The Community-based Sickle Cell Agencies: These agencies, which are located in those areas of the State that have the largest number of African-American citizens, serve as an important complement to the State Sickle Cell Program. Much like the State Program, these community-based agencies provide a wide variety of services to patients and their families and create the vital linkages to the major medical centers.

NC State Hemoglobinopathy Screening Laboratory: The State Laboratory of Public Health provides newborn screening for all infants born in this state. Through this mandated effort, the NC Newborn Screening Program each year identifies over 100 infants who are affected with a major sickle hemoglobinopathy. Once these infants have been identified

by the state lab, the NC State Sickle Cell Syndrome Program, through its newborn screening component, provides case management services and directs these infants and their families to the most appropriate major medical center where they receive the comprehensive medical services that are essential to their good health and long-term survival.

The Comprehensive Sickle Cell Programs: These programs, each of which is based at a major medical center, have developed their own institutional programs capable of providing comprehensive medical and psychosocial care to children and adults with sickle cell anemia and the related hemoglobinopathies. Because sickle cell disease can damage nearly every organ system in the body and does so to a variable degree in different patients, it is crucial that the care provided by such diverse medical disciplines as internal medicine, obstetrics, orthopedics, and ophthalmology is coordinated so that the patient receives the necessary types of care and also avoids complications from such care. Thus, the sickle cell patient undergoing hip replacement needs to be followed by the sickle cell team, to receive appropriate pre-operative transfusions and expert post-operative monitoring for potentially life-threatening complications of surgery not seen in other patients. Out-patients likewise often require frequent medical advice regarding the possible causes and appropriate treatment of symptoms they develop at home, as well as help in negotiating difficulties at work and school created by frequent illness. For that reason, each medical center provides both continuing medical care as well as social services and counseling on a longitudinal basis. In addition, the medical centers, in cooperation with the community centers and the state program, have played a major role in the formation of the North Carolina State Consortium for Sickle Cell Disease. Among the primary goals of the consortium is to improve the quality of care for sickle cell patients that is provided by local physicians. This state consortium has produced a set of guidelines for medical care in sickle cell disease and has surveyed physicians statewide regarding both their medical knowledge and continuing education needs as related to the treatment of sickle cell disease. Finally, it is most important to emphasize how much of this effort from the medical centers is carried out without any form of reimbursement whatsoever to our medical centers. All of the hours communicating with patients, families, state educator/counselors, and local physicians are also spent at no cost to those who benefit from our efforts. The lectures and seminars that we give, the meetings that we organize, and the time that we devote simply reflects our absolute commitment to this patient population.

WHERE DO WE GO FROM HERE

Until now, the bulk of the support for each of the components of this statewide sickle cell effort (**EXCEPT FOR THE MAJOR MEDICAL CENTERS**) has come from the State of North Carolina through the NC Sickle Cell Syndrome Program. As shown on the attached pie chart which depicts the $2.5 million budget received by the NC Sickle Cell Syndrome Program in

fiscal year 1997-1998, the medical centers based at UNC, Duke, ECU, Bowman Gray, and Charlotte are this year receiving a cumulative total of $116,371. This amounts to less that 5% of the total budget and less than $25,000/center/year.

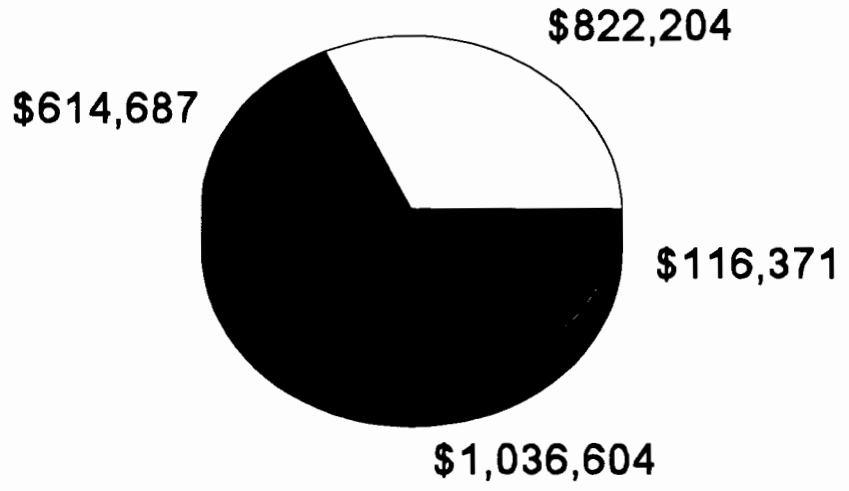
Much of the reason for this inadequate level of funding for the medical centers has been related to the presence of a federal grant to the **Duke-UNC-ECU Comprehensive Sickle Cell Center**. This grant from the National Institutes of Health (NIH), which was originally awarded to us in April, 1983 and has been continuously funded until the present time, has brought more than $2 million/year to the State comprehensive care programs. Unfortunately, our renewal application for this award was not funded, and beginning on April 1, 1998, we will no longer receive any federal support for our sickle cell effort.

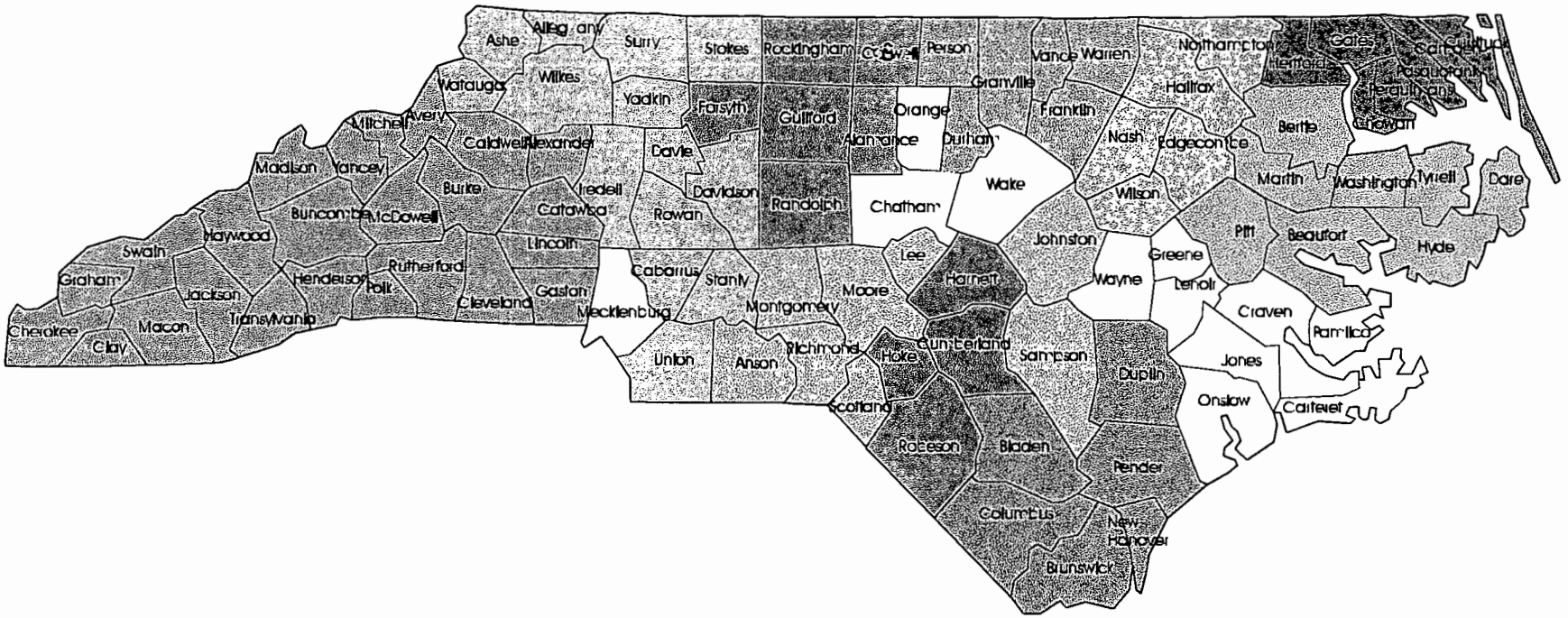
WE MUST NOT LET OUR STATEWIDE SICKLE CELL EFFORT DIE!!

This statewide effort is absolutely vital to our patients and their families. Many other states have long since recognized the importance of their major medical centers to the ongoing health and well-being of their sickle cell patient population. To cite a few examples, the State of Georgia provides $700,000 and $400,000 respectively to each of its two medical centers. The University of Mississippi and the University of Pittsburgh each receive $250,000/year, and Children's Hospital of Philadelphia receives $330,000/year. By contrast, the medical center-based comprehensive sickle cell programs here in North Carolina receive an average of less than $25,000/center/year. In the past, we were able to get by on this modest level of funding because we had the support of the federal government through the Comprehensive Sickle Cell Center grant. However, this year's loss of the center award points out just how insecure this type of grant support actually is. We ask you to help us eliminate the dependence of our patients and their families on the whims of the granting agencies by establishing a much more secure and long-term base of support for our medical center-based comprehensive sickle cell programs.

NC Sickle Cell Syndrome Program Budget FY 97/98

Total Budget - $2,589,866





SICKLE CELL SYNDROME PROGRAM CATCHMENT AREAS

State Regional Educator/Counselors

Community-Based Centers

Leiza Aycock
2-18-98

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

CHILD WELFARE SYSTEM IMPROVEMENT INITIATIVES
Items Needed in Addition to Increases Approved by General Assembly in 1997

GOALS:	Requirements
NC System should meet worker/caseload standards in CPS and Foster Care/Adoptions	
Standards of 1:12 in CPS, 1:20 Foster Care/Adoptions, 1:5 staff:supervisor	**10,493,850**
To maintain adequate worker:caseload standards, NC system should effect culture change	
Grants to counties to hire time-limited staff (36) to work with DSS and local community to develop system changes designed to reduce length of stayand prevent 'backlog' (child in FC>1 yr.)	**2,137,686**
To attract and retain qualified staff, NC system should offer staff protection from lawsuits	
Professional liability insurance for county child welfare staff	**200,000**
To adequately serve children, NC system should ensure that staff are fully trained	
Training for child welfare staff before they're assigned a caseload	**967,442**
To provide adequate oversight of child welfare services, NC system should ensure intensive assistance when problems identified	
State oversight of corrective measures- Fatality Reviews/poor Biennial Reviews	**508,115**
To adequately protect children, NC system should involve communities	
Strengthen outreach capacity of Community Child Protection Teams	**250,000**
TOTAL FUNDING NEEDED TO ACHIEVE GOALS	**14,557,093**

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

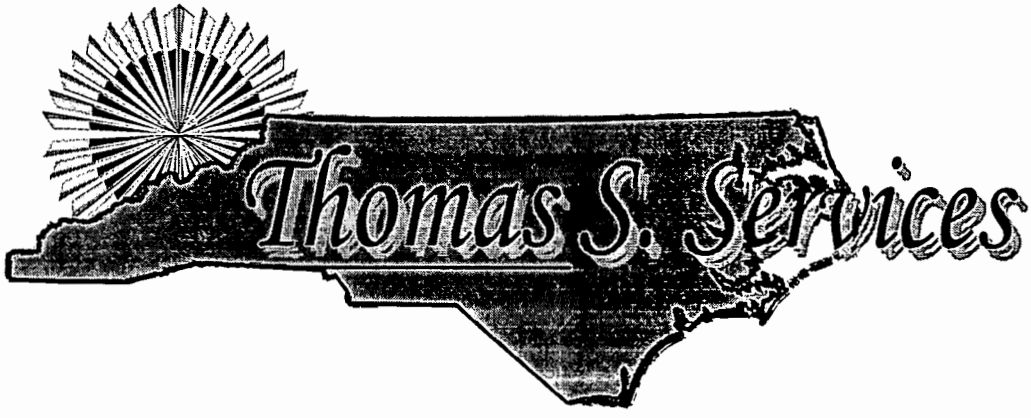
SUMMARY OF PROJECTED CHILD WELFARE SYSTEM IMPROVEMENT FUNDING AND EXPENDITURES
INCLUDES INCREASES APPROPRIATED BY GENERAL ASSEMBLY IN 1997 SESSION
SFY 97-98 through SFY 2001-2002

PROGRAM AREA	STATE FISCAL YEAR 1997-98	1998-99	1999-2000	2000-01	2001-02	TOTAL
Estimated Expenditures:						
Improve County Staffing	10,462,774	19,863,233	19,863,233	19,863,233	19,863,233	89,915,706
Enhance State Oversight & Training	1,206,167	1,475,557	1,475,557	1,475,557	1,475,557	7,108,395
Foster Community Partnerships	250,000	250,000	250,000	250,000	250,000	1,250,000
TOTAL Estimated Expenditures:	11,918,941	21,588,790	21,588,790	21,588,790	21,588,790	98,274,101
Available Funds:						
Social Services Block Grant	1,300,000	1,300,000	1,300,000	1,300,000	1,300,000	6,500,000
Title IVE	5,482,755	10,889,623	10,889,623	10,889,623	10,889,623	49,041,247
Title IVE Training	335,921	513,712	513,712	513,712	513,712	2,390,769
County Funds	735,049	1,507,268	1,507,268	1,507,268	1,507,268	6,764,121
Tfr. from TANF		5,108,435	5,108,435	5,108,435	5,108,435	20,433,740
State Appropriations	2,269,752	2,269,752	2,269,752	2,269,752	2,269,752	11,348,760
TOTAL Funds Available:	10,123,477	21,588,790	21,588,790	21,588,790	21,588,790	96,478,637
Difference:	(1,795,465)	0	0	0	0	(1,795,465)

Note: Given 1st year start-up issues, we do not believe that the $1,795,465 shortfall in the first year will actually occur, since that number assumes ALL county staff are hired effective 12/1/97.

2-18-98
Susan White

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



Prepared For The

JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

February 17, 1998

Thomas S. Services

Historical Overview





Basis for Court Relief

"Defendants have built a system with adequate safeguards to ensure that the constitutional requirements of serving the Thomas S. population are met."



Elements of That System

"The picture almost ten years later is radically different..."

- ✓ Process for identification of class members
- ✓ Person-centered Service plans
- ✓ Providing appropriate community-based services
- ✓ Providing fiscal resources
- ✓ Safeguards (Monitoring, Accreditation)

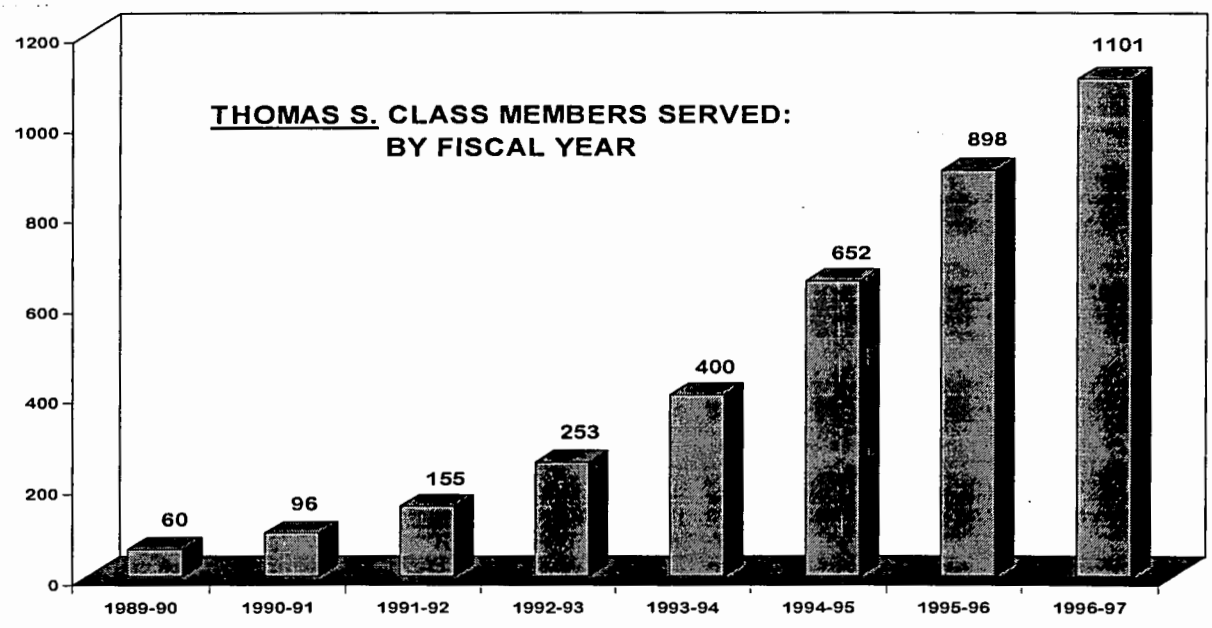
"The success of Defendant's system is obvious by its results..."

Thomas S. Services

Serving the Class

Since 1989, the number of class members served has increased from 60 to 1101.

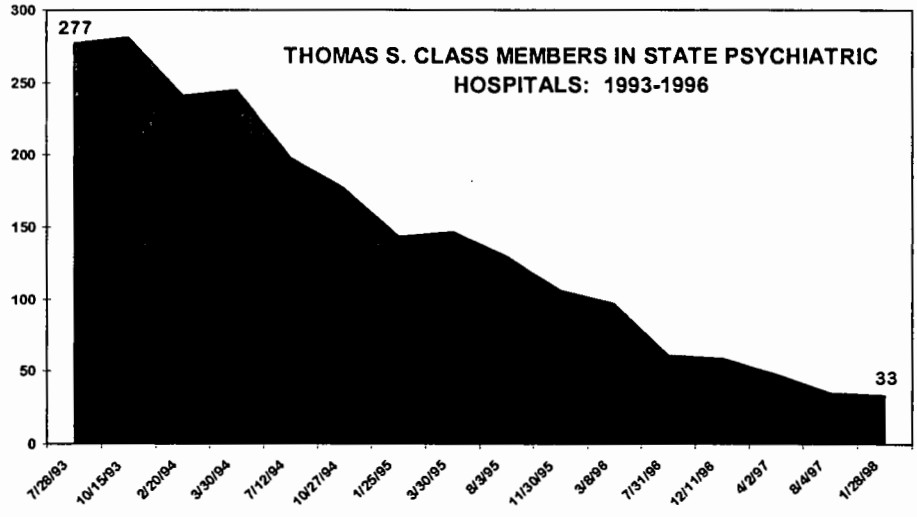
Average yearly increase: 52% per year



Thomas S. Services

Going Home

The number of Thomas S. Class Members residing in State Psychiatric Hospitals has been reduced by an average of 40% per year Since 1993. From 277 to 33.



AT THE SAME TIME:
Class Members in MR Centers -- Reduced from 152 to 86 (40%)



Assuring Quality

MONITORING SERVICES

- ✓ Every class member monitored every year
- ✓ Incident Reports
- ✓ Death Reviews
- ✓ Area Program Status Reviews

"Even in the absence of the Special Master and Plaintiff's counsel, Defendant's monitoring efforts will alert them to any developing deficiencies..."



Assuring Quality

ACCREDITATION COUNCIL

Accreditation Based on Outcomes

1995-96

- ✓ 39 of 41 Area Program Accredited
- ✓ 17 Receive 2-year Accreditations
- ✓ Section Accredited for 1 year

1996-97

- ✓ 22 Area Programs Accredited
- ✓ 10 New 2-Year Accreditations
- ✓ 2 3-Year Accreditations
- ✓ Section Accredited for 2 years

"...the accreditation process will ensure [any developing deficiencies] are corrected in a timely fashion..."



The Judge's Conclusion:

"... that the Secretary acted reasonably in creating and implementing the new Thomas S. service delivery system, ... that the new system has and will continue to provide constitutionally required treatment and to remedy injuries caused to individual class members by their constitutionally inappropriate treatment in the past, and that further judicial monitoring of the 1988 decree is no longer necessary."

Thomas S. Funds/Cost Containment Special Provision
Code No: 97DHR-H058A

Initial Report to the Legislature



December 1, 1997

Thomas S. Services Section
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Department of Human Resources

Introduction

Senate Bill 352, ratified the 28th day of August 1997, requires that the Department of Health and Human Services, in conjunction with area mental health programs, develop and implement cost containment measures to reduce the cost of direct services to Thomas S. class members. This report, dated December 1, 1997, is the first of two that will be presented to the House and Senate Appropriations Subcommittees on Human Resources and to the Fiscal Research Division.

This report covers the following areas as required in Section 11.37 of the legislation:

- Positive client outcomes through developmental disability long-term managed supports;
- Identification and ultimate elimination of non-value added process oriented tasks;
- Single stream funding from all available sources;
- The application for waiver of federal requirements; and
- The review and possible repeal of rules that conflict or interfere with cost containment measures.

As well, this report will briefly review the history of the court action and the progress the Department has made to date in containing costs while complying with the Thomas S. Court order.

Historical Background of the Court Action

- **November 21, 1988.** U. S. District Court Judge James McMillan issued a ruling that the Secretary of the North Carolina Department of Human Resources had violated the constitutional rights of the Thomas S. class . This Class consists of adults with mental retardation or those having been treated as if they had mental retardation, and were inappropriately placed in one of the State's psychiatric hospitals at some point in time since March, 1984.
- **February, 1989.** The first staff member was designated to work specifically with the Thomas S. case. In January, 1992, the Thomas S. Services Section was established.
- **October 29, 1990.** The United States Supreme Court denied the Secretary's request for the court to hear the case.
- **January 7, 1991.** The District Court appointed a Special Master to monitor the State's compliance with the Thomas S. Court order.
- **February 4, 1994.** Judge Richard Voorhees approved the Thomas S. Focus Class/Evaluation Alternative Test Agreement, which serves to facilitate service planning and budget forecasting and to reduce the number of individuals who will eventually be entitled to services as confirmed class members.
- **December 21, 1995.** A petition for relief from court oversight was filed.
- **August 7-8, 1996.** The State appeared before Judge Richard Voorhees as petitioner seeking relief from court oversight. No ruling or action has been taken on this petition as of the date of this report.

The Cost of Supporting Thomas S. Class Members in the Community

The tables below illustrate the sharp increase in the delivery of services and supports to class members since 1989-90 and the accompanying decrease in costs. Initially, there were very few members of the Thomas S. class supported in community settings in approved service plans as required by the court. Implementation of the first service plans were naturally high in cost because of the lack of infrastructure available to support services to a "new" population. In addition, most of the class member's first identified for community placement were moving directly out of psychiatric hospitals and were often those who presented the greatest challenges for success in the community. Often homes had to be purchased and /or renovated prior to community placement. In recent years, the availability and variety of services and supports in the community have grown exponentially. Class members currently being placed into approved services come from an array of living arrangements. They may opt to live in any of a variety of locations including alternative family settings and independent living with supplemental supports.

TABLE 1: COST PER CLASS MEMBER IN STATE DOLLARS, 1993-1997

FISCAL YEAR	COST IN STATE DOLLARS
1993-1994	$91,662
1994-1995	$87,038
1995-1996	$78,381
1996-1997	$77,307

TABLE 2: NUMBER OF PERSONS SERVED THROUGH JUNE 30 OF EACH FISCAL YEAR BY THOMAS S. SERVICES: 1989-1997

FISCAL YEAR	NUMBER PLACED IN SERVICES BY 6/30	% GROWTH PER FY
1989-90	60	
1990-91	96	60%
1991-92	155	61%
1992-93	252	63%
1993-94	400	59%
1994-95	651	63%
1995-96	898	38%
1996-97	1087	21%

Identified Cost Factor	Cost Containment Initiatives
Most challenging class members placed earliest in history of program. Those class members placed in services at the outset of the Thomas S. program were primarily moved from psychiatric hospitals into the community. These individuals often had long histories of hospitalization and thus presented the greatest challenges for success in the community.	• **Community placement in most instances costs less** than continued institutionalization. The annualized cost of stay at a psychiatric hospital is currently $124,000 and the average annual cost at one of the State's MR Centers is $90,301. On average in 1997-98, community placement for class members is expected to cost the State fifty percent less than the annualized cost of residing in a State psychiatric hospital. **The cost of serving class members over time decreases** as area program and provider personnel become more familiar with the class member and adjustments are made to the service plan and staffing patterns to meet his or her needs and treatment goals.
Increased numbers of class members to be served each year. The number of class members to be served has continued to grow by about 250 individuals each year. The size of the confirmed class continues to grow, albeit at a much slower rate. By the end of this biennium, rate of growth of the confirmed class is projected to decrease significantly.	• **Hospital Screening/Diversion Teams** identify and screen potential class members and divert them from hospital admission. • **Passage of the Thomas S. Diversion Law** has significantly decreased admission of persons with mental retardation to State psychiatric hospitals thus curbing the confirmation of new class members. As well, this legislative change has created the opportunity for new service provision alternatives to be developed.
Factors that contribute to the cost of providing Thomas S. Services. In order to be approved for implementation, the service plan must be deemed adequate by treatment teams to meet the class member's needs and to meet the needs of the community.	• **Increased availability and variety of providers. The Thomas S. Section continues to** actively recruit new residential and periodic service providers. Increased competition among providers for service contracts lowers cost and offers a greater variety of models and service options from which the class member may choose. • **Development and implementation of the unit cost reimbursement budgeting and reporting system** required by the General Assembly has resulted in more informed management decisions. • **Maximizing third-party revenues to offset costs of client services.** New State Plan Medicaid service codes and definitions, increased CAP-MR/DD waiver slots, higher individual reimbursement allowances for persons served through CAP-MR/DD, have provided alternative funding sources for Thomas S. client services. Other changes that have contributed to an increase in the collection of third party revenues include the identification and matching of existing Medicaid ID numbers of class members, development of a protocol for the processing of Medicaid eligibility, reimbursement at the area program level; and unbundling state funded Thomas S. 24 hour residential services to enable appropriate periodic services to be billed and reimbursed though Medicaid.
Enhanced Staffing Patterns In Individual Placements. Initially, many Thomas S. class members had one-to-one staffing patterns, twenty-four hours a day. This staffing pattern was utilized for a variety of reasons, including but not limited to, challenging behavior, previous long-term hospitalization, and lack of area program experience in serving the population. The continued reliance on this type of living arrangement is the greatest contributor to the high cost for supporting certain class members in the community.	• **Facilitation and development of new clinical approaches** that constitute an alternative to many common practices in the delivery of services to persons with significant disabilities. These approaches include the development of Community Treatment Teams, alternative family residential settings, and the use of informal support networks as an alternative to one-to-one staffing. • **Decreasing dependence on enhanced staffing patterns** through utilization review and control of the use of service codes used to support this approach has begun to decrease reliance on this model. The capitated approach to allocating Thomas S. client service funds will also be a disincentive for this costly staff intensive approach since funds to cover the costs of this type of support are only available up to the capitated amount. Expenditures beyond this amount will be at the expense of other area program services.

Enhancing Positive Client Outcomes through Developmental Disabilities Long Term Managed Supports

Over the past decade there has been a fundamental change of philosophy in the disability field. This shift has resulted in the creation of a service delivery system designed to support the strengths and expressed goals of individuals and their families thereby enabling persons with disabilities to be contributing members of our communities. The design of past systems relied on the perceived needs of similarly diagnosed groups. This basic change in fundamental principle has brought about modifications in service and support design, planning and implementation. As a result, the expectations of persons with disabilities, their families, policymakers, and service providers have been positively affected.

In 1993, the Mental Health Study Commission endorsed person-centered planning as the State's response to the court action. The Commission's recommendations provide the foundation for the Comprehensive Plan for Services and Supports for persons with Developmental Disabilities. In June 1993, as a result of this endorsement, person-centered planning, and its' related guiding principles, was adopted by the General Assembly.

Accreditation via the Assessment of Personal Outcomes

In the Department's petition to the federal court in 1995, the Thomas S. Services Section introduced a plan to seek accreditation by a nationally recognized agency. This strategy was intended to demonstrate that there was no longer a need for a Special Master or federal court oversight in this case. In FY 1995-96, the Thomas S. Services Section was accredited by the Accreditation Council for Services to People with Disabilities (now known as the Council on Quality and Leadership in Supports for People with Disabilities). Through a methodology designed to assess each area program's success in meeting outcomes important to individual class members, the Council on Quality and Leadership in Supports for People with Disabilities (Council) awarded a one year accreditation to the Thomas S. services system to the Division of MH/DD/SAS in 1995-96 and most recently a two year accreditation in 1996-97.

The Council was selected because of the integrity of its' philosophy and associated value base. The Thomas S. Section and the court order, reflect the same philosophies and values including the expectation for service and supports to be socially integrated into the community. Accreditation has thus become an effective mechanism for evaluating the progress of the Department in achieving the outcomes for Thomas S. Class members. These steps are designed to ensure that providers are rewarded for supporting activities that promote and enhance quality of life.

Developmental Disabilities Long-Term Managed Supports

The person-centered focus emerged in the field of disabilities at the same time that the broader human services field began examining and piloting cost containment strategies. The concurrent system changes have resulted in a movement toward a system of participant-driven

managed supports. This approach merges the basic values of person-centered planning, self-determination and community integration, which are the underpinnings of the Thomas S. Court Action and the Thomas S. mission , with traditional managed care strategies. The goal of this two-prong initiative is to produce a cost-effective system that supports the achievement of outcomes important to the person served.

Historically, in the field of disability services, specific supports were prescribed by professionals who had very little investment in the outcome. In these traditional systems, providers operating specialized services often have financial disincentives for fostering independence and utilization of informal (non-reimbursable) supports. The basic theory in applying managed care strategies to a person-centered approach is that given control of a limited budget, the person with the disability , with support from his/her family and personal network, will choose services and supports that build on their strengths and preferences. The Thomas S. Section embraces the infusion of managed care strategies into its person-centered approach to supporting class members as it has resulted in improved quality of life for the clientele served.

Pilot Study

The Thomas S. Services Section is piloting, with confirmed and prospective class members from Iredell and Davie Counties, the participant-driven managed supports approach. With the dissolution of the Tri-County Area Program, the Thomas S. Services Section was able to collaborate with existing Tri-County Thomas S. Staff, Regional DD staff, the Gaston-Lincoln Area Program and the Arc of North Carolina to establish the Tri-Alliance. The Tri-Alliance will allow the state to study the benefits of a collaborative relationship among the class member, the State, area funding agencies, and private providers.

In its first year, the Tri-Alliance will focus on the development of a participant-based approach to the development of fiscal and programmatic policy, and the conversion of traditional case management services to a support broker/advocate model of arranging for needed supports. The elements of both managed care and long term supports are essential to understanding and promoting the conversion of a traditional system of services to a system of managed supports based on principles of self-determination and cost effectiveness. It is anticipated that this demonstration will put into practice many of the essential elements of participant-driven managed supports while attending to the court compliance and community safety issues that have not diminished. Evaluation of recent self-determination projects, similar to Tri-Alliance in other states has shown a cost savings of 12-15%, with accompanying improvements in client outcomes.

New Cost-Containment Measures

New cost-containment efforts that support the transition to a participant-driven managed supports system were initiated at the onset of the 1997-98 fiscal year. Other potential strategies are being assessed through a collaborative multi-agency process initiated as a result

of the ratified legislation. It is expected that the impact of the strategies already undertaken coupled with those that will be recommended, will produce important decreases in the overall costs of supports for Thomas S. class members.

Capitation

Beginning this year, the Thomas S. Section of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services allocated its client services funds based on a pre-determined capitated amount. An aggregate, capitated allocation amount was formulated for each of the forty area programs with consideration given to the following: number of continuation as well as expansion class members (those individuals on the master list eligible for services but not currently being served); actual previous year's expenditures; average earnings per class member; utilization of past allocations; and, projected annualized costs of infrastructure requests funded in the past.

In previous years, the area program client services allocation, although disbursed as an aggregate sum, was based on a projection of costs for individual class members provided by the area program. This dollar figure was usually based on existing contract costs and requirements. Under this system of allocation, many area programs were hesitant to use moneys projected for one class member in developing services for others.

A capitated allocation based on an average per class member rate introduces an essential element in a move toward managed supports. Each area program is responsible for serving all continuation and expansion class members within the capitated rate. Additionally, it is expected that cost savings achieved through participant determination of services within the capitated allocation amount will be utilized to expand needed services to other confirmed and prospective class members.

Accessing Generic Services

A major cost factor in the provision of services and community supports for class members is that the traditional disability service provider did not have the will nor the incentive to extend services to this difficult to serve population. Following the introduction of the Special Provision, the Section has undertaken two initiatives that will result in an easier access for Thomas S. class members to a broader array of services and supports.

- Vocation Rehabilitation. The Division of MH/DD/SAS and the Division of Vocational Rehabilitation have entered into negotiations and reached an agreement that is intended to increase the awareness of vocational rehabilitation providers to the unique needs of class members. This collaborative process should allow the State to access federal Vocational Rehabilitation funds that support the court mandated vocational services for Thomas S. class members. Historically, the vocational needs of class members have not been adequately addressed by more traditional vocational rehabilitation vendors in North Carolina, leaving the funding and provision of vocational supports for Thomas S. class

members primarily to the State. This joint initiative will open up that avenue of service, as well as the funding stream, to class members and others with significant dual disabilities.

- Community Colleges. The Thomas S. Services Section is currently pursuing an initiative to better utilize North Carolina's Community College System. The State's 58 community college campuses should provide an accessible educational environment to meet the training needs and preferences of class members and others with disabilities. Many class members need and want training to pursue vocational possibilities as well as a means of enhancing their recreational and leisure interests. The Community College system is funded to meet those needs for citizens of the community at large and with some accommodations could also be opened to class members and others with disabilities.

  Community Colleges could also be a provider of training for direct services paraprofessionals in the field of dual diagnosis. Lack of appropriately trained staff was among the findings enumerated in the Thomas S. court order. It is essential that provider staff attain the competencies necessary to support Thomas S. class members and others with co-existing mental retardation and psychiatric disorders. Required competencies and training content must be developed within the disability field and should be offered through North Carolina's generic adult community education system.

Next Steps

With the passage of SB 352, Section 11.37, the Thomas S. Services Section developed a collaborative process to seek input from all of its customers to address the issues of cost containment. In consultation with The Center for Urban Affairs and Community Services at North Carolina State University, the Section will be facilitating focus groups of a variety of customer groups to identify high cost factors, with specific emphasis on those areas delineated in the legislation. The Section will research and report on those issues identified for remediation and propose strategies to amend and/or waive policy, rule and regulations as well as process oriented federal requirements. Those strategies that are identified and piloted through the Tri-Alliance will be evaluated and reported on in relation to cost savings, consumer satisfaction, relevance to court compliance and replicability. The Section will continue to monitor costs and attempt to evaluate and correlate variables initiated this fiscal year with cost reductions separate from the apparent natural progression in the decline of costs as the service system infrastructure matures in providing more effective and efficient support to class members.

Specific to the areas delineated in the Special Provision the following strategies have already been implemented; this table will be expanded significantly as input from Thomas S. customer and stakeholder groups are researched and strategies developed and implemented.

Process Oriented Tasks	• Removal of the Enhanced Staffing Justification Procedures • Removal of the Individual Residential Setting Justification Procedures • Elimination of the Thomas S. Section **System** Monitoring Process
Single Stream Funding	• Merging of DVR and Thomas S. resources / initiatives in order to better meet the vocational needs of Thomas S. class members while maximizing use of federal VR funds. .
Waivers of Federal Requirements	• Collaboration on the proposed changes to the CAP/MR-DD Waiver • Participation on the DD Managed Care Policy Workgroup
Amendment/Repeal of Existing Rules	• Review of licensure rules as applicable to community residences.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services is very proud of the progress made to date in quality and costs of services to Thomas S. class members. At the last printing of the Master List, August 4, 1997 there were 1089 class members in services, defined as having an effectively implemented, approved service plan. There were only 39 class prospective and confirmed class members in State Psychiatric Hospitals and only 99 class members residing in the State's five Mental Retardation Centers. The costs of services have decreased from a high in 1989-90 of $95,000 per class members to $77,000 per class member in 1996-97. More importantly, Thomas S. services are based on the newest practices in the field of disabilities and demonstrate the cost effectiveness and importance of promoting inclusive, individualized supports that assist people in becoming contributing, valued members of our communities.

The Department is committed to implementing its court ordered mandate in a cost effective manner that will ensure that the system of services and supports being developed in North Carolina is able to address the unique needs and goals of all its citizens with disabilities without the presence of court oversight. Through this effort we hope to demonstrate that community supports rather than intensive services can be the most cost effective approach in serving all of North Carolina's citizens with disabilities.

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Thursday, February 19th, 9:00 a.m.
Room 414 - Legislative Office Building

9:00	Overview & Trends In N.C.'s Aging Population	Karen Gottovi, Director Division on Aging
9:30	Discussion of Needs in the Aging Population	Ann Johnson Senior Citizen Coalition
10:00	Status Report on Adult Day Health Expansion Funds	John Tanner, Chief Adult Services Section Teresa Johnson, Director N.C. Adult Day Services Association
11:00	Pharmaceuticals Assistance for Low Income Elderly	Carol Shaw, Fiscal Analyst Fiscal Research Division
11:45	Adult Care Home Bed Vacancies Report	Lynda McDaniel, Director Division of Facility Services

Committee Discussion of Future Meeting Topics

ADJOURN

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Tuesday, February 17th, 10:00 a.m. - 4:00 p.m.
Room 414 - Legislative Office Building

10:00	Children's Health Insurance Program	Governor's Commission on Uninsured Children

LUNCH

1:00	Discussion of Medicaid Growth Reduction Plan *What is the role of managed care in Medicaid?*	Carol Shaw, Fiscal Analyst Fiscal Research Division

2:00 *Discussion of the Role of Public Delivery Systems in N.C.*

-Who are the players in the local public health/mental health care delivery system?
-What is the impact of recent and proposed changes in Medicaid on local public health/mental care?
-What role will local public health/mental health care programs play in the Children's Health Insurance Program?
-What is the role of public health/mental health in Medicaid managed care?
-How will the issue of access be impacted by changes in Medicaid?
-How is the issue of fragmentation of services impacted by changes in Medicaid?
-How are local public health/mental health budgets impacted by changes in Medicaid?
-What are the anticipated patient/client outcomes within the new public-private relationship in Medicaid?

Role of Public Health Departments	Various Directors of Local Public Health Departments
Role of Area Mental Health Programs	Various Directors of Area Mental Health Programs

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Wednesday, February 18th, 9:00 a.m. - 4:00 p.m.
Room 414 - Legislative Office Building

9:00	Sickle Cell Syndrome Program	Gladys Robinson, Chair Sickle Cell Syndrome & Related Disorders Association
10:00	AIDS/HIV Budget	Karen Hammonds-Blanks, Fiscal Analyst Fiscal Research Division
10:30	Child Welfare Expansion Budget	Leza Aycock, Assistant Director Division of Social Services
10:45	Overview of Public Schools Commission Meeting & Discussion re: Schools for the Deaf	Mary Ellen Sylvester, Fiscal Analyst Fiscal Research Division
11:15	Fund Transfer for Cancer Purchase of Care Program	Ron Levine, Deputy Secretary DHHS
11:30	Food Banks	Jerry Hardesty
	LUNCH	
1:00	Division of Mental Health Response to 1/21/98 Constituent Comments (Dorothea Dix Hospital)	Don Willis, Chief Mental Health Services Section
1:45	Progress Report on TANF/Substance Abuse Services Initiative	Starlene Scott-Robbins, Women's Services Branch
2:30	Thomas S. Cost Containment Report	Susan White, Chief Thomas S Services Section
	Update on Recent Court Decision in Thomas S & Willie M	Bob Hargett, Attorney General's Office

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

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Committee Discussion of Future Meeting Topics

ADJOURN

Joint Appropriations Subcommittee on Health and Human Services

Thursday, February 19, 1998

Division of Aging

N.C. Department of Health and Human Services

2-19-98
Karen Shelton

1 ☐ Joint Appropriations Subcommittee on Health and Human Services

Thursday, February 19, 1998
Division of Aging
N.C. Department of Health and Human Services

2 ☐ Discussion Topics

- Today's seniors
- Trends and changes affecting them
- Population shift
- Boomers at mid-life
  - ✓ health
  - ✓ work, education & financial security
  - ✓ future of long term caregiving

3 ☐ The 1998 Profile of Aging in North Carolina

- NC is the only SE state in the top ten in senior growth between 1990-1996 (15%)
- 967,000 North Carolinians are 65+ (12.8%)
- Over 107,000 are 85+
- Older women outnumber older men
- About 51% live in rural areas

4 ☐ Aging Profile, Continued

- Only about 5% live in institutions or group residences
- More than half live with spouse, while 29% live alone
- About 79% own their homes, but about a third live in housing built before 1950
- NC continues to have one of the highest poverty rates among seniors

5 ☐ Changes and Trends

- Home & community care
- Integration of services & managed care
- Personal responsibility & risk

6 ☐ Growth in Total LTC Expenditures for Older Adults between 1990 - 1996/97

7 Growth in LTC Expenditures for Persons 60+ by Category between 1990 - 1996/97

8 Growth in LTC Expenditures for Persons 60+ by Category between SFY's 95-96 & 96-97

9 Characteristics of Persons Receiving Key HCC Services in SFY 1996-97

- average age = 79
- about 23% were age 85+
- 75% were women
- 22% were very frail (3+ ADLs)
- 18% had some cognitive impairment
- informal caregivers received relief in about half of the cases
- 67% were living at or below poverty

10 The Emergence of Community CarePartners

- *a cooperative consolidation of services among 6 non-profits serving Buncombe, Haywood, Henderson, Macon and Transylvania counties*
- *driven by move toward managed care and capitated payments*

11 The Alphabet Soup of Medicare+Choice

12 Division's Web Site
www.state.nc.us/DHR/DOA/home.htm

- *Selected by AoA as "First Choice" site*
- *Searchable databases*
  - ✓ *elder housing locator*
  - ✓ *demographics*
  - ✓ *aging services directory*
- *Host site for NC Senior Games*
- *Information on over 100 topics (A to Z)*

13

14 The Population Equation

- Increased life expectancy
- Graying of the baby boomers
- Migration
- Fertility rate

15

16

17

18

19 ## NC's Baby Boomers [born 1946-1964]

- numbered about two milllion in 1990
- about one-third of population and almost half of work force
- a diverse group of people
- 63% of boomer-headed households had 1989 income of between $15,000-$49,999

20 ## Health-Risk Behaviors among NC Boomers

NC is 12th highest in nation in "preventable deaths"

- *almost 40% get no regular exercise*
- *about a third are overweight*
- *around 28% smoke*
- *around 260,000 boomers have no health insurance (13%)*
- *those with lower levels of income and education average higher rates of risky health behaviors*

21 ## Work and Education

- increasing presence & reliance on older workers, especially women
- shift toward service and information industries
- more techical jobs will require upgrading of skills
- more than half of NC boomers had a high school diploma or less at age 25-34 -- many are acquiring more education

22 ## Financial Security in Later Life

- Current Occupational Status of Boomers
- Sources of Income in Later Life
  - ✓ Pensions
  - ✓ Social Security
  - ✓ Assets
  - ✓ Continued Employment

23 ## Areas of Risk

- only about 40% of NC boomers can expect pensions in retirement
- shift from defined-benefit to defined-contribution plans
- home equity a less likely resource
- inadequate level of savings & investments
- nearly one in five lives in poverty or just above
- African-American boomer women are almost as likely to be single heads of household as to be in married couples

24 ## Future of Long Term Caregiving

Good News

- rates of illness and impairment reduced
- growing interest in long term care insurance, MSA's, and other means of assuming personal responsibility
- development of lower-cost service options
- potential of medical research & technology

25 ## Future of Long Term Caregiving

Not So Good

- numbers of impaired are likely to double
- average boomer couple has more living parents than children

26 ## 1999-2003 State Plan [G.S. 143B-181.1A(a)]

A look at:

- today's seniors
- boomers at mid-life

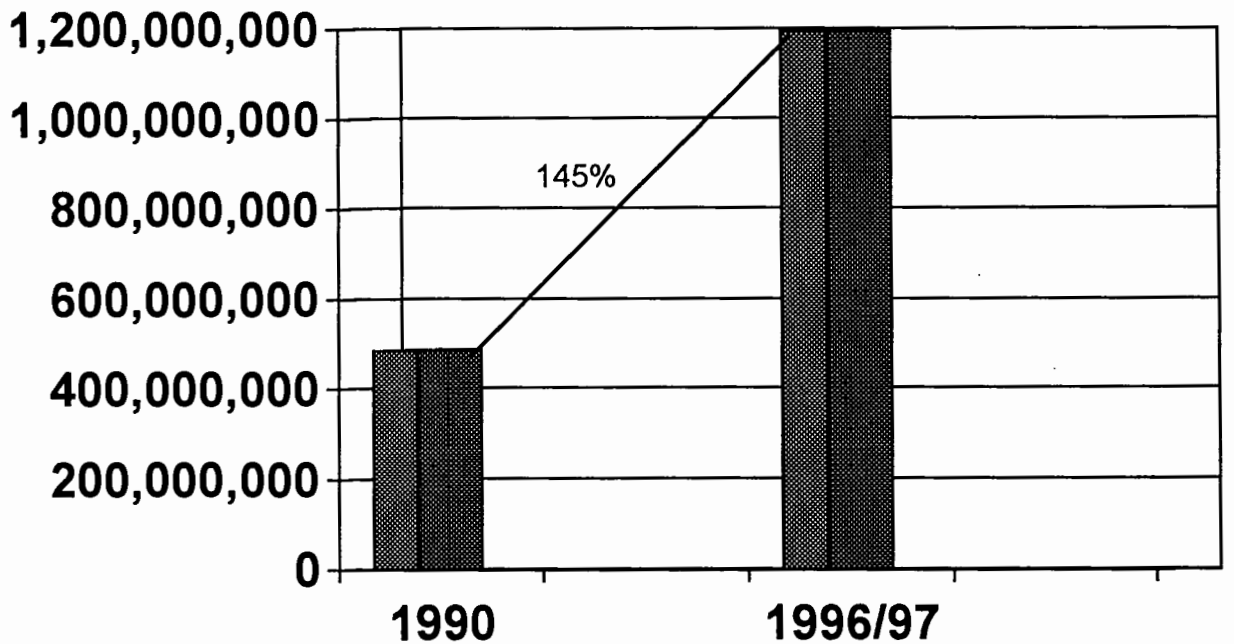
In terms of:

- healthy aging
- work and financial security
- long term caregiving
- implications for local aging programs

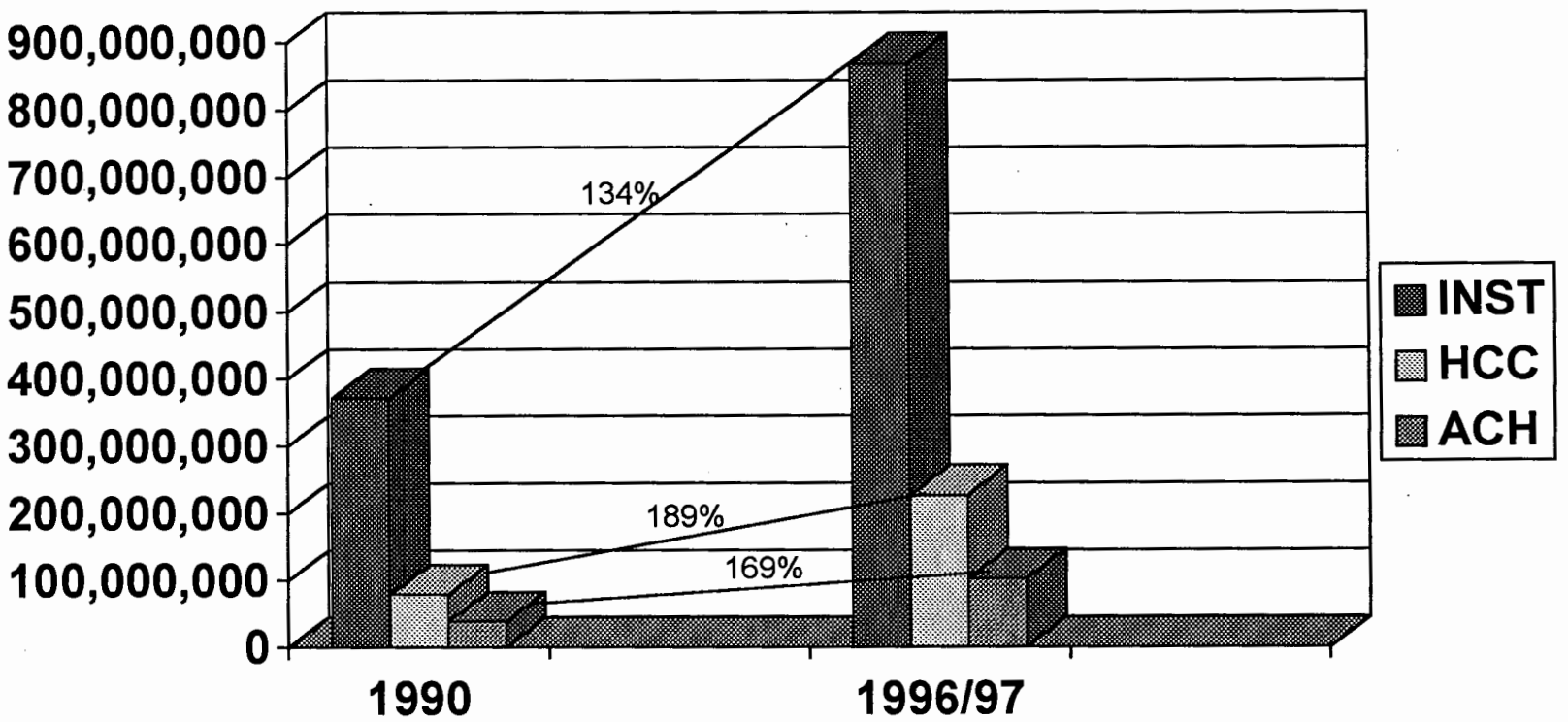
27 ## The Future: What We Know and What We Can Predict

- *a growing older population*
- *continued pressure to slow the rate of growth in public funding & see outcomes*
- *greater pressures and incentives for assuming personal responsibility*
- *continued movement toward home and community care & integration of services*
- *increased need for education and consumer information*

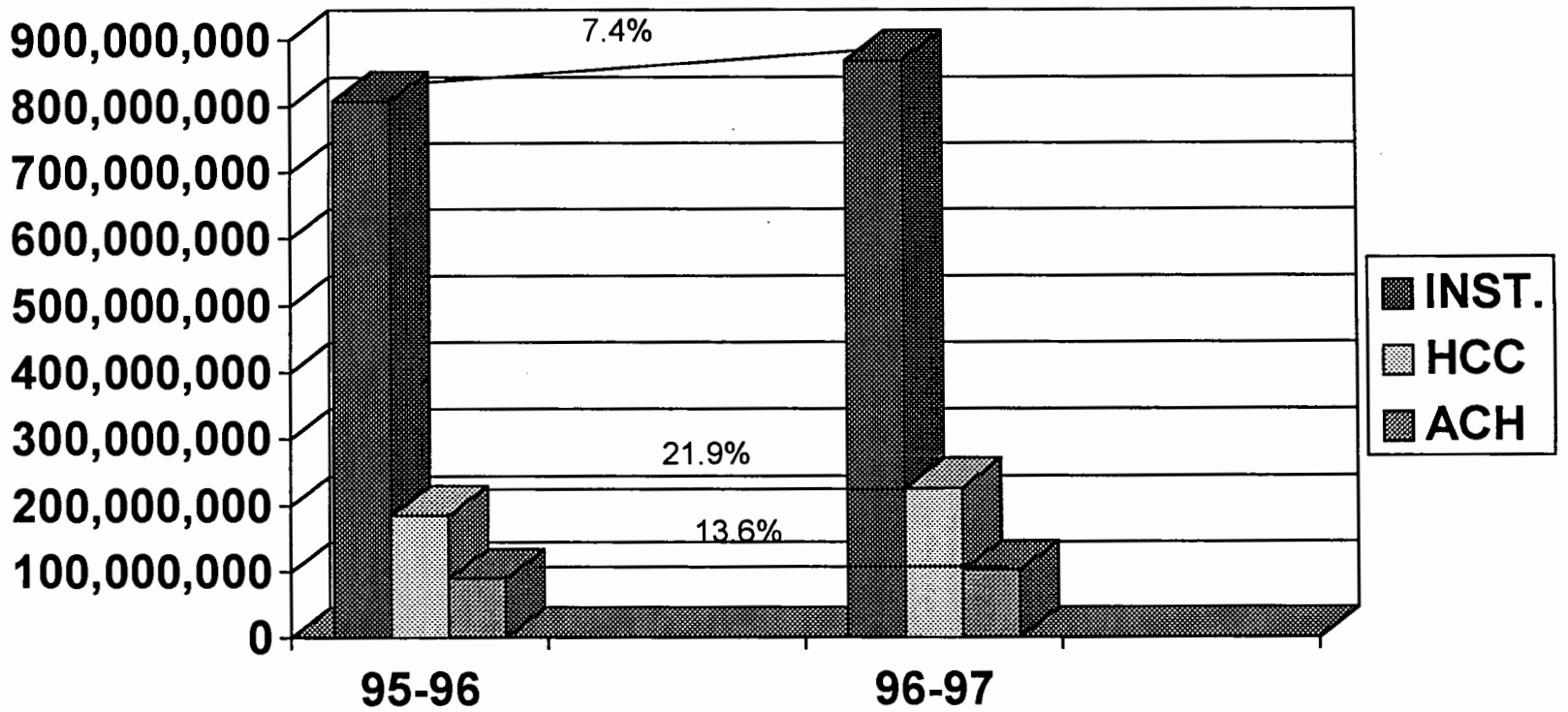
Growth in Total LTC Expenditures for Older Adults between 1990 - 1996/97



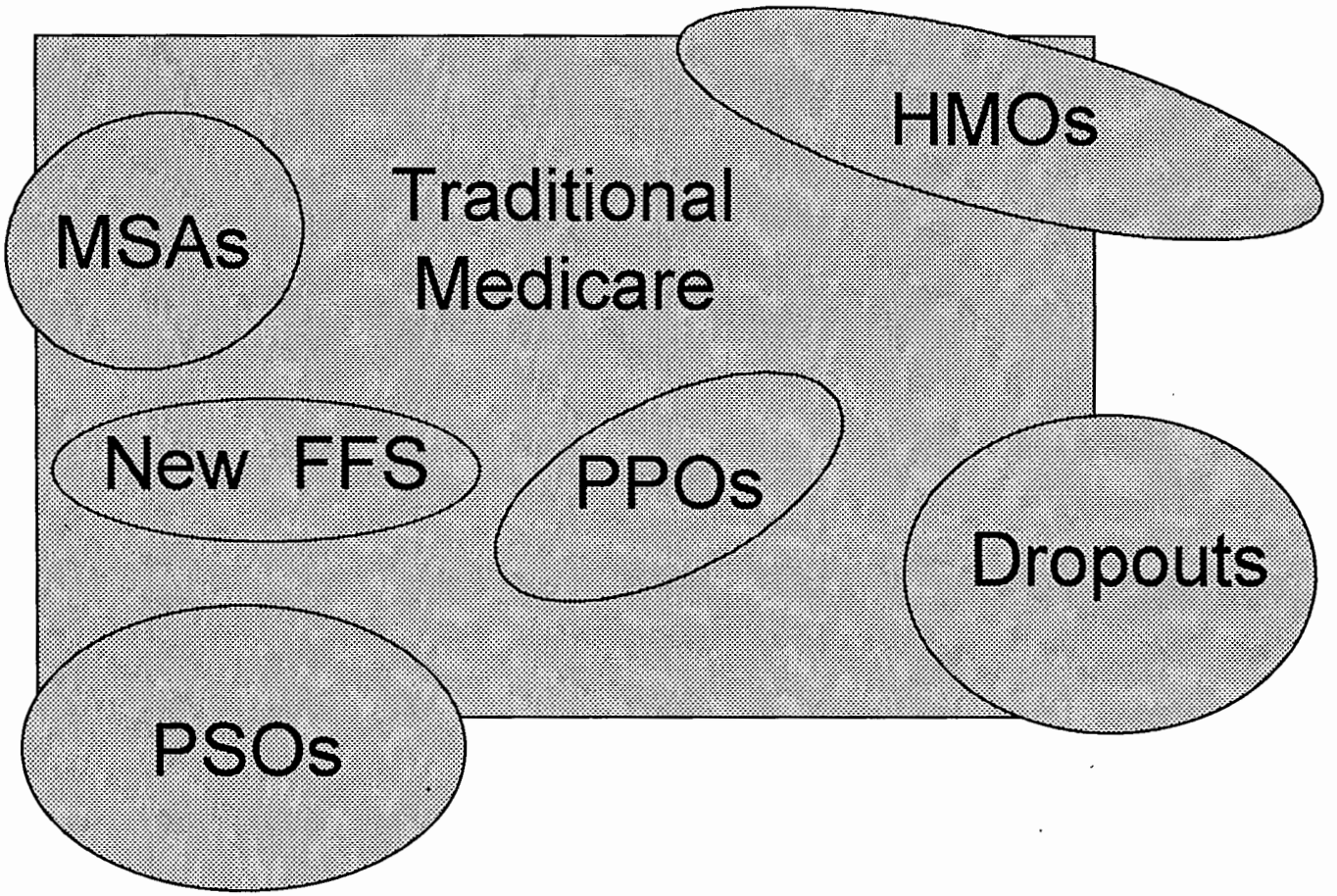
Growth in LTC Expenditures for Persons 60+ by Category between 1990 - 1996/97



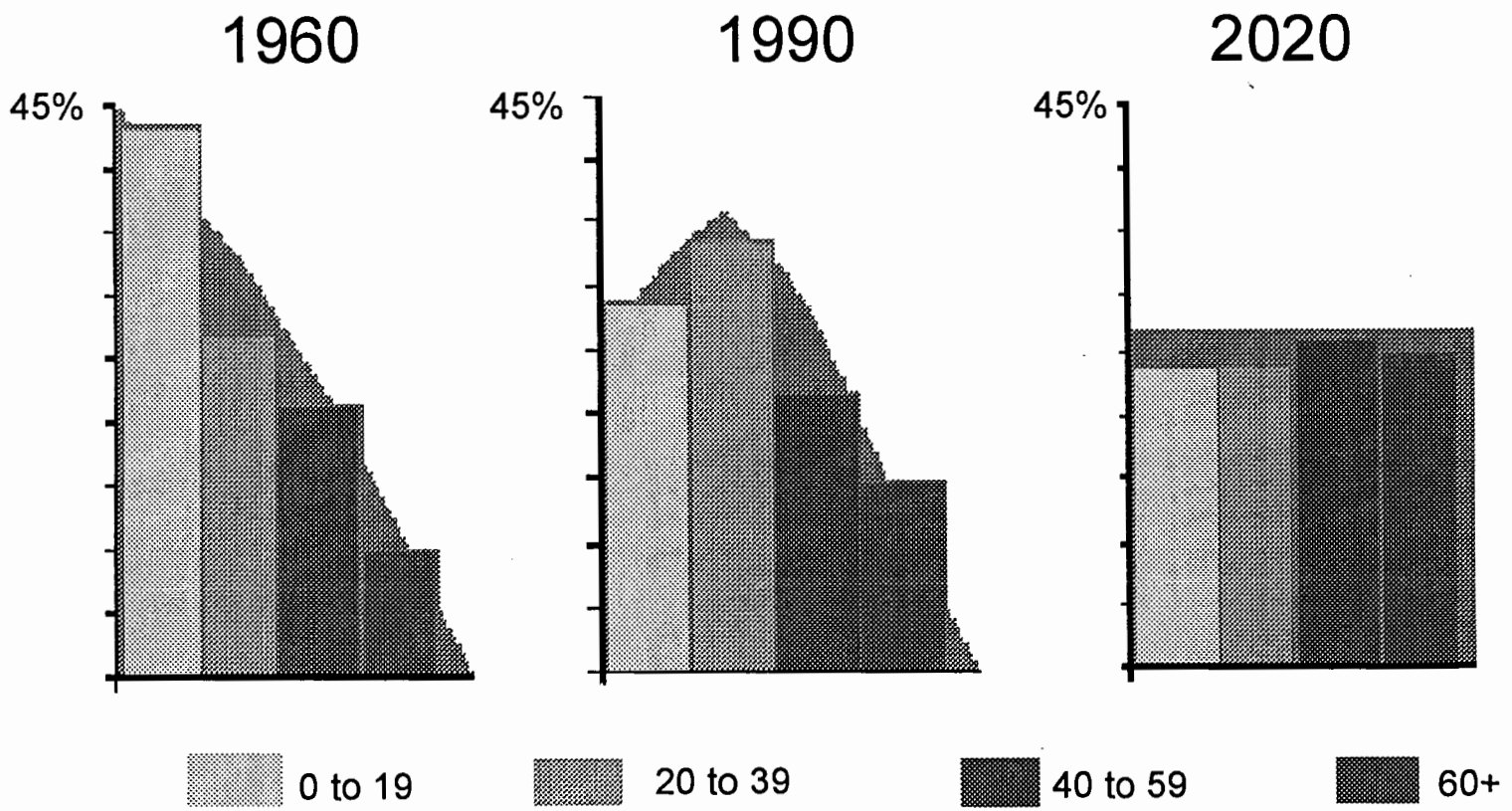
Growth in LTC Expenditures for Persons 60+ by Category between SFY's 95-96 & 96-97



The Alphabet Soup of Medicare+Choice



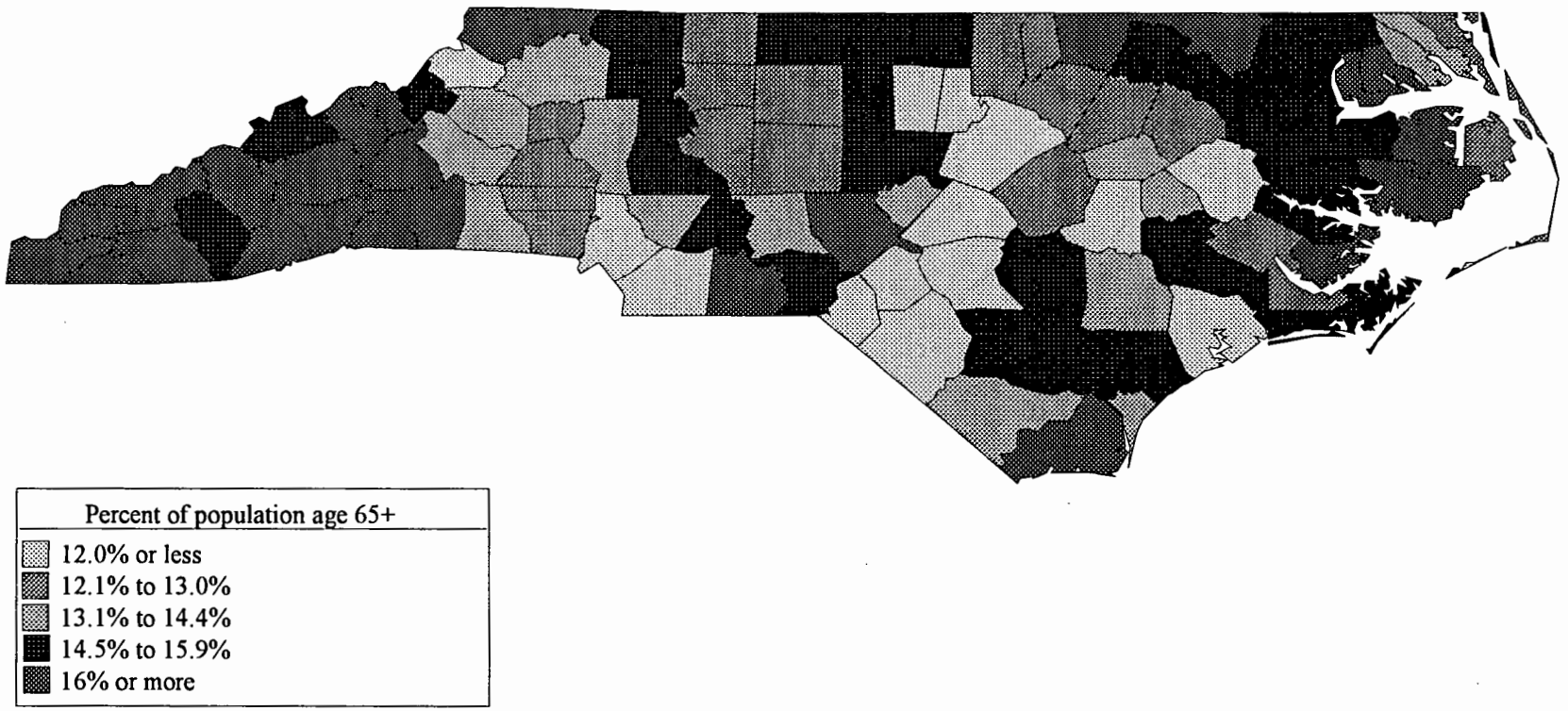
NC: In the Middle of a Major Population Shift



North Carolina's Changing Age Distribution

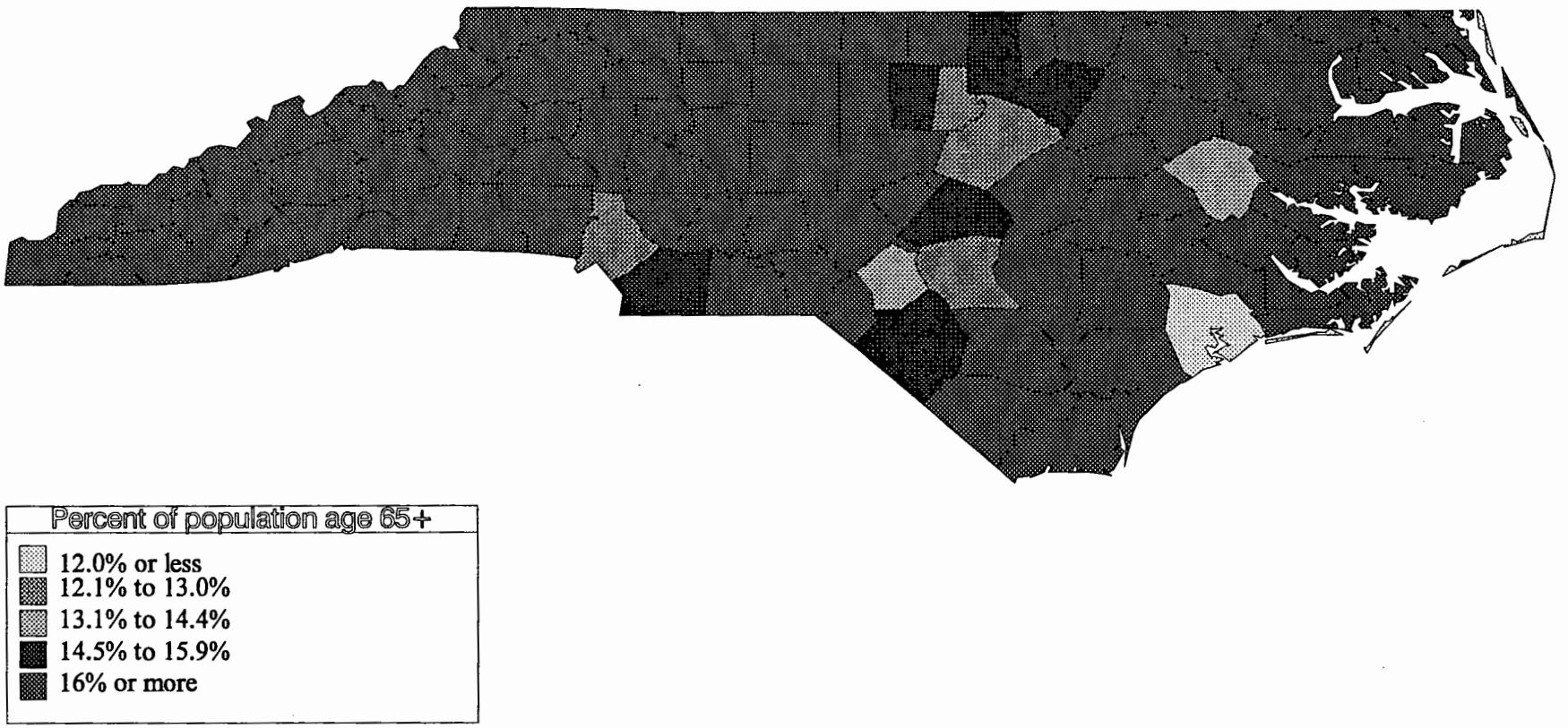
Population 65+ in 1996

12.7% in the state—county range: 5.4% to 25.2%



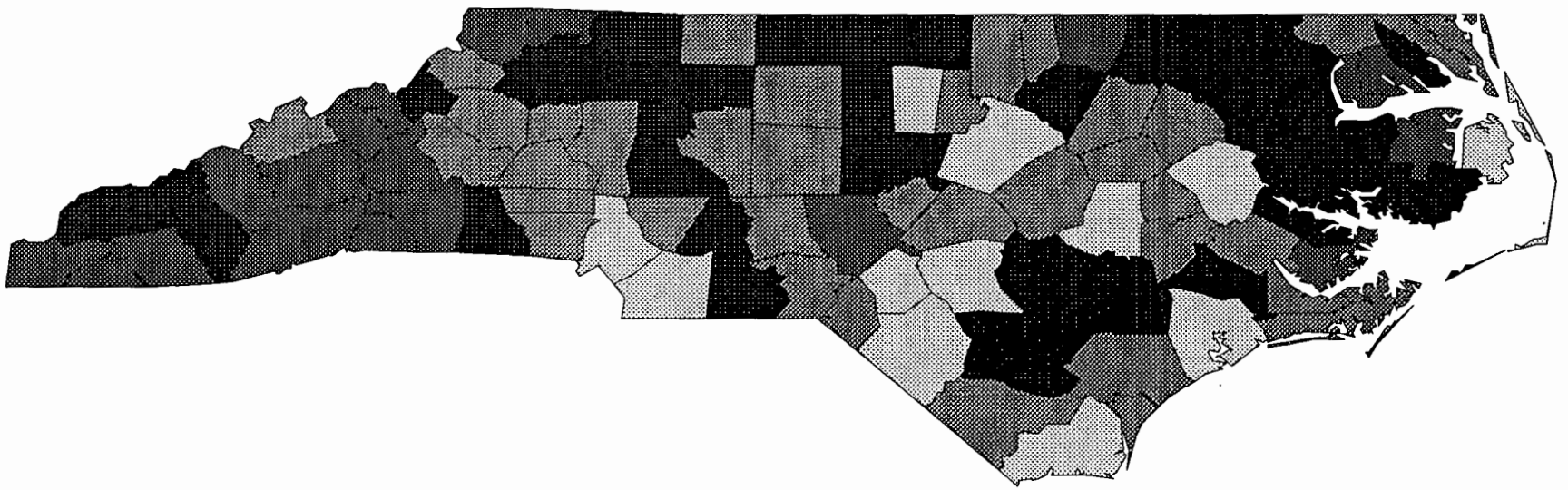
Population 65+ in 2020

17.5% in the state—county range: 9.2% to 31.8%



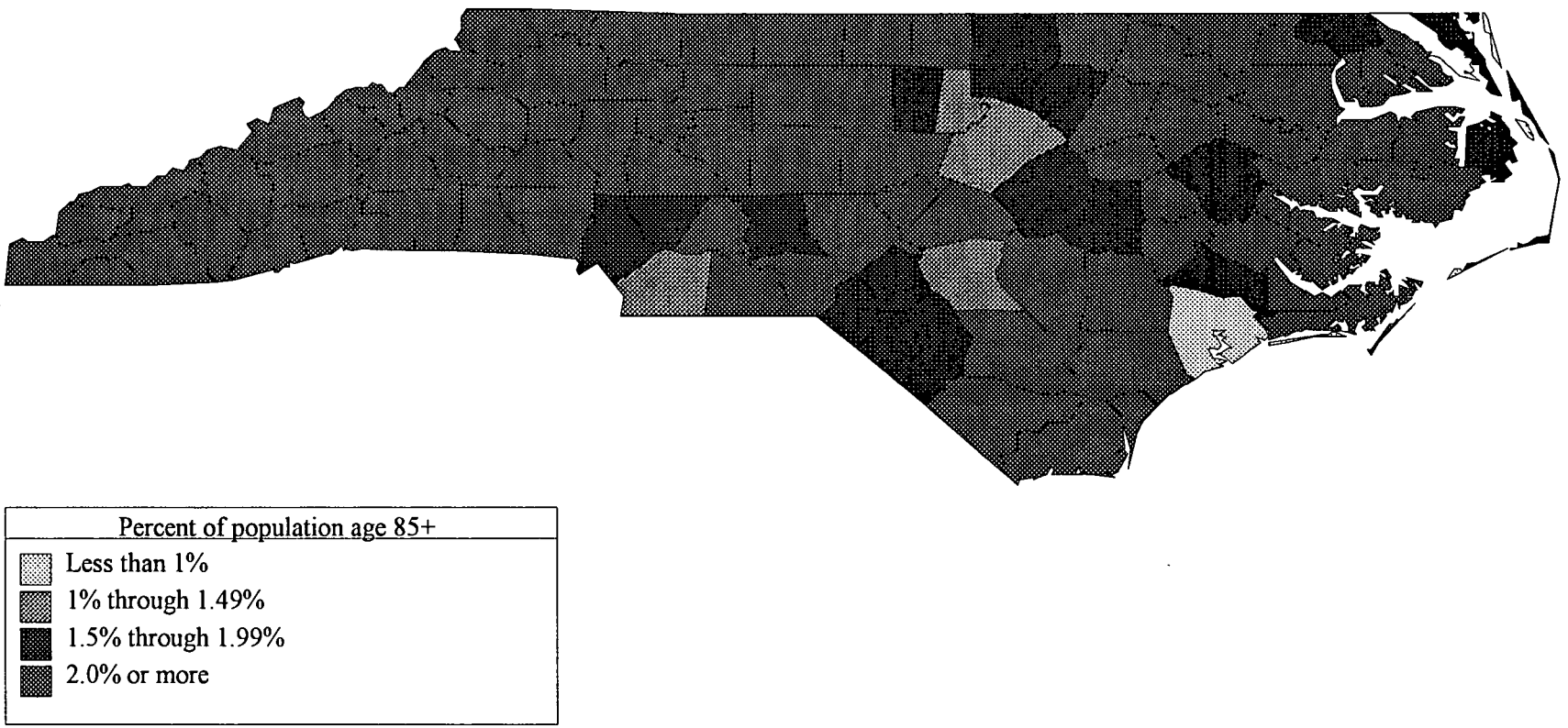
Population 85+ in 1996

1.3% in the state—county range: 0.5% to 3.4%



Population 85+ in 2020

2.2% in the state—county range: 1.0% to 5.3%



How North Carolina Compares to the Nation

While North Carolina was the 11th most populous state in 1995, it was 10th in terms of the older population. By 2025, projections still show North Carolina 11th overall but 8th among older populations. Our percentage of older adults in 1995 (12.5%) was slightly less than what it was nationally (12.8%), ranking North Carolina 31st among states. Our projected increase to 21.4% in 2025 will rank us 11th. In contrast, North Carolina's proportion of youth (underage 20) ranked 38th in 1995; this ranking will dip to 44th in 2025 (when youth will represent 23.2% of the state's population).

Variable	U.S.	N.C.	State Ranking
Population Growth 85+ (1983-1993)	33.8%	51.4%	8
Age 65+ Severely Disabled Per 1000 (1992)	71.4	81.1	8
% 65+ in Poverty (1990)	12.8	19.5	9
% 65+ Minority (1990)	13.6	18.4	11

And How We Compare within the State

Counties, cities and regions are aging at varying rates. The table that follows gives the number and proportion of persons age 65 and older by county for 1997. This ranges from 25.5% in Polk County, where there is a steady influx of retirees, to 5.5% in Onslow County, the location of the Camp Lejeune Marine Base. Many of our western and coastal communities, as well as some in the piedmont, have larger proportions of seniors. Nearly 59% of Pinehurst's population in 1990 were persons age 60 and older. Canton and Hendersonville each had about 35%.

OLDER ADULTS IN NORTH CAROLINA IN 1997

State Total: 946,305 State Percent: 12.7%

COUNTY	AGE 65+	%	COUNTY	AGE 65+	%
ALAMANCE	18,624	15.7	JOHNSTON	12,699	12.5
ALEXANDER	3,860	12.3	JONES	1,434	15.0
ALLEGHANY	1,957	20.6	LEE	6,855	14.3
ANSON	3,827	16.0	LENOIR	8,648	14.8
ASHE	4,389	18.8	LINCOLN	7,105	12.3
AVERY	2,444	16.0	MACON	6,456	23.7
BEAUFORT	6,876	15.7	MADISON	3,178	17.5
BERTIE	3,125	15.0	MARTIN	3,947	15.2
BLADEN	4,623	15.3	MCDOWELL	5,947	15.6
BRUNSWICK	10,887	16.8	MECKLENBURG	57,703	9.5
BUNCOMBE	32,532	16.7	MITCHELL	2,890	19.3
BURKE	11,978	14.2	MONTGOMERY	3,264	13.5
CABARRUS	15,074	13.1	MOORE	15,989	22.7
CALDWELL	10,088	13.5	NASH	11,045	12.7
CAMDEN	936	14.3	NEW HANOVER	19,724	13.3
CARTERET	9,367	15.8	NORTHAMPTON	3,722	18.0
CASWELL	3,395	15.8	ONSLOW	8,365	5.5
CATAWBA	16,608	12.8	ORANGE	9,711	8.8
CHATHAM	6,906	15.5	PAMLICO	2,288	18.9
CHEROKEE	4,572	20.2	PASQUOTANK	4,830	14.3
CHOWAN	2,641	18.6	PENDER	5,481	14.8
CLAY	1,733	21.6	PERQUIMANS	2,059	19.1
CLEVELAND	13,163	14.5	PERSON	4,825	14.6
COLUMBUS	7,502	14.5	PITT	12,020	9.9
CRAVEN	11,071	12.7	POLK	4,112	25.5
CUMBERLAND	22,938	7.6	RANDOLPH	15,248	12.8
CURRITUCK	2,164	13.0	RICHMOND	6,600	14.4
DARE	3,362	12.3	ROBESON	12,312	10.9
DAVIDSON	18,073	12.9	ROCKINGHAM	13,605	15.1
DAVIE	4,655	15.2	ROWAN	18,973	15.4
DUPLIN	6,326	14.4	RUTHERFORD	9,546	15.9
DURHAM	19,825	10.1	SAMPSON	7,728	14.9
EDGECOMBE	7,233	12.7	SCOTLAND	3,987	11.4
FORSYTH	37,673	13.1	STANLY	8,110	14.8
FRANKLIN	5,527	12.7	STOKES	5,216	12.1
GASTON	22,714	12.7	SURRY	10,644	15.9
GATES	1,429	14.4	SWAIN	1,919	16.3
GRAHAM	1,325	17.4	TRANSYLVANIA	5,926	21.3
GRANVILLE	5,208	12.4	TYRRELL	677	18.2
GREENE	2,352	13.5	UNION	10,191	9.8
GUILFORD	49,036	12.8	VANCE	5,296	13.1
HALIFAX	8,596	14.8	WAKE	44,461	8.0
HARNETT	9,741	12.0	WARREN	3,603	19.5
HAYWOOD	10,421	20.5	WASHINGTON	2,068	15.2
HENDERSON	18,193	23.1	WATAUGA	4,775	11.6
HERTFORD	3,436	15.4	WAYNE	12,648	11.2
HOKE	2,903	9.8	WILKES	9,101	14.5
HYDE	851	16.9	WILSON	9,263	13.4
IREDELL	14,765	13.7	YADKIN	5,496	15.7
JACKSON	4,462	15.1	YANCEY	3,029	18.5

INFORMATION SOURCES:
N.C. Office of State Planning
U.S. Census Bureau

The 1997 Profile of Aging in North Carolina

NORTH CAROLINA Division of AGING

Division of Aging
NC Department of Human Resources

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So What's the Bottom Line about the Aging of Our State

- **Older adults are North Carolina's fastest growing population.**
- **Our state's senior population will more than double over the next 30 years. At least one in five North Carolinians will be age 65 or older in 2025.**
- **North Carolina is only one of three states projected to gain more than a million people between 1995 and 2025 through migration into the state. Many of these newcomers will be retirees.**
- **There are large differences among seniors in terms of economic, health and social characteristics.**

What Are the Implications

While the aging of our society is a national trend, it is especially true of North Carolina. This has relevance to all areas of our public and private lives. Government faces decisions about the allocation of public resources. Families must consider living and caregiving arrangements. The health, human service, and education systems must adapt to changes in interests and needs. The business, cultural, and other communities must identify and respond to the challenges and opportunities of our state's demographic shift.

There are large numbers of seniors today who contribute to our families and communities as well as some who must ask for assistance. Our current experience, though, is nothing like what we will encounter in the near future. We must respond to the challenges of today and prepare to meet tomorrow's.

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Today's Older Population

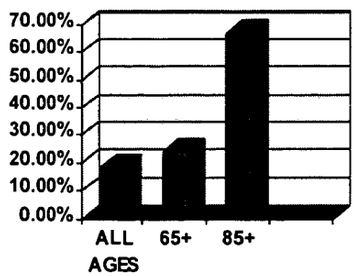
In 1997, 946,000 of our State's 7,437,000 residents are age 65 and older (12.7%). Nearly 103,000 North Carolinians are 85 or older.

Who are our seniors?

There are as many differences among seniors as is true of any age group. Still, there are some defining features:

- **Older women outnumber older men. They represent 61% of those 65 and older, and 74% of the 85+ age group.**
- **About 18% are of a minority race, mostly African-American.**
- **Only about 5% live in institutions or group residences. More than half (58%) live with their spouse; almost 29% live alone.**

POPULATION GROWTH CHART, NORTH CAROLINA
% CHANGE PROJECTED DURING 1990-2000



- **Nearly 57% did not complete high school.**
- **About 51% live in rural areas.**
- **About 79% own their homes, but with 33% living in housing built before 1950.**

"North Carolina's older population grows larger and more diverse each year. And these changes are bringing about plenty of upheaval both in the state and certainly for all aging services."
- Bonnie M. Cramer, *Director, N.C. Division of Aging*

Some Older North Carolinians Face Special Challenges Due to Economic, Health or Other Hardships:

POVERTY **In 1990, 19.5% of those 65 and older, and 30% of those 85+, lived at or below the federal poverty level. Older women (24%) and minorities (39%) were overrepresented among the poor. As of 1995, there was some indication of a decline in the poverty rate among seniors, nationally and in North Carolina. The U.S. Census in the year 2000 will show the extent to which this has occurred. The federal poverty level for an individual in 1997 was $7,890 and $10,610 for a couple.**
Besides the poor, there are a large number of seniors who live close to poverty. As of 1990, 16% of seniors in North Carolina were living within 150% of the federal poverty level.

IMPAIRMENT **Among older North Carolinians in 1990, 23% reported some difficulty in moving around and/or taking care of themselves. The number of severely disabled older adults living in the community is expected to grow from about 78,700 in 1996 to 104,000 in 2010. As of 1997, an estimated 123,000 older persons have some form of dementia, with about 64,000 experiencing a moderate or severe cognitive impairment, such as Alzheimer's disease which affects their memory and ability to reason. We can expect these numbers to increase to about 170,000 and almost 90,000, respectively, by 2010.**

A 1996 Carolinas poll commissioned by the Charlotte Observer found that "caring for elderly relatives is a concern for more than half of Carolinians, including a surprising number of young people."

At the Turn of the Century

As we enter the 21st Century, we can expect the number of North Carolinians age 65 and older to grow to 1,005,000. They will represent 13% of our state's population. The number age 85 and older will rise to 115,000.

Why this demographic shift?

There are many reasons for the shift toward an older society in numbers and proportionately. Greater longevity and in-migration of retirees play an important part in the growth of the senior population we are seeing now. North Carolina ranks 5th in the nation in attracting retirees. It is projected that the net gain of older migrants during the 90's (nearly 122,500) will be more than twice the number in the 1980's. Reduced birthrates also affect the proportionate size of age groups. The loomingBaby Boom generation (born 1946-1964) will have a staggering effect.

The Aging of the Baby-Boomers

By 2010, as the oldest of the large Baby Boom generation nears age 65, we catch a glimpse of the dramatic changes to follow. It is projected that there will be 1,217,000 seniors in 2010 (14.2% of the state's population). Those age 85 and older will equal about 165,000. By 2025, projections show North Carolina with 2,004,000 people age 65 and older. This will represent nearly 21.4% of our state's population. The Baby Boom generation, by its sheer size, has had a staggering effect on every system it has encountered...from hospital delivery rooms... to classrooms...to the job market. We are already seeing how this generation is forcing serious policy discussions about the future of Medicare and Social Security.

The effect of the baby-boomers' retirement will be reminiscent of a "pig being ingested by a python... I don't think there's a lot of people who know what it will all mean."-
-George Myers, director of the Center for Demographic Studies at Duke University

Older adults are North Carolina's fastest growing population

Ages	1995	2000	2005	2015	2025
0-4	514,000	483,000	481,000	508,000	510,000
5-17	1,285,000	1,505,000	1,453,000	1,368,000	1,424,000
18-24	715,000	724,000	796,000	839,000	787,000
25-64	3,782,000	4,154,000	4,416,000	4,680,000	4,624,000
65+	899,000	991,000	1,081,000	1,445,000	2,004,000

Source: U.S. Bureau of the Census

North Carolina Department of Health and Human Services
Division of Aging

James B. Hunt Jr. Governor
H. David Bruton, M.D., Secretary

Karen E. Gottovi
Director

November 7, 1997

Dear Colleague and Friend:

As the newly appointed director of the North Carolina Division of Aging, I am impressed with all that this agency accomplished during the past year. The division's annual report for the period July 1, 1996, through June 30, 1997, gives a good picture of the breadth and quality of work undertaken by the agency's dedicated staff members working in concert with many public and private partners. The comments of my predecessor, Bonnie M. Cramer, summarize well my own sentiment--"we can be proud of what the division has accomplished and excited about its future."

The current year promises to be equally productive. We will again have many challenges as well as opportunities. We must continue to develop a strong network of home and community-based services that enable impaired older adults to live at home and remain active in the community. Our services must reach out to family caregivers who represent the backbone of long term care. For those individuals who require care in facilities, the work of our ombudsman program remains essential.

We will build on efforts begun this past year in such areas as the development of our aging web site, reports on the future of North Carolina's baby boomers, and the study of strategies to help older adults afford the prescription drugs they need. We will continue to support the work of the Area Agencies on Aging and local providers in redefining standards to guide their performance, which is vital in the evolving managed care environment. We will participate in the upcoming "Year of the Volunteer" with our many volunteer initiatives. We will continue to value the work of the Senior Tar Heel Legislature, the Governor's Advisory Council on Aging, the Coalition on Aging, and the many others who make such a positive difference for seniors and their families.

This year will also be a time of change. The Division will be a part of a larger reorganization within the Department of Health and Human Services designed to enhance our service to citizens. We will want and need the active participation of our many partners in this time of transition.

Sincerely,

Karen E. Gottovi

Karen E. Gottovi

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The Future of Aging in North Carolina

Responding to the Challenges and Opportunities Presented by Baby Boomers at Mid-Life

Division of Aging

North Carolina Department of Human Resources

July 1997

The Future of Aging in North Carolina

Responding to the Challenges and Opportunities Presented by Baby Boomers at Mid-Life

A Report Prepared for the Division of Aging, North Carolina Department of Human Resources
by
CARES, Center for Aging Research and Educational Services,
Jordan Institute for Families, School of Social Work
The University of North Carolina at Chapel Hill

July 1997

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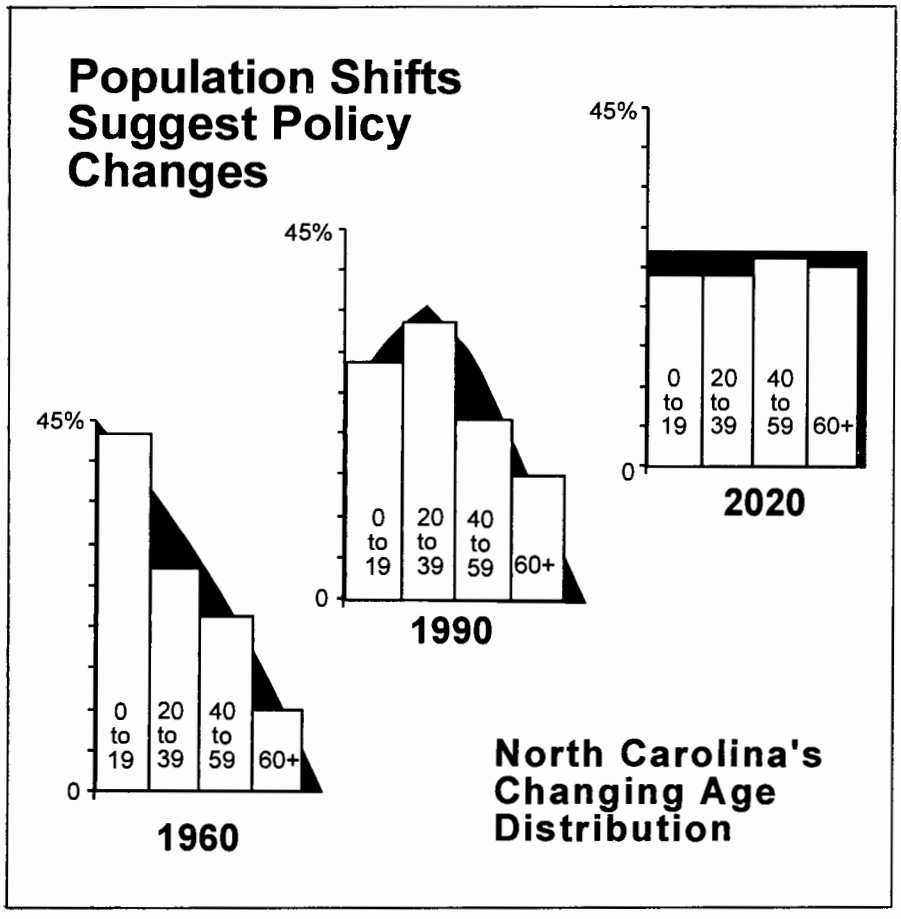
North Carolina's Baby Boomers

Some view aging baby boomers, born between 1946 and 1964, with foreboding, predicting that this "age wave" will drown the state and nation in a sea of red ink when boomers begin to use health and retirement benefits. Others speak optimistically of the resources that can be tapped from this large group of people. The reality is somewhere in between.

The future of the baby boom generation affects all of us. The issues facing boomers are intergenerational and will dictate what our families and communities will be like, now and into the next century. The relationships among our institutions—business, government, family, community—and our own planning for the future will determine whether or not a majority of our citizens are able to ride the crest of the age wave to a positive and rewarding old age.

Rising Numbers of Older People

In 1990 there were 2 million baby boomers in North Carolina, nearly one third of the state's entire population and almost half of its workforce. The oldest boomers turned 50 in 1996, and they will reach 65 in the year 2011—merely 14 years from now. By conservative estimate, about 1.5 million boomers will still be living in 2030, when all of them are past age 65.



Diversity

North Carolina boomers are a diverse group, increasing the challenge of creating a policy framework that benefits all. They differ by race and ethnicity, gender, and education, and all of these have contributed to differences in income and financial well-being. The majority of North Carolina's boomers are White, but the state has had and continues to have a large African American population—at 22 percent, about twice the national average. Under current projections, 18 to 19 percent of the older population will be African American in the year 2030. Among baby boomers, people of Hispanic, Asian, and Native American heritage comprise very small proportions of the population, but younger age groups are becoming more diverse, in North Carolina as in the nation.

Just over half of North Carolina boomers are women (50.6 percent), and their proportion will increase as they out-survive boomer men. Although boomer women as a group are

somewhat better educated than their male counterparts, most will have earned less over their lifetimes. In their later years, they will be more likely to live alone and to suffer from chronic ailments than men.

North Carolina boomers generally are better educated than their parents, but they have lower levels of education than boomers across the country. Eighteen percent of boomers have less than a high school education and have not received a GED. A little more than 20 percent of boomers have completed a college degree.

These demographic characteristics have had a large influence on the current and future financial security of the boomers. About 20 percent of boomer-headed households can be called comfortable or well-to do. In 1989, they had household incomes of $50,000 or more ($63,291 in 1996 dollars). About 17 percent of boomer-headed households can be called poor or near-poor, with household incomes in 1989 less than $15,000 ($18,986 in 1996 dollars). The remaining 63 percent are in the middle.

Although boomers as a generation are better off than their parents, real disparities persist within the group. For example, while 17 percent of all boomers are poor or near-poor, 33 percent of African American boomers fall in this income category, compared to 12 percent of White boomers.

Causes for Optimism

There is promise in the number and diversity of the boomers. As a group, they are both better-educated and wealthier than their parents. As workers now in their peak productive years, they keep the economy strong producing goods and services. They are also the largest group of consumers, whether purchasing for themselves, their children, or their parents. This situation will continue for the next 30 years.

Despite what has been written about intergenerational divides, for the most part, families continue to care well for their members, both older and younger, and boomers participate in the community. At least in North Carolina, they already contribute time and money to charitable causes at rates similar to their parents. More than half do some sort of volunteer work and about 80 percent give money to charity. Whatever differences in attitudes may exist among the generations, it seems safe to assume that this kind of community involvement will continue as boomers age.

Boomers at a Glance

Compared to NC's older adults today, NC boomers

- are much more likely to have finished high school and somewhat more likely to have attended college
- have much higher household incomes during their young adult years, even when inflation is taken into account
- are less likely to own a house, especially the younger boomers
- are more likely to be in occupations that have traditionally offered pensions; however, employers are changing the nature and reducing the extent of pension coverage
- smoke more than their parents do now, but less than their parents did when they were young
- are less likely to be completely sedentary, but also a little less likely to exercise vigorously and regularly
- may experience lower rates of illness and impairment in their later years
- are just as likely to do volunteer work and give to charities

Preparing for the Future Now

Successfully addressing the challenge of aging requires individuals and society to take a broad and long view. The broad view addresses the scope of issues our society considers important. This report touches on a few of these: finances, health, work and education, and family caregiving. The long view emphasizes the importance of early and ongoing planning in these areas.

Future Financial Security

To assure a good future, North Carolina's baby boomers must take increased personal responsibility for financial planning. This may be relatively easy for those in the upper fifth of the income distribution, but for those in the middle and lower-middle income groups, opportunities for private savings and investments may be more limited, and their financial future less certain. For the poor and near-poor, Social Security will become more important than ever.

Social Security is the bedrock on which today's older population bases its financial security, and without it, nearly 60 percent of today's older population would live in poverty. For many of today's older people and for many boomers as they age, it is and will be their only financial safety net. What worked in the past, however, will not work the same way in the future. Social Security has depended on a larger number of people in the workforce paying into it and a smaller number of retired people drawing benefits. It has always given its poorer beneficiaries a better return on their investment than its richer ones. Into the next century, there will be a smaller pool of workers supporting a growing population of beneficiaries. Social Security benefits are likely to be further trimmed, and many feel they will be targeted to poor and lower-middle income recipients.

The good news is that perhaps 40 percent of North Carolina boomers will have pension programs to supplement their Social Security benefits; the bad news is that 60 percent may not. As the private and public sectors change the way they do business—by down-sizing, out-sourcing, and relying on part-time employees, they have reduced or reworked employee benefits. Increasingly, defined-benefit programs, where the organization offered lifelong pensions based on years of work, are being converted to defined-contribution plans, where employees take personal responsibility and many of the risks of planning for their future financial security. They often must choose wisely from among a dizzying array of options—IRAs, 401(k)/403(b) plans, savings, and employer-provided pension plans.

Perhaps 40 percent of boomers will have pensions for retirement, but 60 percent may not.

How well boomers do now, during their working years, will shape their financial security for the future. How well they meet the challenge of saving and investing on their own will determine their future financial well-being, as well as continued political support for Social Security.

Responsibility for Healthy Aging

Although the health of North Carolina's boomers in their later years promises to be better than that of their parents, there is ample opportunity for improvement. Avoiding premature death and impairment depends on making personal changes in unhealthy behaviors and life-styles. Although these are individual changes, social support and incentives can help a larger number of people make these changes. It also depends on societal investment in care for and treatment of chronic conditions and improved access to health care.

North Carolina boomers have among the highest rates of smoking in the country, but fewer smoke than in their parents' generation when they

were the same age. A third maintain a level of obesity that threatens their long-term health, and nearly 40 percent do not do any physical exercise. A significant percent practice unsafe sex. The three leading causes of death of North Carolina's boomers—cancer, heart disease, and AIDS—are attributable in large part to these behaviors, which can be changed.

An effective strategy for improving the health of aging boomers must address issues of personal and social responsibility.

Personal responsibility for continued good health also extends to obtaining routine health care, and this often depends on acquiring health insurance, which can be prohibitively expensive to purchase privately. However, the number of employers who provide coverage is shrinking, and many part-time and occasional workers are not covered. More than half of boomers who have no health insurance are poor or near-poor, but over 40 percent are middle class.

Work and Education across the Life Span

North Carolina's workforce, like the nation's, is changing dramatically. The service sector is rapidly expanding, and most jobs are affected by developing technology. Compared to North Carolina's older adults, boomers are more likely to be in executive, professional, and technical positions that often pay higher salaries and offer health and pension plans. Compared to US boomers, though, a greater proportion are in production and material-handling occupations, which are less likely to offer high salaries and benefits.

North Carolina's economic future, for the boomers as for the rest of the work force, depends on its ability to attract and develop industries that require skilled employees and to provide a well-trained workforce. Access to ongoing education is essential, so that workers at all levels can keep pace with these changes. The community college system, public university system, and private universities all have a pivotal role to play, as does ongoing in-service training, in keeping North Carolina competitive in an increasingly global economy.

Attracting industries that provide better job opportunities may help us avoid the growth of a two-tier economy, with an increasing gap between those with high pay and benefits and those without. Although many boomers may choose to work into their "retirement years," some may have to work because they cannot afford to retire.

Caring for All the Generations

Aging baby boomer couples are in the first generation that has, on average, more parents living than children. Ten years ago, people spoke of the "sandwich" generation, as boomers began to provide care for their aging parents while they raised their children. Today we speak of the "double-decker sandwich"—women in their fifties helping their children care for their grandchildren while they are providing help to their seventy-year-old parents and ninety-year-old grandparent.

The average boomer couple has more living parents than children.

Families continue to care for one another—a North Carolina poll conducted in the mid-1980s found that more that half of the adults surveyed helped a person over 65, and in 1990, about 110,000 children in the state lived in households headed by a grandparent (almost 34,000 did not have parents living with them). However, increased divorce rates, lower marriage rates, fewer children per family, and greater mobility, how families care for one another when boomers get old may change. Whatever happens, aging is—and will be—a family affair. As an even greater responsibility for caregiving falls on families, it is critical that industry and government support their efforts.

A Public-Private Policy Framework

Responding to an Aging Society Is Everyone's Responsibility

Meeting the challenges and realizing the promise of an aging society will require a complex blend of personal and public responsibility. Individuals, families, businesses, communities, and government must take a holistic, long-term view of how we want our state to be in the years before December 31, 2064, when the last boomer will turn 100. Boomers will affect society for a long time to come. We can realize their promise through a public-private framework that emphasizes government, corporate, and individual responsibilities and choices. To meet our needs, this framework should have at least four elements:

1. lifelong learning combined with accessible information
2. incentives for investing in aging well
3. public and private accountability for results
4. community governance.

All these must be supported by the moral precept that we ***leave no one behind***.

Lifelong Learning and Accessible Information

We have moved quickly into an era of increased individual responsibility for choices that affect the aging and well-being of individuals and their families. With this responsibility for choice comes the responsibility to learn continuously and make choices that are as good as possible. It is the corresponding responsibility of business and government to provide complete, accessible information on which individuals and their families can base these choices.

Information that helps people understand and access services should be readily available—for example, clear, simple descriptions of the basic characteristics, eligibility requirements, costs, and benefits associated with health, financial planning, housing, and long-term care options. In addition to its regulatory role in protecting consumers from exploitation, another role of government is providing information by a variety of means, so that consumers learn how to evaluate their options. Such new technologies as the Internet offer fresh ways of disseminating information, but the "old-fashioned ways"—making information available in such places as the mall, family resource centers, libraries, churches, and schools—is also necessary. Issues essential to successful aging should be part of the ongoing educational programs of colleges and universities and reflected in the practices of human resource departments.

Individuals and families need more and better information with which to make the best possible choices.

Incentives for Investing in Aging Well

Because large numbers of boomers will be here for the next 30 to 50 years, it is to everyone's advantage, from a moral, social, and financial perspective, to adopt individual strategies for aging well. A strategy for public and private investments and incentives is also needed to ensure that we age well as a state.

Government needs to invest in research on the prevention and care of chronic health problems. We need strategies to stimulate more individuals to plan for their financial security, such as incentives and social marketing. Public and private incentives are needed to promote desirable behaviors—smoking cessation, exer-

cise and healthy eating, safe sex, and preventive care.

Participation in education and training programs to upgrade work skills, stay abreast of changing technologies, or change careers must become more affordable and readily accessible. Family caregiver responsibilities must be recognized through expanded family leave programs, flexible work schedules, and financial support.

We need a strategy for public and private investments and incentives to ensure that we age well as a state.

Public-Private Accountability for Results

We must develop a culture that expects, fosters, and rewards individual, corporate, and government responsibility. Individuals must make increased efforts to secure their own and their family's health and financial well-being. Individuals and families must also participate in building thriving communities.

Individuals must make increased efforts to secure their own and their family's health and financial well-being.

Private corporations must insure that their "bottom line" includes the welfare of employees, their families, and communities. Corporations have a social responsibility to offer living wages and benefits that provide a basic measure of health care coverage and financial security in retirement. Family-friendly policies that recognize both child and elder care demands are essential to the well-being of family and community.

Corporations have a social responsibility to offer living wages and benefits that provide a basic measure of health care coverage and financial security in retirement.

Government must increasingly measure its work by the results of its programs in tackling social problems rather than by effort expended in providing services. Only when the goals of a program are clear and its results widely publicized will we have a responsive government. Only then can we expect the return of public tust.

Community Governance

Decision making and responsibility for government must be devolved to the lowest level commensurate with effectiveness. Communities must come to understand where they are using their resources, with what results.

Citizens must be involved in policy matters if government is to be effective.

Community ownership and support for government programs are essential for their success. Personal faces must be put on public programs so the community can understand how its citizens benefit. Community governance can also overcome the fragmentation that exists in many service areas. Citizens must be intimately involved in policy matters if government is to be effective.

Leave No One Behind

Finally, a public-private framework for a responsive aging society must have as a moral admonition: leave no one behind. A sense of community and intergenerational interdependence must lead citizens to assume responsibility for themselves, their families, and their communities. It must also lead them to accept responsibility to help those who are less fortunate.

When public policy for an aging society is carefully and thoughtfully constructed, we all stand to benefit.

The problems and challenges of the poor and near-poor boomers will become even more difficult to address as they

age. Less well understood are the challenges that will face middle-class boomers. Continuing cycles of corporate downsizing, combined with changes in the way health insurance and retirement benefits are provided, have created a period of great uncertainty even for those boomers who already are planning carefully for their later years.

Unless we pay greater attention to fairness, choice, accountability, and the involvement of the public in the design of our own future and that of our families, the gains secured for the middle class over the past six decades will be threatened. When public policy for an aging society is carefully and thoughtfully constructed, we all stand to benefit.

What responsibilities would you assign to individuals, families, businesses, communities, and government for assuring successful aging among NC boomers and the general well-being of the state?

Taking Responsibility for Our Future

Issues for Policymakers, Businesses, and Citizens

More than half of NC boomers had a high school diploma or less at ages 25 to 34, although many have since acquired more education.

Our future is promising if—

- All NC boomers are literate and pursue additional knowledge and skills.
- Employers invest in the continuous retraining and skills development of their workforce.
- The community college system and state universities continue to attract and serve boomers.
- Government promotes the continuing education and retraining of boomers through information, incentives to individuals and businesses, and a strong educational infrastructure.
- Government's economic development and education strategies are congruous.
- All together we invest in the application of technology to the education of boomers

Only about 40 percent of NC boomers can expect pensions in retirement.

Our future is promising if—

- NC boomers take responsibility for their financial security in retirement, take advantage of information and activities designed to increase their financial literacy, and make informed decisions about available pension options and savings plans.
- NC boomers obtain jobs, whenever possible, that offer pension coverage and savings plan options as a benefit.
- Employers make offering and supporting pension and savings plans a priority.
- Employers ensure that workers are given accurate and timely information and counseling to help them make informed decisions about saving for retirement.
- Government ensures the solvency of public and private pension coverage and protects against discrimination.

- Government gives incentives for businesses offering pension coverage, especially to low-wage workers, and includes the provision of pension benefits as an important criterion in economic development strategies.
- Government supports the portability of retirement plans.
- Government promotes informed decision making among boomers about their pension and savings plan options and discourages early withdrawal of retirement savings.
- All together we assure the soundness of Social Security because of its importance in the financial security of seniors, especially when pension benefits are weak or not available.

The aging of the boomers invites us to reevaluate what it means to be "old" and what we expect of ourselves, our families, communities, employers, institutions and government.

About 13 percent of NC boomers do not have health insurance.

Our future is promising if—

- NC boomers take responsibility for their health, make use of information and opportunities designed to increase their access to affordable health insurance and care, and make informed decisions about health plan options and the use of services.
- NC boomers take jobs, whenever possible, that offer health insurance coverage for themselves and their families.
- Government, businesses, the health insurance industry, and health care providers develop lower-cost options to enable self-employed and lower-income persons to purchase coverage.
- Government gives incentives to businesses offering affordable health insurance coverage, especially to low-wage workers and their families, and includes the provision of health insurance benefits as an important criterion in economic development strategies.
- Government supports the demonstration of medical savings accounts and other methods of financing health care and takes responsibility for promoting those proven to be effective.
- Government takes responsibility for ensuring that the state's licensed health insurance and managed care systems act in the best interest of the consumer and do not unfairly deny access to care or insurance.
- Government takes responsibility for continuing to track and evaluate the extent to which North Carolina households are uninsured and responds as needed, to include assuring access to health care or insurance when the market does not provide reasonable means of care for those who, through no fault of their own, cannot help themselves.
- All together we assure the soundness of Medicare as a form of health insurance for seniors and Medicaid, QMB, and SLIMB for their roles in the health and long-term care of persons with low income.

Nearly 40 percent of NC boomers do not exercise, about 33 percent are overweight, and 28 percent smoke.

Our future is promising if—

- NC boomers take responsibility for their own well-being and practice healthy behaviors.
- Employers invest in the health and fitness of their employees with information and wellness programs.
- Health care insurers and providers promote healthy behaviors and preventive care.
- Communities provide ample opportunities for recreation that promotes good health.

- Government encourages and rewards the practice of healthy behaviors, especially among those who have higher rates of health behaviors that put them at risk of illness and impairment.
- Government takes responsibility for assuring a safe environment within which to live. Government invests in biomedical and environmental research that can guide future preventive health measures.
- All together we establish and pursue the goal of improving North Carolina's status among states, by the year 2005, from the twelfth highest in "preventable deaths" to at least the twelfth lowest.

The average boomer couple has more living parents than children.

Our future is promising if—

- NC families continue the tradition of caring for their older members who are impaired and need help with activities of daily living.
- NC families make choices that enable each member to enjoy dignity and fulfillment throughout life.
- NC boomers take responsibility for helping their parents and themselves plan for the cost of long-term care.
- NC boomers take jobs, whenever possible, that offer long-term care insurance coverage as a benefit for themselves and their parents.
- Employers operate with family-friendly policies that respect and accommodate the caregiving responsibilities of employees without sacrificing the demands of their jobs.
- Employers invest in eldercare benefits that help employees with information, counseling, referral to services, and the personal financing of long-term care.
- Government operates under a clear public policy on long-term care that recognizes and rewards the contributions of family caregiving and supports it with information, incentives, and such services as respite care for those who cannot afford them privately.
- All together we assure the soundness of such programs as Medicaid, the Older Americans Act, and State-County Special Assistance, especially as they help persons with limited means to have access to quality long-term care in the least restrictive setting.

What issues do you consider most vital?

Nearly one in five NC boomers lives in poverty or just above.

Our future is promising if—

- NC boomers who are living in or near poverty take responsibility for improving their education, job situation, and other circumstances as much as possible.
- Employers and government assure adequate wages and benefits for workers and provide ample opportunities for gainful employment.
- Government takes responsibility for designing well-coordinated, well-targeted, and responsive programs that make best use of public and private resources to improve the long-term economic situation of households living in or near poverty.
- Government pays particular attention to reaching those whose prospect for economic security in later life appears most dim, including African American boomer women who are almost as likely to be single heads of households as to be in married couples.
- All together we assure the soundness of Supplemental Security Income, Medicaid, Food Stamps, Low-Income Energy Assistance, and other such programs that have made an important difference for those without adequate resources of their own for basic necessities.

The Boomer Project Team

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Bonnie M. Cramer, director; Steve Freedman, planning and field operations; Dennis Streets, team leader.

This report is a companion to *Baby Boomers at Mid-Life: The Future of Aging in North Carolina*, a 20-page document prepared for the Division of Aging in July 1997. The many people who provided information for these reports are acknowledged there. The cover design is provided courtesy of the Office of Rural Health and Resource Development.This document may be freely reproduced with acknowledgment of the NC Division of Aging and CARES.

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North Carolina Department of Health and Human Services
Division of Aging

James B. Hunt Jr. Governor
H. David Bruton, M.D., Secretary

Karen E. Gottovi
Director

October 31, 1997

Dear Colleague:

The aging of North Carolina's baby boomers, more than perhaps anything else, will change the nature of future public policies toward older people just as it is now affecting the basic nature of our families, communities, work places, and the market place. For this reason the Division of Aging decided to profile North Carolina's two million baby boomers, review their promise and challenge, and present a framework for responding to the future of aging. I appreciate the leadership of Bonnie Cramer, former director of the division, in undertaking this project last year.

We now have two reports to share with state and local leaders. *Baby Boomers at Mid-Life: The Future of Aging in North Carolina* is our state's first attempt to profile boomers and examine their prospect for financial security, good health, and quality of life in old age. The second report, *The Future of Aging in North Carolina: Responding to the Challenges and Opportunities Presented by Baby Boomers at Mid-Life*, presents a public-private framework that emphasizes government, corporate, and individual responsibilities and choices. We will use these two reports to shatter myths about the aging of the baby boomers and to stimulate a timely and serious discussion of how best to prepare for the future.

We hope you will join us during the next year as we invite public comment about the findings and recommendations contained in these reports. Given the economic, emotional and caregiving interdependence of generations, the present and future circumstance of North Carolina's boomers should concern all of our citizens.

Sincerely,

Karen E. Gottovi

Karen E. Gottovi

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North Carolina: Host of the 1999 Special Olympics World Summer Games

North Carolina Division of Aging

Annual Report

1996 - 1997

North Carolina Department of Health and Human Services

September 1997

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Message from Bonnie M. Cramer

I am pleased to present you with this report of the Division of Aging's efforts for the period July 1, 1996, through June 30, 1997. While it cannot capture all of the work of our 29 employees, it does reflect the range of our efforts and achievements consistent with our goals for the 1990s.

This year was both challenging and gratifying. We survived Hurricane Fran, adjusted to the uncertainty about reform of public policies and programs affecting older adults, and lost some of our national and state leaders for aging. On the other hand, we enjoyed another year of increased state funding for home and community-based services, strengthened our working partnerships, and pioneered new territory that we believe is vital to the future of aging in North Carolina.

We began this fiscal year with the aftermath of Hurricane Bertha, followed closely by Hurricane Fran, which had a devastating effect on our state. Fran came as we were busy helping our state's 18 Area Agencies on Aging host a conference for seven other southeastern states. The Aging Network responded quickly to assure the safety and well-being of seniors, especially the frail and those living on low incomes.

A different sort of disaster loomed in terms of indecision about the future of federal policy and programs. For yet another year, there was no progress toward reauthorizing the federal Older Americans Act, which funds the nutrition and supportive services that help many older people remain living in their homes and communities. Similarly, needed reform of Medicare and Medicaid failed to materialize. The deaths of Dr. Arthur Flemming, former US Commissioner on Aging, and Dr. John Kernodle, vice-chair of our Governor's Advisory Council on Aging, left us without two of our leading visionaries at a time when a clear view of the future is sorely needed. We also experienced the loss of Mr. Ernest B. Messer, a former Assistant Secretary for Aging in North Carolina.

Fortunately our state leaders saw the importance of moving forward with decisive action. Listening to the recommendations of the Legislative Study Commission on Aging, the Governor's Advisory Council on Aging, the Senior Tar Heel Legislature, the NC Coalition on Aging, and others, Governor James B. Hunt, Jr., worked with the General Assembly to increase the funding of home and community-based services for impaired older adults. With the help of these funds, 64,564 older adults and their family caregivers received services during the past year through the efforts of about 330 local agencies.

As the year ended, I accepted a position as director of the state's new Office of Long-Term Care Policy, in the reorganized Department of Health and Human Services. Karen E. Gottovi has been appointed the Division of Aging's new director. Joined by hundreds of partners, including the Area Agencies on Aging, local service provider agencies, senior advocates, and allied agencies within state government, we can be proud of what the division has accomplished and excited about its future.

Sincerely,

Bonnie M. Cramer

Bonnie M. Cramer

North Carolina's Seniors

- Older adults are North Carolina's fastest growing population.
- In 1997, 946,000 of our state's 7,437,000 residents are age 65 and older (12.7 percent).
- Nearly 103,000 are 85 and older.
- About 51 percent live in rural areas.
- As of 1990, 19.5 percent of those age 65 and older lived in poverty, as did 30 percent of those 85 and older.

Goals for the 1990s

- expand in-home and community services for older adults
- support aging-in-place through well coordinated community-based services
- enhance quality of care and quality of life of residents of long-term care facilities
- increase volunteer and employment opportunities for older adults
- collaborate with others to enhance the health and wellness of older adults and their family caregivers
- improve the quality of senior centers
- involve older adults and their families in meaningful public policymaking
- assure an adequately trained workforce to provide aging services
- establish an integrated state, area agency, and county planning process that includes a vision for the future of aging in North Carolina



Home and Community-Based Services

At the heart of the Division of Aging's work is its support of services designed to enable impaired older adults to live at home and remain active in the community. The division's efforts are also geared toward helping family caregivers, including those caring for persons with Alzheimer's disease. In addition, the division is helping to develop a strong network of multipurpose senior centers across the state.

We started the year with about 15,500 seniors on local waiting lists for such assistance as in-home aide service, home-delivered meals, and adult day health care. Impressed by this level of need, Governor Hunt recommended, and the General Assembly appropriated, an additional $5 million in state funding for home and community-based services for fiscal year 1996–97. The General Assembly also added to the Housing Trust Fund, which supports the Urgent Repair Program of the North Carolina Housing Finance Agency. It also appropriated funds for the state's four Alzheimer's Association chapters to help family caregivers with information, training, and support. Possibly the most important act was the legislative endorsement of a set of principles to guide development of a state policy on long-term care. The division has taken these principles into account as it worked with Area Agencies on Aging (AAAs) and local service providers to expand the availability of home and community-based services throughout the state. The sections that follow profile the level of service delivery and the population receiving these services.

A primary goal of the Division of Aging is helping impaired older adults live at home, often with the support of their family.

Services Funded by the Division of Aging

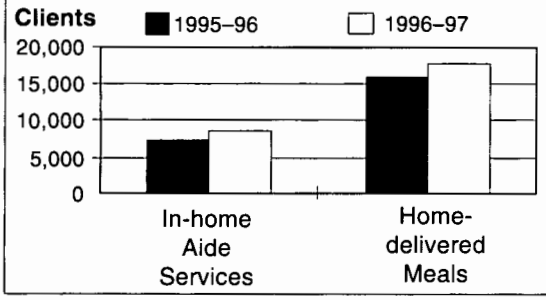
- adult day care/day health care
- care management
- congregate meals
- health promotion/disease prevention
- health screening
- home-delivered meals
- housing/home improvement
- information/case assistance
- in-home aide
- legal
- respite (in-home/group/institutional)
- senior center operations/development/outreach
- senior companion program
- skilled home care
- transportation
- volunteer program development

Service Expenditures

Of the $40.2 million spent during the year for home and community services, 88 percent was used for 5 of the 16 fundable services. About 39 percent of the funds were targeted for nutrition services, and nearly 32 percent for in-home aide services. These expenditures include the federal Older Americans Act funds, state appropriations, required local matching funds, and the cost-sharing contributions of people served. For the nutrition program alone, participants contributed more than $1.5 million toward the

Service/unit	People	Units	Expenditures
In-home Aide/hours	8,645	1,220,180	$12,732,598
Nutrition			
Congregate/meals	30,272	2,755,024	8,443,171
Home-delivered/meals	17,782	2,519,704	7,246,743
Transportation/one-way trips	18,982	1,512,605	4,807,368
Adult Day Care–Day Health/days	975	91,559	1,997,525

Chart 1. Growth in In-home Aide Services and Home-delivered Meals, 1995–96 and 1996–97



costs of congregate and home-delivered meals. The involvement of a large number of volunteers is another strong asset of the nutrition program that enables the service to be extended.

The distribution of funds among the possible home and community-based services is largely a matter determined locally. Under a Home and Community Care Block Grant that the division administ with the AAAs, each county develops a funding plan based on the needs of its local seniors.

The Service Population

A total of 64,564 persons received one or more of the home and community-based services funded through the Division of Aging in state fiscal year 1996–97. This represents nearly a 6 percent increase over the number served during 1995–96. This number does not include the many other individuals and families who benefited from senior center activities, health promotion/disease prevention, and volunteer program development.

A total of 64,564 persons received one or more of the home and community-based services funded through the Division of Aging in state fiscal year 1996-97.

While the total number of people served in 1996–97 did increase over the previous year, this was not part of a well-defined trend. The number served in State Fiscal Year 1995–96 was actually 1,718 fewer than those served in 1994–95. Uncertainty and stagnation in the federal Older Americans Act funds are largely responsible for this inconsistent pattern of service.

Fortunately, though, with strong support from Governor Hunt and the General Assembly for additional state funding in fiscal years 1996–1997 and 1997–1998, we are now moving in a more stable direction to meet the needs of our growing older population. This positive change is shown in chart 1, which shows increases in delivery of two services that are key to the well-being of impaired older adults and their family caregivers. For this two-year period, there was a 19 percent increase in the numbers receiving in-home aide services and a 13 percent increase in recipients of home-delivered meals. Other services that showed impressive increases in the number of participants are adult day care/day health and institutional respite, two programs that provide essential relief to family caregivers. The number participating in adult day care/day health grew by 24 percent, and those receiving institutional respite increased by 57 percent.

Persons eligible to receive home and community-based services are age 60 or older or the caregiver of a person who is 60 or older. While there are no income requirements, older adults with the greatest economic or social need are given special consideration. This includes individuals with low income, the minority population, and seniors living in rural areas. Of those receiving any home and community-based services during the past year, 59 percent had income at or below poverty ($7,890 or less per year).

A primary goal of home and community-based services is helping impaired older adults to live at home, often with the support of their family. The following profile of those who receive one or more of these key services—in-home aide, skilled home care, adult day ca

Principles for Development of a Policy on Long-Term Care for North Carolina

- promote maximum independence, choice, and dignity
- provide an array of health, social, and supportive services
- maintain, develop, and/or expand home and community-based options in the least confusing manner and based on consumer need and preferences
- use limited public resources as efficiently as possible and have those able to help pay for services do so
- tailor services to individual need and deliver them through a seamless system regardless of funding source
- provide institutional care in an environment and manner that promotes quality of life and timely discharge to a less restrictive care setting whenever appropriate

and day health, housing and home improvement, care management, home-delivered meals, senior companion visits, respite, and transportation—certainly suggests that we are reaching a vulnerable population:

- the average age of clients is 79
- about 23 percent are age 85 and older
- 75 percent are women
- 22 percent are impaired in three or more activities of daily living (i.e., eating, bathing, dressing, moving around, and using the toilet)
- at least 18 percent reportedly have some cognitive impairment
- 67 percent have an income at or below poverty
- about half of the cases also provide relief to family caregivers.

"People don't understand the stress of caring for a relative 24 hours a day until they have done it. This program provides socialization for my mother and gives me part-time relief so that I can continue her care with less stress."

—daughter's comment about group respite

Speaking Out on Alzheimer's: A "Silent Epidemic"

In what has been described as a "silent epidemic," Alzheimer's disease and other dementing illnesses relentlessly diminish the quality of life for an estimated 123,000 older North Carolinians who have a mild, moderate, or severe affliction. This condition is also a source of emotional, financial, and caregiving stress for families. That is why the Division of Aging has placed a premium on efforts to inform, educate, and assist those affected.

Working through the state's four Alzheimer's Association chapters, the Duke Alzheimer's Family Support Program, and a federally sponsored demonstration project, the division helped thousands of family caregivers and the staff of service agencies to become better prepared to care for persons with Alzheimer's disease and related disorders. The magnitude of this statewide outreach is captured in the statistics for the association chapters and the Duke program, shown in the box to the right. What these data cannot capture is the sense of relief that persons with Alzheimer's and their family caregivers get in knowing that they are not alone in their battle with the illness.

The division also effectively used a federal Alzheimer's Demonstration Project to inform, educate, and develop services for people with dementia and their families. The project provided support in underserved counties for the development of respite services for families caring for persons with dementia. It also enabled development and distribution of an Alzheimer's care training module, *Home Is Where I Remember Things*, for by more than 700 home care agencies with in-

Help for Those with Alzheimer's Disease and Their Caregivers

Public Awareness

- more than 23,100 persons received newsletters on Alzheimer's disease
- nearly 18,200 attended health fairs, presentations and other community awareness programs
- 473 civic and community leaders were briefed about the disease and available assistance
- 75 other community groups received help in arranging a presentation on Alzheimer's disease
- an undetermined number benefited from 8 radio and television broadcasts

Education and Training

- 5,413 families attended educational seminars and/or received individualized information on Alzheimer's disease
- 422 health and medical care staff received training
- more than 100 college students received special training

Direct Services

- 8,537 persons used toll-free help-lines to get information and assistance
- 538 families received more intense help through case management
- 56 memory-loss victims were registered with the national Safe Return Program
- 9 persons received Care-Trak bracelets to protect those with Alzheimer's who wander

Building a Support Network

- 165 volunteer respite companions were trained and assigned
- 111 local support group facilitators received training
- 61 local support group leaders received monthly technical assistance

home aides throughout the state. In addition, it allowed 10 primary care centers to participate in an Alzheimer's Primary Care Partnership to promote education about Alzheimer's and other dementias.

The experience of Anson County is a good example of the impressive work of these primary care centers. In what could be described as the *Anson County "Blitz,"* Anson Regional Medical Services took a $2,000 grant and—during a four-month period—undertook an intense campaign of information and education. Its strategies for increasing awareness and knowledge of Alzheimer's disease included:

- developing an Alzheimer's resource kit for ministers and working with 55 churches across the county
- developing an Alzheimer's resource manual for primary care providers, which was given to 20 health care professionals and agencies throughout the county
- making 7 community presentations on such topics as "Communicating with the Alzheimer's Patient," "Warning Signs of Alzheimer's Disease and Caregiver Stress," and "Coping with Difficult Behavior in the Alzheimer's Patient"
- having 5 articles featured in the county's local newspaper
- establishing an Alzheimer's Committee to help with ongoing work, including the planning of a countywide educational forum and the start-up of in-home respite care for Anson County residents.

Clearly this was money well spent.

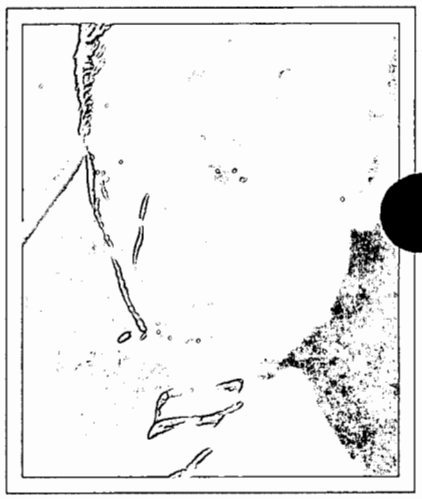
The division was also instrumental in developing *Group Respite* as a new service fundable under the Home and Community Care Block Grant. It is a service that uses trained staff and volunteers to offer temporary, part-time relief to unpaid, primary caregivers of cognitively or physically impaired older adults and to provide meaningful social and recreational activities for those receiving care in a group setting. Because it is scheduled for less than six hours a day, usually for one or two days per week, some call group respite "Caregiver's Day Out." With support from the Brookdale Foundation Group, the Alzheimer's Demonstration Project, and the block grant, 13 counties were serving 85 seniors and their families by the end of the year.

The division was also directly involved in training providers to care more effectively for people with Alzheimer's Disease and other dementias. At more than 58 events held at adult day care centers, respite sites, and long-term care facilities, division personnel demonstrated the effective use of artistic expression in this caregiving.

Nutrition Program Receives High Marks

This is a special year for nutrition programs for older adults. It marks their 25th anniversary under the Older Americans Act. In celebration, the Division of Aging nominated the Mecklenburg County Senior Citizens Program for national recognition as an example of the outstanding work being done by local congregate and home-delivered meals programs across the state. For 24 years the Mecklenburg program has provided proper nutrition, reduced isolation, and promoted meaningful independence among seniors.

The value of the nutrition program was evident in the results of the division's first large-scale, statewide consumer satisfaction and



"My weight has come from 82 to 102 [pounds] since meals on wheels. Need to say more? I would be in a nursing home if I didn't have you."

—a participant in the home-delivered meals program

Mecklenburg County's Program

- served 608,900 meals to 5,681 different persons (about 7.5 percent of the county's nearly 75,950 older adults) this past year
- enjoys the support of 460 volunteers giving 42,000 hours of free service
- provides supplemental meals to frail participants, emergency meals to all clients during holidays and inclement weather, and weekend meals to those who are frail and isolated
- while nearly 90 percent of participants are living with incomes below poverty, 93 percent of congregate participants maintained current health status and nearly 99 percent of home-based participants were appropriately maintained at home during the year
- reduced its waiting list for home-delivered meals from more than 1,000 to about 280 persons.

nutrition screening survey of home-delivered meals and congregate nutrition participants. All of the 1,063 consumers of home-delivered meals participating in the survey rated the program as helpful, with more than 94 percent calling it "very helpful." Similarly, 99 percent of the 979 congregate respondents were positive about their experience in the program, with nearly 80 percent rating it "very helpful."

The importance of these programs was also evident in that about two-thirds of home-delivered participants and 44 percent of congregate participants were found to be at "high risk" of poor nutrition.

Senior Centers

For older persons at risk of losing their self-sufficiency, North Carolina's senior centers are an important entry point to an array of services that will help them maintain their independence. These centers are a valued resource for the entire community, providing services and information on aging, and assisting family and friends who care for older persons. Individuals, families and groups can access a wide variety of services depending on local circumstances.

As of June 30, there were 134 multipurpose Senior Centers in 90 of North Carolina's counties. Other centers are being developed. To assist these centers, the division held several training events. About 60 senior center directors and managers attended the fourth Annual Senior Center Training Conference in August, where there was an emphasis on strengthening health promotion programs. Fortunately, there was also training at the conference on disaster preparedness. Many Senior Centers became a community focal point for assistance a month later in the aftermath of Hurricane Fran. During the year, 40 people met at the Rutherford Senior Center and 35 in Carteret County for follow-up sessions to continue their exchange of ideas and best practices.

This program has meant so much to me and my husband. After seventeen years as a widow, this is where we met. It has truly kept us going. The exercise we get, the great fellowship. . . . We look forward to every day."

—congregate nutrition and senior center participant

Elder Rights



Supporting the rights of seniors is an important part of the work of the Division of Aging and the Area Agencies on Aging (AAAs). This includes promoting and protecting the interests of residents of long-term care facilities, supporting access to legal services, and helping seniors make informed decisions in such areas as employment, housing, health care, and public entitlements.

Ombudsman Program

Since the mid-1970s, the Division of Aging has offered residents of nursing homes and adult care homes (known as rest homes) a friendly and effective advocate. Its State and Regional Long-Term Care Ombudsman Program works in a variety of ways to promote the rights and well-being of these residents.

The program's accomplishments are especially striking, considering that there are only 2 full-time staff members in the Office of the State Ombudsman and 24 regional ombudsmen located in the AAAs. Their effectiveness is enhanced by the dedicated service of the 1,200 volunteer advocates who compose the nursing and adult care home community advisory committees in each county.

The Ombudsman Program's role in the investigation and resolution of complaints is particularly important. The majority of the complaints are investigated by the regional ombudsmen. Chart 2, at the bottom of the next page, shows how this role has expanded.

Between July 1, 1996, and June 30, 1997, the Ombudsman Program

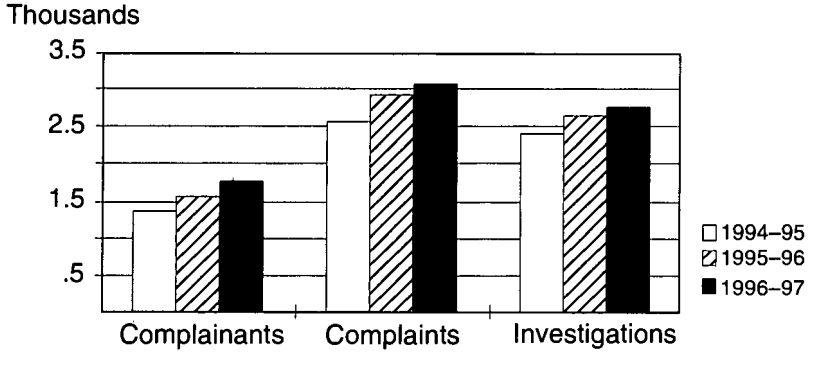
- investigated 3,067 complaints
- provided technical assistance to 14,960 persons
- made 3,915 visits to long-term care facilities
- presented 322 in-service training events
- conducted 353 community workshops and forums
- supported the work of over 1,200 volunteer advocates serving on the nursing and adult care home community advisory committees.

The number of people contacting an ombudsman for assistance with a complaint has increased by 28 percent over the past three years and the number of complaints has grown by nearly 19.5 percent. Ombudsmen at the local level handle about two-thirds of the complaints without having to refer them to a regulatory or other outside agency. The complaints primarily pertain to matters involving resident care and resident rights.

On the state level, the Ombudsman Program was active in helping change the culture of care in nursing and adult care homes. The division chaired a statewide task force whose goal is to promote appropriate use of physical restraints among physicians and health care providers. The education of families of nursing home residents about restraint use is another goal of the task force. The year's activity culminated in a statewide *Releasing Restraints Conference* held in May for nursing facility staff members.

The State Ombudsman also joined with the Division of Facility Services and the provider trade associations on two other important initiatives. The first involved development of quality assurance guidelines focused on the top ten cited deficiencies in nursing homes. These guidelines allow nursing facilities to survey themselves and take appropriate steps to improve care. In the second initiative, these groups have begun a campaign to promote the *Eden Alternative Method* of long-term care, which uses plants, animals, and children to create more of a homelike and vibrant atmosphere for residents of facilities.

Chart 2. Growth of Demand for Ombudsman Services



Elder Abuse

The Division of Aging's interest in promoting and protecting the rights of vulnerable older adults goes well beyond the Ombudsman Program. The division serves as a member of the *Statewide Elder Abuse Task Force*, along with representatives from the Division of Social Services, the Attorney General's Office, local district attorneys, AARP, and many other human services agencies. This task force works to resolve gaps in the protections available to older adults. The division also supports initiatives of the regional ombudsmen that are designed to educate the public and health care professionals on elder abuse, neglect, and exploitation. Each of the 18 AAAs conducted at least one such event during the year. Several AAAs supported the training of "first responders," that is, police, firemen, and emergency medical services. Another initiative, "TRIAD," is designed to build local strategies for reducing the criminal victimization of the elderly. Other efforts included "Respect for the Elderly" presentations and workbooks for children, and workshops on elder abuse assessment and intervention.

Seniors' Plus Program

The division continued its oversight of the Seniors' Plus Volunteer Program, which relies on *160 trained persons* across the state to provide counseling and assistance on matters involving public benefits and pensions. This program helps volunteers of the Seniors' Health Insurance Information Program (SHIIP), discharge planners, workers in the Community Alternatives Program (CAP), and others to provide more complete information to seniors with questions about public benefits and entitlements.

With help from the Social Security Administration and the state Divisions of Medical Assistance and Social Services, the Division of Aging held five training sessions around the state to update these volunteers on the many changes taking place in public programs. The division plans to recruit and train additional volunteers this coming year.

Managed Care

Managed care became a hot topic this year, especially as it related to Medicare. The division undertook several activities to help seniors and the aging network better understand managed care and the possible implications of this change in health care delivery.

The division sponsored a multistate workshop entitled, "Managed Care and the Future of the Aging Network," which included as presenters some of the nation's leading experts on the subject. Working with the Piedmont Triad Council of Governments, the division continued this discussion in forums held for AAAs and local service providers. These forums were facilitated by Brandeis University's Heller School of Public Policy.

The division also sponsored several events for senior consumers. They included a statewide teleconference on Medicare managed care, sponsored in conjunction with AARP, the NC Cooperative Extension Service, SHIIP, and others. The division assisted the NC Senior Tar Heel Legislature in hosting a special forum on the future of Medicare and supported the Piedmont Triad Council of Governments and the National Health Law Program in developing materials for an educational campaign for seniors on managed care. This included the detailed workbook, *Your Right to Know.*

Older Workers



As North Carolina's population grows older, one of our most important economic challenges will involve creation of employment opportunities for older men and women seeking to remain in or return to the labor force. In May 1995, Governor Hunt established an Older Workers Task Force of public and private interests to examine issues affecting older workers and recommend strategies to address them.

Working with the Governor's Commission on Workforce Preparedness and the state Departments of Commerce, Transportation, Community Colleges, and Labor, the Division of Aging has acted on 34 of the 41 major recommendations included in the 1996 report of the Governor's Older Workers Task Force. For example, the division:

- worked with the Wilmington Chamber of Commerce, the Cape Fear Community College, the Cape Fear AAA, and the UNC–Wilmington Small Business and Technology Development Center to develop a model for promoting opportunities for older workers
- helped the Employment Security Commission develop and conduct a statewide survey to determine the number of older persons looking for work and where they live
- helped strengthen the training of older worker specialists in local Employment Security Commission offices
- helped the Department of Transportation develop a plan to increase availability of transportation for older workers, especially those in rural areas
- advocated that the state's new One-Stop Centers adequately serve and promote older workers
- established a committee to examine issues of age discrimination and develop innovative ways to promote employment opportunities for older workers and to recognize employers who hire and promote them
- conducted workshops on older workers' issues at the North Carolina Workforce Development Institute's Annual Conference, which will now become a part of each year's program.

Senior Community Service Employment

The division also demonstrated its support of older workers through the effective administration of the *Senior Community Service Employment Program*, assisting 427 enrollees in 33 counties across North Carolina. Funded by the Older Americans Act, this program helps low-income persons age 55 and older obtain employment. They receive their job training through meaningful community service while earning about $5 per hour.

Of the 337 older workers enrolled at the year's end, 42 percent were helping in public schools, hospitals, social services, public works, and in other services to the general community. The other 58 percent were making a substantial contribution in serving other seniors through nutrition programs, senior centers, health and home care, and other jobs.

These workers represent some of our state's most vulnerable. Nearly 80 percent are female, nearly two-thirds live in poverty, and nearly half have less than a high school education and are 70 years of age or older. One noteworthy change, though, in the profile of workers this past year was an increase in the number ages 55 to 64, the group most likely to need and secure unsubsidized employment.



A Profile of North Carolina's Caregiving Grandparents

- about a third (32%) are age 60 and older
- about two-thirds (62%) do not have a high school education
- more than half (55%) are poor or near-poor
- almost half (44%) work for pay while also caring for their grandchildren
- almost a quarter (23%) of those age 60 and older report having an impairment in mobility, self-care, or both

"Grandcare"

In North Carolina, there are about 111,000 grandchildren under age 18 living in households headed by grandparent(s). About a third of these children have no adult parent living in the household. Grandparents often take over care of grandchildren after a severe disruption in the family. Among the most common causes are parent's substance abuse, child abuse or neglect, teen pregnancy, parent's death, divorce, unemployment, or incarceration. Even though the average age of these caregiving grandparents is 54, about a third are age 60 and over. The division has stepped forward to lead in studying and responding to the issues raised by this growing and disturbing trend.

Assisted by a grant from the Brookdale Foundation Group, the division produced a resource guide and also supported creation of local Grandcare support groups. These groups provide caregiving grandparents with information in such areas as social and economic supports, guardianship and custody issues, child care options, health care, respite and counseling services, and helping children with school assignments and related activities. *Eight counties have already established a support group where grandparents can share caregiving experiences.*

Reverse Mortgage Counseling

Reverse mortgages (RMs) enable people age 62 and over to convert the equity in their homes into cash or monthly income for any purpose. Reverse mortgages can make the difference in enabling some homeowners to remain in their homes.

North Carolina law requires that potential borrowers of RMs receive counseling by a third party who is certified by the North Carolina Housing Finance Agency. To expand access to these counselors, the Division of Aging worked closely with the NC Housing Finance Agency to develop and offer the *state's first HUD-approved training for the certification of Reverse Mortgage Counselors.* The division helped recruit new counselors from the aging network. It also continued its education of the public about reverse mortgages through statewide publications, workshops, and a variety of media.

Consumer Bill of Rights for Purchasers of Long-Term Care Insurance

Following up on its 1996 report—*Increasing Personal Responsibility for Long Term Care through Private Long Term Care Insurance*, the Division of Aging worked with the Department of Insurance's SHIIP program to develop a *Consumer Bill of Rights for Buyers of Long Term Care Insurance.* North Carolina appears to be the first state to produce such a tool, which was created with the input and support of consumer and trade representatives. Plans are under way for an extensive publicity campaign to promote this Bill of Rights.

In addition, the division supported efforts to establish a state tax credit for purchasers of long-term care insurance. While no such bill passed this year's session of the General Assembly, sponsors were encouraged by the level of interest. Consistent with another recommendation of the division's report, the General Assembly did approve a long-term care insurance option for active and retired state employees and their dependents, as well as for retired local government employees and their dependents.

A Year of Firsts!

- The state's first HUD-approved training for the certification of reverse mortgage counselors
- One of the nation's first consumer bills of rights for purchasers of long-term care insurance



Health Promotion

The theme of this year's State Aging Conference held during Older Americans' Month was *Live Better Longer! Enriching the Aging Experience*. It is a goal the division supported through a range of activities during the year.

NC Senior Games

Once again the division served as one of the major sponsors of *North Carolina Senior Games*, a year-round health promotion program for people age 55 and older. What began on a small scale in 1983 is now one of the largest programs of its kind in the country.

During the past year, nearly 39,500 persons participated in the 51 local programs that covered the entire state. These local programs offered athletic events, SilverStrider walking, SilverArts, and educational workshops. This was only possible with the help of 2,876 local volunteers.

For the State Finals, 2,350 participants competed in events staffed by more than 800 volunteers. Of the participants, 259 represented North Carolina at the US Senior Olympics.

Senior Vaccination Sunday

The division joined a coalition of 40 organizations and agencies that launched the state's first *statewide senior vaccination campaign* to increase the rate of influenza and pneumonia immunizations among people age 65 and older. On Senior Vaccination Sunday, November 6, 1996, nearly 55,000 seniors were vaccinated. The Division of Health Promotion and Medical Review of North Carolina led the initiative.

Heat Relief

Since 1985, the Division of Aging has directed a public/private partnership that combines the best of volunteerism with corporate donations to aid seniors threatened by the excessive heat of North Carolina's summers. Since 1987, Duke Power, Carolina Power and Light, and North Carolina Power have together given $42,500 each year for *Operation Fan-Heat Relief*. Through the efforts of AAAs and local aging providers, these funds have been used to purchase fans in bulk, reducing the average cost per fan from $15.87 in 1987 to $11.23 in 1996—more fans purchased and more seniors served—with the same amount of funds. In summer 1996, 3,204 senior households received electric fans distributed by volunteers. We expect an even higher number for 1997. An increasing number of communities are adding funds to help protect the health and safety of older persons who are living at home with inadequate relief from the heat.

Local Initiatives

Working with the AAAs, the division administered federal Older Americans Act funding targeted for *health promotion and disease prevention activities.*

These funds have made a big difference in the types of activities available at senior centers and nutrition sites, and they have reached seniors in the community in many other ways. More than 50,000 seniors benefited from one or more of these activities.

These funds were often multiplied because they attracted additional resources in the form of grants and volunteers. They enabled communities to offer activities to meet the diverse needs of older adults, from traditional health education and screening programs to innovative use of pet, art, and music therapies.

A Sampling of Local Programs

- Davie County seniors worked with middle school children to develop an intergenerational community garden, using the crops to feed the needy.
- Union County volunteer pharmacists provided consultations on drug interactions.
- Rockingham County's Council on Aging helped initiate a prescription assistance and drug education program.
- In Burke County, 27 deaf and hard of hearing seniors participated in a Healthy Heart cholesterol program.
- Cabarrus County seniors enjoyed water aerobics and a weight room made available by the Department of Aging.



Seniors as Volunteers and Advocates

The Division of Aging realizes that there is no greater resource for making a significant difference for seniors and their families than seniors themselves. That is why we value volunteerism and the effective work of advocacy groups. Below we highlight some of the volunteer initiatives we have helped lead and some of the groups to which we provide technical assistance and from which we seek advice.

Volunteerism

Senior Education Corps

The Senior Education Corps (SEC) is an intergenerational partnership that had its beginning in Northampton County and is now taking hold in communities across the state through the division's efforts. The program is at various stages of development in 27 counties. Besides Northampton, it is well under way in Buncombe, Dare, Halifax, Jones, Montgomery, Moore, Pamlico, Rutherford, and Scotland Counties.

Founded on the simple and logical idea of using older adults to help meet the needs of our school systems, this volunteer effort is one of the Department of Health and Human Services' special initiatives to address the Governor's agenda for action. With their broad range of experiences and skills, senior volunteers are serving as role models and mentors to enrich children's lives and motivate them to achievement. In Halifax County, volunteers are working in a preschool, two elementaries, one middle school, and two high schools. A Dare County senior volunteer is helping a mentally handicapped student in a job-training experience. Two Northampton volunteers took a sign language course at the local community college and are now working with the hearing impaired in elementary schools. Volunteers in Northampton and Dare are contributing time and talents to their county's alternative school for students who have difficulty functioning in a traditional school setting. Rutherford's "Rocking Grandparents," take Head Start children in their laps to read to them an hour each week.

"If we work together, there's no limit to what we can do."
—Governor Jim Hunt

Connections for Independent Living

This year the division joined with the American Association of Retired Persons in a new and exciting volunteer initiative aimed at the state's 849,000 AARP members. Named *Connections for Independent Living,* this project connects AARP members who are interested in volunteering with local agencies that need help serving older adults at home and in the community.

As of June 1997, 41 local agencies were benefiting from an expanded pool of volunteers. One agency was able to extend its home-delivered meals into an isolated rural area because of its new Connections for Independent Living Volunteers.

AARP hopes to recruit at least 2,000 of its members in North Carolina to assist in such ways as making home repairs and delivering meals to the homebound. After only a few months, there are already success stories. North Carolina's statewide project is viewed by AARP as a model for other states to follow.

Foster Grandparents

The Division also sponsors the Foster Grandparent Program for three of the state's institutions serving people with special needs. Foster Grandparent volunteers are people who are 60 years and older and have low income. They give their time, talents, and energy and, in return, they receive a modest hourly stipend, lunch, and an annual physical exam.

Senior Advocates

Governor's Advisory Council on Aging

The Governor's Advisory Council on Aging is authorized by state legislation to make recommendations to the governor and the secretary of the Department of Health and Human Resources for improving human services to the elderly, including better coordination among state agencies. The council's 33 members also study and recommend how best to promote public understanding of problems affecting older adults, and they consider the need for new state programs to address these problems.

Chairman John T. Denning again led this group through a year of important discussions, resulting in such calls for action as consumer education and protections related to managed care health plans, a task force to study the need for prescription drug assistance, and a tax credit for purchase of long-term care insurance.

Senior Tar Heel Legislature

Since July 1993, when the General Assembly created the North Carolina Senior Tar Heel Legislature, seniors in North Carolina have had a stronger and more effective voice in state government. With a delegate and alternate from each county, the Senior Tar Heel Legislature has provided information to older adults on the legislative process and matters being considered by the General Assembly, promoted citizen involvement and advocacy about aging issues, and set a legislative agenda. They achieved all of their 1996 legislative priorities, including increased funding for home and community-based services and mandatory criminal background checks for nonlicensed job applicants in nursing homes, adult care homes, and home care.

To elevate attention to the changes being discussed about Medicare, the Senior Tar Heel Legislature hosted a special forum for state leaders at its March meeting and invited two of the nation's leading experts on this topic—Dr. Robert Friedland, director of the National Academy on Aging, and Robert Blancato, who had served as director of the 1995 White House Conference on Aging. This year's success came under the leadership of Doris Dick of Yadkin County, who served as Speaker of the Senior Tar Heel Legislature.

Coalition on Aging

As a statewide coalition of 30 organizations committed to improving the quality of life for older adults, the North Carolina Coalition on Aging is an important bridge among interests who, acting alone, would not be nearly as effective on matters that they share in common. It is said that they represent over one million voting citizens.

These organizations include, for example, Friends of Residents in Long Term Care, Hospice for the Carolinas, the NC AARP State Legislative Committee, the NC Association on Aging, the NC Disabled American Veterans, the NC Senior Citizens Association, and the NC Senior Citizens' Federation. Ann B. Johnson, who was instrumental in founding the coalition, continues to serve as its president.



Information and Program Management

When there is so much to do with so little time and resources, we must operate as effectively and efficiently as we can—that is, on the right things and in the right ways. This became especially important during the year as the total number of Division staff was reduced from 34 to 29 with the loss of two program positions and the transfer of three fiscal positions. Here are some of the initiatives we undertook to improve our management of information and programs that are already showing benefits to consumers and service providers.

Streamlining of Information Systems

This year continued a pattern of significant improvements and important savings in time and money within the division's information systems, resulting in improved electronic communications and greater

efficiencies in processing information. Specifically, the division enhanced its management and maintenance of the Aging Resource Management Systems (ARMS), which is our automated client tracking and reimbursement system.

Working with Area Agencies on Aging, the division provided training and technical assistance to enable all of the local service providers in eight regions and some of the providers in three more to begin keying their client registration and encounter information directly on-line to the division's database. This streamlines our capacity to track clients and services, compute and trigger the reimbursement due to community service providers, and produce reports for use in program and fiscal management.

The division hopes to bring the remaining regions on line this coming year. We also expect to see dramatic upgrading of our in-house computer capacity, as well as major progress in the use of technology in local information and referral services.

Aging Web Site

www.state.nc.us/DHR/DOA/home.htm

The Division of Aging pioneered development of a web site for seniors, their families, baby boomers, service providers, policymakers, students, and others seeking a broad array of information about aging in North Carolina. At year's end, Aging was the only division within the Department of Health and Human Resources with a site on the Internet. The US Administration on Aging identified the division's site as one of the eight best among the nation's state aging agencies.

"A great, brand-new web resource on aging policy and consumer information for the state of North Carolina. This rather large, but well-organized site provides a comprehensive review of services for the elderly along with listings of and links to other agencies, resources, advocacy groups and professional associations."

—comment from the Duke University Long Term Care Resources Program (www.geri.duke.edu/ltc/ltc2.html)

North Carolina Elder Housing Locator

Not surprisingly, older adults and their families often report difficulty locating the specific information they need about various types of retirement communities, subsidized elderly apartments, nursing homes and adult care homes, and other public and private housing and long-term care options. Hopefully this task is now easier with the Division's development of the *North Carolina Elder Housing Locator Service.*

Working with the NC Housing Finance Agency, AARP, the Area Agencies on Aging and other state agencies, the division started a comprehensive database of housing for older adults. While there is much more to be done in the development and maintenance of this source of data, it is already proving useful to consumers and human services workers. It is an important feature of the division's web site, allowing people to search for information by county.

Disaster Preparedness

The Division of Aging's statewide disaster planning was truly tested this year, especially by Hurricane Fran, which brought disaster to at least 57 counties. Two days before the hurricane's landfall, the division began bridging the statewide emergency network and the state's Aging Network to safeguard the well-being of older adults.

Division staff worked double shifts for 14 consecutive days in the State Emergency Operations Center to help AAAs and local organizations provide information, advocate for older hurricane victims, assess local needs, and coordinate assistance. The division was especially interested in reaching frail, low-income older persons to help get them safely reestablished in their own homes whenever possible.

The division is now applying what was learned from this disaster in helping AAAs with regional training and planning. As a member of the state's Special Needs Disaster Task Force, we joined in recommending shelters and registries for people with special needs.

Performance Standards

North Carolina's network of AAAs and local service providers made significant strides this year, with help from the division, in redefining standards to guide their performance.

In an effort that received national praise, the division supported the NC Association of Area Agencies on Aging in developing a set of performance standards to help them plan and measure their work in six areas: advocacy, planning, information brokerage, management and staffing, funds administration and quality assurance, and program and resource development. The division encouraged use of these standards by changing the format for Area Aging Plans and by coordinating visits to half of the 18 Area Agencies that volunteered t

have their work reviewed by a visiting team of state staff, other AAAs, a local service provider, and an older adult.

In a related area, the division led an effort with AAAs and the North Carolina Association on Aging (representing local services providers) to develop a more comprehensive review of the performance of local providers, with an emphasis on quality, management, and fiscal responsibility. This work included revising the approach to the review of nutrition services, drafting a consumer-focused tool for quality improvement, and outlining a plan for training of AAAs and local providers in such areas as fiscal monitoring and unit cost development.



Special Initiatives

Each year the Division of Aging tries to identify and begin work on new areas considered important to seniors, their families, and our state overall. Two years ago, this included the work of the Governor's Older Workers Task Force and the preparation of the report on private long-term care insurance. Both of these activities produced meaningful results, as described in the section on Elder Rights, and hopefully their effect will continue. During the past year, we started two more major research and development initiatives that we also expect will make a positive difference.

Baby Boomers at Mid-Life

North Carolina became only the second state, the other being Hawaii, to undertake a critical look at the aging of the Baby Boom generation—people born between 1946 and 1964. Assisted by the Center for Aging Research and Educational Services of the Jordan Institute for Families, at the UNC–CH School of Social Work, the division produced two reports to be released in early fall. The first report—*Baby Boomers at Mid-Life: The Future of Aging in North Carolina*—profiles North Carolina boomers in terms of basic demographics, financial security, and health status. It compares our state's 2 million boomers at mid-life to North Carolina's current older adults and to boomers across the country.

A companion report—*The Future of Aging in North Carolina: Responding to the Challenges and Opportunities Presented by Baby Boomers at Mid-Life*—draws on key points from the first work and presents them in a public-private policy framework to guide individuals, families, businesses, communities, and government in meeting the responsibilities and realizing the promise of an aging society. The aging of North Carolina's baby boomers, more than perhaps anything else, will change the nature of public policies toward older people, just as it now affects the basic nature of our families, communities, workplaces, and the market place. This coming year we will hold special forums focused on issues raised by these reports.

Prescription Drug Work Group Formed

Many low- and moderate-income older adults have difficulty affording the prescription drugs they need. Responding to the concerns of the NC Senior Tar Heel Legislature, the Coalition on Aging, and the Governor's Advisory Council on Aging, the Division of Aging began collecting and analyzing information about this problem during the year.

In July, the Department of Health and Human Services convened a small work group to examine the issues and identify what might be done to make prescription drugs more affordable, especially for low-income older adults who are not eligible for Medicaid. Cochaired by Lynne Perrin, Assistant Secretary for Aging and Special Needs, and Bonnie Cramer, Director of the Division of Aging, the work group settled in August on a set of recommendations for consideration within the Department of Health and Human Services. The issues studied by the work group are reflected in a paper produced by the Division, *A Study of Options for Making Prescription Drugs More Affordable for Older Adults*, due for release in October 1997.

Education and Training

The division led and supported many initiatives during the year to promote the education and training of aging services professionals, senior leaders, and older consumers. The calendar on the next two pages highlights some of them.

Educational Events in SFY 1996–1997: Highlights

July 1996

- Helped kick off the first annual *Summer Symposium on Aging* for colleges and communities. About 120 people attended this 3-day event at Winston-Salem State University.
- Sponsored *financial planning workshops* for seniors in conjunction with community colleges and area agencies on aging.
- Held training *on disaster preparedness* for local providers in several regions.
- Participated in a series of presentations on long-term care issues and the Ombudsman Program.

August

- Held annual training for 60 *Senior Center* directors/managers.
- Offered a workshop, with the NC Housing Finance Agency, for Elderly Housing Service Coordinators on *Preparing for Emergencies in Senior Housing.*
- Cosponsored the 6-day workshop *Improving the Management and Supervision of In-Home Aide Services* in Asheville for 40 people, in conjunction with the state Divisions of Social Services and Health Promotion.
- Held *Annual Nutrition Education and Food Service Management Training for New Nutrition Program Managers*, in Raleigh, attended by 50 people.

September

- Helped the NC Association of Area Agencies on Aging host the *Annual Conference of the Southeastern Association of AAAs* in Charlotte. This included a special two-day workshop on *Managed Care and the Aging Network*, attended by 180 persons.
- Cosponsored the workshop *Geriatric Mental Health* in Asheville for 38 people.
- Assisted Dr. Sarah T. Morrow, Chairperson of the Governor's Older Workers Task Force, with presentation on work of the task force to Governor's Workforce Commission.

October

- Cosponsored with the NC Cooperative Extension, SHIIP, AARP, and Medical Review of NC, a live video conference on *Medicare Managed Care,* telecast to 11 sites across the state.
- Held five one-day regional workshops, with the NC Association on Aging, on a new approach to reviewing the performance of *local nutrition providers*, at locations in Greenville, Wilmington, Fletcher, Winston-Salem, and Raleigh.
- Offered a workshop, with the NC Housing Finance Agency, for *Elderly Housing Service Coordinators* on Communication and Conflict Resolution.
- Offered a *Post–Hurricane Fran* training at 3 locations for eastern counties.
- Sponsored *financial planning* workshops for seniors in conjunction with community colleges and Area Agencies on Aging in Waynesville and Wilmington.
- Assisted the NC Senior Tar Heel Legislature with its meeting in Raleigh.
- Cosponsored the 6-day workshop *Improving the Management and Supervision of In-Home Aide Services* in Fayetteville for 40 people, in conjunction with the state Divisions of Social Services and Health Promotion.

November

- Assisted the NC Housing Finance Agency in presenting the state's first HUD-approved training for the certification of Reverse Mortgage Counselors.
- Partnered with the NC Association of Area Agencies on Aging to present a 2-day orientation to the new *AAA Performance Standards.*
- Cosponsored the workshop *Introduction to Aging* offered in Boone, in conjunction with Appalachian State's Gerontology Institute.
- Conducted workshops on older worker issues at *NC Workforce Institute's* annual conference in Greensboro.
- Presented a training session on Promoting Resident Independence at the *NC Assisted Living Association's Annual Conference.*

December

- Held Quarterly Nutrition Education Training in New Bern for 38 nutrition coordinators and site managers. Topics included conducting annual client satisfaction surveys, effective menu planning for disasters, and how to offer quality services in rural areas.

Education and training events are typically not scheduled this month because of the holiday season.

January 1997

- Cosponsored the workshop *Introduction to Aging* in Wilson.
- Convened *Governor's Older Workers Task Force* to update members and review implementation of recommendations.
- Assisted Dr. Sarah T. Morrow, Chairperson of the Governor's Older Workers Task Force, with *presentation on older worker issues* aired on UNC Public Television.

February

- Assisted the Area Agencies on Aging with a workshop on North Carolina's requirements for *managed care and long-term care insurance.*
- Assisted Dr. Sarah T. Morrow, Chairperson of the Governor's Older Workers Task Force, with presentation on older worker issues to Governor's Economic Development Board.
- Cosponsored the 6-day workshop *Improving the Management and Supervision of In-Home Aide Services* in Winston-Salem for 40 people, in conjunction with the state Divisions of Social Services and Health Promotion.

March

- Helped the NC Senior Tar Heel Legislature host a special forum on the *Future of Medicare,* attended by 140 people. Two national experts on Medicare and aging—Dr. Robert Friedland and Robert Blancato—led the discussion.
- Cosponsored the workshop *Introduction to Aging* offered in Salisbury for 34 people.
- Assisted the Area Agencies on Aging with a workshop on the *aging network's role in a managed care environment.*
- Held an update session for *Seniors' Plus volunteers* in the Raleigh area.
- Held a "Senior Center Dialogue and Training" session at the Rutherford Senior Center for 40 staff members.
- Offered the workshop *Rediscovering Abilities: Arts and Activities for the Aging* for 100 activities professionals in Greenville and Fayetteville.
- Held Quarterly Nutrition Education Training in Lumberton and Asheville for 95 nutrition coordinators and site managers. Topics included conducting annual client satisfaction surveys, marketing nutrition services, and nutrition education.

April

- Cosponsored with the Division of Mental Health, the Greensboro AHEC, and UNC–CH CARES the third annual *Geriatric Mental Health Conference* in Asheboro, under the theme "Building Bridges in Geriatric Mental Health" It was attended by 109 service professionals, and for the first time, participants included Area Agencies on Aging.
- Assisted the *NC Association on Aging* with its annual training conference held at the Cabarrus County Council on Aging.
- Held an update session *for Seniors' Plus volunteers* in the Lewisville and Wilmington areas.
- Cosponsored the *Geriatric Mental Health* workshop in Charlotte for 46 people.
- Held a "Senior Center Dialogue and Training" session in Carteret County for 35 staff members.
- Cosponsored the 6-day workshop *Improving the Management and Supervision of In-Home Aide Services* in Rocky Mount for 40 people, in conjunction with the state Divisions of Social Services and Health Promotion.
- Offered the workshop *Rediscovering Abilities: Arts and Activities for the Aging* for 150 activities professionals in Greensboro, Asheville, and Charlotte.
- Offered a workshop in Asheville with the NC Housing Finance Agency for elderly housing service coordinators on "Get It in Writing."

May

- Partnered with AARP and NC Senior Games to sponsor a three-day statewide conference, "Live Better Longer! Enriching the Aging Experience," attended by 500 people.
- Supported completion of the workshop on *the aging network's role in managed care.*
- Held an update session for *Seniors' Plus volunteers* in the Mooresville and Asheville areas.
- Cosponsored the workshop *Introduction to Aging* in Asheville for 20 people.
- Helped plan and lead a conference on *Releasing Restraints* aimed at nursing facility staff across North Carolina.

June

- Assisted the *NC Senior Tar Heel Legislature* with its meeting in Raleigh.

State Aging Conference

More than 500 people attended the division's State Conference on Aging, held May 20–23 in celebration of Older Americans Month. Using the theme *Live Better Longer! Enriching the Aging Experience*, the division joined with AARP and North Carolina Senior Games to sponsor this year's event. Participants chose from among 60 workshops on such topics as leadership development, financial planning, the future of Social Security and Medicare, managed care, the baby boomers at mid-life, and health promotion.

Featured speakers included Governor Jim Hunt, national AARP President Margaret Dixon, US Representative Bob Etheridge, NC Citizens for Business and Industry President Phil Kirk, and State Senators Beverly Perdue, Betsy Cochrane, and Frank Ballance. At the Division's Annual Awards Luncheon, Senator Cochrane was selected for the Dr. Ewald W. Busse Award for her work to address health concerns of older adults. Inez Myles, Executive Director of the North Carolina Senior Citizens' Federation received the Dr. George L. Maddox Award for her excellence in creative programming for seniors, and Cleveland County and its LIVE! program were given the Ernest B. Messer Award for effectively using volunteers to help older adults continue to live at home. In addition, the North Carolina Association of Area Agencies on Aging awarded Iantha Mitchell of Sampson County its Margaret Hart Hardee Preeminence in Aging Award for her successful grassroots advocacy.

Seniors Recognized at the 1997 State Aging Conference as Outstanding Examples of Volunteerism, Community Leadership, and Compassionate Caregiving

Dorothy and John Crawford, Macon County
Doris Dick, Yadkin County
James Graeber, Cabarrus County
Ruth Watkins, Richmond County

Other Activities Noted Briefly

In addition to these many activities, the division

- assisted with the planning and development of the new Institute on Aging at the University of North Carolina, which is to serve as an interdisciplinary and interinstitutional program of research, education, and public service.
- participated in Appalachian State University's Annual Institute in Applied Gerontology, held under the theme *Making Our Voices Heard: Social Security in the 21st Century*
- supported the important work of the Duke Long Term Care Resources Program in its promotion of teaching communities, new technologies, and living-at-home initiatives designed to enhance the long term care system
- worked with the North Carolina Cooperative Extension Service in offering a 15-hour course for the certification of new nutrition managers in food sanitation and safety practices.

Recent Publications of the Division

These are some of the major reports prepared by and for the Division of Aging during the last 18 months. Limited copies are available in print, and summaries are also accessible via the division's web site on the Internet. We have also identified several reports that are forthcoming.

- *Area Mental Health Programs: Special Services for Older Adults* was prepared for the division by the Center for Aging Research and Educational Services at the University of North Carolina at Chapel Hill. It reports on the geriatric-related work of the state's 41 area mental health programs.
- *Baby Boomers at Mid-Life: The Future of Aging in North Carolina* and *The Future of Aging in North Carolina: Responding to the Challenges and Opportunities Presented by Baby Boomers at Mid-Life* were recently prepared for the division by the Center for Aging Research and Educational Services at the University of North Carolina at Chapel Hill. The division plans to use these reports to shatter myths about the aging of North Carolina's baby boomers and stimulate discussion and planning for the future.
- *Home Is Where I Remember Things: An Alzheimer's Care Training Module for In-Home Aides* was prepared by the division and the Duke Alzheimer's Family Support Program for use by home care agencies.
- *Increasing Personal Responsibility for Long Term Care through Private Long Term Care Insurance* was a special report of the division. Its recommendations have already spurred some legislative and administrative actions. The division worked closely with the Seniors' Health Insurance Information Program (SHIIP) of the State Department of Insurance and the Division of Medical Assistance in preparing this policy paper.
- *The Resource Handbook for Grandparents Raising Grandchildren* was written to assist grandparent-headed families. It gives an overview of legal rights and financial, social, and

health care programs that may help grandparents meet their grandchildren's needs.

- *The Second 50 Years: Enhancing Employment Opportunities for Older Workers* and *Older Workers in North Carolina* are products of the Governor's Older Workers Task Force, which was staffed by the Division of Aging and the Governor's Commission on Workforce Preparedness.
- *A Study of Options for Making Prescription Drugs More Affordable for Older Adults* is due for release in October 1997. It is based on the work of a small group that met during the summer of 1997 to study issues and recommend ways to make prescription drugs more affordable, especially for low-income older adults who are not eligible for Medicaid.
- *Your Right to Know* is a workbook prepared by the National Health Law Program for the division and the Piedmont Triad Council of Governments Area Agency on Aging to help seniors navigate the changes in health services brought about by managed care. It includes the new state consumer protection laws relevant to managed care. It will be available in fall 1997.

Dedication

This Annual Report is dedicated to the memory of two individuals who made a significant contribution to the development of policies and programs for older North Carolinians.

Ernest B. Messer

Ernest B. Messer was a champion for aging in the General Assembly and served as the state's Assistant Secretary for Aging between 1981 and 1985, during which time great strides were made in addressing the needs of our older citizens.

Dr. John R. Kernodle

Dr. John R. Kernodle, a noted physician and aging advocate, served as vice-chairman of the Governor's Advisory Council on Aging for many years. He was instrumental in developing support for home and community-based services for impaired older adults

Acknowledgments

While we cannot acknowledge the contributions of all who have assisted with activities outlined in this annual report, the Division of Aging does want to pay a special thanks to the following organizations and associations and their leaders for the past year.

Governor's Advisory Council on Aging
John T. Denning, Chairperson

North Carolina Association of Area Agencies on Aging
Gina Shell, President

North Carolina Association on Aging
Donna Creech, President

North Carolina Coalition on Aging
Ann Johnson, President

North Carolina Senior Tar Heel Legislature
Doris Dick, Speaker
Bill Little, Speaker Pro Tempore
Shirley Yates, Deputy Speaker Pro Tempore
Seroba Aiken, Secretary

North Carolina AARP
Thelma Lennon, President
Bob Jackson, State Representative

Governor's Older Workers Task Force
Dr. Sarah T. Morrow, Chairperson

Division of Aging

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Resources

WWW Home Page: http://www.state.nc.us/DHR/DOA/home.htm
***Careline*:** (800) 662-7030 (provides information and referral for human services in North Carolina)
***Eldercare Locator*:** (800) 677-1116 (a nationwide directory assistance service)

Staff

Bonnie M. Cramer, Director*
Debbie Brantley, Chief, Elder Rights
Steve Freedman, Chief, Planning and Field Operations
Susan Harmuth, Chief, Home and Community-Based Services
Jim Lampley, Chief, Budget and Information Systems
Mary Bethel, Special Assistant for Consumer Advocacy and Health Promotion
June Barbour, Public Information Officer

*As of October 6, 1997, Ms. Cramer became director of the new Office of Long-Term Care Policy, Department of Health and Human Services. The new director of the Division of Aging is Karen E. Gottovi.

Writing, Design, and Layout

The annual report was prepared by Dennis W. Streets, Planner for the Division of Aging, with the assistance of the division's staff members.

The cover design and artwork are provided courtesy of the Office of Rural Health and Resource Development.

Photographs come from the US Administration on Aging web site, http://www.aoa.dhhs.gov/aoa/magimage/magimage.html and were previously published in *Aging Magazine.* We use them with thanks.

Layout of the report was done by Margaret Morse, CARES, Jordan Institute for Families, School of Social Work, University of North Carolina at Chapel Hill.

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2-19-98
Teresa Johnson

Adult Day Services in North Carolina

Findings from the 1997 NCADSA Survey

Prepared for
The North Carolina Adult Day Services Association
by
Teresa D. Johnson, BS
Creative Consulting for Adult Day Centers

July 1997

The North Carolina Adult Day Services Association promotes excellence in service provision and program development through advocacy, education, support and training.

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Executive Summary

Key findings from the 1997 NCADSA survey of adult day centers operating in North Carolina reflect growth, value and maturity in an evolving industry. In just four years since the last survey, the findings suggest that centers are operating more successful businesses as they focus on their missions, incorporate new technology, establish measurable outcomes, embrace new possibilities and limit behavior that is resistant to change.

Some of the key findings in the survey include the following:

- Seventy percent of the centers certified to provide health services used levels of care, while a surprising 41% of the social model centers also reported using them.
- Fees averaged about $5.00 more per day in centers certified to provide health services than among social centers.
- Average charges cover only 71% of unit costs.
- Centers certified to provide health services fared better than social centers based on computed unit costs and charge-minus-cost deficits.
- Private pay fees were by far the primary source of operating revenue, followed by the State's Home and Community Care Block Grant (HCCBG).

The most intriguing findings in this survey related to subgroup comparisons of social model centers to those certified to provide health services. In order to meet the demands of the growing population of aging and disabled adults in North Carolina, more centers must give serious consideration to the possibilities of converting their certification status to provide health services since only 39% of the centers were certified to provide health services. As you study the findings outlined in the following pages, may you be challenged to explore new ideas that will further improve this vital service which allows persons to remain part of home and community-based services--right where they want to be!

Teresa D. Johnson
Executive Director

The Centers, the Survey Instrument and Other Data Sources

NCADSA distributed surveys to 81 adult day centers operating across North Carolina that were certified for more than six participants as of March 10, 1997. Surveys were not distributed to the two centers which were certified but not operating on March 10, 1997, or the six centers which were certified for six or fewer participants (most of which were certified as adult day care homes). Of the surveys distributed, 39 were returned either fully or partially completed, a response rate of 48%. Sixty-one of the operating centers in the state (75%) were current members of NCADSA; 36 of the member centers (59%) returned surveys, while only 3 non-member centers (15%) returned them. The data are representative of survey respondents only.

The 1993 NCADCA study can be used as a comparative data source somewhat. Some data limitations exist between the two studies. The 1997 survey expounded on some of the questions asked in the 1993 survey and established more specific parameters for many of its questions.

The eight-page questionnaire asked about four principal aspects of the centers:

1) information about the facility
2) characteristics about the clientele
3) description of services offered
4) funding.

A copy of the questionnaire is provided in the Appendix.

In addition to performing some subgroup analyses by certification type and area served, comparisons to the 1993 NCADCA survey and other relevant data are also discussed. Findings from the most recent national survey offer some comparability even though they were published in 1990 [K.J. Conrad, P. Hanrahan and S.L. Hughes. 'Survey of Adult Day Care in the United States, *Research on Aging* 12(1), March, pp. 35-56]. The National Adult Day Services Association is currently conducting a national study with findings anticipated in fall 1997.

RESULTS

Characteristics of the Facilities: Area Served

There has been a 20% increase in the number of certified adult day centers and adult day care homes since the August 1993 survey. Among the centers that responded to the 1997 (current) survey, 11 of 39 (28%) served small towns, 13 of 39 (33%) described the area served by their centers as the central city of a metropolitan area, 9 of 39 (23%) served suburbs or smaller cities within metropolitan areas, 6 of 39 (16%) served cities not in metropolitan areas. Four of 39 (10%) serving small towns also described the areas served as rural. A guide defining metropolitan areas in North Carolina by size was provided as follows:

Charlotte/Gastonia/Rock Hill
Greensboro/Winston-Salem/High Point
Raleigh/Durham
Fayetteville
Hickory/Morganton
Asheville
Jacksonville
Wilmington
Burlington.

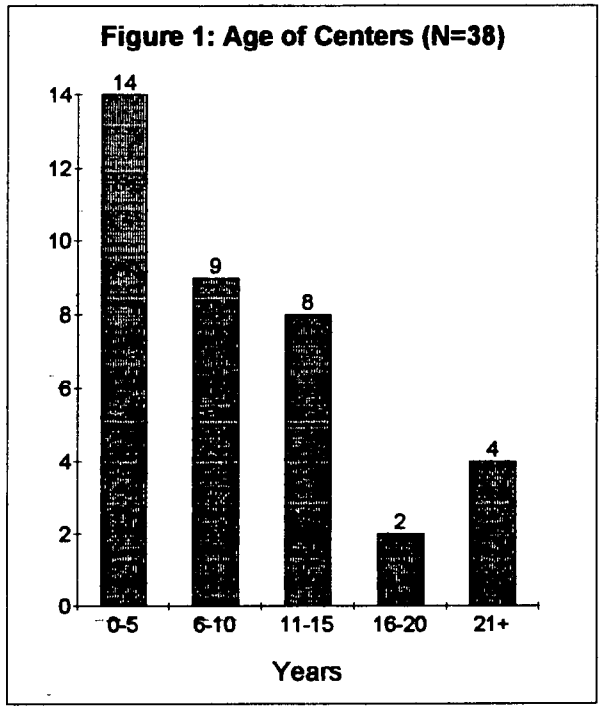
Certification Type. The North Carolina Standards for Certification allow for the provision of adult day services by certifying centers as 'social', 'health' or 'combination'. The primary differences between the types of centers are among the regulations governing staff to participant ratios, minimum square footage, facility setup and staff patterns for centers certified to provide health services. The survey asked respondents to identify whether their center was certified as social, health or

combination (social/health). Only one (2%) of the 39 responding centers was classified as 'health'. Two centers were certified as 'health' centers at the time of the survey. Eighteen respondents (46%) identified their centers as 'social', only 38% of the State's certified 'social' centers. Twenty respondents (51%) identified their centers as 'combination', some 55% of the State's certified 'combination' centers. Only 39% of the adult day programs (homes and centers) in North Carolina are certified to provide health services either as 'health' or 'combination' centers. The margin of percentage difference between responding centers certified as social and combination narrowed to 5% from the 10% margin in the 1993 survey.

Findings from this survey indicated that small towns were twice as likely to have combination centers as social centers. Little differences existed in comparisons of other areas served. Twenty-two counties were represented by the responding centers, 45% of the counties with certified operating centers.

Length and Scope of Operation. Responding centers were open nine years on average. Three centers responding were less than a year old when the survey was conducted, and the oldest was 24 years old (See Figure 1).

The average number of sites operated by an adult day program was one. The highest number of sites operated by a program among respondents was four. When asked about affiliation, the highest number of respondents, 18 of 39 (46%), categorized themselves as having no affiliation or parent organization--they were operationally free-standing. Among the other 21, 9 were affiliated with councils on aging (23%), most of which are private, non-profit businesses; 3 were affiliated with long-term care facilities (8%); 2 were affiliated with hospitals (5%); 2 were affiliated with churches (5%); 2 were affiliated

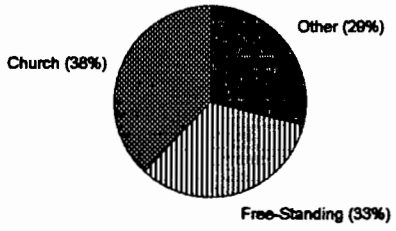


with home health agencies (5%); 1 was affiliated with a private business (3%); other affiliations (5%) included 1 health department and 1 newly formed consortium of health care providers. Social model centers were about 15% more likely to be unaffiliated than combination centers.

Thirty-six of the 39 (92%) respondents classified their centers' tax status as not for profit. Two respondents (5%), both located in central cities of metropolitan areas, operated for profit and one (3%) was publicly operated by county government.

Location and Size of Facilities. Respondents were asked to identify the location of their facilities. Responses are summarized in Figure 2. Little changed whereas 26 of 39 (67%) reported using the property of another organization, compared to 26 of 38 centers (68.4%) in 1993. Fifteen responding centers were located on church property (38%), while 3 were at senior centers (8%) and 4 were at long term care facilities (10%); other settings (11%) included a strip mall, human services center,

Figure 2: Location (N=39)



hospital and hospice. Fifteen centers were physically free-standing (33%). Social model centers were almost three times more likely to operate in churches than were combination centers. Sixty-seven percent of the respondents located in cities not in metropolitan areas operated in free-standing facilities, unlike centers in other locations where churches often served as the primary locations.

Respondents were asked to provide data regarding capacity, enrollment and average daily attendance. The term 'capacity' refers to the number of participants a center is certified to have in attendance at any given time. Enrollment is a term for the number of participants who have registered to attend the center for some amount of time (e.g. daily, once a week). Average daily attendance is simply the number of participants actually present at the center on a typical day as reported by the respondents. Capacities of responding centers ranged from 10 to 60 participants with a mean of 30 (N=39). The average enrollment as of January 1, 1997, was 28, and the mean daily attendance was 17. These data differ only slightly from the 1993 survey when the mean capacity was 26.9, average enrollment as of August 1993 was 25.3 and the mean daily attendance was 15.3. Table 1 shows some comparisons of attendance and related data according to areas served.

Table 1: Some Comparisons According to Areas Served

	Overall	Central City of Metro	City Not in Metro	Small Town	Suburb in Metro
Capacity	30	29	30	30	28
Enrollment	28	28	29	30	28
Avg Attendance	17	19	16	15	18
Utilization Capacity	66%	59%	70%	49%	66%

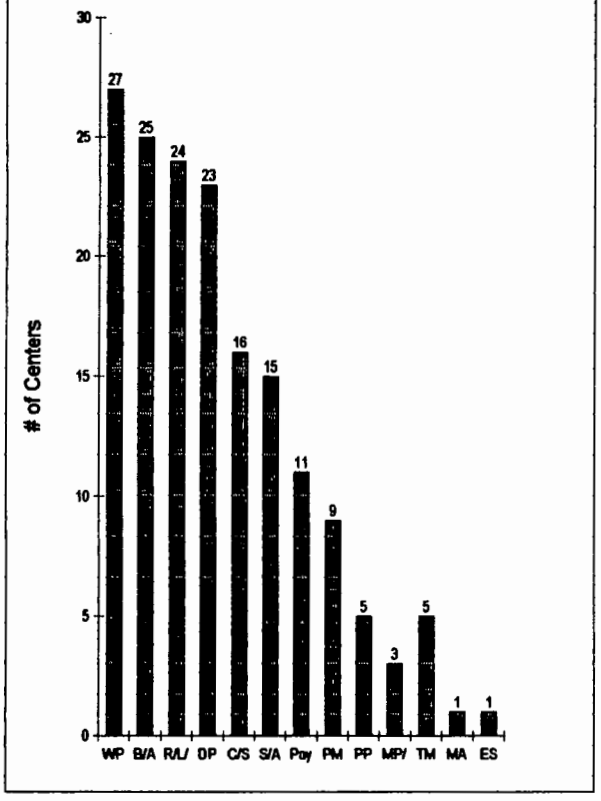
The average overall capacity utilization was computed by multiplying each center's capacity by the number of days open for the year and dividing by the actual units of service provided for the year. The highest capacity maintained by a center for their last fiscal year was 86%, while the average overall was 66%. Centers obviously need to operate at the highest capacity possible to decrease their unit costs, preferably at least 80% capacity.

Centers were asked if they had a current waiting list. Among 39 centers responding, 13 had waiting lists (33%), a considerable increase over the 8 percent reporting waiting lists in the 1993 survey. This could be a result of increased community awareness and funding. Since none of the centers were operating at full capacity, it is concluded that other factors must determine the need for a waiting list, e.g. financial assistance. Although one center reported as many as 25 potential participants on its waiting list, the average number was 2.5.

Use of Computers in Centers. Respondents were also asked to describe the use of computers within their centers. Figure 3 displays computer use for the 30 respondents

with computers. Seven centers (18%) reported not having computers, most of them being social model centers. Word processing was the most common use with 69% of centers using them for this purpose.

Figure 3: Use of Computers
N=32



LEGEND for Figure 3: Uses of Computers

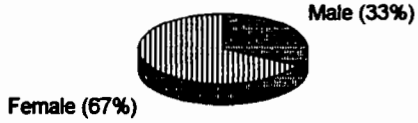
WP	Word Processing	PM	Personnel Management
B/A	Billing/Accounting	PP	Participant Programming
R/L	Reports/Labels/Graphs	MP	Meal Planning/USDA
DP	Desktop Publishing	TM	Transportation Management
C/S	Client/Staff Records	MA	Medication Administration
S/A	Scheduling/Attendance	ES	Electronic Sign-In/Out
Pay	Payroll		

Several multi-site programs noted the use of computers for administrative tasks were performed primarily at administrative offices located off-site from the centers. Additional uses which could be included in future research are web sites/Internet access, e-mail and news groups.

Characteristics of the Clientele: The Participants

Figure 4 represents the gender composition of participants at responding centers (N=37). Similar to the previous findings, women represent a substantial majority of people enrolled in adult day centers (67%) as compared to 70% in the 1993 survey and 68% in Conrad et al's 1990 study. The center with the least number of women enrolled was one, which was the only person enrolled at the center for the time specified in the survey. The next lowest number of women enrolled in a responding center was five, which comprised 83% of the center's enrollment. The lowest number of men enrolled in a center was one and the highest 45, although the high reflects a program with two sites. Subgroup comparisons among areas served reflected the highest percentage of men in centers in small towns (44%). In other comparisons, the ratio of women to men was higher in social centers than in centers certified to provide health services.

Figure 4: Gender of Clients
N=37



Respondents were asked to indicate the following data in relation to the ages of enrolled participants:

- Age of youngest participant
- Age of oldest participant
- Average age of participants
- Median age of participants

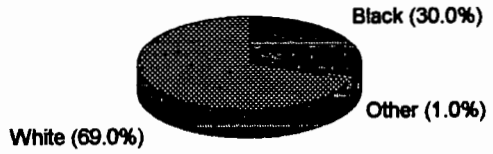
The ages of the youngest participants ranged from 19 to 77 (37 of 39), with the mean being 49. The ages of the oldest participants ranged

from 55 to 103 (38 of 39), with the mean being 93. The average ages of enrolled participants ranged from 35 to 86 (36 of 39), with the mean age being 76. The median ages of enrolled participants ranged from 40 to 84 (31 of 39), with the mean being 77. In the most recent national survey (1990), Conrad et al found the average age of clients in adult day centers to be 72. Centers certified to provide health services served the most diversified ages, including the oldest and youngest participants overall.

Figure 5 shows the distribution of enrolled clients by racial/ethnic origin for 38 responding centers. The distribution is more evenly balanced than the racial/ethnic composition of North Carolina's general population: 76% white, 22% black and 2% other (1990 U.S. Census). The average number of black clients enrolled among the responding centers was 33%, while the median was 30%. Two centers reported 100% of clients enrolled as white; one of those centers had only one client enrolled. Otherwise, the smallest percentage of black clients served was 8% (as compared to 3.7% in the 1993 survey), which was duplicated in two centers. The average number of white participants served in reporting centers was 63%, while the median was 69%. Two centers reported 100% clients enrolled as black. Otherwise, the smallest percentage of white clients enrolled was 17%. Centers certified to provide health services reported larger percentages of black clients served than did social centers.

Unlike the 1993 survey where no Asian clients were reported, four Asian clients were enrolled in four different responding centers in this survey. Two Hispanic clients were enrolled in different responding centers. Two other participants enrolled in different centers were American Indian and Pakistani.

Figure 5: Racial/Ethnic Background
of Enrolled Participants (N=38)



Centers located in central cities or suburbs of metropolitan areas had a higher average percentage of enrolled black clients (33% and 31% respectively) than do centers located in cities not in a metropolitan area (27%) and small towns (17%).

The Caregivers. Adult day centers serve two customers--the clients and their caregivers. Respondents were asked to provide data on the gender and employment status of primary caregivers for the participants enrolled in the center as of January 1, 1997. It was not surprising that 75% of the primary caregivers were female (N=31). A 1996 national survey of caregivers in the United States that was sponsored by the National Alliance for Caregiving, the AARP and Glaxo-Wellcome revealed a similar finding nationwide--72% of caregivers are women. According to our findings, female caregivers were more likely to enroll loved ones at centers certified to provide health services while male caregivers were more likely to enroll loved ones in social centers. Further research related to this finding could lend valuable marketing insight for centers. Four centers reported 100% of their participants' primary caregivers as employed (N=27). The lowest percentage of employed caregivers for enrolled participants was 41%, with the average being 67%. This finding is also consistent with findings from the 1996

National Alliance survey--that 2 out of every 3 caregivers are employed (67%). An overwhelming 91% of caregivers in responding centers located in cities not in metropolitan areas were employed, compared to small towns (68%), central cities of metropolitan areas (67%) and suburbs of metropolitan areas (59%). Caregivers who were employed were almost 10% more likely to enroll loved ones at health centers than social centers.

Diagnoses and Living Arrangements of Participants. Adult day centers serve participants with a variety of physical and mental disorders. Respondents were asked to characterize their clientele according to their diagnoses. (See Table 2.)

Table 2: Percentage of Clients According to Diagnoses N=36

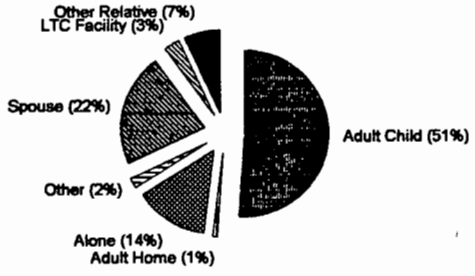
Diagnosis	% Overall	% Social Ctrs	% Combination/ Health Ctrs
Alzheimer's/ Dementia	46%	54%	41%
Hypertension	24%	27%	21%
Stroke/CVA	16%	17%	16%
Arthritis	16%	21%	12%
Diabetes	14%	14%	15%
Cardiac Disorders	12%	17%	10%
Deaf/ Hearing Impaired	9%	10%	8%
Mental Health	9%	11%	7%
Blindness/ Visually Impaired	5%	5%	6%
CHF	4%	4%	4%
Seizure Disorder	40%	3%	4%
Parkinson's	3%	3%	4%
MR/DD	3%	3%	3%
Cancer	3%	3%	3%
HIV/AIDS	2%	0%	3%
COPD	2%	1%	2%
Renal Failure	2%	2%	3%
Head Injury	2%	2%	2%
Nutritional Disorder	1%	<1%	2%
Other	6%	10%	4%

The sums do not equal 100% because some participants had multiple diagnoses. Alzheimer's or related dementia was by far the most frequent diagnosis, with almost 15% more participants with that diagnosis being served in social model centers as opposed to health centers.

Figure 6 shows the distribution of living arrangements for participants enrolled in responding centers on January 1, 1997. Enrolled participants were more likely to live with their adult children than any other arrangement (51%) (N=36). Only 8% more clients lived with spouses (22%) than lived alone. The 14% who lived alone pose serious concerns for potential neglect, given the diagnoses previously outlined and the acuity of care they require as discussed later in the report. However, these findings do reflect that the number living alone is 6% lower than the national average reported by Conrad et al in 1990. 'Other' living arrangements included caregivers other than relatives, usually paid. Persons living with adult children were more likely to enroll at centers certified to provide health services than social centers, while persons living alone were more likely to attend social model centers.

Twice as many participants attending centers in small towns or cities not located in metropolitan areas lived alone as centers in metropolitan areas. Thus, it was not surprising that in those same small towns, only 39% of the participants lived with adult children, while other locations differed little from overall trends.

Figure 6: Living Arrangements
(N=34)



Services Used by Participants Other Than Adult Day Centers. Adult day services complement other community-based services. Respondents were asked to indicate the community support systems used by participants outside of adult day centers. The results are outlined in Table 3. Fewer respondents (27 of 39) answered this question (69%) than any other question regarding clientele. Several respondents noted that the information was available in individual care plans in client charts, and therefore, not easily accessible. This could indicate the need for better tracking systems (and care coordination) regarding the use of outside community support systems.

Table 3: Outside Community Support Systems (N=27)

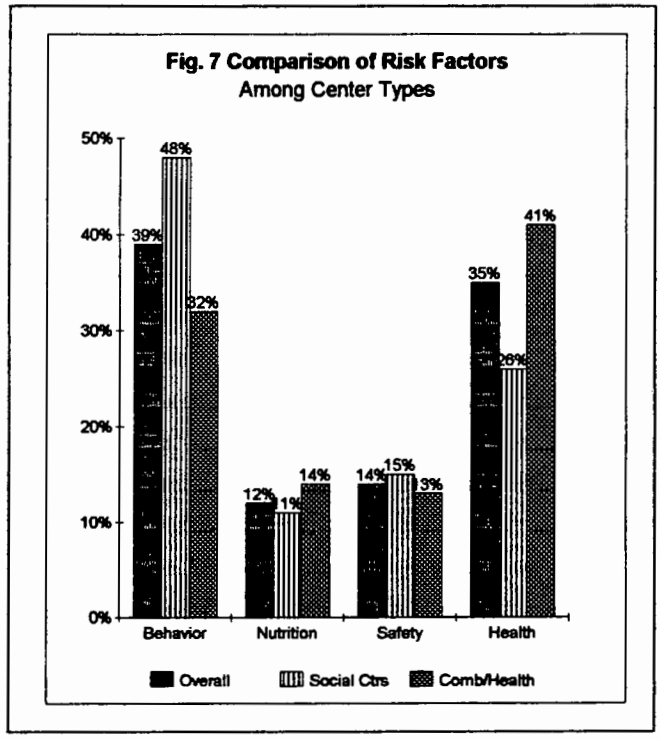
In-Home Services	
Registered Nurse	4%
Therapies	2%
Home Care Aides	8%
Homemaker/Choreworker	3%
Lifeline	3%
Home-Delivered Meals	<1%
Community-Based	
Mental Health Clinic	6%
Other	
Case Management	11%
Senior Center	5%
Congregate Meal Site	1%
Other	3%

Risk Factors. In the centers, staff do not treat the participants' diseases. Rather, they address the diseases and assist the participants with their functional disabilities caused by diseases. To that end, respondents were asked to characterize participants enrolled as of January 1, 1997, according to risk factors or applicable characteristics. Table 4 outlines the results. Risk factors were classified in relation to behavior, nutrition, safety and health. The findings indicate participants in the 34 responding centers were most at risk concerning behavior (39%) and health (35%). Participants were less than half as likely to be at risk for safety (14%) or nutritional concerns (12%). These findings seem critical in shaping the future of adult day services. Only 39% of the adult day programs (homes and centers) in North Carolina are certified to provide health services.

In order for centers to attract managed care payors in the near future, remain competitive and meet the growing needs of participants and their families, adult day centers will have to serve a participant population with a higher acuity level. It was not surprising that the largest percentage of risk factors indicated

among social centers related to behavior, while persons with health problems were twice as likely to enroll at health centers. Although safety concerns were equal at all responding centers, nutritional needs were more prominent at health centers. (See Figure 7.)

Some subgroup analysis according to the locations of centers may provide insight for centers evaluating services. Risks for participants attending centers located in the central cities of metropolitan areas were higher for health factors (37%), followed by behavior (32%), safety (18%) and nutrition (13%). Cities not located in metropolitan areas served participants with considerably higher behavior risks (43%) than the overall average, while health risks (32%) were slightly lower than average. Safety risks (14%) were consistent with the overall average and nutritional risks (10%) slightly below. The findings regarding participants in centers of small towns were similar to non-metropolitan cities (behavior 40% and health 32%), except nutritional risks were higher (13%) than safety risks (12%). Suburbs in metropolitan areas were reflected patterns like small towns but with higher behavioral risks (44%) and lower health risks (33%). Twelve percent of those participants had nutritional risks while 11% indicated safety risks.



Basic Services

On the average, centers are open 10 hours per day (N=39), four hours longer per day than required by the North Carolina Adult Day Care and Day Health Services Standards for Certification (above the national average of 7.8 hours, reported by Conrad, Hanrahan and Hughes). The lowest number of daily operating hours reported was eight and the highest was 12.5. Although one center opened as early as 5:30 a.m., centers opened at 7:30 a.m. on average. No centers reported opening later than 8:00 a.m. A 5:30 p.m. closing time was average; one center closed as late as 7:00 p.m. One center closing at 3:30 p.m. was the exception. Participants respond to the generous hours by spending an average of 7.2 hours per day at centers (N=39), the least reported being six hours and the highest being nine hours.

Table 4: Risk Factors of Enrolled Participants
N=34

BEHAVIOR	%	HEALTH	%
Decreased social interaction	44%	Blood pressure monitoring	49%
Confusion	34%	Assist with basic ADLs	32%
Isolation	32%	Medication administration	23%
Inactivity	26%	Potential for TIAs	17%
Depression	22%	Incontinence	15%
Low self-esteem	21%	Pain and discomfort	13%
Irritability	18%	Vision Impairment	11%
Inappropriate social, emotional or sexual behavior	13%	Poor hygiene	9%
Repetitive behavior	12%	Hypo-/hyperglycemic reaction	9%
Obsessive compulsive	4%	Speech Impairment	8%
Unrealistic demands	4%	Medication interaction/reaction	7%
Catastrophic reactions	3%	Impaction	6%
NUTRITION		Glucometer testing	4%
Dietary As restrictions/Prescribed Diet (e.g. no salt, no added sugar)	28%	Medication restriction	3%
Over-/Underweight	17%	Insulin administration	2%
Assist with eating	10%	Hearing Impairment	1%
Special food preparation (e.g. puree, chop)	9%	UTI	1%
Choking precautions	7%	Other injections	1%
Liquid intake	4%	Oxygen administration	1%
Dehydration	2%	Decubitus care	1%
SAFETY		Tracheotomy care	<1%
Risk of falling	28%	Sterile and non-sterile dressing	<1%
Impaired mobility	22%	Gastrostomy feeding	<1%
Wandering	15%	Change of foley catheters, supra pubic tubes	<1%
Fatigue	7%	Oral hygiene	<1%
Unsafe towards self	5%	Asthma	<1%
Loss of consciousness (diabetic coma)	4%	Shortness of breath	<1%
Dizziness	4%	Dialysis	<1%
Unsafe towards others	2%	Fainting spells	<1%

Centers located in cities not in metropolitan areas were open 9.5 hours on average, while centers in suburbs of metropolitan areas were open 10.5 hours per day. Other centers were consistent with overall trends. One factor that could influence extra time in suburbs of metropolitan areas may be lengthier commute times for working caregivers than those in central cities or small towns.

While centers generally exceeded the minimum number of daily operating hours, most continued to operate only Monday through Friday. Only 4 of 33 (11%) of the respondents offered Saturday service and one opened on Sunday. Rates for some of the Saturday operations are discussed later among all the rates for services centers provide.

Levels of Care. Levels of care refer to an objective assessment and scoring system created to measure functioning levels of persons requesting care through the services adult day centers provide. Measurements may include a person's physical, medical, cognitive, social or other abilities. While levels of care are not addressed per se in the North Carolina Standards for Certification, three levels of care correspond with ranges of care and service outlined in national standards developed by the National Adult Day Services Association (NADSA) and unveiled in spring 1997. To that end, respondents were asked if their centers used levels of care; if so, they were to indicate the number of levels used. An overwhelming 57% of the respondents (21 of 37) used levels of care. Two other respondents noted plans to implement them in the near future. Seventy percent of the centers certified to provide health services used levels of care, while a surprising 41% of the social model centers also reported using them.

Location of centers seemed to influence the use of levels of care in centers. Centers located in metropolitan cities (75%) and suburbs (78%) were more likely to use levels of care than centers in small towns (40%) and cities not in metropolitan areas (17%). Most centers choosing to implement levels of care report a noticeable increase in revenue. Participants in

higher levels of care are charged increased rates. Caregivers tend to be more satisfied with the cost of service when levels of care are implemented because persons who use day services primarily for socialization do not feel that their dollars are subsidizing the care of participants requiring more extensive staff time and skilled care. Findings from this survey indicate alignment of centers in North Carolina with the national trend toward three levels of care. Although two centers incorporated two levels of care in their centers, the highest number of levels reported was five.

Referrals and Discharges. Tracking referral sources of customers provides valuable marketing information for businesses. Respondents were asked to indicate the number of referrals to their centers during the last fiscal year. (See Table 5.) Answers to this question are not presented with strong confidence since some centers may have reported data based on a given month rather than their last fiscal year, even though the question requested data based on the past fiscal year. The primary referral source reported in this survey, 'word of mouth', differed from the 1993 survey where clients' families topped the list. In the current survey, physicians and client's families followed. Surprisingly enough, the referrals from physicians among the respondents were twice as likely to occur at social centers as centers certified to provide health services. Since some people often learn about the center from several different sources, they may just use 'word of mouth' as a 'catch-all' phrase. It seems centers would benefit from more thorough investigation of the 'word of mouth' referrals since the term is often used when people are not pressed for a more specific answer.

One center noted that not all referrals result in enrollments, a very important point. A good topic for future research might address inquiry and referral conversion rates among adult day centers. A disturbing 18% of the respondents (7 of 36) do not track referral sources systematically. That could partially explain why the average overall attendance rate is only 61% of capacity, with the median being 66%. (See Table 1). If centers are not aware of from whence their current customers come, it is likely they will not know where to find more. The highest capacity maintained by a center for its last fiscal year was 86% and the center tracked its referral sources.

Table 5: How Clients Learn about Centers N=27

Word of Mouth	16%	Long Term Care facilities	4%
Participants/Clients' Families	10%	Signs	3%
Physicians	9%	Senior Centers	2%
Home Health Agencies	6%	Staff	2%
Phone book/ Yellow pages	7%	Brochures	2%
Alzheimer's Association	6%	Churches/clergy	2%
Hospital Discharge Planners	6%	Parent organization	1%
Departments of Social Services (DSS)	6%	Mental Health	1%
Case Managers	5%	United Way	<1%
News Media	4%	Other	7%

Centers certified to provide health services reported twice as many referrals from DSS and phone books/yellow pages than did social model centers. One center noted that eight referrals learned about the center through fundraising events.

Statistics on discharges from services can provide valuable information about a center's competition and the health or levels of care of its participants. Respondents were asked to indicate the unduplicated number of participants discharged from the center during their last fiscal year. (See Table 6.) It is not surprising that the largest percentages of discharged participants among the 35 responding centers were placed in nursing homes (41%) as compared to 49% in the 1993 findings.

Seventeen percent of the discharges in the current survey chose home care upon leaving adult day centers as compared to only 11% in 1993. More persons are obviously choosing community-based services over long term care facilities upon leaving adult day centers. Increased funding for home and community-based services has made that possible. The current statistics for terminations to nursing homes and home care may be low, given the fact that additional participants discharged were listed as requiring a different level of care under 'other'. There was an increase in the percentage choosing home care and a decrease in the percentage who died over the findings reported in the 1993 study where only 11.3% chose home care and 13.5% died. Four centers of the 33 responding to the question (10%) did not track discharge statistics.

Table 6: Why Clients Leave Centers N=29	
Moved to Long Term Care Facilities	41%
Chose Home Care	17%
Died	11%
Required different level of care	10%
Moved	8%
Clients Improved	5%
Clients Didn't Like	4%
Transferred to another center	2%
Inadequate financial resources	1%
Distance/transportation	1%

Many factors determine the services centers offer--standards for certification, organization's mission, facility, staff, needs and wants of customers. Most ancillary services are not designed to provide large profits to centers; rather, they are intended to meet the needs and wants of customers, adding value to other services adult day centers provide. Respondents were asked to provide information about services provided at or by the adult day center. In addition to adult day services, categories addressed transportation, personal care, medical services, professional services and care coordination. (Results are outlined later in Table 8.) Findings from the survey overall indicate that centers certified to provide health services were more likely than social model centers to provide ancillary services.

Costs for Services. Respondents were not specifically asked to provide unit cost data, but such data could be computed when respondents thoroughly answered the questionnaire. The average cost to provide adult day services per client per day (expenses for the fiscal year/service units for the fiscal year) was $40.69 ($N$=26), compared to $31.13 per day found in the 1993 survey. (The unit cost reported in the 1993 survey was not presented with much confidence since guidelines were not given for respondents to follow in computing their costs.) The lowest unit cost computed was $28.23 per day and the highest was $61.94 per day. Pricing according to levels of care is certainly reflected in response to this survey. Fifty-one percent of the respondents (18 of 35) listed ranges of charges for adult day services. Among those centers, charges ranged from $13-$58 per day. Fees averaged about $5.00 more per day in centers certified to provide health services than among social centers. Among respondents overall, the average charge per client per day rose from $25.10 in the 1993 survey to $28.77 per day, with the median being $30 per day. While the average charge in the 1993 survey covered only 80% of unit costs, which could not be analyzed with confidence, an even more disturbing finding in the current study is that average charges cover only 71% of unit costs. When the daily rates charged for services were subtracted from the daily unit costs, the average deficit was $12.00 per day. The highest deficit was $27.74 per day and the lowest was $2.32. It is realistic that some centers broke even and even profited if unit costs were computed without the

inclusion of in-kind expenses. Centers obviously need to operate at the highest capacity possible to decrease their unit costs, preferably at least 80% capacity. Coupled with the fact that some public reimbursements for low and moderate income participants do not even match average charges, it is clear why funding is a significant concern for many centers across the state.

In some subgroup analyses, centers certified to provide health services fared better than social centers based on computed unit costs and charge-minus-cost deficits. The median unit cost among responding social centers was $41.28 with a $15.76 per unit deficit, compared to $37.80 with a $5.41 per unit deficit among centers certified to provide health services. The primary factors that seemed to directly influence the differences were the lower charges among social centers and lower capacities being maintained, social centers being at 57% capacity and centers certified to provide health services being at 70%.

Table 7: Costs & Fees According to Location

	Overall	Central City in Metro	City Not in Metro	Small Town	Suburb in Metro
Avg Unit Cost	$40.26	$38.22	$40.85		$46.88
Median Unit Cost	$40.32	$39.24	$37.15		$43.13
Avg Daily Fee	$29.67	$25.17	$27.08		$31.79
Median Daily Fee	$30	$29.50	$25.50		$33
Median Trans. Fee	2.58 per trip	$1.50 per trip	$1.00 per trip		$3.00 per trip
Median Cost-Charge Deficit	$10.35 per day	$10.79 per day	$15.40 per day		$10.70 per day

The median rates and ranges of rates for services outlined in Tables 7 and 8 are only representative of respondents that specified their charges. The totals of those respondents appear under the heading 'Extra Charge Noted (#)'.

Over half of the respondents offered half-day rates to customers for adult day services, often basing the service on about four hours per day without lunch. The median charge for half-day attendance was slightly more than half the median rate for a full day of service. About one-third of the responding centers offered hourly rates to customers. Centers certified to provide health services were more likely than social centers to offer half-day and hourly rates. Only four responding centers offered weekend respite, often at a slightly higher rate than weekday attendance.

Transportation. The Standards for Certification state that centers shall provide transportation in keeping with the needs of participants. Since only 82% of the respondents (N=39) indicated transportation services, it is assumed that centers not directly offering transportation have arranged an alternative method so that transportation is provided to clients through other available resources. Most of the respondents not providing transportation were social model centers. Of the centers providing transportation, 50% (16 of 32) contracted with others for services and 22% (7 of 32) of the respondents indicated providing their own transportation and the other nine did not indicate if services were provided by center staff or contracted with others. Less than 25% of the centers overall provided medical escort or shopping escort services. Few respondents indicated rates for the services--one center stated that shopping was routine programming for the group once per week.

Personal Care. Most centers provided assistance to participants with toileting and manicures and incorporated the fees for the services into the daily charge. Centers using levels of care for pricing usually charge a higher daily rate for participants requiring personal care and medical supervision. As

Table 8: SERVICES PROVIDED AT OR BY ADULT DAY CENTERS

Service	Centers Offering		% Contracted	Extra Charge Noted (#)	Median Rate	Range of Rates
	Percent	Number				
Adult day services (full day)	100%	39	n/a	n/a	$30 per day	$13 - $58
Adult day services (half day)	54%	20	n/a	n/a	$16 per day	$9 - $30
Adult day services (hourly)	32%	12	n/a	n/a	$6 per hour	$2 - $8
Extended Hours	27%	10	n/a	6	$5 per hour	$5 - $6
Weekend Respite (Sat. Service)	11%	4	n/a	2	$32.50 per day	$30 - $35
Transportation						
To/From Center	82%	32	53%	17	$2.50 per trip	$0 - $5 per trip
				2	$.27 per mile	$.24 - $.29 per mile
Medical Escort	22%	8	n/a	3	$2.50 per trip	$2 - $3 per trip
Shopping Escort	24%	9	n/a	3	$2.50 per trip	$2 - $3 per trip
Personal Care						
Bath/Shower	24%	9	13%	5	$12	$7 - $15
Manicure	74%	28	n/a	n/a	n/a	n/a
Pedicure	21%	8	33%	n/a	n/a	n/a
Haircare	37%	14	23%	4	$11	$6 - $12
Toileting	79%	30	n/a	n/a	n/a	n/a
Medical Services						
Monitoring Vital Signs	84%	32	n/a	n/a	n/a	n/a
Dental Care	24%	9	44%	n/a	n/a	n/a
Vision Care	16%	6	67%	n/a	n/a	n/a
Podiatry	16%	6	100%	n/a	n/a	n/a
Audiology	11%	4	100%	n/a	n/a	n/a
Professional Services						
Physical Therapy	49%	18	83%	1	$50	$10 - $90
Speech Therapy	35%	13	92%	1	$50	$10 - $90
Occupational Therapy	38%	14	86%	1	$50	$10 - $90
Music Therapy	78%	29	21%	n/a	n/a	n/a
Art Therapy	62%	23	35%	1	$5	$5
Social Work	68%	25	0.28	n/a	n/a	n/a
Care Coordination						
Participant Support Groups	51%	19	n/a	n/a	n/a	n/a
Counseling	65%	24	29%	n/a	n/a	n/a
Caregiver Support Groups	65%	24	17%	n/a	n/a	n/a
Care Management	51%	19	47%	n/a	n/a	n/a
Home Visits	62%	23	n/a	n/a	n/a	n/a

expected, more intense personal care services such as haircare, baths/showers and pedicures were offered less frequently and for an extra charge. Three centers noted that baths could be given but were not considered routine.

Medical Services. Since the services listed in the survey were not defined beyond their titles, interpretations of some of the medical and professional services seemed varied. Results for some of the questions cannot be presented or analyzed with any great confidence. The Standards for Certification require health care monitoring of each participant's general health and medical regimen in centers certified to provide health services. This includes documenting the periodic assessment of the vital signs, weight, dental health, general nutrition and hygiene of each participant. Monitoring vital signs was the most common service offered in all centers and was performed by center staff. Since most of the respondents indicating the provision of dental care, vision care, podiatry and audiology contracted the services, it is assumed that actual hands-on care at adult day centers is probably limited, e.g. screenings, since most centers are not equipped for more intensive medical care. One center noted that podiatry service was no longer provided by the contracted agency because Medicare did not reimburse for the service.

Professional services. Centers certified to provide health services are required by the Standards for Certification to facilitate specialized services (e.g. speech therapy, physical therapy, counseling) as required by a physician and as available through community resources. Music therapy was the most frequent professional service offered among the respondents. Since only 21% of the centers indicated contracting for the service, it is likely that centers had certified music therapists on staff or as volunteers, or incorporated music into activity programs and considered it therapeutic. It is most likely that most centers employed recreation therapists who planned and coordinated music or art activities which were therapeutic. In some cases, therapists such as Occupational Therapists, Physical Therapists and Speech Therapists prepared the initial care plans and instructed staff at the adult day centers on performing routine exercises which complemented the participants' plans of care.

Care Coordination. The extent to which participant support groups were managed is unclear. Some centers described monthly participant council meetings as being supportive in nature. While 65% of respondents indicated providing counseling, only 29% contracted such services. It is likely that much of the counseling provided by center staff was informal, although significant to the well-being of the persons receiving counseling. Caregiver support groups were more common among adult day centers (65%) in comparison to the 1993 survey where only 54% of the centers provided them. Most of the respondents contracting care management did so with other departments within their parent organizations.

Financial Operations

Almost half of the respondents (17 of 35) managed their finances based on a July 1 - June 30 fiscal year. The majority of the others, 34%, (12 of 35) operated on a January 1 - December 31 fiscal year, while only 4 of 35 (11%) followed an October 1 - September 30 fiscal year. Respondents were asked to indicate the number of days their centers operated in the last fiscal year, as well as the unduplicated number of clients served during the last fiscal year. On the average (N=31), centers operated 242 days per year as 31 responding centers served an average of 49 unduplicated clients.

The survey asked the amount of the centers' annual operating budgets for their last fiscal year. Respondents were asked to include

the fair market value for expenses such as rent or utilities which may have been in-kind contributions. Among respondents operating single sites (15 of 29), budgets averaged about $182,960, while the median was considerably lower at $155,942. This finding suggests that some respondents with very low budgets may not have included the fair market value for some of their centers' in-kind contributions or that their centers' capacities are well below that of the other respondents. Among the 14 respondents operating at multiple sites, the budgets averaged $153,736. The difference in multiple site programs and single site programs is not surprising since some overhead costs (e.g. administrative staff) may be distributed more equitably among multi-site centers. Comparing the sizes of budgets based on location of centers was not as easily computed since most multi-site programs reported one cumulative budget. When budgets of multi-site programs were divided equally among the respective centers, subgroup analyses reflected that centers operating in small towns had the lowest budgets, averaging $137,862. Centers operating in cities, whether in metropolitan areas or not, averaged the highest, $184,445, while suburban centers in metropolitan areas averaged $174,584.

Fixed and Variable Expenses. Fixed or direct expenses were defined as costs that do not change from day-to-day, e.g. salaries, rent and utilities. Variable or indirect expenses are defined as costs that may fluctuate according to the census or season, e.g. program supplies, meals, transportation. Respondents were also asked to indicate the percentages of their centers' expenses which were fixed (direct) and variable (in-direct). Percentages were required to equal 100%. Seventy-nine percent of the expenses (N=28) on average were classified as fixed (direct), while the ranges for fixed expenses ranged from 64% to 91%. Twenty-one percent of the expenses on average were classified as variable (indirect) with ranges from 9 % to 36%. Since most of the respondents operated as nonprofits and their employees are their greatest asset, it is not surprising that the percentage of fixed expenses is high, considering most of them are probably linked to the salaries and benefits of the care providers.

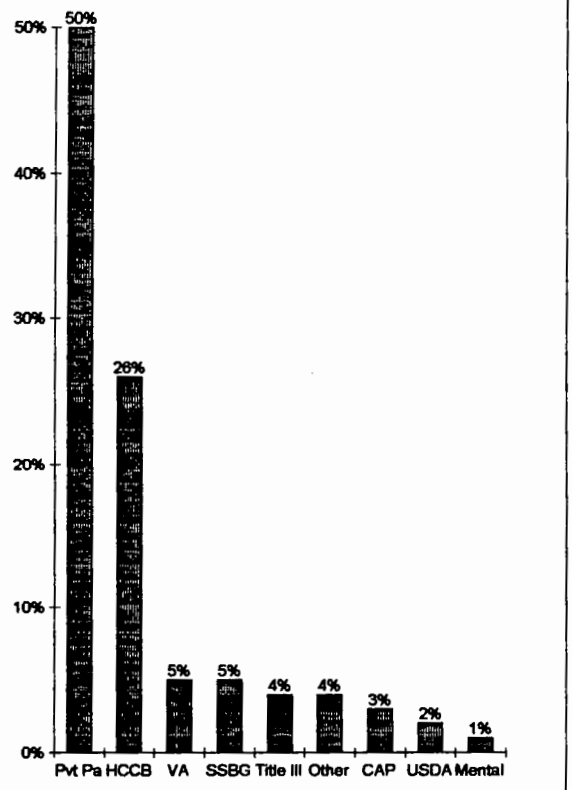
Operating and Non-Operating Revenue. Operating revenue was defined as any income generated from fees for service, e.g. private pay, Department of Social Services (DSS), SSBG/State Adult Day Care Fund, Home and Community Care Block Grant (HCCBG), Title III, Child and Adult Care Food Program (CACFP) from USDA, Veterans Administration (VA), Medicaid Community Alternatives Program (CAP-DA), third party reimbursements. Non-operating revenue is defined as any income generated from sources other than fees for service, e.g. grants, donations and in-kind contributions. Respondents were asked to indicate the percentages of their centers' revenues which were classified as operating and non-operating. Percentages were required to equal 100%. Eighty percent of the revenues (N=32) on average were classified as operating, while the ranges for operating revenues ranged from 44% to 100%. Twenty percent of the revenues on average were classified as non-operating with ranges from <1% to 56%.

When asked to give the breakdown of operating revenue for the past fiscal year, 31 centers responded. (See Figure 8.) Private pay fees were by far the primary source of operating revenue (50%), followed by the state's Home and Community Care Block Grant (HCCBG) (26%). In subgroup analysis, the most significant difference in the breakdown of operating revenue among social model centers and centers certified to provide health services

was the average difference in private pay fees, 58% among responding social centers compared to 42% of responding combination/health centers. Further analysis revealed that centers located in small towns reflected a significantly lower percentage of private pay revenue (45%) than centers located in any other subgroups (57% each). Small town centers made up some of the difference in receiving 3% more Title III funds (8%) than the other centers. Surprisingly, funds from the Veterans Administration (VA) comprised 16% of operating revenues for centers located in small towns, while centers in all other subgroups averaged 2% each. This finding seems to reflect regional bias since accessibility to VA funds in some parts of North Carolina has been restricted due to varying administrative methods among VA hospitals.

Reimbursement rates for each of the funding sources varies: HCCBG and SSBG/State Adult Day Care Fund are reimbursed at a maximum of $21 per day ($208 per month maximum) with additional $45 per month maximum for transportation; VA funds daily reimbursements are based on a negotiated contract price; Title III reimbursements are also based on a negotiated contract price; Medicaid CAP-DA and MRDD were reimbursed $26 per day until May 1, 1997, at which time the rate increased to $33 per day; USDA reimbursements are calculated according to incomes of enrolled participants. Rates for the mental health funds listed and other sources are unknown.

Figure 8: Breakdown of Operating Revenue (N=31)



Conclusions

The certification, but lack of operation, of two centers and one home poses concern about the preparation of operators in opening centers. Given the service nature of the business, the industry often attracts persons and organizations driven by philosophical urges, but often lacking adequate financial resources to ensure the success of the business beyond the start-up phase of operation--two to three years. In the future it would be in the best interest of the proposed centers and the industry, in general, to scrutinize the business expertise and assurance of financial support more closely before the centers are certified to better ensure success.

Findings related to subgroup comparisons of social model centers to those certified to provide health services are quite intriguing. Findings from this survey indicated that small

towns were twice as likely to have combination centers as social centers. Since it is likely that health services are more limited in small towns than metropolitan areas, adult day centers serve needs in the community that otherwise might go unmet. Seventy percent of the centers certified to provide health services used levels of care, while a surprising 41% of the social model centers also reported using them. Referrals among the respondents were twice as likely to occur at social centers as centers certified to provide health services.

There is increasing interest in the use of computers in adult day centers, particularly in managing administrative tasks. Several factors have handicapped the use of computers in centers to date: limited software packages designed especially for adult day centers; limited financial resources; and limited knowledge about computers, software and hardware in general. This is an area that must be addressed in order for the adult day services industry to position itself appropriately in preparing for managed care.

Since the primary population in adult day centers is frequently female, activity programming is often designed for women. Therefore, when men visit or enroll at the center, it is important for staff to ensure that programming meets the needs and interests of men, as well.

It was not surprising that 75% of the primary caregivers were female, just above the national average (72%) found in the 1996 national survey of caregivers sponsored by the NAC, AARP and Glaxo-Wellcome. Coupled with the average of working caregivers (67%) among the centers, this survey should sound a wake-up call to legislators, state governments and employers. The aging of America is clear. Adult day centers are obviously providing a variety of important and needed services to impaired adults and their families across the State.

In order to meet the demands of the growing population of aging and disabled adults in North Carolina, more centers must give serious consideration to the possibilities of converting their certification status to provide health services since only 39% of the centers in the State were certified to provide health services. Legislation passed by the 1997 North Carolina General Assembly to request a waiver from the Health Care Financing Administration (HCFA) to provide adult day health care services to Medicaid recipients who are not participating in a community alternative program in North Carolina further supports this belief. The merging of one formerly free-standing center (for 10 years) with a non-profit consortium of six health care providers demonstrates recognition of the need to collaborate with other businesses and position themselves in preparation for managed care. An issue that arises in considering changing a center's certification status is the location of the facility. Centers have traditionally been located in churches because rent was less expensive, they shared similar missions and churches wanted their space used. Since the largest percentage of social model centers currently exist in churches, it is likely that space and facility use limitations may prohibit centers from making the conversion in existing space. The findings that centers certified to provide health services fared better than social centers based on computed unit costs and charge-minus-cost deficits was surprising. The primary factors that seemed to directly influence the differences were the lower charges and lower capacities being maintained among social centers. Adult day center staff should evaluate the centers' fees in relation to the services they provide, as well as their methods of selling the centers' services to reflect their

value. Implementing levels of care and corresponding fees while unbundling services may help clarify some selling points for potential customers. Since the primary source of operating revenue by far was private pay fees, the abilities of staff members to 'sell' the center to potential customers can significantly impact the centers' revenues.

The average cost to provide adult day services per client per day (expenses for the fiscal year/service units for the fiscal year) was $40.69 ($N$=26), compared to $31.13 per day found in the 1993 survey. (The unit cost reported in the 1993 survey was not presented with much confidence since guidelines were not given for respondents to follow in computing their costs.) The lowest unit cost computed was $28.23 per day and the highest was $61.94 per day. Pricing according to levels of care is certainly reflected in response to this survey. Fees averaged about $5.00 more per day in centers certified to provide health services than among social centers. Among respondents overall, the average charge per client per day rose from $25.10 in the 1993 survey to $28.77 per day. While the average charge in the 1993 survey covered only 80% of unit costs, which could not be analyzed with confidence, an even more disturbing finding in the current study is that average charges cover only 71% of unit costs. When the daily rates charged for services were subtracted from the daily unit costs, the average deficit was $12.00 per day. It is realistic, however, that some centers broke even and even profited if unit costs were computed without the inclusion of in-kind expenses. Centers obviously need to operate at the highest capacity possible to decrease their unit costs, preferably at least 80% capacity. Coupled with the fact that some public reimbursements for low and moderate income participants do not even match average charges, it is clear why funding is a significant concern for many centers across the state. The secondary source of operating revenue among the respondents was the state's Home and Community Care Block Grant (HCCBG), reimbursing only $21 per day per participant for adult day services.

A comparison of the findings from the 1993 and 1997 surveys related to why clients leave centers seems to reflect the belief that services follow dollars. There was a decline in the number of persons leaving adult day centers for nursing homes and an increase in the number of persons choosing home care. Consistent increases in funding for home and community-based services have made it possible for more persons to choose to age in their own homes and communities.

The distribution of funds from the Veterans Administration (VA) seems to reflect regional bias since accessibility to VA funds in some parts of North Carolina has been restricted due to varying administrative methods among VA hospitals. This is an area in which NCADSA may be helpful in the future with encouraging non-participating VA administrators to strongly consider the best interests of their patients, while educating them about the cost benefits of contracting with adult day centers.

Many findings of this survey, including the alignment of many North Carolina centers with national trends to implement levels of care in adult day centers, and providing services and hours well beyond minimum requirements, reflect progression toward striving for excellence in the adult day services industry.

Centers can remain viable in the current fiscal environment by taking several actions:

- Many centers will need to increase the acuity of care their centers provide.
- Market services more effectively.
- Become more consumer-oriented.
- Make evident the value of services.

- Explain the benefits of adult day services relative to long term care.
- Align fees more closely with actual costs, while providing discounts when necessary.

Acknowledgments

This report was prepared for the North Carolina Adult Day Services Association (NCADSA) by Teresa D. Johnson, BS, President of Creative Consulting for Adult Day Centers. As Executive Director for NCADSA, Teresa served as the primary author of the report. Teresa was one of the initiators and overseers of the 1993 survey distributed by NCADSA (formerly NCADCA). Her management of four adult day centers in North Carolina for almost six years provided valuable insight into her work on the 1997 report.

Dennis Streets, MPH, MAT, LNHA, of the North Carolina Division of Aging provided consultation and review of the final draft of the report. Dennis also provided consultation and technical assistance for the 1993 survey when he was formerly employed by the Center for Aging Research and Educational Services (CARES), a part of the North Carolina Family-Centered Services Program at the School of Social Work of the University of North Carolina, Chapel Hill.

Respondents from the 39 centers who chose to complete and return their surveys are to be commended for demonstrating their commitment to strengthening our centers and better preparing us to meet the challenges of tomorrow's health care industry. Special thanks to JoEllen Edwards (NCADSA Treasurer), Mary Warren (NCADSA Secretary), Amber Sheely (1996-97 NCADSA President) and James Lenhart (1994-95 NCADSA President) and Mary Dowless for their work in field testing the draft survey and proofreading the final report.

Appendix

North Carolina Adult Day Services Association

1997 Adult Day Center Survey

A copy of this survey has been mailed to every adult day center in North Carolina certified to serve more than 6 persons per day. If your program operates at more than one site, please complete a separate survey for each site. All responses will be kept strictly confidential.

THE FACILITY

1 What month and year did the center open? _____

2 Please indicate below the type of organization with which the adult day program is affiliated (a parent or sponsoring organization), if any.

- ❑ None, free-standing
- ❑ Council on Aging/Dept. on Aging
- ❑ Private business
- ❑ Home health agency
- ❑ Hospital
- ❑ Long Term Care Facility (nursing home, rest home, etc.)
- ❑ DSS, Mental Health, Health Department
- ❑ Other _____

3 Circle the appropriate tax status for the adult day program:

Not for profit (tax-exempt) **For profit**

Public **Other** _____

4 Which of these statements best describes the area served by your adult day center?

- ❑ The central city of a metropolitan area*
- ❑ A suburb or smaller city within a metropolitan area*
- ❑ A city that is *not* part of a metropolitan area*
- ❑ A suburb that is *not* part of a metropolitan area*
- ❑ A small town
- ❑ A rural area

***Metropolitan Areas in NC (by size)**
Charlotte/Gastonia/Rock Hill
Greensboro/Winston-Salem/High Point
Raleigh/Durham
Fayetteville
Hickory/Morganton
Asheville
Jacksonville
Wilmington
Burlington

5 Please indicate which <u>one</u> of the following best describes the center's location:

- ❑ Church
- ❑ Free-standing
- ❑ Senior Center
- ❑ Other
- ❑ Hospital
- ❑ School
- ❑ LTC Facility (nursing home, rest home, retirement home)

_____
_____

6 Capacity as certified by the NC Department of Human Resources Division of Social Services _____

7 What was the enrollment of the adult day center as of January 1, 1997? _____

8 What was the average daily attendance of the adult day center for December 1996? _____

9 How many potential participants are on the center's waiting list? _____

10 Which of these statements best describes the use of computers in your adult day center? *(Check all that apply.)*

- ❑ We have no computer!
- ❑ To maintain client and staff records
- ❑ To generate billing, accounting
- ❑ For word processing
- ❑ To generate reports, labels and graphs
- ❑ For desktop publishing (newsletters, brochures, etc.)
- ❑ For programming with participants (video, games, educational software, etc.)
- ❑ For scheduling and attendance
- ❑ For medication administration tracking
- ❑ Meal Planning/Managing USDA Food Program
- ❑ Electronic sign-in/sign-out
- ❑ Personnel management
- ❑ Transportation management
- ❑ Prospect management
- ❑ Payroll
- ❑ Other _____

CLIENTELE

11

Please complete the following questions based on participants enrolled in the center as of January 1, 1997, as noted in question 7 above:			
Enrollment		*Ages*	
Gender		Age of youngest participant	
Males		Age of oldest participant	
Females		Average age of participants	
Race		Median age of participants	
White		**The median is the midpoint in a set*	
Black		*of ordered observations. When there*	
Hispanic		*is an even number of observations,*	
Asian		*the average of the two middle observations is the median.*	
Other (Please specify)			

12 Please complete the following questions regarding the **primary caregivers** for the participants who were enrolled in the center as of January 1, 1997.

Male _____ Female _____

Employed _____

❑ *Our center does not track these statistics but I would like more information about how to track them.*

13 *Please enter the **number** of participants enrolled as of January 1, 1997, with the following diagnoses. (Sum might not equal enrollment figures since some participants have multiple diagnoses.)*

Alzheimer's/Dementia		Mental Health Diagnosis	
Arthritis		MR/DD	
Blindness/Visual Impairment		Multiple Sclerosis	
Cancer		Nutritional Disorder	
Cardiac Disorders		Parkinson's	
Cerebral Palsy		Renal Failure	
Congestive Heart Failure (CHF)		Seizure Disorder	
COPD		Stroke/CVA	
Deaf/Hearing Impaired		HIV/AIDS	
Diabetes		Hypertension	
Head Injury		Other	

14 *Please indicate the **numbers** of participants enrolled as of January 1, 1997, for which each of the following support systems applies. (Sum should equal enrollment.)*

Lives with adult child	
Lives with spouse	
Lives with relative other than spouse or child	
Lives alone	
Lives in adult home (domiciliary, group home)	
Lives in LTC facility (rest home, assisted living facility, nursing home)	
Other	

❑ *Our center does not track these statistics but I would like more information about how to track them.*

15 *Please indicate the **numbers** of participants who use the following community support systems OUTSIDE of the adult day center.*

In-Home Services		**Community-Based**	
Registered Nurse		Mental Health Clinic	
Therapies		Other (Specify)	
Home Care Aides		**Other**	
Homemaker/Choreworker		Case Management	
Lifeline		Senior Center	
Home-delivered meals		Congregate Meal Site	
Other (Specify)		Other (Specify)	

❑ *Our center does not track these statistics but I would like more information about how to track them.*

16 In the centers we do not treat the participants' diseases. Rather, we address them and assist the participants with their functional disabilities caused by diseases. To that end, please indicate the **numbers** of participants enrolled in the center as of January 1, 1997, for whom each of the risk factors or characteristics listed below applies.

BEHAVIOR		SAFETY		HEALTH	
Isolation		Risk of falling		Speech impairment	
Repetitive behavior		Wandering		Vision impairment	
Depression		Unsafe toward self		Assist with basic ADLs	
Catastrophic reactions		Unsafe toward others		Medication administration	
Inappropriate social, emotional or sexual behavior		Loss of consciousness (diabetic coma)		Medication interaction/reaction	
Irritability		Impaired mobility		Medication restriction	
Obsessive compulsive		Fatigue		Incontinence	
Inactivity		Dizziness		Pain and discomfort	
Confusion				Poor hygiene	
Unrealistic demands				Potential for TIAs	
Decreased social interaction				Blood pressure monitoring	
Low self-esteem		OTHER *(Please list)*		UPI	
				Hypo-/hyperglycemic reaction	
NUTRITION				Glucometer testing	
Assist with eating				Insulin administration	
Special food preparation (e.g. puree, chop)				Other injections	
Dietary restrictions/Prescribed Diet (e.g. no salt, no added sugar)				Tracheotomy care	
Overweight/Underweight				Oxygen administration	
Liquid intake				Sterile and non-sterile dressing	
Dehydration				Gastrostomy feeding	
Choking precautions				Change of foley catheters, supra pubic tubes	
				Decubitus care	
				Impaction	
				Oral hygiene	

Services

17 What is the average number of hours participants spend per day at the adult day center? _____

18 What are the center's hours of operation? _____ a.m. to _____ p.m.

19 Circle the days the center offers services routinely.
SUN MON TUES WED THURS FRI SAT

20 Indicate the center's certification status:
❑ Social ❑ Combination ❑ Health

21 Does the center use levels of care? ❑ Yes ❑ No

22 If the center uses levels of care, circle the number of levels used. 1 2 3 4 5 6

23

*Complete the table with the unduplicated **number** of participants discharged from the center during the last fiscal year.*	
Moved into long term care facility	
Chose home care	
Moved	
Died	
Client didn't like	
Client improved	
Transferred to another center	
Inadequate financial resources	
Other (please specify)	
TOTAL DISCHARGES	

❑ *Our center does not track these statistics but I would like more information about how to track them.*

24

*Indicate the **number** of referrals to the center during the last fiscal year from the following sources:*			
Physicians		Clients' Families	
Case Managers		News Media	
Hospital Discharge Planners		Phone Book/Yellow Pages	
Home Health Agencies		Brochures	
AAA		Word of Mouth	
Churches/Clergy		Signs	
DSS		Long Term Care Facilities	
Senior Center		Alzheimer's Association	
		Other (specify)	
		TOTAL REFERRALS	

❑ *Our center does not track these statistics but I would like more information about how to track them.*

25 Complete the following table regarding services provided at or by the center.

Service	Yes	No	Charge per unit (specify unit)	Performed by Center Staff	Contracted	Comments
lt Day Services (full day)						
Adult Day Services (half day)						
Adult Day Services (hourly)						
Extended Hours						
Weekend Respite						
Overnight Care						
Transportation To / From Center						
Medical Escort						
Shopping Escort						
Personal Care Bath/Shower						
Manicure						
Pedicure						
Haircare						
Toileting						
Medical Services	**Yes**	**No**	**Charge per unit (specify unit)**	**Performed by Certified Ctr Staff**	**Contracted**	**Comments**
Monitoring Vital Signs						
Dental Care						
Vision Care						
Podiatry						
Audiology						
Professional Services Physical Therapy						
Speech Therapy						
Occupational Therapy						
Music Therapy						
Art Therapy						
Social Work						
Care Coordination Participant Support Groups						
Counseling						
regiver Support Groups						
re Management						
Home Visits						

FINANCIAL

26 Define the center's last fiscal operating year ___/___/___ to ___/___/___

27 How many days did the center operate during the last fiscal year? _____

28 What is the unduplicated number of participants served during the last fiscal year? _____

29 What was the amount of the center's annual operating budget for last fiscal year? *(Please report including the fair market value for expenses such as rent or utilities which are in-kind contributions.)*

_____

30 Refer to the following definitions to complete the table below for the last fiscal year:

Operating Revenue (any income generated from fees for service, e.g. private pay, DSS, SSBG/State Adult Day Care Fund, HCCBG, Title III, USDA, Veterans Administration, Medicaid CAP, third party reimbursements)

Non-Operating Revenue (any income generated from sources other than fees for service, e.g. grants, donations, in-kind)

Fixed (Direct) Expenses (costs that do not change from day-to-day, e.g. salaries, rent, utilites)

Variable (Indirect) Expenses (costs that may fluctuate according to the census, season,, e.g. program supplies, meals, transportation, etc.)

Revenue	**% of Total Revenue**
Operating Revenue	%
Non-Operating Revenue	%
	must =100%
Expenses	**% of Total Expenses**
Fixed Expenses	%
Variable Expenses	%
	must =100%

31

Please complete the following table based on the operating revenue breakdown for the past fiscal year.	
Operating Revenue Sources	**% of Total Operating Revenue**
Private Pay	%
Veterans Administration (VA) contract	%
Home & Community Block Grant (HCCBG)	%
SSBG/State Adult Day Care Fund	%
Title III	%
USDA	%
Long Term Care Insurance	%
Medicaid CAP	%
	%

31 How many units of service were performed in the last fiscal year for

Adult day services: _____ days

Transportation: _____ trips

32 Additional Comments :

_____

_____

_____

_____

_____

_____

33 Is your center a member of NCADSA? ❑ yes ❑ no

Identification

This information will be used only if we need to ask you about your survey or if you would like a copy of the survey findings. **All individual responses will be kept strictly confidential.**

Name of Adult Day Program or Center _____

Name of Parent Organization (if applicable) _____

Contact Person _____

Address _____

City/State/Zip _____

Phone (____) _____ Fax (____) _____

☐ Check here if you would like a copy of the survey results.

Return by April 15, 1997.

FAX: (919) 552-0254

or Mail to: NCADSA
c\o Teresa Johnson
5008 Northriding Court
Fuquay-Varina, NC 27526

Anne Johnson
2-18-98

1998 Legislative Agenda of the North Carolina Coalition on Aging

The North Carolina Coalition on Aging urges support for:

- Appropriation of $1 million in recurring funds for the support of senior centers for the second year of the biennium.

- Legislation to provide a tax credit for purchasers of long term care insurance (Senate Bill 48 and House Bill 74 are eligible for consideration).

- Legislation to continue to address the inequitable access to health care including prescription drugs.

- Enactment of House Bill 1223 for single payer health insurance modeled after the state employees plan.

- Appropriation of an additional $100,000 for Alzheimer's Disease education and support groups.

- Appropriation of $5 million in recurring funds for the Housing Trust Fund.

- Legislation to improve safety, oversight, and quality of care for residents in adult care homes and nursing homes, including fire prevention measures, improved training and salary levels for employees, and limitations on the use of restraints.

- Appropriation of $1 million to be allocated by the N.C. Division of Aging for essential support personnel for program development and service enhancement.

s/commons/corresp/bethel/legprio;doc.

1998 Recommendations of the Governor's Advisory Council on Aging

- Support state funding for the Housing Trust Fund in the amount of $7.5 million.
- Seek $200,000 in state funding to expand and strengthen Alzheimer's support programs and services.
- Provide incentives, including a state income tax credit, for the purchase of long term care insurance.
- Support state funding for senior centers -provide $2 million for capital improvements and $2 million for operations to the Division of Aging, Department of Health and Human Services.
- Provide support for efforts to assist persons who can not afford their prescription medications.
- Increase by $5 million the state appropriation for home and community based services for frail older adults.
- Provide $1.2 million to the Division of Aging, Department of Health and Human Services, to support volunteer development programs which impact older citizens of North Carolina.
- Provide $1 million to the Division of Aging, Department of Health and Human Services, to support the 18 Area Agencies on Aging.
- Provide $1 million to the Division of Aging, Department of Health and Human Services, for support of wellness and preventive services targeted to older adults.
- Support House Bill 564 which allows more flexible use of dental hygienists in such settings as nursing homes and childrens' health clinics.

1998 Legislative Priorities of the Senior Tar Heel Legislature

- Take steps to develop a plan for the reform of the financing and delivery of health care in the state. Such a plan should provide for quality and affordable universal coverage, should allow free choice of health care providers and should provide comprehensive benefits including coverage for home and community-based services, prescription drugs, mental health care, dental health care, hearing care assistance, and wellness and preventive services. The General Assembly is especially encouraged to take steps in the short legislative session to (1) provide support for efforts to assist persons who can not afford their prescription medications, and (2) pass Senate Bill 400 which would provide coverage of mental health benefits equal to health care benefits.

- Enact legislation which provides incentives for North Carolina residents to purchase long term care insurance including providing a state income tax credit or deduction for individuals who purchase private long term care coverage for themselves and/or a family member.

- Appropriate $1.2 million to the Division of Aging, Department of Health and Human Services, to support volunteer development programs which impact older citizens of North Carolina.

- Appropriate $50,000 in continuation funding for each of the 18 Area Agencies on Aging for additional staff for program development and service enhancement.

- Appropriate $1 million in continuation funding to the Division of Aging, Department of Health and Human Services, for the operation, construction, renovation, and/or repair of senior centers.

2-18-98
John Tanner

ADULT DAY CARE AND DAY HEALTH EXPANSION FUNDS
STATUS REPORT

BACKGROUND

SB-352 includes funding for the expansion of adult day care and day health services for elderly and disabled adults. Funding for each year of the biennium was appropriated as follows.

- FY1997-98: $1,665,750
    - $350,000 for Start-Up Grants to establish new adult day care and day health centers, especially in counties where none exist; 25% provider match required.
    - $125,000 for Conversion Grants to assist in the conversion of existing adult day care centers to adult day health; 25% provider match required.
    - $338,630 to provide a 9-month State Adult Day Care Fund (SADCF) allocation to county departments of social services where FY98 Start-Up centers are located; 12.5% county match required.
    - $107,130 to provide SADCF allocations to county departments of social services that had previously been receiving allocations; 12.5% county match.
      $734,990 to provide SADCF allocations to 17 county departments of social services that had adult day care but no SADCF allocation in previous years; 12.5% county match required.

- FY1998-99: $2,181,750
    - $350,000 for Start-Up Grants to establish new adult day care and day health centers, especially in counties where none exist; 25% provider match required.
    - $125,000 for Conversion Grants to assist in the conversion of existing adult day care centers to adult day health; 25% provider match required.
    - $338,630 to provide a 9-month State Adult Day Care Fund (SADCF) allocation to county departments of social services where FY99 Start-Up centers are located; 12.5% county match required.
    - $107,130 to provide SADCF allocations to county departments of social services that had previously been receiving allocations; 12.5% county match.
    - $734,990 to provide SADCF allocations to 17 county departments of social services that had adult day care but no SADCF allocation in previous years; 12.5% county match required.
    - $451,500 to provide an increased, full year State Adult Day Care Fund (SADCF) allocation to county departments of social services where FY98 Start-Up centers are located; 12.5% county match required.
    - $64,500 to provide SADCF allocations to county departments of social services that need to purchase adult day care services in nearby counties, since there are no adult day care centers in the county; 12.5% county match required.

CURRENT STATUS

First Round Grant Process

- Request for Applications (RFAs) were distributed September 19, 1997 to all county departments of social services, adult day care and day health centers, area agencies on aging, local health departments, and approximately 400 interested parties which had requested copies of the adult day care and day health regulations over the prior two years.
- A total of 42 applications for Start-Up Grants and 3 Applications for Conversion Grants were received by the postmark deadline of December 1, 1997.
- Three Conversion Grant and 12 Start-Up Grant recipients were selected December 19, 1997 from the pool of applicants. Selections were guided by a 7 member advisory committee that included representation from the adult day care provider community and DHHS Divisions, following criteria identified in the RFAs and using a standard scoring method.

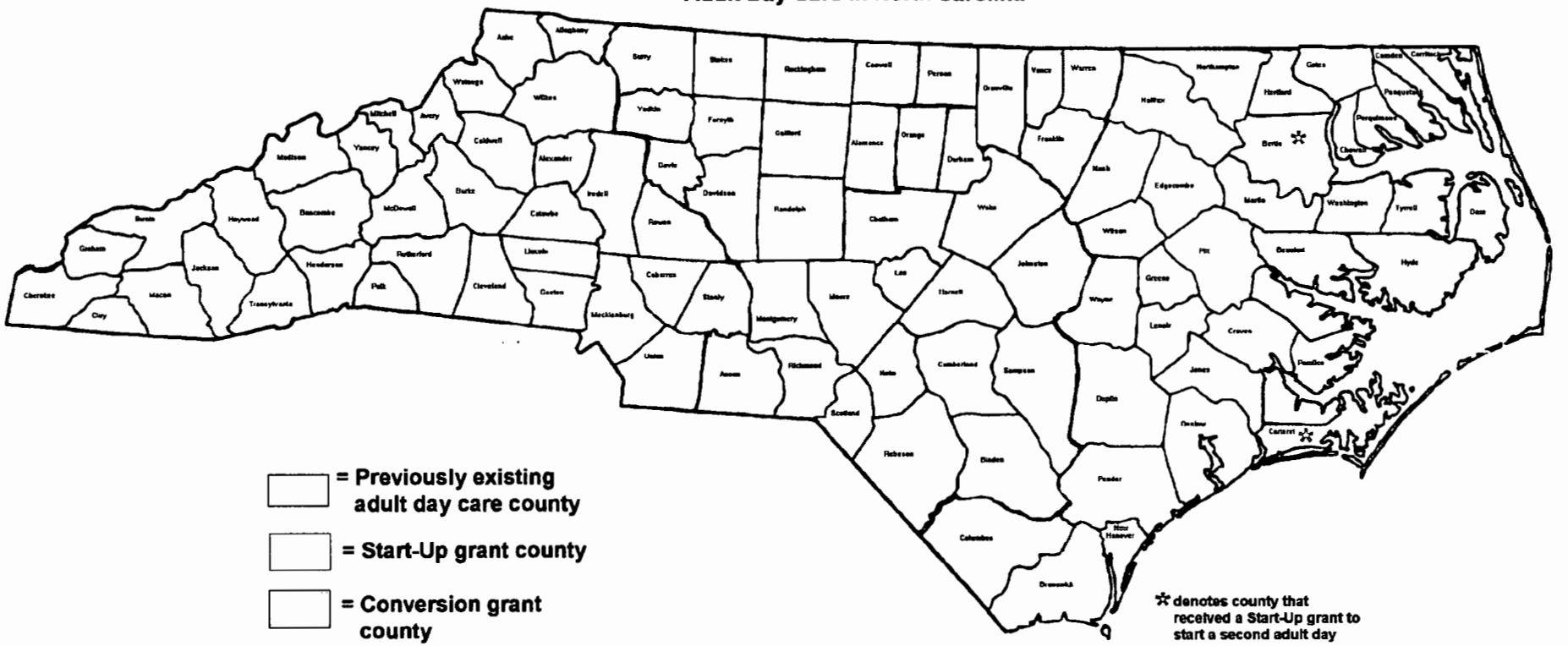
  3 Conversion Grants in the amount of $25,000 each were awarded.

  11 Start-Up Grants in the amount of $35,000 each and 1 Start-Up Grant in the amount of $15,000 were awarded.
- SADCF allocations distributed to the 12 county departments of social services where the new Start-Up centers are located. The allocations will used by the DSSs to purchase adult day care and day health services.
- SADCF allocations distributed to the 51 county DSSs where existing centers are located.
- The attached state map shows the locations of the Start-Up and Conversion Grant recipients as well as the locations of previously existing adult day care and day health centers.

NEXT STEPS

- A second round of RFAs is underway. Requests for Applications (RFAs) were mailed on February 16, 1998 to more than 800 interested parties. The postmark deadline for submission of applications is April 30, 1998. Grant recipients will be selected by end of May 1998.
- We are exploring a contract with Partners in Caregiving: The Dementia Services Program of Wake Forest University School of Medicine as a means of providing specialized technical assistance to the new adult day care and day health centers opening as a result of this new funding from the General Assembly. These centers need assistance with marketing techniques, fund raising, and practical help on how to make their new centers become successful operations. Partners in Caregiving is a nationally recognized resource center on adult day care and provides this type of consultation and technical assistance to adult day care centers across the United States. Previous experience has shown that this type of assistance is needed for new adult day care centers to be successful and continue to operate on an on-going basis after start-up funding has been used.

Adult Day Care in North Carolina



= Previously existing adult day care county

= Start-Up grant county

= Conversion grant county

☆ denotes county that received a Start-Up grant to start a second adult day care program

2-19-98
Teresa Johnson

NCADSA Mission: The North Carolina Adult Day Services Association promotes excellence in service provision and program development through advocacy, education, support and training.

Outcomes of Start-Up Grants for Adult Day Centers in 1980s:

- Typical grants equaled $25,000
- No provision for technical assistance
- Only 53% currently operating

Outcomes of National Sites Granted Technical Assistance Only by Robert Wood Johnson Foundation in Partners in Caregiving Program*:

- Centers that did not receive grant funds improved 42% in their average daily census (from 19 to 27) over four years.
- Revenue went from $168,000/year to $331,000 (a 97% increase)
- Expenses went up 62% due to the increased census
- Ratio of revenue over cash expenses went from 76% to 98%--virtual self-sufficiency

**Respite Report*, Partners in Caregiving: The Dementia Services Program. Summer 1997, Special Issue [9]1, Bowman Gray School of Medicine, Winston-Salem, NC.

Dr. Burton Reifler, director of Partners in Caregiving: "The importance of what we have learned is that adult day centers can be run in a businesslike manner without losing sight of their higher purpose. Through attention to marketing, financial management and programming, gains in enrollment, attendance and financial performance can be achieved in a steady manner over the course of a few years, with full financial self-sufficiency a realistic goal."

Suggestions for Ensuring Success of 1997 & 1998 Start-Up Grants in NC

- View centers as human service businesses
- Allocate funds for technical assistance
- Expand the grants for the first round through the next fiscal year
- Fund centers certified to provide health services only
- Increase start-up allocations per center to at least $75,000

RESPITE REPORT

2-19-98
Teresa Johnson

SPECIAL ISSUE:
Adult Day Services: 10 Years in 2 Days

Adult day services: financial self-sufficiency

As research shows ...



Dr. Burton V. Reifler

"There are very few people who go into adult day services because they sense a huge profit opportunity in it," said Dr. Burton V. Reifler, director of Partners in Caregiving. "People who go into adult day services do so because they are attracted to the human service aspects of it; because they want to offer a service for their communities."

So, can an adult day center, as a community service, achieve financial self-sufficiency? Absolutely.

In the original four-year demonstration program, the Dementia Care and Respite Services Program (DCRSP), the first two sites to become fully self-sufficient through participant fees were the St. Elizabeth Adult Day Care Center in St. Louis, Mo., and the Granat Alzheimer Center, Parker Jewish Geriatric Institute in New Hyde Park, N.Y.

"Three elements," Reifler said, "were judged to be important factors in their financial success: providing consumer-driven services (such as being open a full day to meet the needs of working caregivers), establishing charges high enough to cover the costs of providing services, and maintaining a high level of visibility in the community."

In the final analysis of program characteristics in the DCRSP, three factors were identified as significant predictors of financial success. According to Reifler, they are: being open a full day (defined as 7:30 a.m. to 6 p.m.), having a higher year-end census, and having a higher ratio between the maximum daily participant fee and the unit cost of providing services.

"This last factor," Reifler said, "was often a problem for day centers to deal with. But, even I can figure out that if it is costing you $40 a day to take care of a participant, and your top charge is $30, even if you are filled with full-pay participants, you are never going to break even."

So, top charge should at least equal unit cost. "Then you can discount all you wish," Reifler said, "and work with families on an individual basis. But, if someone who can afford your fee comes to your center, they should at least be given the opportunity to pay what the service actually costs."

Day center staff and board members in the DCRSP were reluctant to raise fees, even when the maximum fee was below actual cost, for fear of losing participants. Experience, however, did not support their apprehensions, and every center that raised its fees to equal or exceed costs, allowing for discounting on a case-by-case basis, showed improved financial performance.

Reifler went on to report that Partners in Caregiving (PIC): The Dementia Services Program (the four-year replication of

Continued on Page 4

As applied in the field ...



Rose Marie Borg

Key elements that helped the Granat Alzheimer Center of the Parker Jewish Geriatric Institute (New Hyde Park, N.Y.) reach financial self-sufficiency were: being consumer responsive; knowing and charging full cost; maintaining a high census; and marketing.

The Granat Alzheimer Center was a start-up program.

"In designing the program we needed to validate some of the assumptions we had made," said Rose Marie Borg, director. "We hired a marketing firm to do a telephone survey of 100 primary caregivers of Alzheimer's patients, in an effort to determine their most important needs. We made a lot of assumptions and didn't know if we were on target."

The center was designed as a drop-in center, offering long hours, and enabling caregivers to use the program whenever they needed. They could create their own schedule.

It was also designed as a one-stop shop. A caregiver could drop off their loved one and have all their needs taken care of, whether it be bathing, grooming, or visits to the doctor or dentist. Transportation, however, was not included in the initial program.

"Many people told us to stay away from transportation," Borg said, "because it was too problematic, and the behaviors of people with Alzheimer's are just too difficult. So we began our program without transportation. Then we received the results of our marketing survey, and guess what the number one requested service was by caregivers? Transportation!!"

So in response to the consumer, how were they going to start a service that had not been budgeted? According to Borg, they went to a local agency for start-up funds and were able to start transportation very early on.

"Providing a wide range of services has helped us develop a consumer-focused philosophy," Borg said. "We are the only Alzheimer's program in the area open seven days a week, 12 hours a day. Very quickly we became the program to call, a one-stop shop with transportation and long, flexible hours of service."

Another result of the marketing survey was the discovery that caregivers had no idea how much the service should cost.

"So we calculated our unit cost and looked at the charges of our local home-care agencies," said Borg. "Our cost was $9.50 per hour and the local home-care agency was charging $10 per hour. We began our program by charging, on the very first day, $10 per hour." And the center unbundled services, charging extra for meals and bathing.

"Soon we realized that not everyone could afford our fee,

Continued on Page 4

With improved census, revenue rose 97%

Reifler, continued from Page 3
the four-year demonstration) was created to apply the lessons learned and expand upon the experience gained in the DCRSP. Results from PIC provide benchmarking data on service utilization and financial performance among adult day centers, and also demonstrate the gains that can be achieved in these areas.

"The principles used in Partners in Caregiving," Reifler said, "are straightforward and transferrable, and fall into three main categories: marketing, financial management, and programming."

The primary marketing concepts are to market continuously and be responsive to consumer needs.

"Realize that marketing is not something you do once a year" Reifler said. "It is continuous; you do it all day, every day. And, to be responsive to consumer needs, you need to be open long hours to serve a variety of caregivers (respite seekers who want a few afternoons and care seekers who want full days, five days a week)."

Other examples of being consumer-responsive are providing transportation, or offering personal care services such as bathing, or weekend/overnight options.

Financial management was another area of attention, which of course involved setting participant fees equal to or greater than the unit cost.

"Other financial management strategies," Reifler said, "included urging day centers to seek a variety of payor sources (i.e., private pay and government reimbursement), offering discounts to full time participants, instituting prepayment similar to how many child care centers operate, and overbooking based on historic cancellation and no-show rates."

The third area of attention was programming, with development of activities appropriate to the interests and abilities of the participants.

"Successful day centers," said Reifler, "have energetic and flexible programming, often with separate programming tracks; one track for people with milder impairment, and another for people with more severe impairment."

Programming tracks allow for greater flexibility within a center. And, the concept is appealing to caregivers because it allows participants to use the program over a longer period of time based on their level of functioning.

In applying these principles, Reifler reported that the PIC technical assistance sites (those that did not receive grant funds) improved 42 percent in their average daily census (from 19 to 27) over four years. Revenue went from $168,000/year to $331,000 (a 97 percent increase). Expenses went up 62 percent, but not as much as revenue, which meant that bottom-line profit increased. And, the ratio of revenue over cash expenses went from 76 percent to 98 percent, or virtual self-sufficiency.

"The importance of what we have learned," concluded Reifler, "is that adult day centers can be run in a businesslike manner without losing sight of their higher purpose. Through attention to marketing, financial management and programming, gains in enrollment, attendance and financial performance can be achieved in a steady manner over the course of a few years, with full financial self-sufficiency a realistic goal."

[For a complimentary reprint of "Financial Performance Among Adult Day Centers: Results of a National Demonstration Program" by Burton V. Reifler, Rona Smyth Henry, Julia Rushing, published in the February 1997 issue of the *Journal of the American Geriatrics Society*, call Diane Joyner at Partners in Caregiving at 1-800-795-3676, or e-mail your request to djjoyner@bgsm.edu.]

Value communicated during admission process

Borg, continued from Page 3
so we wrote grants and began to develop a scholarship fund to be able to offer families a discount."

Everyone was given the opportunity to pay what the service cost, but discounts were offered if needed, so as not to exclude anyone from the program. An annual golf outing, sponsored by the Parker Institute, supports the scholarship program.

Maintaining the census has been the key to generating revenue at the Granat Alzheimer Center.

"I know exactly how many clients per day I need to break even," Borg said. "If the census decreases, or if we need to increase revenue to offset expenses, I think of creative ways to increase the census. We will program some special events to try to increase the census for a given day, and promote it to the caregivers, in the hopes of achieving an increase in attendance for that day."

If the center experiences more discharges than usual, or if the overall census begins to decrease, media coverage is initiated, generating inquiry calls, and eventually more clients.

During the admission process, value is communicated. Families have an opportunity to tour the center and see how staff successfully integrate clients into the activities.

Copies of the activity schedule are given to families, and the program is explained so they can understand what goals staff are working toward.

"We promote our ability to provide individualized activities," Borg said. "Families actually see three different programs going on at the same time. And, they see how their loved one can be engaged in an activity, maybe for the first time in a long time."

Caregivers do not always understand what goes on at the day center because they are not there, and many participants cannot tell them.

"On an ongoing basis we communicate our successes," said Borg. "We share our care plans both with families and physicians. We provide literature on caregiving tips and newsletters. We invite caregivers to the center for social gatherings, whether it be dinners, barbecues or dances."

Two years ago, the Granat Alzheimer Center held its first annual creative art show. Each year, families, referral sources, funding sources, and local agencies are invited. A presentation about the program is conducted, and participants provide entertainment (drama skits and performances by the choir, band, and the bell choir).

"The love and care we provide on a day-to-day basis is portrayed firsthand,"

Continued on Page 14

2-19-98

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

February 9, 1998

The Honorable William N. Martin
Chairman, Senate Appropriations Subcommittee on Health and Human Services
The Honorable Charlotte A. Gardner
The Honorable Lanier M. Cansler
The Honorable Debbie A. Clary
Co-Chairman House Appropriations Subcommittee on Health and Human Services
16 West Jones Street
Raleigh, North Carolina 27601-1096

Dear Senator Martin and Representatives Gardner, Cansler and Clary:

The 1997-98 Appropriations Act, Section 11.69, requires the Department of Health and Human Services to study the effect of high vacancy rates for adult care home beds, the need for state controls on the increase in adult care home beds, the reimbursement amounts for Special Assistance Recipients, and report its findings to you by February, 1998.

As the attached report indicates, the Department has not finished its study pending receipt and analysis of 1997 cost reports for Adult Care Homes. The Department will submit a supplemental report with additional information concerning the above matters at a later date.

If you have questions, please contact James B. Edgerton, Assistant Secretary for Budget and Management.

Sincerely,

H. David Bruton

H. David Bruton, M.D.

Attachment

HDB:dkp

cc: **Tom Covington**
Karen Hammonds-Blanks
Legislative Libraries (2)
Principal Clerk/Senate
Principal Clerk/House
Carol Shaw
Linda Powell
Mary Ellen Sylvester

Report on Adult Care Home Bed Vacancies as Required by Section 11.69 of the 1997-98 Appropriations Act

Introduction

Section 11.69 of S.B. 352 directed the Department of Health and Human Services to study various issues related to high vacancy rates of Adult Care Homes and report to the Chairs of the House and Senate Appropriations Sub-Committee on Health and Human Services by February, 1998.

Vacancies in Adult Care Homes have become an issue in North Carolina because the state has many beds that are not being used. On August 25, 1997, the date the moratorium enacted by Section 11.69 went into effect, occupancy rates of Adult Care Homes averaged about 82%. This contrasts with a rate of nearly 95% in nursing homes.

The following report is based on a partial study of the issues identified in the special provision. Because the cost reports from the Adult Care Homes in the state were not due until December 31, 1997, and still are not complete as of the date of this report, it has not been possible to analyze any of the results of those cost reports prior to preparing this paper. As a result, a subsequent report will be prepared by the Department and submitted to the Chairs of the Health and Human Services Sub-Committee on Appropriations as soon as the cost reports can be thoroughly analyzed. Any recommendations for changes in the payment system for State County Special Assistance or Medicaid reimbursement for personal care services will be included in that report.

Occupancy Rates and the Cost of Care

Based on a December, 1994, study completed by the Management and Productivity Section of the Office of State Budget and Management, the daily cost

of care in adult care facilities varies dramatically according to occupancy. In the model that was constructed for the purposes of this study, a 40 bed facility paying minimum wages was calculated to have a cost of $44.21 per day at 86% occupancy but down to $38.04 at 100% occupancy. Facilities with 80 beds varied from $39.15 at 86% to $33.68 at 100%. In both cases there appeared to be an approximate $6.00 per day gap between the cost of facilities operating at 100% compared to those operating at 86% which was the average occupancy rate as of the date of the study.

The 1994 study by the Office of Budget and Management was based on a model of expected cost prepared by those doing the study. It was not based on actual costs reported by facilities across the state. There were no requirements to submit audited cost reports at the time and providers, the Department, and the Office of Budget and Management all believed that the reports that had been submitted understated costs. Since that time the General Assembly has enacted requirements for adult care homes to submit audited cost reports. As a result of that requirement adult care home providers submitted audited cost reports for 1996 and are currently submitting audited cost reports for 1997.

A limited review of data from the 1996 cost reports does not verify the relationship between cost and vacancy rates demonstrated by the model established for the initial study by the Office of Management and Budget. While the sample shows considerable variation among various cohorts of facilities based on facility size and occupancy rates, a clear pattern to the variation did not emerge. Costs tend to be somewhat higher in smaller facilities, and there is some general decline in costs as facilities move to a higher occupancy but the preliminary analysis is not conclusive.

Because 1996 was the first year that adult care homes submitted audited cost reports, and the analysis of the data was limited, drawing conclusions at this time

would be premature. The 1997 cost reports will be available for analysis soon, and should provide a clearer picture of the relationship between vacancy rates and costs of care. A more complete statistical analysis will be applied to the 1997 data to determine the relationship between vacancy rates and costs as this is the most critical issue under review. The Department wishes to use the 1997 reports rather than the older data in conducting further analyses in order to base any recommendations on the best information available.

Development of New Beds - Effects of Moratorium

In spite of the current average occupancy rate of about 82%, construction plans have been submitted and approved for many new Adult Care Home beds and more have been approved as a result of applicants receiving exemptions from the moratorium which are delineated in the law. When the moratorium went into effect there were 34,667 licensed adult care home beds. In addition, there were 4,588 beds for which plans had been approved but which had not yet been constructed and licensed. Since that time, applicants have been approved for allowable exemptions from the moratorium and either have applications pending or will have applications pending for an additional 8,983 beds as of January 31, 1998. Applications for exemptions continue to be filed.

The number of beds that have been previously approved and for which exemptions have been granted now total 13,571. This represents a 39% increase over the existing inventory in an industry which already has over 18% of its beds vacant.

Neither the beds in the pipe-line, those already approved but not yet licensed, or the beds for which exemptions have been approved seem to have much relationship to the vacancy rates in the respective counties of the State. The chart attached to this report provides a county by county breakdown of the beds available, the beds occupied, and the beds for which either plans have been

approved or exemptions have been granted for each county. Most of the new beds are proposed to be developed in the more metropolitan areas of the state, but there seems to be little pattern to the location of the proposed beds other than that.

Availability of Beds for Special Assistance Clients

With the current number of vacancies in the state and the small annual increase in the number of SCSA recipients (averages approximately 4% annually), there does not appear to be any shortage of available beds for SCSA residents. Obviously not all adult care home facilities admit SCSA residents and those residents do not have the same choice of facilities that private pay persons may have. However, there is little evidence that SCSA recipients cannot find a home which will take them.

Recommendation

On the basis of the information currently available the Department is able to provide only one recommendation at this time:

> With a total of over 13,500 beds now eligible to be constructed in addition to those in currently licensed facilities it is clear that the moratorium will not prevent the development of needed facilities or result in a shortage of beds for persons needing adult care home services. As a result, the moratorium should be continued until the Department has determined and the General Assembly is satisfied that there is no significant relationship between vacancy rates and the cost of care. If it were lifted and then reimposed, an additional group of potential providers would need to be made exempt from the regulation, and the oversupply of beds would become greater.

ADULT CARE BED VACANCY REPORT AS OF 1/31/98

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals								
COUNTY	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	BEDS IN PIPELINE *2	EXEMPTIONS BY(b)(4) *3	EXEMPTIONS BY (b)(2) *4	TOTAL BEDS *5	TOTAL BEDS OCCUPIED	VACANCY RATE *6
ALAMANCE	780	774	565	4	4	1	29		312	1119	566	49.42%
ALEXANDER	66	66	63	0	0	0	3		0	69	63	8.70%
ALLEGHANY	104	104	59	22	22	14	0		0	126	73	42.06%
ANSON	0	0	0	53	47	39	0		60	107	39	63.55%
ASHE	76	76	45	30	30	29	0		0	106	74	30.19%
AVERY	46	46	43	0	0	0	0		0	46	43	6.52%
BEAUFORT	183	181	169	10	10	10	0	72	66	329	179	45.59%
BERTIE	75	70	65	38	36	33	0	20	0	126	98	22.22%
BLADEN	259	259	219	30	29	28	18		6	312	247	20.83%
BRUNSWICK	86	86	63	92	92	74	66		72	316	137	56.65%
BUNCOMBE	1082	1067	872	413	413	333	54		165	1699	1205	29.08%
BURKE	379	354	331	60	60	59	0		151	565	390	30.97%
CABARRUS	623	611	496	54	54	40	259		0	924	536	41.99%
CALDWELL	298	289	268	20	17	14	0		108	414	282	31.88%
CAMDEN	6	6	4	0	0	0	0		0	6	4	33.33%
CARTERET	238	238	44	13	12	5	0		76	326	49	84.97%
CASWELL	252	252	218	0	0	0	12		0	264	218	17.42%
CATAWBA	363	348	313	74	74	73	128		202	752	386	48.67%
CHATHAM	194	194	162	120	113	78	0		90	397	240	39.55%
CHEROKEE	48	48	44	20	20	12	6		12	86	56	34.88%
CHOWAN	60	60	59	30	30	29	0	50	0	140	88	37.14%
CLAY	12	12	7	20	19	18	0		0	31	25	19.35%
CLEVELAND	438	412	396	0	0	0	87		216	715	396	44.62%
COLUMBUS	183	183	178	25	25	22	0	76	0	284	200	29.58%
CRAVEN	466	466	404	33	31	27	0		222	719	431	40.06%
CUMBERLAND	777	762	691	194	174	126	176		120	1232	817	33.69%
CURRITUCK	0	0	0	10	8	8	0	60	0	68	8	88.24%
DARE	0	0	0	18	18	17	0	50	0	68	17	75.00%
DAVIDSON	318	318	255	198	186	162	144		6	654	417	36.24%
DAVIE	105	101	83	64	64	56	0		77	242	139	42.56%
DUPLIN	325	325	271	62	52	46	0		104	481	317	34.10%
DURHAM	933	890	772	167	167	138	121		3	1181	910	22.95%
EDGECOMBE	281	280	277	65	59	48	66		60	465	325	30.11%
FORSYTH	1489	1424	1158	253	165	144	116		494	2199	1302	40.79%
FRANKLIN	270	269	225	10	10	10	0		0	279	235	15.77%
GASTON	531	524	503	214	194	168	0		469	1187	671	43.47%
GATES	0	0	0	10	10	4	0		0	10	4	60.00%
GRAHAM	30	30	21	23	23	20	0		3	56	41	26.79%
GRANVILLE	197	190	163	40	40	36	0	56	0	286	199	30.42%
GREENE	46	46	41	17	17	11	6		0	69	52	24.64%

Division of Facility Services
Adult Care Bed Vacancy Survey
2/9/98 11:03 AM

ADULT CARE BED VACANCY REPORT AS OF 1/31/98

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals								
COUNTY	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	BEDS IN PIPELINE *2	EXEMPTIONS BY(b)(4) *3	EXEMPTIONS BY (b)(2) *4	TOTAL BEDS *5	TOTAL BEDS OCCUPIED	VACANCY RATE *6
GUILFORD	1103	1029	862	480	456	417	577		418	2480	1279	48.43%
HALIFAX	172	156	126	45	40	35	0		0	196	161	17.86%
HARNETT	483	465	426	114	57	51	0	66	0	588	477	18.88%
HAYWOOD	311	311	252	30	30	30	0		18	359	282	21.45%
HENDERSON	358	358	328	40	40	37	0		138	536	365	31.90%
HERTFORD	187	187	173	0	0	0	2	56	0	245	173	29.39%
HOKE	75	71	58	10	10	9	11		0	92	67	27.17%
HYDE	0	0	0	0	0	0	0		0	0	0	0.00%
IREDELL	583	583	473	170	170	151	81		220	1054	624	40.80%
JACKSON	143	143	102	20	20	14	0		0	163	116	28.83%
JOHNSTON	474	471	415	30	28	26	84		60	643	441	31.42%
JONES	6	6	6	20	20	15	6		0	32	21	34.38%
LEE	310	310	253	0	0	0	3		0	313	253	19.17%
LENOIR	286	284	255	0	0	0	6	72	0	362	255	29.56%
LINCOLN	140	138	138	63	63	55	56		56	313	193	38.34%
MACON	52	52	46	30	23	23	0		0	75	69	8.00%
MADISON	54	54	46	20	20	17	0	69	0	143	63	55.94%
MARTIN	165	157	147	0	0	0	0	63	0	220	147	33.18%
MCDOWELL	419	412	346	15	15	13	0		0	427	359	15.93%
MECKLENBURG	940	940	704	628	562	448	612		852	2966	1152	61.16%
MITCHELL	35	35	30	10	10	7	0		0	45	37	17.78%
MONTGOMERY	167	166	154	10	10	10	36		0	212	164	22.64%
MOORE	275	257	239	86	85	72	116		365	823	311	62.21%
NASH	235	233	223	149	143	130	0		60	436	353	19.04%
NEW HANOVER	661	660	526	170	50	31	78		253	1041	557	46.49%
NORTHAMPTON	211	211	176	0	0	0	19		6	236	176	25.42%
ONSLOW	391	391	312	8	8	8	4		160	563	320	43.16%
ORANGE	196	195	158	127	127	120	86		112	520	278	46.54%
PAMILICO	0	0	0	8	8	8	124		0	132	8	93.94%
PASQUOTANK	190	190	177	0	0	0	0		76	266	177	33.46%
PENDER	103	103	57	23	23	20	0		0	126	77	38.89%
PERQUIMANS	64	64	53	0	0	0	0		0	64	53	17.19%
PERSON	73	73	61	5	5	5	0		116	194	66	65.98%
PITT	494	491	362	50	50	42	84		68	693	404	41.70%
POLK	38	35	30	74	74	54	0		0	109	84	22.94%
RANDOLPH	315	315	293	68	67	53	268		0	650	346	46.77%
RICHMOND	287	287	178	10	10	10	0		60	357	188	47.34%
ROBESON	631	629	527	47	25	24	35		30	719	551	23.37%
ROCKINGHAM	359	359	295	39	39	37	146		86	630	332	47.30%
ROWAN	510	504	456	207	207	175	180		118	1009	631	37.46%

Division of Facility Services
Adult Care Bed Vacancy Survey
2/9/98 11:03 AM

ADULT CARE BED VACANCY REPORT AS OF 1/31/98

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals								
COUNTY	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	BEDS IN PIPELINE *2	EXEMPTIONS BY(b)(4) *3	EXEMPTIONS BY (b)(2) *4	TOTAL BEDS *5	TOTAL BEDS OCCUPIED	VACANCY RATE *6
RUTHERFORD	515	506	455	100	100	97	0		76	682	552	19.06%
SAMPSON	173	160	138	60	59	56	53		0	272	194	28.68%
SCOTLAND	158	153	135	20	20	20	0		60	233	155	33.48%
STANLY	55	55	52	52	52	51	6		238	351	103	70.66%
STOKES	123	123	121	58	48	44	0	58	0	229	165	27.95%
SURRY	404	404	371	71	71	62	0		66	541	433	19.96%
SWAIN	50	50	43	0	0	0	0		0	50	43	14.00%
TRANSYLVANIA	32	31	27	30	30	23	98		120	279	50	82.08%
TYRRELL	0	0	0	0	0	0	0	5	0	5	0	100.00%
UNION	289	274	232	67	40	36	122		58	494	268	45.75%
VANCE	204	198	146	77	73	64	6		0	277	210	24.19%
WAKE	1653	1520	1347	229	210	184	124		698			
WARREN	189	169	124	20	20	20	0		0	189	144	23.81%
WASHINGTON	0	0	0	9	9	8	40		0	49	8	83.67%
WATAUGA	102	100	97	0	0	0	0	72	96	268	97	63.81%
WAYNE	537	536	481	32	32	29	184		102	854	510	40.28%
WILKES	161	158	138	19	19	17	0	50	0	227	155	31.72%
WILSON	445	428	389	69	69	33	50		76	623	422	32.26%
YADKIN	169	169	156	20	20	19	0	72	0	261	175	32.95%
YANCEY	29	29	29	0	0	0	0	60	0	89	29	67.42%
TOTALS	**28,422**	**27,768**	**23,506**	**6,245**	**5,692**	**4,842**	**4,588**	**1,027**	**7,956**	**44,479**	**26,817**	**39.71%**

*1. Beds Available differs from licensed beds in facilities where some of the licensed capacity has been temporarily removed from service.
*2. Beds in Pipeline are beds with approved plans due to applications submitted prior to May 18, 1997.
*3. Exemptions by (b)(4) are those that represent applications currently under review from applicants proposing to build facilities in counties with vacancy rates of less than 15%.
*4. Exemptions by (b)(2) are those granted to applicants who have demonstrated that prior to August 25, 1997, they purchased real property, entered into a contract to do so, or otherwise made a binding commitment to establish or expand an adult care home facility.
*5. Total beds is the sum of licensed capacity beds in pipeline and exemptions under (b)(4) or (b)(2).
*6. Vacancy rate is the percentage of beds licensed, approved or exempted that are currently occupied.

ADULT CARE BED VACANCY REPORT AS OF 1/31/98

Corrected 2/19/98

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals								
COUNTY	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	BEDS IN PIPELINE *2	EXEMPTIONS BY(b)(4) *3	EXEMPTIONS BY (b)(2) *4	TOTAL BEDS *5	TOTAL BEDS OCCUPIED	VACANCY RATE *6
ALAMANCE	780	774	565	4	4	1	29		312	1119	566	49.42%
ALEXANDER	66	66	63	0	0	0	3		0	69	63	8.70%
ALLEGHANY	104	104	59	22	22	14	0		0	126	73	42.06%
ANSON	0	0	0	53	47	39	0		60	107	39	63.55%
ASHE	76	76	45	30	30	29	0		0	106	74	30.19%
AVERY	46	46	43	0	0	0	0		0	46	43	6.52%
BEAUFORT	183	181	169	10	10	10	0	72	66	329	179	45.59%
BERTIE	75	70	65	38	36	33	0	20	0	126	98	22.22%
BLADEN	259	259	219	30	29	28	18		6	312	247	20.83%
BRUNSWICK	86	86	63	92	92	74	66		72	316	137	56.65%
BUNCOMBE	1082	1067	872	413	413	333	54		165	1699	1205	29.08%
BURKE	379	354	331	60	60	59	0		151	565	390	30.97%
CABARRUS	623	611	496	54	54	40	259		0	924	536	41.99%
CALDWELL	298	289	268	20	17	14	0		108	414	282	31.88%
CAMDEN	6	6	4	0	0	0	0		0	6	4	33.33%
CARTERET	238	238	44	13	12	5	0		76	326	49	84.97%
CASWELL	252	252	218	0	0	0	12		0	264	218	17.42%
CATAWBA	363	348	313	74	74	73	128		202	752	386	48.67%
CHATHAM	194	194	162	120	113	78	0		90	397	240	39.55%
CHEROKEE	48	48	44	20	20	12	6		12	86	56	34.88%
CHOWAN	60	60	59	30	30	29	0	50	0	140	88	37.14%
CLAY	12	12	7	20	19	18	0		0	31	25	19.35%
CLEVELAND	438	412	396	0	0	0	87		216	715	396	44.62%
COLUMBUS	183	183	178	25	25	22	0	76	0	284	200	29.58%
CRAVEN	466	466	404	33	31	27	0		222	719	431	40.06%
CUMBERLAND	777	762	691	194	174	126	176		120	1232	817	33.69%
CURRITUCK	0	0	0	10	8	8	0	60	0	68	8	88.24%
DARE	0	0	0	18	18	17	0	50	0	68	17	75.00%
DAVIDSON	318	318	255	198	186	162	144		6	654	417	36.24%
DAVIE	105	101	83	64	64	56	0		77	242	139	42.56%
DUPLIN	325	325	271	62	52	46	0		104	481	317	34.10%
DURHAM	933	890	772	167	167	138	121		3	1181	910	22.95%
EDGECOMBE	281	280	277	65	59	48	66		60	465	325	30.11%
FORSYTH	1489	1424	1158	253	165	144	116		494	2199	1302	40.79%
FRANKLIN	270	269	225	10	10	10	0		0	279	235	15.77%
GASTON	531	524	503	214	194	168	0		469	1187	671	43.47%
GATES	0	0	0	10	10	4	0		0	10	4	60.00%
GRAHAM	30	30	21	23	23	20	0		3	56	41	26.79%
GRANVILLE	197	190	163	40	40	36	0	56	0	286	199	30.42%
GREENE	46	46	41	17	17	11	6		0	69	52	24.64%
GUILFORD	1103	1029	862	480	456	417	577		418	2480	1279	48.43%

Division of Facility Services
Adult Care Bed Vacancy Survey
2/19/98 9:56 AM

ADULT CARE BED VACA[redacted]REPORT AS OF 1/31/98

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals								
COUNTY	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	BEDS IN PIPELINE *2	EXEMPTIONS BY(b)(4) *3	EXEMPTIONS BY (b)(2) *4	TOTAL BEDS *5	TOTAL BEDS OCCUPIED	VACANCY RATE *6
HALIFAX	172	156	126	45	40	35	0		0	196	161	17.86%
HARNETT	483	465	426	114	57	51	0	66	0	588	477	18.88%
HAYWOOD	311	311	252	30	30	30	0		18	359	282	21.45%
HENDERSON	358	358	328	40	40	37	0		138	536	365	31.90%
HERTFORD	187	187	173	0	0	0	2	56	0	245	173	29.39%
HOKE	75	71	58	10	10	9	11		0	92	67	27.17%
HYDE	0	0	0	0	0	0	0		0	0	0	0.00%
IREDELL	583	583	473	170	170	151	81		220	1054	624	40.80%
JACKSON	143	143	102	20	20	14	0		0	163	116	28.83%
JOHNSTON	474	471	415	30	28	26	84		60	643	441	31.42%
JONES	6	6	6	20	20	15	6		0	32	21	34.38%
LEE	310	310	253	0	0	0	3		0	313	253	19.17%
LENOIR	286	284	255	0	0	0	6	72	0	362	255	29.56%
LINCOLN	140	138	138	63	63	55	56		56	313	193	38.34%
MACON	52	52	46	30	23	23	0		0	75	69	8.00%
MADISON	54	54	46	20	20	17	0	69	0	143	63	55.94%
MARTIN	165	157	147	0	0	0	0	63	0	220	147	33.18%
MCDOWELL	419	412	346	15	15	13	0		0	427	359	15.93%
MECKLENBURG	940	940	704	628	562	448	612		852	2966	1152	61.16%
MITCHELL	35	35	30	10	10	7	0		0	45	37	17.78%
MONTGOMERY	167	166	154	10	10	10	36		0	212	164	22.64%
MOORE	275	257	239	86	85	72	116		365	823	311	62.21%
NASH	235	233	223	149	143	130	0		60	436	353	19.04%
NEW HANOVER	661	660	526	170	50	31	78		253	1041	557	46.49%
NORTHAMPTON	211	211	176	0	0	0	19		6	236	176	25.42%
ONSLOW	391	391	312	8	8	8	4		160	563	320	43.16%
ORANGE	196	195	158	127	127	120	86		112	520	278	46.54%
PAMILICO	0	0	0	8	8	8	124		0	132	8	93.94%
PASQUOTANK	190	190	177	0	0	0	0		76	266	177	33.46%
PENDER	103	103	57	23	23	20	0		0	126	77	38.89%
PERQUIMANS	64	64	53	0	0	0	0		0	64	53	17.19%
PERSON	73	73	61	5	5	5	0		116	194	66	65.98%
PITT	494	491	362	50	50	42	84		68	693	404	41.70%
POLK	38	35	30	74	74	54	0		0	109	84	22.94%
RANDOLPH	315	315	293	68	67	53	268		0	650	346	46.77%
RICHMOND	287	287	178	10	10	10	0		60	357	188	47.34%
ROBESON	631	629	527	47	25	24	35		30	719	551	23.37%
ROCKINGHAM	359	359	295	39	39	37	146		86	630	332	47.30%
ROWAN	510	504	456	207	207	175	180		118	1009	631	37.46%
RUTHERFORD	515	506	455	100	100	97	0		76	682	552	19.06%
SAMPSON	173	160	138	60	59	56	53		0	272	194	28.68%

Division of Facility Services
Adult Care Bed Vacancy Survey
2/19/98 9:56 AM

ADULT CARE BED VACANCY REPORT AS OF 1/31/98

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals								
COUNTY	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	LICENSED CAPACITY	BEDS AVAILABLE *1	BEDS OCCUPIED	BEDS IN PIPELINE *2	EXEMPTIONS BY(b)(4) *3	EXEMPTIONS BY (b)(2) *4	TOTAL BEDS *5	TOTAL BEDS OCCUPIED	VACANCY RATE *6
SCOTLAND	158	153	135	20	20	20	0		60	233	155	33.48%
STANLY	55	55	52	52	52	51	6		238	351	103	70.66%
STOKES	123	123	121	58	48	44	0	58	0	229	165	27.95%
SURRY	404	404	371	71	71	62	0		66	541	433	19.96%
SWAIN	50	50	43	0	0	0	0		0	50	43	14.00%
TRANSYLVANIA	32	31	27	30	30	23	98		120	279	50	82.08%
TYRRELL	0	0	0	0	0	0	0	5	0	5	0	100.00%
UNION	289	274	232	67	40	36	122		58	494	268	45.75%
VANCE	204	198	146	77	73	64	6		0	277	210	24.19%
WAKE	1653	1520	1347	229	210	184	124		698	2552	1531	40.00%
WARREN	189	169	124	20	20	20	0		0	189	144	23.81%
WASHINGTON	0	0	0	9	9	8	40		0	49	8	83.67%
WATAUGA	102	100	97	0	0	0	0	72	96	268	97	63.81%
WAYNE	537	536	481	32	32	29	184		102	854	510	40.28%
WILKES	161	158	138	19	19	17	0	50	0	227	155	31.72%
WILSON	445	428	389	69	69	33	50		76	623	422	32.26%
YADKIN	169	169	156	20	20	19	0	72	0	261	175	32.95%
YANCEY	29	29	29	0	0	0	0	60	0	89	29	67.42%
TOTALS	**28,422**	**27,768**	**23,506**	**6,245**	**5,692**	**4,842**	**4,588**	**1,027**	**7,956**	**47,031**	**28,348**	**39.72%**

*1. Beds Available differs from licensed beds in facilities where some of the licensed capacity has been temporarily removed from service.

*2. Beds in Pipeline are beds with approved plans due to applications submitted prior to May 18, 1997.

*3. Exemptions by (b)(4) are those that represent applications currently under review from applicants proposing to build facilities in counties with vacancy rates of less than 15%.

*4. Exemptions by (b)(2) are those granted to applicants who have demonstrated that prior to August 25, 1997, they purchased real property, entered into a contract to do so, or otherwise made a binding commitment to establish or expand an adult care home facility.

*5. Total beds is the sum of beds available, beds in pipeline and exemptions under (b)(4) or (b)(2).

*6. Vacancy rate is the percentage of beds licensed, approved or exempted that are currently occupied.

Division of Facility Services
Adult Care Bed Vacancy Survey
2/19/98 9:56 AM

A Study of Options for Making Prescription Drugs More Affordable for Older Adults

Prepared by the
North Carolina
Division of Aging

Carol Shaw 2-19-98

Options Used/Considered by Other States

- State Funded Prescription Drug Programs

  - 11 states known to be operating such programs

- 1115 Medicaid Waivers to cover drugs only, for new coverage group(s)

  - Vermont only state to get such a waiver
  - 15 states and District of Columbia have Medicaid income eligibility level of 100% of poverty for aged/disabled. This gives more low-income persons access to Medicaid coverage for drugs. ('93 HCFA data)

- Extending Multi-State Purchasing Alliance Discounts to Other Groups

  -1 state (MN) looking at setting up a state administered purchasing alliance

"Home Grown" Options

1. Possibly extend Medicaid discounts to QMB's and SLIMBY's.

2. Consumer Education by local Drug Assistance Programs is vitally important.

3. Work with Medical Society to streamline Drug Manufacturer Patient Assistance Programs.

4. Promote new Medicare Supplement policies that offer a drug benefit w/lower cost plans.

   (Dept. of Insurance is seeking HCFA approval)

5. Encourage AARP to make permanent and market their "Member Choice" drug enrollment program.

Extending Medicaid Discounts to QMB's & SLIMBY's

- Discounts currently average about 20%.
- Manufacturers & pharmacies would need to agree to offer discounts to this limited group.
- Identification cards would ensure purchasers eligible for discount (QMB's already have).
- Up-front funds needed to cover lag time in rebate payments by manufacturers.
- Pharmacy Network National Corporation (PNNC) is willing to look at this option.

QMB/SLIMBY Discounts

- Could help about 60,000 of most vulnerable older/disabled adults ('98-99).
- $9.2 million in one-time funding needed to cover 6 months of rebates due to lag time in payment of rebates by manufacturers.
- Requires agreement by pharmacy network and manufacturers.
- Need to protect start-up investment by requiring discount be offered for a specified period of time.

More Consumer Education

- Consumer education very important given 89% of elderly use prescription drugs and strategies used to manage costs.
- Appropriate use of prescription/over the counter medications important to health status.
- Public and/or private support needed to implement this option.

Actions Already Underway by DHHS & Dept. of Insurance

1. Streamlining Manufacturer Assistance Programs

- This may be area of interest to Medical Society.
  - Could coalition be formed with other states to strengthen efforts?
- Is there an interest by manufacturers to streamline or standardize these programs?
- Success in this area could mean more health providers tapping this resource.
- This option would benefit low-income persons.

2. New Medicare Supplement Policy Options

- Combine drug benefit (plan J) with lower cost plans to make drug coverage more affordable.
- HCFA approval required (being sought by DOI).
- Cost differential estimated at $31 p/month.
- Benefits new Medicare enrollees of moderate and upper income.
- If 20% of new purchasers bought such a policy, would benefit approximately 1,700 in 1998.

3. AARP's "Member Choice" Drug Discount Enrollment Program

- AARP's "Member Choice" drug discount enrollment program will be continued and expanded in North Carolina.

- AARP will re-market the availability of this program in January 1998.

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Minutes
March 17, 1998

The Joint Appropriations Subcommittee on Human Resources met on Tuesday, March 17, 1998 in Room 414 LOB at 10:00 a.m. Senator Bill Martin presided. There were five Senators present and the following Representatives:

Representative Lanier Cansler	Representative Julia Howard
Representative Bill Hurley	Representative Debbie Clary
Representative Charlotte Gardner	Representative Martha Alexander
Representative Henry Aldridge	Representative Alma Adams
Representative Cindy Watson	Representative Edd Nye

Staff present were: Mary Ellen Sylvester, Karen Hammonds-Blanks and Carol Shaw from Fiscal Staff and Gann Watson and Susan Sabre from Bill Drafting.

Governor's Commission on Juvenile Crime and Justice

Marcia Morey, Executive Director of the Governor's Commission on Juvenile Crime and Justice, summarized the commission's report and will make copies available to the members when it is published as expected in the next few days. Members expressed concern for the policy changes and funds needed to implement the plans.

Paula Wolfe of the Covenant for North Carolina's Children and Martha Livengood, research associate with Youth Advocacy and Involvement who acted as facilitator for the commission, spoke about the need for prevention and early intervention with families who have at-risk children. Senator Martin asked for a summary of Dr. Olds's report to which Ms. Wolfe referred.

Audit of the NC Immunization Program

Barry Goldstein , Deputy Director of the Division of Women's and Children's Health, gave the Division response to the audit of the NC Immunization Program. (See Attachment #1.) Barbara Laymon, Assistant Section Chief of Immunization, answered members questions about physician reports, wastage, and immunization rates.

Representative Cansler requested the Office of the State Auditor to audit the NC Immunization program because he was unable to resolve the discrepancies in the figures the Division put forth. Representative Gardner wanted to know if they have documentation on the wastage of vaccine. She also wanted to know who is correct on the rate of pre-school age immunization, Smart Start or the Division of Immunization. Senator Martin asked for follow-up information on these figures. Senator Phillips said the Division has poor accounting procedures, record keeping and business practices. Representative Clary asked staff to bring back to the committee a proposal to institute a

replacement program system in the Immunization Division instead of the present system of dispersing vaccine. Representative Aldridge asked for the record of the amount of vaccine replaced by drug companies. Senator Martin wanted to know the percentage of wastage due to power outages and negligence. Representative Gardner wanted a report on the physicians who haven't reported on vaccine usage.

Division's Response to the Performance Audit on the Division of Service for the Blind
Mary Ellen Sylvester of the Fiscal Staff presented the Division's Response to the Performance Audit on the Division of Service for the Blind. (See Attachment's #2 & #3.)

Senator Martin asked to the Division to determine what is a "reasonable" level of income for the vendors. Mr. DeLuca, Director, said he would not be comfortable limiting a blind person's income. Representative Alexander asked if it had been determined whether #21, requiring vendors to repay inventory and petty cash advances, is contrary to federal regulations. Mary Ellen said she would find out.

Status of DHHS-Related Criminal Background
Peggy Ball, Deputy Director of the Division of Child Development; Marc Lodge, General Counsel for DHHS, and Ron Hawley of the State Bureau of Investigation reported on the status of the DHHS-related criminal background checks. (See attachments #4 & #5.) In answer to Representative Adams's question of what kind of assistance does the Division need to solve the backlog problems, Ms. Ball asked for support for the SBI who does the actual background checks and needs equipment and personnel to meet the increasing demand. Senator Martin and Representative Adams asked the FBI to respond to the feasibility of contracting with business to do these checks.

Services for Children with Special Health Care Needs
Mr. Vitaglione, Chief of the Division of Children and Youth, reported on services for children with special health care needs. (See attachment #6.)

At the end of the presentations, Senator Martin announced the full Appropriations Committee will meet to hear State Budget Officer Martin Dorman. The subcommittee will meet after it adjourns.

Barbara R. Hocutt, Clerk

Senator Martin, CO-Chairman

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES
MARCH 17, 18 & 19, 1998 MARCH 17 1998

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paula Wolf	Covenant w/ NC's Children
Whitney Ortiz	DMHDDSAS
Lyn McGuire	NC Assoc. for Home Care
Becki Strut	PPAP
Roe Sawtelle	NC Child Care Coalition
AC DeITCH	YAI/DOA
Martha Livengood	Youth Advocacy & Involvement Office
Wayne Williams	OSBM
NELS ROSELAND	OSBM
RICHARD TRIDEOUT	DHHS - DYS
Wanda Mandeville	DHHS - Budget, Planning, and Analysis
Jim Elgart	DHHS
Brooke [illegible]	Speed Boards
John Bordish	Zeb Alley PA
Tommy Worth	Carolinas HealthCare System
Annette Ethridge	Office of the Governor
Lynne Hamlet	Senator Ellie Kinnaird
C.D. Cochran	UCPNC - Coalition 2001
Barbara Layman	DHHS / WCH
Barry Goldstein	DHHS/DWCH
Joe Herbert	CCPS
Ann Schumdaman	NC Council of Community Programs
Mary Greene	OSBM

MAR 17 AM

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES
MARCH 17, 18 & 19, 1998 MARCH 17, 1998
Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Roslyn Savitt	NC Child Care Coalition
Mary Beeson	OSBM
Barbara Laymon	DHHS/DWCH
Debbie Jackson	Services for Blind
John Dilusca	" "
Richard Cash	State Auditor
[illegible] Farmer	DHHS/DCD
Ron Hawley	DOJ SBI
Stan Lewis	DOJ SBI
Carolyn Nichols	DOJ SBI
Osbonne Shamberg	DSS
Kevin FitzGerald	DSS
Vernon Cox	DSB
Tommy Simmons	DSB
Angie McMillan	DHHS
Wayne Williams	OSBM
[illegible] Wilson	DHHS

10M

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Tuesday, March 17, 1998, 10:00 a.m. - 4:00 p.m.

10:00	**Report on the Recommendations from the Governor's Commission on Juvenile Crime and Justice**	**Marcia Morey**, Executive Director, Governor's Commission on Juvenile Crime and Justice
	State Auditor's Special Purpose Review of the North Carolina Immunization Program	

LUNCH

1:00	**Division's Response to the Performance Audit on the Division of Services for the Blind**	**Mary Ellen Sylvester** Fiscal Research Division
	Status of DHHS-Related Criminal Background Checks	**Peggy Ball**, Deputy Director Division of Child Development **Ron Hawley** State Bureau of Investigation
	Services for Children with Special Health Care Needs	**Tom Vitaglione**, Chief Children and Youth Section, DHHS

North Carolina General Assembly
House of Representatives
State Legislative Building
Raleigh 27601-1096

REPRESENTATIVE CHARLOTTE A. GARDNER
35TH DISTRICT

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March 10, 1998

COMMITTEES:

APPROPRIATIONS
CHAIRMAN: HUMAN RESOURCES
ENVIRONMENT
HUMAN RESOURCES: AGING
INSURANCE
JUDICIARY II
WELFARE REFORM

STUDY COMMISSION ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE: CO-CHAIRMAN
STUDY COMMISSION ON DHR REORGANIZATION: CO-CHAIRMAN

MEMORANDUM

TO: **House Appropriations Subcommittee on Human Resources Members**

FROM: **Representative Charlotte A. Gardner**
Representative Debbie Clary
Representative Lanier Cansler

SUBJECT: **Joint meetings, March 17, 18 and 19, 1998**

JOINT APPROPRIATIONS/SUBCOMMITTEE ON HUMAN RESOURCES MEETING

DATES: **Tuesday, March 17, 1998 - 10 a.m. to 4 p.m.**
Wednesday, March 18, 1998 - 9 a.m. to 4 p.m.
Thursday, March 19, 1998 - 9 a.m. to 1 p.m.

PLACE: **Room 414 LOB**

If you have any questions about these meetings contact Fiscal Staff: Carol Shaw, Karen Hammonds-Blanks and Mary Ellen Sylvester. (919-733-4910)

Barbara R. Hocutt, Committee Clerk
919-715-3017 (Thursdays)

Joint Appropriations Subcommittee on Health & Human Services
DRAFT AGENDA

Tuesday, March 17, 1998, 10:00 a.m. - 4:00 p.m.

10:00	Report on the Recommendations from the Governor's Commission on Juvenile Crime and Justice	Marcia Morey, Executive Director, Governor's Commission on Juvenile Crime and Justice
	LUNCH	
1:00	Division's Response to the Performance Audit on the Division of Services for the Blind	Mary Ellen Sylvester Fiscal Research Division
2:00	Status of DHHS-Related Criminal Background Checks	DHHS
3:00	Services for Children with Special Health Care Needs	Tom Vitaglione, Chief Children and Youth Section, DHHS

Wednesday, March 18, 1998, 9:00 a.m. - 4:00 p.m.

9:00	Division's Review of Area MH Programs	John Baggett, Director DMH/DD/SAS, DHHS
	Report on Special Alzheimer's Units	
	Report on Impact of Downsizing Mental Retardation Centers	
11:00	Cancer Control Programs	DHHS
	LUNCH	
1:00	Report on DHHS's Management Initiatives at the NC School for the Deaf	Lynne Perrin, Assistant Secretary for Aging, Disability, and Long Term Care
2:00	Independent Living Rehabilitation Program	John Dalrymple, Assistant Director for Independent Living, DHHS
3:00	Department-wide Automation Initiatives	DHHS

Thursday, March 19, 1998, 9:00 a.m. - 12:00 p.m.

9:00	Tour of Dorothea Dix Hospital	

STATE OF NORTH CAROLINA
Office of the State Auditor

RALPH CAMPBELL, JR.
STATE AUDITOR

300 N. SALISBURY STREET
RALEIGH, N. C. 27603-5903
TELEPHONE: (919) 733-3217
FAX: (919) 733-8443

March 13, 1998

Representative Lanier M. Cansler
Room 419-A
Legislative Office Building
Raleigh, NC 27601-1096

Dear Representative Cansler:

Per your request, we conducted a special purpose review of the North Carolina Immunization Program administered by the Department of Health and Human Services. Our review was limited to determining compliance with certain requirements of the North Carolina Administrative Code related to provider reporting. Attached is a detailed description of the results of our review. The results of our review indicate that:

- Reports submitted by private providers are incomplete of required data.
- Generally, private providers file reports untimely.
- Private providers are not suspended from the Program for failure to meet reporting requirements.
- Currently, the North Carolina Immunization Registry does not include data on children served by private providers.
- No private provider reports have been entered on the tracking system since the September 1997 reporting period.

I also wish to bring to your attention that our plan to audit fiscal 1998 includes the North Carolina Immunization Program since it is a major recipient of federal financial assistance. Please contact me if you have any questions or desire further assistance.

Respectfully,

Ralph Campbell, Jr.
State Auditor

RCjr/:wl

cc: Dr. H. David Bruton, Secretary

NORTH CAROLINA IMMUNIZATION PROGRAM
COMPLIANCE WITH THE NORTH CAROLINA ADMINISTRATIVE CODE

The primary objective of our review was to determine if the North Carolina Immunization Program was in compliance with selected sections of the North Carolina Administrative Code. The selected sections along with the results of our review are described below.

Background

The North Carolina Immunization Registry (NCIR) is a statewide computerized immunization monitoring and follow-up database. It is a component of the Health Services Information System (HSIS), a mainframe system developed and supported by the State for local health departments to report health service data. The NCIR, introduced in 1995, is the only HSIS component that is statewide and that allows record sharing among the 100 local health departments. Sixty-five health departments are entering information on-line, and the other thirty-five use private vendor software systems to record immunization data. An interface document was developed and implemented to transfer data to the NCIR monthly for these health departments. It was a major undertaking to incorporate the health departments on the NCIR.

Private providers that serve Medicaid patients are required to participate in the State's Immunization program. By participating in the program, providers are provided vaccine free of charge. If vaccines are administered that are not required by the State, then the provider must buy the vaccine from another source. Although required to be in the program, private providers are not presently in the NCIR reporting system. The estimated completion dates for including private providers into the system have been extended.

Durham County was selected as the first site for the implementation of private providers to the NCIR. The Department of Health and Human Services is now in the early stages of this pilot project. The Department plans for private providers who have a computerized immunization data system to enter data into the NCIR through a batch interface mechanism. A data exchange document has been developed that outlines the fields and information required in order to transfer data to the NCIR. For private providers who do not have a computerized immunization data system, two options are being considered. The first option is the use of a scannable FAX form. This option will require providers to complete a form which can be faxed or mailed to the Immunization Section. The second option uses bar code technology. This system will require the Immunization Section to dispense bar code sticker sheets to all immunization providers. The providers will use these sheets, along with a reporting sheet, to indicate which vaccine doses have been given to a specific child. The reporting sheets will be periodically sent to the Immunization Section to be scanned into the computer system.

Findings

CHILDREN SERVED BY PRIVATE PROVIDERS ARE NOT ON THE NORTH CAROLINA IMMUNIZATION REGISTRY

Presently, children served by local health departments are on the North Carolina Immunization Registry. Children served by private providers are not on the Registry. March 1999 is the goal for including these children. The Registry will allow providers to identify county children who are delinquent for immunizations. It will also allow providers to obtain a child's immunization record if medical records are not brought from other physicians or clinics.

15A NCAC 19A.0502 (c) (6): PROVIDERS ARE REQUIRED TO REPORT VACCINE ADMINISTERED

This section of the North Carolina Administrative Code requires providers to report to the Immunization Section in writing or electronically, at least monthly by the fifth day of each month, the name and social security number of the person to whom vaccine was administered, the date of administration, the type and dose of vaccine administered and the provider number of the physician or clinic administering the vaccine.

The Monthly Vaccine Doses Administered Report currently used by private providers does not include the name and social security number of the person to whom the vaccine was administered nor does it include the date of administration of the vaccine. Private providers report the vaccines administered by type, doses, and age group. The Department believes the information not being reported is not necessary at this time, but will be necessary when the Registry is completed and operating. The names and social security numbers requirement was included in the North Carolina Administrative Code because at the time the code was written management believed that the Registry would be completed within a short time. The Registry has taken longer to complete than expected for children served by private providers, but management did not want to take the requirement out of the Code only to have to include it at a later date.

The Code requires providers to report by the fifth of the month. However, the agreement the Department has with providers states that reports are due by the tenth of the month. Management states that the reports are due by the fifth and the date shown in the provider agreement is in error.

Reports received from private providers are keyed into a separate computer tracking system, which shows only that a report has been received for a particular reporting period, not the date of receipt. Because of staff shortages and vacancies, no reports have been keyed into the tracking system since the September 1997 reporting period. Since the current provider reports were not being tracked, we reviewed all reports that had been received for December 1997. The results are shown below.

Total private providers at December 31	926	
Reports received prior to January 6	245	26%
Reports received from January 6-10	249	27%
Reports received after January 10	184	20%
Reports not received as of March 10	248	27%
	926	

As shown above, only 26% of the providers reported in a timely manner. Another 27% of the providers still had not submitted the required reports for the December 1997 reporting period a full two months after the due date.

15A NCAC .0502 (d): PROVIDERS WHO FAIL TO REPORT SHALL BE SUSPENDED

A provider who fails to submit timely and accurate reports, as required in paragraph (c) of 15A NCAC .0502, twice in any twelve month period shall have its eligibility to receive state vaccine suspended for a period of one year. A provider who fails to comply with any of the other requirements of this rule may have its eligibility suspended by the Department for a period determined by the Department and may be subject to an action brought pursuant to G.S. 130A-27. All suspensions shall be in accordance with G.S. 130A-23.

We were able to determine that there were numerous providers who had failed to file reports twice in a twelve month period. None of them had their eligibility to receive state vaccine suspended. The Immunization Section management has decided that the objective of the program is to give vaccine, not to discourage providers from participating in the program. Providers are not suspended for filing late reports.

North Carolina
Department of Health and Human Services
Division of Women's and Children's Health
1330 St. Mary's Street • Post Office Box 29597 • Raleigh, North Carolina 27626-0597
Courier 56-20-11

James B. Hunt Jr., Governor
H. David Bruton, M.D., Secretary

Ann F. Wolfe, M.D., M.P.H., Director

February 20, 1998

MEMORANDUM

TO: Mary Ellen Sylvester, Analyst
Fiscal Research Division

FROM: Ann Wolfe, M.D., M.P.H. AFW

SUBJECT: Questions Regarding North Carolina's Immunization Program

Attached are the answers to questions posed regarding the immunization program. Also included is the answer to the question from February 12, 1998.

If you need further information, please call me at 715-3663. Thank you.

AFW:rpp

Attachment

c: Jim Edgerton
Lee Kittredge
Pam Kilpatrick

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February 20, 1998

IMMUNIZATION PROGRAM

I. *For the year 1997...*

(1) ***What were the total number of vaccine doses distributed to providers?***
2,494,696 doses

(2) ***What were the total number of doses reported as being administered?***
2,458,741 doses

(3) ***What were the total number of doses reported as unused?***
35,955 doses were reported as unused. This is 1.4 percent. The state has made a goal to keep wastage under 3 percent.

(4) ***What were the reported dispositions of unused doses?***
Unused doses were reported as expired or wasted.

(5) ***Did providers account for all doses distributed to them?***
When a provider joins the program, he/she is given a monthly doses administered report to complete and return to the program each month. It is difficult for providers to report all doses given. The program is scheduled to go to a new accountability system utilizing the registry by March of 1999. Difficulty in accounting for doses administered is not unique to North Carolina and CDC has agreed to support enhancement of this component.

(6) ***If not, how many doses were unaccounted for?***
Unknown.

(7) ***Was there any investigation into the disposition of those unaccounted for doses?***
Yes. Every quarter, a review of provider ordering patterns is conducted to looking at excess ordering or wastage by any given practice. Any provider with an extraordinary history is contacted. The situation is resolved and documented, and filed in their record. To date, there have not been any fraudulent situations. All wastage situations are reviewed by vaccine accountability staff and situations over $300 are followed and resolved before replacement vaccine is shipped. North Carolina began the site visit program as a result of increased accountability. One result of the site visit program is the confirmation that providers are doing a good job utilizing the vaccine, but have noted that the current reporting system is difficult to maintain.

(8) ***Did the Department comply with the statues regarding provider reporting and failure to report? If no, under what authority?***
Yes.

(9) ***Did we receive all available Federal dollars due from Vaccine for Children? If no, why?***
Yes.

(10) ***What was the total dollars spent for the immunization program in FY 1996-97.***

State dollars	$11,921,919 (including vaccine)
Federal dollars	$16,655,543 (vaccine)
Federal dollars	$ 6,215,451 (operations)
TOTAL	$34,792,913

II. Are the providers screening patients for VFC eligibility?

All providers are required to screen a child, each time the child is seen, for VFC eligibility. This requirement is clearly stated in the agreement that every practice signs before becoming part of the program. At every opportunity, providers are given more information and counseling on VFC eligibility screening and documentation. North Carolina has implemented a site visit program where VFC screening and documentation are reviewed among other components such as safe vaccine handling and storage procedures and a practice's unique immunization rate. Local health departments utilize the HSIS system to document VFC eligibility. The registry will enable providers to screen and document VFC eligibility more easily.

III. Are providers being audited for compliance with the rules established under statute, etc. for this program? How are we assuring program integrity?

Yes. With the institution of the site visit program, private providers are being audited for compliance on a more regular basis. The regional immunization consultants closely monitor local health department activity and some private provider activity. In addition to the annual provider information requirement, all providers signed an updated agreement (contract). Consultation is provided at every contact.

IV. What action is being taken when providers do not comply with statutory, etc., requirements?

Depending on the nature of the problem, the regional immunization consultant, section chief or assistant section chief telephone the lead physician and reconcile the problem. Generally, problems are solved quickly. However, if a problem can not be resolved, the provider's participation in the program would be terminated and any remaining vaccine in their stock would be retrieved. To date, this has not happened.

V. How does 1997 data compare with 1996?

	1996	1997
Doses Distributed	2,207,406	2,494,696 (12% increase)
Doses Wasted	55,315 (2.5%)*	35,955 (1.4%)
Provider Sites as December 31**	980	1,098 (11% increase)

*Largely due to Hurricane Fran

**A site can have multiple providers

Follow-up on DWCH Presentations to Appropriations Subcommittee, January 21, 1998

2. How does this expenditure compare with other states?

Four states were contacted. All states requested that their identities be withheld.

STATE	1993 BIRTH COHORT	UNIVERSAL STATUS	TOTAL EXPENDITURE	ESTIMATED DOSES	PROGRAM COST PER DOSE
North Carolina	101,357	Yes	$34,792,913	2,343,872	$14.84
State #1	78,745	Yes	$23,000,000	1,885,943	$12.20
State #2	84,668	Yes	$37,300,000	3,401,229	$10,97
State #3	110,622	No	$24,635,000	1,000,000	$24.64
State #4	83,949	No	$25,300,000	1,000,000	$25.30

Every year state has different vaccine requirements and some do not routinely offer varicella (chicken pox) vaccine. North Carolina aggressively promotes the use of varicella vaccine.

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North Carolina
Department of Health and Human Services
Division of Services for the Blind
309 Ashe Avenue - Raleigh, N.C. 27606-2165

James B. Hunt, Jr., Governor
H. David Bruton, M.D., Secretary

John B. DeLuca, Director
(919) 733-9822
FAX (919)733-9769

February 11, 1998

MEMORANDUM

TO: Mary Ellen Sylvester

FROM: John B. DeLuca
John B. DeLuca

RE: Responses to audit questions of 1-28-98

I am attaching the responses to the questions contained in your memorandum of January 28, 1998. The response to question 1. is contained in a spreadsheet that lists the finding/recommendation, responsible person, a proposed action time frame, and action required. Answers to questions 2-6 follow that spreadsheet.

Please contact me regarding additional information needed.

Attachments

cc: Lynne Perrin
Jim Edgerton

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January 28, 1998

MEMORANDUM

To: John DeLuca, Director
Division of Services for the Blind

From: Mary Ellen Sylvester MES
Fiscal Research Division

Subject: Follow-up on Appropriations Subcommittee Meeting, 1/20/98

Please provide the following information in response to legislators' requests during last week's meeting of the Health and Human Services Appropriations Subcommittee. Thank you.

1. A detailed report of how the Division plans to respond to each item in the performance audit, including making recommendations for statutory changes,

2. A set of the governing laws, regulations, policies and procedures from the Business Enterprise (BE) program,

3. A description of the accounting services and policies/procedures for vendors participating in the BE program,

4. The number of BE counselors in the Division,

5. A matrix indicating, for each BE vendor in CY 1997 (or the latest year available), the following information (do not use names):

    a. the number and type of sites (e.g., highway vending)
    b. the length of time serving these sites
    c. the degree of vision loss (e.g., totally blind, legally blind, not legally blind)
    d. level of accounting services required (i.e., A,B,C, or D)
    e. annual income
    f. set-aside amount paid.

6. The number of BE licenses revoked in the past five years. What were the primary reasons these licenses were revoked? What are the performance standards which must be met so licenses will not be revoked?

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

RECOMMENDATION	LEAD STAFF	COMPLETION DATE	ACTION	OUTCOME
COMMISSION F/T BLIND POLICIES	BREEZE/JACKSON	6/30/98	ADOPTION OF BYLAWS	
ORGANIZATIONAL LINES NOT CLEAR	BASS/JACKSON	3/30/98-ONGOING	WSDO OFFICE MEETING	
WORKLOADS NOT EQUITABLE	BASS/JACKSON	6/30/98-ONGOING	RESTRUCTURE 3 IDENTIFIED POSITIONS & STUDY OTHERS AS APPROPRIATE	
B.E. COUNSELOR REPORT TO AREA REHAB SUPERVISOR	NONE	ONGOING	NO SPECIFIC ACTION PLANNED	
ROLE OF NURSES MEDICAL EYE CARE PROGRAM	SYRIA/JACKSON	6/30/98	IDENTIFY NEED; DETERMINE FOCUS; REFLECT IN JOB DESCRIPTION	
ILR COUNSELOR FUNCTIONS/ROLES	SYRIA/REHAB. CHIEF	9/30/98	ANALYZE FUNCTIONS, NEEDS, & JOB DESCRIPTIONS; MAKE RECOMMENDATIONS FOR NEEDED CHANGES	
STATUTORY AUTHORITY/ RESPONSIBILITY	DELUCA	3/30/98	INTERNAL REVIEW OF STATUTES WITH IDENTIFICATION OF NEED FOR POSSIBLE CHANGES	
CENTRALIZED DATABASE	JACKSON/ DIRM/AMAC	6/30/98	REVIEW EXISTING CAPABILITY; IDENTIFY OPTIONS/COSTS; IMPLEMENT ANY CHANGES FOR YEAR BEGINNING 7/1/98	
UPDATE POLICIES	CUTLER	6/30/98-ONGOING	B.E. POLICY MANUAL TO BE REVISED BY 6/30/98	
COMPREHENSIVE TRAINING PROGRAM	DELUCA/ JACKSON	9/30/98	IDENTIFY NEED; ASSESS RESOURCES; POSSIBLE FUNDING REQUEST	
BUDGET INFORMATION DISSEMINATION	PRIVETTE	2/28/98	WRITTEN PLAN OF HOW BUDGET INFORMATION WILL BE MADE AVAILABLE TO EACH CHIEF AND FIELD SUPERVISOR; DETAIL TYPE OF INFORMATION AVAILABLE, FORMAT, FREQUENCY	
NCAS/VENDING FACILITY DATA	CUTLER/ CONTROLLER OFFICE	4/30/98	STATEMENT ON CURRENT AVAILABILITY; WORK NEEDED FOR MODIFICATIONS; RECOMMENDATION ON WHETHER TO MODIFY	

GMS SUBSTITUTE FUNDS	BASS/BERNARDO	IMMEDIATELY/	IMMEDIATELY CEASE USING SUBSTITUTE POSITIONS FOR THOSE
		9/30/98	TEMPORARILY FILLING TEACHER/AIDE POSITIONS; IDENTIFY
			OPTIONS RELATIVE TO CONTRACT SERVICE NEEDS AND HAVE
			RECOMMENDATION
PRIOR YEAR AUDIT	N/A	N/A	NO FURTHER ACTION REQUIRED
EMPLOYMENT SERVICES	REHAB CHIEF/	4/30/98	REVIEW/REVISE TRAVEL POLICY FOR REHAB CLIENTS
	JACKSON		
POLICY - VEHICLE PURCHASES	REHAB CHIEF/	6/30/98	CLARIFY EXISTING POLICY; VERY RARELY USED
	JACKSON		
SET-ASIDE RATE	NONE	N/A	NO SPECIFIC ACTION PLANNED
AUDIT VENDOR RECORDS (B.E.)	NONE	N/A	NO ACTION NEEDED
NUMBER OF HIGHWAY VENDORS	DELUCA	6/30/98-	RE-STATE AGENCY POSITION TO CURRENT VENDORS;
		ONGOING	ASSESS SITES AS THEY ARE VACATED
B.E. CONTRACTS MISLEADING	CUTLER	6/30/98	HAVE ANY NEEDED CHANGES IN PLACE BY 7/1/98
OPERATOR START-UP GRANTS	NONE	N/A	NO ACTION REQUIRED
REHAB TRAINING FACILITY	FESPERMAN/	ONGOING	REVIEW OF STUDENT NEEDS; RESOURCE AVAILABILITY;
	APPLE/JACKSON		NEW PROGRAM OPPORTUNITIES
2/6/98			

2. See attached federal, state, and Division of Services for the Blind documents which serve as authority for operation of the Business Enterprises Program (Randolph-Sheppard Program).

a. Federal Law
b. Federal Regulations
c. NC General Statute
d. Administrative Procedures Act Rules
e. Business Enterprises Operators' Manual

3. The operator in the Business Enterprises program has four options for maintaining his records and reporting his invoices to the Accounting Office of the DHHS Controller's Office. These options are identified as "categories" and designated as A, B, C, or D. New operators must begin as Category A or B operators. Operators are allowed an opportunity to request category changes once each year for the upcoming calendar year.

Category A operators send all invoices and overcash (gross receipts minus that which has been paid to suppliers for invoices and petty cash) to the Accounting Office on the last day of each month. Along with this, he/she sends in a monthly tally sheet of all daily purchases and receipts. The Accounting Department uses the invoices and overcash to generate the profit and loss statement and sends a net proceeds check to the operator with set-aside charges deducted. Category A operators have all payroll functions performed by the Accounting Office, except for payments to the federal and state governments for unemployment tax.

Category B operators retain invoices in the facility and send in a summation (daily/monthly report) of his purchases for resale and all expenses paid from the facility to the Accounting Office at the end of each month with his overcash. The Accounting Office generates a profit and loss statement from the summation and sends the net proceeds check back to the operator.

Category C operators do everything a Category B operator does and in addition they also do all their own payroll, including payments to employees, maintaining payroll records, making timely deposits of withheld funds, and sending W-2, NC-2, and W-3 and NC-3 forms at year end.

Category D operators do everything that Category B and C operators do but they calculate their own profit and loss statements from their invoices and then calculate their net proceeds and set-aside due, sending in only that set-aside due along with an accounting of their daily/monthly sales and expenses.

Operators in Categories B, C, or D have their records reviewed every six months to insure accurate record keeping. For additional information about the accounting categories and procedures, please see the Manual for Business Enterprises Operators, Pages 71-74.

4. There are seven Business Enterprises Counselors across the State.

5. See attached spreadsheet.

6. In order to compete for the opportunity to operate a food service facility which is part of the Randolph-Sheppard Program, an individual must first be licensed by the North Carolina Division of Services for the Blind. Once a facility is awarded to a blind licensed vendor, that operator must sign an agreement with the Division which relates to the operation of a specific location.

The license of an operator may be revoked or suspended for any of the following reasons: failure to comply with the terms of the Agreement to operate the facility, vision improves so that the operator is no longer eligible to hold a license, extended illness occurs with prolonged incapacity of the operator to manage a facility, withdrawal of the operator from the program, gross misconduct or conduct so reprehensible as to bring discredit to the program; conviction of crime or moral turpitude, falsification of information pertaining to eligibility, willful acts that would endanger the lives and property of others, possession of unauthorized firearms or lethal weapons on the job, or reporting to the facility under the influence of alcohol or illegal drugs or partaking of such on the job.

Each licensee who accepts a facility assignment must enter into a contractual operating Agreement with the Division. These Agreements are subject to cancellation or termination if the Division finds that the business of the facility is not conducted in accordance with this Agreement or with applicable federal, state, or local law or regulations. Specifically, the Agreement calls for an operator to cooperate fully with officials of the Division, have the facility open for business as specified, be accountable to the Division for the proceeds of the business, carry out the business in compliance with applicable health laws and regulations, maintain a neat and businesslike appearance and conduct the facility in an orderly, businesslike manner, take proper care of the equipment assigned to the facility, notify the Division a reasonable time in advance of taking any leave from the facility, keep such records as required, obtain and maintain liability insurance and other insurance as required, operate the facility as an individual business devoting his full managerial attention to the operation, and striving to maintain good customer relations.

Each facility has two standards developed, which the operator must agree to maintain: one standard for monthly gross sales volume and another for a gross profit percentage that must be maintained.

The termination of an Agreement to operate at a particular facility does not automatically cause any action to be taken against the license of an operator. Often the Agreement termination is threatened and the offending operator will simply resign in lieu of being terminated from the location. Licenses have been revoked following resignations by operators who were faced with imminent Agreement termination. Since January, 1993, three operators have had their licenses revoked outright and nine operators have left the

program either through resignation in the face of termination or as a result of having their Agreements to operate at a particular location canceled.

The primary reason for the license terminations was failure to properly account to the Division for the proceeds of the business. The reasons for Agreement terminations vary greatly from an inability to profitably operate a location to a failure to maintain customer relations. Each case is somewhat different. Every operator has a generous due process and appeal process available to him/her as required by federal regulation, and the Division always attempts to "rehabilitate" an offending operator consistent with our role as human services providers.

Response to Question 5

BUSINESS ENTERPRISE FACILITIES

1997 CALENDAR YEAR OPERATIONS

VENDOR	FACILITY	TYPE	BEGIN DATE AT FACILITY	ENDING DATE AT FACILITY	ACCOUNTING CATEGORY	GROSS PROFITS FROM OPERATION	SET-ASIDE	NET INCOME TO OPERATOR
1	A	SNACK	12/04/96	4/6/97	B	$ 7,486.77	$ 1,272.75	$ 6,214.02
2	A	SNACK	05/03/82	N/A	D	$ 29,108.46	$ 4,948.44	$ 24,160.02
3	A	HWY. VENDING	09/09/92	N/A	D	$ 50,596.47	$ 8,601.40	$ 41,995.07
4	A	SNACK	06/01/96	COMB #0672	D	$ 979.80	$ 166.57	$ 813.23
	B	VENDING	09/01/95	N/A	D	$ 21,536.61	$ 3,661.22	$ 17,875.39
5	A	SNACK	12/03/96	N/A	B	$ 12,047.49	$ 2,048.07	$ 9,999.42
6	A	SNACK	08/01/96	1/31/97	A	$ 1,239.43	$ 210.70	$ 1,028.73
	B	SNACK	05/10/93	N/A	A	$ 26,821.37	$ 4,559.63	$ 22,261.74
7	A	HWY. VENDING	05/01/93	N/A	D	$ 60,084.75	$ 10,214.41	$ 49,870.34
8	A	VENDING	08/18/95	10/31/97	D	$ 19,015.53	$ 3,232.64	$ 15,782.89
	B	VENDING	10/1/97	N/A	D	$ 6,723.23	$ 1,142.95	$ 5,580.28
9	A	VENDING	03/08/94	N/A	A	$ 11,930.86	$ 2,028.25	$ 9,902.61
10	A	VENDING	01/16/96	N/A	A	$ 4,416.78	$ 750.85	$ 3,665.93
11	A	SNACK	12/1/97	N/A	B	$ 1,120.84	$ 190.54	$ 930.30
12	A	SNACK	04/30/95	N/A	A	$ 25,333.54	$ 4,306.70	$ 21,026.84
13	A	1 sided hwy. vndg	12/16/93	N/A	A	$ 21,517.56	$ 3,657.99	$ 17,859.57
14	A	VENDING	02/01/96	N/A	A	$ 23,865.07	$ 4,057.06	$ 19,808.01
15	A	SNACK	07/07/97	11/30/97	B	$ 6,268.50	$ 1,065.65	$ 5,202.85
	B	VENDING	11/01/97	N/A	B	$ 1,999.97	$ 339.99	$ 1,659.98
16	A	CAFETERIA	08/01/96	9/28/97	B	$ 28,408.04	$ 4,829.37	$ 23,578.67
	B	CAFETERIA	09/01/97	N/A	B	$ (476.34)	$ -	$ (476.34)
17	A	HWY. VENDING	09/01/92	N/A	D	$ 52,789.89	$ 8,974.28	$ 43,815.61
18	A	HWY. VENDING	10/01/92	N/A	D	$ 73,876.49	$ 12,559.00	$ 61,317.49
19	A	SNACK	05/31/94	N/A	A	$ 32,144.27	$ 5,464.53	$ 26,679.74
20	A	CAFETERIA	08/01/96	N/A	A	$ 31,892.34	$ 5,421.70	$ 26,470.64
21	A	HWY. VENDING	07/16/90	N/A	B	$ 82,970.45	$ 14,104.98	$ 68,865.47

BUSINESS ENTERPRISE FACILITIES

1997 CALENDAR YEAR OPERATIONS

VENDOR	FACILITY	TYPE	BEGIN DATE AT FACILITY	ENDING DATE AT FACILITY	ACCOUNTING CATEGORY	GROSS PROFITS FROM OPERATION	SET-ASIDE	NET INCOME TO OPERATOR
22	A	CAFETERIA	08/19/97	N/A	D	$ 317.94	$ -	$ 317.94
	B	1 sided hwy. vndg	05/01/94	N/A	D	$ 12,907.16	$ 2,194.22	$ 10,712.94
23	A	1 sided hwy. vndg	02/01/96	N/A	A	$ 7,896.62	$ 1,402.41	$ 6,494.21
24	A	VENDING	12/31/96	7/14/97	D	$ 22,946.76	$ 3,430.19	$ 19,516.57
	B	1 sided hwy. vndg	04/29/94	N/A	D	$ 55,759.82	$ 9,479.17	$ 46,280.65
25	A	VENDING	11/03/97	N/A	A	$ 627.98	$ 106.76	$ 521.22
26	A	VENDING	07/15/97	N/A	D	$ 15,907.50	$ 2,704.28	$ 13,203.22
	B	VENDING	08/01/94	N/A	D	$ 36,724.92	$ 6,243.24	$ 30,481.68
27	A	SNACK	09/02/97	11/1/97	A	$ 2,772.42	$ 471.31	$ 2,301.11
	B	SNACK	04/01/97	N/A	B	$ 26,546.90	$ 4,440.58	$ 22,106.32
28	A	SNACK	10/09/95	N/A	A	$ 2,969.01	$ 504.73	$ 2,464.28
29	A	SNACK	06/02/97	7/31/97	A	$ 2,659.79	$ 452.16	$ 2,207.63
	B	CAFETERIA	12/01/93	N/A	B	$ 43,404.45	$ 7,378.76	$ 36,025.69
30	A	VENDING	05/02/97	N/A	B	$ 18,735.00	$ 3,184.95	$ 15,550.05
31	A	VENDING	02/01/96	N/A	D	$ 13,109.74	$ 2,228.66	$ 10,881.08
32	A	SNACK	07/01/97	N/A	B	$ 12,429.63	$ 2,113.04	$ 10,316.59
33	A	SNACK	06/09/97	8/1/97	D	$ 2,235.26	$ 379.99	$ 1,855.27
	B	HWY. VENDING	09/10/93	N/A	D	$ 80,670.24	$ 13,713.94	$ 66,956.30
34	A	VENDING	11/01/96	COMB #0750	C	$ 1,126.37	$ 191.48	$ 934.89
	B	SNACK	07/01/96	N/A	C	$ 13,398.73	$ 2,277.78	$ 11,120.95
35	A	HWY. VENDING	01/01/93	N/A	D	$ 52,559.30	$ 8,935.08	$ 43,624.22
36	A	SNACK	04/05/93	N/A	B	$ 1,012.35	$ 172.10	$ 840.25
37	A	HWY. VENDING	11/09/93	N/A	D	$ 47,298.23	$ 8,040.70	$ 39,257.53
38	A	SNACK	04/01/92	N/A	B	$ 17,341.92	$ 2,948.13	$ 14,393.79
39	A	SNACK	03/11/96	5/2/97	D	$ 2,653.83	$ 451.15	$ 2,202.68
	B	SNACK	12/06/96	6/2/97	B	$ 9,077.34	$ 1,543.15	$ 7,534.19
	C	SNACK	04/07/97	11/30/97	B	$ 4,136.48	$ 703.20	$ 3,433.28
40	A	SNACK	02/01/89	N/A	A	$ 12,964.36	$ 2,203.94	$ 10,760.42
41	A	SNACK	10/12/93	N/A	D	$ 15,176.63	$ 2,580.03	$ 12,596.60

BUSINESS ENTERPRISE FACILITIES

1997 CALENDAR YEAR OPERATIONS

VENDOR	FACILITY	TYPE	BEGIN DATE AT FACILITY	ENDING DATE AT FACILITY	ACCOUNTING CATEGORY	GROSS PROFITS FROM OPERATION	SET-ASIDE	NET INCOME TO OPERATOR
42	A	HWY. VENDING	09/01/92	N/A	D	$ 66,361.10	$ 11,281.39	$ 55,079.71
43	A	HWY. VENDING	10/01/89	N/A	D	$ 63,131.40	$ 10,732.34	$ 52,399.06
44	A	VENDING	12/01/86	N/A	D	$ 25,751.17	$ 4,377.70	$ 21,373.47
45	A	VENDING	02/16/93	N/A	A	$ 43,297.71	$ 7,360.61	$ 35,937.10
46	A	SNACK	05/20/96	N/A	B	$ 26,496.96	$ 4,504.48	$ 21,992.48
47	A	HWY. VENDING	07/01/90	N/A	D	$ 95,721.32	$ 18,830.60	$ 76,890.72
48	A	SNACK	09/01/92	N/A	D	$ 61,220.11	$ 10,407.42	$ 50,812.69
49	A	CAFETERIA	01/20/92	N/A	A	$ 30,559.71	$ 5,195.15	$ 25,364.56
50	A	CAFETERIA	05/20/96	N/A	A	$ 45,087.13	$ 7,664.81	$ 37,422.32
51	A	CAFETERIA	09/29/97	N/A	B	$ 4,202.53	$ 714.43	$ 3,488.10
	B	SNACK	10/15/96	9/28/97	B	$ 10,423.27	$ 1,771.96	$ 8,651.31
52	A	CAFETERIA	06/11/79	N/A	D	$ 57,006.56	$ 9,691.12	$ 47,315.44
	B	VENDING	03/20/97	8/19/97	D	$ 212.38	$ 36.10	$ 176.28
53	A	SNACK	08/02/82	N/A	A	$ 17,545.44	$ 2,982.72	$ 14,562.72
54	A	SNACK	05/20/96	4/29/97	B	$ 8,281.13	$ 1,407.79	$ 6,873.34
55	A	CAFETERIA	06/01/95	N/A	A	$ 17,269.67	$ 2,935.84	$ 14,333.83
56	A	VENDING	11/01/96	N/A	D	$ 25,739.26	$ 4,375.67	$ 21,363.59
57	A	SNACK	09/15/96	N/A	B	$ 4,939.92	$ 839.79	$ 4,100.13
58	A	SNACK	08/01/97	N/A	B	$ 5,943.62	$ 1,010.42	$ 4,933.20
59	A	SNACK	12/01/86	3/31/97	A	$ 2,027.90	$ 344.74	$ 1,683.16
60	A	SNACK	10/01/87	N/A	A	$ 5,494.21	$ 934.02	$ 4,560.19
61	A	SNACK	06/10/91	N/A	A	$ 30,189.09	$ 5,132.15	$ 25,056.94
62	A	SNACK	02/01/97	7/31/97	A	$ 208.23	$ 35.40	$ 172.83
63	A	1 sided hwy. vndg	09/08/92	N/A	B	$ 104,555.69	$ 23,247.79	$ 81,307.90
64	A	SNACK	04/01/82	N/A	D	$ 16,986.52	$ 2,887.71	$ 14,098.81
65	A	VENDING	11/01/95	N/A	D	$ 24,003.97	$ 4,080.67	$ 19,923.30

BUSINES TERPRISE FACILITIES

1997 CALENDAR YEAR OPERATIONS

VENDOR	FACILITY	TYPE	BEGIN DATE AT FACILITY	ENDING DATE AT FACILITY	ACCOUNTING CATEGORY	GROSS PROFITS FROM OPERATION	SET-ASIDE	NET INCOME TO OPERATOR
66	A	SNACK	07/10/95	N/A	B	$ 19,152.54	$ 3,255.93	$ 15,896.61
67	A	1 sided hwy. vndg	10/15/90	N/A	A	$ 26,493.59	$ 4,503.91	$ 21,989.68
68	A	VENDING	07/15/96	N/A	B	$ 14,224.49	$ 2,418.16	$ 11,806.33
69	A	SNACK	09/01/94	N/A	B	$ 19,535.79	$ 3,321.08	$ 16,214.71
70	A	SNACK	03/01/96	9/18/97	B	$ 9,629.05	$ 1,636.94	$ 7,992.11
71	A	SNACK	09/29/97	N/A	A	$ 2,691.36	$ 457.53	$ 2,233.83
72	A	SNACK	10/16/96	N/A	B	$ 43,427.27	$ 7,382.64	$ 36,044.63
	A	SNACK	04/01/92	3/31/97	B	$ 8,797.48	$ 1,495.57	$ 7,301.91
73	A	SNACK	06/01/94	N/A	D	$ 26,899.00	$ 4,572.98	$ 22,326.02
74	A	CAFETERIA	12/31/96	3/31/97	A	$ (1,055.20)	$ -	$ (1,055.20)
75	A	SNACK	03/24/86	N/A	A	$ 11,852.94	$ 2,015.00	$ 9,837.94
76	A	SNACK	12/01/96	5/31/97	A	$ 530.52	$ 90.19	$ 440.33
77	A	VENDING	06/08/95	N/A	B	$ 12,468.84	$ 2,104.09	$ 10,364.75
78	A	SNACK	01/13/86	N/A	B	$ 18,265.15	$ 3,105.08	$ 15,160.07
79	A	CAFETERIA	12/01/92	N/A	B	$ 88,576.82	$ 15,258.35	$ 73,318.47
80	A	SNACK	09/18/95	N/A	D	$ 31,593.84	$ 5,370.95	$ 26,222.89
	B	SNACK	06/03/97	7/31/97	D	$ 2,580.54	$ 438.69	$ 2,141.85
81	A	SNACK	08/01/97	9/14/97	B	$ 1,303.69	$ 221.63	$ 1,082.06
82	A	VENDING	11/17/97	N/A	A	$ 5,034.71	$ 855.90	$ 4,178.81
	B	SNACK	12/01/93	N/A	A	$ 24,116.04	$ 4,099.73	$ 20,016.31
83	A	VENDING	08/01/95	N/A	B	$ 2,893.31	$ 491.86	$ 2,401.45
84	A	HWY. VENDING	08/27/92	N/A	D	$ 77,174.53	$ 13,119.67	$ 64,054.86
85	A	SNACK	06/06/94	N/A	A	$ 22,480.28	$ 3,821.65	$ 18,658.63
86	A	1 sided hwy. vndg	07/01/91	N/A	D	$ 41,420.62	$ 7,041.51	$ 34,379.11
87	A	SNACK	09/29/95	N/A	D	$ 57,776.38	$ 9,821.98	$ 47,954.40
88	A	1 sided hwy. vndg	08/01/96	N/A	B	$ 37,853.91	$ 6,435.16	$ 31,418.75

BUSINESS ENTERPRISE FACILITIES

1997 CALENDAR YEAR OPERATIONS

VENDOR	FACILITY	TYPE	BEGIN DATE AT FACILITY	ENDING DATE AT FACILITY	ACCOUNTING CATEGORY	GROSS PROFITS FROM OPERATION	SET-ASIDE	NET INCOME TO OPERATOR
89	A	HWY. VENDING	02/01/94	N/A	D	$ 37,096.63	$ 6,306.43	$ 30,790.20
90	A	SNACK	01/01/88	N/A	D	$ 43,480.72	$ 7,391.72	$ 36,089.00
91	A	HWY. VENDING	07/01/94	N/A	D	$ 76,810.84	$ 13,057.84	$ 63,753.00
92	A	VENDING	05/01/96	N/A	A	$ 17,334.64	$ 2,946.89	$ 14,387.75
93	A	SNACK	02/01/90	N/A	A	$ 40,592.15	$ 6,900.67	$ 33,691.48
94	A	SNACK	12/31/91	N/A	B	$ 25,496.11	$ 4,334.34	$ 21,161.77
95	A	VENDING	06/01/95	6/1/97	A	$ (941.00)	$ -	$ (941.00)
96	A	HWY. VENDING	12/01/93	N/A	D	$ 39,760.88	$ 6,759.35	$ 33,001.53
97	A	SNACK	05/11/84	N/A	B	$ 10,251.80	$ 1,742.81	$ 8,508.99
98	A	HWY. VENDING	09/01/92	N/A	D	$ 107,108.59	$ 24,524.24	$ 82,584.35
						$ 2,964,429.70	$ 518,368.09	$ 2,446,061.61

Federal law and regulation mandate that every individual licensed to operate under the Randolph-Sheppard Act (all vendors in the NC Business Enterprises Program must be licensed under this Act) must be a "blind person." "Blind person" is defined as a person who after examination by a physician shall be determined to have "not more than 20/200 central visual acuity in the better eye with correcting lenses; or an equally disabling loss of the visual field as evidenced by a limitation to the field of vision in the better eye to such a degree that its widest diameter subtends an angle of no greater than 20 degrees." All vendors operating in the Business Enterprises Program were determined to have met this standard for "blindness" at the time of licensure. Eye reports are on file to document these facts. The vendors individually evidence a great variety of degree of vision loss from the totally blind to those with good central vision in very limited fields of vision.

Performance Audit on the [illegible]sion of Services for the Blind
Division's Response to the State Auditor's Recommendations

ORGANIZATIONAL ISSUES

Number	Recommendation	Division's Response	Proposed Action or Rationale for Nonconcurrence	Completion Date
1	**Commission for the Blind:** - Establish written operational policies & procedures, including one on meeting attendance which addresses remedies for excessive absences	Concur	- Will work with the Commission to develop and implement operational policies and procedures	6/30/98
2	**Regional Offices:** - Review lines of reporting authority within each region; communicate them to staff - Immediate supervisors should conduct employees' performance evaluations -Re-evaluate all job descriptions and pay grades to reflect actual duties and responsibilities	Mixed	- Unique circumstances in Winston-Salem office - Will work with staff in that location to clarify lines of reporting authority - Agree immediate supervisors should conduct employees' performance evaluations	3/30/98
3	**Workload Among Headquarters and Field Personnel:** - Initiate workload study - Examine job descriptions for accuracy of duties being performed - Develop and use workload indicators - Request assistance from State Personnel	Concur	- Will continue to review and update job descriptions as vacancies occur - State Personnel reviewed all clerical positions 3 years ago - State Personnel now reviewing BE Counselor positions - Division has identified 3 positions for potential restructuring	6/30/98
4	**Supervision of Business Enterprise Counselors:** - Place BE Counselors under the direct technical supervision of the Chief of Business Enterprises	Nonconcur	- Counselors used to report to the Chief of Business Enterprises - Area Rehabilitation Supervisors represent the Division on-site in local issues and must stay informed about program operations - Will continue to strengthen the informal relationships which exist between the BE Counselors and the BE Chief - Area Rehabilitation Supervisors must be involved for BE set-aside funds to help pay for their positions	N/A
5	**Medical Eye Care Program:** - Abolish Nurse positions or redesign positions to be trainers of field staff - Refer clients served in the Personal Care Services program to private providers	Concur	- Will review positions and may redesign them to provide more low vision evaluations for elderly persons and to provide in-service training for Division staff	6/30/98
6	**Independent Living Rehabilitation Counselors:** - Clarify roles and duties of IL Counselor and Social Worker for the Blind positions - Determine the level of case service funding needed to purchase specialized equipment for clients and make program more effective	Concur	- Will review roles of IL Counselor and Social Worker for the Blind positions - Will develop a cost estimate for meeting case service needs more effectively	9/30/98

Performance Audit on the Division of Services for the Blind
Division's Response to the State Auditor's Recommendations

OPERATIONAL ISSUES

Number	Recommendation	Division's Response	Proposed Action or Rationale for Nonconcurrence	Completion Date
7	**Statutory Authority Vague and Open to Interpretation:** - Review all DSB-related statutes, rules, and regulations and report recommended changes to the General Assembly	Concur - G.S. last reviewed in 1973 - DSB rules reviewed in 1989 - many repealed in 1990 - BE and VR rules amended in 1996	- Will review General Statutes internally and solicit input from clients and advocates - Recommend delaying comprehensive rules review until after completion of statutory review and amendment process	Forward results to General Assembly for consideration in 1999 Session
8	**Database Does Not Contain Statistics for All Programs:** - Modify system to include records for all DSB programs - Develop an unduplicated count of the number of individuals served, in addition to the number of clients receiving services per program - Identify costs and request funding from the General Assembly	Mixed	- For the 4 major programs, can obtain an unduplicated client count now - Programs not covered include BE, Governor Morehead School, Special Assistance for the Blind, and Personal Care Services - Will estimate time and funds required to modify database; however, it may not be worth the investment due to the small numbers of clients and the low risk of duplication of services among these remaining programs	6/30/98
9	**Policies and Procedures Not Current and Not Being Followed Consistently:** - Update and clarify all policies and procedures immediately - Establish system for periodic update and distribution of changes to staff - Client authorization should be based on DSB policies and procedures; deviations should be documented and require Central Office approval	Mixed	- Required BE Manual update is in progress - Manuals for Independent Living Services, Medical Eye Care, Personal Care Services, and VR programs have been reviewed and revised within the last 2 years - Rehabilitation Services Administration reviews VR policies annually for federal compliance - Will reinforce with staff the importance of acting within policy and seeking support from the Central Office for deviations prior to taking action	9/30/98
10	**No Comprehensive Training Program:** - Develop a comprehensive training program for staff - Develop a plan of study for each specialized area - Develop a training plan for each staff person - Estimate cost and request funding from the General Assembly	Concur	- Training funds vary widely by program; VR program has an employee committee in-place to assess and arrange training for VR staff - GMS provides adequate training opportunities for staff - In the Independent Living program, training and travel funds are both in short supply - Will develop an estimate of the funding needed to implement this recommendation	9/30/98

Performance Audit on the [illegible]ision of Services for the Blind
Division's Response to the State Auditor's Recommendations

FINANCIAL ISSUES

Number	Recommendation	Division's Response	Proposed Action or Rationale for Nonconcurrence	Completion Date
11	**More Timely Budget Information to Program Managers:** - Complete conversion to the NC Accounting System - Provide computer equipment and training to all program managers - Grant authority to program managers and hold them accountable for managing their programs	Concur	- All district offices do not have Local Area Network access; therefore, they cannot access their budgets directly - Will develop a written plan of how budget information will be made more available to each chief and area supervisor - Reluctant to make significant financial investment in leased office space	6/30/98
12	**No Financial Data by Vending Facility:** - Need to capture financial data by vending location to monitor profitability of each site and offer maximum number of opportunities for client participation	Mixed	- Information could be retrieved from existing database system if necessary - Will assess need to begin generating this information	4/30/98
13	**GMS Substitute Teacher Funds:** - Pay substitute teachers filling long-term vacancies from budgeted salaries for those positions - Stop creating lapsed salaries to pay for needed contractual services - Request funds from General Assembly for contractual services	Concur	- Will begin paying substitute teachers filling long-term vacancies from positions' budgeted salaries immediately - Occupational and physical therapist positions were eliminated in budget cuts because they were difficult to fill and remained vacant for long periods of time - Understood we were to use lapsed salaries to contract for these services - Will identify budget shortfall for contractual services and develop options	Completed
14	**Follow-up to Prior Related Financial Audit:** - Medical Eye Care Program: Modify written operational procedures to reinforce requirement that eye exam reports must be in client files prior to authorizing medical or surgical treatment	Concur	- Issued written reminder to staff - Check for eye exam reports during the Quality Assurance review process	Completed

Performance Audit on the [illegible]ision of Services for the Blind
Division's Response to the State Auditor's Recommendations

EMPLOYMENT/BUSINESS ENTERPRISE ISSUES

Number	Recommendation	Division's Response	Proposed Action or Rationale for Nonconcurrence	Completion Date
15	**Questionable Employment Services:** - Examine and enforce regulations and procedures for approving and reimbursing client travel	Concur	- Will document future justifications and approvals for out-of-state travel - Will review and revise travel policy for rehabilitation clients	4/30/98
16	**Open-Ended Purchase of Vehicles Policy:** - Rewrite policy to lessen potential for abuse - Allow DSB input into negotiating the purchase price, set maximum downpayment amount per vehicle, establish client payback terms, and communicate consequences of clients' not fulfilling requirements	Concur	- Will consider recommendations and revise existing policy as appropriate	6/30/98
17	**Business Enterprise Set-Aside Structure:** - Establish a graduated scale of set-aside fees, requiring a minimum income level before contributing to set-aside - Petition the General Assembly for the authority to manage the set-aside rate structure	Mixed	- Current set-aside structure is fair and equitable. It is appropriate for vendors to pay set-aside on first dollar of net income earned and according to the same rules as every other vendor - Would welcome the ability to manage set-aside rate structure, in conjunction with the Rehabilitation Services Administration, as was done prior to 1992	N/A
18	**Audit Vendor Records for Accuracy:** - Develop and implement a Standard Financial Review program to review vendors' financial operations - Analyze and bill for accounting services separately	Mixed	- Standard review mechanism exists for Categories B through D vendors (DSB sees all invoices for Category A vendors.) - Costs for DSB management services are known and charged against set-aside collections every year, per federal regulations -- to bill separately would be to charge a second set-aside amount	N/A
19	**Increase Number of Highway Vending Operators:** - Review income produced at each location - Determine reasonable level of net income per operator - Allocate locations to maximize the number of employment opportunities	Mixed	- Revenues at highway vending locations have been higher than projected originally - Plan to consider creating 2 separate operator contracts from dual-sided highway vending locations as vacancies occur - Program does not have a waiting list of 20 clients -- more like a mailing list for advertising vacancies	N/A

Performance Audit on the [illegible]ision of Services for the Blind
Division's Response to the State Auditor's Recommendations

EMPLOYMENT/BUSINESS ENTERPRISE ISSUES (CONT'D)

Number	Recommendation	Division's Response	Proposed Action or Rationale for Nonconcurrence	Completion Date
20	**Business Enterprise Contracts are Misleading:** - Lifetime franchise conflicts with overall VR program goal of preparing clients for competitive employment - Modify policies and procedures to train and place as many clients as possible - Tailor contracts to individual vending locations, as necessary	Mixed	- It is not our goal to transition clients into other types of employment - Self-employment as a BE operator is a legitimate employment outcome, recognized by the Rehabilitation Services Administration - Will work with the Elected Committee of Vendors to improve the wording of contractual agreements	6/30/98
21	**BE Start-up Grants:** - Require vendors to repay inventory and petty cash advances, with a reasonable rate of interest, beginning at 6 months with full repayment in 2 years (contract period)	Nonconcur	- May be contrary to federal regulations - Important that the Division retains title to this inventory - Would be as cumbersome to track client payback as it is to track inventory now	N/A
22	**Rehabilitation Training Facility Underutilized:** - Expand BE program to provide training and placement of clients in other areas of the food services industry - Chief of Rehab Facilities and Chief of Business Enterprises should develop a cooperative plan for using this training facility - Develop methods to enhance client and industry awareness of BE training opportunities	Mixed	- Will review resource availability and develop new program opportunities - BE training is conducted in one classroom in the Rehab Center - Rehabilitation Center offers a variety of training, including "Introduction to Food Sciences," which provides other job opportunities -- cashier, short order cook, dishwasher. Uses same classroom area as BE training - Have developed brochures and a handbook for both client and business use	Ongoing

#4
Mark Lodge

HEALTH AND HUMAN SERVICES
RECENT CRIMINAL RECORD CHECK PROVISIONS

Category	Division	Statute	Year	Comments
Child Care Facilities	DCD	G.S. 110-90.2	1995	• Employees, owner/operators, household members of child care facilities that are licensed or receive State/federal funding • Required at initial application for employment • Division submits information to SBI, receives report • Division determines fitness based on report • Local and state, federal if not in NC for during previous 5 years
Foster Parents	DSS	G.S. 131D-10.3A	1995	• Foster parents and adults in foster family home • Required at licensure and relicensure • Department submits information to SBI • Department determines fitness based on report • Local, state and federal for licensure; local and state for annual relicensure
Adult Care Homes Nursing Homes Home Care Agencies	DFS	G.S. 131D-40 G.S. 131E-265 G.S. 114-19.3	1996	• Applicants for employment at these facilities • Required at initial application for employment • Facility submits information to SBI, receives report • Facility determines fitness based on report • No role specified for Department or Division • "Relevant offense" is a State crime
DHHS employees in direct care, criminal justice and schools	*Various*	*Various*		*Records checks conducted through DCI system.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATUS OF RECENT CRIMINAL RECORD CHECK INITIATIVES

	CHILD DEVELOPMENT	SOCIAL SERVICES	FACILITY SERVICES
Legislation Authorizing Criminal Record Checks:	General Statute 110-90.2 requires a criminal record check (CRC) for • all operators and employees in child care centers and homes; • any individual in a nonlicensed home who receives state or federal funds for providing child care; and • all household members in any new child care home or nonlicensed child care home who are present when children are in care, and are over 15 years of age. The legislation specifies that the Department of Justice is authorized to provide state and federal CRCs as requested by the Division of Child Development.	General Statute 131D-10.3A requires that the supervising agency conduct criminal record checks for • all foster parents applying for relicensure of a family foster home; • new foster parent applicants; and • any member of the foster parent's or prospective foster parent's household who are 18 years of age or older The legislation specifies that the Department of Justice is authorized to provide state and federal CRCs to the Department of Health and Human Services.	General Statute 131D - 40 and 131E - 265 requires a criminal record check for all unlicensed personnel employed in nursing homes, home care agencies and adult care homes. The legislation specifies that the employer shall submit the request for the criminal background check to the Department of Justice.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATUS OF RECENT CRIMINAL RECORD CHECK INITIATIVES

	CHILD DEVELOPMENT	SOCIAL SERVICES	FACILITY SERVICES
Specific Requirements in the Legislation regarding time frames within which to check and/or report:	The only time frame specified in the legislation requires a provider to appeal a disqualification, within 60 days to district court. Within the child care rules there are time frames concerning when a provider must submit forms to the Division. • Prospective child care provider submit CRC forms at the time of license application. • All other providers (teachers, directors, cooks, drivers, etc.) submit the CRC forms to their employer within five (5) working days after beginning work. The employer must submit the forms to the Division within three (3) days after receiving them. • nonlicensed child care home providers to submit the CRC forms to the local purchasing agency (LPA) within five (5) working days after applying for enrollment. Providers are not required to redo the CRC process unless they switch to a new child care program.	The legislation did not impose any time frames.	The legislation specifies that the employer shall submit the CRC request within five business days of making a conditional offer of employment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATUS OF RECENT CRIMINAL RECORD CHECK INITIATIVES

	CHILD DEVELOPMENT	SOCIAL SERVICES	FACILITY SERVICES
Targeted Population:	As of February 28,1998, there were 3,717 licensed child care centers and 5,090 child care homes.	As of January 1997, there were a total of 4,195 family foster homes.	As of January 1998, there were 417 nursing homes, 900 home care agencies and 1,438 adult care homes.
Level of Checks Required:	Local, State & Federal criminal record checks are required. Local Check: A certified name check from the Clerk of Court in the county of residence is required. For prospective owners, a certified name check from the Clerk of Court in all counties of residence during the prior 12 months are required Federal Checks: For all individuals who have lived in NC for less than five (5) years continuously, federal criminal records check are required.	The following criminal record checks are required for all individuals: Local (any convictions on the local level) State Federal	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATUS OF RECENT CRIMINAL RECORD CHECK INITIATIVES

	CHILD DEVELOPMENT	SOCIAL SERVICES	FACILITY SERVICES
How the Division Staffs This Function:	The following positions staff these CRC functions: • Staff attorney, coordinator, one administrative assistant, and one processing assistant are all state funded • Two time limited and one temporary clerical assistants funded with a Governor's Crime Commission grant and state funds.	Family foster home licensing is a part of the Division's overall child welfare licensing program. Licensing staff working with the County DSS's currently relicense over 250 family foster homes monthly in addition to processing approximately 70-90 new applications on a monthly basis. Since 1993, the number of County DSS supervised family foster homes has increased approximately 12%. Additionally, since 1993 the number of private agency licensed family foster homes has increased by 109.4%. Funding is state and federal IV-E. The Division did not receive any additional funding to implement this process.	Facility Services does not staff the process by which the CRC's are obtained. The provider obtains the CRC through an Access Agreement with the SBI.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATUS OF RECENT CRIMINAL RECORD CHECK INITIATIVES

	CHILD DEVELOPMENT	SOCIAL SERVICES	FACILITY SERVICES

The Process the Division Uses to Implement Criminal Record Checks:	• Each provider
	  * obtains a local criminal history check from the Clerk of Court's office in the county of residence,
	  * completes a fingerprint card (or two if both a state and federal check are needed),
	  * completes an identification form, and signs a fingerprint card release form.
	• The forms are then submitted by the provider to their employer or Local Purchasing Agency(LPA).
	  * Copies of forms are maintained by the employer/LPA and
	  * the originals are mailed to the Division CRC unit.
	• The packet is reviewed in the CRC unit.
	  * If the packet is incomplete, it is returned to the employer/LPA with a letter of explanation.
	  * If the packet is complete it is entered in a database and the fingerprint card is sent to the SBI.
	  * The local history is also reviewed.
		• Foster parents are fingerprinted in the counties and
		• Fingerprint cards are then forwarded to the Division who in turn processes the cards for submission to the SBI.
		• The cards are hand delivered for security and confidentiality reasons to the SBI.
		• Fingerprint cards are then returned from the SBI to the Division most often with "NO RECORD", which means there were no convictions and
		  * in these cases the cards are filed in the foster home files, and
		  * the foster parents are notified that they meet the necessary qualifications
		• In the case of fingerprint cards which are returned with a record attached, the cards and the records are routed to the staff assigned to the agency for review.
		  * If the same information has been provided and discussed in the family foster home application by the supervising agency and positive license action was taken, no further action is needed or taken.
			Facility Services is not involved in the process by which the CRC's are obtained. The provider obtains the CRC through an Access Agreement with the SBI.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATUS OF RECENT CRIMINAL RECORD CHECK INITIATIVES

	CHILD DEVELOPMENT	SOCIAL SERVICES	FACILITY SERVICES

	• If there are any convictions related to child abuse/neglect, drugs, violent crimes, etc.
	  * the local history is also reviewed by the Division review panel.
	  * The panel may decide to "fast track" the fingerprint card with the SBI so that the Division receives a response within a few days.
	• When results of the state check are received from the SBI, providers with major convictions are reviewed by the Division review panel which determines if the person is qualified to be a child care provider or not.
	• A notice of qualification or disqualification is mailed to the Provider and employer/LPA.
		* If, however, staff find upon review of the file that the information from the SBI is not contained in the family foster home file, the consultant takes several additional steps to determine if the applicant meets or does not comply with the rule.
		* Based on the continued analysis, the license is either continued or terminated.
		
		(It is important to note that Division staff work very close with the supervising agency to reach a decision that is in the best interest of the child.)	

Payment for CRCs	The employer or employee is responsible for covering the cost of the local check and the fingerprint card. The Division has an appropriation to cover the cost of the state and federal level checks.	The State DSS has an appropriation to cover the cost of the local and federal level checks.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATUS OF RECENT CRIMINAL RECORD CHECK INITIATIVES

	CHILD DEVELOPMENT	SOCIAL SERVICES	FACILITY SERVICES
Results of Implementation of Local, State, and/or Federal Criminal Record Checks:	From May, 1996 to March 1, 1998, the Division has processed records for 49,118 individuals, and has received results from the SBI on 20,617 individuals. Results are pending on 28,501. A total of 53 individuals have been disqualified. There have been no appeals.	The total number of applications sent to the SBI since the legislation was enacted equals 10,903. Of those, 7,734 fingerprint applications have been processed by the SBI since July 1, 1996. As of March 1998, the SBI still had 3,169 applications to process. A total of 5 licenses have been terminated as a result of criminal convictions. To date there have been no appeals even though a foster parent who disagrees with the Department's decision may request a hearing pursuant to Chapter 150B of the General Statutes, the Administrative Procedures Act.	Not tracked by DFS
Problems Encountered in Implementing Criminal Record Checks:	• Providers have not completed forms correctly or packets have been incomplete. Packets are returned to be corrected. • There has been a high volume of rejected fingerprint cards. These are cards which the SBI is unable to read because the fingerprints were smudged or taken incorrectly. • Providers are not submitting the paperwork or are not getting the CRC done at all. • The volume of work has been higher than anticipated, and each individual	• Forms have been returned to be completed correctly. • Division staff currently transport all cards in large boxes to and from the SBI. This process is cumbersome; however, until automation efforts are enhanced at the SBI, this process will probably remain as it is.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATUS OF RECENT CRIMINAL RECORD CHECK INITIATIVES

	CHILD DEVELOPMENT	SOCIAL SERVICES	FACILITY SERVICES
	packet is taking longer to review than anticipated. The total number of packets submitted has exceeded our original estimate of 40,000 child care providers by about 8,000 people. Some of the reasons for this has been the increase in child care programs across the state during the last 12 to 18 months and the high turnover in the child care profession.		
How has the division attempted to overcome these problems?	• Forms have been revised to make them more user-friendly. As child care consultants have visited programs, they have offered consultation on the correct process. • The SBI is doing an up front review of the cards to identify bad fingerprint cards. However, because the legislation does not specify who can take fingerprints, this will be an ongoing problem. • In the past few weeks the Division has stopped sending the release form along with each fingerprint card. The SBI had requested this change so that they could decrease the turnaround time. Since this change, the Division has been receiving an average of 75 to 100 fingerprint results per day from the SBI. This is a substantial increase over prior months.	• The Division has met on a regular basis with the SBI to discuss procedural concerns, and most importantly their automation plans. The Division is hopeful that they will keep the Division's needs in mind as they automate the process through a variety of means.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATUS OF RECENT CRIMINAL RECORD CHECK INITIATIVES

	CHILD DEVELOPMENT	SOCIAL SERVICES	FACILITY SERVICES
	• Licensing consultants are citing child care programs with rule violations when forms are not submitted. Family child care home license renewals packets are not being processed until providers furnish proof that CRC forms have been submitted. • Two time limited positions and a temporary position were established to help with the backlog at the Division level.		
Backlog problems with respect to SBI processing the criminal record checks?	The turnaround time is averaging 10 to 13 months. The turnaround time is longer if the card has to go to the FBI. The Division provisionally approves licenses, renewal of licenses and employment based on the local CRC while waiting results of the SBI check.	The backlog period for processing of 4-6 months delays the Division's ability to finalize the foster parents' licensure status.	Providers have indicted there is a long delay in getting the CRCs.
Additional criminal record checks that will be needed	None anticipated.	The Adoption and Safe Families Act of 1997 mandates states to provide procedures for any approved for placement of a child for federal subsidies. This means an increase in the number of criminal background checks that the Division currently does.	

#5

Criminal History Checks

Report to the Joint Appropriations Subcommittee on Health and Human Services

Assistant Director Ronald P. Hawley

Presentation Outline

- *Current Workload*
- *Historical Review*
- *Personnel*
- *Identification Response to Workload*

1997 Submissions to Identification

- Criminal Fingerprint Cards
  - 141,941
- "Fee for Service" Fingerprint Cards and Name Checks
  - 118,068
    - 79,162 Fingerprint Checks
    - 38,906 Name Checks
- TOTAL SUBMISSIONS = 260,009*

*Revised 03/17/98

Non-Criminal Justice Growth

- 1993
  - 14,729*
- 1994
  - 17,329*
- 1995
  - 29,576*
- 1996
  - 69,676*
- 1997
  - 79,162**

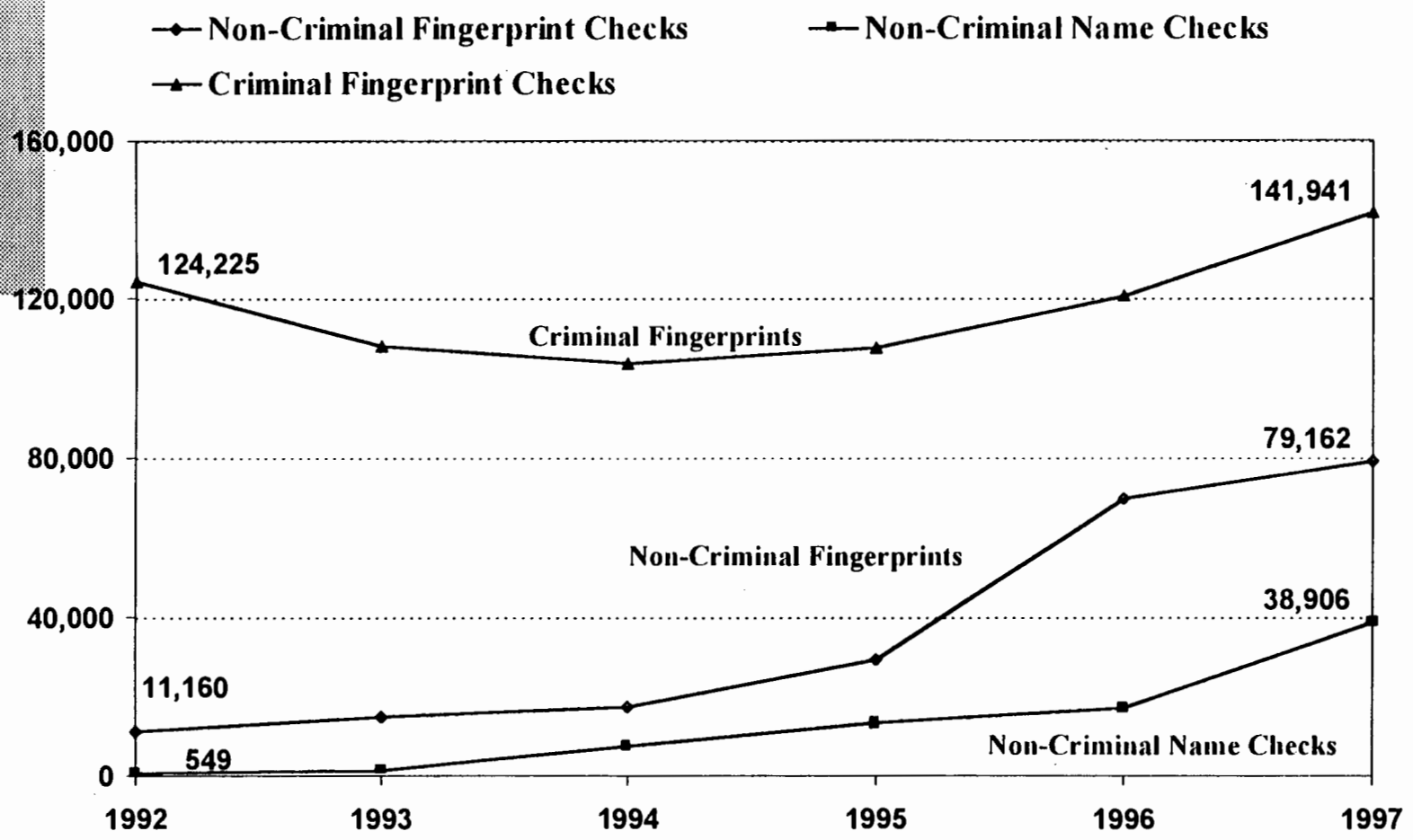
*Revised 3/17/98

**Estimated Number

Criminal Justice Growth

- *1993*
  - *107,968*
- *1994*
  - *103,510*
- *1995*
  - *107,528*
- *1996*
  - *120,619*
- *1997*
  - *141,941*

Name and Fingerprint Checks 1992 - 1997



Personnel Assigned to Identification

- 65 Total Employees
  - 29 Fingerprint Technicians
  - 29 Processing Assistants
- Vacancies
  - 5 (3 - Fingerprint Technicians)
  - Training
    - 2 year Trainee Progression
- Resource Measure
  - 10,000 Cards = 1 FTE - Fingerprint Technician and .5 FTE Processing Assistant
  - This measure is being reevaluated

Actions Addressing Workload

- Overtime & Temporary Employees
  - Interim Solution
    - Plan to use Lapse Salary
      - 6 months - Estimate to reduce the back log
      - 6 months - to keep up with volume
  - Permanent Solution
    - Automation
      - Livescan Devices
      - Bar Coding

Automation of Identification Work

- *Criminal Justice Information Network(CJIN)*
  - *Livescan fingerprinting in the counties*
  - *40 (est.) additional counties by 1st quarter 1999*
- *Bar Coding Project*
  - *Lower cost solution for agencies to submit data*
  - *Eliminate or reduce redundant data entry*

#6 Itinerant

CHILDREN'S SPECIAL HEALTH SERVICES

Purpose: To maximize the health and functioning of children with chronic illnesses and disabilities

Objectives: To create access
To establish standards of care
To introduce new diagnostic and treatment methodologies

ACCOMPLISHMENTS THROUGH THE YEARS

- Created access to specialists
- Stimulated specialty board certification
- Helped introduce iron lung
- Stimulated interventions for polio
- Prevention of rheumatic fever through antibiotics
- Introduced newborn metabolic screening
- Implemented medical genetics services
- Demonstrated multi-disciplinary evaluation for mental retardation
- Standards for restoration of oral-facial anomalies
- Introduced prophylactic penicillin for newborns with sickle cell disease
- Pioneered selective dorsal rhizotomy
- Stimulated bone marrow transplants for leukemia
- Introduced pulmozyme for cystic fibrosis
- Introduced cochlear implants

Current Budget	Total	$14,093,852
	State	10,908,436
	Federal	3,185,416

Personnel	$1,956,080
Operating Expenses	706,362
Contracts	7,754,704
Purchase of Care	3,676,706

Physical Therapists

Contracts: 69 clinics serving 12,000 children annually

Purchase of Care: serving 2,900 children annually

PRIORITY LIST OF NEW SERVICES

• Assessments for attention deficit/hyperactivity disorder for non-Medicaid eligible children in Grades K-3	$1,400,000
• Neonatal Intensive Care Assessments and Developmental Follow-up	$ 800,000
• Establish regional child maltreatment resource centers	$ 400,000
• Provide child service coordination to selected children with special needs ages 5-18	$1,200,000
• Provide special therapies to non-Medicaid eligible children ages 0-3 as required by the Individuals with Disabilities Education Act	$ 810,000
• Develop a system to measure and continuously monitor outcomes of care	$ 400,000
• Provide assistance to medical centers to establish referral and training networks to assure that primary care providers offer appropriate care to children with special needs.	$ 480,000

JOINT APPROPRIATIONS SUBCOMITTEE ON HUMAN RESOURCES

Minutes
March 18, 1998

Senator Bill Martin convened the Joint Appropriations Subcommittee on Human Resources on Wednesday, March 18, 1998 at 10:30 a.m. in Room 414 of the Legislative Office Building. Six Senators were present and the following House Members:

Representative Henry Aldridge	Representative Alma Adams
Representative Cindy Watson	Representative Edd Nye
Representative Julia Howard	Representative Bill Hurley
Representative Martha Alexander	Representative Charlotte Gardner
Representative Debbie Clary	Representative Lanier Cansler

Karen Hammonds-Blanks, Mary Ellen Sylvester of Fiscal Staff and Susan Sabre and Gann Watson of Legal Staff were present also.

Agenda

Senator Martin announced that the first 3 items on the agenda dealing with the Review of Area Mental Health Programs, the Special Alzheimer's Units and the Impact of Downsizing Mental Retardation Centers would be postponed due to the meeting of the Appropriation Committee this morning. The first item on the truncated agenda will be the Cancer Control Programs.

Cancer Control Programs

Linda Devlin, Director of the Division of Community Health gave an overview of the prevention and the causes of cancer. (See Attachment #1.) Mr. Joe Holiday, Chief of the Chronic Disease Prevention and Control, gave an slide presentation documenting the division's efforts to control cancer in North Carolina. Representative Nye wanted to know who changes income eligibility levels and was told that was done by the Commission on Health Services. He hopes someone in the Department brings to the legislature a way to address the withholding of services by the modification of the eligibility level. He would like the legislature to reinstate the income eligibility level at 200% of poverty and, if funds run out, allow Secretary Bruton to put more money in the fund. Senator Martin asked what the cost would be on guaranteeing 200% of poverty without making this an entitlement. Dr. Levine, Deputy Secretary of the Department of Health and Human Services, said the Division got into financial difficulty with an income eligibility level of 200% of poverty and reduced it to 115% of poverty, but they could again attempt to project that level for the committee. Senator Martin said that if the Governor's budget is silent on this issue perhaps the committee could consider raising the eligibility level. Representative Gardner said she did not like decisions of this nature being made outside the legislative process and wants actual financial cost information in order to make an educated decision. Senator Forrester said the use of the money should

be reversed and the larger percentage, 85%, used for treatment and the smaller amount, 15%, used for prevention.

Mr. Booker, Director of the State Center for Health Statistics gave a brief statement of the mission of the center and introduced Dr. Rebecca Martin, Director of the Central Cancer Registry, who explained the function of the registry. Senator Martin asked what the barriers were to getting the information needed. She said that the 1947 law was innovative for its time but did not require facilities to report. Most cancer cases are diagnosed and treated in hospitals and day treatment facilities. The law needs to include all facilities that diagnose and treat cancer and to have some kind of penalty for non-compliance according to Dr. Martin. Prior to advent of the large hospital consortiums, hospitals cooperated on a voluntary basis. The VA hospitals have been the biggest problems. Senator Martin was told the Advisory Committee of which he will be asked to be a member is working on a solution to these access problems. Representative Gardner said she would send out a letter composed by the Division to the Salisbury VA Hospital to ask why they don't cooperate, and she will copy her district Congressman. Senator Phillips agreed to add his name to the inquiry. Dr. Levine said the Advisory Committee and the Hospital Association will be working together to address this problem and will come to the legislature with a proposal.

Representative Nye asked what can be done to get a definitive answer about cancer clusters, and Dr. Martin said it is difficult to document. Representative Watson pointed out constituent documentation on the location of hog and poultry farms and the occurrence of cancer. She wanted to know what funds the Division needs to do the job to investigate the health impact of the hog and poultry farms. Dr. Martin said the division requested 3 positions and received 1 in the budget. They need a Geographical Information System position and a quality assurance position, as well. Ms. Devlin asked for copies of the information Representative Watson has gathered.

The subcommittee took a lunch break.

Report on DHHS's Management Initiatives at the NC School for the Deaf

Secretary Bruton described the management team he had set up at the School for the Deaf at Morganton. He introduced Iverson Riddle, newly appointed Director at the Morganton School for the Deaf, who outlined the problems he has found and the plans he is implementing to solve the problems that have accumulated from years of inattention. Dr. Riddle hopes that the renovation needs can be included in the Secretary's critical needs budget.

Representative Gardner said the Fiscal Staff has not received an answer to an inquiry made in February. She is very concerned about the educational achievement level of the deaf students. Senator Martin and Representative Gardner met with Senator Lee and Representative Arnold and decided that communication and close collaboration on the educational standards and the ABC Plan with DPI and the special schools should be effected. Senator Martin wanted him to include the plans to address this. Dr. Riddle

assured him he is working toward this goal and will be in touch with DPI. Dr. Riddle said he would get to Representative Gardner the answers to the 12 questions presented to him by the Morganton parents. (See Attachment #2.)

Representative Gardner wanted to know about Dr. Green's status, and she wanted to who is in charge of the Division. She also wanted to know why the Division hasn't responded to Fiscal Staff. Lynne Perrin, Assistant Secretary of Aging and Disabilities, said that Dr. Green is ill. Jim Edgerton's staff is working on getting answers to the Fiscal Staff, but had not been able to report because they don't have staff in the Division that can get them reliable information.

Senator Dannelly supports Dr. Riddle and congratulated Dr. Bruton in his courageous handling of the problem at Morganton.

Representative Adams asked about the overlap in problems that are revealed today with what the subcommittee discussed in the past and addressed in the Budget. She wanted to know what happened to the money appropriated in this Division. According to Ms. Sylvester, In 1995 there was $1.5 million appropriated on a recurring basis for which the Division wrote a plan that included computers, special teaching supplies, etc. for each of the four campuses. Also the General Assembly gave $7 to 8 millions to take care of renovation needs. Morganton got money to set up a unit for Behaviorally and Emotionally Handicapped children. She does not know the what happened to the plans or the money. Senator Martin asked the Department for an assessment of what has happened and a plan for addressing these problems. Mary Ellen Sylvester of the Fiscal Staff is working with the Department to get the information. Lynn Perrin said the report was not in condition to be presented to the subcommittee at this time, and Senator Martin asked that if it could be ready for the April meeting to which Ms. Perrin agreed.

Dr. Henry Johnson of DPI was present to listen to the discussion and offered the status on the efforts of DPI and DHHS to add the ABC Program to the Schools for the Deaf this coming school year. He said adding the training schools to the ABC Program would be delayed until 1999-2000.

Representative Watson pointed out that children at CA Dillon don't get diplomas; they get certificates only. DPI has so much money in its budget and should be accountable for educational standards.

Senator Martin asked if it would be a good idea to put a hold on renovation plans and look at other options. Secretary Bruton asked for the support of the subcommittee on going forward in solving the problems. He said he thought everything was in place at Morganton to succeed, and they were reassessing the renovation plans. Mr. Edgerton said the subcommittee might want to consider building smaller facilities. Senator Clark mentioned preferential hiring due to political influence, and asked if Dr. Bruton was trying to change this. Dr. Bruton hopes he is making headway on this problem.

Representative Alexander wanted to know how many children under 18 are deaf in North Carolina but no one knew the exact figure.

Senator Dannelly wanted to know if the deteriorating acoustical tiles were asbestos. Dr. Riddle said they were trying to find that out. He speculated that the facility might be closed down by safety inspectors because the buildings are in such a state of disrepair.

Independent Living Rehabilitation Program

John Dalrymple, Assistant Director for Independent Living, described the program and its history. (See Attachment #3.) He introduced Donna Holt, Program Specialist; Tammy Murphy, IL Office Manager; George Foster, Casework Assistant; and Susan Wood, Rehabilitation Therapist. A slide program showing the kind of services provided to its clients was presented. (See Attachment #4.)'

Representative Watson pointed out that there are 800 on a waiting list and asked what amount of money would be necessary to eliminate the waiting list. Mr. Dalrymple said $3.2 million would be necessary. Representative Aldridge asked Dalrymple to document the needs of the Independent Living program and to submit a monetary request to fund these needs.

Representative Gardner asked the Department for the names of the 200 people who were contacted about the Alzheimer's units. She doesn't understand the lack of response to her special provision calling for providers to submit information about how much they would charge to accommodate Alzheimer's patients. She has been told by the industry representatives that they knew nothing about the survey.

The meeting was adjourned.

Barbara R. Hocutt, Clerk

Senator Bill Martin, Co-Chairman

Attachments

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES
MARCH 17, 18 & 19, 1998

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John M. Booker	Dir., State Ctr Health Statistics
Marion S. White	Dir. Advisory Committee on Cancer Coordination
Mary Pigeon	OSBM
Sandra Long	Hospice of the Carolinas
[illegible] Hollis	DCH, DHHS
Glenn Wells	DCH, DHHS
Pam Kilpatrick	DNHS Budget & Analysis
Jerry Hardesty	Food Banks
Dave Redmond	ARC/NC
Wayne Williams	OSBM
Ed Cockerham Brown	DHHS—SA+P
Joyce Kelley	Western Carolina Center
Holly Riddle	DD Council, DHHS
Lee Kittrell	DHHS
Lynne Repkin	DHHS
Jim Edgerton	DHHS
David Brunton	DHHS
Al Dietch	YAJO/DOA
Susan Sien	CNCSD
Steve Wilcher	ENCSD
Henry Johnson	DPI
Carol Potter	DD Council

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Wednesday, March 18, 1998, 9:00 a.m. - 4:00 p.m.

9:00	**Division's Review of Area MH Programs**	**Tara Larson** CAP-MR/DD Program, DHHS
	Report on Special Alzheimer's Units	**Don Willis**, Chief Adult Mental Health Services, DHHS
	Report on Impact of Downsizing Mental Retardation Centers	**Pat Porter**, Chief Developmental Disabilities, DHHS
	Cancer Control Programs	**Leah Devlin**, Director Division of Community Health, DHHS **Joe Holliday**, Chief, Chronic Disease Prevention & Control, DHHS **John Booker**, Director State Center for Health Statistics **Rebecca Martin**, Director Central Cancer Registry
	LUNCH	
1:00	**Report on DHHS's Management Initiatives at the NC School for the Deaf**	**David Bruton**, Secretary DHHS **Iverson Riddle**, Director Western Carolina Center, DHHS
	Independent Living Rehabilitation Program	**John Dalrymple**, Assistant Director for Independent Living, DHHS **Donna Holt**, IL Program Specialist **Tammy Murphy**, IL Office Manager **George Foster**, Casework Assistant **Susan Woods**, Rehabilitation Therapist
	Department-wide Automation Initiatives	**Jim Edgerton**, Assistant Secretary for Budget, Mgmt, and Planning, DHHS **Staff, Division of Information Resource Management**, DHHS
		Ron Aycock, Director County Commissioners Association

NC Department of Health and Human Services
Cancer Control Programs

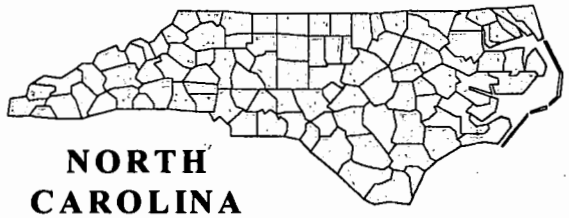
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PROGRAMS	PURPOSE	ESTABLISHED	FY 98 FUNDS
Cancer Control Phyllis Rochester - 715-3369	❑ Indigent Care (Purchase of Care) ❑ Education	1947	$3,530,050 (State funds)
Central Cancer Registry Rebecca Martin - 715-4556	❑ Statewide Cancer Data ❑ Cancer Cluster Evaluation	1987	$1,125,982 (State & Federal funds)
Breast and Cervical Cancer Control Larry Jenkins - 715-0123	❑ Early Detection ❑ Education ❑ Quality	1992	$ 3,900,000 (Federal funds) Center for Disease Control
Advisory Committee on Cancer Coordination and Control Marion White - 715-3337	❑ Planning ❑ Advisory	1993	$ 393,502 (State funds)

Leah Devlin, Director, Division of Community Health (DCH), DHHS - 715- 4177
Joe Holliday, Chief, Chronic Disease Prevention and Control Section, DCH, DHHS - 715-0125
John Booker, Director, State Center for Health Statistics, Division of Epidemiology, DHHS - 715-4499

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Cancer Profiles



A Fact Sheet from the Advisory Committee for Cancer Coordination and Control and from the Central Cancer Registry Department of Environment, Health, and Natural Resources

April 1997

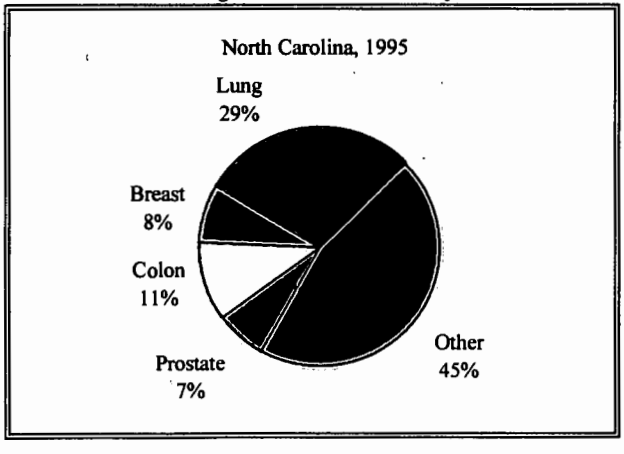
CANCER TAKES TOO MANY LIVES IN NORTH CAROLINA

Cancer is the second leading cause of death in North Carolina and in the U.S. In 1995, 14,862 persons in North Carolina died from cancer. It is estimated that nearly 40 percent of North Carolinians will develop cancer during their lifetime.

Deaths	1995 North Carolina	1993 United States
% of Deaths Due to Cancer	22.9%	23.4%

Cancer is a group of more than 100 different diseases, but all are characterized by uncontrolled growth and spread of abnormal cells. Cancer risk increases with age, and varies by gender and race. As the average age of the population increases, the incidence of cancer will increase as well. Cancer is expected to surpass heart disease and become the leading cause of death in North Carolina and the nation by the year 2000. The majority of cancer deaths occur at four sites: lung, colon, female breast, and prostate (Figure 1).

Figure 1. Cancer Deaths by Site



It is generally accepted that 65-80 percent of all cancers are related to personal lifestyle or environmental factors, such as smoking and diet, and are therefore preventable. Other factors such as age, gender, and family history of specific cancer are also associated with cancer and aid in the identification of people at high risk.

For several cancers, effective treatment is available. Thus, for these cancers, early detection saves lives. For example, early detection of breast cancer in women 50 years and older has decreased breast cancer mortality by 30 percent. Access to detection services is a key consideration. These patterns indicate opportunities for disease control and for reducing the number of cancer deaths through prevention, early detection, and treatment of the disease.

NOT EVERYONE WITH CANCER DIES FROM CANCER

In 1996, approximately 32,097 North Carolina residents were diagnosed, with cancer. These numbers are projected to increase.

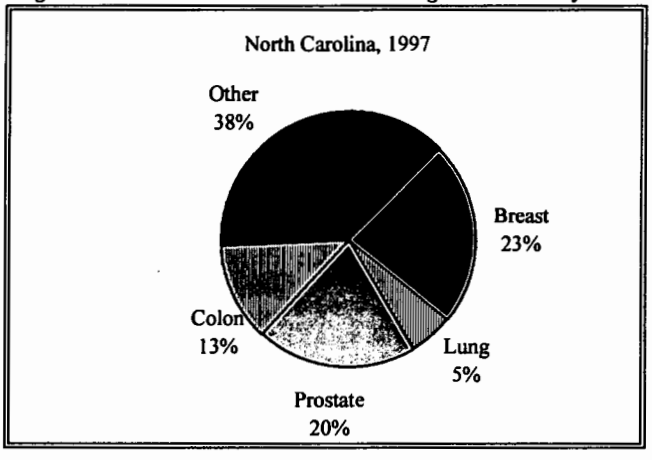
1997 Projected New Cancer Cases	North Carolina	United States
Lung Cancer	4,820	178,100
Colon Cancer	3,770	131,200
Female Breast Cancer	5,140	180,200
Prostate	4,875	334,500
All Sites	31,440	1,382,400

Due to early detection and improved treatment, more people who have been diagnosed with cancer are alive today than ever before. Assessing how many people are being treated for specific cancers reveals the burden on the health care system and needs for cancer control activities.

Persons are regarded as "cured" when they remain disease free for five years; otherwise they are termed "living with cancer." In 1997, over 95,000 North Carolinians are "living with cancer." The data in Figure 2 (next page) indicate the relative needs for cancer care and follow-up services for people living with cancer, by cancer site. A comparison with Figure 1 (cancer deaths) reveals the large numbers of deaths for some cancers as opposed to the number of persons "living with" other cancers (Figure 2). These data point out the different methods needed to control different cancers; each has its own

strategies for intervention. For example, most patients with **lung cancer**, as indicated by the figures, die within a few months of their diagnosis. Early detection and treatment options are extremely limited resulting in few persons living with lung cancer. However, for **colon cancer**, there is good potential for both early detection and successful treatment; improving access to screening and educating both providers and consumers are the keys. Recognizing persons at high risk, providing education about screening options and insuring access to state-of-the-art care, offer our best defense against dying from colon cancer.

Figure 2. Estimated Pattern of Persons Living with Cancer by Site.



RISK FACTORS AND INTERVENTIONS

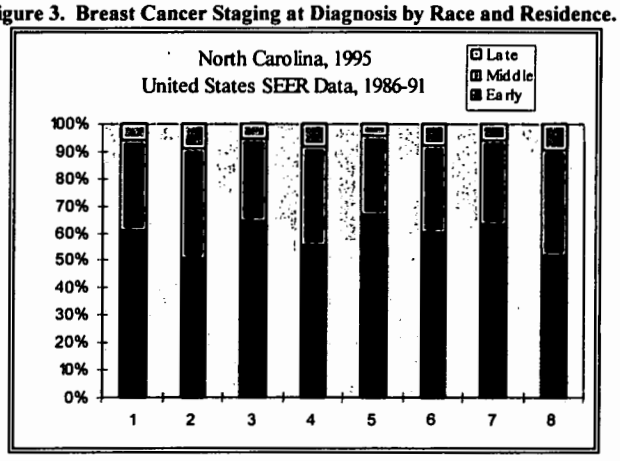
Aging: Because the population of North Carolina is aging, the number of cancer deaths that occur each year will increase unless the trend is reversed by significant improvements in prevention, early detection, and treatment.

Smoking: Smoking and the use of smokeless tobacco is responsible for the majority of all cancers of the lung, trachea, bronchus, larynx, pharynx, oral cavity, and esophagus. Smoking is the leading cause of preventable death in the United States.

Diet: The U.S. Department of Agriculture recommends the following dietary guidelines for managing a healthy diet: eat a variety of foods; maintain a healthy weight; choose a diet low in total fat with plenty of fruits, vegetables, and grain products; limit the use of sugar, salt, and sodium; and minimize alcoholic beverage consumption.

Screening: Early detection is extremely important for those cancers that can be cured and which can be discovered early. Breast cancer is a good example of this. Stage-at-diagnosis is the strongest predictor for survival from breast cancer. The rate of new breast cancer cases is higher for whites, yet breast cancer death rates are greater in minority populations. This poorer survival is often due to later stage at diagnosis among minority women. In 1997, a projected 180,200 women in United States will be diagnosed with breast cancer; 5,140 in North Carolina. Many of these women will be diagnosed early (Figure 3), yet others, who are diagnosed at a later stage, will face premature death.

Figure 3. Breast Cancer Staging at Diagnosis by Race and Residence.



1 = US Whites	5 = Urban NC Whites
2 = US Blacks	6 = Urban NC Blacks
3 = NC Whites	7 = Rural NC Whites
4 = NC Blacks	8 = Rural NC Blacks

For women 50 years and older, annual bilateral screening mammography is recommended. For women 40-49 years of age, decisions regarding screening mammography should be based on personal risk factors. For both groups, an annual breast examination by a health professional is recommended.

FOR MORE INFORMATION

N.C. Central Cancer Registry. Call (919) 715-4555 or write P.O. Box 29538, Raleigh, NC 27626-0538.

Cancer Information Services. This is a program of the National Cancer Institute, located at the Duke Cancer Center. Call 1-800-4CANCER.

American Cancer Society, North Carolina Division. Call 1-800-ACS-2345 or write: 11 S. Boylan Ave., Raleigh, NC 27603.

N.C. Advisory Committee on Cancer Coordination and Control. Call (919) 715-3337 or write: P.O. Box 29605, Raleigh, NC 27626-0605.

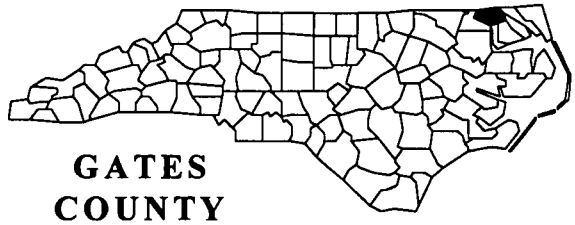
This ***Cancer Profile*** sheet was produced by the Central Cancer Registry (CCR) and the Advisory Committee for Cancer Coordination and Control (ACCCC). The formula for the data in Figure 2 were provided by David Grogan. The CCR is in the State Center for Health Statistics; the ACCCC is located in the Division of Adult Health Promotion.

DEHNR
NCPH North Carolina Public Health
AMERICAN CANCER SOCIETY

♦Jonathan B. Howes, Secretary♦
♦State of North Carolina ♦ James B. Hunt, Jr., Governor♦
Printed courtesy of N.C. American Cancer Society. 4/97

#1 3-18-98

Cancer Profiles



A Fact Sheet from the Advisory Committee for Cancer Coordination and Control and from the Central Cancer Registry Department of Environment, Health, and Natural Resources

April 1997

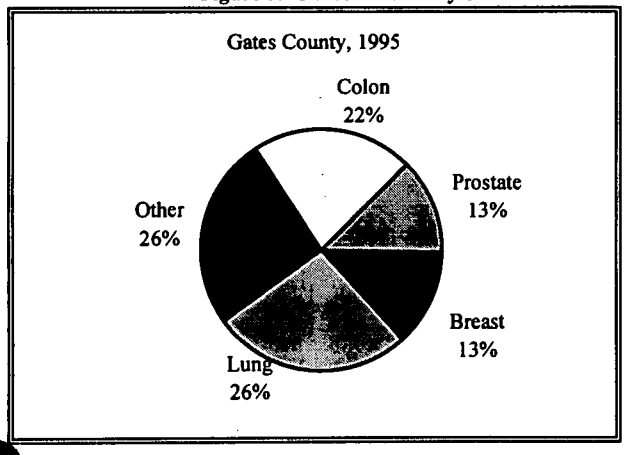
CANCER TAKES TOO MANY LIVES IN N.C. AND IN GATES COUNTY

Cancer is the second leading cause of death in North Carolina and in the U.S. In 1995, 14,862 persons in North Carolina died from cancer, 23 in Gates County. It is estimated that one in three North Carolinians will develop cancer during their lifetime.

1995 Deaths	Gates County	North Carolina
% of Deaths Due to Cancer	21.9%	22.9%

Cancer is a group of more than 100 different diseases, but all are characterized by uncontrolled growth and spread of abnormal cells. Cancer risk increases with age, and varies by gender and race. As the average age of the population increases, the incidence of cancer will increase as well. Cancer is expected to surpass heart disease and become the leading cause of death in North Carolina and the nation by the year 2000. The majority of cancer deaths occur at four sites: lung, colon, female breast, and prostate (Figure 1).

Figure 1. Cancer Deaths by Site



It is generally accepted that 65-80 percent of all cancers are related to personal lifestyle or environmental factors, such as smoking and diet, and are therefore preventable. Other factors such as age, gender, and family history of specific cancer are also associated with cancer and aid in the identification of people at high risk.

For several cancers, effective treatment is available. Thus, for these cancers, early detection saves lives. For example, early detection of breast cancer in women 50 years and older has decreased breast cancer mortality by 30%. Access to detection services is a key consideration. These patterns indicate opportunities for disease control and for reducing the number of cancer deaths through prevention, early detection, and treatment of the disease.

NOT EVERYONE WITH CANCER DIES FROM CANCER

In 1996, approximately 30 Gates County residents were diagnosed, with cancer. These numbers are projected to increase.

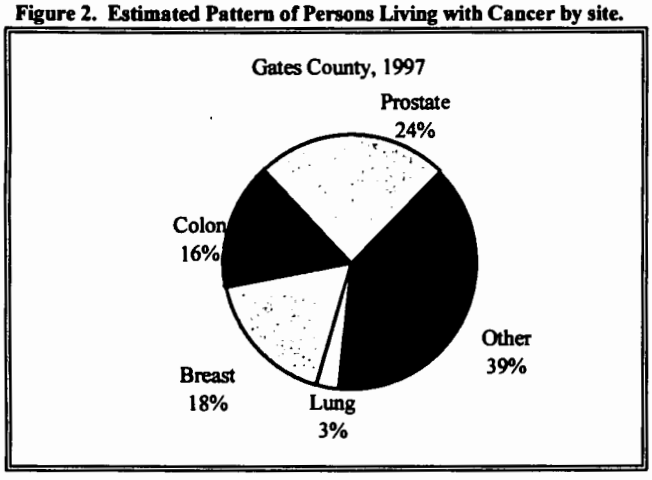
1997 Projected New Cancer Cases	Gates County	North Carolina
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

Due to early detection and improved treatment, more people who have been diagnosed with cancer are alive today than ever before. Assessing how many people are being treated for specific cancers reveals the burden on the health care system and needs for cancer control activities.

Persons are regarded as "cured" when they remain disease free for five years; otherwise they are termed "living with cancer." In 1997, over 95,000 North Carolinians are "living with cancer", 74 in Gates County. The data in Figure 2 (next page) indicate the relative needs for cancer care and follow-up services for people living with cancer, by cancer site. A comparison with Figure 1 (cancer deaths) reveals the large numbers of deaths for some cancers as opposed to the number of persons "living with" other cancer (Figure 2). These data point out the different methods needed to control different

cancers; each has its own strategies for intervention. For example, most patients with **lung cancer** , as indicated by the figures, die within a few months of their diagnosis. Early detection and treatment options are extremely limited resulting in few persons living with lung cancer. However, for **colon cancer**, there is good potential for both early detection and successful treatment; improving access to screening and educating both providers and consumers are the keys. Recognizing persons at high risk, providing education about screening options and insuring access to state-of-the-art care, offer our best defense against dying from colon cancer.

Figure 2. Estimated Pattern of Persons Living with Cancer by site.



RISK FACTORS AND INTERVENTIONS

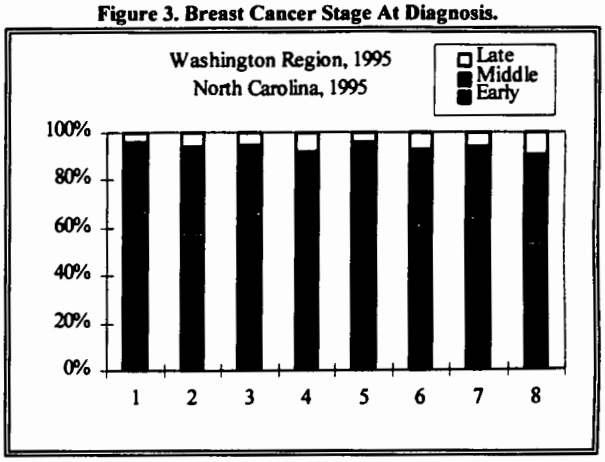
Aging: Because the population of North Carolina is aging, the number of cancer deaths that occur each year will increase unless the trend is reversed by significant improvements in prevention, early detection, and treatment.

Smoking: Smoking and the use of smokeless tobacco is responsible for the majority of all cancers of the lung, trachea, bronchus, larynx, pharynx, oral cavity, and esophagus. Smoking is the leading cause of preventable death in the United States.

Diet: The U.S. Department of Agriculture recommends the following dietary guidelines for managing a healthy diet: eat a variety of foods; maintain a healthy weight; choose a diet low in total fat with plenty of fruits, vegetables, and grain products; limit the use of sugar, salt, and sodium; and minimize alcoholic beverage consumption.

Screening: Early detection is extremely important for those cancers that can be cured and which can be discovered early. Breast cancer is a good example of this. Stage-at-diagnosis is the strongest predictor for survival from breast cancer. The rate of new breast cancer cases is higher for whites, yet breast cancer death rates are greater in minority populations. This poorer survival is often due to later stage at diagnosis among minority women. In 1997, a projected 5,140 women in North Carolina will be diagnosed with breast cancer; 10 in Gates County. Many of these women will be diagnosed early (Figure 3), yet others, who are diagnosed at a later stage, will face premature death.

Figure 3. Breast Cancer Stage At Diagnosis.



1 = Washington Region Whites	5 = NC Urban Whites
2 = Washington Region Blacks	6 = NC Urban Blacks
3 = NC Whites	7 = NC Rural Whites
4 = NC Blacks	8 = NC Rural Blacks

For women 50 years and older, annual bilateral screening mammography is recommended. For women 40-49 years of age, decisions regarding screening mammography should be based on personal risk factors. For both groups, an annual breast examination by a health professional is recommended.

FOR MORE INFORMATION

N.C. Central Cancer Registry. Call (919) 715-4555 or write P.O. Box 29538, Raleigh, NC 27626-0538.

Cancer Information Services. This is a program of the National Cancer Institute, located at the Duke Cancer Center. Call 1-800-4CANCER.

American Cancer Society, North Carolina Division. Call 1-800-ACS-2345 or write: 11 S. Boylan Ave., Raleigh, NC 27603.

N.C. Advisory Committee on Cancer Coordination and Control. Call (919) 715-3337 or write: P.O. Box 29605, Raleigh, NC 27626-0605.

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DEHNR NCPH North Carolina Public Health

♦Jonathan B. Howes, Secretary♦
♦State of North Carolina ♦ James B. Hunt, Jr., Governor♦

150 copies of this public document were printed for $390.00 or $0.03 per copy.

2
3-18-98

To: Dr. Iverson Riddle
From: Concerned Parents
Re: Educational Changes
Date: March 12, 1998

After our meeting with you on March 6, 1998, the parents felt is was necessary to reiterate to you our list of educational recommendations. We feel that these changes are essential in the effort to obtain the best quality education for our children. Listed below are our major priorities that we discussed with you at our original meeting.
We ask that you give serious thought to all of these recommendations and get back to us with your plan of action, so that we can all work towards getting our children the education that they deserve.

1. A qualified Superintendent needs to be put in place that would lead us to the educational standards that we are seeking to achieve. One that can repair the credibility of the administration of the school to the staff and parents.

2. A qualified Curriculum Coordinator

3. Follow the same standards as that of public schools including following the North Carolina Standard Course of Study.

4. Purchase new grade level materials including textbooks, workbooks, etc. Materials for end-of-grade testing would also be essential.

5. Put back in place testing that monitors our children's progress and performance that has been stopped.

6. Training made available to teachers/staff regarding all current educational issues.

7. Qualified tutors that are certified in the academic area they are tutoring.

8. All IEP's must be reviewed regularly and followed by all school personnel.

9. A summer school program geared to help cover areas that have been ignored in recent years.

10. A behavior program that would not take valuable time out of the classroom. Behavior issues need to be dealt with on an individual bases by school administrators. Classroom time needs to be used for instructional purposes rather than correcting "bad" behavior.

11. The following workshops need to be established and made available for all parents/guardians: Writing and understanding your child's IEP, available services for deaf/hard of hearing children.

12. Set up standardized guidelines for promotion/demotion criteria. Children should not be "passed on" without acquiring specific objectives.

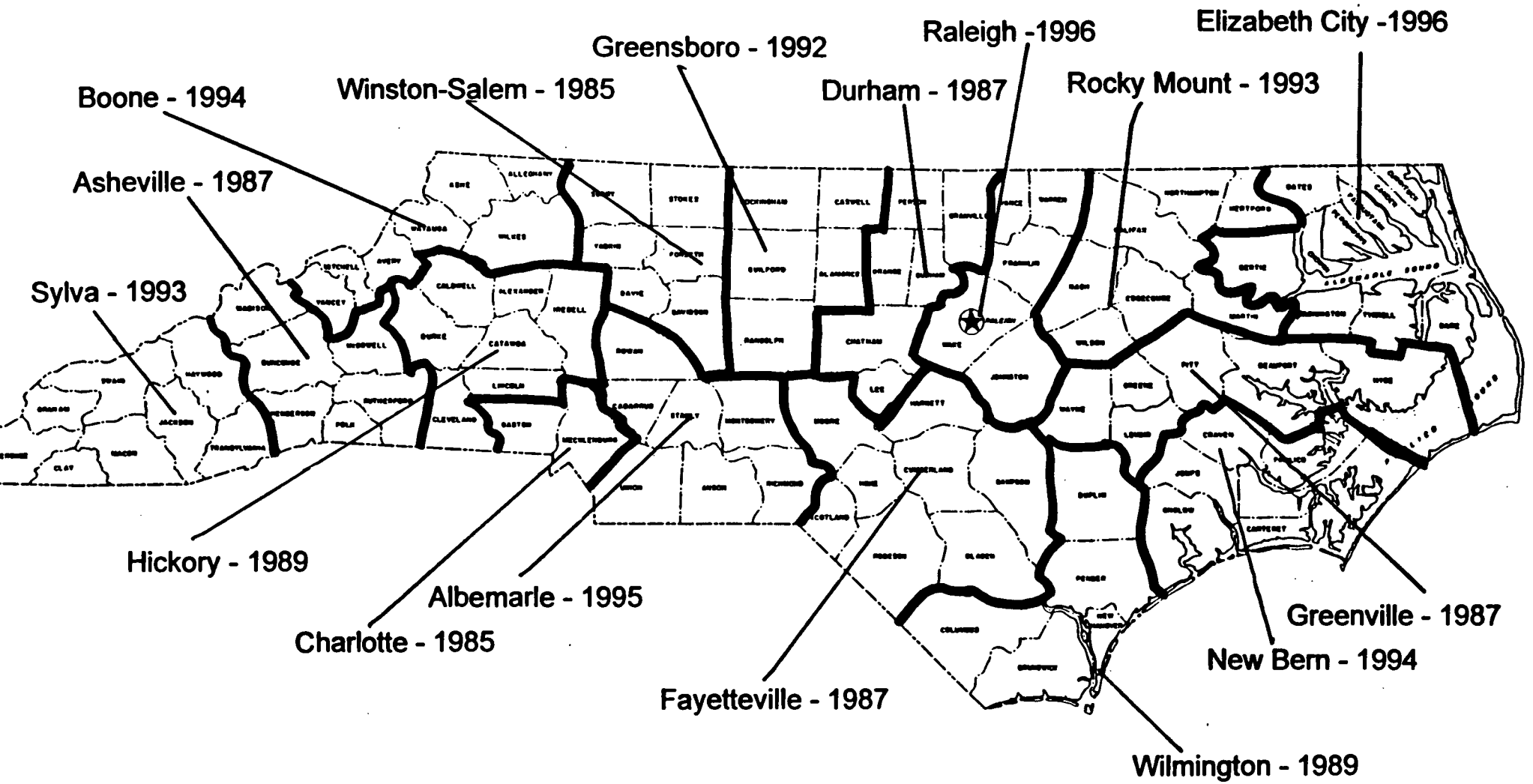
#3
3-18-98
John Dalrymple

Independent Living Rehabilitation Program

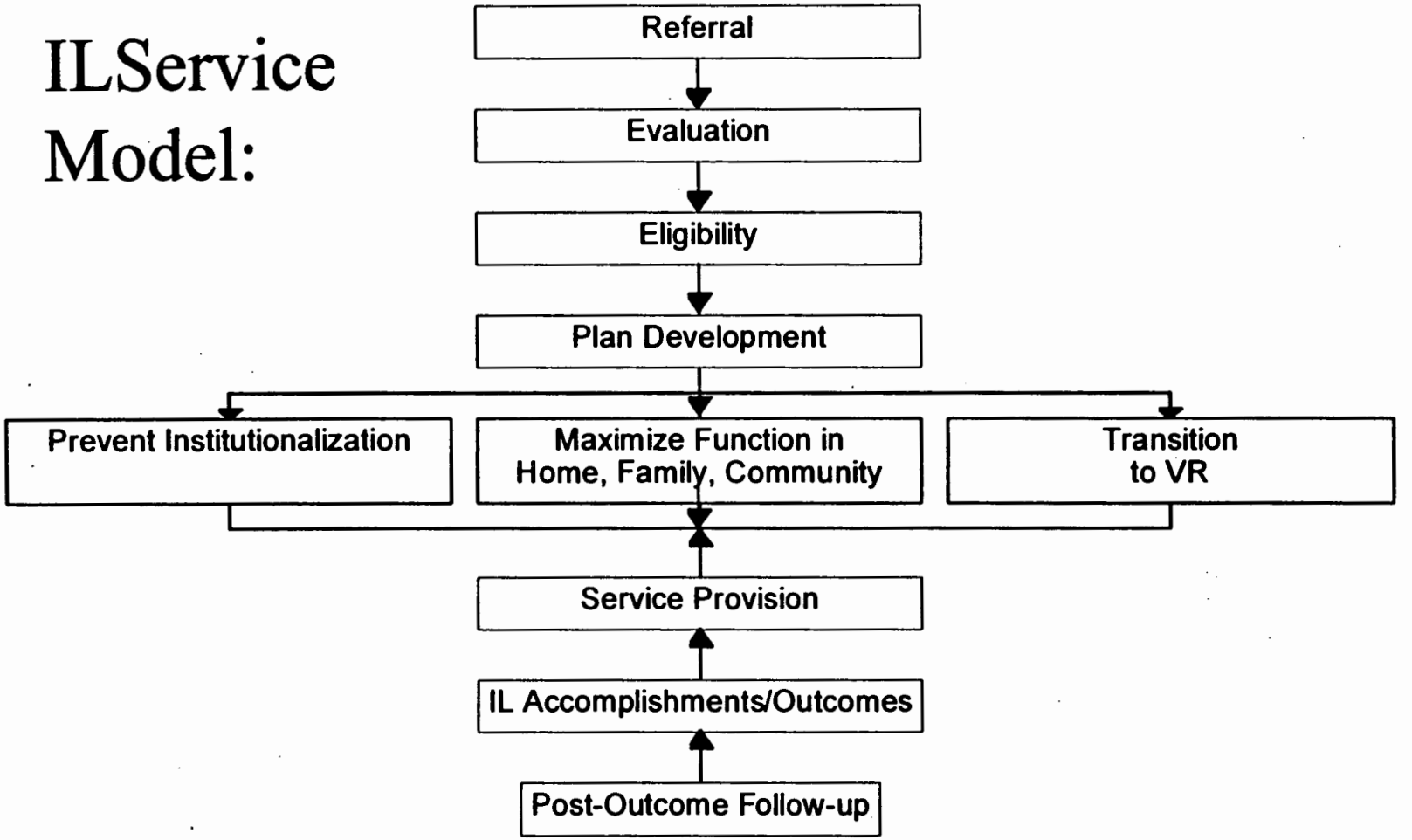
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Vocational Rehabilitation Services

Independent Living Rehabilitation Program
Offices and Service Areas

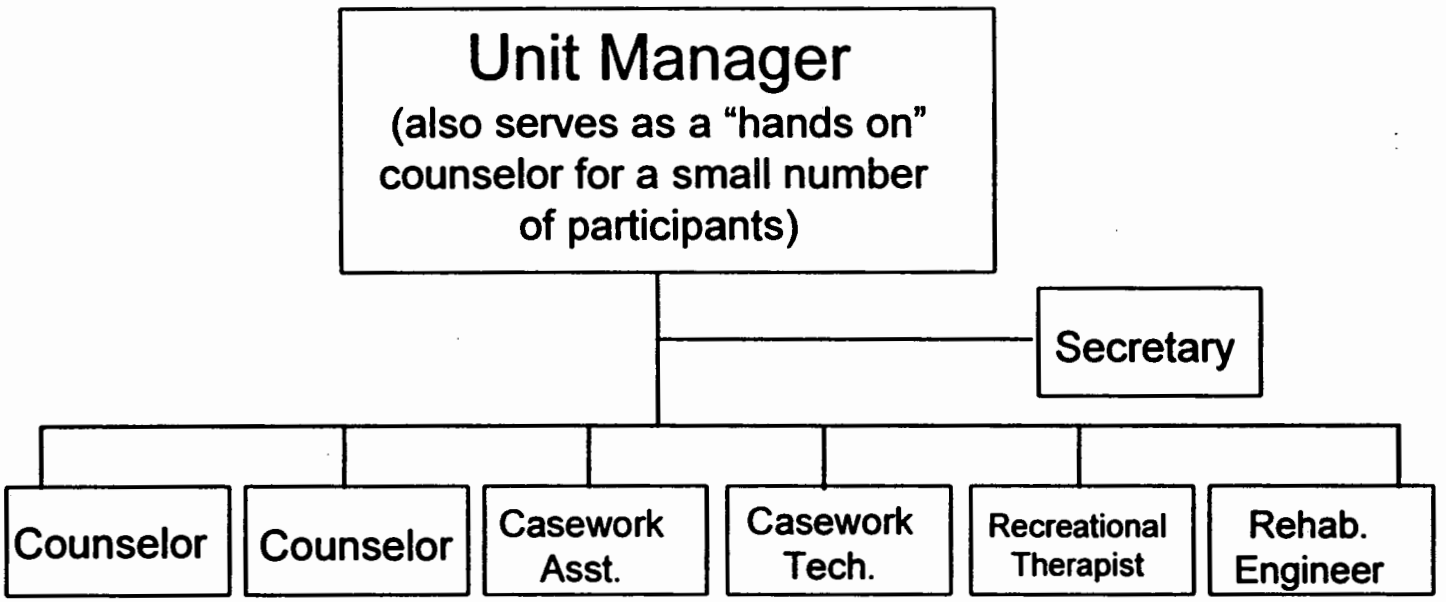


IL Service Model:



ILRP's priority focus -- persons with severe disabilities who can manage or learn to manage on their own in the community.

Model Office Organization*

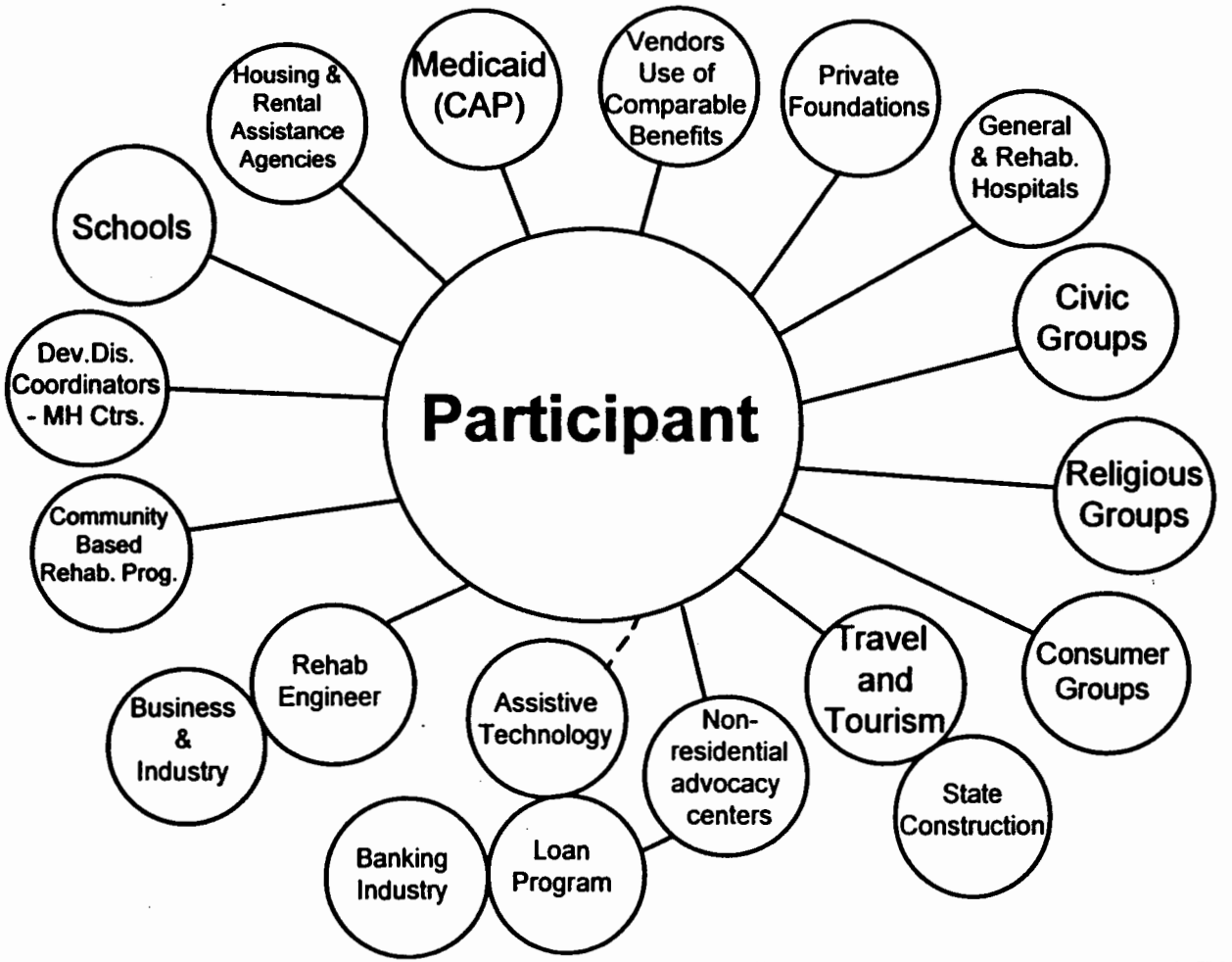


* not yet available in all areas

IL Basic Services

- Rehabilitation Engineering
- Home and Vehicle Modification
- Purchase of Adaptive Equipment
- Housing Placement and Assistance
- Personal Assistance Care
- Personal Assistance Care Management Training
- Guidance and Counseling Services
- Rehabilitation Therapy
  (individualized planning for leisure therapy)

Independent Living Rehabilitation Program
Community Partners



#4 3-18-98

Donna Holt

From: Dbal555
To: Dholt@dhr.state.nc.us
Subject: appreciation for computer
Date: Friday, March 06, 1998 1:07PM

Dear Ms. Holt,

My name is Deborah Baldwin. I am E-mailing you on a computer I recently received through Susan Woods with the Greensboro Office of Independent Living, and which was donated by Jefferson-Pilot Insurance Co. Being able to use this computer has made a great difference in my life which I would like to share with you.

I am basically a shut-in due to severe asthma and lung disease, as well as being in a wheelchair with avascular necrosis from lung medications.

With this computer I have been able to access a support group and home page for the AVN. Before this I never knew another person with this disease so it is wonderful to be able to share ideas and coping skills, research, emotions, etc.

I've also been recovering for 7 1/2 years from drug and alcohol addiction and this enables me to access meetings and support, and also with co-dependency. Christianity Online has also helped me spiritually, as well as Bible studies.

I love doing research on the computer, for myself and others. I love getting daily mail, both from people, and from websites such as Intelihealth and Chicken Soup for the Soul. I love humor, and find a lot when I need it online.

I hope someday I may be able to work from home, possibly doing legal research which I am familiar with. I also do creative writing, and as all authors hope to be published someday. The computer gives me hope for the future.

In closing, I hope you can see the changes this computer has made in my life. I would like to express my appreciation for being allowed this chance, and hope many others will be able to receive the same in the future.

Sincerely,

Deborah C. Baldwin (dbal555)

cc: John Dalrymple
Jack Gilchrist

Status of Plan to Assure Program Compliance with Medicaid and other DMH/DD/SA Requirements

March 18, 1998

Report to Subcommittee for Appropriations on Human Resources

Intensive Reviews

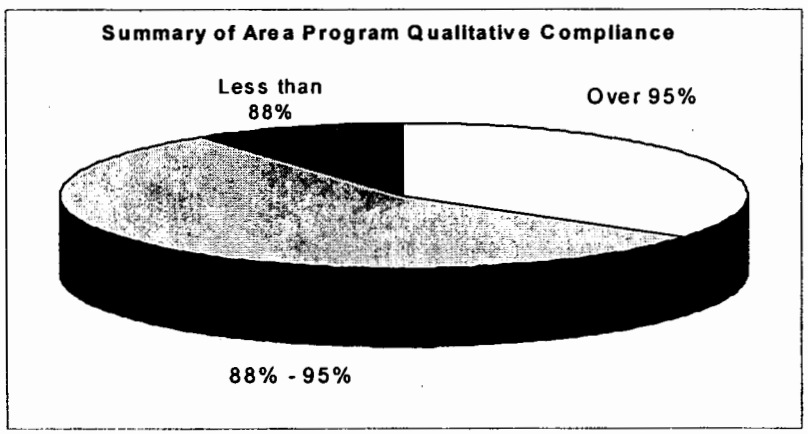
- Wayne, Onslow and Pitt Area Programs were reviewed in November and December, 1997
- Preliminary results shared with Area Directors at conclusion of review
- Final report has been distributed and area programs are writing their correction plans
- Results indicate:
  - Genuine desire to improve the area program quality
  - Consumers were satisfied with services they received
  - Positive components of service delivery in all 3 area programs- inconsistency regarding variety and options across the disability programs

Next Steps

- Plan of Corrections required from each area program
- Accreditation deferred pending correction plan and verification of correction
- Overall, areas of improvement:
  - Documentation of services (documentation existed, need to improve in the quality of the documentation)
  - Communication - internal and external to the agency
  - Coordination of service delivery across disabilities and agencies
  - Coordination of management and supervisory functions
  - MIS development and data support
  - Expansion of service options and consistency of options across disabilities.

Medicaid Record Review

- All 40 reviews completed with validation review conducted on 17%of area programs
- Summary of findings has been released. Area Program reports will be released March 1. Area Programs already have the findings.
- Results indicate:
  - Services were delivered to consumers
  - Contents of documentation need to improve
  - Improvements in the coordination between fiscal (billing) and program/clinical staff
  - Area Program results



Next Steps

- Targeted technical assistance to be completed by July, 1998
- Statewide training for problems that were common to most area programs (service documentation, service orders, service definitions) to be completed by July, 1998
- Development, implementation and training of standardized forms (admission assessments, service orders, treatment/habilitation plans, and progress note format) to be completed by July, 1998
- Review of Medicaid billings will be a part of the Division accreditation process
- Division staff will conduct an annual review of Medicaid paid claims
- Coordination and cross-training of DMA and DMH staff to establish consistent review standards and criteria to be completed by July, 1998
- Modification of existing Medicaid service definitions and Medicaid policy interpretation to be completed by October, 1998
- Writing and distribution of new DMH Medicaid Manual by December, 1998

Disability Specific Reviews

- 8 of the 8 reviews have been conducted
- Common results across reviews:
  - More proactive approach to consumer treatment/care rather than reactive
  - Improved communication and co-ordination among internal staff and external agencies
  - Increase in service options
  - Increase in community education and outreach to address area program role, access to services, co-ordination of services
  - Use of data in decision making and management operations

DMH/DD/SAS Impact

- Division staff have learned from the monitoring/review process
- Has resulted in:
  - formation of a cross disability, consistent monitoring tool
  - formation of consistent review/accreditation teams
  - Greater focus on technical assistance and on-site presence in area programs
  - Identification of statewide training issues including documentation
  - Need for consistency at state level in policy and rule interpretation
  - Need for greater communication and coordination across the sections at the Division level

Summary Action for DMH/DD/SAS

- Follow up visits planned to verify correction
- Technical assistance scheduled to assist in the correction plans
- Training scheduled for area programs and for DMH staff
- Work groups formed to address consistency
- Policy and manual development/modification to assist with guidance and consistency

Report on Special Alzheimer's Unit at Black Mountain Center and the Planned Unit at the North Carolina Special Care Center

The following summary and attachment comprise the response of the Department of Health and Human Services to Section 11.40(b) of Senate Bill 352, which reads as follows:

> The Department of Human Resources shall solicit information from private providers for the operation of the special Alzheimer's Units in Wilson and Black Mountain. The Department shall report to the members of the House and Senate Appropriations Subcommittees on Human Resources and the Fiscal Research Division by March 1, 1998. The report shall provide the cost of operation of the units by the State as compared to the cost of operation by private providers who have submitted information.

In early October, a task force representing the Division of MH/DD/SA Services, the Division of Medical Assistance and the Department began the initial planning which resulted in the attached Request for Information which was mailed on December 12, 1997, to a total of 195 individual and corporate offices representing approximately 366 nursing facilities.

In summary, the Request for Information included a statement of the Special Provision; and a description of the history and programs, accountability, operating philosophy, admission criteria and process, and applicable statistical data for the Alzheimer's Program at Black Mountain Center and the future Alzheimer's Program at the North Carolina Special Care Center. Additionally, the document conveyed a set of assumptions deemed important to the provider in developing cost estimates.

- The essential elements of admission criteria to each facility are that

  - The applicant has a diagnosis which indicates probable Alzheimer's Disease.
  - The applicant's primary need is management of problem behaviors associated with Alzheimer's Disease. In other words, the applicant exhibits physically aggressive and combative behaviors (biting, kicking, shoving, attacking, for example), making him or her dangerous to self or others.
  - Other community resources (nursing homes, adult day programs, local hospitals, for example) have been explored and are inappropriate or unavailable.
  - The applicant and/or legal representative is a resident of North Carolina at the time of application.

- The essential elements of the assumptions are that

  - The Unit at Black Mountain would continue to be operated at its present location, and the Unit at Wilson would be operated at the location currently being renovated for that purpose.
  - The Unit at Black Mountain would continue to operate with 71 certified beds, and the planned Unit at Wilson would operate with 40 certified beds.
  - All criteria specified for admission to the Unit at Black Mountain and the future Unit at Wilson would apply.

- All elements of the philosophy of operation of the Unit at Black Mountain would be ensured, including continuous training of staff, and the prohibition of mechanical and chemical restraints to manage behaviors.

Central to the Request for Information are cost forms (pages 8 and 9 of the Request for Information) on which providers were asked to estimate costs on an annual basis for cost centers integral to the cost report required of private provider nursing homes, Black Mountain Center and the Special Care Center by the Division of Medical Assistance in order to establish Medicaid reimbursement rates. In accordance with instructions consistent with the Medicaid cost reporting requirements, interested private providers were asked to give their estimated costs for operating the 71 bed Alzheimer's Unit at Black Mountain Center and the 40 bed planned Unit at Wilson. Cost centers included property ownership, physical plant maintenance, housekeeping, dietary, nursing, laundry, social services, patient activities, administration, pharmacy, radiology, laboratory, physical therapy, occupational therapy, speech therapy, medical records, dental, physician, and other services.

Responses from interested private providers were requested to be received by January 30, 1998. As of that date, the only response received (other than one response marked "NA-Do not provide Alzheimer Services") was from a hospital-based nursing home with an estimated bed capacity of 110-120 and an Alzheimer's population of approximately 13 percent of census. After consultation between the Department and the Division staff involved in this project, it was determined that the response did not provide the requested information and could therefore not serve as a cost comparison.

Consequently, there is no basis upon which to compare the operation of these units by the State with the cost of operation by private providers.

A copy of the Request for Information package is found at Attachment 1.

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities
and Substance Abuse Services
325 North Salisbury Street • Raleigh, North Carolina 27603 • Courier # 56-20-24
James B. Hunt, Jr., Governor
H. David Bruton, MD, Secretary
John F. Baggett, Ph. D., Director
(919) 733-7011

December 12, 1997

MEMORANDUM

TO: Providers of Nursing Facility Care

FROM: North Carolina Department of Health and Human Services,
Division of Mental Health, Developmental Disabilities,
and Substance Abuse Services

SUBJECT: Solicitation of Information On the Operation of Alzheimer's Units in Wilson and Black Mountain

The purpose of this memorandum is to request information from private nursing facility providers in accordance with Section 11.40(b) of Senate Bill 352, ratified by the 1997 Session of the N.C. General Assembly. Section 11.40(b) reads as follows:

> The Department of Human Resources shall solicit information from private providers for the operation of the Special Alzheimer's Units in Wilson and Black Mountain. The Department shall report to the members of the House and Senate Appropriations Subcommittees on Human Resources and the Fiscal Research Division by March 1, 1998. The report shall provide the cost of operation of the Units by the State as compared to the cost of operation by private providers who have submitted information.

The Department (now the Department of Health and Human Services) is requesting information from you in response to the above legislative directive. The information you send us will be used in the preparation of our report to the legislature.

This request is for information only. No award will be made as the result of any information reviewed by the Department in response to this request.

December, 1997

Request For Information
Alzheimer's Units

LOCATION: Black Mountain Center
1280 Old US Highway 70
Black Mountain, N.C. 28711

North Carolina Special Care Center
4761 Ward Boulevard
Wilson, N.C. 27893

HISTORY AND PROGRAMS

Black Mountain Center began as a satellite unit of Western Carolina Center, in Morganton, in 1977 and was housed in the Western North Carolina Specialty Hospital (formerly the Western North Carolina Sanatarium for the treatment of tuberculosis, dedicated in 1937). In 1982, the facility was officially separated from Western, thereby becoming the fifth State institution serving persons with mental retardation. In 1988, the N.C. Legislature appropriated funds to establish at Black Mountain Center a program for the care and treatment of persons in the mid-stage of Alzheimer's Disease who because of combative and assaultive behaviors are typically unable to find placements in local nursing homes.

Black Mountain Center currently serves its residents and persons in the community through the following programs:

Developmental Disabilities Program: Consisting of 119 beds, is Medicaid certified as an intermediate care facility for individuals with severe to profound mental retardation and serves the 13 westernmost counties of the State.

Alzheimer's Program: Consisting of 71 beds, is Medicaid certified as a nursing facility and serves persons from throughout the State who have a diagnosis of Alzheimer's Disease and whose assaultive and combative behaviors have resulted in denial of care in traditional nursing home settings.

Outreach Services: Consultation, technical assistance, education and training designed to enhance the abilities of individuals, families, agencies and providers to serve persons with Alzheimer's Disease, Developmental Disabilities, Traumatic Brain Injury and other disabling conditions. The multi-disciplinary team of Outreach professionals utilizes the expertise of all other Black Mountain Center staff.

Respite Services: Day and overnight (24 hours) assistance to families who need temporary relief from the intense pressures of constant caregiving responsibilities. Respite to persons with Developmental Disabilities typically is provided on the units. Respite to persons with Alzheimer's Disease is provided in a two-bedroom, one-bath house called Greenwood Inn on the Center campus and is intended to extend the period of time which individuals with Alzheimer's Disease may remain in their homes, thus avoiding premature admission to traditional nursing homes. This program is not Medicaid certified.

Foster Grandparent Program: A Federally funded county-wide program for which Black Mountain Center is the host agency. There are 70 active low income Foster Grandparents and 21 volunteer stations in Buncombe County.

The North Carolina Special Care Center was developed in October, 1978, from the Eastern North Carolina Hospital, one of three State owned regional specialty hospitals for the diagnosis and treatment of chronic diseases, especially chest and pulmonary conditions. From January, 1943, until 1973, the facility had been operated as Eastern North Carolina Sanatarium, the third of four centers for the treatment of tuberculosis. The North Carolina Special Care Center was created from the budgets of the State psychiatric hospitals which represented the exclusive referral sources of residents who needed long-term nursing care and not active psychiatric treatment. As a federally funded nursing facility, this made it possible for the State to be reimbursed for the cost of care for these individuals. Private facility operators verified that they could not provide the necessary care required for these individuals and this remains a condition for admission. The North Carolina Special Care Center was organized within the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

The North Carolina Special Care Center serves its residents and the communities by providing the following programs:

Long-Term Nursing Care Program: Provided in four Medicare/Medicaid certified units consisting of 105 Skilled Nursing beds and 103 Intermediate Care beds, this serves qualified residents from across the State. In 1996, the facility was approved for community referrals when none were available from the psychiatric hospitals. These residents are placed only having been denied admission by private facilities. This program is accredited by the Joint Commission for Accreditation of Healthcare Organizations.

Eastern Adolescent Treatment Program: This secure, non-medical facility, provides comprehensive treatment and educational services for up to 8 adolescent boys under 18 years of age. Since 1995, this unit serves "Willie M" class members who need secure treatment and live in Eastern North Carolina. These clients have typically shown an extensive history of severe psychiatric and psychosocial problems, including substance abuse, drug dealing, anti-social behaviors, sex offenses and learning problems.

Alzheimer's Program: This program was authorized by the 1995 Legislature to meet the clinical, behavioral and emotional needs of those citizens whose assaultive and violent behaviors have resulted in the denial of care in traditional nursing home settings. Renovations are currently underway for the construction of 2 modern, specially designed units of 20 nursing beds each. These will be JCAHO accredited and Medicare/Medicaid certified Nursing Facility beds. Program operation is expected to begin in the fall of 1998.

ACCOUNTABILITY

Black Mountain Center and the N.C. Special Care Center are agencies of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services of the newly formulated Department of Health and Human Services. Accountability is accomplished through compliance with State statutes, rules and regulations, as well as compliance with Health Care Finance Administration regulations for Medicaid certification for nursing facilities. Fiscal audits, sanitation inspections, Life Safety Code reviews and program surveys are conducted routinely, therefore, by regulatory agents of State and Federal government.

PERSONNEL

As employees of the State, staff of Black Mountain Center and the N.C. Special Care Center are subject to the policies, regulations and procedures of the Office of State Personnel which apply to all employees covered by the provisions of the State Personnel Act contained in Chapter 126 of the N.C. General Statutes.

THE ALZHEIMER'S PROGRAM AT BLACK MOUNTAIN CENTER AND THE FUTURE ALZHEIMER'S PROGRAM AT THE NORTH CAROLINA SPECIAL CARE CENTER

PHILOSOPHY: It is the philosophy of the Alzheimer's Programs to ensure respect, dignity, equality and the protection of human rights while sustaining the human spirit. The specialized services of the program utilize an interdisciplinary team approach which includes families, agency representatives and caregivers. The programs accept, support and accommodate individuals with Alzheimer's Disease by managing problematic behaviors in a safe, secured environment.

Individuals are valued as they are, and attempts to force conformity or change are not imposed. Staff are instructed and assisted to recognize that behaviors are the result of changes in personality and losses in cognition and impulse control associated with Alzheimer's Disease and are not willful, intentional acts of aggression or combativeness. Staff recognize that providing a safe and structured environment, in combination with appropriate personal interactions, is key to the reduction and prevention of inappropriate behaviors. To that end, all staff who work with the Alzheimer's Programs receive training in understanding the behaviors associated with Alzheimer's Disease and appropriate approaches for addressing those behaviors.

The Alzheimer's Programs employ the principles of redirection and validation as important tools in working with individuals with Alzheimer's Disease. These non-confrontational approaches to behavior management are at the core of all formal interventions. Redirection is the principle of diverting inappropriate behaviors or actions through refocusing attention on positive activities or interactions. Validation is the principle of acceptance of reality as the individual presents it, rather than an attempt to challenge the individual's reality by imposing the perceptions of staff. Intervening with behaviors is never used for disciplinary purposes, for the convenience of staff or as a substitute for active care and treatment.

Mechanical and chemical restraints are not used to manage behaviors. All medication supports are monitored through a stringent monthly psychotropic drug review process to ensure the continued necessity of all medications. The administration and management of all medications are made in compliance with OBRA Nursing Home regulations.

OBJECTIVES: The objectives of the Alzheimer's Programs are to:

1. Provide state of the art nursing home services for persons with a diagnosis of Alzheimer's Disease who exhibit combative and assaultive behaviors which make other living arrangements unrealistic.

2. Establish positive working relationships with families, nursing homes and other community agencies in an effort to engage in problem solving prior to admission and to seek appropriate alternative placements once the specialized services of the Black Mountain Center or the N.C. Special Care Center Alzheimer's Program are no longer indicated.

ADMISSION CRITERIA:

1. The applicant has a diagnosis which indicates probable Alzheimer's Disease.

2. The applicant's primary need is management of problem behaviors associated with Alzheimer's Disease. The applicant exhibits physically aggressive and combative behaviors (biting, kicking, shoving, attacking, for example), making him or her dangerous to self or others.

3. Other community resources (nursing homes, adult day programs, local hospitals, for example) have been explored and are inappropriate or unavailable.

4. The applicant is independently mobile (either walks or uses wheelchair without assistance).

5. The applicant and/or legal representative is a resident of North Carolina at the time of application.

6. Guardianship of the Person must be obtained in those circumstances in which neither Health Care Power of Attorney nor Durable Power of Attorney has been established. If, however, none of these legal arrangements have been made, then Black Mountain Center or N.C. Special Care Center staff will assist the responsible person to secure the necessary guardianship immediately following admission.

7. A current FL-2 (required for Medicaid eligibility). Black Mountain Center or N.C. Special Care Center staff will assist the responsible person to secure immediately following admission if necessary.

8. A current PASARR.

9. A current medical history (within the past 12 months) which includes medication, psychiatric and social data.

10. A letter from the applicant's Area Program for Mental Health, Developmental Disabilities and Substance Abuse Services which indicates the applicant's need for admission to the Alzheimer's Program at the N.C. Special Care Center or Black Mountain Center.

ADMISSION PROCESS:

Completed applications are reviewed weekly and as necessary by an interdisciplinary Admissions Committee. Individuals deemed appropriate for admission based on the written application materials and any telephone contacts are then screened for compliance with admission criteria through a visit by Alzheimer's Program staff to the location of the applicant. In this way, the applicant's current mobility status and combative and assaultive behaviors may be assessed. Admission to the Alzheimer's Program is facilitated as quickly as possible following a determination of appropriateness and the availability of a bed.

CENSUS DATA AUGUST, 1991, THROUGH AUGUST, 1997 (BLACK MOUNTAIN CENTER ONLY):

1. **Number of Admissions:** 198

2. **Number of Male Admissions:** 124

3. **Number of Female Admissions:** 74

4. **Ages of Admissions:**

55-59:	4
60-64:	10
65-69:	17
70-74:	35
75-79:	63
80-84:	46
85-89:	18
90-94:	5

5. **Average Length of Stay of All Discharges:** 358 Days

6. **Median Length of Staff of All Discharges:** 248 Days

7. **Total Number of Bed Days Represented by All Admissions (Including Both Discharged Clients and Current In-house Clients):** 85,409

8. **Racial Composition of Admissions:**

White:	182
Black:	13
Hispanic:	3

9. **Source of Admissions:**

Home:	43
State Hospital	39
Psychiatric Hospital	7
Community Hospital	39
Veterans' Hospital	2
Nursing Home	59
Rest Home	7
Retirement Home	2

10. **Approximately 95% of all admissions have come from counties located west of Alamance.**

OCCUPANCY RATE JULY 1, 1996, THROUGH JUNE 30, 1997 (BLACK MOUNTAIN CENTER ONLY): 94%

THE FOLLOWING ASSUMPTIONS ARE MADE AND SHOULD BE CONSIDERED AS COST ESTIMATES ARE DEVELOPED FOR THE OPERATION OF EITHER THE ALZHEIMER'S UNIT AT BLACK MOUNTAIN OR THE ALZHEIMER'S UNIT AT WILSON OR BOTH

1. The unit at Black Mountain would continue to be operated at its present location on the third floor of the main Administration building at Black Mountain Center, a State owned facility.

2. The future unit at Wilson would be operated in the South Wing of the N.C. Special Care Center in Wilson currently being renovated for that purpose and will, therefore, be located in State owned property.

3. The unit at Black Mountain would continue to operate with 71 Medicaid certified beds.

4. The future unit at Wilson would operate with 40 Medicare/Medicaid certified beds.

5. The catchment area for the unit at Black Mountain and the future unit at Wilson would be the State of North Carolina.

6. All criteria specified in this document for admission to the unit at Black Mountain and the future unit at Wilson would continue to apply.

7. All elements of the philosophy of operation of the unit at Black Mountain would be ensured, including continuous training of staff, and the prohibition of mechanical and chemical restraints to manage behaviors.

8. The operation of the existing Alzheimer's Respite Program at Black Mountain Center is included in this request for information.

9. Admission criteria as previously stated would continue to apply.

10. All requirements for compliance with APSM 95-1 (07-01-89), Human Rights for Clients in State Facilities, would continue to apply and would be periodically reviewed.

COST FORMS

The attached Cost Forms for either the North Carolina Special Care Center Alzheimer's Unit or the Black Mountain Center Alzheimer's Units, or both, should be completed in accordance with the instructions provided. For each cost center designated, total costs should be reflected. In other words, costs reflected should assume no separate billing to Medicaid, Medicare, families or third parties for any portion of cost.

If additional information or further clarification is needed, please contact either individual listed below, as appropriate:

Mr. Rusty Benton, Director
North Carolina Special Care Center
4761 Ward Boulevard
Wilson, North Carolina 27893
Phone: (919) 399-2112 - Ext. 242

Dr. Sally Ludlum, Director
Black Mountain Center
1280 Old U.S. Highway 70 West
Black Mountain, North Carolina 28711
Phone: (704) 669-3100

NORTH CAROLINA SPECIAL CARE CENTER
ALZHEIMER'S UNIT
ANNUAL COST OF OPERATIONS
TWO 20 BED NURSING CARE UNITS

Estimated cost on an annual basis should be entered beside each cost center. Amounts should include all cost associated with the provision of the services listed. See attached instructions for completion.

	ANNUAL COST
Property Ownership and Use	_____
Operation and Maintenance of Plant	_____
Housekeeping	_____
Dietary	_____
Nursing Services	_____
Laundry and Linen	_____
Social Services	_____
Patient Activities	_____
Administrative and General	_____
Pharmacy	_____
Radiology	_____
Laboratory	_____
Physical Therapy	_____
Occupational Therapy	_____
Speech Therapy	_____
Nursing Care (ICF & SNF)	_____
Medical Records	_____
Dental Services	_____
Physician Services	_____
Other	_____
Other	_____
TOTAL ANNUAL COST	_____

BLACK MOUNTAIN CENTER ALZHEIMER'S UNIT
ANNUAL COST OF OPERATIONS FOR
36 BED NURSING HOME UNIT
35 BED NURSING HOME UNIT
4 BED RESPITE CARE UNIT

Estimated cost on an annual basis should be entered beside each cost center. Amounts should include all cost associated with the provision of the services listed. See attached instructions for completion.

	ANNUAL COST
Property Ownership and Use	_____
Operation and Maintenance of Plant	_____
Housekeeping	_____
Dietary	_____
Nursing Services	_____
Laundry and Linen	_____
Social Services	_____
Patient Activities	_____
Administrative and General	_____
Pharmacy	_____
Radiology	_____
Laboratory	_____
Physical Therapy	_____
Occupational Therapy	_____
Speech Therapy	_____
Nursing Care (ICF & SNF)	_____
Medical Records	_____
Dental Services	_____
Physician Services	_____
Other	_____
Other	_____
TOTAL ANNUAL COST	_____

Instructions for Completion of Cost Estimates

Property Ownership and Use

Cost should include all annual depreciation, taxes, and insurance expense for the operation of the units.

Operation of Plant

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include maintenance, heating, utilities and all supply and material cost associated with the operation of the units.

Housekeeping

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include all housekeeping functions, linen distribution, bed making, floor maintenance and trash pick-up for the units.

Dietary

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include all meals, supplies, snacks and nutritional supplements. This cost center should include the services of a registered dietitian to meet requirements.

Nursing Services

Cost should include all personnel cost including fringe benefits for the operation of this area. Administrative cost for medical services including all medical supply cost.

Laundry and Linen

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include linen, personal clothing maintenance, washing folding and storing personal clothing, making client items and laundry service for the units.

Social Service

Cost should include all personnel cost including fringe benefits for the operation of this area. This cost center should include all social work activities, admission and discharge functions. Supplies and materials necessary for this operation.

Patient Activities

Cost should include all personnel cost including fringe benefits for the operation of this area. This cost center should include Psychological Services, Volunteer Services, Religious Services and Patient Activities Administration. Supplies and materials necessary for this operation.

Administrative and General

Cost should include all personnel cost including fringe benefits for the operation of this area. Include Administrative Staff, Purchasing, Personnel, Business Office, Staff Development, Quality Assurance and Warehouse. Cost should include Home Office Cost and all supplies and materials associated with Administrative Operations.

Pharmacy

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include all prescription and over the counter medication. Dispensing and delivery to the units. Services should also include medication administration records.

Radiology

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include all aspects of radiology operations including reading of x-rays and supply cost.

Laboratory

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include all aspects of laboratory operations including sample collection, testing cost and supplies.

Physical Therapy

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include all Physical Therapy cost including supplies and materials.

Occupational Therapy

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include all Occupational Therapy cost including supplies and materials.

Speech Therapy

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include all Speech Therapy and Testing cost including supplies and materials.

Nursing Care (ICF & SNF)

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should RN's, LPN's, CNA's and unit supervision. Cost should include all supplies and materials for the operation to the unit.

Medical Records

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include maintenance of client records, Utilization Review and maintenance of confidentiality.

Dental Services

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include all Dental Service cost including supplies and materials.

Physician Services

Cost should include all personnel cost including fringe benefits for the operation of this area. Cost should include all Physician cost including supplies and materials.

Other

Any cost of operations not listed above. Please be specific in description of cost.

COST INFORMATION SHOULD INCLUDE TOTAL COST OF PROVIDING CARE TO ALZHEIMER RESIDENTS. COST ESTIMATES FOR PURPOSES OF THIS REQUEST FOR INFORMATION SHOULD INCLUDE COSTS OF THOSE SERVICES WHICH ARE TYPICALLY BILLED THROUGH OTHER PROVIDERS, E.G., COSTS OF PHYSICAL AND OCCUPATIONAL THERAPY, SPEECH AND HEARING THERAPY, PHARMACY, PHYSICIAN SERVICES, RADIOLOGY, LABORATORY AND DENTAL SERVICES.

ADDENDA

At the suggestion of the North Carolina Health Care Facilities Association, the data in the attached addenda are provided regarding the 35 bed and 36 bed Alzheimer's Units at Black Mountain Center. Since the two proposed 20 bed Alzheimer's Units at the North Carolina Special Care Center in Wilson are not expected to become operational prior to the fall of 1998, comparable data for those units are not available at this time. It is anticipated, however, that the units at the North Carolina Special Care Center will function with admission criteria, philosophy and resident characteristics equivalent to those of Black Mountain Center:

Attached Addenda:

1. **Resident Characteristics, December 12, 1997**
2. **RN, LPN and CNA Total Nursing Hours Paid Per Unit Per Year**
3. **Special Cost by Cost Center - July 1, 1996 - June 30, 1997**

BLACK MOUNTAIN CENTER Addendum 1
RESIDENT CHARACTERISTICS

The following inventory reflects characteristics of impairment and, therefore, need for treatment and assistance of the Alzheimer's population at Black Mountain Center effective December 12, 1997. The form used is an adaptation of the HCFA required Medicare and Medicaid Survey Form Number 672. The definitions of characteristics are consistent with those provided in HCFA Form 672 and are intended to provide a "snapshot" of a Nursing Facility's resident population at any given time. Each category, therefore, reflects the number and percentage of residents who have significant problems in that area.

CHARACTERISTICS TOTALS PERCENT

Total Census: 64

Language/Communication	64		100.00%	
Vision	64		100.00%	
Hearing	9		14.06%	
Sensory	63		98.44%	
Abrasion	8		12.50%	
Bruise	8		12.50%	
Fracture	0		0%	
Restraints	2		3.13%	
Admission/Transfer/Discharge	7		10.94%	
MR/MI (Non-Dementia)	7		10.94%	
Behavioral Symptoms - Assaultive	64		100.00%	
Psychoactive Meds	51		79.69%	
Non-Responsiveness	0		0%	
Incontinence/Toileting Programs	53		82.81%	
Catheter	0		0%	
Tube Feedings	0		0%	
Weight Change/Nutrition Needs	7		10.94%	
Hydration/Electrolyte	0		0%	
Assistive Device/Denture	47		73.44%	
Swallow/Dining Program	64		100.00%	
Antibiotics/Infections	6		9.38%	
Pressure Sores	0		0%	
ROM/Contractures/Positioning	64		100.00%	
Specialized Rehab	64		100.00%	
Respiratory Care	0		0%	
Special Needs	64		100.00%	
Other				
Dementia - Alzheimer's Type	64		100.00%	
Depression	11		17.19%	

BLACK MOUNTAIN CENTER ALZHEIMER'S PROGRAM

RN, LPN, CNA TOTAL NURSING HOURS PAID PER UNIT PER YEAR

	Gravely 3	Rasberry 3
RN's	**12,480**	**10,400**
LPN's	**4,160**	**4,160**
CNA's	**81,120**	**83.200**
TOTAL	**97,760**	**97,760**

BLACK MOUNTAIN CENTER ALZHEIMER'S PROGRAM

SPECIAL COST BY COST CENTER - July 1, 1996 - June 30, 1997

COST CENTER	TOTAL
Pharmacy	$285,659
Laboratory	$ 19,295
Radiology	$ 32,259
Physical Therapy	$ 5,196
Occupational Therapy	$ 15,988
Speech Therapy	$100,896
Dental	$ 41,596

Total cost includes Medicaid non-allowable cost.

DOWNSIZING of REGIONAL MENTAL RETARDATION CENTERS

Report to the Fiscal Research Division
and
House and Senate Appropriations Subcommittee
on
Human Resources
(SB352, Section 11.49)

March 2, 1998

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

- Many families feel strongly that they want their loved ones to continue to reside in the Centers' many of these persons have lived in the Centers for 30 or more years; specific concerns are lack of services and no community advocacy and Human Rights monitoring system which is not as strong as that in place in the Centers.

- Concern among Center employees that continued reduction in residential census will result in lost jobs. This has resulted in the report of some reduction in staff morale.

Future

- Continued reduction in long term residential population.

- Expansion of specialized units designed to provide short and medium term diagnostic, therapeutic and respite services.

- Continued need to expand Outreach Services Departments to provide communities with training, consultation and technical assistance.

- Expansion in Center-Based Clinics designed to provide those specialized services unavailable in communities.

- Center operated satellite programs; community programs into which small home-like of residents and staff within their living units can move together into small home-like settings off campus.

Fiscal Yr.	Budget Requirements	Budget Receipts	Appropriations	Census: Mild Adult	Mild Child	Moderate Adult	Moderate Child	Severe Adult	Severe Child	Profound Adult	Profound Child	Total Adult	Total Child	Total Alz.	Respite Adult	Respite Child	Respite Alz.	Total Resp. Days	MR Disc.	Alz Disc.	Total Disc.	Adm. MR	Adm Alz.	Total Adms	Deaths MR	Deaths Alz.	Total Deaths
93-94																											
BLK MT	$ 15,125,003.00	$ 12,828,480.00	$ 2,296,523.00	9	3	5	1	10	0	82	3	107	7	35	33	30	57	826	10	24	34	6	30	36	1	3	4
CASW	$ 61,412,142.00	$ 51,350,161.00	$ 10,061,981.00	29	0	52	0	117	0	517	1	715	1		41	20		3464	16		16	3		3	13		13
MURD	$ 53,021,005.00	$ 48,057,978.00	$ 4,963,031.00	4		41		115	3	529	5	689	8		17	13		1530	24		24	11		11	10		10
OBER	$ 38,395,257.00	$ 34,830,599.00	$ 3,564,658.00	4	2	13	3	47	0	363	2	427	7		0	1		28	20		20	14		14	7		7
WCC	$ 39,527,686.00	$ 34,977,263.00	$ 4,550,432.00	4	0	24	0	92	0	303	3	423	3		5	12		656	22		22	7		7	3		3
TOTAL	$ 207,481,093.00	$ 182,044,481.00	$ 25,436,625.00	50	5	135	4	381	3	1794	14	2361	26	35	96	76	57	6504	92	24	116	41	30	71	34	3	37
94-95																											
BLK MT	$ 14,772,554.00	$ 13,851,659.00	$ 920,853.00	4	2	2	0	10	1	77	2	93	4	34	20	12	82	736	23	16	39	7	16	23	1	1	2
CASW	$ 59,518,107.00	$ 53,544,871.00	$ 5,973,236.00	26	0	46	0	115	0	489	1	676	1		40	13		4048	34		34	3		3	10		10
MURD	$ 53,931,588.00	$ 49,126,059.00	$ 4,805,529.00	4		36		101	3	520	4	661	7		14	8		1378	30		30	6		6	5		5
OBER	$ 37,678,203.00	$ 36,343,741.00	$ 1,234,462.00	4	2	13	3	47	0	356	2	420	7		0	1		17	22		22	18		18	3		3
WCC	$ 38,069,283.00	$ 35,807,054.00	$ 2,262,229.00	4	0	26	0	92	2	279	6	401	8		20	18		1101	17		17	7		7	5		5
TOTAL	$ 203,969,735.00	$ 188,673,384.00	$ 15,196,309.00	42	4	123	3	365	6	1721	15	2251	27	34	94	52	82	7280	126	16	142	41	16	57	24	1	25
95-96																											
BLK MT	$ 16,869,515.00	$ 15,008,292.00	$ 1,861,223.00	5	1	4	0	9	0	71	2	89	3	65	16	2	71	788	14	26	40	10	61	71	1	4	5
CASW	$ 59,518,107.00	$ 53,544,871.00	$ 5,973,236.00	26	0	46	0	115	0	489	1	676	1		40	13		4048	34		34	3		3	10		10
MURD	$ 57,223,174.00	$ 52,987,204.00	$ 4,235,970.00	4		30		99	3	501	4	634	7		10	3		959	20		20	6		6	13		13
OBER	$ 37,050,042.00	$ 35,836,544.00	$ 1,213,488.00	6	2	12	1	43	1	344	1	405	5		3	1		68	25		25	13		13	5		5
WCC	$ 38,092,810.00	$ 38,074,641.00	$ 13,169.00	2	0	25	0	82	2	281	3	390	5		23	6		1182	17		17	8		8	4		4
TOTAL	$ 208,753,648.00	$ 195,451,552.00	$ 13,297,086.00	43	3	117	1	348	6	1686	11	2194	21	65	92	25	71	7045	110	26	136	40	61	101	33	4	37
96-97																											
BLK MT	$ 17,185,019.00	$ 14,941,797.00	$ 2,243,222.00	4	0	4	0	8	0	67	1	83	1	67	13	6	92	843	8	21	29	3	30	33	3	7	10
CASW	$ 59,258,636.00	$ 57,112,713.00	$ 2,145,923.00	24	0	42	1	106	1	479	2	651	4		34	3		577	8		8	7		7	14		14
MURD	$ 57,828,521.00	$ 55,590,444.00	$ 2,238,077.00	2		21	1	63	3	523	5	609	9		10	6		791	19		19	8		8	12		12
OBER	$ 38,030,724.00	$ 36,900,707.00	$ 1,130,017.00	4	1	11	2	39	2	333	1	387	6		1	0		29	26		26	14		14	5		5
WCC	$ 38,430,655.00	$ 37,247,165.00	$ 1,183,480.00	2	0	23	0	42	1	263	6	380	7		17	8		1195	11		11	5		5	3		3
TOTAL	$ 210,733,555.00	$ 201,792,826.00	$ 8,940,719.00	36	1	101	4	258	7	1665	15	2110	27	67	75	23	92	3435	72	21	93	37	30	67	37	7	44

Fiscal Yr.	Direct Care	Administrative	Professional	Support	Total
93-94					
*Blk Mt MR	104	21	48	124	297
CASW	821	87	233	677	1818
MURD	735	93	189	603	1620
OBER	540	6	126	312	984
WCC	379	60	171	429	1039
Total	2579	267	767	2145	5758
94-95					
*Blk Mt MR	104	21	47	123	295
CASW	822	87	231	663	1803
MURD	756	96	200	589	1641
OBER	546	61	120	306	1033
WCC	379	59	168	416	1022
Total	2607	324	766	2097	5794
95-96					
*Blk Mt MR	103	21	42	123	289
CASW	817	87	207	676	1787
MURD	755	94	200	571	1620
OBER	557	59	111	299	1026
WCC	379	58	167	407	1011
Total	2611	319	727	2076	5733
96-97					
*Blk Mt MR	103	21	42	123	289
CASW	817	87	207	676	1787
MURD	751	92	210	555	1608
OBER	562	58	109	293	1022
WCC	379	57	166	403	1005
Total	2612	315	734	2050	5711

*Does not include staff for Alzheimer's Unit

Fiscal Yr.	Downsizing	Salary Reserve Transfers	Lapsed Salary Transfers	Position Transfers	*Other	Total
93-94						
BLK MT	55,046	19,415	105,400			179,861
CASW	576,983	156,436	317,050	138,691	307,725	1,496,885
				**6		
MURD	522,943	100,424	323,824		583,712	1,530,903
OBER	440,368	6,914	0	86,923	167,518	701,723
				**3		
WCC	441,305	80,503	93,500	75,175	23,227	713,710
				**2		
TOTAL	2,036,645	363,692	839,774	300,789	1,082,182	4,623,082
94-95						
BLK MT	114,602	9,221		26,944	309,085	459,852
				**1		
CASW	677,461	55,388	72,547	54,906	1,109,649	1,969,951
				**2		
MURD	647,411	183,195	139,916		4,870,942	5,841,464
OBER	433,005	14,209	0	34,431	51,657	533,302
				**1		
WCC	422,308	144,189			704,456	1,270,953
TOTAL	2,294,787	406,202	212,463	116,281	7,045,789	10,075,522
95-96						
BLK MT	121,399	14,921		36,940	2,434,420	2,607,680
				**1		
CASW	662,051	82,908	0	17,597	10,334	772,890
				**1		
MURD	650,994	47,761	1,362,387		1,769,101	3,830,243
OBER	441,138	38,432	565,751	51,264	820,107	1,916,692
				**1		
WCC	428,007	38,534	371,172	50,004	934,685	1,822,402
				**1		
TOTAL	2,303,589	222,556	2,299,310	155,805	5,968,647	10,949,907
96-97						
BLK MT	142,656	18,138		89,638	91,511	341,943
				**3		
CASW	777,862	96,507	398,460	212,125	828,712	2,313,666
				**9		
MURD	736,309	108,827	863,035	17,065	1,092,337	2,817,573
				**1		
OBER	483,285	156,905	709,732	302,398	609,652	2,261,972
				**8		
WCC	506,576	128,103	269,040	245,832		1,149,551
				**8		
TOTAL	2,646,688	508,480	2,240,267	867,058	2,622,212	8,884,705
GRAND TOTAL	9,281,709	1,500,930	5,591,814	1,439,933	16,718,830	34,533,216
				**48		

*ARBs, Receipts, Retiree Salary Reserve

**Number of Positions

MRC

MENTAL RETARDATION CENTERS
Technical Assistance/Consultation and Training
OUTREACH INITIATIVES

	TECHNICAL ASSIST/CONSULT.		TRAINING	
Fiscal Yr.	# Hours	# Clients	# Hours	# Persons Served
93-94				
BLK MT	874	371	335	100
CASW	3,680	599	1,794	4,563
MURD	3,032	647	504	3790
OBER	14,152	900	694	885
WCC	813	652	1,222	2,170
TOTAL	22,551	3,169	4,549	11,508
94-95				
BLK MT	1,328	557	294	796
CASW	4,842	858	1,450	4,703
MURD	4,920	779	743	4208
OBER	12,068	800	3331	2,236
WCC	4,253	1,871	784	3,502
TOTAL	27,411	4,865	6,602	15,445
95-96				
BLK MT	1,633	2,436	614	939
CASW	9,371	641	1,588	4,486
MURD	5,491	1,096	716	4836
OBER	6,294	382	2,811	722
WCC	19,336	3,841	3,412	2,993
TOTAL	42,125	8,396	9,141	13,976
96-97				
BLK MT	2,125	1,710	264	604
CASW	7,181	510	1,972	5,809
MURD	5,700	1,092	1,094	6,056
OBER	3,921	379	178	174
WCC	20,206	2,457	2,216	3,076
TOTAL	39,133	6,148	5,724	15,719
*97-98				
BLK MT	1,094	734	341	865
CASW	3,820	347	1,819	1,777
MURD	3,145	458	518	2,210
OBER	1,516	155	**	**
WCC	14,498	1,164	1,198	1,318
TOTAL	24,073	2,858	3,876	6,170
GRAND TOTAL	155,293	25,436	29,892	62,818

*Two (2) quarters reporting

**Training provided by contracts

mrcout.xls

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Thursday, March 19, 1998, 9:00 a.m. - 12:00 p.m.

9:00 **Tour of Dorothea Dix Hospital**

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Minutes
March 25, 1998

The House Appropriations Subcommittee on Human Resources was convened on March 26, 1998 at 10:00 a.m. in Room 421LOB. Representative Gardner presided. The following members were present:

Representative Beverly Earle	Representative Cherie Berry
Representative Cindy Watson	Representative Billy Creech
Representative Edd Nye	Representative Julia Howard
Representative Theresa Esposito	Representative George Holmes
Representative Henry Aldridge	Representative Alexander
Representative Charlotte Gardner	Representative Lanier Cansler
Representative Debbie Clary	Representative Leo Daughtry

Senator Rand presented to the committee an overview of Senate Bill 2, An Act to establish the State Children's Health Insurance Program and to appropriate funds therefore. (See attachment #1.) Several members expressed concern over the fairness issue of some state employee's children receiving more benefits free than the others who are paying premiums, as well as the cost of bringing all State Employees' the same benefits. The fiscal note on the bill was passed out to the members. (See Attachment #2.)

Representative Gardner gave an overview of the Proposed Committee Substitute. (See attachment #3.) She said it was a more balanced, fair package of benefits that mirrors the present benefits state employees receive. Representative Cansler explained the tax credit offered in the Proposed Committee Substitute. A fiscal note, summary sheet of proposals in the bill and a sheet showing categorical costs of the program were provided the members. (See attachments #4,5 & 6.)

Representative Debbie Clary, Co-Chair, moved the consideration of the Proposed Committee Substitute and it passed. Representative Howard moved a favorable recommendation for the Committee Substitute for SB 2 and unfavorable for Senate Bill 2. After further discussion, Representative Gardner called for the question, and it passed. On a voice vote on the Proposed Committee Substitute, Representative Adams called for a division, and the vote was called by a show of hands. The Proposed Committee Substitute was given a favorable recommendation by a vote of 11 for and 4 against. The meeting was adjourned.

Barbara R. Hocutt
Barbara R. Hocutt, Clerk

Charlotte Gardner
Representative Charlotte Gardner, Co-Chair

Attachments

would provide a 15 percent tax credit on long-term care insurance, capped at $350 a year. The tax credits would not be limited to families in the income range covered in the proposed insurance program.

Cansler estimated that the tax credits would cost the state more than $200 million a year.

Democrats and supporters of the Senate plan questioned why tax credits were being debated.

In the House Finance Committee, Rep. Paul Luebke, D-Durham, questioned why the plan would extend the tax credit to the wealthy instead of targeting it at just lower- and middle-class taxpayers.

Published: March 26, 1998

3-25-98
#1

GENERAL ASSEMBLY OF NORTH CAROLINA

EXTRA SESSION 1998

S 1

SENATE BILL 2*

Short Title: State CHIP. (Public)

Sponsors: Senators Rand; Albertson, Ballance, Basnight, Carrington, Cooper, Dalton, Dannelly, Forrester, Gulley, Hoyle, Jenkins, Kerr, Kinnaird, Lee, Lucas, Martin of Pitt, Martin of Guilford, Miller, Odom, Perdue, Phillips, Plyler, Purcell, Reeves, Shaw of Cumberland, Soles, Warren, Weinstein, Wellons, and Winner.

Referred to: Committee of the Whole.

March 24, 1998

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM AND TO APPROPRIATE FUNDS THEREFOR.

The General Assembly of North Carolina enacts:

Section 1. Article 2 of Chapter 108A of the General Statutes is amended by adding the following new Part to read:

"Part 8. Children's Health Insurance Program.

"**§ 108A-70.18. Short title; purpose; no entitlement.**

This Part may be cited as the Children's Health Insurance Program Act of 1998. The purpose of this Part is to provide comprehensive health insurance coverage to uninsured low-income children who are residents of this State. Coverage shall be provided from State and federal funds appropriated and other funds made available for this purpose. Nothing in this Part shall be construed as obligating the General Assembly to appropriate funds for the Program or as entitling any person to coverage under the Program.

"**§ 108A-70.19. Program established.**

There is established the Children's Health Insurance Program. The Program shall be administered by the Department of Health and Human Services in accordance with this Part and as required under Title XXI, and related federal rules and regulations. Claims processing, benefits administration, and eligibility determination processes for the Program shall be as provided under the Medical Assistance

Program. The Department may authorize coverage under the Program to be provided by private insurers so long as the private coverage meets the requirements for coverage under the Program and under Title XXI, and the cost of the private coverage is equal to or less than the cost of equivalent coverage under the Program.

"**§ 108A-70.20. Definitions.**

Unless the context clearly requires otherwise, the term:

(1) 'Comprehensive health coverage' means creditable health coverage as defined under Title XXI.

(2) 'Family income' has the same meaning as used in determining eligibility for the Medical Assistance Program.

(3) 'FPL' or 'federal poverty level' means the federal poverty guidelines established by the United States Department of Health and Human Services, as revised each April 1.

(4) 'Medical Assistance Program' means the State Medical Assistance Program established under Part 6 of Article 2 of Chapter 108A of the General Statutes.

(5) 'Program' means the children's health insurance program established in this Part.

(6) 'State Plan' means the State Child Health Plan for the State Children's Health Insurance Program established under Title XXI.

(7) 'Title XXI' means Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552, codified in scattered sections of 42 U.S.C. (1997).

(8) 'Uninsured' means the applicant for Program benefits is not covered under any private or employer-sponsored comprehensive health insurance plan at the time of application.

"**§ 108A-70.21. Program eligibility; benefits; cost-sharing; appeals.**

(a) Eligibility. -- The Department may enroll eligible children based on availability of funds. In order to be eligible for benefits under the Program, children must:

(1) Be under the age of 19;

(2) Be ineligible for Medicaid, Medicare, or other government-sponsored health insurance;

(3) Be uninsured;

(4) Be in a family that meets the following family income requirements, without regard to assets:

a. Infants under the age of one year whose family income is from one hundred eighty-five percent (185%) through two hundred percent (200%) of the federal poverty level;

b. Children age one year through five years whose family income is from one hundred thirty-three percent (133%) through two hundred percent (200%) of the federal poverty level; and

c. Children age six years through eighteen years whose family income is from one hundred percent (100%) through two hundred percent (200%) of the federal poverty level; and

(5) Be a resident of this State or otherwise eligible under federal law.

Proof of family income and residency and a declaration of uninsured status shall be provided by the applicant.

Enrollment shall become effective beginning in the month in which the application is received and shall be effective for one year. Applicants may reapply for enrollment at the end of each year. If during the period of enrollment an enrollee fails to meet the requirements of subdivision (1), (2), (3), (4), or (5) of this subsection due to a change in status, the enrollee shall be ineligible for further coverage and shall be disenrolled from the Program. The family member who is legally responsible for the children enrolled in the Program has a duty to report any change in an enrollee's status within 60 days of the change of status.

(b) Benefits. -- Health benefits coverage provided to children eligible under the Program shall be the same as authorized under the Medical Assistance Program in the Current Operations Appropriations Act. Except as otherwise provided in this Part, terms, conditions, and limitations on Program benefits shall be the same as apply under the Medical Assistance Program.

(c) Cost-sharing. -- There shall be no premiums charged to Program participants. There shall be no deductibles, copayments, or other cost-sharing charges for families covered under the Program whose family income is at or below one hundred fifty percent (150%) of the federal poverty level. Families covered under the Program whose family income is above one hundred fifty percent (150%) of the federal poverty level shall be responsible for copayments to providers as follows:

(1) Three dollars ($3.00) per child for each physician visit, clinic visit, dental visit, and optometry visit, except that no copayment shall be required for preventive services;

(2) Five dollars ($5.00) per child for each outpatient hospital visit;

(3) Three dollars ($3.00) for each brand name prescription filled;

(4) Twenty dollars ($20.00) for emergency room services for nonemergency care. As used in this subsection, 'nonemergency care' shall consist of diagnoses not meeting the definition of 'true emergency' under the Carolina Access Program.

The total annual aggregate cost-sharing with respect to all children in a family receiving Program benefits under this Part shall not exceed five percent (5%) of the family's income for the year involved.

(d) Appeals. -- Applicants for and participants in the Program who are dissatisfied with the actions of a county or State agency pertaining to eligibility for and benefits under the Program may appeal the action in accordance with procedures established for the Medical Assistance Program pursuant to G.S. 108A-79 and applicable federal regulations. To the extent the process for appeal under G.S. 108A-79 is inconsistent with appeals under Chapter 150B of the General Statutes, the process under G.S. 108A-79 shall control.

"**§ 108A-70.22. Application for enrollment; outreach.**

(a) The Department shall develop an application form and enrollment process that makes application for and enrollment in the Program as simple, accessible, and efficient as possible.

(b) The Department shall conduct outreach activities statewide that will effectively provide information about the Program and will encourage potential participants to inquire and apply for enrollment. The outreach activities shall be targeted toward families likely to be eligible for benefits under the Children's Health Insurance Program or other health coverage programs to explain the eligibility requirements and benefits available. The Department may seek private and federal grant funds to conduct outreach activities. The Department may work with the State Health Plan Purchasing Alliance Board to develop programs that utilize the expertise and resources of the Alliances in outreach activities to employees of small businesses.

"**§ 108A-70.23. State Plan for Children's Health Insurance Program.**

The Department shall develop and submit a State Plan to implement the Child Health Insurance Program authorized under this Part to the federal government as application for federal funds under Title XXI. The Department shall report to the Joint Legislative Health Care Oversight Committee amendments to the State Plan for the Committee's review.

"**§ 108A-70.24. Data collection; reporting.**

(a) The Department shall establish procedures for the collection and analysis of data pertinent to the implementation and continuing evaluation of the Program.

(b) The Department shall report on October 1 of each year, and more frequently if requested, to the Joint Legislative Health Care Oversight Committee on the implementation of the Program. The report shall include, but is not limited to, the following:

(1) Number of children enrolled in the Program;

(2) Program areas that are working well and those that need improvement;

(3) Recommendations on ways to improve the efficiency and effectiveness of the Program; and

(4) Any other items requested by the Joint Legislative Health Care Oversight Committee.

The Department shall provide a copy of the report to the Joint Appropriations Subcommittee on Health and Human Services.

"**§ 108A-70.25. Fraudulent misrepresentation.**

(a) It shall be unlawful for any person to knowingly and willfully, and with intent to defraud, make or cause to be made a false statement or representation of a material fact in an application for coverage under this Part or intended for use in determining eligibility for coverage.

(b) It shall be unlawful for any applicant, participant, or person acting on behalf of the applicant or participant to knowingly and willfully, and with intent to defraud, conceal or fail to disclose any condition, fact, or event affecting the applicant's or participant's initial or continued eligibility to receive coverage under this Part.

(c) It is unlawful for any person knowingly, willingly, and with intent to defraud, to obtain or attempt to obtain, or to assist, aid, or abet another person, either directly or indirectly, to obtain money, services, or any other thing of value to which the person is not entitled as a participant under this Part, or otherwise to deliberately misuse a Program identification card. This misuse includes the sale, alteration, or lending of the Program identification card to others for services and the use of the card by someone other than the participant to receive or attempt to receive Program coverage for services rendered to that individual.

Proof of intent to defraud does not require proof of intent to defraud any particular person.

(d) A person who violates a provision of this section shall be guilty of a Class I felony if the value of the coverage wrongfully obtained is more than four hundred dollars ($400.00). A person who violates a provision of this section shall be guilty of a Class 1 misdemeanor if the value of the coverage wrongfully obtained is four hundred dollars ($400.00) or less.

(e) For purposes of this section, the word 'person' includes any natural person, association, consortium, corporation, body politic, partnership, or other group, entity, or organization."

Section 2. G.S. 120-70.111 reads as rewritten:

"**§ 120-70.111. Purpose and powers of Committee.**

(a) The Joint Legislative Health Care Oversight Committee shall review, on a continuing basis, the provision of health care and health care coverage to the citizens of this State, in order to make ongoing recommendations to the General Assembly on ways to improve health care for North ~~Carolinas~~ Carolinians. To this end, the Committee shall study the delivery, availability, and cost of health care in North Carolina. The Committee shall also review, on a continuing basis, the implementation of the State Children's Health Insurance Program established under Part 8 of Article 2 of Chapter 108A of the General Statutes. The Committee may also study other matters related to health care and health care coverage in this State.

(b) The Committee may make interim reports to the General Assembly on matters for which it may report to a regular session of the General Assembly. A report to the General Assembly may contain any legislation needed to implement a recommendation of the Committee."

Section 3. G.S. 143-626(2) reads as rewritten:

"(2) Accept applications by carriers to qualify as Accountable Health Carriers, determine the eligibility of carriers to become Accountable Health Carriers according to criteria described in G.S. 143-629, designate carriers as Accountable Health Carriers, ~~and~~ approve one additional qualified health care plan to be offered to small employers beyond the basic and standard health care ~~plans.~~ plans, and approve programs that provide options for the purchase of private insurance for dependent coverage that meets the requirements of the Children's Health Insurance Program

established under Part 8 of Article 2 of Chapter 108A of the General Statutes and Title XXI of the Social Security Act."

Section 4. (a) There is appropriated from the General Fund to the Department of Health and Human Services the sum of fourteen million nine hundred eighty-four thousand four hundred forty-seven dollars ($14,984,447) in recurring funds for the 1998-99 fiscal year to be used for the Children's Health Insurance Program established under this act and under Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552. The Office of State Budget and Management shall establish a Contingency Reserve for fiscal year 1998-99 and shall deposit into the Reserve ten percent (10%) of the funds appropriated under this section. Funds in the Reserve shall be used for unanticipated start-up, enrollment, and services costs occurring during the first year of Program implementation. The Office of State Budget and Management shall include in the proposed continuation budget the amount of State funds necessary for Program implementation for the budgeted fiscal year but not more than the amount necessary to draw down the maximum amount of federal funds available to the State for the budgeted fiscal year for the Children's Health Insurance Program under Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552.

(b) Of the funds appropriated under subsection (a) of this section, the Department may use up to two million dollars ($2,000,000) to cover unmatched start-up costs for the Children's Health Insurance Program established under this act.

(c) Funds appropriated under this section and not expended or obligated in the 1998-99 fiscal year shall revert to the General Fund on June 30, 1999.

(d) No State funds appropriated under this act may be expended for any purpose other than implementation of the State Children's Health Insurance Program established under this act and approved by the United States Secretary of Health and Human Services under Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552.

Section 5. Section 4 of this act becomes effective July 1, 1998. Health insurance coverage provided to children under the Children's Health Insurance Program established in this act shall become effective no earlier than October 1, 1998. The remainder of this act is effective when it becomes law.

3-25-98
#2

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: Senate Bill 2 (Extraordinary Session)

SHORT TITLE: State CHIP

SPONSOR(S): Senator Rand

FISCAL IMPACT

Yes (X) **No ( )** **No Estimate Available ( )**

	FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03
A. Health & Human Services					
Total Expenditures	$50,533,236	$90,886,688	$96,294,384	$102,028,075	$108,106,700
Federal Funds	$36,911,012	$67,264,329	$71,097,995	$ 75,124,292	$ 79,395,722
State Funds	**$14,984,447**	**$23,622,359**	**$25,196,389**	**$ 26,903,783**	**$ 28,710,977**
POSITIONS:	(7)	(7)	(7)	(7)	(7)
B. Corrections	**No Fiscal Impact**				
C. Judicial	**No Fiscal Impact**				

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED:

Department of Health and Human Resources
County Departments of Social Services
Department of Corrections
Judicial Department

EFFECTIVE DATE: Appropriations for this Act are effective July 1, 1998. Health insurance coverage provided to children under this Act is effective no earlier than October 1, 1998. The remainder of the Act is effective upon ratification.

BILL SUMMARY:

This legislation establishes the Children's Health Insurance Program (CHIP) Act of 1998 which will provide comprehensive health insurance coverage to uninsured low-income children who are residents of this state. This program is not an entitlement and nothing in the Act shall be construed as obligating the General Assembly to appropriate funds for this Program. The Program will be administered by the Department of Health and Human Services. Claims processing and benefits administration shall be provided under the Department's Medical Assistance Program.

Eligibility for the program is as follows:

(1) Be under the age of 19;
(2) Be ineligible for other government sponsored health insurance;
(3) Be uninsured;
(4) Be in a family that meets the following income requirements, without regard to assets:
    a. Infants under age one in families with incomes from 185 % to 200% of the federal poverty level;
    b. Children age one through five years in families with incomes from 133% to 200% of the federal poverty level; and
    c. Children age six through eighteen years in families with incomes from 100% to 200% of the federal poverty level; and
(5) Be a state resident or otherwise eligible under federal law.

Benefits under this Program are the same as those authorized under the Medical Assistance Program in the Current Appropriations Act.

There are no premiums under this Program. There are no deductibles, copayments, other cost-sharing charges for families with incomes below or at 150% of the federal poverty level. Families with incomes above 150% of the federal poverty level shall be responsible for copayments authorized in the legislation. Cost-sharing shall not exceed 5% of family income.

The legislation establishes an appeal process. The Department is required to develop a simple and efficient application and to conduct outreach activities statewide to encourage families to participate in the program. The Department is authorized to submit a State Plan to the federal government as required by federal law. The legislation provides for a penalty for fraudulent misrepresentation which is the same as for Medicaid/Food Stamp fraud. The Joint Legislative Health Care Oversight Committee provides legislative oversight for the implementation of the Program.

Appropriates $14,984,447 in recurring funds for Program implementation and start-up. Funding is restricted so that no more than $2,000,000 can be spent on start-up costs and a 10% one year reserve is provided for unanticipated expenses. Unexpended funds revert on June 30, 1999 and the Department may not use funds for any other purpose. The Office of State Budget and

Management shall include in the proposed continuation budget the amount of State funds necessary for Program implementation, but not more than the amount necessary to draw down the maximum amount of available federal funds budget for the Children's health Insurance Program (CHIP).

ASSUMPTIONS AND METHODOLOGY:

A. Children's Health Insurance Program

In 1997, Title XXI of the Social Security Act or the State Children's Health Insurance Program (CHIP) was established by the U.S. Congress to provide health insurance to uninsured children. Federal funding for the program is provided through fiscal year 2007-08. North Carolina's federal allotment is estimated to be $79.5 million for 1998-99 through 2001-02, $58.6 million for 2002-03 through 2004-05, $76.6 million for 2005-06 through 2006-07, and $94.5 million for 2007-08. Federal funds remain available for three years. Since North Carolina can roll forward unexpended federal funds, this fiscal note assumes that adequate federal funding will be available to fund this program over the ten year period even though federal fund availability is significantly reduced in years 2002-03 through 2004-05.

The following assumptions and methodology were used to estimate the cost of the CHIP program for the first five years beginning with 1998-99:

1. **Eligible Children:** Assumes that the estimated number of eligible children -- who are uninsured, below the age of 19, not eligible for Medicaid, and in families with incomes at or below 200% of the federal poverty level -- for 1998-99 is 74,224 and that the number of estimated eligible children will increase by 2% each year in future years. Assumes that the Program will serve 85% of the eligible children. The 1998-99 estimate of children is based on data from the Current Population Survey which has been adjusted for 1998-99.

2. **Annual Cost Per Child:** Assumes that the annual cost per child to provide comprehensive health insurance coverage which is identical to the Medicaid program is $1,234.01 for 1998-99; and assumes that the cost will increase by 4% each year in future years. The 1998-99 cost per child estimate is based on an actuarial study conducted by Mercer and Co. for the Division of Medical Assistance. The annual rate is the average cost of serving all eligible children. The rate was derived by multiplying the rate for each age category times the number of children in each age category and then divided by the total number of eligible children (74,224). The rate does not include long term care services because it is assumed that children eligible for long term care services are already enrolled in Medicaid. The rate also takes into consideration the copayments required under the proposed legislation.

3. **Eligible Months and Payment Months:** Assumes that the enrollment of children will be phased in over a six month period in 1998-99 (33% in October, 67% by November,

77% by December, 87% by January, 97% by February, and 100% by March). The assumed phasing of enrollment results in 7.61 eligible months for 1998-99. Assumes that there will be lag of one month between eligibility determination and payment of claims which results in 6.61 payment months for 1998-99. Assumes 12 months of eligibility and claims payment for each year in future years.

4. **Total Services Cost:** The cost of providing services for enrolled children is determined by multiplying the estimated number of enrolled children times cost per month times the number of payment months for each year.

5. **Eligibility Determination:** Assumes that eligibility determination will be done by county departments of social services because federal law requires that uninsured children who are eligible for Medicaid must be served through Medicaid and not the CHIP program. County departments of social services are currently responsible for determining Medicaid eligibility. While the counties will be responsible for doing determination, they will not be responsible for the cost.

   The Department of Health and Human Services has estimated that the average time to do mail-in and interview applications is 1.01 hours with an estimated cost of $37.34 per hour. Based on experience with the Medically Indigent Children's Medicaid program, assumes that 87.6% of the applications will be approved or a ratio of 1.14. The total cost for eligibility determination is determined by multiplying $37.34 times 1.14 times the estimated number of children enrolled. Assumes that eligibility determination costs will increase 5% each year in future years.

6. **Staffing:** The Department of Health and Human Services has estimated that the Division of Medical Assistance will need four to five additional staff positions and their associated operating costs ($250,000) to administer CHIP program. Positions are as follows: 1 EIS Systems Programmer, 1 Claims Analyst, 1 Health Check support person, and 2 QC Analysts. Assumes no inflation for staffing costs in future years.

7. **Other Administrative Costs:** Other administrative costs include claims processing, postage, and printing. Assumes the average cost of processing one claim is $1.80 and assumes one claim per estimated enrolled child per payment month. Assumes that the cost of printing and mailing eligibility cards each month to each eligible child is $.25 per month per child. Assumes that the costs for claims processing, postage and printing will increase 2% each year in future years.

   In addition, assumes start-up costs for one-time systems modifications to the State's EIS system (eligibility) and EDS's MMIS system for processing claims and producing reports. The one-time cost for the EIS system changes is estimated to be $500,000. The one-time cost for EDS's system changes is estimated to be $1,200,000.

8. **Outreach:** Assumes the creation of an outreach office for children's health services to do outreach for both the CHIP program and Medicaid for children. The estimated cost

includes the following three staff positions and funds to prepare and disseminate information on the programs: 1 Outreach Office Director (25% of the cost), 1 Education Specialist, and 1 management support position. Assumes the costs for outreach will increase 2% each year in future years.

9. **Federal Financial Participation Rates:** Title XXI of the Social Security Act provides funding for the CHIP program established by the proposed legislation by using an enhanced federal matching rate. The enhanced matching rate is equal to the state's existing federal medicaid matching rate plus 30% of the state share. North Carolina's enhanced federal matching rate for 1998-99 is 74.16% with a state share of 25.84%. Historically, the federal medicaid match rate for North Carolina has decreased each year and it is assumed that these decreases will continue. The following matching rates are assumed in this fiscal note:

	Federal	State
1998-99	74.16%	25.84%
1999-00	74.01%	25.99%
2000-01	73.83%	26.17%
2001-02	73.63%	26.37%
2002-03	73.44%	26.56%

The enhanced matching rate applies to all program costs, administration, and outreach for the CHIP program.

9. **Federal 10% Cap on Administration and Outreach:** Federal legislation limits cost-sharing for administration and outreach for the CHIP program to 10% of the program expenditures each year. This 10% federal cap impacts funding for the CHIP program during 1998-99 because one-time start-up costs and the October 1, 1998 starting date cause the estimated administration and outreach costs to exceed 10% of the estimated program costs. This fiscal note assumes that 100% state funds will be used to cover the costs exceeding the 10% cap during 1998-99. In addition, this fiscal notes assumes that outreach costs for 1998-99 will be covered by the Medicaid program which allows for a 50% federal match. In fiscal years following 1998-99, the estimated administration and outreach costs are below 10% of the program costs and the costs are fully matched with federal funds.

10. **10% Reserve for 1998-99:** This fiscal note assumes a one-time 10% reserve funded from 100% state funds to cover unanticipated costs for start-up, enrollment, and services. The reserve is not included in the estimates for future years.

B. Judicial Department

The proposed fraudulent penalties outlined in this bill are the same as existing penalties in G.S.108A-64 which covers medicaid fraud representation. Since these penalties cover similar populations, the Fiscal Research Division believes that the most reliable way of

determining the fiscal impact of this bill would be to review the number of defendants charged and sentenced to criminal penalties under G.S.108A-64.

Currently, the Judicial Department does not have a specific code for offenses relating to medicaid fraud representation. This indicates a small number of offenses since "offense codes" are established only when the number of offenses is significant (usually more than 100 offenses). The Judicial Department believes that the few additional cases which may result from this legislation could be absorbed within existing court resources.

C. Department of Correction

Based on this finding, the Sentencing Commission does not expect that the proposed changes would have any significant impact on prison populations. The Sentencing Commission estimates, for example, that if 10 individuals were convicted of these offenses per year approximately 1 or 2 additional inmates would be added to the prison population. If there were as many as 25 convictions no more than 3 to 5 additional inmates would be added to the prison system. It is anticipated that the vast majority of individuals would be incarcerated as a result of probation revocations. This very small increase in incarcerated individuals could be absorbed within existing Department of Correction resources.

TECHNICAL CONSIDERATIONS: None.

FISCAL RESEARCH DIVISION
733-4910
PREPARED BY: L. Carol Shaw, Charles Perusse L Carol Shaw Charles Perusse
APPROVED BY: Tom Covington for Tom Covington
DATE: 3-23-98

3-25-98
#3

GENERAL ASSEMBLY OF NORTH CAROLINA

EXTRA SESSION 1998

S **D**

SENATE BILL 2*
Proposed Committee Substitute S2-PCS4645

Short Title: RITE Care. (Public)

Sponsors:

Referred to:

March 24, 1998

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH RITE CARE: THE CHILD HEALTH INSURANCE PROGRAM TO PROVIDE HEALTH INSURANCE FOR CHILDREN UP TO ONE HUNDRED EIGHTY-FIVE PERCENT OF THE FEDERAL POVERTY LEVEL AND UNINSURED FOR SIX MONTHS PRIOR TO APPLICATION; TO PROVIDE ADMINISTRATION OF PROGRAM BENEFITS UNDER THE NORTH CAROLINA TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN; TO REQUIRE THAT APPLICATION BE MADE AT LOCAL HEALTH DEPARTMENTS AND COUNTY DEPARTMENTS OF SOCIAL SERVICES; TO AUTHORIZE PROGRAM ENROLLEES TO PURCHASE EXTENDED OR ADDITIONAL COVERAGE UNDER THE PROGRAM; TO AUTHORIZE PREMIUMS AND OTHER COST-SHARING UNDER THE PROGRAM; TO ESTABLISH THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON CHILD HEALTH INSURANCE; AND TO AUTHORIZE A TAX CREDIT FOR CERTAIN PURCHASERS OF DEPENDENT HEALTH INSURANCE AND LONG-TERM CARE INSURANCE.

The General Assembly of North Carolina enacts:

Section 1. Article 2 of Chapter 108A of the General Statutes is amended by adding the following new Part to read:

"Part 8. Health Insurance for Children.

"**§ 108A-70.18. Definitions.**

Unless the context clearly requires otherwise, the term:

(1) 'Comprehensive health coverage' means credible health coverage as defined under Title XXI.

(2) 'Family income' means the total amount of combined annual income for each member of the household who is legally responsible for support of the child covered under the Program. The total amount of child support received during the prior year shall be included in calculating family income.

(3) 'FPL' or 'federal poverty level' means the federal poverty guidelines established by the United States Department of Health and Human Services, as revised each April 1.

(4) 'Program' or 'RITE Care' means the child health insurance program established in this Part.

(5) 'State Plan' means the State Child Health Plan for the State Children's Health Insurance Program established under Title XXI.

(6) 'Title XXI' means Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552, codified in scattered sections of 42 U.S.C. (1997).

(7) 'Uninsured' means the applicant for RITE Care benefits is and was not covered under any private or employer-sponsored comprehensive health insurance plan at the time of application and for the six months immediately preceding application. If within the six months immediately preceding application a child has lost Medicaid eligibility due to a change in family income or has lost employer-sponsored comprehensive health care coverage due to layoff by the employer or cessation of the employer's business, and no other employer-sponsored comprehensive health care coverage is available to the family, then the child is deemed uninsured for purposes of eligibility for RITE Care benefits.

"§ 108A-70.19. Short title; purpose; no entitlement.

This act may be cited as 'RITE Care: The Child Health Insurance Program Act of 1998.' The purpose of this Part is to provide health insurance coverage to uninsured low-income children who are residents of this State. Coverage shall be provided from State and federal funds and other funds appropriated for this purpose. Nothing in this Part shall be construed as obligating the General Assembly to appropriate funds for 'RITE Care' or as entitling any person to coverage under 'RITE Care.'

"§ 108A-70.20. Program established.

'RITE Care: The Child Health Insurance Program' is established. RITE Care shall be administered by the Department of Health and Human Services in accordance with this Part. Administration of RITE Care benefits and claims processing shall be as provided under Part 5 of Article 3 of Chapter 135 of the General Statutes.

"§ 108A-70.21. Program eligibility; benefits; premiums and other cost-sharing; coverage from private plans; purchase of extended or additional coverage.

(a) Eligibility. -- In order to be eligible for benefits under RITE Care, children must:

(1) Be under the age of 19 and, if high-school age, be enrolled in high school;
(2) Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;
(3) Be uninsured;
(4) Be in a family that meets the following family income requirements:
a. Children age one year through five years whose family income is from one hundred thirty-four percent (134%) through one hundred eighty-five percent (185%) of the federal poverty level; and
b. Children age six years through eighteen years whose family income is from one hundred one percent (101%) through one hundred eighty-five percent (185%) of the federal poverty level;
(5) Be a resident of this State; and
(6) Have paid the Program premium required under this Part.

Proof of family income and residency, and declaration of uninsured status shall be provided by the applicant at the time of application for RITE Care coverage.

If a responsible parent is under a court order to provide medical support or maintain health insurance for a child and has failed to comply with the court order, then the child is deemed uninsured for purposes of determining eligibility for RITE Care benefits if the following conditions are met at the time of application:
(1) The custodial parent shows proof of subsequent legal action taken to enforce the order to obtain medical support or health insurance, and
(2) There is no other government- or employer-sponsored comprehensive health insurance available to cover the child.

If medical support or health insurance is provided to the child after enrollment and prior to the expiration of the eligibility period for which the child is enrolled in RITE Care, then the child is deemed to be insured and ineligible for continued coverage under RITE Care. The custodial parent has a duty to notify the Department within 10 days of receipt of medical support or health insurance, and the Department, upon receipt of notice, shall disenroll the child from RITE Care. As used in this paragraph, the term 'responsible parent' means a person who is under a court order to pay child support.

Except as otherwise provided in this section, eligibility shall be continuous for one year. At the end of each year, applicants may reapply for Program benefits. If, at the time of reapplication, the Department verifies that the applicant has not paid part or all of the premiums due for prior year coverage, then the applicant is not eligible for coverage until the past-due premiums have been paid in full. The amount owed for unpaid premiums shall be adjusted to apply only to the period for which coverage was provided.

It shall be the duty of enrollees in the Program to promptly inform the Department of any change in the enrollee's family income, residency, or uninsured status occurring during the period of enrollment.

(b) Benefits. -- Except as otherwise provided for eligibility, premiums, deductibles, copayments, and other cost-sharing charges, health benefits coverage provided to children eligible under RITE Care shall be equivalent to coverage provided for dependents under the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, including optional prepaid plans.

Prescription drug providers shall accept as payment in full for outpatient prescriptions filled ninety percent (90%) of the average wholesale price for the prescription drug or the amounts published by the Health Care Financing Administration plus a dispensing fee not to exceed the amount authorized under subsection (d)(2) of this section. All other health care providers providing services to Program enrollees shall accept as payment in full for services rendered the maximum allowable charges under the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan for services less any copayments assessed to enrollees under this Part.

(c) Premiums. -- There shall be no premium for RITE Care coverage for enrollees whose family income is less than one hundred thirty-four percent (134%) of the federal poverty level. The premium for RITE Care coverage for enrollees whose family income is at or above one hundred thirty-four percent (134%) of the federal poverty level shall be according to the following schedule:

Family Income	Monthly Premium
134%-150% FPL	$5.00 per child with a maximum monthly premium of $15.00 for three or more children.
151%-185% FPL	$10.00 per child with a maximum monthly premium of $28.00 for three or more children.

Premiums shall be collected by and payable to the Department in monthly installments. The Department shall adopt rules for the efficient collection of premiums. The rules shall provide maximum flexibility for the payment of premiums by enrollees. The Department may contract with private business to provide premium collection and payment services.

(d) Cost-Sharing. -- There shall be no deductibles, copayments, or other cost-sharing charges for families covered under RITE Care whose family income is at or below one hundred fifty percent (150%) of the federal poverty level. Families covered under RITE Care whose family income is above one hundred fifty percent (150%) of the federal poverty level shall be responsible for copayments to providers as follows:

(1) Five dollars ($5.00) per child for each visit to a physician or clinic, except that there shall be no copayment required for well-baby, well-child, or age-appropriate immunization services;

(2) Six dollars ($6.00) dispensing fee for each outpatient prescription drug purchased.
(3) Twenty dollars ($20.00) for each emergency room visit unless:
a. The child is admitted to the hospital, or
b. No other reasonable care was available as determined by the Claims Processing Contractor of the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan.

Copayments required under this subsection for prescription drugs apply only to prescription drugs prescribed on an outpatient basis.

The Department shall ensure that the total annual aggregate cost-sharing, including premiums, with respect to all children in a family receiving RITE Care benefits under this Part shall not exceed five percent (5%) of the family's income for the year involved.

(e) Coverage From Private Plans. -- The Department shall, from funds appropriated for RITE Care, pay the cost for dependent coverage provided under a private insurance plan for persons eligible for coverage under RITE Care if all of the following conditions are met:

(1) The person eligible for RITE Care coverage requests to obtain dependent coverage from a private insurer in lieu of coverage under RITE Care and shows proof that coverage under the private plan selected meets the requirements of this subsection;
(2) The dependent coverage under the private plan is actuarially equivalent to the coverage provided under RITE Care;
(3) The cost of dependent coverage under the private plan is the same as or less than the cost of coverage under RITE Care; and
(4) The total annual aggregate cost-sharing, including premiums, paid by the enrollee under the private plan for all dependents covered by the plan, do not exceed five percent (5%) of the enrollee's family income for the year involved.

The Department may reimburse an enrollee for private coverage under this subsection upon a showing of proof that the dependent coverage is in effect for the period for which the enrollee is eligible for RITE Care.

(f) Purchase of Extended Coverage. -- An enrollee in RITE Care who loses eligibility due to an increase in family income above one hundred eighty-five percent (185%) of the federal poverty level and up to and including two hundred percent (200%) of the federal poverty level, may purchase at full premium cost continued coverage under RITE Care for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The same benefits, copayments, and other conditions of enrollment under RITE Care shall apply to extended coverage purchased under this subsection.

(g) Option to Purchase Additional Benefits. -- An enrollee in RITE Care may purchase, on a fully contributory basis, optional coverage for dental, vision, and

hearing services. The Department shall select coverage options for enrollees that offer the best benefit package at the most reasonable cost.

(h) No State Funds for Voluntary Participation. -- No State or federal funds shall be used to cover, subsidize, or otherwise offset the cost of coverage obtained under subsection (f) or (g) of this section.

"§ 108A-70.22. Coverage for children with special needs.

(a) Definition. -- As used in this section, the term 'children with special needs' or 'special needs child' means children who are enrolled in RITE Care and who have or are at elevated risk for (biologic or acquired) chronic physical, developmental, behavioral, or emotional conditions and who also require health and related (but not educational and not recreational) services of a type and amount not usually required by children of the same age.

(b) Eligibility for Special Needs Coverage. -- In order to be eligible for coverage under this section a special needs child must be a child who is enrolled in RITE Care. A child with special needs shall, to the extent funds are available for coverage under this section, be eligible for coverage for services that are necessary to enable the child to remain in the child's home as an alternative to institutionalization, and that are not covered under RITE Care. The level of and reimbursement for services for special needs children under this section shall be the same as available for special needs children under the Medical Assistance Program as authorized in the Current Operations Appropriations Act.

(c) Evaluation Required. -- No funds may be expended for coverage under this section unless the Department has made a determination that coverage for the services is not available under RITE Care. The Department shall conduct an evaluation of each RITE Care enrollee requesting special needs coverage to determine eligibility under this section.

(d) The Department may adopt rules for eligibility for coverage under this section.

"§ 108A-70.23. Claims processing; payments.

(a) The North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan shall be responsible for the administration and processing of claims for benefits under the Program, as provided under Part 5 of Article 3 of Chapter 135 of the General Statutes.

(b) The Department shall, from premiums collected, from State and federal appropriations, and from any other funds made available for this purpose, make payments to the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan as determined by the Plan for its administration, claims processing, and other services authorized to provide coverage to children eligible for benefits under this Part.

"§ 108A-70.24. State Plan for Children's Health Insurance Program.

The Department shall develop and submit a State Plan to implement 'RITE Care: the Child Health Insurance Program' authorized under this Part to the federal government as application for federal funds under Title XXI. The State Plan submitted under this Part shall be developed by the Department only as authorized by and in accordance with this Part. No provision in the State Plan submitted under

this Part may expand or otherwise alter the scope or purpose of RITE Care from that authorized under this Part. The Department shall include in the State Plan submitted only those items required by this Part and required by the federal government to qualify for federal funds under Title XXI and necessary to secure the State's federal fund allotment for the applicable fiscal period. The Department shall not amend the State Plan nor submit any amendments thereto to the federal government for review or approval without the specific approval of the General Assembly.

"**§ 108A-70.25. Application process; outreach efforts; appeals.**

(a) Application. -- The Department shall use an application form for RITE Care that is concise, relatively easy for the applicant to comprehend and complete, and only as lengthy as necessary for identifying applicants, determining eligibility for RITE Care or Medicaid, and providing information to applicants on requirements for application submission and proof of eligibility. Application forms shall be obtainable from public health departments and county departments of social services. Applications shall be processed by the county department of social services and may be submitted by mail. The Department may adopt rules for the submission and processing of applications and for securing the proof of eligibility for benefits under this Part.

The application form for RITE Care shall have printed on it or attached to it a notice stating substantially: 'RITE Care: A Child Health Insurance Program' is a federally funded program that may be discontinued if federal funds are not provided for its continuation. Applicants who lose health care coverage under RITE Care because the program has ended may not be able to obtain coverage from a private insurer because of health conditions arising while covered under RITE Care. Applicants are encouraged, therefore, to obtain private health insurance as soon as possible.

(b) Outreach Efforts. -- The Department shall adopt procedures governing outreach activities at the State and local level to ensure that RITE Care is adequately publicized statewide and to comply with federal outreach requirements. The Department shall make information about the Program available through the Internet, and shall explore the feasibility of securing a 24-hour toll-free telephone number for purposes of enhancing outreach and access to program information. In developing outreach procedures, the Department shall establish system linkages to ensure the collaboration and coordination of expertise, funding streams, delivery systems, and other appropriate resources and activities between and among RITE Care and such ongoing programs and efforts as:

WIC Program
Maternal and Child Health Block Grant
Children's Special Health Services
Smart Start.
Head Start.

The Department may seek private and federal grant funds for outreach activities. The Department shall also seek the participation of the private sector in providing

no-cost or low-cost avenues for publicizing RITE Care in local communities and statewide.

(c) A person who is dissatisfied with the action of a county department of social services with respect to the determination of initial, continuing, or renewed eligibility for benefits under the Program may appeal the action in accordance with G.S. 108A-79.

"**§ 108A-70.26. Data collection; reporting.**

(a) The Department shall ensure that the following data is collected, analyzed, and reported in a manner that will most effectively and expeditiously enable the State to evaluate Program goals, objectives, operations, and health outcomes for children:

(1) Number of applicants for coverage under the Program;
(2) Number of RITE Care applicants deemed eligible for Medicaid;
(3) Number of applicants deemed eligible for RITE Care, by income level, age, family size;
(4) Number of applicants deemed ineligible for RITE Care and the basis for ineligibility;
(5) Number of applications made at county departments of social services, public health departments, and by mail;
(6) Total number of children enrolled in RITE Care to date and for the immediately preceding fiscal year;
(7) Total number of children enrolled in Medicaid through the Program application process;
(8) Trends showing the Program's impact on hospital utilization, immunization rates, and other indicators of quality of care, and cost-effectiveness and efficiency;
(9) Trends relating to the health status of children;
(10) Other data that would be useful in carrying out the purposes of this Part.

(b) The Department shall report annually to the Joint Legislative Oversight Committee on Child Health Insurance the following information:

(1) Data collected as required under subsection (a) of this section and an analysis thereof giving trends and projections for continued Program funding;
(2) Program areas working most effectively and least effectively;
(3) Performance measures used to ensure Program quality, fiscal integrity, ease of access, and appropriate utilization of preventive and medical care;
(4) Effectiveness of system linkages in addressing access, quality of care, and Program efficiency;
(5) Recommended changes in the Program necessary to improve Program efficiency and effectiveness;
(6) Any other information requested by the Committee pertinent to the provision of health insurance for children and the implementation of RITE Care.

The Department shall provide a copy of the report to the members of the Joint Appropriations Subcommittee on Health and Human Services.

"**§ 108A-70.27. Fraudulent misrepresentation.**

(a) It shall be unlawful for any person to knowingly and willfully, and with intent to defraud, make or cause to be made a false statement or representation of a material fact in an application for coverage under this Part or intended for use in determining eligibility for coverage.

(b) It shall be unlawful for any applicant, recipient or person acting on behalf of the applicant or recipient to knowingly and willfully, and with intent to defraud, conceal or fail to disclose any condition, fact, or event affecting the applicant's or recipient's initial or continued eligibility to receive coverage or benefits under this Part.

(c) It is unlawful for any person knowingly, willingly, and with intent to defraud, to obtain or attempt to obtain, or to assist, aid, or abet another person, either directly or indirectly, to obtain money, services, or any other thing of value to which the person is not entitled as a recipient under this Part, or otherwise to deliberately misuse a Program identification card. This misuse includes the sale, alteration, or lending of the Program identification card to others for services and the use of the card by someone other than the recipient to receive or attempt to receive RITE Care program coverage for services rendered to that individual.

Proof of intent to defraud does not require proof of intent to defraud any particular person.

(d) A person who violates a provision of this section shall be guilty of a Class I felony.

(e) For purposes of this section the word 'person' includes any natural person, association, consortium, corporation, body politic, partnership, or other group, entity, or organization."

Section 2. Legislative oversight committee. (a) There is established the Joint Legislative Oversight Committee on Child Health Insurance. The powers and duties of the Committee shall be to:

(1) Monitor the implementation of RITE Care: The Child Health Insurance Program established under this act;

(2) Review reports from the Department of Health and Human Services, the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, and other government and public and private sector agencies and organizations on the implementation of RITE Care and other child health insurance initiatives; and

(3) Make recommendations to the General Assembly regarding RITE Care and other issues relating to child health and health insurance coverage for children.

(b) The Speaker of the House of Representative shall appoint to the Committee six members of the House of Representatives, one of whom shall be

appointed cochair, and the President Pro Tempore of the Senate shall appoint six members of the Senate, one of whom shall be appointed cochair.

Section 3. (a) Division II of Article 4 of Chapter 105 of the General Statutes is amended by adding a new section to read:

"**§ 105-151.27. Credit for child health insurance.**

(a) Credit. -- A taxpayer is allowed a credit against the tax imposed by this Division equal to one-third of the taxpayer's child health insurance premium paid during the taxable year. The credit may not exceed five percent (5%) of the taxpayer's adjusted gross income (AGI), as calculated under the Code, for the taxable year. A nonresident or part-year resident who claims the credit allowed by this section 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. In order to claim a credit under this section, a taxpayer must provide any information required by the Secretary to establish the taxpayer's eligibility for the credit and the amount of the credit.

(b) Definitions. -- The following definitions apply in this section:

(1) Child health insurance premium. -- The amount paid by the taxpayer for insurance coverage of the taxpayer's dependent children under a private or employer-sponsored comprehensive health insurance plan and the amount paid to purchase extended coverage under the RITE Care Program pursuant to G.S. 108A-70.21. The term does not include, however, amounts deducted from or not included in the taxpayer's gross income for the taxable year.

(2) Dependent child. -- A child under the age of 19 for whom the taxpayer is allowed to deduct a personal exemption under section 151(c)(1)(B) of the Code for the taxable year.

(c) Credit Refundable. -- If the credit allowed by this section exceeds the amount of tax imposed by this Division for the taxable year reduced by the sum of all credits allowable, the Secretary shall refund the excess to the taxpayer. The refundable excess is governed by the provisions governing a refund of an overpayment by the taxpayer of the tax imposed in this Division. In computing the amount of tax against which multiple credits are allowed, nonrefundable credits are subtracted before refundable credits."

(b) G.S. 105-160.3(b) is amended by adding a new subdivision to read:

"(4) G.S. 105-151.27. Credit for child health insurance."

(c) The Department of Revenue shall withhold from collections under Division II of Article 4 of Chapter 105 of the General Statutes for the 1999-2000 fiscal year the amount necessary to reimburse it for its additional costs of printing, postage, programming, and administration directly attributable to this act. It is the intent of the General Assembly to appropriate funds to the Department of Revenue for the 1999-2001 fiscal biennium to cover the costs of auditing ten percent (10%) of the tax credits claimed under this section. These costs include salary, benefits, and work space for 10 auditors and two clerical support positions. It is also the intent of the General Assembly to appropriate funds to the Department of Revenue for the

1999-2000 fiscal year for the one-time programming costs required for the credit authorized by this section.

(d) This section is effective for taxable years beginning on or after January 1, 1999, and expires for taxable years beginning on or after January 1, 2001.

(e) This section becomes effective only if the United States Secretary for Health and Human Services approves the State Plan to implement RITE Care: A Child Health Insurance Program established under this act.

Section 3.1. (a) Chapter 105 of the General Statutes is amended by adding a new section to read:

"**§ 105-151.28. Credit for premiums paid on long-term care insurance.**

(a) Credit. -- An individual is allowed, as a credit against the tax imposed by this Division, an amount equal to fifteen percent (15%) of the premium costs paid during the taxable year on a qualified long-term care insurance contract that offers coverage to either the individual, the individual's spouse, or a dependent for whom the individual was allowed to deduct a personal exemption under section 151(c)(1)(A) of the Code for the taxable year. The credit allowed by this section may not exceed three hundred fifty dollars ($350.00) for each qualified long-term care insurance contract for which a credit is claimed. A nonresident or part-year resident who claims the credit allowed by this subsection shall reduce the amount of the credit by multiplying it by the fraction calculated under G.S. 105-134.5(b) or (c), as appropriate.

(b) 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.

(c) Credit Refundable. -- If the credit allowed by this section exceeds the amount of tax imposed by this Division for the taxable year reduced by the sum of all credits allowable, the Secretary shall refund the excess to the taxpayer. The refundable excess is governed by the provisions governing a refund of an overpayment by the taxpayer of the tax imposed in this Division. In computing the amount of tax against which multiple credits are allowed, nonrefundable credits are subtracted before refundable credits."

(b) G.S. 105-160.3(b) is amended by adding a new subdivision to read:

"(4) G.S. 105-151.28. Credit for long-term care insurance."

(c) The Legislative Research Commission shall study the effectiveness of the credit enacted by this act. The Department of Revenue shall provide the Commission data on the usage of this credit, including profiles of taxpayer categories using the credit. The Division of Aging, Department of Human Resources, shall provide the Commission data on the effect of the credit on the State's Medicaid costs. The Commission shall report its findings and recommendations to the 2001 General Assembly.

(d) This section is effective for taxable years beginning on or after January 1, 1999, and expires for taxable years beginning on or after January 1, 2001.

Section 4. (a) Article 3 of Chapter 135 of the General Statutes is amended by adding the following new Part to read:

"Part 5. Child Health Insurance Program.

"**§ 135-42. Undertaking.**

(a) The State of North Carolina undertakes to make available a child health insurance program (hereinafter called the 'Program') to provide comprehensive major medical coverage to low-income, uninsured children who are residents of this State and who meet the eligibility requirements established for the Program under Part 8 of Article 2 of Chapter 108A of the General Statutes. The Executive Administrator and Board of Trustees of the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (hereinafter called the 'Plan') shall administer the Program under this Part and shall carry out their duties and responsibilities in accordance with Parts 2 and 3 of this Article and with applicable provisions of Part 8 of Article 2 of Chapter 108A.

(b) The benefits provided under the Program shall be equivalent to and made available through the Plan pursuant to Articles 2 and 3 of this Chapter and administered by the Plan's Executive Administrator and Board of Trustees. To the extent there is a conflict between the provisions of Part 8 of Article 2 of Chapter 108A and Part 3 of this Article pertaining to eligibility, premiums, deductibles, copayments, and other cost-sharing charges, the provisions of Part 8 of Article 2 of Chapter 108A shall control. In administering the benefits provided by this Part, the Executive Administrator and Board of Trustees shall have the same type of powers and duties that are provided under Part 3 of this Article for hospital and medical benefits.

(c) The benefits authorized by this Part are available only to children who are residents of this State and who meet the eligibility requirements established for the Program under Part 8 of Article 2 of Chapter 108A of the General Statutes.

"**§ 135-42.1. Right to alter, amend, or repeal.**

The General Assembly reserves the right to alter, amend, or repeal this Part."

(b) G.S. 135-38(c) reads as rewritten:

"(c) The Committee shall review programs of hospital, medical and related care provided by Part 3 and Part 5 of this Article and programs of long-term care benefits provided by Part 4 of this Article as recommended by the Executive Administrator and Board of Trustees of the Plan. The Executive Administrator and the Board of Trustees shall provide the Committee with any information or assistance requested by the Committee in performing its duties under this Article. The Committee shall meet not less than once each quarter to review the actions of the Executive Administrator and Board of Trustees. At each meeting, the Executive Administrator shall report to the Committee on any administrative and medical policies which have been issued as rules and regulations in accordance with G.S. 135-39.8, and on any benefit denials, resulting from the policies, which have been appealed to the Board of Trustees."

(c) G.S. 135-39.5 is amended by adding a new subdivision to read:

"(23) Implementing and administering a program of child health insurance benefits pursuant to Part 5 of this Article."

(d) G.S. 135-39.6 is amended by adding the following subsection to read:

"(d) Separate and apart from the special funds authorized by subsections (a) and (b) of this section, there shall be a Child Health Insurance Fund. All appropriations,

allocations, or any other receipts, including earnings on investments, occurring or arising in connection with benefits provided under the Child Health Insurance Program shall be deposited into the Child Health Insurance Fund. Disbursements from the Child Health Insurance Fund shall include any and all amounts required to pay the benefits and administrative costs of the Child Health Insurance Program as may be determined by the Executive Administrator and Board of Trustees."

(e) G.S. 135-39.6A is amended by adding the following subsection to read:

"(c) The Executive Administrator and Board of Trustees shall establish premium rates for benefits provided under Part 5 of this Article. The Department of Health and Human Services shall, from premiums collected, from State and federal appropriations, and from any other funds made available for the Child Health Insurance Program established under Part 8 of Article 2 of Chapter 108A of the General Statutes, make payments to the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan as determined by the Plan for its administration, claims processing, and other services authorized to provide coverage to children eligible for benefits provided under Part 5 of this Article."

(f) G.S. 135-39.8 reads as rewritten:

"**§ 135-39.8. Rules and regulations.**

The Executive Administrator and Board of Trustees may issue rules and regulations to implement Parts ~~2, 3, and 4~~ 2, 3, 4, and 5 of this Article. Rules and regulations of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules and regulations issued under this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a rule or regulation, and to any other parties requesting a written description and approved by the Executive Administrator and Board of Trustees to receive a description on a timely basis."

(g) The title of Chapter 135 of the General Statutes reads as rewritten:

"Retirement System for Teachers and State Employees; Social ~~Security.~~ Security; Child Health Insurance Program."

(h) The title of Article 3 of Chapter 135 of the General Statutes reads as rewritten:

"Other Teacher, Employee ~~Benefits.~~ Benefits; Child Health Benefits."

Section 5. In order to ensure that health insurance coverage provided to children from public funds is not duplicative of coverage provided to the same children pursuant to court orders for medical support or health insurance, the Department of Health and Human Services shall develop a plan for collecting and retrieving data from child support orders filed by the clerks of court of this State. The purpose of the plan shall be to enable the Department to readily identify children covered by support orders and also covered under private health insurance, or eligible for coverage under the State Medicaid Program or the State Child Health

Insurance Program. No later than October 1, 1998, the Department shall report on the development of this plan to the Joint Legislative Oversight Committee on Child Health Insurance.

Section 6. (a) There is appropriated from the General Fund to the Department of Health and Human Services the sum of twelve million three hundred seven thousand three hundred twelve dollars ($12,307,312) for the 1998-99 fiscal year to be used for the State Child Health Insurance Program established under this act and under Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552. The Office of State Budget and Management shall include in the proposed continuation budget the amount of State funds necessary for Program implementation for the budgeted fiscal year but not more than the amount necessary to draw down the maximum amount of federal funds available to the State for the budgeted fiscal year for the Child Health Insurance Program under Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552.

(b) Special needs funds. Of the funds available to the Department of Health and Human Services for health insurance coverage for children enrolled in RITE Care, the sum of fifteen million dollars ($15,000,000) shall be deposited into the Children's Special Health Services Fund in the Department of Health and Human Services to provide coverage for special needs children in accordance with G.S. 108A-70.22 as enacted in this act.

(c) No State funds appropriated under this act may be expended for any purpose other than as provided under this act for the implementation of the State Child Health Insurance Program established under this act and approved by the United States Secretary of Health and Human Services under Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552.

(d) Funds appropriated under this section and not expended or obligated in the 1998-99 fiscal year shall revert to the General Fund on June 30, 1999.

Section 7. The Department of Health and Human Services shall apply to the Health Care Financing Administration for an 1115(b) Medicaid waiver to allow the State to make ineligible for Medicaid a person who is covered under a private or employer-sponsored comprehensive health care insurance plan.

Section 8. Section 6 of this act becomes effective July 1, 1998. Health insurance coverage provided to children under the Child Health Insurance Program established under this act shall become effective no earlier than October 1, 1998. The remainder of this act is effective when it becomes law and expires on June 30 of the State fiscal year for which federal funds appropriated to the State under Title XXI of the Social Security Act amount to less than seventy percent (70%) of total prior year expenditures for the Child Health Insurance Program established under this act pursuant to Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552.

3-25-98
#4

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE FISCAL NOTE

BILL NUMBER: Proposed House Committee Substitute for Senate Bill 2 (Extraordinary Session)

SHORT TITLE: RITE Care

SPONSOR(S):

FISCAL IMPACT

Yes (X) **No ( )** **No Estimate Available ( )**

	($million) FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02	FY2002-03
REVENUES					
General Fund					
Child Health Insurance Credit		($218.6)	($229.3)		
Long Term Care Credit		($31.8)	($36.7)		
EXPENDITURES					
A. Health & Human Services					
Total Expenditures	$50,203,759	$84,097,343	$88,690,262	$93,543,171	$98,671,098
Federal Funds	$35,321,603	$59,175,390	$62,361,270	$65,703,329	$69,236,446
State Funds	**$12,307,312**	**$20,780,549**	**$22,104,760**	**$23,531,126**	**$25,039,761**
Premiums	$ 2,574,844	$ 4,141,232	$ 4,224,232	$ 4,308,717	$ 4,394,891
POSITIONS:	(7)	(7)	(7)	(7)	(7)
B. Corrections & Judicial	**No Fiscal Impact**				

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED:
Department of Health and Human Services
County Departments of Social Services
State Employees Health Plan
Department of Revenue

EFFECTIVE DATE: Appropriations for this Act are Effective July 1, 1998. Health insurance coverage provided to children under this Act is effective no earlier than October 1, 1998. The Child Health Insurance Tax Credit and the Long Term Care Insurance tax Credit are effective for taxable years beginning on or after January 1, 1999 and expire for taxable years beginning on or after January 1, 2001.

BILL SUMMARY:

This legislation establishes RITE Care: The Children's Health Insurance Program Act of 1998 which will provide comprehensive health insurance coverage to uninsured low-income children who are residents of this state. This program is not an entitlement and nothing in the Act shall be construed as obligating the General Assembly to appropriate funds for this Program. The Program will be administered by the Department of Health and Human Services. Claims processing and benefits administration shall be provided by Executive Administrator and Board of Trustees of the N. C. State Employees' Health Plan.

Eligibility for the program is as follows:

(1) Be under the age of 19 and enrolled in high school;
(2) Be ineligible for other government sponsored health insurance;
(3) Be uninsured for six months prior to application;
(4) Be in a family that meets the following income requirements:
    a. Children age one through five years in families with incomes from 133% to 185% of the federal poverty level; and
    b. Children age six through eighteen years in families with incomes from 100% to 185% of the federal poverty level;
(5) Be a state resident; and
(6) Paid required premium.

Benefits under this Program are the same as those provided by the N. C. Teachers and State Employees' Health Plan..

Premiums are required under RITE Care. No premiums for families at or below 133% of the federal poverty level (FPL). Premiums are as follows:

134% - 150% FPL	$5/per child/per month with a $15 per month family limit..
151% - 185% FPL	$10/per child/per month with a $28 per month family limit.

There are no deductibles or copayments for families with incomes below or at 150% of the federal poverty level. Families with incomes above 150% of the federal poverty level shall be responsible for copayments authorized in the legislation. Cost-sharing shall not exceed 5% of family income.

Private providers may provide coverage under RITE Care if the provider meets the requirements established in the legislation. RITE Care enrollees who lose RITE Care coverage due to an increase in income may purchase extended RITE Care coverage at full premium cost. Extended coverage is not longer than one year. RITE Care enrollees may purchase, at full cost to the enrollee, additional coverage for dental, vision, and hearing services. No state or federal funds may be used to offset cost of extended or optional additional coverage.

Provides additional coverage for children with special needs through a special fund. Children eligible for additional coverage must be enrolled in RITE Care and be a "special needs child" as defined. Services paid for out of these funds must be ones which are not covered under RITE Care. Services are limited to those provided under the Medicaid program and the purchase of services must be at the Medicaid rate.

The Department is authorized to submit a State Plan in accordance with this act. No amendments to the State Plan are allowed without General Assembly approval.

The legislation specifies requirements for application, outreach efforts, data collection, and reporting. Provides for a penalty for fraudulent misrepresentation which tracks Medicaid and Food Stamp fraud provisions. Establishes the Joint Legislative Oversight Committee on Child Health Insurance to provide legislative oversight.

Authorizes two tax credits:

1. Tax credit for premiums paid by persons who purchase dependent health coverage
2. Tax credit for premiums paid by persons who purchase long term care insurance

Appropriates funds to support the RITE Care program. The Office of State Budget and Management shall include in the proposed continuation budget the amount of State funds necessary for Program implementation, but not more than the amount necessary to draw down the maximum amount of available federal funds budget for the RITE Care program.

ASSUMPTIONS AND METHODOLOGY:

A. <u>Children's Health Insurance Program</u>

In 1997, Title XXI of the Social Security Act or the State Children's Health Insurance Program (CHIP) was established by the U.S. Congress to provide health insurance to uninsured children. Federal funding for the program is provided through fiscal year 2007-08. North Carolina's federal allotment is estimated to be $79.5 million for 1998-99 through 2001-02, $58.6 million for 2002-03 through 2004-05, $76.6 million for 2005-06 through 2006-07, and $94.5 million for 2007-08. Federal funds remain available for three years. Since North Carolina can roll forward unexpended federal funds, this fiscal note assumes that adequate federal funding will be available to fund this program over the ten year period even though federal fund availability is significantly reduced in years 2002-03 through 2004-05.

The estimates in this fiscal note which impact the N. C. State Employees Health Plan were developed by the Fiscal Research Division, and these estimates are subject to change based on actuarial notes which have been requested in accordance with GS 120-114 and the rules of the North Carolina Senate and House of Representatives.

The following assumptions and methodology were used to estimate the cost of the RITE Care program for the first five years beginning with 1998-99:

1. **Eligible Children:** Assumes that the estimated number of eligible children -- who are uninsured, below the age of 19 and enrolled in high school, not eligible for government sponsored health insurance, and in families with incomes at or below 185% of the federal poverty level -- for 1998-99 is 64,427 and that the number of estimated eligible children will increase by 2% each year in future years. Assumes that RITE Care will serve 100% of the eligible children. The 1998-99 estimate of children is based on data from the Current Population Survey which has been adjusted for 1998-99.

2. **Annual Cost Per Child:** The RITE Care program provides comprehensive health insurance coverage which is identical to the coverage provided under the N. C. Teachers and State Employees Health Plan except that cost-sharing requirements have been modified to meet the limits established under federal law. The estimated annual cost per child is $876.64 for children in families with incomes at or below 150% of the federal poverty level and $854.04 for children in families with incomes between 151% and 185% of the federal poverty level. These rates take into consideration the copayments required under the proposed legislation. The rate for children in families with incomes at or below 150% of the federal poverty level is higher because it assumes the Health Plan will cover dispensing fees for pharmacies. These rates are based on 1996-97 date-paid claims information for an average of some 70,500 dependent children enrolled in the N. C. Teachers and State Employees' Health Plan during the year. Assumes that the annual cost per child will increase 4% each year in future years.

   The cost for the N. C. Teachers and State Employees Health Plan to administer the benefits provided under the RITE Care program and to establish appropriate claims reserves has been included in the annual cost per child and is considered a program cost and not an administrative cost. Federal rules allow the reimbursement rates associated with the payments for health insurance coverage to include administrative costs of entities providing child health assistance for the State. These administrative costs included in the child health assistance reimbursement rates are not considered State administrative expenditures and do not count toward the 10 percent limit discussed in assumption #12.

3. **Coverage for Children with Special Needs:** Assumes that the coverage for special needs children will be provided through a separate $20,000,000 fund. Assumes that funding for the coverage for children with special needs will increase 4% a year in future years to cover increased costs.

4. **Eligible Months and Payment Months:** Assumes that the enrollment of children will be phased in over a six month period in 1998-99 (33% in October, 67% by November, 77% by December, 87% by January, 97% by February, and 100% by March). The assumed phasing of enrollment results in 7.61 eligible months for 1998-99. Assumes that there will be lag of one month between eligibility determination and payment of claims which results in 6.61 payment months for 1998-99. Assumes 12 months of eligibility and claims payment for each year in future years.

5. **Total Services Cost:** The cost of providing services for enrolled children is determined by multiplying the estimated number of enrolled children times cost per month times the number of payment months for each year.

6. **Premiums:** Assumes no premiums are charged to families with incomes below 133% of the federal poverty level. Assumes that the average family participating in the RITE Care program has two children. Assumes the average premium charged to families with incomes between 133% and 150% of the federal poverty level will be $10 per month or $120 per year. Assumes the average premium charged to families with incomes between 150% and 185% of the federal poverty level will be $20 per month or $240 per year. Assumes that the premiums remain at the same level during the five years covered by this fiscal note. Premium collections are adjusted each year to cover the 2% annual increase in the number of children served under RITE Care.

   Assumes the cost of collecting premiums from families will be contracted out at a cost of $2 per month per family or $24 annually. The estimate for premium collections is based on information provided by Blue Cross/Blue Shield of North Carolina documenting their cost for collecting premiums from individuals.

7. **Eligibility Determination:** Assumes that eligibility determination will be done by county departments of social services because federal law requires that uninsured children who are eligible for Medicaid must be served through Medicaid and not the CHIP program. County departments of social services are currently responsible for determining Medicaid eligibility. While the counties will be responsible for doing determination, they will not be responsible for the cost.

   The Department of Health and Human Services has estimated that the average time to do mail-in and interview applications is 1.01 hours with an estimated cost of $37.34 per hour. Based on experience with the Medically Indigent Children's Medicaid program, assumes that 87.6% of the applications will be approved or a ratio of 1.14. The total cost for eligibility determination is determined by multiplying $37.34 times 1.14 times the estimated number of children enrolled. Assumes that eligibility determination costs will increase 5% each year in future years.

8. **Start-Up Costs:** Assumes $500,000 in start-up costs for one-time systems modifications to the State's EIS system which is used to determine eligibility.

9. **Staffing:** Assumes that the Division of Medical Assistance will need two staff positions to monitor eligibility determination and premium collection. Assumes five additional staff positions will be needed by the Department of Health and Human Services to administer the funding provided for coverage for children with special needs. These positions will determine eligibility for special needs coverage and determine when services will be paid out of the fund set aside for children with special needs.

10. **Outreach:** Assumes that 1998-99 outreach expenditures for the RITE Care will be $500,000 to fund a campaign to encourage families to participate in the new program. Assumes outreach expenditures can decrease to $250,000 per year in future years after the first year campaign is completed.

11. **Federal Financial Participation Rates:** Title XXI of the Social Security Act provides funding for the CHIP program established by the proposed legislation by using an enhanced federal matching rate. The enhanced matching rate is equal to the state's existing federal medicaid matching rate plus 30% of the state share. North Carolina's enhanced federal matching rate for 1998-99 is 74.16% with a state share of 25.84%. Historically, the federal medicaid match rate for North Carolina has decreased each year and it is assumed that these decreases will continue. The following matching rates are assumed in this fiscal note:

	Federal	State
1998-99	74.16%	25.84%
1999-00	74.01%	25.99%
2000-01	73.83%	26.17%
2001-02	73.63%	26.37%
2002-03	73.44%	26.56%

The enhanced matching rate applies to all program costs, administration, and outreach for the RITE Care program.

Under federal law, premiums and other cost sharing cannot be used to provide the state match to draw down federal funds. Federal law requires that any cost sharing funds must be deducted from total program cost before the federal and state matching requirements are determined. This requirement reduces the amount of federal and state funds required to support the RITE Care program because part of the cost of the program is covered by premiums. This fiscal note applies this federal requirement when determining the federal and state funding required to support the RITE Care program.

Even though the level of federal funds supporting the RITE Care program is reduced by this requirement, the federal funds will continue to be available for three years and will help cover the programs funding needs during 2002-03 through 2006-07 when federal funding for the program is reduced. In addition, the funds collected from premiums will allow the RITE Care program to expand beyond the combined federal and state funding in future years without increasing state appropriations because part of the program will be covered by premium collections.

11. **Federal 10% Cap on Administration and Outreach:** Federal legislation limits cost-sharing for administration and outreach for the RITE Care program to 10% of the program expenditures each year. The estimated administrative costs for RITE Care do not exceed the cap during the five year period discussed in this fiscal note and it is assumed that the cap will not be reach in future years.

13. **Effective Date:** Expenditures for 1998-99 have been adjusted to reflect the October 1, 1998 start date. Future years' expenditures are annualized.

B. Judicial Department

The proposed fraudulent penalties outlined in this bill are similar to existing penalties in G.S.108A-64 which covers medicaid fraud representation. Since these penalties cover similar populations, the Fiscal Research Division believes that the most reliable way of determining the fiscal impact of this bill would be to review the number of defendants charged and sentenced to criminal penalties under G.S.108A-64.

Currently, the Judicial Department does not have a specific code for offenses relating to medicaid fraud representation. This indicates a small number of offenses since "offense codes" are established only when the number of offenses is significant (usually more than 100 offenses). The Judicial Department believes that the few additional cases which may result from this legislation could be absorbed within existing court resources.

C. Department of Correction

Based on this finding, the Sentencing Commission does not expect that the proposed changes would have any significant impact on prison populations. The Sentencing Commission estimates, for example, that if 10 individuals were convicted of these offenses per year approximately 1 or 2 additional inmates would be added to the prison population. If there were as many as 25 convictions no more than 3 to 5 additional inmates would be added to the prison system. It is anticipated that the vast majority of individuals would be incarcerated as a result of probation revocations. This very small increase in incarcerated individuals could be absorbed within existing Department of Correction resources.

D. Tax Credit for Child Health Insurance

This section creates an individual income tax credit for child health insurance. The credit is one-third of the premium paid during the taxable year for a child under the age of 19, but may not exceed 5% of the taxpayer's adjusted gross income. Taxpayers who have their health insurance premiums deducted from their income before it is taxed do not qualify for the credit. It is estimated that this tax credit will produce a revenue loss of $218.6 million in FY 1999-00.

Premiums

Using 1995-96 Current Population Survey data from the US Census Bureau, the staff of the Task Force on Child Health Insurance estimated **1,156,050** children under age 18 were insured by group or private health insurance in 1997. Based on data from the Teachers', State Employees' and Retirees' Health Benefit Plan , there are 1.6 children per health insurance policy. Of primary families with children, 77.2% are married couples and 22.8% are head of households.

The National Research Corporation performed a Health Care Market Guide survey in 1996 of selected Metropolitan Statistical Areas (MSAs). The metropolitan areas surveyed covered 52% of the state's population and found the following health insurance coverage:

Fee For Service (FFS)	26.8%
Preferred Provider Organization (PPO)	35.3%
Point of Service (POS)	3.4%
Health Maintenance Organization (HMO)	34.5%

Assuming this data is representative of the state and that these coverage rates are the same for the state's insured children, the number of children per plan are as follows:

Fee For Service (FFS)	309,821
Preferred Provider Organization (PPO)	408,086
Point of Service (POS)	39,306
Health Maintenance Organization (HMO)	398,837
	1,156,050

The Teachers', State Employees' and Retirees' Health Benefit Plan is used to estimate the premiums paid for children. A state employee may choose to cover one or more children under an Employee/Child(ren) option in the Comprehensive Major Medical Plan or in one of 12 HMOs. To cover one or more children in the Major Medical Plan, a hybrid FFS/PPO, a state employee pays $90.12 per month. Sam Byrd of the Legislature's Fiscal Research Division recommends increasing this premium by 30% to get a standard private market rate of $117.16 per month for FFS and PPO plans. To cover one or more children in one of the state approved HMOs, the state employee pays an average rate of $125.14 per month above the amount he or she would pay for individual coverage. The HMO rate is also assumed for POS plans.

The annual premium prices for 1998 are as follows:

FFS/PPO	$117.16/mo X 12 = $1,405.92/yr
HMO/POS	$125.14/mo X 12 = $1,501.68/yr

The Congressional Budget Office projects that employment-based health insurance premiums will experience inflationary increases of 5.2% in 1999 and 4.9% in 2000. These inflationary rates are used to project annual premium amounts in fiscal years 1999-00 and 2000-01 as shown below.

	FY 1999-00	FY 2000-01
FFS/PPO	$1,479.03	$1,551.50
HMO/POS	$1,579.77	$1,657.17

Tax Credit Eligibility

Shown below is a breakdown of North Carolina employees by employment type. Employment data for small and large firms and for public employees is provided by the Employment Security Commission for 1996. The number of self-employed is derived from 1996 national data from the Small Business Administration.

Self Employed	226,402	6.1%
Small Firm (<100)	1,571,536	42.2%
Large Firm (>100)	1,352,731	36.4%
Government	570,000	15.3%
	3,720,669	100.0%

The chart below assumes the 1,156,049 children now insured by individual or group coverage can be grouped according their parents' employment type. Those taxpayers that have pre-tax payroll deduction of their health insurance premium under IRC Section 125 cafeteria plans or under the self-employed health insurance deduction are not eligible for this tax credit. The Bureau of Labor Statistics (BLS) reported in 1994 that 22% of the firms with less than 100 employees use Section 125 plans for health insurance premiums. A 1995 BLS study found that 55% of the firms with more than 100 employees offered Section 125 cafeteria benefits. According to a state health plan administrator, approximately 99% of those enrolled in the Teachers', State Employees' and Retirees' Health Benefit Plan take advantage of pre-tax deduction of their health insurance premium. Based on data from the Small Business Administration and on 1995 individual income tax returns, approximately 26.6% of the self-employed take advantage of the deduction of health insurance costs for self-employed individuals.

According to the chart below, 40.2% of the parents now paying health insurance premiums for their children and receiving an income tax deduction will not receive the proposed credit.

Employer Type	% of Insured	# of Insured	Percent in Pre-Tax Plan	Number in State Health Plan	Not Eligible for Credit	Eligible for Credit
Self Employed	6.1%	70,519	26.6%		18,758	51,761
Small Firms (<100 employees)	42.2%	487,853	22.0%		107,328	380,525
Large Firms (>100 employees)	36.4%	420,802	55.0%		231,441	189,361
Government	15.3%	176,875		106,821	106,821	70,054
		1,156,049			464,348	691,701

Tax Credit - Married Couples

Approximately 77.2% of the privately insured children live in married couple households. These insured children are divided among income groups based on Current Population Survey data. Since the average insurance policy covers 1.6 children per family, the income groups represent federal poverty guidelines for a family of 4. The income amount on each column assumes an average family income for the parents of the children. The premium amount is the 1999 estimate divided by 1/3. The AGI cap of 5% is shown, but it has no impact on the credit amount. The credit multiplied by the number of policies is shown in the bottom three rows. The total credit amount for married couples is $168,787,489.

Federal Poverty Level		<100%	100 to 200%	200 to 399%	400%+
Age 0 -18 Insured Eligible		31,597	120,668	317,457	221,980
Income Level		$16,450	$32,900	$65,800	$65,800
Married couples	77.2%	24,393	93,156	245,077	171,369
Policies (1.6 kids per)		15,246	58,222	153,173	107,105
FFS/PPO policies	62.1%	9,467	36,156	95,120	66,512
HMO/POS policies	37.9%	5,778	22,066	58,053	40,593
5% AGI	5%	$823	$1,645	$3,290	$3,290
FFS/PPO 1/3 premium	$493	$493	$493	$493	$493
HMO/POS 1/3 premium	$527	$527	$527	$527	$527
FFS/PPO		$4,667,559	$17,825,270	$46,895,257	$32,791,241
HMO/POS		$3,042,666	$11,619,850	$30,569,851	$21,375,794
Married Couple		$7,710,225	$29,445,120	$77,465,108	$54,167,036

Credit - Married Couples **$168,787,489**

Tax Credit - Head of Household

Approximately 22.8% of the insured children in families live in single head of households. These insured children are divided among income groups based on Current Population Survey data. Since the average insurance policy covers 1.6 children per family, the income groups represent federal poverty guidelines for a family of 3. The income amount on each column assumes an average income for the parent of the children. The premium amount is the 1999 estimate divided by 1/3. The AGI cap of 5% is shown, but it has no impact on the credit amount. The credit multiplied by the number of policies is shown in the bottom three rows. The total credit amount for head of households is $49,849,155.

Federal Poverty Level		<100%	100 to 200%	200 to 399%	400%+
Age 0 -18 Insured Eligible		31,597	120,668	317,457	221,980
Income Level		$13,650	$27,300	$54,600	$54,600
Head of Household	22.8%	7,204	27,512	72,380	50,611
Policies (1.6 kids per)		4,503	17,195	45,238	31,632
FFS/PPO	62.1%	2,796	10,678	28,093	19,644
HMO/POS	37.9%	1,706	6,517	17,145	11,989
5% AGI	5%	$683	$1,365	$2,730	$2,730
FFS/PPO 1/3 premium	$493	$493	$493	$493	$493
HMO/POS 1/3 premium	$527	$527	$527	$527	$527
FFS/PPO		$1,378,502	$5,264,458	$13,849,895	$9,684,460
HMO/POS		$898,611	$3,431,769	$9,028,401	$6,313,058
Head of Household		$2,277,113	$8,696,227	$22,878,296	$15,997,518
		Total - Head of Household			$49,849,155

Summary

The tax credit is effective for the 1999 tax year. Since taxpayers will file their 1999 returns in the year 2000, the fiscal impact will be in FY 1999-00. The total credit given married couples and head of households in FY1999-00 is $218,636,644. This credit will produce an equivalent loss in the General Fund for FY 1999-00. The General Fund revenue loss in FY 2000-01 is $229,349,740 due to 4.9% inflation in the premium amounts in the year 2000.

E. Tax Credit for Long Term Care Insurance

This section provides an individual income tax credit equal to 15% of the premium paid each year on long term care insurance. The credit is capped at $350 per policy. The tax credit is available for tax years 1999 and 2000 only.

The base data for this fiscal note comes from the National Association of Insurance Commissioners' 1995 Long Term Care Insurance Experience Report. In 1995, North Carolina had 77,503 citizens with long term care insurance. These insured persons paid premiums that averaged $1,535.

An official with the Technical Services Group in the Department of Insurance recommended calculating the growth in the number of policies at 10% a year and the growth rate for premiums at 5% a year. The projected high growth in policies is prompted by the passage of the Health Accountability and Portability Act of 1996. The act qualified long term care insurance premiums as a deductible medical expense on individual income taxes. The federal act also allowed employers to offer long term care insurance as an untaxed benefit. The premium rate increase of 5% is the actual change from 1994 to 1995 and is believed to be an acceptable rate for the near future.

The cost of the tax credit is calculated below.

	Avg Premium	Avg Tax Credit	Number of Policies	Estimated Cost
1995	$ 1,535	$230	77,503	$17,845,066
1996	$ 1,612	$242	85,253	$20,611,051
1997	$ 1,692	$254	93,779	$23,805,764
1998	$ 1,777	$267	103,156	$27,495,657
1999	$ 1,866	$280	113,472	$31,757,484
2000	$ 1,959	$294	124,819	$36,679,894

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION
733-4910
PREPARED BY: L. Carol Shaw, Richard Bostic, Charles Perusse
APPROVED BY: Tom Covington
DATE: 3-24-98

3-25-98
#5

PROPOSED HOUSE COMMITTEE SUBSTITUTE - SB2
RITE Care: The Child Health Insurance Program
(S2-PCS4645)
March 25, 1998

	Bill pg.#
Eligibility	
185% FPL	3
Under age 19 (enrolled in high school)	2
Uninsured (6 month look-back)	2
Ineligible for Medicaid	3
Resident	3
Premium paid for prior year coverage	3
Continuous for one year; duty to report changes in residency, income, insured status	3
Benefits	4
Except for premiums/cost-sharing, equivalent to benefits provided under State Employees' Health Plan	
Premiums	4
No premiums for families at or below 133% FPL.	
134-150% — $5/per child/per month. $15/mo. Max.	
151-185F — $10/per child/per month. $28/mo. Max	
Cost-sharing	4
No cost sharing at or below 150% FPL.	
Above 150%: $5/per child for each physician visit	
$6/per child for each prescription filled	
$20/per emergency room visit unless hospitalized	
Cost-sharing capped at 5% of aggregate family income for all children	
Private plans may provide coverage under RITE Care	5
RITE Care enrollee may opt for private coverage if:	
Private Provider meets requirements	
Private plan is actuarially equivalent to RITE Care coverage	
Cost of private plan is equal to or less than RITE Care	
Cost-sharing under private plan does not exceed 5% of enrollee's annual family income	
Option to purchase extended coverage	5
RITE Care enrollee who loses RITE Care eligibility due to increase in income may purchase extended RITE Care coverage at full premium cost. Extended coverage is not longer than 1 year.	

Option to purchase additional benefits 5
RITE Care enrollee may purchase, at full cost to the enrollee, additional coverage for dental, vision, and hearing services.

No State funds for options. 6
No State or federal funds may be used to cover, subsidize, or otherwise offset cost of extended or additional coverage.

Coverage for Children with Special Needs 6
Separate fund to provide coverage for children with special needs Child must be enrolled in RITE Care, be a "special needs child" as defined, and coverage only for items not covered under RITE Care.

Administration/Claims processing 6, 12
Administration of benefits and claims processing shall be undertaken by Executive Administrator and Board of Trustees of the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan.

State Plan 6
DHHS submits plan in accordance with this act. No amendments to State Plan without General Assembly approval.

Application; outreach; data collection; reporting 7
Requirements for application, outreach efforts, data collection, reporting.

Fraudulent misrepresentation 9
Class I felony for fraudulent misrepresentation. Tracks Medicaid and food stamp fraud provisions.

Legislative oversight 9
Establishes Jt. Legislative Oversight Committee on Child Health Insurance.

Tax Credits 10
Tax credits for premiums paid by purchasers of dependent health coverage, and for purchase of long-term care insurance

Plan to avoid duplication of Medicaid/private coverage 13

DHHS to apply for Medicaid waiver 14
Directs DHHS to apply for Medicaid waiver to make ineligible for Medicaid a person covered under a private or employer plan.

Appropriations provisions 14
$12,307,312 for State match; $15,000,000 for special needs.

3-25-98
#6

RITE CARE PROPOSAL

	1998-99	1999-00	2000-01	2001-02	2002-03
Estimated Eligibles <150% FPL	36,764	37,499	38,249	39,014	39,795
Average Cost per Eligible < 150% FPL	$ 878.64	$ 913.79	$ 950.34	$ 988.35	$ 1,027.88
Estimated Eligibles >150% FPL	27,663	28,216	28,781	29,356	29,943
Average Cost per Eligible>150% FPL	$ 854.04	$ 888.20	$ 923.73	$ 960.68	$ 999.11
RITE Care Coverage	$ 30,806,803	$ 59,328,029	$ 62,935,174	$ 66,761,632	$ 70,820,739
Children Special Health Needs Fund	$ 15,000,000	$ 20,800,000	$ 21,632,000	$ 22,497,280	$ 23,397,171
Total Program Cost	**$ 45,806,803**	**$ 80,128,029**	**$ 84,567,174**	**$ 89,258,912**	**$ 94,217,911**
Administration					
Eligibility Determination	$ 2,742,503	$ 2,879,628	$ 3,023,609	$ 3,174,790	$ 3,333,529
DMA Administration	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000
Outreach	$ 500,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000
Premium Collection Administration	$ 304,453	$ 489,686	$ 499,479	$ 509,469	$ 519,658
EIS System Changes	$ 500,000	$ -	$ -	$ -	$ -
Children's Special Health Needs Admin.	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000
Total Administration	**$ 4,396,956**	**$ 3,969,314**	**$ 4,123,089**	**$ 4,284,259**	**$ 4,453,188**
Total Rite Care Cost	**$ 50,203,759**	**$ 84,097,343**	**$ 88,690,262**	**$ 93,543,171**	**$ 98,671,098**
Funding Sources					
Federal	$ 35,321,603	$ 59,175,390	$ 62,361,270	$ 65,703,329	$ 69,236,446
State	**$ 12,307,312**	**$ 20,780,549**	**$ 22,104,760**	**$ 23,531,126**	**$ 25,039,761**
Premiums	$ 2,574,844	$ 4,141,404	$ 4,224,232	$ 4,308,717	$ 4,394,891

1998 PERMANENT SUBCOMMITTEE REPORT
HOUSE OF REPRESENTATIVES

FOR RECOMMENDING BILLS TO STANDING COMMITTEE OR TO THE FLOOR OF THE HOUSE
The following report(s) from permanent sub committee(s) is/are presented:
By Representative(s) **Gardner, Cansler and Clary** for the Permanent Subcommittee on Human Resources of the Standing Committee on APPROPRIATIONS.

☐ Committee Substitute for
S.B. 2 ☒A BILL TO BE ENTITLED AN ACT TO ESTABLISH THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM AND TO APPROPRIATE FUNDS THEREFOR.

REPORTED TO THE STANDING COMMITTEE ON

RECOMMENDED ACTION:

☐ With a favorable recommendation.

☐ With a favorable recommendation and recommend that the bill be re-referred to the Committee on .

☐ With a favorable recommendation, as amended.

☐ With a favorable recommendation, as amended, and recommend that the bill be re-referred to the Committee on .

☐ With an unfavorable recommendation.

☐ With a favorable recommendation as to proposed committee substitute bill which changes the title, unfavorable as to original bill.

☐ With a favorable recommendation as to proposed House committee substitute bill, which changes the title, unfavorable as to Senate committee substitute bill.

☐ Without prejudice.

☐ Other recommended action: _____.

WITH APPROVAL OF STANDING COMMITTEE CHAIR FOR REPORT TO BE MADE DIRECTLY TO THE FLOOR OF THE HOUSE:
Reps. Holmes, Creech, Esposito and Crawford for the Standing Committee on APPROPRIATIONS.

s/ George N. Holmes

☐ With a favorable report.
☐ With a favorable report, as amended.
X With a favorable report as to House committee substitute bill, X which changes the title, unfavorable as to original bill..
☐ And having received a unanimous vote in committee, be placed on the Consent Calendar. (PUBLIC BILLS ONLY)

3/25/98

VISITOR REGISTRATION SHEET

HUMAN RESOURCES (APPROPRIATIONS) MARCH 25, 1998

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	Davis Bradshaw	Health Alliance Board
2.	LYMAN COOPER	CSX CORP.
3.	Tommy Worth	Carolina Health Care System
4.	Sharnese Ransome	DSS
5.	Chris Fitzsimon	Common Sense Foundation
6.	B. Lynne Hamlet	Senator Ellie Kinnaird
7.	Angie McMillan	DHHS
8.	Amy Fullbright	Hunton & Williams
9.	Ann Case	NCRMA
10.	John Kystin	NCFPC
11.	Henry Jones	Attorney - Raleigh
22.	Dave Richard	The Arc/NC
23.	Athena Miller	NCARF
24.	Mark Smarean	NCARF.
25.	Tom Vitaglione	DHHS
26.	DW GORELICK	NCBK
27.	Brenda Hammers	NC Equity
28.	Frank Freeman	Gov.'s office
29.	Annette Ethridge	Gov's Office
30.	Rep Runnette Gupton	House
31.	Catherine Davis	ElectriCities of NC

VISITOR REGISTRATION SHEET

HUMAN RESOURCES (APPROPRIATIONS) MARCH 25, 1998

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1. James B Hardy	
2. Jamey Penner	Leadership Person Co.
3. Sarah J Dacier	Person Industries
4. Evelyn Bass	Person County Library
5. Patricia Ragan	NCACC
6. [illegible] Shaber	Adam Rice Wall Gray Jones
7. Jim Edgerton	DHHS
8. Wendy Wilks	SEANC
9. David Simmons	Zebulon D. Alley, PA
10. HUGH TILSON	NC Hosp. Ass'n
11. Garland Daniels	Gov. Office
22. Joanne Schoen	NCNA
23. Judy Barker	NCNA
24. George Reed	NC Council of Churches
25. JACK McGEE	MARCH OF DIMES BIRTH DEFECTS FDN
26. Martha Glass	DOA
27. John Hood	John Locke Foundation
28. Mike Kiltie	OSBM
29. Ruth Shipp	NCDOT
30. Paul Gibbs	OSBM
31. Nancy Bradley	NCCBC

VISITOR REGISTRATION SHEET

HUMAN RESOURCES (APPROPRIATIONS) MARCH 25, 1998

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	Myron Phillips	NASW-NC
2.	P. Pressnyi	DMA/DHHS
3.	A Briggs	NC HAC
4.	P MAYNARD	9pm
5.	Hank Rogers	
6.	Mark Clem	NCMed Soc.
7.	Mari Santos	AL SA
8.	Willie Riddick	DOR
9.	Nancy Pomeranz	DOR
10.	AL DEITCH	DOR/NATO
11.	Jill Moore	Legis. Reporting Svc.
22.	Edwin Mickham	Eqts
23.	Craig Souza	NCHCFA
24.	Jim Crowley	N.C. Public RADIO
25.	Dennis Patterson	HP
26.		
27.		
28.		
29.		
30.		
31.		

JOINT APPROPRIATION SUBCOMMITTEE ON HUMAN RESOURCES

April 20, 1998
Minutes

The Joint Appropriations Subcommittee on Human Resources met on Monday, April 20, 1998 at 1:30 p.m., Senator Bill Martin presiding. There were 3 Senators present, and the following Representatives were in attendance:

Representative Charlotte Gardner	Representative Theresa Esposito
Representative Ed Nye	Representative Lanier Cansler

Staff present was Carol Shaw, Mary Ellen Sylvester, Gann Watson and Barbara Boone.

Overview

Secretary Bruton gave an overview of the need for a modular, top-down automation system at the Department of Health and Human Resources. Ron Aycock, Director of the County Commissioners' Association, gave the perspective from the County Commissioners' side of the issue. Jim Edgerton, Assistant Secretary for Budget Planning & Analysis for DHHS, reviewed pages 1-7 of the handout on DHHS Automation (See attachment #1). He introduced the DIRM management team: Vince Batts, Chief Operating Architect; Rick Moore, Chief Technology Officer; Donna Gregory, Chief of Policy and Planning; Randy Cook, Information Manager; Mary Cone, Administrative Assistant and Daryl Locklear, Networking Services. It was announced that Randy Cook has taken the position of Assistant Secretary of Information Systems of the Department of Revenue. He called on Bill Cox of the Division of Information Resource Management of DHHS to complete the presentation. Mr. Cox gave a computerized slide presentation. (See attachment #1)

DHHS Automation

Randy Cook told Representative Gardner she would receive a letter from IRMC indicating that the ACTS had received final approval and certification from the Federal government at the end of February.

Representative Gardner wanted clarification about the money needed for the year 2000 fix and was told that would require $20 million above the projected amount for information technology. Regarding the AG lawsuit, Mr. Edgerton said they were still working on that. She was assured the food stamp program would be compliant with federal regulations on schedule.

Senator Dannelly was dissatisfied with the amount of money that was budgeted for the Youth Division for information technology since these youngster need to be prepared for the outside world. Senator Martin thought the Governor's Commission on Juvenile Justice was addressing that issue which will be presented to the committee.

Mr. Cox was not able to tell Senator Dannelly the cost of mailing food stamps versus electronic transfer although he did say postal cost per item is 16 cents. However, that does not reflect the cost of actually handling each item.

Senator Phillips asked if with the new system there would be better control over collecting accounts or assets in the lag time between death or release from treatment. Edgerton will look into this problem. Senator Phillips was also concerned about confidentiality of the information gathered on clients. Mr. Edgerton acknowledged the department is addressing the confidentially issue. Senator Phillips asked for a time frame for realizing the goal of interfacing data, and Mr. Cox said implementation is projected for the end of 1999. He was also interested in the cost of continually upgrading the system and was told technology is changing so fast that it will have to be done on a planned basis to be most effective.

Senator Martin said that there had been discussion on a technology reserve to address the problem Senator Phillips brought up. Purchasing and Contract was requested to consider all the factors Mr. Cox and Senator Phillips have mentioned when contracts are let and perhaps we need to check up on that. He asked if there are any problems anticipated with the time line Mr. Cox has projected. Mr. Cox thought the deadlines would be met. Senator Martin requested the committee be advised if there is any slippage. However, Mr. Edgerton said that none of the dates are firm because there are unanticipated factors such as difficulty getting qualified employees and other issues to resolve before the department can get started. He said a technology reserve is well worth considering.

Senator Martin, in follow-up, requested that if there needs to be some revisions of the time-line, the department, early on in the Short Session, give an update based upon the circumstances that have changed and, secondly, whether any modifications of the time line will have a negative impact on program implementation and meeting Federal requirements.

Adolescent Parenting

Sydney Atkinson, State Consultant, Adolescent Parenting Program for DHHS, gave an overview of the evaluation of the Adolescent Parenting Program. The East Carolina University School of Social Work conducted the study. She introduced Myra Powell who is the project coordinator who presented the executive summary of the full evaluation which will be forwarded to the committee members. (See attachment #2.) Ms. Atkinson said that the final report was on target but she did not know when the department would approve and release it. Senator Martin questioned the parameters of the program comparison and felt the data would not be meaningful unless like groups over the same time frame were compared. Ms. Powell said she would look into whether that could be remedied.

Senator Phillips asked whether the program was going to be entirely state funded by dropping the volunteer component, and if so he questioned having 2 state programs when it is the job of the Social Services to handle the problem of teen pregnancy. Dr. Wolfe said they were still evaluating the report. Dr. Wolfe said this program concentrated on preventing first pregnancies and the two programs would be coordinated.

Representative Gardner said there were unanswered questions concerning the report and she would like to give them another opportunity to come before the committee during the short session.

She called attention to the fact the press has complete copies of the report on the study of the psychiatric hospitals Representative Cansler requested and the legislators have yet to receive anything about the study. Representative Gardner said the committee has been put off on receiving the report and she is very displeased. Lee Ketteridge said he did not know how that happened. The department wanted more staff time to develop recommendations pursuant to the report before it was presented to the committee. He said he would get the report to the committee this week.

Senator Phillips complained that he doesn't get information available to the committee chairs and he wants that information instead of getting it piecemeal at the meeting. He wants an agenda in order to prepare for the meeting. He said the chairs should not have information on an agenda item that he does not have. Representative Gardner has the same concerns he has because either she can't get information or gets it the day of the meeting. The staff doesn't get the information from the department in a timely manner. Representative Gardner said in the interim the chairs have sat down after each meeting to plan the next months' agenda and a month seems ample time to have these materials available to the committee members. Angie McMillan said the department will do its best to meet deadlines for reports the committee needs and also to communicate with the committee.

Senator Martin said the immunization agenda item would be carried over until tomorrow. There will be reports on the impact of downsizing Mental Retardation Centers, Medicaid eligibility criteria for in-home care versus institutional care services and Medicaid cost growth reduction.

The meeting was adjourned.

Barbara R. Hocutt, Clerk

Senator William N. Martin, Co-Chair

Joint Appropriations Subcommittee on Health and Human Services

AGENDA

Monday, April 20, 1998, 1:30 p.m.
Legislative Office Building, Room 414

DHHS Automation	Dr. David Bruton, Secretary, DHHS Ron Aycock, Director County Commissioners' Association Jim Edgerton, Assistant Secretary for Budget Planning & Analysis, DHHS Bill Cox, Director, Division of Information Resource Management, DHHS
Adolescent Parenting Program Evaluation	Sydney Atkinson, State Consultant, Adolescent Parenting Program, DHHS Reginald York, Principal Investigator, ECU School of Social Work
Immunization Program	Ann Wolfe, Director Division of Women's and Children's Health, DHHS

JOINT APPROPRIATON SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE MEETING NOTICE
CANCELLED

You are hereby notified that the Joint Appropriation Subcommittee on Human Resources will meet as follows:

DAY & DATE: **Monday, April 20, 1998 and Tuesday, April 21, 1998 and Wednesday, April 22, 1998 CANCELLED**

TIME: **1:30 p.m., Monday, April 20, 1998**
9:00 a.m., Tuesday, April 21, 1998
***9:00 a.m., Wednesday, April 22, 1998* CANCELLED**

LOCATION: **Room 414**

The following bills will be considered (Bill # & Short Title):

Respectfully,

Representatives Gardner, Clary, and Cansler
Co-Chairmen

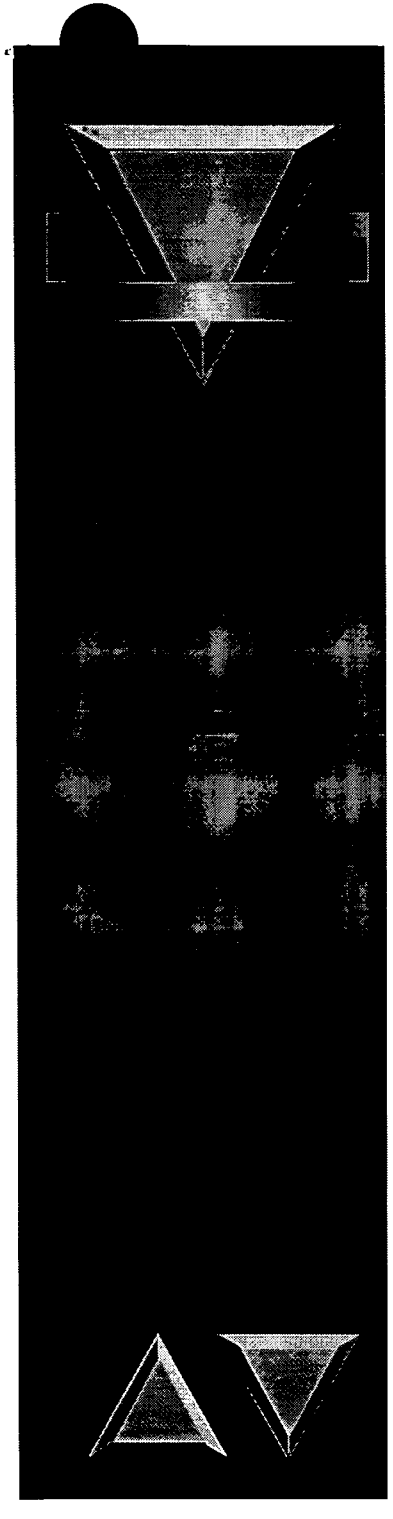
I hereby certify this notice was filed by the committee clerk at the following offices at **4:30 p.m.** on **April 20, 1998.**

___Principal Clerk
___Reading Clerk - House Chamber

Barbara R. Hocutt (Committee Clerk)

4-20-98
Jim Edgerton
Bill Cox, Director - Information Mgmt.

#1



DHHS Mission

To serve the people of North Carolina by enabling individuals, families, and communities to be healthy and secure, and to achieve social and economic well-being.

To achieve this mission, the department will...

- provide comprehensive and coordinated services for prevention, intervention, assistance, education, and empowerment;
- ensure equal access to services;
- be accountable for achieving meaningful results;
- continuously improve service delivery by involving citizens; and
- support and develop employees as diverse, invaluable resources.

DHHS Partners

- Federal agencies
  - USDHHS, USDA
  - Financial participation
  - Program administration
  - System guidance
- Other State agencies
  - Shared population
  - Interfaces
- Local agencies & stakeholders
  - Department of Social Services, Area Mental Health Programs, Health Department
  - Private non-profit
  - Advocates
  - Providers

DHHS Serves

- Direct service contacts: 20,400,000/year duplicated contacts
- Indirect services touch all citizens
- Locations in all 100 counties, regional, and Raleigh based facilities
- Continuum of care - birth through death

DHHS Budget

- DHHS Total Budget $ 8.4 Billion
- DHHS IT Expenditures $109.4 Million
  (Information technology)

Comparison to Industry Standard

- Industry standard for IT expenditures:
  - 7.7% of revenue for public agencies
  - 4.1% of revenue for all industries
- DHHS IT Expenditures is 1.30%

DHHS Automation Budgets

Operations, Maintenance & Development	74,444,805
DMA Fiscal Agent Contract	19,824,745
SIPS Data Processing Charges	15,174,933
Total DHHS Information Technology Budgets	109,444,483

DHHS IT Budgets by Division

Division	Total $	%
Central Administration	1,183,211	1.08%
Division of Aging	270,566	0.25%
Division of Facility Services	488,167	0.45%
Division of Medical Assistance	41,952,704	38.33%
Division of Vocational Rehabilitation	1,491,504	1.36%
Division of Youth Services	153,681	0.14%
Division of Social Services	53,873,233	49.22%
Division of Services for the Blind	318,946	0.29%
Division of Mental Health	5,502,207	5.03%
Division of Child Development	1,584,594	1.45%
Division of Deaf and Hard of Hearing	885,670	0.81%
Health Services	1,740,000	1.59%
Total DHHS Information Technology Budgets	109,444,483	100%

Bill [redacted]
Director
Information Mgmt

DHHS Information Resource Management

- Strategic Planning
- Service Delivery
- Applications Delivery

Information Systems Profile

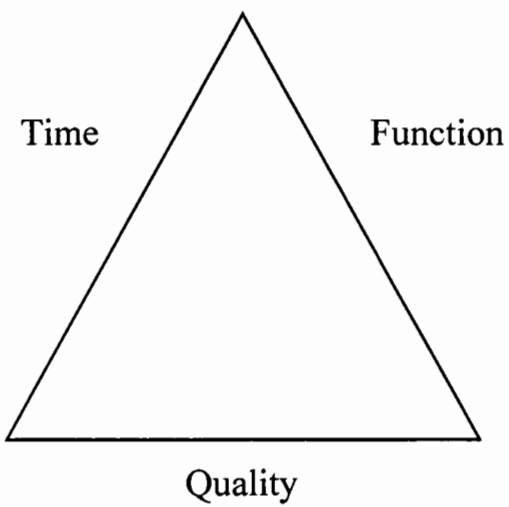
- What DHHS systems do
  - Produce benefits
  - Log events
  - Produce reports
  - Support program administration
  - Support local operations

Information Systems Profile

- DHHS operates 130+ systems
  - New Systems:
    - Automated Collection & Tracking System
    - Electronic Benefits Transfer (EBT)
    - DMA Decision Support System (DRIVE)
  - Old Systems (over 16 years)
    - Eligibility Information System
    - Food Stamp Information System
  - Personal Computer Solutions

System Development Process

- Project Initiation
- Project Definition & Planning
- Design
- Construction (Coding)
- Implementation
- Post-Implementation/Support



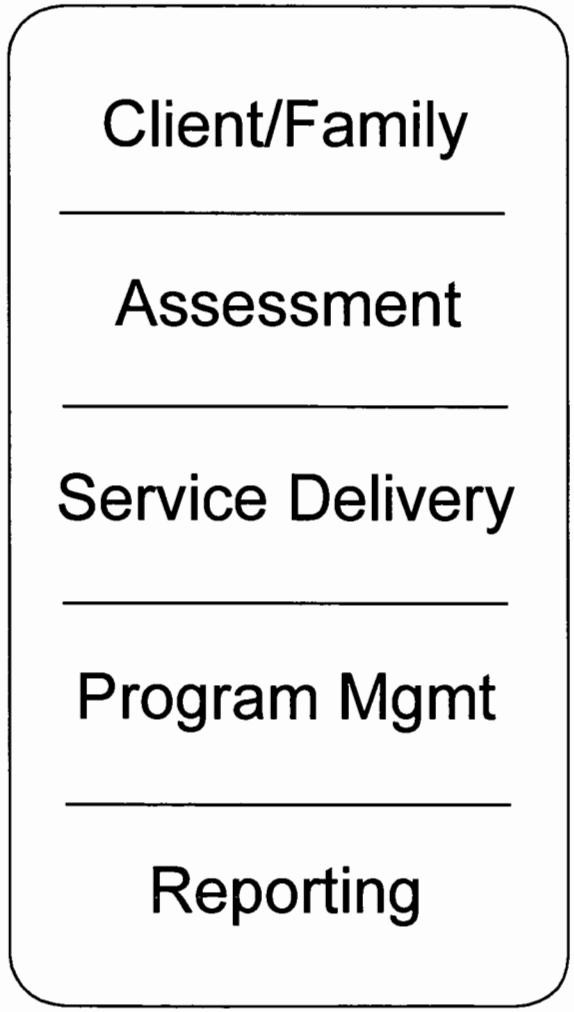
Information Systems Profile

- Daily transactions
  - Automated Collection & Tracking System 750,000
  - Eligibility Information System 850,000
  - Food Stamp Information System 150,000
  - Accounts Receivable Billing System 50,000

- Monthly U.S. Mail volume 1,425,000 pieces

AFDC checks
Medicaid cards

The Current Approach



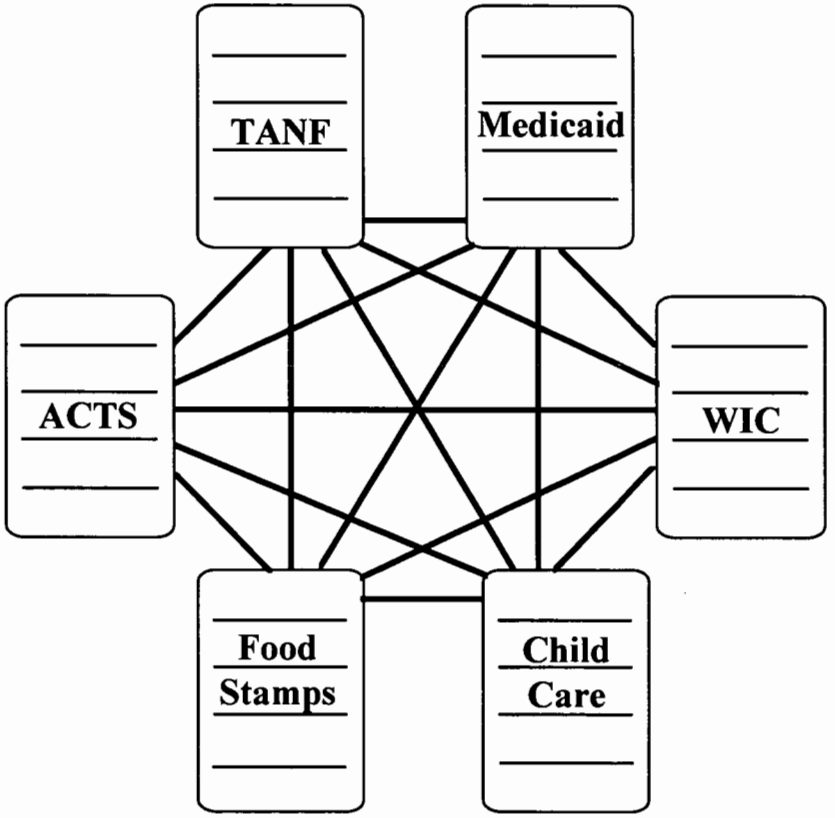
Program

Specific

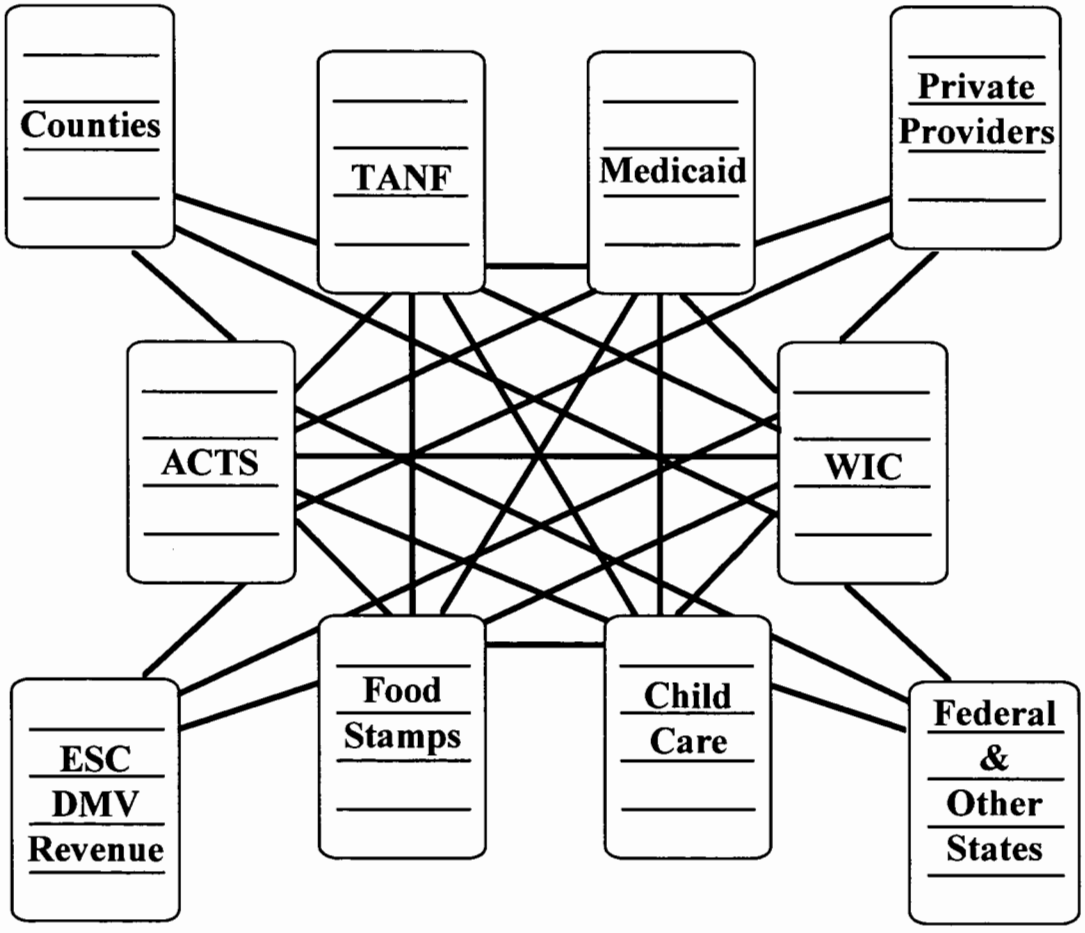
Application

Systems

The Current Approach



The Current Approach



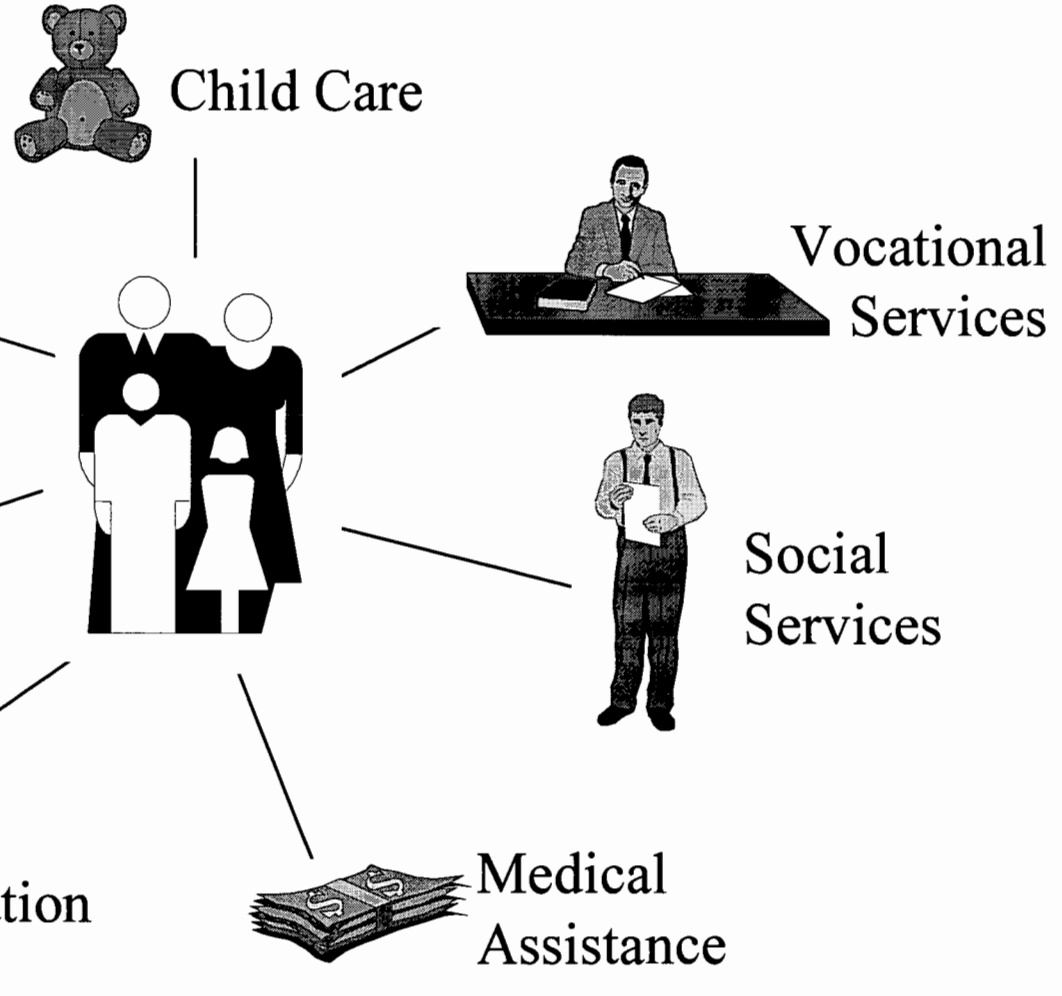
Current Approach Issues

- Redundant Development
- Redundant Support
- Rigid and Inflexible
- Overly Complex and Slow to Change
- Prone to Failure
- Increasingly Unable to Meet Today's Demands

Pressures Forcing Change

- **Increasing Interdependency of Programs**
  - Health & Human Services Reorganization
  - Welfare Reform/First Stop
- **Increasing Rate of Policy and Program Change**
  - Managed Care
  - Welfare Reform
  - Regulatory Issues
- **Increasing Rate of Technology Change**
  - Internet
  - Growth of Local Systems

A Vision for the Future



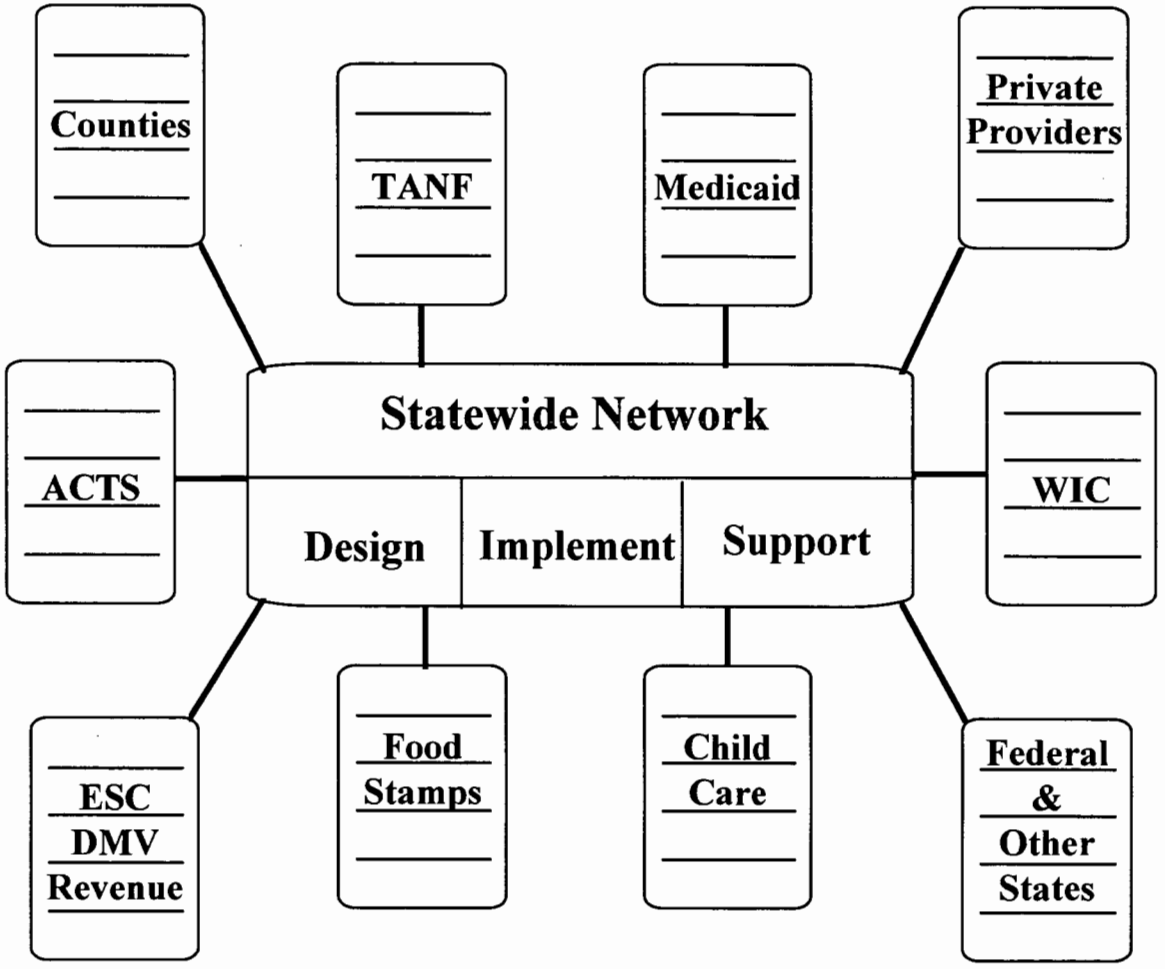
Information Needs Assessment

- Define Information Necessary to Support Seamless Service Delivery
- Holistic View of Health & Human Services Across the State
- 200+ Participants
- 14 Focus Groups and Many Individual Interviews
- Action Plan

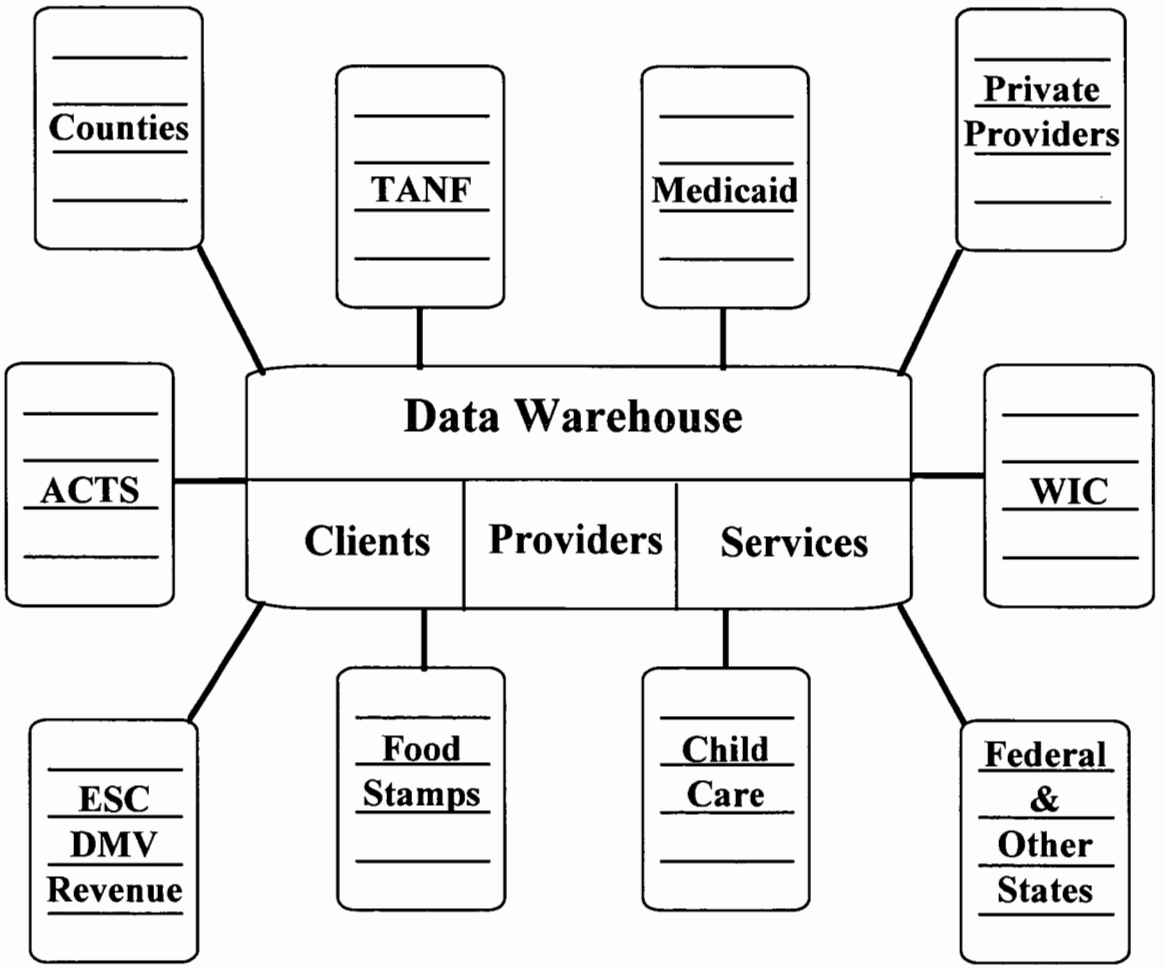
Information Needs Assessment Themes

- Consistent Definition of Confidentiality
- Common Client/Family Information
- Information on Local Services
- History of Services to Client/Family
- Outcomes, Evaluation & Accountability

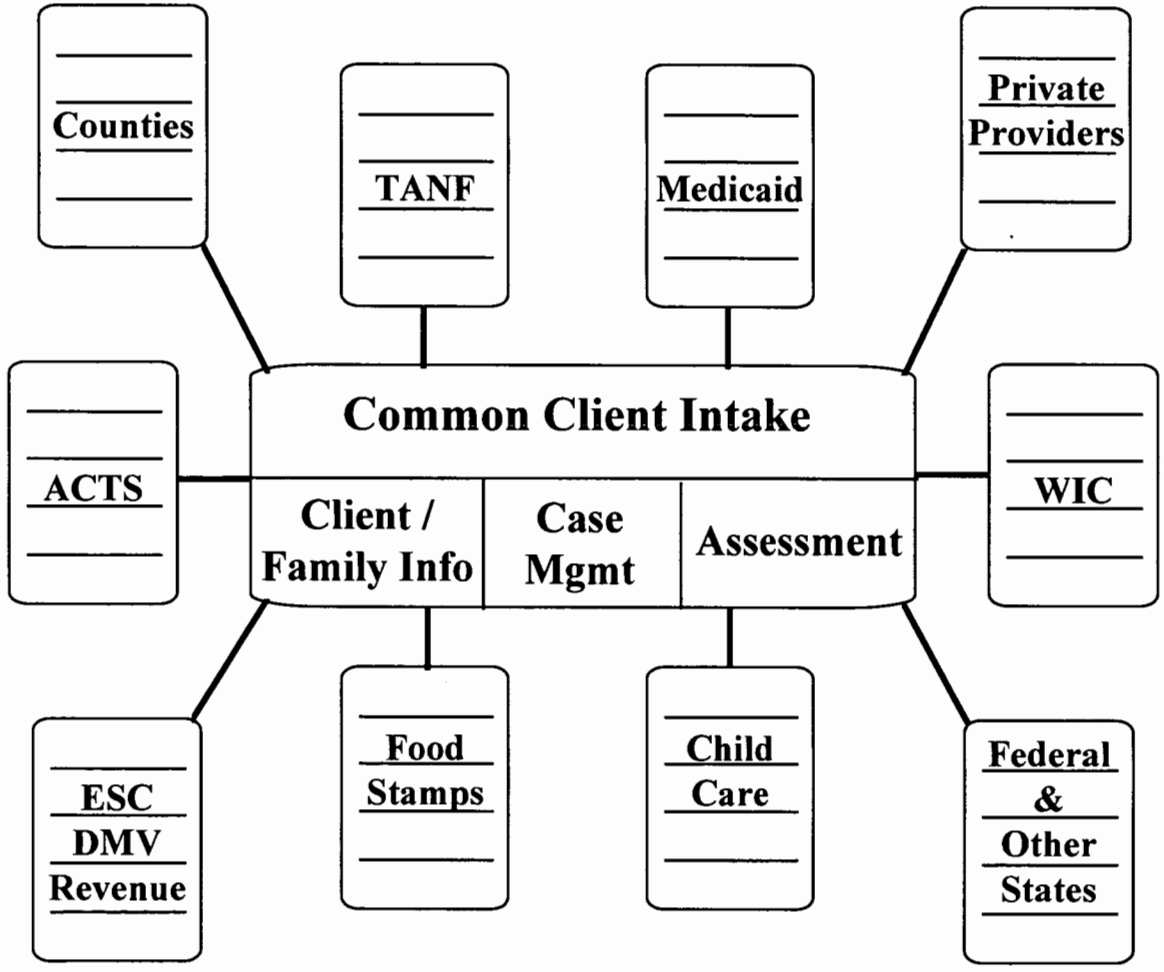
New Approach for Infrastructure



New Approach for Information



New Approach for Serving Families

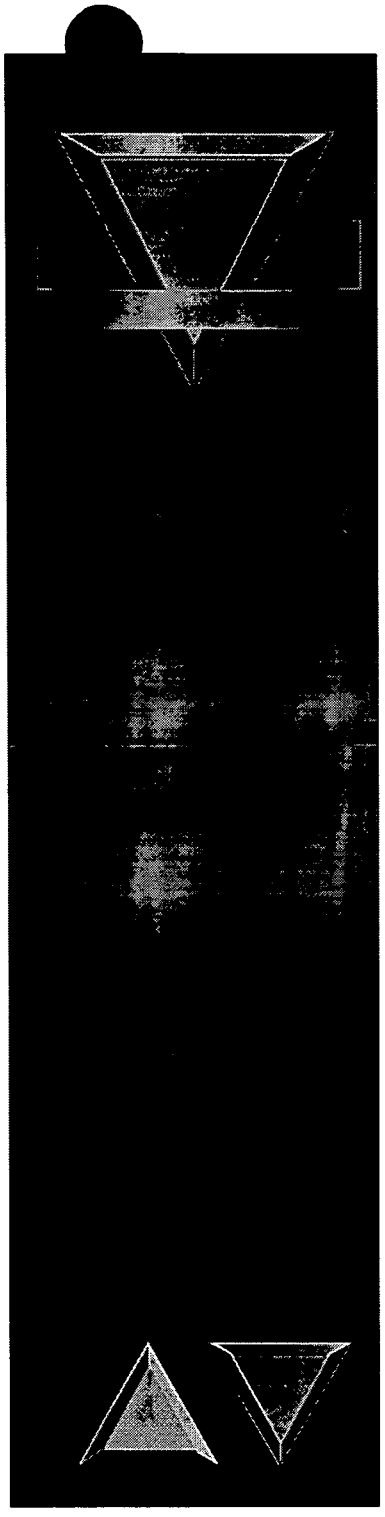


New Approach Benefits

- Develop Once and Reuse
- Reduce Redundant Support
- Simpler and More Reliable
- Flexible and Adaptable
- Easier to Change
- Capable of Meeting Today's Demands

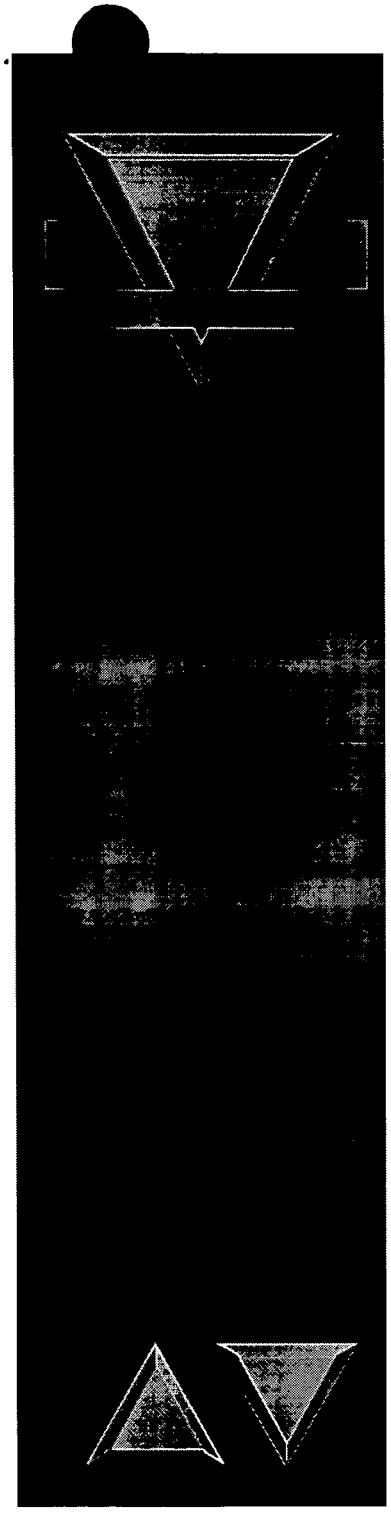
A Vision for the Future

- Client & Family at the Center
- Seamless Service Delivery across all programs
- Shared information resources and processes
- Statewide networked infrastructure



ONGOING SUPPORT and OPERATIONS

- Application support
- IRM Policy and Planning
- Computer Services
- Technical Services



YEAR 2000

ONGOING SUPPORT and OPERATIONS

- Application support
- IRM Policy and Planning
- Computer Services
- Technical Services

YEAR 2000 FUNDING

Estimated Need	$38,327,505
Federal	$ 8,876,737
State	
Year 2000 Fund	$ 9,800,776
To be Paid by DHHS	$19,649,992

WELFARE REFORM

- Interim changes
- EPICS
- County State Interface
- Client registration
- Common Client ID
- After hours query (EIS/FSIS)
- Reporting requirements
- Support Electing Counties

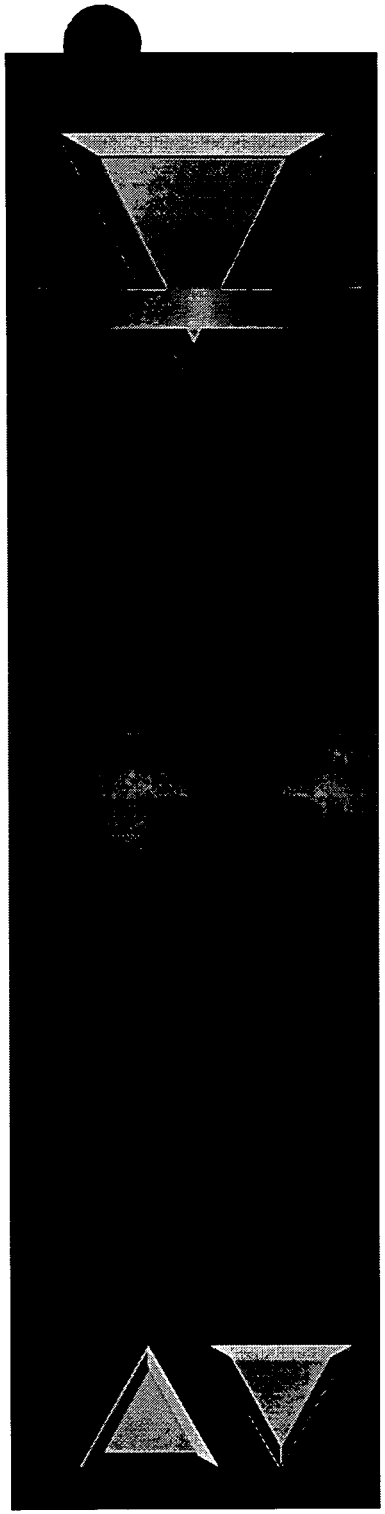
YEAR 2000

ONGOING SUPPORT and OPERATIONS

- Application support
- IRM Policy and Planning
- Computer Services
- Technical Services

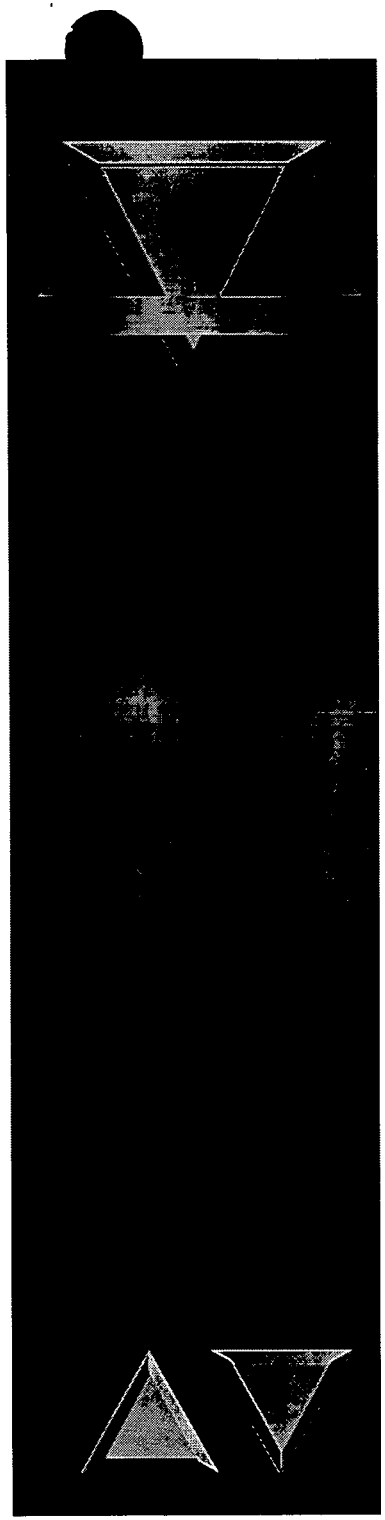
WELFARE REFORM REINVESTMENT PLAN

- Enables integration of eight programs
- Provides networked PC environment
- Phased replacement of existing high risk systems
- Integrated screening, intake, eligibility, update, and review processing
- 62.8M over 5 years from TANF Plan Share
- 86M over 5 years leveraged from other participating programs



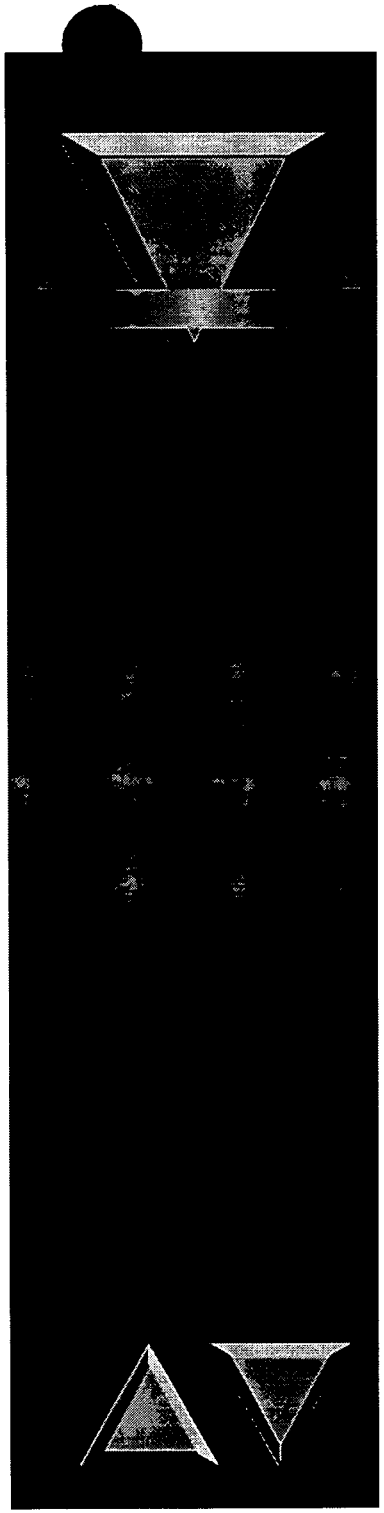
WELFARE REFORM REINVESTMENT PLAN

	FY97-98	FY 98-99
Infrastructure and Interfaces	$ 1,373,522	$16,570,310
Federal Requirements affecting Current Systems	$ 9,785,780	$10,648,545
Management Information & Tracking	$ 3,009,425	$ 7,740,536
Systems Development	$ 1,350,000	$ 7,089,590
Administration & Development Environment	$ 634,370	$ 1,022,571
TOTAL	$16,153,097	$43,071,552



WELFARE REFORM

Initiative	Time Start	Line Complete	TOTAL REQUIREMENTS FY97-98	FY98-99
WELFARE REFORM REINVESTMENT				
Infrastructure and Interfaces				
SW Connectivity (Distr Computing Guidelines)	Jul-97	May-98	147,334	41,972
SW Connectivity (Network Operations Center)	Jul-97	Jun-98	499,869	77,901
SW Connectivity (Service Delivery Mapping)	Feb-98	Aug-98	218,174	62,981
SW Connectivity (Network Integrity)	Mar-98	Aug-98	100,000	650,000
County Interface (Interface Engine)	Sep-97	Jul-99	408,145	893,525
Partner Interfaces - Develop Approach	Jul-98	Dec-98	0	296,480
SW Connectivity (Implementation Planning)	Jul-98	Jun-00	0	685,286
SW Connectivity (Implementation Projects)	Sep-98	Jun-00	0	13,862,165
Federal Reqmt's Affecting Current Systems				
Child Support Enf - Welfare Reform	Oct-97	Oct-00	8,130,950	9,003,045
Work First (Short-term Tactical)	Jan-98	Jun-99	965,000	1,645,500
Interim Welfare Reform (already expended)	Jan-97	Mar-98	659,830	0
SIS/Co Admin Interface/WorkFirst	Tbd	Jun-98	30,000	0
Management Information and Tracking				
EPICS - Development/Implementation	Feb-98	Dec-99	1,023,725	3,549,343
EPICS - Auxillary Functions	May-99	Dec-99	0	390,293
Data Warehouse (Federal Reporting)	Apr-98	Nov-98	1,985,700	1,302,820
Data Warehouse (New Data Reporting)	Jul-98	Feb-99	0	2,498,080
Systems Development				
Common Client ID	Apr-98	Sep-98	1,125,000	1,183,680
After Hours Query (EIS/Food Stamps)	Jun-98	Nov-98	225,000	1,070,640
Common Client Enterprise	Mar-99	Nov-99	0	813,210
Common Intake Phase 1 (EIS & FSIS)	Sep-98	Mar-99	0	2,149,760
Appl/Assessment (Common Intake - Phase II)	Jan-98	Sep-99	0	1,575,820
Develop Real-Time Approach (Analytic-EIS/FS)	Jan-99	Apr-99	0	296,480
Adminstn and Development Environment				
Cool:GEN Environment Installation	Apr-98	Jul-98	514,600	515,169
Welfare Reform Planning Analysis	Mar-98	Jun-00	119,770	507,402
			$16,153,097	$43,071,552



BUSINESS AUTOMATION INITIATIVES

- Biometrics
- CHIP
- Managed Care
- HEARTS
- Email/Remote Access
- Statewide Connectivity
- Day Care

WELFARE REFORM

- Interim changes
- EPICS
- County State Interface
- Client registration
- Common Client ID
- After hours query (EIS/FSIS)
- Reporting requirements
- Support Electing Counties

YEAR 2000

ONGOING SUPPORT and OPERATIONS

- Application support
- IRM Policy and Planning
- Computer Services
- Technical Services

Summary

- Interdependency of Programs & Services
- Accelerating Rates of Change
- Client Centered - Not Program Focused

4-20-98
Myra Powell
#2

EXECUTIVE SUMMARY
Adolescent Parenting Program

The Adolescent Parenting Program is funded by the state of North Carolina and administered by 27 local agencies spread throughout the state. Under the supervision of the N. C. Division of Social Services, this program began as a pilot project in 1984 when it was administered by eight county departments of social services. Presently, it is administered by a variety of local agencies in addition to county departments of social services. These include school systems, health departments, and nonprofit enterprises.

The general mission of the Adolescent Parenting Program is to reduce the negative impact of adolescent parenthood upon the teen mother and her child. The target population is the teenage mother who is pregnant for the first time. The objectives of this program are to prevent a second pregnancy, assure the client remains in school, enhance parenting abilities, assure the mother and child receive appropriate medical care, and prepare the teen mother for independent living after school.

Each local program is expected to offer social casework services, peer group activities, and mentors for each client. Each program is assisted by a Program Coordinator, a casework supervisor, an In-House Management Team, and a Community Advisory Committee.

The Evaluation

This evaluation of the Adolescent Parenting Program was funded by the North Carolina General Assembly in 1997 for the purpose of determining how well this program has been working since the last overall evaluation that took place in 1992. The present evaluation was undertaken by a team of faculty members of the School of Social Work of East Carolina University and was guided by a State Oversight Committee comprised of a variety of key actors on the state and local levels. The time period covered by this evaluation includes July, 1994 through June, 1997.

This evaluation examines the following questions:

1. To what extent do the clients of the Adolescent Parenting Program exhibit high risk for problems related to adolescent parenthood?
2. To what extent are the objectives of this program being achieved?
3. How well is this program being implemented on the local level?

The answers to the above questions led to a set of general observations and recommendations on the improvement of the program.

Both quantitative and qualitative data were collected in the evaluation of the Adolescent Parenting Program. The quantitative data came from (a) a survey of a random sample of all clients served during the three year period of the evaluation, (b) data reports from Program Coordinators, © a participant satisfaction survey, (d) a volunteer satisfaction survey, (e) a survey of risk factors completed by participants, and (f) an examination of the Central Registry for Child Neglect and Abuse. Qualitative data were collected from site visits to 14 of the 27 agencies administering this program. This information focused primarily upon the implementation of the program.

Risk Factors

It was found that the clients of the Adolescent Parenting Program exhibited a high degree of the risk factors associated with teenage pregnancy. Such persons are viewed as less likely than others to endure the early years of parenthood without serious problems such as child abuse, dropping out of school, and having a second pregnancy. Among the findings of the survey of risk factors are the following:

1. Only one-fourth of the APP clients were living with both parents.
2. About three-fourths of these clients were from households with income low enough to qualify for Medicaid.
3. A majority of the mothers of these clients had gotten pregnant as a teenager while one in four had an older sister who had done the same.
4. A majority of these clients had a friend who was a teen mother.

These findings have two major implications. First, the program has adequately targeted those most in need of assistance to overcome the impact of teenage pregnancy. Second, high risk individuals are more difficult to treat; thus, outcomes should be evaluated with reference to the fact that targeting lower risk teen mothers would have resulted in more positive outcome data. Had local programs selected higher functioning clients, they could have erroneously taken credit for positive outcomes that would have been better attributed to the client's abilities and environment rather than the effect of the program. In other words, they could have erroneously taken credit for outcomes that would have been achieved without the program.

It was discovered that the local programs differed significantly in the degree to which they served clients who exhibited high risk factors. Of the nine risk factors measured, the local programs had an average that ranged from 2 to 5, meaning that one agency served clients with an average of 2 risk factors while another served clients with an average of 5 risk factors. This finding should be taken into consideration in the evaluation of the outcomes of local programs.

Program Outcomes

In general, the findings of this evaluation indicate a significant degree of achievement of the objectives of the Adolescent Parenting Program. The clients of this program were found to have a higher degree of functioning than the general population of teenage mothers on each of the following objectives:

1. ***Teen mothers who are not participants are about three times as likely as APP participants to become pregnant a second time.*** Only 7 percent of the APP clients were terminated from service because of a second pregnancy, whereas approximately 25 percent of statewide teen births are estimated to be a subsequent births (beyond the first one).
2. ***Teen mothers who are not participants are about three times as likely as APP participants to drop out of school.*** Only 16 percent of APP clients were terminated because of a school dropout, whereas 50 percent of teen mothers drop out of school.
3. ***Teen mothers who are not participants are about twice as likely as APP participants to be substantiated for child neglect or abuse.*** Only 4 percent of APP clients were substantiated for child neglect or abuse as compared to 8 percent of teen mothers statewide.
4. ***APP clients were more likely to have received prenatal and perinatal care.*** Fully 93 percent of APP clients received regular prenatal care as compared to only 67 percent of teen mothers nationwide. Regular perinatal care of the newborn was reported for 97 percent of APP clients.

Satisfaction surveys of both clients and volunteers indicated a high degree of satisfaction with the contribution of the program in preventing a second pregnancy, keeping the client in school, teaching the clients about parenting, and keeping both the client and the baby healthy. Lower

satisfaction was indicated for the objective of preparing the client for independent living. ***Nearly all (98 percent) of the clients of the Adolescent Parenting Program would recommend it to others who became pregnant.***

Program Implementation

Information on program implementation was acquired through site visits to one-half of the 26 local agencies that administer the Adolescent Parenting Program. In these site visits, interviews were conducted with the Program Coordinator, the Supervisor, the agency Director, members of the In-House Management Team, members of the Community Advisory Committee, and clients of the program. The following are overall impressions of the site visitors:

1. ***The Adolescent Parenting Program is generally being implemented appropriately.*** All agencies visited were rated as either "exceptional" (79 percent) or "good" (21 percent) for the case management (casework) service, while a substantial majority were rated as "exceptional" (57 percent) or "good" (29 percent) for the peer support component. A substantial majority of favorable ratings were also given for the supervisory component and the In-House Management Team. Lower ratings were given to the volunteer component and the Community Advisory Committee. The majority (57 percent) of the visited agencies were found to be in "need of improvement" in the volunteer component, while 36 percent were found to be needing substantial improvement in the Community Advisory Committee component.
2. ***The Program Coordinator is the number one key to effectiveness.*** The work of the social worker with individual clients was cited by clients and volunteers as the most important thing that happens to the clients. This service keeps clients goal-focused and helps them solve many problems that get in the way of progress. Coordinators were generally found to be quite dedicated to the mission of the program and skilled in their jobs.
3. ***The Program Coordinator's job description is unrealistic.*** It is not realistic to expect the Program Coordinator to serve as social worker to 18 clients, to develop and run the monthly peer support group meetings, to recruit and train volunteers for each client, and to develop and lead both the In-House Management Team and the Community Advisory Committee.
4. ***Case management (social casework) is the most important service and should be***

strengthened. The extensive duties of the Program Coordinator pulls time away from the most critical function--individual casework. There should be more time available for this function.

5. ***The peer support component is the second most important service and should be strengthened.*** The peer support component is working well, but should be strengthened by more meetings and the availability of a uniform curriculum.

6. ***The volunteer component works much better in theory than in practice and should be re-evaluated.*** In cases where the volunteer component was working well, it was found to be a meaningful component of the program. However, the Program Coordinator does not have adequate time to effectively develop this component.

7. ***Local agencies do not need both a Community Advisory Committee and an In-House Management Team.*** While agencies ideally should have both of these components, it was not found that weakness in one or the other was instrument to the outcomes of the program.

8. ***The policy changes that led to greater emphasis upon serving only those eligible for Medicaid has had the effect of reducing diversity and making the outcomes of the program more difficult to achieve.*** Greater use of Medicaid funds for the Adolescent Parenting Program may be a wise investment for the state, but it has some unintended consequences. Lower diversity in the peer groups means that fewer positive role models are available for clients to follow.

9. ***The most effective model for administration is to have complete access to the school but it is not necessary that the school administer the program.*** Programs housed in schools appeared to have more active involvement in the lives of clients. They had more access to clients on a regular basis and were in a good position to monitor school behavior. However, some of these programs were not administered by the schools and it was not found that the schools administered the program better.

10. ***There is no one type of organization that administers the program better than others.*** There is a diversity of types of agencies administering the program, but this factor does not seem to determine program outcome. Similar success was achieved by different agency auspices.

11. ***The Adolescent Parenting Program funds a position rather than a program and should study the implications of this fact.*** Agencies receive funds that are adequate

only for the funding of a position, and have to be creative in obtaining funds for activities and general administrative support. This fact reduces the ability of the programs to fully serve clients.

12. ***Attention should be given to those excluded from the program because of a second pregnancy or for dropping out of school.*** Many of the persons interviewed in the site visits were concerned for those few clients whose services had been terminated because they became pregnant again or dropped out of school. It is not recommended that this rule of eligibility be dropped, but it is recommended that some attention be given to helping these clients in some ways. They are in much need of further attention.

13. ***The information system for the Adolescent Parenting Program is inefficient and ineffective and should be improved.*** There is limited data being collected on a statewide basis, and some of it is not adequately recorded. A better information system needs to be developed with attention both to effectiveness and efficiency.

14. ***Most programs did not report effects on services of the change from JOBS to Work First.*** There were some notable exceptions to this observation. A few agencies cited negative effects of this change, but most did not.

A chart on study findings and recommendations is provided on the following two pages. The study findings were composed by the Evaluation Team, while the recommendations were developed by the Evaluation Oversight Committee.

Summary of Findings and Recommendations -- Adolescent Parenting Program Evaluation (1998)

Study Findings	Recommendations
The Adolescent Parenting Program has been effective in preventing second pregnancies, keeping teen mothers in school, and preventing child neglect and abuse.	Provide funding for more programs statewide. Presently, only 27 counties are served by this program.
Funding is presently provided only for a position rather than a full program.	Provide program-level funding for agencies that administer the APP.
The Coordinator is the key to effectiveness	Upgrade the salary for the Coordinator position.
The Coordinator's job description is unrealistic. Case management is the most important service and should be strengthened.	Reduce the scope of the Coordinator's job duties. Assure that the coordinator has more time available to offer individual casework services.
Peer support is the second most important service and should be strengthened.	Encourage local programs to provide more than one monthly peer support activity, and develop a uniform training curriculum that would be available at the discretion of the local agency.
The volunteer component works better in theory than in reality and should be reevaluated.	Make the volunteer component optional. Encourage linkages to other community organizations that are providing volunteer mentoring, e.g. Big Brothers/Big sisters.
Local programs do not need both a Community Advisory Committee and an In-House Management Team.	Require that agencies have either a Community Advisory Committee or an In-House Management Team. Encourage agencies to have both when they find both to be beneficial.
Policy change that encouraged local agencies to serve only Medicaid eligible clients has reduced the diversity of the clients and made the outcomes of the program more difficult to achieve.	Decrease the dependence of the program on Medicaid funding in order to allow programs to serve more non-Medicaid eligible participants.
The clients served in the APP exhibit numerous high risk factors as do those who are terminated from the program.	Take into consideration the extent of risk factors of APP participants in the evaluation of the program on both the state and local levels. Promote linkages with other programs that serve pregnant and parenting teens (Maternal Care Coordination and Child Service Coordination)

Study Findings	Recommendations
The school is the best physical location for program activities, but it is not necessary that the school system administer the program.	Require a formal partnership between the school and at least one additional agency (the APP in cases where the school is not administering the program). This partnership should facilitate, where possible, the location of APP activities in the school.
No one type of organization is generally superior to others in the administration of the program.	Continue to allow different types of organizations to administer the program.
The information system of the APP is inefficient and ineffective.	Develop a new information system that efficiently collects data on both program process and program outcome. Data should be kept and recorded on individual clients with regard to risk factors, parent skills, school behavior, training, second pregnancy, etc A biennial evaluation of APP is imperative.

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