

1998

**JOINT
APPROPRIATIONS -
HUMAN RESOURCES
COMMITTEE**

MINUTES

HOUSE OF REPRESENTATIVE
APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

1997-98 Session

Representative Charlotte Gardner, Co-Chair
Representative Lanier Cansler, Co-Chair
Representative Debbie Clary, Co-Chair

MEMBERS

Representative Alma Adams
Representative M.W. Aldridge
Representative Martha Alexander
Representative J. W. Hurley
Representative Edd Nye, Ranking Minority Member
Representative Cindy Watson

Representative Theresa Esposito, Appropriations Co-Chair
Representative George Holmes, Appropriations Co-Chair
Representative Leo Daughtry, House Majority Leader
Representative Steve Woods, House Pro Temp

Staff:

Carol Shaw
Mary Ellen Sylvester
Karen Hammonds-Blanks

Staff Attorneys:

Gann Watson
Dianna Jessup

Clerks:

Barbara R. Hocutt
Barbara Cansler
Mary Jamison

**JOINT MEETINGS OF THE APPROPRIATIONS SUBCOMMITTEES ON
HUMAN RESOURCES, 1998**

May 13, 1998

May 14, 1998

May 20, 1998, a.m. & p.m.

May 26, 1998, a.m. & p.m.

May 27, 1998, a.m. & p.m.

May 27, 1998, Public Hearing

May 28, 1998, a.m. & p.m.

June 1, 1998, Block Grants Hearing

June 2, 1998, a.m. & p.m.

June 3, 1998

***Material from these meeting can be found in the notebooks of the Joint meetings of
the Appropriations Subcommittee on Human Resources for 1998**

1998

RESOURCES

[illegible]

1998

**HOUSE APPROPRIATIONS SUBCOMMITTEE ON HUMAN
RESOURCES**

[illegible]

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Wednesday, May 13th, 8:30 a.m.
Room 424 - Legislative Office Building

Opening Remarks	Chairmen
Departmental Overview	Secretary David Bruton HHS
Budget Reductions	Lee Kittredge Budget & Analysis
Expansion Budget	Lee Kittredge Budget & Analysis

Reports

Proposed Health Standards

Title IVA-Emergency Assistance Funding

Integration Of Health Functions

State Child Fatality Review Team

Special Children Adoption Fund

Providing Adult Day Health Care Services Through Medicaid

JOINT APPROPRIATIONS SUBCOMMITTEES ON HUMAN RESOURCES

Minutes May 13, 1998

The meeting of the Joint Appropriations Subcommittees on Human Resources was held Wednesday, May 13, 1998 at 8:30 a.m. Representative Charlotte Gardner presided. Six Senators were present and the following House members were in attendance:

Representative Lanier Cansler	Representative Edd Nye
Representative Bill Hurley	Representative Alma Adams
Representative Debbie Clary	Representative Henry Aldridge
Representative Cindy Watson	Representative Martha Alexander
Representative Theresa Esposito	Representative Julia Howard

The following staff was present: Karen Hammonds-Blanks, Carol Shaw, Mary Ellen Sylvester, Susan Sabre, Gann Watson and Romona Burton who was introduced as a new Fiscal Staff member.

Recommended Reductions

In the absence Secretary Bruton, Lee Kittredge began with the Recommended Reductions for the Department of Health and Human Services. (See Attachment #1.) Representative Edd Nye asked about the controversial transfer of reserve fund, item #3, and was assured it was approved by the State Budget Office.

Senator Clark asked why the fees charged for the Certificate of Need were not reduced since there was a surplus that goes into the non-recurring funds. Lynda McDaniels, Chief of Facility Services, said that the fees are in the rules. They can be changed. However, the income fluctuates markedly, and its hard to know if the surplus would continue.

Senator Phillips apologized for the remarks he made at a previous meeting. He has since learned that he was misinformed, and the case cited about the wastage of vaccine was hypothetical rather than real as he had understood. Representative Gardner remarked that while the scenario was hypothetical, the incident that she was told about was very near to an actual occurrence. Representative Nye believed it was an actual occurrence and the wastage was over \$10,000. The staff confirmed that it was an actual occurrence, and the wastage was about \$10,300. Representative Gardner said that she would like accurate information about how many times this occurs and how many corrective action plans have been filed and rejected. Representative Gardner wants to pursue the issue since the facts do not fit.

Overview

Dr. Bruton gave an overview of the budget of the Department of Health and Human Services. (See attachment #2.) Representative Cansler questioned the fourfold increase

Minutes, 5-13-98

in costs while the numbers served have only doubled. Dr. Bruton said the cause was inflation and an increase in the cost of services. Allen Gamble agreed with Secretary Burton. They expect this trend to continue. Representative Cansler said that he wanted to look at the impact of the increase of programs and coverage on the growth of the budget. Mr. Gamble said there were a number of reviews on this subject, and he would get them to Carol Shaw for him.

Senator Martin wanted to know what the chart would look like if Medicaid was backed out. Lee Kittredge said they can do that and would have a chart reflecting that for the committee tomorrow.

Expansion Budget

Mr. Lee Kittredge presented the Department of Health and Human Services Supplemental Expansion Budget, SFY 98-99. (See Attachment #3.) He made corrections to the report on page 1: FFP projection is 14 million and decreased utilization is \$9.5 million.

There were several questions about the fewer number of Medicaid eligibles than was projected (Item #1). The reduction does not represent a policy change according to Allen Gamble. Representative Gardner said the staff will present a report which may clarify how this all meshes.

Representative Nye said it would be helpful to see in what programs the reductions are being proposed rather than being presented a net figure. He is particularly interested in the "add-backs", such as, the 62 employees that were added after the budget was completed last year. Representative Gardner wanted to know how much they're going to increase the reimbursement to the doctors and dentists because she has been told that increased reimbursement fees alone won't solve the problem. Carol Shaw will work with Allen Gamble to put all the information together that Representative Nye and Gardner have mentioned for presentation to the committee next week. Representative Nye wants the position numbers on the 62 "add-back" positions.

Representative Adams requested a list of the positions proposed in Child Support Enforcement, and Mr. Kittredge will provide the list. (Item #6)

Representative Gardner and other members had several questions about the process of criminal records checks and employment needs. (Item #9) Stephanie Fanjul said the department was making an effort to centralize the criminal record checks that are now taking place in the responsible divisions such as foster care, day care, etc. Representative Gardner said she needs to see this process in its entire context because there are several unknowns such as costs and the impact on turn around time. Ms. Fanjul and Mr. Kittredge said they would try to make a written report drawing the elements of concern together. Senator Dannelly was concerned about the list of people who received

provisional license and are on a fairly long waiting list. He suggested that the Governor's budget be monitored to ascertain whether the SBI gets the money for the technology to address the backlog it has in criminal background checks. If it isn't in the Governor's budget, we should see that the SBI gets the \$3 million they need. Representative Gardner assured Senator Dannelly the staff would get the information the committee needed to understand the whole picture. Senator Martin understands the SBI is looking into contracting out some of the checks while they work on a long range solution.

Representative Julia Howard, House Majority Whip, suggested the committee pursue getting Private Protective Boards to reduce the backlog. The turf battle is preventing children and the elderly from being protected. Representative Gardner said the staff is going to make a comprehensive report but that the SBI is outside the purview of this committee.

Representative Cansler asked, if due to high turnover in the health care and child care positions, the same persons are being checked over and over again. Senator Martin suggested the department issue a card showing the length of time since a person's last background check to keep from having to do this every time they change jobs. Mr. Kittredge said he would follow-up on these ideas.

On the subject of the year 2000 compliance (Item #10), Representative Nye asked how many characters or lines of codes would be necessary, and Mr. Cox of the Information Management Division said he would get those figures. In answer to Representative Gardner's question about Randy Cook's replacement, she was told it was Doris McCloud of the Comptrollers office.

Representative Cansler was assured by Mr. Kittredge there will be a report on the operations and priorities of local area authorities with reference to providing services and the cost. There was extensive discussion about the autonomy, funding unmet needs in local area mental health organizations. (Item #14)

Representative Gardner said she needs more information on the Child Mental Health Training project (item #15). Dr. Behar responded with information about the conferences referred to by Representative Gardner. The conferences are sponsored by different agencies and are virtually self-supporting but the curriculum development that results needs funding.

Representative Gardner questioned whether the proposed expenditures for "Emerging Health Issues Risk Assessment" (item #16) was another example of subsidizing of corporate hog farms. Senator Martin said the committee needs orientation on what falls in the purview of Environmental Health and if there is an overlap with Public Health. Also, he wanted to know the time line for the decision on whether Environment Health is

going to remain where it is or coming under HHS. Chris Hoke said that issue was assigned to the Environmental Review Commission who were charged with making a recommendation to the legislature during this short session. It is expected that the Commission will recommend an expansion of their review to include studying the rule making power of these agencies. Senator Martin was still uncertain about the Commission deciding on the location for the Environmental Health Division. Representative Watson said she is concerned that this division does not have a departmental home and is not getting the budgetary attention it needs. Representative Gardner wants more information about the proposed expenditure.

After some discussion on the efficacy of the program, Senator Martin requested additional information on the HIV Medications program (Item #17).

Representative Cansler questioned a 30% increase in the Immunization funding request (Item #19). Barbara Starrett, Chief of the Immunization Section, explained the request. Representative Gardner was skeptical about the children being immunized on a timely basis and would like to see more numbers on that. Ms. Starrett said she would be happy to furnish that information. Senator Dannelly asked what the average influx of 1-19 year olds into the state is, but Ms. Starrett does not have those figures and will look it up.

Representative Gardner questioned the use of educational pamphlets that are not understandable to the general public. Mr. Kittredge will furnish more information on the use of these materials and the efficacy of the educational program (Item #21). Senator Dannelly asked if the rate of strokes was decreasing, if there were sections in the state where strokes were more prevalent and if the rate among African-Americans was higher. He was told that was true, and although the incidence of strokes fell dramatically in previous years there has been an increase in the past year, according to Mr. Anderson.

Representative Watson wanted to know which counties were the 10 pilot counties for training Public Health nurses and nutrition teams in diabetes care (Item #22). Mr. Anderson said the pilot counties would be those that are not receiving federal funds for this now, and he will get a list of those counties to Representative Watson.

Senator Dannelly asked about the funds for Children's Vision Screening being used to pay people to do the screening (Item #23). It was explained these funds are for training volunteers not paying them to perform the screenings. Mr. Kittredge said he was still working on Senator Dannelly's previous request for the names of the counties where they are experiencing difficulty getting volunteers.

Representative Gardner requested more information on the Healthy Start Foundation proposed budget item (Item #24). She is concerned about duplication.

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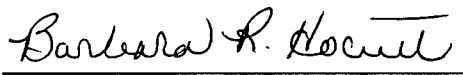
Representative Gardner said she wanted to flag the item on the "Study on Access to Dental Care" (Item #25) She said she is opposed to another study. There are dentist who are successfully serving Medicaid patients and can share their successful techniques.

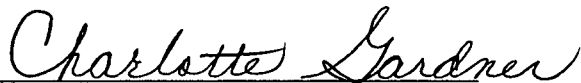
Representative Gardner asked for more information on Long Term Care Systems Reform (Item #27)

Representative Gardner said that it close to time for session and asked Mr. Kittredge to run through the rest as quickly as possible.

On the request for Long Term Care Insurance Study (Item #30), Representative Gardner said there was a bill would be considered by the House today that will take care of that and the expenditure of \$50,000 for the study will not be needed.

Representative Gardner asked the House members to remain because there is a bill that needs to be handled by the House committee. The Joint meeting was adjourned


Barbara R. Hocutt, Clerk


Representative Charlotte A. Gardner,
Co-Chair

CAG:brh

VISITOR REGISTRATION SHEET

APPROPRIATIONS HUMAN RESOURCES SUBCOMMITTEE APRIL 22, 1998

May 13, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Bob Havelly	Prevent Blindness NC
Phillips Hoffman	DMH/DD/SAS
Claudia Hoffman	DMH/DD/SAS
July Holland	DMH/DD/SAS
Kim Foster	DYS
Steve Shaba	Jordan Price
Myrna Miller	NASW-NC
Stephanie Farrel	DCD - DHHS
Angie McMillan	DHHS
AK DC, PEH	DOA/PAFO
Wendy Mills	SEANC
PAUL CLARK	AV ASHEVILLE CITIZEN - TIMES
Stephen Miller	NCHHS
Angie De Ban	Smith Anderson
Sardine #37	
John Rott	NCFPC
Meghan Jure	Easton Seals
Robert Riddout	DHHS/DYS
Robertson	Bone Assoc NCALTF
Lynne Meekins	North Carolina Hunger Network Raleigh
Sandra Colon	N.C. Hunger Network
Barbara Warren	N.C. Hunger Network
Maria Williams	N.C. Hunger Network
Shirley McMillan	NC Hunger Network
John Aiken	DHHS
John Aiken	McPIT
John Schirot	NCJCCO

VISITOR REGISTRATION SHEET

APPROPRIATIONS HUMAN RESOURCES SUBCOMMITTEE ~~APRIL 21-23, 1998~~

May 13, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Ignacio Behar	MHI/DO/SAS
Tom V. Haglund	DHHS - DWCH
John A. Gancey	SCSL/APPCNC / FRIC
William Potter	NC DENTIM SOC & NCDTA
by farmer	NC Div of Child Dev.
Theresa Cheng	~~COOP~~ NONE
Mike (Ker)	"
Don Price	"
Matt Beeman	NONE
Jinda Duster	Cary High
Lon Wilson	N.C. ARTC7.
Carmen Hooker Buell	Carolina's Health Care System
Glennia Long	Healthy Start Foundation
Jamie Freedman	Healthy Start Foundation
Wayne Williams	OSBM
Don McCRQUODALE	NCRMA
FRAN Preston	NCRMA
Kay E. Glend	NICPA
Lynhia S. Darnall	AARP
Priscilla Swindell	CCTF / AARP

VISITOR REGISTRATION SHEET

APPROPRIATIONS HUMAN RESOURCES SUBCOMMITTEE ~~APRIL 13, 1998~~ *May 13, 1998*

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
<i>Lynda McDaniel</i>	DHHS / DFS
<i>Bozlyn Sawitt</i>	NC Child Care Coalition / NC HIV/AIDS Alliance
<i>Debra Warner</i>	DHHS - HIV/STD Prev. + Care Section
<i>Mary Leane</i>	OSBM
<i>Byron K. Harris</i>	OSBM
<i>Betty Wier</i>	D Com. Health
<i>John Tate</i>	MHA/NC - C2001
<i>David Richard</i>	The Doc/NC
<i>Charles Davis</i>	DMH/DO/SAS
<i>Marci White</i>	DMH/DO/SAS
<i>Peter Anderson</i>	DHHS / DCH
<i>Paul Stenard</i>	DHHS - DCH - IMM
<i>Kevin Ryan</i>	DHHS - DWCH
<i>Barry Golostein</i>	DHHS - DWCH
<i>Karen Grotzer</i>	Div. of Aging DHHS
<i>John Bowdich</i>	Zeb Alley P.A.
<i>Georgette Irving</i>	Johnson, Johnson
<i>Chuck Buchanan</i>	DHHS - Epidemiology
<i>AUGIE TILSON</i>	NCHA
<i>George Parrish</i>	DVRS
<i>Esther Manheimer</i>	Bill Daffney
<i>Just Smooreau</i>	NCAAF
<i>BILL COX</i>	DHHS / DERM
<i>C. L. Cochran</i>	UCP/NC C2001
<i>Bryan Summers</i>	NC Equity
<i>Tommy Walth</i>	Carolina Practice System
<i>Jennifer Green</i>	Prevent Blindness NC

May 13, 1998
L. Kittredge
#1

Recommended
Reductions
for
Department of Health
and Human Services

April 21, 1998

May 13 1998
3

Department of Health and Human Services

Supplemental Expansion Budget

SFY 98-99

Division of Social Services

1998-99

5. **Reduce State/County Special Assistance**

It is recommended that funding for State/County Special Assistance be adjusted to reflect a more current forecast of requirements.

Requirements	\$ (1,065,947)
Receipts	<u>(532,973)</u>
Appropriation	\$ (532,974)

6. **Eliminate County AFDC/Child Support Reimbursements for State Managed Operations**

Prior to the creation of the 1996 TANF block grant, IVD child support collections were used to offset the county share of AFDC payments. Today, these collections offset the cost of supporting IVD Child Support operations in county operated programs. The North Carolina Division of Social Services operates child support programs for 31 counties. Since Work First Cash Assistance (formerly AFDC) is now funded through 100% federal TANF funds, these 31 counties no longer need this reimbursement to offset local costs for cash payments. It is recommended that these funds be budgeted to reduce appropriations.

Requirements	\$ -
Receipts	<u>2,700,000</u>
Appropriation	\$ (2,700,000)

7. **Welfare Reform Reserve Funding**

It is recommended that \$20 million in recurring appropriations to the welfare reform reserve be replaced in 1998-99 with nonrecurring state funds. It is further recommended that, in future years, nonrecurring funds be used to fund the balance of the reserve, until total availability in the reserve reaches the \$50 million maximum.

Requirements	\$ -
Receipts	<u>20,000,000</u>
Appropriation	\$ (20,000,000)

Division of Facility Services

8. **Certificate of Needs Fees**

It is recommended that the Division of Facility Services transfer \$1.5 million in receipts from the Certificate of Need (CON) Section to the Treasurer's Office as a nontax revenue. The CON Section is supported with appropriations and these funds revert annually.*

	\$ 0 -

Division of Health Services - Women's and Children's Health

1998-99

9. Maternity Care Coordination Start-up Grants

Since state fiscal year 1990-91, the Women's Health Sections has received \$500,000 annually to provide Maternity Care Coordination start-up grants to local health departments and migrant, rural and community health centers. The purpose of the grants was to rapidly increase the number of Medicaid eligible pregnant women receiving case management services by providing start up funds for the new Maternity Care Coordinators. As local agencies have added new Maternity Care Coordinators each year to serve the Medicaid population, the demand for the start-up grants has declined reducing the funding need for this activity. It is recommended that requirements be reduced in this program.

\$ (232,000)

10. Immunization Program

Operating cost such as printing and postage can be supported with federal funds without adversely impacting program operations. It is recommended that federal receipts be increased to reduce appropriations.

Requirements
Receipts
Appropriation

\$ (178,000)
178,000
\$ (178,000)

Division of Youth Services

11. Detention Construction Delays

Due to the delayed opening of the Richmond Boundover Unit, it is recommended that the unit's operating reserve be reduced.

\$ (200,000) NR

Subtotal - Department of Health and Human Services

Requirements
Receipts
Appropriation

\$ (65,449,491)
(7,369,309)
\$ (57,880,182)
\$ (200,000) NR
\$ (58,080,182)

Total

* This sum is documented under HHS operating efficiencies, but will be reflected in the totals for nontax revenues.

**Department of Revenue
Operating Efficiencies**

1998-99

1. **Reduce Funding for Administration of Federal Retiree Refund Program**

Nonrecurring funds in the amount of \$1.2 million were provided for administering the federal retiree refund program through April 15, 2001. The department will absorb the administrative cost of the program from its operating budget, thereby reverting the available balance \$741,902 to the general fund.

\$ (741,902) NR

2. **Reduce Contractual Services**

Reduce contractual services in the Planning Development and Technology (PDT) Division.

(326,098)

Subtotal - Department of Revenue

\$ (326,098)

\$ (741,902) NR

Total

\$ (1,068,000)

**Department of Health and Human Services
Operating Efficiencies**

Office of the Secretary

1998-99

1. **Increase Use of Medicaid Receipts for Rural Health**

It is recommended that the Office of Rural Health budget increases in Medicaid receipts and reduce appropriations to support program services.

Requirements

\$ -

Receipts

226,024

Appropriation

\$ (226,024)

Division of Child Development

1998-99

2. Increase Federal Receipts for Regulatory Activities

It is recommended that federal Child Care and Development Block Grant receipts be increased to support child care regulatory activities, thereby reducing the need for appropriations. This action will not reduce services or adversely affect child care subsidy funding.

Requirements

Receipts

Appropriation

\$ -
1,011,184
 \$ (1,011,184)

Division of Medical Assistance

3. Transfer Reserve Funds

G.S. 143-23.2 limits the use of DMA reserve funds to support the Medicaid program. Current availability in this dedicated reserve exceeds \$109 million and receipts are expected to grow by \$25 million annually, resulting in a fiscal year 1998-99 availability of \$134 million. It is recommended that the reserve maintain a minimum balance of \$100 million to meet unanticipated future needs in the Medicaid program. It is further recommended that 10% of total availability be budgeted in fiscal year 1998-99, and in future years, to support the growth in current services costs and reduce appropriations.

Requirements

Receipts

Appropriation

\$ -
13,000,000
 \$ (13,000,000)

4. Medicaid Adjustments

Based on revised projections, a reduction in the 1998-99 certified Medicaid budget is recommended to reflect more current eligibility and utilization information and to reflect a more favorable federal funds participation rate.

Requirements

Receipts (Federal and County)

Appropriation

\$ (63,713,544)
(43,713,544)
 \$ (20,000,000)

May 13, 1998
#2 Dr. Bruton

Department of Health And Human Services

Overview

May 1998

State Fiscal Year 1997-1998

General Fund Operating Budget as of December 31, 1997

DHHS's budget is 36% of all State government's total budget

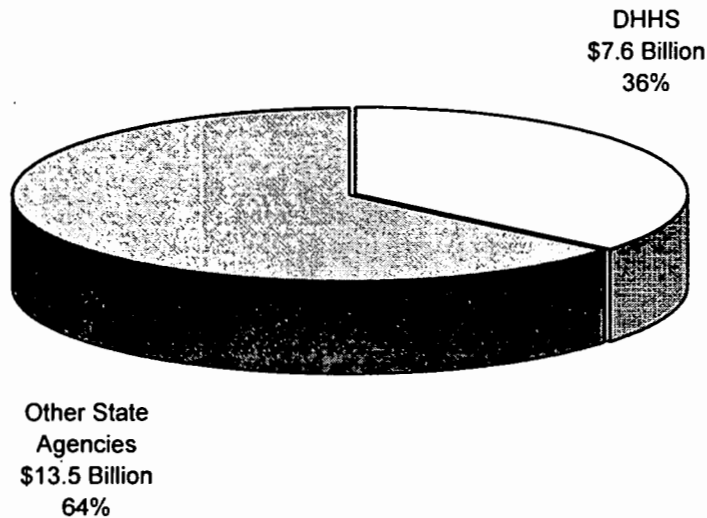


Chart 1
Total Budget

20% of all State appropriations go to DHHS

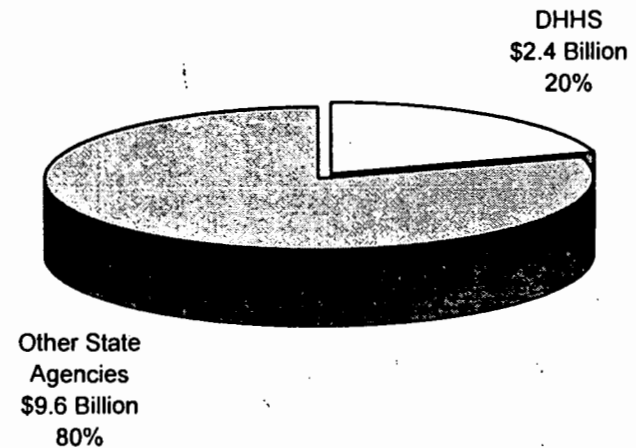


Chart 2
State Appropriation

- Other State Agencies Amounts as of July 31, 1997
- Includes only General Fund Budget Codes.
- Amounts exclude intradepartmental transfers.

55% of DHHS's budget comes from federal sources; 32% comes from the state

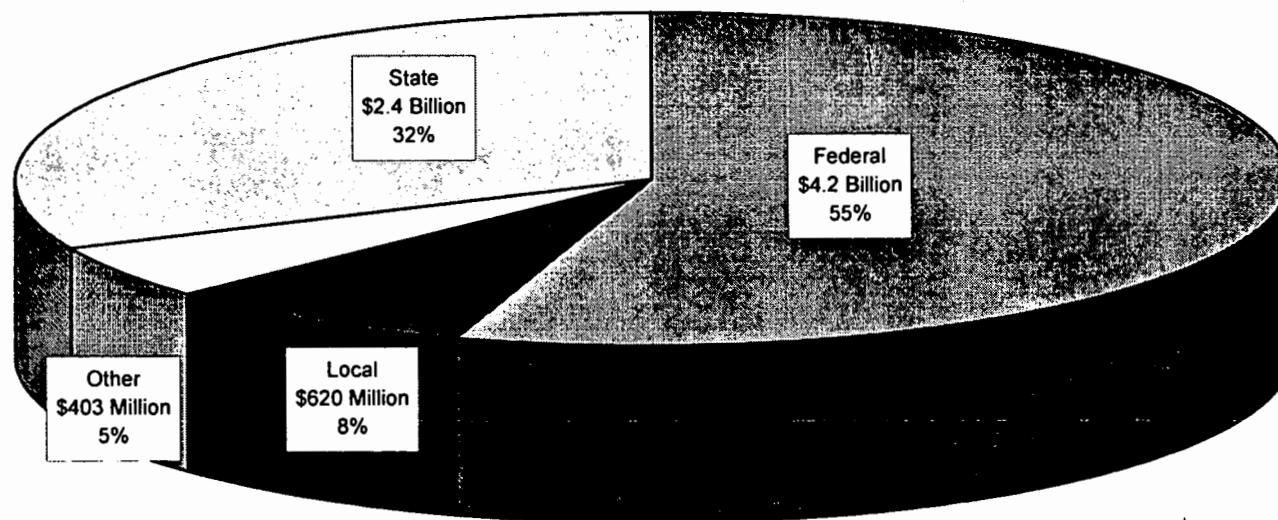


Chart 3
DHHS Source of Funds - 1997-98

87% of the total budget goes for programs & benefits to individuals,
such as TANF and Medicaid

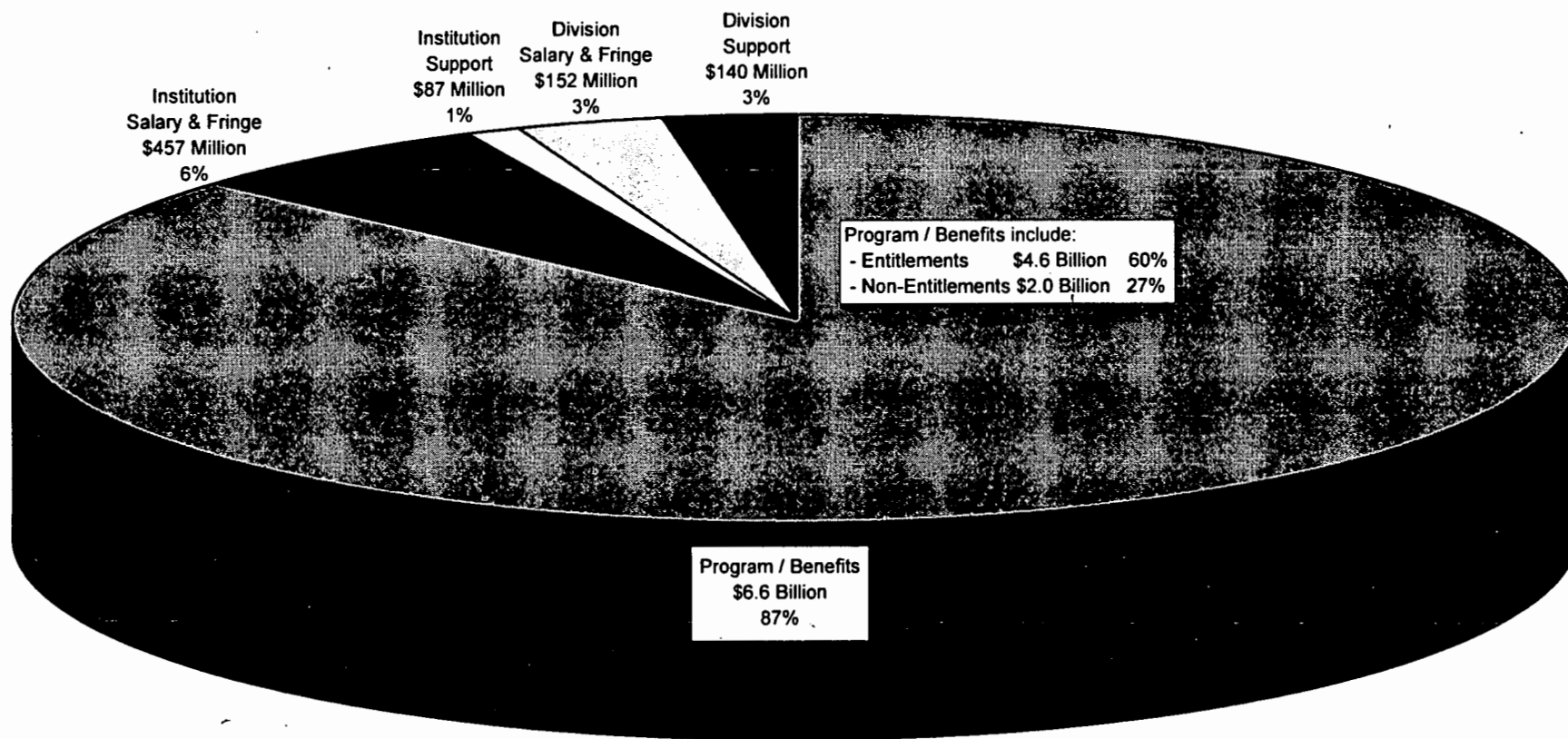
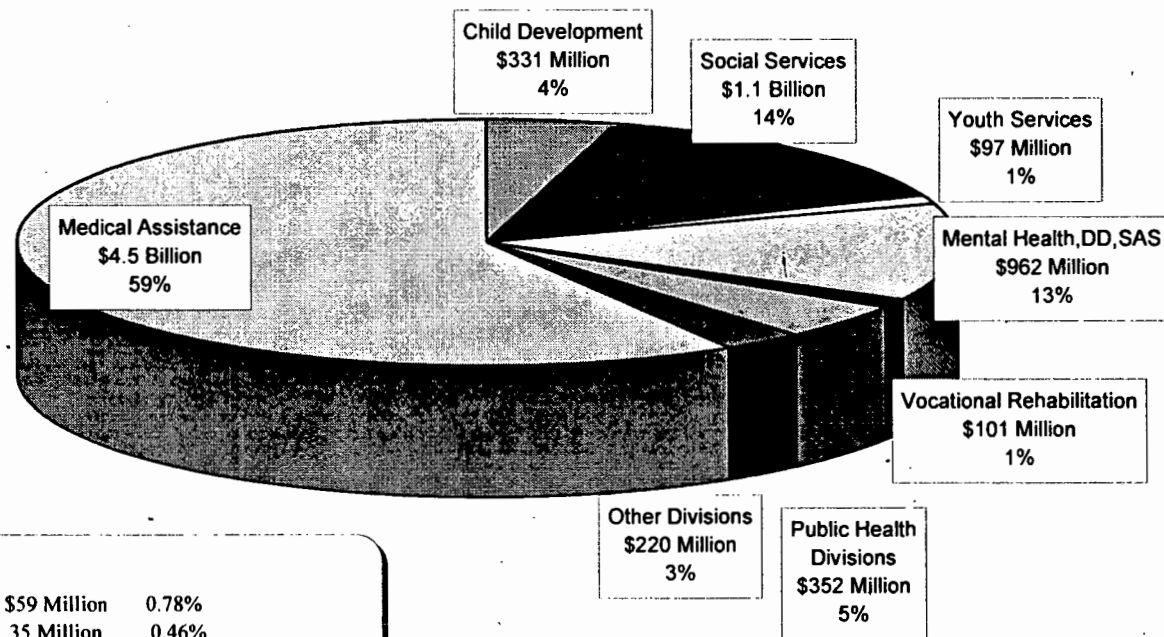


Chart 4
DHHS Total Budget By Category - 1997-98

59% of DHHS's total budget goes solely for Medicaid



Other Divisions:

Aging	\$59 Million	0.78%
Services for the Blind	35 Million	0.46%
Deaf & Hard of Hearing	30 Million	0.39%
Facility Services	19 Million	0.26%
Economic Opportunity	16 Million	0.21%
Information Resources Mgt.	24 Million	0.32%
Central Administration	24 Million	0.31%
Rural Health	9 Million	0.12%
DD Council	2.2 Million	0.03%

Chart 5
DHHS Total Budget By Division - 1997-98

Of DHHS's 19,552 positions, 72% are in institutions,
15% are based in Raleigh, and 13% are in field offices

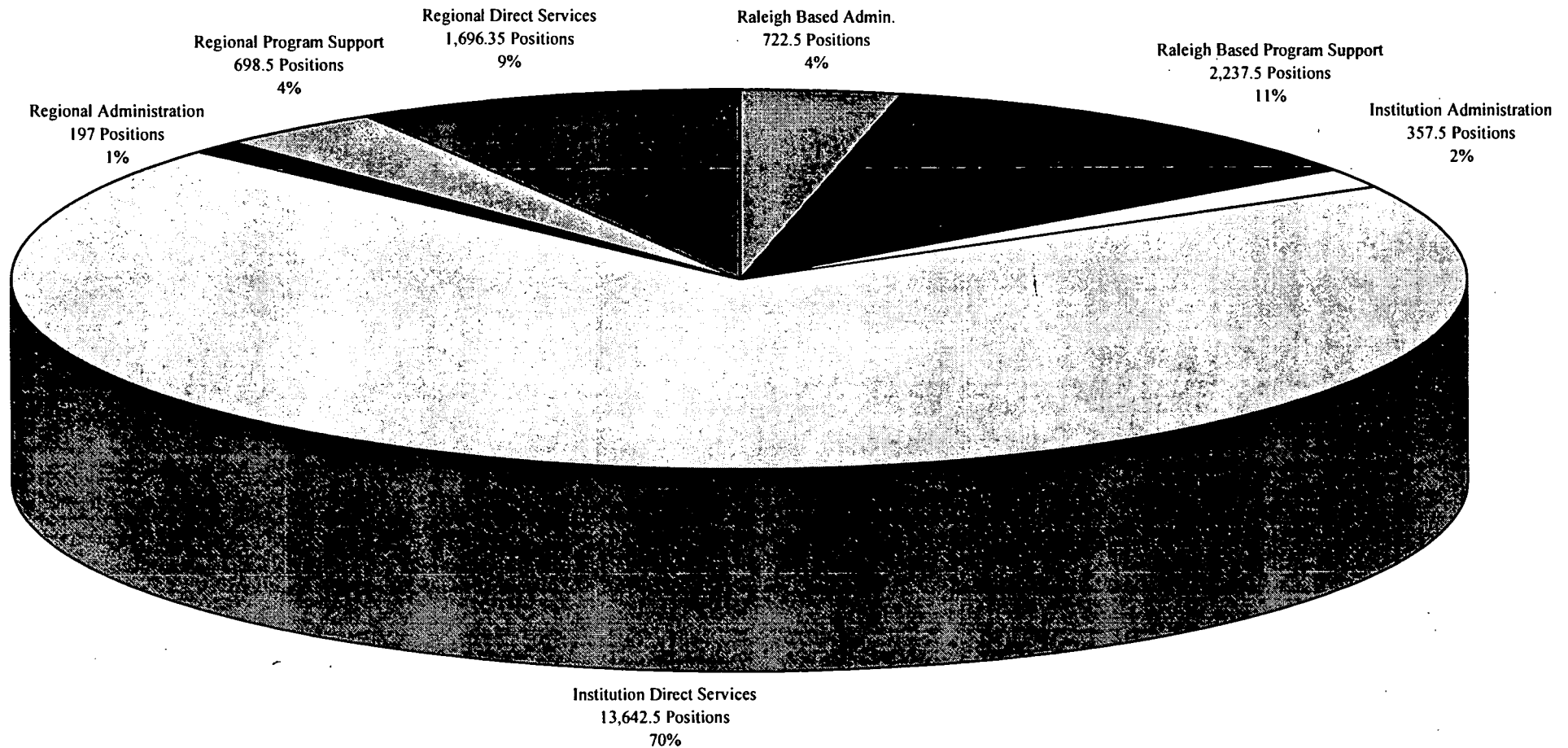
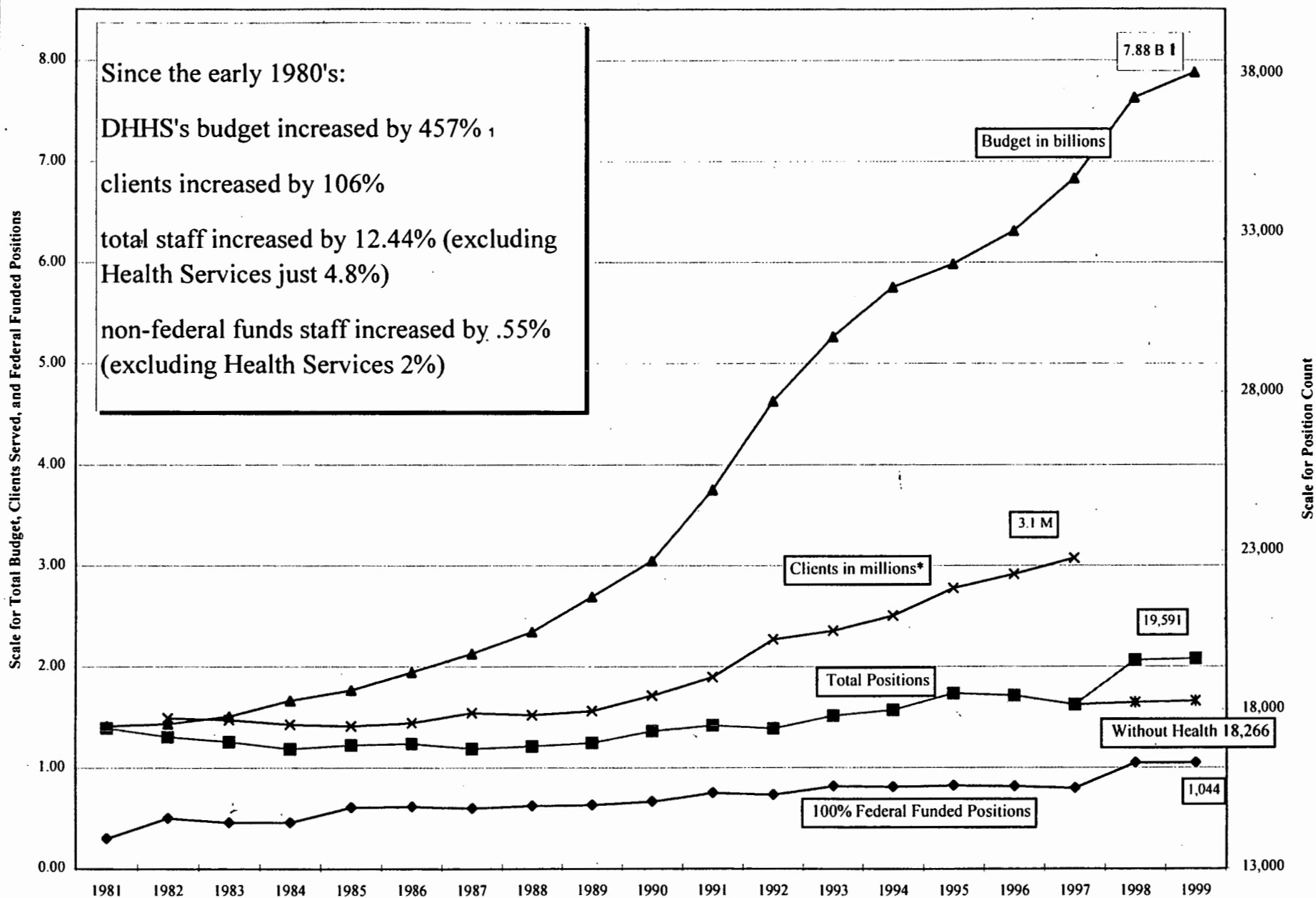


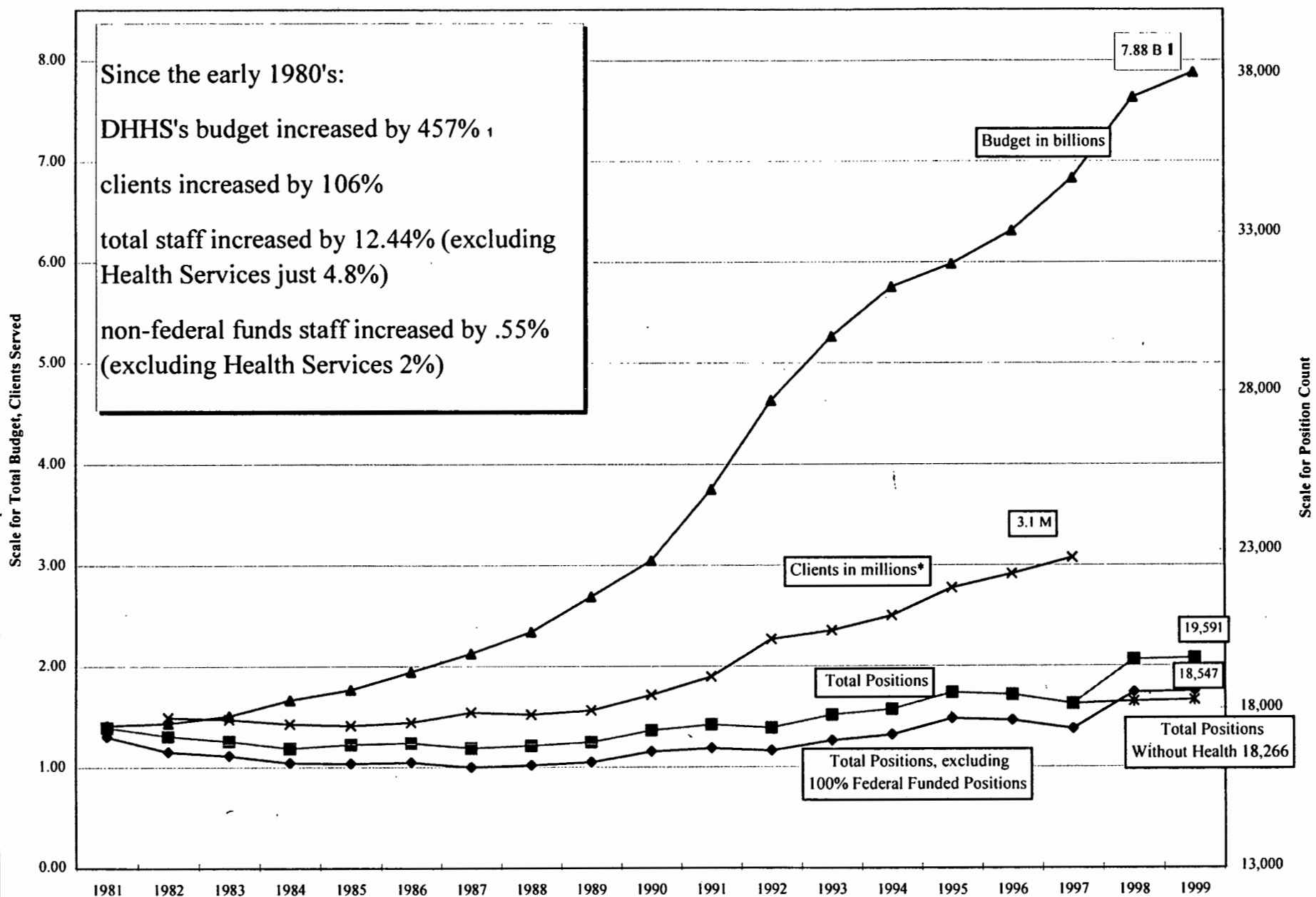
Chart 6
DHHS Positions By Location and Function - 1997-98



* 1981 information incomplete or not available; health divisions added in SFY 1997-98.

¹ Transfers have not been netted out of SFY 1998-99 Budget.

Chart 7
DHHS Growth in Budget and Clients vs. Positions
1981 - 1999



* 1981 information incomplete or not available; health divisions added in SFY 1997-98.
 1 Transfers have not been netted out of SFY 1998-99 Budget.

Chart 7
DHHS Growth in Budget and Clients vs. Positions
1981 - 1999

#1 Medicaid Adjustments

A reduction to the program's budget is recommended based on a revised forecast that makes use of more current expenditure and utilization information. This reduction is coupled with the earlier reduction of \$20 million for a total reduction of \$45.5 million in SFY 98-99.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements			(81,234,768)
Receipts			(55,734,768)
Federal			0
Local			0
Other			0
Appropriation			(25,500,000)
No. of Positions			0.00

Decrease can be attributed to these factors;

Fewer eligibles = \$22 million

Better FFP than projected = \$16 million - a 0.5% increase can save the State \$14 million

Decreased utilization, lower inflation and cost containment efforts = \$7.5 million

 Fewer people using services for a shorter period of time

 Use of general practitioners instead of hospital emergency rooms

No worksheet prepared

#1 Expand Smart Start

The request for additional Smart Start funds includes direct service funds and planning funds for all 100 counties. Direct services funding would be \$54.7 million of the request which will bring North Carolina to 50% of the full statewide funding needed for the Smart Start program. Also, all 45 counties which initiated planning in SFY 97-98 will be included in 30 Partnerships funded at \$100,000 each year for Planning/Local Partnership costs.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	97,370,615	100,410,828	56,634,743
Receipts	0	0	
Federal			0
Local			0
Other			0
Appropriation	97,370,615	100,410,828	56,634,743
No. of Positions	0.00	0.00	0.00

Percent of direct services fully funded could be at
75% for 32 counties,
50% for 11 counties
45% for 12 counties
25% for 45 counties

See pages 1 through 3 for detail.

#2 Support for the Office of the State Auditor

In order to meet the increased auditing demands due to Smart Start program growth since 1993, additional funding is requested for the Office of the State Auditor for four professional positions, two clerical positions and contractual audit activities. Of this amount, \$38,940 is non-recurring.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	121,271	121,271	688,069
Receipts			
Federal	0	0	0
Local	0	0	0
Other	0	0	0
Appropriation	121,271	121,271	688,069
No. of Positions	0.00	0.00	0.00

Note: The corresponding item for the State Auditor's office is on page 27 of the Governor's recommended budget. Due to the high volume of required annual audits and lack of resources, audits are current only through SFY 95-96.

The Division of Child Development has transferred \$250,491 to the State Auditor's Office this fiscal year for conducting Smart Start audits. Of this amount, \$120,271 is in the Division's continuation budget as a transfer to the State Auditor. The remainder transferred this year (\$130,22) is one-time Smart Start contract refunds.

See pages 4 through 6 for detail..

#3 Expand T.E.A.C.H.

Additional funds are requested for the Teacher Education and Compensation Helps (T.E.A.C.H.) Program, a child care training and education initiative, to address increased demand. The increased demand is a result of child care legislation enacted during the 1997 Session of the General Assembly. The recommended funding increase of \$178,000 will raise the total funding level to \$1.6 million.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	1,422,000	1,422,000	178,000
Receipts	0	0	
Federal			0
Local			0
Other			0
Appropriation	1,422,000	1,422,000	178,000
No. of Positions	0.00	0.00	0.00

1,989 individuals received scholarships from the TEACH Program in FY 1996-97. Through the training these individuals received, it is estimated that 40,219 children were impacted.

See pages 7 through 9 for detail.

#4 Children's Health Insurance Program

The NC General Assembly adopted SB 2 in the 1998 Extra Session which establishes a non-entitlement Health Insurance Program for Children effective no earlier than October 1, 1998. The plan covers children through age 18 and whose family income is through 200% FPL. The Governor's budget was printed prior to the passage of SB 2. The numbers below reflect the amounts supported by SB 2.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	0	0	61,987,018
Receipts			
Federal	0	0	44,822,664
Local	0	0	0
Other	0	0	1,546,532
Appropriation	0	0	15,617,822
No. of Positions	0.00	0.00	7.00

Estimated # of children eligible in 98-99 is 74,224 and for 99-00, 75,708.

Estimated # of children enrolled in 98-99 is 63,091 and for 99-00, 64,352.

Note: A six month phase-in is assumed for SFY 98-99, beginning October 1, 1998.

No worksheet prepared.

#5 State County Special Assistance/Adult Care Home Rate Increase

A rate increase from \$915 to \$956 is proposed, effective October 1, 1998. This amounts to a 4.5% increase over the rate authorized for SFY 98-99 and is based on 1997 actual cost data adjusted for inflation. The blended rate is set at 75th percentile of the reported direct cost and 60th percentile of the indirect cost as required by 10 NCAC 01B.0501.

The current rate is \$893 and there are funds in the SFY 98-99 budget to cover an increase to \$915 per month.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	99,775,147	106,594,720	7,531,298
Receipts			
Federal	0	0	0
Local	49,887,574	53,297,360	3,765,649
Other	0	0	0
Appropriation	49,887,573	53,297,360	3,765,649
No. of Positions	0.00	0.00	0.00

of adult care homes - 1,438

of Special Assistance recipients -

See pages 10 through 12 for detail.

#6 Increase Staffing in Child Support Enforcement

In order to increase child support collections and implement welfare reform, child support caseloads need to be reduced to manageable levels instead of the current 1:540 agent:caseload ratio in the state operated Child Support Enforcement (CSE) offices which serve 31 counties. An additional 100 positions in State-operated CSE offices are requested to allow for an agent:caseload of no more than 1:403. Eight positions are needed to respond to the dramatic increase in the number of calls. All positions are effective October 1, 1998. Funds in the amount of \$1.2 million are also requested to allow an orderly replacement of equipment that is nearing the end of its useful life.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	11,969,820	11,969,820	4,959,585
Receipts			
Federal	9,188,233	9,188,233	3,273,326
Local	0	0	0
Other	0	0	0
Appropriation	2,781,587	2,781,587	1,686,259
No. of Positions	298.00	298.00	108.00

See pages 13 through 15 for detail.

#7 Work First Reserve

It is recommended that non-recurring state funds be used in SFY 98-99 to support the Work First Reserve established pursuant to G. S. 143-15.3C. It is further recommended that non-recurring funds be used to in future years to fund the balance of the reserve, until the total availability in the reserve reaches the \$50 million maximum .

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99	
Requirements	16,000,000	20,000,000	20,000,000	
Receipts				
Federal	0	0	0	
Local	0	0	0	
Other	0	0	0	
Appropriation	16,000,000	20,000,000	20,000,000	NR
No. of Positions	0.00	0.00	0.00	

No worksheet prepared.

#8 Criminal Records Checks for Foster Care and Adoptive Parents

The recently enacted Adoption and Safe Families Act of 1997 mandates criminal record checks on all foster care and adoptive parents. NC law has previously mandated criminal record checks on foster parents as a condition of licensure, but we have not previously required checks for adoptive parents. Costs of \$95,000 include costs of fingerprinting and fees for checking state, local and national data bases (\$48 per parent, 2300 checks per year) and one support position to monitor the checking process in the Division.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	0	0	147,676
Receipts			
Federal	0	0	52,277
Local	0	0	0
Other	0	0	0
Appropriation	0	0	95,399
No. of Positions	0	0	1.00

Estimated number of checks per year - 2,300.

See pages 16 through 19 for detail.

#9 Criminal Records Checks Needs Assessment

Funds are needed to address a significant backlog in processing the increasing volume of mandated State and Federal Criminal Record Checks (CRC) due primarily to the labor-intensive process currently in place. DHHS proposes to work with the SBI to 1) define and reengineer, as needed, business requirements related to CRCs, 2) evaluate alternative solutions for meeting those requirements, 3) develop a plan that takes advantage of available technology and 4) implement the plan. This request includes 3 staff and resources as well as a time-limited contractor to carry out the first three activities. These are non-recurring funds.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	0	0	391,744
Receipts			
Federal	0	0	39,383
Local	0	0	0
Other	0	0	0
Appropriation	0	0	352,361 NR
No. of Positions	0.00	0.00	3.00

Child care centers = 3,717

Child care homes = 5,090

Family foster homes = 4,195

Average turnaround time 6 to 12 months

Nursing homes = 417

Home care agencies = 900

Adult care homes = 1,438

See pages 20 through 23f for detail.

#10 New Systems for Year 2000

Non-recurring funds are requested to support the replacement of the current ARBS patient accounts receivable system and to ensure that sufficient funds are available for the Eligibility Information System in order to have both systems Year 2000 compliant. While funding for both of these systems has been obtained from the statewide Year 2000 Steering Committee, it is insufficient to complete the tasks.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	0	0	6,864,399
Receipts			
Federal	0	0	
Local	0	0	0
Other	0	0	0
Appropriation	0	0	6,864,399 NR
No. of Positions	0.00	0.00	0.00

\$40 million estimated total cost to be Year 2000 compliant.

a. ARBS - Total requirements \$5,409,661

b. EIS - Total Requirements \$1,454,238

OF CLIENTS IN EIS - 710,000

OF CHECKS WRITTEN - 100,000 MONTHLY - 1,200,000 ANNUALLY

OF MA CARDS SENT - 600,000 MONTHLY - 7,200,000 ANNUALLY

OF KEYSTROKES PER YEAR - 850,000 DAILY TIMES 250 WORKDAYS/YEAR =
212,500,000 KEYSTROKES ANNUALLY

See pages 24 through 26 for detail.

#11 Automation Support

Funding is recommended to support pressing Department automation needs.

Electronic Benefits Transfer System Implementation will improve recipient access to Food Stamp Service through a magnetic stripe card at Point-of-Sale devices at retail stores authorized by USDA. Funds in the amount of \$185,544 are needed to complete the rollout of all counties during SFY 1998-99.

Additional funds are needed for State Information Processing System (SIPS) costs associated with the many and varied benefit and information systems maintained by the department, which serve the citizens of North Carolina. The addition of statewide on-line systems and the resultant expanding end user base; an increase in the citizen population being served by many of these systems; the changes which have occurred in operating environments; and growth in collaborating and sharing data with other state agencies have contributed to an increase in SIPS cost.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99	
Requirements	10,082,553	10,081,836	4,371,088	
Receipts				
Federal	4,878,086	4,876,604	2,146,744	
Local	0	0	0	
Other	0	0	0	
Appropriation	5,204,467	5,205,232	2,224,344	NR
No. of Positions	0.00	0.00	0.00	

See pages 27 through 29 for detail.

EBT Implementation and Operational Cost

1998-2003

	Description		1998-1999	1999-2000	2000-01	2001-02	2002-03
	DHHS COSTS						
531213	Salaries Continuing		\$113,189.00	\$113,189.00	\$113,189.00	\$113,189.00	\$113,189.00
531213	Salaries Non-recurring		\$49,014.00				
	(Number of Positions)		8	3	3	3	3
	74@M/POINT \$43,309X3	\$129,927.00					
	72@M/POINT \$39,558X3	\$118,674.00					
	66@M/POINT \$30,322x2	\$60,644.00					
	ANNUAL SALARY	\$309,245.00					
531513	Social Security Continuing		\$8,659.00	\$8,659.00	\$8,659.00	\$8,659.00	\$8,659.00
531513	Social Security Non-recurring		\$3,750.00				
531523	Retirement Continuing		\$12,258.00	\$12,258.00	\$12,258.00	\$12,258.00	\$12,258.00
531523	Retirement Non-recurring		\$5,308.00				
531563	Hospitalization Continuing		\$5,208.00	\$5,208.00	\$5,208.00	\$5,208.00	\$5,208.00
531563	Hospitalization Non-recurring		\$2,170.00				
533110	Office Supplies		\$7,500.00	\$6,000.00	\$6,000.00	\$6,000.00	\$6,000.00
534710	Software (8@\$1625)						
5327XX	Travel Continuing		\$45,480.00	\$45,480.00	\$45,480.00	\$45,480.00	\$45,480.00
5327XX	Travel Non-recurring		\$14,220.00				
532811	Telephone		\$3,600.00	\$2,400.00	\$2,400.00	\$2,400.00	\$2,400.00
532840	Postage		\$1,200.00	\$600.00	\$600.00	\$600.00	\$600.00
532850	Printing		\$3,600.00	\$3,600.00	\$3,600.00	\$3,600.00	\$3,600.00
532821	SIPS Cost		\$350,000.00	\$350,000.00	\$350,000.00	\$350,000.00	\$350,000.00
532199	Misc Contr. (DIRM)- Continuing Cost		\$75,000.00	\$100,000.00	\$100,000.00	\$100,000.00	\$100,000.00
532199	Misc. Contracts (DIRM) Non -recurring Cost.		\$158,340.00				
	TOTAL		\$858,504.00	\$647,397.00	\$647,397.00	\$647,397.00	\$647,397.00
	STATE SHARE OF COSTS		\$429,252.00	\$323,698.50	\$323,698.50	\$323,698.50	\$323,698.50
	FEDERAL SHARE OF COSTS		\$429,252.00	\$323,698.50	\$323,698.50	\$323,698.50	\$323,698.50

#12 Willie M.

An increase in the current eligible assaultive and violent children (Willie M.) caseload has required the need for additional community service dollars. The current appropriation plus the one-time use of the Willie M. restricted fund balances are sufficient to meet the SFY 97-98 costs for the increased caseload. Funding in the amount of \$5.35 million is needed to cover existing clients in SFY 98-99 because the fund balances will no longer be available.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	53,304,566	55,000,466	5,353,003
Receipts			
Federal	6,577,300	6,577,300	0
Local	0	0	0
Other	0	0	0
Appropriation	46,727,266	48,423,166	5,353,003
No. of Positions	0.00	0.00	0.00

Current Willie M. caseload, as of 5/11/98 is 1,540 children.

Total number of children served in FY96-97 was 1,806.

The average cost for serving a Willie M. child, including all state appropriations for Willie M. (DHHS and DPI) and all Medicaid dollars was about \$40,000.

See pages 30 through 32 for detail.

#13 Atypical Antipsychotics Drugs/State Psychiatric Hospitals

Newer, more effective atypical antipsychotics are now considered the standard of care. They offer the potential to improve the quality of life for clients and decrease the need for inpatient treatment. Costs for the new drugs range from \$250 to \$750 per patient per year.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	6,201,959	6,374,229	1,539,814
Receipts			
Federal	857,166	880,975	212,816
Local			0
Other			0
Appropriation	5,344,793	5,493,254	1,326,998
No. of Positions	0.00	0.00	0.00

See pages 33 through 35 for detail.

#14 Medicaid Match Shortfall for Area Mental Health Programs

In order to continue existing services, funds are requested to establish a Medicaid match reserve for area mental health programs. To date, the Medicaid match requirements have been met by certification of state and local funds allocated to the area authorities. Growth in the service system and expanded Medicaid reimbursable services have outstripped the capacity of state and local funds appropriated for indigent care to serve as match. These expansion funds will be combined with area authority state and local funds currently supporting Medicaid services to set up a Medicaid reserve which will permit payment of 100% of the Medicaid rate to area programs. If these funds are not approved, area programs would have to realign their existing funds to cover this need, in effect, \$38 million would not be available to serve non-Medicaid eligible children and adults.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	0	0	38,000,000
Receipts			
Federal	0	0	0
Local	0	0	0
Other	0	0	0
Appropriation	0	0	38,000,000
No. of Positions	0.00	0.00	0.00

See pages 36 through 38 for detail.

#15 Child Mental Health Training Project

One-time funding is recommended for the Children and Family Services Mental Health Section for planning and delivery of training programs to build cultural competencies for providers of services to children, families, and communities.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99	
Requirements	0	0	75,000	
Receipts				
Federal	0	0	0	
Local	0	0	0	
Other	0	0	0	
Appropriation	0	0	75,000	NR
No. of Positions	0.00	0.00	0.00	

See pages 39 through 41 for detail.

#16 Emerging Health Issues Risk Assessment

Funds are recommended to establish an epidemiological unit dedicated to risk assessment and evaluation of human health exposure to various emerging environmental issues such as pfiesteria and emerging occupational exposures. The purpose of this epidemiology unit will be to: 1) conduct ongoing surveillance using existing data bases (hospital discharges, death certificates, Medical Examiner records, etc.) to identify and track trends or new emerging conditions; 2) develop teams that have the capability to investigate and assess reports of environmental problems that could potentially affect human health; 3) monitor the long term and cumulative effects of environmental problems on human health using geographic information software; and 4) analyze, evaluate and design effective intervention strategies and/or recommend a course of action to state policy makers.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	0	0	1,978,242
Receipts			
Federal	0	0	0
Local	0	0	0
Other	0	0	0
Appropriation	0	0	1,978,242
No. of Positions	0.00	0.00	23.00

HIV Medications Program

Funds are requested to provide medications coverage at the federally- recommended level of care to all HIV positive individuals who meet the program's financial eligibility criteria. Expensive new medications and the growing number of combinations of medications have revived seriously ill individuals, proven to delay the onset of illness, and minimized the likelihood of disease transmission by those who are infected. These changes have resulted in an increased demand on the HIV Medications Program. Use of the new medications allow infected individuals to remain healthy longer, thus delaying the need for more costly medical treatment and possible reliance on Medicaid for health coverage.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	7,166,622	5,869,553	18,130,447
Receipts			
Federal	4,062,280	4,498,516	0
Local	0	0	0
Other	733,440	600,000	2,066,871
Appropriation	2,370,902	771,037	16,063,576
No. of Positions	0.00	0.00	0.00

See pages 45 through 47 for detail.

#18 COMPREHENSIVE SICKLE CELL SERVICES

This request would enable five of the state's medical centers to continue to provide medical services to approximately 800 persons a year who have Sickle Cell Disease and are unable to pay of their cost of their care.

Federal funding for the treatment of these individuals is being terminated on March 31, 1998.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	921,691	921,691	1,200,000
Receipts			
Federal	0	0	0
Local	0	0	0
Other	0	0	0
Appropriation	921,691	921,691	1,200,000
No. of Positions	0.00	0.00	0.00

Over 4,000 North Carolinians have sickle cell anemia.

See pages 48 through 50 for detail.

#19

IMMUNIZATION AGAINST CHICKENPOX AND HEPATITIS B

This funding request would enable the Immunization Program to implement the Advisory Council for Immunization Practices' recommendations that all susceptible children born on or after January, 1983, be vaccinated against chickenpox and that all children 0 - 18 years of age be vaccinated against hepatitis B.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	11,321,194	11,321,194	3,356,120
Receipts			
Federal	0	0	0
Local	0	0	0
Other	0	0	0
Appropriation	11,321,194	11,321,194	3,356,120
No. of Positions	0.00	0.00	0.00

Cost savings of \$5 in health care for every \$1 spent are projected based on prior studies.

See pages 51 through 53 for detail.

#20

Maternal Outreach Program

State funds are requested to replicate the "Olds" maternal outreach model in up to 7 sites in addition to the current sites that are demonstrating the "Olds" and "Healthy Families" models. Intensive home visiting has been shown to be effective in improving the health and social functioning of low-income, first time mothers and babies. Nurse home visits begin during pregnancy and continue for two years after the child is born. The program addresses women's health behavior during pregnancy and family caregiving for the infants after delivery following a specific curriculum developed over 19 years of use. The target population will be Medicaid eligible mothers with incomes under 100% of federal poverty.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	0	0	800,000
Receipts			
Federal	0	0	0
Local	0	0	0
Other	0	0	0
Appropriation	0	0	800,000
No. of Positions	0.00	0.00	0.00

See pages 54 through 56 for detail.

#21

Heart Disease and Stroke Prevention Initiative:

This Initiative targets the prevention of the leading cause of death in North Carolinians - cardiovascular disease. This funding supports the efforts of the Heart Disease and Stroke Prevention Legislative Task Force 1) by establishing sound data collection on cardiovascular disease (which began in 1998 on nonrecurring funds), 2) by implementing the Be Active North Carolina (BANC) project to increase physical activity among North Carolinians, and 3) by implementing the strategies proven to be successful in model "Strike out Stroke" projects. These are non-recurring funds.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99	
Requirements	100,000	0	645,626	
Receipts				
Federal	0	0	0	
Local	0	0	0	
Other	0	0	0	
Appropriation	100,000	0	645,626	NR
No. of Positions	0.00	0.00	7.00	

See pages 57 through 63 for detail.

#22 Diabetes

The majority of these funds, \$214,000, will be used to build the capacity in local health departments to provide increased patient education to control diabetes which will help prevent such incapacitating and disabling conditions as blindness and limb amputation. Of the total, \$30,360 will be used to train local nurses and nutrition teams in diabetes care. These teams will provide individual and group education at local health departments. The remainder of \$5,640 will be used for resource materials.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99	
Requirements	0	0	250,000	
Receipts				
Federal	0	0	0	
Local	0	0	0	
Other	0	0	0	
Appropriation	0	0	250,000	NR
No. of Positions	0.00	0.00	0.00	

277,000 North Carolinians have diabetes.

Prevalence is 57% higher in African-American population.

Diabetes is the seventh leading cause of death.

See pages 64 through 66 for detail.

#23 **CHILDREN'S VISION SCREENING IMPROVEMENT PROGRAM**

This funding request would continue funding for Prevent Blindness North Carolina to conduct a public/private training and certification program for vision screeners in all 100 counties. The program will assure there is one trained and certified screener for every 100 students in grades K-6. These funds are non-recurring.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	419,000	0	419,000
Receipts			
Federal	0	0	0
Local	0	0	0
Other	0	0	0
Appropriation	419,000	0	419,000 NR
No. of Positions	0.00	0.00	0.00

25% of children have a vision impairment that require correction before sixth grade

See pages 67 through 69 for detail.

#24 HEALTHY START FOUNDATION

North Carolina's infant mortality rate declined from 12.6 deaths per 1,000 live births in 1988 to 9.2 deaths per 1,000 live births in 1996. Despite this improvement, North Carolina continues to have one of the highest infant mortality rates in the nation.

This funding request would allocate non-recurring state funding for the FIRST STEP public information and education campaign and enable the Healthy Start Foundation to provide mini-grants to local communities to fund activities and services designed to reduce infant mortality and low-birth weight.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99	
Requirements	650,000	0	650,000	
Receipts				
Federal	0	0	0	
Local	0	0	0	
Other	0	0	0	
Appropriation	650,000	0	650,000	NR
No. of Positions	0.00	0.00	0	

NC ranks 42nd in the nation.

See pages 70 through 72 for detail.

#25 Study on Access to Dental Care

Health and social services agencies across the state report that private dentists do not welcome low-income children as patients. A study of dental care access for North Carolina's children is recommended to further examine this issue and explore solutions. DHHS proposes to contract with the North Carolina Institute of Medicine to conduct the study. The study will include, but not be limited to, an analysis of Medicaid rates, dental manpower, licensure procedures, preventive dental programs and local dental care delivery systems. Recommendations to improve access to dental care will be made.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99	
Requirements	0	0	100,000	
Receipts				
Federal	0	0	0	
Local	0	0	0	
Other	0	0	0	
Appropriation	0	0	100,000	NR
No. of Positions	0.00	0.00	0	

See pages 73 through 75 for detail.

#26 State Games

It is recommended to continue support for the State Games of North Carolina to promote health and fitness through athletic activities for all North Carolinians. The State Games of North Carolina is a multi-sport athletic event for all North Carolinians. The Games promote health and physical fitness through athletic activities and are hosted annually by North Carolina Amateur Sports.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99	
Requirements	150,000	0	150,000	
Receipts				
Federal	0	0	0	
Local	0	0	0	
Other	0	0	0	
Appropriation	150,000	0	150,000	NR
No. of Positions	0.00	0.00	0.00	

23 sports for the participation of all ages and skill levels

See pages 76 through 78 for detail.

#27 Support for Long Term Care Systems Reform

Provide grants of approximately \$250K-\$300K for up to 5 counties to support long term care systems reform efforts. Funds would be awarded on an RFP basis and criteria would be consistent with Departmental concepts and goals. Criteria would include the extent to which the application addressed service delivery systems that serve multi-county areas and both physically disabled and elderly adults. Other criteria would include plans and capacity to implement a centralized information and referral and care management system for both Medicaid and non-Medicaid eligible. These projects would involve a collaborative effort with Aging, Vocational Rehabilitation, Services for the Blind and Services for the Deaf and Hard of Hearing.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	0	0	1,333,333
Receipts			
Federal	0	0	133,333
Local	0	0	0
Other	0	0	0
Appropriation	0	0	1,200,000
No. of Positions	0.00	0.00	0

See pages 79 through 81 for detail.

#28 Support for Senior Centers

This recommendation will provide approximately 140-150 senior centers that have full time programs and the capacity to meet the Division of Aging Senior Center Operations Services Standard as of July 1, 1998 with equal amounts of discretionary funding. The use could include facility maintenance and repair, community outreach, program development, administrative support, and equipment purchases.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99	
Requirements	1,111,111	0	2,222,222	
Receipts				
Federal	0	0	0	
Local	111,111	0	222,222	
Other	0	0	0	
Appropriation	1,000,000	0	2,000,000	NR
No. of Positions	0.00	0.00	0	

51 senior centers have Home & Community Care Block Grant funding for operations.

See pages 82 through 84 for detail.

#29 In-Home and Community Based Care for Elderly

This recommendation will further reduce the number of people in need of in-home and community based services. These older adults are not eligible for Medicaid and cannot afford to pay privately for the essential in-home and/or caregiver support services. Services included are in-home aid, adult day care/day health care, skilled home care, home delivered meals, medical transportation and out-of-home respite care.

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	27,291,780	27,291,780	2,777,777
Receipts			
Federal	0	0	0
Local	6,688,490	6,688,490	277,777
Other	0	0	0
Appropriation	20,603,290	20,603,290	2,500,000
No. of Positions	0.00	0.00	0.00

2,330 additional persons are projected to be served

See pages 85 through 87 for detail.

#30 Long Term Care Insurance Study

This recommendation will support a study to encourage the development of and access to long-term care insurance for North Carolina citizens. Key issues to be examined would include the following:

- make employers aware of group rate long term care insurance offerings
- educate baby boomers on tax incentives
- analyze the fiscal impact of tax incentives to purchase LTC insurance

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99	
Requirements	0	0	50,000	
Receipts				
Federal	0	0	0	
Local	0	0	0	
Other	0	0	0	
Appropriation	0	0	50,000	NR
No. of Positions	0.00	0.00	0	

See pages 88 through 90 for detail.

#31 Staff for health and Safety inspections

Improve health and safety of residents and regulatory compliance 1) by hiring additional staff in the Construction Section to inspect new construction and facilities not currently inspected by federally-funded staff, 2) by hiring additional staff in the Health Care Personnel Registry to investigate and take action against Health Care Personnel, and 3) by hiring additional staff in to improve response time to nursing facility complaints. \$886,929 in fees for construction plan reviews and inspections could be used to offset appropriations in SFY 1998-99. These fees would be budgeted as a non-tax revenue to the State Treasurer. (The Health Care Personnel Registry and Licensure and Certification positions require appropriations which cannot be offset with fees.)

	Authorized SFY 97-98	Authorized SFY 98-99	Request SFY 98-99
Requirements	12,322,785	12,322,785	1,632,125
Receipts	8,529,001	8,529,001	
Federal			0
Local			0
Other			0
Appropriation	3,793,784	3,793,784	1,632,125
No. of Positions	220	220	37.00

- 17 positions in construction
- 4 RN investigative positions in the Health Care Personnel Registry
- 16 positions in Licensure and Certification
- 23.5 FTE's in SFY 98-99

May 13, 1998



North Carolina
Department of Health and Human Services
Division of Community Health
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James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

**Report to the Osteoporosis Prevention Task Force on
Staff Activities addressing the Duties of the Task Force**

April 30, 1998

Duties of the Task Force:

1. **To undertake a statistical and qualitative examination of the incidence of an causes of osteoporosis deaths and risks, including identification of subpopulations at highest risk for developing osteoporosis, and establish a profile of the osteoporosis burden in North Carolina.**
 - a. Contracted with the Cecil G. Sheps Center for Health Services Research at the University of North Carolina-Chapel Hill to conduct a study of the burden of osteoporosis in North Carolina.
 - b. Received an oral report and preliminary printed report "Estimating the Burden of Osteoporosis in North Carolina." This report included the incidence, projected incidence prior to the year 2020, and the cost of osteoporosis in North Carolina. An oral report was given to the Osteoporosis Prevention Task Force by Dr. Shula Bernard at the March 20, 1998, meeting.
 - c. Received a fact sheet outlining the Burden of Illness of Osteoporosis on the people of North Carolina at the April 17, 1998 Task Force public hearing and meeting.
 - d. Draft of final report "Burden of Osteoporosis in North Carolina" received at the May 1, 1998 Task Force meeting.

2. To raise public awareness on the causes and nature of osteoporosis, personal risk factors, value of prevention and early detection, and options for diagnosing and treating the disease

Contracted with the UNC-CH School of Medicine, Program on Aging, to develop a plan for raising public awareness of risk, prevention, diagnosis, and treatment of osteoporosis. This includes planning for the education of health care professionals and the education of consumers and the general public and planning for a public awareness campaign.

Planned for and developed a statewide Osteoporosis Workshop "Osteoporosis and You" for both health care professionals and consumers to be held on May 14, 1998 in Hickory, N.C. There are 17 different sponsoring organizations, that include both public agencies and private organizations and corporations.

Arranged for a national satellite videoconference "Osteoporosis: Successful Programs For Strong Bones" to be shown in Chapel Hill at the Distance Learning Center in the School of Public Health on Tuesday, May 19, 1998 from 1:00-4:00 Eastern Daylight Time. This program is designed to provide professionals with information on how to develop osteoporosis prevention and control activities. The program also features a discussion panel comprised of representatives from national organizations dedicated to osteoporosis. Viewers will have the opportunity to phone in or fax questions to the speakers. It is possible to arrange for it to be shown at other locations in the state.

Prepared an Osteoporosis Educational Exhibit that has been taken to ten locations to date this fiscal year. Educational materials were distributed, questions were answered and staff networked with other exhibitors to build partnerships for osteoporosis prevention.

Facilitated the development of five Osteoporosis support groups that are affiliated with the National Osteoporosis Foundation, one in Clyde, one in Concord, one in Fayetteville, and two in Raleigh. Provided information and assistance to other communities interested in developing support groups.

Obtained a proclamation from the Governor proclaiming May, 1998 as Osteoporosis Prevention Month in North Carolina and provided model proclamations and encouraged interested organizations and persons to seek proclamations from their county and municipal government officials.

3. **To identify priority strategies which are effective in preventing and controlling risks for osteoporosis, and in diagnosing and treating osteoporosis**
 - a. Contracted with Flynt Mullinix Health Care Consulting to conduct a review of literature and assessment of the technology for preventing, diagnosing, and treating osteoporosis.
 - b. Reviewed and commented on first draft of literature review and technology assessment (5/1/98)
4. **To identify, examine limitations of, and recommend to the Governor and the General Assembly changes to existing laws, regulations, programs, services, and policies to enhance osteoporosis prevention, diagnosis, and treatment for the people of North Carolina.**
5. **To determine and recommend to the Governor and the General Assembly the funding and strategies needed to enact new or to modify existing laws, regulations, programs, services, and policies to enhance osteoporosis prevention, diagnosis, and treatment for the people of North Carolina.**
 - a. Reviewed other states' laws on osteoporosis
 - b. Reviewed existing North Carolina laws on osteoporosis
 - c. Reviewed the work of the osteoporosis coalition and presented the results to the Osteoporosis Prevention Task Force
6. **To develop a statewide, comprehensive Osteoporosis Prevention Plan, and strategies for Plan implementation and for promoting the Plan to the general public, State and local elected officials, various public and private organizations and associations, businesses and industries, agencies, potential funding sources, and other community resources.**

Contracted with Flint Mullinix Health Care to work on a statewide plan for reducing the burden of illness of osteoporosis in North Carolina as well as to work on all the duties numbered above and below.
7. **To identify strategies to facilitate specific commitments to help implement the Plan from the entities listed in subdivision (6).**

8. **To facilitate coordination of and communication among State and local agencies and organizations regarding current or future involvement in achieving the aims of the Osteoporosis Prevention Plan.**

Staff has communicated with the Osteoporosis Coalition of North Carolina, providing information about the Task Force's meetings and information about osteoporosis. The coalition members are supportive of the Task Force's work.

Convened a statewide interagency group that meets quarterly. The agencies in this group are partners in osteoporosis prevention efforts, for example, they are cosponsors of the statewide workshop.

9. **To receive and consider reports and testimony from individuals, local health departments, community-based organizations, voluntary health organizations, and other public and private organizations statewide, to learn more about their contributions to osteoporosis diagnosis, prevention, and treatment, and their ideas for improving osteoporosis prevention, diagnosis, and treatment in North Carolina.**

Conducted a focus group with the Osteoporosis Coalition on learning more about its contribution to osteoporosis diagnosis, prevention, and treatment, and ideas for improving these.

Plans have been made for two more focus groups, one to be held on May 4 and one on May 27. We anticipate holding a couple more focus groups.

Support for the hearing at North Carolina A & T University, Greensboro, on April 17, 1998, to receive testimony on the burden of illness, diagnosis, treatment and ways to lessen this burden on the people of North Carolina.

Note: A progress report on the work of the Task Force was submitted to DHHS Secretary Bruton for forwarding to the Joint Legislative Commission on Government Operations, the Governor, and the Fiscal Research Division.



North Carolina
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James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

Memorandum

To: Joint Legislative Health and Human Services Committee

Through: Carol Shaw
Fiscal Research

From: Jim Edgerton *JK*
Lee Kittredge

Date: May 26, 1998

Attached are the Department's responses to questions asked at the HHS Committee Meeting May 13, 1998. Only questions that were not answered at the meeting are attached. The questions were related to DHHS expansion requests. A description of the expansion item and the item number are listed followed by the questions and responses.

Increase Staffing in Child Support Enforcement (ITEM #6)

What are the State operated County Offices and counties covered.

Response has been forwarded.

Criminal Records Checks Needs Assessment (ITEM #9)

What will be the new turnaround time after this is implemented?

Over the last few years state and federal law changes have required criminal record checks for child care employees, foster parents, adult care, and nursing home employees. Divisions in the Department of Health and Human Services have responded by accumulating and processing data needed to perform the criminal records. The Department has been working closely with SBI in examining the backlog problem. To address this issue the Department wants to examine duties, procedures, processing time, etc. in order to determine if any changes are needed in divisions' business practices and in automation of these functions. The exact benefits cannot be determined until the procedural examination is completed and an implementation plan is put into place to make business practice and/or automation changes.

New Systems for Year 2000 (ITEM #10)

How many characters will be added to solve this problem?

14.886 BILLION characters

Emerging Health Issues Risk Assessment (ITEM #16)

What is the million dollar pfisteria contract buying?

The contract funds a large prospective cohort study - via contract with a medical consortium (including UNC, ECU, and Duke medical schools) - that is coordinated with other states (including Maryland, Virginia and Delaware) that will tell us whether or not there are human health effects from exposure to our estuaries and what the cause is likely to be. It also allows for the staffing of a public health response to the threat of Pfiesteria and related organisms by funding a hotline and information exchange, coordination with local doctors and affected county health departments, a web page with daily updates re fish kills and their locations, the safety of the state's rapid response teams, etc. The contract it is expected to continue for several years, subject to the dictates of the US Congress.

IMMUNIZATION AGAINST CHICKENPOX AND HEPATITIS B (ITEM #19)

What is the annual influx (from out of state) of children per year?

From 1980-1990 the total number of persons 0-17 years of age who moved into North Carolina is 102,880. This figure takes into account all the people aged 0-17 who moved out, so 102,880 represents a total net effect of immigration and emigration. Stated another way, approximately 10,288 children aged 0-17 come into the state each year. It should be noted that the majority of states in the US have implemented a Hepatitis B infant vaccination

program. Such programs been in place since 1994 and 1995. Thus, children two or three years of age who move into the state are already likely to be vaccinated against Hepatitis B.

Heart Disease and Stroke Prevention Initiative (ITEM #21)

What type of prevention work is done with this money, what types of results (impact) has this program generated, and can we get more information on Strike Out Stroke?

Here is the requested information on Strike Out Stroke.

There are 3 components to the prevention work:

1) Public awareness:

Many hypertensives are not aware of their hypertension. Others are not treated, and among those who are treated, many are not controlled. So there are messages that must get out, particularly among those population groups with the highest rates of high blood pressure (and therefore, stroke).

- a) Know your numbers
- b) See your doctor if your BP is at or above 140/90
- c) Lifestyle changes can help lower BP and reduce need for medications
- d) If medicines are prescribed - take them!

There is also another, newer piece to this. There are two types of stroke. 80% are ischemic - ie caused by a clot. The rest are hemorrhagic - caused by bleeding into the brain. Ischemic strokes can be treated and possibly reversed if the patient gets to appropriate care within 3 hours of onset of symptoms. They have to have a CT scan to establish the type of stroke and are then given "clot buster" drugs such as TPA. But the 3 hour window means we have to get the word out to:

- a) Recognize the warning signs of stroke
- b) Stroke is an emergency that may be able to be treated if you get there in time - call 911 at once.

(Studies have shown that the critical factor in awareness about stroke symptoms is that people around the victim must recognize what is happening and know what to do about it.)

2) Professional Education

A needs assessment done at the beginning of the NIH funded Strike Out Stroke project found that many professionals in all clinical settings did not know how to accurately measure blood pressure. Furthermore, many places are using inadequate or uncalibrated equipment. It is important to note that BP is often measured by nurses and aides. Phase I of SOS in NC did a great deal of training of Pub. Health professionals, but, due to turnover, there is need for ongoing work with this. And there is a need to ensure that health care professionals in all settings are using accurate and well calibrated equipment.

With the advent of the new therapy for stroke, we cannot tell the public that they must recognize the warning signs and get to treatment without ensuring that they will receive the appropriate care when they get there. This means that EMS people must know what to do and where to take people within that 3 hour window, and the system must be prepared to deal with patients appropriately when they show up.

3) Patient Education

Phase I of SOS developed, printed and disseminated low literacy, culturally sensitive patient education materials and continues to have requests from Local Health Departments and Community Health Centers for these materials. In addition, we have been requested to make these electronically available for downloading at clinical sites around the state.

Results of Phase I:

The materials and training were very well received and we have on-going requests for both that we are unable to meet. A targeted Awareness Campaign was developed and delivered through Webb Patterson Communications, but it dealt with BP only - the stroke treatment piece is new.

There is a full final report available for review that details numbers trained and volume of printed materials distributed, along with community level activities. But this was not a research project and there was not sufficient funding for a strenuous evaluation with pre- and post- measures of awareness in targeted populations, etc.

Diabetes (ITEM #22)

What counties are federal dollars used in? and verify that federal grant is \$328K.

The local health departments receiving federal Diabetes Control Program funds for Diabetes Today projects have been:

1994-95	Robeson, Graham-Swain
1995-96	Macon, Forsyth, Caswell, Chatham, Bertie
1996-97	Union, Ashe, Wilkes, PPCC
1997-98	Wilkes, PPCC, Gaston, Rockingham

The award for the Diabetes Control Program this year is \$328,821

HEALTHY START FOUNDATION (ITEM #24)

The committee needs more information on Healthy Start Foundation.

See attached report.

Study on Access to Dental Care (ITEM #25)

Does the North Carolina institute of Medicine receive any State funds?

The Institute of Medicine does not receive state funds. According to Gordon DeFriesse, Director, Cecil Shepp Center for Health Services Research, the Institute received \$25,000 in state appropriation in 1983 and has not received state funding since.

Support for Long Term Care Systems Reform (ITEM #27)

The committee needs a lot more information about this.

Response has been forwarded.



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James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

May 21, 1998

MEMORANDUM

To: Carol Shaw, Fiscal Analyst
Fiscal Research Division

From: Lee D. Kittredge, Director *LDK*
Division of Budget, Planning and Analysis

Re: Staff for State Operated Child Support Enforcement Offices

I am forwarding a worksheet which outlines the type and location of the positions requested for the state operated Child Support Enforcement Offices

If you have any questions or need additional information, please contact me at 733-6396.

Attachment

cc: James B. Edgerton
Kevin FitzGerald
Nina Yeager

Positions requested in the 1998 Short Session								
Number of Request	IV-D Prg.	Grade	Classification	Effective Date	1998-99 Total Positions	Annual Salary	Budgeted Salary	Function (Brief description of work, such as, policy development, consultation, etc.)
Total Positions in Expansion Budget								
	Multiple	67	CSE Supvs II	10/1/98	6	33,148	149,166	Supv. local child support office
		65	CSE Agents	10/1/98	78	30,358	1,775,976	Case management (local)
		70	Program Consultant II	10/1/98	4	37,888	113,664	Assist county operations
		59	Office Assistant IV	10/1/98	12	23,604	212,436	Clerical (local)
		59	Client Services <i>OFFICE</i>	10/1/98	8	23,604	141,624	Central office customer service unit
			Total		108			
Allocation of Positions to the State Operated IV-D Programs								
5	Ahoskie	65	CSE Agents	10/1/98	4	30,358	91,072	
		59	Office Assistant IV	10/1/98	1	23,604	17,703	
4	Albemarle	65	CSE Agents	10/1/98	4	30,358	91,072	
8	Anson/ Richmond	67	CSE Supv II	10/1/98	1	33,148	24,861	
		65	CSE Agents	10/1/98	5	30,358	113,840	
		59	Office Assistant IV	10/1/98	2	23,604	35,406	
1	Boone	65	CSE Agent	10/1/98	1	30,358	22,768	
4	Bryson City	65	CSE Agents	10/1/98	4	30,358	91,072	
2	Carteret	65	CSE Agents	10/1/98	2	30,358	45,536	
9	Cumberland	67	CSE Supv II	10/1/98	1	33,148	24,861	
		65	CSE Agents	10/1/98	7	30,358	159,376	
		59	Office Assistant IV	10/1/98	1	23,604	17,703	

3	Franklin	65	CSE Agents	10/1/98	3	30,358	68,304
4	Harnett	65	CSE Agents	10/1/98	4	30,358	91,072
5	Manteo	67	CSE Supv II	10/1/98	1	33,358	24,861
		65	CSE Agents	10/1/98	3	30,358	68,304
		59	Office Assistant IV	10/1/98	1	23,604	17,703
33	Mecklenburg	67	CSE Supv II	10/1/98	3	33,358	74,583
		65	CSE Agents	10/1/98	26	30,358	591,968
		59	Office Assistant IV	10/1/98	4	23,604	70,812
3	New Bern	65	CSE Agents	10/1/98	2	30,358	45,536
			Office Assistant IV	10/1/98	1	23,604	17,703
6	Pender	65	CSE Agents	10/1/98	5	30,358	113,840
		59	Office Assistant IV	10/1/98	1	23,604	17,703
4	Randolph	65	CSE Agents	10/1/98	4	30,358	91,072
5	Union	65	CSE Agents	10/1/98	4	30,358	91,072
		59	Office Assistant IV	10/1/98	1	23,604	17,703
			Total		96		



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James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

May 21, 1998

MEMORANDUM

To: Carol Shaw, Fiscal Analyst
Fiscal Research Division

From: Lee D. Kittredge, Director 
Division of Budget, Planning and Analysis

Re: Senator Dannelly's Request

During a Senate Appropriation Subcommittee on Health and Human Services meeting Senator Dannelly asked for a breakdown on positions in the expansion requests by function or type. The attached list includes information on all of the requested positions excluding the 7 positions for Children's Health Insurance which were approved during the Special Session.

If you have any questions or need additional information, please contact me at 733-6396.

Attachment

cc: James B. Edgerton
Nina Yeager

Positions Requested in the 98 Short Session

Division	Grade	Classification	Effective Date	1998-99 Total Positions	Annual Salary	Budgeted Salary	Function (Brief description of work, such as, policy development, consultation, etc.)
Child Support Enforcement for State Offices							
DSS	67	Child Support Enforcement Supvs II	10/1/98	6	33,148	149,166	Supervise local child support office
DSS	65	Child Support Enforcement Agents	10/1/98	78	30,358	1,775,976	Case management (local)
DSS	70	Program Consultant II	10/1/98	4	37,888	113,664	Assist county operations
DSS	59	Office Assistant IV	10/1/98	12	23,604	212,436	Clerical (local)
DSS	59	Office Assistant IV	10/1/98	8	23,604	141,624	Central office customer service unit

Adoptive Parent Criminal Record Checks

DSS	59	Office Assistant IV	10/1/98	1	23,604	17,703	Manage the criminal records check process

Subtotal Social Services

109

Criminal Records Check Needs Assessment

CA	72	Business Analyst - Time limited	7/1/98	2	41,358	82,716	Analyze & redesign criminal record checks process
CA	74	Project Manager - Time limited	7/1/98	1	45,279	45,279	Analyze & redesign criminal record checks process

Subtotal Central Management and Support

3 Time limited

Emerging Health Issues Risk Assessment

EPI	75	Public Health Nurse Cons. II	7/1/98	1	37,304	37,304	Risk assessment/evaluation of human exposure to environmental issues
EPI	4	Public Health Physician II SER	7/1/98	1	82,962	82,962	Risk assessment/evaluation of exposure
EPI	8	Public Health Physician III	7/1/98	2	85,083	170,166	Risk assessment/evaluation of exposure
EPI	72	Public Health Epidemiologist II	7/1/98	3	32,656	97,968	Risk assessment/evaluation of exposure
EPI	77	Industrial Hygiene Consultant	7/1/98	3	40,855	122,565	Risk assessment/evaluation of exposure
EPI	70	Computer Consultant II SER	7/1/98	1	30,038	30,038	Risk assessment/evaluation of exposure
EPI	73	Computer Consultant III (GIS) SER	7/1/98	1	38,475	38,475	Risk assessment/evaluation of exposure
EPI	73	Applications Progr. II (GIS) SER	7/1/98	1	38,475	38,475	Risk assessment/evaluation of exposure
EPI	73	Statistician II SER	7/1/98	1	37,476	37,476	Risk assessment/evaluation of exposure
EPI	81	Environmental Toxicologist	7/1/98	2	49,013	98,026	Risk assessment/evaluation of exposure
EPI	68	Info. & Comm. Spec. II	7/1/98	1	27,557	27,557	Risk assessment/evaluation of exposure
EPI	59	Processing Assistant IV	7/1/98	3	19,138	57,414	Clerical support for risk assessment/ evaluation
EPI	59	Office Assistant IV	7/1/98	2	19,138	38,276	Clerical support for risk assessment/ evaluation
EPI	59	Accounting Clerk IV	7/1/98	1	19,138	19,138	Clerical support for risk assessment/ evaluation

Subtotal Epidemiology

23

Positions Requested in the 98 Short Session

Division	Grade	Classification	Effective Date	1998-99 Total Positions	Annual Salary	Budgeted Salary	Function (Brief description of work, such as, policy development, consultation, etc.)
Improve Health and Safety of Residents and Regulatory Compliance							
DFS	75	Facility Architect II	10/1/98	3	47,411	106,675	Facility plan reviews/safety inspections
DFS	77	Building Systems Engineer II	10/1/98	4	51,975	155,925	Facility plan reviews/safety inspections
DFS	57	Processing Assistant II	10/1/98	1	21,897	16,423	Clerical support for Construction Sect.
DFS	75	Facility Architect II	1/1/99	4	47,411	94,822	Facility plan reviews/safety inspections
DFS	77	Building Systems Engineer II	1/1/99	4	51,975	103,950	Facility plan reviews/safety inspections
DFS	57	Processing Assistant II	1/1/99	1	21,897	10,949	Clerical support for Construction Sect.
DFS	72	Facility Survey Consultant I	10/1/98	4	35,000	105,000	Investigate allegations re health workers
DFS	72	Nurse Consultant	10/1/98	8	35,000	210,000	Investigate complaints/monitor facilities
DFS	72	Nurse Consultant	1/1/99	8	35,000	140,000	Investigate complaints/monitor facilities
Subtotal Facility Services				37			
Total New Positions*				172			

* Excludes the 7 positions for Children's Health Insurance which were approved during the Special Session.

NORTH CAROLINA HEALTHY START FOUNDATION
Annual Report - Calendar Year 1997

The North Carolina Healthy Start Foundation (the "Foundation") was created in 1990 with a \$5 million pledge over five years from Glaxo Inc. (now Glaxo Wellcome Inc.). Its programs included the funding of the Governor's Commission on Reduction of Infant Mortality (the "Commission") and the First Step Campaign ("First Step"). The Foundation also sponsored a grants program, in which they funded 129 projects, in 85 counties in North Carolina. By the end of 1995, the Foundation provided more than \$2 million in funding through this grants program. The Foundation also sponsored successful individual business initiatives and industry-wide initiatives (with the latter funded by Burroughs Wellcome). Until 1995, neither the Foundation nor First Step received any state funds for operating expenses. Throughout its existence, the Commission never received any state funds.

At its inception, the Foundation was due to be terminated as a programmatic entity in 1995. However, due to the success of its programs, the Foundation requested a state appropriation to continue its activities. The General Assembly appropriated \$200,000 in 1995 for First Step, and \$650,000 in both 1996 and 1997 for First Step and a smaller scaled grants program. As a condition of receiving these funds, the General Assembly required that the Foundation provide this report to the Joint Legislative Commission on Governmental Operations. This report will focus on the efforts of First Step and of the Community Grants Program.

The Commission was terminated as of December 31, 1995 which meant an end to the Commission's activities and Commission staff's employment. Remaining First Step members continue to administer First Step from the Foundation office. Janice Freedman, Director of the First Step Campaign has prepared a summary of First Step Campaign activities for 1997 and a preview of goals for 1998, which is included as Attachment A.

The Foundation has contracted with the Sheps Center at the University of North Carolina at Chapel Hill to manage the Community Grants Program. Dr. Milton Kotelchuk and Dr. Julia Skatrud from the Sheps Center have prepared a report on the Community Grants Program, which is included as Attachment B.

A copy of the Compliance Reports, which include the latest audit for year ending December 31, 1996, as prepared by KPMG Peat Marwick, is included as Attachment C.

Copies of Statements and Expenses are included as follows:

Attachment D	1996 - 1997 First Step Campaign Budget
Attachment E	1997 - 1998 First Step Campaign Budget
Attachment F	First Step Contract
	Immunization Contract
	Video Contract



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James B. Hunt Jr., Governor

May 14, 1998

H. David Bruton, M.D., Secretary

MEMORANDUM

TO: Carol Shaw
Fiscal Research Division
NC General Assembly

THROUGH: Lee D. Kittredge, Director *LDK*
Division of Budget, Planning and Analysis

FROM: Lynne M. Perrin, Assistant Secretary for Aging, Disability
and Long Term Care *Lynne M. Perrin*

SUBJECT: Support for Long Term Care Systems Reform

In response to Representative Gardner's request for additional information about Expansion Item 27, "Support for Long Term Care Systems Reform," I am attaching a description of the process that will be utilized in awarding the Long Term grants, eligibility for funding, major criteria to be included in the Request for Proposals, selection process, project evaluation, and the Department's project management strategy. If you have any additional questions, please let me know.

LD/wm

Attachment

cc: James B. Edgerton
Nina Yeager
Karen Gottovi
Bonnie Cramer

LONG TERM CARE GRANTS

Governor Hunt's 1997-99 biennial budget includes funding of \$1.2 million to provide annual grants to counties to support long term care system reforms with emphasis on multi-county systems serving both physically disabled and elderly adults. Grant funds are to provide staff support as well as funding for technology and automation strategies to implement automated screening and assessment tools and to enhance the use of automated data across agencies.

1. Purpose

To move North Carolina's long term care system reform efforts further ahead by providing financial and technical support to counties in the forefront of long term care systems change. These grants will fund counties that commit to take major steps to alter the way in which long term care services are delivered. They are not intended to fund solely planning and/or consensus building efforts.

Primary Objectives:

- Encourage multi-county partnerships based on minimum population of older and disabled adults and geographic alignment for provision of intake, information and referral, eligibility determination, quality assurance and access to long term care services.
- Simplify consumer access to information about long term care services and supports through:
 - the establishment of centralized I&R/Case Assistance systems and access to long term care services and supports (initially access to home and community care —ultimately adult care home and nursing home care).
- Build upon managed care concepts for the provision of long term care services to:
 - improve coordination of health and long term care services
 - promote home and community care whenever possible
 - constrain the growth of public costs for long term care through (ultimately) risk based contracting with provider networks that are locally developed and operated by public or non-profit entities
 - use standardized and automated screening and assessment tools for access to Medicaid, non-Medicaid, or fully private pay long term care services.

2. How will grants be awarded?

Grants will be awarded through a competitive Request for Proposal (RFP) process.

3. Who is eligible for funding?

- County Government — only one proposal per county may be submitted
- All proposals must be endorsed by the County Commissioners
- Multi-county proposals must be endorsed by County Commissioners from all project counties

4. How will funds be awarded?

- \$1.2 million will be awarded — a 10% match will be required from each project
- DHHS will award funds directly to selected projects
- Up to 8 projects will be funded
- Up to a maximum of \$250,000 per county/project awarded per year
- Recommend that initial projects selected be funded for 3 years based on progress in meeting goals. After 3 years, a new RFP process would be implemented with first round projects eligible to compete for additional funds.

5. What major criteria will be included in the RFP?

A. General Criteria

- capacity to implement a centralized I&R/Case Assistance system
- capacity to test/use a standardized and automated client assessment tool
- evidence of developed provider networks tied to long term care reform efforts

- demonstrated linkages with the health care delivery system
- demonstrated readiness to take significant steps leading to a managed long term care delivery system
- capacity to implement long term care reforms for Medicaid, non-Medicaid, and private pay consumers
- capacity to incorporate telehealth supports

* Priority will be given to projects with capacity to implement multi-county projects and/or include both aging and disabled adult populations.

B. Key Administrative Responsibilities to be Carried Out:

Projects must designate a public or non-profit entity responsible for:

- Providing/arranging a centralized system for:
 - providing I&R/Case assistance and client advocacy functions for consumers, family caregivers, health care providers and others
 - determining eligibility for Medicaid/non-Medicaid funded home and community based long term care services (ultimately to include adult care home and nursing home care)
 - conducting screening and assessments for home and community based services using a standardized and automated assessment tool issued by state
- Monitoring the quality of home and community based long term care services provided to Medicaid, non-Medicaid and fully private pay clients through a provider network for the delivery of long term care services.

C. Key Service Delivery Responsibilities Required:

- Establishment of a provider network for the provision of an array of home and community based services administered by a public or private non-profit organization:
 - network would be expected to have capacity to move toward accepting risk for provision of services to publicly supported clients
 - must have capacity to provide an array of home and community based services needed to support older adults at home for Medicaid, non-Medicaid, and fully private pay persons
- Automated data collection and reporting capacity for network of providers including encounter data client demographic, client profile and functional capacity information, etc.
- Use of telehealth concepts – specific strategies to be used will be identified in proposal

6. How will projects activities be linked to the Health Care system?

Projects will have to describe the role of:

- rural and community health care providers relative to project activities
- local and/or regional hospitals relative to project activities

7. What will the selection process be?

- A selection committee will be established to review proposals and make decisions regarding projects to be funded.
- Expect grants to be awarded by mid-fall. Applicants would be given 45-60 days to complete RFP.

7. How will project evaluation be handled?

- Each project will be responsible for conducting/arranging an evaluation of project activities in accordance with state issued criteria.

8. What will DHHS's project management strategy be?

- The Long Term Care Policy Office, in consultation with the Assistant Secretary for Aging, Disability and Long Term Care, will have leadership responsibility for this effort and will work closely with the Office of Rural Health and the Medicaid Demonstration effort to build upon concepts being tested in the demonstration sites (i.e. global budget, standardized assessment tool, etc.)

JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES

MAY 14, 1998

The Joint Appropriations Subcommittee on Health and Human Services met at 8:30 a.m. on Thursday, May 14, 1998 in Room 424 of the Legislative Office Building. There were six Senate members and ten House members present. Senator Bill Martin, co-chairman, presided.

Senator Martin called the meeting to order. Senator Forrester asked DHHS Secretary David Bruton questions regarding Hepatitis B vaccine and the times it's given. Senator Forrester requested from DHHS a supplemental expansion budget summary page with the total number of positions included in it with the total budget amount.

Next, Senator Martin introduced a new Fiscal Research staff member, Ramona Burton, and intern Stephanie Marshall.

Senator Martin called for the Thomas S. report, which was presented by Susan White, Section Chief of DHHS Mental Health, Developmental Disabilities and Substance Abuse Services. (See attachment #1). Ms. White said the Thomas S. federal court case was recently dismissed in January of 1998. It involved adults 18 years old who had mental retardation and were inappropriately served in the state's psychiatric hospitals. Ms. White addressed what has been learned from the court case, what was learned about the people involved in the case and about putting together a service delivery system that can respond to very seriously disabled individuals. She also addressed the larger system and why it failed initially, what the issues are with that system, and how serving the population over the long term can be accomplished while incorporating cost containment measures.

Ms. White responded to members questions. Senator Martin mentioned that Rep. Gardner is co-chair of the Mental Health Study Commission and Karen Hammonds-Blanks is the staff person, and he requested that when the commission starts meeting again that if Ms. White and others could pull together a report with regard to the distinctions between the medical and habilitation models from a standpoint of cost and effective service delivery; if the chairs of the Mental Health Study Commission agree to it. Ms. White said John Baggett has already asked that they start to work with the Financial Initiative Section to look at the waiver proposals that are being prepared now both for home and community-based services as well as the Carolina Alternatives waivers in order for everyone to access how to achieve better Medicaid funding for long term support, not just hourly clinical services.

Next, Senator Martin recognized Judy Holland of DHHS to present the Carolina Alternatives Medicaid Waiver Program Progress Report (see Attachment #2). Ms. Holland gave a brief overview of the history of Carolina Alternatives. The primary mission of Carolina Alternatives is to provide cost effective, individualized care through the public mental health/substance abuse service system. The focus has been on children aged 0-17 years. The Carolina Alternatives program is designed differently from the Willie M. and Thomas S. programs. Each area program is paid a capitation payment for each child who is made Medicaid eligible in that county. The area programs are responsible for providing whatever services the children are entitled to. Following the history and overview, Ms. Holland reported on the progress DHHS has made in meeting the requirements of the special provision. Members of the committee asked various questions of Ms. Holland during her presentation. Following Ms. Holland's presentation, the committee adjourned until 1:30 p.m.

1:30 p.m.

Co-Chairman Bill Martin called the meeting to order. There were four senators and seven representatives present. Co-Chairman Gardner requested the committee members not make any money commitments, including the chairs. Senator Martin agreed with Rep. Gardner.

Senator Martin gave an overview of next week's meeting schedule as follows: The joint Appropriations subcommittee will meet Tuesday, Wednesday and Thursday May 19-20 at 8:30 and Tuesday, May 19 at 1:30. On Thursday, May 21 at 3:00 p.m., a public hearing will be held in the Auditorium on the Work First State Plan. The following Thursday, May 28, representatives from the National Conference of State Legislatures will be here to do a presentation on child welfare, focusing on Florida and Missouri. The meeting times are 8:30 a.m. and 2:00 p.m. On Monday, June 1 at 4:00 p.m., the block grant hearing for LIHEAP and community service block grants will be held.

Rep. Gardner requested a meeting notice be sent to all members. She also stated the NCSL commitment is serious and they are asking that committee members be present for the meeting. They're offering their expertise to committee members. Rep. Gardner suggested a working lunch.

Senator Dannelly asked Senator Martin to inform people who are making reports to please do an executive summary instead of a long report. Senator Phillips requested budget preference.

Next, Senator Martin recognized Marcy White of DHHS to report on the Willie M. program (see Attachments #3, 4 and 5). Ms. White reported that the federal court found the Willie M. program in compliance with requirements and that the state had a very impressive service system that is serving over 1800 children a year. The case was dismissed.

The program served 1800 children last year, and has 1540 eligible for services today. In response to a question about growth in the class, there was an 8 percent growth in the past year. Senator Phillips' asked about the nomination process. There are six independent reviewers when cases come in, and there are 80 cases being reviewed. Another 40 cases are incomplete without all the information. Area mental health programs are on-line with the program and can enter the information needed to process an application on-line. More children are being nominated but are not eligible at a greater percentage.

The average cost on Willie M. with federal, state DHHS and DPI Willie M. dollars total last year was \$82 million. Sixty-one percent of that is DHHS money, about 7% is DPI money, and about 31% is federal Medicaid dollars. Total cost per child spent last year was around \$41,000, state cost was about \$31,000. It cost \$45,000-\$50,000 to keep a child in a training school for a year, well over \$100,000 to keep a child in a psychiatric hospital, only 10% of the children cost more than \$100,000.

The most serious effort to help contain cost is that outcome data is showing that even when controlling for risk, the children do better when placed in therapeutic homes, not in group homes. Ms. White says DHHS is making programmatic, administrative and budget incentives so that more children can be shifted to therapeutic homes rather than group settings. In outcomes measurement, Ms. White said there is no other program in the country that is collecting and has the kind of information this state does, that has the impact that these services is having on this group of children. There is a detailed assessment of every child within 45 days of eligibility to examine family history, risk factors, how he's doing, his status, and to that they have protective factors. More information on this can be found in Attachment #4 (Annual Report to the Governor and General Assembly).

Senator Martin asked has there been any effort to reduce risk factors with the family settings? Ms. White referred the committee to page 21 of Attachment #4. She said that all the literature says that if a child has four or more of the identified risk factors he is at high risk for poor outcome. Willie M. children average close to fifteen. So they start off in a deep hole. However, the protective factors help mitigate or off-set the rate of risk factors. Ms. White said efforts are made to instill in children the positive protective

factors. Ms. White concluded her presentation following a few more questions from committee members concerning risk factors, the availability of this information to the Juvenile Justice Study Committee, and other related issues.

Next, Senator Martin recognized Dr. Joe Holliday from the Division of Community Health to give the Osteoporosis Task Force progress report (see Attachment #6). The task force was created in the summer of 1997 by the General Assembly to study the problem of osteoporosis and to make recommendations in the form of a plan for prevention. Appointments were completed in March of this year. Four meetings have been held since March including a public hearing in Greensboro at A&T State University. People with osteoporosis, physicians and other health care professionals spoke at the hearing. The task force is looking at (1) the burden of osteoporosis in this state - one preliminary finding is that half of women over age fifty have low bone density, and 18% of all women over age 50 have osteoporosis. For men the figure ranges from 7% and 5% respectively. One of the complications noticed by the task force and those working in hospitals is fractures in patients. In North Carolina there were over 4300 admissions for hip fractures in 1995, costing about \$22,000 in medical cost per hip fracture. One thing realized by the task force is that of those persons in hospitals with hip fractures, 10-20% will die in the next six months; about 50% will never walk without some form of help, or won't walk at all; about 25% will have to go to nursing homes. The burden is more important as one looks at the aging population in North Carolina.

Rep. Gardner expressed her concern about the delays in appointments to task forces when the General Assembly specifically notes in legislation the time by which appointments must be made.

Senator Dannelly asked whether the Governor made any appointments, taking into consideration Senator William Purcell's concern. (At the second meeting of the Osteoporosis Prevention Task Force, Senator Purcell noted the lack of ethnic diversity in the group). Dr. Holiday said Senator Purcell's concern was taken into consideration and Governor Hunt's last appointment, an internist who deals with this problem in the African-American community, has joined the task force. Dr. Holiday concluded his report after a few more questions on how to prevent osteoporosis in the long-run and conclusions of the task force findings. Rep. Watson talked about the astronomical cost to the state in the future if proactive measures are not taken to prevent osteoporosis.

Next, Senator Martin recognized Dr. Kevin Ryan of the Office of Women's Health. The office was established in the 1997 session. Its purpose is to extend the state's public health concerns and focus to include a comprehensive outlook on the overall health status of women. The primary goals is to prevent disease and to improve

the quality of life of women their entire life span (see Attachments #7 and #8). Dr. Ryan gave a brief overview from the report, addressing the activities to date, including a summit, a women's health report card, and strategies on which to move forward.

Following Dr. Ryan's report, Sen. Phillips asked questions about whether more women are more likely to have a physician than in the past and are receiving services like pap smears, etc., and about costs. Dr. Ryan said that some populations are not being screened but are being marginalized from the medical service delivery system; there are great inequalities across the state. Dr. Ryan concluded his report after further comments about outcomes from the focus groups meetings. Rep. Gardner made comments about the statements made last year that there would be no cost for the transfer bill but now there is talk about money needed. Rep. Gardner noted her concerns about publication materials and reaching the populations who need the information. Rep. Watson asked about the data collection process.

Following that report, Sen. Martin recognized Dr. David Bruton to report on proposed health standards. Dr. Bruton said the report is not available today but requested the opportunity to make a report before the committee before it convenes for the biennial session.

Next, Sen. Martin recognized Lee Kittredge to report on the Title IVA-Emergency Assistance funding. Mr. Kittredge gave a status update on where DHHS is on the special provision in SB 352 section 11.4 that authorizes the department to use up to 25% of the Federal Title IVA Emergency Assistance funds received after June 30, 1997 as reimbursement for retroactive claims that were filed. From the remaining funds, the department was to give a prioritized list of recommendations from the department. No funds have been received, and therefore, no recommendations or prioritized list is available.

The report on the Integration of Health Functions was not heard at this meeting.

Next Sen. Martin recognized Chuck Harris of the Division of Social Services to report on the State Child Fatality Review Team (see Attachment #9.) The Child Fatality Review Team shows that there is a need for more regular and in-depth sharing of information and coordination of effort between local Departments of Social Services, law enforcement personnel, medical personnel and other community-based agencies. The review team investigated nine child fatalities in eight counties meeting the review criteria. The reports from the reviews are made public, going back to whomever in the community requests it. Sometimes they are requested by the media and there is extensive media coverage.

The persons who serve on the review team are a medical professional, child abuse and neglect prevention specialist, a representative from each community child protection team, the community child fatality prevention team, and a law enforcement officer.

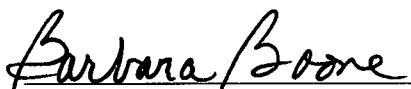
Rep. Gardner made comments about some of the problems the review team encountered from the community, and asked for recommendations from Mr. Harris. The team is requesting modifications in the special provision to enable them to obtain copies of confidential information from various agencies. Discussion followed concerning how to get more cooperation from law enforcement agencies

Mr. Harris concluded his presentation following further comments by Rep. Gardner and Sen. Phillips.

Following Mr. Harris's presentation, Senator Martin adjourned the meeting at 3:00 p.m. to resume Tuesday morning at 8:30 a.m.


Sen. William N. Martin, Co-Chair

Rep. Charlotte Gardner, Co-Chair


Barbara Boone, Committee Clerk

Princ. Clerk
Reading Clerk
Sgt.-at-arms
Senate Pages

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SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on **Health & Human Services** will meet at the following time:

DATE: May 13, 1998 and May 14, 1998

TIME: 8:30 a.m.thru 12:00 and 8:30 a.m. thru 10:00 a.m. respectively

ROOM: 424

This Is A Joint Appropriations Subcommittees Meeting!!

The following bills or resolutions will be considered:

Sen. Bill Martin, Chairman

Correction on Afternoon Meeting, Please Note

Princ. Clerk _____
Reading Clerk _____
Sgt.-at-arms _____
Senate Pages _____

SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on **Health & Human Services** will meet at the following time:

DATE: Thursday, May 14, 1998
TIME: 8:30 a.m. - 9:50 a.m. and 1:30 p.m. - 3:00 p.m.
ROOM: 424 LOB

This is a Joint Appropriations Meeting

The following bills or resolutions will be considered:

Senator Bill Martin, Chairman

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Thursday, May 14th, 8:30 a.m.

Room 424 - Legislative Office Building

DHHS Reports

Thomas S Cost Containment Measures

Carolina Alternatives Progress Report

Willie M Annual Report

Osteoporosis Task Force Progress Report

Office of Women's Health

Proposed Health Standards

Title IVA-Emergency Assistance Funding

Integration Of Health Functions

State Child Fatality Review Team

Special Children Adoption Fund

Providing Adult Day Health Care Services Through Medicaid

VISITOR REGISTRATION SHEET

APPROPRIATIONS HUMAN RESOURCES SUBCOMMITTEE

MAY 14, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Lynne Aycock	DHHS- BSS
Helen Kipina	Meck. Co. Social Services
Chuck Harris	DHHS - DSS
Jack Simonson	NICARF
Bob Phillips	DHHS- DURS
Tommy Ward	Carolina Health Care System
Hugh Tilton	NCHA
Esther High	DHHS- DSS
Wendy Mills	SEANC
Lenore Behar	DHHS- MH 100/SAS
John Baggett	"
Mario Suter	61010 Wellcom
John Bowditch	Zeb Alley P.A.
Allen Duffey	DHHS- Budget, Planning + Analysis
NELS ROSEBAND	OSBM

VISITOR REGISTRATION SHEET

APPROPRIATIONS HUMAN RESOURCES SUBCOMMITTEE

MAY 14, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

GL Holladay	Director of Community Health DHHS 1330 St Marys Street, Raleigh
Don Wether	DMHDDSSAS
Sharnese Ransome	DSS
Windy McNeely	Thomas S.
Jim Parraro	Thomas S.
Peggy Balah	Thomas S.
Mary Greene	OSBM
Byron Harris	OSBM
Marc White	DMHDDSSAS
Lisa Abatemarco	DHHS, office of the Secretary
Terry Stelle	DMHDDSSAS
David Richmond	The HRC
Adam Searing	NCHAC
Myra MILK	NASW-NC
AL DEITRI	DOA/YAIO

VISITOR REGISTRATION SHEET

APPROPRIATIONS HUMAN RESOURCES SUBCOMMITTEE

MAY 14, 1998

Name of Committee

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VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME _____

FIRM OR AGENCY AND ADDRESS

NAME John Rustin

NCFR

Judy Holland

DMH / SD / SAS

Vicini Ryan

D W C H

BARRY COLOSTEIN

DHHS/DWCH

Don Levine

DHHS

Lee H. Hedges

D445

Daphne Lyken

DHHS - DMA

P. Perruz

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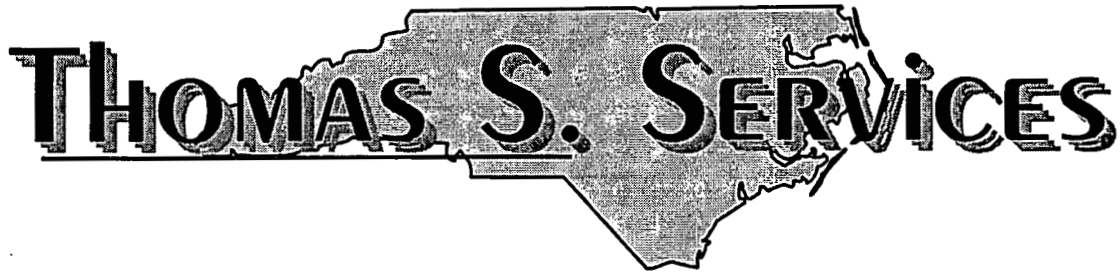
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DAVE BROWN

DH-5

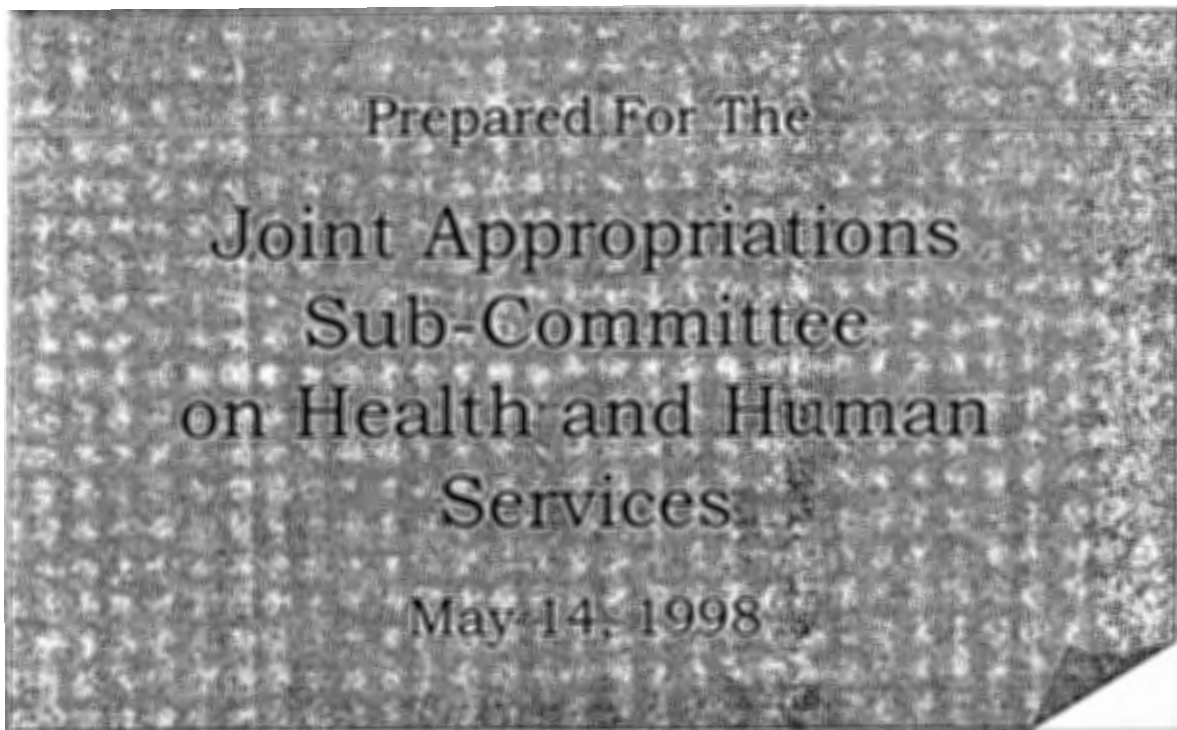
Angie McMillan

DATA



Susan White, Section Chief

Department of Health And Human Services
Division of Mental Health, Developmental
Disabilities and Substance Abuse
Services





**What Have
We Learned?**

**in the
Thomas S. Court Action
and the related
Cost Containment Study?**

THOMAS S. SERVICES

What Have We Learned?

We've learned that we can do this! We can provide long term support for very seriously disabled adults and also implement effective cost containment strategies.

Indeed, **North Carolina is now a leader** in the development of service delivery mechanisms to very challenging, multiply disabled adults in the community.

The Thomas S. system is the **first state-wide community based service delivery system in the nation to be accredited** by a national accreditation body.

Our Longitudinal Study has indicated some of the **best progress ever reported for community services** developed in response to a court mandate.

Judge Voorhees agrees..... found that **the State had demonstrated it's ability and commitment to serve this population appropriately....and dismissed the court injunction** in January, 1998.

We've learned that **Federal Court oversight is not a terminal condition!**

THOMAS S. SERVICES

What Have We Learned?

...about the people we support in Thomas S. services?

Each person is unique. There are few universal descriptors for this group.

People do **not** arrive for services with **discreet needs** that can **easily fit into either MH/DD or SA categories.** (*Only our funds and our professionals arrive that way!*)

Even very seriously disabled individuals are **more like us than different from us.**

Our field consistently pays high dollars for consultants to tell us that **people with disabilities want the same things we all want:**

*a decent place to live,
a way to make their own living,
a say in everyday decisions,
friends,
caring relationships,
some control over their lives.*

THOMAS S. SERVICES

What Have We Learned?

...about the people we support in Thomas S. services? (continued...)

The reason these adults inappropriately remained in the state hospital (resulting in the court case) was not due to the quality of mental health supports in the community; rather it was related to the **inability of the system to provide the needed long term supports in everyday living.**

When we **treat people as incompetent and unworthy of our respect** (and warehouse them for decades on the backwards of our institutions), they **assume the role and behavior** -- and **play the part.**

When we **treat people as capable and contributing members of our communities,** they can **assume that role as well.** Time and time again we have been amazed at this simple fact.

When empowered to select the supports and services they receive, **people tend to use only those supports and services they need** and will **routinely choose less** than professionals would prescribe.

Their ability to **make friends, hold a job** and **live successfully in the community** is **not related** to their ability to **button their own shirt, tie their own shoes,** or even the ability to **remember to their take medications!**

THOMAS S. SERVICES

What Have We Learned?

About developing a service delivery system for challenging, seriously disabled adults?

The real challenge is not the capacity to respond to their mental health or developmental needs (that was the part we knew how to do); rather, the challenge is to design, organize, implement and maintain a system of long term supports for individuals with serious and multiple disabilities.

Providing long term supports is costly, whether it is provided in the state hospital or in the community. The provision of long term supports in our state hospitals may get the job done; however, it cannot meet the long term needs of individuals, and results in costly class action lawsuits. This is a lesson worth our attention and respect.

It is indeed costly to initiate and build an infrastructure to implement, coordinate, oversee and monitor services to a small but unique population.

As a system of services expands to a greater number of individuals, and greater utilization of the investment is achieved, the cost per person decreases.

Just the knowledge that a person is a member of a class action lawsuit causes local communities to respond cautiously. This fear of the unknown has been a cost factor in service development. Time and experience, for the class member and the professionals who support them, have proven to be the best remedy.



About North Carolina's service delivery system outside Thomas S.?

Beds, slots, facility based programs still rule in North Carolina. Our state continues to be more reliant than most on facility and program models that deliver a prescribed set of services to all served.

The larger system has developed with separate funding, programs, and professionals in mental health, developmental disability and substance abuse. People who do not fit into the pre-packaged programs developed, often do not get services.

Increasingly, North Carolina is a provider driven system. Incentives are firmly in place to encourage providers to recommend more and more services for more and more people at higher and higher costs.

Individuals with disabilities are often viewed and treated as commodities that can be traded among the provider network upon which others will make a living.

North Carolina's system of services does not consistently include mechanisms for providing or funding the long term support that is necessary for more seriously disabled individuals to be successful in the community.

Fueled by the direction established by Medicaid funding, public mental health and substance abuse services appear to be moving toward a medical model focused on intense short term clinical care with the assumption that this will decrease the need for long term remedial care.



About Funding and Costs?

Funding requirements, not mission statements, drive the nature and direction of service/support development.

The cost of services and supports in the community is generally less than the cost of care in institutions. 95% of Thomas S. class members are served for less than the average cost of residing in the State hospital.

Medicaid dollars continue to be the largest funding source for services and supports for people with disabilities. Until recently, North Carolina has lagged behind the nation in the use of lower cost waiver services.

When Medicaid rates go down, the cost differential is shifted to the state.

Medicaid waivers allow for the opportunity to recognize a richer array of long term supports; yet until now North Carolina has chosen to apply the medical model to waiver services as well.

The medical model relies on health related professionals to prescribe services resulting in higher cost services. This model encourages the growth of clinically based periodic services and inpatient services as well as the development of more complex documentation requirements.

(For example, ICFs-MR using an habilitation model are required to make quarterly progress notes. Clinical periodic services tend to require documentation hourly or at 15 min. intervals often resulting in more attention to our medical charts than to individuals.)

Under North Carolina's Medicaid State Plan, in order to meet the General Assembly's mandate to maximize Medicaid revenue to support the class action lawsuit, we had to unbundle our service descriptions and provide and bill for services on a periodic or hourly basis. This created a predictable rise in the overall cost of services and a dramatic increase in documentation requirements.

THOMAS S. SERVICES

What Have We Learned?

Are there more cost-effective models of service and support for this population from which we can learn?

One model is emerging nationally that combines the cost containment strategies of managed care with the consumer empowerment approach to service / support provision.

Participant-Driven Managed Supports

is based on the
following concepts:

- ✓ **Community Inclusion and Participation**
- ✓ **Self-Determination**
- ✓ **Responsibility/ Contribution**
- ✓ **Flexible array of supports**
- ✓ **Community Supports**
- ✓ **Personal advocates/ Brokers**
- ✓ **Unified funding**
- ✓ **Outcome focus**
- ✓ **Cost-Containment**



How will cost containment be achieved?

- Over the next year, pursue the implementation of the strategies identified in this study.
- Expand the services available to the other groups eligible for Thomas S. funding: the prospective and "at risk" populations.
- Move toward a consumer or participant driven managed supports model with an emphasis on class member responsibility for contributing to others in need of services.
- Continue the collaboration with the Division and Department to streamline documentation requirements.
- Implement strategies developed to create better access to generic services rather than continued reliance on specialized services.
- Build on the strengths of the Thomas S. system and expand what is useful and relevant to the larger system (Connectivity, individual reporting, outcome based services).
- Actions should be sufficient to bring the average costs of services down to \$65,000 or below by the year 2000. *per person* *Currently still in the \$90s*
- Examine and expand Medicaid Waiver to assure adequacy of long-term supports.



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

May 12, 1998

To: The Health and Human Services Appropriation Subcommittee
From: H. David Bruton, M.D. *HDB*
Re: *Carolina Alternatives* Progress Report

As directed in Senate Bill 352, Section 11.34, ratified by the 1997 General Assembly, I am submitting the attached progress report on the *Carolina Alternatives* 1915(b) Medicaid waiver program to the Health and Human Services Appropriation Subcommittee.

I am confident that you will find the report reflects the positive efforts of staff at DMH/DD/SAS and DMA, as well as staff of the area authorities for Mental Health, Developmental Disabilities and Substance Abuse Services participating in the waiver pilot.

cc: James Edgerton
Karen Hammonds-Blanks
John Baggett
Paul R. Perruzzi

**North Carolina Division of Mental Health, Developmental
Disabilities and Substance Abuse Services
North Carolina Division of Medical Assistance**

CAROLINA ALTERNATIVES

**Report to General Assembly
May 1998**

**North Carolina Division of Mental Health, Developmental Disabilities and
Substance Abuse Services
North Carolina Division of Medical Assistance**

CAROLINA ALTERNATIVES

**Report to General Assembly
May 1998**

Special Provision, Section 11.34

"The Department of Human Resources shall move forward with planning, readiness assessments, and other necessary activities to be able to expand the Carolina Alternatives Child and Adult Waiver Pilot Program. Prior to actual implementation of additional covered populations, the Department shall:

- (1) Receive approval from the Health Care Financing Administration;

The Health Care Financing Administration granted two 90-day extensions to the current waiver to allow time for audits of the ten existing Carolina Alternatives sites; to allow for actuarial evaluation of the current capitation rates and a calculation of the Upper Payment Limits to be submitted in the waiver application; and to allow completion of the Independent Evaluation. The proposed start date for the next waiver cycle is thus July 1, 1998.

A waiver application requesting renewal of the existing sites, expansion of the child program to the rest of the state, and expansion to the adult population was placed on hold by the Office of State Budget and Management pending negotiation of fee for service Medicaid match requirements. Therefore, a waiver application requesting continuation of the current ten area program pilot sites for the next waiver cycle, July 1998 through June 2000 is currently under review at DMA for submission to HCFA. Approval from HCFA is thus pending.

- (2) Continue the 10-site Carolina Alternative Pilot Programs;

The ten area programs have continued to provide mental health and substance abuse services to the children eligible for Medicaid in the 32 covered counties. A more detailed discussion of the activities over the past waiver cycle is attached.

- (3) Make a determination that each area authority that is going to participate in the pilot has the capacity to implement the waiver;

A detailed pre-implementation review process is in place. It is incorporated into the DMH/DD/SAS accreditation/monitoring process that is used to evaluate all

area programs. An interdisciplinary team, including DMA representation, will conduct an on-site review consisting of observation of services, interviews of providers and enrollees, and clinical and financial record reviews of each area program prior to its implementation of the waiver.

(4) Obtain certification from the OSBM that the expansion of Carolina Alternatives is budget neutral, excluding payment of claims related to the transition from fee for service to Medicaid managed care, and authorization from the OSBM to proceed with the pilot;

A determination was made in the spring of 1998 that the mechanism for providing the non-Federal share of the Medicaid funds paid by Area Programs at the service level did not meet Federal requirements. This determination by DHHS required a request for additional funds for DMH/DD/SAS. Although this situation was not created by Carolina Alternatives (which may help in reducing the need for match as Medicaid funds are capitated), OSBM placed a hold on further expansion of Carolina Alternatives until the fee for service match funding issues are resolved. Carolina Alternatives does meet HCFA Federal cost effectiveness requirements because expenditures are less than they would have been under a fee for service system. However, the requirement of additional match funds for the fee for service funds in the mental health system means that the State requirement of budget neutrality could not be met. Once overall funding issues are resolved, OSBM will be asked to permit the waiver expansion request to be submitted to HCFA.

(5) Evaluate capitation rates to determine if they are adequate to provide appropriate services.

Area programs submit monthly financial reports to DMH/DD/SAS showing the units of services provided to enrollees. The Carolina Alternatives Branch made site visits to all ten area programs within the last twelve months. The Branch also tracks enrollee complaints and appeals of service decisions. The DMH/DD/SAS client satisfaction survey was analyzed for Carolina Alternatives enrollees. None of these indicators reveal an inability of the area programs to provide needed services to enrollees under the current capitation rate structure. Interviews with enrollees, providers, and community service agency providers indicate overall satisfaction with increased access to services, more available services, and more coordinated care.

DMH/DD/SAS is implementing an expanded outcome initiative which is intended to provide client specific outcome information under Carolina Alternatives. This information combined with an anticipated change to a more detailed encounter data reporting system should allow better analysis of client outcomes based on services provided.

(6) Develop five year cost estimates for Carolina Alternatives;

A fee for service rate study is being conducted by DMA. Until this rate study is completed, five year estimates can not be accurately completed. The actuarial study conducted with the participating Carolina Alternatives sites has been completed, but will be affected by the fee for service rate study results.

(7) Submit a progress report to the 1997 General Assembly, Regular Session 1998 and the Fiscal Research Division not later than May 1, 1998.

The requested report is attached. Delays in receipt of data necessitated a submission to the Fiscal Research Division on May 11, 1998.

CAROLINA ALTERNATIVES PROGRESS REPORT

Overview

The Waiver program known as Carolina Alternatives is an innovative publicly operated managed behavioral health care initiative.

Basic Principles

Carolina Alternatives was developed with the belief shared by policy makers, stakeholders, and consumers, that the public system should retain the management and operation of the behavioral health service system. The use of the public system assures that accountability and decision-making will remain in the community, and that any savings generated through efficiencies and good management are reinvested into the local mental health/substance abuse service system. The North Carolina public mental health system is represented by local area authorities for MH/DD/SA services governed by local boards which include representatives of local government, stakeholders, consumers and professionals. This system guarantees a high level of commitment to consumer rights, performance standards and quality improvement.

The financial incentives of a public sector capitated system require that Area Programs increase (1) productivity and efficiency, (2) better coordinate client care across levels of care and among service providers, and (3) efficiently manage scarce public resources. *Carolina Alternatives* requires that Medicaid recipients access Medicaid covered mental health and substance abuse services through the local Area Program that serves the recipient's county of Medicaid eligibility.

Since January 1, 1996, all ten pilot area programs have been paid a fixed capitation rate for both inpatient and outpatient mental health and substance abuse services for children aged 0-17 years.

Primary Mission

To provide cost effective, individualized care through the public mental health/substance abuse service system.

Goals of the program are to:

1. Increase access to mental health and substance abuse services for enrollees in need of crisis care and/or routine care.
 - More children were served as Area Programs expanded services through the more efficient use of capitation resources that promoted coordination and use of a wider range of community-based services. The number of children served doubled, from 5,149 children served in CY92 to 11,265 in CY97.
 - The penetration rate (percentage of eligible children served) increased from serving 5.3% of Medicaid recipients in CY92 to 8.5% in CY97. The penetration rate in non-waiver sites was 6.4% in CY97.
2. Maintain or improve the quality of care while stabilizing and containing costs.
 - *Carolina Alternatives* includes all Medicaid covered mental health and substance abuse services available to Medicaid recipients in North Carolina
 - Staff from DMH/DD/SAS have visited all of the area programs currently participating in *Carolina Alternatives* and will continue to do site visits regularly as part of a quality monitoring process. These post-implementation site visits include interviews with clients and providers as well as review of performance indicators. An evaluation instrument was developed and incorporated into the DMH/DD/SAS accreditation/monitoring process and will be used in visits to Carolina Alternatives sites beginning June 1998.
3. Provide the most appropriate level and amount of service to enrollees via the use of standardized levels of care criteria.
 - Levels of Care guidelines for Child and for Adults were developed in this waiver cycle with input from Division staff, area program staff, and consumers/advocates. The Levels of Care guidelines for Children are being used in all ten sites.
 - Record reviews are conducted annually in all ten sites to determine the appropriateness of services provided. These reviews are conducted during monitoring visits by DMH/DD/SAS staff. Audits of records have also been conducted in the last year by DMA staff.

Records are reviewed for compliance with Medicaid documentation requirements and to assure that treatment plans are appropriate to the level of need indicated. Future reviews will evaluate the use of the Levels of Care Criteria for children across all sites.

4. Expand the types of available services, especially family-centered and community-based services.
 - Access to care was improved by increasing the numbers and types of providers serving Medicaid recipients, assuring that services were available on a 24-hour basis, and that a wider range of mental health and substance abuse services were available. The number of contract providers increased from 114 in December, 1993, to 278 in December, 1994, to 697 in June, 1997;
 - More children were served in less restrictive settings. The average number of inpatient days per enrollee served decreased from 50.1 days in CY92 to 19 days in CY97. As noted below, care has increased in non-hospital settings.
 - Resources were shifted from institutional settings to community based settings for children, providing less restrictive services and services closer to families and communities. In CY92, almost 74% of the Medicaid dollars in waiver sites were spent on inpatient services. In CY97, only 12.3% of the dollars were spent on inpatient services. Actual dollars spent on inpatient services decreased by half from \$11.8M to \$5M in CY97. A similar shift was seen in the non-waiver sites, but the actual dollars spent on inpatient services decreased only \$3M from CY 92-97.
 - The expansion of crisis services to allow short-term interventions to stabilize crisis situations is a major improvement to the service system and has greatly assisted in diverting enrollees from inappropriate inpatient placements.
5. Provide coordinated care which is responsive to the individual needs of each enrollee.
 - Each enrollee is provided care management by an individual who is responsible for overseeing implementation of the enrollee's treatment plan, coordinating care, and linking the enrollee with other service providers. Carolina Alternatives sites used more case management than non-CA sites. Over 43% of enrollees served in CY97 received case management services in Carolina Alternatives sites compared to 34% in non -CA sites.

- Continuity of care was improved through these care management functions that made Area Programs responsible for coordinating and delivering or arranging for the delivery of all services provided to Medicaid recipients. Levels of Care guidelines for children were in use in all ten pilot sites, promoting a more consistent system of services through the waiver sites.
6. Ensure that enrollees (and their families or guardians) have full information about their right to service, to choose providers when available, and to appeal treatment authorization decisions.
- DMH/DD/SAS provides information about *Carolina Alternatives* to children and their families eligible for Medicaid services. Local departments of social services provide information about *Carolina Alternatives* to individuals who receive Medicaid services. Area programs also have responsibility for providing information to enrollees, responding to grievances and appeals, implementing the provider choice policy.
 - The appeals policy was significantly revised to comply fully with federal regulations and to be more user-friendly.
 - A grievance and appeals policy has been developed and implemented at the area authority level, with the option for further appeal to the Division level. All Medicaid recipients have the right to an evidentiary hearing at the Office of Administrative Hearings
 - Area programs are responsible for providing information to enrollees, responding to grievances and appeals, and generally addressing enrollee satisfaction with *Carolina Alternatives*. This policy is monitored on site visits and through tracking of appeals and complaints.
 - Training on the appeals policy has been provided to advocacy groups whose toll free numbers are listed as resources on the *Carolina Alternatives* informational brochures.
 - A Spanish language version of the informational brochure and all information about appeal rights will be available by July 1, 1998.
7. Increase participation and cooperation among public and private mental health and substance abuse providers and facilities through an expanded provider network, and to minimize cost-shifting across agencies.

- Access to care was improved by increasing the numbers and types of providers serving Medicaid recipients, assuring that services were available on a 24-hour basis, and that a wider range of mental health and substance abuse services were available. The number of contract providers increased from 114 in December, 1993, to 278 in December, 1994, to 697 in June, 1997;
 - Participating area programs have developed community-based delivery systems that include both in-house and contract providers.
8. Ensure the quality of care through State-level monitoring of performance and client oriented outcomes.
- Division staff have visited all of the area programs currently participating in *Carolina Alternatives* and will continue to do site visits regularly as part of a quality monitoring process. These post-implementation site visits include interviews with clients and providers as well as review of performance indicators.

Management and Governance

The State of North Carolina, through the Department of Health and Human Services, administers the public funding of behavioral health services through area MH/DD/SA authorities.

The Division of Medical Assistance (DMA) has entered into an interagency Agreement with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to operate the *Carolina Alternatives* program. DMA provides oversight of the program.

The Division of MH/DD/SAS has contracts with the participating area programs to carry out the local coordination, delivery and fiscal management of covered mental health and substance abuse services for eligible Medicaid recipients.

The ten area programs currently implementing *Carolina Alternatives* manage the pre-paid capitation system and provide a portion of services to the enrollees. If future expansion occurs, many area programs will follow this model. Some, however, may retain their functions as service providers only and will subcontract the management functions to another area program.

The *Carolina Alternatives* Policy Advisory Group (CAPAC), was formed in August 1996 to bring representatives from all stakeholders groups to the same table for discussion of policy guidance regarding the successful delivery of quality mental health and substance abuse services under *Carolina Alternatives*. CAPAC has

been actively involved in the development of the appeals policy, provider choice policy, and the development of the Levels of Care Criteria.

Expansion Proposal

The Health Care Financing Administration granted two 90-day extensions to the current waiver in order to allow for calculation of the Upper Payment Limit and capitation rates by an actuarial firm. The proposed new waiver period is from July 1, 1998 through June 30, 2000. The Office of State Budget and Management has not approved submission of a waiver expansion request until fee for service match funding issues are resolved. Therefore, the waiver submission requests maintenance of the current ten pilot sites only. If expansion is allowed, an expansion request will be submitted to HCFA as soon as possible. If HCFA approves the request, Carolina Alternatives will expand its coverage to children and adults statewide, and by the end of this period will include over 700,000 children and adults through age 64 in all 100 counties.

Under expansion, each Area Program will implement the waiver for both children and adults simultaneously, thus achieving a managed care system of services for enrollees 0 through 64 years of age. Area programs will be permitted to implement Carolina Alternatives only after meeting accreditation and readiness requirements and approval by the Director of DMH/DD/SAS.

ATTACHMENT 1

The 1915(b) Medicaid Waiver

The purpose of the waiver is to capitate the Medicaid dollars and prepay the funds to local area authorities.

The waiver began January 1, 1994 and serves approximately 131,000 Medicaid eligible children under 18 years of age in 32 of North Carolina's 100 counties.

Medicaid eligible children under 18 years of age who reside in participating counties can access a comprehensive system of community-based mental health and substance abuse services.

Medicaid recipients whose eligibility is determined in participating counties are automatically enrolled in *Carolina Alternatives*.

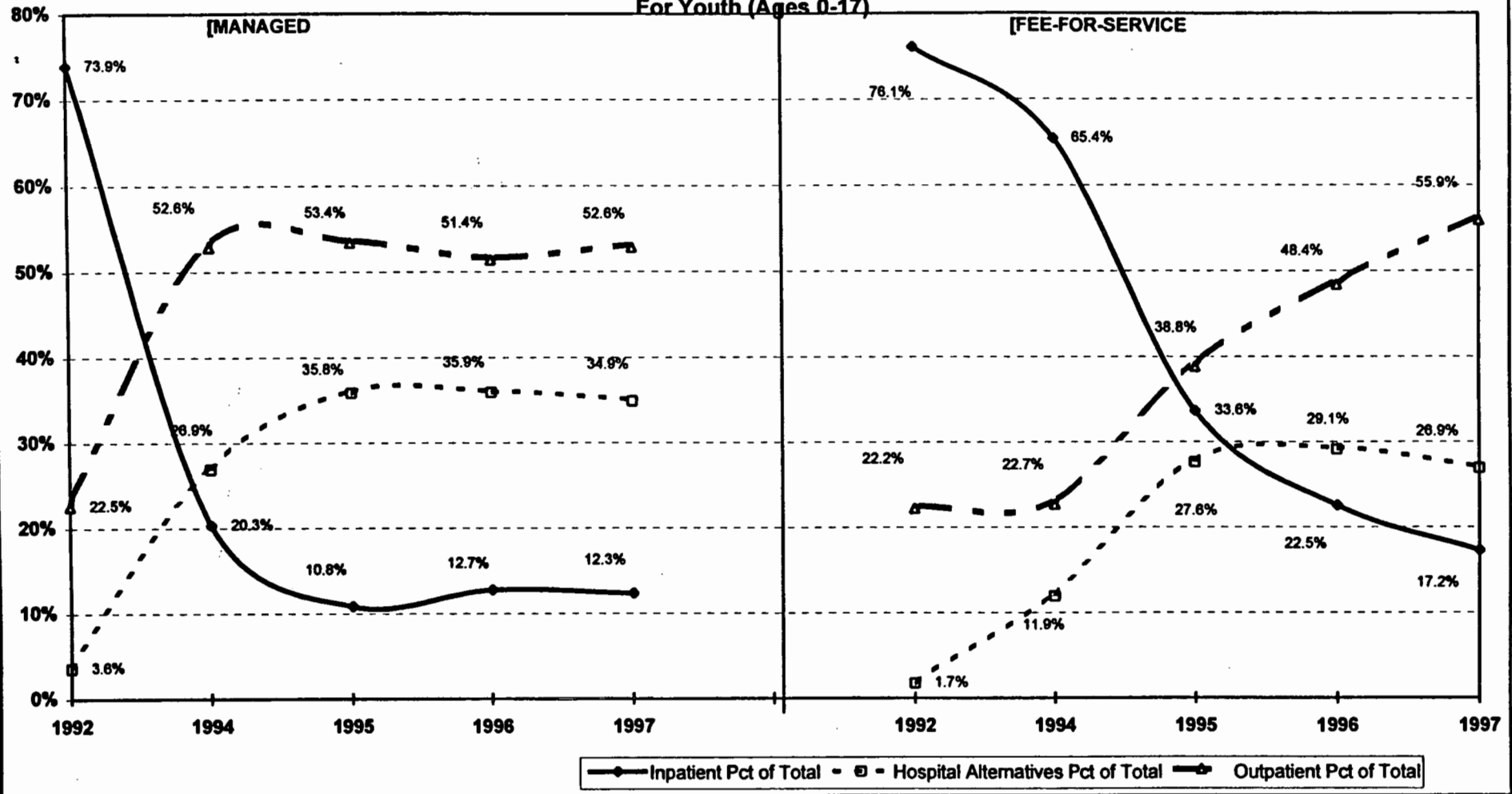
The participating area programs must meet managed care readiness criteria developed by DMH/DD/SAS and DMA as well as meet accreditation requirements developed by DMH/DD/SAS. Accreditation reviews are scheduled beginning in June 1998.

ATTACHMENT 2

**Charts showing comparison between Carolina Alternatives
and Fee For Service Medicaid.**

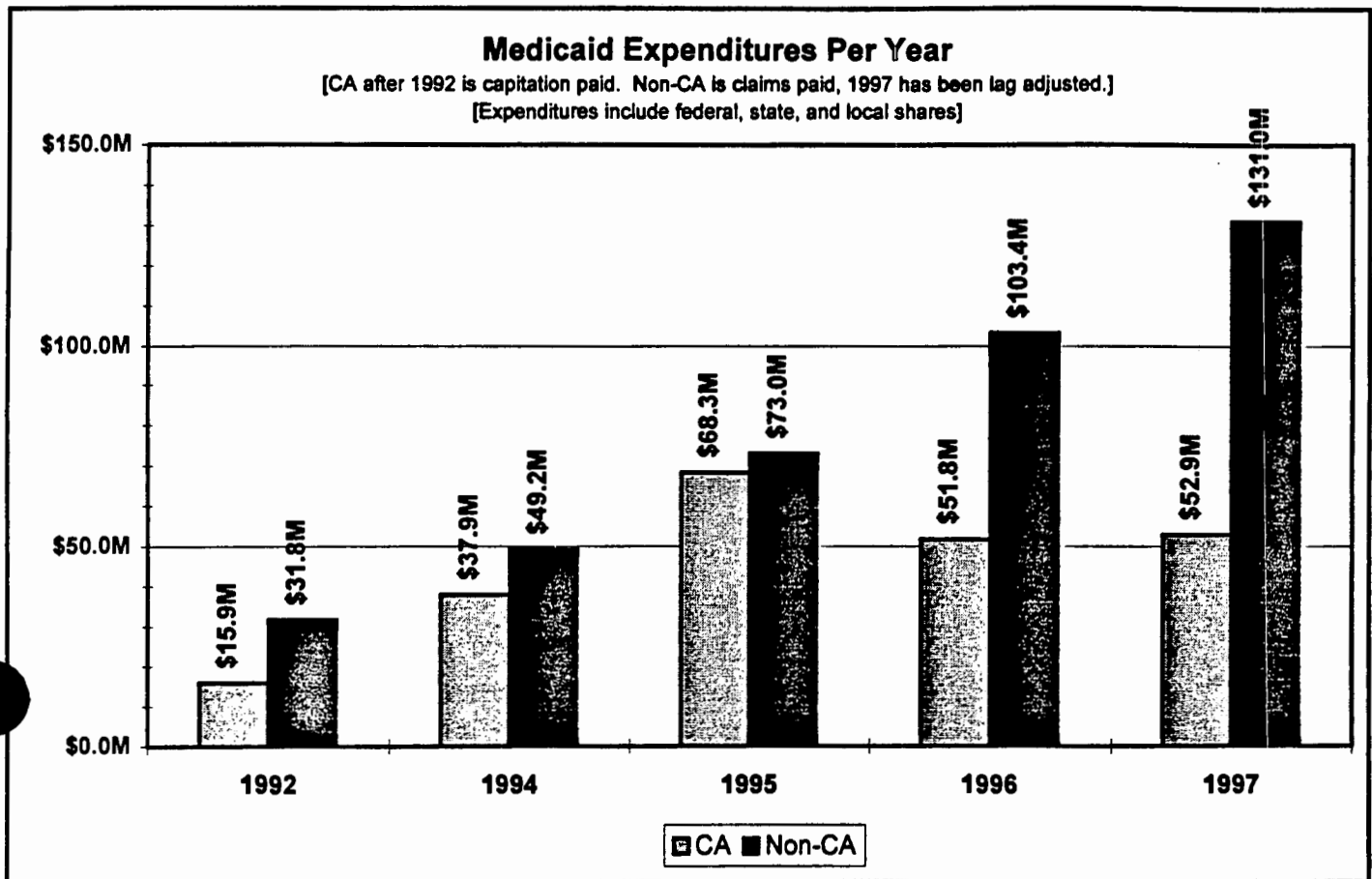
- Chart 1 Proportion of Medicaid MH/SA Dollars by Level of Care**
- Chart 2 Comparison of Medicaid Covered Services Provided by Carolina
Alternative and Non-Carolina Alternatives Area Programs,
Calendar Years 92-97. *Medicaid Expenditures per Year***
- Chart 3 Comparison of Medicaid Covered Services Provided by Carolina
Alternative and Non-Carolina Alternatives Area Programs,
Calendar Years 92-97. *Average Expenditures per Client per Year.***

Proportion Of Medicaid MH/SA Dollars By Level Of Care For Youth (Ages 0-17)



	1994	1995	1996	1997	1994	1995	1996	1997
Percent of outpatient that is								
HRI-P + CBI:	47.2%	54.0%	33.9%	35.1%	14.6%	52.0%	67.6%	73.0%
Case Mgt:	19.0%	17.7%	25.6%	25.9%	22.5%	14.7%	12.0%	10.8%
Outpt periodic:	33.8%	28.3%	40.5%	39.0%	62.9%	33.3%	20.4%	16.2%
Percent of hospital alternative that is								
HRI-R (High):	76.4%	79.5%	80.3%	84.4%	79.0%	89.4%	90.0%	91.5%
HRI-R (Mod):	10.8%	9.1%	7.8%	5.1%	5.6%	3.8%	3.4%	3.0%
PH/Day Tx:	12.9%	9.5%	11.5%	9.9%	15.3%	6.8%	6.5%	5.4%

Comparison Of Medicaid Covered Services Provided By Carolina Alternatives And Non-Carolina Alternatives Area Programs Calendar Years 1992 - 1997

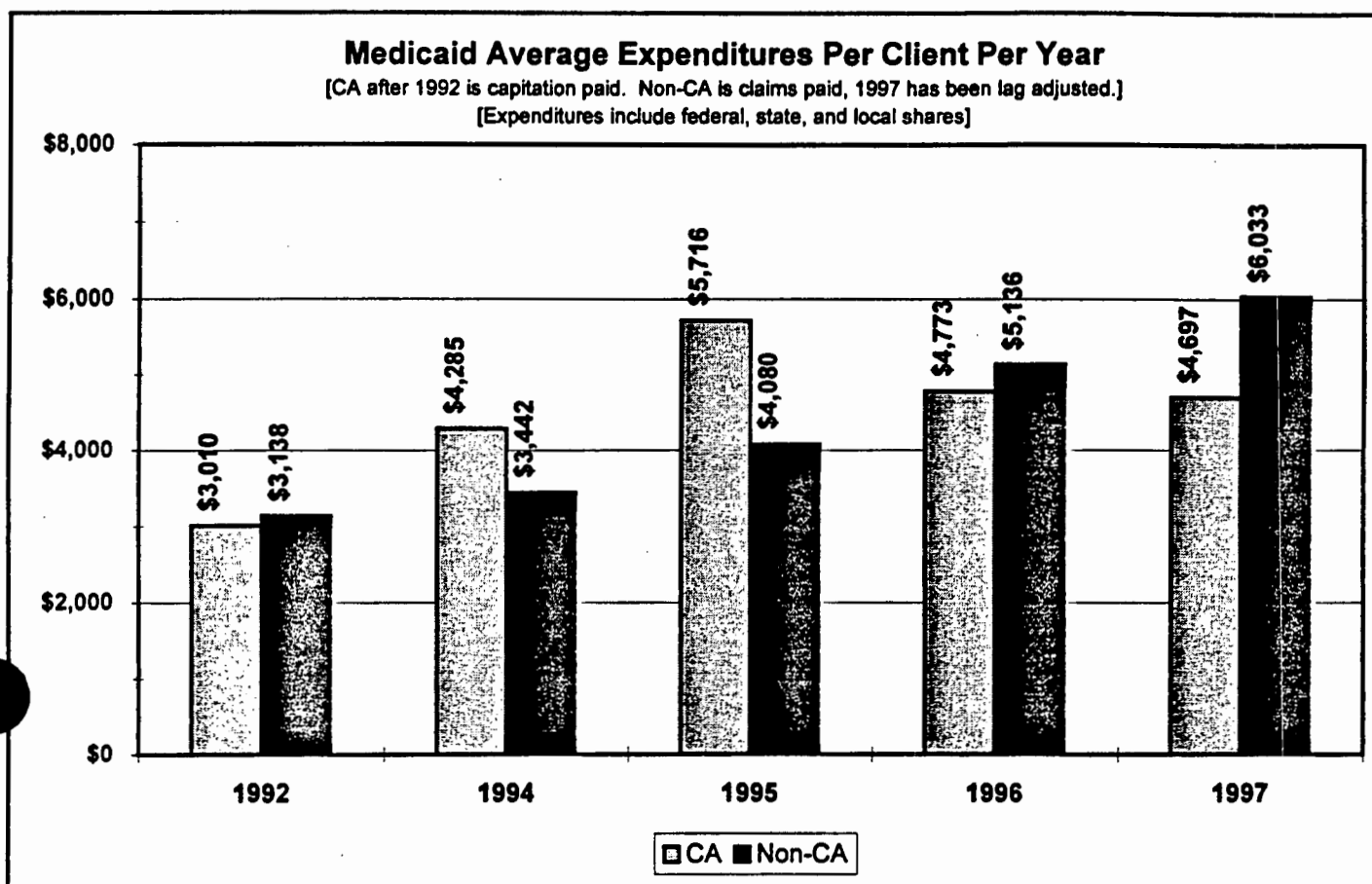


Note the difference in trends in expenditures between the CA and Non-CA sites.

At the CA sites, after increasing linearly each year, total expenditures decreased in 1996 and leveled off in 1997 as capitation rates were reduced to remove inpatient savings and the area programs managed care under a fixed capitation rate.

In contrast, at the Non-CA sites, total expenditures have continued to increase linearly each year.

Comparison Of Medicaid Covered Services Provided By Carolina Alternatives And Non-Carolina Alternatives Area Programs Calendar Years 1992 - 1997



Note the difference in trends in average expenditures per client per year between the CA and Non CA sites.

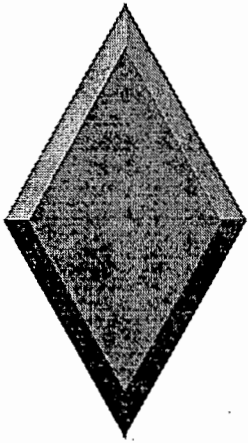
Average expenditures per client are about the same in 1992 (pre-CA). In 1994 and 1995, they are higher at the CA sites as CA sites started putting more resources into serving clients. Average expenditures per client dropped below the Non-CA sites in 1996 and leveled off in 1997 as CA area programs managed care under a fixed capitation rate.

In contrast, average expenditures per client have steadily increased at the Non-CA sites, passing expenditures at the CA sites in 1996 and 1997.

It is interesting to note that although expenditures per eligible at both CA and Non-CA sites are about the same in 1997 (equal resources per eligible), average expenditures per client are lower at the CA sites indicating more efficiency in serving clients under CA. Inpatient utilization is lower and utilization of hospital alternatives is higher at the CA sites.

Attachment #3

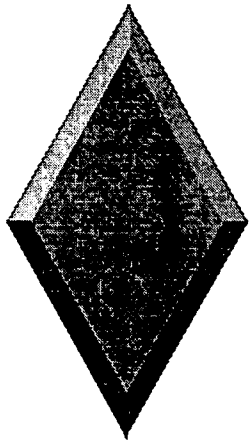
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WILLIE M. PROGRAM

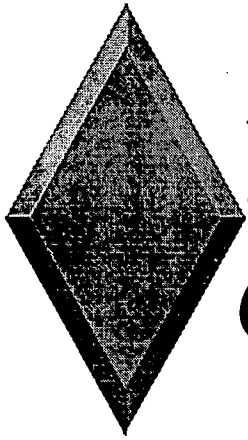
ANNUAL REPORT TO THE
GOVERNOR AND
GENERAL ASSEMBLY

SUMMARY - MAY 1998



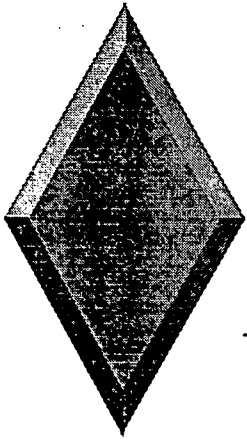
WILLIE M. - 1998 HIGHLIGHTS

- END OF COURT OVERSIGHT!
- GROWTH IN WILLIE M. CLASS
- IMPROVEMENT IN CLIENT
FUNCTIONING
- UNDERSTANDING OF
RESILIENCY
- BUDGET SHORTFALL - NEED
TO DEMONSTRATE ONGOING
COMMITMENT



WILLIE M - END OF COURT OVERSIGHT!

- JANUARY 1998 - COURT FOUND THAT “STATE HAS COMPLIED TO THE EXTENT PRACTICABLE”
- STATE’S SYSTEM OF SERVICES CAN SUBSTITUTE FOR FEDERAL COURT OVERSIGHT - PANEL DISMISSED
- JUDGE IMPRESSED WITH QUALITY OF SERVICES AND STATE COMMITMENT



WHAT MADE THE DIFFERENCE?

■ 18 YEARS AGO, JUDGES HAD
NO ALTERNATIVE TO
TRAINING SCHOOL AND
HOSPITAL WARDS

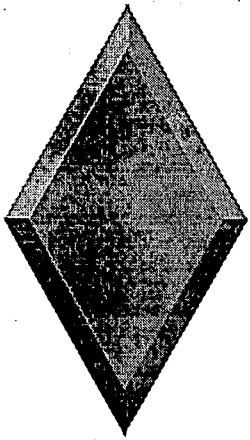
■ TODAY, THE WILLIE M.
SYSTEM OF CARE:

➔ IS IN STATUTE AND STATE
FUNDED

➔ PLANS INDIVIDUALIZED
TREATMENTS

➔ SERVES KIDS IN COMMUNITY
SETTINGS

➔ ACHIEVES POSITIVE OUTCOMES



GROWTH IN WILLIE M. CLASS

■ GROWTH EXCEEDED
BUDGETED LEVELS FOR LAST
2 YEARS

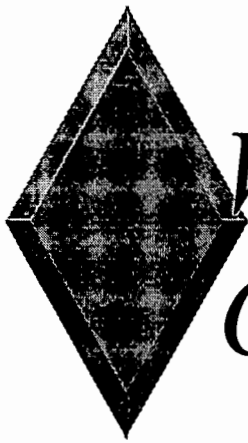
■ REASONS FOR GROWTH:

➔ INCREASED CHILD
POPULATION

➔ YOUNGER CHILDREN
CERTIFIED

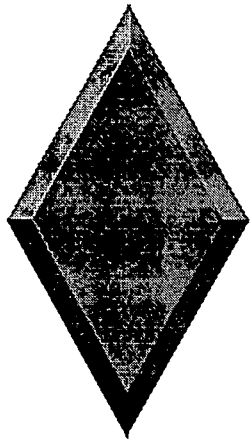
➔ INCREASED SOCIAL PROBLEMS

➔ GREATER PUBLIC KNOWLEDGE
OF WILLIE M. PROGRAM



WILLIE M.- POSITIVE OUTCOMES

- CHILDREN MOVING TO LESS RESTRICTIVE COMMUNITY SETTINGS (50% LIVE AT HOME OR IN THERAPEUTIC HOMES)
- AGGRESSIVE, VIOLENT BEHAVIORS DECREASING AMONG CLASS MEMBERS, MORE SO THE LONGER THEY STAY



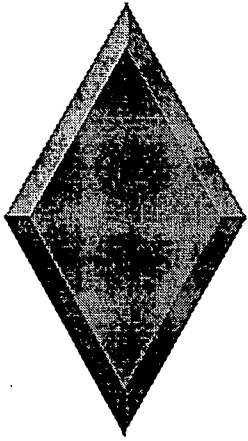
RESILIENCY OF KIDS

■ WILLIE M. KIDS - HIGHER
NUMBER OF “RISK FACTORS”
THAN OTHER MENTAL
HEALTH CLIENTS:

➔ 38.5% HAVE DEVELOPMENTAL
DELAYS

➔ 76.6% HAVE WITNESSED
EXTREME CONFLICT OR
VIOLENCE

➔ 68.9% HAVE BEEN REMOVED
FROM FAMILY



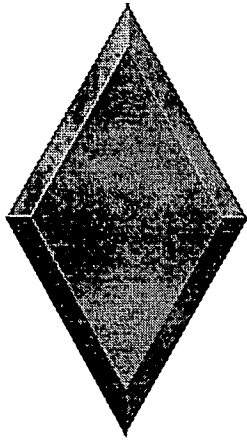
RESILIENCY OF KIDS

■ WILLIE M. TRIES TO INSTILL
“PROTECTIVE FACTORS” TO
BUILD RESILIENCY:

➔ CHILD BELIEF IN OWN
COMPETENCIES

➔ POSITIVE RELATIONSHIPS
WITH FAMILY MEMBERS OR
MENTOR ADULTS

➔ SOCIAL SKILLS - HUMOR,
EMPATHY

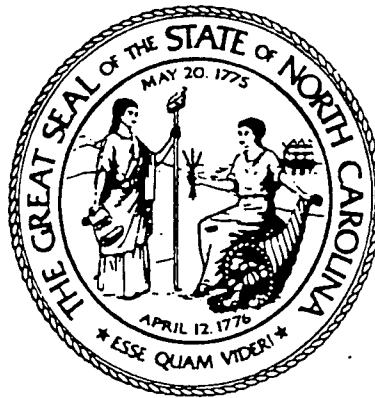


1997-98 BUDGET SHORTFALL

- BEGAN YEAR
SIGNIFICANTLY BEHIND
- USED ALL \$7 MILLION IN
AREA FUND BALANCES
- CUT \$3 MILLION IN
ALLOCATIONS IN JANUARY
- SUPPLEMENTAL REQUEST TO
ALLOW PROGRAM TO
CONTINUE FOR CURRENT
CLASS IN FY1998-99

**REPORT TO THE GOVERNOR AND
THE GENERAL ASSEMBLY
ON
THE WILLIE M. PROGRAM**

1997-1998



**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 27603-5906**

AND

**NORTH CAROLINA
DEPARTMENT OF PUBLIC INSTRUCTION
Exceptional Children Support Team
301 North Wilmington Street
Raleigh, North Carolina 27601-2825**

May 1, 1998

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Appendix 3: Other State Funds Spent on Willie M. Children

Executive Summary

The purpose of this report is to summarize the progress achieved in serving children of the **Willie M.** class over the past year. The key highlights from this year's report are:

The federal court found the state in compliance and has dismissed the Willie M. consent decree and lawsuit.

- The court found that the State had put in place a complete program of services along with formalizing the State's obligations to the **Willie M.** class of children under state law and regulations. This, together with changes in federal law since the Consent Decree, removed the basis for federal court jurisdiction in the case.

The number of Willie M. children continues to grow.

- The number of currently eligible **Willie M.** children grew to 1523 by the end of 1997. This represents an 8.5 percent increase from the prior year and a 40 percent increase in the last five years. Due to continued growth in the number of children in North Carolina, younger children being certified as eligible class members, and other demographic factors, growth in class members can be expected to continue.

Willie M. children continue to be very "high-risk" children, although they are gaining more 'protective factors' to cope with the risks they face.

- Evidence from a variety of evaluative measures continues to show that **Willie M.** members are very "high-risk" children with respect to their ability to function normally in society now and in the future. On average, current **Willie M.** children have been identified as having 13 different "risk factors" which predict poor outcomes later in life. Research has shown that the presence of four or more risk factors places a child at "high-risk" for poor results later in life.
- "Protective factors" help lessen the effects of risk factors. **Willie M.** children who have been in the program through at least two formal evaluations have added on average four new protective factors while only adding two new risk factors, producing a net gain for protection against poor outcomes such as criminal involvement, mental illness, and substance abuse.

The average costs of serving a Willie M. child now exceed \$40,000 per year.

- Total expenditures for the **Willie M.** program totaled \$82.3 million in Fiscal Year 1996-97. Of this total, \$5.6 million was granted to local schools by the Department of Public Instruction, \$73.8 million provided treatment services through the Department of Health and Human Services, and the remaining \$2.9 million covered state administration, program evaluation, and training activities.
- The statewide average cost of DHHS treatment services per child was \$40,874 in Fiscal Year 1996-97. As in previous years, costs per child varied significantly, with ten percent of the class costing over \$100,000 per child and over forty percent of the class costing less than \$20,000 per child. These differences are caused by the need for much more intensive services, especially residential services, for some class members.

Willie M. children are making progress toward improved functioning in the community. Assessment of new data collected in the last few years shows promising results.

- As a result of new data collection efforts over the last several years, we now have better information tracking the progress of **Willie M.** children. Evaluation of progress in seven different life domains show that over time **Willie M.** children are making progress or being stabilized and that the progress made appears lasting and greater the longer children are in the program. Progress appears most evident in moving children to less restrictive residential settings, reducing violent or aggressive behavior, and keeping class members in school.

Section One

Introduction: History and Objectives of the Willie M. Program

This report will provide an overview of what the **Willie M.** program does and describes the progress being achieved in serving the children in this program. This section of the report will provide:

- the purpose and structure of the report;
- a brief history of the **Willie M.** program;
- the program goals for individual class members;
- the current status of the program; and
- the management of the **Willie M.** program.

A. Purpose and Structure of This Report

The purpose of this report is to provide a description of the operation and performance of the **Willie M.** program. This fulfills a statutory requirement in place since 1984 under the annual Appropriations Act that the Department of Health and Human Resources (DHHS)¹ and the Department of Public Instruction (DPI) submit a report to the Governor and General Assembly detailing progress made in meeting the special needs of the **Willie M.** children. This requirement includes a number of specific detailed data requirements, all of which are covered within the report. The report is also meant to provide information to the general public about how the system is meeting its responsibilities.

The structure of this report will be to describe the **Willie M.** program, the children being served, the services provided, the costs of those services, and progress being achieved by the children. The sections of the report are as follows:

- The remainder of **Section 1** will provide a brief history of the program with a summary of the current status and a description of the objectives and management of the program.
- **Section 2** will characterize the membership of the **Willie M.** class including data on its numbers, demographics, and psychosocial conditions.
- **Section 3** will describe the service system in place and how it is designed to meet the needs of the children.

¹ The Department of Health and Human Services (DHHS) was newly named in 1997. Prior to this time the name was the Department of Human Resources (DHR). The latter name is used in this report when it refers to actions taken place before 1997.

- **Section 4** will report on the costs of running the **Willie M.** program along with information on high-cost children, waivers granted to reimbursement rules, and other state funds spent on **Willie M.** class children.
- Finally, **Section 5** will summarize important information about the progress and status of **Willie M.** children with regards to basic objectives for improving their ability to function in society.

B. Brief History of the Willie M. Program

Willie M. was one of four children for whom a class action lawsuit was filed in October, 1979. The plaintiffs, all minors, sought the right to receive treatment and educational services which had repeatedly been denied to them. Because these children had a history of violent behavior and mental or emotional handicaps, they were often blocked from entering, or asked to leave, programs that were not really designed to meet their needs. After repeated, unsuccessful efforts by attorneys, social workers, judges, and others to obtain services, the plaintiffs concluded that the State of North Carolina would continue to deny services to these children unless forced to do so through litigation.

In the lawsuit, the plaintiffs defined the children they were representing as every North Carolina citizen under 18 who fits all of the following:

- now, or will in the future, suffer from serious emotional, mental, or neurological handicaps;
- exhibits violent or assaultive behavior;
- is, or will be, involuntarily institutionalized; and
- is not receiving appropriate treatment and education services.

The defendants were state government officials, including the Governor, the Secretary of the Department of Human Resources, the State Superintendent of Public Instruction, and the Chairman of the North Carolina Board of Education.

The case was set for a hearing in September, 1980. On the day before the hearing, both parties worked out a settlement. In the document titled, "Second Set of Stipulations," they agreed that the State would provide appropriate treatment and education for each child in the class defined by the plaintiffs; and that the Court would appoint an independent panel of experts to monitor the State's compliance efforts and report that status to the Court.

After further negotiations, both parties agreed to a "Third Set of Stipulations," which established procedures for identifying **Willie M.** class members and determining their needs. These stipulations also described the composition of the Review Panel and laid out its responsibilities.

The settlement outlined in the Second and Third Sets of Stipulations was subject to enforcement by the Court. Therefore, any disputes about interpretation of the agreement were to be resolved by the Court.

During the ensuing years following the settlement, the state agencies, with the assistance of the General Assembly, established a program of services around the state to serve class members. This service system includes routine procedures for the identification, nomination and certification of class members; requirements for individualized assessment and treatment planning; provision of both generic and child-specific services to meet individual needs; and requirements for individual service monitoring and progress information gathering. These services are provided by a range of providers at the local level, including area mental health agencies, local school systems, social services departments, and private child caring and treatment providers. Services are coordinated by the local mental health program in most areas, and the state agencies provide statewide policy, financial, training, and monitoring support.

C. Program Goals for Individual Class Members

The most important part of the **Willie M.** Consent Decree was known as "Paragraph Nine" of the Second Set of Stipulations which describes what the State would do for individual **Willie M.** class members. Paragraph Nine stated:

"In recognition of the above-stated rights, defendants agree and acknowledge their obligation to provide all plaintiffs with appropriate treatment. The scope of defendants' obligation shall be as follows:

(A) Each plaintiff shall be provided habilitation, including medical treatment, education, training and care, suited to his needs, which affords him a reasonable chance to acquire and maintain those life skills that enable him to cope as effectively as his own capabilities permit with the demands of his own person and of his environment and to raise the level of his physical, mental and social efficiency. Such habilitation shall create a reasonable expectation of progress toward the goal of independent community living. Defendants do not guarantee each plaintiff a "cure," but do guarantee each plaintiff a program of habilitation which is a good faith effort to accomplish the goals set forth herein.

(B) Each plaintiff shall be provided with the least restrictive, i.e., most normal, living conditions appropriate for that person. Among the factors to be considered in determining the least restrictive living conditions appropriate for the individual are the need to minimize the possibility of harm to the individual and society.

(C) The goal of habilitation shall be to enable each plaintiff, as appropriate for that individual, to move from:

- (1) Living and programming segregated from the community to living and programming integrated with the community;
- (2) More structured living to less structured living;
- (3) Group residences to individual residences; and
- (4) Dependent living to independent living.

(D) Each plaintiff shall be provided such placements and services as are actually needed as determined by an individualized habilitation plan rather than such placements and services as are currently available. If placements and services actually needed are not available, the person shall be entitled to have them developed and implemented within a reasonable period. Prior to development and implementation of needed placements and services, the person shall be entitled to placement and services which meet as nearly as possible his actual needs."

Paragraph Nine has served as the standard by which all individual **Willie M.** services have been developed over the years. It remains to this day the single driving philosophy of the program. The definition for class membership has been enacted into law [N.C.G.S. 122C-3(13a)] and the service requirements have been codified into Rules [NC Administrative Code T10: 14V.7000].

While Paragraph Nine did not guarantee a "cure" to children, the state agencies have always attempted to design and deliver services that would have positive long-term impacts on children's functioning. In 1992, the General Assembly directed DHR and DPI to develop a plan to achieve compliance with the lawsuit and to collect and report on whether **Willie M.** children make progress while receiving services. Along with an overall plan for achieving compliance, DHR and DPI developed a statement of desired outcomes for **Willie M.** class members at age 18. Although no one can guarantee successful outcomes for all class members, the State adopted the following service goals:

- Education - The class member attends and participates in educational services appropriate to his needs.
- Health - The class member will, to the extent that he is able, maintain a state of health sufficient for his participation in normal, productive, and rewarding activities.
- Housing/Residential - The class member has a "home," even if it is not his natural home, which provides him with a safe, nurturing environment conducive to the achievement of all of his other goals and objectives.

- Social - The class member has at least one person who is also an advocate, friend, and confidant who maintains a long-term relationship with the child, fostering trust, self-esteem, and social competence.
- Vocation - The class member is engaged in meaningful employment in a real work setting of his choice, or in activities leading toward that goal.
- Behavior - The class member develops the social competence and coping skills he needs in order to reduce or ameliorate assaultive and aggressive behaviors.

In 1994, DHR began collecting simple measures of current functioning of class members and has collected the same information on all certified class members six times since then. Starting in 1995, DHR began annual formal assessments of each child's current functioning, as well as an inventory of the conditions and experiences which put the child "at-risk" for poor outcomes in life as well as "protective factors" which might reduce such poor outcomes. Results from these ongoing assessment activities are reported later in this report (Section 5).

D. Current Legal Status of the Willie M. Program

The 1995 General Assembly enacted legislation [N.C.G.S. 122C-3(13a)] defining clients eligible for **Willie M.** services in a manner consistent with the definition in the original lawsuit. In addition, the legislation authorized DHR to adopt rules governing determination of eligibility for services, ensuring provision of services and providing for contested case hearings [N.C.G.S. 122C-194-200]. These actions by the General Assembly were to enable the State to assume complete responsibility for the operation of the **Willie M.** program without continued oversight by the federal court.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services implemented the above-referenced rules, effective March 1, 1997 [N.C. Administrative Code T10: 14V.7000]. The Rules cover the following general areas of the program:

- Detailed eligibility criteria for services;
- Application and eligibility determination procedures;
- Needs assessment, service planning and service provision requirements;
- Area program and Division requirements;
- Procedures for providing prior notice to parents of proposed changes in the service plan or services;
- Procedures for responding to and resolving disputes about a child's needs assessment, service plan or services (including the availability of third party mediation, the right to file a petition for a contested case hearing, and administrative review by a departmental review officer).

Over the past number of years, the State has demonstrated its commitment to these children by putting in place and providing the services they need. This, coupled with the state statute defining the children eligible for **Willie M.** services and the resulting rules for the **Willie M.** program, provided the basis for the State's motion to the federal court in January, 1997, that the Court find the State in compliance with the **Willie M.** lawsuit and dismiss the case, thus ending the need for continued federal court oversight. The defendants and plaintiffs presented evidence and oral arguments on behalf of their motions in September, 1997.

On January 22, 1998, Judge Graham Mullen ordered the dismissal of the **Willie M.** Consent Decree and lawsuit. Judge Mullen found that the state's program of services for **Willie M.** class members complied with the decree "to the extent practicable." He further found that changes in law since the Consent Decree was signed in 1980 removed the basis for federal court jurisdiction in the case. While noting that the changes in federal law since the filing of the lawsuit removes this case from federal jurisdiction, he also emphasized that the State's obligations to these children under state law are still subject to enforcement by state courts.

In 1979, when the lawsuit was brought, these youngsters would have been shuffled off to training schools, state hospital wards, or inappropriate home placements with little or no attention given to their unique problems and disabilities. Today, however, there is an integrated system of care in place for these children that is unsurpassed in the nation. The system:

- identifies these kids;
- determines their needs and develops individualized services to address them;
- supports those services through ongoing funding;
- provides redress to clients and families who have complaints about services;
- monitors and regulates itself;
- has been enacted into state law and administrative regulation;
- experiences long-term funding support from the General Assembly; and
- is achieving positive outcomes for a group of extremely challenging youngsters, who without these services would not be making this kind of progress but still would be costing the State extensive amounts of money to serve or contain.

The end of the lawsuit does not mean the end of the State's commitment to identify and serve children and adolescents with serious mental, neurological, or emotional disabilities accompanied by violent or aggressive behavior. It simply means that we can now exercise our responsibilities to serve these children without the oversight of the federal court. These children are still out there and in need.

E. Management of the Willie M. Program

The **Willie M.** Program now encompasses over 1,500 active clients, over \$82 million in state and federal funding, and thousands of people working full or part time all over the state serving this very difficult population. Management of an endeavor this large and complex requires a commitment to quality, efficiency, and results. The state agencies have invested significant resources in quality improvement efforts to ensure that public funds are spent in ways that provide the maximum opportunity for class members to heal, develop, and progress into productive adulthood.

The quality improvement philosophy under which the program is managed requires that a variety of data collection and monitoring activities be conducted on a continuous basis. The purpose of these activities is to learn as much as possible about the problems our clients face, the services they receive, the costs of those services, the outcomes they achieve, and the factors associated with good or bad outcomes. With these types of findings, the program staff can then adjust service packages, clinical practices, organizational and financial arrangements, training needs, or other aspects of the system to better serve the clients.

The **Willie M.** Program has always maintained a focus on the individual child, his/her particular needs, and his/her service planning. Accordingly, much of our monitoring system is aimed directly at individual child needs, services, and outcomes. In order to achieve the best outcomes for all children and in order to ensure cost-effective service provision, the program staff must also monitor how whole systems of services perform for large groups of clients. With this in mind, staff prepare aggregate statistics on children, services, and expenditures; monitor performance of local agencies involved in **Willie M.** services; and monitor trends in demographics, social problems and service practices in the larger human services world and general society. The results of system monitoring can be used in designing service system improvements and enhancing clinical knowledge and practice. In addition, the results can and should be used for reporting to the general public to whom the system is ultimately accountable.

Section Two

Description of Willie M. Class Members

This section of the report will describe the children who have qualified as **Willie M.** class members. The section will provide information on:

- how children become class members,
- the number of children served,
- demographic characteristics of the children,
- psychosocial characteristics of the children, and
- understanding the growth in **Willie M.** class members.

A. How Children Become Willie M. Class Members

Anyone who knows a child and is familiar with his problems may request that the child be considered for **Willie M.** services. A nomination/application form is usually submitted to the child's area mental health center, where staff assist with completion of the application form, obtain consent form signatures, and gather supportive documentation.

Since **Willie M.** class membership is voluntary, the child's parent or legal guardian must provide consent before a child can be certified. Two separate signatures are required; one for a general release of information, and the other for educational information. The child's nomination will be halted if consent is withdrawn at any time during the certification process.

Once consent is granted by the parent or guardian and the necessary information collected to demonstrate the child's need for services, the nomination is sent to the **Willie M.** Section in Raleigh for determination of eligibility for the program. Section staff, with the assistance of contracted specialists, review the nomination and render decisions on whether the child meets each of the criteria for eligibility. If the child meets all of the criteria, the Section certifies the child as a class member eligible for services and notifies all relevant parties of the decision. At that point, the Area Mental Health Program staff begin the treatment planning process to bring the child into appropriate services.

If the child does not meet all of the criteria, the application/nomination is turned down, and all parties are notified of this decision and the reasons for it. If the applying party or the parent/guardian has additional information for consideration of the nomination, the nomination may be reactivated on request. The state staff will

reconsider the decision rendering a new decision as warranted and notifying parties of the decision. If the applying party disagrees with the decision, he/she may appeal the decision through the Program's Contested Case Hearing Process.

This application process has remained essentially the same throughout the history of the Program. Since 1981, over 8,000 children have been nominated for class membership, and over 5,000 have been certified as class members.

B. Number of Willie M. Class Members

The number of Willie M. class members has been growing. As of December 31, 1997, there were 1,523 certified eligible Willie M. class members. This represented an increase of more than 8% over the previous year-end total. During the fiscal year 1996-1997, the Willie M. Program served 1,806 class members. The number served in a year is always higher than the number certified eligible at a point in time due to new certifications and class members turning 18 or "aging out" during the year so that they are no longer eligible.

Table 1 presents the historical data for the number of certified children by calendar year as well as the number of new nominations and certifications. The number of children currently eligible has been growing over time with most of the growth occurring in the last five years, an approximate 40 percent increase in currently eligible members since 1992. Because of the importance of this growth and its

Table 1 History of Nominations, Certifications, and Eligibles by Calendar Year				
Period Ending	Number Nominated	Number Certified	Number Pending End of Period	Number Certified Eligible End of Period
Through 1982	2455	1060	N/A	951
1983	559	294	457	1078
1984	337	257	162	1099
1985	360	249	N/A	1060
1986	279	226	N/A	1109
1987	273	229	144	1041
1988	351	211	207	1033
1989	312	242	122	1062
1990	378	232	160	1028
1991	356	218	179	1033
1992	327	267	130	1091
1993	523	351	97	1230
1994	427	215	122	1215
1995	489	334	146	1245
1996	557	396	145	1407
1997	602	439	104	1523

connection to other changes in class membership, the issue of growth is discussed in greater detail later at the end of this section of the report (See Section E, page 23).

Nominations and certifications are also at historic highs and increasing. There were 602 children newly nominated during 1997--an increase of 8 percent from the prior year--and 439 were certified as class members during the same period--an increase of 11 percent from 1996. The number of nominations and new certifications has grown substantially over time. In the last ten years the number of nominations has more than doubled, increasing by 120 percent since 1987. Similarly the number of certifications has climbed significantly, increasing by 92 percent in the same ten year period.

The number of **Willie M.** children being served in public schools has followed the same pattern of growth. The Department of Public Instruction is responsible for ensuring that **Willie M.** class members receive appropriate educational services. These services are also provided in accordance with federal and state laws governing programs for exceptional children. The vast majority of **Willie M.** students are classified as exceptional children and receive special education and related services through Local Educational Agencies (LEA).

A periodic headcount is conducted as a partial means of monitoring the educational services being provided in local educational agencies to class members. The number of **Willie M.** children being served by LEAs as of June 15, 1997, was 1,205, an eight percent increase over the prior year (see Table 2). The number of class members being served by LEAs is always less than the total number of class members because some children are being served in other educational settings such as state institutions and others are no longer in school. The number of members being served by local school systems naturally shows the same upward trend as the entire class population over time, although it is increasing faster, up sixty-five percent in the last five years. The effect of this faster increase is that a greater proportion of **Willie M.** class members are now being served in the public schools. In 1992, approximately sixty-seven percent of the certified members were in public schools, while in 1997 the number had climbed to seventy-nine percent. Keeping keep class members in school is one of the important goals for these children and represents a sign

Table 2 Number of Children Served and Local Education Agencies (LEAs) Providing Service		
Period Ending June 15th	Number of Class Members Served by LEAs	Number of LEAs Providing Services
1991	770	100
1992	731	98
1993	853	104
1994	970	98
1995	1008	99
1996	1117	96
1997	1205	102

of overall progress for the program. The fluctuation in number of LEAs providing service is primarily due to the effect of small school districts which may not always have a class member from year to year and the declining number of school districts across the state due to consolidations.

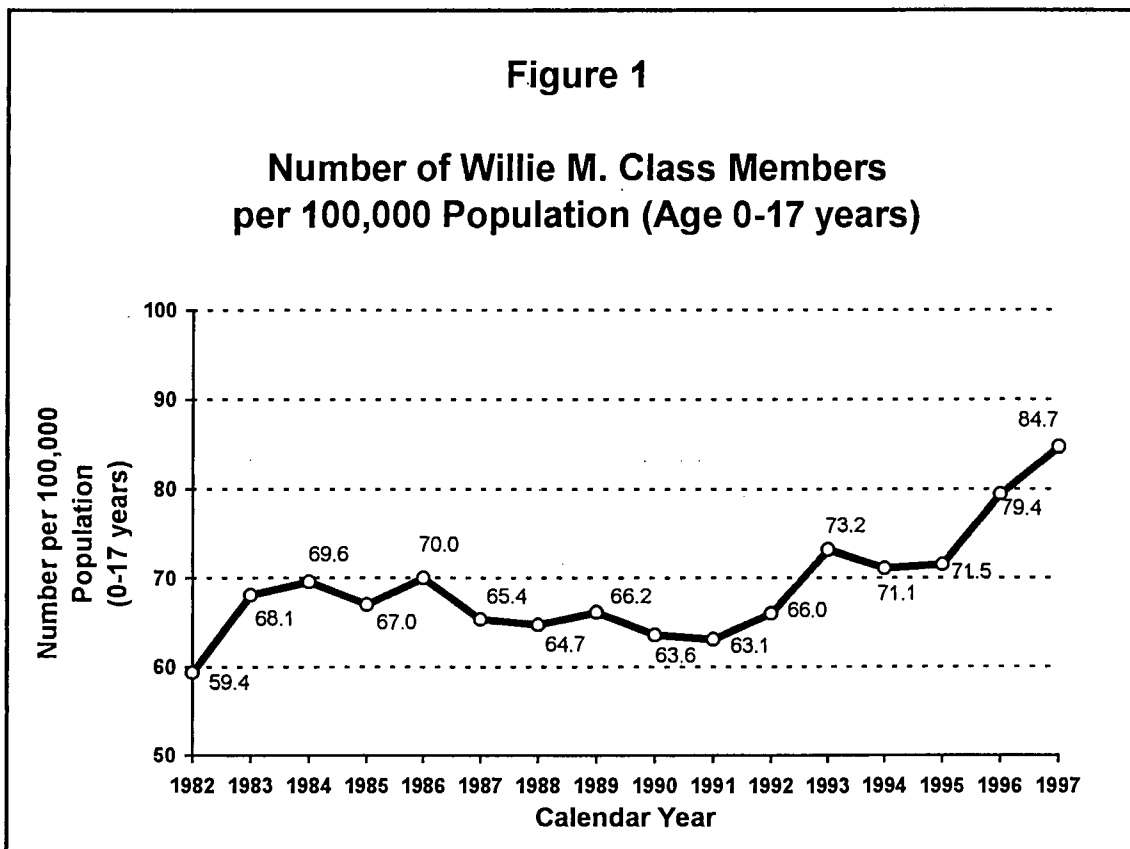
C. Demographic Characteristics of Willie M. Children

While the number of Willie M. children has been increasing, the demographic characteristics of those being served has remained relatively stable over time. Class members come from across the state and are predominantly male teenagers which is primarily a function of the certification criteria for the program.

1. Frequency of Willie M. Children in the General Population

The number of Willie M. children is fairly small when compared to the population as a whole. With 1523 class members at the end of 1997, this is only 0.085 percent of the child population aged 0-17 in North Carolina or roughly one Willie M. child for every 1,200 children in the state.

The number of Willie M. children relative to the population has been increasing. Figure 1 shows the number of currently eligible Willie M. children in



North Carolina per 100,000 children by year since the program's start. While the rate remained relatively stable in the early years, the frequency has noticeably increased beginning in the last few years. Before 1993, the rate never exceeded 70 Willie M. kids per 100,000 population, but since that time it has not been below this level. The increase in the rate from 66.0 in 1992 to 84.9 in 1997 is 28.6 percent. This increase is caused in large part by an increasing number of nominations and certifications to the class and by children being certified at a younger age which means that they stay in the program longer.

2. Distribution of Willie M. Children Across North Carolina

Children being served by the Willie M. program can be found all across the state. Table 3 shows the number of class members who were eligible to receive services at the end of 1997 by their home area mental health program. The table also shows the frequency of eligible children relative to the total child population in the respective areas.

Standardizing rates of certification per 100,000 population under 18 provides a perspective on how local catchment areas compare to one another. In particular, relative participation in the Willie M. program for each local mental health catchment area can be measured against the state totals listed in the last line of the table. There is a large range about the state average. Rutherford-Polk, the highest area in 1997, had a rate of participation relative to the youth population four times higher than the lowest area, Duplin-Sampson. Differences are probably due to a combination of referrals, local administrative operation, and social demographics, but examination of the participation rates have not revealed a clear pattern which would explain the variation. Areas with the highest number of active certified children relative to the population include Foothills, Rutherford-Polk, Smoky Mountain, Vance-Granville-Franklin-Warren, and Wayne. Areas with particularly low rates compared to the state include Duplin-Sampson, Onslow, Roanoke-Chowan, and Wake.

It is worth mentioning that although some local areas have high rates and others low ones, many programs have wide variations in their certification rates across time. This variation is probably more a reflection of organizational and administrative changes within the local systems than due to changes in the characteristics of their youth population. Changes such as the emerging presence of managed care in the last few years, shifts in philosophical orientations of mental health practitioners, and changes in service composition in mental health and educational areas may account for fluctuations of certification rates over time. An examination of rates over time has shown that the range of rates across area programs has narrowed over time suggesting a higher degree of consistency across the state.

Table 3

**Location of Certified Eligible Willie M. Class Members
by Area Mental Health Program as of December 1997**

Area Program	Certified Eligibles as of Dec. 97	Eligibles per 100,000 Population, Age 0-17
<i>Eastern Region</i>	291	77.1
Albemarle	20	74.6
Duplin Sampson	8	33.2
Edgecombe-Nash	24	64.3
Halifax	11	70.7
Lenoir	12	81.5
Neuse	32	79.8
Onslow	21	50.8
Pitt	32	105.2
Roanoke-Chowan	9	47.6
Southeastern-Central	56	101.2
Tideland	13	57.4
Wayne	36	126.9
Wilson-Greene	17	78.7
<i>North Central Region</i>	339	85.5
Alamance-Caswell	29	92.4
Durham	50	104.4
Forsyth-Stokes	48	56.1
Guilford	61	69.5
Orange-Person-Chatham	41	105.6
Rockingham	23	111.3
Surry-Yadkin	37	76.5
Vance-Granville-Franklin-Warren	50	138.9
<i>South Central Region</i>	381	84.0
Cumberland	70	80.7
Davidson	33	100.5
Johnston	19	76.3
Lee-Harnett	34	103.2
Randolph	32	110.4
Sandhills	49	102.8
Southeastern Region	74	116.1
Wake	70	51.5
<i>Western Region</i>	512	89.8
Blue Ridge	61	115.4
Catawba	24	78.9
Cleveland	20	91.1
Foothills	68	130.8
Gaston-Lincoln	58	98.1
Mecklenburg	87	56.3
New River	23	77.2
Piedmont	83	83.0
Rutherford-Polk	24	138.5
Smoky Mountain	43	137.0
Trend	21	100.2
<i>Entire State</i>	1523	84.7

3. Age of Willie M. Children

Most of the Willie M. children are teenagers. The average age of children in the program at the end of 1997 was 14.6 years. However, it is very important to understand that there is a wide range in the ages of Willie M. children with the youngest in 1997 being only 4 and the oldest 18. While children in the program generally are removed from the active list at their 18th birthday, some members remain past this time if they are near completion of school or other services. Table 4 shows the distribution of Willie M. children by their age. Although most of these children are teenagers, it is important to recognize that a large number are quite young. One-fourth of the class membership, 24 percent, are 12 years of age or younger.

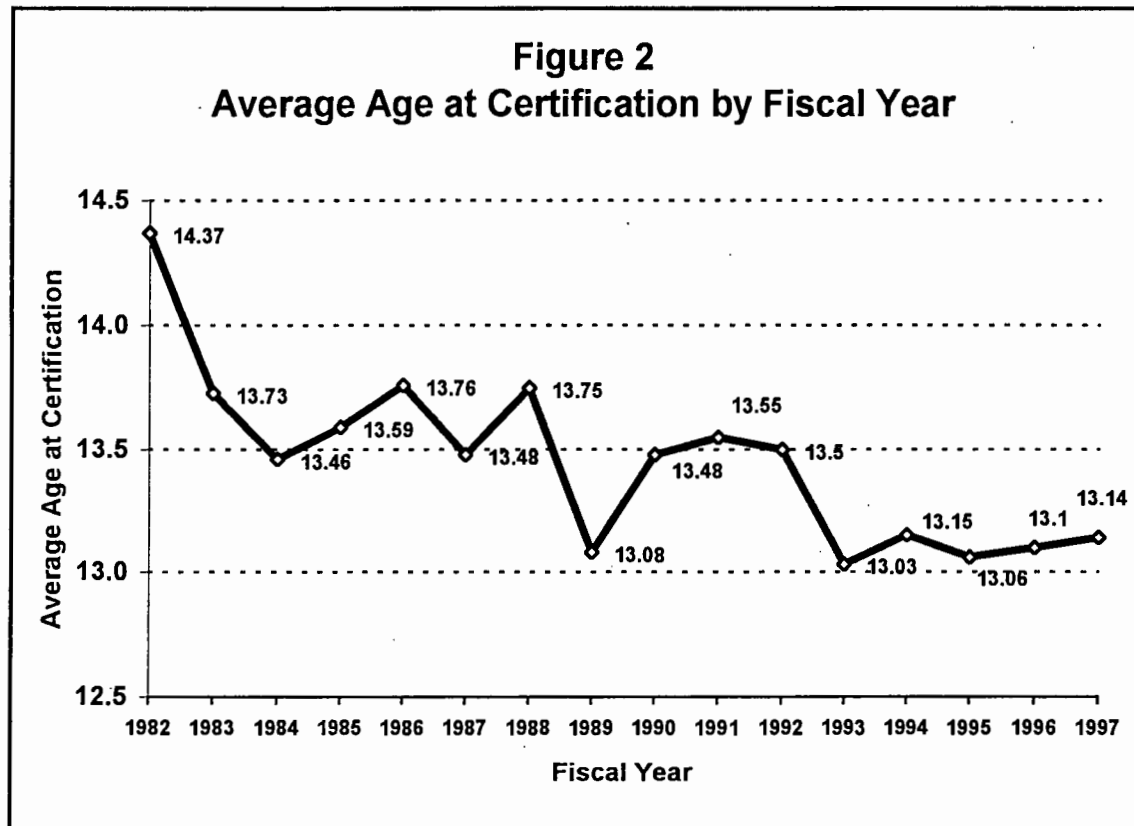
While the average age of class members has remained relatively stable over time, there is a modest trend in younger children being admitted to the program over time. Figure 2 shows the average age of newly certified children for each year the program has been operating. For the most recent fiscal year, the average age at the time of certification was 13.14. Over the course of the program, the average age at certification has ranged from a high of 14.37 years for the first period recorded (FY82) and a low of 13.03 occurring more recently (FY93).

Examination of Figure 2 shows a trend with a modest decline in the average age at certification. Excluding the first year, which was unusual due to factors associated with program startup, the average age has declined from 13.73 in FY83 to 13.14 in FY97. While this difference is only 0.59 years, the effect on the number of children in the program is noticeable. For FY83 the average child could have been expected to stay in the program 4.27 years, while children entering in FY97 would be expected to remain in the program 4.86 years on average. This small difference would have the effect of increasing the total number of children being served at any given time by approximately fourteen percent all other things being equal. The identification of younger children is desirable because it allows for earlier and longer provision of

Table 4
Age Distribution of Willie M. Children as of December 1997

Age	Number	Percent of Total
4	1	0.1
5	4	0.3
6	3	0.2
7	15	1.0
8	37	2.4
9	36	2.4
10	68	4.5
11	92	6.0
12	110	7.2
13	144	9.5
14	204	13.4
15	249	16.3
16	286	18.8
17	248	16.3
18	26	1.7
Total	1523	100.0

services to class members with, what is hoped, more positive outcomes. Whether the downward trend will continue or will level off at approximately 13 years of age is unclear. It seems likely that given the certification requirements of violent behavior, the average age should probably not drop significantly further.



4. Grade Placement in Schools for Willie M. Children

The distribution of Willie M. children across grade levels in public schools ranges from day care up to the 12th grade as would be expected given the wide range of ages in the class members. The average placement for these children is the seventh grade level. Most class members are either in junior high or high school (see Table 5). However, more than one-fourth of the class members are in grade school or below. Ungraded children are class members who are severely impaired and are not classified into a grade level because of the impairment. Grade level placement was also unavailable for some of the children.

Table 5		
Grade Placement as of June 15, 1997		
Grade Level	Number	Percent of Total
Day Care	3	0.2
Kindergarten	4	0.3
1	20	1.7
2	21	1.8
3	42	3.5
4	53	4.4
5	79	6.6
6	110	9.1
7	149	12.4
8	155	12.9
9	215	17.8
10	154	12.8
11	103	8.5
12	34	2.8
Ungraded	45	3.7
Unavailable	18	1.5
Total	1205	100.0

5. Race of Willie M. Children

The racial distribution of certified class members has remained relatively stable over time with the percentage of white members hovering just over half of the total class. At the end of 1997, whites represented 53 percent of the total class, African-Americans were 42 percent, and other groups represented the remaining 5 percent. In any given year the proportion of newly certified children will vary but this pattern has been fairly consistent. There is a recent upward trend in the percentage of those in the "Other" category. In North Carolina there has been a significant increase in the number of Spanish speaking people and in the number of Asiatic persons over the past few years. This trend is beginning to be reflected in the Willie M. population with the "Other" category growing, but the overall percentage is still very small.

6. Gender of Willie M. Children

The class has always had an overwhelming predominance of males. At the end of 1997, males were 83 percent of the total class membership. This percent has remained relatively stable over time with males generally representing 80-85 percent of the total population in most past years. The preponderance of males is clearly a function of the criteria for certification, which include behaviors that are traditionally associated with males, such as externalizing and/or aggressive behaviors.

D. Clinical and Psychosocial Characteristics of Willie M. Children

The most important issue to understand about the **Willie M.** class of children is that they are a population that has significant emotional, psychological, and social problems and are facing substantial obstacles to normal functioning in society. Indeed, by a variety of different measures, **Willie M.** class members can be seen to be not just another group of children "at risk," but are in fact very "high-risk." The needs of class members are correspondingly much higher and their prognosis much less certain.

1. Clinical Characteristics

It is clear from statewide data that **Willie M.** class members, as a group, have much more severe problems and more seriously impaired functioning than all other children who come to area mental health programs for services in North Carolina. The Division of Mental Health requires that all children served by area mental health programs be assessed for overall global functioning using a standardized instrument for clinical populations which is used for determining eligibility for mental health services. This instrument is the Child and Adolescent Functional Assessment Scale (CAFAS). A 1996 survey of CAFAS scores revealed an average score of severity of 92.7 for **Willie M.** youth, compared to 47.8 for non-**Willie M.** youth who used mental health services in North Carolina.

Assessment of the class members shows that most have multiple psychiatric disorders. Two-thirds of the class members had two or more major psychiatric disorders while one-third had three or more disorders. The most prevalent psychiatric diagnoses listed for class members (counting multiple diagnoses) on the **Willie M.** Simple Outcome Checklist were:

- Conduct Disorder (55 percent),
- Attention Deficit/Hyperactivity Disorder (36 percent),
- Other Disruptive Behavior Disorders (21 percent),
- Mental Retardation (19 percent),
- Depressive Disorders (19 percent),
- Post-Traumatic Stress and Related Disorders (16 percent), and
- Substance Abuse Disorders (13 percent).

Other disorders present in less than 5 percent of class members included: Bipolar Disorder, Psychotic Disorder, Pervasive Developmental Disorder, Other Anxiety Disorders, and Paraphilias.

Given the psychological problems facing Willie M. children it should not be surprising that they are classified as having numerous educational handicaps as well. The Department of Public Instruction collects information about educational handicaps faced by class members. As in previous years, the most common classification is that of Behaviorally/Emotionally Handicapped (BEH) with more than three-fifths of all class members being so classified (see Table 6). Fourteen percent or one in every seven of the Willie M. children in public schools were not identified as having any educational handicap.

Table 6 Educational Handicap Classification as of June 15, 1997		
Primary Handicapping Condition	Number	Percent of Total
Academically Gifted (AG)	14	1.2
Autistic (AU)	10	0.9
Behaviorally/Emotionally Handicapped (BEH)	755	62.6
Deaf-Blind (DB)	1	0.1
Educable Mentally Handicapped (EMH)	97	8.0
Hearing Impaired (HI)	10	0.9
Multihandicapped (MU)	6	0.5
Orthopedically Impaired (OI)	0	0.0
Other Health Impaired (OHI)	26	2.2
Preschool-Developmentally Delayed (PD)	4	0.3
Severe/Profound Mentally Handicapped (S/P)	5	0.4
Specific Learning Disabled (SLD)	66	5.5
Speech-Language Impaired (SLI)	4	0.3
Trainable Mentally Handicapped (TMH)	30	2.5
Traumatic Brain Injury (TB)	3	0.2
Visually Impaired (VI)	3	0.2
<i>Not Identified as Handicapped</i>	171	14.2
Total	1205	100.0%

2. Psychosocial Risk and Protective Factors

Willie M. class members are “high risk” children. The literature on “high risk” children identifies a number of psychosocial *risk factors* or negative experiences which seem to substantially increase the likelihood of poor life outcomes in realms of mental illness, socioeconomic status, education, vocational instability, criminal justice involvement, and substance abuse. Previous research has found that the presence of four or more *risk factors* predict poor outcomes later in life. However, not all children with multiple risk factors fail to thrive. There is a subgroup of children who possess *protective factors* or positive experiences that allow them to avoid those poor outcomes later in life. It is these protective factors and their ability to play a role in improving functioning for at-risk populations of children that has given rise to the notion of “resiliency” as a concept that helps explain why some children go on to lead fairly normal and productive lives even in the presence of great handicaps and obstacles.

A list of risk factors and protective factors consistently identified in the literature and used for assessment in the **Willie M.** program is provided in Table 7. These factors are evaluated for all **Willie M.** children on the Assessment Outcome Instrument (AOI), and can be divided into several conceptual categories: early developmental factors, skills and competencies, social skills, confident attitudes, family factors, and social support network. A major goal of treatment of “high risk” children is to increase their protective factors or positive experiences to allow them to improve themselves.

Table 7

PSYCHOSOCIAL RISK AND PROTECTIVE FACTORS

Risk Factors

Early Developmental

Premature birth or complications
Fetal drug/alcohol effects
"Difficult temperament
Poor infant attachment to mother
Shy temperament
Siblings within 2 years of child
Developmental delays
Long-term absence of caregiver
in infancy

Childhood Disorders

Repeated aggression
Delinquency
Substance abuse
Chronic medical disorder
Behavioral or emotional problems
Low IQ < 70

Parental Disorders

Parent with substance abuse
Parent with mental disorders
Parent with criminality

Family Stress

Family on public assistance or
living in poverty
Separation/divorce/single parent
Large family, 5 or more children
Frequent family moves

Experiential

Witness to extreme conflict/violence
Removal of child from home
Substantiated neglect
Physical abuse
Sexual abuse
Negative relationship with parent(s)

Social Drift

Academic failure or drop-out
Negative peer group
Teen pregnancy, if female

Protective Factors

Early Developmental

"Easy temperament
Positive attachment to mother
Independence as a toddler

Child Competencies

Reasoning and problem solving skills
Good student
Good reader
Child perception of competencies
Extracurricular activities or hobbies
IQ > 100

Family

Lives at home
Parent(s) consistently employed
Parent(s) with high school degree or better
Other adults or children to help with childcare
Regular Involvement in church
Regular rules, routines, chores in home
Family discipline with discussion and fairness
Positive relationship with parent(s)
Perception of parental warmth

Child Social Skills

Gets along with other children
Gets along with adults
"Likeable" child
Sense of humor
Empathy

Extra-Familial Social Support

Adult mentor outside family
Support for child at school
Support for child at church
Support for child from faith
Support for child from peers

Outlooks and Attitudes

Internal locus of control as teen

2. (a) Psychosocial Risk Factors

Risk factors are traits, characteristics, innate abilities or deficits, and life experiences that increase the chances of poor outcomes later in life. These are factors that have been identified by researchers over the last twenty-five years in studies of child functioning over time. As already noted, research has shown that when a child has four or more of these risk factors present, he will probably face significant problems later in life. Based on the most recent assessments done of class members, the average Willie M. child had 13.0 risk factors, placing this group of children at extremely high risk for poor life outcomes.

By definition of the class, all **Willie M.** children have the risk factors of behavioral aggression and emotional/mental disorder at the time of initial certification. Review of the data reveals that about half of the class members had aggressive behavior noted in preschool years, while over 90 percent had developed aggression by the time they reached school age. Listed below is information on the prevalence of some of the known risk factors among **Willie M.** class members as a group from the most recent assessment done for 1635 children through February 1998. Because this information is based on the most recent assessment, many of the children actually were worse off at their initial certification.

The early development of **Willie M.** children is marked by adversity.

- 38.5 percent showed developmental delays
- 17.6 percent experienced long-term absence of a primary caregiver in infancy
- 13.2 percent experienced fetal alcohol or drug exposure
- 11.7 percent were born prematurely or had complications at birth

Willie M. children have had significant negative experiences past infancy.

- 76.6 percent have witnessed extreme conflict or violence
- 72.1 percent have negative relationships with one or both parents
- 68.9 percent have been removed from their homes at some point
- 52.0 percent have been documented as being physically abused
- 33.2 percent have been documented as being sexually abused

Most class members come from extremely stressed families.

- 78.3 percent of the children come from families living in poverty
- 75.4 percent come from single parent, divorced, or separated families
- 43.4 percent of the families made frequent moves

Most **Willie M.** children have parents with considerable problems themselves.

- 56.7 percent have parents with mental disorders
- 53.0 percent have parents with substance abuse problems
- 35.4 percent have parents with some criminal involvement

Willie M. children have numerous childhood disorders.

- 96.8 percent have a problem with repeated aggression
- 93.0 percent have behavioral or emotional problems
- 85.7 percent have been in trouble with the law
- 24.5 percent have chronic medical disorders
- 20.2 percent have a substance abuse problem
- 18.1 percent are mentally retarded (IQ below 70)

For the class as a whole, females have slightly more risk factors on average. The difference is statistically significant but totals less than one risk factor. It is clear that the **Willie M.** class members represent a very troubled group of children. While many of these risk factors cannot be eliminated now that the damage has been done, focusing on protective factors may allow a base to be built which will give these children the capacity to overcome the difficulties they have faced.

2. (b) Psychosocial Protective Factors

Protective factors are specific characteristics of a child, or aspects of the child's history, family life, and social support network, which studies have shown to confer protection against poor outcome in high-risk youth. Studies of resiliency in certain high-risk youth suggest that the extent to which a child possesses these positive qualities or experiences offers the possibility of averting common undesirable outcomes, including mental illness, school drop-out, vocational instability, criminal involvement, substance abuse and social dysfunction. Based on the most recent assessments done of class members, the average **Willie M.** child had 13.3 protective factors, slightly more than the number of risk factors.

Because of the importance of protective factors for fostering resilience or the ability to overcome risk factors, adding protective factors for children has become a key focus of treatment plans. Results suggest that some success is being achieved in this area. For children who have been assessed more than once while in the program, on average these class members have added four protective factors to what they had at their first evaluation versus an increase of only two additional risk factors since the first evaluation. This net increase in positive factors should increase the likelihood that these children will overcome their difficulties.

Examination of the protective factors and their frequencies among **Willie M.** youth reveals marked deficiencies of certain protective factors, although a surprising number of class members possess a perception of competency at some activity and the perception that their parents truly care about them, both of which are perceptions shown to protect against adversity. Of great concern, and of considerable importance in planning treatment strategies, is the observation that only around half of all class members perceive themselves to have an adult mentor, outside the immediate family, to provide emotional support. Studies of resilient youth suggest that nearly all of those who rose above their risk factors were able to identify some adult mentor figure who was there for them as a refuge and support in times of need. Listed below is information on the prevalence of some of the known protective factors among **Willie M.** class members as a group.

Self-perception of competency at some activity is high, though specific competencies are generally low.

- 94.1 percent of the **Willie M.** children perceived themselves as being competent at some activity
- 45.1 percent engaged in some hobby or extra-curricular activities
- 42.6 percent showed problem-solving skills
- 24.0 percent were good readers
- 14.2 percent were judged good students

Family support varies widely for **Willie M.** children, though more than half show some degree of positive family nurturing.

- 78.6 percent of the children feel their parents care
- 74.1 percent had other adults or children to help with childcare
- 71.9 percent had parents who were consistently employed
- 61.4 percent had parents with a high school degree or better
- 58.2 percent of the children came from families with regular rules, routines, and chores at home
- 55.2 percent of the children had fair discipline at home
- 48.1 percent had positive relationships with their parents
- 41.4 percent of the children were in families with regular church involvement

Social skills for **Willie M.** children are frequently absent.

- 63.2 percent of the children are perceived as "likeable"
- 55.9 percent are described as having a sense of humor
- 48.1 percent show ability to get along with adults
- 39.8 percent have shown ability to get along with other children
- 28.9 percent have shown empathy or nurturing behavior

Less than half show strong social support outside the child's family.

- 51.8 percent of the children had a positive relationship with someone at school
- 47.0 percent had an adult mentor outside the family
- 42.8 percent had some reliance on inner faith
- 34.1 percent had special support from peers
- 30.5 percent had special support from church

Finally, it is worth noting that there are certain areas of marked gender differences in frequency of protective factors. Specifically, it appears that female class members had fewer early developmental protective factors and fewer family-related protective factors, but presently receive somewhat more social support than boys.

E. Understanding the Growth in Numbers of Willie M. Children

As already discussed earlier in this section, the number of **Willie M.** children has been growing, particularly over the last five years. Since 1992, the number of children being served at the end of the calendar year has grown by nearly 40 percent. Given the importance of this growth for the operation and funding of the **Willie M.** program, it is worth trying to understand why class membership has been increasing. Examination of the available information suggests that there are four primary trends at work which may explain most of the growth and need to be considered in turn:

- a growing youth population
- younger children being certified
- greater social problems, and
- greater notice of the **Willie M.** program.

The youth population of North Carolina has been growing. Since 1981 when the **Willie M.** program began to 1997, the number of children in the state under eighteen years of age has increased by 10.6 percent according to population estimates from the State Planning Office. The total number of children in the state actually declined to a low in 1984 and has been increasing since then. In the last five years, the number of children has increased by 8.7 percent. As the number of children in the state increase over time, there should be an expectation that the number of children being served by the **Willie M.** program will also increase. This growth in the youth population in North Carolina is expected to continue with a further 3 percent increase by the year 2000 and a 5 percent increase by the year 2005.

A second trend in place is that younger children are being certified as **Willie M.** class members. As discussed earlier, the average age at which children become certified as class members has been slowly declining over time. Because all class members remain certified to at least their eighteenth birthday, the effect has been to

increase the total number of children being served. From FY83 to FY97, the average age at certification has dropped from 13.73 to 13.14. This change alone would have the effect of increasing the total number of **Willie M.** class members by 14 percent.

A third set of trends which has probably increased the number of **Willie M.** class members is the rise in a number of social problems such as crime and low-weight births. As already noted in the discussion on risk factors, certain experiences are likely to increase the likelihood that a child will be at risk for mental illness, violence, and other forms of social dysfunction. Therefore, if certain social problems increase substantially, we would expect to see increases in the number of at-risk children such as **Willie M.** class members. For example, the number of violent crimes in North Carolina has increased by 75 percent between 1982 and 1995 (the most recent year for which data was available from the Office of State Planning). Since exposure to violence or extreme conflict is an important risk factor, we might reasonably expect to see noticeable increases in at-risk children. Similarly, premature births or complications at birth is another demonstrated risk factor. The number of low-weight births in North Carolina has increased by 29 percent between 1982 and 1995. It is important to understand that even if these negative trends were to stop today, the lingering effects would continue to manifest themselves in children already born so that it might be five to ten years before the complete negative impact would register. A reasonable method for estimating how much these negative social trends would affect the specific numbers of at-risk children is not available, but it is clear that given the magnitude of these trends some significant effect should be expected.

The fourth important trend which helps explain the growth in the **Willie M.** class size is that the program is receiving more attention and consequently referrals. The program relies on parents, mental health case workers, judges, teachers, and others to refer potential children. Ten to fifteen years ago, the **Willie M.** program was still relatively new and not well-known. With the passage of time more people have become aware of the program and its potential to help severely at-risk children. Within the last ten years the number of children certified as eligible for services at the end of the calendar year has increased by 92 percent or nearly doubled. This is despite the fact that certification criteria have not substantially changed since the program began. Therefore, it would appear that the informal network which refers potential candidates to the program has gotten better at identifying children who meet standards for class membership. Further supporting this argument is the realization that as awareness of the program grows, we would expect to see not only an increase in children who meet the criteria for membership but also an increase in children who do not meet the full requirements even though they have significant problems. The data on referrals supports this view. The number of nominations to the program has been increasing even faster than the number of certifications. In the last ten years, the number of children nominated annually has increased by 120 percent or more than doubled. This means that a growing proportion of children who are nominated or referred do not meet the eligibility standards. In 1987, approximately 84 percent of the children nominated were found to meet certification standards, but by 1997 the proportion of nominations

that were eventually certified had dropped to 73 percent. Again, because certification criteria have not substantially changed since the program began, the lower percentage of children meeting the standards suggests that more people are aware of the program and referring candidates who do not meet the full criteria. Thus, an important factor explaining the growth in **Willie M.** class members is that the informal referral network is finding more of the children who do meet the certification standards.

The overall combination of these four trends would suggest that the increase in **Willie M.** class membership appears to be due to demographic and referral factors which are outside the control of the program. Thus, even if the certification criteria used since the program's start and now established in state law remain unchanged, further increases in the class size are likely. There is insufficient information to predict whether the rate of growth will continue at the pace of the last five years or slow down. It will be necessary to further monitor and study the growth in class membership.

Section Three

The Willie M. Service System

This section of the report will describe the service system currently in place to meet the needs of the **Willie M.** class of children. This service system is composed of a state level administrative organization with actual service provision primarily occurring at the local level with some state provided services also in place to meet the needs of the class. Included in this section will be:

- a description of the service system and
- an explanation of service coordination and planning for individual children.

A. Description Of The Service System

The Department of Health and Human Services (DHHS) and the Department of Public Instruction (DPI) share the responsibility to provide services to the children who are certified as **Willie M.** The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) within (DHHS), acts as the *lead agency* by providing direction, leadership, and "vision" to other state and local agencies and individuals, guaranteeing the class member's entitlement as stipulated in state law and administrative regulations.

1. State Level Administrative System

Within (DHHS), the state **Willie M.** office operates as a Section within DMH/DD/SAS. The Section performs a myriad of administrative and programmatic functions including but not limited to: strategic planning; state level program planning; development and approval of plans for local systems of service; consultation and technical assistance to area programs and contract providers; certification of class members; budget planning and execution; allocation and approval of funding; development and provision of specialized training; monitoring and evaluation of services, both at the individual and system level; operation and management of two secure non-medical treatment units and the coordination of services with relevant agencies and/or contracting with providers or other service systems for the provision of direct services for class members.

The **Willie M.** Section has five different Branches that work on various aspects of administering operations of the program. These Branches are:

- The Service Management Branch monitors all aspects of service planning and service provision to class members.
- The Information Systems Branch manages the **Willie M.** Information System (WMIS) and continuously strives to enhance its quality.
- The Training Branch develops, administers, coordinates, and evaluates training to staff who work directly with class members.
- The Program Evaluation Branch collects and analyzes information regarding the impact of services on the clients as well as monitoring the degree of appropriateness of services that the children receive.
- The Client Eligibility and Information Branch manages the nomination and certification process and implements formal rules regarding the operation of the application/eligibility determination-based system.

In addition to the functions performed by the Branches, administrative staff within the Section oversee the operations of the entire section. This includes working in conjunction with the DPI **Willie M.** Section; interacting with other Sections within the Division and local area programs serving **Willie M.** clients; supervising the overall functioning of the secure treatment units operated directly by the Section; representing the Section as well as coordinating activities with key external stakeholders such as advocates, parents, judges, court counselors, other community agencies and entities, the General Assembly, the Legislative Study Commission on Mental Health, Developmental Disabilities and Substance Abuse Services, private providers, etc.; and handling budgetary and contractual arrangements with area programs and some private providers who work directly with the state level program.

Lastly, the Department of Public Instruction (DPI), is responsible for ensuring that class members receive appropriate educational services in accordance with the administrative regulations as well as federal and state laws governing programs for exceptional children. Within the DPI Exceptional Children's Division, the **Willie M.** Section exists as a separate section set aside specifically to help support **Willie M.** students in the Local Educational Authorities (LEAs) statewide.

A major effort underlying all of the work done by the state offices is the **Willie M.** Quality Improvement Process, a series of comprehensive and ongoing efforts developed by DHHS and DPI to ensure that the local service system is able to meet the changing needs of **Willie M.** class members. The quality improvement process entails monitoring activities which are directly connected to improvement areas in the operation of the program. The primary thrusts of the monitoring activities are directed at individual children and at the system level with part of the system level monitoring relying on aggregated data of individual children. These monitoring activities in turn are connected to efforts to improve quality in individual service planning, clinical knowledge and

practice, and system design and change. Additionally, the **Willie M.** program has engaged in a series of training efforts designed to improve the quality of the knowledge and skills of the people serving these children.

2. Service Delivery System

Providing services for the **Willie M.** children is primarily done at the local level. The **Willie M.** Section arranges with local area mental health programs to develop, coordinate and/or deliver services for class members in their catchment areas. Where that is not possible, the Section contracts with other organizations referred to as "surrogate area programs" or "surrogates" to perform those services. Presently the State arranges services with 38 of the 40 local Area Mental Health Programs and contracts with private providers for services in the remaining two catchment areas. Additionally, a limited number of treatment services are operated directly by the State.

2.(a) The Local Service Provider Delivery System

The local area programs or surrogates have the responsibility of developing, directly providing, and/or contracting for a variety of services to meet the diverse needs of their class members. The organizational aspects of the local **Willie M.** system are determined at the local level with guidance and approval from the State. Each system varies according to size and needs of the class members; internal organization preferences; geography; and the support by and preferences of the area director, area boards, county commissioners and the community at large. Historically, area mental health programs have been organized according to disability areas. With the advent of various changes within the mental health field, such as Carolina Alternatives, a number of area programs have moved to a cross-disability service delivery system, separated by functions rather than disability. These alternative methods of organizing and developing staff are supported by the State so long as class members are served appropriately.

Within the **Willie M.** service system, it is crucial to have a balance of services, with a minimum of core mental health services being provided in every local system. Core services include: case management, clinical assessment and treatment, crisis back-up and stabilization, para-professional/in-home support services, educational services, alternative family living homes and other residential services (group residential treatment, supervised living, secure non-medical treatment, inpatient hospital, etc.), or at least access to those services. Over the past four fiscal years, one of the **Willie M.** Section's major objectives has been the establishment of core mental health services within each area program. Some of these services are provided directly by the local area mental health program and others are available through other service providers such as the Local Educational Authority, Department of Social Services, etc. Each area mental health agency or "surrogate" organizes and structures its **Willie M.** program differently and is reimbursed by the State for the services provided. It may

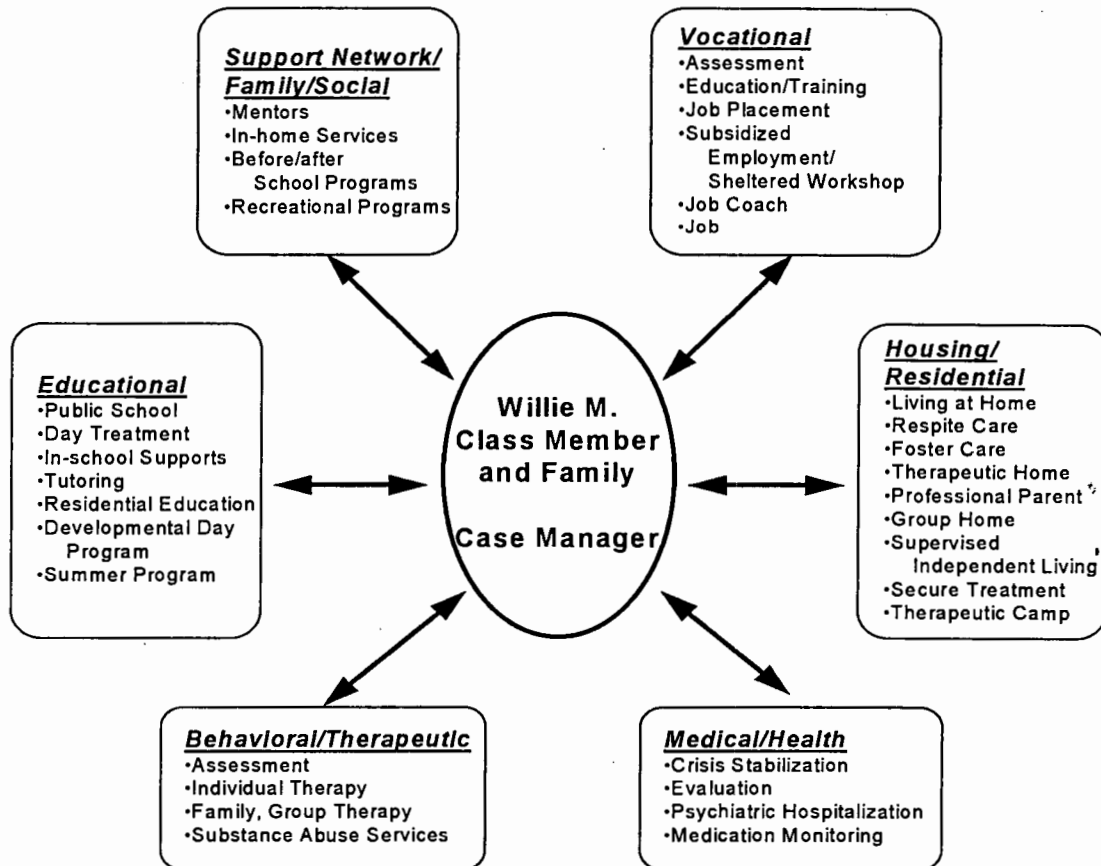
choose to provide all or some of the services directly or contract with private providers and oversee the provision of contracted services. If needed services do not exist within an area, the local area program develops those services within its community or secures an appropriate alternative, such as using established services in another area program or those provided by a private agency.

Willie M. services include housing, education, counseling, medical treatment, vocational training, and other social and human services (see Figure 3 - **Willie M.** System of Services). A case manager assesses the child's needs and coordinates appropriate services from a wide range of providers, including area mental health centers, local school districts, and community and private treatment specialists. The **Willie M.** system of services falls under five categories:

- **Clinical and Staff Services** - These are services, including case management, provided for a child by individual professional or paraprofessional staff in accordance with the child's individual treatment and habilitation plan. In-home services can include crisis intervention, parent training, and counseling for the child and other family members. Outpatient treatment services offer ways to improve or stabilize the child's family environment, to minimize the necessity for out-of-home placement, and to increase the child's family's understanding of how they can affect the child and family's developmental growth.
- **Educational Services** - The majority of **Willie M.** children attend regular or self-contained classes in public schools. Others require even more specialized educational services, such as combined day treatment/education, developmental day care, in-home or inpatient education, or a state-operated program. Related services include before- and after-school programs, and summer camps.
- **Residential Services** - There is a broad range of options for children who cannot live in their own homes, from structured, individual and group environments to independent living. Some live in homes with specially trained staff who serve as "parent substitutes." For children who live at home, respite care provides family members an occasional break.
- **Vocational Services** - Older class members (ages 16-18) may learn pre-vocational and vocational skills, including job interviewing, work values and behavior training, and job skills. Some have supervised work experiences - such as sheltered workshop placements, apprenticeships, and part-time jobs - that help prepare them for independent employment as adults.

Figure 3

Willie M. System of Services



- **Inpatient or Secure Services.** Some class members need short- and long-term hospitalization for diagnostic testing, medical care, and psychiatric treatment. This would also include crisis stabilization when a child is undergoing a psychiatric or emotional episode too severe to be handled in the home, but the child does not need to be hospitalized. Treatment in secure (locked) settings for children who cannot be treated safely or effectively in more normalized community services is also included here.

The type and location of services available are listed in Appendix 1. This Appendix notes the area programs where particular services were given to class members during Fiscal Year 1996-97.

2.(b) State Level Services Contracts

Because of the substantial infrastructure and local networks available through local area programs, it is the policy and preference of the **Willie M.** Section to provide most services through local mental health agencies and to do otherwise only in extraordinary circumstances. The State has entered into contracts with private providers to operate a number of treatment services across the state:

- **Carolina Treatment Services** is under contract with the State to operate a five bed high management group home in Guilford County.
- **NOVA HRS, Inc.** operates eight three-bed supervised residential treatment facilities along with a day treatment program with capacity for 24 students in Wayne County. This program serves class members from throughout the state with preference given to class members from the eastern portion of the state.
- A contract with **Lutheran Family Services (LFS)** was established in Fiscal Year 92-93 to provide services to **Willie M.** class members in Johnston County.
- In Fiscal Year 94-95, the State entered into a contract with the **Institute for Family Centered Services (IFCS)** to provide services for class members from the Albemarle area.

2.(c) State Level Provided Services

In addition to the local provider delivery system, there are a limited number of services operated directly by the State. These are:

- the **Butner Adolescent Treatment Center (BATC)**, a secure non-medical treatment facility serving 12 **Willie M.** class members who require a locked environment in order to participate in appropriate services. The Center opened in February 1992 and operates in four wards of John Umstead Hospital and includes a school program.

- the **Oakview Supervised Apartment Program**, also located on the Umstead campus. Oakview was opened by the State in October 1993 and consists of five apartments capable of housing up to 12 clients. Oakview has 24-hour staffing and provides a transitional residential program for class members leaving secure treatment, institutions, training school or other settings and who may not be ready for full re-integration back into the community. Class members served at Oakview receive their education at BATC, local schools, or adult education programs through the community college. Vocational programming and training are key competencies for older class members. The clients in this program remain under a 122C mental health commitment.
- the **Eastern Adolescent Treatment Program (EATP)**, a program modeled after BATC, opened in September 1995 at the North Carolina Special Care Center in Wilson. EATP is an 8 bed, secure non-medical treatment facility. The **North Carolina Special Care Center**, part of the state system of services, operates this program.

B. Service Coordination and Planning for Individual Class Members

The focus of the **Willie M.** program has always been on the individual child with the aim of meeting his or her needs. Each child has an individual plan developed to address specific treatment issues and a case manager who coordinates the range of services necessary to meet the child's needs.

1. The Individualized Planning Concept

Individualized planning and care are at the heart of **Willie M.** services. Planning for each class member's treatment/habilitation is accomplished under the direction of the case manager through the development of an individualized Treatment/Habilitation Plan or T/HP. Each class member is required to have a T/HP which is now reviewed on an annual basis at minimum, or whenever the individual class member's needs and/or circumstances change. A new Treatment/Habilitation Plan (T/HP) plan form (previously referred to as the Individualized Habilitation Plan or IHP) was developed as a shared plan by **Willie M.**, CAP/MR, and **Thomas S.** during Fiscal Year 94-95. The **Willie M.** Section provided statewide training as the new plan was implemented. This included training in Appropriateness Review monitoring and an overview of the interactive and comprehensive planning process for an individual class member that includes the Appropriateness Review, the Assessment and Outcome Instrument (AOI), and the T/HP. In addition, the Section provides intensive training to new case managers each year in T/HP requirements and **Willie M.** treatment philosophy.

2. Case Management In The "System Of Services"

Case management is the core mechanism around which the complex system of services operates, and case managers are pivotal to the successful operation of **Willie M.** services. An individual case manager is assigned to every **Willie M.** class member to assume the lead role in coordinating the child's treatment and other services. The case manager's responsibilities include planning, coordinating, documenting, and monitoring services provided to a class member and his/her family/guardian or custodian as well as serving as an agency advocate for the class member, particularly with regards to service development and acquisition.

Area programs typically also have an individual person designated as the Coordinator of **Willie M.** services in the catchment area. This person acts as the liaison to the state **Willie M.** Section and is responsible for managing and monitoring the local service system. This person may or may not have other responsibilities within the local agency system.

One key concept in the delivery of **Willie M.** services is the "system of services" model that calls for a broad array of services to be used in the treatment of the **Willie M.** population. This holistic approach looks at the medical, psychological, social, behavioral, educational, vocational, residential and legal aspects of a child's life. **Willie M.** class members have multiple needs that span a variety of services, agencies, community arenas, and systems. Local service systems must be able to respond to the changing needs of their children by changing services or implementing new ones to meet evolving client needs.

Section 4

Expenditures for the Willie M. Program

This section of the report describes the costs of providing services to the Willie M. class of children. The section provides information on:

- Willie M. program funding and expenditures,
- average expenditures for Willie M. children,
- waivers of cost rules, and
- other state funds spent on Willie M. children.

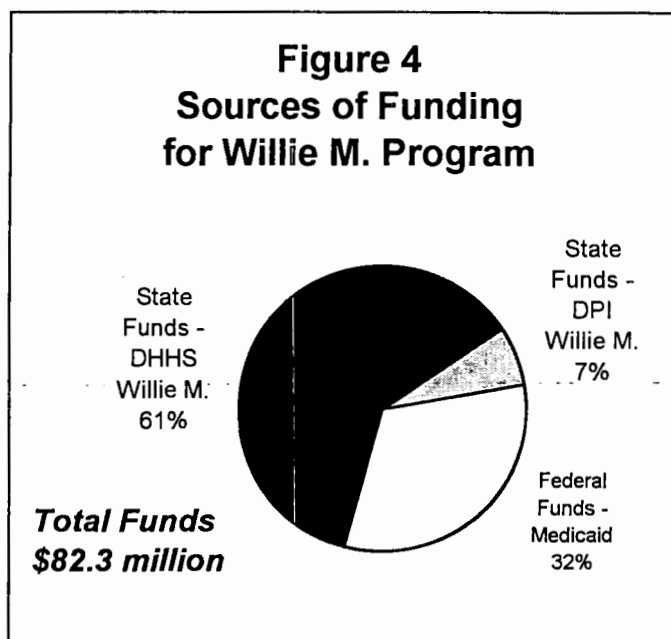
A. Willie M. Program Funding and Expenditures

In Fiscal Year 1996-1997, over \$82.3 million was spent in the Willie M. program. This includes state appropriated funds as well as federal Medicaid dollars. The totals for the program, however, do not include other state expenditures on children in the Willie M. class which were not part of the program's operation. This latter category of spending will be discussed at the end of this section of the report.

1. Sources of Funding for the Willie M. Program

Of the total \$82.3 million spent on the Willie M. program in FY96-97, two-thirds or 68 percent was from state appropriations (see Figure 4). The majority of funds, \$50.5 million or 61 percent, were state appropriations earmarked for the Willie M. program through the Department of Health and Human Services (DHHS). An additional \$5.6 million, seven percent of the total, came from state funds through the Department of Public Instruction's (DPI) portion of the Willie M. program. Federal Medicaid funds accounted for

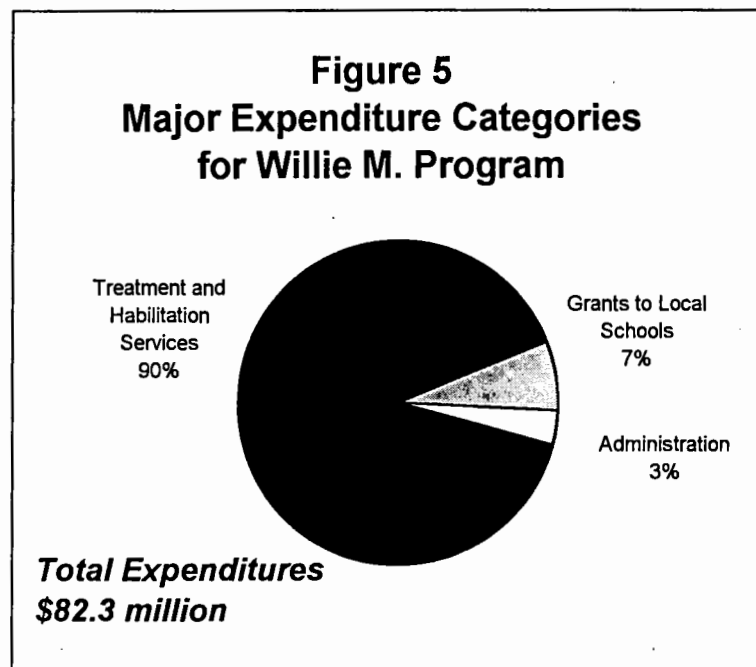
\$26.2 million or one-third of program funds. This large proportion of federal funds reflects strong efforts in the last few years to identify Willie M. children who qualify



for Medicaid in order to further extend state resources. Much of the overall program expenditure growth has been achieved by greater use of federal dollars.

2. Expenditure Categories for the Willie M. Program

Of the total expenditures in FY96-97, \$73.8 million, 90 percent, was for DHHS treatment and habilitation services such as case management and residential services. DPI money, \$5.6 million, accounted for seven percent of the total and was distributed in the form of grants to local school districts for services provided to Willie M. children. Administrative costs for the program totaled \$2.9 million, three percent of the total, with one-fourth of that amount coming from federal Medicaid dollars.



2 (a). Treatment and Habilitation Services Expenditures

Treatment and habilitation services are the largest category of the Willie M. program expenditures. During FY96-97, these services cost a total of \$73.8 million. This total includes not only state expenditures but also federal Medicaid dollars as well. During FY96-97, the Willie M. program served a total of 1,806 children. This was an increase of 14.2 percent over the 1,581 served in the prior fiscal year. The average cost per child for services was \$40,874 in FY96-97, a 10 percent increase from the \$37,135 of the previous year. This average cost per child includes both state appropriations and federal Medicaid dollars. Closer examination of the data show the increase in average cost per child is due to additional units of service being provided rather than increases in the average costs per unit of service.

The treatment and habilitation services can be divided into five functional subcategories: case management, core staff services, alternate family living, group residential, and day services (see Figure 6). Residential services - group residential and alternate family living - are the major categories representing nearly two-thirds of Willie M. program service expenditures. This matches the prior fiscal year where 64

percent of service expenditures were also for residential services.

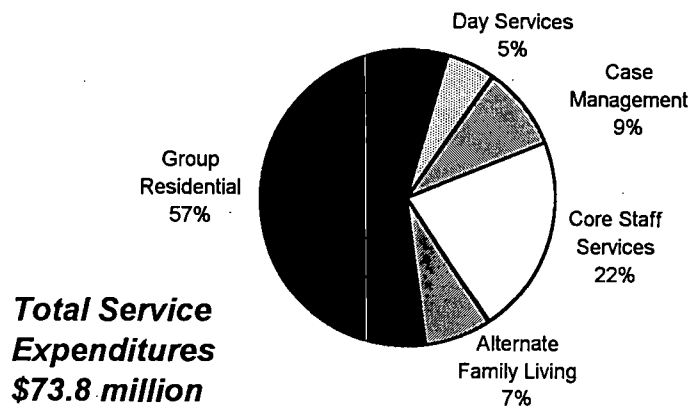
Group residential services represent the largest set of costs and are used for children who require more intensive monitoring or who cannot live at home.

For FY96-97, group residential expenditures represented 57 percent of total treatment and habilitation expenses.

Alternate Family Living represents additional residential services including respite care,

foster care, and other alternative family living arrangements and totaled 7 percent of all of the treatment and habilitation costs. Core staff services represent both outpatient treatment such as counseling but also paraprofessional services designed to help the child meet his/her particular needs.

Figure 6
Treatment and Habilitation
Services for Willie M. Program



As described in the Service Delivery System section, the **Willie M.** system of services is provided through local area mental programs. The actual costs of providing treatment and habilitation services varies by program and by the providers that are used. Further detail about expenditures by service category and the average costs of providing the services in Fiscal Year 1996-97 can be found in Table 8. The expenditures in the table include state appropriations and Medicaid funds. The average unit cost for each service is simply the total expenditures divided by the total number of units provided. As can be seen in Table 8, the cost for particular services can vary with the highest payment frequently being two to four times higher than the lowest payment. However, most payments tend to be near the averages. Unless granted cost waivers, all providers stay within state maximum rates.

Comparisons of average payments paid in FY96-97 with the prior fiscal year show rates being paid increased in some cases but declined in others. Services showing substantial increases in average payments included Evaluation, Group Living - Special, Crisis Stabilization, Inpatient Hospitalization, Before/After School Programs, and Special Summer Programs. However, a number of services had lower average payments in FY96-97 including, Para-Professional Services, Residential Treatment, and Vocational Education. On balance, the effect of average rate changes added less than one percent to the costs of the program for FY96-97. The increase in program service expenditures was due to increased number of children being served and more units of service being provided.

Table 8
Willie M. Program Service Expenditures and Unit Costs
for Fiscal Year 1996-97

Service Component	Number of Providers	Total Expenses	Total Units	Average Payment	Range of Payments	
					Minimum Payment	Maximum Payment
Case Management		\$6,713,493.73				
Case Management	41	\$3,890,251.31	94,997.72	\$40.95	\$26.57	\$49.67
Case Mgmt Support	41	\$2,823,242.42	66,713.55	\$42.32	\$7.03	\$48.69
Core Staff Services		\$16,126,867.32				
Outpatient Treatment	76	\$5,776,432.27	137,042.26	\$42.15	\$18.53	\$90.91
Outpatient Support	51	\$1,948,248.08	46,061.97	\$42.30	\$14.44	\$90.91
Evaluation	43	\$273,056.69	5,446.20	\$50.14	\$17.25	\$180.63
Evaluation Support	27	\$450,815.73	8,908.68	\$50.60	\$33.77	\$100.59
Para-Professional	44	\$6,662,275.42	307,555.47	\$21.66	\$9.58	\$31.06
Para-Prof. Support	27	\$1,016,039.13	46,244.73	\$21.97	\$13.16	\$31.06
Alternate Family Living		\$5,156,250.37				
Respite Care	20	\$205,535.16	3,152	\$65.21	\$57.00	\$234.00
Foster Care	4	\$30,119.20	429	\$70.21	\$63.54	\$81.76
Alternative Family	58	\$4,920,596.01	61,834	\$79.58	\$53.25	\$150.00
Group Residential		\$41,911,164.24				
Group Home-Moderate	4	\$608,699.98	2,978	\$204.40	\$66.00	\$223.33
Group Home-High	83	\$14,980,249.74	65,270	\$229.51	\$90.74	\$312.92
Group Living-Secure	4	\$4,484,158.32	12,368	\$362.56	\$167.31	\$521.32
Group Living-Special	41	\$1,806,640.50	8,956	\$201.72	\$36.79	\$405.62
Crisis Stabilization	6	\$157,038.78	737	\$213.08	\$21.54	\$414.44
Residential Treatment	70	\$16,214,766.03	59,177	\$274.00	\$13.27	\$528.45
Wilderness Camps	33	\$2,298,721.23	11,055	\$207.93	\$78.58	\$300.00
Inpatient Hospital	32	\$1,360,889.66	5,107	\$266.48	\$59.59	\$790.68
Day Services		\$3,910,063.79				
Day Treatment	43	\$3,578,946.78	141,847	\$25.23	\$10.56	\$43.68
Vocational Education	4	\$1,985.74	311	\$6.39	\$5.29	\$9.04
Vocational Placement	5	\$82,241.40	5,525	\$14.89	\$7.93	\$17.58
Before/After School	5	\$71,692.31	4,303	\$16.66	\$15.97	\$22.00
Special Summer Prog.	28	\$175,197.55	19,057.25	\$9.19	\$4.33	\$9.82
TOTAL		\$73,817,839.44				

2. (b) Educational Expenditures

The Department of Public Instruction **Willie M.** funds are designated as "add-on" funds. The Local Educational Agency (LEA) requests funding to supplement and strengthen services for the most difficult to educate class members. Initial allocations are made in August, with adjustments made throughout the year. The State's total allocation was \$5,628,927, an increase of almost 12 percent over the prior fiscal year allocation of \$5,030,757. The allocations by LEA are shown in Table 9.

Table 9
Department of Public Instruction Willie M. Allocations
to Local Educational Authorities, Fiscal Year 1996-97

LEA	Allotment	Students	LEA	Allotment	Students
Alamance	78,693	10	Iredell-Statesville	32,022	4
Alexander	47,997	5	Mooreville City	0	1
Alleghany	9,864	2	Jackson	64,038	6
Anson	0	2	Johnston	121,255	24
Avery	0	9	Lee	47,026	12
Beaufort	36,872	6	Lenoir	109,000	32
Bladen	41,442	5	Lincoln	26,712	10
Brunswick	32,746	8	Macon	870	3
Buncombe	166,998	16	Martin	0	1
Asheville City	73,406	16	McDowell	53,674	11
Burke	109,099	13	Charlotte-Mecklenburg	460,160	108
Cabarrus	102,806	8	Montgomery	0	4
Kannapolis City	16,046	1	Moore	71,179	13
Caldwell	199,143	34	Nash	48,534	6
Camden	9,595	3	New Hanover	76,123	21
Carteret	16,363	5	Northhampton	0	2
Caswell	8,476	1	Onslow	67,941	15
Catawba	3,106	3	Orange	34,256	8
Hickory City	205	0	Chapel Hill/Carrboro City	16,000	2
Chatham	23,521	3	Pamlico	17,592	3
Cherokee	21,577	6	Elizabeth City/Pasquotank	43,638	7
Cleveland	59,877	11	Pender	14,338	4
Shelby City	0	2	Person	58,526	13
Kings Mountain City	0	1	Pitt	131,784	26
Columbus	19,065	5	Polk	25,893	1
Whiteville City	28,794	1	Randolph	16,188	11
Craven	60,146	16	Asheboro City	15,984	8
Cumberland	364,231	83	Richmond	15,551	6
Currituck	5,696	1	Robeson	183,531	50
Dare	31,286	2	Rockingham	86,338	15
Davidson	14,714	8	Rowan-Salisbury	124,108	21
Thomasville City	0	4	Rutherford	15,885	8
Lexington City	46,146	9	Sampson	0	3
Davie	13,793	3	Scotland	16,519	3
Duplin	18,524	0	Stanly	7,336	4
Durham	138,408	30	Albemarle City	0	3
Edgecombe	38,113	6	Stokes	0	2
Winston-Salem/Forsyth	138,153	20	Surry	5,800	5
Franklin	22,844	3	Elkin City	2,560	1
Gaston	132,728	31	Mount Airy City	0	1
Graham	31,130	4	Swain	9,248	3
Granville	31,746	11	Transylvania	0	3
Greene	0	1	Union	176,050	36
Guilford	336,149	68	Vance	110,275	20
Halifax	53,776	7	Wake	164,108	53
Weldon City	0	1	Warren	11,600	4
Harnett	12,130	8	Watauga	38,229	5
Haywood	25,145	4	Wayne	179,335	54
Henderson	96,494	10	Wilkes	60,020	8
Hertford	18,520	3	Wilson	45,674	11
Hoke	33,369	11	Yadkin	35,642	8
Hyde	4,979	1	Yancey	14,504	1
Total for State	\$5,628,927	1,205			

Along with the allocations for Fiscal Year 1996-97, Table 9 also shows the number of children served. For LEAs which show students but no allotment, no funds were requested. LEAs which show allotments but no students actually had students for a brief period but none at the time when the count of students was taken.

B. Average Treatment Costs for Willie M. Children

The average cost per child served was \$40,874 for all treatment and habilitation services, and the median was \$28,179, and includes both state and federal funds. The large difference between the average and the median reflects the fact that the cost of serving most of these at-risk children is not high, but a sizable number of kids are expensive to treat. Table 10 divides the children into six groups according to the total amount of expenditures made for services for the fiscal year. This table does not include educational expenditures because the DPI grants are made to the local schools and not reported in a manner which connects them to individual children.

The first group of children in Table 10 are those for whom total program expenditures totaled less than \$20,000 or less than half of the statewide average. This group of children represented 42 percent of the kids served in FY97. The average cost of serving these children was \$5,130. This amount is somewhat low in that it reflects a number of children who received services for only part of the year as they were either newly certified at some point during the fiscal year or turned eighteen and left the program.

The first three categories of children in Table 10 represent all those children

Table 10 Costs of Treatment and Habilitation Services for Willie M. Children for Fiscal Year 1996-97					
Range of Costs (in \$1,000)	Number of Children	Percent of All Children	Total Expenditures (in millions)	Percent of All Expenditures	Average Cost per Child
0-19	762	42.2%	\$ 3.9	5.3%	\$5,130
20-39	302	16.7%	\$ 8.9	12.1%	\$29,512
40-59	213	11.8%	\$10.6	14.3%	\$49,581
60-79	179	9.9%	\$12.4	16.9%	\$69,527
80-99	161	8.9%	\$14.4	19.5%	\$89,412
100 +	189	10.5%	\$23.6	32.0%	\$124,839
State Total	1806	100.0%	\$73.8	100.0%	\$40,874

whose cost was below 150 percent of the statewide average cost, a legislatively defined standard for defining high-cost cases. Thus, 71 percent of the total number of children served were below the 150 percent standard or \$60,000. This distribution is very similar to the prior fiscal year where 73 percent of the children were below the 150 percent standard.

The large differences in average cost per child are primarily a function of the degree to which a child requires residential services as part of his/her treatment.

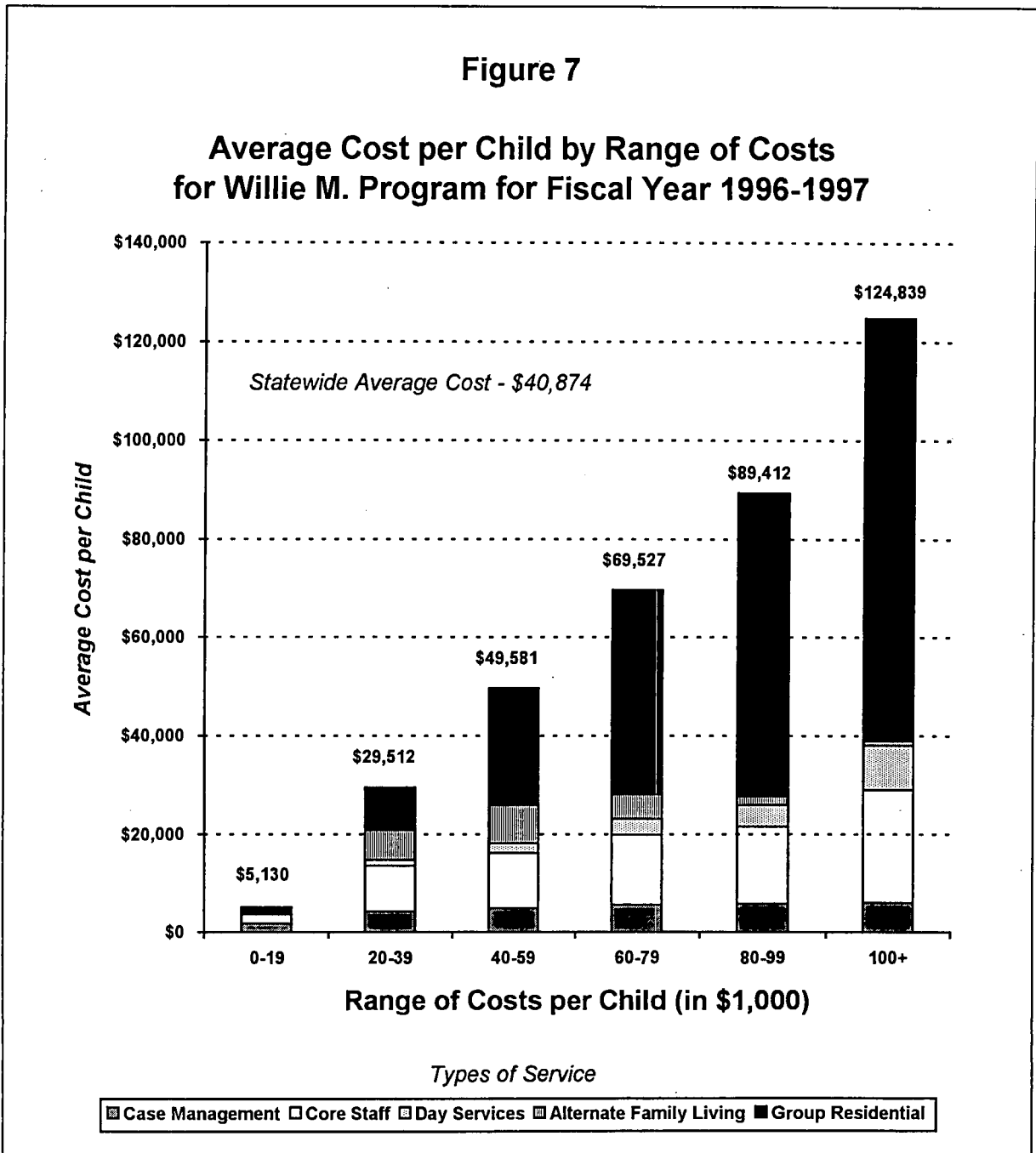


Figure 7 shows bars representing each of the six groups of children by range of costs found in Table 10. The graph shows the average amount spent by type of service for each of these categories. The first group whose total costs were less than \$20,000 used small amounts of all services. Again, it is important to remember that this group includes many children who only received services for part of the year. For the other five categories of children in Figure 7, the most important difference between them is the amount spent on group residential services. While there are variations in the amount of the other types services, it is the level of group residential services used that helps explain how children become high-cost kids. Residential services are more intensive and more expensive than community support services. The children who require group residential services have higher needs, particularly intensive monitoring. This higher level of supervision is needed both for the child, and the community. Thus, requirements for safety and supervision of high-risk children are primary determinants of cost in the program. It is critical to realize that these particularly high-risk and thus high-cost children have such pressing needs that even if the Willie M. program were not in place these children would probably still be requiring state expenditures through psychiatric hospitals and juvenile or adult correctional facilities.

C. Waivers of Departmental Cost Rules

Waivers of departmental rules are occasionally granted in order to assure the continued availability of services to Willie M. class members. The annual Appropriations Act requires the Department to report on waivers granted during the year. There are two types of waivers granted, each of which allows providers to be paid more than would otherwise be allowed under the Unit Cost Reimbursement System (UCRS) for the Willie M. Program. The two types are a maximum rate waiver and a utilization requirement waiver.

- A maximum rate waiver allows the provider to charge a unit cost rate higher than the published maximum allowable rate in the UCRS Plan. These are typically situations where local staff salaries are higher due to greater expertise or child-specific services requiring more intense or specialized care which is more costly.
- A utilization requirement waiver lets a provider earn reimbursement where some anomaly in reporting or payment causes earnings to be too low for an area program. Examples include service units that were initially not properly reported resulting in underpayment or unexpected empty beds in a treatment unit raising the average cost per bed being used.

In either case, only the Division Director may approve a waiver in extraordinary situations. The discussion below briefly describes both types of waivers which were approved during FY96-97. Generally, these waivers are for prior fiscal years.

1. Maximum Rate Waivers

Approvals of twenty-one waivers of maximum rates were granted during FY96-97 (see Appendix 2 for more detail). Of these maximum rate waivers:

- 16 were for residential services
 - 5 for Group Home - High Management
 - 4 for Residential Treatment
 - 4 for Alternative Family Living
 - 2 for Group Living Moderate,
 - 1 for Respite Services,
- 2 were for Case Management,
- 1 for Clinical Services
- 1 for Day Treatment, and
- 1 for Special summer Program.

Two area programs had the highest number of waivers. VGFW was granted seven waivers, five for residential services, one for Day Treatment and one for Special Summer Program. Mecklenburg had five residential waivers.

The rationale for most of the group residential waivers related to increased staffing patterns to meet client needs and associated salaries and cost of living adjustments. Several of the excess rates related to Alternative Family Living contracts in Mecklenburg where documentation suggests that there is minimal contract agency competition within the area program. Given this environment, the area program negotiates the best rates possible. In VGFW, the Alternative Family Living program increased stipends to families to retain trained and qualified families and increased support to this service to keep quality high.

In the area of periodic services, staff salaries and early census fluctuations created higher costs in VGFW's Day Treatment and Special Summer programs. There were no requests for waivers of paraprofessional services this year indicating that this service, although used quite extensively, is being provided at or under state maximum rates. The expanded use of paraprofessional services has demonstrated again this year that the use of such services is impacting the need for widespread waivers in Group Living.

Case Management waivers were granted to two area programs. These anomalies resulted from factoring in administrative and general support costs that had

not been incorporated last year. Only one periodic waiver related to Clinical Services was granted. The state level contract with Pride In Carolina, Inc. included the services of a contract clinician at 100% utilization.

2. Utilization Requirement and Earnings Waivers

Eleven utilization waivers were approved in all during FY96-97. These waivers cover multiple years from FY93-94 through FY95-96 resulting in a total waiver amount of \$500,169. Although several other waivers have been approved since the end of the fiscal year, the reporting cutoff date for this report was June 30, 1997. Any waiver requests approved by the Division Director after this date will be reflected in next year's report. The eleven waivers granted during the last fiscal year listed by area program, type of service, cost, and relevant fiscal year include:

- Cleveland: Residential Services, Stepping Stones for \$122,454, FY95-96.
- Surry-Yadkin: Residential Services, Bridgeway Residential Treatment for \$4,515, FY95-96.
- Tideland: Residential Services, Beaufort House for \$34,808, FY95-96.
- Blue Ridge: Group Living-High Management and Paraprofessional Support Services, \$229,825, FY94-95.
- Guilford: Day Treatment, \$54,208, FY95-96.
- Surry-Yadkin: Day Treatment, \$5,824, FY95-96.
- Cumberland: 3 waivers for Periodic Services, totaling \$12,187, FY93-94.
The services included Clinical In-Home Services (\$5,392), In-Home Paraprofessional Services (\$337), and Outpatient Services (\$6,457).
- Cleveland: Various Services, \$23,740, FY95-96.
- Surry-Yadkin: Capital Funds for purchasing hardware and software to connect to the Willie M. Section's newly developed reimbursement and reporting system, \$12,609, FY95-96.

D. Other State Funds Expended on Willie M. Children

Willie M. class members are entitled to all services and resources normally entitled by any other child in North Carolina. The Assaultive Children's Funds are to be considered the last dollar spent. Once these other funds have been utilized, Willie M. program funds are to be spent on services for the class. More aggressive efforts are being undertaken by area programs in response to urging by the Willie M. Section to ensure utilization of other funding, including non-state funding such as Medicaid and Supplemental Security Income (SSI).

These other state expenditures are not directly controlled or tracked through the **Willie M.** program. Indeed, most of these expenditures would be incurred even if the program was eliminated since they relate to other entitlements or requirements. For example, state education funds for the regular student allocation and for exceptional children are not distributed based on status in the **Willie M.** program. While these other state funds are not controlled by the program, it is important to understand that there can be an indirect influence. If the **Willie M.** program is successful at keeping the class children in school, this will increase state educational fund expenditures. However, by keeping the children out of correctional facilities or psychiatric hospitals, the **Willie M.** program may effectively reduce other state expenditures. The net effect cannot be estimated here.

A summary of these other state funds can be found in Table 11. The total of all these other State funds expended, in FY 1996-97 were estimated at \$12.1 million, a one percent increase from the prior fiscal year. Roughly half of this total is from state education funds. Appendix 3 provides further details about the contribution of each of these state sources.

Table 11 Other State Funds Spent on Willie M. Children for FY 96-97	
Source of Funds	Amount
Medicaid (State share for all services not in State Facilities)	\$1,579,901.00
State DMH/DD/SAS Facilities (Including Medicaid)	\$1,867,091.00
Training Schools	\$2,306,049.32
Detention Centers	\$135,858.00
N.C. School for the Deaf	\$6,543.27
State Education Funds	\$6,215,085.63
TOTAL OTHER STATE FUNDS	\$12,110,528.22

Section 5

Progress and Functioning of Willie M. Children

This section of the report describes the level of functioning of current **Willie M.** children and the progress they have made. Information is provided about:

- functioning and progress in seven different areas,
- an evaluation report on aged-out class members, and
- overall patterns of progress in outcomes.

A. Assessment of Willie M. Children's Functioning and Progress

As noted in the introductory section to this report, the Department of Health and Human Services (DHHS) and the Department of Public Instruction (DPI) have a statement of desired outcomes for **Willie M.** children by the time they reach age 18. Six dimensions or domains of desired outcomes were developed: Residential, Health, Behavioral, Social, Educational, and Vocational. These domains are consistent with those adopted by the Division of MH/DD/SAS for all clients of the mental health service system. A seventh domain was added, Legal, due to the frequency with which **Willie M.** children have contact with the juvenile or adult justice system. Over the last few years, the **Willie M.** Program, with the support of the General Assembly, has invested in the development and implementation of an extensive system to monitor outcomes and progress of **Willie M.** children. An extensive amount of information is being collected at various times and using various survey instruments. Following is a brief highlighting of some of the information about how these children are functioning and progressing along these seven outcome domains.

1. Residential Domain

The desired goal or outcome for this domain is for a class member to have a "home," even if it is not his natural home, which provides him with a safe, nurturing environment conducive to the achievement of all of his other goals and objectives.

Placing children in the least restrictive environment appropriate for their needs is beneficial both for providing a supportive environment and for containing costs. **Willie M.** children live in a variety of settings. Based on the most recent assessment done in the spring of 1998:

- 34 percent live at home,
- 16 percent live in alternative family living arrangements such as foster care,
- 32 percent live in group care facilities,
- 5 percent live in training school, jail, prison, or other detention facility,
- 4 percent are in secure treatment facilities, and
- the remaining 9 percent are in a variety of other settings.

Thus, half of the children are still in facilities requiring more than minimal levels of age-appropriate adult supervision but some progress is being made. As part of the ongoing formal assessment process, the level of restrictiveness in residential setting is assessed. For class members who have been through at least two assessments, there has been a statistically significant improvement in moving from restrictive settings such as locked or 24 hour monitored unlocked facilities to residential choices that involve less adult supervision or even living at home. This improvement was an important consideration for the federal court in dismissing the **Willie M.** lawsuit. As an example of this improvement, in the last year alone, the percent of class members living at home has increased from 32 to 34 percent. While placing children in less restrictive settings reduces expenses, this must be balanced against the safety needs of the child, family, and community.

2. Health Domain

The desired outcome of the Health domain is that the class member will, to the extent that he/she is able, maintain a state of health sufficient to his/her participation in normal, productive, and rewarding activities.

Willie M. children are generally healthy like most children. In the most recent assessment for all children being served, the average assessment of health and medical status was between excellent and good with only minor problems which rarely impaired activities. The major non-mental health problem for most of these children is drug or alcohol abuse. The most recent assessment found that 18 percent had been suspected of substance abuse in the prior three months. This represents a slight decline from the prior year where 20 percent had been suspected of substance abuse.

3. Behavioral Domain

The desired outcome for this domain is that the class member develop the social competence and coping skills he/she needs in order to reduce or ameliorate assaultive and aggressive behaviors.

Reducing aggressive behavior is one of the most important goals for the **Willie M.** children. All of these children have exhibited violent or assaultive behavior as this

is one of the key certification requirements for becoming a class member. For the most recent survey in 1998, 41 percent of the children had been found to have assaultive behavior in the prior three months. One in eight, 12 percent, had injured themselves in the same period.

Aggression is a tenacious behavior, but assessments done over time show progress is being made in this domain. The percent of children who had assaultive behavior in the prior three months declined by 2 percent between 1997 and 1998. Of children who had been violent in earlier assessments, 24 percent had made progress when surveyed a year later, and 29 percent had made progress for periods two years or longer. In addition to progress made in having no violent behaviors, information suggests that when violent behavior continues it happens less often. A more detailed assessment done with the *Assessment and Outcome Instrument* (AOI) has found that when looking at an array of specific violent behaviors, aggressive behaviors are occurring less often the longer a child stays in the program.

4. Social Domain

The desired outcome for the Social domain is for the class member to have at least one person who is an advocate, friend, and confidant who maintains a long-term relationship with the child, fostering trust, self-esteem, and social competence.

Building stable and solid social relationships is an important element in helping Willie M. children. Assessments of support from family averaged a rating of 4.13 on a scale from 1 to 5 or "Some Support" in the most recent round of evaluations for all children being served. Some research is indicating that support from an adult mentor may be critical in predicting future success. On the same 1 to 5 scale, the average for mentor support was 3.25 or slightly above "Little Support." Importantly, both types of support showed gains in the most recent assessments although the gains were very small.

5. Educational Domain

The desired outcome of the Educational domain is that the class member attends and participates in educational services appropriate to his/her needs.

Most of the children being served by the Willie M. program are enrolled in school. The most recent survey showed that 86 percent or six in seven of the children are in school. Furthermore, most of the children are able to remain in school across time. Three-quarters of the children who have been tracked over time have been in school at each survey time. In addition to the information collected by DHHS as part of its broad assessment process, DPI has within the last year begun an additional data collection process meant to further assess educational progress. Information is not yet

available on all of the children, but a sample provides additional information on what these children are doing in school. Nearly two-thirds, 64 percent, were passing in their grade. For children in high school, grades 10-12, 70 percent were on a diploma track. Unfortunately, a large proportion of these children, 31 percent, had had a least one out-of-school suspension, with 17 kids or 5 percent of the total sample having had more than ten suspensions. This level of ten suspensions is important because of a new state effort to remove disruptive children from school.

Evidence of progress is available in the educational domain. For children who were not enrolled in school a year earlier, 80 percent were in school in the most recent survey. For children not enrolled at their first survey, two to four years earlier, fully 96 percent were now in school. The progress made in keeping more children in school can also be seen in the growing proportion of class members enrolled in public school. As described earlier in the report, five years ago 67 percent of class members were in public schools but this proportion had grown to 79 percent as of 1997. These numbers are slightly lower than the survey results as they do not include students enrolled in alternative non-public schools.

6. Vocational Domain

The desired outcome of the Vocational domain is for the class member to be engaged in meaningful employment in a real work setting of his/her choice, or in activities leading toward that goal.

For most children, staying in school is the key means to further the desired outcome in the vocational domain. However, some children are not in school for a variety of reasons or chose to engage in work. For the most recent survey in the spring of 1998, 11 percent of the **Willie M.** children were gainfully employed and earning money for their work. There has not been any change along this domain in the last year. Given that current employment is not a primary goal, the small percent who are employed should not be seen as a low number.

7. Legal Domain

The desired outcome for the Legal domain is that the child function in the community with a minimum of contact with social control agencies ranging from the police to the court system.

Since the **Willie M.** classification requires evidence of violent assaultive behavior, contact with the law is an ongoing concern for these children. Nevertheless, most of these children manage to stay out of trouble after becoming class members. As of the most recent survey in the spring of 1998, 76 percent of the children had not had any contact with law enforcement in the last three months, 90 percent had not been

arrested in this time, and 93 percent had not been convicted of any crime during the three months. However, many of the children do have ongoing legal problems. One-fourth of the children or 27 percent are currently on probation, 2 percent are in training school, and another 2 percent are in jail or prison.

There has been slight improvement in some areas of legal outcomes. During the last year, the number of children who had any contact with the law in the prior three months declined from 26 to 24 percent. The percent in training school dropped from 4 to 2 percent. There was a half a percent increase in the number of children convicted for some offense, but no change in the other measures. For children who did have contact with the law as of a year ago, one-fourth had made progress by not having any contact in the three months prior to the survey in the spring of 1998.

B. Evaluation Report on Aged-Out Children

As part of its ongoing evaluation efforts, the **Willie M.** program funds various research projects designed to answer important questions. At the end of 1997, a major project was completed which followed up on class members after they had turned 18 and "aged out" or left the program. The purpose of the study was to provide insight into the life experiences of **Willie M.** class members after they reach adulthood and to determine the impact the program had on their lives.

The **Willie M. Aged Out Follow-Up Study** was conducted by the Center for Urban Affairs and Community Services (CUACS) at North Carolina State University during Fiscal Years 1996 and 1997. This study was a partial replication of previous work done in 1988 by John Weisz, Professor of Psychology at UNC. However, in several important ways, the new aged out study emphasized the use of a comparison group of former class members who had not received services before. The study examined adult functioning among individuals, aged nineteen to thirty-three, who were certified as **Willie M.** Program class members between 1984 and 1995. The study collected both secondary and primary data on the aged out class members. Secondary data were gathered from the data files of state agencies on a representative sample of 946 persons from the pool of 2,965 persons who aged out of the program prior to 1995. Primary data were gathered through in-person interviews with a sub-sample of 199 persons. The interview portion of the study was descriptive, rather than inferential.

The study examined a number of different concerns related to how these former class members were functioning in society. Importantly, the addition of a control group that was reasonably comparable (children who qualified for class membership but never received services) added new insight to the effects of the program on long-term functioning. Several important findings from the study stand out.

Former class members still exhibit mental health problems and use mental health services at a higher rate than the comparison group.

- Former class members were more likely to receive outpatient mental health treatment than the comparison group. For class members who had received **Willie M.** services, 79.5 percent had received outpatient treatment versus only 25.8 percent for the comparison group.
- Since leaving the program, 17.0 percent of the class members had been institutionalized versus only 4.5 percent of the comparison group.
- For the respondents who were given in-person interviews, nearly one-third or 29.2 percent exhibited signs of depression, with 12.9 showing symptoms of dysthymia or chronic depression.
- More than half, 52.8 percent, showed symptoms of antisocial personality based on standardized psychological tests. The problem was worst among males aged 25 or older.

The study was not able to address whether greater use of mental health services was due to greater need. An alternative explanation of the greater service use was simply that former **Willie M.** children had a greater willingness or greater understanding of how to get mental health services based on their experience in the program.

Former class members commit significant amounts of crime but less than the comparison group.

- The greatest number of convictions was within the crimes against property category. About a quarter of sample members had been convicted of property crimes since age eighteen. About fifteen percent of sample members had felony convictions for property crimes. Among persons convicted of felonies, the average number of convictions since age eighteen was 4.5. Slightly over thirteen percent had committed crimes against persons and non-drug related crimes against society since aging out of the program.
- Comparison group members had more criminal convictions and were sentenced to longer periods of time than former class members who had received treatment.
- Violence towards others continues to be a major problem. Since leaving the program, 59.3 percent indicated they had hit or attacked another person and 38.7 percent had threatened violence. However, 40.8 percent indicated that they were able to control themselves so that hardly ever were they ever angry enough to want to hurt someone. Given that all the children had to exhibit

violence behavior to get in the **Willie M.** program initially, this suggests substantial progress for some.

Former class members' level of social functioning in other areas is not high, but progress is evident for many.

- Under twenty percent of respondents had completed high school and slightly under a quarter had received a GED or an AHS certificate. Twenty-one respondents were enrolled in school at the time of the survey. Most were enrolled in high school or a junior/community college.
- About forty percent of respondents were employed at the time of the survey. Most of the employed respondents had worked full-time eleven out of the twelve months prior to the survey and had spent slightly over two years at the current job.
- About twenty-two percent of respondents reported that they had a savings account, nineteen percent had a checking account, and ten percent had a credit card. Slightly under twenty percent reported having experienced several types of negative experiences due to financial difficulties. The most common problems were not having enough food, eviction, and bankruptcy.

When asked to assess their experience with the **Willie M.** program, more than two-thirds felt the program had helped them with roughly the same number indicating they were satisfied with the services received. More than half of the respondents indicated they were less violent, had better relationships with family and friends, and were less angry than when they entered the program. The major problem cited by aged-out class members was the need for more help when leaving the program. The discontinuity that takes place when children have their 18th birthday is significant. Most of the services, if not all, are no longer available free of cost. Also, many of the behaviors that were classified as conduct disorder while they were juveniles are now more likely to end up in the criminal justice system.

Results of the study will be used to further knowledge of the **Willie M.** participants and to assist the **Willie M.** Services Section in planning future directions for the program and its participants.

C. Overall Patterns of Progress

When viewed from an overall perspective, several clear patterns emerge about the progress being made by **Willie M.** children. First, in no area was there signs of clear regress for the class as a whole and most measures of functioning showed at least slight improvements. Thus, at a minimum, the program has been effective at

stabilizing children once they get into the program and is frequently able to make progress. The areas where progress is most evident is in the residential, behavioral, and educational domains. Class members are being moved to less restrictive living situations, violent or aggressive behavior declines with participation in the program, and more class members are remaining in school.

Second, progress achieved in the program appears to increase with longer class membership and appears to be lasting. Children who have been in the program longer show more progress than children who have been in only a short period. Furthermore, the aged-out study suggests that the progress achieved is maintained even after former class members leave the program when compared with higher violent and assaultive behavior in children who were not treated.

Third, while progress is being made for these troubled children as a group, it is clear that participation in the program does not eliminate aggressive and non-social behavior for children either while still class members or after aging out of the program. Some children fully participating in the program still assault or threaten others, abuse drugs or alcohol, and get in trouble with the law. Later on some of these former class members still commit crimes or have mental health problems after turning 18. The program does not cure these children or completely eliminate socially unacceptable behavior. Progress will always have to be measured in modest but clearly positive steps forward.

The **Willie M.** Sections of DHHS and DPI continue to move forward in both the extent and sophistication of how they use collected information to monitor and improve services provided to class members. In the next few years, the ability to more clearly understand what helps some children make progress and to implement useful treatment and system changes should increase substantially.

APPENDIX 1 - TYPE AND LOCATION OF SERVICES

AREA PROGRAMS - WESTERN REGION							
SERVICE COMPONENT	SMOKY MT.	BLUE RIDGE	TREND	RUTHERFORD POLK	CLEVELAND	GASTON-LINCOLN	NEW RIVER
CASE MANAGEMENT	X	X	X	X	X	X	X
CLINICAL*	X	X	X	X	X	X	X
PARAPROFESSIONAL	X	X	X	X	X	X	X
INDEPENDENT LIVING							X
RESPIRE		X	X	X	X	X	
ALTERNATIVE FAMILY LIVING	X	X	X	X	X	X	
GROUP LIVING (MODERATE)					X		
GROUP LIVING (HIGH)	X	X	X	X	X	X	X
GROUP LIVING (SECURE)							
GROUP LIVING (SPECIAL)	X	X	X	X	X	X	
CRISIS STABILIZATION	X	X					
RESIDENTIAL TREATMENT	X	X	X		X	X	X
WILDERNESS CAMPING	X	**X	X		X	X	X
INPATIENT HOSPITAL	X	X	X	X		X	
EDUCATION PRIVATE, PUBLIC				X			
DAY TREATMENT	X	X	X	X		X	
VOCATIONAL EDUCATION							
VOCATIONAL PLACEMENT		X	X				
BEFORE/AFTER SCHOOL		X	X				
SPECIAL SUMMER PROGRAM		X	X	X	X		

*COMBINES ALL CLINICAL

**Represents Camp Elliott, a private nonprofit year-round camping program that is physically located within Blue Ridge Area Program's catchment area and serves numerous area programs in the region.

APPENDIX 1 - TYPE AND LOCATION OF SERVICES

SERVICE COMPONENT	AREA PROGRAMS - WESTERN REGION				
	FOOTHILLS	CATAWBA	PIEDMONT	MECKLENBURG	TRI-COUNTY
CASE MANAGEMENT	X	X	X	X	X
CLINICAL*	X	X	X	X	X
PARAPROFESSIONAL	X	X	X	X	X
INDEPENDENT LIVING					
RESPIRE	X	X		X	X
ALTERNATIVE FAMILY LIVING	X	X	X	X	X
GROUP LIVING (MODERATE)	X			X	
GROUP LIVING (HIGH)	X	X	X	X	X
GROUP LIVING (SECURE)				X	
GROUP LIVING (SPECIAL)	X	X	X	X	X
CRISIS STABILIZATION	X				
RESIDENTIAL TREATMENT	X	X	X	X	X
WILDERNESS CAMPING	X		X	X	X
INPATIENT HOSPITAL	X			X	X
EDUCATION PRIVATE, PUBLIC					
DAY TREATMENT	X	X	X	X	X
VOCATIONAL EDUCATION				X	X
VOCATIONAL PLACEMENT				X	
BEFORE/AFTER SCHOOL					
SPECIAL SUMMER PROGRAM		X		X	X

*COMBINES ALL CLINICAL

APPENDIX 1 - TYPE AND LOCATION OF SERVICES

SERVICE COMPONENT	AREA PROGRAMS - NORTH CENTRAL REGION							
	SURRY YADKIN	FORSYTH- STOKES	GUILFORD	ROCKINGHAM	ALAMANCE- CASWELL	OPC	VGFW	DURHAM
CASE MANAGEMENT	X	X	X	X	X	X	X	X
CLINICAL*	X	X	X	X	X	X	X	X
PARAPROFESSIONAL	X	X	X	X	X	X	X	X
INDEPENDENT LIVING								
RESPITE					X	X	X	
ALTERNATIVE FAMILY LIVING		X	X	X	X	X	X	X
GROUP LIVING (MODERATE)						X		
GROUP LIVING (HIGH)	X	X	X	X	X	X	X	X
GROUP LIVING (SECURE)			X					
GROUP LIVING (SPECIAL)	X	X				X	X	
CRISIS STABILIZATION		X			X		X	X
RESIDENTIAL TREATMENT	X	X	X	X	X	X	X	X
WILDERNESS CAMPING	X	X			X		X	X
INPATIENT HOSPITAL	X	X	X			X	X	
EDUCATION PUBLIC, PRIVATE								
DAY TREATMENT	X		X		X	X	X	
VOCATIONAL EDUCATION			X					
VOCATIONAL PLACEMENT			X		X			
BEFORE/AFTER SCHOOL			X					
SPECIAL SUMMER PROGRAM			X		X	X	X	

*COMBINES ALL CLINICAL

**Represents the Three Springs of North Carolina, Inc. Therapeutic Camping Program. It is physically located in Chatham County and contracts with numerous Area Programs across the state.

APPENDIX 1 - TYPE AND LOCATION OF SERVICES

SERVICE COMPONENT	AREA PROGRAMS - SOUTH CENTRAL REGION							
	DAVIDSON	SANDHILLS	WAKE	SOUTHEASTERN REGIONAL	CUMBERLAND	LEE HARNETT	RANDOLPH	** JOHNSTON
CASE MANAGEMENT	X	X	X	X	X	X	X	X
CLINICAL*	X	X	X	X	X	X	X	X
PARAPROFESSIONAL	X	X	X	X	X	X	X	X
INDEPENDENT LIVING								
RESPIRE			X		X		X	
ALTERNATIVE FAMILY LIVING	X	X	X	X	X	X	X	X
GROUP LIVING (MODERATE)								
GROUP LIVING (HIGH)	X	X	X	X	X	X	X	X
GROUP LIVING (SECURE)								
GROUP LIVING (SPECIAL)		X	X					
CRISIS STABILIZATION								
RESIDENTIAL TREATMENT	X		X		X	X	X	X
WILDERNESS CAMPING	X	X	X					
INPATIENT HOSPITAL	X	X	X			X		
EDUCATION PUBLIC, PRIVATE								
DAY TREATMENT			X		X	X	X	
VOCATIONAL EDUCATION								
VOCATIONAL PLACEMENT			X					
BEFORE/AFTER SCHOOL								
SPECIAL SUMMER PROGRAM		X	X		X	X	X	

*COMBINES ALL CLINICAL

**Services to Johnston County are provided through state level contract with Lutheran Family Services

APPENDIX 1 - TYPE AND LOCATION OF SERVICES

SERVICE COMPONENT	AREA PROGRAMS - EASTERN REGION						
	ONSLOW	WAYNE	WILSON GREENE	SOUTHEASTERN CENTER	EDGEcombe NASH	HALIFAX	NEUSE
CASE MANAGEMENT	X	X	X	X	X	X	X
CLINICAL*	X	X	X	X	X	X	X
PARAPROFESSIONAL	X	X	X	X	X	X	X
INDEPENDENT LIVING							
RESPIRE			X	X		X	X
ALTERNATIVE FAMILY LIVING	X	X	X	X	X		X
GROUP LIVING (MODERATE)		X					
GROUP LIVING (HIGH)	X	X	X	X	X	X	X
GROUP LIVING (SECURE)							
GROUP LIVING (SPECIAL)	X	X		X	X		X
CRISIS STABILIZATION							
RESIDENTIAL TREATMENT	X	X	X	X	X	X	X
WILDERNESS CAMPING	X	X			X	X	
INPATIENT HOSPITAL	X	X		X	X		
EDUCATION PUBLIC, PRIVATE							
DAY TREATMENT	X	X	X	X	X	X	X
VOCATIONAL EDUCATION					X		X
VOCATIONAL PLACEMENT						X	X
BEFORE/AFTER SCHOOL	X						
SPECIAL SUMMER PROGRAM		X	X	X	X	X	X

*COMBINES ALL CLINICAL

APPENDIX 1 - TYPE AND LOCATION OF SERVICES

SERVICE COMPONENT	AREA PROGRAMS - EASTERN REGION						
	LENOIR	PITT	TIDELAND	ROANOKE CHOWAN	ALBEMARLE	DUPLIN SAMPSON	NOVA HRS ***
CASE MANAGEMENT	X	X	X	X	X	X	
CLINICAL*	X	X	X	X	X	X	X
PARAPROFESSIONAL	X	X	X	X	X	X	
INDEPENDENT LIVING							
RESPITE				X			
ALTERNATIVE FAMILY LIVING	X		X	X	X	X	
GROUP LIVING (MODERATE)							
GROUP LIVING (HIGH)	X	X	X	X	X	X	
GROUP LIVING (SECURE)							
GROUP LIVING (SPECIAL)	X						
CRISIS STABILIZATION		X					
RESIDENTIAL TREATMENT	X	X	X		X		X
WILDERNESS CAMPING	X						
INPATIENT HOSPITAL							
DAY TREATMENT	X	X	X	X	X	X	X
EDUCATION PRIVATE, PUBLIC							
VOCATIONAL EDUCATION							
VOCATIONAL PLACEMENT							X
BEFORE/AFTER SCHOOL							
SPECIAL SUMMER PROGRAM	X	X	X	X	X	X	X

*COMBINES ALL CLINICAL

**Services to Albemarle Region are provided through State Level Contract with the Institute for Family Centered Services.

*** State Level Contract to ensure a residential capacity, primarily for the Eastern Region.

Appendix 2
DIVISION OF MH/DD/SAS
WILLIE M. SECTION
MAXIMUM RATE WAIVERS FOR FY96-97

BUDGET COPY	AP CODE	AREA PROGRAM	SERV OBJ	TITLE	PROV CODE	PROVIDER	UCR RATE	MAX RATE	OVER RATE	JUSTIF LTR DATE	JUSTIFICATION
X	101	Smoky	109	Case Management	1010	SMOKY MTN AREA MH/DD/SA PRGM	49.98	47.94	2.04	3/23/98	Higher travel costs due to geography of catchment area
X	105	Foothills	222	Group Home - High Mgmt	1052	FOOTHILLS AREA MH/DD/SA PRGM	312.92	242.11	70.81	2/12/98	Staffing pattern more intensive than typical program to meet ICF standards
X	110	Mecklenburg	215	Alternative Family Living	7690	LIFE GAINS	94.99	90.07	4.92	1/8/97 & 2/9/98	Difficult to place client w/ costs consistent with other similar contracts in area
X	110	Mecklenburg	215	Alternative Family Living	8675	ATLANTIC BEHAVIORAL HEALTH SYS	93.90	90.07	3.83	1/8/97 & 2/9/98	Best negotiated rate for this contractor. Only three local agencies provide this support. Rate is competitive with local market.
X	110	Mecklenburg	215	Alternative Family Living	8717	YOUTH HOMES INC.	93.90	90.07	3.83	1/8/97 & 2/9/98	Best negotiated rate for this contractor. Only three local agencies provide this support. Rate is competitive with local market.
X	110	Mecklenburg	221	Group living - Moderate	1104	MECKLENBURG GRP HOME/WATEROAK	223.33	177.83	45.50	1/8/97	Increase % in salaries/fringes for BMT Supervisor and support staff
X	110	Mecklenburg	222	Group Home - High Mgmt	1103	MECKLENBURG GROUP HOME/HANNA C	283.59	242.11	41.48	1/8/97 & 2/9/98	Implemented cost reductions that reduced rate from last year. Higher staff ratios (1:2) with max of 4 beds increases overall costs.
X	208	VGFW	213	Respite	2080	VGFW AREA MH/DD/SA PRGM	93.63	78.00	15.63	12/23/96	Increase stipends/increase staff support to keep quality up
X	208	VGFW	215	Alternative Family Living	2080	VGFW AREA MH/DD/SA PRGM	93.75	90.07	3.68	12/23/96	Increase stipends/increase staff support to keep quality up
X	208	VGFW	222	Group Home - High Mgmt	2082	VGFW GROUP HOME - MALE	309.08	242.11	66.97	12/23/96	1. Bed allocation formula used in house changed to accurately reflect true costs. 2. Increase in staff costs due to clients transitioning from SRT to Group Home.
X	208	VGFW	222	Group Home - High Mgmt	2083	VGFW GROUP HOME - FEMALE	309.08	242.11	66.97	12/23/96	1. Bed allocation formula used in house changed to accurately reflect true costs. 2. Increase in staff costs due to clients transitioning from SRT to Group Home.
X	208	VGFW	231	Residential Treatment	2080	VGFW AREA MH/DD/SA PRGM	325.78	315.11	10.67	12/23/96	1. Direct staff time to cover increasingly disturbed clients and unusually high staff turnover. 2. Planned phase-down of program which decreased the # of days of care projected.
X	208	VGFW	350	Day Treatment & Education	2081	VGFW DAY TREATMENT	46.18	36.19	9.99	12/23/96	Staff salaries increased/ early census fluctuation.
X	208	VGFW	370	Specialized Summer Program	2080	VGFW AREA MH/DD/SA PRGM	39.16	10.28	28.88	12/23/96	Staff salaries increased/ early census fluctuation.
X	302	Davidson	100	Case Management	3020	DAVIDSON AREA MH/DD/SA PRGM	54.00	47.94	6.06	11/7/96	True picture of costs due to factoring in Admin and General and Support services
X	305	Cumberland	231	Residential Treatment	3050	CUMBERLAND AREA MH/DD/SA PRGM	349.04	315.11	33.93	7/22/96	Covers 2 SIL's and 1 MR/BD facility. Increase in staffing costs.
X	403	Wayne	221	Group living - Moderate	7850	AMERICAN HUMAN SERVICES	225.74	177.83	47.91	11/4/96 & 1/30/98	Higher competitive salaries for mental health workers in local labor market
X	403	Wayne	231	Residential Treatment	7130	PRIDE IN CAROLINA	401.75	315.11	86.64	11/4/96 & 1/30/98	Higher competitive salaries for mental health workers in local labor market
X	405	Edgecombe-Nash	222	Group Home - High Mgmt	4052	EDGE-NASH UPSTREAM GROUP HOME	266.17	242.11	24.06	7/10/96 & 2/2/98	Across the board salary increases pushed the total operating costs above maximum rate. Program has been reconfigured for FY97-98 and rate brought down to the statewide average.
X	405	Edgecombe-Nash	231	Residential Treatment	7990	INNOVATIVE PROGRAMS ASSOC	356.15	315.11	41.04	7/10/96 & 9/16/96	Contract budgeted at 100%; \$10/unit increase in rate to allow for Administrative expenses
X	504	Pride in North Carolina *	119	Clinical Services	7130	PRIDE IN CAROLINA	70.00	58.06	11.94		Clinician contract rate was at 100% utilization.

* State Level Contractors

**APPENDIX 3. STATE FUNDS SPENT ON WILLIE M. CLASS MEMBERS FY 1996-97
OTHER THAN WILLIE M. APPROPRIATIONS**

PROGRAM	NUMBER CLASS MEMBERS	NUMBER DAYS	COST PER DAY	TOTAL COST
PSYCHIATRIC HOSPITALS (1)				
BROUGHTON				
MEDICAID ELIGIBLE	22	851	288.00	245,088.00
NON-MEDICAID ELIGIBLE	20	364	296.00	107,744.00
CHERRY				
MEDICAID ELIGIBLE	31	2,148	299.00	642,252.00
NON-MEDICAID ELIGIBLE	10	200	187.00	37,400.00
DOROTHEA DIX				
MEDICAID ELIGIBLE	22	1,873	341.00	638,693.00
NON-MEDICAID ELIGIBLE	29	1,004	360.00	361,440.00
UMSTEAD				
MEDICAID ELIGIBLE	25	1,407	286.00	402,402.00
NON-MEDICAID ELIGIBLE	24	956	299.00	285,844.00
SUB-TOTAL	183	8,803		2,720,863.00
LESS NON-STATE MEDICAID SHARE				1,296,625.00
<i>NET STATE COST</i>				<i>1,424,238.00</i>
MENTAL RETARDATION CENTERS (1)				
WESTERN CAROLINA CENTER				
MEDICAID ELIGIBLE	2	235	254.00	59,690.00
NON-MEDICAID ELIGIBLE	1	37	257.00	9,509.00
MURDOCH CENTER				
MEDICAID ELIGIBLE	1	235	237.00	55,695.00
NON-MEDICAID ELIGIBLE	NONE REPORTED			
CASWELL CENTER				
MEDICAID ELIGIBLE	1	196	238.00	46,648.00
NON-MEDICAID ELIGIBLE	NONE REPORTED			
O'BERRY CENTER				
MEDICAID ELIGIBLE	NONE REPORTED			
NON-MEDICAID ELIGIBLE	NONE REPORTED			
BLACK MOUNTAIN CENTER				
MEDICAID ELIGIBLE	1	134	267.00	35,778.00
NON-MEDICAID ELIGIBLE	NONE REPORTED			
SUB-TOTAL	6	837		207,320.00
LESS NON-STATE MEDICAID SHARE				152,875.00
<i>NET STATE COST</i>				<i>54,445.00</i>
RE-EDUCATION SCHOOLS (2)				
WHITAKER SCHOOL	25	2,842	118.35	336,350.70
WRIGHT SCHOOL (excluding Ed)	5	305	170.68	52,057.40
SUB-TOTAL	30	3,147		388,408.10
DIVISION OF MH/DD/SAS FACILITIES (including Medicaid) SUB-TOTAL				1,867,091.10

PROGRAM	NUMBER CLASS MEMBERS	NUMBER DAYS	COST PER DAY	TOTAL COST
TRAINING SCHOOLS (3)				
DILLON	26	3,261	163.82	534,217.02
DOBBS	36	2,343	121.48	284,627.64
JACKSON	30	2,406	134.76	324,232.56
JEC	48	6,580	110.63	727,945.40
SAMARKAND	44	3,483	124.90	435,026.70
<i>SUB-TOTAL</i>	<i>184</i>	<i>18,073</i>		<i>2,306,049.32</i>
ECKERD CAMPS (2)	<i>0</i>	<i>0</i>	<i>74.89</i>	<i>0.00</i>
REGIONAL DETENTION CENTERS (3)				
BUMCOMBE	13	170	63.00	10,710.00
DURHAM	2	8	66.00	528.00
FORSYTH	4	161	66.00	10,626.00
GUILFORD	12	120	48.00	5,760.00
GATLING	20	222	63.00	13,986.00
CUMBERLAND	24	386	63.00	24,318.00
GASTON	20	269	63.00	16,947.00
LEONARD	0	0	63.00	0.00
PITT	11	275	63.00	17,325.00
WILKES	21	222	63.00	13,986.00
WAKE	11	106	63.00	6,678.00
NEW HANOVER	9	183	63.00	11,529.00
UMSTEAD	2	55	63.00	3,465.00
<i>SUB-TOTAL</i>	<i>147</i>	<i>2,122</i>		<i>135,858.00</i>
NC SCHOOL FOR THE DEAF (4)				
EAST	1	69	94.83	6,543.27
WEST	NONE REPORTED			
<i>SUB-TOTAL</i>	<i>1</i>	<i>69</i>		<i>6,543.27</i>
STATE SHARE OTHER MEDICAID SERVICES (5)				1,579,901.00
STATE EDUCATIONAL FUNDS EXPENDED OTHER THAN WILLIE M. FUNDS (6)				
FUND SOURCE	NUMBER STUDENTS	AMOUNT PER STUDENT	TOTAL AMOUNT	
REGULAR ALLOCATION	1235	3,195.77	\$3,946,775.95	
STATE AID EXCEPTIONAL CHILDREN	1064	2,131.87	\$2,268,309.68	
<i>TOTAL</i>			<i>\$6,215,085.63</i>	
TOTAL ALL STATE FUNDS EXPENDED OTHER THAN WILLIE M. FUNDS IN FY 1996-97				12,110,528.32

APPENDIX 3

OTHER STATE FUNDS FOOTNOTES

- (1) Data was separated into Medicaid and Non-Medicaid categories by facility. The *Medicaid Eligible* source data was provided by the Division of Medical Assistance and analyzed by DMH/DD/SAS. The *Non-Medicaid Eligible* client counts and number of days of services were derived by matching the Medicaid clients, by **Willie M.** ID, to **Willie M.** data, reporting only those units not paid by Medicaid or **Willie M.**.

The cost per day for Medicaid and non-Medicaid clients were provided by the DHHS Controller's office from the approved rate schedule.

- (2) Data on the number of clients served and days of service derived from **Willie M.** Section data. Daily rates obtained from the respective facility. Wright and Whitaker School cost data excludes educational costs.
- (3) Data on number of clients served, days of service and rates provided by the Division of Youth Services.
- (4) NC Schools for the Deaf cost per day data used. The number of clients and days of service provided were derived from **Willie M.** Section data.
- (5) Division of Medical Assistance data used. The total cost figure represents the State Medicaid share of paid claims for FY 1996-97. This figure includes all Medicaid services for **Willie M.** class members except for outpatient settlement costs for Carolina Alternative sites. In descending order the largest sources over \$100,000 are as follows:

Cost Center	State Share
Inpatient Hospital, Mental, State Owned	\$557,730
Inpatient Hospitals - General	
\$288,928	
Mental Hospitals, Under 21, Not State Owned	\$367,703
ICF/MR, Not State Owned	\$282,149
Prescribed Drugs	\$201,907
Physician	\$139,705

- (6) Number of Student figures based on average quarterly enrollment. Data provided by the Department of Public Instruction.

Willie M. Program

Facts about the Children, Services, Costs, and Outcomes

Willie M. Children:

- Are seriously emotionally, mentally or neurologically handicapped;
 - Have accompanying severe violent and assaultive behaviors;
 - Have had state intervention in their lives (adjudicated abused, neglected, dependent, delinquent or undisciplined and placed out of the home; hospitalized in a psychiatric hospital; placed in training school, etc.); and
 - Are not receiving the services they need.
-
- 1534 children eligible for services, April, 1998, ranging in age from 4 to 18
 - Receive a range of services, based on individual needs. Services include case management, in-home services, residential, day treatment/education, special educational services, specialized therapies/medication, etc.
 - Live in a variety of residential settings, with 80% living in community-based settings:
 - 34% natural homes;
 - 16% in therapeutic/alternative family homes;
 - 32% in community-based, staffed individual or group settings;
 - 6 % in psychiatric hospitals or secure (locked) treatment programs;
 - 2.5 % in training schools or detention;
 - 2 % in jail or prison; and
 - 7 % in other non-community settings (wilderness camps, children's homes, etc.)

Costs of Services

- Total Federal and State Funds: \$82.3 million (\$50.5 million, DHHS state; \$5.6 million, DPI state; \$26.2 million Medicaid)
 - More than 1,800 children served during FY96-97, with an average cost per child of about \$41,000.
- 42% of the children cost less than \$20,000, and 10% of the children cost more than \$100,000. The range is primarily a function of whether the child receives residential services, since 64% of the total service expenditures are for residential services.

Willie M. Services



Progress and Outcomes for Willie M. Children

In 1992, the Willie M. Section began developing outcome instruments to measure progress being made by Willie M. children in seven life areas (residential, educational, health, social, behavioral, vocational and legal). In 1994, it began collecting "Simple Outcome" information on all class members on an annual basis, and has continued to gather that same information five additional times since then. In 1995, the Willie M. Section began collecting comprehensive information annually on standardized instruments, gathered from multiple sources (child, parent, teacher, clinician, and case manager). These instruments collect information on the numbers and types of both "risk factors" and protective factors that Willie M. children have, as well as information on current functioning and progress since the last assessment.

Results (from 1635 Initial Outcome Assessments)

- Of approximately 30 risk factors identified in the literature as being predictive of poor outcomes as adults, Willie M. children have an average of 13 (4-5 are considered "high-risk" for poor outcomes). Examples include: 39% showed developmental delays; 13% experienced fetal alcohol or drug exposure; 12% were premature or had birth complications; 77% have witnessed extreme family conflict or violence; 69% have been removed from their homes at some point; 52% have been documented as having been physically abused; 33% have been sexually abused; 78% come from families living in poverty; 57% have parents with mental disorders; 53% have parents with substance abuse problems; 86% of the children have had some kind of trouble with the law, etc.
- Of approximately 30 protective factors known to help ameliorate or offset the effects of risk factors, Willie M. children have approximately 13 as well. Examples include: 78% of the children believe their parents care about them; 72% had parents who were consistently employed; 58% came from families with regular rules, routines, and chores at home; 41% were in families with regular church involvement; 63% are perceived as "likeable;" 56% are described as having a sense of humor; 48% have shown ability to get along with adults; 40% have shown ability to get along with children, etc.
- For children assessed at least 2 times with these instruments, they are adding, on average, 4 protective factors since the last assessment, while only adding 2 additional risk factors.
- For those with 2 or more assessments, they are making *statistically significant* progress in the areas of moving toward less restrictive residential settings and reducing violent and assaultive behavior.
- As of January, 1998, our Simple Outcome Information reveals:
 - 86 % enrolled in school;
 - 11 % over the age of 14 earning money legally from employment;
 - 59% have not been physically violent in the previous 3 months;
 - 75 % have had no contact with the law in the previous 3 months;
 - 90% had not been arrested; and
 - 92 % had not been convicted of a crime.

Attachment #6

5/17/98
1:30 p.m.
Dr. Joe Holliday



North Carolina
Department of Health and Human Services
Division of Community Health
1330 St. Mary's Street • P.O. Box 29605 • Raleigh, NC 27626-0605
Ph: 919-733-7081 • Fax: 919-715-3144

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

April 22, 1998

H. David Bruton, M.D.
DHHS Secretary
Adams Building, 101 Blair Drive
P.O. Box 29526
Raleigh, NC 27626-0605

Dear Dr. Bruton:

Enclosed is our revised report to the Joint Legislative Commission on Governmental Operations and the Fiscal Research Division, pursuant to Senate Bill 352, Part XV, Section 15.32(1).

This has been reviewed by division management and is acceptable in format and content. We would appreciate your review and signature on the enclosed letter that it may be forwarded to complete the reporting process.

Sincerely,

A handwritten signature in cursive script, appearing to read "Leah Devlin".

Leah Devlin
Director

ljt
Enclosures



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

May 12, 1998

The Honorable Marc Basnight
President Pro Tempore of the
North Carolina Senate

The Honorable Harold Brubaker
Speaker of the North Carolina
House of Representatives

Dear Senator Basnight and Representative Brubaker:

Enclosed is the report submitted to you under Senate Bill 352, Part XV, Section 15.32, to provide information on (1) progress being made in fulfilling the duties of the Task Force and in developing the Osteoporosis Prevention Plan; (2) the anticipated time frame for completion of the Prevention Plan, and (3) recommended strategies or actions to reduce the occurrence of burdens suffered from osteoporosis by citizens of this State.

A detailed explanation of FY 1997-1998 projects and initial plans for FY 1998-99 are attached. We look forward to reporting on the successful completion of these projects in the future.

This report was prepared by the Division of Community Health. If you have any questions, please call Dr. Leah Devlin at (919) 715-4177, or Dr. Betty H. Wiser at (919) 715-0122.

Sincerely,

A handwritten signature in dark ink, appearing to read "H. David Bruton".

H. David Bruton, M.D.

HDB:bhw:ljt
Enclosure

cc: Nina Yeager
Karen Hammonds-Blanks
Mary Ellen Sylvester
Carol Shaw
Tom Covington
Legislative Libraries

**Department of Health and Human Services
Division of Community Health
Report to the Joint Legislative Commission on Governmental Operations
and the Fiscal Research Division
Relating to Senate Bill 352, Part XV, Section 15.32
Osteoporosis Task Force Funds**

April 1, 1998

The following report is filed pursuant to Senate Bill 352, Part XV, Section 15.32 (l) (attached as Appendix A) to provide information regarding:

- (1) Progress being made in fulfilling the duties of the Task Force and in developing the Osteoporosis Prevention Plan
- (2) The anticipated time frame for completion of the Prevention Plan, and
- (3) Recommended strategies or actions to reduce the occurrence of burdens suffered from osteoporosis by citizens of this State.

Background

Twenty-one of the 25-member Task Force were appointed by February 16, 1998, the date Rep. Flossie Boyd-McIntyre was appointed chair. She convened the Task Force on February 20, 1998. A listing of the members appointed to date is included in Appendix B.

Progress to Date

Two meetings have been held with a third scheduled for April 17, 1998.

To date the group has received information on the disease, number of North Carolina citizens affected by the disease, and the projected increase in the number of people affected by the years 2010 and 2020.

At the first meeting of the Task Force, held February 27, 1998, the following items were discussed:

- (1) An educational newsletter for dissemination to civic organizations on a quarterly basis.
- (2) Osteoporosis educational programs or an educational videotape for civic organizations such as the Rotary Club or the American Businesswomen's Association. Representative Boyd-McIntyre requested that the staff make ready a list of organizations that might be amenable to approach during a public awareness campaign.
- (3) School curriculum programs, realizing that it would be beneficial for young children to learn that they need to increase their bone mass as much as possible in their formative years, and to promote healthy lifestyles.
- (4) The need for physician education as well as less expensive methods of screening, with repeat bone density testing being vital to ascertain the progression of degeneration of bone mass. The interval of testing is something that needs further discussion.
- (5) The merit of physician education was debated. All agreed that physician education was very important, but the conclusion was that the education of the general public, and bringing osteoporosis to

the forefront of the average North Carolinian would be of greater value, since historically, physicians focused on health promotional issues that were requested by the patient.

The Task Force has agreed that public awareness of the disease is an important aspect of its work. Osteoporosis is a silent disease with the first symptoms often evidenced as a hip fracture.

At the second meeting of the Osteoporosis Prevention Task Force, Virginia Ann Foxx was elected by the group as Vice Chair.

Two subcommittees were established as follows, to wit: the *Burden of Illness Sub-Committee* and the *Education and Public Awareness Sub-Committee*.

The *Burden of Illness Sub-Committee* is charged as follows:

Describe the diagnosis, treatment, prevention, as well as mechanisms of reimbursement for osteoporosis on the citizens of North Carolina.

1. The current and projected incidence and prevalence of low bone density and osteoporosis by age, race, and gender.
2. The impact of osteoporosis on North Carolina citizens' quality of life, financial status, independence, and pain/suffering.
3. The diagnosis and treatment of the disease and financial mechanisms for citizens to pay for diagnosis and treatment.
4. The primary, secondary, and tertiary prevention of osteoporosis.

Task Force members of this sub-committee are: Dr. Andrew Laster, Dr. James Hundley, Dr. Suzanne Craig, and Ms. Debra Lee Bateman.

The *Education and Public Awareness Sub-Committee* is charged as follows:

Describe North Carolina citizens' knowledge about osteoporosis and ways to enhance or supplement this knowledge. This description will include the following:

1. An estimate of the number of people who have osteoporosis but are unaware that they have the disease.
2. Strategies for preventing osteoporosis through diet, exercise, medication, and caution.
3. Knowledge of osteoporosis by health professionals (physicians, nurses, nutrition, physical therapists, pharmacists).
4. Strategies for informing citizens about the disease.
5. Strategies for enhancing the knowledge of health professionals about osteoporosis, its diagnosis, treatment, and prevention.

Task Force members of this sub-committee are: Dr. Carolyn Dunn, Mr. Dave Plyler, Ms. Carolyn Sexton (designee of Paul R. Perruzzi), Ms. Joyce Carlisle, Ms. Mary Bethel (designee of Karen Gottovi).

Sen. William Purcell noted that there was a lack of ethnic diversity in the group, and the following statement was issued by the Osteoporosis Prevention Task Force to Governor Hunt who had two vacancies on the Task Force remaining: "In the opinion of this group, there is a need for efforts to be made to include minorities on this Task Force to help education efforts of the group."

A preliminary report on the "Burden of Osteoporosis" was given by Dr. Shula Bernard, into which Dr. Laster, Dr. Gold, and Dr. Craig provided input.

The third meeting of the Osteoporosis Prevention Task Force is scheduled for April 17, 1998, at North Carolina A & T University, Greensboro, as a Public Hearing.

Meeting IV is scheduled for May 1, 1998, in Room 1425 of the Legislature.

Work Yet to be Accomplished

The Task Force plans to do a comprehensive review of the diagnosis, treatment, prevention, and cost of osteoporosis. Background for this review is in progress by the Department of Health and Human Services, Division of Community Health staff. Public hearings will be conducted in order to understand the impact of the disease on North Carolina citizens. Recommendations to address this burden, including the fiscal note, will be forwarded to the General Assembly, by October 1, 1999, as specified in the legislation. The Osteoporosis Prevention Task Force Projected Timeline is as follows:

July, 1997	Legislation passed enabling Osteoporosis Prevention Task Force
September, 1997	Project staff begins to work to define resources
February, 1998	Appointment of Task Force members and first meeting of Task Force.
March, 1998	Completion of the description of the status of consumer education and education of health professions about osteoporosis.
March, 1998	Completion of the data analysis of the burden of illness of osteoporosis on the people of North Carolina, including cost.
April, 1998	Completion of the literature review on osteoporosis prevention, diagnosis and treatment.
April, 1998	Interim report due
May, 1998	Make recommendations
October 1, 1999	Final report due

children from ingesting lead such as encouraging children to wash their faces and hands frequently and especially after playing outdoors."

(c) The Commission for Health Services shall adopt rules in accordance with Chapter 150B of the General Statutes to implement subsection (b) of this section.

(d) Subsections (b) and (c) of this section become effective October 1, 1997.

Requested by: Senator Martin of Pitt, Representatives Mitchell, Baker, Carpenter
CANCER CONTROL FUNDS

Section 15.31. Of the funds appropriated in this act to the Department of Environment, Health, and Natural Resources, the sum of two hundred fifty thousand dollars (\$250,000) for the 1997-98 fiscal year and the sum of two hundred fifty thousand dollars (\$250,000) for the 1998-99 fiscal year shall be allocated for promoting the prevention, early detection, data collection, coordination, and optimal care in the control of cancer. Purposes for which funds appropriated under this section may be used include a total of five full-time positions for the Central Cancer Registry, the Division of Health Promotion, and the Advisory Committee on Cancer Coordination and Control. Funds shall be allocated upon the advice of the Advisory Committee on Cancer Coordination and Control. The Department shall report to the Joint Legislative Commission on Governmental Operations and the Fiscal Research Division by February 1, 1998, on the allocation and use of the funds.

Requested by: Senator Martin of Pitt
OSTEOPOROSIS TASK FORCE

Section 15.32. (a) Of the funds appropriated in this act to the Department of Environment, Health, and Natural Resources, Division of Health Promotion, the sum of two hundred thousand dollars (\$200,000) for the 1997-98 fiscal year shall be allocated for the Osteoporosis Prevention Task Force created under this section.

(b) The North Carolina Osteoporosis Prevention Task Force is created in the Division of Health Promotion, Department of Environment, Health, and Natural Resources.

(c) The Task Force shall have 25 members. The Governor shall appoint the Chair, and the Vice-Chair shall be elected by the Task Force. The Director of the Division of Health Promotion in the Department of Environment, Health, and Natural Resources, the Director of the Division of Medical Assistance in the Department of Human Resources, and the Director of the Division of Aging in the Department of Human Resources, or their designees, shall be members of the Task Force. Appointments to the Task Force shall be made as follows:

- (1) By the President Pro Tempore of the Senate, as follows:
 - a. Two members of the Senate;
 - b. A representative of a women's health organization;
 - c. A local health director;
 - d. A certified health educator;
 - e. A representative of the North Carolina Association of Area Agencies on Aging; and
 - f. A person with osteoporosis.
- (2) By the Speaker of the House of Representatives, as follows:
 - a. Two members of the House of Representatives;
 - b. A county commissioner;
 - c. A licensed dietician/nutritionist;

- d. A pharmacist;
 - e. A registered nurse; and
 - f. A person with osteoporosis.
- (3) By the Governor, as follows:
- a. A practicing family physician, rheumatologist, or endocrinologist;
 - b. A president or chief executive officer of a business upon recommendation of a North Carolina wellness council which is a member of the Wellness Councils of America;
 - c. A news director of a newspaper or television or radio station;
 - d. A representative of a North Carolina affiliate of the National Osteoporosis Foundation;
 - e. A representative from the North Carolina Cooperative Extension Service;
 - f. A representative of the Governor's Council on Physical Fitness and Health; and
 - g. Two members at large.

(d) Each appointing authority shall assure insofar as possible that its appointees to the Task Force reflect the composition of the North Carolina population with regard to ethnic, racial, age, gender, and religious composition.

(e) The General Assembly and the Governor shall make their appointments to the Task Force not later than 30 days after the adjournment of the 1997 General Assembly, Regular Session 1998. A vacancy on the Task Force shall be filled by the original appointing authority, using the criteria set out in this section for the original appointment.

(f) The Task Force shall meet at least quarterly or more frequently at the call of the Chair.

(g) The Task Force Chair may establish committees for the purpose of making special studies pursuant to its duties and may appoint non-Task Force members to serve on each committee as resource persons. Resource persons shall be voting members of the committees and shall receive subsistence and travel expenses in accordance with G.S. 138-5 and G.S. 138-6. Committees may meet with the frequency needed to accomplish the purposes of this section.

(h) Members of the Task Force shall receive per diem and necessary travel and subsistence expenses in accordance with G.S. 120-3.1, 138-5, and 138-6, as applicable.

(i) A majority of the Task Force shall constitute a quorum for the transaction of its business.

(j) The Task Force may use funds allocated to it to establish one full-time limited position and for other expenditures needed to assist the Task Force in carrying out its duties.

(k) The Osteoporosis Prevention Task Force has the following duties:

(1) To undertake a statistical and qualitative examination of the incidence of and causes of osteoporosis deaths and risks, including identification of subpopulations at highest risk for developing osteoporosis, and establish a profile of the osteoporosis burden in North Carolina.

(2) To raise public awareness on the causes and nature of osteoporosis, personal risk factors, value of prevention and early detection, and options for diagnosing and treating the disease.

- (3) To identify priority strategies which are effective in preventing and controlling risks for osteoporosis, and in diagnosing and treating osteoporosis.
- (4) To identify, examine limitations of, and recommend to the Governor and the General Assembly changes to existing laws, regulations, programs, services, and policies to enhance osteoporosis prevention, diagnosis, and treatment for the people of North Carolina.
- (5) To determine and recommend to the Governor and the General Assembly the funding and strategies needed to enact new or to modify existing laws, regulations, programs, services, and policies to enhance osteoporosis prevention, diagnosis, and treatment for the people of North Carolina.
- (6) To develop a statewide comprehensive Osteoporosis Prevention Plan, and strategies for Plan implementation and for promoting the Plan to the general public, State and local elected officials, various public and private organizations and associations, businesses and industries, agencies, potential funding sources, and other community resources.
- (7) To identify strategies to facilitate specific commitments to help implement the Plan from the entities listed in subdivision (6) above.
- (8) To facilitate coordination of and communication among State and local agencies and organizations regarding current or future involvement in achieving the aims of the Osteoporosis Prevention Plan.
- (9) To receive and consider reports and testimony from individuals, local health departments, community-based organizations, voluntary health organizations, and other public and private organizations statewide, to learn more about their contributions to osteoporosis diagnosis, prevention, and treatment, and their ideas for improving osteoporosis prevention, diagnosis, and treatment in North Carolina.

(1) The Task Force shall submit a progress report to the Joint Legislative Commission on Governmental Operations, the Governor, and the Fiscal Research Division not later than April 1, 1998. The progress report shall address:

- (1) Progress being made in fulfilling the duties of the Task Force and in developing the Osteoporosis Prevention Plan,
- (2) The anticipated time frame for completion of the Prevention Plan, and
- (3) Recommended strategies or actions to reduce the occurrence of and burdens suffered from osteoporosis by citizens of this State.

The Task Force shall submit its final report to the 1999 General Assembly, the Governor, and the Fiscal Research Division not later than October 1, 1999.

(m) Upon submission of its final report to the Governor and the 1999 General Assembly, the Task Force shall expire.

Requested by: Representatives Mitchell, Baker, Carpenter, H. Hunter, Senator Martin of Pitt

PREVENT BLINDNESS, INC./REPORTING

Section 15.33. Prevent Blindness, Inc., shall:

OSTEOPOROSIS PREVENTION TASK FORCE

Roster

Appointed in SB 352

Name	Address	County	Telephone
Devlin, Leah, D.D.S. (1) Director, Division of Community Health	P.O. Box 29605 Raleigh, NC 27626-0605 leah_devlin@mail.ehnr.state.nc.us	Wake	O: (919) 715-4177 F: (919) 733-0488
(Dr. Joe Holliday, substitute, in the event Dr. Devlin cannot attend)			
Perruzzi, Paul R., (2) Director, Division of Medical Assistance Carolyn Sexton, designee	1985 Umstead Drive Kirby Building Raleigh, NC 27603 paul_perruzzi@mail.ehnr.state.nc.us	Wake	(919) 733-2060
Karen Gottovi (3) Director, Division of Aging Bethel, Mary, designee	693 Palmer Drive P.O. Box 29531 Raleigh, NC 27626-0531 mbethel@dhr.state.nc.us	Wake	(919) 733-3983

Senate Pro-Tem Appointed

Name	Address	County	Telephone
Foxx, Virginia Ann (4) Member of Senate	11468 Highway 105 Banner Elk, NC 28604 virginiaf@ms.ncga.state.nc.us	Watauga	H: (704) 963-5829 O: (704) 963-5829
Purcell, William R., M.D. (5) Member of Senate	1301 Dunbar Drive Laurinburg, NC 28352 williamp@ms.ncga.state.nc.us	Scotland	(910) 276-7328
Summers, Brenda (6) Rep. of Women's Health Organization	NC Equity 3900 Barrett Dr. Suite 311 Raleigh, NC 27609	Wake	(919) 783-8088
Harrington, Dennis (7) Local Health Director	Davie County Health Dept. 210 Hospital Street P.O. Box 665 Mocksville, NC 27028 dehdavie@ix.netcom.com	Davie	O: (336) 751-8701 F: (336) 751-0335
Cale, Barbara R. (8) Certified Health Educator	Chowan Hospital P.O. Box 629 Edenton, NC 27932	Chowan	(919) 482-8451
Padgett, Diane (9) Rep. Of NC Assoc. Area Agencies on Aging	Isothermal Commission PO Box 841, W. 101 Ct. St. Rutherfordton, NC 28139 ipdc@blueridge.net	Rutherford	H: (704) 287-2281 F: (704) 287-2735
Mills, Nancy M. (10) Person with Osteoporosis	161 Kensington Street Lumberton, NC 28358 mcneill@interpath.com	Robeson	(910) 738-9211

Speaker of the House of Representatives Appointed

Name	Address	County	Telephone
Boyd-McIntyre, Flossie Chairperson (11) Member of House of Representatives	217 Cloverbrook Drive Jamestown, NC 27282 flossieb@ms.ncga.nc.us	Guilford	(336) 841-6220
Russell, Carolyn (12) Member of House of Representatives	304 Glen Oak Drive Goldsboro, NC 27534 carolynr@ms.ncga.nc.us	Wayne	(919) 736-2665
Walker, Derl (13) County Commissioner	P.O. Box 602 Mount Olive, NC 28365	Duplin	(919) 658-3857
Craig, Suzanne, M.D., Ph.D. (14) Licensed Dietitian/ Nutritionist	Medical Review of N.C., Inc. P.O. Box 37309 Raleigh, NC 27627 ncpro.scraig@sdps.org	Wake	(919) 851-2955 1 (800) 682-2650
McPhail, Neil, R.Ph. (15) Pharmacist	P.O. Box 429 Erwin, NC 28339	Harnett	(910) 897-7165
Bateman, Debra Lee, M.S.N., F.N.P. (16) Registered Nurse	309 Edinboro Drive Southern Pines, NC 28387 dbateman@ac.net	Moore	(910) 692-5598
Dick, William (Bill) (17) Person with Osteoporosis	4429 Old US Hwy 421 W. Hamptonville, NC 27020	Yadkin	H: (910) 468-4681 F: (910) 468-4811

Governor Appointed

Name	Address	County	Telephone
Laster, Andrew J., M.D. (18) Practicing family physician, etc.	Presbyterian Health Care Assoc. 125 Baldwin Avenue Charlotte, NC 28204 ajll@phsc.com	Mecklenburg	(704) 338-6300
vacant (19) (Pres/CEO recommended by Wellness Council)			
Plyler, Dave (20) News director	WTOB-AM 4405 Providence Lane Winston-Salem, NC 27106	Forsyth	(336) 759-0363
Gold, Deborah, Ph.D. (21) Rep. of N.C. Affiliate of N.O.F.	Duke University Medical Center Box 3003 Durham, NC 27710 dtg@geri.duke.edu	Durham	O: (919) 660-7530 F: (919) 684-8569
Carlisle, Joyce D. (22) Rep. of N.C. Cooperative Ext. Svc.	138 Jupiter Trail Jacksonville, NC 28546	Onslow	(910) 346-8265
Dunn, Carolyn, Ph.D. (23) Rep. of the Governor's Council on Physical Fitness & Health	N.C. Cooperative Ext. Svc. N.C. State University Box 7605 Raleigh, NC 27695 carolyn_dunn@ncsu.edu	Orange	H: (919) 732-8563 O: (919) 515-9142
Hundley, James, M.D. (24) Member at Large	2001 South 17th Street Wilmington, NC 28401	New Hanover	H: (910) 762-3119 O: (910) 763-7344
Arline Bohannon, M.D. (25) Member at Large	Duke University Med. Ctr. Box 3003 Durham, NC 27710	Durham	

Attachment #7

*5/14/98
1:30 p.m.
Kerri Ryan*

REPORT TO THE GENERAL ASSEMBLY:

THE OFFICE OF WOMEN'S HEALTH

MAY 11, 1998

**DEPARTMENT OF HEALTH AND HUMAN SERVICES,
DIVISION OF WOMEN'S AND CHILDREN'S HEALTH,**

**WOMEN'S HEALTH SECTION,
OFFICE OF WOMEN'S HEALTH**



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APPENDICES

Appendix A--Legislation Creating the Office of Women's Health

Appendix B--Focus Group Report

Appendix C--The Women's Health Report Card

Appendix D--Proceedings from the Women's Health Summit

I. INTRODUCTION

In the 1997 session, the North Carolina General Assembly established the Office of Women's Health. As described in the authorizing legislation (S.B. 626) (Appendix A), the purpose of the Office is to "expand the State's public health concerns and focus to include a comprehensive outlook on the overall health status of women." The Office's primary goals are "the prevention of disease and improvement in the quality of life for women over their entire lifespan."

In the authorizing legislation, the Office was given several specific charges. They are:

- (1) Develop a strategic plan to improve public services and programs targeting women;
- (2) Conduct policy analyses on specific issues relating to women's health;
- (3) Facilitate communication among the Department's programs and between the Department and external women's health groups and community-based organizations;
- (4) Build public health awareness and capacity regarding women's health issues by providing services such as evaluation, recommendation, technical assistance and training;
- (5) Develop initiatives to improve or expand women-oriented services and support public-private partnerships; and
- (6) Study the feasibility of implementing initiatives to promote early intervention services for women infected with HIV and improved outreach, treatment and follow-up services for women at high risk for contracting sexually transmitted diseases.

The following is submitted, as directed by the General Assembly, to report on the implementation of the Office of Women's Health and to provide recommendations necessary to fully implement and enhance the effectiveness of the Office.

II. ESTABLISHING THE OFFICE OF WOMEN'S HEALTH

The Office of Women's Health has been established in the Department of Health and Human Services (DHHS) and is housed in the Women's Health Section of the Division of Women's and Children's Health (DWCH). In order to secure the resources to support the Office, a position in the Office of Rural Health and Resource Development was identified and transferred to DWCH. This position was transformed into that of the Head of the Office of Women's Health and was filled on January 1, 1998 by Sheila Cromer, R.N.C., M.S.

Ms. Cromer is extremely well qualified to head the Office of Women's Health. As a trained nurse practitioner, she brings a wealth of women's health experience to her position. As the former state Maternal Health Nurse Consultant for DWCH, she has a statewide network of women's health contacts and extensive experience with the state's public health system. She is a former member of the Statewide Perinatal Council and a former appointee to the Governor's Task Force on Health Objectives for the Year 2000. She has been honored as the Maternal and Child Health Nurse of the Year by the North Carolina Nurses Association and the March of Dimes and has been selected to the "Great 100 Nurses in North Carolina." Ms. Cromer is already serving in the capacity of State Women's Health Coordinator, having been appointed to that position by Dr. Ron Levine in 1994. The Chief of the Women's Health Section is Kevin Ryan, M.D., M.P.H., an obstetrician-gynecologist and a public health physician with a longstanding commitment to improving the health of women throughout the lifecycle. Because of the magnitude of the task and the lack of staff resources, several staff of the Women's Health Section participated in the activities of the Office completed to date.

III. INITIAL ACTIVITIES OF THE OFFICE OF WOMEN'S HEALTH

The initial activities of the Office of Women's Health (OWH) have focused on a careful attempt to determine how the Office can best carry out the mandate given it by the General Assembly. At each point, the focus has been on the "value added" standard, the principle that the Office must assume only those roles that will represent added value to the citizens of North Carolina, and reject any roles where its impact is likely to be negligible or where its presence would be redundant. The Office has focused on several key issues: helping the current health care system address women's health care needs more effectively; effectively helping women adopt healthier lifestyles; promoting coordinated planning; supporting best practices; advocating for needed initiatives and promoting public/private partnerships.

Public Input

To gather input from the grassroots level, OWH contracted with the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill to conduct eleven focus groups across the State. These focus groups included women of diverse racial and ethnic groups, able and disabled, rural and urban, of various ages and a wide range of income levels. The members of the focus groups were asked to explain what services and activities are needed to improve the health of North Carolina women and how the Office could help. The full reports from these focus groups are included as Appendix B. They provide fascinating reading and will reward careful attention.

Women's Health Report Card

Since it was important to look at existing data related to women's health status, a multidisciplinary public/private partnership was established to examine existing women's health data. This partnership, led by the Women's Health Section, and with the support of the North Carolina Institute of Medicine, the North Carolina Obstetrical and Gynecological Society and the State Center for Health Statistics, created the first North Carolina Women's Health Report Card (Appendix C).

The Report Card, one of the first in the nation, provides invaluable information about where North Carolina is doing well with respect to women's health and where improvement is greatly needed. It will clearly provide focus to OWH, policymakers, researchers and legislators by identifying North Carolina's areas of greatest need. It will also help inform the general public about the status of women's health in the State. The 1998 Report Card will also provide an important benchmark by which the State may judge its future successes and failures in improving women's health. One important message which emerges from the Report Card is that in areas where the legislature, policymakers and service providers of the State have focused their attention, such as the provision of early prenatal care to all pregnant women, very good progress has been made. This leads one to hope that focused efforts in other important areas will result in similarly impressive gains.

Women's Health Summit

Last, it was felt to be important to hear from experts in women's health. In order to bring women's health experts together to provide input, the first North Carolina Women's Health Summit was held on March 30-April 1, 1998. Eighty-eight participants, selected from 200 nominations, twenty delegates from major sponsors of the event and staff from DHHS agencies met in Chapel Hill to hear from national, state and local leaders in women's health. They also participated in a strenuous series of working sessions to craft a shared vision for women's health in North Carolina and a set of objectives, strategies and action steps to promote longer and healthier lives for the women of the state (Appendix D).

These activities, carried out by the Office of Women's Health, the Women's Health Section and many colleagues, represent an extraordinary effort which grew out of the staff's commitment to the principle of an Office of Women's Health and their desire to respond responsibly to the General Assembly's charge. These activities cannot be sustained with existing resources. Staff worked beyond their job responsibilities and donated many extra hours to these efforts. With the exception of support for the position of the Head of the OWH, dedicated funding for these activities does not exist. All other funding for these activities came from "one-time" funds or from private donations. More than \$60,000 in donations were raised through an active campaign to support the Summit and related activities.

IV. THE OFFICE OF WOMEN'S HEALTH IN THE FUTURE

After reviewing the input from the grassroots focus groups, the data from the Women's Health Report Card and the deliberations of the experts assembled for the Women's Health Summit, several key roles for the Office of Women's Health have emerged.

Strategic Planning

First, there is a great need for an agency that will facilitate and coordinate the development and maintenance of a strategic plan to promote women's health. Although many planning efforts currently exist which touch on one aspect or another of women's health, it appears that none attempt to address in a coordinated fashion the full spectrum of women's health issues across the lifecycle. A well conceived and well coordinated strategic plan will help North Carolina's women's health stakeholders utilize the resources they expend on women's health more effectively, both by reducing redundancies and by channeling resources toward best practices and interventions of demonstrated effectiveness. OWH is optimally positioned to carry out this function because of its crosscutting position and its present and projected expertise in women's health issues. The Office will engage all relevant agencies and groups in the planning process.

Policy Analysis

The Office of Women's Health must also create the capacity to carry out the policy analysis role it has been assigned by the General Assembly. It should be capable of analyzing policy statements generated outside the Office as well as conducting its own policy analyses on topics it identifies as of great importance to women's health. A wide range of key areas for policy analysis were identified by focus group and Summit participants. A sample of issues raised include effective strategies for reducing HIV infection among women; effective ways to blend public health and managed care strategies for providing comprehensive and coordinated women's health services, and effective means of educating providers about the needs of disabled women. The Office will engage all relevant agencies and groups in this process.

Data Collection and Management

In order to formulate a strategic plan, and in fact in order to do any meaningful planning concerning women's health issues, accurate, timely, appropriate and useful data must be available. The lack of systematic data about women's health in North Carolina prevents the legislature, policymakers and providers from designing and delivering optimal women's health care. Data on women's health based on socioeconomic status, race, ethnicity and age are often unavailable.

The Office of Women's Health will attempt to carry out a number of data-related functions. OWH needs to support a survey of the women's health data currently available within the state. It needs to work with women's health data experts to identify gaps in the State's data system and to assess efficient ways to fill those gaps. The Office should actively support the collection, analysis, interpretation and reporting of data which will comprehensively describe the health of women in North Carolina and address health needs. As a center for policy analysis and planning, OWH should also directly gather some key women's health information. A biannual consumer survey and ongoing focus group sessions will help the Office stay closely focused on the needs of consumers and will allow the Office to function as an early warning system, alerting policymakers to emerging issues. The Office should also plan to consult with experts to determine how best to support a women's health information network in order to make women's health data more accessible to a wide range of users, from interested consumers using the Internet to policymakers to researchers.

Public Awareness and Education

A message that came through very clearly from the focus groups concerning a key role for the Office was that consumers want to be better educated concerning women's health issues, about healthy behaviors and about preventive health services. Consumers felt that OWH should address this need. The Women's Health Report Card is one means of educating the public about women's health, and it should be widely disseminated and updated on a regular basis. The Office should continue and expand the partnerships it has formed with groups like the Institute of Medicine and the Obstetrics and Gynecology Society to tailor versions of the Report Card to specific settings and specific target groups.

The need for building public health awareness concerning women's health issues was noted by the General Assembly in the legislation authorizing the Office of Women's Health. The need for more visible public awareness initiatives promoting women's wellness, particularly mass media initiatives, was noted in both the focus groups and at the Women's Health Summit. The Office will explore other ways of meeting the public's educational needs. For the computer literate, the Office should establish a Women's Health Web site with carefully reviewed hyperlinks to related sites. Gearing a portion of the site to adolescents could prove highly effective but low cost means of reaching this population which is traditionally hard to reach but which is increasingly comfortable accessing information from the Internet.

Evaluation, Technical Assistance, and Training

The Office is also charged by the General Assembly to build the State's capacity regarding women's health issues by providing services such as evaluation, technical assistance and training. Both focus group and Summit participants felt the Office faced a major challenge in this area. Both groups felt that many health services for women are not provided in a manner that is

respectful of women or sensitive to their needs. Several groups noted the need to reform the training that health care providers receive concerning the provision of gender-sensitive care. Many noted that the "feminization of poverty" has left many working class women without access to health care for themselves or their families. The elderly, the most rapidly growing segment of our state's population, are predominantly female and have a number of unmet health care needs, such as the need for access to a more flexible range of long term care options. Women comprise the fastest growing segment of the HIV-positive population, in part because medical and public health professionals were slow to recognize the importance of heterosexual transmission in HIV infection. Women with cardiovascular disease (the largest killer of women, as well as men) are under-diagnosed by physicians and suffer excess morbidity and mortality because cardiovascular disease is viewed as "a man's disease." As this brief sampler of needs demonstrates, there are a wide range of issues and a great number of organizations with which the Office will need to interact to build the State's capacity to promote women's health.

V. RECOMMENDATIONS

The process which the Office of Women's Health has sponsored to define the roles and responsibilities of the Office has led to a great degree of consensus about how the Office can be implemented in a way that will maximize its effectiveness for the residents of North Carolina and carry out the full intent of the General Assembly in establishing the Office.

At the present time, the Office of Women's Health is without a dedicated operational budget and is staffed solely by Ms. Cromer, the Head of the Office. Ms. Cromer is very well qualified to support the networking responsibilities of the Office. She will also be able to devote a limited amount of time to supporting public and provider awareness of women's health issues and to participating in policy analyses relevant to women's health.

In order for the Office to carry out the full charge given it by the General Assembly, additional staff and operational resources will be needed. The creation and maintenance of a thoughtful strategic plan to improve women's health will be a labor-intensive undertaking. Active participation in the analysis of the wide range of policy issues relevant to women's health will also be very labor-intensive. The development, analysis and dissemination of data relevant to women's health is currently done rather badly and in an uncoordinated fashion; the Office will need resources to bring a coordinated vision to women's health data issues. The General Assembly has also charged the Office with public awareness, training, evaluation and technical assistance responsibilities.

Ideally, the Office will be staffed in such a way that it will be a statewide resource for excellence in addressing women's health issues, with expertise in strategic planning, policy analysis, data analysis and dissemination, public awareness and training and evaluation. It should also have the

operational resources to support consensus conferences on women's health, updates of the Women's Health Report Card, surveillance of women's health status, public awareness initiatives and public-private partnerships to promote women's health.

Although the activities proposed for the Office cannot be accomplished with existing resources, the benefits the State will receive from coordinated planning concerning women's health issues, better promotion of healthy behaviors among women and the support of best practices for women's clinical services will repay the State's investment in the Office many times over.

VI. SUMMARY

It should be clear from the discussion above that one of the key roles the Office will carry out will be to provide leadership concerning women's health issues. The Head of the Office will work with other state agencies, community-based organizations, consumer groups, professional societies, policymakers and leaders of schools of Nursing, Medicine, Public Health and Social Work to give visibility to women's health issues and to promote best practices. The Office will emphasize its role as a facilitator, as a networking agency and as a change agent. It will promote a cooperative, coordinated effort to improve women's health. It will work not to assume control of existing women's health programs but to ensure that existing programs work together as efficiently and effectively as possible. The work of the Office of Women's Health will help North Carolina realize the gains which are possible from thoughtful strategic planning, better networking and a greater public and professional understanding of effective means of promoting women's health.

NOTE: The contents of Appendix D reflect the proceedings of the Women's Health Summit. They do not represent policy positions of the Office of Women's Health, the Division of Women's and Children's Health or the Department of Health and Human Services.

Appendix A

Legislation Creating the Office of Women's Health

GENERAL ASSEMBLY OF NORTH CAROLINA
1997 SESSION

S.L. 1997-172
SENATE BILL 626

AN ACT TO ESTABLISH IN THE DEPARTMENT OF ENVIRONMENT,
HEALTH, AND NATURAL RESOURCES THE OFFICE OF WOMEN'S
HEALTH.

The General Assembly of North Carolina enacts:

Section 1. The title of Article 5 of Chapter 30 of the General Statutes reads as rewritten:

"Maternal and Child Health. Health and Women's Health."

Section 2. Article 5 of Chapter 130A of the General Statutes is amended by adding the following new Part to read:

"Part 8. Office of Women's Health."

"§ 130A-131.19. Office of Women's Health established."

(a) There is established in the Department the Office of Women's Health. The purpose of the office is to expand the State's public health concerns and focus to include a comprehensive outlook on the overall health status of women. The primary goals of the Office shall be the prevention of disease and improvement in the quality of life for women over their entire lifespan. The Department shall develop strategies for achieving these goals, which shall include but not be limited to:

- (1) Developing a strategic plan to improve public services and programs targeting women;
- (2) Conducting policy analyses on specific issues related to women's health;
- (3) Facilitating communication among the Department's programs and between the Department and external women's health groups and community-based organizations;
- (4) Building public health awareness and capacity regarding women's health issues by providing a series of services including evaluation, recommendation, technical assistance, and training; and
- (5) Developing initiatives for modification or expansion of women-oriented services with the intent of establishing meaningful public/private partnerships in the future.

(b) The Office shall study the feasibility of establishing initiatives for:

- (1) Early intervention services for women infected with HIV; and
- (2) Outreach, treatment, and follow-up services to women at high risk for contracting sexually transmitted diseases.

In conducting the study the Department shall take into consideration related services already in place in the Department and at the local level."

Section 3. The Department of Environment, Health, and Natural Resources shall report to the 1997 General Assembly, 1998 Regular Session, upon its convening, on the implementation of the Office of Women's Health. The

Department's report shall include recommendations for legislation necessary to fully implement or enhance the effectiveness of the Office of Women's Health.

Section 4. The Department of Environment, Health, and Natural Resources shall implement this act using funds available to it for the 1997-98 and 1998-99 fiscal years.

Section 5. This act becomes effective July 1, 1997.

In the General Assembly read three times and ratified this the 4th day of June, 1997.

s/ Dennis A. Wicker
President of the Senate

s/ Harold J. Brubaker
Speaker of the House of Representatives

s/ James B. Hunt, Jr.
Governor

Approved 3:31 p.m. this 12th day of June, 1997

Attachment #9

*5/14/98
1:30 pm
Chuck Harris*

ACTIVITY REPORT ON THE STATE CHILD FATALITY REVIEW TEAM

Prepared by the

DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF SOCIAL SERVICES

Pursuant to Section 11.57 of Senate Bill 352 (S.L. 1997-443), the following is the final report on the activities of the State Child Fatality Review Team since the enactment of the legislation. The comprehensive, multi-disciplinary team approach was implemented on October 1, 1997, based on the membership prescribed in the legislation. The two staff persons hired to represent the State Division of Social Services have extensive backgrounds in reviewing county Departments of Social Services records and evaluating the effectiveness of child protection programs. Since the implementation of the State Child Fatality Review Team, the Division has received information on nine child fatalities in eight counties meeting the review criteria.

The fatality reviews continue to show the need for more regular and in-depth sharing of information and coordination of effort between local DSS's, law enforcement personnel, medical personnel, and other community-based agencies. The reviews commonly reveal that more than one agency was involved with the family with little knowledge of what each other was doing and observing. The recommendation from the Review Team calls for the DSS to engage in developing protocols with the agencies in question to try to remedy the problems identified by the fatality review. Too often we also find that individuals, and sometimes even professionals, minimize or ignore the signs of child abuse and neglect and either do not report their concerns or downplay their seriousness. The findings further document the variability of quality services to protect children from one county to another.

In general, the more comprehensive fatality review process has been well-received and has resulted in the disclosure of considerably more information than previous review methodologies. The involvement of community representatives and medical and prevention experts on the review teams has contributed to greater insight in the findings and recommendations. The community reviewers frequently voice a new appreciation and understanding of the complexity and danger faced daily by DSS staff in child protection work.

In a few instances, the Division of Social Services has encountered some resistance to the new fatality review process. One review was completed without the benefit of a law enforcement representative; all three law enforcement agencies in the county declined the invitation to participate. In one review, a mental health agency did not want to release its records to the team. Several agencies have asked for verification of the team's authority to request records and are reluctant to accept a legislative special provision as "real law." A standing committee of the Child Fatality Task Force had concerns about each team including a reviewer from the local DSS. We have addressed

this concern by excluding the local DSS representative following the fact-finding stage of the process.

A real test of the effectiveness of the more comprehensive review process is what the community does with the information contained in the fatality review report. Especially when the review process attracts significant media attention, it frequently becomes difficult for reporters and some members of the community to move beyond a need to assign culpability for the child's death to an individual or agency. The failure of the review team's report to address this issue draws heavy criticism in such instances. In a number of situations, however, community groups have used the report productively to develop and implement new strategies to prevent future child fatalities. The Division continues to seek ways to ensure that the review process is used for constructive purposes.

The Division is requesting modifications to the special provision to address the problems encountered by the review teams. Specifically, the modifications will enable the teams to obtain copies of otherwise confidential materials and will make the team's authority to conduct interviews explicit.

The comprehensive, multi-disciplinary fatality review process is far more labor-intensive and time-consuming than the Division's previous process. We believe that the new approach is a mechanism to encourage broader community participation in protecting children. The depth of the information learned from these reviews can help to ensure that state and community-based agencies, groups and individuals work collaboratively to protect our State's children and prevent the tragedy of child fatalities whenever possible.

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

Legislative Office Building - Room 643

Tuesday, May 20, 1998

8:30 a.m.

Opening Remarks

Senator Bill Martin, Co-Chair
Rep. Charlotte Gardner, Co-Chair
Rep. Lanier Cansler, Co-Chair
Rep. Debbie Clary, Co-Chair

Efficiency Study of the State
Psychiatric Hospitals

Steve Humphrey, Senior Partner
MGT of American, Inc.

Lyn Davis, Senior Associate
MGT of American, Inc.

O'Brien & Atkins

DHHS Response to MGT Study

Don Willis, Chief
Mental Health Services Section,
Division of Mental Health

Committee Discussion

Next Meeting

Adjourn

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Minutes
May 20, 1998
8:30 a.m.

The Joint Appropriations Subcommittee on Human Resources meeting was held on Tuesday, May 20, 1998 at 8:30 a.m. Senator Martin presided. Four Senators were present. The following House Members were present:

Representative Henry Aldridge	Representative Edd Nye
Representative Bill Hurley	Representative Debbie Clary
Representative Lanier Cansler	Representative Cindy Watson
Representative Charlotte Gardner	

Staff members attending: Ramona Burton, Karen Hammonds-Blanks, and Mary Ellen Sylvester.

Senator Martin introduced the Partners in Policy Class and Consumers and Parents of Persons with Disabilities who are visiting.

Steve Humphrey and Lyn Davis of MGT of American that did the study of the State Psychiatric Hospitals gave their findings before the committee. (See attachment #1.) They did not include Mental Health Programs and Area Mental Health Authorities in the study.

Representative Gardner questioned the problems with the State Personnel System. The study revealed that it takes 5 months to do paperwork when hiring specially qualified persons. Also, the pay is low for health care technicians in relation to what other departments pay. She wants the department's response on these issues. She praised the report, and she felt it was worth the cost.

She also questioned the differential in the cost per bed in each hospital and thought understanding these differences was key. She asked if they had any recommendations about how to encourage handling mental health problems on the local area rather than utilizing the psychiatric hospitals. Ms. Davis said that since the study did not include the Area Mental Health Authorities, she could not make a recommendation.

Senator Phillips asked if the study looked at the community-based care to see if the funds are being transferred with these clients. Ms. Davis said they looked at the fiscal impact on Psychiatric Hospitals, but the area mental health programs were not addressed.

Senator Martin said that he and Representative Gardner have discussed extending the study to include these issues particularly regarding the Area Mental Health Authorities.

Minutes, May 20, 1998

Senator Forrester said that some Alzheimer patients cannot be cared for locally due to their disruptive behavior and asked what the study recommends. Ms. Davis said this problem can not be decided unilaterally and the affected industry needs to be included in the dialogue.

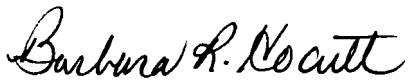
Senator Phillips wanted to know the cost to the local community in following the recommendation to treat children in a local setting. Ms. Davis said the study did not encompass local costs of delivering this kind of service. Senator Phillips said that he supports extending the study to understanding the costs of these recommendations to the local community.

Representative Gardner agreed that antiquated units need replacement but wanted to know why the study recommended 4 new Psychiatric hospitals. Ms. Davis said that because they did not look at Area Mental Health Authorities, they couldn't assess the coverage and the need. She was pretty sure about the number of beds needed.

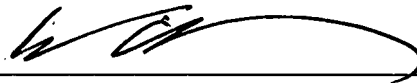
Rebecca Ross of MGT spoke about Disproportionate Share money being used to build new psychiatric hospitals which is recommended by the study. She inferred that the Feds might make some changes in the DSH regulations, and this money might not be available for hospital construction in the future. Representative Gardner said she disagreed with Representative Nye about the DSH money being used appropriately. She does not think it has been used appropriately in the past, and it could have been used to address inequities in allocations to Area Authorities. She favors beginning to plan for a new psychiatric hospital to address the problems of the current system.

Steve Humphrey summarized the findings of the study.

It was announced that the afternoon meeting would convene at 3:00 p.m to hear the department's response to the MGT study, and the morning meeting was adjourned.



Barbara R. Hocutt, Clerk



Senator Martin, Chairmen

WGM:brh
attachments

VISITOR REGISTRATION SHEET

HUMAN RESOURCES (APPROPRIATIONS) MAY 20, 1998
 Name of Committee Date a.m.

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Low Wilson	NCA LTC 7.
Cynthia McEnt	Partners + Policy
DIANNA LITTLE	Partners + Policy
Sally Cameron	NC Psychological & Coalitia for Person Disabled by Mental Illness
Marian Hartman	DD Council
Janice McEwen	Partners Class
Don Baker	Partners Class
Kevin Green	Partners Class
EUGENE D POWELL	Partners Class
Jeff Ange	Partners Class
Donna Lykes	Partners Class
CONNIE	Partners Class
Kim Sobot	Partners in Policymaking
Mary Lou Sobot	Partners in Policymaking
Paula R. Indurcin	Partners in Policymaking

HUMAN RESOURCES (APPROPRIATIONS)

Name of Committee

MAY 20, 1998

Date

a.m.

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Susan Reed	The Arc of Wake County 401 Oberlin Rd. Ste 225 Raleigh, NC 27605
Megan Soyler	Easter Seals
Glennette Henderson	Partners in Policy making from Columbus County NC
M. Terry Miller	Partners "
Kathy Rider	Partners in Policy Making (Henderson County NC)
Linda C Brody	Partners in Policy Making Dare County
Naren Scanderiata	Partners in Policy making (Wake County)
Tom Bainbridge	DMH/DD/SAS
Marni Saunders	Partners in Policy Making T.D.D
Kelly Phelan	Partners in Policy making (Watauga County)
Jeanette Wilhelm	The Arc of Stanley County PO Box 68 Albemarle, NC 28002
Peggy Terhune	The Arc of Stanley County PO Box 68 Albemarle, NC 28002
Jo Stein	DMH/DD/SAS
Doug Baker	DMH/DD/SAS
Peggy Bales	Thomas Service

HUMAN RESOURCES (APPROPRIATIONS)

Name of Committee

MAY 20, 1998

Date

A.M.

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Theresa Anderson	Partners
Sharon Rose	Partners in Policymaking
Denise Morando	The Arc of CC
Lamarr Long	Partners in Policymaking (Eastern Seals)
Tashi Brea	Division of Community Health, A.H.S.
Carolyn Herring	Partners in Policymaking
Charles Luther	" "
Randall Spaz	" "
John Peyton	" "
Carmen Green	" "
Lonnie Cunningham	" "
MARTHA BRACEY SAWYER	" "
C.L. Gehron	~~UCPAC~~ UCPAC - C-2001
John Emery	NICARE (C-2001)
Bob Muck	NAMI VC C-2001

HUMAN RESOURCES (APPROPRIATIONS)

Name of Committee

MAY 20, 1998

Date

A.M.

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NAME

FIRM OR AGENCY AND ADDRESS

Tommy Worth	Carl's Health Care System
John Lail	DHHS Property & Construction
Byron K. Harris	OSBM
Allyn Duffey	DHHS - Div. of Budget, Planning & Analysis
Lisa Abatemarco	DHHS, BPA
Helen Lipman	Mecklenburg Co.
Don Dixon	NCRA
Terry Stelle	DHHS - DMHDDSS
Don Wilber	DMHDDSS
Curtis Farrance	DMHDDSS
NELS ROSELAND	OSBM
Lee Kettle	DHHS
DAVE BLANTON	DHHS
Steve Keene	NCHS
Amey D. Bain	Smith Anderson

#1, Steve Humphrey
Lynn Davis

Presentation to the:

*Joint Appropriations Subcommittee
on
Health and Human Services
Efficiency Study of State Psychiatric Hospitals
Final Report*



MGT of America, Inc.

and

OBrien/Atkins Associates, PA

May 20, 1998

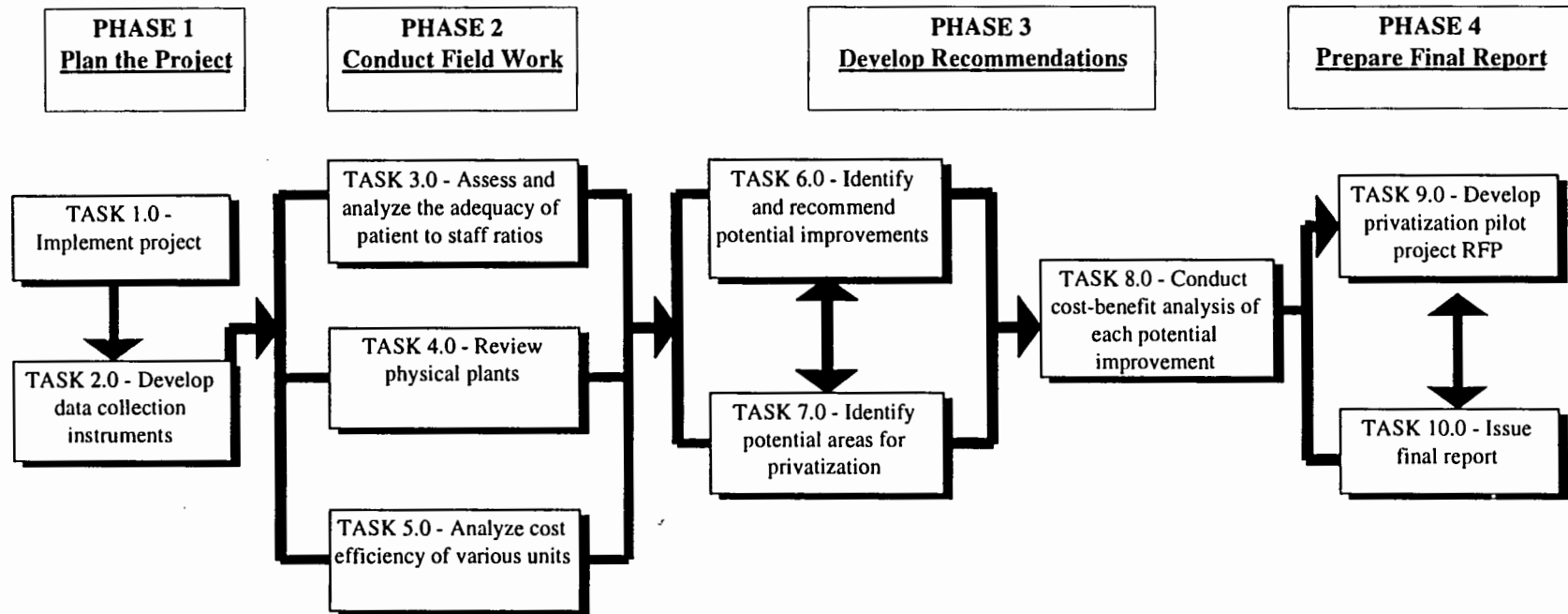
SCOPE OF SERVICES

- Identify areas for improved hospital operations and efficiency
- Identify changes in hospitals' physical plants for greater efficiency
- Identify outsourcing to achieve greater hospital cost efficiency
- Determine impact of hospital changes on revenue sources and state appropriations

MENTAL HEALTH SYSTEM COMPONENTS OUTSIDE THE STUDY SCOPE

- Mental Health, Developmental Disabilities, and Substance Abuse Area Authorities
- Local Government Social Services
- State Facilities, such as the Special Care Center and ADATCs
- Private Providers

APPROACH AND WORK PLAN



Use of Experts in:

- Extensive On-site Review of Service Delivery, Operations, and Plant
- Detailed Data Collection Analysis
- Peer Review
- Architecture
- Finance
- Mental Health
- Nursing
- Hospital Administration
- Engineering
- Architecture
- Finance
- Staffing and Personnel

REPORT CONTENTS

- Executive Summary
- Introduction
- Overview of North Carolina's Mental Health System
- Dix Hospital Review
- Broughton Hospital Review
- Umstead Hospital Review
- Cherry Hospital Review
- Outsourcing Opportunities
- Comparisons Among Hospitals
- Findings and Recommendations
- Appendices:
 - Glossary of Terms
 - RCC Codes
 - RFPs

STATE PSYCHIATRIC HOSPITAL PROFILE

	Broughton	Cherry	Dorothea Dix	John Umstead
Number of Buildings	102	52	137	50
Square Footage	1.2 million	710,821	1.3 million	1 million
Campus Size (Acres)	300	344	355	200
Bed Capacity	632	661	430	593
Counties Served	35	33	16	16
Population Served	2.5 million	1.5 million	1.8 million	1.5 million



KEY FINDINGS

- Systems and Services
- Administration
- Direct Care
- Physical Plant



KEY FINDINGS ON SYSTEM AND SERVICES

- All four hospitals serve youth, adults, and elders
- Some hospitals offer special programs for specific populations
- The cost per bed per day varies widely from unit to unit and hospital to hospital

COST PER BED PER DAY

Hospital	Youth	Adult Admissions	Rehabilitation	Clinical Research	Deaf	Adult Long Term	High Management	Geriatric Admissions	Geriatric Long Term	Nursing Facility	Medical/Surgical	Nursing	TB	Pre-Trial Evaluation
Dix	\$448	\$346	---	\$425	\$349	\$313	\$1,313	\$311	\$306	---	\$708	---	---	\$370
Broughton	\$352	\$241	\$247	---	---	\$218	---	\$209	\$197	\$233	\$495	\$213	---	---
Umstead	\$442	\$268	\$191	---	---	---	\$499	---	\$330	\$252	---	\$410	---	---
Cherry	\$389	\$244	\$214	---	---	\$200	\$334	\$258	\$239	\$218	---	\$195	\$204	---

KEY FINDINGS ON ADMINISTRATION

- Some factors affect hospital administration
 - State personnel system
 - Hospitals' timekeeping systems
- Other factors affect hospital operations
 - Number of substance abuse patients
 - Number of miles between certain area authorities and hospitals

SUBSTANCE ABUSE PATIENTS

PRIMARY DIAGNOSES OF PATIENTS ADMITTED TO STATE PSYCHIATRIC HOSPITALS DURING THE LAST FIVE FISCAL YEARS

Diagnosis	Fiscal Year									
	1996-97		1995-96		1994-95		1993-94		1992-93	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Substance Abuse	3,592	28.1%	2,725	22.1%	2,610	20.3%	2,778	21.5%	2,252	19.5%
Mental Retardation	51	0.4%	72	0.6%	120	0.9%	126	1.0%	137	1.2%
Mental Illness	9,138	71.5%	9,524	77.3%	10,106	78.7%	9,995	77.5%	9,159	79.3%
Total	12,781	100.0%	12,321	100.0%	12,836	100.0%	12,899	100.0%	11,548	100.0%

COST OF TREATING PATIENTS WITH A PRIMARY DIAGNOSIS OF SUBSTANCE ABUSE IN STATE PSYCHIATRIC HOSPITALS

FISCAL YR	DIX	BROUGHTON	UMSTEAD	CHERRY	TOTAL
1996-97	\$ 4,311,360	\$ 4,287,856	\$12,720,955	\$ 956,215	\$22,276,386
1995-96	\$ 1,367,520	\$ 2,333,705	\$ 9,266,312	\$ 982,352	\$13,949,889
1994-95	\$ 1,813,840	\$ 2,687,704	\$ 4,546,368	\$ 1,098,072	\$10,145,984
1993-94	\$ 2,037,568	\$ 3,194,620	\$ 5,987,520	\$ 1,125,076	\$12,344,784
1992-93	\$ 1,971,550	\$ 2,295,306	\$ 4,078,948	\$ 4,577,363	\$12,923,167
TOTAL	\$11,501,838	\$ 14,799,191	\$36,600,103	\$ 8,739,078	\$71,640,210

SELECTED AREA AUTHORITIES' UTILIZATION OF STATE PSYCHIATRIC HOSPITALS

Area Program	Major City	Regional Hospital	Population		95-96 and 96-97 Admissions		Adms % vs. Pop %	Number of Air Miles
			Number	Regional Percent	Number	Regional Percent		
Wake	Raleigh	Dix	539,187	29.4%	3,177	54.0%	45.6%	0
Durham	Durham	Umstead	194,956	12.5%	1,476	22.3%	43.8%	12
Mecklenburg	Charlotte	Broughton	593,514	23.4%	529	7.3%	-221.0%	64

KEY FINDINGS ON DIRECT CARE

- Patients' physical needs are adequately met
- Patients' psychiatric needs are not always adequately met
 - Inadequate number and scheduling of support staff reduces direct care staff's ability to care for patients
 - Professional and other direct care staff do not have adequate communication and support systems
 - Direct care staff are frequently pulled from their home units to cover other units

ESTIMATED COST OF RNs PERFORMING SUPPORT STAFF DUTIES

Hospital	RN Hours per Week per Ward				Number of Wards	Total Annual Hours	Hourly Cost	Annual Cost
	House-keeping	Time-keeping	Medical Records	Total				
Dix	1.00	1.75	0.50	3.25	25	4,225	\$24	\$102,375
Broughton	1.00	1.75	0.50	3.25	28	4,732	\$24	\$114,660
Umstead	1.00	1.75	0.50	3.25	36	6,084	\$24	\$147,420
Cherry	1.00	1.75	0.50	3.25	30	5,070	\$24	\$122,850
TOTAL	4.00	7.00	2.00	13.00	119	20,111		\$487,305

ESTIMATED COST OF HCTs PERFORMING SUPPORT STAFF DUTIES

Hospital	HCT Hours per Week per Ward				Number of Wards	Total Annual Hours	Hourly Cost	Annual Cost
	House-keeping	Time-keeping	Medical Records	Total				
Dix	11.00	0.75	0.75	12.50	25	16,250	\$12	\$187,031
Broughton	11.00	0.75	0.75	12.50	28	18,200	\$12	\$209,475
Umstead	11.00	0.75	0.75	12.50	36	23,400	\$12	\$269,325
Cherry	11.00	0.75	0.75	12.50	30	19,500	\$12	\$224,438
TOTAL	44.00	3.00	3.00	50.00	119	77,350		\$890,269

KEY FINDINGS ON PHYSICAL PLANT

- Except for the Barrett Building at Umstead, all hospitals' physical plants are obsolete
 - Hospitals' estimates of deferred maintenance is over \$56 million
 - Multi-story buildings with insufficient number of working elevators impede patient movement and family visitation
 - Ward layout is ineffective
 - Mechanical systems are drastically outdated
- Space drives staffing

NET SQUARE FEET, OPERATIONAL BEDS, AND DIRECT CARE STAFF TO OPERATIONAL BED RATIO

Listed in Descending Order by Operational Beds per Net Square Foot

Hospital	Direct Care Net Sq Ft	Operational Beds	Net Sq Ft per Oper. Bed	Direct Care Staff to Patient Ratio
Dix	350,379	429	817	2.13
Umstead	267,669	513	522	1.72
Broughton	246,878	632	391	1.65
Cherry	238,138	661	360	1.71

KEY RECOMMENDATIONS

- Provide services for some persons in more appropriate settings
- Provide the highest possible level of intensive therapeutic activities for all patients
- Amend some hospital operating procedures and implement others
- Expend funds in specified target areas
- Increase certain receipts and vigorously explore outsourcing opportunities
- Build four state-of-the-art psychiatric hospital complexes

KEY RECOMMENDATION - Provide Services for Some Persons in More Effective Settings

In conjunction with area authorities, state facilities, and affected industries and agencies:

- Develop policies requiring agencies that receive state funds to accept patients who are intoxicated, still actively using, and/or threaten violence to themselves or others
- Close Youth, Geriatric Long Term, and Nursing Facility Units, and utilize community-based resources for these individuals
- Serve all legal status patients at one hospital
- Bring certain state psychiatric hospital populations in line with their percentage of the state's population:
 - reduce Wake and Durham area authorities' state psychiatric hospital admissions
 - reduce number of adult beds at Umstead and Cherry

CURRENT AND RECOMMENDED NUMBER OF OPERATIONAL BEDS

Unit	Dix		Broughton		Umstead		Cherry		Total	
	Cur.	Rec.	Cur.	Rec.	Cur.	Rec.	Cur.	Rec.	Cur.	Rec.
Youth	51	0	32	0	64	0	38	0	185	0
Adult Admissions	70	33	161	129	150	97	136	112	517	371
Rehabilitation	0	0	101	81	136	96	62	51	299	228
Clinical Research	12	9	0	0	0	0	0	0	12	9
Deaf	17	13	0	0	0	0	0	0	17	13
Adult Long Term	128	100	0	0	0	0	187	154	315	254
High Management	4	3	118	94	40	29	16	15	178	141
Geriatric	37	28	44	35	0	0	20	18	101	81
Admissions										
Geriatric Long Term	49	0	48	0	59	0	14	0	170	0
Nursing Facility	0	0	44	0	30	0	173	0	247	0
Medical/Surgical	31	31	22	22	0	0	0	0	53	53
Nursing	0	0	62	62	34	34	10	10	106	106
TB	0	0	0	0	0	0	5	0	5	0
Pre-Trial Evaluation	30	30	0	0	0	0	0	0	30	30
Wilson House	0	0	0	0	0	0	1	1	1	1
Total	429	247	632	423	513	256	662	361	2,236	1,287

KEY RECOMMENDATION - Provide The Highest Possible Level of Intensive Therapeutic Activities for All Patients

- Ensure that every unit provides the highest possible level of intensive therapeutic activities for its patients

KEY RECOMMENDATION - Amend Some Hospital Operating Procedures and Implement Others

- Ensure consistency among financial and accounting practices and procedures
- Assess patients' psychiatric as well as physical acuity
- Institute unit-centered direct care staffing
- Reallocate staffing on some units and shift hours for some types of staff

KEY RECOMMENDATION
Expend Funds In Specified Target Areas

- Conduct a market assessment of Licensed Practical Nurses and Health Care Technicians
- Update hospitals' computer, maintenance work order, personal protection, and paging systems
- Obtain an automated timekeeping system

***KEY RECOMMENDATION - Increase Certain Receipts
and Vigorously Explore Outsourcing Opportunities***

- Increase annual receipts from services performed by state psychiatric hospitals for other agencies
- Continue to explore outsourcing identified in the study
- Further investigate outsourcing of either or both Medical/Surgical Units

ANNUAL COSTS OF PROVIDING SERVICES TO OTHER INSTITUTIONS

Hospital	Continuous Insourcing				Episodic Insourcing				Total Insourcing			
	FTEs	Cost	Receipts	Net Cost	FTEs	Cost	Receipts	Net Cost	FTEs	Cost	Receipts	Net Cost
Dix	22.91	\$1,582,100	\$1,189,845	\$392,255					22.91	\$1,582,100	\$1,189,845	\$392,255
Broughton	26.52	\$1,289,221	\$782,403	\$506,818	1.75	\$65,694	\$0	\$65,694	28.27	\$1,354,915	\$782,403	\$572,512
Umstead	6.11	\$620,647	\$274,992	\$345,655		\$6,000		\$6,000	6.11	\$626,647	\$274,992	\$351,655
Cherry	37.90	\$2,257,449	\$2,046,608	\$210,841					37.90	\$2,257,449	\$2,046,608	\$210,841
TOTAL	93.44	\$5,749,417	\$4,293,848	\$1,455,569	1.75	\$71,694	\$0	\$71,694	95.19	\$5,821,111	\$4,293,848	\$1,527,263

AREAS IDENTIFIED AS APPROPRIATE FOR OUTSOURCING

Hospital	Area
Dix	Housekeeping and extermination services at DHHS buildings
Broughton	Vehicle maintenance and physical therapy
Umstead	Beauty/barber shop and office area housekeeping functions
Cherry	Vehicle maintenance

***KEY RECOMMENDATION - Build Four
State-of-the-Art Psychiatric Hospital Complexes***

- Using the Barrett Building at Umstead as a model, build four state-of-the-art psychiatric hospital complexes

10-YEAR COSTS ASSUMING NO CHANGE IN BEDS

ASSUMING NO NEW BUILDINGS OTHER THAN CAPITAL REPLACEMENT

Hospital	Number of Operational Beds	Unit Salaries and Expenses	Energy Costs	Housekeeping	Maintenance Repair and Renovation	Other Overhead	Capital Replacement	GRAND TOTAL	
								Dollars	Cost per Bed per Day
Dix	429	\$276,081,027	\$17,647,680	\$26,035,520	\$25,666,770	\$249,471,737	\$71,653,333	\$666,556,066	\$426
Broughton	632	\$279,568,910	\$21,076,800	\$18,386,330	\$28,642,480	\$213,757,020	\$10,895,600	\$572,327,140	\$248
Umstead	513	\$339,273,330	\$18,980,090	\$14,439,580	\$9,545,260	\$185,429,480	\$5,823,333	\$573,491,073	\$306
Cherry	661	\$311,547,515	\$19,236,270	\$14,337,880	\$30,959,250	\$186,458,130	\$18,473,167	\$581,012,212	\$241
TOTAL	2,235	\$1,206,470,781	\$76,940,840	\$73,199,310	\$94,813,760	\$835,116,367	\$106,845,433	\$2,393,386,491	\$293

Note: Projected costs for Cherry do not take into account the proposed replacement for the McFarland Building, which presumably will be more energy efficient and benefit from a honeymoon period where no major alterations will be required.

10-YEAR COSTS WITH FEWER BEDS

ASSUMING NO NEW BUILDINGS OTHER THAN CAPITAL REPLACEMENT
REDUCING NUMBER OF OPERATING BEDS

Hospital	Number of Operational Beds	Unit Salaries and Expenses	Energy Costs	Housekeeping	Maintenance Repair and Renovation	Other Overhead	Capital Replacement	GRAND TOTAL	
								Dollars	Cost per Bed per Day
Dix	247	\$170,657,757	\$7,326,370	\$11,663,913	\$11,319,046	\$154,209,391	\$71,653,333	\$426,829,810	\$473
Broughton	423	\$187,497,300	\$16,922,820	\$14,506,814	\$24,002,398	\$143,359,518	\$10,175,025	\$396,463,875	\$257
Umstead	256	\$153,161,533	\$14,486,380	\$10,901,883	\$7,006,221	\$83,710,274	\$3,070,000	\$272,336,290	\$291
Cherry	361	\$160,562,146	\$19,187,150	\$12,904,092	\$28,977,858	\$96,094,868	\$17,842,583	\$335,568,697	\$255
TOTAL	1,287	\$671,878,735	\$57,922,720	\$49,976,702	\$71,305,523	\$477,374,051	\$102,740,941	\$1,431,198,672	\$305

1. Dix would house patients in Spruill, Hargrove (CCU) and McBryde East, North and South.
2. Broughton would close wards V & W and 28 through 32, as well as the Reece, Harper, Scroggs and Saunders buildings.
3. At Umstead, the Barrett Building and Buildings 29 through 37 would remain in service. Buildings 38 through 40 and 44 through 54, along with Service Units 3 & 4, would be closed.
4. At Cherry, patients would be housed in the McFarland Replacement, U-1, U-2, U-3, U-4 and Royster. Support functions would infill Woodard, and outlying buildings would be decommissioned. C.I., Linville and Richardson could be demolished or transferred to other Agencies.
5. Energy costs were derived by eliminating costs for buildings closed or demolished per notes 1 through 4 above. Housekeeping and maintenance costs were derived by taking respective weighted square footages of buildings remaining in operation and dividing by current weighted square footages.
6. Other overhead costs were reduced proportionately to unit salaries and expenses.

10-YEAR COSTS FOR BUILDING NEW HOSPITALS WITH FEWER BEDS

REDUCING TOTAL NUMBER OF OPERATIONAL BEDS
CONSTRUCTING NEW BUILDINGS AT ALL FOUR HOSPITALS
AND RETAINING THE BARRETT BUILDING AT UMSTEAD

Hospital	Number of Operational Beds	Unit Salaries and Expenses	Energy Costs	Housekeeping	Maintenance Repair and Renovation	Other Overhead	New Construction	GRAND TOTAL	
								Dollars	Cost per Bed per Day
Dix	247	\$118,200,121	\$1,580,800	\$4,618,900	\$4,742,400	\$68,251,981	\$12,800,000	\$210,194,202	\$233
Broughton	423	\$187,939,323	\$2,622,600	\$6,971,250	\$7,867,800	\$108,457,696	\$16,533,333	\$330,392,003	\$214
Umstead	256	\$113,135,360	\$1,689,600	\$4,254,250	\$5,068,800	\$64,788,041	\$11,000,000	\$199,936,051	\$214
Cherry	361	\$176,621,055	\$1,650,000	\$4,618,900	\$7,147,800	\$104,919,407	\$11,000,000	\$305,957,162	\$232
TOTAL	1,287	\$595,895,859	\$7,543,000	\$20,463,300	\$24,826,800	\$346,417,126	\$51,333,333	\$1,046,479,418	\$223

1. Costs are generally given on a per-square-foot basis. Inpatient psychiatric facilities range between 600 and 700 square feet per bed.
2. Energy costs are based on rule-of-thumb rates provided by Duke Power Co.
3. Construction costs represent the first 10 years of the buildings' expected 30 years life.
4. Other overhead costs were computed at Umstead's current overhead rate of 67 percent, as Umstead has the newest direct care building.
5. Unit salaries and expenses were computed on the basis of 1.3 unit staff per bed and a per unit staff position cost per hospital.

FORECAST FOR DSH FUNDING BASED ON FEDERAL FORMULA REQUIREMENTS ASSUMING CURRENT CAPACITY

Fiscal Year	Projected Expenditures	DSH Funds
1997-1998	\$247,939,872	\$140,384,674
1998-1999	\$255,378,068	\$129,253,526
1999-2000	\$263,039,410	\$130,255,499
2000-2001	\$270,930,592	\$130,218,767
2001-2002	\$279,058,510	\$127,016,688
2002-2003	\$287,430,265	\$123,500,866

FORECAST OF REVENUES AND EXPENDITURES

KEEPING EXISTING BUILDINGS

Item	Current Capacity	Reduced Capacity				
	1997-98	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
Expenditures	\$247,939,872	\$143,119,867	\$147,413,463	\$151,835,867	\$156,390,943	\$161,082,672
DSH Transfer	\$140,384,674	\$83,157,652	\$83,802,290	\$83,778,658	\$81,718,541	\$79,456,572
Total Expenditures	\$388,324,546	\$226,277,520	\$231,215,754	\$235,614,525	\$238,109,484	\$240,539,243
Revenues						
Medicare	\$18,318,940	\$10,574,355	\$10,891,586	\$11,218,334	\$11,554,884	\$11,901,530
Medicaid not DSH	\$6,177,241	\$3,565,727	\$3,672,699	\$3,782,880	\$3,896,366	\$4,013,257
Insurance	\$2,573,707	\$1,485,637	\$1,530,206	\$1,576,112	\$1,623,396	\$1,672,098
Other Patient Revenue	\$8,339,483	\$4,813,851	\$4,958,267	\$5,107,015	\$5,260,225	\$5,418,032
Other Non-Patient Revenue	\$9,158,652	\$5,286,705	\$5,445,307	\$5,608,666	\$5,776,926	\$5,950,234
Sub-Total, All Revenues	\$44,568,024	\$25,726,276	\$26,498,065	\$27,293,006	\$28,111,797	\$28,955,151
DSH	\$140,384,674	\$83,157,652	\$83,802,290	\$83,778,658	\$81,718,541	\$79,456,572
State Appropriation	\$203,371,848	\$117,393,591	\$120,915,399	\$124,542,861	\$128,279,147	\$132,127,521

CONSTRUCTING NEW BUILDINGS AND RETAINING BARRETT AT UMSTEAD

Item	Current Capacity	Reduced Capacity				
	1997-98	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
Expenditures	\$247,939,872	\$104,647,942	\$107,787,380	\$111,021,001	\$114,351,631	\$117,782,180
DSH Transfer	\$140,384,674	\$60,804,117	\$61,275,470	\$61,258,191	\$59,751,852	\$58,097,921
Total Expenditures	\$388,324,546	\$165,452,059	\$169,062,850	\$172,279,192	\$174,103,483	\$175,880,101
Revenues						
Medicare	\$18,318,940	\$7,731,872	\$7,963,828	\$8,202,743	\$8,448,826	\$8,702,290
Medicaid not DSH	\$6,177,241	\$2,607,227	\$2,685,444	\$2,766,007	\$2,848,987	\$2,934,457
Insurance	\$2,573,707	\$1,086,284	\$1,118,873	\$1,152,439	\$1,187,012	\$1,222,623
Other Patient Revenue	\$8,339,483	\$3,519,844	\$3,625,440	\$3,734,203	\$3,846,229	\$3,961,616
Other Non-Patient Revenue	\$9,158,652	\$3,865,591	\$3,981,559	\$4,101,005	\$4,224,035	\$4,350,757
Sub-Total, All Revenues	\$44,568,024	\$18,810,819	\$19,375,143	\$19,956,397	\$20,555,089	\$21,171,742
DSH	\$140,384,674	\$60,804,117	\$61,275,470	\$61,258,191	\$59,751,852	\$58,097,921
State Appropriation	\$203,371,848	\$85,837,123	\$88,412,237	\$91,064,604	\$93,796,542	\$96,610,438

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 20, 1998

Afternoon meeting

Minutes

The Joint Appropriation met on Wednesday afternoon, May 20, 1998 in Room 643. Senator Bill Martin presided. Three Senators were present and the following House members:

Representative Charlotte Gardner

Representative Debbie Clary

Representative Edd Nye

Representative Lanier Cansler

Representative Cindy Watson

Staff present were Karen Hammonds-Blanks, Carol Shaw and Susan Sabre.

Steve Humphrey of MGT of America finished the report on the Efficiency Study of the State Psychiatric Hospitals.

Don Willis, Chief of the Mental Health Services Section, gave the department's response to the MGT study (See attachment #1, "Efficiency Study of State Psychiatric Hospitals"). He pointed out those key items on which they agree with the recommendations of the study and those with which they disagree.

Representative Gardner questioned ADD children being admitted to a psychiatric hospital. Mr. Tom Bainbridge responded that this occurrence is rare. Children between 5-12 years placed in hospitals have post traumatic stress disorder and severe emotional impairment that manifests itself in behavior that may be injurious to themselves and others. He assured Senator Martin that most mental health professionals would agree hospitalization is appropriate. Dr. Ross of MGT said that it is rare to find children in psychiatric hospitals in other states.

Representative Cindy Watson asked what the percentage is of children, ages 10-18 years who are in the psychiatric hospitals, have drug and alcohol related problems. Mr. Tom Bainbridge of the Division of Mental Health, Developmental Disabilities and Substance Abuse said he would get the figures for her, but they tend to be very high. He said mental illness and drug problems go hand in hand.

In answer to Representative Gardner's concern that there is no incentive or disincentive for the use of the psychiatric hospitals, Mr. Willis said the department would be making recommendations on this issue.

Senator Martin announced the committee will not meet tomorrow morning. The meeting was adjourned.



Barbara R. Hocutt, Clerk



Senator Bill Martin, Chair



Don Willie
May 20, 1998

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

May 12, 1998

MEMORANDUM

TO: The Honorable Charlotte Gardner
North Carolina House of Representatives
North Carolina General Assembly

The Honorable Lanier Cansler
North Carolina House of Representatives
North Carolina General Assembly

The Honorable Debbie Clary
North Carolina House of Representatives
North Carolina General Assembly

The Honorable William N. Martin
North Carolina Senate
North Carolina General Assembly

Mr. Tom Covington, Director
Fiscal Research

FROM: H. David Bruton, M.D. *HDB*

RE: Efficiency Study of State Psychiatric Hospitals

The General Assembly of North Carolina directed, through Section 11.44(a) of SB 352, the Department of Health and Human Services to contract with an independent consulting firm to conduct a study of the management and operations of the four State psychiatric hospitals. That same legislation stated that the results of the study and the Department's response to the study would be provided to the co-chairs of the House and Senate Appropriations Subcommittees on Health and Human Services and the Fiscal Research Division.

Memorandum to the Honorable Charlotte Gardner, the Honorable Lanier Cansler,
the Honorable Debbie Clary, the Honorable William N. Martin and Mr. Tom Covington
May 12, 1998
Page 2

Pursuant to Section 11.44(a) of SB 352, the Department of Health and Human Services contracted with the consulting firm, MGT of America, Inc., to conduct a study of the operations and management of the State's four psychiatric hospitals. The study resulted in an extensive report and a wide range of recommendations for improved operations and increased efficiency. After reviewing the report, along with its findings and conclusions, the Department agrees that implementation of the majority of the recommendations would lead to improved patient care and increased operating efficiency. To achieve these efficiencies the report outlines some rather fundamental changes to a system of institutions that is more than 125 years old and that has evolved in response to a number of competing and conflicting internal and external political, financial and service delivery demands. While the study identifies substantial savings that would accrue if the recommendations are implemented, it is also insightful in its assessment that successful implementation of the recommendations would require many of those savings to remain within the mental health system.

In accordance with Section 11.44(A) of SB 352, attached herewith are the results of the Hospital Efficiency Study and the Department's response to the study.

HDB/DW/ng

Attachment

Recommendation 9.1: Develop a policy requiring ADATCs and other community based substance abuse treatment facilities that accept state funds to accept patients who are intoxicated, still actively using, and/or threaten violence to themselves or others. The state should ensure that training is provided to ADATCs and other substance abuse treatment facility staff in managing and treating these patients.

Workgroup Members:

Doug Baker, Branch Head Adult Services, Substance Abuse Services Section
Ann Davis, Deputy Director Quality Management, Neuse Center for MHDDSAS
Ellis Edney, Director Substance Abuse Services, Blue Ridge Center for MHDDSAS
Spence Lylerly, Ph.D., Clinical Director, Crisis Services Section
Phil Mooring, Director, Walter B. Jones ADATC
Bill Rafter, Director, Julian F. Keith ADATC
Philip Veenhuis, M.D., MPH, Medical Director, Division MHDDSAS

Departmental Response and Plan of Action:

The Department supports the concept of treating substance abuse clients in the most clinically appropriate setting. However, achieving this objective is more complex than simply developing a policy requiring substance abuse facilities to accept these patients. The Department will take the following actions to implement this recommendation:

1. Convene a group of Department, Institution (ADATCs and psychiatric hospitals), and area program staff to (a) study and adapt the Best Practice Principles currently available to meet consumer needs in North Carolina and prevent the inappropriate admission of substance abuse patients to state psychiatric hospitals, (b) develop a "Clinical Pathway" for individuals diagnosed with co-occurring substance abuse and mental disorders, and (c) develop a plan for ADATC conversion/expansion and the expansion of community capacity to serve most of the substance abusers who are currently entering the State hospitals. The work of this committee should be completed within 12 months from the date of its appointment. The results of the committee's work will provide the blueprint for service development or reconfiguration such that we will begin diverting substance abusers from the State hospitals during fiscal year 2000.
2. Provide training to staff in psychiatric hospitals, ADATCs, and area programs designed to address the specific needs of persons with co-occurring substance abuse and mental disorders.

Rationale for Departmental Response:

One of the reasons the State hospitals treat such a large number of substance abusers is associated with the lack of capacity on the part of current substance abuse treatment facilities to handle these patients. Another issue that is central to this recommendation is that of the client who is mentally ill as well as a substance abuser. The department will address this

recommendation in a manner that reflects best practice for serving the substance population, that builds on existing policy and that reflects the most efficient use of all system resources.

Based on additional analysis of available data, the Department believes that the report understates the clinical picture of those substance abusers who are served by the State hospitals. While, clearly, some of these people could be served through existing resources, the vast majority will require service settings that are more highly structured and that have medical management capability.

Many of the current community detoxification facilities were originally developed to provide low cost care to individuals who were withdrawing from alcohol and other drugs. These existing community detoxification facilities as well as the Alcohol and Drug Abuse Treatment Centers are not currently staffed to provide a medically managed level of care or equipped to provide lockup, seclusion or restraints to ensure the safety of patients and staff. The comparatively low cost of treating individuals diagnosed with substance abuse in community detox facilities and the ADATCs are based on a significantly less intensive level of care than is provided in state psychiatric hospitals. Major modifications would be required before most of the existing community detoxification facilities or the ADATCs could begin to serve the persons who are receiving services in the State hospitals. Facilities would have to be renovated, staffing patterns would have to be altered to handle violent patients and the medical management capacity of these facilities would have to be expanded significantly. Another factor that must be considered is that there currently is no surplus capacity in local detox facilities or the ADATCs. This would, naturally, mean the development of new services with the attendant issues associated with the Certificate of Need process.

Additionally, the ADATCs are currently providing inpatient treatment for patients in their mainstream programming and in specialized programming for pregnant and parenting women and for deaf and hard of hearing substance abusers. These programs are offered in response to needs identified by area programs and are successfully serving motivated patients who are experiencing positive outcomes. The displacement of the population currently served at the ADATCs would place a serious burden on area programs especially in resource poor areas of the State. The ADATCs served 3,692 patients in SFY 1995-96.

Successful implementation of this recommendation will require the reinvestment of most of the dollars saved along with the development and enunciation of policies and practices to govern the provision of services to those who have the single diagnosis of substance abuse as well as those who have co-occurring diagnoses.

Recommendation 9.2: Develop a strategy in conjunction with area authorities, rest homes, and nursing home providers to close geriatric long-term and nursing facility units and utilize community resources for these patients.

Workgroup Members:

Mac Brownlee, GACPD
Ed Burnett, Halifax Area Program
Polly Godwin, NC Health Care Assoc.
Dale Hilburn, Cherry Hospital
Bonnie Morell, DMHDDSAS
Regina Schaaf-Dickins, Halifax Area Program
Paula Wilcenski, NCMHCO
Lou Wilson, NC Assoc. LTC Facilities

Departmental Response and Plan of Action:

The Department supports this recommendation if given the flexibility to develop and implement a plan to address the needs of people who are now being served by long term geriatric and nursing units in state hospitals. Addressing the needs of this population will require extensive planning over a period of time. The Department will implement this recommendation as follows:

The Department will develop a plan to accomplish the transition of nursing facility services from state hospitals to more appropriate community facilities. The planning will be done within a framework that addresses desired outcomes, models of service, regulation, and reimbursement. The plan must address the following elements:

- (1) Needs Assessment. The issue of appropriate placement of elderly patients with moderate to substantial psychiatric and behavioral needs cannot be viewed in the narrow context of those currently residing in state hospitals.
- (2) Development of several program designs/options. Based on the anticipated differences in needs, it is clear that no currently existing type of facility could simply begin serving these individuals. Programmatic and facility design should be based on needs of people to be served. Planning is needed to outline several options which can be compared to the types of models that are currently available in the community. It is anticipated that new, specialized options would need to be developed that match needs more closely than existing options

Options should be as small as possible while still being able to achieve economies of scale in order to afford to provide the programming/services required, e.g. ranging in size from 20 to 30 beds. Physical environments that will promote well being

must be considered, e.g. privacy rather than shared rooms; ability to get outdoors; to walk; to engage in activities that are familiar and meaningful.

- (3) Careful consideration and planning about impact of current regulations and funding on feasibility. Feasibility and success will also require addressing adaptation of current regulations if needs are to be met. For example, current nursing facility regulations are felt to deter facilities from accepting residents whose primary needs include both nursing care and treatment for mental illness.
- (4) Careful planning regarding transition, accountability and evaluation. This must include both (A) system issues and (B) individual resident issues that are outlined below:
 - (A) System Issues. After appropriate options (programmatic, facility requirements; and staffing) have been identified, demonstration projects could be undertaken as a public-private partnership, with clear expectations about desired outcomes for the residents and oversight to be carried out by the state. A central point of accountability is essential since these new options could not be implemented as effectively if accountability was based on having to fit piecemeal within the “existing regulatory / monitoring maze.”
 - (B) Individual Issues. Implementation would require careful planning regarding how to ensure that individual transitions have positive outcomes.

Planning and full implementation will require approximately four years.

Rationale for Departmental Response:

Implementation of this recommendation would provide an opportunity to match individuals' needs more closely with programming, services, and facility design. Both service responsiveness and efficiency could be increased by identifying and grouping geriatric patients with similar needs in small (20-30 bed) community based facilities. While the recommendation calls for a reduction of 417 beds (170 geriatric long term beds and 247 nursing facility beds), this reduction will have to be achieved over time with careful planning and adequate funding. Specialized community-based facilities that are staffed to address both the nursing/medical and mental health needs would be essential. Thus, some of the savings would be needed to support that care in these specialized facilities. Planning must include, not only the current state hospital patients on these units, but also must consider increased need for community based geriatric mental health services. Addressing this population appropriately will require resources to increase area program capacity to provide effective geriatric services which would likely reduce the need to place people in these specialized facilities.

Recommendation 9.3: Develop a strategy in conjunction with area authorities to close youth units and utilize community resources for these patients.

Workgroup Members:

Sally Cameron, Exec. Dir. N.C. Psychological Assoc.
Jim Mayo, Psychiatrist, Dix Hospital
Mark Stein, Psychologist, Dix Hospital
Mary Ellen Anderson, Wake Co. Human Services
Clyde Evely, OPC Area Program
Lynn Mizelle, Advocate, NC Families CAN
Debbie Simmers, Director, Wright School

Consultants:

Charles Davis, Division, Willie M. Program
Dan Searcy, Director, Johnston Area Program
Jim Brawley, Charter/Holly Hill Hospital
Lisa Abatemarco, Budget Analyst, DHHS

Departmental Response and Plan of Action:

The Department does not support the recommendation presented by MGT to close the child and adolescent units. The services provided by the State psychiatric hospitals are necessary for a range of children and adolescents whose treatment needs periodically or persistently exceed the greatly expanded community based service capacity that has been developed in recent years. The Department, however, does support an assessment and, if warranted, a realignment of the services provided to children and adolescents by the state hospitals. To accomplish this objective the Department will take the following actions:

1. Convene a group of stakeholders, including area programs, state hospitals, private hospitals, and consumers/family members to assess the services that the State hospitals currently provide to children and adolescents and to make recommendations for system improvement.
2. Use the recommendations as the basis of a system change plan.

Planning and implementation of program changes could be expected to take 12 to 18 months.

Rationale for Departmental Response:

It appears that this recommendation was made without data to support the conclusion. Additionally, no argument was advanced that moving services to the community would achieve either treatment or cost efficiency. The prevailing view is that the children and adolescents served in the State hospitals have intense service needs and have already

been stigmatized by their low level of functioning in the community. The sub-population served in these State facilities tends to be at the most extreme end of the need continuum. Private sector facilities are not structured to meet the needs of this population. If private facilities were to serve this population, there would have to be a corresponding increase in service intensity and cost in those settings.

The State hospitals represent a 'safety net' which should not be removed. The state hospital system operates as a treatment service of last resort for some consumers and provides a guarantee that appropriate services will be available to all children and adolescents in the state of North Carolina, regardless of how severe or unusual service needs may be. The State hospitals also serve as a 'safety' net for private providers who commit children to the state hospitals when those children's treatment needs exceed the treatment capacity of the private provider.

Recommendation 9.4: DMHDDSAS should work closely with the Wake and Durham area authorities to help them reduce admissions to the state psychiatric hospitals.

Workgroup Members:

Don Willis, DMHDDSAS

Consultants:

Maria Spaulding, Wake Co. Human Services
Meg Houseworth, Wake Co. Human Services
Camille Schaffer, Wake Co. Human Services
Steve Ashby, Durham Area Program

Departmental Response and Plan of Action:

The department agrees with this recommendation. The resources of the State hospitals should be made available to all citizens on an equitable basis. To ensure that no county or catchment area uses more than its fair share of State hospital beds the Department will take the following actions:

1. Develop a formula for the allocation of hospital bed days by January 1999.
2. Begin phased implementation of the bed day allocation formula in July 1999 - formula will be fully implemented by July 2002.
3. Require counties or area authorities to pay, on a per diem basis, for any use above their stated allocation.

Rationale for Departmental Response:

The Wake and Durham area programs have traditionally used a disproportionate number of the beds at Dix and Umstead hospitals respectively. There are a number of reasons for this over utilization such as proximity to the hospitals, the lack of local inpatient alternatives, etc. In past years the Division has worked with these two programs to address this issue through special projects aimed at increasing local capacity, encouragement and coercion. These efforts have had some success in that each area's proportionate use of the hospitals is somewhat lower than their peak in the mid to late 1980s.

Aside from the Efficiency Study recommendation, the Division's bed day allocation process also calls for the two programs to reduce their use of the hospitals so that bed days can be allocated equitably among the area programs.

Recommendation 9.5: The number of adult beds at Umstead and Cherry hospitals should be downsized to equal each region's proportion of the state's population

Workgroup Members:

Don Willis, DMHDDSAS

Departmental Response and Plan of Action:

The Department does not agree with this recommendation.

Rationale For Departmental Response:

The number of beds at the different hospitals is not determined by the population of the region. A number of factors such as the availability of local inpatient services, the availability of community based mental health services, and the capacity of the communities to deal with persons who need involuntary commitment determine the size of the hospitals. Any decision to downsize a hospital should only be made after a careful planning process to assure that those services previously offered by the hospital will be made available in an alternative setting.

Recommendation 9.6: Develop a strategy in conjunction with area authorities to: treat substancabusers in facilities other than hospitals: close Youth Geriatric Long Term and Nursing Facility Units and transfer patients in those units to community based programs: reduce the number of beds used by Wake and Durham area authorities at Dix and Umstead hospitals: downsize the number of adult beds at Umstead and Cherry hospitals.

Departmental Response: See responses to 9.1, 9.2, 9.3, 9.4, and 9.5.

Recommendation 9.7: Build four state-of-the-art psychiatric hospital complexes, using DSH (Disproportionate Share Hospital) money to fund construction.

Workgroup: Steve Johnson with input from the four hospital directors.

Departmental Response and Plan of Action:

The Department agrees with the recommendation to build replacement hospitals and to use DSH receipts to fund the construction. While the report provides documentation as to the amount of savings that could be realized from new construction, the Department will also consider in its planning whether the same kinds of efficiencies and savings along with improved patient care can be achieved through major retrofitting of existing facilities. If the decision is made to proceed with this recommendation the Department will take the following actions:

1. Appoint a concept team to develop the project and building/retrofitting concept in preparation of selecting a designer. Estimated time required for completion: 3 months
2. Select a designer. Estimated time required for completion: 3 months
3. Design work completed; projects ready for bid. Estimated time frame for completion: 1 year
4. Construction completed. Estimated time frame for completion: 30 months
5. Buildings ready for occupancy. Estimated time frame: 6 months

Rationale for Departmental Response:

The MGT Inc., report goes into considerable discussion about the need for new facilities. One of the most significant findings of the study is the conclusion that our hospitals' relative higher staffing ratios are due to hospital buildings' configuration. The report notes a direct correlation between size of the facilities, in terms of square footage, and staffing requirements. This correlation holds true for both direct care staff and non-direct care staff. The current layout of patient care areas prevents the efficient deployment of direct care staff. The lack of privacy for patients is not only a human rights issue but is an impediment to effective care and treatment.

The report further points out that the age and condition of the hospitals greatly affect the total operating costs, particularly, energy and maintenance costs. The study provides a comparison of the projected 10-year operating costs of the four hospitals "as is" versus the operating costs of four new facilities, assuming no downsizing. The combined savings in energy costs; housekeeping; maintenance, repair and renovation;

and other overhead over the 10-year period for same-size hospitals is projected at \$385,814,006. A comparison of capital replacement costs versus the cost of building new hospitals (assuming a 30-year life for the new facilities) over a 10-year period reflects a \$23,000,000 savings from building new facilities. The construction of a new hospital to replace Dorothea Dix was recommended by the Capital Area Master Plan in 1995. A new hospital at Dix combines the efficiencies of new construction with the advantage of conversion of the old hospital and surrounding buildings to office space for Departmental programs. This greatly reduces the annual cost of leased space to the Department and eliminates the costs associated with demolition.

The combined savings of approximately \$408,814,006 over the period, or \$41,000,000 a year, does not include savings that could be gained through more efficient direct care staffing of these new facilities. MGT, Inc., estimates these additional savings to be as much as \$17,000,000 per year. The actual staffing pattern of a new facility would require a great deal of study and planning before finalization, but there is no question that considerable efficiencies would accrue from the building of these new facilities.

Note: This financial analysis does not take into account savings which MGT, Inc., says could be achieved through downsizing in accordance with other recommendations contained in the report.

Recommendation 9.8: Create a Single Stream of Funding for Mental Health Services

Workgroup Members:

Kathleen Meriac, Foothills MHC
Dan Searcy, Johnston County MHC
Beth Melcher, NAMI NC
Paula Wilcenski, NCMHCO
John Tote, NC MHA
Mike Orndoff, Broughton Hospital

Departmental Response and Plan of Action:

The Department supports the concept of a single stream of funding for mental health services. The Department does not endorse immediate implementation of the concept. Successful implementation of a complex project such as single stream funding requires comprehensive and detailed planning to address issues such as clinical services, broad policy, and fiscal concerns. To implement this recommendation the Department will appoint, in fiscal year 2000, a workgroup to further develop this concept.

Rationale for Departmental Response:

Single stream funding is a fiscal and client care concept intended to improve the availability, continuity and quality of client care through the allocation of the State hospitals' resources to the area authorities in a "single stream" of financial control. Area authorities would then be assigned the responsibility for management of these and other resources to meet the hospital and non-hospital treatment needs of clients with mental illness through a seamless array of services. A single stream funding system would improve services and improve the efficiency of the service system in the following ways:

- ◆ Responsibility for the care management of the client will rest with a single accountable agency, the area program
- ◆ The area program will be able to make treatment decisions based on the best type of care for the client across the entire continuum of services
- ◆ Responsible care management will require better communication, collaboration, and treatment planning coordination between area programs and hospitals, thus improving continuity of care
- ◆ Improved continuity of care will ensure that fewer clients "fall between the cracks"
- ◆ Fiscal incentives would be in better alignment with clinical philosophy—funds could follow clients into the community allowing for a shift from institutional to community-based care and increased community service capacity
- ◆ Increased community service capacity, particularly in the areas of crisis response and tertiary crisis prevention, could result in cost savings, which could then be reinvested in the service system

- ♦ Area programs and hospitals negotiation and planning regarding service provision will result in services which are better targeted to both client needs and unique local/regional characteristics, thus creating a more responsive and effective system

Cost projection and cost benefit analyses for single stream funding, however, are difficult to complete at this time. The details of an actual model for this recommendation would need to be defined prior to estimating cost. While we expect that single stream funding will result in a more effective and efficient system , it will not result in “cost savings” *per se*, but rather result in a redistribution of existing dollars within the mental health system to maximize positive outcomes for clients. A number of issues must be resolved before the true cost implications of single stream funding can be determined.

Recommendation 9.9: Serve all legal status patients on the Forensic Treatment Unit at Dix Hospital.

Workgroup Members: Steve Johnson with input from Mike Pedneau, Patsy Christian, Jerry Edwards, and Seth Hunt, Jr.

Departmental Response and Plan of Action:

The Department agrees with the recommendation that additional forensic treatment beds are needed. The actual number and location of the additional forensic beds will depend on the acceptance of recommendation 9.7-Build four new hospitals. The Department will take the following actions to implement this recommendation:

1. Determine the most appropriate alternative for the location of additional forensic treatment beds.
2. Develop detailed cost and staffing estimates for the appropriate alternative.
3. Pursue legislative changes such as the elimination of state hospitals as "safekeeping" alternatives for jail detainees.

Detailed planning can be completed within four months from the time the decision is made regarding the building of new hospitals.

Rationale for Departmental Response:

The MGT Inc., report accurately points out the difficulties with the current policy and practice of mainstreaming forensic patients among the general hospital population.

This practice results in the disproportionate allocation of nursing staff to a relatively small number of patients strictly for the purpose of minimizing the threat of aggression or escape. The hospitals are attempting to overcome the lack of secure facilities and structures by providing additional staff resources around these often highly aggressive individuals to the deprivation of other patients. This intensive staffing response is an inefficient and costly response.

The legal status population (i.e., NGRI patients; patients found not capable of proceeding to trial; and other patients with legal detainers requiring release only to law enforcement) in the four hospitals is growing, with the census in the four facilities as of March 15, 1998, at 154 patients, excluding the 17 patients currently on the forensic treatment unit at Dix Hospital. By way of comparison, the hospitals housed a total of 125 such patients on July 15, 1992. Additionally, the 1992 legal status population consisted of 30 persons who had been charged with murder while the 1998 legal status population contains 64 patients who have been charged with murder - an increase of over 100 percent.

Ideally, from a treatment and transportation perspective we would like to develop additional forensic treatment capacity at each of the four hospitals in accordance with regional needs.

The Department will explore the following alternatives pursuant to implementation of this recommendation:

Alternative 1: (If four new hospitals are built as recommended by MGT, Inc.): Each hospital would have a forensic treatment unit incorporated into the design of the new facility. This alternative would facilitate the provision of treatment services closer to the patient's home and would resolve the significant logistical problems associated with transporting patients back and forth across the state.

Alternative 2: (If four new hospitals are built as recommended by MGT, Inc.): Forensic Treatment Units would be incorporated into the design of the Dorothea Dix and Broughton replacement facilities. This alternative would allow the concentration of forensic patients in two facilities designed to meet their unique needs. It would also address some of the logistical problems associated with transporting patients back and forth between Morganton and Raleigh.

Alternative 3: (If no new hospitals): This alternative would involve the establishment of a forensic treatment unit at Broughton Hospital and the expansion by 25 beds of the Dix forensic treatment unit.

This alternative would likely require extensive renovations, if not new construction. Cost estimates are not currently available. This alternative would also reduce the transportation difficulties encountered in transferring patients back and forth between Morganton (or points further West) and Raleigh as pointed out in the first alternative.

Recommendation 9.10: Financial and accounting practices and procedures should be consistent across the four hospitals.

Workgroup Members:

Karen Anderson, DHHS, North Central Controller's Office
Nancy Brown, DHHS Controller's Office
Anita Bunch, Dorothea Dix Hospital, Business Office
Steve Corley, Broughton Hospital, Business Office
Phillip Hoffman, DMHDDSAS, Budget Office
Larry Huffman, DHHS, Western Region Controller's Office
Barry Mayo, DMHDDSAS, Budget Office
Earl Quincy, DHHS, Data Processing
Paul Rock, Dorothea Dix Hospital, Business Office
Bea Tullis, Broughton Hospital, Business Office

Departmental Response and Plan of Action:

The Department agrees with the recommendation that there should be greater uniformity among the hospitals in the use of the cost center structure. To implement this recommendation the Department will take the following actions:

1. Create a task force comprised of relevant department staff and staff from the hospitals to review the current cost center structure. The task force will identify areas where the cost structure is inadequate or ill-defined and make recommendations for revisions in order for the cost structure to be more representative of the hospitals' organizational structure. In addition, the task force will identify commonalties among hospital patient treatment areas so that cost centers assigned to those areas may be used appropriately and as consistently as possible. Medicare and Medicaid regulations will be a major factor in the formulation of a revised cost structure since the ability to prepare the Medicare/Medicaid cost report is one of the primary requirements of the cost structure. As a final step in implementing a more consistent cost structure, hospital staff will be trained in the proper use of the agreed-upon cost centers.
2. Convene a separate task force comprised of staff from the Controller's Office to evaluate the Medicare/Medicaid cost report preparation for the hospitals. This task force will identify inconsistencies and adopt as uniform an approach as possible in application of Medicare/Medicaid regulations. The Department is considering issuing a RFP to obtain a contractor to review the current practices for completion of Medicaid/Medicare cost reports.
3. Re-educate employees to enhance understanding of the chart of accounts and the necessity for coding of purchases to the unit or cost center. This re-education effort should result in more reliable financial information that could enhance the planning, organizing and comparison of each of the hospitals.

4. Proceed with the development of two new systems- inventory control and automated timekeeping- which should enhance the integrity of the hospitals' internal controls. Using these tools as a base, the hospitals should produce a more reliable and efficient service to its clients and ensure accountability to the public. Each institution would be responsible for the education of its staff to ensure consistent and reliable cost reporting.
5. As improvements through more consistent use of the chart of accounts and cost centers are recognized, certain accounting and materials management systems will be implemented and replaced. The replacements and/or implementations should enhance the overall effectiveness of monitoring and comparing personnel and other costs.

Rationale For Departmental Response:

While the Department agrees with the recommendation, it should be noted that revisions to the current cost structure may be limited, given the various organizational structures of the hospitals. While it is certainly important to have comparability among the hospitals, we currently lack much of the means to efficiently compile this type of information. In particular, we do not have the means of costing all expenditures associated with the treatment of a patient back to the unit where the patient is treated. While this is accomplished through the Medicare/Medicaid cost report for each service type, it is not done at the unit level. We do not currently cost individual units separately in the Medicaid/Medicare cost report since we are reimbursed on a per diem basis, with one per diem for each type of service provided. We will include the study of the cost effectiveness of costing services at the unit level as one of the requirements of the Request For Proposals for reviewing current cost report preparation practices.

Recommendation 9.11: Obtain and implement an acuity assessment system that measures patients' psychiatric as well as medical needs.

Workgroup Members:

Seth P. Hunt, Jr., Director, Broughton Hospital
Vivian Streater, Director of Nursing, Broughton Hospital

Telephone consultation:

Neal Branski, Director of Nursing, Dorothea Dix Hospital
Dale Hilburn, Director of Nursing, Cherry Hospital
Renee Gorby, Director of Nursing, John Umstead Hospital

Departmental Response and Plan of Action:

We agree with the recommendation to obtain and implement an acuity assessment system that measures patients' psychiatric as well as medical needs. The hospital will need appropriate computer equipment in the units/wards to enter and compile patient acuity data to be used to calculate staffing. A proper system will allow each hospital to customize staffing to reflect individual differences within the various treatment programs. To implement this recommendation the Department, as part of the HEARTS billing system, will purchase an acuity assessment software system with accompanying computer hardware. Full implementation of the acuity system will require six to nine months from the date of purchase.

Rationale for Departmental Response:

The MGT, Inc., report accurately reflects the need for a new acuity system. As the report stated an appropriate patient acuity system will lead to improved efficiency and effectiveness of nursing staff. Allocation of nursing staff would be done based on the needs (both physical and psychological) of the patients and would reflect the proper amount of staff needed to carry out prescribed treatment. The amalgamated system currently in use does not provide sufficient information to determine continuing staffing needs. An appropriate acuity system would reflect the proper number of staff needed to meet the psychiatric and medical needs of the patients and therefore improve patient outcomes.

Recommendation 9:12: Institute unit-centered staffing at Broughton, Cherry, and Dorothea Dix hospitals

Workgroup Members:

Patsy Christian, Ph.D., RN., Hospital Director, John Umstead Hospital
Renee Gorby, RN, Director of Nursing, John Umstead Hospital

Consultants:

Neil Branski, Director of Nursing, Dorothea Dix Hospital
Dale Hilburn, Director of Nursing, Cherry Hospital
Vivian Streater, Director of Nursing, Broughton Hospital

Departmental Response and Plan of Action:

The Department agrees with this recommendation. To implement this recommendation the Department will take the following action:

Cherry, Dix and Broughton hospitals will develop a system to achieve unit-centered staffing. Some modification in the delivery of care at Cherry, Dix and Broughton hospitals might be necessary in order to implement in-unit coverage. While John Umstead Hospital uses the "red dot" system, each hospital will be allowed to develop its own unique plan to achieve unit-centered staffing. This will be accomplished within 12 months of the General Assembly's acceptance of the Hospital Efficiency Study.

Rationale for Departmental Response:

John Umstead Hospital currently uses the unit centered staffing approach and finds it to be very beneficial to patient care as well as addressing issues of coverage. Nursing staff (as well as other clinical staff) are hired for a particular unit, not wards, within the unit. Staff are competent to work anywhere on the unit by virtue of successfully completing a competency based orientation. The net result is that "floating" from one unit to another is virtually non-existent, except under extraordinary circumstances. This method of assigning staff also lends itself well to achieving economies of scale in handling annual staff training mandates, as well as updating staff regarding policy or procedure changes, which are done largely on a unit basis. Having training on the unit minimizes downtime. Unit centered staffing also helps to build a sense of ownership and commitment from the staff to the unit as a whole, rather than to an individual ward. Unit centered staffing works best when staff are available from a significant number of wards within the unit.

Recommendation 9.13 Hospital administrators and staff should ensure that every unit provides the highest possible level of intensive therapeutic activities for its patients.

Workgroup Members:

Philip E. Veenhuis, M.D., M.P.H., Chair, Medical Director, Medical Services, DMHDDSAS
Regina Alexander, BSN, MA, Director of Standards/Performance Improvement,
Dorothea Dix Hospital
Krista Ayscue, MSW, COSW, Director of Social Work and Special Programs,
Dorothea Dix Hospital
Neal Branski, RN, MSN, Director of Nursing Services, Dorothea Dix Hospital
Kevin Kilbride, M.D., Director of Clinical Services, Broughton Hospital
Kumbaiah Murthy, M.D., Director of Clinical Services, Cherry Hospital
Barbara Murray, MA, Chief of Professional Services, Broughton Hospital
Vivian Streater, RNC, MSM/HSM, Director of Nursing, Broughton Hospital
Bill Unger, MS, TRS, Director of Rehabilitation Therapies, Dorothea Dix Hospital

Consultants:

Peter Irigaray, M.D., Director of Clinical Services, John Umstead Hospital
Beth Melcher, Ph.D., Executive Director, NC Alliance for the Mentally Ill

Departmental Response and Plan of Action:

The Department agrees with this recommendation. It is entirely consistent with the prevailing philosophy and policy of all four psychiatric hospitals. The Department does not agree, however, with the assertion the hospitals provide limited intensive therapeutic activity in many patient units. All institutions have for some time, well before the performance of the efficiency study, had in place workgroups and committees working regularly and intensively to ensure that every unit provides the highest possible level of intensive therapeutic activities for all patients. The Department acknowledges that, although all hospitals are JCAHO and HCFA certified and therefore in compliance with the mandates of those accrediting bodies to provide active and individualized treatment, that hospitals could do better in providing active treatment, and all institutions are striving to do what can be done to overcome barriers to better treatment for all patients. We also acknowledge that the physical environment of the hospitals is not optimal for feelings of well being and that space for formal treatment is often unsuitable for adequate active treatment and may even limit the active treatment for some patients. It is possible to perform lifesaving surgery in a mobile hospital tent, but one would prefer and probably do better in a modern hospital.

To ensure that each hospital continues to emphasize the importance of providing the highest level of therapeutic activity for its patients the Department will take the following actions:

1. The Department will restate and emphasize to all employees the expectation of active treatment for all patients and facilitate the sharing of information among institutions about advances in integration and coordination of active treatment.
2. Each hospital shall increase its efforts to see that all patients are engaged in active biopsychosocial treatment. In addition each hospital shall make measurements of active

treatment part of its Continuous Quality Improvement program. Such outcome measures as number of hours/day patients are engaged in active treatment and/or number of hours watching TV or sitting doing little on the ward will be used in guiding these efforts. Progress on this effort will be incorporated into each hospital's quarterly Performance Improvement Report submitted to the Governing Body.

Rationale for Departmental Response:

All of the four hospitals adhere to and have regularly passed JCAHO standards. JCAHO standards may be succinctly summarized as requiring that treatment planning be done on all patients to identify care and service appropriate to an individual's specific needs, the severity of illness, impairment or disability and contain specific goals for achieving emotional and physical health as well as maximum growth and adaptive capabilities. Each patient in our hospitals has an individual treatment plan specifying the services and interventions needed to meet the goals and objectives and these are derived from assessing that individual's needs.

Each hospital is also HCFA certified. HCFA standards require a similar diagnostic assessment and active treatment programs designed to treat those diagnoses established for a patient.

With regard to active psychological and social treatment, the following may be said. Active treatment may be divided into informal and formal aspects. Informal elements consist of the manner in which the staff of every discipline interact with the patient, particularly the direct care staff, who have the most contact with the patient. All our healthcare technicians are listed by HCFA as certified nursing assistants. To achieve this status they are required to take a course which is provided by either our state hospitals or by community colleges that includes courses in what is called "therapeutic communication." Before being listed as certified nursing assistants, health care technicians are required to pass the course. This means that the direct care staff are expected to know how to and how not to talk to patients, including how to be helpful. This is a key component in any active therapy program. The formal aspects of the program consist of such things as counseling, individual and group, occupational therapy, recreational therapy or other forms of activities therapy. Included in the individual and group therapy are social skills training, training in activities of daily living. All patients are expected to be actively treated in our hospitals both in their daily contacts with staff and in the formal treatment programs. Another important aspect of the treatment regime is the therapeutic use of psychotropic medication. All patients in our hospitals receive the newest and most appropriate drug for their condition, including the new atypical antipsychotic medications.

All that being said, the Department acknowledges that there are present in our institutions certain barriers to efficiently providing active therapy. Some can be overcome without additional cost, but most would require additional resources. Those not requiring additional cost come into close and continued attention by the previously mentioned hospital committees and workgroups.

Recommendation 9.14: The hospitals should reallocate their admissions unit staffing to provide more coverage for second and third shift to better match staffing needs. The medical staff should assign physicians and psychiatrists to those shifts with a history of high admissions, such as weekend/nights.

Workgroup Members: Mike Pedneau, with input from Patsy Christian; Jerry Edwards; and Seth Hunt, Jr.

Departmental Response and Plan of Action:

The Department agrees with the intent of the recommendation to assure adequate coverage of those shifts and days with high numbers of admissions. The Department, however, will need additional time to determine the most efficient way to accomplish this objective. To implement this recommendation the Department will take the following actions:

1. Each hospital will establish a Quality Improvement Team to: (1) review the current nursing and physician coverage of its admissions office and admissions units; (2) review the current nursing and physician staffing of these units by shift and weekend/weekday; and (3) determine if there is an alternative that is less costly and as or more effective and efficient than the current staffing strategy in use.
2. Each hospital Quality Improvement Team will submit its recommendations to the Department within 9 months of the General Assembly's acceptance of the Efficiency Study.

Rationale for Departmental Response:

The number of nursing and physician staff assigned to first shift is driven less by the number of admissions than by the scheduling of treatment team meetings, and other standing and ad hoc committees that are required for accreditation. Additionally, much of the active treatment programming occurs on first shift and directly involves nursing personnel as does assuring that patients receive daily outdoors time as required by patient rights regulations.

The Department must also determine whether the increase in second shift staffing on admissions units involving nursing personnel will result in increased shift differential costs that will not be offset by reduced on-call and callback pay in nursing as there is currently very little if any such expense. Increased physician staffing on second shift would likely result in a reduction of on call and callback pay that could be used as salary to recruit permanent second shift physicians. However, we are very concerned that we will be able to recruit high quality physicians for permanent second shift or even a first-second swing shift. This has been attempted several times and always without success.

Recommendation 9.15: Rearrange the work schedules of housekeeping staff so they cover seven days each week, at least two shifts per day. Examine other support staff schedules to determine how re-deployment of those staff would lead to better utilization of direct care staff. Housekeeping should provide the coverage within current resources.

Workgroup Members: Jerry Edwards with input from Patsy Christian, Mike Pedneau, Seth Hunt, Jr.

Departmental Response and Plan of Action:

The Department supports further examination of this recommendation to determine the feasibility of its implementation. Staff from the Department along with staff from each hospital will review current practices to determine if there are more efficient ways to utilize existing housekeeping staff. Part of the review will include determining the types, time, and location of housekeeping tasks that are currently being performed by nursing staff.

This review should be completed within 12 months from the time this Efficiency Study is accepted by the General Assembly.

Rationale for Departmental Response:

On the surface this recommendation seems logical and should result in cleaner facilities with fewer nursing staff performing housekeeping duties on second shift and weekends. However, there are no hard data to support this recommendation. It is possible that shifting housekeeping staff will only move the problem from one shift to another. Rearranging the work schedule of housekeeping staff to cover two shifts, seven days per week may not lead to better utilization of nursing staff. These staff might still do the same amount of housekeeping duties, only at a different time.

We must look at a host of issues such as increased cost associated with shift premium and holiday pay, additional supervisory staff as well as coverage during absences for a much smaller number of housekeeping staff before we can determine the feasibility of this recommendation.

Recommendation 9.16: The Division should request the Office of State Personnel (OSP) to conduct a market assessment of LPNs and HCTs

Workgroup Members:

Don Webb, DHHS Human Resources
Terry Johnston, DHHS Human Resources

Departmental Response and Plan of Action:

The Department agrees with the finding that recruitment and retention of Health Care Technicians is problematic and that the constant turnover creates organizational inefficiencies. However, a market analysis by OSP is not the solution to this problem. To address this recommendation the Department's Division of Human Resources is currently facilitating a project with MH/DD/SAS management to review targeted selection practices and other recruitment modalities to ensure that quality applicants are attracted to HCT positions. This project should enhance our ability to attract and maintain quality applicants which should lead to reductions in staff turnover and training costs.

Rationale for Departmental Response:

The majority of recruitment and retention problems for the Health Care Technician class series is with Health Care Technician I positions. Even though the latest market data indicated the State's pay for HCTs was competitive, DHHS continued to experience recurring retention problems. As a means of addressing this problem the Department, in fiscal year 96-97, invested \$3.8 million dollars in pay range revisions for all HCT positions-approximately \$6.1 million dollars was needed to fully fund the range revisions. In 1996-1997, the average voluntary turnover rate of HCTs at the four State hospitals was 16.22%. The range revision has had minor impact, lessening the turnover rate by only 1.7% to 14.52% in 1997-1998. Based on the current cost to train newly employed HCTs, this 14.52% turnover rate causes the system to spend an additional \$471,028 annually for training. Recent survey data indicate that the pay for LPNs is competitive with the market. The actual pay is .5% above the market. Turnover for LPNs is approximately 8%.

Recommendation 9.17: The division should obtain an automated timekeeping system for use in the state psychiatric hospitals.

Workgroup Members:

Lee Kittredge, Director of the Division of Budget, Planning and Analysis

Allyn Guffey, Chief of Budget, Management and Analysis

Bill Cox, Director of the Division of Information Resource Management

Departmental Response and Plan of Action:

The Department has endorsed the piloting of a new timekeeping system at Western Carolina Center, Broughton Hospital and the Western School for the Deaf and we are in the process of identifying appropriate funding to begin the project. Reference response to recommendation 9.10 for additional comments.

Recommendation 9.18: The state needs to provide funding to upgrade the hospitals' computer systems, the maintenance work order system, personal protection, and paging systems.

Workgroup Members:

Lee Kittredge, Director of the Division of Budget, Planning and Analysis
Allyn Guffey, Chief of Budget, Management and Analysis

Departmental Response and Plan of Action:

The Department will assess the computer and other automation needs in the psychiatric hospitals and will attempt to identify funding to support those needs. With regard to the recommendation to purchase 41 additional computers to be used with a new patient acuity system, the Department will evaluate the capabilities of the patient acuity program in the hospitals to determine if additional capabilities are needed over and above those of the new HEARTS billing system. See response to recommendation 9.11 for additional comments on this subject.

Recommendation 9.19: We believe that outsourcing of either or both of the Medical/Surgical Units merits additional investigation.

Workgroup Members:

Karen Anderson, DHHS, North Central Controller's Office
Nancy Brown, DHHS Controller's Office
Tom Washburn, DHHS Controller's Office
Joyce Johnson, DHHS Controller's Office
Mike Pedneau, Director of Dorothea Dix Hospital
Seth Hunt Jr., Director of Broughton Hospital
Lee Kittredge, Director of the Division of Budget, Planning and Analysis
Allyn Guffey, Chief of Budget, Management and Analysis

Departmental Response and Plan of Action:

We agree with the recommendation that the practice of outsourcing merits further study particularly in regard to the Medical/Surgical Units at Dorothea Dix and Broughton Hospital. The Department of Health and Human Services will create a task force that will consist of Dorothea Dix and Broughton Hospital's staff representing the Budget Office, the Purchasing Department, the Personnel Office, Clinical Divisions, the Division's Central Office, the Division of Budget, Planning and Analysis, and DHHS Controller's Office to review the possibilities for outsourcing opportunities. We believe that a study could investigate market opportunities, staffing issues, and other concerns that are inherent in the concept of sending hospital patients to outside providers for medical care. If there are other viable options to providing this type of care in-house, they would be identified and also considered for implementation.

While we basically agree with the recommendation to investigate the merit of outsourcing, it should be noted that there were studies done back in the late eighties and early nineties concerning outsourcing Medical/Surgical Services which recommended that these services not be outsourced.

Recommendation 9.20: Increase annual receipts for providing continuous insourcing services.

Workgroup Members:

Lee Kittredge, Director of the Division of Budget, Planning and Analysis
Allyn Guffey, Chief of Budget, Management and Analysis

Departmental Response and Plan of Action:

The Department is generally in agreement with the recommendation of recouping costs associated with providing services to other institutions and agencies and the psychiatric hospitals are currently collecting receipts for most of the items listed in the report. The Department will review those insourcing items to determine if the proper amounts are being collected and will also review the other items to determine whether collections should be initiated.

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

MAY 20 , 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

<i>Felice Brown</i>	<i>Div. of Community Health, DHHS</i>
<i>Tommy Wacht</i>	<i>Carolina HealthCare Spc</i>
<i>John Bowditch</i>	<i>266 Alley, P.A</i>
<i>Helen Lyman</i>	<i>Mech Co.</i>
<i>MT Burnette</i>	<i>GAC PD - DOA</i>
<i>Tom B.A.M. Bridges</i>	<i>DMH/DD/SAS</i>
<i>Lisa Abatemarco</i>	<i>DHHS BPA</i>
<i>Ally Duffey</i>	<i>DHHS - B, P & A</i>
<i>Byron K. Harris</i>	<i>OSBM</i>
<i>Terry Stelle</i>	<i>DHHS - DMH/DD/SAS</i>
<i>Allan Zader</i>	<i>NC Council of Comm Programs</i>
<i>Harleen Scott-Rahlin</i>	<i>DMH/DD/SAS</i>
<i>Don Balne</i>	<i>DMH/DD/SAS</i>
<i>Jo Klein</i>	<i>DMH/DD/SAS</i>
<i>Bernie Paine</i>	<i>DHHS - HR</i>

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

MAY 20 , 1998

Name of Committee

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FIRM OR AGENCY AND ADDRESS

John W. Fair	DHHS Property & Construction
Tom Washburn	DHHS Controlling Office
Lu Kettle	DHHS
Curtis Farrance	DMHDDSS
Dan Willis	" " "
Sally Cameron	NC Psychological & Coalition for Persons Disabled by Mental Illness
Stephen Humphrey	MGT of America, Inc.
Lyn Davis	MGT of America, Inc.
Rebecca Ros	MGT of America, Inc. Tallahassee, FL
David Browne	O'Brien/Atkins ^{RTP, NC} consultant to MGT

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Name of Committee

100

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FIRM OR AGENCY AND ADDRESS

[illegible]

Joint Appropriations Subcommittee on Health & Human Services

AGENDA

Tuesday, May 26th, 8:30 a.m.

Room 643 - Legislative Office Building

Division of Medical Assistance

L. Carol Shaw
Fiscal Research Division

- JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 26, 1998

Minutes

8:30 a.m

The Joint Appropriations Subcommittee on Human Resources convened at 8:30 a.m. on Tuesday morning, May 26, 1998 in Room 643. Representative Gardner presided. There were 5 Senators present and the following House members:

Representative Bill Hurley	Representative Alma Adams
Representative Henry Aldridge	Representative Edd Nye
Representative Martha Alexander	Representative Cindy Watson
Representative Charlotte Gardner	

These staff members were present: Ramona Burton, Karen Hammonds-Blanks, Mary Ellen Sylvester and Carol Shaw of the Fiscal Staff and Susan Sabre and Gann Watson of the Legal Staff.

Carol Shaw presented a review of the 1998-1999 Budget of the Division of Medical Assistance. (See attachment #1.)

Representative Adams asked about medical assistance for children whose mother's are leaving Work First. She was assured that there was an effort to sign them up for the medically indigent children's program. She wanted to know if there was a process to capture these children and was told that the Department of Social Services might answer this questions in the afternoon session.

Senator Forrester asked for a comparison in the inflationary increases from last year. Carol Shaw told him the increase proposed in the budget is not driven by inflation but represents a policy change.

Representative Gardner questioned whether raising doctor's Medicaid reimbursement will help the problem of recruiting doctors. She asked about managed care and was assured the bulk of the Medicaid recipients in Mecklenburg County are in a capitated program. She would like to know why the doctors in her county don't participate in this program.

Senator Dannelly and Representative Aldridge questioned doctor participation in treatment of Medicaid patients and the effect of the Medicaid level of payment.

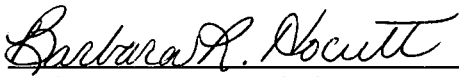
Representative Nye was interested in the CAPMRDD slots being released so that the 1500 on the waiting list can be served and was told there were 1732 on the waiting list which would be taken care of in this budget.

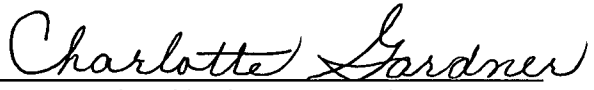
Minutes, 5-26-98

Senator Martin asked for a list of how DSH revenue is being utilized in the budget to know what would have to be cut in order to redirect parts of the \$85 million. It is up to the committee to decide the usage, according to Carol Shaw.

Carol Shaw called to the committee members' attention a document comparing the 1980-81 budget to the 1998-1999 budget (See attachment #2).

The Division of Medical Assistance will present a status report on the new administrative positions in the afternoon meeting. The department will make a presentation on the child welfare issue. The meeting was adjourned.


Barbara R. Hocutt, Clerk


Representative Charlotte A. Gardner

CAG:brh
attachments

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

MAY 26, 1998

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Date

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FIRM OR AGENCY AND ADDRESS

Bernice Crisp	DHHS-152
DAVE BRADY	DHHS
P. Perruzzi	DMA DHHS
Daphne Lynn	DHHS-DMA
Alfred	DHHS-DMA
ANGIE McILLAN	DHHS
Lee D. Hedges	DHHS
John Tate	MA/NC-C2001
William Wong	Intern
Lynne Perrin	DHHS
Barbara Duntz	NCMS-F
HUGH TILSON	NCHA
James S. Smeed	NCARF

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FIRM OR AGENCY AND ADDRESS

C. L. Cochran	UCPNC - C2001
Adam Searing	NCHAC
Luke Barber	CTPC
LAURA DELAPP	LEGISLATIVE INTERN - ALDRIDGE
Susan Aldridge	Citizen
Rodlyn Sawall	NC Child Care Coalition NC HIV/AIDS Alliance
Paula A. Hoy	Covenant w/NC's Children
Beth McChes	XAMI NC
Peggy Maynard	GPMA
Low Wilbur	NCARTC7
Debbie Street	PPAB
Jocia Peel	NC med Soc
CHRIS SOWERS	NCHCA
Ms' Brogan	NC DHHS
Ann Richard	ACPR

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

MAY 26, 1998

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FIRM OR AGENCY AND ADDRESS

John Bourdich	Zeb Alley P.A.
Patrice Renter	NCACC
Allyson	OSBM
Walt Jay	NCAHC
Jim Slate	Division of Aging
Jan Ranganathan	NCDHA
Steve Keene	NC Med Soc.
Steve Shaber	Jordan Price

1 5-26-98
Carol Shaw

DEPARTMENT OF HEALTH & HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE 1998-99 BUDGET

FISCAL RESEARCH DIVISION
MAY 1998

DIVISION OF MEDICAL ASSISTANCE

1997-99 TOTAL CONTINUATION BUDGET

<u>Description</u>	<u>1995-96 Actual</u>	<u>1996-97 Actual</u>	<u>1997-98 Projected</u>	<u>1998-99 Recommended</u>
Total Requirements	\$4,117,852,544	\$4,640,421,917	\$4,831,482,467	\$4,609,192,045
Total Estimated Receipts	<u>(\$3,077,645,486)</u>	<u>(\$3,489,963,641)</u>	<u>(\$3,706,505,848)</u>	<u>(\$3,263,866,129)</u>
Net Appropriation	\$1,040,207,058	\$1,150,458,276	\$1,124,976,619	\$1,345,325,916

DIVISION OF MEDICAL ASSISTANCE

1997-99 CONTINUATION BUDGET

MEDICAL ASSISTANCE PAYMENTS (Fund 1310)

<u>Description</u>	1995-96 <u>Actual</u>	1996-97 <u>Actual</u>	1997-98 <u>Projected</u>	1998-99 <u>Recommended</u>
Total Requirements	\$3,549,309,274	\$3,910,496,650	\$4,075,932,999	\$4,484,054,049
Total Estimated Receipts	<u>(\$2,692,614,430)</u>	<u>(\$2,947,211,346)</u>	<u>(\$3,042,870,135)</u>	<u>(\$3,164,378,937)</u>
Net Appropriation	\$856,694,844	\$963,285,304	\$1,033,062,864	\$1,319,675,112

The Medical Assistance Payment Fund budgets the payments to the providers of medical and other services for Medicaid recipients. Payments to providers represent 98% of the total budget for the Division of Medical Assistance.

MEDICAL ASSISTANCE PAYMENTS

1997-98 Authorized Budget vs. Estimated Expenditures

Source of Funds (In Millions)	1997-98 Authorized Budget	1997-98 Estimated Expenditures	Difference
Federal	\$2,712.3	\$2,639.2	(\$73.1)
State	\$1,252.5	\$1,213.5	(\$39.0)
County	\$230.3	\$223.2	(\$7.1)
Total	\$4,195.1	\$4,075.9	(\$119.2)

MEDICAL ASSISTANCE PAYMENTS

Source of Reductions

- Lower Utilization *80% \$119 million*
- Medicaid Growth Reduction Measures
 - No Inflation for Hospitals for 1997-98
 - Lower Nursing Facility Inflation Rates for 1997-98
 - Other Rate Adjustments for Physicians, Home Health, Personal Care Services, and Non-State ICF-MR.
 - Managed Care

MEDICAL ASSISTANCE PAYMENTS

Proposed Budget Increases (In Millions)

GROWTH FACTOR	Total 1999-98	GF 1998-99
Inflation	\$189.5	\$58.1
Utilization	\$97.5	\$29.9
Intensity	\$121.1	\$43.7
Total	\$408.1	\$131.7

PROJECTED INFLATION RATES

ACCOUNT	CATEGORY OF SERVICE	SFY 1997-98 4/10/97 INFLATION RATES	SFY 1998-99 PROJECTED INFLATION RATES	SFY 1998-99 ADJUSTED INFLATION RATES
536140	PART B BUY-IN NON CASH	5.32%	10.70%	5.32%
536141	PART B BUY-IN CAT NEEDY	5.32%	10.70%	5.32%
536173	PART A MEDICARE SUB-TOTAL	9.61%	8.00%	9.61%
536174	PART B BUY-IN MQBQ	7.00%	8.00%	7.00%
536175	PART B BUY-IN DUAL Q	7.00%	8.00%	7.00%
53617A	PART B BUY-IN MQBB	7.00%	8.00%	7.00%
53617B	PART B BUY-IN DUAL B	7.00%	8.00%	7.00%
536176	PART B BUY-IN MQB PREM ONLY	7.00%	8.00%	7.00%
536156	HOSP INPT-GENERAL-XOVERS	4.77%	5.30%	4.77%
536158	HOSP OUTPT-GENERAL-XOVERS	5.67%	6.00%	5.67%
536170	HMO PREMIUMS	5.67%	6.00%	5.67%
536180	HEAD START	0.00%	0.00%	0.00%
536181	HOSP INPT-INDIAN HEALTH	4.77%	5.30%	4.77%
536182	HOSP OUTPT-INDIAN HEALTH	5.67%	6.00%	5.67%
536183	NF-INDIAN HEALTH	4.27%	4.70%	4.27%
536186	HOME HEALTH-INDIAN HEALTH	3.17%	3.60%	3.17%
536103	HOSP INPT-MTL, SO < 21	0.00%	0.00%	0.00%
536104	HOSP OUTPT-MTL, SO <21	0.00%	0.00%	0.00%
536106	HOSP INPT-MTL, SO > 65	0.00%	0.00%	0.00%
536107	HOSP OUTPT-MTL, SO >65	0.00%	0.00%	0.00%
536114	LTC-ICF MRC, SO	0.00%	0.00%	0.00%
536123	CLINICS-MENTAL HEALTH-FSO	5.67%	6.00%	5.67%
536124	CLINICS-HEALTH DEPT	5.67%	6.00%	5.67%
536136	FAMILY PLAN-HEALTH DEPT	5.67%	6.00%	5.67%
536138	HEALTH CHECK-HEALTH DEPT	5.67%	6.00%	5.67%
536151	CAROLINA ALT - MGD CARE	3.67%	4.00%	3.67%
536163	LOCAL EDUCATION AGENCIES-F	3.17%	3.50%	3.17%
536188	TRANSPORTATION-CNTY ADMIN	3.17%	3.50%	3.17%
536189	ACF-TRANSPORTATION	3.17%	3.50%	3.17%
536194	EDS-A/R INELIGIB CLAIMS	0.00%	0.00%	0.00%
536196	INDO-CHINESE MED ASST	0.00%	0.00%	0.00%
536112	TRNS-DMH-ADMIN EXP			
536150	INTRA-DEPT TRANSFER			
536188	CLINICS-DHS IMMUNIZATIONS	5.67%	6.00%	5.67%
536162	CASE MANAGEMENT-FSO	3.17%	3.50%	3.17%
536115	PHYSICIAN	3.17%	4.00%	3.17%
536116	DENTAL	3.17%	4.00%	3.17%
536117	OPTICAL SUPPLIES	3.67%	4.00%	3.67%
536118	CHIROPRACTIC	3.17%	4.00%	3.17%
536119	OPTICAL	3.17%	4.00%	3.17%
536120	PODIATRY	3.17%	4.00%	3.17%
536128	LAB AND X-RAY	3.17%	4.00%	3.17%
536135	FAMILY PLAN-PHYSICIAN	3.17%	4.00%	3.17%
536148	HEALTH CHECK-RURAL HLTH CT	5.67%	6.00%	5.67%
536147	HEALTH CHECK-OTHER PROV	4.67%	5.00%	4.67%
536179	HEALTH CHECK-FQHC	5.67%	6.00%	5.67%
536101	HOSP INPT-GENERAL	4.77%	5.30%	4.77%
536102	HOSP INPT-SPECIALITY	4.77%	5.30%	4.77%
53610A	HOSP INPT-MTL, NSO < 21	4.77%	5.30%	4.77%
53610B	HOSP INPT-MTL, NSO > 65	4.77%	5.30%	4.77%
536105	HOSP INPT-MTL, NSO	4.77%	5.30%	4.77%
536108	HOSP OUTPT-MTL, NSO	5.67%	6.00%	5.67%

ACCOUNT	CATEGORY OF SERVICE	SFY 1997-98 4/10/97 INFLATION RATES	SFY 1998-99 PROJECTED INFLATION RATES	SFY 1998-99 ADJUSTED INFLATION RATES
536121	HOSP OUTPT-GENERAL	5.67%	6.00%	5.67%
536122	HOSP OUTPT-SPECIALITY	5.67%	6.00%	5.67%
536133	FAMILY PLAN-HOSP INPT	4.77%	5.30%	4.77%
536134	FAMILY PLAN-HOSP OUTPT	5.67%	6.00%	5.67%
536132	FAMILY PLAN-STERILIZATION	4.77%	5.30%	4.77%
536154	HOSP OUTPT-EMERGENCY ROO	5.67%	6.00%	5.67%
536109	LTC-SNF SO AND NSO	3.50%	4.60%	4.60%
536110	LTC NF-SNF SWING BEDS	4.27%	4.70%	4.27%
536111	LTC-ICF SO AND NSO	3.50%	4.60%	4.60%
536112	LTC NF-ICF SWING BEDS	4.27%	4.70%	4.27%
536152	HOSP INPT-LONG TERM CARE	4.77%	5.30%	4.77%
536155	LTC NF-HEAD LEVEL OF CARE	4.27%	4.70%	4.27%
536157	LTC NF-VENT LEVEL OF CARE	4.27%	4.70%	4.27%
536159	LTC CAP-DISABLED	3.07%	3.60%	3.07%
536161	LTC CAP-CHILDREN	3.07%	3.60%	3.07%
536113	LTC-ICF MRC, NSO	3.40%	1.45%	1.45%
536160	LTC CAP-MENTALLY RETARDED	3.07%	3.60%	3.07%
536166	LTC NF-SNF SWING VENT CARE	4.27%	4.70%	4.27%
536167	HOSP INPT-VENT CARE	4.77%	5.30%	4.77%
53618G	CAP AIDS	3.07%	3.60%	3.07%
53618A	LTC ACF - PCS BASIC	3.17%	3.50%	3.17%
53618D	LTC ACF - PCS BASIC/EATING AS	3.17%	3.50%	3.17%
53618E	LTC ACF - PCS BASIC/TOILET ASS	3.17%	3.50%	3.17%
53618F	LTC ACF - PCS BASIC/EATING/TOI	3.17%	3.50%	3.17%
536130	PRESCRIBED DRUGS	9.67%	10.00%	9.67%
536149	FAMILY PLAN-DRUGS	4.67%	5.03%	4.67%
536150	DRUG REBATE	0.00%	0.00%	0.00%
536125	CLINICS-FREE STANDING	5.67%	6.00%	5.67%
536126	CLINICS-RURAL HEALTH	5.67%	6.00%	5.67%
536129	LTC HOME HEALTH	3.17%	3.60%	3.17%
536137	FAMILY PLAN-FREE STANDING	5.67%	6.00%	5.67%
536142	AMBULANCE	3.17%	3.50%	3.17%
536143	HEARING AIDS	3.67%	4.00%	3.67%
536144	LTC PERSONAL CARE	3.17%	3.50%	3.17%
536148	FAMILY PLAN-RURAL HLTH CTR	5.67%	6.00%	5.67%
536165	DURABLE MED EQUIPMENT	3.67%	4.00%	3.67%
536169	PHYSICAL MED-NON PHYSICIAN	3.17%	4.00%	3.17%
536171	HOME INFUSION THERAPY	3.17%	3.60%	3.17%
536172	HOSPICE	4.77%	5.03%	4.77%
536177	CLINICS-FQHC, CORE & AMBULAT	5.67%	6.00%	5.67%
536178	FAMILY PLANNING-FQHC	5.67%	6.00%	5.67%
53618H	HIV CASE MANAGEMENT	4.67%	5.02%	4.67%
536187	AMBULATORY SURG CENTER	4.77%	5.30%	4.77%
536151	CAROLINA ALTERNATIVES	3.67%	4.00%	3.67%

MEDICAL ASSISTANCE PAYMENTS

1998-99 Estimated Utilization Rates

Category of Eligible	Utilization Rate	Average Monthly Eligibles
Aged	0.2%	106,039
Blind	7.8%	2,319
Disabled	2.2%	149,487
Work First	(8.2%)	255,124
Other Children	3.0%	2,943
Pregnant Women	1.4%	22,700
MIC Children	22.4%	257,485
MQBQ <i>100% poverty</i>	3.0%	40,435
MQBB <i>135% poverty</i>	19.8%	17,776

MEDICAL ASSISTANCE PAYMENTS

Intensity (In Millions)

Description	1998-99 Increase
HMO Premiums	\$4.5
Health Check	\$2.7
Physicians	\$39.1
Dental	\$20.6
CAP-Disabled	\$20.0
CAP-Mentally Retarded	\$13.3
ACH-Personal Care	\$6.5
Drugs	\$10.6
Personal Care	\$3.7
Total	\$121.1

MEDICAL ASSISTANCE PAYMENTS

Intensity

- **HMO Premiums** - HMOs are being offered as an option to Medicaid eligibles living in the Triangle and Triad areas. This increase offsets the first year cost of old fee for service claims and the monthly premiums for HMOs.
- **Health Check** - North Carolina is screening about 51% of the eligible Health Check population. Additional funds have been budgeted to support an 8% increase in child screenings.
- **Physicians** - Medicaid pays physicians about 92% of the allowed Medicare payment which is 58% of the average billed by physicians. This 10.5% increase will change physician fee rates to equal Medicare and increase fees to 64% of average billing rate.
- **Dental** - Rates for dental services by Medicaid have been historically low and access to services has been limited. This change will increase the rates for the 40 dental codes most utilized by children from 58% of average cost billed to 82%.
- **CAP-Disabled** - Currently, 8,700 individuals participate in this program as an alternative to nursing facility level of care. This increase adds 1,300 additional slots to this program.

MEDICAL ASSISTANCE PAYMENTS

Intensity

- **CAP-Mentally Retarded** - Currently, 3,600 slots are available under this program. This increase will add 1,732 slots to the program and provide services to the people identified by HHS to be eligible for services under this waiver.
- **Adult Care Home Personal Care Services** - The current hourly rate for this service is \$8.07 which was set in August 1995. The initial review of the 1997 cost reports suggests that the hourly rate should be \$9.81. DMA is reviewing the cost report data against paid claims. The rate of pay will be adjusted to the extent justified and approved by HCFA.
- **Drugs** - The cost and use of more effective drugs has increased in double digit levels during the last few years. This adjustment recognizes an average 12% increase per prescription over 1997-98.
- **Personal Care Services** - This adjustment supports a 5% increase in the number of persons receiving this service.

MEDICAL ASSISTANCE PAYMENTS

1998-99 Authorized Budget Vs. Projected Expenditures

Source of Funds (In Millions)	1998-99 Authorized budget	1998-99 Projected Expenditures	Difference
Federal	\$2,965.2	\$2,893.0	(\$72.1)
State	\$1,407.1	\$1,345.2	(\$61.8)
County	\$257.9	\$245.8	(\$12.1)
Total	\$4,630.1	\$4,484.0	(\$146.1)

MEDICAL ASSISTANCE PAYMENTS

Continuation Budget Reductions (In Millions)

Description	Total 1998-99	GF 1998-99
Governor's Reductions	(\$107.5)	(\$45.5)
Medicaid Growth Reduction	(\$38.6)	(\$16.3)
Total Reductions	(\$146.1)	(\$61.8)

MEDICAL ASSISTANCE PAYMENTS

Source of Reductions

- FFP Rate Change
- Lower Utilization *decrease in eligibles*
- Medicaid Growth Reduction Measures
- New Position Budget Adjustments

FEDERAL FINANCIAL PARTICIPATION RATE

IMPACT OF RATE DECREASES

- The Federal Financial Participation (FFP) Rate determines the federal share of the Medicaid program. The rate is based on the relationship between each state's per capita personal income and that of the nation as a whole. The 1999 federal share is calculated using per capita income data for 1994-96.
- Since N.C.'s per capita income has increased significantly in recent years, the state's FFP rate has declined. The rate has decreased from 68.01% for federal fiscal year 1989 to 63.09% for federal fiscal year 1999 -- a 7.2% decrease in ten years.
- The FFP rate for state fiscal year 1997-98 decreased .85%. This decline resulted in an \$19 million increase in state appropriations.
- **The estimated FFP rate for state fiscal year 1998-99 only decreased .34%. The original budget estimate assumed the FFP rate would decline by .56%. This lower decline resulted in an \$16 million decrease in state appropriations.**

AVERAGE MONTHLY ELIGIBLES

1990-91 Through 1998-99

Fiscal Year	Average Monthly Eligibles
1990-91	468,260
1991-92	573,686
1992-93	658,129
1993-94	715,543
1994-95	780,459
1995-96	815,276
1996-97	826,251
1997-98 est.	822,636
1998-99 est.	854,808

AVERAGE MONTHLY ELIGIBLES

Initial vs. Revised Estimates

Fiscal Year	Initial Estimate	Revised Estimate	Percent Change
1996-97	832,612	826,251	-0.7%
1997-98	867,013	822,636	-5.2%
1998-99	898,111	854,808	-4.8%

AVERAGE MONTHLY ELIGIBLES

Impact of "Woodwork" Children

- DMA estimates that 70,000 uninsured children are eligible for Medicaid. These children have been called the "Woodwork" children.
- Federal Law requires that any uninsured child who is eligible for Medicaid must be covered by Medicaid and not through the new children's Health Insurance Program recently enacted by the General Assembly.
- DMA has estimated that 35,000 additional children may participate in Medicaid due to the outreach for the new program and the federal push to identify and cover all Medicaid eligible children.
- The "Woodwork" children were included in average monthly eligibles used to develop the proposed Medicaid Budget. Including these children added \$26.7 million to the total budget (\$17.5 M Federal Share, \$7.9 M State Share, and \$1.4 M County Share).

DISPROPORTIONATE SHARE HOSPITALS

BACKGROUND INFORMATION

- Disproportionate Share Hospital (DSH) payments are allowed by federal law to help cover the costs of hospitals which have a disproportionate share of patients with little or no insurance.
- North Carolina earns DSH payments by making payments to the five state hospitals for uninsured care by using state appropriations in the Medicaid budget to provide the non-federal match.
- 1997 federal law set DSH allotments for N.C. through 2002. The 1998 allotment is \$278 million and declines each year to \$236 million in 2002. Even though N.C.'s allotment declines, DSH payments are projected to remain stable at least \$85 million per year through 2002.
- The federal share of the DSH payments is usually deposited as nontax revenue and is included in the revenue estimates for each fiscal year as nonrecurring revenues. The 1997 General Assembly allowed DMA to retain and budget DSH payments for the 1997-98 fiscal year.

DISPROPORTIONATE SHARE HOSPITALS

Payments to State Hospitals

Fiscal Year	Payments
1992-93	\$158,681,965
1993-94	\$303,132,954
1994-95	\$95,595,394
1995-96	\$77,999,540
1996-97	\$101,000,000
1997-98	\$97,000,000
1998-99 est.	\$85,000,000
1999-00 est.	\$85,000,000
2000-01 est.	\$85,000,000
2001-02 est.	\$85,000,000

NOTE: DSH stands for Disproportionate Share Hospitals

MEDICAID TRUST FUND

BACKGROUND INFORMATION

- G.S. 143-23(a) of the Executive Budget Act allows public and private hospitals to transfer a portion of federal revenues to the Department of Human Resources for the Medicaid program. The Medicaid Trust Fund has been established to receive these funds.
- The Medicaid Trust Fund can only be used to benefit the Medicaid program and cannot be used to reduce state general fund revenues.
- The Medicaid Trust Fund does not revert to the General Fund, but these funds can be allocated as provided in the current appropriations act.

DISPROPORTIONATE SHARE HOSPITALS

Payments to Non-State Hospitals

Fiscal Year	Medicaid Trust Fund	Hospital Payments
1995-96	\$50,000,000	\$80,000,000
1996-97	\$35,000,000	\$174,000,000
1997-98	\$40,000,000	\$166,000,000
Total	\$125,000,000	\$428,000,000

MEDICAID TRUST FUND

RECURRING OR NONRECURRING?

- The Division of Medical Assistance has been successful for the past three federal fiscal years in working with non-state public hospitals to draw down additional DSH payments.
- The federal law for DSH payments has stabilized and allotments have been set through federal fiscal year 2001-2002.
- The Division of Medical Assistance is currently negotiating with non-state public hospitals to continue these DSH payments this year.

MEDICAID TRUST FUND

OPTIONS FOR USING THE FUND

- The governor has proposed using the Medicaid Trust Fund, during the 1998-99 and future years, to support Medicaid program expenditures and reduce the need for state appropriations. His budget recommends that the Medicaid Trust Fund maintain a minimum balance of \$100 million to meet unanticipated future Medicaid needs and that 10% of the total availability be budgeted in 1998-99 (\$13 million).
- Other options for using the Medicaid Trust Fund are as follows:
 - A Medicaid Rainy Day Fund which can be used when Medicaid expenditures grow unexpectedly due to a recession or other causes.
 - Provide cash flow for establishing capitated managed care programs.
 - Provide funding for nonrecurring Medicaid expenditures such as automation improvements.
 - Provide funding for other activities which benefit the Medicaid program.

MEDICAID PROGRAM

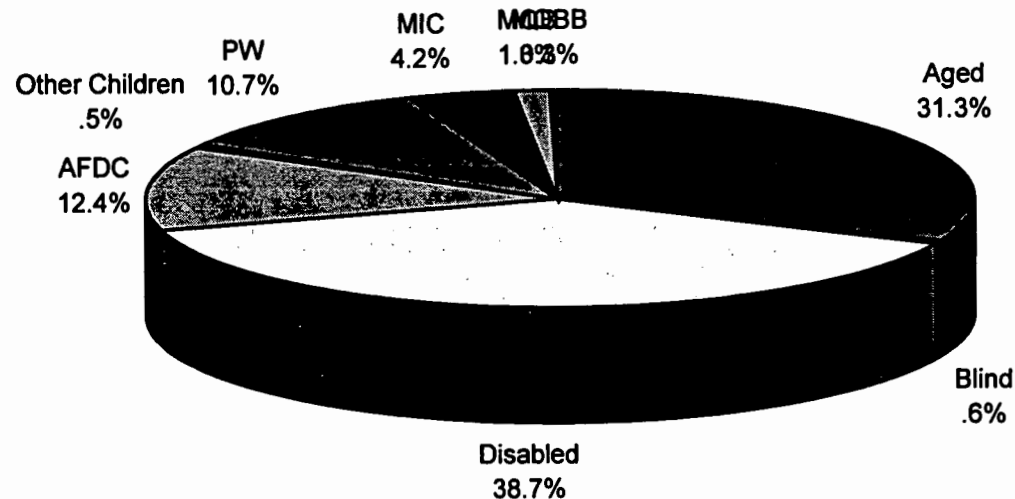
OTHER ISSUES

- Medicaid Special Provision
- Medicaid Growth Reduction
- Continuous Eligibility
- Comparison of 1980-81 Budget to 1998-99
- Status of New Administrative Positions

May 26, 1998
2 Carol Shaw

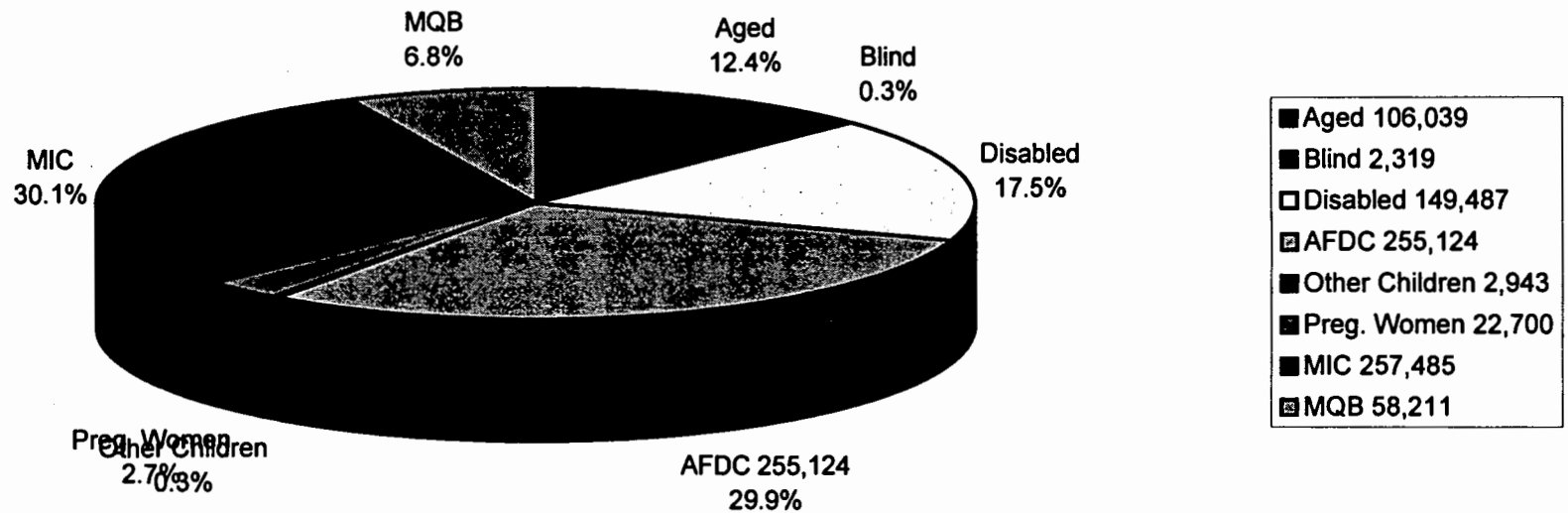
SFY98-99 Budget by Category of Eligibility
Total Estimated Budget \$4,484,054,050

■ Aged	\$1,405,755,389
■ Blind	\$26,301,838
□ Disabled	\$1,735,496,457
▣ AFDC	\$555,600,082
■ Other Children	\$25,185,009
■ PW	\$478,227,507
■ MIC	\$188,758,487
▣ MQB	\$57,324,614
■ MQBB	\$11,404,667



*It is estimated that \$231,000,000 of the dollars budgeted for Aged, Blind, and Disabled is necessary for the elimination of the 209B option.

SFY98-99 Estimated Eligibles **Total Estimated Eligibles 854,308**



*It is estimated that 60,000 of the Aged, Blind, and Disabled are eligible due to the elimination of the 209B option.

SFY98-99 Budget by Category of Eligibility

Category of Eligibility	Budget Amount	Percent
Aged	\$ 1,405,755,389	31.35%
Blind	\$ 26,301,838	0.59%
Disabled	\$ 1,735,496,457	38.70%
AFDC	\$ 555,600,082	12.39%
Other Children	\$ 25,185,009	0.56%
*PW	\$ 478,227,507	10.67%
*MIC	\$ 188,758,487	4.21%
*MQB	\$ 57,324,614	1.28%
*MQBB	\$ 11,404,667	0.25%

Total **\$ 4,484,054,050**

*\$966,000,000 added by eligibility (\$231,000,000 for elimination of 209B) since SFY80-81.

SFY98-99 Estimated Eligibles

Category of Eligibility	Population	Percent
Aged	106,039	12.41%
Blind	2,319	0.27%
Disabled	149,487	17.50%
AFDC	255,124	29.86%
Other Children	2,943	0.34%
*Preg. Women	22,700	2.66%
*MIC	257,485	30.14%
*MQB/MQBB	58,211	6.81%

Total **854,308**

*398,396 eligibles added (60,000 for the elimination of 209B) since SFY80-81.

Examination of Expenditures - Overall
Comparison of SFY80-81 to SFY98-99

Fund	Actual 1980-81	Recommended SFY 98-99	Percent Change Recomm/Actual
Admin	\$ 28,258,842	\$ 166,514,136	589%
1310	\$473,169,384	\$4,484,054,049	948%
Other	\$ 6,174,467	\$ (41,376,140)	-670%
total	\$ 507,602,694	\$ 4,609,192,045	908%
# of positions	124	348	281%
\$ per position	\$ 4,093,570	\$ 13,244,805	324%

Examination of Expenditures - Fund 1310
Comparison of SFY80-81 to SFY98-99

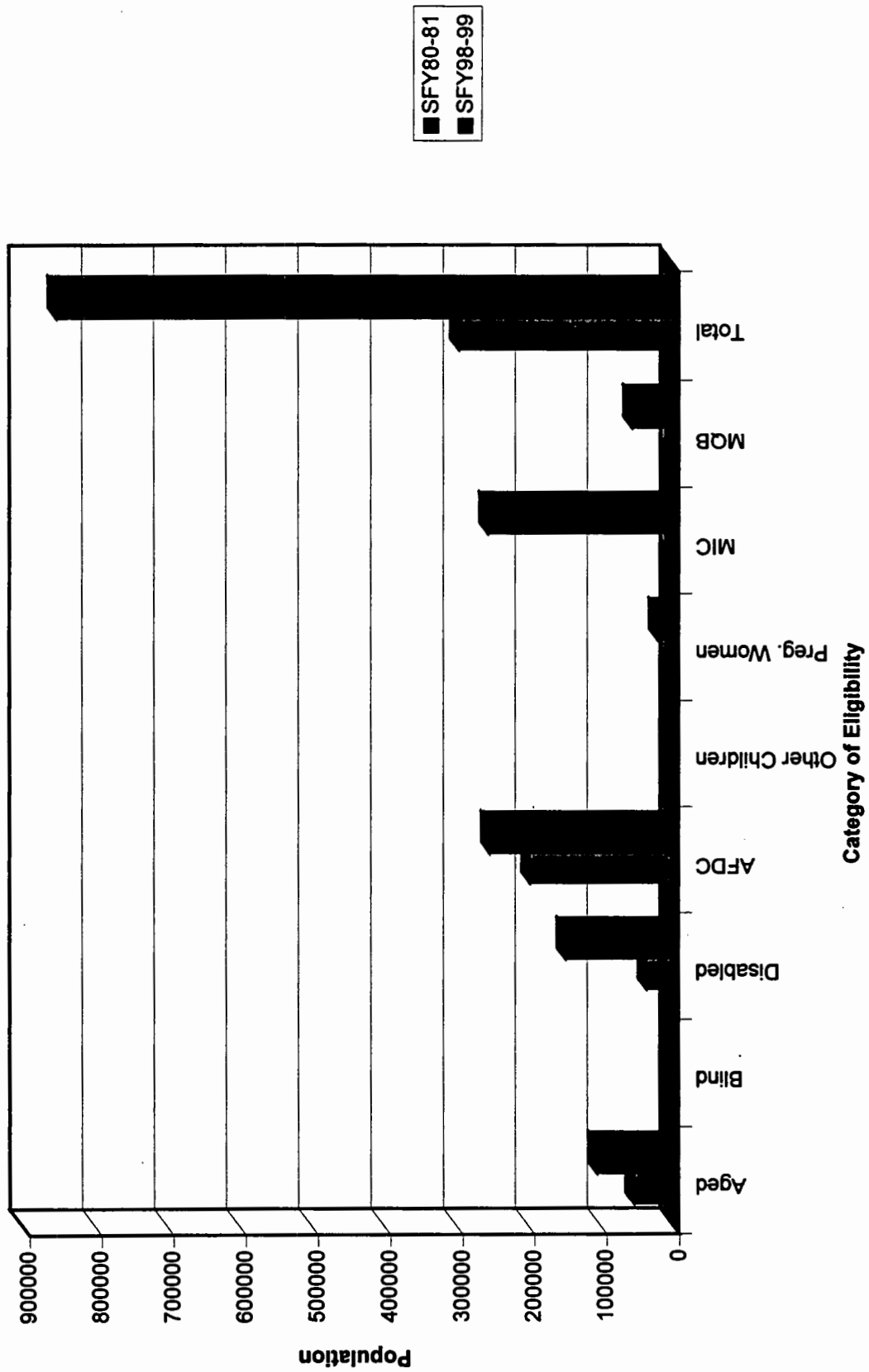
Make up of Fund 1310	Actual	Recommended	Percent Change
Traditional Services	1980-81	SFY 98-99	Recomm/Actual
LTC	\$202,623,070	\$ 975,368,418	481%
NLTC	<u>\$270,546,314</u>	<u>\$2,775,654,674</u>	1026%
Subtotal	\$473,169,384	\$3,751,023,092	793%
 New Services			
LTC		\$ 195,336,348	
NLTC		<u>\$ 537,694,608</u>	
Subtotal	\$ -	\$ 733,030,956	
 Total			
LTC	\$202,623,070	\$1,170,704,766	578%
NLTC	<u>\$270,546,314</u>	<u>\$3,313,349,282</u>	1225%
Total	\$473,169,384	\$4,484,054,048	948%

Examination of Expenditures - Fund 1310
Comparison of SFY80-81 to SFY98-99

Average Mnthly Eligibles	Actual 1980-81	Recommended SFY 98-99	Percent Change Recomm/Actual
Aged	54988	106039	193%
Blind	2188	2319	106%
Disabled	38128	149487	392%
AFDC	199000	255124	128%
Other Children	3885	2943	76%
Preg. Women	0	22700	
MIC	0	257485	
MQB	0	58211	
Total	298189	854308	286%

There are approximately 60,000 added eligibles due to the elimination of the 209B option.

Comparison of Eligibles SFY80-81 vs. SFY98-99



Budget Projections for New Services SFY98-99
Services Added Since SFY80-81
All Eligibles

ACCOUNT	CATEGORY OF SERVICE	SFY 1998-99 EXPENSE SUBTOTALS
536113	LTC-ICF MRC, NSO	195,336,348
536144	PERSONAL CARE	80,408,125
536159	CAP-DISABLED	159,145,770
536160	CAP-MENTALLY RETARDED	152,841,237
536161	CAP-CHILDREN	6,594,181
536162	CASE MANAGEMENT-FSO	3,440,095
536163	LOCAL EDUCATION AGENCIES-FSO	1,348,810
536165	DURABLE MED EQUIPMENT	28,133,398
536168	CLINICS-DHS IMMUNIZATIONS	186
536169	PHYSICAL MED-NON PHYSICIAN	16,058,677
536171	HOME INFUSION THERAPY	6,265,901
536172	HOSPICE	10,179,107
53618A	ACF - PCS BASIC	56,592,907
53618D	ACF - PCS BASIC/EATING ASSIST	280,533
53618E	ACF - PCS BASIC/TOILET ASSIST	9,244,383
53618F	ACF - PCS BASIC/EATING/TOILET	5,937,224
53618G	CAP AIDS	93,039
53618H	HIV CASE MANAGEMENT	1,131,033
	LTC REQUIREMENTS	195,336,348
	NLTC REQUIREMENTS	537,694,608
	TOTAL REQUIREMENTS	733,030,956

**Examination of Average Cost Per Eligible
Comparison of SFY80-81 to SFY98-99**

	Actual 1980-81	Recommended AFY 98-99	Percent Change Recomm/Actual
Cost Per Monthly Eligible			
Traditional Services			
LTC	\$ 57	\$ 95	168%
NLTC	\$ 76	\$ 281	372%
Subtotal	\$ 132	\$ 376	285%

Personal Consumption Deflator-Medical Care Services rate of change:
80-81 index = 111.5, Projected 98-99 index = 303.01
 $(303.01/111.5)-1 = 171\%$ change

New Services			
LTC	\$ -	\$ 19	
NLTC	\$ -	\$ 42	
Subtotal	\$ -	\$ 61	

Total All Services			
LTC	\$ 57	\$ 114	202%
NLTC	\$ 76	\$ 323	427%
Total	\$ 132	\$ 437	331%

MAJOR MEDICAID ELIGIBILITY CHANGES

<u>DATE</u>	<u>CHANGE</u>	<u>M OR O</u>
1/85	Expanded eligibility coverage to: - All pregnant woman with income <AFDC payment level - Change <age 19 in 2 parent household - Change in custody of private adoption agency - Automatic coverage for 1 year from infant whose mother was receiving XIX at time of delivery	M M O M
4/87	- Expanded eligibility coverage to: - Pregnant woman and infants with income up to 100% poverty	O
10/87	- Change < age 2 with family income up to 100% poverty [added a year in age each October thru age 5 by October 1990]	O
1/89	- Qualified Medicare Beneficiaries with income up to 80% FPL [added 5% increments each January thru January 1993 to = 100% FPL]	M
4/90	- Transitional XIX for two 6 month periods after loss of AFDC due to employment	M
1/91	- QMB "B" added to pay Part B premium for beneficiaries with name up to 110% FPL [income to 120% January 1995]	M
10/90	- Added children > age 6 who were born on or after October 1, 1983 with family income up to 100% FPL	M
7/91	- Qualified Disabled Working Individuals added to pay Medicare Part A premium	M
10/94	- Accelerated coverage of children born on or after October 1, 1983 with family income up to 100% FPL - Added coverage for adopted children with special needs without regard to income and assets of adoptive parents	O
1/95	- Changed from 209(b) to 1634 status [Automatic XIX eligibility for SSI recipients]	O
1/98	- Qualified Individuals with income between 120-135% FPL for Part B premium payment - QI with income between 135-175% FPL for payment of \$1.07 one month enhanced Part B premium	M M

M - Mandatory

O - Optional

afternoon

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

MAY 26, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Chuck Harris	DHHS - DSS
Jan Arnold	" "
JoAnn Lamm	DHHS - DSS
Lisa Aycock	DHHS - DSS
Lee Stevens	DHHS - Wash. DC Ofc.
HUGH TILSON	NCHA
Michelle Hughes	Nc Civic Agency
AL DETCH	YAT/DCA
Steve Shaler	Jordan Price
Robert Bone	Bone & Assoc
Pam Mays	GA
Lon B. Wilder	NEH TC 7
John Bowditch	Zeb Alley P.A.
Bernie Opre	DHHS - HR

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 26, 1998

Afternoon

Minutes

Joint Appropriations Subcommittee on Human Resources met on Tuesday afternoon, May 26, 1998 in Room 643. Representative Lanier Cansler chaired the meeting. Four Senators were present. The following House members attended:

Representative Bill Hurley	Representative Charlotte Gardner
Representative Lanier Cansler	Representative Debbie Clary
Representative Martha Alexander	Representative Theresa Esposito

Susan Sabre and Gann Watson of the Legal Staff were present as was the Fiscal Staff, Mary Ellen Sylvester, Karen Hammonds-Blanks, Ramona Burton and Carol Shaw.

Carol Shaw continued with her presentation on the Division of Medical Assistance 1998-99 Budget. She explained the continuous eligibility concept that was incorporated into the recently enacted Children's Health Insurance Program. Since Medicaid children do not have continuous eligibility status the department is proposing to change their rules to grant them continuous eligibility. This will require a special provision to overcome the time it would take to change the rules. It is budget neutral.

Mr. Dick Perruzzi, Director of the Division of Medical Assistance, gave a status report on the 63 administrative positions that were added after the General Assembly adjourned last year. Senator Martin asked for clarification on whether these were new positions, and Mr. Perruzzi said they are all new positions.

The legislators were disturbed that the division was able to add all these positions without legislative approval. They were told that a special provision in the budget allows them to do this. Senator Forrester said that something should be done about leaving the legislature out of these decisions.

Representative Cansler asked if the projected savings will be a result of these additional positions, and Dr. Perruzzi assured him this is the case. Representative Cansler asked about the pharmacies he mentioned as a part of the projected savings and in what particular areas we are getting savings returned from pharmacies. Mr. Perruzzi said he would ask for more specific information on those cost savings. Cansler also wanted to know if legislation proposing to expand prescriptions for the elderly and disabled to 100% of poverty was going to increase the need for staff. Perruzzi said he would let staff come back with the need and justification for more staff

Minutes, 5-26, 1998, p.m.

Representative Gardner requested a list of where these new Medicaid employees are going. She is skeptical that adding 64 employees can save money. Perruzzi said the information was provided the committee at the January meeting. She suggested contracting for services instead of adding new staff.

Senator Phillips asked about the 6 prescription limit and the exceptions allowed. Senator Forrester said the real problem physicians had regarding prescriptions is with the HMO's rather than with Medicaid.

Fiscal Staff member Karen Hammonds-Blanks announce that the discussion would be on child welfare issues and the committee would hear from Kevin Fitzgerald and Chuck Harris of the Division of Social Services. They will be doing an overview of the system. If there is time she will be talking about some of the issues in child welfare that North Carolina is facing. She told the members that on Thursday representatives from NCSL would give a presentation on this issue, specifically citing action in Florida and Missouri.

Kevin Fitzgerald, Director of the Division of Social Services, spoke about some of the critical system objectives that were put in place last session. He said they had worked very hard to implement House Bill 896 which presaged the federal legislation. They make the safety of the child preeminent. (See attachment #1, "Assuring Safe, Permanent Homes for Children".)

Senator Phillips asked about the qualifications of child welfare workers. Mr. Fitzgerald said they did not have documentation but what he is hearing anecdotally is that it is a mixed picture in the counties. Mostly they have Bachelor degrees and are offered continuous in-service training.

Senator Phillips was assured by Mr. Fitzgerald that there is a corrective action plan for those ten counties who have not met the standards for child protection.

Chuck Harris, Chief of Children Services, presented data on the performance of the child welfare system, specifically for children who abused and neglected as defined by the General Assembly. He also made recommendations for improvement.

Representative Cansler asked if the trend in the increase of the numbers of children substantiated as neglected and abused due to domestic violence or substance abuse in the home is continuing. Mr. Harris said they do not have the figures for 1997-1998 yet.

Senator Phillips wanted to know about the placement of children and was told that they are placed with relatives, reunited with their families and adopted. They will be testing another way of protecting children in July which is called assisted guardianship which

Minutes, 5-26-98, p.m.

several states are doing. The main goal is to place children to safe permanent homes, and shorten the time in which children are held in foster care which is now too long.

The meeting was adjourned


Barbara R. Hocutt, Clerk


Representative Lanier Canstler, Co-Chair

LC:brh
attachments

May 28, 1998
#1 Kevin Fitzgerald
Chuck Harris

ASSURING SAFE, PERMANENT HOMES FOR CHILDREN

SYSTEM OBJECTIVES

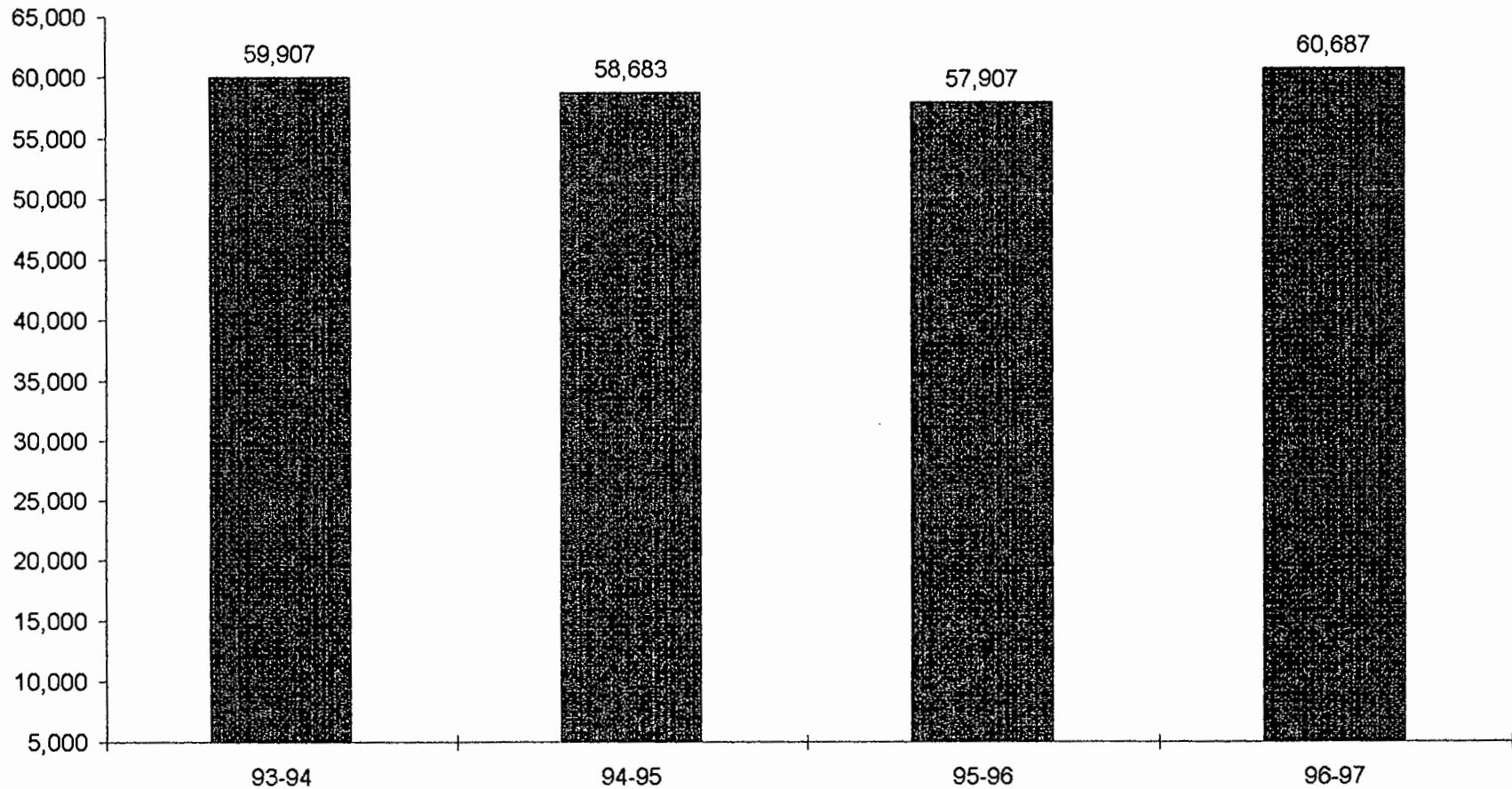
- SB 896 IMPLEMENTED: COMMON FOCUS ON SAFETY AND PERMANENCE
- SB 941 IMPLEMENTED
- COUNTIES MEET STAFFING STANDARDS
- WORKERS TRAINED TO DO THEIR JOBS
- LOCAL COMMUNITY CHILD PROTECTION TEAMS INTEGRAL TO PROTECTING CHILDREN
- FOSTER CARE AND ADOPTION PERFORMANCE IMPROVED
- LIABILITY COVERAGE FOR WORKERS PROVIDED
- STATE REVIEWS OF CHILD FATALITIES CONDUCTED
- INTENSIVE STATE SUPPORT FOR POOR PERFORMING COUNTY CHILD WELFARE PROGRAMS IN PLACE

ASSURING SAFE, PERMANENT HOMES FOR CHILDREN

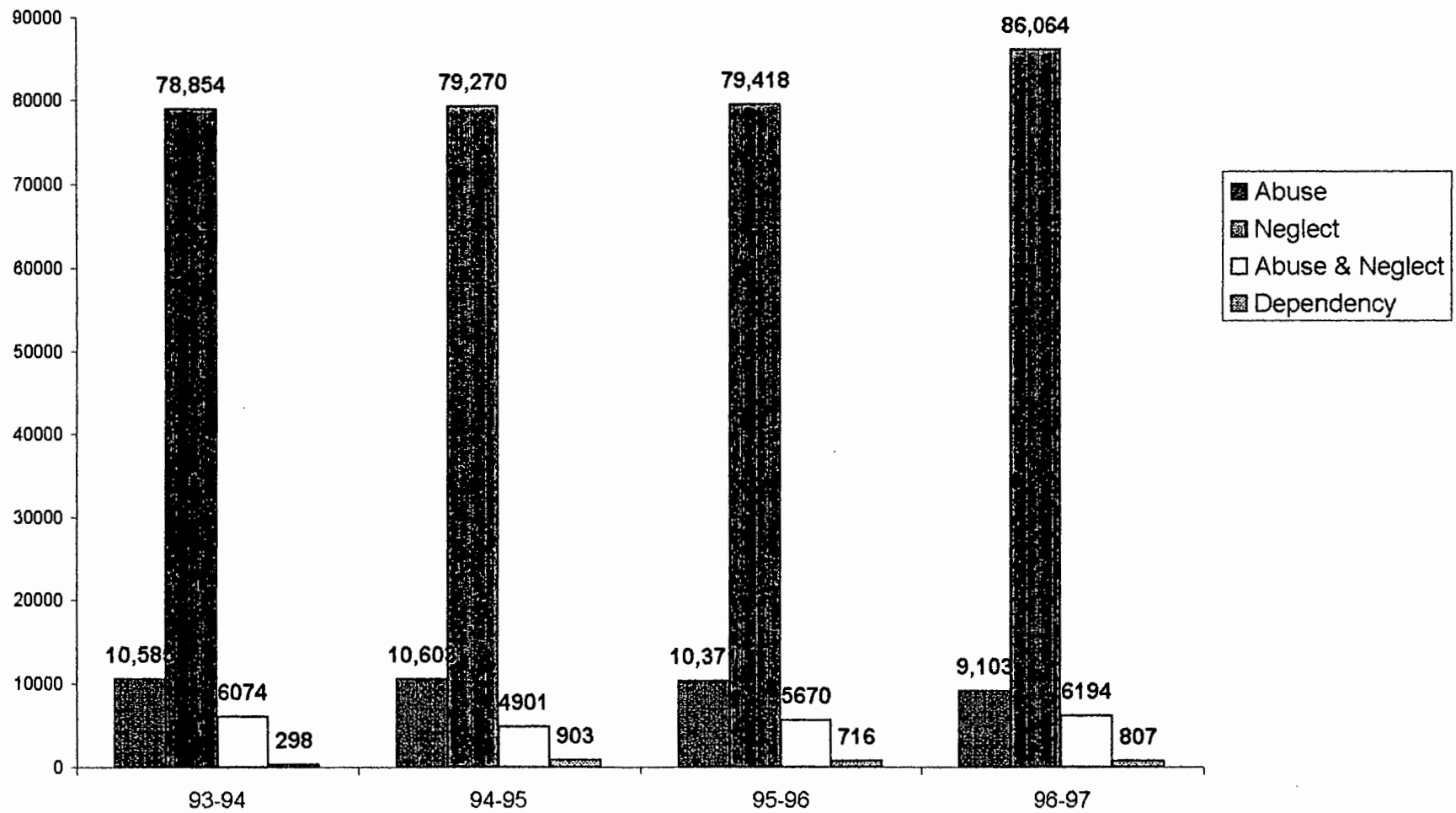
SYSTEM ISSUES

- IMPLEMENT FEDERAL ADOPTION AND SAFE FAMILIES ACT
- STAFFING AND TRAINING CAPACITY MEETS CHANGING CASELOADS
- IMPROVE WORKING RELATIONSHIPS WITH MEDICAL, EDUCATION AND LAW ENFORCEMENT SYSTEMS
- EFFECTIVE PREVENTION MEASURES IN PLACE
- PROVIDE EFFECTIVE TREATMENT FOR SUBSTANCE ABUSE, SEXUAL ABUSE AND DOMESTIC VIOLENCE
- DEVELOP BETTER STRATEGY FOR WORKING WITH CHILDREN AND FAMILIES OF ALL RACES

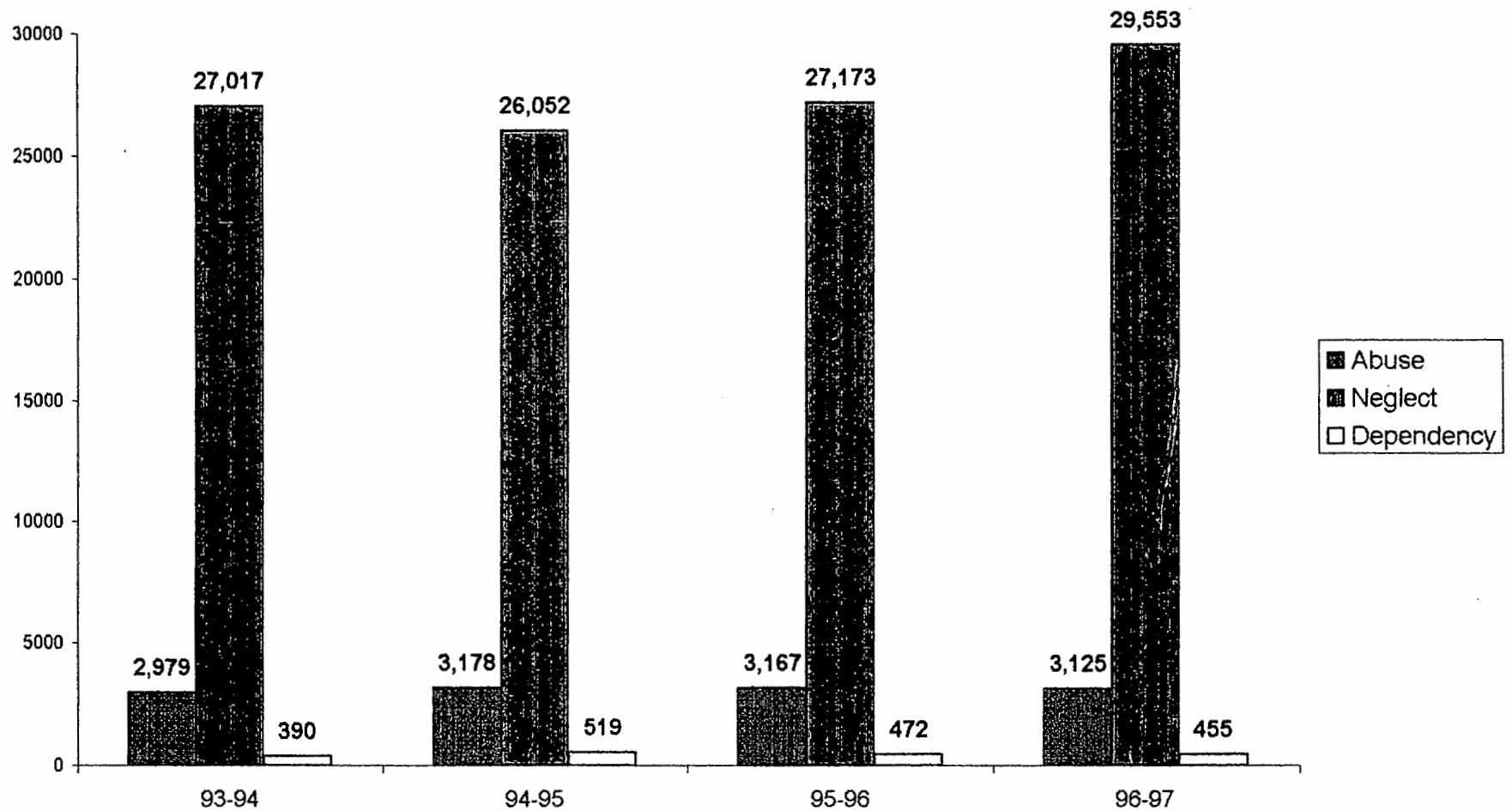
Reports of Child Abuse, Neglect, Dependency



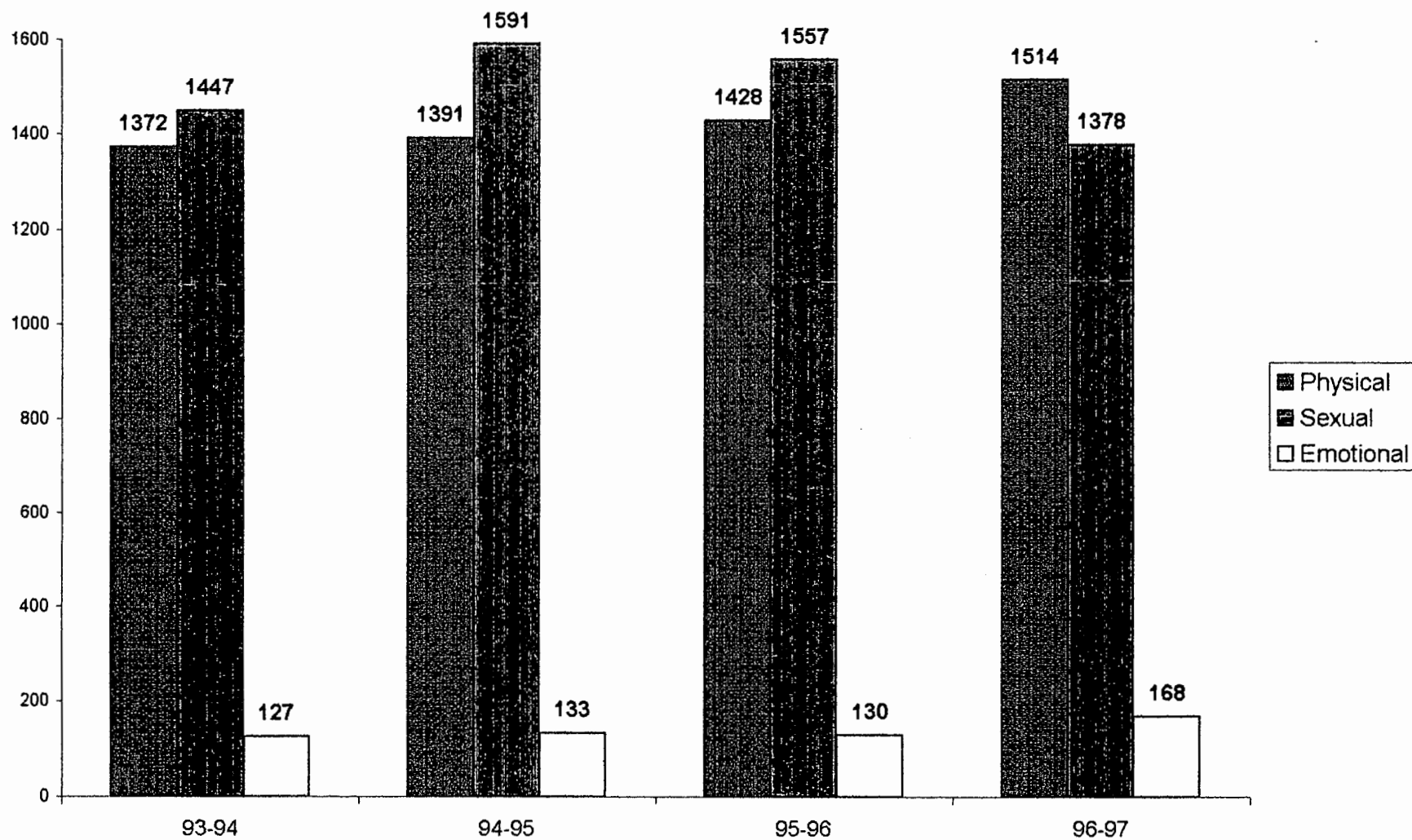
Children Reported For Abuse, Neglect, Dependency



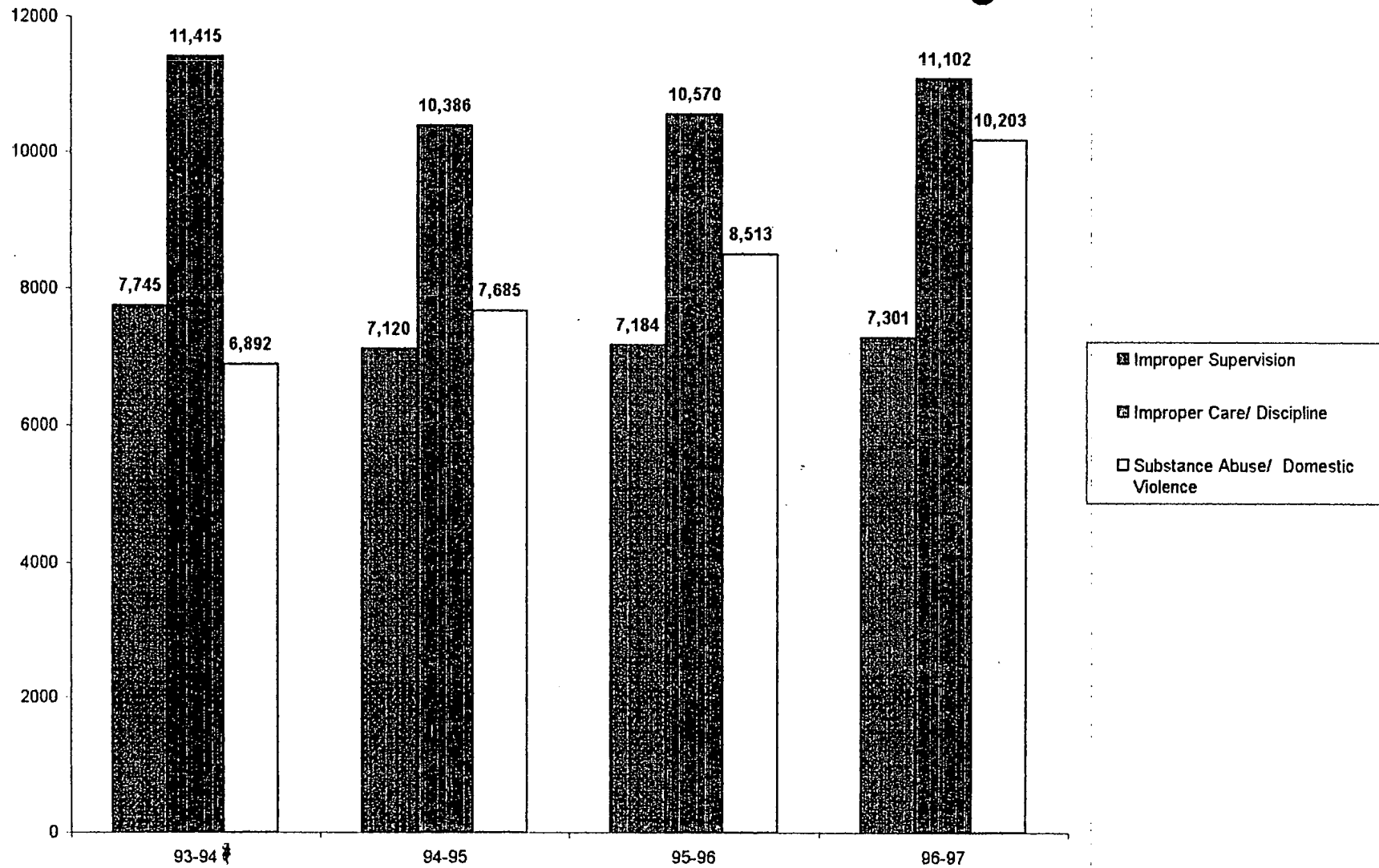
Children Substantiated for Abuse, Neglect, Dependency



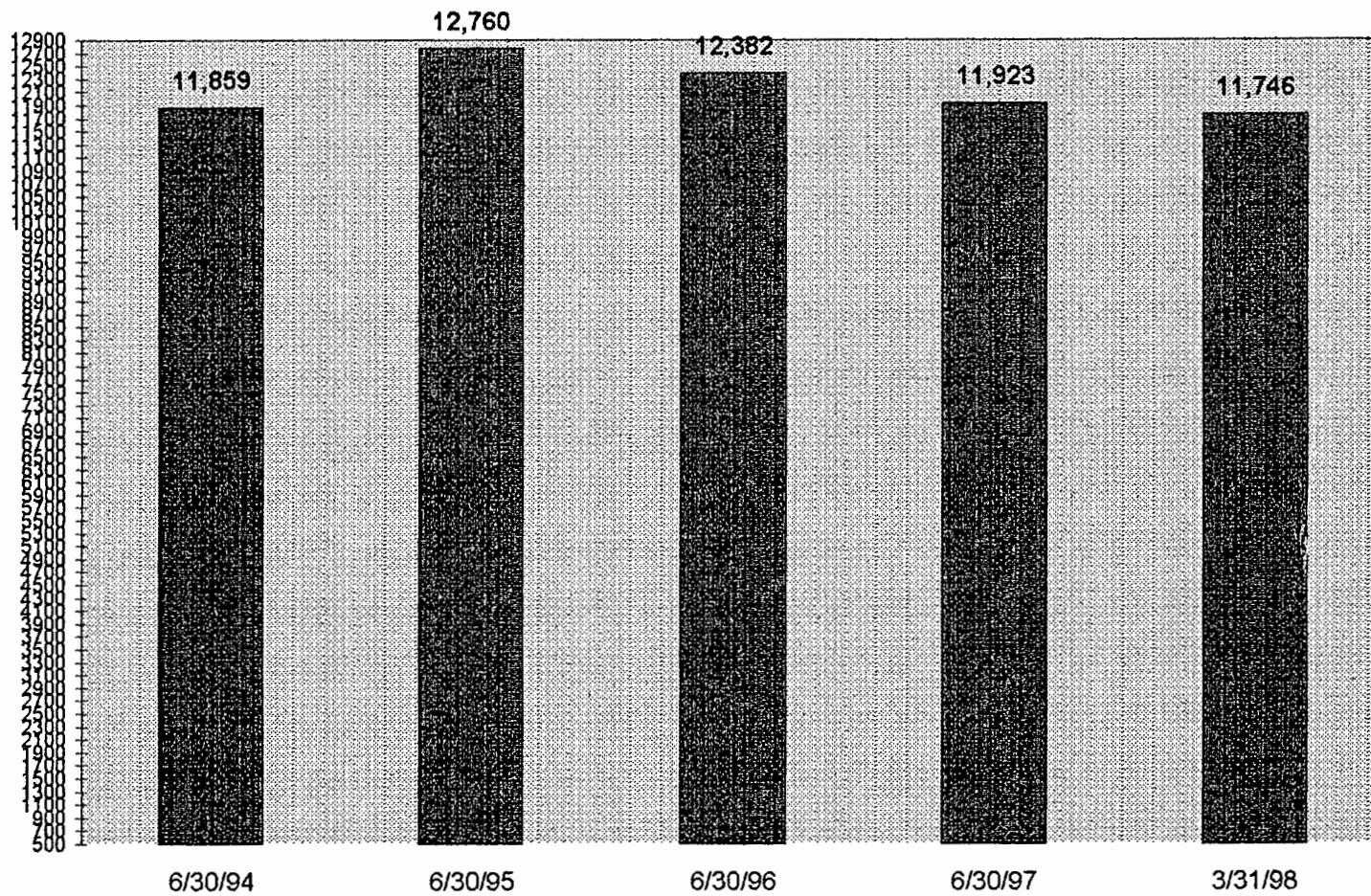
Children Substantiated for Abuse



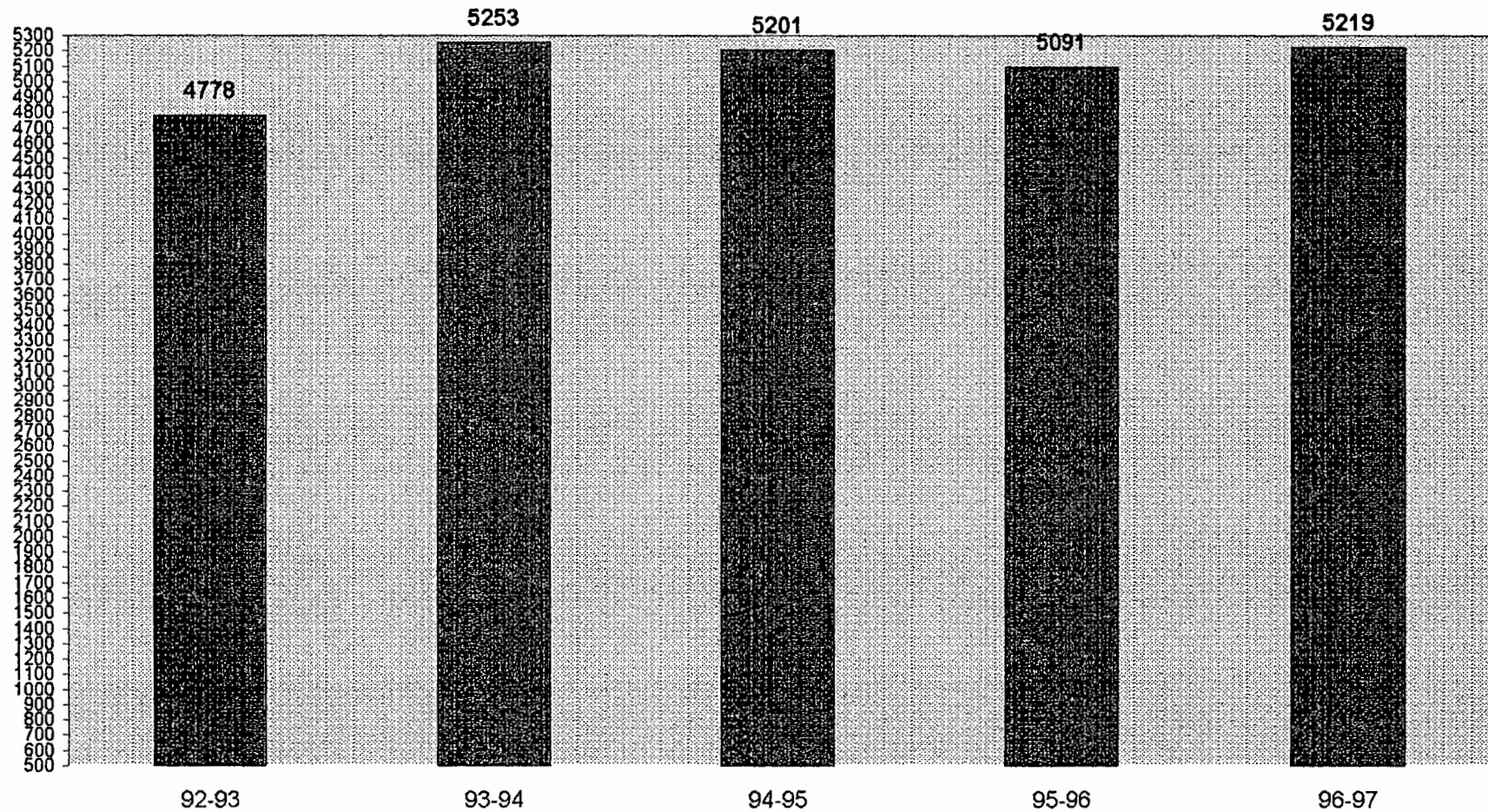
Children Substantiated for Neglect



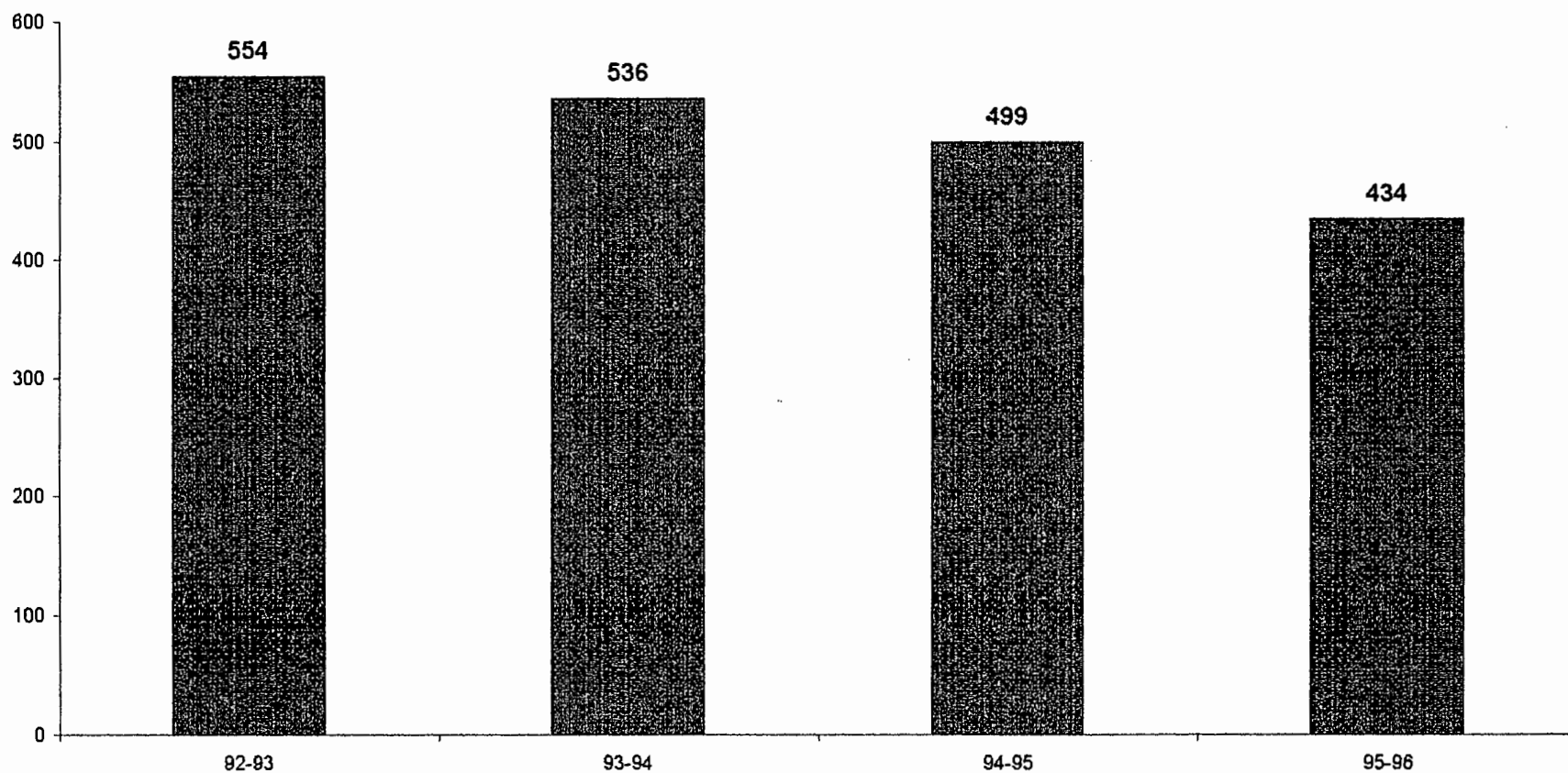
Children in DSS Custody/Placement Responsibility



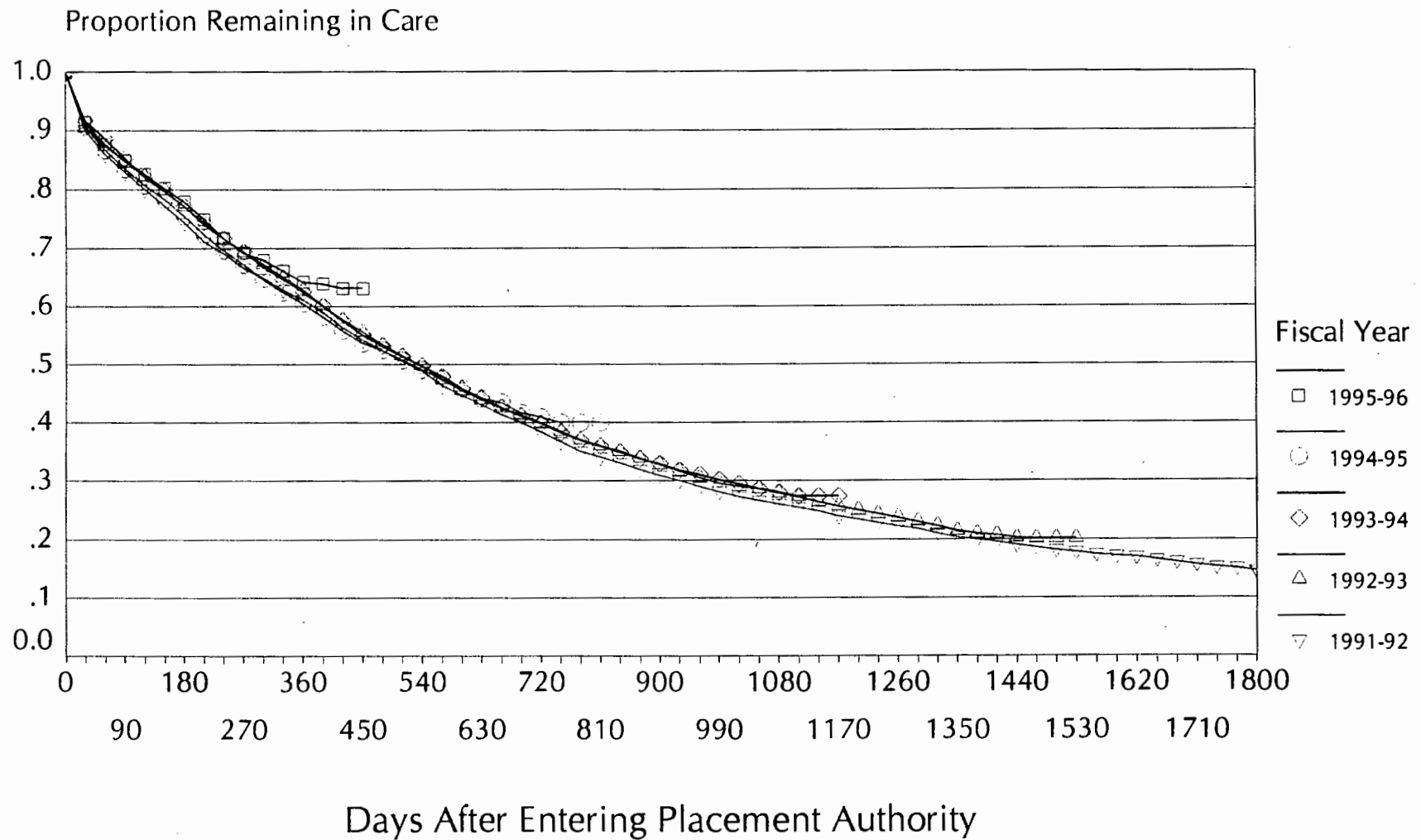
Children Entering DSS Custody/Placement Responsibility for First Time



Median Length of Stay (Days) in DSS Custody/Placement Responsibility by Entry Cohort



Duration of First Spell in Placement Authority



**NUMBER OF CHILDREN IN LEGAL
CUSTODY MORE THAN TWELVE
MONTHS AT END OF YEAR**

1993 7,999

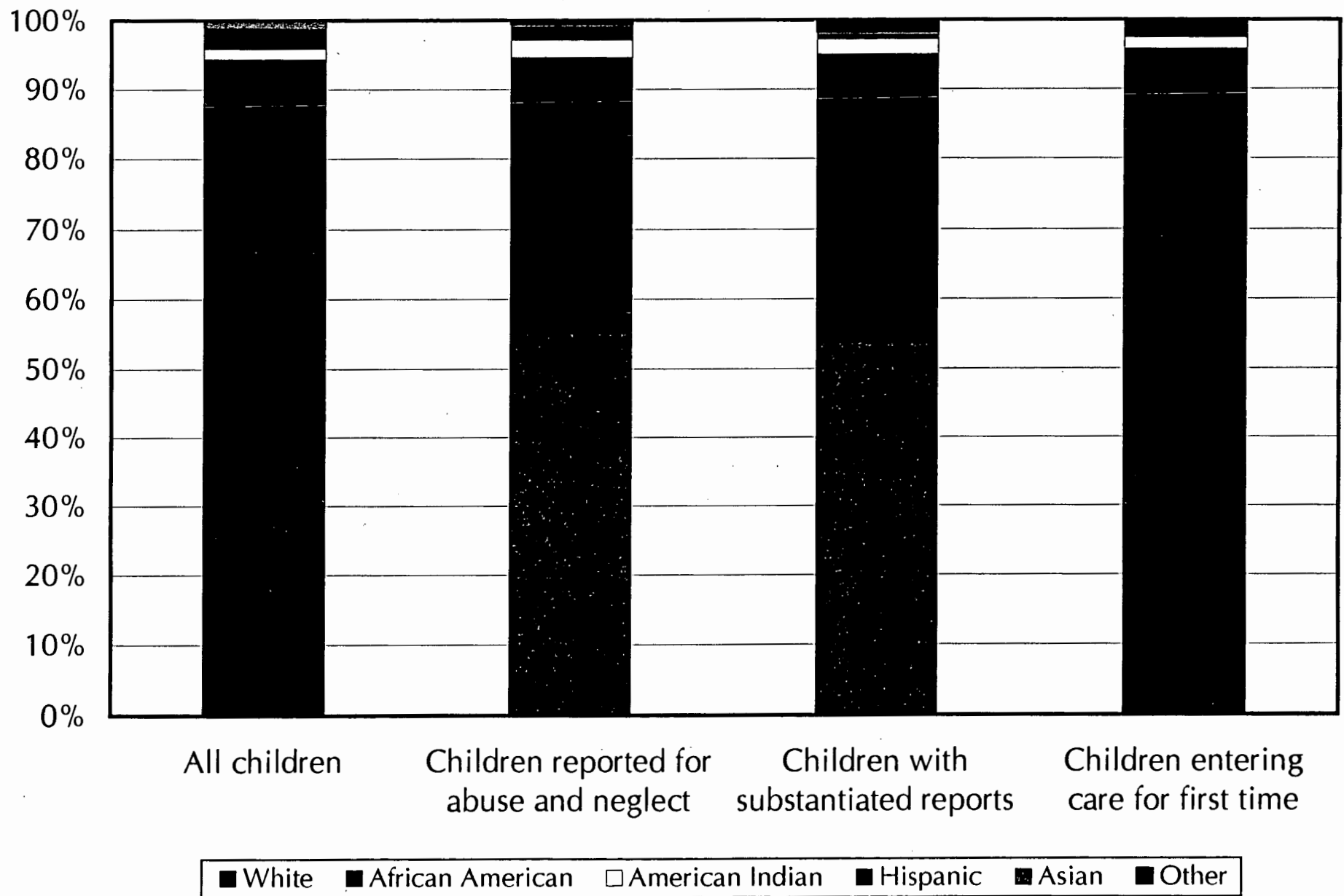
1994 8,439

1995 9,231

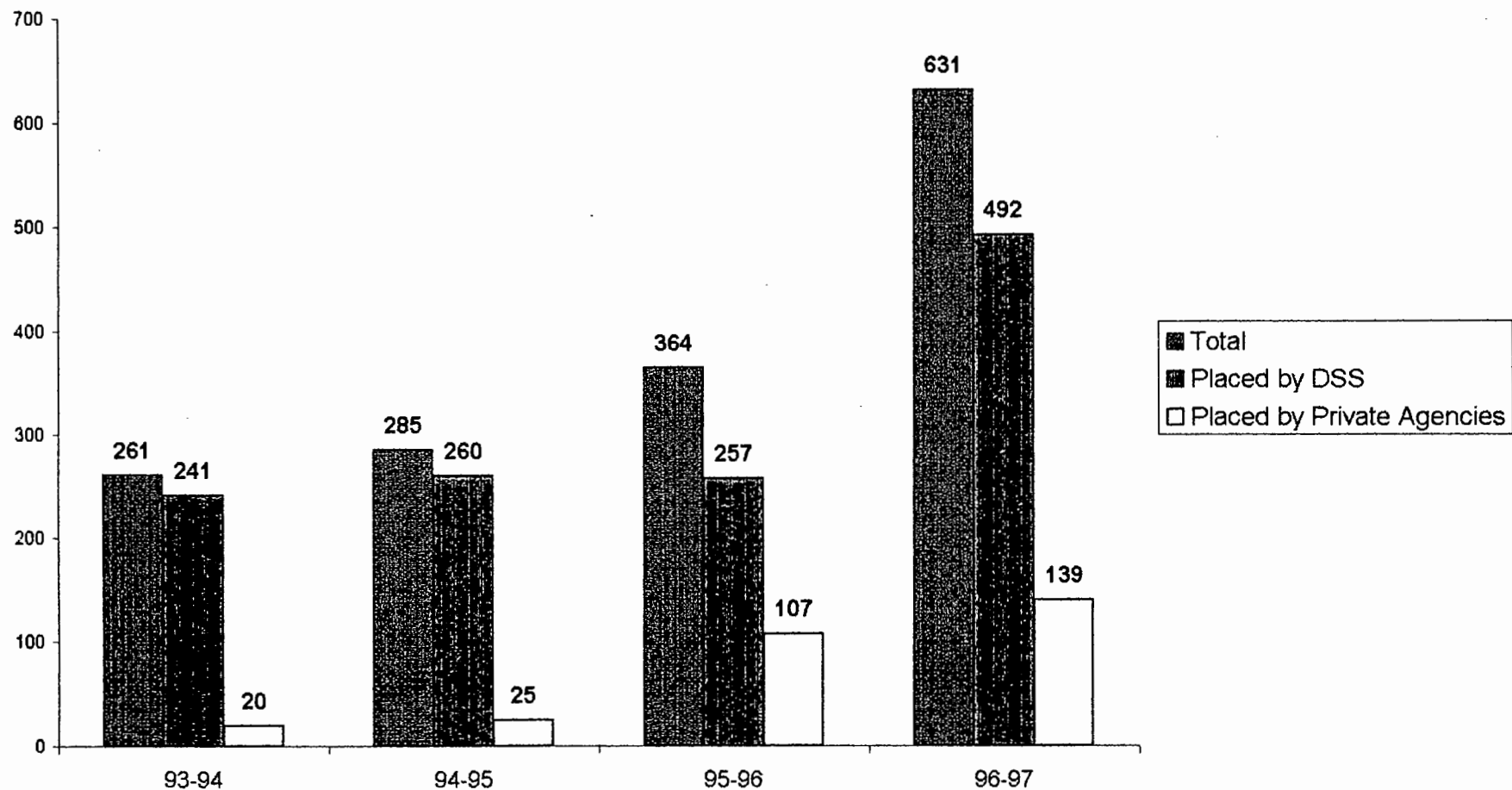
1996 8,702

1997 8,196

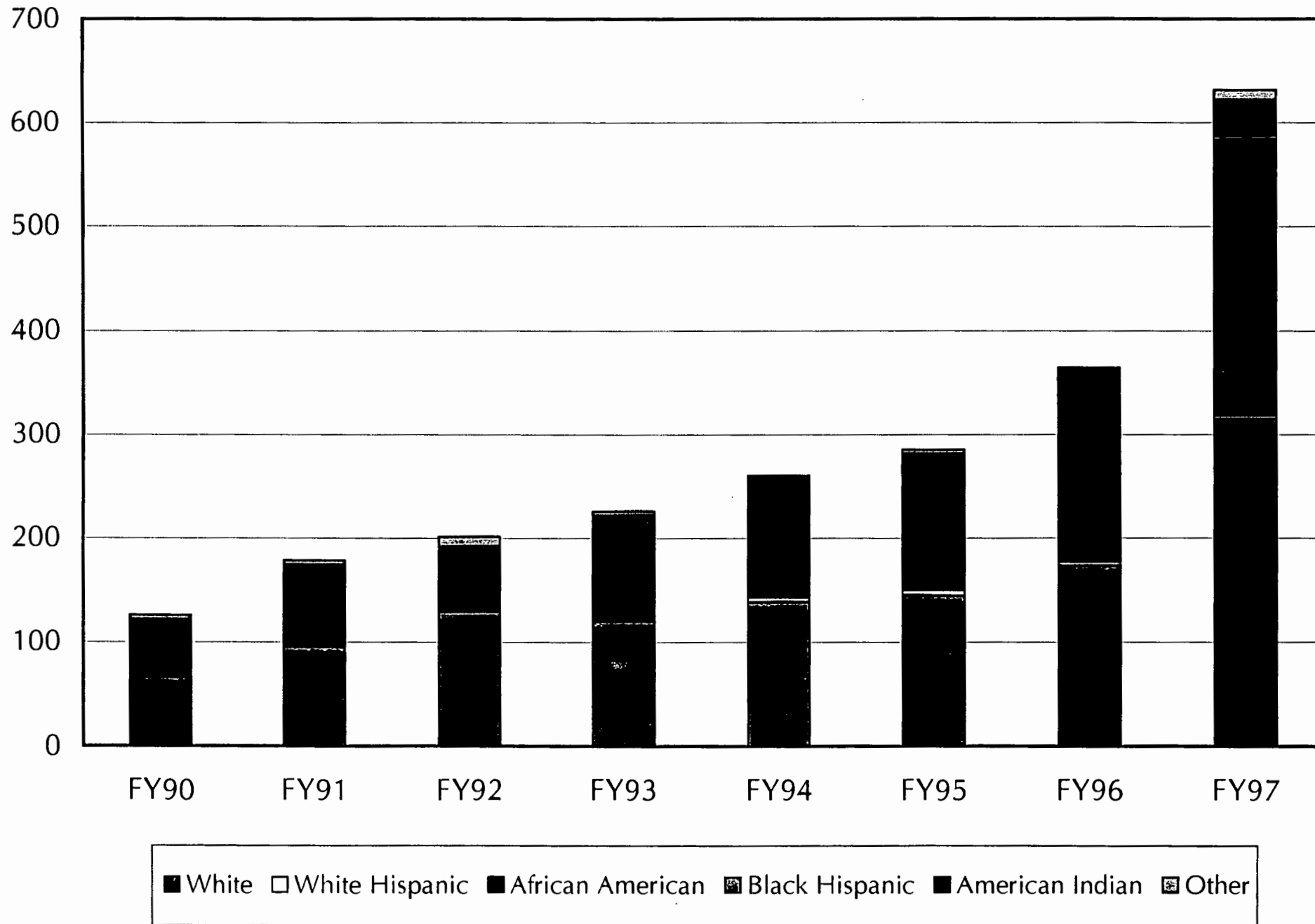
Racial and Ethnic Patterns in Child Abuse Reports and Entries to Out-of-Home Care



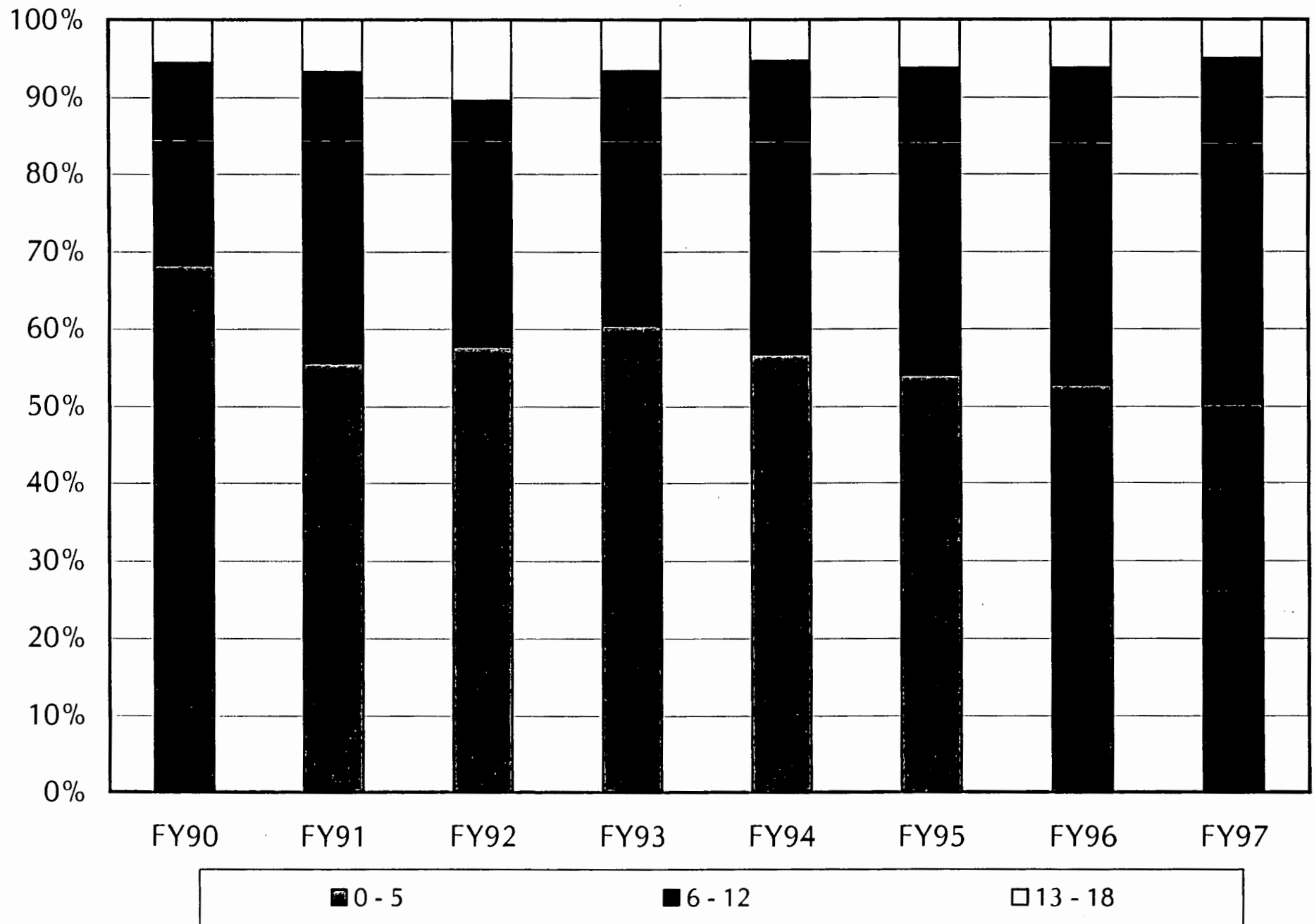
Children Exiting Foster Care Due to Final Decree of Adoption



Exits From Child Welfare Through Adoption, by Race



Age of Children Exiting Through Adoption



SUMMARY OF MAJOR TRENDS AND IMPLICATIONS

Trend: Recent increase in number of reports of child abuse and neglect. 12th highest rate of child victims per 1,000 child population among the states.

Implication: Need to resolve staff recruitment and support issues to ensure responsiveness. Need to expand prevention efforts to every county.

Trend: Increase in number of maltreated children due primarily to increase in neglect resulting from substance abuse and domestic violence. Sexual abuse is as prevalent as physical abuse.

Implication: Need for effective treatment programs dealing with sexual abuse, substance abuse, and family violence. Need to examine role of law enforcement in investigations of sexual abuse and severe physical abuse.

Trend: Recent decrease in number of children in foster care, rate of initial entry, and median length of stay. Disproportionate representation by children of color still problematic.

Implication: Need for more effective approach to addressing issues of child neglect that arise from chronic family poverty. Need to demonstrate potential effect of "assisted guardianship". Need for more cultural awareness and sensitivity across all elements of the child welfare system.

Trend: Significant increase in the number of children exiting foster care through Final decree of Adoption. Problematic delays in terminating parental rights so children are "legally free" to be adopted.

Implication: Need to strengthen legal assistance for DSS agencies. Need to strengthen capacity for recruiting, training, and supporting foster and adoptive families.

JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES

MAY 27, 1998

The Joint Appropriations Subcommittee on Health and Human Services met on Wednesday, May 27, 1998 at 8:30 a.m. in Room 643 of the Legislative Office Building. There were six senators and seven representatives present. Co-chairman Bill Martin presided.

Chairman Martin introduced Fiscal Research staff Karen Hammonds-Blanks to continue yesterday's presentation on the N. C. Child Welfare Services System.

Ms. Hammonds-Blanks said the purpose of her presentation was to focus the committee's attention on any changes, issues and reforms in the child welfare system. She spoke about the issues that affect the entire system, and made the committee aware that they need to consider those issues when they hear the presentation tomorrow from the National Conference of State Legislatures (NCSL) representatives about what other states are doing. Ms. Hammonds-Blanks identified five issues that affect the North Carolina system (see Attachment #1) which were structural, inadequate system resources, disproportionate representation of African-American children, substance abuse and other system challenges, and system accountability in child welfare services.

Senator Dannelly asked about worker-to-caseloads ratios. Ms. Joanne Lamb of DHHS said in Child Protective Services Investigations the national standard is one worker per 12 families; in child protective treatment cases it's 1-to-15 families; in foster care and adoptions the Child Welfare League of America recommends one worker to 15 children, in N. C. the standard for foster care and adoptions is one worker for 15 families not to exceed 20 children.

Rep. Cansler asked if there is a plan in place to correct the problems associated with attracting and retaining skilled workers. Ms. Hammonds-Blanks said many counties have hired social workers, but there are no plans to standardize educational requirements. Rep. Cansler asked about the kind of training the workers have. Ms. Hammonds-Blanks said there is a combination of qualifications in Wake County; other counties hire who they can and train them. Rep. Cansler said the committee needs to try to establish some kind of procedure or plan on how to get to where the state needs to be in hiring qualified staff.

Ms. Lisa Aycock of DHHS said the department is working to strengthen the per-service training capacity and DHHS is working with schools of social work in the state

university system to strengthen their bachelor and master of social work programs, and hopefully, will increase the numbers of graduates coming out of the programs.

A discussion followed on incentives needed to attract people to do social work. Sen. Phillips said he has noticed over a 40-year period that problems are more complicated than ever before, there are more numbers to deal with now and they continue to grow. Committee members agreed that discussion needs to continue and solutions need to be addressed following the NCSL presentation.

Ms. Hammonds-Blanks continued to address questions from the committee members about micro-management and other findings in her investigation. Sen. Martin elaborated on the presentation from Ms. Hammonds-Blanks, stating that the committee has been successful in coming up with solutions on other key issues in the past, and that after the NCSL presentation, should sit down and come up with solutions to the child welfare system problems.

The meeting adjourned at 9:52 a.m. to reconvene at 2:45 p.m.

Co-chairman Martin reconvened the meeting at 2:45 p.m. and recalled Ms. Hammonds-Blanks to continue her presentation. She began by focusing on the disproportionate numbers of African-American children in N. C.'s welfare system. Problems impacting the numbers, based on a study, included living conditions, insufficient income, inadequate housing and other issues like single-parent homes, alcohol and delinquent behavior. Sixty-percent of child abuse and neglect cases were driven by poverty.

Sen. Phillips asked whether there were any parallels noted in the study between delinquency and some of the other problems noted. Ms. Hammonds-Blanks said there were no parallels noted in this particular study but some other research efforts and literature have focused on parallels.

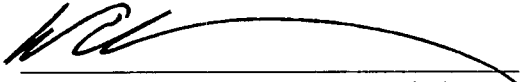
Ms. Hammonds-Blanks concluded her presentation with the following policy issues for consideration in the child welfare services system: a) maintain the current system but it is headed for disaster if millions of dollars for staffing and resources are not put in place, b) consider other direct system reforms for North Carolina using models from other states, c) direct the state to formally develop and implement strategies addressing the over-representation of minorities in the system. Ms. Hammonds-Blanks

said the overrepresentation will include Hispanics in the future also, considering the increase in that population in the state.

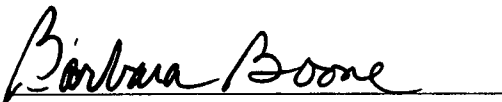
Sen. Phillips asked staff to check with the NCSL staff and see what kind of experience they have academically and practically in their backgrounds? He thinks there many not be enough people with the right experience on the teams responding to calls.

Next, Co-chairman Martin recognized Mr. Terry Steele, Assistant Director of DHHS's Division of Mental Health, and Mr. William Sears of Sears, Hackney, Keener and Williams Architects, to report on the Whitaker School Replacement Facility (see Attachment #2). Due to time restraints affecting the start of the Work First State Plan Public Hearing, the Whitaker School Replace report was deferred until Tuesday, June 2.

Co-chairman Martin adjourned the meeting and the committee was directed to the Auditorium for the public hearing.


Sen. William N. Martin, Co-Chairman

Rep. Charlotte A. Gardner, Co-Chairman


Barbara Boone, Committee Clerk

**SENATE NOTICE OF JOINT APPROPRIATIONS
SUBCOMMITTEE MEETING**

Principal Clerk _____
Reading Clerk _____

**SENATE
NOTICE OF JOINT SUBCOMMITTEE MEETING**

The Joint Appropriations Subcommittee on Human Resources will meet at the following times:

DATE: Tuesday, Wednesday, Thursday
May 26-28, 1998

TIME: 8:30 a.m.

ROOM: 643 LOB

The Joint Committee will also meet Thursday afternoon, 15 minutes after the last chamber adjournment.

Senator Bill Martin, Chairman

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

Legislative Office Building - Room 643

Wednesday, May 27, 1998

8:30 a.m.

Opening Remarks

Senator Bill Martin, Co-Chair
Rep. Charlotte Gardner, Co-Chair
Rep. Lanier Cansler, Co-Chair
Rep. Debbie Clary, Co-Chair

Issues Facing N.C.'s Child Welfare
Services System

Karen Hammonds-Blanks
Fiscal Research Division

Whitaker School Replacement
Facility Report

Terry Stelle, Assistant Director
Division of Mental Health

William W. Sears, AIA
Sears, Hackney, Keener, & Williams

Committee Discussion

WORK FIRST STATE PLAN PUBLIC HEARING

Legislative Auditorium
3:30 p.m.

Adjourn

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE FOR HUMAN RESOURCES

MAY 27, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Shanese Ransome	DSS
ANGIE McMillan	DHHS
Terry Stelle	DMHDDSAS
Judy Batten	NCAAD 1397 Hurdle Mills Rd. Rothero, NC 27573
John Bowditch	Zeb Alley P.A.
Myra Mull	NASW-NC
Ken Brackenbrough	DD Council
Byron Harris	OSBM
James Ramquist	NCSOS
Robin Huffman	Charter Behavioral Health
Nina Reeves	HSP, Inc.
Jesse J. See	Addiction Professionals of NC

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE FOR HUMAN RESOURCES

MAY 27, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

R.A. LODDENGARD	CHAIR, HUMAN RIGHTS, WHITAKER
C.L. Cochran	UCPNC (C-2001)
John Tote	M.H.A. (C-2001)
Jan Connelly	NCEAPA (C-2001)
Stacy Flannery	NCANPHA
NELS ROSELAND	OSBM
DEAN SHIELDS	(C-2001) Grandfather Home for Children
Cassandra Sadler	Caston Lincoln Mental Health
Brandy Lane	G.L. M. H.
Bo Muehler	G.L. M. H.
Michael S. King	G.L. M. H.
Amy Jo Bain	Smith Anderson
Joseph W. Douglas	NCAD
Tom McMillan	More Van Allen
Adam Holtzman	DMH/BAISA

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE FOR HUMAN RESOURCES

MAY 27, 1998

Name of Committee

Date

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NAME

FIRM OR AGENCY AND ADDRESS

Luke Barber	CTPC
Lisa Antemaco	DHHS, BP+A
James Amiel	DHHS-DSS
JoAnn Lamm	DHHS-DSS
Lynne Ayres	DHHS-DSS
Adele Spitz Roth	DHHS, DMH/DD/SAS
Bob Lewis	Peterson
John Lail	DHHS Prop. & Construction
BILL SEARS	SHRW, INC., CARY, N.C.
Lee Kittledge	DHHS
DAVE ELLISON	DHHS
Rochyn Savitt	Lobbyist
Gregg Hanksley	N.C. Food Bank Association
AL DEITCH	DOA/YAID
Marian Hartman	DD Council

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE FOR HUMAN RESOURCES

MAY 27, 1998

Name of Committee

Date

AFTERNOON

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NAME

FIRM OR AGENCY AND ADDRESS

Mary Pat	NASW-NC
Harv Friel	NCACDSS
David Engram	Crossroads Behavioral Healthcare Glen/ Yadkin/ Fredell Counties
Dave Richard	The Pro/uc
Calvin H. Lewis	NCAEDSS/Burcombe DSS
LANA Dial	NC Admin Office of the Courts
Dale Burton	DHHS
Lee Kottreys	DHHS
Terry Stelle	DMHPPSAS
Lisa Abolomarcio	DHHS BR&A
Byron Harris	OSBM
Kevin Fitzgerald	NC DSS
Joanne Lumm	NC DSS
Paula A. Holy	Covenant w/ NC's Children
Michael Doyle	WC Child Advocacy

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE FOR HUMAN RESOURCES

MAY 27, 1998

Name of Committee

3212

AFTERNOON

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Patricia A. Gentry

APPCNE / SSC

Zach Seck

Speaker's Office

Issues Facing North Carolina's Child Welfare Services System

Fiscal Research Division

May 26, 1998

Attachment #1

*May 27, 1998
Kara Thompson-Bleake*

I. Structural Issues

A. State Supervision - County Administration

- **Inconsistency in Practice**
 - ➔ Lack of Consistent Reporting Requirements
 - ➔ Lack of Consistent Application of State Policies
 - ➔ Some Counties Are More Progressive Than Others
- **Disparities in Resources**
 - ➔ Many Counties Exceed/Supplement State Assistance Rates; Others Pay Less
 - ➔ Some Counties are Hampered by Ability to Pay (Wide Variations Exist)
 - ➔ Many Counties Consistently Dedicate Resources to CWS
- **Inherent Tensions Between State & County**
 - ➔ Perceptions of Micro-management
 - ➔ Local Demands Exceed Local Resources
 - ➔ Perceptions of State Being Too Removed from "Real System"

I. Structural Issues (continued)

B. Allocation of Resources

- Financial Incentives are Misplaced
 - ➔ Funding Methodologies Perpetuate Out-of-Home Placements
 - ➔ Seed Funding Policies Perpetuate Inequities
 - ➔ Pilot Program Policies Perpetuate Inequities
 - ➔ Little-to-No Rewards for Successes
- No Shared Vision Between Legislature, State & Counties
 - ➔ Little Financial Support
 - ➔ Child Protective Services Traditionally Dominated Funding

I. Structural Issues (*continued*)

C. Fragmentation of Human Services

- Lack of Coordination within DHHS
- Local Public Health, Area Mental Health, Social Services, Law Enforcement and Other Human Services Don't Consistently Coordinate Services for Children and Families
- Lack of a Well-Defined & Coordinated Multidisciplinary Approach to the Complex Issues in Child Welfare Cases

I. Structural Issues (*continued*)

D. N.C.'s System Still Based on Traditional Model

- All CPS Reports "Investigated"
- "Foster Care Drift" Remains a Problem
- Local DSS's Are Still Primary Service Provider
- Perceptions of DSS As "Adversary" Rather Than "Helper"
- DSS's Interventions Are Often Episodic

E. Disconnect with Law Enforcement & the Courts

- State Policy & Practice are Inconsistent
- Variations from County-to-County in Law Enforcement Involvement
- Backlog in Courts
- Assistance in Investigations Suffers

II. Inadequate Resources in the System

A. Lack of Statewide/Legislative Policy

- Who funds?

B. Disparities in County-by-County Funding

- Child Protective Services Expenditures (1993-94)
Ranged from \$343 - \$10,687/report
- Foster Care Expenditures (1993-94)
Ranged from \$434 -\$11,626/child
- Adoptions Expenditures (1993-94)
Ranged from \$503 -\$6,997/child

C. Lack of Comprehensive Services to Children & Families

- Inadequate Resources for Multiple Need Children and Families in Substantiated Cases of Abuse & Neglect (approximately 1/3 of all reports)
- Little-to-No Resources for 2/3 of Children and Families Investigated But Not Substantiated
- Local Human Service Resources Haven't Kept Pace With Service Needs

II. Inadequate System Resources (*continued*)

D. Court & Law Enforcement Priorities

- No Dedicated Resources for Child Welfare Cases
- Child Welfare Cases Aren't Always High on the Priority List

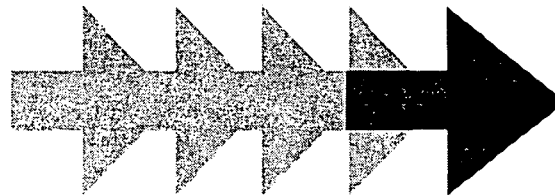
E. Inability to Attract and Retain Skilled Workforce

- No Standardized Educational Requirements for CWS Social Workers
- Low Wages
(Average Annual Salary Ranges from \$25,065 - \$43,766)
- Historically High Worker-to-Caseload Ratios
- High Turnover & Staff Burnout

III. Disproportionate Representation of African-American Children

A. Lack of Understanding of the "Problem"

- Poverty
- Substance Abuse
- Cultural Issues
- Domestic Violence
- Racial Bias



***Complex &
Complicated;
Multiple Need
Families***

III. Disproportionate Representation of African-American Children

B. Overrepresentation In Child Welfare System

- African-American Children Constitute Approximately 22% of N.C.'s 2.3 Million Children; Yet 57% of Children in DSS Custody/Placement Responsibility Are AA;
- AA Children Are More Likely to Enter the System at Younger Ages Than Others (*28% under the age of 1 year*);
- Approximately 60% of all N.C. Children in Foster Care Are African-American; and
- African-American Children Are at Higher Risk of Foster Care Drift

III. Disproportionate Representation of African-American Children

C. Lack of Services Provided to African-American Children and Families

- Average of 29% AA Children and Families Received Intensive Family Preservation Services Over the Last Four Fiscal Years (34% for FY96/97); However AA Children Constitute Approximately 52% of the Children in Custody/Placement Responsibility and 49% in Foster Care;
- In 1977, 70% of AA Children Received In-Home Services Compared to 37% in 1994 (*no corresponding decreases occurred for other groups*)

D. Lack of State & Legislative Policy for Addressing the Problem

What Does the Research Say?

"Decision-Making for Black Children in Placement in North Carolina"
published in 1989 by National Child Welfare Leadership Center, School
of Social Work, University of North Carolina at Chapel Hill found:

- Problems Named Most Frequently: living conditions
(e.g., insufficient income, inadequate housing) alcohol and delinquent behavior;
- 60% of Child Abuse & Neglect Cases Were Poverty Driven; and
- 78% of Local Social Workers Reported that Change was
"Unlikely-to-Not Possible" for AA Families in the CWS System

What Does the Research Say?

"National Study of Protective, Preventive and Reunification Services Delivered to Children and Their Families" published in 1994 by the (federal) Department of Health and Human Services, Administration for Children and Families found:

- Minority Children (in particular African American) Are More Likely to be in Foster Care Placement than Receive In-Home Services, Even When They Have the Same Problems and Characteristics as White Children; and
- In 1977 Minority and Non-Minority Children Were as Likely to be In Out-of-Home Placement

What Does the Research Say?

"Child Maltreatment in the African-American Community" published in *Advances in Applied Developmental Psychology* (1993) by M.N. Wilson and E.W. Saft found:

- Disparities in Actual Incidence or Severity of Abuse for African-American Children Are Not Explained by the Higher Reports of Substance Abuse; and
- Differences May Result From Cultural Differences Between African-American Families and Case Workers, Discriminatory Attitudes, or the Relative Lack of Family Support that Case Workers Perceive as Available to African-American Families.

What Does the Research Say?

National Study of Protective, Preventive and Reunification Services Delivered to Children and Their Families Published by the federal Department of Health and Human Services (1994) found:

- Findings Suggest that Different Races/Ethnicities Receive Differential Attention Somewhere during the Process of Referral, Investigation, and Service Allocation; and
- Differential Representation of Minorities Does Not Derive From Inherent Differences in the Rates at Which They Are Abuse or Neglected.

IV. Substance Abuse & Other System Challenges

A. Overwhelming Magnitude of the Problem

- Estimated 28% of N.C. Cases Involve Substance Abuse Problems
- Most Cases Involving Substance Abuse Result in Foster Care Placements of Longer Duration Than Others
- Estimated 2/3 of Young Foster Children Had Been Prenatally Exposed to Drugs and Alcohol (General Accounting Office, *"Parental Substance Abuse: Implications for Children, the Child Welfare System and Foster Care Outcomes,"* 1991)

B. Impacts on the Child Welfare System

- Emphasis on Expedited Termination of Parental Rights May Sometimes Conflict with the Realities of Recovery
- Complexity of Cases Puts Greater Strain on an Already Stressed System
- Child Welfare System Costs Continue to Rise

What Does the Research Say?

"Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children", (1994) the U.S. General Accounting Office reported:

- Alcohol and drug abuse are factors in the placement of more than **75%** of the children who enter care.

The National Committee to Prevent Child Abuse's 1995 Annual Fifty State Survey estimated:

- 10 Million Children in the U.S. are Being Raised by Addicted or Alcoholic Parents and at Least 675,000 Children are Seriously Maltreated Each Year by an Alcoholic or Drug-Abusing Caretaker.

IV. Substance Abuse & Other System Challenges *(continued)*

C. Other System Challenges

- Homelessness
- Domestic Violence
- Incarcerated Parents
- Mental Illness

V. System Accountability in Child Welfare Services

A. Lack of Statewide Policy

- Current Method for Assessing Accountability - Biennial Reviews
- State Promulgates Rules and Policy Without the Force of Law

B. Lack of Statewide Outcome Measures

- System is Still Largely "Process" Oriented
- System is Heavily Weighted Toward "Undesirable" Outcomes

C. Lack of Legislatively Directed Outcomes

- State Level Changes Are Underway
- Legislative Expectations Are Unclear

VI. Future Policy Issues In Child Welfare Services

A. Maintain Current System

B. Direct System Reform for N.C.

- Missouri Model
- Florida Model

C. Direct the State to Formally Develop and Implement Strategies Addressing the Overrepresentation of Minorities in the Child Welfare System



SEARS
HACKNEY
KEENER
WILLIAMS

INCORPORATED

ARCHITECTS

1142 EXECUTIVE CIRCLE • SUITE D
CARY, NORTH CAROLINA ZIP 27511
TEL 919/467-5703 FAX 919/467-2512

Attachment #2

*May 27, 1998
Jerry Steele +
William Sears*

April 10, 1998

N.C. Department of Health and Human Services
101 Blair Drive
Raleigh, North Carolina 27603

Attn: Mr. John Lail
Chief – Property and Construction

EXECUTIVE SUMMARY

Re: DHHS – Design Study
The Whitaker School Replacement Facility
Butner, North Carolina
Code 49740, Item 4701, ID# 4497404701A

Dear Mr. Lail:

In accordance with the Provisions of Section 11.47 in Senate Bill 352 and as directed by your office, we present herewith the recommendations and conclusions of our Design Study with respect to a suitable Replacement Facility for the Whitaker School, currently located in converted barracks buildings at John Umstead Hospital in Butner, North Carolina.

PREAMBLE

Whitaker School is an Adolescent Re-education Facility whose mission is "to serve the behaviorally and emotionally disturbed youth, needing secure residential care in the State of North Carolina by providing competent and compassionate behavioral health interventions; providing training to our youth, their families and communities across the State." With an existing bed capacity for twenty-four (24) residents and an average length of stay approximating two hundred sixty-four (264) days, Whitaker School can serve approximately seventy-two (72) children annually and has achieved an 80% success rate in returning functional children to their respective communities. Regional demand for additional intervention and treatment capability appears to be both significant and urgent.

Specific objectives of this Design Study included the development of a Detailed Program describing Minimum Facility Requirements for Whitaker School, the identification and evaluation of suitable Existing Facilities and/or sites for a Replacement Facility, the production of Schematic Drawings to illustrate Program Requirements and Replacement Facility options, the preparation of detailed Statements of Probable Cost setting forth budget requirements for selected options, and the presentation of conclusions and recommendations based upon information gathered during the Design Study process.

In order to provide valid cost comparisons between the renovation option and replacement options, the program and size of the existing Whitaker School (adjusted to correct existing space deficiencies) was presumed to be the Basic Program for a replacement facility. The notable deficiency of this Basic Program presumption is a Center Court/Multi-Purpose Unit which could serve multiple functions of indoor recreation during inclement weather, community outreach programs, and staff training facilities. Expanded Facility recommendations include a Center Court/Multi-Purpose Unit (considered mandatory for an expanded juvenile population), thus accounting for a larger unit cost per juvenile than the Basic Program.

The material contained in this Report is based upon the able assistance of Dr. Joseph G. Murphy, Ph.D., and his staff in providing resource material (see attached Appendix "A") and defining Minimum Facility Requirements, multiple reviews of program content and facility standards by the Whitaker School Human Rights Committee, the identification of available facilities and/or sites by the State Property Office, and the co-ordination efforts of Ms. Pam Massey, Property Officer for the Dept. of Health and Human Services, in obtaining required data in a timely fashion.

OBSERVATIONS

It is our opinion that approximately 34,000 square feet of gross floor area will be required in order to address existing deficiencies and to replace the existing Whitaker School Facilities Program. The Existing Program can accommodate from twenty-four (24) to thirty-three (33) juveniles in residence. Current waiting lists from the four regions served by Whitaker School and trends toward more violent behavior within public school systems strongly suggests the need for an expanded Whitaker School Facility containing approximately 51,000 square feet of gross floor area and one which could accommodate from thirty-two (32) to forty-four (44) juveniles in residence.

No existing structures are available for renovation within the geographic boundaries defining a suitable location except for facilities at the John Umstead Hospital in Butner currently occupied by the Whitaker School. Available sites for New Replacement Facilities are limited to the site of the Central School for the Deaf in Guilford County, the site of the Carolina Living and Learning Center for Autistic Adults in Chatham County, and existing undeveloped property at Butner in Granville County.

Since the opportunity exists for either building a new replacement facility or renovating an existing facility, Schematic Drawings illustrating Proposed Program solutions have been prepared for both options. In the case of a new Replacement Facility, Schematic Drawings have been prepared for each component of the Basic Program Requirements (Facilities to accommodate from 24 juveniles to 33 juveniles) as well as components required for an Expanded Program (Facilities to accommodate from 32 juveniles to 44 juveniles), thus illustrating one of the obvious advantages of constructing a New Facility.

Existing Facilities if renovated, can only accommodate Minimum Program Requirements, and must be expanded by approximately 3,800 square feet of new gross floor area in addition to the renovation of approximately 29,800 square feet of existing floor area. Because of the condition of existing facilities, both the current Whitaker School occupants on the floor to be renovated and the BATC Willie M Program and the Umstead Detention Center on the floor above must be vacated during the renovations process. At least sixteen (16) months is estimated for the duration of renovations.

The anticipated cost of a New Replacement Facility meeting the Basic Program Requirements is \$ 4,910,435.00. Based upon a Minimum Program requirement of 34,285 square feet with a maximum accommodation of thirty-three (33) juveniles, the cost per square foot of New Construction = \$ 143.22 and the cost per juvenile = \$ 148,801.06.

If the Basic Program Requirement is expanded by one third, then the anticipated cost of a New Replacement Facility will increase to \$ 7,004,200.00. Based upon a Minimum Program Requirement of 50,764.00 square feet of gross floor area with a maximum accommodation of forty-four (44) juveniles, the cost per square foot of new construction = \$ 137.98 and the cost per juvenile = \$ 159,186.36. The primary difference in facility cost per juvenile between the Basic Program and the Expanded Program is the cost of a Center Court/Multi-Purpose Unit. Significant efficiencies in an expanded facility are expected to be in the area of staffing and central plant operating costs.

Alternatively, the anticipated cost of Renovating Existing Facilities to meet Basic Program Requirements is \$ 4,154,822.00. In addition to the direct cost of renovations noted above, the Owner should consider the impact of costs associated with relocating the Whitaker School, the BATC Willie M Program and the Umstead Detention Center while renovations are in progress. **These Indirect costs when combined with the actual costs of renovations are expected to exceed the cost of a New Replacement Facility.** Based upon a Minimum Program Requirement of 33,630 square feet of gross floor area with a maximum accommodation of thirty-three juveniles, the direct cost per square foot of renovated space = \$ 123.55 and the direct cost per juvenile = \$ 125,903.70.

CONCLUSIONS

The Facilities currently occupied by Whitaker School do not meet either State or National accessibility standards and are in desperate need of major renovation, regardless of the conclusions reached from this study. Existing mechanical systems (plumbing and HVAC systems) are of the age and condition that system failure should be considered imminent. Asbestos exposed on ceilings, in floor finishes, and concealed in pipe chases poses an indeterminate hazard to building occupants and is a deterrent to normal building maintenance. Existing building security/detention capabilities are illegal as defined by the State Building Code (ref. Section 1012.6 - Special Locking Arrangements) and life threatening to building occupants in the event of an emergency. Notable deficiencies exist in classroom/instructional space, dormitory space, and administrative support space. Approximately 3,800 square feet of new construction will be required to correct these existing deficiencies.

Given the site options available to us and taking into consideration the direct costs of renovating existing facilities (estimated at \$ 4,154,822.00) plus the indeterminate but substantial cost of relocating the Whitaker School, the BATC Willie M Program, and the Umstead Detention Center while renovations are in progress, it is our opinion that new facilities can be constructed more economically and with less disruption than can existing facilities be renovated. It is also our opinion that new facilities afford the opportunity for expansion, either now or in the future, whereas existing facilities afford no reasonable expansion opportunity.

If no action is taken with respect to this study, then the Owner should be prepared to immediately spend at least \$ 2,600,000.00 in direct cost plus the indeterminate cost of relocating occupants at the existing Whitaker School in order to correct significant life safety deficiencies and accumulated deferred maintenance problems.

Of the available sites for new construction, all three sites meet the criteria for a Whitaker School Replacement Facility. The preferred site is the site of the Carolina Living and Learning Center for Autistic Adults in Chatham County because of its proximity to the resources of the University of North Carolina, its proximity to a major trauma center, and its central location within the boundaries defining a suitable location.

PERSPECTIVE

A Re-Education Facility is by definition a detention facility, a dormitory, a psychiatric treatment center, and a school. Elements of each of these specialized facilities are included in the program of the composite facility known as Whitaker School. With estimated costs ranging from \$ 4,910,435.00 for the simultaneous treatment of thirty-three (33) resident juveniles to \$ 7,004,200.00 for the simultaneous treatment of forty-four (44) resident juveniles, the total capital cost per bed for Whitaker School is expected to range from \$ 148,801.06 to \$ 159,186.36.

Page 5 - April 10, 1998
Mr. John Lail
Whitaker School Design Study

By comparison, the average cost per bed for detention facilities ranges from \$ 23,500.00 to \$ 38,700.00, the average cost per bed for dormitories ranges from \$ 31,900.00 to \$ 68,400.00, the average cost per bed for hospitals ranges from \$ 93,300.00 to \$ 135,400.00, and the average cost per student for educational facilities ranges from \$ 10,800.00 to \$ 16,100.00. The average capital cost per bed of these combined facilities ranges from \$ 159,500.00 to \$ 258,600.00.

Trusting that the information contained herein is as you have requested, we remain

Sincerely,



William W. Sears, AIA
Sears, Hackney, Keener & Williams, Inc.

Enclosures: Program Statements
Site Location/Evaluation
Schematic Drawings (Reduced)
Statements of Probable Cost
Appendix "A" : Program Resources

Attached: Schematic Drawings (to Scale)

cc: Dr. Joseph G. Murphy, Ph.D.
Mr. David Bullock
File

5/27/98
Karen Hammock-Bloch
additional handouts

ASSURING SAFE, PERMANENT HOMES FOR CHILDREN

SYSTEM OBJECTIVES

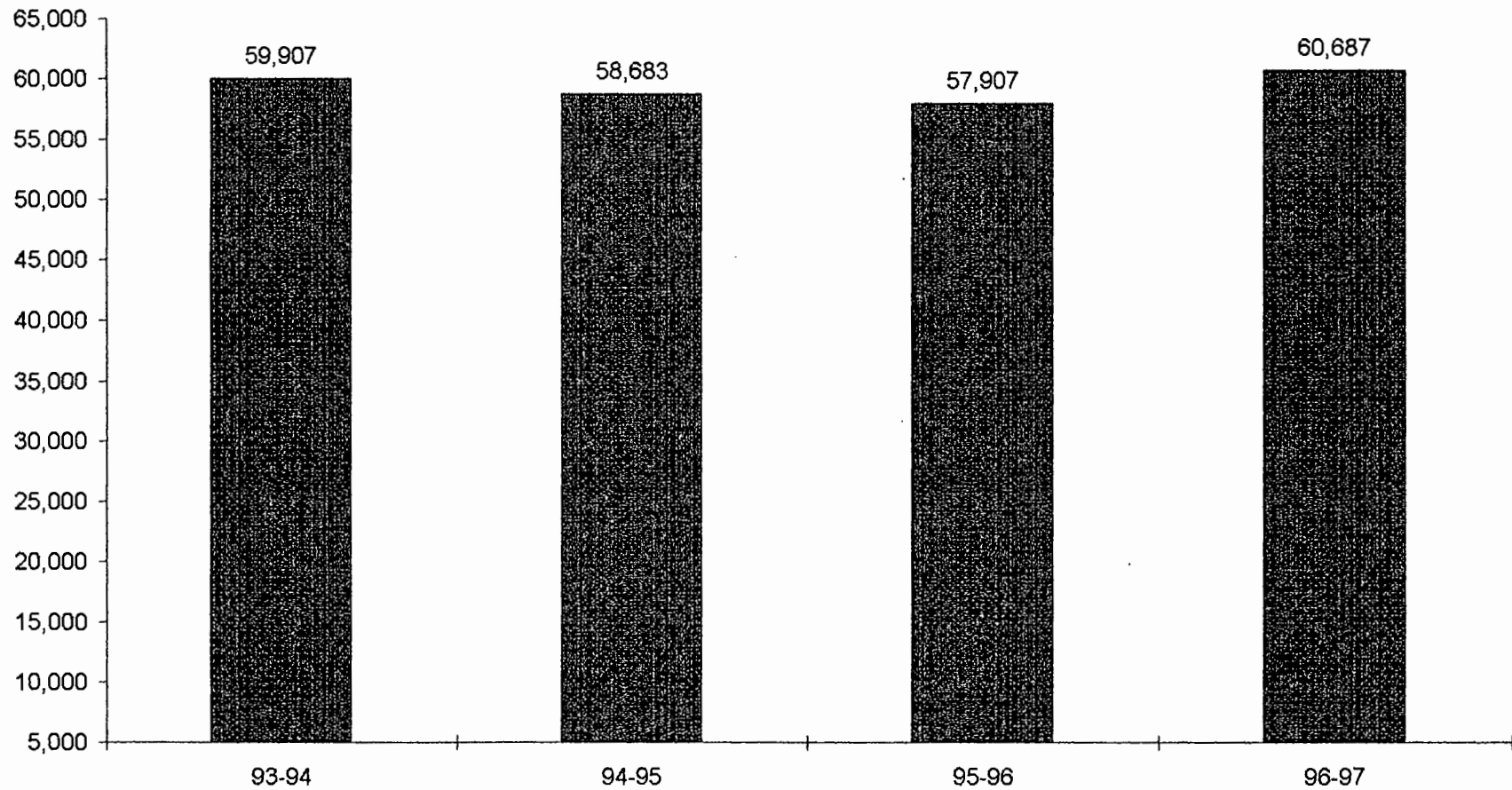
- SB 896 IMPLEMENTED: COMMON FOCUS ON SAFETY AND PERMANENCE
- SB 941 IMPLEMENTED
- COUNTIES MEET STAFFING STANDARDS
- WORKERS TRAINED TO DO THEIR JOBS
- LOCAL COMMUNITY CHILD PROTECTION TEAMS INTEGRAL TO PROTECTING CHILDREN
- FOSTER CARE AND ADOPTION PERFORMANCE IMPROVED
- LIABILITY COVERAGE FOR WORKERS PROVIDED
- STATE REVIEWS OF CHILD FATALITIES CONDUCTED
- INTENSIVE STATE SUPPORT FOR POOR PERFORMING COUNTY CHILD WELFARE PROGRAMS IN PLACE

ASSURING SAFE, PERMANENT HOMES FOR CHILDREN

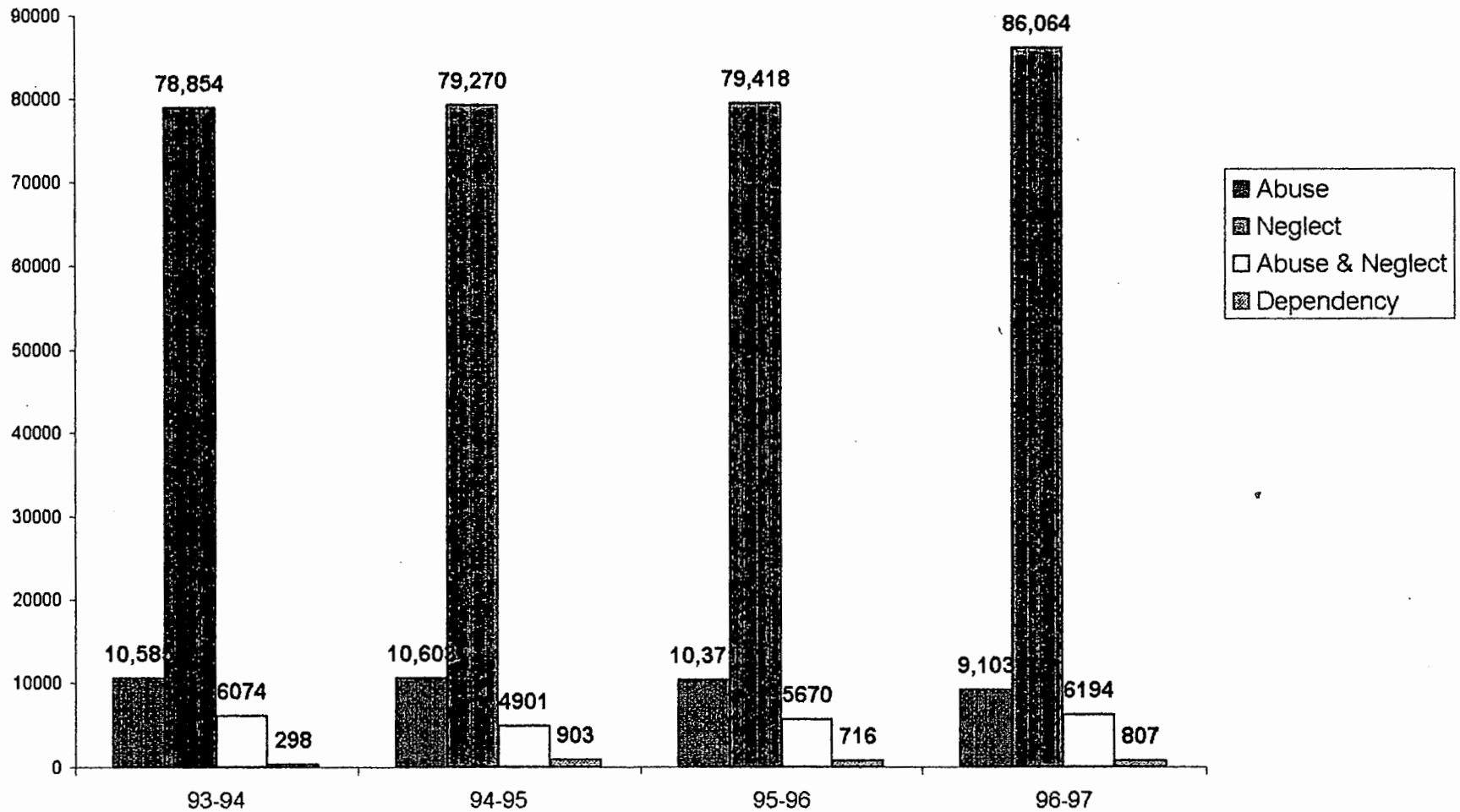
SYSTEM ISSUES

- IMPLEMENT FEDERAL ADOPTION AND SAFE FAMILIES ACT
- STAFFING AND TRAINING CAPACITY MEETS CHANGING CASELOADS
- IMPROVE WORKING RELATIONSHIPS WITH MEDICAL, EDUCATION AND LAW ENFORCEMENT SYSTEMS
- EFFECTIVE PREVENTION MEASURES IN PLACE
- PROVIDE EFFECTIVE TREATMENT FOR SUBSTANCE ABUSE, SEXUAL ABUSE AND DOMESTIC VIOLENCE
- DEVELOP BETTER STRATEGY FOR WORKING WITH CHILDREN AND FAMILIES OF ALL RACES

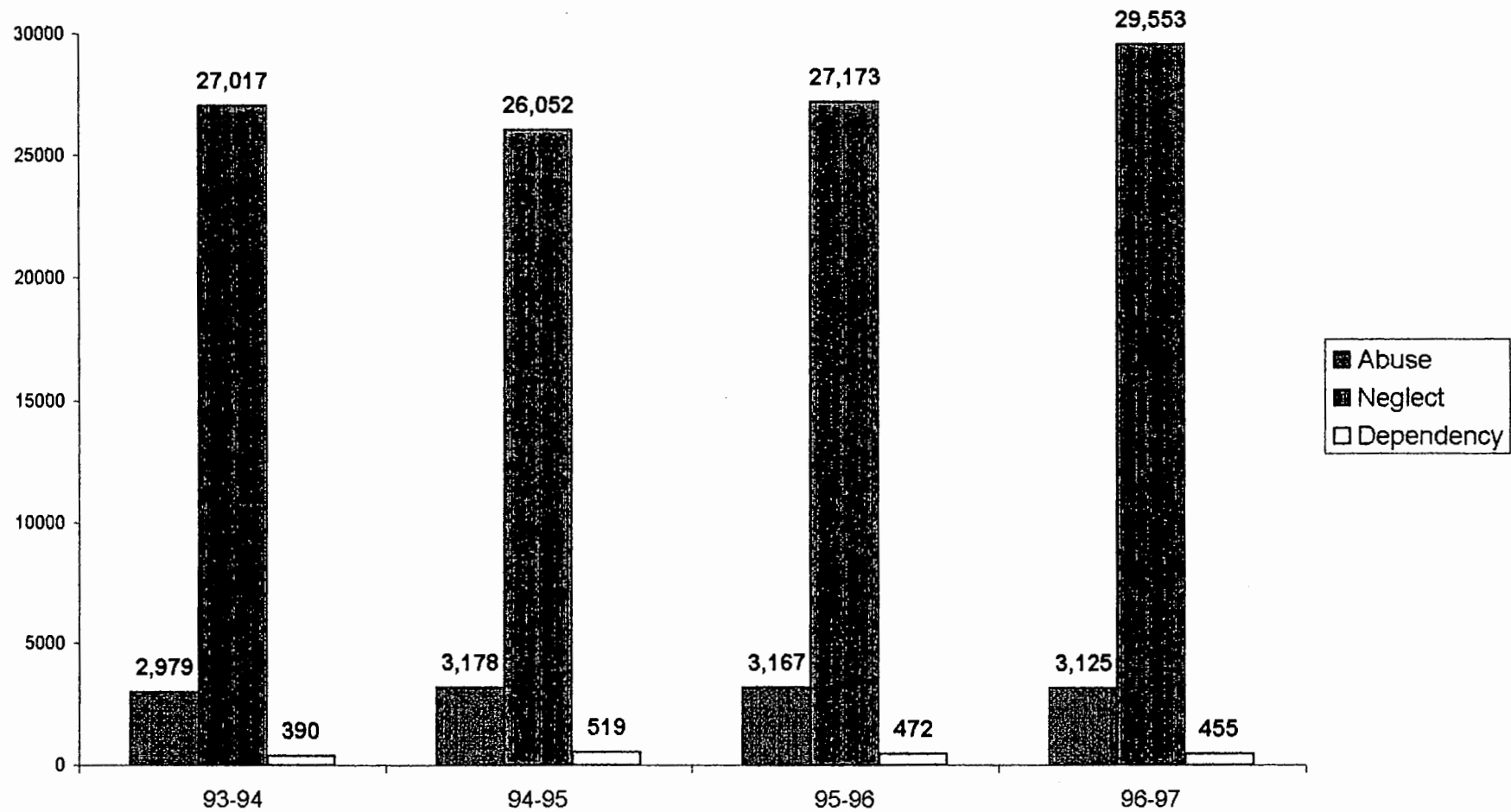
Reports of Child Abuse, Neglect, Dependency



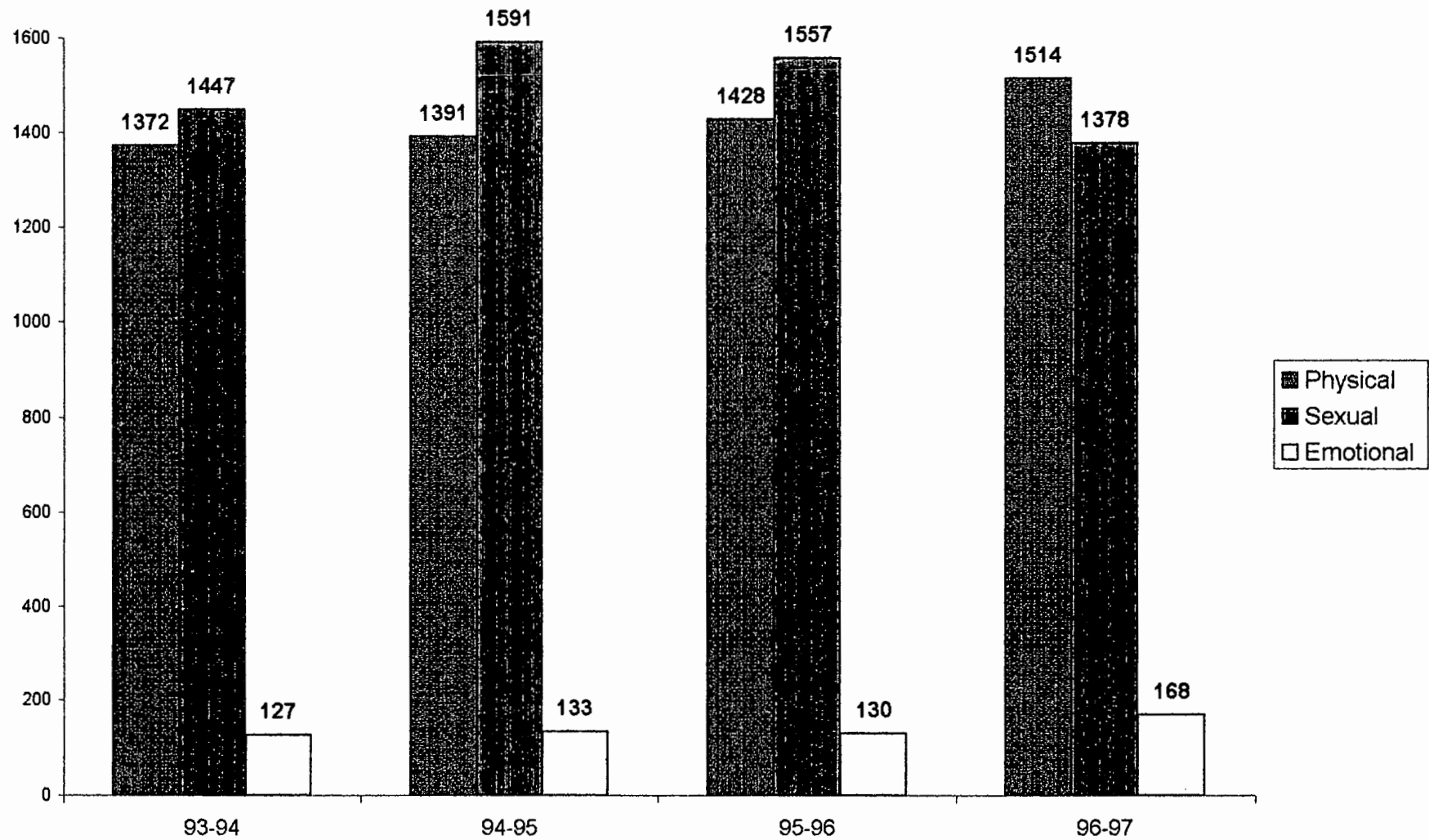
Children Reported For Abuse, Neglect, Dependency



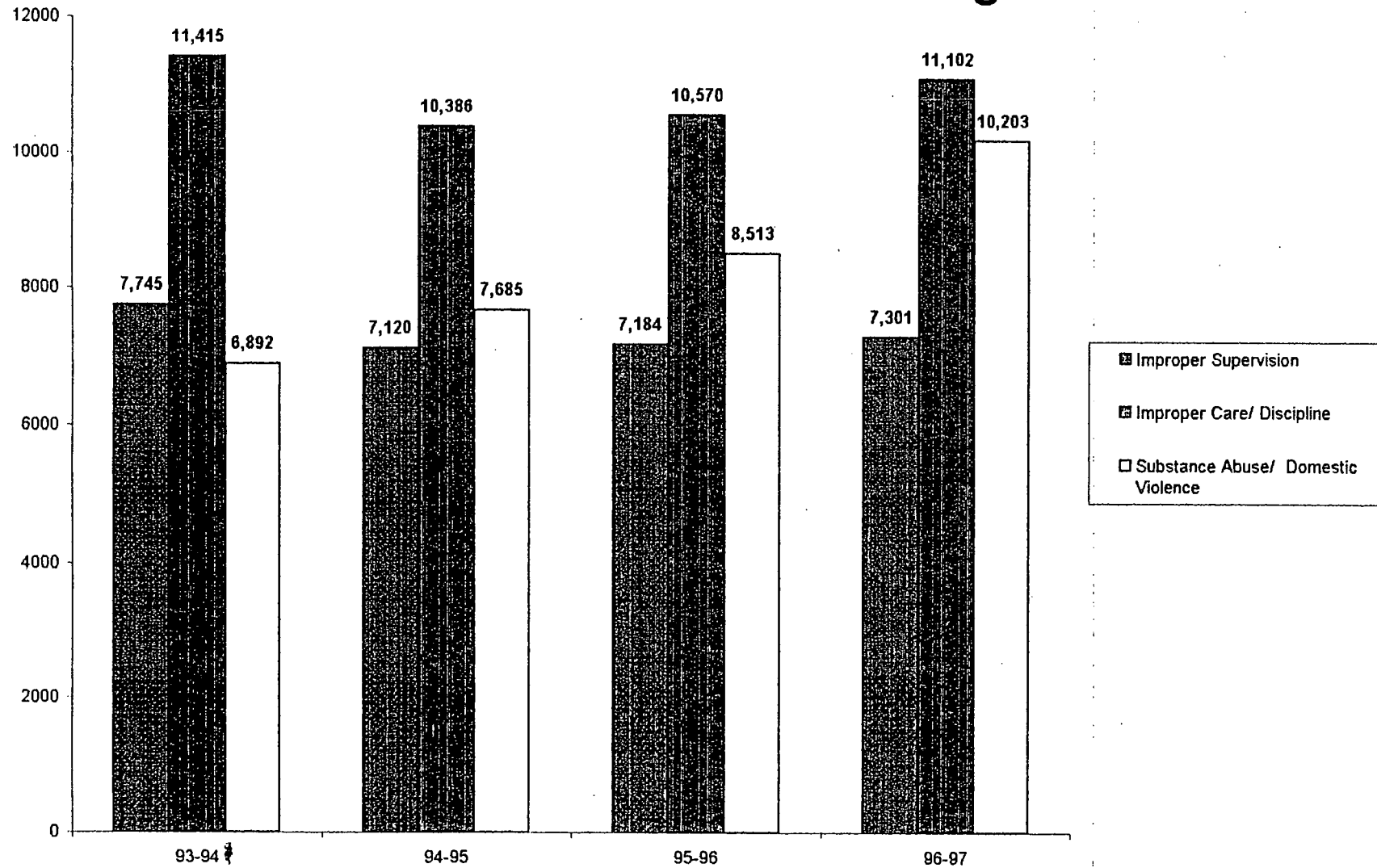
Children Substantiated for Abuse, Neglect, Dependency



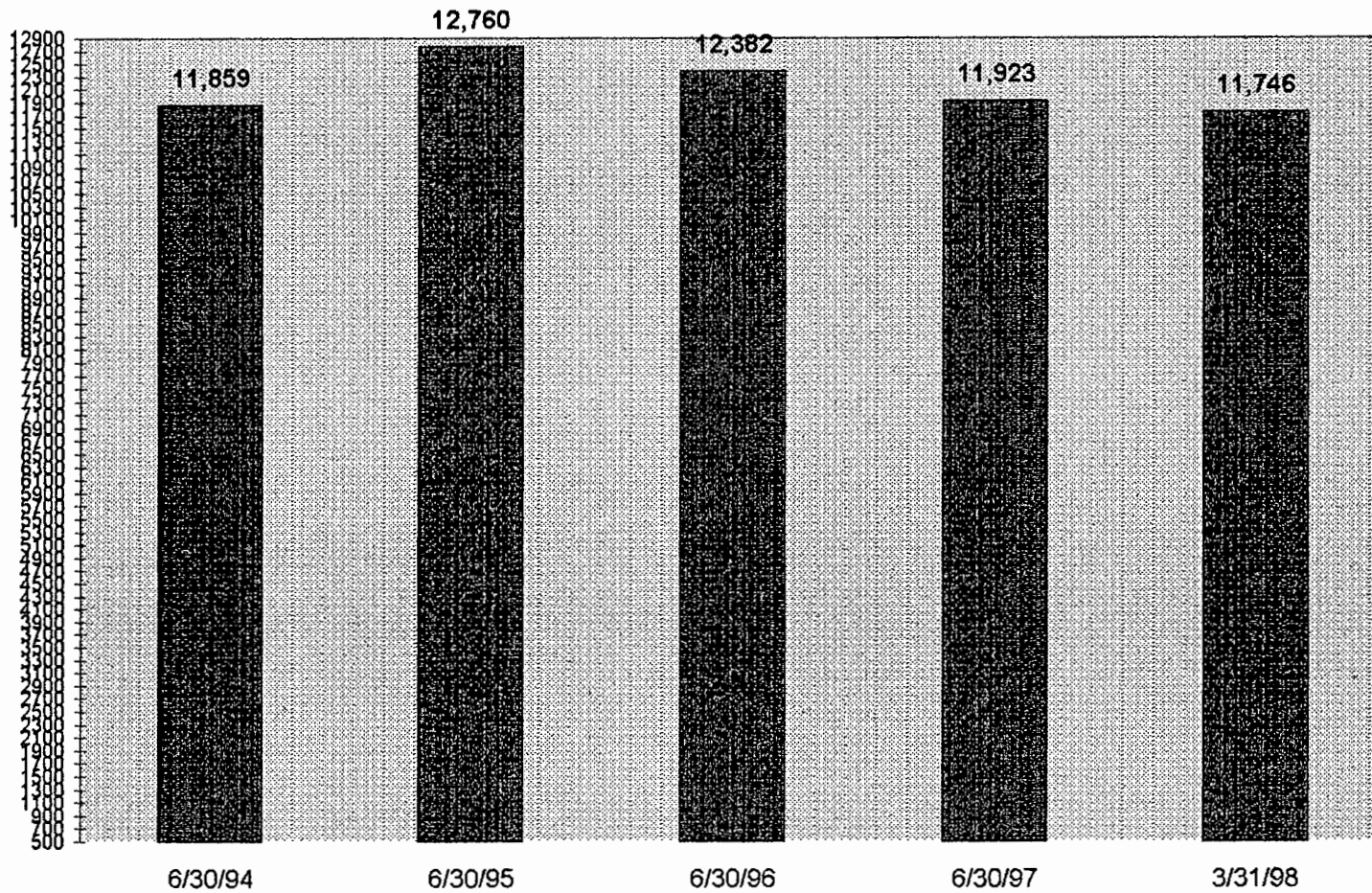
Children Substantiated for Abuse



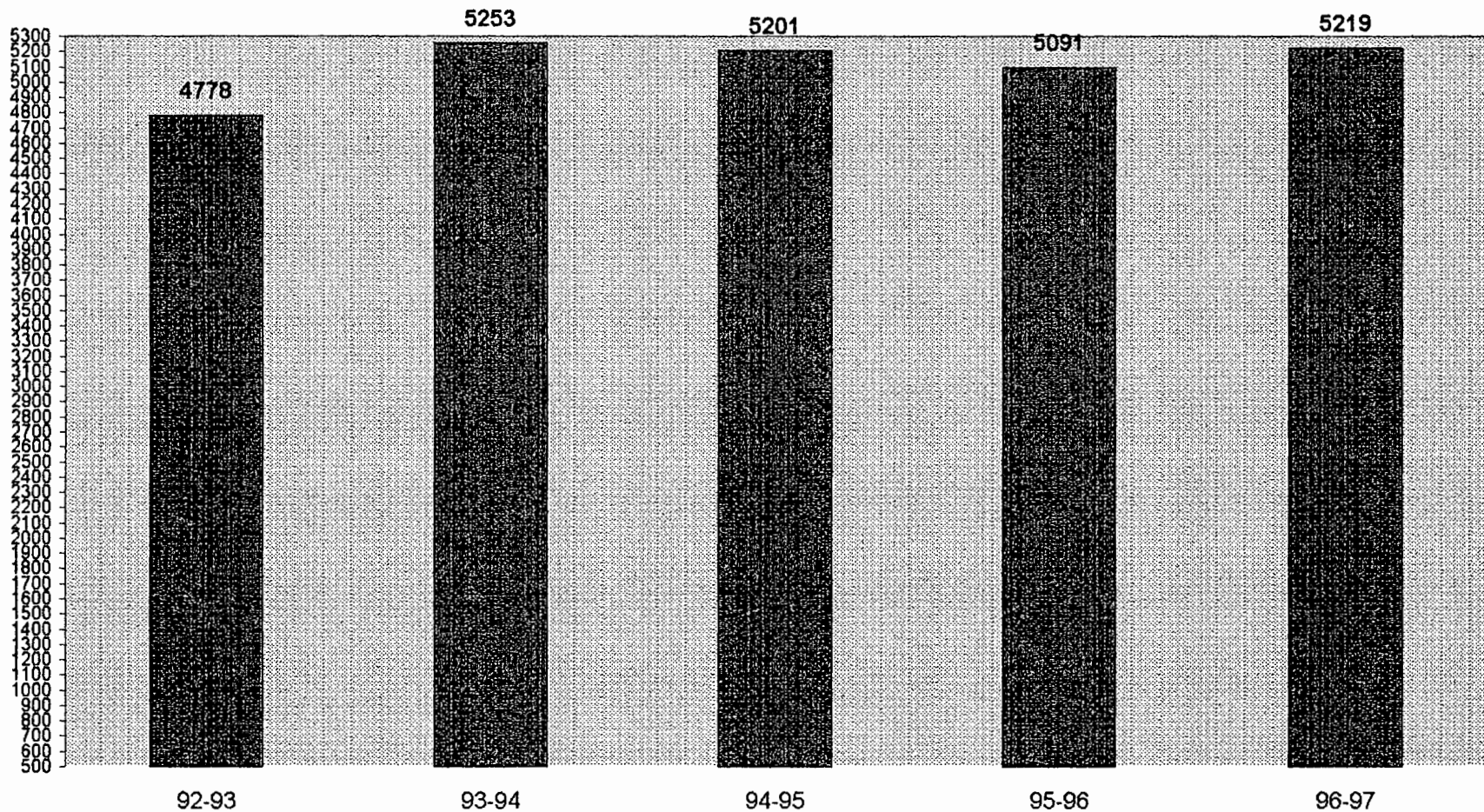
Children Substantiated for Neglect



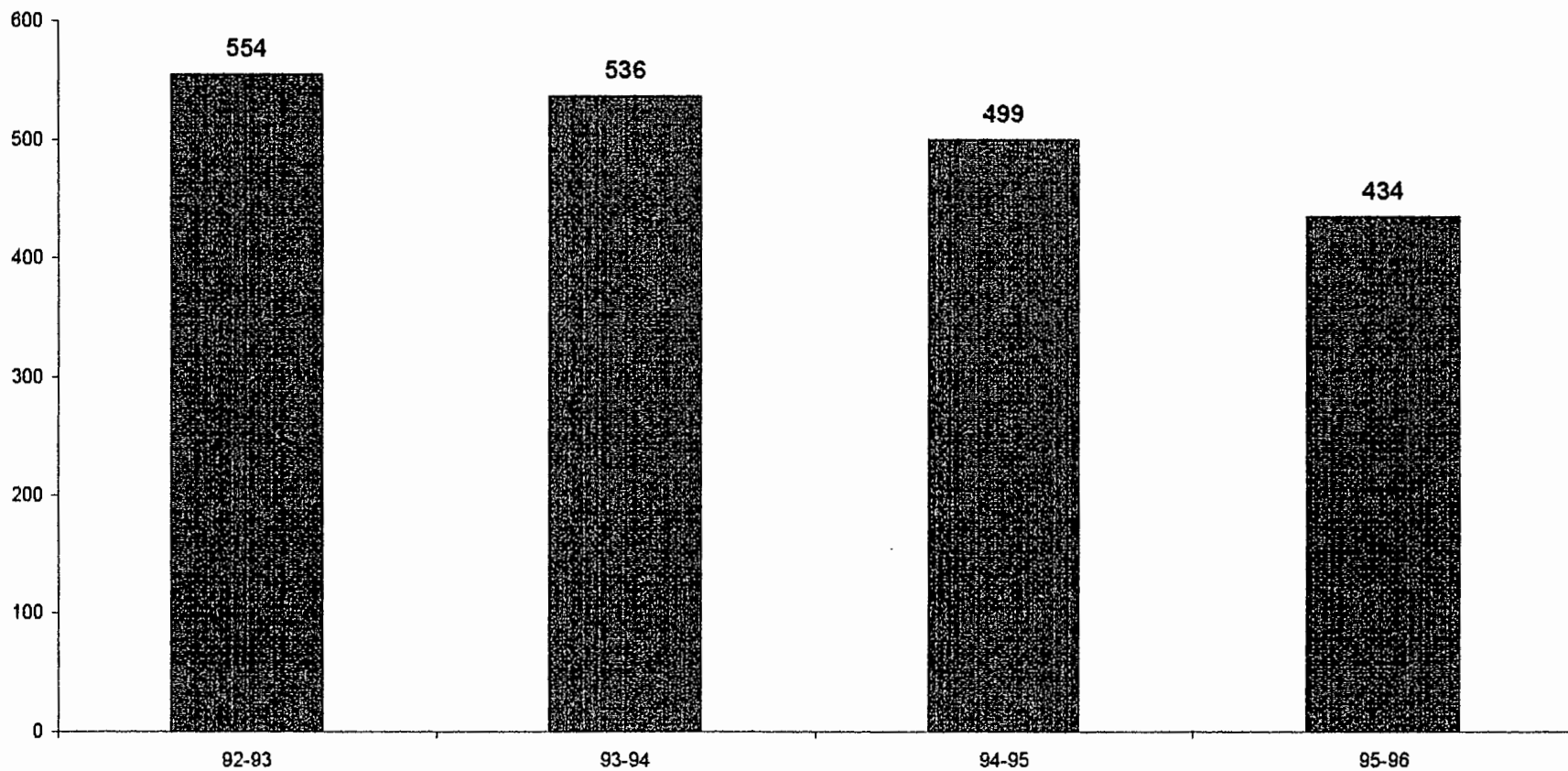
Children in DSS Custody/Placement Responsibility



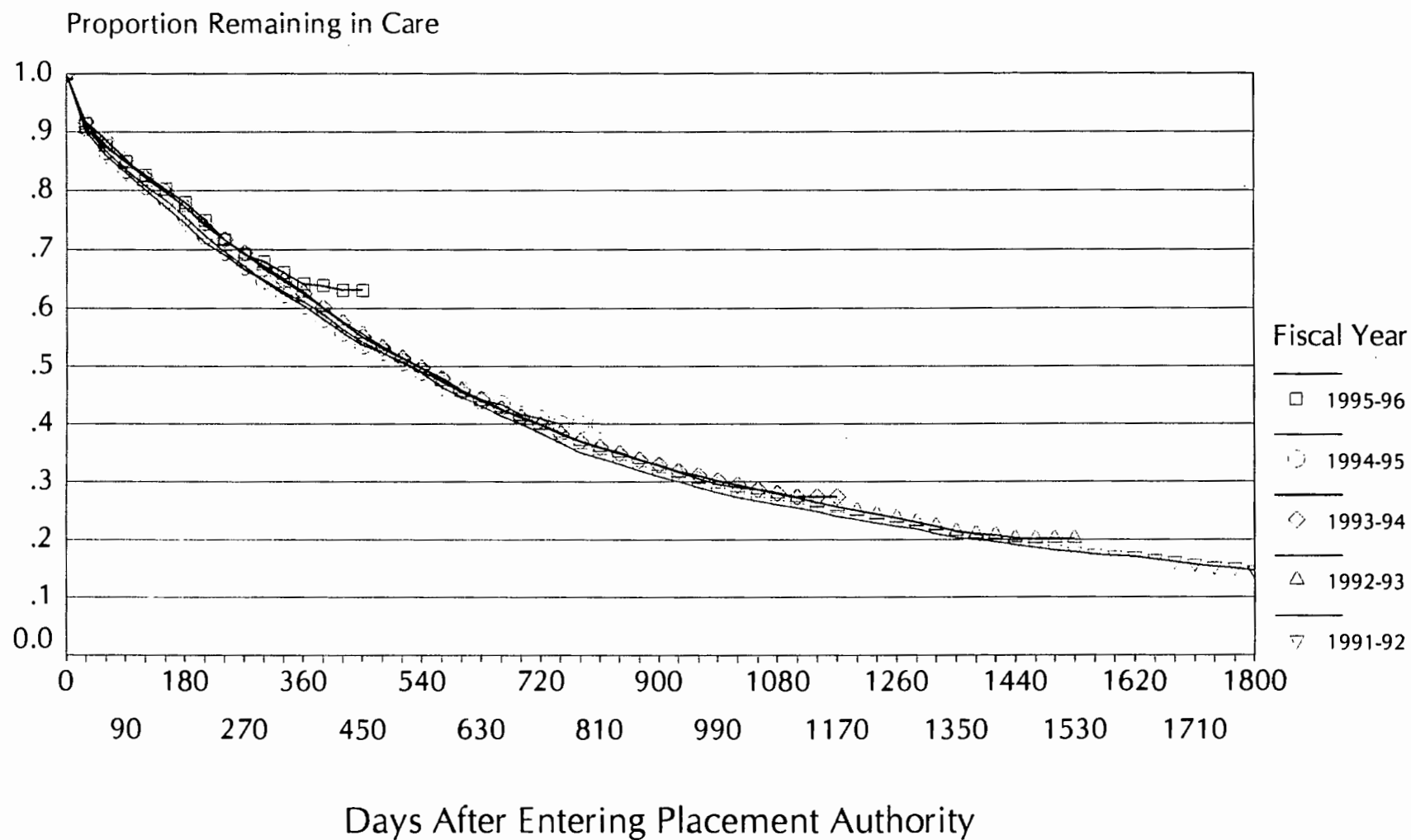
Children Entering DSS Custody/Placement Responsibility for First Time



Median Length of Stay (Days) in DSS Custody/Placement Responsibility by Entry Cohort



Duration of First Spell in Placement Authority



**NUMBER OF CHILDREN IN LEGAL
CUSTODY MORE THAN TWELVE
MONTHS AT END OF YEAR**

1993 7,999

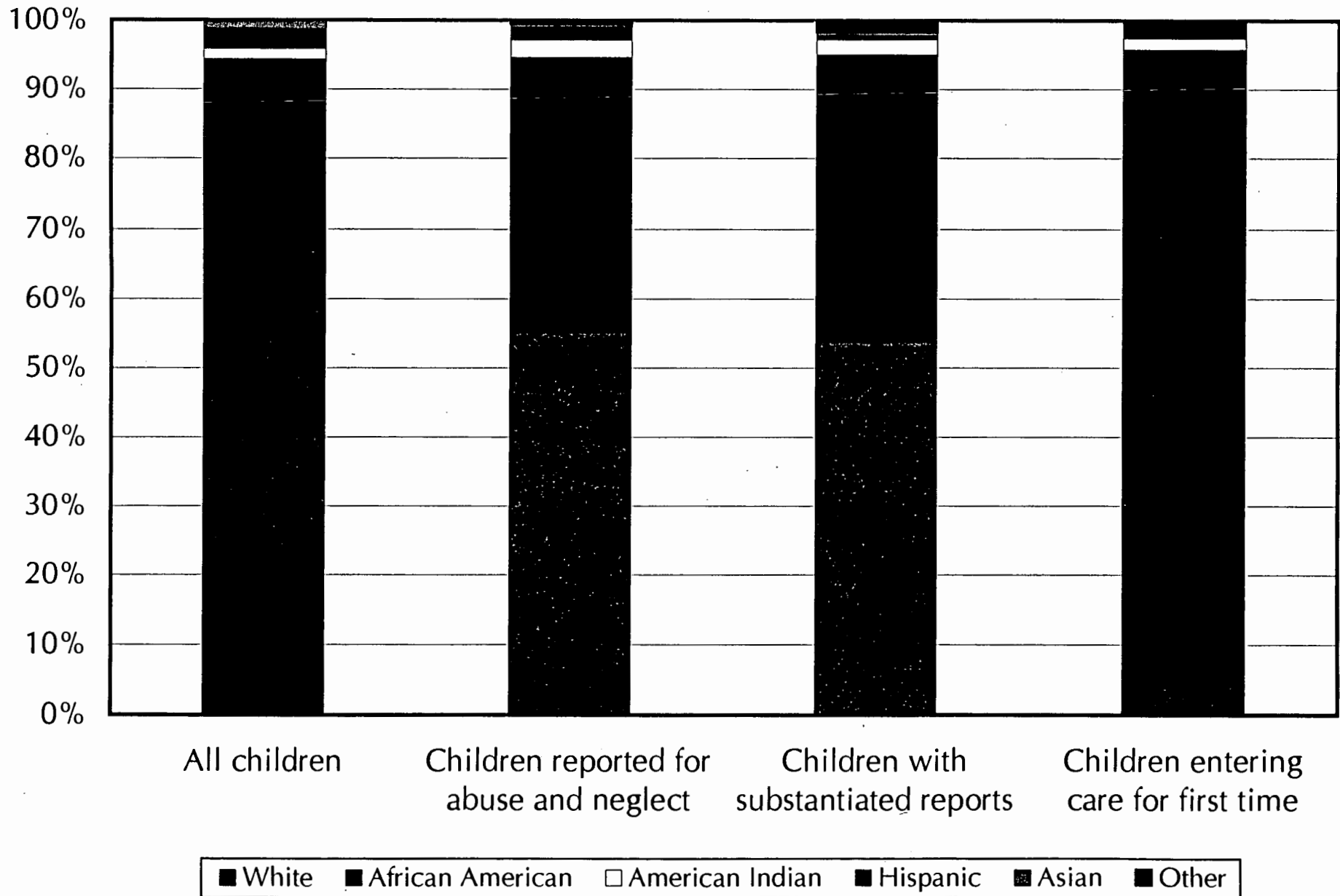
1994 8,439

1995 9,231

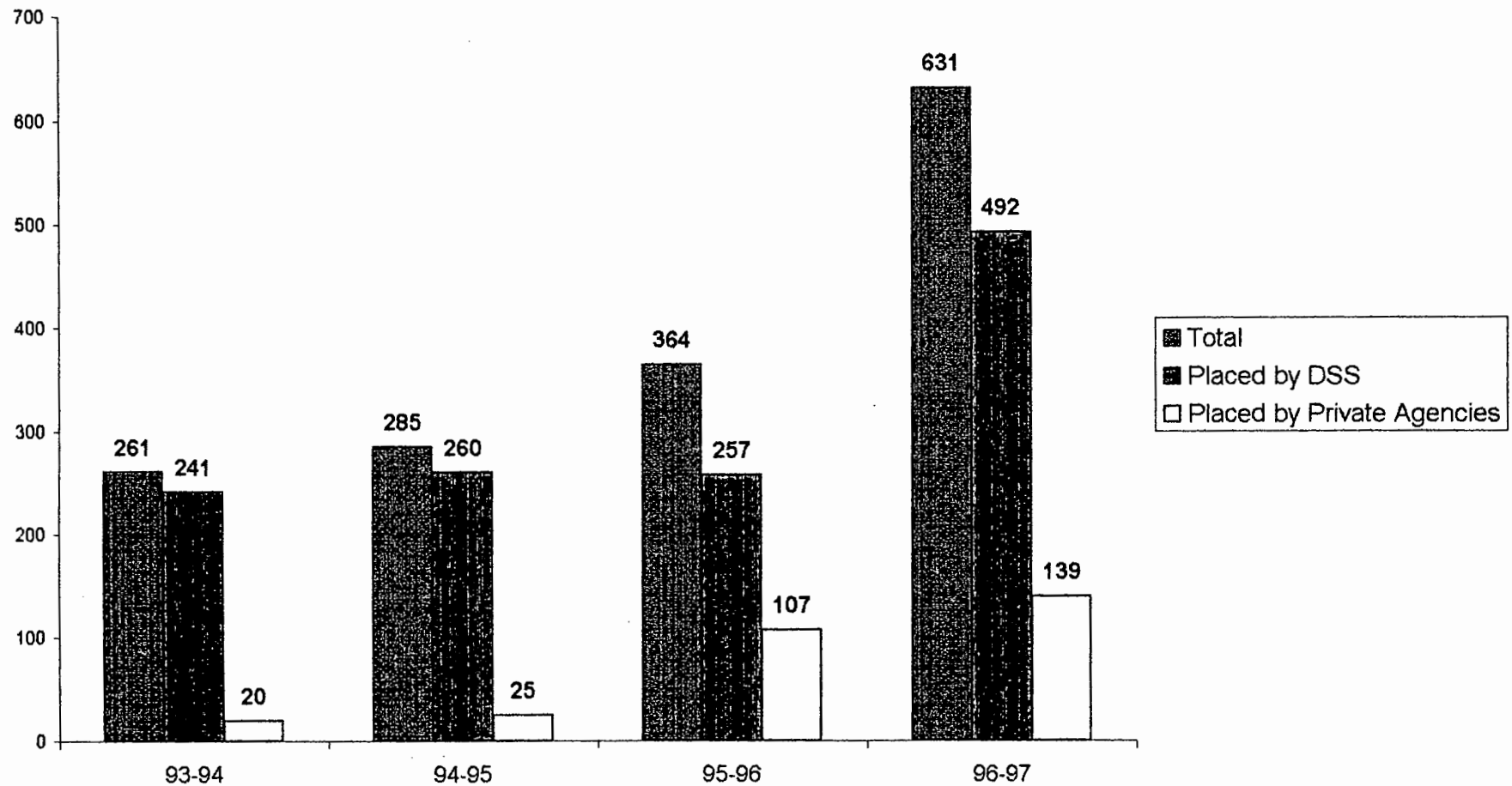
1996 8,702

1997 8,196

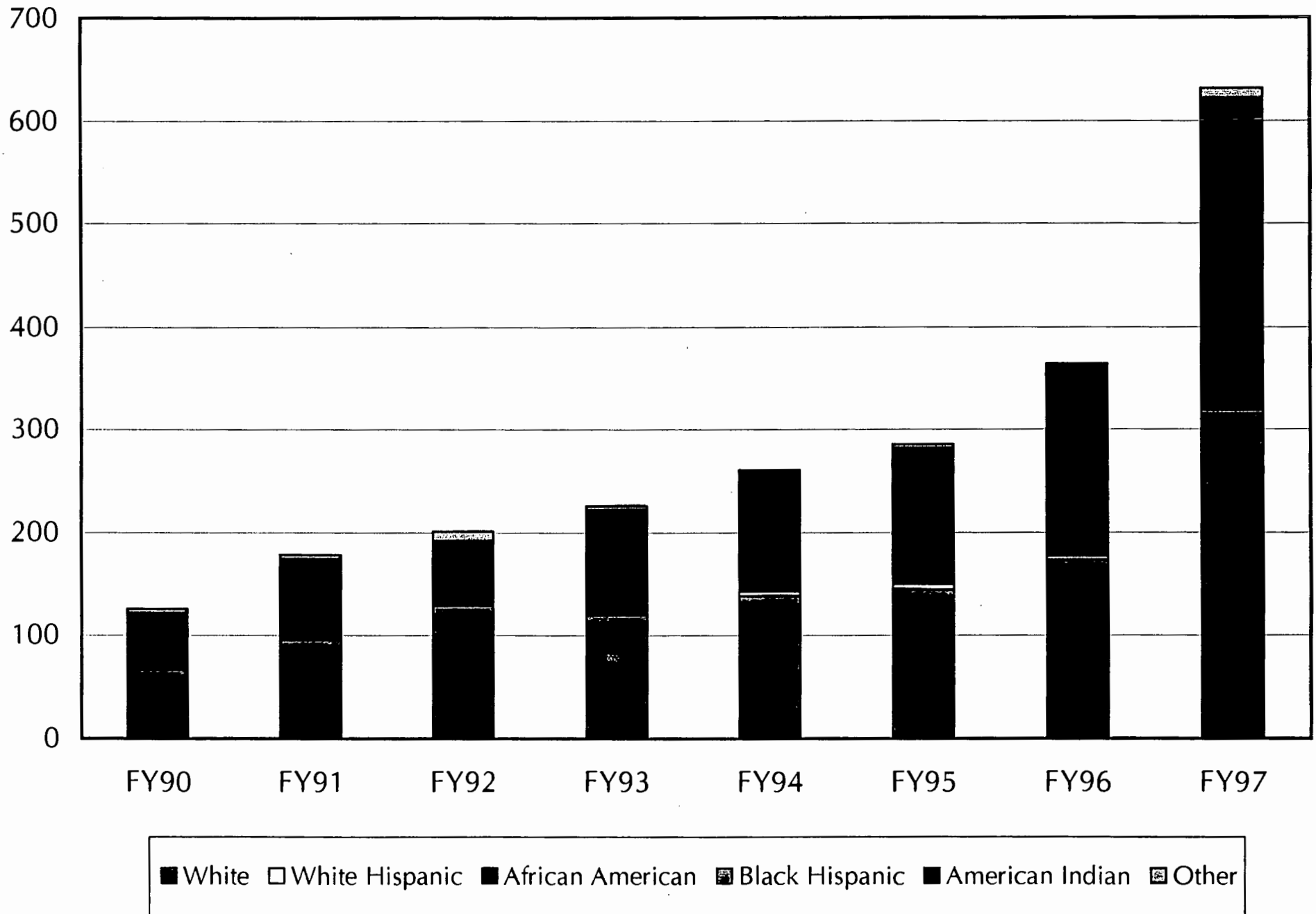
Racial and Ethnic Patterns in Child Abuse Reports and Entries to Out-of-Home Care



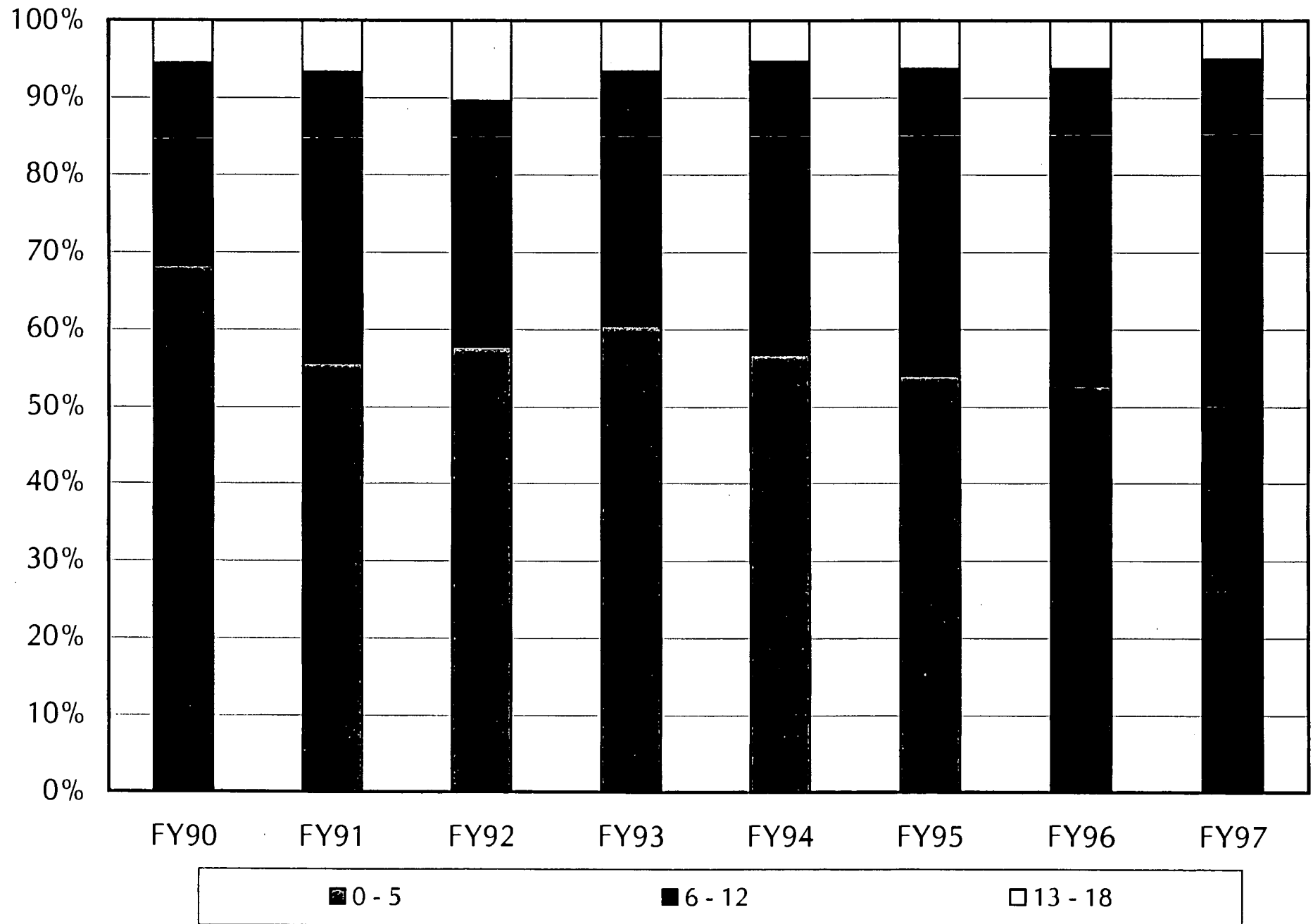
Children Exiting Foster Care Due to Final Decree of Adoption



Exits From Child Welfare Through Adoption, by Race



Age of Children Exiting Through Adoption



SUMMARY OF MAJOR TRENDS AND IMPLICATIONS

Trend: Recent increase in number of reports of child abuse and neglect. 12th highest rate of child victims per 1,000 child population among the states.

Implication: Need to resolve staff recruitment and support issues to ensure responsiveness. Need to expand prevention efforts to every county.

Trend: Increase in number of maltreated children due primarily to increase in neglect resulting from substance abuse and domestic violence. Sexual abuse is as prevalent as physical abuse.

Implication: Need for effective treatment programs dealing with sexual abuse, substance abuse, and family violence. Need to examine role of law enforcement in investigations of sexual abuse and severe physical abuse.

Trend: Recent decrease in number of children in foster care, rate of initial entry, and median length of stay. Disproportionate representation by children of color still problematic.

Implication: Need for more effective approach to addressing issues of child neglect that arise from chronic family poverty. Need to demonstrate potential effect of "assisted guardianship". Need for more cultural awareness and sensitivity across all elements of the child welfare system.

Trend: Significant increase in the number of children exiting foster care through Final decree of Adoption. Problematic delays in terminating parental rights so children are "legally free" to be adopted.

Implication: Need to strengthen legal assistance for DSS agencies. Need to strengthen capacity for recruiting, training, and supporting foster and adoptive families.

*5/27/98
Karen Hammond-Blanks
Additional Handout*

**DEPARTMENT OF HEALTH & HUMAN
SERVICES**

**DIVISION OF MEDICAL
ASSISTANCE
1998-99 BUDGET**

**FISCAL RESEARCH DIVISION
MAY 1998**

DIVISION OF MEDICAL ASSISTANCE

1997-99 TOTAL CONTINUATION BUDGET

<u>Description</u>	<u>1995-96 Actual</u>	<u>1996-97 Actual</u>	<u>1997-98 Projected</u>	<u>1998-99 Recommended</u>
Total Requirements	\$4,117,852,544	\$4,640,421,917	\$4,831,482,467	\$4,609,192,045
Total Estimated Receipts	<u>(\$3,077,645,486)</u>	<u>(\$3,489,963,641)</u>	<u>(\$3,706,505,848)</u>	<u>(\$3,263,866,129)</u>
Net Appropriation	\$1,040,207,058	\$1,150,458,276	\$1,124,976,619	\$1,345,325,916

DIVISION OF MEDICAL ASSISTANCE

1997-99 CONTINUATION BUDGET

MEDICAL ASSISTANCE PAYMENTS (Fund 1310)

<u>Description</u>	1995-96 <u>Actual</u>	1996-97 <u>Actual</u>	1997-98 <u>Projected</u>	1998-99 <u>Recommended</u>
Total Requirements	\$3,549,309,274	\$3,910,496,650	\$4,075,932,999	\$4,484,054,049
Total Estimated Receipts	<u>(\$2,692,614,430)</u>	<u>(\$2,947,211,346)</u>	<u>(\$3,042,870,135)</u>	<u>(\$3,164,378,937)</u>
Net Appropriation	\$856,694,844	\$963,285,304	\$1,033,062,864	\$1,319,675,112

The Medical Assistance Payment Fund budgets the payments to the providers of medical and other services for Medicaid recipients. Payments to providers represent 98% of the total budget for the Division of Medical Assistance.

MEDICAL ASSISTANCE PAYMENTS

1997-98 Authorized Budget vs. Estimated Expenditures

Source of Funds (In Millions)	1997-98 Authorized Budget	1997-98 Estimated Expenditures	Difference
Federal	\$2,712.3	\$2,639.2	(\$73.1)
State	\$1,252.5	\$1,213.5	(\$39.0)
County	\$230.3	\$223.2	(\$7.1)
Total	\$4,195.1	\$4,075.9	(\$119.2)

MEDICAL ASSISTANCE PAYMENTS

Source of Reductions

- Lower Utilization
- Medicaid Growth Reduction Measures
 - No Inflation for Hospitals for 1997-98
 - Lower Nursing Facility Inflation Rates for 1997-98
 - Other Rate Adjustments for Physicians, Home Health, Personal Care Services, and Non-State ICF-MR.
 - Managed Care

MEDICAL ASSISTANCE PAYMENTS

Proposed Budget Increases (In Millions)

GROWTH FACTOR	Total 1999-98	GF 1998-99
Inflation	\$189.5	\$58.1
Utilization	\$97.5	\$29.9
Intensity	\$121.1	\$43.7
Total	\$408.1	\$131.7

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
FINANCIAL OPERATIONS
1997-99 BIENNIAL BUDGET PROJECTIONS

PROJECTED INFLATION RATES

ACCOUNT	CATEGORY OF SERVICE	SFY 1997-98 4/10/97 INFLATION RATES	SFY 1998-99 PROJECTED INFLATION RATES	SFY 1998-99 ADJUSTED INFLATION RATES
536140	PART B BUY-IN NON CASH	5.32%	10.70%	5.32%
536141	PART B BUY-IN CAT NEEDY	5.32%	10.70%	5.32%
536173	PART A MEDICARE SUB-TOTAL	9.61%	8.00%	9.61%
536174	PART B BUY-IN MQBQ	7.00%	8.00%	7.00%
536175	PART B BUY-IN DUAL Q	7.00%	8.00%	7.00%
53617A	PART B BUY-IN MQBB	7.00%	8.00%	7.00%
53617B	PART B BUY-IN DUAL B	7.00%	8.00%	7.00%
53617C	PART B BUY-IN MQB PREM ONLY	7.00%	8.00%	7.00%
536156	HOSP INPT-GENERAL-XOVERS	4.77%	5.30%	4.77%
536158	HOSP OUTPT-GENERAL-XOVERS	5.67%	6.00%	5.67%
536170	HMO PREMIUMS	5.67%	6.00%	5.67%
536180	HEAD START	0.00%	0.00%	0.00%
536181	HOSP INPT-INDIAN HEALTH	4.77%	5.30%	4.77%
536182	HOSP OUTPT-INDIAN HEALTH	5.67%	6.00%	5.67%
536183	NF-INDIAN HEALTH	4.27%	4.70%	4.27%
536186	HOME HEALTH-INDIAN HEALTH	3.17%	3.60%	3.17%
536103	HOSP INPT-MTL, SO < 21	0.00%	0.00%	0.00%
536104	HOSP OUTPT-MTL, SO <21	0.00%	0.00%	0.00%
536106	HOSP INPT-MTL, SO > 65	0.00%	0.00%	0.00%
536107	HOSP OUTPT-MTL, SO >65	0.00%	0.00%	0.00%
536114	LTC-ICF MRC, SO	0.00%	0.00%	0.00%
536123	CLINICS-MENTAL HEALTH-FSO	5.67%	6.00%	5.67%
536124	CLINICS-HEALTH DEPT	5.67%	6.00%	5.67%
536136	FAMILY PLAN-HEALTH DEPT	5.67%	6.00%	5.67%
536139	HEALTH CHECK-HEALTH DEPT	5.67%	6.00%	5.67%
536151	CAROLINA ALT - MGD CARE	3.67%	4.00%	3.67%
536163	LOCAL EDUCATION AGENCIES-F	3.17%	3.50%	3.17%
536188	TRANSPORTATION-CNTY ADMIN	3.17%	3.50%	3.17%
536189	ACF-TRANSPORTATION	3.17%	3.50%	3.17%
536194	EDS-A/R INELIGIB CLAIMS	0.00%	0.00%	0.00%
536196	INDO-CHINESE MED ASST	0.00%	0.00%	0.00%
536112	TRNS-DMH-ADMIN EXP			
536150	INTRA-DEPT TRANSFER			
536168	CLINICS-DHS IMMUNIZATIONS	5.67%	6.00%	5.67%
536162	CASE MANAGEMENT-FSO	3.17%	3.50%	3.17%
536115	PHYSICIAN	3.17%	4.00%	3.17%
536118	DENTAL	3.17%	4.00%	3.17%
536117	OPTICAL SUPPLIES	3.67%	4.00%	3.67%
536118	CHIROPRACTIC	3.17%	4.00%	3.17%
536119	OPTICAL	3.17%	4.00%	3.17%
536120	PODIATRY	3.17%	4.00%	3.17%
536128	LAB AND X-RAY	3.17%	4.00%	3.17%
536135	FAMILY PLAN-PHYSICIAN	3.17%	4.00%	3.17%
536146	HEALTH CHECK-RURAL HLTH CT	5.67%	6.00%	5.67%
536147	HEALTH CHECK-OTHER PROV	4.67%	5.00%	4.67%
536179	HEALTH CHECK-FQHC	5.67%	6.00%	5.67%
536101	HOSP INPT-GENERAL	4.77%	5.30%	4.77%
536102	HOSP INPT-SPECIALITY	4.77%	5.30%	4.77%
53610A	HOSP INPT-MTL, NSO < 21	4.77%	5.30%	4.77%
53610B	HOSP INPT-MTL, NSO > 65	4.77%	5.30%	4.77%
536105	HOSP INPT-MTL, NSO	4.77%	5.30%	4.77%
536108	HOSP OUTPT-MTL, NSO	5.67%	6.00%	5.67%

ACCOUNT	CATEGORY OF SERVICE	SFY 1997-98 4/10/97 INFLATION RATES	SFY 1998-99 PROJECTED INFLATION RATES	SFY 1998-99 ADJUSTED INFLATION RATES
536121	HOSP OUTPT-GENERAL	5.67%	6.00%	5.67%
536122	HOSP OUTPT-SPECIALITY	5.67%	6.00%	5.67%
536133	FAMILY PLAN-HOSP INPT	4.77%	5.30%	4.77%
536134	FAMILY PLAN-HOSP OUTPT	5.67%	6.00%	5.67%
536132	FAMILY PLAN-STERILIZATION	4.77%	5.30%	4.77%
536154	HOSP OUTPT-EMERGENCY ROO	5.67%	6.00%	5.67%
536109	LTC-SNF SO AND NSO	3.50%	4.60%	4.60%
536110	LTC NF-SNF, SWING BEDS	4.27%	4.70%	4.27%
536111	LTC-ICF SO AND NSO	3.50%	4.60%	4.60%
536112	LTC NF-ICF SWING BEDS	4.27%	4.70%	4.27%
536152	HOSP INPT-LONG TERM CARE	4.77%	5.30%	4.77%
536155	LTC NF-HEAD LEVEL OF CARE	4.27%	4.70%	4.27%
536157	LTC NF-VENT LEVEL OF CARE	4.27%	4.70%	4.27%
536159	LTC CAP-DISABLED	3.07%	3.60%	3.07%
536161	LTC CAP-CHILDREN	3.07%	3.60%	3.07%
536113	LTC-ICF MRC, NSO	3.40%	1.45%	1.45%
536160	LTC CAP-MENTALLY RETARDED	3.07%	3.60%	3.07%
536166	LTC NF-SNF SWING VENT CARE	4.27%	4.70%	4.27%
536167	HOSP INPT-VENT CARE	4.77%	5.30%	4.77%
53616G	CAP AIDS	3.07%	3.60%	3.07%
53618A	LTC ACF - PCS BASIC	3.17%	3.50%	3.17%
53618D	LTC ACF - PCS BASIC/EATING AS	3.17%	3.50%	3.17%
53618E	LTC ACF - PCS BASIC/TOILET ASS	3.17%	3.50%	3.17%
53618F	LTC ACF - PCS BASIC/EATING/TOI	3.17%	3.50%	3.17%
536130	PRESCRIBED DRUGS	9.67%	10.00%	9.67%
536149	FAMILY PLAN-DRUGS	4.67%	5.03%	4.67%
536150	DRUG REBATE	0.00%	0.00%	0.00%
536125	CLINICS-FREE STANDING	5.67%	6.00%	5.67%
536126	CLINICS-RURAL HEALTH	5.67%	6.00%	5.67%
536129	LTC HOME HEALTH	3.17%	3.60%	3.17%
536137	FAMILY PLAN-FREE STANDING	5.67%	6.00%	5.67%
536142	AMBULANCE	3.17%	3.50%	3.17%
536143	HEARING AIDS	3.67%	4.00%	3.67%
536144	LTC PERSONAL CARE	3.17%	3.50%	3.17%
536148	FAMILY PLAN-RURAL HLTH CTR	5.67%	6.00%	5.67%
536165	DURABLE MED EQUIPMENT	3.67%	4.00%	3.67%
536169	PHYSICAL MED-NON PHYSICIAN	3.17%	4.00%	3.17%
536171	HOME INFUSION THERAPY	3.17%	3.60%	3.17%
536172	HOSPICE	4.77%	5.03%	4.77%
536177	CLINICS-FQHC, CORE & AMBULAT	5.67%	6.00%	5.67%
536178	FAMILY PLANNING-FQHC	5.67%	6.00%	5.67%
53618H	HIV CASE MANAGEMENT	4.67%	5.02%	4.67%
536187	AMBULATORY SURG CENTER	4.77%	5.30%	4.77%
536151	CAROLINA ALTERNATIVES	3.67%	4.00%	3.67%

MEDICAL ASSISTANCE PAYMENTS

1998-99 Estimated Utilization Rates

Category of Eligible	Utilization Rate	Average Monthly Eligibles
Aged	0.2%	106,039
Blind	7.8%	2,319
Disabled	2.2%	149,487
Work First	(8.2%)	255,124
Other Children	3.0%	2,943
Pregnant Women	1.4%	22,700
MIC Children	22.4%	257,485
MQBQ	3.0%	40,435
MQBB	19.8%	17,776

MEDICAL ASSISTANCE PAYMENTS

Intensity (In Millions)

Description	1998-99 Increase
HMO Premiums	\$4.5
Health Check	\$2.7
Physicians	\$39.1
Dental	\$20.6
CAP-Disabled	\$20.0
CAP-Mentally Retarded	\$13.3
ACH-Personal Care	\$6.5
Drugs	\$10.6
Personal Care	\$3.7
Total	\$121.1

MEDICAL ASSISTANCE PAYMENTS

Intensity

- **HMO Premiums** - HMOs are being offered as an option to Medicaid eligibles living in the Triangle and Triad areas. This increase offsets the first year cost of old fee for service claims and the monthly premiums for HMOs.
- **Health Check** - North Carolina is screening about 51% of the eligible Health Check population. Additional funds have been budgeted to support an 8% increase in child screenings.
- **Physicians** - Medicaid pays physicians about 92% of the allowed Medicare payment which is 58% of the average billed by physicians. This 10.5% increase will change physician fee rates to equal Medicare and increase fees to 64% of average billing rate.
- **Dental** - Rates for dental services by Medicaid have been historically low and access to services has been limited. This change will increase the rates for the 40 dental codes most utilized by children from 58% of average cost billed to 82%.
- **CAP-Disabled** - Currently, 8,700 individuals participate in this program as an alternative to nursing facility level of care. This increase adds 1,300 additional slots to this program.

MEDICAL ASSISTANCE PAYMENTS

Intensity

- **CAP-Mentally Retarded** - Currently, 3,600 slots are available under this program. This increase will add 1,732 slots to the program and provide services to the people identified by HHS to be eligible for services under this waiver.
- **Adult Care Home Personal Care Services** - The current hourly rate for this service is \$8.07 which was set in August 1995. The initial review of the 1997 cost reports suggests that the hourly rate should be \$9.81. DMA is reviewing the cost report data against paid claims. The rate of pay will be adjusted to the extent justified and approved by HCFA.
- **Drugs** - The cost and use of more effective drugs has increased in double digit levels during the last few years. This adjustment recognizes an average 12% increase per prescription over 1997-98.
- **Personal Care Services** - This adjustment supports a 5% increase in the number of persons receiving this service.

MEDICAL ASSISTANCE PAYMENTS

1998-99 Authorized Budget Vs. Projected Expenditures

Source of Funds (In Millions)	1998-99 Authorized budget	1998-99 Projected Expenditures	Difference
Federal	\$2,965.2	\$2,893.0	(\$72.1)
State	\$1,407.1	\$1,345.2	(\$61.8)
County	\$257.9	\$245.8	(\$12.1)
Total	\$4,630.1	\$4,484.0	(\$146.1)

MEDICAL ASSISTANCE PAYMENTS

Continuation Budget Reductions (In Millions)

Description	Total 1998-99	GF 1998-99
Governor's Reductions	(\$107.5)	(\$45.5)
Medicaid Growth Reduction	(\$38.6)	(\$16.3)
Total Reductions	(\$146.1)	(\$61.8)

MEDICAL ASSISTANCE PAYMENTS

Source of Reductions

- **FFP Rate Change**
- **Lower Utilization**
- **Medicaid Growth Reduction Measures**
- **New Position Budget Adjustments**

FEDERAL FINANCIAL PARTICIPATION RATE

IMPACT OF RATE DECREASES

- The Federal Financial Participation (FFP) Rate determines the federal share of the Medicaid program. The rate is based on the relationship between each state's per capita personal income and that of the nation as a whole. The 1999 federal share is calculated using per capita income data for 1994-96.
- Since N.C.'s per capita income has increased significantly in recent years, the state's FFP rate has declined. The rate has decreased from 68.01% for federal fiscal year 1989 to 63.09% for federal fiscal year 1999 -- a 7.2% decrease in ten years.
- The FFP rate for state fiscal year 1997-98 decreased .85%. This decline resulted in an \$19 million increase in state appropriations.
- **The estimated FFP rate for state fiscal year 1998-99 only decreased .34%. The original budget estimate assumed the FFP rate would decline by .56%. This lower decline resulted in an \$16 million decrease in state appropriations.**

AVERAGE MONTHLY ELIGIBLES

1990-91 Through 1998-99

Fiscal Year	Average Monthly Eligibles
1990-91	468,260
1991-92	573,686
1992-93	658,129
1993-94	715,543
1994-95	780,459
1995-96	815,276
1996-97	826,251
1997-98 est.	822,636
1998-99 est.	854,808

AVERAGE MONTHLY ELIGIBLES

Initial vs. Revised Estimates

Fiscal Year	Initial Estimate	Revised Estimate	Percent Change
1996-97	832,612	826,251	-0.7%
1997-98	867,013	822,636	-5.2%
1998-99	898,111	854,808	-4.8%

AVERAGE MONTHLY ELIGIBLES

Impact of "Woodwork" Children

- DMA estimates that 70,000 uninsured children are eligible for Medicaid. These children have been called the "Woodwork" children.
- Federal Law requires that any uninsured child who is eligible for Medicaid must be covered by Medicaid and not through the new children's Health Insurance Program recently enacted by the General Assembly.
- DMA has estimated that 35,000 additional children may participate in Medicaid due to the outreach for the new program and the federal push to identify and cover all Medicaid eligible children.
- The "Woodwork" children were included in average monthly eligibles used to develop the proposed Medicaid Budget. Including these children added \$26.7 million to the total budget (\$17.5 M Federal Share, \$7.9 M State Share, and \$1.4 M County Share).

DISPROPORTIONATE SHARE HOSPITALS

BACKGROUND INFORMATION

- Disproportionate Share Hospital (DSH) payments are allowed by federal law to help cover the costs of hospitals which have a disproportionate share of patients with little or no insurance.
- North Carolina earns DSH payments by making payments to the five state hospitals for uninsured care by using state appropriations in the Medicaid budget to provide the non-federal match.
- 1997 federal law set DSH allotments for N.C. through 2002. The 1998 allotment is \$278 million and declines each year to \$236 million in 2002. Even though N.C.'s allotment declines, DSH payments are projected to remain stable at least \$85 million per year through 2002.
- The federal share of the DSH payments is usually deposited as nontax revenue and is included in the revenue estimates for each fiscal year as nonrecurring revenues. The 1997 General Assembly allowed DMA to retain and budget DSH payments for the 1997-98 fiscal year.

DISPROPORTIONATE SHARE HOSPITALS

Payments to State Hospitals

Fiscal Year	Payments
1992-93	\$158,681,965
1993-94	\$303,132,954
1994-95	\$95,595,394
1995-96	\$77,999,540
1996-97	\$101,000,000
1997-98	\$97,000,000
1998-99 est.	\$85,000,000
1999-00 est.	\$85,000,000
2000-01 est.	\$85,000,000
2001-02 est.	\$85,000,000

NOTE: DSH stands for Disproportionate Share Hospitals

MEDICAID TRUST FUND

BACKGROUND INFORMATION

- G.S. 143-23(a) of the Executive Budget Act allows public and private hospitals to transfer a portion of federal revenues to the Department of Human Resources for the Medicaid program. The Medicaid Trust Fund has been established to receive these funds.
- The Medicaid Trust Fund can only be used to benefit the Medicaid program and cannot be used to reduce state general fund revenues.
- The Medicaid Trust Fund does not revert to the General Fund, but these funds can be allocated as provided in the current appropriations act.

DISPROPORTIONATE SHARE HOSPITALS

Payments to Non-State Hospitals

Fiscal Year	Medicaid Trust Fund	Hospital Payments
1995-96	\$50,000,000	\$80,000,000
1996-97	\$35,000,000	\$174,000,000
1997-98	\$40,000,000	\$166,000,000
Total	\$125,000,000	\$428,000,000

MEDICAID TRUST FUND

RECURRING OR NONRECURRING?

- The Division of Medical Assistance has been successful for the past three federal fiscal years in working with non-state public hospitals to draw down additional DSH payments.
- The federal law for DSH payments has stabilized and allotments have been set through federal fiscal year 2001-2002.
- The Division of Medical Assistance is currently negotiating with non-state public hospitals to continue these DSH payments this year.

MEDICAID TRUST FUND

OPTIONS FOR USING THE FUND

- The governor has proposed using the Medicaid Trust Fund, during the 1998-99 and future years, to support Medicaid program expenditures and reduce the need for state appropriations. His budget recommends that the Medicaid Trust Fund maintain a minimum balance of \$100 million to meet unanticipated future Medicaid needs and that 10% of the total availability be budgeted in 1998-99 (\$13 million).
- Other options for using the Medicaid Trust Fund are as follows:
 - A Medicaid Rainy Day Fund which can be used when Medicaid expenditures grow unexpectedly due to a recession or other causes.
 - Provide cash flow for establishing capitated managed care programs.
 - Provide funding for nonrecurring Medicaid expenditures such as automation improvements.
 - Provide funding for other activities which benefit the Medicaid program.

MEDICAID PROGRAM

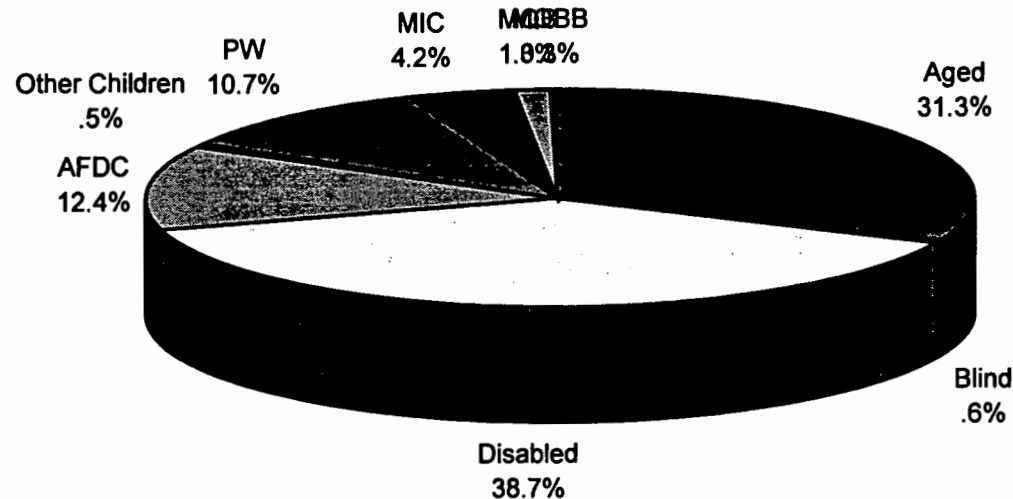
OTHER ISSUES

- Medicaid Special Provision
- Medicaid Growth Reduction
- Continuous Eligibility
- Comparison of 1980-81 Budget to 1998-99
- Status of New Administrative Positions

5/27/98
Karen Hammonds-Blanks
Additional handout

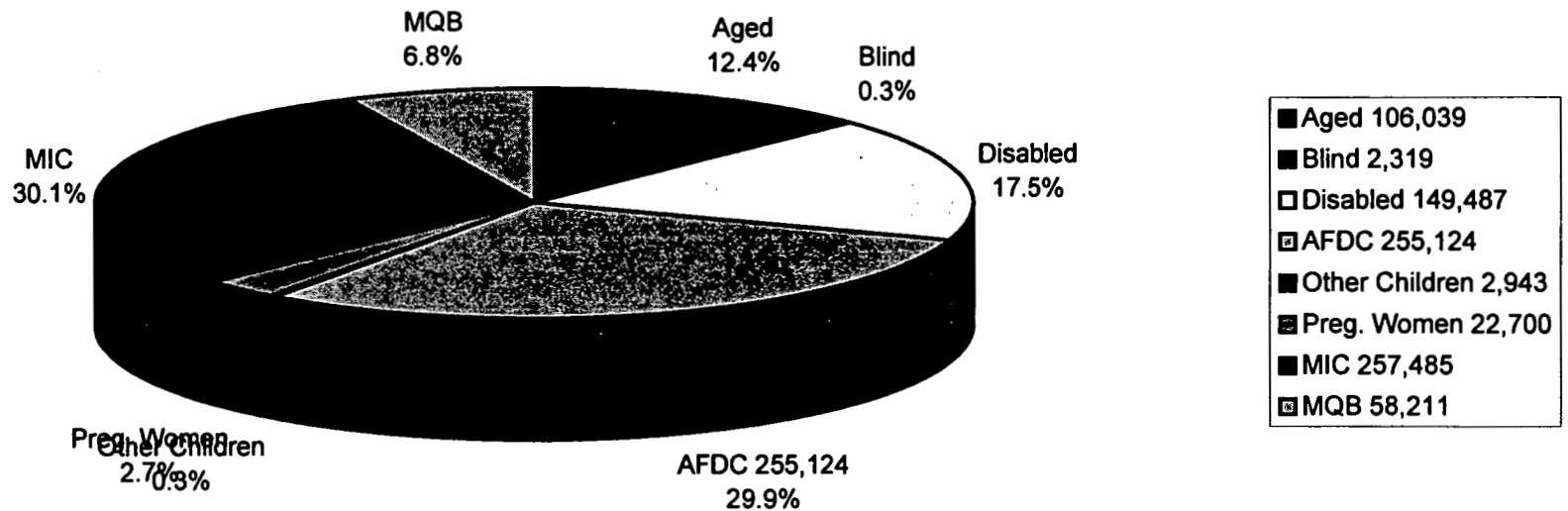
SFY98-99 Budget by Category of Eligibility
Total Estimated Budget \$4,484,054,050

■ Aged	\$1,405,755,389
■ Blind	\$26,301,838
□ Disabled	\$1,735,496,457
▣ AFDC	\$555,600,082
■ Other Children	\$25,185,009
■ PW	\$478,227,507
■ MIC	\$188,758,487
▣ MQB	\$57,324,614
■ MQBB	\$11,404,667



*It is estimated that \$231,000,000 of the dollars budgeted for Aged, Blind, and Disabled is necessary for the elimination of the 209B option.

SFY98-99 Estimated Eligibles **Total Estimated Eligibles 854,308**



*It is estimated that 60,000 of the Aged, Blind, and Disabled are eligible due to the elimination of the 209B option.

SFY98-99 Budget by Category of Eligibility

Category of Eligibility	Budget Amount	Percent
Aged	\$ 1,405,755,389	31.35%
Blind	\$ 26,301,838	0.59%
Disabled	\$ 1,735,496,457	38.70%
AFDC	\$ 555,600,082	12.39%
Other Children	\$ 25,185,009	0.56%
*PW	\$ 478,227,507	10.67%
*MIC	\$ 188,758,487	4.21%
*MQB	\$ 57,324,614	1.28%
*MQBB	\$ 11,404,667	0.25%

Total **\$ 4,484,054,050**

*\$966,000,000 added by eligibility (\$231,000,000 for elimination of 209B) since SFY80-81.

SFY98-99 Estimated Eligibles

Category of Eligibility	Population	Percent
Aged	106,039	12.41%
Blind	2,319	0.27%
Disabled	149,487	17.50%
AFDC	255,124	29.86%
Other Children	2,943	0.34%
*Preg. Women	22,700	2.66%
*MIC	257,485	30.14%
*MQB/MQBB	58,211	6.81%

Total **854,308**

*398,396 eligibles added (60,000 for the elimination of 209B) since SFY80-81.

Examination of Expenditures - Overall
Comparison of SFY80-81 to SFY98-99

Fund	Actual 1980-81	Recommended SFY 98-99	Percent Change Recomm/Actual
Admin	\$ 28,258,842	\$ 166,514,136	589%
1310	\$473,169,384	\$4,484,054,049	948%
Other	\$ 6,174,467	\$ (41,376,140)	-670%
total	\$ 507,602,694	\$ 4,609,192,045	908%
# of positions	124	348	281%
\$ per position	\$ 4,093,570	\$ 13,244,805	324%

Examination of Expenditures - Fund 1310
Comparison of SFY80-81 to SFY98-99

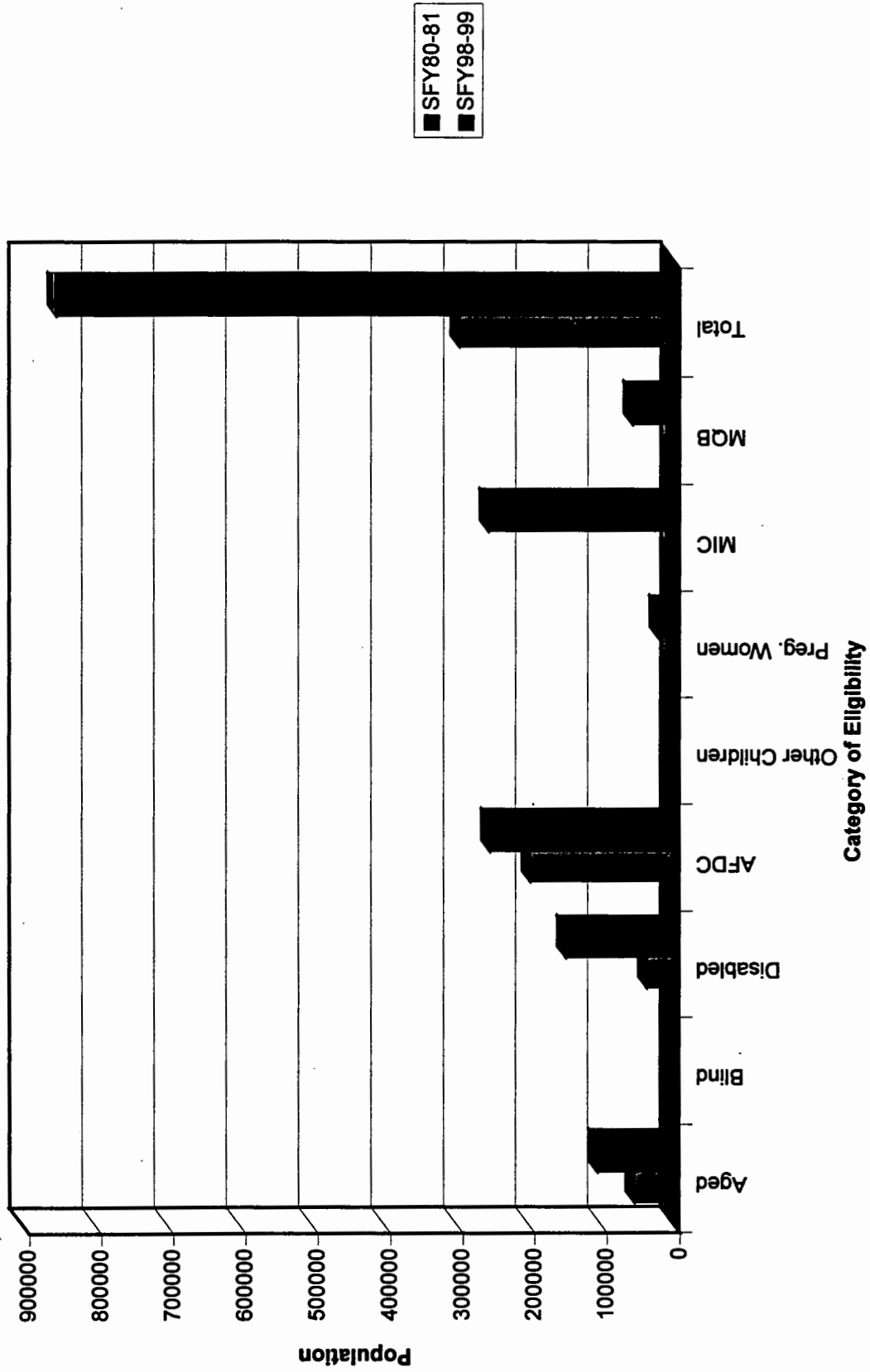
Make up of Fund 1310	Actual	Recommended	Percent Change
Traditional Services	1980-81	SFY 98-99	Recomm/Actual
LTC	\$202,623,070	\$ 975,368,418	481%
NLTC	<u>\$270,546,314</u>	<u>\$ 2,775,654,674</u>	1026%
Subtotal	\$473,169,384	\$ 3,751,023,092	793%
 New Services			
LTC		\$ 195,336,348	
NLTC		<u>\$ 537,694,608</u>	
Subtotal	\$ -	\$ 733,030,956	
 Total			
LTC	\$202,623,070	\$ 1,170,704,766	578%
NLTC	<u>\$270,546,314</u>	<u>\$ 3,313,349,282</u>	1225%
Total	\$473,169,384	\$ 4,484,054,048	948%

Examination of Expenditures - Fund 1310
Comparison of SFY80-81 to SFY98-99

	Actual 1980-81	Recommended SFY 98-99	Percent Change Recomm/Actual
Average Mnthly Eligibles			
Aged	54988	106039	193%
Blind	2188	2319	106%
Disabled	38128	149487	392%
AFDC	199000	255124	128%
Other Children	3885	2943	76%
Preg. Women	0	22700	
MIC	0	257485	
MQB	0	58211	
Total	298189	854308	286%

There are approximately 60,000 added eligibles due to the elimination of the 209B option.

Comparison of Eligibles SFY80-81 vs. SFY98-99



Budget Projections for New Services SFY98-99
Services Added Since SFY80-81
All Eligibles

ACCOUNT	CATEGORY OF SERVICE	SFY 1998-99 EXPENSE SUBTOTALS
536113	LTC-ICF MRC, NSO	195,336,348
536144	PERSONAL CARE	80,408,125
536159	CAP-DISABLED	159,145,770
536160	CAP-MENTALLY RETARDED	152,841,237
536161	CAP-CHILDREN	6,594,181
536162	CASE MANAGEMENT-FSO	3,440,095
536163	LOCAL EDUCATION AGENCIES-FSO	1,348,810
536165	DURABLE MED EQUIPMENT	28,133,398
536168	CLINICS-DHS IMMUNIZATIONS	186
536169	PHYSICAL MED-NON PHYSICIAN	16,058,677
536171	HOME INFUSION THERAPY	6,265,901
536172	HOSPICE	10,179,107
53618A	ACF - PCS BASIC	56,592,907
53618D	ACF - PCS BASIC/EATING ASSIST	280,533
53618E	ACF - PCS BASIC/TOILET ASSIST	9,244,383
53618F	ACF - PCS BASIC/EATING/TOILET	5,937,224
53618G	CAP AIDS	93,039
53618H	HIV CASE MANAGEMENT	1,131,033
	LTC REQUIREMENTS	195,336,348
	NLTC REQUIREMENTS	537,694,608
	TOTAL REQUIREMENTS	733,030,956

**Examination of Average Cost Per Eligible
Comparison of SFY80-81 to SFY98-99**

	Actual 1980-81	Recommended AFY 98-99	Percent Change Recomm/Actual
Cost Per Monthly Eligible			
Traditional Services			
LTC	\$ 57	\$ 95	168%
NLTC	\$ 76	\$ 281	372%
Subtotal	\$ 132	\$ 376	285%

Personal Consumption Deflator-Medical Care Services rate of change:
80-81 index = 111.5, Projected 98-99 index = 303.01
 $(303.01/111.5)-1 = 171\%$ change

New Services			
LTC	\$ -	\$ 19	
NLTC	\$ -	\$ 42	
Subtotal	\$ -	\$ 61	

Total All Services			
LTC	\$ 57	\$ 114	202%
NLTC	\$ 76	\$ 323	427%
Total	\$ 132	\$ 437	331%

MAJOR MEDICAID ELIGIBILITY CHANGES

<u>DATE</u>	<u>CHANGE</u>	<u>M OR O</u>
1/85	Expanded eligibility coverage to: - All pregnant woman with income <AFDC payment level - Change <age 19 in 2 parent household - Change in custody of private adoption agency - Automatic coverage for 1 year from infant whose mother was receiving XIX at time of delivery	M M O M
4/87	- Expanded eligibility coverage to: - Pregnant woman and infants with income up to 100% poverty	O
10/87	- Change < age 2 with family income up to 100% poverty [added a year in age each October thru age 5 by October 1990]	O
1/89	- Qualified Medicare Beneficiaries with income up to 80% FPL [added 5% increments each January thru January 1993 to = 100% FPL]	M
4/90	- Transitional XIX for two 6 month periods after loss of AFDC due to employment	M
1/91	- QMB "B" added to pay Part B premium for beneficiaries with name up to 110% FPL [income to 120% January 1995]	M
10/90	- Added children > age 6 who were born on or after October 1, 1983 with family income up to 100% FPL	M
7/91	- Qualified Disabled Working Individuals added to pay Medicare Part A premium	M
10/94	- Accelerated coverage of children born on or after October 1, 1983 with family income up to 100% FPL - Added coverage for adopted children with special needs without regard to income and assets of adoptive parents	O
1/95	- Changed from 209(b) to 1634 status [Automatic XIX eligibility for SSI recipients]	O
1/98	- Qualified Individuals with income between 120-135% FPL for Part B premium payment - QI with income between 135-175% FPL for payment of \$1.07 one month enhanced Part B premium	M M

M - Mandatory
O - Optional

**JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN
SERVICES**

PUBLIC HEARING

MAY 27, 1998

The Joint Appropriations Subcommittee on Health and Human Services met at 3:30 p.m. on Wednesday, May 27, 1998 in the Auditorium of the Legislative Building for the Work First State Plan Public Hearing. There were two senators and three representatives present. Senator Bill Martin chaired the hearing.

Senator Martin called the hearing to order at 3:43 p.m. He introduced the co-chairs Reps. Charlotte Gardner, Lanier Cansler and Debbie Clary.

The speakers were called in the order as pre-registered with staff and were asked to leave written comments or to send a copy afterwards. Speakers were limited to 3 minutes each. Written comments from the speakers are included with these minutes.

The following is a list of speakers who did not have written comments:

Marie Hill-Faison - recommended eliminating the two year time period. She also supports the ten recommendations identified by the N. C. Welfare Reform Collaborative (see its copy),

Linda Pitts - requested both an increase in benefits and that recipients not be sanctioned,

Mabel Bemer - asked the General Assembly to provide educational opportunities for persons who'd like to continue their training,

Shirley Dixon - said she is presently off welfare but may have to go back into the system in order to help support her fifteen-year-old who is a teenage parent,

Brenda Griffin - said she was sanctioned and made an example by a social worker. She recommended that instead of the system evaluating clients all together, evaluate them individually,

Sherrell Thomas - Asked the committee and the state to use more sensitivity to people affected by regulations. She said the recommendations will affect the entire state,

Barbara Moore asked the committee to involve people who will be affected by the plans in the process before the decisions are made,

Angela Glenn is taking care of a child who is not hers, and feels she should not be sanctioned. Ms. Glenn said she cannot support a family on \$147 a month,

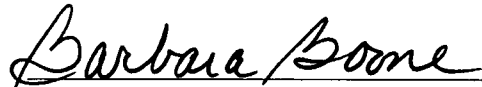
Marlena Moore said the Work First Plan makes it impossible for young people to make it out of the system. She asked the committee to go back to the table and look at the proposed recommendations and help people get out of the system,

Ebony Wilson asked the committee to help with transportation or improve the transportation system.

Following the last speaker, Senator Martin thanked everyone for their participation and adjourned the hearing at 5:40 p.m.



Sen. William N. Martin, Co-Chairman



Barbara Boone, Committee Clerk

Principal Clerk ____
Reading Clerk ____

SENATE
PUBLIC HEARING

The Joint Senate and House Appropriations Subcommittees on **HUMAN RESOURCES** will have a **PUBLIC HEARING** at the following time:

DATE: **Wednesday, May 27, 1998**
TIME: **3:30 p.m.**
ROOM: **Auditorium, Legislative Building**

Senator Bill Martin, Chairman

RE: Welfare Reform - Work First State Plan.

PUBLIC HEARING:

**North Carolina's Temporary Assistance for Needy Families
State Plan FY1998-2000**

Joint Appropriations Subcommittee on Health & Human Services

**Legislative Auditorium
Wednesday, May 27th
3:30 p.m.**

Opening Remarks

Senator Bill Martin, Co-Chair
Rep. Charlotte Gardner, Co-Chair
Rep. Lanier Cansler, Co-Chair
Rep. Debbie Clary, Co-Chair

Open Public Hearing

Public Comment (limit 3 minutes)

Close Public Hearing

Committee Discussion

Adjourn

VISITOR REGISTRATION SHEET
WELFARE REFORM/WORK FIRST STATE PLAN PUBLIC HEARING

Joint Appropriations Subcommittee on Human Resources May 27, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Paula Langner	citizen Fayetteville N.C.
Myrna Miller	NASW-NC
Lavern S. Oxendine	PO BOX 963 Lumberton NC 28359
Kay Michaels	PLANNED PARENTHOOD P.O. BOX 3258 CHAPEL HILL, NC 27515
S. Lynne Hamlet	citizen and member of NASW-NC
Donna Dudley	New Life P.O. Box 1174 Winston, NC 27892
WAB FOREST	URBAN-RURAL MISSION, WORLD COUNCIL OF CHURCHES 10 BOX 240, DURHAM NC 27702
BILL LONG	PEOPLE'S ALLIANCE, DURHAM, NC
Shirley Dixon	
Mable Y. Beamer	426 Chavasse Ave. Henderson, N.C. 27536
Audrey Hawley	Southones for Economic Justice Durham, NC

Name of Committee	Date
Joint Appropriations Subcommittee on Human Resources	May 27, 1998

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

FIRM OR AGENCY AND ADDRESS

VISITOR REGISTRATION SHEET
WELFARE REFORM/WORK FIRST STATE PLAN PUBLIC HEARING

Joint Appropriations Subcommittee on Human Resources May 27, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Erika G. Chou	P.O. Box 506 Islamorada, FL 33036
Amelia Blessing	3430 Al Hwy 147 North Opelika, AL 36801
Allan Huntley	969 Springwell Cir., Cary NC 27511
Ryan Streeter	314 Oakridge Rd, Cary, NC 27511
Matt Shaw	NC Assn of County Commissioners
Rebecca Troutman	NC Assoc. of County Commissioners
Opine Smi. Uh	NC DSS
Liza Aycock	DHHS - DSS
Jan Owen	DHHS/DSS
Dwayne Patterson	DHHS/Budget & Analysis
Bill Farley	N.C. House

VISITOR REGISTRATION SHEET
WELFARE REFORM/WORK FIRST STATE PLAN PUBLIC HEARING

Joint Appropriations Subcommittee on Human Resources May 27, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Curtis Whalley	580 Lee Rd 112 Opelika AL 36804
Nim Chant	8952 Wilbur Road Ft. NC 27503
Kathleen G. Hoon	PO Box 506 Islamorada, FL 33036
Kristin Douglas	607 SE Maynard Rd Cary NC 27511
Betty Elmerbee	6220 COOKOUT COOP RALEIGH NC 27612
Jeff Madry	110 Leckford Way Cary NC 27513
Bridgette Davis	1708 Shackleton Rd. Apex, NC 27502
Theresa Huntley	909 Springwell Cir, Cary 27511
Kristina Madry	110 Leckford Way Cary, NC 27513
Vanessa Streeter	314 Oakridge Rd. Cary, NC 27511
J. Smith	500 W. 2nd St. Summerville SC

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE FOR HUMAN RESOURCES PUBLIC HEARING

MAY 27, 1998

Name of Committee

100

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME _____

FIRM OR AGENCY AND ADDRESS

Shirley McClain

NC Hunger Network - Raleigh, NC 27540

R. W. Verrill Collins

5114 Yaden Rd, Fay, NC 28303
Women Informational Network
Nc Hunger Network 6006 Lt Wade H. Laign, NC 27540

Sherry Mason

Women International network 514 yadkin rd

Amelia Morris

DEVAN'S WORLD FOUNDATION

5114 Suite 128 Yadkin Rd Fay. NC. 28303

(Intern)

Denise Haller

San. Lucas NC General Assembly

Sen. Lucas

NC General Assembly

DAVE BRANTON

DAHS

Kevin FitzGerald

Nc ①SS

Leonard C. Beckman

The Cardinal on Beauty

ANDREW DOBELSTEIN

Conference on Poverty ^{CHARGE WILL INC} P.O. Box 694 27514

Stacey Slaughter

Legislative Intern

Deborah Weissman

level Sucs. of NC

Allen Danner

Center for Employment Training/NC; Health Care

Margie Rose

Adolescent Pregnancy Prevention Coalition

Linda Rignabee

Adal. Preg. Pres. Coalition of NC

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE FOR HUMAN RESOURCES PUBLIC HEARING

MAY 27, 1998

Name of Committee

Date

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NAME

FIRM OR AGENCY AND ADDRESS

<i>Robert Taylor</i>	ESC
<i>Jack S. ...</i>	NCARE
<i>Minor ...</i>	
<i>L. Carl Miller, Jr.</i>	Lutheran Family Services 112 COX AVE, Raleigh, NC 27605
<i>Jane Kinney</i>	Macon Co DSS 5 W. Main St, Franklin, NC 28734
<i>Carolyn Jackson</i>	DHHS - Div of Human Resource Mgmt
<i>Patricia C. Gentry</i>	APPCNQ
<i>Polly Pearson</i>	Western, N.C. Conf. United Methodist Women of United Methodist Ch.
<i>Sharon Skuse</i>	NCAEDSS
<i>Stine Shaber</i>	NC Social Services Consortium
<i>Koshyn Savitt</i>	NC Child Care Coalition inc Coalition Against Domestic Violence
<i>NRES ROSEBAND</i>	STATE BUDGET
<i>DAN GURACH</i>	NC BUDGET TAX CENTER
<i>Pam Samano</i>	United Way of NC & Covenant w/ NC's Children
<i>Paula A. Hoef</i>	Covenant w/ NC's Children

VISITOR REGISTRATION SHEET

WELFARE REFORM/WORK FIRST STATE PLAN PUBLIC HEARING

Joint Appropriations Subcommittee on Human Resources May 27, 1998

Name of Committee

Date

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NAME

FIRM OR AGENCY AND ADDRESS

<i>Lafayette</i>	426 Chowasse Ave. Henderson, N.C. 27536
<i>[Signature]</i>	N.C. Senate
Brenda N. Griffin	New Life Women's Leadership Project P.O. Box 1174-Wilmington N.C. 27892 (792) 7499
<i>Brenda Summers</i>	NC Equity 3900 Bennett Dr #311 Raleigh 27609
Geraldine Blackston	Project Rescue 1604 #8 Kincaid Ave 252 Parent Involvement Program Wilson N.C. 27893 7365
Kyle Armstrong	NC Senate
Amy Pingiak	NC Senate

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE FOR HUMAN RESOURCES PUBLIC HEARING

MAY 27, 1998

Name of Committee

2011

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NAME

FIRM OR AGENCY AND ADDRESS

Melanie Ramsey, ^{Habilitation} ^{Technician} (111) 232 N. Edgeworth St. Also UNCG-Lesure ^{Services} Dept.
Guilford County Greensboro NC, 27401

WELFARE REFORM/WORK FIRST STATE PLAN
PUBLIC HEARING
WEDNESDAY, MAY 27, 1998

REGISTERED SPEAKERS

<u>SPEAKER</u>	<u>ORGANIZATION</u>	<u>CITY</u>
1 ✓ <u>Rev. Keith Miller</u>	<i>Project Jubilee</i> <u>NC Council of Churches</u>	<u>Gastonia</u>
~~Karen Small~~	~~<u>Open Door Ministries</u>~~	~~<u>High Point</u>~~
2 ✓ <u>Calvin Underwood</u>	<u>Buncombe Social Services</u>	<u>Asheville</u>
4 ✓ <u>Cynthia Brown</u>	<u>Southerners for Economic Justice</u>	<u>Durham</u>
3 ✓ <u>Yolanda Bagley</u>	<u>Citizen</u>	<u>Durham</u>
5 <u>Marie Hill-Faison</u>	<u>Work First Recipient</u>	<u>Durham</u>
~~Johnnie Poole~~	<u>Citizen</u>	<u>Durham</u>
<u>Holly Smith</u>	<u>Citizen</u>	<u>Durham</u>
6 <u>Linda Pitts</u>	<u>Work First Recipient</u>	<u>Durham</u>
7 <u>Mabel Bemmer</u>	<u>Work First Recipient</u>	<u>Henderson</u>
8+9 <u>Shirley Dixon and Brenda Griffin</u>	<u>New Life Women's Leadership Proj.</u>	<u>Williamston</u>
10 <u>Pam Seamans</u>	<u>United Way of North Carolina</u>	<u>Raleigh</u>
~~Brenda Somers~~	~~<u>North Carolina Equity</u>~~	~~<u>Raleigh</u>~~
10 <u>Shirell Thomas</u>	<u>Domestic Violence</u>	<u>Warsaw</u>
11 <u>Gail McRae</u>	<u>Sandhills Mediation Center</u>	<i>Scotland + Hyde Cky</i>
12 <u>Geraldine Blackstone</u>		<u>Wilson</u>
8+12 <u>Deborah Ross</u>	<u>ACLU</u>	<u>Raleigh</u>
13 <u>Paula A. Wolf</u>	<u>Covenant with NC's Children</u>	<u>Raleigh</u>
14 <u>Carl Miller</u>	<u>St. Counc. For Social Legislation</u>	<u>Raleigh</u>
15 <u>Polly Pearson</u>	<u>St. Counc. For Social Legislation</u>	<u>Western NC</u>
16 <u>Margie Rose</u>	<u>Adolescent Pregnancy Prevention...</u>	<u>Wake CO</u>
17 <u>Myrna Miller</u>	<u>NC Chptr, Nat'l Socl Workrs Assoc</u>	<u>Raleigh</u>
18 <u>Sorien Schmidt</u>	<u>NC Justice & Commu. Dev. Ctr.</u>	<u>Raleigh</u>
19 <u>Barbara Moore</u>	<u>Charlotte Organizing Project</u>	<u>Charlotte</u>
20 <u>Angela Glenn</u>	<u>Charlotte Organizing Project</u>	<u>Charlotte</u>
21 <u>Marlena Moore</u>	<u>Fairview Homes Tenant Assoc.</u>	<u>Charlotte</u>
22 <u>Dr. Andrew Dobelstein</u> + <i>Dr. Leonard Beckum</i>	<u>Conference on Poverty</u>	<u>Chapel Hill</u>
23 <u>Shirley McClain</u>	<u>NC Hunger Network</u>	<u>Raleigh</u>
24 <u>Sherry Mason</u>	<u>Hunger Network</u>	<u>Fayetteville</u>
~~Linda Meekins~~	<u>The Phoenix Group</u>	<u>Fayetteville</u>

25 Vivian Collins
29 Dr. Jonathan Sher
26 Deborah Weissmon
17 Ebony Wilson
30 Mab Segrest

Women's International
NC Child Advocacy Institute
Family Violence Option/Legal Sav.
Southerners for Eco just.
Urban-Rural Mission
World Council of Churches

Fayetteville
Raleigh
Raleigh
Durham
Durham



JUBILEE

WORKING WITH FAITH COMMUNITIES ON WELFARE CHANGES

A Project
of the
NC
COUNCIL
OF
CHURCHES

To: Barbara Boone, Office of Senator Bill Martin, Greensboro

From: Project JUBILEE

RE: Joint Public Hearing on WorkFirst, May 27, 1998

Ms. Boone:

Could you please see that copies of this testimony on faith community involvement in WorkFirst is given to all members of the Joint House and Senate Subcommittee on Human Resources Appropriations?

Thank you very much for doing that and holding the hearing.

Respectfully submitted,

The Rev. Keith Miller, Board Chair

Barbara Earls, Project Director

Barbara Zelter Earls
Project Director
9257 Chapel Hill Road
Cary, NC 27513-3612

Kathy Putnam
Field-Based Services
Wilson JUBILEE Coordinator
1206 Highland Trail
Chapel Hill, NC 27516

Micheline Ridley Malson
Families First Services
Durham JUBILEE Coordinator
26 Copper Hill Court
Durham, NC 27713



Project JUBILEE of the NC Council of Churches

Educating and Organizing Faith Communities on Welfare Changes—Ministry and Advocacy

9257 Chapel Hill Road, Cary, NC 27513-3612 919-460-7666 earls@ntwrks.com

Testimony to the Joint Appropriations Subcommittee on Health and Human Services Public Hearing on the WorkFirst State Plan: May 27, 1998

**The Rev. Keith Miller, Board Chair, Project JUBILEE
Pastor, New St. Paul Baptist Church, Gastonia, NC, 704-864-8063
President, Gaston County Inter-Denominational Ministerial Alliance**

Good afternoon, members of the House and Senate and concerned citizens. I come before you today to specifically address the issue of faith community involvement in welfare reform in North Carolina. The success of WorkFirst depends on extensive local volunteer support for families losing cash assistance and facing mandates to go to work. Page 4 of the proposed state plan highlights this need. We at Project JUBILEE have been intensively involved in organizing that kind of support, and in sober analysis of the faith community's capacity to expand our community services. So we hope you take under serious advisement our perspectives from working on this across North Carolina.

JUBILEE was formed as a Special Project of the NC Council of Churches last spring, to educate and organize churches across North Carolina about WorkFirst and new conditions for families who had been able to depend on public assistance in the past. The project was built on the work of our director, who since participating in 1995 and 1996 on our state's welfare reform task force, had been bringing information to churches across the state for two years. In Wilson County, where we have had a pilot program operating for over a year, we have helped build an official faith community partnership with the Department of Social Services. Our Families First training program has equipped "faith teams" in several churches to form covenant partnerships of support with families moving from the WorkFirst program into jobs. We have a similar pilot project developing in Durham County. And our director travels the state organizing denominations, individual churches, and community groups about welfare supports needed for families, as well as ways they can help shape public policies in forums like these.

**Project Director: Barbara Earls Field Services and Wilson Coordinator: Kathy Putnam
Families First Services and Durham Coordinator: Micheline Malson**

We are here today to say that while we applaud the creative ventures to coordinate community-based services for families, the faith community in North Carolina has nowhere near the capacity to take on the enormous burden caused by \$64 billion dollars of reductions in Food Stamp benefits and other benefit terminations.

At the press conference sponsored by the Coalition for Bread, Jobs, and Justice here a couple of weeks ago, we were represented by a worker at High Point's Open Door Ministries, Karen Small, who runs their Project Emmaus for WorkFirst families. Karen expressed her deep concern about her crisis center's lack of capacity to meet the needs of mothers in the WorkFirst program and those who are trying to make ends meet on low-wage jobs. She has sent in her statement there as testimony to this panel. I hope you find that statement and read it.

While we find that many individuals and pastors are eager to step up and find new ways of coordinating their church-based community services, many also express deep anger at government's retrenchment from a guarantee of basic safety net.

Those of us who are actively involved in tutoring, mentoring, job skills training, child care, etc., can tell you how labor-intensive these efforts are. For example, in Wilson, First Presbyterian Church, the Governor's church, runs a fine program where several volunteers drive women to work. This program has gotten a lot of publicity. What we don't hear is that these eager volunteers have only been able to serve three families. Our work building faith teams in Wilson and Durham, where helpers learn the actual conditions of those they want to assist, and link effectively with Social Services for a smooth transition for families, takes months—this is what it takes for respectful, skillful partnerships to take place.

Because the WorkFirst state plan says explicitly that community supports like the ones we encourage are necessary in all counties, and because we have found that most church folk are still confused about WorkFirst and only beginning to see if and how they might step out in new ways for families, we bring you these recommendations:

1. Eliminate the 2-year time limit. It is unconscionable to end cash assistance and the benefits that accrue to that, when we do not have the child care, transportation, and other necessities in place for workers.
2. Alter the WorkFirst plan to include wise recommendations from mothers in WorkFirst, from the Justice Center, The NC Welfare Reform Collaborative, NC's Covenant With Children, and the DSS Directors Association. Our page of state

plan recommendations, submitted to Kevin FitzGerald of state DSS, is attached here.

If we as a state are to be guided by moral principles of love and justice, we will act first to raise wage levels, welcome labor union organizing, institute a universal health care system that doesn't leave one out of seven North Carolinians uninsured, and build adequate systems for public transit and child care, before we rush to punish those who for many often valid reasons have not been the lucky or the strong. When Jesus held out his hand, he did not ask if the person had a job.

When work is first, where is justice? Where is compassion? End the 2-year time limit this summer, before it is imposed. We all need time to build a state in which more working families can earn enough to not only survive but thrive. Let's not pander to those who only want tax cuts and to judge those in whose shoes they have not walked.

Project JUBILEE of the North Carolina Council of Churches

*Educating and Organizing Faith Communities in North Carolina on Welfare Changes
and Ministries Against Poverty, Toward Economic Justice*

9257 Chapel Hill Rd., Cary, NC 27513-3612; 919-460-7666, FAX: 919-468-4285; earls@ntwrks.com

Comments on the State WorkFirst Plan

Eliminate the 2-year time limit for WorkFirst cash assistance. Page 4 of the state plan says, "Because broad-based community involvement is essential to help families become self-sufficient, the local block grant plan must describe how businesses, community groups, nonprofits, and religious groups will be involved in their WorkFirst program." JUBILEE can report from work across the state that most religious and community groups are still at the stage of learning about WorkFirst and planning whether and how they might increase support services to families. We believe that ending cash assistance for families before "basic supports" (transportation, child care, etc.) and new local emergency and job retention services are organized is punitive and unrealistic. To do so only serves the goal of caseload reduction, not poverty reduction and child well being.

Make easily available to the public, on a quarterly basis, reports on the monitoring data of Maximus and The Jordan Institute for Families. If these monitoring systems do not cover family financial status 6 months and 1 year after ending WorkFirst involvement, add this kind of monitoring program, so we can see whether or not employment means self-sufficiency. Use NC Equity's Self-Sufficiency Standard as the measure of families' actual ability to be self-supporting; arrange benefits accordingly.

Include a provision to review and adjust work participation rate requirements, sanctions, and benefit level calculations, based on results of the "working poor" county studies submitted to the state by the Employment Security Commission on May 1, 1998.

Adhere to the welfare principles and electing county suggestions raised in the April 1998 position paper of the Covenant With NC's Children.

Change the approval date for electing county plans and the state plan to January 1999. The process of county plan development has been rushed. Time to soberly assess community resources for families and workable county-level procedures was not given. By January 1999, more thorough and sensible county plans can be designed.

JUBILEE commends the many creative initiatives to assist families who face work requirements and benefit deadlines: transportation and child care funding, case management with future planning, community collaborations for families.

North Carolina Association Of County Directors Of Social Services

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To: Joint Appropriations Subcommittee on Health and Human Services
From: Calvin Underwood, President, North Carolina Association of County Directors of Social Services
Date: May 27, 1998
Re: State TANF Plan

The North Carolina Association of County Directors of Social Services has been committed to implementing and improving the state's Work First program. We recognize the importance of having our agencies engage our qualifying citizens toward active pursuit of self-sufficiency. All counties have worked hard to develop their local plans and have devised new service delivery strategies under the flexibility provided with the new state legislation. The following comments on the Draft State TANF Plan are intended to strengthen the program and make it more helpful to citizens moving from welfare to employment.

1. First, we urge the Department to recommend that ***no more than 15.5% of the caseload be approved as electing counties***. It is premature to allow more counties to embark on this experiment with changing eligibility criteria and benefit levels until evaluation data can show that these efforts are helping families gain self-sufficiency; that families are not moving across county lines to receive more generous payments; and that child well being is not jeopardized. Monitoring and accounting mechanisms must be established to ensure that target goals are achieved and not simply through caseload reduction.
2. **Family Violence Option:** We support the use of this option and the pilot effort to develop this program. It will be vitally important to share the best practice results from these pilots for statewide implementation after this initial two year plan. We do not support eligibility staff being responsible for screening for domestic violence. We strongly recommend that family violence training be made available to our *social work staff* that will be working with these families, not our eligibility staff. We are hopeful that such training can include cross-training with local family violence program staff to promote greater collaboration and cooperation at the local level.
3. **Caseload Reduction Goal:** The State Plan appears to focus on reducing the caseload rather than the placement of welfare recipients in jobs and improving child well-being

as the federal and state law indicates. Caseload reduction is merely one of many measures of the program's successes. County Departments of Social Services should be measured by the reasons people leave welfare. Losing benefits due to a time limit or sanction should *not* be considered successful caseload reduction or a measure of self-sufficiency. Success should be measured by employment, wages and the well-being of children.

4. **Diversion Assistance:** The Draft State Plan requires clients to repay Diversion Assistance if they subsequently receive TANF cash assistance within 36 months. We recommend the elimination of this repayment clause from the policy or some appropriate language added to the Plan that enables counties to waive this policy locally.
5. **More Restrictive Eligibility Criteria:** The plan indicates in error that there are no more restrictive financial eligibility criteria in Work First today and therefore no one needs to be assessed for Medicaid eligibility under the July 16, 1996 rules. A separate category of Medicaid eligibility must be created to ensure persons who qualified under the July 16, 1996 rules can still qualify for Medicaid. Further, utilizing the "standard of need" rather than "payment standard" in calculating eligibility is unnecessarily hard. NC had the 10th lowest benefit level in the country under AFDC. A more practical program allowing families to keep more income while working will be more effective in helping to establish and keep individuals working. We suggest eliminating the use of the "standard of need," but increase the "payment standard" from which the eligibility would be derived.
6. **Housing Needs:** Families should be encouraged to self-declare their housing needs so that our staff can refer them to appropriate community resources. Consolidation of targeted funding sources and many conclusions of the Housing Committee of the Human Services Task Force should be incorporated.
7. **Pay After Performance:** This policy does not allow for "good cause" for not meeting hours required. For example, a person could have worked 139 hours in a month and have missed an hour of work to care for a sick child and have all benefits and services denied. We do not believe that it is wise to force families to make bad choices about child care and illnesses in order to receive their Work First assistance checks. We need to use some common sense to adjust this rule to better support our families who are working hard to become self-sufficient.
8. **Sanctions:** While many advocates have expressed strong concerns about the use of sanctions, we believe that they are necessary to let families know that the time limits and requirements are serious and to encourage people to begin searching for employment as soon as possible. However, we recommend that requirements for county agencies regarding their responsibilities for counseling families about the sanctions, good cause consideration and internal and external review of decisions be included in the State TANF plan to make this more palatable to the advocacy community and ensure it's fair and equal implementation statewide.
9. **Time Limits:** County DSS Work First programs are in the business of helping those who are helping themselves reach self-sufficiency. The State Plan needs to place greater emphasis on helping people who are progressing, but who are hitting the two-year time limit. What message are we sending to families by stopping all assistance

when they are progressing in a job, but hit the time limit? We suggest that greater transitional assistance with extensions of their cash assistance is appropriate for families meeting the work requirements, but who are not yet able to support their families without the additional Work First cash assistance payment. Time limits should not be used as punitive measures if critical supportive services, such as child care and transportation, are not available and the client has otherwise made appropriate good faith efforts to comply. The State Plan must include the specifics on the extensions/appeals policy.

10. **Transportation**: We support the recommendation to explore the use of Geographic Information Systems (GIS) to develop better transportation solutions for welfare to work. We further recommend funding for counties to develop programs that could be used with individual clients since GIS have been used primarily for policy analyses and program planning.
11. **Substance Abuse Issues**: The State Plan should provide local options regarding where local DSS employees and substance abuse professionals are housed. Their respective responsibilities may be carried out in various ways in addition to same office locations. When local governments assume responsibility to provide office space to house personnel providing public services, they should have the authority to make decisions about specific office assignments. Further, the focus on substance abuse for service design under the Enhanced Employee Assistance Program is seriously flawed in its unnecessarily narrow attention at the expense of other problems, such as chronic depression, mental deficiencies, and poor skills for family financial management. We would encourage a more holistic approach to serving the WFFA population who leave welfare for work.
12. **Medical Coverage**: The State Plan benefits calculation causes people to lose their TANF payments sooner by using smaller disregards, which also accelerates the rise in the need for Transitional Medicaid. The adults with very low incomes will face serious health insurance problems before their finances can cope with that need (we assume the new Children's Health Insurance Program will provide coverage for the children of these families). There has been no support for longer Transitional Medicaid. We urge the State to clarify whether counties could use a portion of the savings from reduced caseloads to purchase health insurance for these working adults. This will help us to ensure that those who go to work can stay at work.
13. **Simplification and Automation**: Our Association has long championed the need for simplification of the eligibility process and for automation to collect this data for simplified eligibility and greater access to data necessary to evaluate the success of our programs. Any automation and simplification initiative in Work First should be based on providing greater service and access to clients, to have appropriate data to manage and evaluate the program, and to eliminate duplication of tax-paid time and resources in collecting data, *not* to facilitate privatization and outsourcing. We support privatization efforts where they are most cost effective, but privatization should not be the public policy goal of automation. Public policy goals must be based on improving services and providing the most efficient use of tax dollars for our citizens. Further, the State Plan does not address the use of an automated, simplified single application.

We must streamline and simplify this process for our staff and recipients so that we are not wasting tax payer dollars on duplicative and inefficient eligibility processes.

Finally, we support the development of a TANF Reinvestment Plan that transfers savings from reduction in the Work First Caseload to County Work First Block Grants, much as counties shared in the *increased* costs of AFDC in the early 1990's. That's where the savings are earned, and that's where the reinvestment decisions should be made. The share of county savings should be equal to its share of the non-federal costs of the program. County block grants should be used for employment, training and supportive services. Funding for these programs does not increase significantly over time in current reinvestment plans; however, the families remaining on the caseload face greater barriers to successful employability. Job training, transportation, literacy and child care needs will intensify for this population.

We further support TANF reinvestments at the State level. There are many unmet needs for helping families gain self-sufficiency and we, therefore, strongly oppose efforts to displace or supplant current State funding for supportive services with savings from caseload reductions. Our recommendations for State Level reinvestment are in:

1. CPS, Foster Care and other child welfare needs. Funding for child welfare has traditionally been funded, in large part, by AFDC-EA. We need to continue to watch for the impact of case termination on children and the child welfare system. Reinvestments in child welfare are an investment in our children most at-risk of abuse, neglect, poor health, poor school performance, juvenile delinquency, out of wedlock pregnancies and future welfare dependency.
2. Emergency Assistance Cash Payments. Current funding is inadequate and only available during a portion of the year. This funding could help many families to avoid welfare dependency by meeting emergency, one-time needs.
3. Transfers to SSBG: Up to 10% of TANF funds can be transferred to the Social Services Block Grant under federal law. Such transfers can be made at the State or County Levels to offset substantial cuts counties have experienced in recent years. No provision is made for this in the current plan.
4. Financial Incentives for counties: A financial incentive to counties could stimulate greater outcomes for families. Such incentives could include matching funds for new initiatives, high rate of placement in good-paying jobs, etc., but *not judged on caseload decline*.
5. Child Day Care: The current reinvestment plan calls for nearly all of the reinvested savings to go to child day care. This is a critical piece, but not the only piece of the puzzle in helping families go to and stay at work. We recommend that the balance of the State savings be reinvested in child day care subsidies with 5% to help offset administration at the local level.

We appreciate this opportunity to comment on the State TANF Plan, sincerely hope that our comments will be utilized to amend the plan before final approval by the General Assembly.

Memorandum

DATE: May 27, 1998

TO: Joint Appropriations Committee on Health and Human Services

FROM: Calvin Underwood, President, NCACDSS

RE: State TANF Plan Input

Guiding Principle: One single, automated application process for all publicly funded, means-tested programs. Caution: Do not make the mistake of viewing TANF in isolation from all other programs. Such a fragmented approach promises to perpetuate the categorical thinking that has resulted in the waste of tax paid resources on duplicative and inefficient eligibility processes. DHHS has the resources to make a single, simple automated application become a reality. You should mandate that they deliver this important tool by January, 1999.

Guiding Principle: Maximum flexibility to local communities for all non-cash assistance services. ALL Counties have demonstrated creative use of flexibility for non-cash assistance services. We urge you to reinvest TANF savings into County TANF Block Grants to allow local communities to invest in strategies that will work to support families in moving from welfare to work. The Counties are where the savings are earned. The Counties are where a substantial amount of savings should be reinvested for support services. Allow Counties the flexibility to reinvest up to 10% in SSBG; to reinvest into Child Welfare Services; and to Child Day Care and other critical support services.

Guiding Principle: Statewide cash assistance rules and payment system. We recommend that you hold the line on the 15.5% of caseload being under County promulgated rules. These are experiments from which we all can learn. These experiments must be monitored and evaluated for at least two years regarding their impact on children and families. We should be prepared to take the successful aspects and consider incorporating them into the State Plan.

Guiding Principle: Welfare Reform is not just about caseload reduction. It is about strengthening parents abilities to nurture, protect and provide for their children. Monitoring and evaluation of all County TANF programs must focus on child well-being.

Caution: While we support programs to help victims of domestic violence, we can not expect 'eligibility staff' to be responsible and accountable for the identification of spousal abuse.

Pay After Performance and Sanctions: Unfortunately, some parents accept the modest sanction now in place rather than to act in a cooperative and responsible manner. Therefore, we support strengthening of sanctions and pay after performance to gain

cooperation. HOWEVER, provision must be made for 'good cause' exceptions and 'due process' to allow families to be heard should they feel that they are treated unfairly.

Medical Coverage for the parent expires after the 12 month Transitional period. We support extending the Transitional period to 24 months. Healthy employees continue to work. We must minimize the occurrence of becoming reconnected to welfare during times of illness just to get the health coverage by providing for coverage. Counties could be authorized to use TANF Block Grant dollars to purchase coverage for parents.

Child Day Care is a critical support for the low wage earning parent. We urge the reinvestment of TANF savings for Child Day Care. As the Child Day Care service support workload has increased at the local level, the resource to pay for that support has not. We urge your support increased resources for local service support.

Support services for obtaining and maintaining work have been incorporated into all County TANF Plans. We urge you to continue to allow maximum flexibility. Clients should self-declare needs such as Housing. **Caution:** Please do not mandate additional assessments to be performed by Eligibility staff.

Thank you for this opportunity to share our perspective with you.

Statement of Yolanda Bagley:

Good afternoon. Thank you to the legislators and the committee staff for taking the time to listen to me this afternoon. My name is Yolanda Bagley. I would like to start with a couple of my thoughts, tell you my story, then make a few recommendations for changes to the state's plan.

Thoughts

1.) The emphasis on case load reduction by any means necessary means social workers are insensitive to individual cases and extraordinary circumstances.

2.) Sanctions are unfairly applied

I have five children and live in Durham. I have three years of college where I studied nursing and am certified with Duke Medical as a phlebotomist technician. Part of the way through college I got a divorce and was no longer able to be in school. The father of my children did not provide any sort of financial support for ~~us~~ our children. The DSS system and the courts have failed to help me get the full support the court had ordered to this day.

Nonetheless, I made a life for my family. In 1996, I was working full-time at IBM as a final inspector in their computer assembly operation. I was classified as a temporary employee, but planned to be there permanently. It was a good job and enabled me to provide a living for my family. My children were cared for by my father because I worked third shift and didn't have child-care available. This wasn't a perfect arrangement, but it was working out okay for us. I re-enrolled in school during the day to finish my nursing degree. Then, my life changed a lot in October of 1996. I am just one example of how honest people with a desire to work hard can fall on difficult times and need assistance that is increasingly hard to get.

I had other good jobs before this one, but had a hard time getting day care centers to accept all five of my children and so would have to leave my jobs. I was very happy at IBM and hoping to

become an IBM employee rather than merely a contractor, so that I would be entitled to full benefits.

Then I got a job related injury to my shoulder, arm, and hand in October of 1996. I lost 75 % usage of my right arm and had to have surgery. The recovery period meant lots of physical therapy, heavy pain medication, and I could no longer perform my job. Also, the side effects of the medication were that I was often very drowsy. Because of that I had to rely on AFDC, since I did not worker's comp. The new Work First rules were in effect and part of receiving AFDC benefits was that I had to go to the Work First training program each day until I found a job.

That doesn't sound like a big problem, but let me tell you the reality of what I was expected to do. The woman, who was in charge of my case said that I had to come in and sit down looking through the paper for jobs, circling, and writing down details about ones I was able to do. My doctor said that there was no way I would use my hand to do circling and writing out of any sort. Even sitting down for the period of time required was bad for my injury. I explained that my case worker. My doctor provided a written notice to that effect. She did not accept the notice, demanded I get another one. The next time there was some confusion between the doctor and his assistant about how to explain my case. This was straightened out by the doctor, but in the meantime, I was sanctioned for failing to comply with the "rules." The case worker said she had already put in the sanction and there was no way to stop it from going through. I went through reduced benefits as a result of these sanctions for between six months and a year.

During this time, my family did without basic needs like clothes, shoes, and school supplies. Sometimes there wasn't enough money for basic things like pencils and paper for homework, much less calculators, binders, and money for the extra costs of participating in sports programs. Thanks to help from my father and the church, we were never hungry for a long periods of time, but it was very overwhelming time. Sometimes things got so bad that I began to think of different people who would take care of my children if we had to separate until I could get on my feet. In the meantime, my caseworker was very rude, mean, and insensitive. At a time, when a person has a lot of struggles to begin with, a little sensitivity would have gone a long way.

Eventually I went over her head to her supervisor and now receive the full AFDC benefits to which I am entitled. This experience has given me an opportunity to see what some of the problems are with the current way the Welfare Reform plan is working and I have some specific thoughts and recommendations.

Recommendations:

1. Sensitivity training for case workers and supervisors on service is a must!
2. When people have legitimate reasons for not complying with the Work First requirements, we should not be sanctioned.
3. There needs to be a clear grievance process in a timely manner for people who are unfairly sanctioned.

Southerners for Economic Justice, Inc.

NC Work First Welfare Plan
Public Hearing Statement

to

The Joint Appropriations Subcommittee on Health and Human Services

Good Afternoon!! My name is Cynthia Brown and I am the Executive Director of Southerners for Economic Justice. Our organization is a member of the NC Welfare Reform Collaborative. Over the past year, we have worked diligently on the local and the state level with our allies to enhance the participation of Work First participants in the policy making process. We believe it is essential that the perspectives of participants in the Work First Program who are directly impacted by the policy be included in the way the policy is shaped. So, I want to thank Senator Martin and the Joint Appropriations Subcommittee on Health and Human Services for sponsoring this public hearing and allowing the public the opportunity to comment on the state's Work First Plan.

I support all of the 10 recommendations of the NC Welfare Reform Collaborative which are attached to my statement for your review. In the interests of time, I want to make only a couple of key points today. My points are as follows:

1. **The emphasis on caseload reduction is bad public policy and means that:**
 - a) Counties are not being creative in their program development. Despite language that says the goal of our county plans is to help public assistance recipients achieve self-sufficiency, recipients are being forced off the rolls into low-wage jobs without benefits; cut off without adequate support services, and being discouraged from pursuing long-term education and job training programs. **Therefore, families should be provided cash benefits for six months after the recipient has received a job with poverty wages and no benefits.**
 - b) Social workers are being made to implement harsh punitive rules that are inhumane. Social workers are merely processing papers and complying with rules and regulations that totally ignore important issues that should be taken into consideration when women are receiving benefits. Women have often talked about feeling like they are being herded through the social services offices like cattle. Social workers are under a great deal of stress which often is taken out on Social Service clients. **Social Workers need sensitivity training and the flexibility to offer women options that address women's individual circumstances.**
 - c) **Families are made to endure unreasonable pressure.** Women want to work, but they want to receive salaries that allow them to meet their basic needs. It

is very stressful when women are confronted with homelessness, hunger, and other issues related to living in poverty.

2. **The money that has been saved by massive caseload reduction should be invested in creative programs that HELP NOT HURT women and their families!!** These programs could include purchasing cars to provide women transportation, job training programs that will allow women to access higher paying jobs that will lead to self sufficiency, creating separate county and state funded programs that do not have to have federal time limits, etc.
3. **Two year time limit needs to be eliminated.** People terminated from receiving assistance should be terminated when it has been determined that they can be self-sufficient. Within a three year time period after a person has been terminated from receiving assistance, a person could legitimately need to receive cash assistance. This would be the case if a person has a job that is providing a decent wage with benefits and their employer downgrades their position to a part-time or temporary status or the company decides to move and the employee is left without work. Potentially, a person could be without work beyond their unemployment benefits or their unemployment benefits could be inadequate to help them pay basic living expenses and childcare while looking for a job. I am sure there are other scenarios that make the time limit unrealistic.
4. **Sanctions need to be fairly applied and women need to have access to a clear appeals process.**

Cynthia Brown
5/27/98

N.C. WELFARE REFORM COLLABORATIVE

331 W. Main Street, Box 38
Durham, NC 27701

April 30, 1998

Mr. Kevin Fitzgerald
Director
Division of Social Services
325 N. Salisbury Street
Raleigh, NC 27603-5905

VIA Facsimile 919-733-9386

Dear Mr. Fitzgerald:

The enclosed statement represents the collective response of the members of the North Carolina Welfare Reform Collaborative to the proposed North Carolina Temporary Assistance for Needy Families State Plan (Work First Program).

The North Carolina Welfare Reform Collaborative is a one year old statewide initiative involving the constituencies of three multi-racial, advocacy organizations including N.C. Fair Share, N.C. Hunger Network, and Southerners for Economic Justice. Each organization is committed to grassroots organization and leadership, policy advocacy, and economic empowerment as strategies to end hunger, poverty, and the unjust policies that impact our constituency. To date, participants in the Collaborative activities reside in seventeen NC counties including Guilford, Cumberland, Durham, Hoke, Nash, Perquimmons, Robeson, Wake, Martin, Edgecomb, Mecklenberg, Vance, Warren, Buncombe, Lee, Granville, and Alamance.

Collaborative partner's staff and constituents have reviewed the proposed State Plan. We are deeply concerned at the over emphasis on caseload reduction without adequate consideration of the factors that would support Work First participant's transition from public assistance to self-sufficiency. Our comments and recommendations regarding ten key areas are outlined below.

Benefit Diversion- This allows for a family to receive one time assistance to help them stay off Work First. This gives families cash equaling three months of benefits of food stamps, Medicaid, and child care assistance. The current plan requires families to pay back cash received under benefit diversion if they should ever (lifetime) apply for Work First assistance again. The proposed plan requires repayment if families apply within 36 months of receiving diversion assistance.

Recommendation: No repayment requirements. (Buncombe County DSS has proposed no repayment or permission for counties to waive repayment.) The policy of no repayment by families for diversion assistance should be uniform throughout NC.

Vehicle Exclusion- All families will be allowed to keep one vehicle regardless of value.
Recommendation: While this is helpful to families with cars, it does not begin to address the needs of families without cars. A statewide transportation plan for families to acquire autos at low or no cost should be implemented. In addition, when two working people in a family use cars for transportation, the second car should also be exempt.

Job Bonus- Families that get jobs while on Work First are allowed continued cash benefits with no reductions for three months.

Recommendation: This practice should be linked to an across-the-board increase in benefits. Any reduction in benefits should be phased in to allow an additional 6 months of receiving cash assistance. The formula should consider family expenses and whether or not job earnings provide a self-sufficiency wage.

Family Violence - It is very good that the state has proposed adoption of the federal Family Violence Option to protect victims of domestic violence.

Recommendation: The plan to do screenings should be replaced with universal notification for all DSS applicants for benefits. The Durham County Work First Plan Amendment provides clear direction and protections for victims of abuse. (see attached)

Sanctions- The state proposal is to reduce benefits by 25% on the first infraction; then pay-after-performance for a minimum of three months. Families are subject to termination if deemed non-compliant.

Recommendation: The state proposal amounts to a "3 strikes" policy. This condemnation of people in poverty is unresponsive to the charge given social services to help families succeed in moving from welfare poverty to self-sufficiency. Strategies that are pro-active and provide positive reinforcement opportunities could include motivational training, mentoring, job search and job readiness assistance. Sensitivity training for case workers and supervisors on service delivery to needy populations is a must. There should be a review of all persons sanctioned. Persons under sanctions or terminated for rules infractions should be advised of their appeal rights.

Electing Counties- North Carolina is the first state to allow counties to select whether they will follow standards set by the state or pilot total control over Work First programs.

Recommendation: There should be uniform standards for benefits, eligibility and an appeals process to protect the rights of needy families whether in Electing or Standard counties.

Two-year Time Limit- The proposed plan continues the two-year time limit.

Recommendation: Eliminate the two-year time limit. It is especially harsh in that recipients of cash assistance must be off for three years before eligible for participation in Work First for cash assistance. The state had previously said it would better define who is eligible for extensions to ensure families unable to support themselves would not be denied assistance. Eliminating the two-year time limit takes the pressure off counties to find alternative means of providing assistance to needy families allowing more time for creative practices to be developed with public agencies, community and faith institutions. A review of families subject to the two-year time limit should be done to determine if those families no longer need assistance.

Eligibility- The proposed state plan eliminates the Standard of Need. This makes major changes in how income eligibility and benefit amounts are calculated for recipient families. The elimination of the Standard of Need also impacts Medicaid eligibility.

Recommendation: Do not eliminate the Standard of Need. Instead, take into consideration expenses versus income to allow families to move from welfare poverty to self-sufficiency. Federal welfare law requires that all persons who would have qualified under the Work First income and resource rules in place on July 16 1996 must still be found eligible for Medicaid today. The Medicaid eligibility standard should be a part of an overall uniform eligibility standard for counties throughout the state.

Pay-After-Performance for two Parent Families- The state implemented this change on March 1, 1998. Two-parent families must meet the work requirement of 35 hours per week before receiving Temporary Assistance for Needy Families benefits.

Recommendation: Eliminate the policy to provide benefits after work requirements are met. This is punitive without cause. Families attempting to stay together should be supported with services to overcome barriers to self-sufficiency and employment.

Grievance/Appeals Procedure- The state plans provides for punishment that leads to termination on a fast track. However, there is no mention of an appeals process to address any unfair enforcement of work requirements.

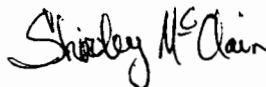
Recommendation: A clear appeals process should be provided to all Work First participants. Persons who are sanctioned should be provided an explanation of the sanction and reason for the sanction. The appeals process should be uniform statewide providing for appeals up to the maximum redress. Persons making appeals should be informed that they have the right to legal counsel and any other advocates they choose.

In closing, we urge you to give careful consideration of our comments and recommendations. Our comments have been largely developed by the concerns of women who currently receive public assistance or those who have been welfare recipients. We are all committed to welfare reform that is humane and addresses the best interests of families living in poverty. We believe for NC's plan to comply with that standard, the plan must incorporate our recommendations.

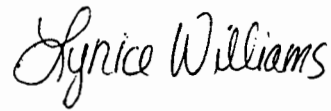
Sincerely,



Cynthia D. Brown
Southerners for Economic
Justice



Shirley McClain
NC Hunger Network



Lynice Williams
NC Fair Share Education Fund

cc:

Senator Jeanne Lucas (Durham), Senator Wilbur Gulley (Durham), Representative Paul Luebke (Durham), Representative Henry Michaux (Durham), Representative George Miller (Durham), Senator Bill Martin (Greensboro), Representative Alma Adams (Greensboro), Eleanor Kinnaird (Carrboro), Representative Howard Hunter (Conway), Representative Milton F. Fitch (Wilson), Representative Beverly Earle (Charlotte), Representative Larry Womble (Winston-Salem), Chairperson Micheline Malson, Durham County Work First Advisory Committee, Director Dan Hudgins, Durham County Department of Social Services, Chairperson Mary Ann Black, Durham County Board of County Commissioners.



United Way of North Carolina

**STATEMENT OF PAM SEAMANS
PUBLIC POLICY DIRECTOR, UNITED WAY OF NORTH CAROLINA
BEFORE THE JOINT HUMAN RESOURCES APPROPRIATIONS COMMITTEE
MAY 27, 1998**

Good afternoon. My name is Pam Seamans and I am the Public Policy Director for the United Way of North Carolina (UWNC). I am here today on behalf of UWNC's Board of Directors and the 64 local United Ways which are members of the United Way of North Carolina.

The United Way of North Carolina has serious concerns about several provisions in the State's Welfare Plan and their potential impact on the children, families and nonprofit agencies served by local United Ways.

UWNC supports compassionate welfare reform that promotes the well being of children and families and promotes true economic independence. Despite the action taken by the legislature last summer, UWNC continues to support a statewide system for cash assistance and eligibility. In light of this position, we would not support expanding the number of electing counties beyond the current 15.5 percent of caseload limit. We feel the state should evaluate the success of proposed electing county programs and their impact on children and families before considering an expansion.

With regard to the proposed State Welfare Plan, we are concerned that the primary goal of the Work First Plan is to reduce caseload. Our state's primary goal should be to move families toward employment and self-sufficiency while also enhancing the total well-being of the family. Reducing caseload should be one of many outcome measures but not the primary goal. With a primary goal of reducing the caseload, we will be forcing many families to depend on crisis assistance programs, emergency food centers and homeless shelters to survive. We must address the underlying causes of poverty before we can expect Work First families to achieve self-sufficiency and thereby reduce their dependence on public assistance.

If child and family well-being are to be a primary goal, we suggest that the plan incorporate mechanisms to monitor the impact of these reforms on children and families and that the state look to the nonprofit sector for assistance in this area. Rather than creating new mechanisms and bureaucracies, the state could rely on nonprofits which have unique access to local communities and to this population in particular.

We are also concerned that the proposed state plan calls for pay-after-performance sanctions to be imposed immediately for all two-parent families and as the second sanction for all other families. This sanction seems to be designed to reduce the welfare rolls rather than help families move toward self-sufficiency. Requiring families to meet work requirements before they can receive cash assistance (which pays for food, shelter and clothing – all items needed to be

successful at work) or other TANF services such as transportation, is setting these families up for failure and an inability to meet work requirements. And to continue to run the time clock on these families for the three months they are not receiving services adds insult to injury. The pay-after-performance policy ultimately punishes the children who are innocent bystanders in this process. UWNC believes the current sanctions should be maintained.

Due to a lack of time, I will simply state that UWNC would also like to see the plan clarify the state's policy on exemptions and extensions to the two-year time limit and we support the inclusion of the family violence option.

With the right support systems and assessment plans in place, North Carolina can be a model for the nation in reducing our welfare caseload while simultaneously helping our families become responsible, self-sufficient citizens. Thank you for making the plan available for review and for this opportunity to comment.

Remarks to Joint Appropriations Committee on Health and Human Services
For Public Hearing on TANF
By Brenda Summers, Ed.D.
5/27/98

Members of the committee, other members of the General Assembly, representatives of the Department of Health and Human Services and citizens, I am Brenda Summers, President of NC Equity, which operates a Sustainable Family Initiative. Our work focuses on helping families obtain economic self-sufficiency.

I appreciate this opportunity to speak to you today. My concerns are in the following areas: caseload reduction, sanctions, child care and the Family Violence Option.

The Department of Health and Human Services and the General Assembly have taken some important strides in assuring child well-being with the implementation of the Smart Start program. The initiative is designed to provide some basic necessities for children. However, if we do not plan for the well-being of parents by providing them with jobs and skills to provide for their families, then the work of Smart Start will not succeed. Children learn from their parents, and if their parents do not have hope for a better life and do not have opportunities to achieve more than minimum wage jobs, then the children of those families lose hope for their own future.

In our state, many of the jobs only provide low-wages and it takes planning and job training to provide Work First recipients with an opportunity for self-sufficiency. As some of you are aware, NC Equity released a study last fall on the wages individuals would need to earn to become self-sufficient, that is what they would need to earn if they did not get any government assistance from TANF funds or child care, housing or transportation subsidies. The state TANF plan does recognize the need for transportation and child care assistance. However, the sanctions that would be imposed through pay-after-performance could seriously jeopardize a family's efforts to become self-sufficient. Also if recipients are not given more opportunities for job training and job counseling then families will not become self-sufficient. Recent statistics indicate that the unemployment rate is rising in some counties. Does that mean individuals who cannot find jobs will be left to a life of extreme poverty?

During our training sessions in local communities, individuals have expressed concern that the state plan does not adequately address child care needs. Work First recipients are taking second and third shift jobs in order to meet work requirements and also in an effort to earn higher wages. However, after-hours care remains almost non-existent in many communities. In one area a company has asked NC Equity to work with it to contact other groups in the community to form a coalition to provide the needed care. We have genuine concerns that some children may be left alone so parents can work, and we have seen too many bad examples of what can happen to children when they are left alone.

The division has done a lot of work in collaborating with other groups to find out more about domestic violence issues facing Work First recipients. We are pleased that the department is adopting the Family Violence Option. We have heard stories of individuals who have lost their

jobs after an abusive spouse or partner entered the workplace and caused problems. While we can understand the department's interest in piloting the program to get a more accurate assessment of the situation, we encourage the General Assembly to move quickly to implement this statewide so that domestic violence victims are not further penalized when they already face very difficult circumstances.

We are pleased the plan does encourage counties to establish Individual Development Account projects. This offers a wonderful opportunity for Work First recipients to begin planning for their future, and we appreciate the division's encouragement of this effort and the General Assembly's support..

We thank you for your willingness to hear from the public on this issue and we look forward to working with you as you make decisions about the state plan for Temporary Aid to Needy Families.

Thoughts on Welfare Reform for North Carolina's Poor

respectfully submitted by Gail McRae, Director of Sandhills Mediation Center, Inc.,
serving Scotland and Hoke Counties

The plight of the poor in North Carolina is so complex that it is sometimes overwhelming to those of us who work with welfare recipients to help them gain independence. Since 1979 I have worked with North Carolina's poor -- and yes, poor is the word, for they have so little hope, such a minimal education, and often an abusive upbringing as the precursor to an abusive adulthood. Through those nearly 20 years, I have made some observations that I would like to share with you before telling you what Sandhills Mediation is working on right now.

First, there are many myths about the poor: They like to be poor; they don't want to work; all they do is have babies to get more money; they are all drug addicts or alcoholics. While there may be some who seem to fit into one of those categories, they are the exception, not the rule. Not only that, having babies is not a way to make money, but it is a sure way to go broke.

Second, most of my experience is first-hand. And I can honestly tell you that if the main threats were acknowledged and remedies put into place, most of the poor would be able to stop draining society and become contributing members. Some of these threats are as follows:

- the deplorable crime-ridden neighborhoods in which they must live
- violence within the home
- inappropriate response to problems
- poor or no education
- sense of hopelessness
- sense of powerlessness
- low or no self-esteem
- poor parenting skills
- dehumanizing treatment by service agencies and society in general
- no regular transportation

Finally, thanks to a North Carolina DHHS one-time grant, we at SMC have developed and are as we speak implementing an intensive 2-week training program for each group of participants that addresses positive ways to resolve conflicts on the job, in the neighborhood, and in the home. As part of that training, we take the participants, who are all in the Work First program, through comprehensive analysis of emotional and verbal abuse, violence against women, positive parenting techniques, changing attitudes from negative (I can't) to positive (I can), acceptable work behavior, and many role plays for each situation. The program is interactive and requires the participants to THINK. Our premise is that if given the opportunity and treated with respect, these people can begin to grasp the notion that they are capable of learning the skills necessary to be successful employees, neighbors, spouses, and perhaps most importantly, parents. As a result of this training experience, we have identified a huge gap in our area in terms of welfare reform: No one is working with the men, unless they are getting a public assistance check. The women are only part of the equation. The men need to know that it is not acceptable to beat anyone, especially not women and children. There needs to be intensive training for the men equivalent to that of the women if welfare reform is ever to be successful.

Recommendation: Depts of SS. coordinate w/ Gail McRae
their area dispute resolution centers
to provide the intensive, comprehensive
services as described above AND to
include adult males in each work 1st household in similar
training 5-27-98

Pam Seamans *Chairperson*
Paula A. Wolf *Chief Lobbyist*

COMMENTS ON NORTH CAROLINA'S TEMPORARY ASSISTANCE FOR NEEDY FAMILIES STATE PLAN

Senate Public Hearing
Raleigh, NC - May 27, 1998
By Paula A. Wolf
Chief Lobbyist

I appreciate the opportunity to speak to you today to comment on the Temporary Assistance for Needy Families (TANF) State Plan. My name is Paula Wolf and I represent the Covenant with North Carolina's Children. The Covenant is a multidisciplinary, statewide coalition advancing public policy to benefit North Carolina's children. Over 85 organizations, from Murphy to Manteo, belong to the Covenant. We came together in 1995 to give voice to issues of importance to children in the areas of law, policy, and rules. The Covenant has seven substantive Work Groups that mirror the issues for which we advocate - *Child Welfare and Protection, Early Childhood, Economic Security and Welfare Reform, Education, Health, Juvenile Justice, and Safety.*

The State TANF Plan will ultimately affect thousands of children in North Carolina. The Covenant is submitting these comments to offer suggestions for improving the State TANF Plan to provide more support and help to our children most at-risk of abuse, neglect, poor health, poor school performance, juvenile delinquency, out-of-wedlock pregnancies and future welfare dependency.

1. THE PRIMARY GOALS OF TANF SHOULD BE MOVING FAMILIES TO SELF-SUFFICIENCY AND IMPROVING CHILD WELL-BEING, NOT CASELOAD REDUCTION.

The first purpose of the Federal Welfare Reform law (The Personal Responsibility and Work Opportunity Reconciliation Act of 1996) is to provide assistance to needy families so that children may be cared for in their own homes. Since the federal legislation provided the impetus for North Carolina's creation of a State Plan, the State should make child well being its first purpose. Child well being should be a primary goal in moving families to self-sufficiency. Currently, child well being is the last goal listed, and is not fully defined.

A coalition advancing public policy that benefits children in North Carolina



Child well being is defined in the Plan as the percentage of Work First children receiving intensive Child Protective Services that have a safety plan in effect. The goal is for 100% of children receiving CPS services to have such a safety plan. However, this goal is already a requirement in all 100 counties. The definition of child well being should be more broadly based.

Throughout the Plan, it states the importance of moving families to self-sufficiency. On page 2, the Plan states that, "ultimately, North Carolina's goal is to help all families move to self-sufficiency." Unfortunately, when the program goals are listed, there is an unnecessary and dangerous switch to "reduction of caseload" as the primary goal. While self-sufficiency is addressed in the second program goal, in this case it is equated with employment.

According to the Self-Sufficiency Standard for North Carolina (1997) by NC Equity/Wider Opportunities for Women, it takes \$9.42 an hour for a single mother with two children in Anson County to be self-sufficient. Employment alone does not equal self-sufficiency. Caseload reduction is only a measure of how many families have left the rolls, not a measure of how many families have moved to employment or self-sufficiency. Success should be measured by employment, wages, and child well being.

Moving families to self-sufficiency must be a primary goal, and all Work First policies should encourage this goal. For example, if the standard of need is eliminated as a method for determining eligibility (as proposed by the Plan), then the payment standard from which eligibility would be derived must be substantially increased.

The Plan must also provide more details to help children in families that reach the two-year time limit without becoming self-sufficient. Community organizations, including nonprofits and religious organizations, do not have the capacity to care for all of these families. Until we can ensure availability of necessary services (including child care, housing and transportation) and the underlying issues of poverty are addressed (including lack of jobs and low wages), the two-year time limit should be eliminated.

In addition to setting the above goals and policies, we believe that mechanisms to monitor and evaluate Work First's impact on child well-being and the number of families attaining self-sufficiency are critical to determine if this experiment with welfare is working. The Covenant offers the resources and experience of our membership to help craft appropriate measures and policies.

2. PAY-AFTER-PERFORMANCE POLICIES SHOULD BE REMOVED FROM THE STATE PLAN.

The proposed State Plan imposes pay-after-performance immediately on all two-parent families and as the second sanction on all other families. Pay-after-performance is bad policy in both situations and will place children at unnecessary risk of harm because it will completely cut off all cash assistance to families who cannot meet the work requirements prior to requesting aid.

For two-parent families, this penalty is justified by pointing to federal work quotas. While North Carolina is not meeting these quotas, more than half the states are in the same position because the policy incorrectly assumes that it is easier for these families to work. Actual experience from local DSS employees shows that many two-parent families do not apply for assistance until they are in severe crisis, and at that point they face barriers that are often long-term and difficult to solve. The State should provide funds and services to the families to help them become self-sufficient, rather than denying children and families cash benefits.

The two-parent pay-after-performance policy is also having the unintended consequence of breaking up stable families. We have heard real-life examples of families splitting up so the mother and child can get assistance. We advocate for policies that strengthen families and encourage families to stay together.

The Plan also makes pay-after-performance the second penalty for families who fail to meet the requirements of the Work First program. The pay-after-performance second sanction for all families is unnecessary. The state should maintain current sanctions, and increase supportive services to those hardest to place in employment.

3. WE SUPPORT IMPLEMENTATION OF THE FAMILY VIOLENCE OPTION.

The Covenant strongly supports the inclusion of the Family Violence Option. This is appropriately titled "family violence", as any domestic violence in a family will affect ALL members of the family, including any children. We recommend that the State make modifications to immediately implement this option statewide for all women who identify themselves as victims of domestic violence, and to ensure appropriately trained staff are available. We support efforts to establish methods to screen for domestic violence in all counties. Also, all counties must be able to immediately exempt a family from the child support cooperation requirement when the mother or children are at risk of domestic violence.

4. WE ENDORSE THE DISAPPROVAL OF ELECTING COUNTIES WITH UNCONSTITUTIONAL PROVISIONS

The Covenant supports the exclusion of those counties with provisions such as mandatory drug testing and residency requirements. Such plans should not be approved and should not be included in the State Plan.

Members of the Joint Appropriations Subcommittee on Health and Human Services

My name is Carl Miller and I am pleased to have the opportunity to speak to the state welfare reform plan --Work First-- on behalf of the State Council for Social Legislation on which I serve as Vice President.

The State Council, which was founded in 1920, has been working in education and advocacy for social issues for many years. We represent 26 organizations and numerous individuals from across the state who are concerned about family support and self-sufficiency, health care and health promotion, job security and economic issues, children's services, and domestic and societal violence. My own organization, Lutheran Family Services is a member of the State Council.

Many points have been made about the state plan but I would like to focus on one area, that of evaluation. How will we really measure the outcomes of Work First? Our organization would encourage the Division of Social Services to include and secure funding for a permanent and ongoing evaluation of the State's welfare program to determine its impact on the well-being of children and families. Assessing the "change in family income" as is currently included in the state plan will not provide a sufficient picture of the well-being of families and children. We would urge you to require the evaluation to be more comprehensive and to be conducted by an outside, independent evaluator. The evaluation results should be able to answer some of the following questions:

- What percent of the families who have left the welfare rolls are earning a livable wage?
- What percent of the families who have left the welfare rolls have been able to acquire child care that will keep their children safe, healthy, and appropriately stimulated during the parents working hours?

- What percent of the families who have left the welfare rolls have been able to access immunizations, vision exams, hearing exams, and wellness care for their children?
- What percent of the families who have left the welfare rolls do not live in substandard housing?
- What percent of the families who have left the welfare rolls have parents who are able to be actively involved in their child's education program?
- What percent of the working parents who have left the welfare rolls have had the opportunity to increase their educational and skill level before and after leaving the public assistance programs?
- What percent of the working parents who have left the welfare rolls have reliable transportation to get to work?

By being able to answer some of these questions in a positive manner we believe the State of North Carolina could really begin to demonstrate the real power of improving the well-being of its citizens. That's what Work First should be about. We urge you to think boldly in your planning and in your evaluation.

Thank You

The State Council For Social Legislation

President- Dorothy Gamble, Tel. 919-929-7698

Intergovernmental Relations Consultant- Patricia A. Yancey, Tel. 919-781-9337

Members of the Joint Appropriations Subcommittee on Health and Human Services

My name is Polly Pearson and I am pleased to have the opportunity to speak to the state welfare reform plan --Work First-- on behalf of the State Council for Social Legislation. My organization, the Western North Carolina Methodist Women, is a member of the State Council.

The State Council, which was founded in 1920, has been working in education and advocacy for social issues for many years. We represent 26 organizations and numerous individuals from across the state. The State Council's goals and objectives include the coordination of Views of member organizations on state wide social issues for the purpose of education and legislative support.

I do not want to repeat the many comments that have been made (will be made) here today but would rather highlight just a few points regarding the State Plan for Work First.

It seems very important that we focus on strengthening the family in our efforts to help people become more self-reliant. We must have in place the resources in local counties to help parents of very different kinds build their capacities to care effectively for their children and each other. Sometimes this requires a lot of work and time on the part of helping individuals and the developing parent, but when it works right we save children, we save adults, we save public funds, we save grief and pain, and

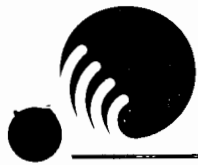
in fact we gain productive citizens. To get there, as I mentioned, takes time and effort and resources. Our plea is that while we are working toward the successful goal we will not penalize children when the adult has not yet met their obligations under the Work First Program. We would encourage you to remove all sanctions that are more harsh than those provided under the current federal and state law.

Thank you for your focus on the most vulnerable families in our state. Please have in place the supportive people and resources necessary so that when the economy turns downwards we will not have a whole new group of destitute families in our counties.

The State Council For Social Legislation

President- Dorothy Gamble, Tel. 919-929-7698

Intergovernmental Relations Consultant- Patricia A. Yancey, Tel. 919-781-9337



NASW

NORTH CAROLINA CHAPTER

National Association of Social Workers

**NATIONAL ASSOCIATION OF SOCIAL WORKERS-NC CHAPTER
COMMENTS ON NORTH CAROLINA'S
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES STATE PLAN
MAY 27, 1998**



The North Carolina Chapter of the National Association of Social Workers (NASW-NC) is pleased to have the opportunity to submit comments on North Carolina's State TANF Plan. NASW-NC is the largest professional social work organization in the State, representing more than 3,600 members. Our members work every day with clients who will be impacted by this State Plan. Actually, we believe every citizen of the state will be impacted in some way by this Plan. We hope you will consider our recommendations in the final revisions of the Plan.

RECOMMENDATION 1:

THE PRIMARY GOAL OF WORK FIRST SHOULD BE MOVING FAMILIES TO SELF-SUFFICIENCY

The Plan states that North Carolina's ultimate goal is to help all families move to self-sufficiency. NASW-NC supports this ultimate goal for our state. However, the first Statewide Work First Goal is caseload reduction. Reduction of caseload is not an appropriate measure of the number of families moved to self-sufficiency. Counties may feel such pressure to reduce caseload that this measure will actually be harmful to the goal of moving families to self-sufficiency. When families are moved to self-sufficiency, everyone benefits (the County, the State, and the families and children in the system). Moving families to self-sufficiency will involve establishing policies that address issues such as child care, transportation, health care and increasing the minimum wage. Caseload reductions should NOT be a goal, although it could be used as one measure of another goal, such as getting adults into employment. We urge the State to revise the Work First Goals to remove caseload reduction as a goal and to state that the primary goal of Work First is moving Families to self-sufficiency.

RECOMMENDATION 2:

CHILD WELL-BEING MUST BE CLEARLY DEFINED AND MORE OF A PRIORITY

The first purpose of the Federal Welfare Reform law (The Personal Responsibility and Work Opportunity Reconciliation Act of 1996) is to provide assistance to needy families so that children may be cared for in their own homes. Yet, in evaluating the impact of the State's Plan, the number of children removed from their home is not listed as an indicator to be considered. While child well-being is listed as a Work First Goal, it is listed last and is not very well defined. NASW-NC urges that child well-being be given a higher priority in the Work First Goals. It should be one of the top goals of the program after moving families to self-sufficiency.

Child well-being also needs to be defined (the definition in the Plan is insufficient in that it is narrow and only measures something the counties are already required to do). We need a definition of child well-being that measures the factors all children need to grow optimally and to develop into adulthood as citizens contributing to their own support and the support of their community. We know that children need: 1) a loving relationship with their parents and other adults, 2) a safe and healthy environment and 3) a learning environment. The Plan should choose indicators that broadly measure child well-being.

**RECOMMENDATION 3:
PAY-AFTER-PERFORMANCE POLICIES SHOULD BE REMOVED**

Pay-after-performance is bad policy that places families and children unnecessarily at risk, because it completely cuts off all cash assistance to families who cannot meet the work requirements prior to requesting aid. The Plan specifies a pay-after-performance policy immediately for all two-parent families, and as the second sanction for all families. Both should be removed, as they are unnecessarily harsh. NASW-NC understands that the state is concerned about federal work quotas for two-parent families, and possibly penalties for the state. We would suggest that the State provide for these families with other funds and services, as well as actively advocate for the federal government to change its policy.

**RECOMMENDATION 4:
THE TWO-YEAR TIME LIMIT SHOULD BE ELIMINATED**

The Plan does not directly address what will happen to families that reach the two-year time limit. Local community agencies (including religious groups and non-profits) say that while they want to help, they cannot provide the safety net for all of these families. Until the State can address some of the broader issues involved in helping families become self-sufficient, and can show that Work First will indeed be successful in moving families to self-sufficiency, the two-year time limit should be eliminated. The federal law only restricts families to a 5-year time limit, and North Carolina families should be allowed this time frame in order to overcome barriers and become truly self-sufficient.

**RECOMMENDATION 5:
EMPHASIS SHOULD BE PLACED ON HIRING QUALIFIED PROFESSIONALS**

In all cases, the State will be more likely to achieve its goals if it hires qualified professionals to work with Work First Families. When a program hires Social Workers, those persons should be professionally educated BSWs or MSWs who have the education to understand the barriers facing these families and the skills to help families achieve self-sufficiency. NASW-NC is willing to help the State recruit qualified professional social workers.

**RECOMMENDATION 6:
WE SUPPORT THE INCLUSION OF THE FAMILY VIOLENCE OPTION**

Unfortunately, many people in our State are the victims of family violence. The Plan appropriately recognizes victims of family violence need exceptions to some of the normal Work First rules and policies. We recommend the State expand the Plan further to immediately implement this option statewide for all women who identify themselves as victims of domestic violence. Also, it should be clarified that ALL counties can IMMEDIATELY exempt a family from the child support cooperation requirement when the mother or children are at risk of domestic violence.

**RECOMMENDATION 7:
WE SUPPORT THE EXCLUSION OF ILLEGAL AND UNCONSTITUTIONAL ELECTING COUNTY PLANS**

No family should be denied their constitutional rights as a result of receiving Work First Family Assistance. County plans with mandatory drug testing or residency requirements were appropriately excluded. The State should continue to monitor County Plans for such legal concerns.

**RECOMMENDATION 8:
THE PROCESS FOR PUBLIC INPUT INTO COUNTY PLANS SHOULD BE IMPROVED**

We commend the State on allowing this opportunity for public input. Every County should be required to offer at least a 30-day comment period on its County Plan. This year, many counties gave only a cursory period for comments. Public hearings should be encouraged in every county.



North Carolina Justice and Community Development Center

MAY 27, 1998

**PUBLIC HEARING ON THE WORK FIRST STATE PLAN
TESTIMONY OF SORIEN K. SCHMIDT
NC JUSTICE AND COMMUNITY DEVELOPMENT CENTER**

My name is Sorien Schmidt and I am a public interest attorney and advocate at the NC Justice and Community Development Center. The Justice Center is a private, non-partisan, non-profit working to secure legal, social and economic justice for low-income, minority and working poor North Carolinians. I would like to discuss some positive aspects and some concerns regarding the North Carolina TANF State Plan and the Electing County Plans. I will conclude with a few of our recommendations.

We commend the North Carolina Department of Health and Human Services for identifying and steering clear of unconstitutional practices such as drug testing without suspicion and residency requirements. The plan is also stronger because it does not propose to count SSI income which would severely hurt all families with a disabled family member.

We do have concern about some provisions of the State Plan, however. First, the primary goal of the program should be to improve the well-being of families and children, not to reduce the rolls. Reduction of the rolls does not guarantee that any family is helped and does not address the root causes of poverty.

Second, there is no reason for the state to implement Pay-after-Performance. This policy also focuses solely on moving people off the rolls, and specifically states that families cannot receive assistance until they have worked their full work requirement. This is the harshest policy of its kind in the country. It will put families in an absurd Catch-22. When a family cannot work and support itself because they need transportation help, we won't provide them with transportation assistance until they work. This will only hurt children.

Third, the services are not yet in place to ensure that families can support themselves before their two year time limit runs out. Consequently, more emphasis should be placed on addressing critical barriers to self-sufficiency such as lack of child care, housing and transportation. Until adequate services are available the two year time limit should be stopped.

Finally, my office, in collaboration with six other organizations, has written an analysis of the Electing County plans that I will enter today with my testimony. For now I will summarize our findings by saying that it is clear from the plans that the Electing County Work First planning committees have worked extremely hard to write a plan for their counties. It was unreasonable, however, to expect these largely volunteer committees to replace 60 years of welfare policy in four months. This lack of adequate time has meant that counties did not have adequate information about the new law and policy options available to them and counties were not able to include all of the critical people in the local planning process. Consequently, plans are often vague and unclear and counties could not take advantage of the policy opportunities provided to them. This is evidenced by the fact that Electing Counties have continued to revise their plans from the moment they turned them in until less than two weeks ago.

Therefore, we recommend that the Electing Counties be given six more months in which to write their plans. During this time they must be provided more information about the requirements of the law and of policy options available to them. This also allows the State more time to try to accommodate the state computer system to the county proposals.

Regardless of when Electing County plans are reviewed there also must be adequate monitoring and evaluation of the impact the plans have on families. Only monitoring and evaluation will let us identify positive policies for replication and harmful policies that should be ended.

Finally, we recommend that a Work First family support program be put in place that follows up with all families leaving the rolls to ensure they can support themselves and to promote the improved well-being of these families.

Thank you very much for the opportunity to share my views with you today.

WILL DEVOLUTION HELP WELFARE FAMILIES?

A

n analysis of the proposed electing county welfare plans



the north carolina justice and community development center

in collaboration with The Common Sense Foundation. JUILIE Project of the Council of Churches. NC Equity. NC Fair Share. NC Hunger Network and Southerners for Economic Justice

WILL DEVOLUTION HELP WELFARE FAMILIES?



n analysis of the proposed electing county welfare plans



the north carolina justice and community development center

**PO Box 28088 • Raleigh, NC • 27811
818/858-2570 • www.ncjustice.org**

In collaboration with The Common Sense Foundation, JUBILEE Project of the Council of Churches, NC Equity, NC Fair Share, NC Hunger Network and Southerners for Economic Justice

North Carolina policy makers are about to review the preliminary products of their decision to shift welfare policy decision-making to the county level. The initial planning stage of the State's sweeping welfare reform law of 1997 is about to draw to a close, as the legislature chooses to approve or disapprove twenty seven separate county welfare plans. The implications for public assistance recipients, over two-thirds of whom are children, are enormous. While it may be too soon to measure the full results of North Carolina's far-reaching experiment with devolution, critical policy changes have been proposed which will have a dramatic impact on the well-being of low-income families.

The purpose of this report is to provide policy makers and the citizens of North Carolina with the information necessary to engage in informed debate about the Electing County proposals individually and the Electing County experiment generally. This report is not a ranking or rating of the county plans. Rather the report *provides an analysis* of several of the key issues and components of the Electing County plans including the treatment of time limits, sanctions, eligibility criteria and the counties' ability to address the needs they identified. It compares each of these components, not only to those of other Electing Counties, but also to the State's current and proposed Work First plan. The report discusses the choices made by the Electing Counties and analyzes the likely implication of those choices for welfare recipients.

Finally, this analysis provides policy makers with recommendations to be used during the upcoming legislative review of the plans.

To conduct this analysis, the Justice Center reviewed the initial plan and the revisions submitted by each of the twenty seven counties that have applied for Electing County status. Mitchell County, which got permission to submit all documents a month late due to local flooding, is included in the report. The plans and revisions each contain an estimated Budget Summary by Category of Expenditure. Some plans also include a Budget Summary by Purpose of Expenditure. Because this process remains fluid, counties may have submitted additional revisions which are not included here. Where we have learned from NC HHS of additional revisions they have been noted in the text.

The twenty seven counties that applied for Electing County status are: Alamance, Cabarrus, Caldwell, Caswell, Catawba, Chatham, Cherokee, Craven, Davidson, Davie, Forsyth, Henderson, Iredell, Lincoln, Macon, McDowell, Mitchell, Moore, New Hanover, Polk, Randolph, Rutherford, Sampson, Stokes, Surry, Transylvania, and Wilkes. Cabarrus County subsequently voted to remove its application for Electing County status; however, this was done at such a late date that information about their plan remains in this report.

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Welfare Reform Background

Since it was established as part of the Social Security Act of 1935, the Aid to Families with Dependent Children program (AFDC) had provided monthly cash assistance to children living in homes determined to be “deprived of parental support and care.” Typically the children’s father, who would be expected to provide the family’s income, was absent or could not work. Since its inception, the social welfare system in the United States was based on the belief that all children, regardless of the actions of their parents, should be protected from poverty. The goals of our nation’s publicly-funded welfare programs have been two-fold: to provide a safety net for many of our most vulnerable citizens, while at the same time allowing them to become productive, useful, and self-supporting individuals for the benefit of society as a whole.

During the past two decades, public support for the nation’s welfare system has eroded substantially. Spurred by the welfare system’s apparent failure to end the presence of a large economic underclass, many Americans have argued that the system was a self-perpetuating trap that kept families in poverty and dependency. Others argued that the failure was instead attributable to the system’s chronic under-funding, improper implementation, and rules and goals that had not kept pace with greater societal changes. Public debates about welfare have also been greatly influenced by concerns about the cost, size and inefficiency of government generally, as well as broader societal issues such as the rise in out of wedlock births.

In 1996, the debate over welfare reached its most critical juncture. Siding with those who favored elimination of the old system, the federal government took the dramatic step of reversing 60 years of national welfare policy by transferring the responsibility for the design and operation of welfare programs to the 50 state governments. This process, sometimes referred to as “*devolution*,” was based upon the premise that state

governments would be able to act more efficiently, more flexibly and with a much better understanding of the needs of their citizens than was possible for a federal bureaucracy.

In most states, devolution has worked as expected to foster new statewide welfare programs. While national uniformity no longer exists, the poor are largely subject to uniform policies throughout their individual states. North Carolina, however, has chosen to follow another path that is unique among the states. In 1997, building upon the premise of devolution, State policy makers chose to experiment further by permitting a specified number of counties to “elect” to design and run their own welfare programs. North Carolina has thus created a laboratory for experimentation in social welfare policy that will have consequences for its citizens for years to come.

Under the new law, counties that wished to operate their own welfare systems (called “Electing Counties”) were required to develop a local plan and submit the plan to the North Carolina Department of Health and Human Services (NC HHS) for review. Counties were required to describe the process they used to adopt their local plan, what benefits and services they would offer low-income citizens, and the policies and procedures they would use to operate their systems. Given the experimental nature of allowing counties to set their own welfare rules and policies, the new law limited the number of counties which could be approved by NC HHS to no more than 15.5% of the State’s total welfare caseload. Twenty seven counties, with a total aggregate population of 20.83% of the welfare caseload have requested “Electing County” status.¹ NC HHS was given responsibility to review the competing plans and to make recommendations to the General Assembly for final review and approval. In May, NC HHS completed its review of the competing proposals and revisions, recommending that 19 of the 27 proposed county plans be approved by the General Assembly.

¹ With the withdrawal of Cabarrus county’s plan, 20.11% of the Work First population is covered by the applicant counties. The 27 counties are listed in the Preface.

North Carolina's unique experiment with devolution is a high stakes game. First and foremost, the stakes are high for low-income families and children whose lives will soon be subject to a host of new policies, many of which dismantle the historic safety net provided to protect women and children. If the experiment fails, the lives of thousands of low-income North Carolinians will be fundamentally changed for years to come. The stakes for local communities, the faith community, charities and non-profits are also high as these groups are being asked, in many instances, to replace the role played by government. Lastly, the stakes for taxpayers and the State of North Carolina are enormous. Short term reductions in the number of citizens receiving public assistance may be replaced with higher poverty, higher unemployment, and host of unintended social and financial consequences that may well accompany any untested social experiment. Given these high stakes, it is imperative that policy makers act carefully to ensure that North Carolina's citizens, communities and economic future are protected.

The stated policy objective for welfare reform has never been to remove families from the welfare rolls, but to improve their economic situation so they no longer need public assistance to support their families. In light of this objective, the Justice Center believes that the guiding principles of any attempt to reform our social welfare system should be as follows:

- The goal should be to reduce poverty, not just welfare.
- People have legitimate barriers to achieving economic independence that must be acknowledged and addressed.
- Public policy should promote full employment at a living wage.
- The basic necessities of life must be provided to all persons who for good reasons cannot work and still need help.

- Individuals and families need the support of businesses and communities to take charge of, and be responsible for, their financial, emotional and physical well-being.
- Reforms must be based on social respect, trust, fairness and compassion for all in our society and affirm the worth of each individual and the right to individual self-determination and responsibility.

Scope of this Report

The Justice Center reviewed and analyzed each of the twenty-seven Electing County plans submitted to NC HHS and their revisions. This process was made difficult because the plans are not easy to compare or analyze. Each varies greatly in the way issues are addressed, and in the depth and detail in which policy decisions are described. Furthermore, Electing Counties were revising their plans and submitting additional information almost from the moment they submitted their initial plan. The plans are also often difficult to interpret or understand because critical details are missing, making it hard to determine what services will be provided or exactly what policies counties intend to implement.

Electing Counties were required to submit a plan that described the basis on which the county's plan was built. Plan authors were required to describe: the planning process used, including the composition of the welfare planning committee; the conditions within the county; the outcomes and goals for the county; plans to measure and achieve those goals; plans for administration; their community service program; the services to be provided; eligibility criteria; their emergency assistance program, if any; the program budget; and innovative county strategies. In short, each plan contains numerous choices which will directly or indirectly impact the economic viability of public assistance families.

For purposes of this report, the Justice Center identified the policy options that counties proposed for fifteen discrete issues. These issues were selected for review for several reasons. Many are federal or state law requirements. Some relate to eligibility criteria or benefit levels, which are the primary issues over which Electing Counties have new policy making power. Others were reviewed because they address critical client needs or have constitutional implications. The fifteen policy and program issues reviewed are:

Time limits

Residency Requirements

Who can apply/be included in payment

Benefit levels and treatment of income

Impact on Disabled Families

Resources

Domestic violence

Transportation

Child care

Substance abuse

Pay after performance

Sanctions

Community service programs

Appeals procedure

Maintenance of effort

The analysis of each issue is organized into the following categories:

The Issue: Here, the importance of the issue is summarized.

Policy Background: Any federal or state statutory requirements, and constitutional or other legal issues are noted.

Standard County Policy: This section describes what rules the Standard Counties will follow. If NC HHS has recommended changes to the current state plan, these proposals are discussed as well. This will give the reader some basis upon which to compare the Electing County plans with current and proposed state rules.

Electing County Options: Here, the report discusses the choices available to the Electing Counties, including questions that need to be answered, and issues to be considered.

Electing County Plans: This section of the report summarizes the decisions made by the Electing Counties, describes how these compare to those of other counties, and analyzes how these choices are likely to impact families. Where county proposals are unclear, it is so noted.

Conclusion: The last section on each issue provides general conclusions and recommendations regarding the proposals on that issue to be used during the legislative review of the plans.

In addition to the analysis of these fifteen issues, the Justice Center identified several common issues that impact all or most of the plans. These are discussed before the analysis of the specific issues to provide the reader with further background on the plans. Finally, we provide our conclusions and recommendations based on what was revealed by this analysis.

The seven issues discussed below affected most or all of the Electing County plans or will affect their implementation. While these issues may not be evident on the surface of the plans, the planning process, county goal setting and the State computer system had a major affect on what proposals are or are not included the plans. For example, many counties did not implement policies they would have liked because the policy would have made their program incompatible with the State computer system.

Other issues make the plans hard to understand or hard to implement. When Counties indicate they adopt the State policy, for example, do they mean the policy at the time the county plan was written or State policy adopted after that date. Monitoring and evaluation should impact the implementation of policies and inform future policy decision-making, yet these components are missing from the plans and their role is unclear. Consequently, these seven issues common to most of the plans influenced the planning process, impacted the plan outcomes and will continue to shape the implementation of reforms. They are critical issues for understanding the Electing County process and evaluating this experiment as a whole.

1. The Planning Process

One premise upon which the decision for devolution of welfare to the local level was based, is that communities would use a democratic process to create programs with broad-based community involvement and support. However, this process proved to be challenging to achieve. The Electing Counties had an unreasonably short planning period and were provided little guidance or information on welfare policy options and State requirements. In four months, counties had to decide whether to apply for Electing County status, assign citizens to a Work First planning committee, educate the committee about the new law and the current programs, prepare a plan, conduct a public comment period, review the plan in light of the public

comments and secure County Commissioners' approval of the final plan. Not surprisingly, in spite of enormous effort on the part of county Work First planning committees and county staff, counties found it difficult to complete their plans and to take advantage of many of the policy making opportunities afforded them. This is evidenced by the fact that several counties have continued to revise their plans, some substantially, ever since they first turned them in to the State.

First, many Counties did not have full public participation. Some county welfare planning committees did not include all of the persons required by statute. Other critical community members were not included in the process. Nineteen of the twenty seven Electing Counties planning committees included no welfare recipients. In fact, only 13 of the 457 total people appointed to committees were welfare recipients. In addition, while committees proposed that local private service programs and the faith community provide critical service components to Work First recipients, these other community members were sometimes not consulted or included in the planning process.

Second, in spite of a statutory requirement for public comment, many counties did not allow for meaningful public participation. Some counties held one or two day public comment periods. Others did not make their draft plans readily available to the public. Several counties only allowed public comment at the County Board of Commissioner's meeting where the plan was up for a final vote of approval, allowing no time for revisions in response to public input. Not surprisingly, few public comments were made, and at least one commentator noted that his comments were not shown to the Commissioners or the planning committee.

The local planning process in many of the Electing Counties was far from open to public participation. Opportunities were lost to learn of unique and new ideas from the broader community and to enlist their support for the

proposals. Plans thus lack the benefit of the knowledge and experience of many local citizens envisioned by State policy makers when they created the Electing County process. Some plans do not even meet the minimum requirements of State law. It also means that county planners may not have realized there are alternatives to some of the policies they considered. The planners were often limited to following State recommendations since that was all they knew or had time for.

2. County Welfare Goal Setting

Another of the premises upon which devolution of welfare to the county level was based is that Counties would be better able to create goals that address their specific needs and conditions. State law provides broad purpose and goal statements, but Electing Counties are given wide latitude in setting their own goals. In fact, State welfare law requires that each Electing County Board of Commissioners establish county outcome and performance goals.

Nonetheless, with the exception of a very few counties, Electing Counties did not define their own goals, but chose instead to use eight goals recommended by NC HHS. Electing Counties thus did not take advantage of their opportunity to determine perhaps the most critical component for shaping their Work First program to meet their individual needs.

In addition, any weaknesses in NC HHS' recommended goals are replicated unnecessarily in each Electing County. For example, the top HHS recommended goal is caseload reduction. This goal does nothing to meet the statutory purpose of the North Carolina Work First program which is "to provide eligible families with short-term assistance to facilitate their movement to self-sufficiency through employment." Achieving caseload reduction only guarantees that fewer families are served, not that they are employed or self-sufficient.

Another problematic goal recommended by HHS concerns child well-being. Improving the well-being of participating children and families should be a cornerstone of any welfare program. Moreover, both Electing Counties and the State are required by law to monitor and evaluate the impact of the Work First Program on several specific child and family well-being indicators (e.g. economic security, health, child abuse and neglect, and school attendance). The only HHS recommended goal regarding child well-being, however, states that all children in Work First that are known to Child Protective Services must have a protection plan. This goal narrowly focuses on abuse and neglect only, ignoring many other children not in this situation and numerous other important issues including the health, education, nutrition, social development and economic security of children. The goal also does not address the child's well-being until he or she is already abused and neglected, instead of focusing on prevention. Furthermore, every child known to Child Protective Service should already have a protection plan. Nonetheless, every Electing County adopted the State's goal and failed to provide any further goals or benchmarks for improving child and family well-being.

3. Computer Support and Its Impact on Policy Decisions

A new issue raised by the Electing County experiment is whether the NC HHS can continue to provide computer support to Electing Counties that implement rules varying from State policy. This is critical not only for everyday implementation issues that require computer support, such as calculating family eligibility and benefit levels and cutting monthly benefit checks, but also for completing the federal reporting requirements.

Until the State's computer system can be upgraded and altered to address these new variations in policy, it is clear the State cannot support some of

the policy changes initially proposed by Electing Counties. The NC HHS notified counties that they could not provide computer support to any county implementing benefit and eligibility rules that would result in some families receiving Work First assistance when they were not also eligible for Medicaid. This resulted in many counties removing policy changes from their plans. These proposed changes included things such as allowing families to remain on Work First with higher income levels as a reward for working, and exempting the value of a car from the allowable asset limit. Consequently, the lack of computer support means that many counties felt unable to use aspects of the new authority given to them, especially to implement more positive, rewarding types of reforms.

This calls into question whether Electing Counties are needed, since it is primarily the eligibility and benefit policy authority that is unique to them. It is also a clear example of the additional layer of administration required when counties have broad policy making authority over a statewide program. NC HHS has estimated that it will take them six months to adjust the computer system to implement proposed policy changes for Standard Counties. It is unclear whether if Electing County implementation is delayed, the State could adapt the computer to more of the Electing County's proposed policy changes.

4. Needs Assessment versus the Provision of Services and Benefits

By allowing local leaders to set their own welfare policy it was expected that they would be better able to address the unique realities of their county and low-income community. Each Electing County was therefore required to include in their plan a description of the conditions within the county in order to "build the case" for the county's proposed Work First plan. The description was to include the "current realities" for low-income families in

the county, including the most pressing problems they face in gaining employment; a vision statement for the county's Work First program; and a description of the current economic conditions of the county. It was hoped that the county's needs would drive the policy rather than policy decisions driving the program regardless of local needs.

On the whole, counties did an excellent job of detailing the needs and conditions of their community. They consistently noted four issues in their assessment: 1. lack of coordinated public transportation; 2. lack of adequate child care; 3. their client's lack of skills and education background; and 4. low wages, lack of benefits and reduced hours in the majority of entry level jobs available. Some counties also noted a lack of jobs in their area, or the probability that a recession will serve a particular hardship on the families they serve and may drive their Work First rolls back up straining limited funds.

Nonetheless, many counties latched onto similar policies, rather than creating or choosing policies that met their unique needs. This may reflect a lack of information regarding policy alternatives, or a lack of time to craft policies unique to the county. Whatever the reason, it means many families still cannot get access to all of the resources they need to obtain employment. For example, while all the counties noted the lack of transportation and child care, few counties funded expansion of these services or made proposals beyond exploring certain options or starting limited services. The issues of lack of skills and education, and low wages in available jobs, while widely noted, went largely unaddressed. While some North Carolina Counties already provide some limited job training and education, the Electing County plans rarely discuss beginning such programs if they did not already exist, or expanding existing programs.

Other county needs and issues, such as low wages, were viewed as beyond the scope of the welfare planning committee. Yet, by not addressing these

issues, the planning committees missed a critical opportunity to get the broader community to work toward the goal of Work First and toward the vision statement of most of the counties, which is to help families get employment and reach self-sufficiency. Furthermore, all of the plans propose to cut off assistance to families through sanctions and time limits, even though they did not address the needs identified. Plans also did not discuss what will happen to parents who cannot work in spite of their best efforts or who work but cannot earn enough to support their families.

Other barriers to economic sufficiency were not even raised. Few counties, for example, mentioned the lack of safe, affordable housing or identified it as a barrier to family self-sufficiency. Also conspicuously absent from the all but two of the county plans is the problem of domestic violence.

Finally, what is clear from the needs statement of most of the plans is that poverty is a problem not only for those receiving Work First assistance, but also for many who are working. Some counties did begin to address providing "transitional" assistance to families, or assistance after they leave Work First for employment. But this assistance is usually quite limited in scope and time, and the plans generally do not address the broader issue. While it is true that working poverty issues need to be addressed by the broader community and at all levels of government, counties again missed this critical opportunity to acknowledge this dilemma by eliminating arbitrary time limits and sanctions that punish poor families for circumstances beyond their control and thereby challenge the broader community to correct these problems.

5. Personal Responsibility for Counties: Accountability

With additional policy making authority comes greater responsibility for the funds and programs that are subject to that authority. All Electing Counties

must ensure their welfare plans are constitutional and meet state and federal welfare law requirements. NC HHS is charged with ensuring this as well. Electing Counties must notify the public of their policies in a clear, understandable manner that gives the public notice of what services are provided and of what is expected of service recipients. Furthermore, all county policies must be available for public scrutiny. The public, NC HHS and State legislators must have available sufficient information about county policy and budgeting to hold Electing Counties accountable for the use of taxpayer money. This is critical to ensure the legal use of funds and to ensure that the State is not at risk of losing federal funding.

Unfortunately, the plans are vague and missing critical details, without which it is unclear whether counties are meeting state and federal law or, in some cases, how the welfare policies will be carried out. Without further clarification of the plans, it will be impossible for the State to hold counties accountable, and for citizens to know what services are being offered with what requirements. For example, most plans are unclear or silent about when they will offer child care or transportation assistance to recipients, for how long they will provide these services, and what, if anything, they will do to help recipients who lose employment when these services end.

6. The Impact Of State Work First Policy Revisions On Electing County Plans

Electing County plans are difficult to understand in instances where counties indicated their preference to follow "current" State policy. This is problematic because the State has already changed some of its policies since the inception of the Electing County planning process, and has proposed to change others. Where an Electing County has chosen to adopt a policy that is the "same as State policy", it is unclear whether they intend to adopt the policy that was in effect at the time the Electing County plans were

submitted to the State, the revised State policy, or the proposed State policy. A strong argument can be made that any reference to the State policy can only refer to the properly enacted policy in effect at the time the plan was approved by the County Board of Commissioners. This is the only way to ensure that these important issues are properly considered by the welfare planning committees, the County Boards of Commissioners, and that the general public is given adequate notice and an opportunity to comment.

7. Evaluation And Monitoring

When implementing any change in welfare policy, either statewide or in individual counties, it is critical to monitor the immediate impact of the changes so that unintended consequences and unforeseen issues can be addressed quickly. In addition, evaluation is needed to determine the success of welfare reforms and their long term impact on families and children. Without appropriate and adequate evaluations and monitoring, policy makers and social service providers are unable to end poor practices, improve the reforms or identify which reforms should be duplicated.

Both Electing Counties and NC HHS are required by state law to “[m]onitor and evaluate the impact of the Work First Program on children and families, including the impact of the Program on the economic security and health of children and families, child abuse and neglect, caseloads for child protective services and foster care, school attendance, and academic and behavioral performance; and report the findings...” No Electing County plan, however, includes an explanation of how this will be done or even a reference to this requirement. The limited monitoring that is mentioned only looks at figures currently kept by HHS that are not specifically geared toward Electing Counties or the specific policies they proposed.

While NC HHS is conducting some evaluations, these were contracted for before passage of the 1997 state welfare law and the creation of Electing Counties. It is unclear that the current evaluations are applicable or cover the variations that will occur with the implementation of Electing County plans.

A analysis of the proposed electing county welfare plan

The Issue

In an attempt to discourage a perceived dependency on government assistance, the federal welfare reform bill imposed a five-year lifetime limit on benefits. In reality, most families cycle on and off welfare for shorter periods of time. There is some concern, however, that time limits will punish those people who cannot find work by the end of the time limit, or those who simply cannot support their families through work alone for reasons beyond their control such as health problems, domestic violence, lack of jobs, low wages, or lack of other needed services like child care and transportation. Arbitrarily-set time limits do not take into account the many different situations faced by welfare families and ignore the realities of the job market. Time limits may expose children in some destitute unemployed families to neglect, perhaps resulting in costly and wrenching foster care placements. These concerns become even more pronounced in states like North Carolina, which have implemented a shorter time limit.

Policy Background

The federal law requires all parent caretakers and their families to receive no more than 60 cumulative months (five years) of assistance paid for with federal Temporary Assistance for Needy Families (TANF) block grant dollars in their lifetime. States can exempt up to 20% of the caseload from the federal time limit for hardship reasons and can exempt families experiencing domestic violence. In addition, states can set up separate programs funded with only state or county welfare dollars to help families that have

used their 60 months of federally funded assistance. Such a program could provide emergency housing assistance, vouchers, cash or other types of help to needy families. Federal law does not require, but does not prevent, states from implementing additional shorter time limits.

Standard County Policy

In Standard Counties, the amount of time that Work First cash assistance can be provided to a person or family is limited to only 24 cumulative months. After the time limit is up, a family can reapply after being off assistance for 36 months, as long as the federal five-year time limit has not been exceeded. In other words, families can receive 24 months of Work First, go off for 36 months, reapply and receive 24 more months of assistance, go off for 36 months, and then reapply but will have only 12 months remaining in their federal time limit.

The 24-month time limit applies only to families receiving employment services with their cash assistance. Counties can exempt some families from the time limit and can extend benefits beyond the 24 months for good cause. Parents of a child under one year can be exempt from the time limit for up to 12 months in their lifetime. Non-parent caretakers can receive assistance for the child only and not be subject to work requirements or time limits.

North Carolina has not yet defined who will be exempt from the 60-month lifetime limit. NC HHS has proposed in its 1998 State Plan that families experiencing domestic violence be exempted. North Carolina has not created any separate programs funded

only with State and local money to assist persons beyond the 60-month time limit, or to stop the clock now for some families, but could do so at any time.

Electing County Options

Electing Counties are free to set any time limitations they would like as long as they do not violate the federal 60 month lifetime limit. This means that Electing Counties can choose to eliminate the 24 month time limit, to extend it for a longer period, or to shorten it. In addition, Electing Counties can define the circumstances under which a family is exempt from the federal lifetime limit and from any other time limit they may implement. They can also define when a family can get an extension of any time limit shorter than the federal limit. Electing Counties can implement policies to provide greater assistance to families nearing the end of their time limit, in order to help ensure the family is able to support itself, and they can use county funds to provide families with assistance beyond the 60 months.

Electing County Plans

- Two counties (Caswell and Mitchell) shortened the 24-month state time limit. Caswell shortened it to 20 months and Mitchell shortened it to 12 months.
- Two counties (Alamance and Moore) implemented a shorter *lifetime* limit. They each allow only 24 months in a lifetime. Alamance will start families' clocks over when they become Electing, but Moore will count past time on the State program even though this is a dramatic change in policy.

■ Two counties (Forsyth and Henderson) did not address the time limit, which was required to be in the plan.

■ Twenty-one counties chose to continue the federal and state time limits as currently defined by the State. Thirteen of these do not state whether they will count past time on the State program or will start families' clock over when they become Electing, even though the State requested this information.

■ No county extended or eliminated the 24-month time limit.

■ No county established procedures for exempting families from the time limit (other than child-only cases) or specified that they would exempt families experiencing domestic violence. No counties specified who could receive extensions, other than the general, State-set, good cause rule.

Conclusion

Electing counties did not take advantage of the opportunity to provide assistance for a greater length of time than the State-prescribed two-year time limit. Many plans lack necessary detail concerning the implementation of their time limit policy. No plan has a proposal for how to help families nearing the end of their time limit. Only a very few have plans to monitor families once they leave Work First. In addition, no county has in place the systems, funding, and programs they identified as necessary for families to become self-sufficient. Nonetheless, the time limit ticks on for thousands of children and their families.

The Issue

In an effort to discourage families from moving to a new state in order to obtain higher welfare benefits, some states have tried to implement "residency" requirements. Under such a requirement, a person or family must live in the state for a certain period of time before they are eligible for the same benefits available to all other people in that state. Since North Carolina will now allow counties to set their own benefit levels and rules, some counties are concerned that families from other counties, as well as from other states, will move there for higher benefit amounts or less punitive sanctions. Numerous studies of the former AFDC program have shown, however, that higher welfare grants have no significant impact on migration rates. Residency requirements punish low-income families who move to a new area for legitimate reasons, such as job availability or family obligations.

Policy Background

Neither the federal nor the North Carolina welfare laws contain provisions regarding residency requirements. However, the U.S. Supreme Court and many lower courts have repeatedly struck down residency requirements for public assistance as unconstitutional. Because welfare benefits are considered "necessities of life," even relatively short durational requirements have been found to violate the constitutional right to travel. As one court stated in a

recent decision, "[o]ne can as well starve in six months as in twelve...[E]ven temporary deprivations of very important benefits can operate to penalize migration." Residency requirements have been held unconstitutional both under the former Aid to Families with Dependent Children program and under the new federal block grant.

Standard County Policy

The State has not implemented any residency requirements for Work First program eligibility in Standard Counties.

Electing County Options

Electing Counties are under no obligation to implement a residency requirement, and, in fact, have been discouraged from doing so by NC HHS since it is unconstitutional.

There are numerous variations in how residency requirements have been attempted in other areas of the country. They include limiting new residents of the area to the maximum grant available in their former area of residence, or imposing different eligibility or sanction rules on new residents. While State law does not specifically prevent an Electing County from exercising such options, the county should consider that any residency requirement would certainly be subject to challenge through the courts. Furthermore, Electing Counties cannot allow the implementation of a residency rule in the Work First program to affect the taking or processing of food stamp or Medicaid applications in any way.

Electing County Plans

■ Twenty-four Electing Counties chose not to implement any type of residency requirement.

■ Macon County does not propose to implement a delay in the receipt of benefits, but would continue any penalties or sanctions imposed by another state, and will apply the corollary Macon County sanction if it is greater than the sanction imposed by the other state. In addition, if the family member quit a job to leave the other state, then an additional "job quit" monetary penalty will be imposed upon them when they apply for assistance. It is not stated how long the family must live in Macon County before this no longer applies. While these are not explicit residency requirements, they may have the same effect and therefore, may be unconstitutional.

■ Rutherford County initially planned to require a family to live in the *county* for 90 days before an application could be approved, however, they have removed this provision from their plan according to NC HHS.

■ Sampson County initially planned to require a family to live in the *state* for 90 days before an application could be approved, however, they have removed this provision from their plan according to NC HHS.

Conclusion

According to NC HHS, no counties are proposing to implement a straight-forward residency requirement. If any plans had continued to pursue such a requirement, they would have been challenged in court as unconstitutional and should not have been approved. While Macon County's plan is not as clearly unconstitutional, it may be subject to challenge as well.

The Issue

Historically, a child could only get welfare benefits while living with an adult relative. This eligibility rule was enacted to discourage people from taking in unrelated children solely for the purpose of receiving a welfare check. This rule causes a hardship, however, in those situations where a child has no choice but to live with a non-relative, even temporarily. If the non-relative caretaker has limited income, sometimes the only option may be foster care, which may not always be appropriate or beneficial. Many professional child welfare workers have requested that this "kinship requirement" be removed so that Work First may better support beneficent adults who take in children in need.

Policy Background

The federal welfare act gives states broad new authority to run their welfare programs, including more flexibility to set eligibility rules for cash assistance. The federal law does make it clear that the time limits and work rules apply to any adult receiving benefits. So, if an adult caretaker is included in the payment amount, she would be subject to the work rules and time limits. For those households where the adult caretaker is not included in the payment (called "child-only" cases), the work rules and time limits do not apply.

Standard County Policy

Under the current State Plan, parents and all siblings must be included in the payment. Many other relatives can apply for children in their care and be included (or not, at their option) in the payment. Relatives, such as a grandmother, can apply for benefits just for the child or be included in the benefit payment amount as well. Non-related adults cannot apply for children. Children and adults who receive SSI are not included as recipients.

Under the plan as proposed by NC HHS for 1998, parents, including biological, adoptive or stepparents would still be included in the payment with their child. Many other relatives would still be able to apply, and non-related adults with legal custody or guardianship may also apply for children. These non-parents may not be included in the payment, and are therefore not subject to the time limit or work requirements.

Electing County Options

Electing Counties can make it easier for children who cannot live in a traditional family setting to receive benefits by making rules for who can apply on behalf of a child more flexible, and leaving it up to the caretaker to decide whether to be included in the payment amount.

Electing County Plans

■ Fourteen counties (Cabarrus, Chatham, Davidson, Davie, Forsyth, Henderson, McDowell, Mitchell, New Hanover, Polk, Randolph, Rutherford, Surry and Wilkes) have elected to follow the State rules on who can apply for benefits, who must be included in the payment amount, and who may be included in the payment amount. It is unclear, however, that these counties will continue this policy if the proposed State Plan is adopted and the State rules are changed.

■ Four counties (Alamance, Macon, Sampson, and Lincoln) have made the rules more restrictive.

■ Caswell County has excluded certain relatives from their eligibility rule, but has added others.

■ Other counties have proposed to allow certain non-relatives to apply for benefits. In Catawba, Moore and Stokes counties, a custodian or guardian would be able to apply. In Catawba, Iredell, Stokes and Sampson counties, a person would be able to apply on behalf of a child who is at risk of coming into DSS custody or foster care. Caldwell County would propose to remove the kinship requirement completely, but feels a federal waiver is necessary to do so.

■ In Sampson County, non-parental caregivers would have to have legal custody and be included in the payment amount. This means that the work rules and time limits would apply to the adult caregiver.

■ In seven counties (Caswell, Catawba, Cherokee, Craven, Iredell, Stokes and

Transylvania), non-parental relatives cannot be included in the payment amount.

Conclusion

Limiting the number of adults who can apply for Work First assistance for a child has had the effect of preventing some stable, but low-income households from taking care of a child that can no longer live with his or her parents. The counties that impose restrictions on who can apply for benefits on behalf of a child, put children at risk unnecessarily, and may force the placement of the child into foster care with strangers at greater taxpayer expense.

The Issue

In North Carolina, the maximum amount of cash assistance for a family of three is \$272 per month. There has been no increase in monthly support in this State since 1990, despite spiraling housing, utility, and other living costs. In 1995, North Carolina had the tenth-lowest benefit level offered in the country, with maximum cash levels equaling approximately 25% of the federal poverty level. This extremely low level of assistance leaves poor families unable to address life's most basic subsistence needs, making it harder for families to become stable. This lack of adequate cash assistance leaves welfare families vulnerable to many crises, from car malfunctions to losing their homes, which interferes with their ability to get and keep employment.

When a parent starts working, their welfare benefits are immediately cut, which creates a disincentive to get a job. When welfare recipients are able to find work, they typically earn low wages in an entry-level, part-time or seasonal position. They often need supplemental assistance to adjust to work expenses and to help them gradually transition off welfare.

Policy Background

The federal welfare act gives states broad new authority to run their welfare programs, including more flexibility to set benefit payment amounts and

eligibility rules for cash assistance. States can increase benefit levels and change the rules to make it easier for families to apply for and retain eligibility for benefits.

Standard County Policy

Under current policy in North Carolina, the State uses a complex formula to determine both eligibility for and amount of benefits. This formula calculates a family's "countable" income, subtracting set amounts and excluding other amounts and percentages from wages, and compares this to a "need standard." If the "countable" income is below the need standard (less than half of the poverty level), then the family is eligible for assistance. The State will then subtract their income from the need standard and divide this figure in half to arrive at the monthly benefit, or payment amount.

The benefit amount in standard counties is currently the same as under prior AFDC law (\$272 per month for a family of three with no income). Once a family starts working, a certain part of their income is immediately counted against them and the amount of monthly benefits received is reduced. Under the current formula, deductions are made from the amount of earned income that is counted against the family. The amount of deductions is reduced gradually over a 12-month period, and the family's benefit payment drops correspondingly. At all times, families' benefits remain less than roughly 25% of the poverty level, and if their income rises over about 50% of

the poverty level, they no longer qualify for assistance.

The State, however, has proposed to change the way benefits are calculated. Under the 1998 proposed State Plan, the State will no longer use the needs standard to determine eligibility, but will instead use the payment level, which is half of the needs standard. This means that applicants for aid must have "countable" income below one-half of the current level to be eligible. This is not a significant change for families with no income. For families with "unearned income" such as workers' compensation, however, or for families that have some earnings when they apply for Work First, such as through a part-time job, benefit levels will be immediately decreased by half, and many will no longer be eligible. Families who begin working after they start receiving Work First benefits will be given the opportunity to benefit from a one-time "job bonus", under which a family can work for three months without seeing any reduction in their monthly benefits. After three months, though, their checks will be sharply reduced.² Thus, while this proposed plan increases benefits one time for some working families for three months, it sharply decreases benefits after this period, and provides no advantage to those already working when they first begin receiving Work First assistance.

Electing County Options

Electing Counties have several options to make it easier for families to achieve self-sufficiency. First of all, counties can raise the benefit payment level.

This will help ensure that families have enough cash assistance to provide for their basic life necessities. Instead of being forced to cope with evictions and utility shut-offs, they can instead focus on a path to work.

Secondly, counties can make it easier for families who are able to find work to keep more of their welfare benefits (through *earned income disregards*), at least temporarily. Under this type of policy, once a parent starts working, a certain portion of his or her wages is not counted when determining the family's eligibility for continued benefits. This helps a family gradually work their way off welfare. Other types of job bonuses can provide different incentives for finding and keeping a job.

Electing County Plans

■ Eight counties (Caldwell, Catawba, Chatham, Forsyth, McDowell, Mitchell, Rutherford, and Wilkes) have proposed to follow the current State rules for disregarding earned income. Cabarrus County will use the current formula, but will extend the disregard for up to two years, which greatly benefits families in that county. It is unclear, however, whether these counties will continue this policy if the proposed State Plan is adopted and the State rules are changed.

■ Six counties (Davidson, Iredell, Lincoln, New Hanover, Stokes and Transylvania) have indicated they will follow the proposed State Plan, which provides a one-time three month job bonus, but reduces benefits for all other families with income.

■ Surry County's plan is similar to the

proposed State Plan, but will disregard 100% of income for only one month, and 55% thereafter.

- Craven will disregard 40% of earned income for the entire time the family is eligible for benefits, but will continue using the need standard. This will simplify the benefit level calculations, and will not dramatically cut assistance for most families.

- Six counties will disregard earned income, but only for a limited period of time. Five counties (Alamance, Davie, Henderson, Randolph and Sampson) will disregard 100% of income for three months, but will not disregard any of the income thereafter. In addition, Alamance and Sampson counties will eliminate the need standard. Alamance has replaced it with a new method for calculating benefits. Caswell, which would disregard 100% of earned income for only one month, would maintain the need standard but would reduce it by 5%.

- Three counties (Cherokee, Macon, and Moore) will not disregard any earned income, which will render all but the largest of families in these counties immediately ineligible for benefits the moment a job is obtained. This will create an even greater disincentive for these families to find a job.

- In addition to the earned income disregard, nine counties (Alamance, Cabarrus, Craven, Davidson, Forsyth, Iredell, Mitchell, Stokes, Surry) have indicated that they will provide some type of job retention bonus, which provides an added incentive for families to find and keep a job. Four of these counties (Alamance, Craven, Davidson and Stokes) will provide a cash bonus

for working families. The maximum that can be received by a family in these counties would be \$450 in Alamance, \$600 in Stokes County, \$840 in Davidson County, and \$500 per year in Craven County.

- Cabarrus County plans to continue its job incentive program started under a federal AFDC waiver. In that county, a grant diversion program is used to transfer the cash benefit amount and food stamp amount to the employer to be paid to the recipient as a portion of wages. This adds incentives to employers to retain Work First families and is supposed to increase the family's wages. The wages are not treated as income for purposes of determining eligibility, and part of the earned income is disregarded for determining food stamp eligibility as well.

- In Iredell and Forsyth County, the public housing authority will provide a housing credit for those recipients living in publicly assisted housing who are able to retain a job. In Mitchell County, a \$100 grocery certificate can be obtained, and in Surry County, drawings for small gifts will be held. Catawba County will provide T-shirts and movie passes.

- The remaining seventeen counties (Caldwell, Caswell, Catawba, Chatham, Cherokee, Davie, Henderson, Lincoln, Macon, McDowell, Moore, New Hanover, Polk, Randolph, Sampson, Transylvania and Wilkes) have not elected to implement any sort of additional job bonus. Rutherford indicates that they may implement such an incentive in the future.

- In addition to the type of income counted, and the treatment of earned income, seven counties have proposed

to change the way a recipient's monthly cash benefit amounts are calculated:

- Three counties (Davidson, New Hanover and Surry) have elected to use the proposed 1998 State Plan. Some families in these counties who obtain employment will initially benefit from this policy, but will quickly see their benefits more sharply reduced. Moreover, families that already have income will lose benefits or become ineligible.

- In Craven and Alamance Counties, it appears that benefit levels will be altered for many families. Craven County has proposed to give a flat payment of \$220 to all families, and would disregard 40% of families' gross earnings. Alamance County would establish new benefit levels.

- In Caswell and Sampson Counties, the benefit level calculations would harm families. Caswell County would reduce both the need standard and payment amounts by five percent. Under Sampson County's revisions, a family of three earning as little as \$500 per month would no longer qualify for any benefits.

Conclusion

The North Carolina maximum benefit amount is already among the lowest in the nation. Lowering benefit amounts further will make families even less stable and more vulnerable to crises. Plans that lower benefit amounts hinder a family's efforts to become self-sufficient and should not be approved.

Some of the Electing County plans contain excellent provisions that encourage and enable work, including earned income disregards, and job bonuses. It is disappointing that more did not do so. For welfare reform to succeed, counties must provide key supports and rewards for the work effort.

2 Under current policy, if a parent with two children begins earning \$500 per month, her monthly benefit check would go from \$272 per month to \$145 per month for four months, would be reduced to \$82 for the next four months, and then be reduced further to \$67 indefinitely (until the parent earns too much to qualify for benefits). By contrast, under the proposed policy, her monthly benefit check would remain the same at \$272 for three months, but then would be reduced thereafter to \$47 indefinitely.

The Issue

As of December, 1996, over 32,000 children in North Carolina were receiving Supplemental Security Income (SSI), which is a federally administered cash assistance program for disabled people. In order to qualify for SSI, a child must have a serious physical or mental disorder. Many of these children reside in households that also receive Work First cash assistance. The new welfare legislation made it much harder for a child to qualify for SSI. At the same time, the new law pulled support away from many of these most vulnerable families. It did so by ending the requirement that states exclude a child's SSI benefit amount when determining whether to allow welfare benefits for other children and adults in the household. Many families with disabled children or adults in North Carolina are now in danger of losing their eligibility for Work First cash assistance, as well as supportive services such as child care and transportation.

Policy Background

Under former AFDC law, states were not allowed to include an SSI-eligible child or adult in the welfare budgeting unit or count their monthly SSI benefits in determining eligibility for AFDC. The federal welfare act, however, repeals this prohibition. The North Carolina legislature decided last year to continue the former policy that provides added

protection to families with disabled members.

Standard County Policy

Under the current and the proposed State Plan, the State does not count SSI benefits received by a family member as income when calculating the family's Work First eligibility and benefit level. Persons receiving SSI are not included in the Work First family unit, and their SSI income is not counted against the family.

Electing County Options

Electing Counties are free to set any benefit or eligibility level they want, and can decide how SSI income will be treated in making eligibility determinations. In making this important decision, policy members should consider the serious implications for families. Families raising a child or caring for an adult with a serious physical or mental disorder or emotional disturbance face significant financial, emotional and social stress. They experience high divorce rates, social isolation and limited access to support systems. Often, a parent of a disabled child cannot work, or must miss work often, because he or she has to stay home to care for the child. Many families caring for disabled members have lower incomes and have to rely on more than one public program for assistance, including welfare. While some counties may perceive these families as "double dipping," the reality is that families with disabled individuals need the additional SSI money to help

with their special costs. A recent study of families receiving SSI for children in Alabama, for example, found that the families are indeed using the money to meet basic needs for the disabled child.

In most cases, if SSI is counted when determining eligibility, the family would not be eligible for any Work First assistance. Social Security law specifically states, however, that SSI funds for a child must be used only for that child, and cannot be used to support the entire family. Cutting off a family from Work First cash assistance also cuts that family off from important supportive services, such as transportation, child care and help with finding and keeping a job.

Electing County Plans

- Almost half of the Electing Counties will count SSI in determining eligibility for Work First (Alamance, Caswell, Catawba, Craven, Davidson, Forsyth, Iredell, Macon, McDowell, Mitchell, Moore, Surry, and Wilkes.) These plans will drastically cut benefits to all families that have SSI income. In fact, most of these families will lose all Work First benefits, including supportive services.
- The remaining fourteen Electing Counties have chosen to follow the State Plan and will not count SSI benefits received by the family as income. They are: Cabarrus, Caldwell, Chatham, Cherokee, Davie, Henderson, Lincoln, New Hanover, Polk, Randolph, Rutherford, Sampson, Stokes, and Transylvania.

Conclusion

Families of children with disabilities will be further impoverished under any policy that proposes to count SSI as income in determining eligibility for TANF benefits. The proposed policy in these thirteen counties will have serious implications for families with disabled children, and should not be approved.

The Issue

Under traditional welfare rules, a family cannot own assets or property worth over a certain amount and still be eligible for assistance. This rule hinders the efforts of many families trying to save for education or a reliable car. Once a family acquires a car that is worth more than \$5,000, for example, they immediately become disqualified from the program. For welfare reform to succeed, families must be able to acquire the resources to provide for their families and to get and keep a job.

Policy Background

The federal welfare act gives states broad new authority to run their welfare programs, including more flexibility to set eligibility rules for cash assistance. States can change the rules to make it easier for families to acquire resources and still retain eligibility for benefits.

Standard County Policy

Under the current State Plan, the total asset limit is \$3,000, with very few assets excluded from consideration. A family can exclude up to \$5,000 of the value of a car; the remainder counts toward the \$3,000 limit.

Under the State Plan as proposed by NC HHS for 1998, only assets that can be "readily converted" will be counted. The asset limit will remain \$3,000 for non-vehicles, but one vehicle per adult is excluded.

Electing County Options

Electing counties are free to set any benefit or eligibility level they want. Counties can further support and enable work by allowing families to build assets and acquire reliable automobiles, by raising or eliminating the ceiling on allowable resources.

Electing County Plans:

- Four counties (Alamance, Craven, New Hanover and Surry) have eliminated the asset ceiling on the value of automobiles, as recommended in the draft 1998 State Plan. This will allow families in these counties to own reliable automobiles.
- Iredell will allow families to own a car worth up to \$10,000 and still be eligible.
- Eighteen counties have opted to follow existing State policy (Cabarrus, Caldwell, Catawba, Chatham, Davie, Davidson, Forsyth, Henderson, Lincoln, McDowell, Mitchell, Moore, Polk, Randolph, Rutherford, Stokes, Transylvania, and Wilkes). It is unclear, however, whether these counties will continue this policy if the proposed State Plan is adopted and the State rules are changed.
- Macon County has decreased the allowable value of a vehicle to \$4,650.
- No county proposed raising the non-vehicle resource limit.
- Three counties have actually made it harder for families to obtain resources and still remain eligible for benefits. Macon County has decreased the

allowable amount for non-vehicle assets to \$2,000. Caswell County has decreased the non-vehicle asset level to \$2,000. Cherokee County will count assets of all property, even if non-salable.

Conclusion

Elimination of the ceiling on the allowable value of automobiles is an excellent policy decision that provides key support and rewards for the work effort. It is disappointing that not every Electing County took this opportunity to make it easier for families to achieve self-sufficiency. It is even more disappointing that some counties chose to lower the asset ceiling. These counties are hindering, rather than helping, the economic viability of public assistance families, and their plans should not be approved.

The Issue

Recent studies have found that between 34% and 65% of women receiving cash assistance have been past victims of domestic violence and between 15% and 32% are currently abused. Many of these recipients face significant problems in finding or keeping work until this violence and its after-effects are addressed. Under welfare reform, however, they will be expected to work and be subject to the federal and state time limits unless exempted. States may be given protections from federal penalties for failure to move the required number of parents into the workforce if they provide certain protections to victims of domestic violence.

Policy Background

The federal welfare law requires states to move increasing percentages of welfare recipients into the workforce. The law also includes a five-year lifetime limit on receipt of cash assistance, but allows states to exempt up to 20% of the state's caseload from this time limit. Under the proposed US DHHS regulations, victims of domestic violence will be included in both the calculation of the work participation rates and the 20% limit on exceptions to the time limit. Under these proposed regulations, however, states will not be penalized for failing to meet the participation rates and for exceeding the 20% exemption allowance if that failure and excess is attributable to the granting of good cause waivers pursuant to the

Family Violence Option. North Carolina plans to opt into the Family Violence Option of the federal welfare act, to ensure that victims of domestic violence receive the services they need, and to take advantage of any added protections from monetary penalties that may be granted in the event that the State is unable to meet the work participation rates. Under the Family Violence Option, North Carolina should screen for and identify domestic violence among welfare recipients. They should refer those women to supportive services, and provide temporary waivers from requirements and penalties when compliance would make it more difficult for the welfare recipient to escape domestic violence, or would penalize her for failure to comply when such failure is a result of domestic violence.

Standard County Policy

Under the proposed State Plan, Standard Counties will screen and identify Work First applicants and recipients with a history of domestic violence. These individuals will be referred to counseling and supportive services. They may be exempt from certain requirements such as time limits, child support cooperation, work requirements and family cap provisions, in cases where compliance would make it more difficult for the recipient to escape domestic violence or would penalize her for failure to comply when such failure is a result of domestic violence. Before statewide implementation of this procedure, pilots will be established in a number of counties.

Electing County Options

Electing Counties were given the opportunity to address the overlap between welfare receipt and domestic violence, and to look at the additional challenges this causes to obtaining and maintaining employment. Counties must decide what services need to be provided to victims of domestic violence to overcome the extra barriers. Counties must also consider policy implications, such as whether to exempt battered women from time limits or work requirements, and whether to grant extensions to time limits. Counties must also decide what training, if any, is necessary to prepare service delivery personnel to address these needs.

Electing County Plans

- Only two Electing Counties even mention domestic violence in their plans.
- Forsyth County proposes to screen for domestic violence issues and refer for specialized services.
- Stokes County plans to refer recipients in need to community programs, but the plan contains no details on how screening or referral will take place.
- All other counties fail to take into account or address the additional problems faced by Work First participants who are victims of domestic violence.
- No county adequately meets the needs of domestic violence victims.

Conclusion

It is disappointing that only two plans even mention this very serious problem. Domestic violence has been recognized by many as a significant barrier to achieving self-sufficiency. For welfare reform to succeed, counties need to address the issue and provide support for victims. No plan should be adopted that does not ensure the safety of battered women and their children, while encouraging applicants and recipients to fulfill the requirements of Work First. The failure of these counties to address the domestic violence issue may also jeopardize the entire State's protection from fiscal penalties. Under the Family Violence Option, if the State does not meet work participation rates, the US DHHS has proposed to look at services provided to domestic violence victims. If not uniformly provided, the State's claim that domestic violence services have been provided may not pass muster. The failure of Electing Counties to provide services and implement policy changes not only hurts victims in the individual counties, but potentially hurts all Work First participants.

The Issue

Working parents must be physically able to get to jobs and to supportive services, like day care. Low-income households, however, typically lack reliable forms of transportation for commuting. In 1995, only six percent of welfare families nationwide had cars. These families must rely on other forms of transportation to get to work. Many lower skilled jobs require evening, night, and weekend work. Public transportation, if it exists at all, is often unavailable at those times. Welfare reform will not succeed unless the transportation barriers are adequately addressed.

Policy Background

A clear goal of the federal welfare reform bill is to move people off welfare and into jobs. On the issue of transportation, the State welfare reform law merely requires counties to develop transportation plans to help TANF recipients achieve economic self-sufficiency. Under Governor Hunt's original welfare reform proposal in 1996, parents who lacked access to transportation were exempt from mandatory work requirements and qualified for an extension to North Carolina's two-year time limit. It is no longer clear that these important protections still exist, making the need for adequate transportation at the local level even more critical.

Standard County Policy

There are no transportation requirements under the State Plan. Standard Counties, as well as Electing Counties, are free to provide as many or as few transportation services they deem appropriate to enable Work First recipients to get to work or day care. Transitional transportation assistance may also be provided, but it is no longer mandatory.

Under the State Plan currently in effect, a person cannot own a car that is worth more than \$5,000 and still be eligible for Work First assistance. This prevents many recipients from acquiring a reliable form of transportation. Under the State Plan proposed by NC HHS for 1998, one vehicle per adult will be excluded.

Electing County Options

As counties move to implement their welfare programs, an important issue will be whether the county is able to create effective systems that assist program participants in reaching stable employment. Electing Counties, like Standard Counties, have great flexibility in designing and implementing transportation programs.

Communities addressing the issue must first establish a clear assessment of need and a comprehensive inventory of potential resources. To create an effective program, they must recognize that the resources involve a wide range of players, both public and private. Key players include the State Department of Transportation and its local

counterparts, public transit authorities, human service agencies, and employers. To successfully address the transportation barrier to enable people to become self-sufficient, a community should use a variety of methods, explore various initiatives, involve all the necessary key players, and institute some important policy changes.

A quality transportation plan could include the following components:

- (1) Addressing individual needs such as the purchase or lease of cars, mileage reimbursement, vouchers for gas, tags, insurance, down payments;
- (2) Coordination of existing resources including transportation mapping systems, inter-agency task forces and business/community partnerships;
- (3) Full use of public or shared transportation such as increasing bus service and routes, and rural vanpooling programs;
- (4) Instituting policy changes such as providing adequate subsidies to implement a meaningful transportation plan and assuring that recipients are not punished at the end of the time limit when no adequate transportation is available.

Electing County Plans

How the Electing Counties plan to address transportation is difficult to determine, due to the lack of sufficient detail concerning transportation in most of the Electing County plans submitted to the State. While many Electing County planning committees appear to have made impressive starts in their efforts to address the transportation needs of low-income families in their communities, it is evident that most of

the counties will fail to provide even a minimum of services to meet the pressing needs of Work First families. Many plans either do not specify in detail what these services will entail, or do not state for how long the services will be provided. No proposed plan guarantees that the county will address the transportation needs of welfare recipients during the time that the individual is subject to work requirements. No county has budgeted over one percent of its Work First budget to meet the transportation needs of participants, and many county plans do not even have a line item for transportation.

Most counties will continue to rely heavily on temporary transportation measures, on an individual level, as opposed to expanding public transportation options. Thus, most plans state that they will provide mileage reimbursement or gas vouchers, to clients or volunteers (Cabarrus, Caswell, Cherokee, Craven, Davidson, Forsyth, Henderson, Lincoln, Macon, McDowell, Mitchell, Randolph, Rutherford, Sampson, Stokes, Surry and Transylvania). Others either will provide demand/response transportation (i.e., taxi service) (Cabarrus, Randolph and Rutherford) or will consider doing so (Chatham, Craven).

Many counties would also like to make it easier for Work First families to own their own automobile. To that end, several are exploring the donation of vehicles (Alamance, Catawba and Henderson), and exploring the use of DUI-seized or county surplus cars (Alamance, Cabarrus, Craven, Davidson, Forsyth and New Hanover). Only two

counties have a "wheels to work" program in place (Forsyth and Henderson), while six other are exploring this possibility for the future (Alamance, Chatham, Davidson, Lincoln, Polk and Randolph). Three counties will or may help clients purchase cars (Cabarrus, Chatham and Craven), and will help with purchase of tax and title (Cabarrus, Craven and Mitchell), purchase of insurance (Cabarrus, Craven and Mitchell) and payment for car repair (Caldwell, Chatham, Craven, Henderson, Mitchell, Randolph, Sampson and Transylvania). Catawba County is exploring a car repair donation program, and Chatham may explore a low cost lease/purchase program. Several counties plan to work with the faith community and other volunteers in these efforts (Cabarrus, Catawba, Craven, Henderson, Lincoln and Stokes), and several plan to work with employers (Cabarrus, Moore, and New Hanover).

One unintended result of owning an automobile, however, may be to immediately disqualify the family from Work First assistance due to the asset ceiling rule. Alamance, Craven, New Hanover and Surry have responded to this problem by allowing families to own vehicles of any value. Caldwell and Iredell will allow families to own a car worth up to \$10,000 and still be eligible. Macon County, on the other hand, has decreased the allowable value to \$4,650. The prohibition on owning a car worth more than \$5,000 still poses a significant barrier to achieving self-sufficiency in the remaining nineteen counties that opted to follow existing State policy (Cabarrus, Caswell, Catawba, Chatham, Cherokee, Davie, Davidson, Forsyth,

Henderson, Lincoln, McDowell, Mitchell, Moore, Polk, Randolph, Rutherford, Stokes, Transylvania, and Wilkes).

A number of counties recognize the need for the local welfare agency to collaborate with the local coordinated transportation system. Ten counties already do so or make a commitment to doing so in the coming year (Caldwell, Davidson, Davie, Iredell, McDowell, New Hanover, Polk, Randolph, Surry, and Transylvania), and five others will explore this as an option in the future (Alamance, Chatham, Moore, Sampson and Davie). Caldwell plans to coordinate with other human service agencies, and Alamance and Moore counties are considering doing so in the future.

A few counties are looking at the possibility of expanding public transit routes and hours (Chatham, Craven and Davidson). Polk County has a plan in place to test new routes on March 1, 1998, with plans for a route to serve second shift workers to begin soon thereafter. Eleven counties (Cabarrus, Caldwell, Cherokee, Davie, Iredell, Macon, Lincoln, Polk, Rutherford, Stokes and Surry) purchased fixed routes and/or have contracts with the local transportation authority to provide transportation. Chatham, Craven and Wilkes intend to explore these options in the future. Moore and Cabarrus counties expressed an interest in employing Work First recipients as monitors on local school buses.

Conclusion

If welfare reform is to be successful, transportation must necessarily be a strong component. While many counties have made strides in assessing the need and availability of transportation in their communities, all of the counties have fallen short in instituting the policy changes and budgeting the funds that are necessary to help families overcome barriers to obtaining employment. For example, no county makes it clear that adequate transportation subsidies will be provided to all who are in need. No county has made it clear that adequate case management will be provided to ensure that transportation barriers are addressed. No county has assured that recipients are not punished or prevented from receiving continued assistance at the end of the county-imposed time limit if no transportation is available. While some Electing Counties have made a good start in their attempts to address transportation, no county has agreed to implement the basic policy changes needed to ensure that families are not punished before the transportation problem is resolved. It understandably will take time for the innovative ideas proposed by many of the counties to come to fruition. Unfortunately, however, many welfare families will likely be thrown off of public assistance before these plans can become a reality.

The Issue

The need for safe and affordable child care is becoming more and more important as many parents of young children enter the labor market as a result of welfare reform. Parents of young children cannot work if they are unable to arrange child care during their work hours. Parents who live in poor neighborhoods, work odd hours, lack transportation, or have children of varied ages have an even more difficult time finding adequate child care options. The typical cost of unsubsidized child care in North Carolina far exceeds the amount received by a parent in cash assistance, especially if there is an infant or more than one young child. The cost of child care may also exceed what a parent can earn in a job paying at or slightly above the minimum wage. More child care services must be created to meet their needs if welfare reform is to be successful.

Policy Background

With the passage of welfare reform, the federal entitlement to child care ended, both for Work First recipients participating in work or work-related activities, as well as for those needing transitional child care. The new law consolidates existing child care funding sources with the Child Care Development Fund Block Grant. An additional federal appropriation was authorized, to be used for child care for low-income working families.

Under Governor Hunt's original welfare

reform proposal in 1996, parents of children under six who could not obtain appropriate child care were exempt from mandatory work requirements and qualified for an extension to North Carolina's two-year time limit. Under federal law, states can choose to exempt single adult parents with children under age one from the work requirements.

Standard County Policy

There are no child care requirements under the State Plan. Standard Counties, as well as Electing Counties, are free to provide as many or few child care services they deem appropriate to enable Work First recipients to become self-sufficient. Transitional child care may also be provided, but it is no longer mandatory.

Electing County Options

As counties move to implement their welfare programs, an important issue will be whether the counties are able to plan a more cohesive child care system that responds to the needs of Work First families and helps promote safe and healthy care for children of all ages.

A quality child care plan could include the following components: (1) Addressing individual needs by (a) reimbursing parents for child care to allow parents to engage in work activities, training, education, community service, and to allow a teen parent to attend high school; (b) providing higher reimbursement for "special needs" children who have developmental or physical disabilities;

and (c) ensuring that transportation to and from day care is provided; (2) coordination of existing resources such as the existence or establishment of an adequately staffed child care resource and referral center; and (3) increasing the supply of quality child care by (a) ensuring flexible and extended hours for both day care and transportation to day care, (b) providing child care for emergency situations; (c) providing incentives for recruitment of child care providers, especially those offering care for nonstandard work hours such as nights and weekends; (d) providing start-up grants for nonstandard hour day care; and (e) enhancing before- and after-school child care programs for middle-school-aged children. Counties should also consider what policy changes are needed to ensure the success of child care programs. Policies to consider include providing adequate subsidies in welfare reform initiatives; a guarantee of child care for recipients who are working, participating in approved education or training, or transitioning off welfare; exemption from mandatory work program participation when necessary child care is not available for a child below age 6; providing parents the right to choose appropriate care; assuring that adequate case management is provided; and assuring that recipients are not punished or removed from the welfare roles at the end of the time limit when no adequate and affordable child care is available

Electing County Plans

■ Exactly how the Electing Counties plan to address child care is somewhat difficult to analyze due to the lack of sufficient detail concerning child care in most of the Electing County plans submitted to the State. It is difficult to compare policies, because the descriptions of the child care services to be provided did not address the same issues in each plan. Not all counties have a separate line item for child care listed in their proposed budget. Counties may be addressing some child care issues through Smart Start or other initiatives and may be providing services for Work First families that are not specifically delineated in their plans.

■ While most counties identified increased supply of child care as a pressing need in their communities, the counties addressed this need with varying degrees of commitment. Most of the proposed Electing County plans contain very little detail on what child care assistance will be provided to Work First recipients, and what, if anything, the county will do to increase the supply of available, affordable child care. Four counties state that child care assistance will be provided, but only if funds are available (Cabarrus, Caswell, Iredell, and Lincoln). Most plans describe how they will prioritize State-allocated child care funds, but state little else about assistance to be provided. (Alamance, Catawba, Cherokee, Davie, Henderson, Macon, McDowell, Moore, Polk, Randolph, Sampson, Surry, and Wilkes). While most of these plans do include Work First families as priorities for their expenditure of State-allocated child care funds, three counties have not chosen to

do so (Cabarrus, Cherokee, and Stokes). Several counties appear to be relying on Smart Start to serve at least some of the child care needs of Work First families, but without describing a plan to ensure that this happens (Craven, Davidson, Mitchell and Rutherford).

■ Several counties did have innovative ideas and have developed fairly comprehensive plans. Two counties, in particular have proposed to address the need to increase the supply of quality day care in their communities, using innovative approaches. Transylvania, for example, included recruitment of providers, technical assistance, support and training, expansion of extended-time child care, and better advertisement of current services. New Hanover County plans to fund a guaranteed number of slots to allow the establishment of twenty-four hour day care services, with supplements to ensure second and third shift care, sick care, and transportation to day care. The county will encourage local businesses to provide on-site services or funding, and is exploring models for sick child care.

■ Several other counties appear to have made a commitment to provide services to all recipients. Forsyth County, for example, states that they will provide any necessary child care to enable participants to obtain and/or maintain full-time employment or to participate in the employment program and its components, as long as the participant is involved in employment programs, or, after leaving Work First, is income-eligible and has need. They plan to use a GIS system to facilitate the location of available child care. Randolph County, while stating only that child care "will be

provided," appropriates \$400,000 from its Work First budget for this effort. Davie County also states that child care "will be provided," and Caldwell County anticipates that it will have adequate funds to serve the child care population, but neither plan provides additional details. Stokes County, in its revised plan, states that in at least some cases, child care will be provided for up to two years.

■ Several other counties did a good job of identifying needs and ways to address those needs, but fell short in committing resources to meet the needs. Chatham, for example, provided an excellent list of issues to be addressed and opportunities to address the issues, but the plan specifically notes that these ideas are suggestions of a subcommittee and no county monies are being committed to fund the suggestions. Other counties list many good ideas, but only commit to exploring those ideas. Only two (New Hanover and Randolph) allocate significant funds from the Work First budget for child care expenditures.

Conclusion

With the increased emphasis on moving families from welfare rolls to work, it is critical that services such as child care be in place to ensure that the children are not harmed. While many other Electing Counties have made a good start in their attempts to address child care issues, all of the counties have fallen short in instituting the policy changes that are necessary to help families overcome this barrier to obtaining employment. No county, for example, makes it clear that adequate child care

subsidies will be provided to all who are in need. No county has made it clear that adequate case management will be provided to ensure that child care barriers are addressed. No county has provided assurances that recipients are not punished or prevented from getting continued assistance at the end of the county-imposed time limit if no child care is available. In fact one county, Caswell, has proposed to implement a policy change that specifically sanctions families if they fail to place their children in *unregulated* child care if licensed care is not available. While non-licensed care may indeed be appropriate and even preferred by many families, no parent should be forced to place their child in an unregulated setting if he or she does not chose to do so. No county plan should be approved unless it adequately addresses the need to expand the availability of decent and safe day care.

The Issue

According to the U.S. Department of Health and Human Services, between 10 and 20 percent of welfare recipients have a substance abuse problem, with about five percent of recipients affected enough to substantially limit their day-to-day functioning. Welfare programs have begun to adopt substance abuse policies as a result of efforts to require most welfare recipients to work or participate in employment programs. A substance abuse policy also addresses the fear that recipients will use welfare funds to obtain abused substances. These policies, though, which often include screening and testing for drug abuse, may be very costly, and may improperly invade the privacy rights of individuals.

Policy Background

Neither state nor federal law requires that applicants or recipients be screened, assessed or tested for substance abuse. While states have the option to test recipients for illegal drugs, substance abuse screening procedures are fraught with constitutional and other legal problems. The government must show that there is individualized suspicion, or probable cause, to conduct a substance abuse test within the mandates of the Fourth Amendment. Several other legal issues arise with testing. Individuals have the right to have positive test results confirmed and to have re-tests. There can be false positive results, caused by over-the-counter drugs or

even normal food items like poppy seeds. Counties must be able to prove who had control of the urine or blood sample at all times, known as "chain of custody," to prove the sample taken from a specific individual is the one that tested positive. Screening questionnaires have also been struck down as unconstitutional when they are too broadly written.

Standard County Policy

In March and April 1998, the State began requiring all counties to implement a substance abuse screening policy. After July 1, 1998, this will be required only of Standard Counties. The State's policy requires all applicants to be screened by a Work First caseworker (not a substance abuse professional) for risk of substance abuse. The State has provided two questionnaires to be answered by each applicant; one created to identify a risk of alcohol abuse and the other, to detect a risk for drug abuse. Any applicant found to be at risk for abuse is to be referred to a Qualified Substance Abuse Professional (QSAP) hired by the Area Mental Health Agency serving that county. In most counties, the QSAP will be located at the DSS office at least a few days per week. The QSAP will then do a more thorough assessment of the individual to try to determine if they have a substance abuse problem. The QSAP will refer individuals for more treatment, which usually includes drug testing, as appropriate. Testing is only conducted as part of treatment. If treatment is recommended, the cost is covered by Medicaid and the treatment plan becomes part of the family's

Mutual Responsibility Agreement. This means if the family violates substance abuse treatment, their Work First benefits will be sanctioned.

Electing County Options

Counties do not have to implement a substance abuse detection policy, but have the option to do so. The components of a substance abuse detection program fall into three categories: substance abuse screening, assessments and testing. A substance abuse *screening* involves asking an applicant or recipient questions from a standardized questionnaire to determine whether they may be *at risk* for substance abuse. A screening can be given orally or in writing by non-professional staff and is not intended to definitively identify substance abuse. A substance abuse *assessment* is a more in-depth review of the individual by a QSAP to identify in a more definitive manner if the individual may have a substance abuse problem now or have had one in the past and, if so, to what extent. Substance abuse *testing* refers to a test of a physical property such as blood or urine in order to identify the presence of legal or illegal substances.

Whichever detection policy is proposed, counties must set a clear protocol for how it will be conducted in order to make it more likely that the policy will be effective, accurate and legal. A fundamental issue is whether counties are looking to help recipients with a problem or merely to deny them assistance. Any testing done to detect criminal behavior must be left to the police. Urinalysis will usually not detect

alcohol and therefore may not suit a county's purpose if the goal is to help recipients obtain treatment. Counties must also decide whether screening, assessment or testing is appropriate for their goals, who will be screened or tested, when in the application process or receipt of benefits it will be conducted, by whom and whether there will be referral to other services. If, for instance, recipients are referred to Mental Health for treatment, counties should answer whether adequate treatment exists or whether the county will need to provide additional funds to make more treatment available to Work First recipients. Protocols must be established to address and reduce the legal issues to the extent possible; however, when testing is implemented, even after individual suspicion has been established, some legal issues continue even with effective protocols.

In addition to the unresolved legal issues, counties should also consider the high cost of testing all welfare recipients, the questionable reliability of any one test and the shortage of available treatment in many areas, especially in residential settings for families.

Electing County Plans

- Many county plans lack critical details and adequate protocols to address the above mentioned legal and constitutional issues.
- New Hanover and Iredell counties would test all applicants and randomly test all recipients. These are both clearly unconstitutional practices. Iredell notes that failure of a drug test will result in

termination of assistance, not in treatment, and that this will help them meet the goal to reduce caseload.

- Catawba and Stokes initially planned to test all persons in community service, a policy also likely to be unconstitutional, however, NC HHS now states that both Catawba and Stokes have removed this policy from their plans.

- While drug testing can be a normal part of a treatment plan, some counties seemed to indicate they would implement different or additional tests, but this is unclear. Caldwell, New Hanover, Polk, and Rutherford each indicated they would randomly test all in treatment.

- Davidson County was unclear regarding testing and continued to state in their revised plan "case managers may require participation in substance abuse assessment, treatment and/or testing..." If their policy is that case managers can directly refer a Work First applicant or recipient for testing without first obtaining a professional assessment of abuse, it is unconstitutional.

- Seven counties (Chatham, Davie, Forsyth, Mitchell, Randolph, and Sampson) provided so little detail that it is unclear what they intend to implement regarding substance abuse screening, assessment and/or testing. Some counties seemed confused about the difference between screening and testing. Most of these counties may intend to implement the State policy, but do not so state.

- Nineteen counties intend to follow the State Plan fairly closely (Alamance, Cabarrus, Caldwell, Caswell, Catawba, Cherokee, Craven, Davidson, Davie,

Henderson, Macon, McDowell, Moore, Polk, Rutherford, Stokes, Surry, Transylvania, and Wilkes). They will screen, refer those at risk to a QSAP or a Substance Abuse Counselor (it is unclear if this is different than a QSAP), and the QSAP/SAC will assess the individuals and refer them to treatment when necessary. No drug testing, other than through treatment, is proposed.

- Of these 19, at least six (Cabarrus, Craven, Davidson, Davie, Macon and Surry) were unclear about who they would screen: all applicants, all recipients, or some subgroup of one or the other. Many did not indicate what, if any, impact there was if the person refused the screen.

- Many counties would sanction the family for a violation of the parent's treatment plan. Some would cut off the parent and impose a protective payee to receive the remainder of the check for the children. At least 13 counties were unclear what impact referral to treatment had on the Work First case.

- Only four counties (Alamance, Caldwell, Moore and Wilkes) stated they would provide child care and transportation for clients to meet assessment and treatment requirements. Chatham County would stop a family's two year time clock if the parent's substance abuse treatment team thought it appropriate.

Conclusion

No plans should contain provisions that violate the constitutional rights of an applicant or recipient. Iredell and New Hanover Counties clearly plan to implement drug testing without individualized suspicion of abuse, which is unconstitutional and likely to face challenge in the courts. These should not be approved. Other counties may intend testing without suspicion, but it is not clear in their plan. If they do intend this, they too should be denied.

The goal of any substance abuse program should be to provide the necessary help to families so this barrier to self-sufficiency can be removed. Plans that implement screening, assessment and/or testing with suspicion should be required to set out a clear description of when these procedures will be conducted, whether benefits are contingent upon taking or passing the screen/assessment, whether treatment will be offered and a detailed protocol that addresses legal and practical issues raised. Any plan that implements screening, assessment or testing with the intent to deny assistance if substance abuse is detected, rather than to get the family treatment, should be denied. Counties must also have adequate funds allocated to cover the costs of testing and treatment.

Issue

Pay-After-Performance is the policy of requiring welfare recipients to complete their work requirement (35 hours of work/week) before they receive any cash benefits and other types of assistance, like transportation services. The intent of this policy is to help the State meet work participation requirements mandated by federal law. Unfortunately, the policy may serve only to push families off the rolls without helping them get a job. This policy is often targeted at two-parent families, on the theory that this population should find it easier to meet work requirements. Both the State and counties have said, however, that this particular group of welfare recipients actually has more barriers that prevent them from getting and keeping employment. For welfare reform to succeed, these barriers need to be addressed.

Policy Background

Neither the federal nor the state welfare laws require a pay-after-performance or a pay-for-performance policy. These policies are implemented to force families to meet their work requirement, so the State can meet its federal work quotas. The federal law requires 35% of all TANF families to work 20 hours per week and 90% of all two parent TANF families to work 35 hours per week. Pay-after-performance is where the family must meet the work requirement before they can receive any assistance.

Many states have implemented pay-for-performance in order to more closely simulate a work environment while still helping families address barriers. Under pay-for-performance, the family receives initial assistance and subsequently, receives only the percentage of their check that reflects the percentage of required hours they worked. Exceptions may be made for good cause to miss work.

Standard County Work First Policy

On March 1, 1998, NC HHS implemented pay-after-performance for all two parent families. Under the proposed Standard County State Plan, this policy will be continued for two parent families. In addition, the State has proposed to impose pay-after-performance as a second sanction for all families. The NC HHS policy means a family cannot receive cash assistance or services (such as transportation) until they prove they worked 35 hours per week for a full month. If the family is short even by one hour for any reason, they will not receive assistance. North Carolina is the only state we know of to dock the family their entire check amount for missing even small amounts of work per month when good cause exists. The family will have their needs assessed, but no assistance will be provided to them, even if the assessment shows they need the assistance to work, until they meet the work requirement. If a family does meet the work requirement, even if earning minimum wage, they will probably not qualify for assistance because they are over income, since NC HHS has also proposed to eliminate the

Standard of Need. (See section on Benefit Levels and Treatment of Income).

Electing County Options

Electing Counties are free to decide whether or not to implement this rule. In making this decision, counties should bear in mind that North Carolina's pay-after-performance policy may be the harshest version yet implemented in the country. Other options are available for those counties concerned about meeting work requirements. There is a great deal of funding currently available, for example, to initiate or expand employment, domestic violence, transportation, child care and other services that families need in order to obtain employment. Not only does North Carolina have TANF funds to provide more services, but federal Welfare-to-Work funds are also available specifically to provide services to hard-to-serve families.

If a decision to implement a pay-after-performance policy is made, counties must explore many issues, including to whom it will apply; what grounds will be allowed for exemptions; what services, if any, will be provided to help these families gain employment; and how many hours of work will be required. Counties should consider what provisions should be made if a parent has to miss work during any given month for good cause reasons, such as to care for a sick child. Counties should also consider whether their policies are actually much harsher than the typical work environment many are trying to emulate. As referred to

above, counties could implement pay-for-performance, where families receive assistance equal to the proportion of the required hours they worked. Counties may also couple any performance policy with a special Crisis Assistance fund to help families with a good cause reason that could prevent them from getting or keeping employment in months when they do not qualify for cash assistance.

Electing County Choices

■ No Electing Counties proposed any other type of pay-after-performance or pay-for-performance policy than what NC HHS put forward, although a few would apply it to other groups of clients. This failure to deviate from proposed State policy is the case even though the NC HHS policy is by far the most harsh of all of the states which have chosen to implement a pay-after-performance policy. This implies that Electing Counties either did not want to be less strict than other counties (a race to the bottom) or that they were unaware of other policy options. This inference is further supported by the fact that although 15 counties chose not to implement pay-after-performance in their initial plans, 10 added it to their revised plan after they learned that NC HHS would implement pay-after-performance in Standard Counties.

■ No county proposed to address the additional needs and employment barriers faced by two parent families, even though many counties specifically noted that this population has more barriers.

■ No county provided for tracking and

evaluating the impact this policy will have on families.

■ While 15 counties did not mention pay-after-performance, or rejected it as a policy, in their first plan submitted to the State, ten counties (Alamance, Craven, Henderson, McDowell, Mitchell, Polk, Randolph, Rutherford, Stokes, and Wilkes) revised their first plan to adopt the new State policy that applies to two parent families. Ten counties have said they would implement pay-after-performance for all two parent families since their initial plan. (Caswell, Catawba, Cherokee, Davidson, Davie, Lincoln, Macon, Moore, New Hanover, and Transylvania). It is unclear whether any of these 20 counties will also implement pay-after-performance as a second sanction as recommended by the State in the revised State Plan.

■ Three counties (Caldwell, Chatham, Forsyth) did not mention pay-after-performance in their plan or plan revisions.

■ Three counties would implement pay-after-performance for two parent families and many, or all, single parent households (Cabarrus, Iredell, and Surry)/

Conclusion

While a pay-after-performance policy may have the effect of causing a drop in the rolls, it does not address the core reasons that prevent families from obtaining employment. A policy of providing no assistance does nothing to further the goal of moving families into sustaining jobs; it merely guarantees that fewer

families are served. In those counties where families are being denied employment services as well as cash assistance, the family seeking assistance is caught in an absurd Catch 22. If the recipient needs transportation to get to work, for example, she will need to prove that she worked *before* she can get the transportation assistance. Many two parent families may find they have no choice but to separate in order to get the assistance they need to care for their children. Finally, while it appears virtually certain that this type of policy will harm some families, no county provides for tracking and evaluating its impact. No plans containing pay-after-performance should be approved, as they are certain to hurt children, and pay-for-performance should only be allowed in test counties and with adequate monitoring and evaluation to prevent harm to children.

Issue

As a condition of receiving welfare benefits, all adult recipients must meet or complete certain program requirements. These requirements range from attending certain meetings with a case worker to making sure their children attend school regularly, from getting their children immunized to participating in work or work-related activities. To foster "personal responsibility," participants are punished for failure to comply with any of these requirements. This punishment typically takes the form of a system of progressive sanctions, where a specific amount is reduced from the welfare benefit amount for several months, followed by increased reductions over increased time periods for subsequent sanctions. Even a small cut in a family's assistance can lead to great hardship, since Work First recipient families usually have income well below the poverty level. A loss of assistance for even short periods can lead to homelessness, missed meals, or an inability to obtain other items necessary for daily living.

Policy Background

"Personal responsibility" is a cornerstone of the federal welfare law. In addition to strict work requirements and short time limits, the law mandates that states impose sanctions on welfare recipients for failure to comply with work, child support, and other program

rules. The law allows states to develop their own sanction schemes as long as the minimum sanction for failure to comply is a *pro rata* reduction for refusing to work, or a 25-percent reduction in the grant for non-cooperation with child support enforcement. A state cannot sanction a single head of household if she has a child under the age of 6 and does not have child care that is available, suitable and affordable. All sanctions are subject to "good cause" and "other exceptions as the state may establish."

Standard County Work First Policy

Under the State Plan currently in effect, sanctions for failure to comply with the rules of the program are as follows:

- First Violation:* \$50 for 3 months
- Second Violation:* \$75 for 3 months
- Third Violation:* \$75 for 6 months
- Fourth Violation:* \$75 for 12 months

NC HHS has proposed to change the sanctions for 1998. According to the proposed State Plan, if a parent or caretaker fails to cooperate with child support enforcement, the family will have their Work First payment reduced by 25% until they cooperate. For failure to participate in work activities, or for leaving a job without good cause, or for other failure to follow the rules, the family will be sanctioned as follows:

- First Violation:* 25% reduction for 3 months

Second and subsequent violations:

Pay-after-performance for a minimum of 3 months. If compliance has not been reached at the end of 3 months, case will be terminated.

While the first revised sanction does not present a significant change from current rules, the second sanction is dramatically harsher and will work to end service to many families.

Electing County Options

Electing counties are free to establish their own sanction policies as long as they reduce benefits by at least 25% for failure to comply with child support enforcement, and provide for a *pro rata* reduction in benefits for failure to comply with work requirements. Counties have the option to lessen the punitive nature of the sanction process through several options. These include options to: apply sanctions only on adults (reduce, rather than terminate benefits); create a more graduated progression of penalties; provide that sanctions are immediately "curable," that is that full benefits levels are reinstated immediately as soon as the family is in compliance; exempt certain families from penalties (for example, people with disabilities, or those experiencing domestic violence); provide procedural protections so that families are less likely to be wrongly penalized, require an extensive review process, including an interdisciplinary team review and home visit prior to termination of benefits to ensure sanction is appropriate and that children's needs are protected; and

consider third party protective payees as an alternative to a full family sanction.

Electing County Plans

- No county adopted a sanction policy that lessens the punitive effects on families (when compared to current State rules), or ensures adequate protections for children.
- Five counties elected to keep a sanction policy that is essentially the same as the State policy (Chatham, Cherokee, Forsyth (except for additional job quit penalty, see below), McDowell and Polk). All other counties chose a more punitive approach.
- Twenty two Electing Counties have opted to impose sanction policies that are more punitive than current State policy. Mitchell and Caldwell Counties would terminate benefits after the first violation of program rules. In Mitchell County, which has proposed the most punitive sanction policy, the family is immediately terminated from the program and is not given any opportunity to reapply. In Caldwell County, the entire family will be terminated if the family fails to cooperate after a three month period where DSS "works with" the family.
- Cabarrus has chosen to institute a pay-after-performance policy as a sanction, as opposed to monetary penalties. Under their plan, a family who fails to participate in minimum hours of work will not get their next month's benefit check until they can show that they are in compliance with the work rules.
- The remainder of the counties

propose a graduated system of penalties. Most impose a harsher first penalty by increasing the reduction of benefits for varying periods of time. For example, six counties impose a penalty of \$100 for three months (Catawba, Iredell, Moore, Rutherford, Transylvania and Wilkes). Davidson imposes a \$100 penalty for one month. Lincoln County would reduce the benefit amount by one-third for three months; Alamance County would reduce benefits by 30% for three months; and Craven and New Hanover Counties propose to reduce benefits by 25% for the first offense. In Caswell County, the benefit amount is reduced 25% for the first month and if there is no compliance the check is reduced 50% for the second, and if still no compliance is achieved, the check is reduced to \$0 for the third month. At the end of the third month, the grant is terminated and the family cannot reapply for three months. In Sampson County, the penalty for the first violation is \$100 or 25% of the grant amount, whichever is greater.

■ Many counties have also chosen a much harsher approach for the family's second violation of program rules. Eight counties will punish the entire family by imposing a full family sanction for three months (Catawba, Lincoln, Macon, Moore, Rutherford, Surry, Stokes and Wilkes); Transylvania County will impose a full family sanction for two months. Iredell will terminate the grant for one month or until compliance. Caswell will follow the same sanction schedule as described above, but the family cannot reapply for 12 months.

■ The remaining seven counties would

impose a financial sanction for the second violation, which in most cases, is harsher than current policy. Davidson will cut the benefit amount by \$200 for one month. Alamance will cut the benefit amount by 60 percent and New Hanover will cut the benefit amount by 50 percent. Sampson County would cut benefits by \$100 for three months, while two counties (Davie and Henderson) have opted to keep the State sanction amount of \$75 for three months for the second violation.

■ Several counties do not even have a sanction for a third violation listed in their plans, because the family would no longer be eligible to receive benefits by the time they made it through the punishment period of the first or second sanction. Participants living in Caswell, Iredell, Mitchell and Moore would fall into this category.

■ In many of the other counties, the sanctions are even harsher for the third violation, and often involve the complete cut-off of assistance. Only Sampson has chosen a penalty that is not significantly harsher than the State policy by imposing a penalty of \$100 or 25%, whichever is greater, for 12 months. Fourteen other counties have chosen to either give \$0 payment or terminate the entire family from the grant. Alamance, Catawba, Davie, Henderson, Lincoln, Macon, New Hanover, Randolph, Rutherford, Surry, Transylvania, and Wilkes would terminate families for specific periods of time. Davidson and Stokes would terminate the grant until the family complies with the requirement.

■ Eleven counties have a separate job-quit policy that imposes different

sanctions on families when the adult in the household quits or gets fired from a job without good cause. It is unclear how the job-quit policy in Alamance will be applied; a monetary sanction proportionate to their job bonus policy will somehow be imposed. The job-quit policies in all other counties imposing them will result in termination from the grant for some length of time. Four counties will terminate the family permanently (Caldwell, Davidson, Iredell, and Surry). One county (Rutherford) proposes termination for six months, and the remaining five counties would terminate the family for three months (Caswell - for first offense; 12 months for second - Catawba, Forsyth, Moore and Stokes). Catawba and Stokes allow the recipient the opportunity to cure the job quit sanction.

Conclusion

It is disappointing that no Electing County has chosen to implement a sanction policy that sufficiently protects children living in households that receive welfare. Family economic security is sure to suffer in the 20 Electing Counties that would impose harsher sanctions on families that are already subject to strict work requirements and short time limits. For the most part, the plans' multiple and overlapping sanctions are overly punitive and confusing. While some counties claim that harsh sanctions are necessary to prepare recipients for time limits, full family sanctions serve only to cut families off from assistance without ensuring their economic self-sufficiency. The definition of good cause is not sufficiently broad in many of these plans, and needs to be clarified. Plans that propose denying benefits to the entire family are unnecessary and harm children for the behavior of their parents.

The Issue:

In order to help families meet their weekly work requirement and gain practical work experience, many states and counties have begun to offer community service work to welfare recipients. Community service involves placing the parent in a work slot with a non-profit or public (government) employer for no wages other than their welfare check. The employer does not pay the community service participant, but, in theory at least, does provide training and supervision and must conduct some administrative duties. The goals of a community service program are to provide a benefit to the employer by getting free help on a regular basis, and to give the participant some real work experience and the opportunity to develop job skills. Ideally, the employer will hire the community service participant when a job becomes available, or can serve as a reference for them with other employers. Historically, however, workfare-type programs have often exploited people who have been unable to find paid employment, so it is critical to protect the rights of workers and carefully monitor any such programs.

Policy Background

Community service is an issue subject to great confusion. The community service requirement is unclear in the North Carolina welfare statutes, and there are important U.S. Department of Labor

(DOL) instructions that apply to community service programs which appear to have complicated the matter for many counties. Under state law Electing Counties must "[p]rovide community service work for any recipient who cannot find employment." N.C. Gen. Stat. §108A-27.3 (a) (7). This is clear on its face, but later in the statute is a second, different definition of who must be served with community service. These two statements make it unclear whether Electing Counties must provide community service to all Work First recipients who cannot find employment of *any* type, or to all recipients who cannot find *full-time* employment. Both references to community service also seem to conflict with the Electing County option to exempt some people from work requirements.

It is also unclear whether Electing Counties must offer community service work that is equivalent to full-time employment (an average of 30 hours per week). Because Electing Counties have to comply with the Fair Labor Standards Act (FLSA), a recipient could not be required to work more community service hours *per month* than their Work First check divided by minimum wage, unless they are paid minimum wage for the additional hours. For example, if a family's check is \$220 per month they could only be required to work \$220/month divided by 5.15/hour = 42.7 hours per month. This is far shorter than 30 hours per week that seems to be required by North Carolina's statute. Counties would have to pay the individual minimum wage for the remainder of the required hours in order to comply with

state law and FLSA. No additional money was allocated at the state level to cover these costs.

What is clear under state law is that Electing Counties must ensure that no community service workers are displacing paid workers that the employer would otherwise have hired. Community service employees must not be treated differently than other similarly situated employees, especially regarding safety training and equipment.

Standard County Policy

Standard counties do not have to offer community service work to Work First recipients. They may initiate such a program, but must ensure it meets FLSA requirements and does not displace paid workers. Many North Carolina counties already have in place a community service work program, also known as work experience, on a first come, first served basis.

Electing County Options

There is understandably a great deal of confusion concerning the requirements of Electing County community service programs. There are six basic issues each county should answer in order to implement a community service program: (1) What is the goal of the community service program? (2) Whom will it serve? (3) What will the sites be that provide the work? (4) How many hours must be provided for each community service position and how will the county then meet the FLSA requirements? (5) How will the county

administer the program? and (6) What other supportive services will be provided with community service? In addition, counties can consider setting up job training and skill development programs in conjunction with community service, in order to make the experience more meaningful for the participant, and more likely to help them secure paid employment in the future.

While NC HHS's Work First Plan Template does not require that counties put this much detail in their plans, if they do not, it leaves many issues unanswered that counties must still address during implementation. In addition, without clarification of the statute about who must be served and how many hours must be provided in each community service position, the Electing Counties are left to struggle with unclear and conflicting demands. This has often meant counties' intentions were not clearly defined. Ultimately, this makes it difficult for counties to meet, and for the State to ensure that counties meet, all federal and state legal and regulatory requirements. While a well-planned and staffed community service program could provide essential job training and skills development to welfare recipients, this goal will be difficult to achieve without further clarification of the state statute.

Electing County Plans

■ Two counties, Alamance and Transylvania, originally stated they would not provide community service. After being informed this is a clear violation of the state statute, they revised their plans to say they would provide community service if required, but did not explain any aspect of their program such as a list of work sites, who would be required to participate or if they would comply with FLSA. Stokes County only mentions that they have several sites and lists them, but provides no other information about their program or compliance with federal and state requirements.

■ The remaining 24 counties did state they will provide community service work but each of them left out critical detail regarding who must participate, how they will meet FLSA requirements, or what other services would be provided. Many left out the FLSA requirement even after the State specifically requested it be included. Only Forsyth and Surry fully described how they would administer such a program.

■ Forsyth County proposes an innovative, collaborative strategy to test a community service program within a public housing community available to 10 to 12 of "the hardest to serve" and providing many supportive employment services. This strategy should be tested, but does not alone clearly meet the requirement that all recipients who cannot find full-time employment be placed in community service work.

■ Seven counties (Caldwell, Catawba, Chatham, Cherokee, Forsyth, Surry and

Wilkes) intend to exempt some families from community service, or to provide it only to a certain number of people or "as resources allow." Two counties (Davidson and McDowell) will provide community service only to those subject to work requirements. These are contrary to the statutory provision that community service must be provided to *all* who are unemployed and to all who do not have full-time employment.

■ Nine counties (Caswell, Craven, Davie, Lincoln, Mitchell, New Hanover, Polk, Stokes) do not define who they will serve. Randolph stated it would provide community service "as appropriate" but did not explain when it may be appropriate.

■ Six counties (Cabarrus, Craven, Iredell, Lincoln, Moore, and Sampson) did not discuss either the 30 hours/week requirement or the application of FLSA even though NC HSS sent them a comment requesting the counties to revise their plans to specifically note they will comply with FLSA. New Hanover is also unclear about their compliance, saying participants will have to work 10 to 13 hours per week which could be over FLSA allowed hours for some families.

■ Eleven counties (Caldwell, Caswell, Catawba, Chatham, Cherokee, Davie, McDowell, Polk, Randolph Rutherford, and Surry) stated that they would comply with FLSA minimum wage requirements but did not address whether they would provide 30 hours/week community service work slots. Davidson County stated they would not require more than 25 hours/week in community service work.

■ Three counties (Forsyth, Henderson

and Macon) grappled directly with the issues around FLSA and the State 30 hours/week requirement by proposing an alternative of combining community service work and other employment activities to equal 30 hours/week and to provide no more community service hours than the recipient's Work First payment divided by minimum wage. Henderson County specifically requested a waiver from the 30 hours/week requirement.

■ Only Wilkes County stated they would provide 30 hours/week of community service and meet minimum wage requirements. However, Wilkes allocated no funding at all for community service, thereby making it impossible for them to pay minimum wage to anyone for community service hours worked beyond those covered by their Work First check.

■ Mitchell County planned to meet "the current hours of minimum participation" (presumably the 30 hours/week requirement) but then went on to say no one would work more hours than their benefit check divided by minimum wage, which is far less than 30 hours/week. Mitchell did allocate \$50,450 toward community service but does not indicate if this is for paying participants' minimum wage.

■ Davidson and Mitchell are the only counties to allocate funds for implementation of a Community Service program. Davidson plans to allocate \$30,000 and Mitchell plans to allocate \$50,450.

■ All other counties failed to allocate funds for their community service programs, even though providing and administering such a program for all

recipients without full-time employment clearly has a cost.

Conclusion

Because of the lack of clarity as to what is required regarding community service, the Electing County plans are, on the whole, vague, and vary widely regarding what community service they will provide, to whom, for what time period and with which funds. Each Electing County should be required to provide more detail on this issue. Participants should not be required to work 30 hours/week in community service alone, since they will likely need other related training activities. Community Service Work can be provided in creative, productive ways that help recipients gain needed work experience and skills that lead to paid employment, but only if adequate funding is set aside for these programs, minimum wage laws are met and the State, including the legislature, clarifies what is expected.

The Issue

A basic tenet of our democratic society is the right to address grievances against the government. The Constitution provides for and protects this right. To ensure accountability and fairness of program rules, a welfare agency must establish clear procedures for their enforcement and interpretation.

Policy Background

The federal welfare law requires that states establish fair procedures when implementing programs under the block grant. The North Carolina welfare law directs Electing Counties to develop and implement a Work First appeals process that substantially complies with the existing North Carolina statute section on public assistance appeals, which is found in General Statute Section 108A-79. This statute sets out a fairly detailed process for how all applicants for and recipients of public assistance in North Carolina can appeal a decision or modification made in their application or case. This same appeals procedure applies to other public assistance programs in the State as well as cash assistance, including food stamps and Medicaid. The steps outlined in this appeals process comply with the procedural protections mandated by the federal and state constitutions, as well as the federal law and regulation governing the other public assistance programs.

Standard County Policy

State law requires that Standard Counties continue to follow the appeals procedure as set out in the statute (108A-79) described above. Under this procedure, an applicant or recipient is entitled to three levels of appeal. The first two levels are held before the social services agency. At the first stage, a hearing officer employed by the local county conducts the hearing. At the second stage, the hearing is before a state-level hearing officer. The third level of appeal is before a Superior Court judge. Specific time frames for appealing, notices to be given, methods for requesting an appeal, and processes to conduct the hearings are set forth in the statute.

The State currently provides for the state-level hearing officers, who are well-trained in Work First policy and procedure and preside over cases throughout the State. Because Electing Counties will no longer be complying with the State's uniform rules and procedures, however, the State will no longer be able to conduct the second-level hearings in these counties.

Electing County Options

The Electing Counties must develop a policy that is in "substantial compliance" with 108A-79. Counties must include all of the components described in the statute, including a description of how adequate notice will be provided, and the manner in which an individual or the county can request an appeal and the time frame for doing so. A process must be developed for

the conduct of hearings, and must include the right to appear and present evidence, the right to cross-examine witnesses, and the right to be represented by counsel. The second hearing must be recorded or transcribed.

Since Electing Counties can no longer avail themselves of the state-wide hearing officers, they must appoint a substitute person or panel. In determining replacement hearing officers, counties should keep in mind that independence of the hearing officer is critical not only to ensure the integrity of the appeals process but also to avoid the impression that an appeal is futile, which might discourage applicants from exercising their appeal rights. Counties have the option of contracting with a local attorney (who has no direct connections to the Department of Social Services or the County Commissioners) to conduct these hearings. Such an attorney could handle the adversarial dispute resolution process effectively as well as analyze both substantive and procedural issues which may arise. Counties should not use the County Attorney because that person may ultimately represent the DSS if the case is appealed to Superior Court.

It is important that all citizens should have a clear understanding of the process regarding appeals. Counties can adopt the procedural policies and protections contained in 108A-79, which will ensure that all the necessary details are covered, and will make the Work First appeals process as consistent as possible with other public benefit programs in the county.

Electing County Plans

■ Most of the Electing County plans leave out critical information regarding their appeals process. In many of the plans, few details, if any, were provided concerning the appointment of the appeals referee and the process to be used. Many counties may have inadvertently left out important information regarding the hearing referee and need simply to add a few more details on how that person would be appointed.

■ Wilkes did not describe a hearings process or who will hear appeals, except to say they will conduct a second level hearing that substantially complies with 108A-79.

■ Forsyth County did not appoint a second level hearing referee, stating they believe the state referees can still conduct their hearings due to the limited nature of their policy changes.

■ Eight counties (Catawba, Craven, Iredell, Lincoln, McDowell, Mitchell, New Hanover and Surry) indicated they would designate a second level referee but left out details on who it would be, how they would be designated or they proposed a person who may have conflicts or other problems filling this position. Mitchell said the hearings panel would be supervised by the County Attorney which is a conflict of interest since the County Attorney could eventually represent the county in the case. Surry intends to use the Magistrate, who, as part of the State court system, lacks jurisdiction to hear these types of cases.

■ Fifteen counties (Alamance, Caldwell, Craven, Davidson, Davie,

Lincoln, Mitchell, Moore, New Hanover, Randolph, Sampson, Transylvania, and Wilkes) did not describe or did not adequately describe their appeals process such as the notice, time frames for appealing, methods to appeal, that hearings would be evidentiary, whether hearings would be recorded, etc. Many of these counties may intend to continue using current procedures as set out under 108A-79 but they did not so state.

■ Other county plans contain legal problems because they propose to not allow a critical element needed for a fair and due appeals process. Caldwell appears to limit appeals to issues regarding application of policy and not to whether policy follows state, federal or constitutional law. Cherokee County would not record or transcribe, and Mitchell would not transcribe, the evidentiary hearing from which Judicial Review would follow. Moore County proposes to not allow Judicial Review in Superior Court.

■ Nine counties (Cabarrus, Caswell, Chatham, Cherokee, Henderson, Macon, Polk, Rutherford and Stokes) described a complete appeals procedure and who and how a referee would be designated. Henderson set out a detailed description of their process and the others adopted 108A-79 with some exceptions noted in their plans.

Conclusions

Many counties fail to meet the minimum standards required under North Carolina law. Most plans lack critical details concerning appeals. The counties that have stated their intent not to designate a second level hearing referee do not have a complete appeals process as required by the law. Many county plans contain illegal provisions such as providing for hearing referees with a conflict of interest, failure to provide for an evidentiary hearing, proposals which do not include recording the evidentiary hearing, or proposals to eliminate judicial review. Except for the nine counties that submitted a complete description of their appeals procedure, all counties should be required to clarify their proposed appeals process and remove illegal provisions or referees with a conflict or they should not be approved.

The Issue

North Carolina's Work First cash assistance program is funded in part by the federal government and in part by the State and counties. Under federal law, in order to receive the full amount of federal funds, the State and counties must maintain their funding at at least 80% of 1994 levels. This is known as "maintenance of effort." If the State or counties choose not to maintain their current funding effort, it means fewer funds are available to help low-income families. This could result in reductions in direct cash assistance or reductions in services to help families move into work. While this may be less problematic during the current strong economy, it could mean there is insufficient funding to meet the needs of all families during an economic downturn. Under the new TANF block grant program, unlike with AFDC, federal funding will not increase, even during economic downturns.

Policy Background

The federal welfare law requires that state and local governments maintain a level of financial support for TANF and related programs of at least 80% of 1994 levels. States that meet the federal work requirement targets may reduce their maintenance of effort further to 75%. State and local monies counted toward maintenance of effort cannot be used as state match for other federal programs.

The State and the counties share the cost of running North Carolina's cash assistance programs and some related programs. The North Carolina welfare law requires the state to maintain 100 percent of its 1996-97 spending on TANF-related programs. Some of that state money, however, may be used to match federal dollars for other programs, such as child welfare. In other words, some of the TANF funds can be transferred to other programs not directly related to TANF recipients.

Standard County Policy

Standard Counties must maintain their local effort at at least 100% of 1996-97 levels. Counties that fail to meet the maintenance of effort requirement may lose some of their state welfare funding.

Electing County Options

Electing Counties, for their first year, can reduce their local effort for TANF and related programs to 90% of 1996-97 spending. Like other counties, they can also increase support. If the Electing County meets all of its goals set forth in its plan in the first year, then the county can further reduce its local effort to 80% of 1996-97 levels for the second year forward. Electing Counties can also establish reserve funds in case of an economic downturn and resultant increased caseloads. If the Electing County reduces its effort toward TANF programs, it must explain how the funds will be used otherwise.

Electing County Plans

- Four counties (Davidson, Macon, New Hanover and Polk) provide more local effort than they were required to during the 1996-97 fiscal year.
- Two counties (Craven, Rutherford) maintain their local effort at 100 percent of 1996-97 levels.
- Fourteen counties (Cabarrus, Caldwell, Chatham, Cherokee, Forsyth, Henderson, Iredell, McDowell, Moore, Randolph, Sampson, Stokes, Transylvania and Wilkes) reduce their local effort from 1996-97 level, but not by the full ten percent.
- Two counties (Caswell and Catawba) reduce their local effort by the full ten percent.
- Five counties (Alamance, Davie, Lincoln, Mitchell and Surry) have reduced their local effort by more than ten percent and therefore failed to comply with statutory requirements.

Conclusion

While all of the Electing Counties wrote detailed accounts of the unmet needs that make it difficult or impossible for low-income families to obtain and keep work, only four counties took advantage of the new choices available to them to provide more funding to assist families with these needs. The most notable of these is New Hanover, the only county putting substantial funding toward child care availability, a large problem noted by nearly every county. The twenty one counties that reduce their funding did not explain

how they would meet these needs. Many simply implement harsher sanctions for families who could not meet the work requirements. Five counties have proposed to cut more than 10% from their funding and therefore, directly violate the statutory limit of cutting only 10% in the first year. Therefore, their plans should be denied.

Conclusions and Recommendations

North Carolina's ambitious and unprecedented decision to transfer control of welfare policy to the local level presented Electing Counties with both a unique opportunity and a daunting task. While Electing Counties were granted vast new authority, they were required to exercise the authority with lightning speed and Solomon-like wisdom. Volunteers and county officials, many of whom had little or no experience in welfare policy, were directed to formulate in a matter of weeks a series of plans to replace a national policy that has existed for six decades. This analysis of the Electing County plans confirms that this was an unrealistic process with impossible expectations.

Provided with sufficient time, guidance and resources, many counties may well have been able to capitalize on such an opportunity to reduce poverty and promote economic security for poor citizens. Unfortunately, this was not a possibility given the unrealistic time schedule and unstructured grant of authority provided by State policy makers. In addition, regardless of the effectiveness of county plans, helpful efficiencies are lost with total elimination of statewide policy, and many issues facing poor families require a regional, statewide, or larger effort to address them adequately.

Devolution to the county level was touted as a vehicle to improve the lives and living conditions of the poor. In the light of the experience in the Electing Counties and the plans that have emerged, however, it is clear that policy makers based their groundbreaking decision to transfer welfare policy making to the local level on a number of expectations that were not realized.

EXPECTATION 1: Local leaders are uniquely poised to address the barriers to self-sufficiency for welfare families.

In reality, no Electing County adequately addressed the barriers to self-sufficiency for welfare recipients. While many counties did an excellent job at assessing the needs in their communities, counties did not commit the

resources and implement the policy changes necessary to meet these needs.

Most counties identified lack of transportation, lack of child care, low education, low skill levels and low wages as the most significant problems preventing families from reaching self-sufficiency. Other critical barriers include the lack of entry-level jobs, the seasonal or part-time nature of available work, and the possibility of a down-turn in the economy due to plant closings or a recession. Yet, counties did not propose adequate solutions to resolve these problems. Indeed, many of these problems cannot realistically be solved by the counties alone.

Furthermore, no county ensured that recipients will not be punished or prevented from getting continued assistance at the end of the time limit if necessary services are unavailable. Few counties discuss the lack of safe, affordable housing or identified it as a barrier to family self-sufficiency. And only two counties even mention domestic violence in their plans, which is another significant barrier to self-sufficiency.

For the most part, counties did not take advantage of their new freedom to expend funds in an unrestricted fashion; instead, many counties do not even maintain their funding at the current level.

EXPECTATION 2: Local communities would adopt new and innovative policies.

In reality, most counties chose to follow the State's current or proposed policies with little deviation. In fact, the only consistent variance from current or proposed State policy seen in these plans is in the implementation of harsher sanctions. Moreover, many of the counties that did propose creative ideas did not commit the resources to fund them adequately, if at all. Other ideas, such as increasing the supply of child care or public transportation, are still in the planning stages and are likely to take a long

time to bear fruit. Yet, no corresponding exemption from the short time limits was put in place for families. Finally, many of the innovative ideas that were suggested in these plans could have been carried out by Standard Counties under the State Plan.

EXPECTATION 3: Communities would use a democratic process with broad-based community involvement.

In reality, due, at least in part, to the unrealistically short time frame in which these plans were developed, many critical citizens concerned or affected by welfare reforms were not included in the local planning process. Some committees did not include all of the statutorily required persons, and most included no welfare recipients or working poor people. Many counties did not make the draft plans readily available to the public, and allowed only very limited comment periods.

EXPECTATION 4: Counties would comply with State and Federal law.

In reality, many plans proposed unconstitutional or illegal provisions. While it appears that all counties except two have removed unconstitutional provisions, some policies still raise other legal issues. Many counties have not put the procedures in place to ensure that Work First recipients' rights are protected under other public assistance programs such as Food Stamps and Medicaid. Many plans lack critical detail necessary to determine if they are in compliance with requirements. This is in part because Counties were forced to complete this process quickly, with little guidance. Neither the State nor the counties had sufficient time to interpret the complex new State and Federal welfare laws, and many issues raised by the new laws remain unclear.

EXPECTATION 5: Giving counties control of welfare policy would create less government bureaucracy, resulting in lower cost for administration and more funding available for services for families.

In reality, new layers of bureaucracy and administrative expense have been created. The State agency's computer system cannot adequately process varying rules from county to county, which has made it too administratively burdensome for many of the counties proposing innovative ideas. Many of the counties will now be required to track even more data to ensure compliance with the new rules created (varying time limits, sanctions, eligibility requirements, etc.). In addition, counties have had to devote hours of staff time to preparing welfare policy, instead of having those staff available to help low-income families get jobs and address their barriers to employment. At this time, it appears the confusion, cost and administrative burden of having varying county policies is not outweighed by the creation of new and innovative policies that move families out of poverty.

EXPECTATION 6: County officials would adopt plans that will further the economic self-sufficiency of welfare families and improve child well-being.

In reality, the proposed Electing County plans do not significantly improve the economic viability of welfare families. In some counties, the economic situation for the poor may actually decline. Many counties have made negative incentives and sanctions the centerpieces of their welfare policies, even when children are adversely affected. The county plans place very little emphasis on support for training, education or effective job search skills. While some counties have proposed "job bonuses" to encourage work, few counties will be able to reinforce the work effort through positive incentives and supports (e.g., adequate child care and transportation, job training etc.).

Some counties have reduced benefit amounts and imposed shorter time

limits. Almost half will no longer allow families with disabled family members receiving SSI benefits to get Work First benefits. At the same time, no county substantially increased benefit amounts. No county increased the time limit or clarified their exceptions or extensions to the time limit. Little support is promised for the working poor as they transition from public assistance programs to meaningful work.

In addition, improving child well-being is the lowest goal in all counties and is narrowly addressed. Significant indicators of child well-being such as health care and nutrition, school performance, and developmental levels are largely ignored.

Based on the findings and conclusions of this analysis, we offer the following recommendations to policy makers regarding the Electing County Plans:

- 1. The General Assembly should defer approving any of the Electing County plans at this time. Instead, the legislature should give counties six additional months to improve and refine their plans to ensure that they fully comply with the law, involve a broader democratic process and meet the expectations of policy makers and the people of North Carolina.**

Rationale — As noted in this analysis, the process of developing Electing County plans involved an unrealistic timeline and process that placed unreasonable pressures on local communities to address some of the most complex issues in this society about poverty, work, barriers to self-sufficiency, support for work and protecting those who cannot work due to no fault of their own. As a result of this unrealistic process, all of the plans are “works in progress” that lack sufficient details upon which state officials, policy makers and the citizens of North Carolina can make informed decisions about the Electing County process or plans. This is evidenced by the fact that counties have been revising their plans since they were submitted. During an additional planning period, Counties must be provided more information on policy options and further clarification of the legal and constitutional requirements. Additional time will also allow the State to better accommodate County proposals through changes in the State computer system or other means. Furthermore, the General Assembly should clarify the goals of Work First, emphasizing that improving and protecting the well-being of children is the first priority and applies to all children not just those known to protective services. The Electing County process is a high stakes experiment in social welfare policy. Children, families, communities

and all tax payers have something to gain and much to lose depending on the outcome of this experiment. A six month delay in the process can do nothing but result in improved and more fully developed plans.

- 2. Under no circumstances should plans affecting more than 15.5% of the Work First population be approved.**

Rationale — This is a dramatic experiment likely to have far reaching implications for the State, the counties, and especially low-income families and children. It should not be expanded to additional counties beyond the current limit until it has been fully tested and the results are known.

- 3. In the event that some plans are eventually approved, adequate provisions must be in place to monitor and evaluate their impact on families and children.**

Rationale — Monitoring and evaluation are critical to end harmful and to replicate successful policies. A comprehensive evaluation should be required at the county level, the State agency level, and at the legislative level to monitor the effects of the multifaceted reforms that many counties have proposed, or may propose, to attempt. Monitoring needs to take place early on in the process, and often, and counties should be required to amend programmatic rules if the monitoring indicates that public assistance families are being harmed.

- 4. Finally, whether or not plans are approved, the North Carolina General Assembly should commit the use of State funds to assist families who cannot support themselves through no fault of their own at the end of the federal time limit.**

Rationale — Such “carve out” programs, which are permissible under

federal law, are being implemented in several other states. Even Wisconsin, which has eliminated their cash assistance system, continues to provide cash assistance, at a higher level than before, to disabled parents with children. In addition, funding should be allocated to provide transitional and supportive services for those who have worked their way off welfare, but continue to need some support to stay employed and provide for their families. This can be accomplished in part by assisting low-wage families with a State Earned Income Tax Credit. However, even with that thousands of hard working North Carolina families will continue to need assistance with housing, child care and transportation.

REMARKS BEFORE THE NORTH CAROLINA JOINT LEGISLATIVE APPROPRIATIONS
SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES, May 27, 1998

BY

DR. LEONARD BECKUM AND DR. ANDREW DOBELSTEIN, CONFERENCE ON POVERTY, Inc.

TALKING POINTS

- * Electing counties were faced with the rather enormous task of developing a county Work First Plan essentially from scratch, within a period of ten weeks that included Thanksgiving, Christmas and New Years holidays.
- * The Conference on Poverty was retained to assist 29 counties develop their Electing county plans, and to further assist Electing counties undertake those activities that would lead to successful implementation of their plans.
- * The plans developed by the 27 counties, as submitted February 1, 1998 not only represented well thought out ways to address welfare problems in their counties, but perhaps more important, provided an unusual opportunity for local leaders to grapple with welfare issues. Conference on Poverty consultants attended planning meetings in approximately 15 counties, and conducted an analysis of the planning process after it was completed. We found that many local business leaders, county commissioners, county managers, as well as others, were completely unfamiliar with how welfare was being provided in their county. For many local leaders this planning process was a learning experience that opened many eyes.
- * All told 439 persons participated in the planning process in the 26 surveyed counties, with an average committee size of 16.88 members per planning committee. Information on how frequently these committees met was available from 17 Electing counties. These seventeen counties met 139 times between October, 1997, when they had to notify the Division of Social Services of their intent to become an Electing County, through January, 1998, when their plans were due - approximately a 12 week period. This equates to an average of 8 meetings per county during this time period that covered getting ideas for the plan, developing a draft plan, refining a draft plan, and getting final approval for the plan. This is a remarkable amount of work, involving a large number of persons, within a short time period.
- * The lack of clear policy guidance from the Division reflected a difficulty in responding to the scope of policy changes made possible by Federal and State welfare reform legislation. From the Federal perspective, block grant funds to the State could be used for any activity so long as the funds were used to insure that welfare recipients went to work and that welfare caseloads were reduced. The Division was already operating a welfare reform under the Governor's Work First program before the General Assembly passed its legislation. With a few exceptions, the creation of the possibility of having counties Elect to develop their own plan made them immune from policies previously developed for Work First under the Governor's waiver. Thus, with few exceptions, Electing counties were only bound by Federal limitations, not the same limitations counties were bound by under the previous Work First program. It became clear in our meetings with Division Staff, Field Staff, and County Directors that the distinction between Electing counties and Standard counties was never fully realized.

Conference on Poverty, Talking Points

The Conference on Poverty, as well as Electing Counties were caught off guard when the Division notified counties which they had recommended as Electing counties in the State plan, by letter dated March 12. First the Division had ranked the Electing county plans, based on their ratings, and the Division added 9 evaluation points that were not previously available to the counties in the Model Plan counties used as a basis for writing their plans. Counties were also given bonus points for the quality of their plans for addressing issues of child well being. Again counties were not notified in advance this criteria would be used in this way. Counties wondered how they could be ranked high and still not qualify as electing counties. The Division disqualified counties that included "legally problematic components", namely issues related to drug testing and residency restrictions. Yet neither of these two issues was included as evaluation issues in the Division's review of county plans. Moreover, the Division's objections to both drug "testing" (most counties rejected **did not** "propose mandatory drug **testing** without suspicion") and residency restrictions may be "legally problematic", in the Division's words, but may not be illegal according to Federal and State law.

* In summary, the content of the Electing county plans departed very little from existing Work First activities, and it would be difficult to say that there will be great variability in how Electing counties implement their Work First plans and how Work First is implemented in the other counties in the State. In developing their plans counties were extremely cautious in moving too far beyond present Work First practices. Instead, Electing counties were more motivated to have control of their welfare programs, and the funds used to support welfare, so as to use these funds in more flexible ways, than they were in creating new and innovative programs.

* The final irony in this plan review process comes from information that Standard counties were not ranked and reviewed as were the Electing counties. Electing county plans were produced with the assistance of competent policy experts and plan writers from the Conference on Poverty. The plans were rigorously reviewed by the State Division of Social Services. The plans were revised and reviewed again. Twenty-three Electing county plans were found acceptable by the Division of Social Services. With the possible exception of New Hanover County, all Electing county plans meet all the criteria for Electing county status. But we know nothing about how adequate Standard county plans are since they were not subjected to a rigorous evaluation. In this regard there is no rational reason to exclude any of the Electing counties from Electing status in the State Plan.

* **we recommend that all counties that requested Electing county status and developed an acceptable Electing county plan be included in the State Work First plan.**

The 15.5 percent Work First population cap was a political compromise reached without any good knowledge of how counties would respond to the opportunity to develop and administer their own Work First plans, as set forth in the North Carolina statutes. The evidence from Electing counties shows that they have been prudent in the authority provided to them. They have taken the task of writing county plans seriously, involving many citizens, using good judgment, and producing products that they believe will work in their counties. There is no reason to believe these Electing counties will in any way treat Work First families in punishing ways, and indeed, there is evidence to suggest Electing counties will go further in working with their post welfare clients long after they leave the welfare roles. Raising the cap to include all Electing counties in the State plan is the most important legislative change that could be made, given the experiences of the past nine months.

REMARKS BEFORE THE NORTH CAROLINA JOINT LEGISLATIVE APPROPRIATIONS
SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES, May 27, 1998

BY

DR. LEONARD BECKUM AND DR. ANDREW DOBELSTEIN, CONFERENCE ON POVERTY, Inc.

Who are we and what have we done?

The Conference on Poverty is a private corporation, chartered in 1987 in of North Carolina as a not-for-profit organization, and recognized by the Federal government as a tax exempt organization under Section 501, C, (3) of the Internal Revenue Code. The Conference on Poverty provides information regarding poverty conditions in North Carolina, and facilitates the use of relevant information by private and public organizations to help reduce poverty. Over the past eleven years we have published more than 30 NEWSLETTERS explaining and discussing poverty in North Carolina, developed and implemented 26 county based Poverty Forums, assisted several local poverty agencies develop and implement strategic plans, assisted three counties develop an Empowerment Community application, and provided extensive community based consultation and training to staff persons employed in anti-poverty activities.

On November 20, 1997 the Conference on Poverty entered into a contract with the North Carolina House of Representatives to assist North Carolina counties who had declared their intention of becoming Electing Counties as set forth in the recently enacted North Carolina welfare reform legislation. (S.L. 1997 - 443) According to this legislation, North Carolina counties had the option of operating Work First as Standard counties, in which case they would operate under welfare rules set by the North Carolina Division of Social Service, or counties could Elect to develop their own welfare programs under rules set by the county, so long as the operation of these Electing county programs were not inconsistent with Federal and State legislation. The number of Electing counties is limited to that number of Electing counties that represent, in aggregate, no more than 15.5 percent of the total Work First caseload as of October of each year.

By October 30, 1997 twenty-nine counties had notified the North Carolina Division of Social Services of their intention to seek Electing county status. Under the terms of State legislation the

Division of Social Services was required to notify counties of their planning status by November 15, 1997, and Electing counties had to submit a plan approved by their County Commissioners to the Division by February 1, 1998. While there were numerous features of both Federal and State welfare reform legislation that differed significantly from previous welfare practices, Standard counties could rely on the rules presently in use by the Division to implement the existing Work First program. Electing counties were faced with the rather enormous task of developing a county Work First Plan essentially from scratch, within a period of ten weeks that included Thanksgiving, Christmas and New Years holidays.

The Conference on Poverty was retained to assist these 29 counties develop their Electing county plans, and to further assist Electing counties undertake those activities that would lead to successful implementation of their plans. This contract with the Conference on Poverty was a bit unusual. Generally speaking once legislation is enacted the administrative agency, the Division of Social Service in this case, has responsibility for implementation. Implementing the innovative features of North Carolina's new welfare statute required a different approach. First, State legislation itself was not finalized until August, 1997. Second, Federal and State legislation constituted a new experience and there was considerable uncertainty at the Division of Social Services level as to how Federal and State law would be implemented. Finally, there was considerable opposition from the administration to the idea of turning responsibility for welfare program development over to counties. Thus the climate was not conducive for smooth implementation of this legislation. It was in this environment that the House of Representatives sought assistance from the Conference on Poverty for Electing counties in the development of their plans.

The Conference on Poverty prepared summaries of the Federal welfare reform (TANF) law, the recently passed State welfare reform statute, critical issues that had to be addressed in Electing county plans, and a series of policy questions raised during discussions over implementing North Carolina's welfare reform statute. The Conference on Poverty prepared a Custom Data Package for each electing county to use in its community analysis, and for incorporation into its County Plan. Each county, then, was assisted in developing its county plan by Conference on Poverty consultants

who helped each county write pertinent sections of their county plans. All told 21 counties participated in orientation and planning meetings, and 21 counties left the meetings with some form of rough draft plan.

During the time period of the last week in November through January 30, 1998, the Conference on Poverty also responded to over thirty-five telephone inquiries on its special 800 telephone "hot line" installed specifically to respond quickly to local questions and concerns. In addition 15 staff days were spent in individual counties assisting with various problems that developed in the plan preparation process. By February 1, 1998 27 counties submitted completed Electing county plans to the Division of Social Services, the deadline set by the statute.

The Electing county planning process

The plans developed by the 27 counties, as submitted February 1, 1998 not only represented well thought out ways to address welfare problems in their counties, but perhaps more important, provided an unusual opportunity for local leaders to grapple with welfare issues. Conference on Poverty consultants attended planning meetings in approximately 18 counties, and conducted an analysis of the planning process after it was completed. We found that many local leaders, including county commissioners and even county managers, as well as others, were completely unfamiliar with how welfare was being provided in their county. For many local leaders this planning process was a real eye opener.

North Carolina's Work First statute required a minimum of seven members on each Electing county planning committee, including representation from "community-based organizations representative of the population to be served." (Sec. 108A-27.3, (c)) A survey of 26 Electing counties showed that all Electing counties had planning committees composed of the required named representatives, and all Electing counties had committees larger than that required by the statute.¹ Wilkes had the smallest committee, nine members, and Craven had the largest, thirty-three members. All told 439 persons participated in the planning process in the 26 surveyed counties, with an average committee size of 16.88 members per planning committee. Information on how frequently these committees met was available from 17 Electing counties. These seventeen counties met 139 times between October, 1997, when they had to notify the Division of Social Services of

their intent to become an Electing County, through January, 1998, when their plans were due - approximately a 12 week period. This equates to an average of 8 meetings per county during this time period that covered getting ideas for the plan, developing a draft plan, refining a draft plan, and getting final approval for the plan. This is a remarkable amount of work, involving a large number of persons, within a short time period.

Given the participation of large numbers of persons who had limited experience with the administration of Work First in North Carolina, and the potentially contentious nature of developing an Electing County plan, the capacity of counties to develop plans in such a short time frame required several strategies to keep the counties focused on the task. Open communication, and use of small sub-groups were most frequently identified as strategies used to keep the committees on their tasks, but the most important factor in the work of these committees, according to our survey, was a positive attitude and commitment to being an Electing county. This attitude, along with strong leadership for the planning committees, was affirmed during the times our consultants participated in planning committee meetings. The goal of achieving Electing county status, again and again, took preference over individual differences, and the Electing county plans reflect strong unity and agreement.

We also found the leadership in the planning process was excellent. Business leaders chaired the committees in about one-third of the counties while County Managers or Commissioners chaired the meetings in another third of the counties. Thus a new element of leadership was brought into the process in these Electing counties, and while it is difficult to quantify, the Conference on Poverty consultants were continuously impressed with demeanor of the planning process. It was not contentious, but cooperative. The welfare of the Work First client was a constant theme in this planning work, as counties came to realize that many on welfare were members of their community, and one way or another the responsibility for welfare persons was greater than just getting them off the welfare roles.

Comment has been made that Electing counties did not include welfare recipients in developing their Work First plans. Our survey found that 57 percent of the Electing counties included recipients in the development of their plans while 43 percent did not. The overwhelming

Reason for including recipients was that they offered a different perspective on welfare than had been usually expressed by welfare administrators, and, secondly, that they were good committee members in their own right. The major reason welfare recipients were not included was that the structure of the committees was controlled by the County Commissioners who did not offer public input into the design of the committees.

Unfortunately there is no summary information regarding Standard county planning activities in order to allow comparison between the two groups.

The process of developing the plans was greatly complicated by incomplete, and often confusing information Electing counties received from the Division of Social Services. What could and could not be done in Electing counties was in a constant state of debate, and this uncertainty caused frustration, and contributed to the decision on the part of at least two counties to abandon their plans to be an Electing county.

On September 29, 1997 the Division of Social Services held a state-wide teleconference with county managers, commissioners and Directors of Social Service regarding North Carolina's new Work First statute. This teleconference, lasting over two hours, was conducted in a question/answer format, with little in the way of unsolicited policy information provided by the Division of Social Services. The Division did not provide a written summary of this teleconference until November 18, 1997, well after counties had to decide on whether to be Electing or stay Standard!

In some cases information regarding Electing counties provided in this teleconference was equivocal. For example, in clarifying the difference between Electing and Standard counties, the Division stated: "Determination of eligibility criteria for and benefit levels of cash assistance is a primary distinction between Standard and Electing counties." The Division failed to provide information as to how flexible the use of Electing county funds could be. Other responses raised unanswered questions for potentially Electing counties. For example when asked how funds would be available in the event of increased welfare demands, the Division pointed out that if expenditures exceed two-thirds of the amount of expenditures for the year, additional funds would be sought, but when the Department added. "[I]f conditions in an individual, Electing county are unique, we do not believe that provision applies."

Because the material in the Division's November 18 memorandum was so lacking in clarity, the Conference on Poverty met with Mr. Fitzgerald and his staff on December 5 to reach agreement on ten policy questions that needed clarity before we began to work with Electing counties to develop their plans. While we had answers to these questions verbally December 5, Social Service field staff were not immediately briefed on these decisions, and written confirmation from the Division was not available until December 17, 1998 after serious plan writing had already begun.

The Conference on Poverty held plan writing meetings for Electing counties in Siler City, December 11 and 12, in Hendersonville, December 15 and 16, and in Statesville, December 17 and 18, 1997. Twenty-eight persons attended the Siler City meeting, 30 attended the Hendersonville meeting, and 34 attended the Statesville meeting. Legal issues, policy questions, automation and computerization issues, and related technical questions were answered at these meetings, to the extent the questions could be answered. Each county, then, was assisted in developing its county plan by the Conference on Poverty consultants who helped each county write pertinent sections of their county plans. All told 21 counties were represented at these meetings, and 21 counties left the meetings with some form of rough draft plan.

Following this series of meetings, however, the Division of Social Services Field Staff questioned the accuracy of the information provided to Electing counties. As a result a second meeting was held with Mr. Fitzgerald, and he and Dr. Dobelstein developed further policy clarity on a number of issues raised. On January 14, 1998 a joint memorandum from Mr. Fitzgerald and Dr. Dobelstein was provided to Electing county contact persons and Directors of Social Service. Unfortunately, some of these same issues surfaced again as the Division reviewed and evaluated Electing county plans. (See below.)

The lack of clear policy guidance from the Division reflected a lack of appreciation for the scope of change made possible by Federal and State welfare reform legislation. From the Federal perspective, block grant funds to the State could be used for any activity so long as the funds were used to insure that welfare recipients went to work and that welfare caseloads were reduced. The Division was already operating a welfare reform under the Governor's Work First program before the General Assembly passed its legislation. With a few exceptions, the creation of the possibility of

having counties Elect to develop their own plan made them immune from policies previously developed for Work First under the Governor's waiver. Thus, with few exceptions, Electing counties were only bound by Federal limitations, not the same limitations counties were bound by under the previous Work First program. It became clear in our meetings with Division Staff, Field Staff, and County Directors that the distinction between Electing counties and Standard counties was never fully realized.

One example might help clarify the problems. When on December 2, 1997 the Division of Social Services distributed projections of funds Electing counties they might receive from Federal and State sources the Division broke the funds down into two categories: Work First Family Assistance (Cash) and Work First Services. This was confusing since the Federal TANF block grant to the State made no distinction between the funds. They were lumped together. Likewise, the North Carolina statute specified passing federal and state funds to the counties without breaking them into any categories, much the same as the Federal procedure. Electing counties were confused as to what would happen to the money provided for "Assistance" if they did not need it for "Assistance". In Standard counties these savings stayed with the State, but State legislation said that all cost savings would remain with the Electing counties. Yet State staff continued to be confused by this issue, and continued to talk about separate "pots" of money. Understandably the counties were reluctant to accept the advice of the Conference on Poverty on this issue in developing their plans when the Division and Field Staff remained equivocal.

In another instance the Conference on Poverty learned that the Division had previously secured a waiver from the Federal government to use Federal Emergency Assistance funds to support salary costs of hiring child abuse and neglect workers. Under welfare reform Federal Emergency Assistance was lumped into the block grant to the State, but the Division at first notified Electing counties that their Emergency Assistance money could not be counted in the block grant they received, but instead had to be used to support child abuse and neglect workers. Upon further discussion and clarification the Division agreed that Emergency Assistance money indeed was available as part of the block grant to Electing counties, although counties would have to continue to fund child abuse and neglect services, if not out of the county block grant, then out of other sources.

Thus the policy environment for Electing counties as they developed their plans presented most counties a considerable challenge. Electing counties responded to this situation by taking a very conservative approach in the use of the flexibility they were given under State law. In those cases where policy questions could not be adequately resolved, counties elected to develop their plans so as to stay within the general framework that the State could support. One notable exception was New Hanover county that had language in its plan that suggested mandatory *routine* drug testing of all Work First applicants. The Division said that the language made the plan illegal, the county believed that the language and its procedure was, indeed, legal and allowable. The Division failed to include New Hanover in its recommended list of Electing Counties on the grounds the plan contained illegal drug testing.

Evaluating Electing county plans

In the November 18 report of the teleconference the Division informed counties that they were given a Work First Block Grant Plan Model. Counties were not told they would be ranked from highest to lowest, based on individual county evaluations nor were counties told they could improve their ranking if they improved elements of their plan that were ranked low. It was on the basis of this Work First Block Grant Plan Model that the Conference on Poverty went about helping Electing counties develop their plans. We had in place a group of technical grant plan writers that worked with each county to make sure that all elements of the Plan Model were followed. Electing counties submitted their draft plans to us by January 20, 1998, and our staff reviewed each plan in detail to make sure they meet the legal requirements and the written expectations of the Division. We returned the plans to each county with our comments in order to give each county time to revise their plan and still submit it by February 1, 1998, the deadline.

In general most plans were complete. The most bothersome issues were county efforts to control residency, drug screening, and appeals processes. We worked out language for each plan that had trouble in these areas and provided the counties with this language.

The Division of Social Services invited us to a meeting February 23, and provided us with a summary of problems it had found in the plans as submitted by Electing counties. In this meeting the Division reported it found 14 legal issues, 6 medicaid issues, 3 automation issues and 1 budget

is for a total of 22 issues raised about the Electing county plans. According to the Division's analysis these issuers appeared in more than one county, constituting 160 individual issues spread throughout the 27 Electing county plans. Exactly where in the county plan these issues occurred, however, was not clear. The Conference on Poverty consultants analyzed these 22 issues and 160 items against Federal law and Policy and state law. In this analysis, only 12 issues raised were relevant to Federal and State law. The remaining 10 issues were recommendations by the Division. Comparing these issues with the Electing county plans found an average of 2.6 (median 3) problems per Electing county plan. Some counties had no corrections to make. One county had as many as 5 corrections to make. Most of these issues were found in Electing county budgets, that lacked an item or had not been completed fully enough. (N=17 counties) The second largest number was in the appeals process. (N=14 counties)

The Conference on Poverty called all counties and suggested changes to their plans. At the same time the Division sent letters to each county documenting their concerns, but not separating required changes from recommended changes. Only 5 working days were allowed for changes to be made and received by the Division. We worked through the week with each county to make sure the changes were made, so that revisions could be submitted by the deadline set by the Division.

The Conference on Poverty, as well as Electing Counties were caught off guard when the Division announced which counties it had recommended as Electing counties in the State plan, by letter dated March 12. First the Division had ranked the Electing county plans, based on their ratings, and the Division added 9 evaluation points that were not previously available to the counties in the Model Plan counties used as a basis for writing their plans. Counties were also given bonus points in the Division's evaluations for the quality of their plans for addressing issues of child well being. Again counties were not notified in advance this criteria would be used in this way. Counties wondered how they could be ranked high and still not qualify as electing counties. The Division disqualified counties that included "legally problematic components", namely issues related to drug testing and residency restrictions. Yet neither of these two issues was included as evaluation issues in the Division's review of county plans. Moreover, the Division's objections to both drug "testing"

most counties rejected **did not** "propose mandatory drug **testing** without suspicion") and residency restrictions may be "legally problematic", in the Division's words, but may not be illegal according to Federal and State law.

Some counties got in touch with the Division and made further modifications to their plans in order to make them more acceptable. Other counties did not know they could do this. When the draft State Plan was published only 19 counties were recommended as Electing counties.

The final irony in this plan review process comes from information that Standard counties were not ranked and reviewed as were the Electing counties. Electing county plans were produced with the assistance of competent policy experts and plan writers from the Conference on Poverty. The plans were rigorously reviewed by the State Division of Social Services. The plans were revised and reviewed again. Twenty-three Electing county plans were found acceptable by the Division of Social Services. With the possible exception of New Hanover County, all Electing county plans meet all the criteria for Electing county status. By contrast, nothing is known about how adequate Standard county plans are since they were not subjected to a rigorous evaluation. We know the Electing county plans are of high quality and in this regard there is no rational justification to exclude any of the Electing counties from Electing status in the State Plan.

Content of Electing county plans

While it is difficult to summarize the content of many different plans it is clear the fears that Electing counties would treat clients harshly were greatly exaggerated and completely unfounded. In general counties were more interested in establishing autonomy for themselves as Electing counties, and with few exceptions stuck close to the guidelines provided by the State Division of Social Services. Counties also realized that it would be prudent to start with small changes and depending on how effective the changes were, modify them in subsequent years.

A survey of Electing county plans² revealed that 20 of the Electing counties built sanctions into their plans. These sanctions, all financial in nature, would be applied in a 2 to 4 step process, depending on nature of the offense. The length of the sanction ranged from 1 month to one year, depending on the county and the violation. For example, Chatham proposed a 4 step process: deduction of \$50.00 for the first violation, \$75.00 each for the second, third, and fourth violation.

length of the sanction would be 3 months in the first instance, another 3 in the second, and so forth up to a full year.

Only two counties wanted to restrict eligibility to county residents of one year duration, but, following strong advice from the Division dropped this restriction. None of the counties proposed restrictive eligibility requirements.

But at the same time counties proposed sanctions, 6 counties proposed incentives to reward compliance. All the incentives, except one set, were financial, and again were proposed to be implemented in stages, ranging from 1 to 3. Thus, for example Davidson proposed a three step cash payment incentive: \$480 additional the first reward for 3 months of continued employment, an additional \$240.00 for the second reward for an additional 9 months, and finally \$120.00 extra for the third reward for the balance of 12 months. One county proposed "T" shirts and gift certificates, in a two step process as rewards for staying employed.

Counties differed in the priority they assigned to provision of child day care for Work First families. Only 9 counties ranked Work First clients first priority for day care; another 5 counties ranked Work First clients second, behind child abuse cases. Five counties ranked Work First clients third priority or lower, and the remaining counties did not rank the use of day care for Work First families. All counties had transportation plans, and eleven counties will provide some sort of subsidy to maximize the use of private vehicles, through gas vouchers, small grants to purchase automobiles, car pooling, and even cooperative ventures for Work First participants.

In general Electing counties accepted state goals as their Work First goals as well. These goals emphasized reduced caseloads and putting Work First recipients to work. These goals are also mandated by Federal legislation. At the same time counties offered few county specific goals that were not required by the State or the Federal government. The general thinking among counties on this issue was that counties could pursue optional activities without making them goals in their plans, thus avoiding evaluation by the State on new goals.

In summary, the content of the Electing county plans departed very little from existing Work First activities, and it would be difficult to say that there will be great variability in how Electing counties implement their Work First plans and how Work First is implemented in the other counties

e S. In developing their plans counties were extremely cautious in moving too far beyond present Work First practices. Instead, Electing counties were more motivated to have control of their welfare programs, and the funds used to support welfare, so as to use these funds in more flexible ways, than they were in creating new and innovative programs.

Recommendations for the State Plan

With due respect for the efforts of the Division of Social Service, but based on our intensive work in and with Electing counties, the Conference on Poverty offers the following recommendations.

First, we recommend that all counties that requested Electing county status and developed an acceptable Electing county plan be included in the State Work First plan.

The 15.5 percent Work First population cap was a political compromise reached without any good knowledge of how counties would respond to the opportunity to develop and administer their own Work First plans, as set forth in the North Carolina statutes. The evidence from Electing counties shows that they have been prudent in the authority provided to them. They have taken the task of writing county plans seriously, involving many citizens, using good judgment, and producing products that they believe will work in their counties. There is no reason to believe these Electing counties will in any way treat Work First families in punishing ways, and indeed, there is evidence to suggest Electing counties will go further in working with their post welfare clients long after they leave the welfare roles. Raising the cap to include all Electing counties in the State plan is the most important legislative change that could be made, given the experiences of the past nine months.

Second we recommend that the State Work First plan be amended to provide the broad base for welfare reform intended by Federal and State law.

The present State Plan focuses almost exclusively on caseload reduction and putting welfare families to work, when both Federal and State law see work as a means to developing greater self-sufficiency. The State Plan suffers from the lack of a comprehensive picture of the relationship between welfare dependency and the complex social, economic and demographic issues that contribute to welfare dependency in North Carolina. After all, the State TANF plan should be a road map for what we want to accomplish with the use of our welfare dollars. Most of us are aware that getting welfare dependent people into jobs does not require either much planning or much cost,

particularly in a healthy economy. Helping this population keep their jobs, and helping them move up to the maximum level of self-sufficiency that they are capable of will require the most investment of time and resources, and this task can only be completed successfully when the barriers to this objective are carefully identified, and then resources are so directed.

Third, we recommend that the State plan provide social goals and benchmarks to reach those goals through the use of Work First dollars.

The very simple goal of reducing poverty, and benchmarks for achieving this goal, should be stated in the State's work first plan. Simply reducing caseloads will not reduce poverty, and the current North Carolina situation bears out. In 1990 13.93 percent of the families with children lived in poverty. In spite of a 30 percent reduction in the welfare caseload in North Carolina, today, according to the U.S. Census, 14.22 percent of the families with children live in poverty. Single parent families have risen as well. Welfare dollars should be used to combat the underlying causes of poverty.

Fourth, we recommend that the State plan include strategies to make the best use of public dollars currently being spent on social problems work better for Work First families.

It makes little sense to continue to spend for Smart Start, or CHIPS, for example, if these funds are not directed for use by the most vulnerable families, Work First families, first.

Fifth, we recommend that evaluation efforts not be concentrated in a single evaluation plan, but instead spread around to the various University research centers in North Carolina.

It is extremely important for the State plan to include a group of prominent research persons who can help develop appropriate research designs that will provide useful policy information, rather than information that policy makers prefer to hear.

In conclusion

The Conference on Poverty has been pleased to be associated with the implementation of a portion of welfare reform in North Carolina. Our organization and our consultants have experienced the hard work by dedicated persons in twenty-nine counties in our state as they struggled with issues of creating a welfare reform plan for their county that they believe will work. These are not radical plans, but are plans that give counties more control over how they spend their welfare dollars. We

firmly believe that it would be short sighted to deny the counties who worked so hard to come up with acceptable plans, the opportunity to administer them under North Carolina's State Plan.

The Federal welfare reform legislation (TANF) and S.L. 1997-443 both provide a long sought opportunity to use public funds free of the kinds of restrictions that have made their use ineffective in the past. Wide ranging changes have caused the Federal administrative agency to re-think how it relates to the states. These same changes also require North Carolina's Department of Health and Human Resources and the Division of Social Services to re-think how both relate to counties.

Rather than directing what should be done at the local level, the Division of Social Services must now find more effective ways to help localities accomplish what localities want to accomplish.

Welfare reform is about change, not only about changing how welfare recipients use welfare funds, but how welfare agencies go about administering these funds. As difficult as it might be to accept, welfare reform is designed to re-shape the welfare bureaucracy. We hope this committee keeps this factor in mind as it goes about its important work.

¹ This survey was conducted by Jennifer Bell, student, Terry Sanford Institute for Public Policy Studies, and Supervised by Leonard C. Beckum, Ph. D. Professor. The full report is available from the Conference on Poverty.

² This survey was conducted by Lisa Haire, student, School of Social Work, University of North Carolina, Chapel Hill, and supervised by Andrew W. Dobelstein, Ph.D. Professor. the full report is available from the Conference on Poverty.

PERSONAL INFORMATION

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July 18, 1934, Pittsburgh, PA.

PROFILE

Andrew W. Dobelstein, Ph. D. has been Associated with the University of North Carolina since 1968, first as an Assistant Professor, and then as full Professor in 1980. He teaches social welfare policy, conducts research in the field of welfare politics, and provides extensive community service to state, local and national organizations concerned with poverty problems. He has held joint appointments with the Bush Institute for the Study of Children's Policy, Greensboro College, U.N.C. Greensboro, and University of California at Los Angeles. In 1977, with the assistance of two professional colleagues he formed the Conference on Poverty, a 501, C.(3) non-profit corporation which provides data, training and consultation to local organizations working with poverty persons.

Dr. Dobelstein received his Ph.D. in Political Science from Duke University in 1973. He also received degrees from Case Western Reserve University and Valparaiso University (IN). He has been a Guest Scholar at The Brookings Institution, Washington, DC. He is a fellow in the Institute of Political Leadership, and he has completed Commitment for Leadership training at the Center for Creative Leadership. He has served on the North Carolina General Assembly's Joint Legislative Welfare Reform Study Commission, and most recently he has assisted in developing and implementing North Carolina's welfare reform plan.

Dr. Dobelstein has published six major textbooks on social welfare policy, and authored, individually or jointly, over 30 articles. His seventh book, *Moral Authority, Ideology, and the Politics of American Welfare*, a discussion of welfare for the general public, will be published by Westview Press in the summer of 1998. He lives in Carrboro, North Carolina where he is active in local public affairs.

LEONARD C. BECKUM

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EDUCATION

- 1973 Ph.D. Psychological Studies of Education
 Stanford University
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- 1969 B.A. Interdisciplinary Social Sciences
 California State University
 San Francisco, CA

CURRENT POSITION

- 1996 *Professor of the Practice of Public Policy Studies and Education*
 Terry Sanford Institute of Public Policy
 Duke University
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PREVIOUS EXPERIENCE

- 1990-95 *University Vice President and Vice Provost*
 Professor of the Practice of Education
 Duke University
 Durham, NC
- 1985-90 *Dean of the School of Education*
 Professor in the Psychological Studies of Education
 The City College, City University of New York
 New York, NY
- 1974-85 *Associate Laboratory Director*
 Far West Laboratory for Educational Research and Development
 San Francisco, CA
- 1977-80 *Professor of Psychology* (part-time)
 San Francisco State University
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- 1972-75 *Professor, Criminal Justice Program* (part-time)
 San Francisco City College
 San Francisco, CA

Shirley McClain
North Carolina Hunger Network
Public Hearing
May 27, 1998

Good Evening members of the Joint Legislative Welfare Reform Commission, other legislators, members of the public and colleagues. I too want to thank this committee for holding this public hearing if this is a real public hearing. I mean a hearing where the testimony of the participants are really weighed when the laws are made. I hope that this one is real. I ask both Democrats, and Republicans, Senate and House and our Governor to consider the results of the work First Program over the past two years. You know that the program was not perfect. Look at the flaws and look at the good things. Take out what is not working. Add in those recommendations for improvements coming from low-income individuals and their advocates.

In fact we encourage you today to vote favorably for the a welfare reform legislation to be introduced by Rep. Alma Adams and Senator Jeana Lucas. This legislation offers recommendations for improvements in the current State Plan.

If we do not significantly change the current legislation, the state of North Carolina will face charges of human rights violations. For those who do not know, I will read articles 23, 25 and 26 of the Universal Declaration of Human Rights. Several upcoming event over the next two weeks will highlight some of the violations and those violation will be taken to the United Nations.

I have more copies of the document and you can call my office at 821-5300. or write me at North Carolina Hunger Network.

Sherry Mason

N.C. WELFARE REFORM COLLABORATIVE

331 W. Main Street, Box 38
Durham, NC 27701

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April 30, 1998

Mr. Kevin Fitzgerald
Director
Division of Social Services
325 N. Salisbury Street
Raleigh, NC 27603-5905

VIA Facsimile 919-733-9386

Dear Mr. Fitzgerald:

The enclosed statement represents the collective response of the members of the North Carolina Welfare Reform Collaborative to the proposed North Carolina Temporary Assistance for Needy Families State Plan (Work First Program).

The North Carolina Welfare Reform Collaborative is a one year old statewide initiative involving the constituencies of three multi-racial, advocacy organizations including N.C. Fair Share, N.C. Hunger Network, and Southerners for Economic Justice. Each organization is committed to grassroots organization and leadership, policy advocacy, and economic empowerment as strategies to end hunger, poverty, and the unjust policies that impact our constituency. To date, participants in the Collaborative activities reside in seventeen NC counties including Guilford, Cumberland, Durham, Hoke, Nash, Perquimmons, Robeson, Wake, Martin, Edgecomb, Mecklenberg, Vance, Warren, Buncombe, Lee, Granville, and Alamance.

Collaborative partner's staff and constituents have reviewed the proposed State Plan. We are deeply concerned at the over emphasis on caseload reduction without adequate consideration of the factors that would support Work First participant's transition from public assistance to self-sufficiency. Our comments and recommendations regarding ten key areas are outlined below.

Benefit Diversion- This allows for a family to receive one time assistance to help them stay off Work First. This gives families cash equaling three months of benefits of food stamps, Medicaid, and child care assistance. The current plan requires families to pay back cash received under benefit diversion if they should ever (lifetime) apply for Work First assistance again. The proposed plan requires repayment if families apply within 36 months of receiving diversion assistance.
Recommendation: No repayment requirements. (Buncombe County DSS has proposed no repayment or permission for counties to waive repayment.) The policy of no repayment by families for diversion assistance should be uniform throughout NC.

Vehicle Exclusion- All families will be allowed to keep one vehicle regardless of value.
Recommendation: While this is helpful to families with cars, it does not begin to address the needs of families without cars. A statewide transportation plan for families to acquire autos at low or no cost should be implemented. In addition, when two working people in a family use cars for transportation, the second car should also be exempt.

Job Bonus- Families that get jobs while on Work First are allowed continued cash benefits with no reductions for three months.

Recommendation: This practice should be linked to an across-the-board increase in benefits. Any reduction in benefits should be phased in to allow an additional 6 months of receiving cash assistance. The formula should consider family expenses and whether or not job earnings provide a self-sufficiency wage.

Family Violence - It is very good that the state has proposed adoption of the federal Family Violence Option to protect victims of domestic violence.

Recommendation: The plan to do screenings should be replaced with universal notification for all DSS applicants for benefits. The Durham County Work First Plan Amendment provides clear direction and protections for victims of abuse. (see attached)

Sanctions- The state proposal is to reduce benefits by 25% on the first infraction; then pay-after-performance for a minimum of three months. Families are subject to termination if deemed non-compliant.

Recommendation: The state proposal amounts to a "3 strikes" policy. This condemnation of people in poverty is unresponsive to the charge given social services to help families succeed in moving from welfare poverty to self-sufficiency. Strategies that are pro-active and provide positive reinforcement opportunities could include motivational training, mentoring, job search and job readiness assistance. Sensitivity training for case workers and supervisors on service delivery to needy populations is a must. There should be a review of all persons sanctioned. Persons under sanctions or terminated for rules infractions should be advised of their appeal rights.

Electing Counties- North Carolina is the first state to allow counties to select whether they will follow standards set by the state or pilot total control over Work First programs.

Recommendation: There should be uniform standards for benefits, eligibility and an appeals process to protect the rights of needy families whether in Electing or Standard counties.

Two-year Time Limit- The proposed plan continues the two-year time limit.

Recommendation: Eliminate the two-year time limit. It is especially harsh in that recipients of cash assistance must be off for three years before eligible for participation in Work First for cash assistance. The state had previously said it would better define who is eligible for extensions to ensure families unable to support themselves would not be denied assistance. Eliminating the two-year time limit takes the pressure off counties to find alternative means of providing assistance to needy families allowing more time for creative practices to be developed with public agencies, community and faith institutions. A review of families subject to the two-year time limit should be done to determine if those families no longer need assistance.

Eligibility- The proposed state plan eliminates the Standard of Need. This makes major changes in how income eligibility and benefit amounts are calculated for recipient families. The elimination of the Standard of Need also impacts Medicaid eligibility.

Recommendation: Do not eliminate the Standard of Need. Instead, take into consideration expenses versus income to allow families to move from welfare poverty to self-sufficiency. Federal welfare law requires that all persons who would have qualified under the Work First income and resource rules in place on July 16 1996 must still be found eligible for Medicaid today. The Medicaid eligibility standard should be a part of an overall uniform eligibility standard for counties throughout the state.

Pay-After-Performance for two Parent Families- The state implemented this change on March 1, 1998. Two-parent families must meet the work requirement of 35 hours per week before receiving Temporary Assistance for Needy Families benefits.

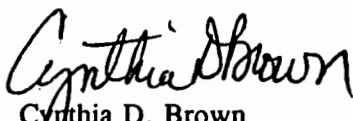
Recommendation: Eliminate the policy to provide benefits after work requirements are met. This is punitive without cause. Families attempting to stay together should be supported with services to overcome barriers to self-sufficiency and employment.

Grievance/Appeals Procedure- The state plans provides for punishment that leads to termination on a fast track. However, there is no mention of an appeals process to address any unfair enforcement of work requirements.

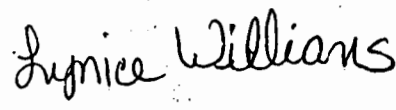
Recommendation: A clear appeals process would be provided to all Work First participants. Persons who are sanctioned should be provided an explanation of the sanction and reason for the sanction. The appeals process should be uniform statewide providing for appeals up to the maximum redress. Persons making appeals should be informed that they have the right to legal counsel and any other advocates they choose.

In closing, we urge you to give careful consideration of our comments and recommendations. Our comments have been largely developed by the concerns of women who currently receive public assistance or those who have been welfare recipients. We are all committed to welfare reform that is humane and addresses the best interests of families living in poverty. We believe for NC's plan to comply with that standard, the plan must incorporate our recommendations.

Sincerely,


Cynthia D. Brown
Southerners for Economic
Justice


Shirley McClain
NC Hunger Network


Lynice Williams
NC Fair Share Education Fund

cc:

Senator Jeanne Lucas (Durham), Senator Wilbur Gulley (Durham), Representative Paul Luebke (Durham), Representative Henry Michaux (Durham), Representative George Miller (Durham), Senator Bill Martin (Greensboro), Representative Alma Adams (Greensboro), Eleanor Kinnaird (Carrboro), Representative Howard Hunter (Conway), Representative Milton F. Fitch (Wilson), Representative Beverly Earle (Charlotte), Representative Larry Womble (Winston-Salem), Chairperson Michelene Malson, Durham County Work First Advisory Committee, Director Dan Hudgins, Durham County Department of Social Services, Chairperson Mary Ann Black, Durham County Board of County Commissioners.

Rev. Vivian Collins / W.I. N.

PREPARED BY	
DATE	

We live with the burden of an unlimited view of profane pronouncements of godless philosophies, silenced church leaders, helpless and deprived mothers, hungry children and jobless fathers. Let us see and feel this darkness in our cities, the sadness and fear of its children, the ruthlessness of its exploiters, and the utter helplessness of its leaders. We have a global problem, God calls it sin; man calls it everything but sin.

There is an urgency of the hour in our state and in our nation to battle for BREAD, JOBS, and JUSTICE.

"We want reform not deform."

Field work in the state of North Carolina.

PREPARED BY	
DATE	

From the desk of Dr. Vivian Collins-Kelley
president of Women International Network
of Fayetteville, N.C.

Article 23

- (1) Everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment.
- (2) Everyone, without any discrimination, has the right to equal pay for equal work.
- (3) Everyone who works has the right to just and favorable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
- (4) Everyone has the right to form and to join trade unions for the protection of his interests.

STATEMENT TO THE JOINT SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
OF THE NC GENERAL ASSEMBLY BY DR. JONATHAN P. SHER (PRESIDENT, NC
CHILD ADVOCACY INSTITUTE & VICE-CHAIR, COVENANT WITH NC's CHILDREN)

Welfare reform ought to improve the welfare – the well-being – of the families in such dire need that they have to rely upon the not always tender mercies of government agencies to survive. The State Plan – and each of the county welfare plans you will consider for approval -- must place improving the well-being of children at the top of the list of priorities; **not** at the bottom (where it currently resides).

Economic self-sufficiency (rather than mere caseload reduction) is a worthy goal. But, children will never be self-sufficient, economically or otherwise. All children need and deserve assistance from both the public and private sectors in order to have an even minimally adequate childhood – and more than the faint hope of growing up healthy, safe, educated and able to function as good citizens and productive adults.

The children who need the most assistance from outside their families are – to no one's real surprise – the youngsters who receive the least support and nurture within their families. And yet, there are those who would give the least to those children who need the most and who would penalize children for having had the bad luck to have been born to parents who are unable or unwilling to raise them well. Having parents who fail you surely is penalty and punishment enough all by itself. It is just plain wrong to allow further harm to come to children because of the failings of their families.

God Bless the Child remains a classic song, but Billie Holliday should not be setting the tone for North Carolina's welfare reform when she sings that "them that's got shall get and them that not shall lose"! By placing child well-being first instead of last; by broadening the Plan's definition of child well-being; by rigorously evaluating the impacts of welfare upon children; and by changing both policy and practice based on this evaluation to enhance positive impacts and eliminate negative impacts, North Carolina has the opportunity to implement welfare reform that will bless – rather than curse – the hundreds of thousands of children your decisions and actions will affect.

Please do not forego this opportunity nor forsake these children.

I would like to address my comments to the NC Family Violence Option, found on page 13 of the proposed plan under Domestic Violence.

First I would like to sincerely thank and applaud NCDHHS for including the FVO in our state plan. The FVO is an amendment to the federal welfare law that allows states to screen for and identify D.V. among welfare recipients, to refer those women to supportive services, and to provide temporary waivers from requirements and penalties when compliance would make it more difficult for the welfare recipient to escape D.V. or would penalize her for failure to comply when such failure is a result of D.V.

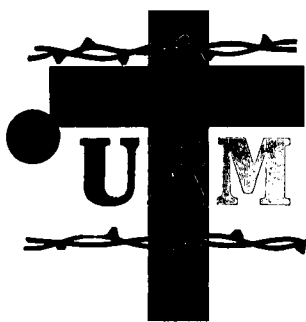
The correlation between D.V. and welfare is very significant. D.V. has been found to be one of the chief barriers for women's economic self-sufficiency. Among battered women on welfare, studies show that between 60% and 95% of the women who seek services from D.V. shelters spend some time on welfare and four recent studies of welfare programs show that between 34% and 65% of women on AFDC were past victims of domestic violence and between 15% and 32% were currently abused. Anecdotal reports also indicate that battered women on welfare are among some of the most motivated to leave welfare and become economically self-sufficient so that they can have the means to be and remain independent from abusive and violent relationships.

As a result of adopting the FVO, NC will not be penalized for failing to meet participation rates and for exceeding the 20% exemption allowance if that failure and excess is attributable to the granting of good cause waivers pursuant to the FVO and if NC complies with DHHS regulations in implementing the FVO. This means that NC should assure that screening and referrals, and waivers if necessary, are provided throughout the entire state, in all counties, to assure that NC is implementing the FVO in accordance w/ fed. regulations.

We urge that the state continue its efforts to implement the FVO, support the idea of a pilot program but suggest

1. that the plan be clarified so indicate that all counties may exempt a family from child support cooperation requirements when it would put the mother or children at risk of D.V.
2. that workfirst applicants be immediately notified of the provisions of NC's FVO, even in counties which are not being piloted.
3. Most importantly that funds be provided to DHHS so that they can provide appropriate training to their caseworkers and staff about domestic violence screening and making referrals to community agencies and services for battered women.

Deborah Wassman
Legal Services of N.C.
856-2133



United States
URBAN-RURAL MISSION
World Council of Churches

P.O. Box 240, Durham, NC 27702 (919) 683-3145; FAX (919) 683-3428

Board Chair: Carol Zippert
International Contact Person: Nelson Carrasquillo
Coordinator: Mab Segrest

**STATEMENT AT THE STATE PLAN PUBLIC HEARING
ON PROPOSED CHANGES TO WORK FIRST
May 27, 1998**

My name is Mab Segrest. I am Coordinator for the Urban-Rural Mission (USA), with a national office based in Durham. URM is affiliated with the World Council of Churches, the Protestant ecumenical organization based in Geneva, Switzerland and representing over 300 million Protestants worldwide. We at the Urban-Rural Mission believe that the mission of God is for justice, for a fulfilling of the Gospel mandate of "fullness of life to all people."

I am concerned that this welfare reform plan will bring not fullness, but diminished, life to many people it is intended to "reform." As part of a global network of community organizers, our experience in URM shows us how global changes in the economy, in which U.S. workers compete with workers in poorer countries making 1/8 the wages, have created more low waged jobs here, with little benefits or job security, and how the supposed boom in our U.S. economy comes from stock market profits fueled by this contingent work and by corporate downsizing, which affects people all across the workforce.

To work in such an economy is not necessarily to be self-sufficient. In Durham County, a self-sufficiency standard for a single parent with an infant and preschooler is \$14.63, and most entry level wages for Work First participants are half of that. Public transportation in our county is not designed to get people from where they live to where there are jobs, and low wages and poor transportation make access to safe and affordable childcare difficult, sometimes impossible. One member of Durham County's task force observed that our "Work First" Plan could be called a "Work Force" Plan, because the problems it seeks to address of wages, transportation, and childcare, affect 40% of the county's residents.

Genuine *self-sufficiency* requires a living wage that comes from a government and corporate belief in our *interdependence*. URM (USA) supports the proposals of the NC Welfare Reform Collaborative; we specifically request that you end the two-year time limit; eliminate the punitive revision in the procedure for sanctions; and continue cash benefits for families after getting jobs until they reach genuine self-sufficiency. Until wages are higher and benefits more secure, we consider that subsidized childcare, medicaid, and food stamps should be part of self-sufficiency.

A story in Matthew illustrates what is at stake in these deliberations. When the Son of Man comes in his glory, he sets about to separate the sheep from the goats. To those on his right hand, he says, "I was hungry, and you gave me meat; I was thirsty, and you gave me drink; I was a stranger, and ye took me in; naked and ye clothed me: I was sick and ye visited me: I was in prison and ye came unto me." And they respond, "When did we...?" and he responded, "When you have done it unto the least of these my brothers and sisters you have done it unto me." And to those on the left, "Depart from me, ye cursed, into everlasting fire."

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

Legislative Office Building - Room 643

Thursday, May 28, 1998

8:30 a.m.

Opening Remarks

Senator Bill Martin, Co-Chair
Representative Charlotte Gardner, Co-Chair
Representative Lanier Cansler, Co-Chair
Representative Debbie Clary, Co-Chair

Morning Session

Overview and Introductions

Steve Christian, Policy Specialist
National Conference of State Legislatures

CPS Reform in Missouri:
SB 595

Former Senator Joe Moseley

CPS Reform in Missouri:
Implementation & Evaluation

Richard Matt, Deputy Director, Missouri
Department of Social Services, Division of
Family Services

Afternoon Session

CPS & Law Enforcement
Partnership in Manatee County,
Florida

Captain Connie Shingledecker
Manatee County Sheriff's Office

Margaret Fender, Operations Manager
Florida Department of Children and
Family Services

Discussion

Adjourn

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Minutes May 28, 1998 Morning Meeting

The Joint Appropriations Subcommittee on Human Resources met on May 28, 1998 at 8:40 a.m. in Room 643 and was chaired by Representative Charlotte Gardner. Five Senators were present and the following Representatives:

Representative Charlotte Gardner
Representative Debbie Clary
Representative Martha Alexander
Representative Bill Hurley

Representative Lanier Cansler
Representative Edd Nye
Representative Alma Adams

These staff members were in attendance: Gann Watson, Susan Sabre, Karen Hammonds-Blanks, Romona Burton, Carol Shaw and Mary Ellen Sylvester.

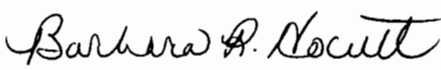
Steve Christian, Policy Specialist with the National Conference of State Legislatures, gave an overview of the status of Child Protective Services and the changes that are being implemented. (See Booklet, "New Directions for Child Protective Services")

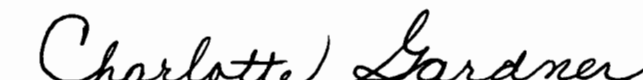
Former Senator Joe Mosley of Missouri talked about Child Protective Services Reform in Missouri (See Attachment #1.)

Richard Matt, Deputy Director, Missouri Department of Social Services, Division of Family Services, gave the picture of the implementation and evaluation of CPS reform in Missouri. (See attachment #2, Missouri's Child Protection Demonstration and attachment #3, Family Assessment and Response Demonstration Impact Evaluation findings Executive Summary.)

Representatives Alexander and Adams asked questions concerning retention problems, turnover and caseload issues.

The meeting was adjourned until 12:30 p.m. Representative Gardner announced that Pages will be available to take lunch orders so that the afternoon meeting can get started promptly.


Barbara R. Hocutt, Clerk


Representative Charlotte A. Gardner, Co-Chair

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

MAY 28, 1998

Name of Committee

Date /

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Jennifer Tolle

Prevent Child Abuse

Sharon Bird

NC ACDSS

Peter Morris

Wake Co Human Services

Myra Pull

NASW-NC

AL DEITCH

TAID/DOA

Lee Kellough

DHHS

Chuck Harris

DHHS-DSS

DD Otter

DHHS-DSS

Jane Smith

DHHS-DSS

JoAnn Lamm

DHHS-DSS

Kristen Guilford

DHHS-DSS

Greg McAllister

DHHS-DSS

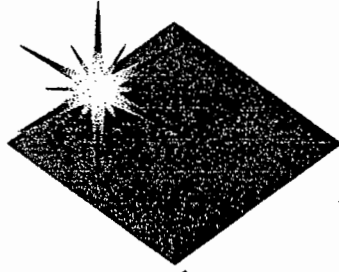
Gene Wilson

CFTF

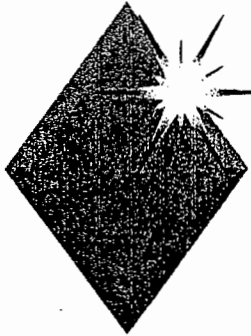
Garland Gaudin

Gov. Office

Richard M.
Deputy Director, DSS
Division of Family Services
May 28, 1998 PJ

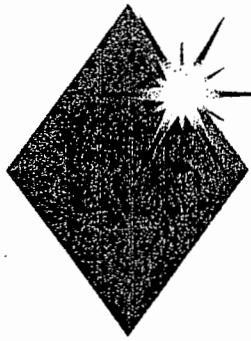


Missouri's Child Protection Demonstration



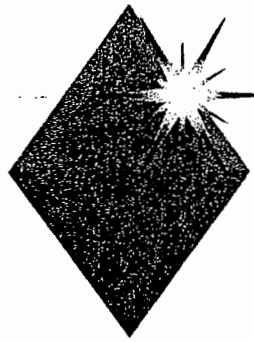
MULTIPLE RESPONSE SYSTEM FOR HANDLING REPORTS OF CHILD ABUSE AND NEGLECT

- ◆ Wide variety in nature and severity of child abuse/neglect reports received
- ◆ Response to reports should be tailored to best meet needs of the family
- ◆ Response must meet the mandate of the child abuse/neglect statute



COMMUNITY AND FLEXIBLE RESPONSE TO CHILD PROTECTION SERVICES

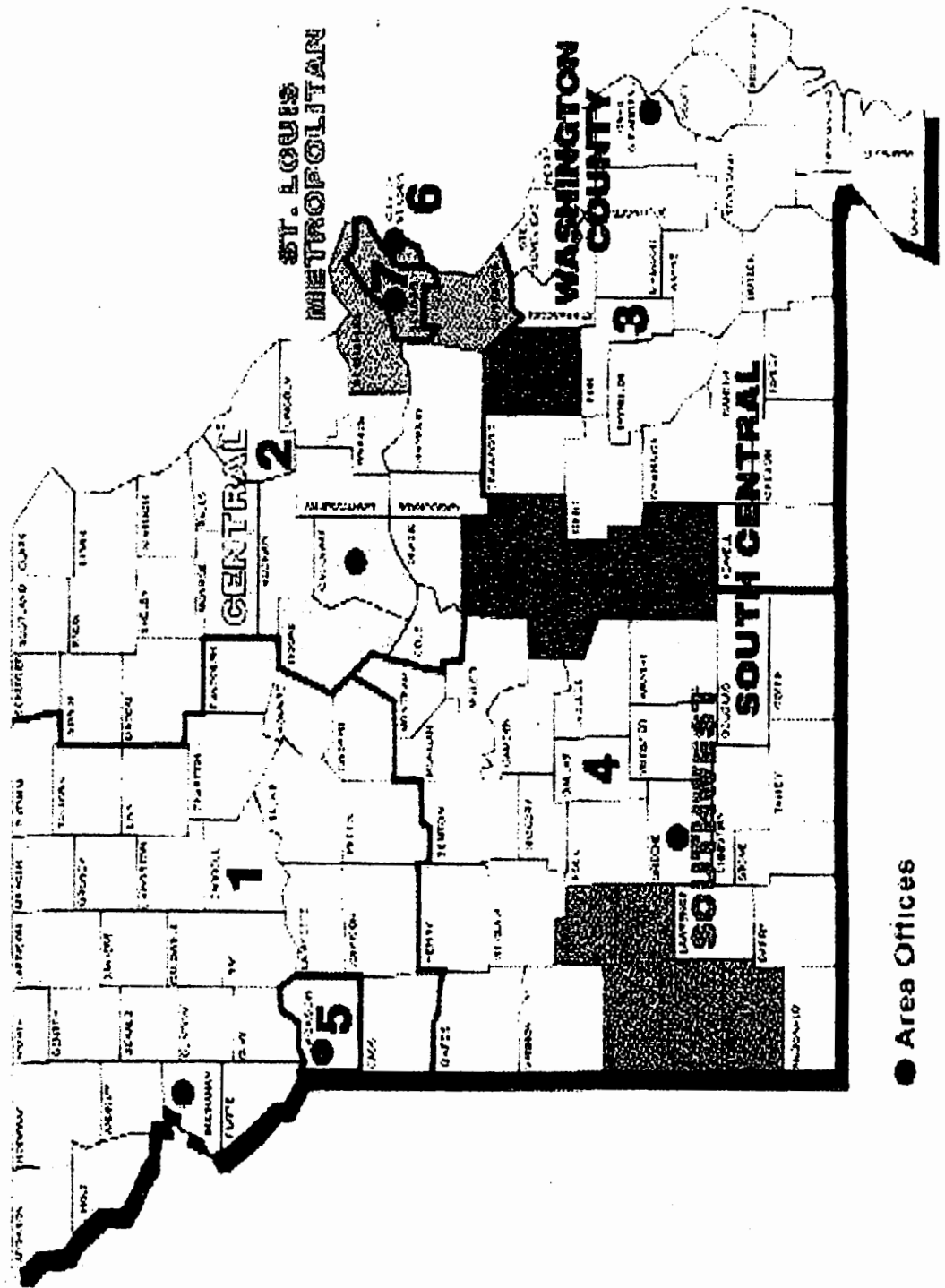
- ◆ Recognize the need for a differential response to reports of abuse/neglect
- ◆ Limits use of “traditional investigation”
- ◆ Less threatening family assessment
- ◆ Encourage family collaboration
- ◆ Focus on assessment for safety, risk and well being



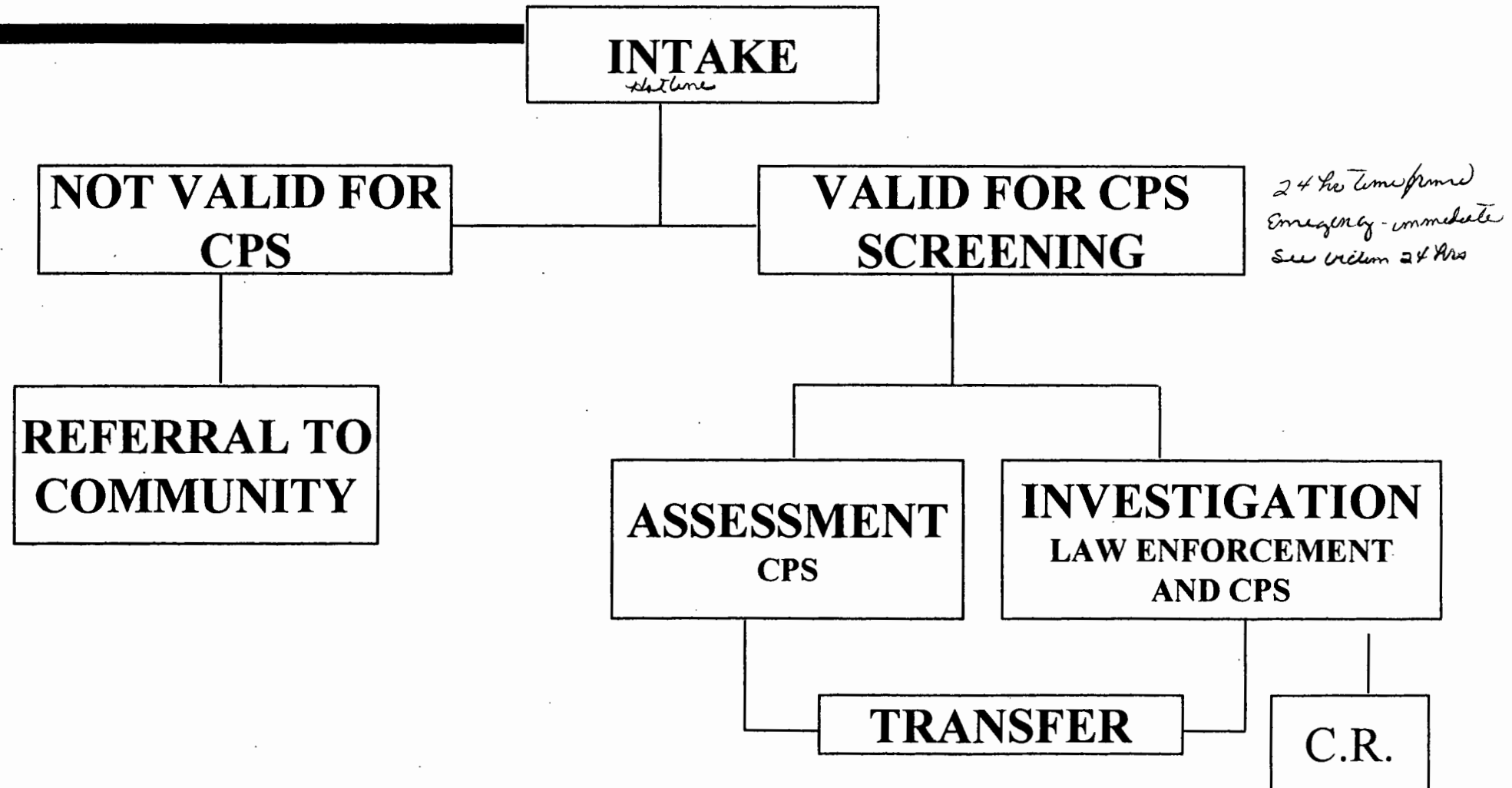
COMMUNITY AND FLEXIBLE RESPONSE (CONT.)

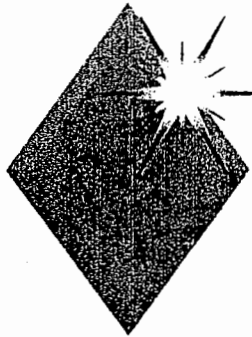
- ◆ All families receive an assessment of their needs.
- ◆ Enhance timely services
- ◆ Agency seen as support and resource
- ◆ Prevent unnecessary labeling
- ◆ Promote community involvement
- ◆ Promote diversion services

Missouri Department of Social Services Division of Family Services SB 595 Demonstration Areas



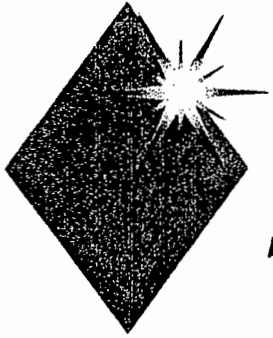
MULTIPLE RESPONSE SYSTEMS





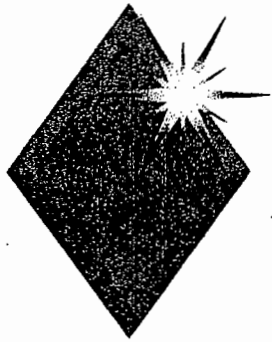
SCREENING OF REPORTS INTO APPROPRIATE RESPONSE HANDLED IN LOCAL DEMONSTRATION COUNTY

- ◆ Definition of Child Abuse Neglect has not changed
- ◆ Reports involving allegations of criminal child abuse/neglect or alleged perpetrator who is not a member of the family/household are screened as investigations (law enforcement will be contacted for any report involving criminal allegations).



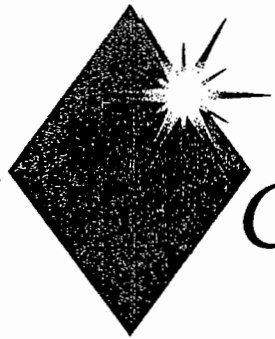
SCREENING OF REPORTS (CONT.)

- ◆ All other reports are screened as family assessments
- ◆ Local County may take into consideration information about any prior contact with the family in making the screening decision



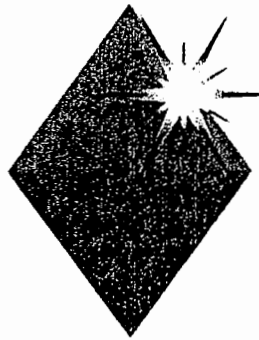
Family Assessments/Investigations

- ◆ Family Assessments/Investigations will be initiated within 24 hours for all reports(except educational neglect)
- ◆ Staff are required to assure for the safety of the child in both investigations and family assessments
- ◆ Investigations require face to face contact with the child within 24 hours of receipt of the report to assure for the safety of the child
- ◆ Investigation and Assessment must be completed within 30 days



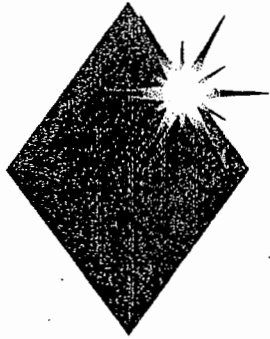
COMMUNITY COLLABORATION

- ◆ Community resources and the Division of Family Services will collaborate in providing support, assistance, and services to children and families
- ◆ Comprehensive local services and access to those services for children and families were there is a risk of abuse or neglect



INDEPENDENT EVALUATION

- ◆ Independent Contractor-Institute of Applied Research
- ◆ 3 year evaluation
- ◆ Comparison and Pilot counties
- ◆ Multi-faceted
 - ◆ Interviews
 - ◆ Case Readings
 - ◆ Data Analysis
 - ◆ Special Surveys



CHILD PROTECTION SERVICES EVALUATION FINDINGS

- ◆ No evidence that safety of children in assessment cases has been compromised and in some cases it was improved.
- ◆ Hotline reports have declined slightly in most of the pilot counties
- ◆ Increase in Percentage of reports where workers provided some assistance

Figure 3.3. Safety Changes in Assessment-Type Families during the first 30 Days of Contact and at the Time of Last Contact with Family

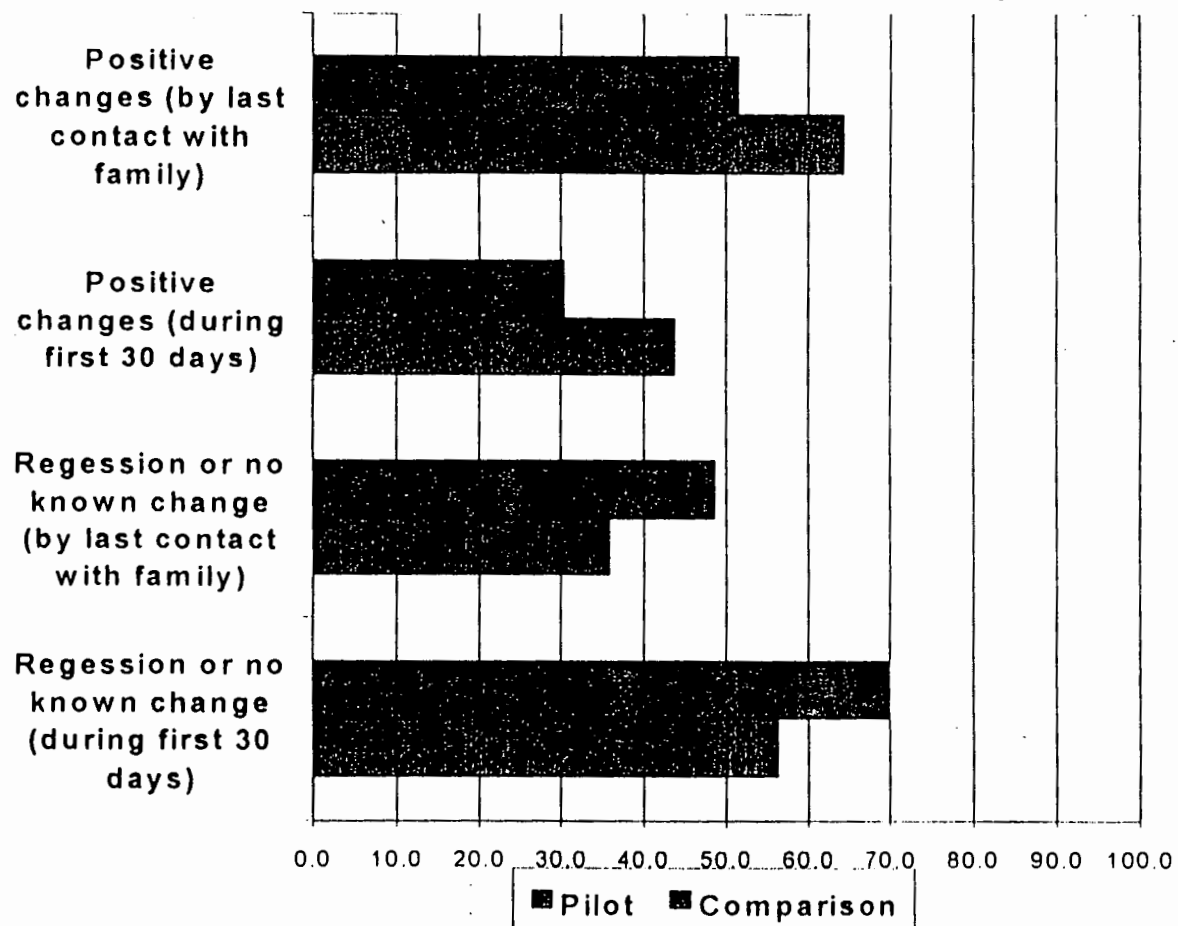
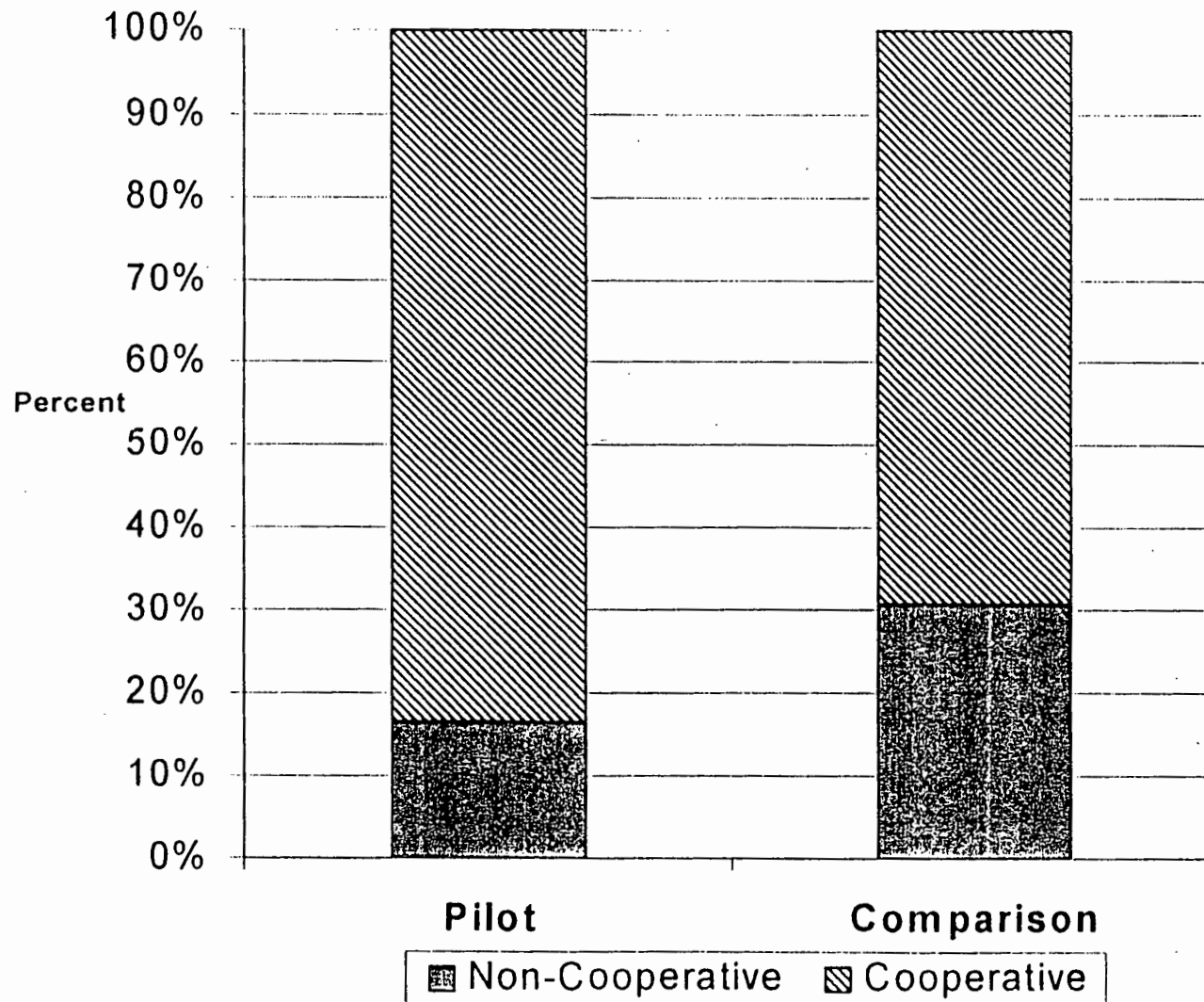


Figure 3.2. Percent of Verified Safety Issues Involving Family Flight or Refusal to Cooperate by Study Areas



Mean Number of New Hotline Reports per Month

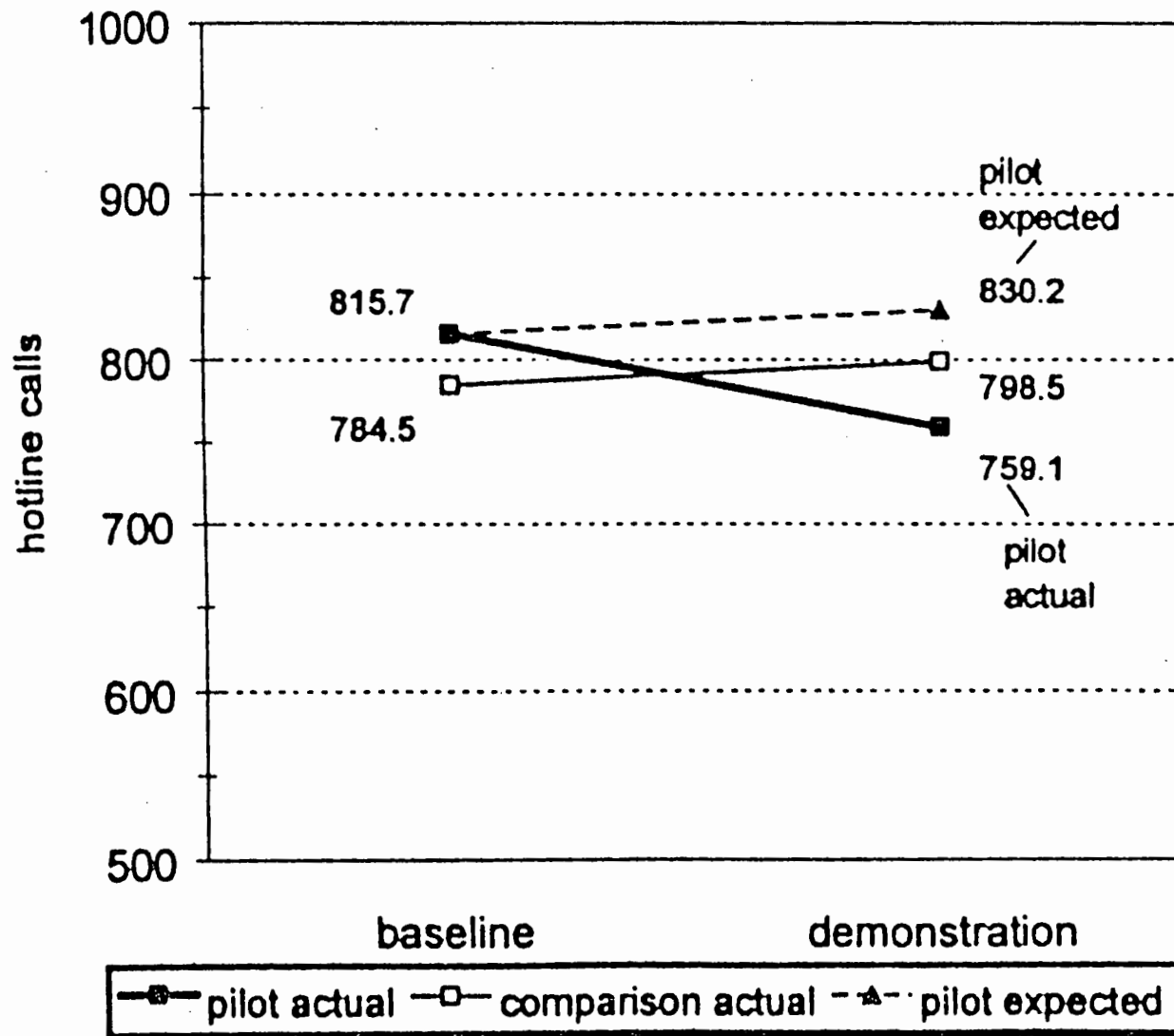
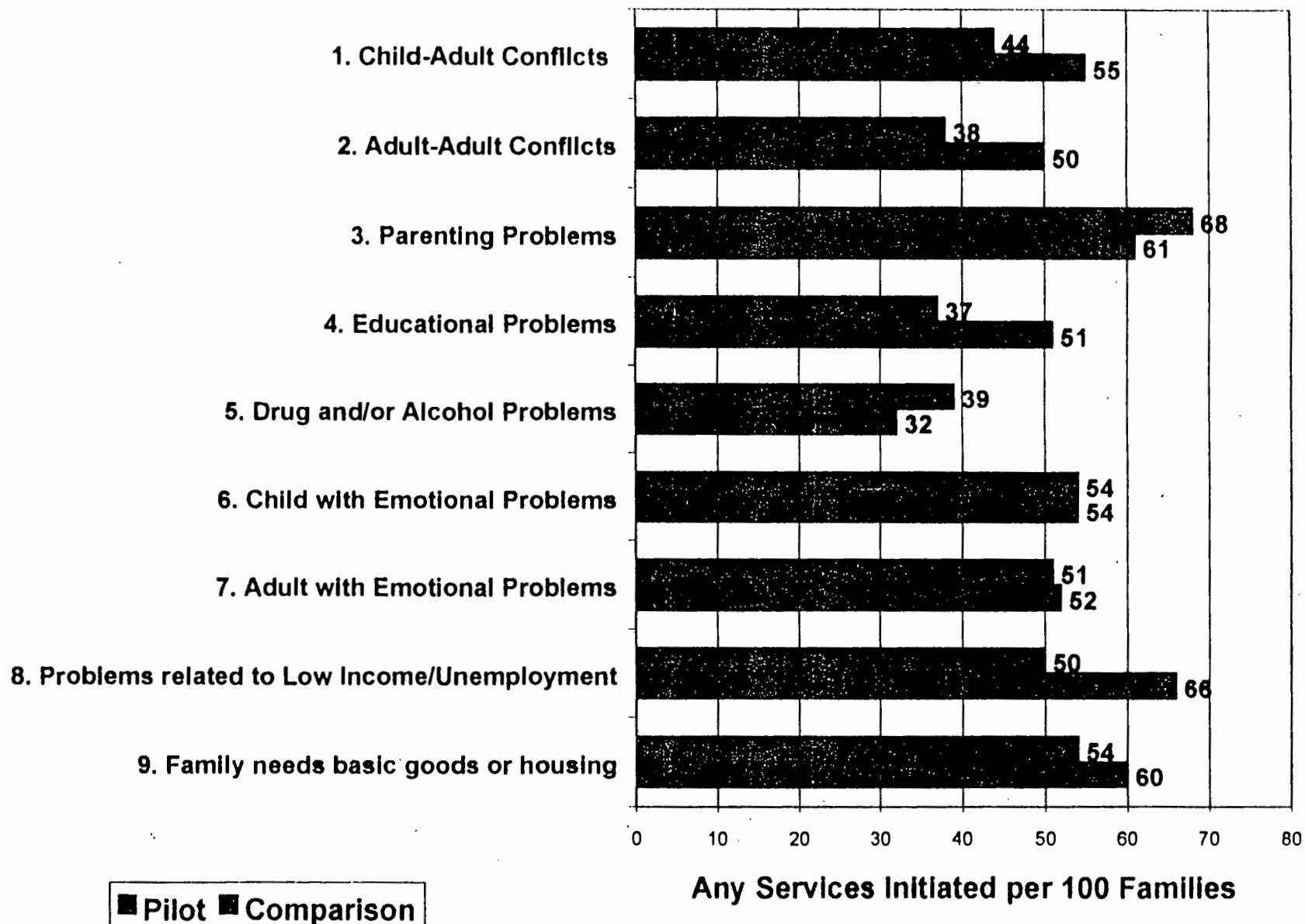
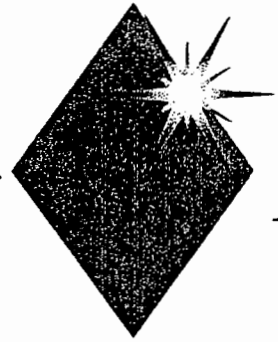


Figure 4.14 Number of DFS Initiated Services per 100 Families by Nine Major Problem Area





EVALUATION FINDINGS (CONT.)

- ◆ Timeliness and Appropriateness of Services was improved.
- ◆ Decline in Families who received formal intervention by the public agency
- ◆ Utilization of Community Resources increased.

Figure 6.1. Days to First Service for Cases with Different Outcomes in Pilot and Comparison Areas

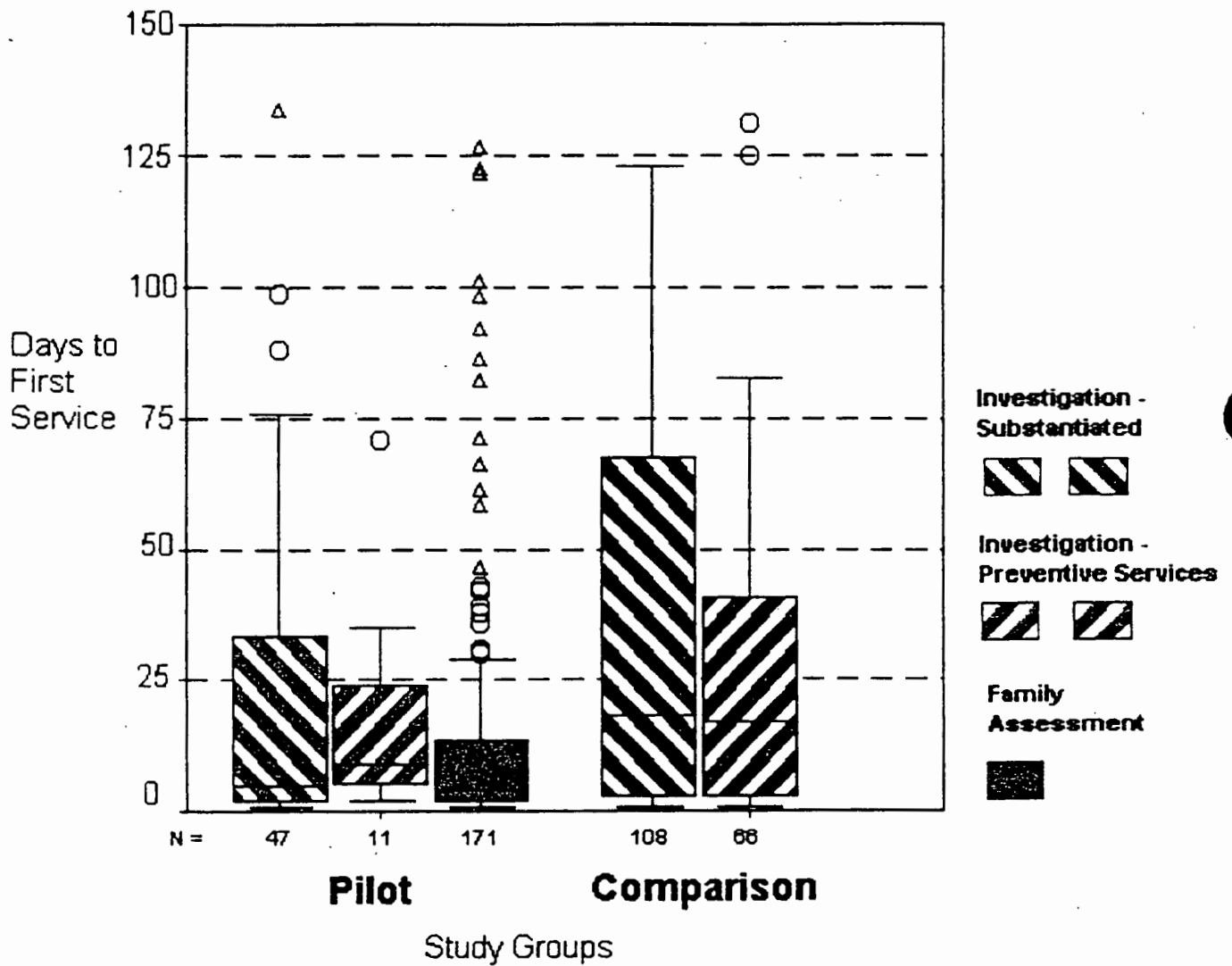
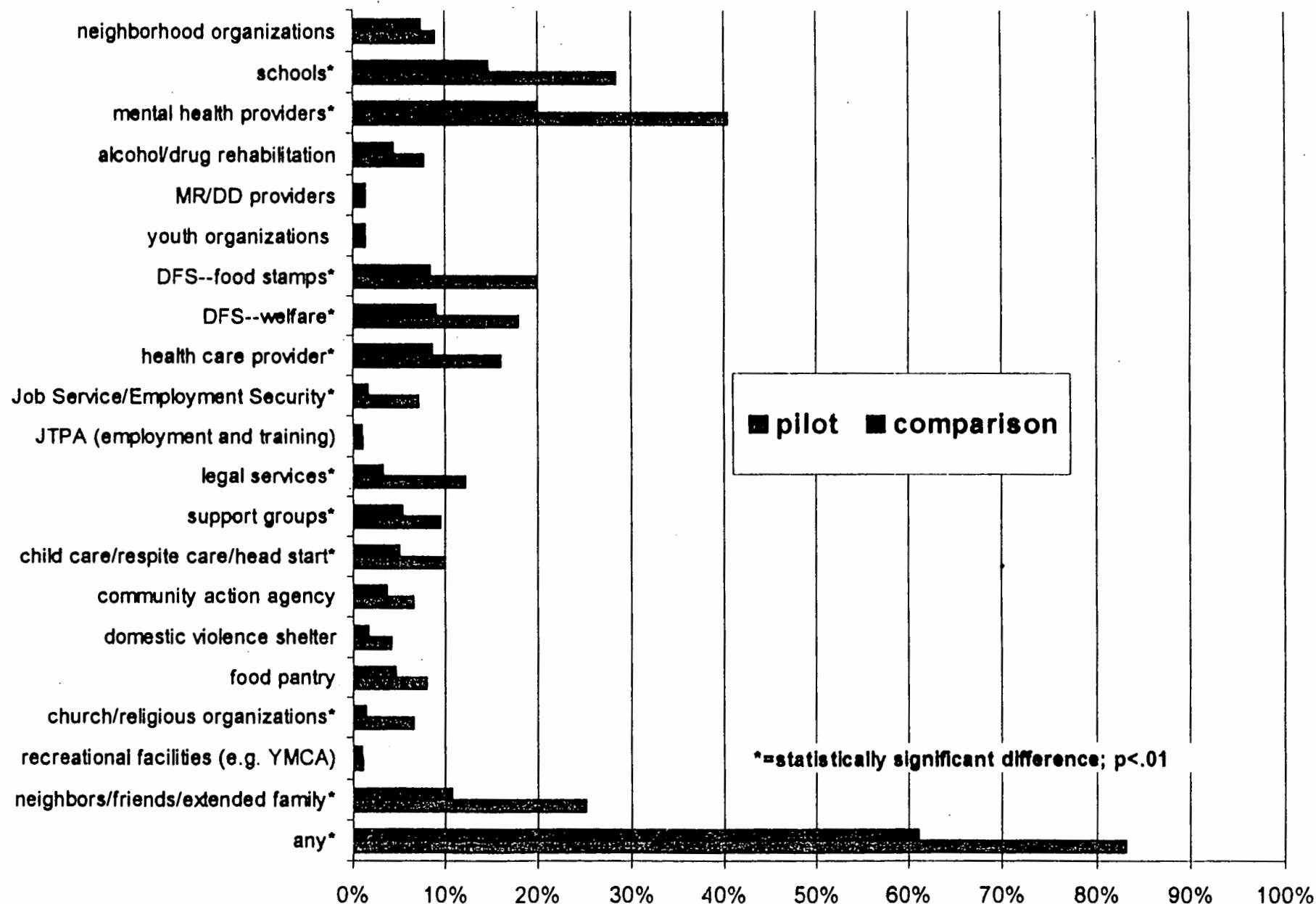
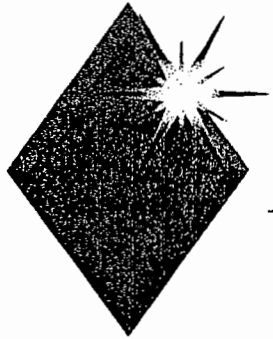


Figure 9.1. Percent of Families Linked with Various Community Resources in Pilot and Comparison Areas According to Workers





EVALUATION FINDINGS (CONT.)

- ◆ Recidivism was reduced
- ◆ Out of Home Placements remained the same.
- ◆ Families report being more satisfied with intervention, considered that staff were more friendly and engaged them more in the case plan and more often stated they were better off after involvement

Figure 5.2. Comparison of Recidivism Means for New Reports of Children Lacking Basic Necessities, Lack of Supervision or Proper Care and Lack of Proper Concern for Education

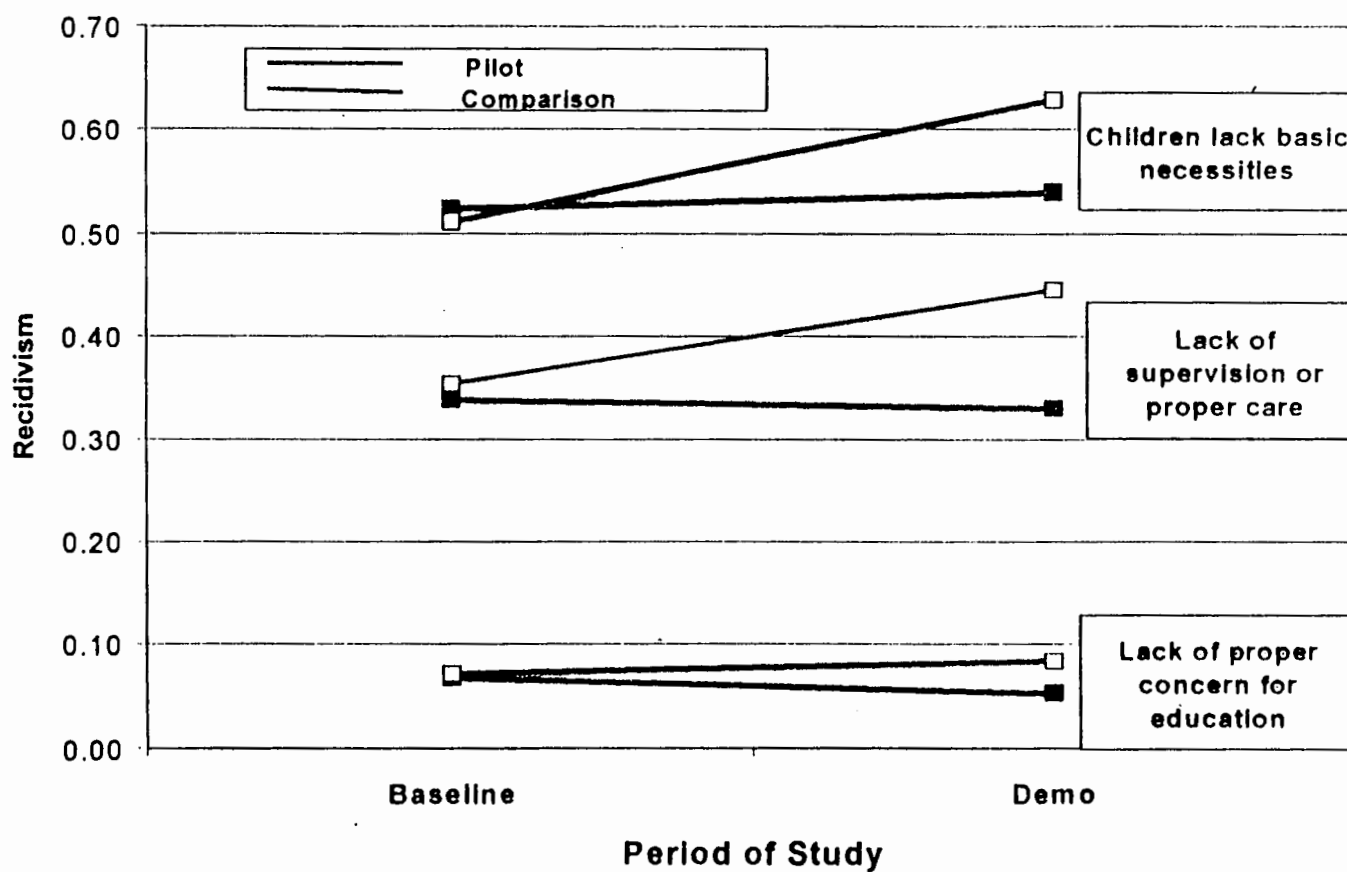


**Figure 6.6. Percent of Families in the Study Sample
on Which Workers Provided Assessments of Specific Strengths and Deficits**

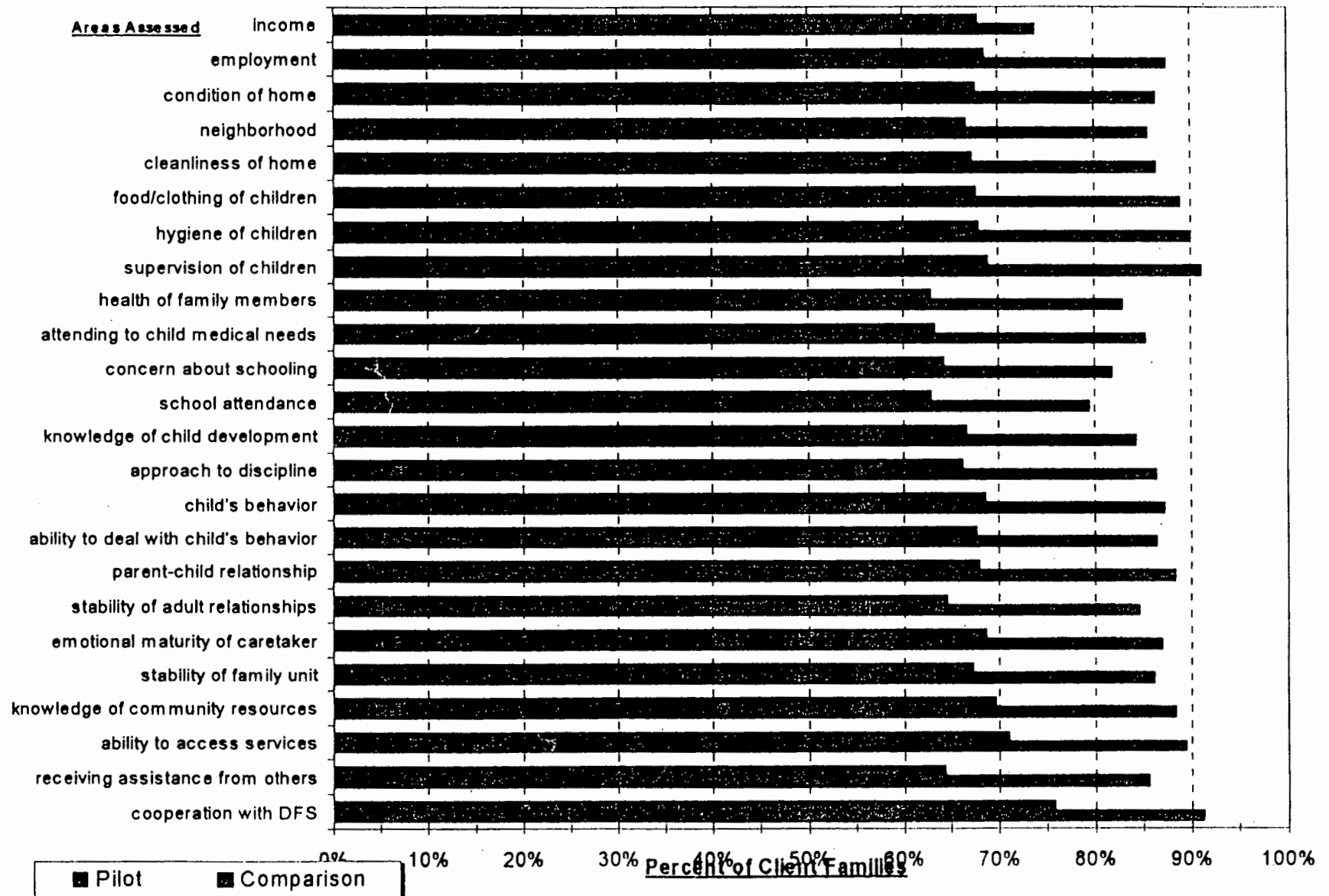
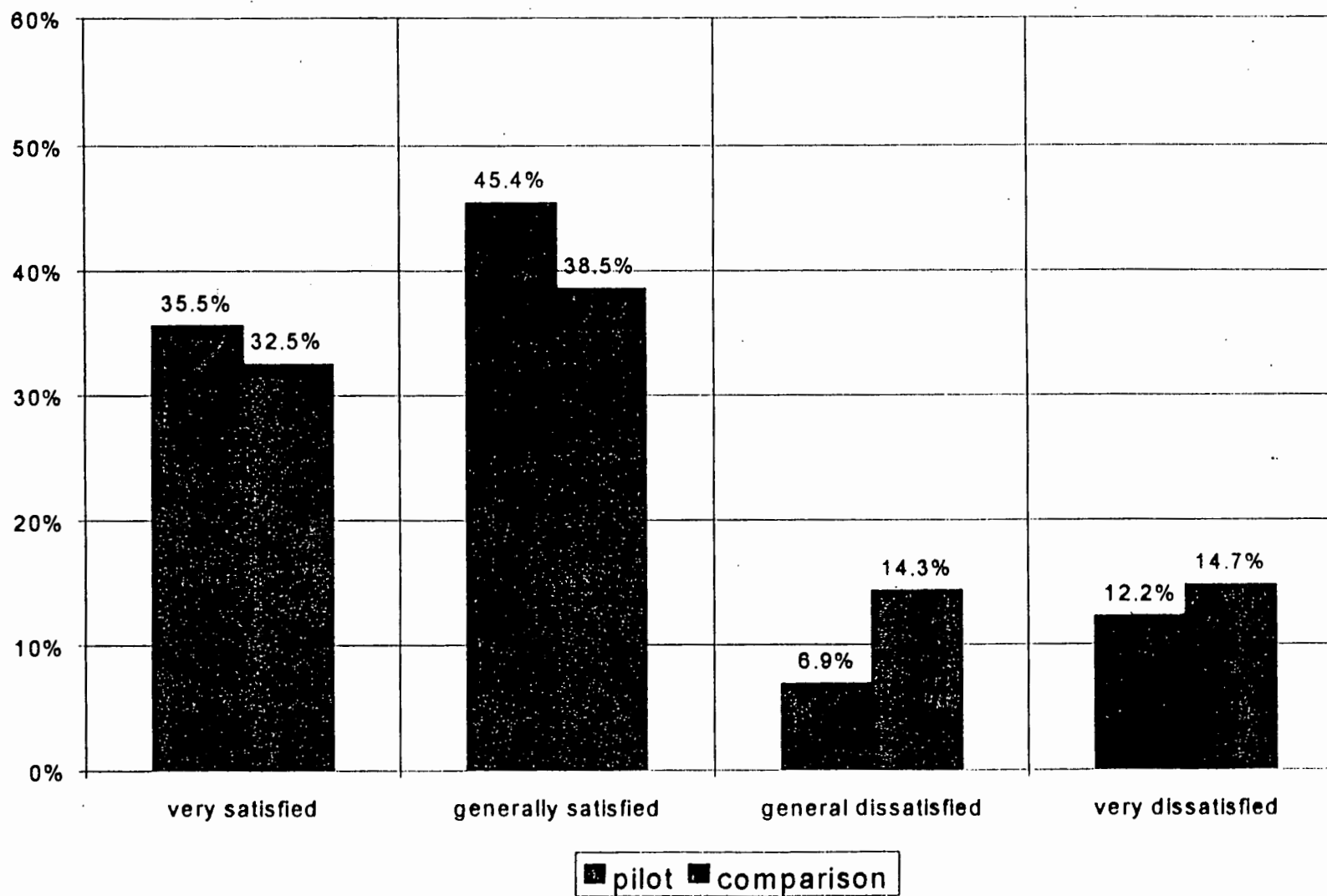
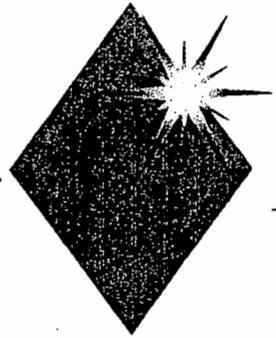


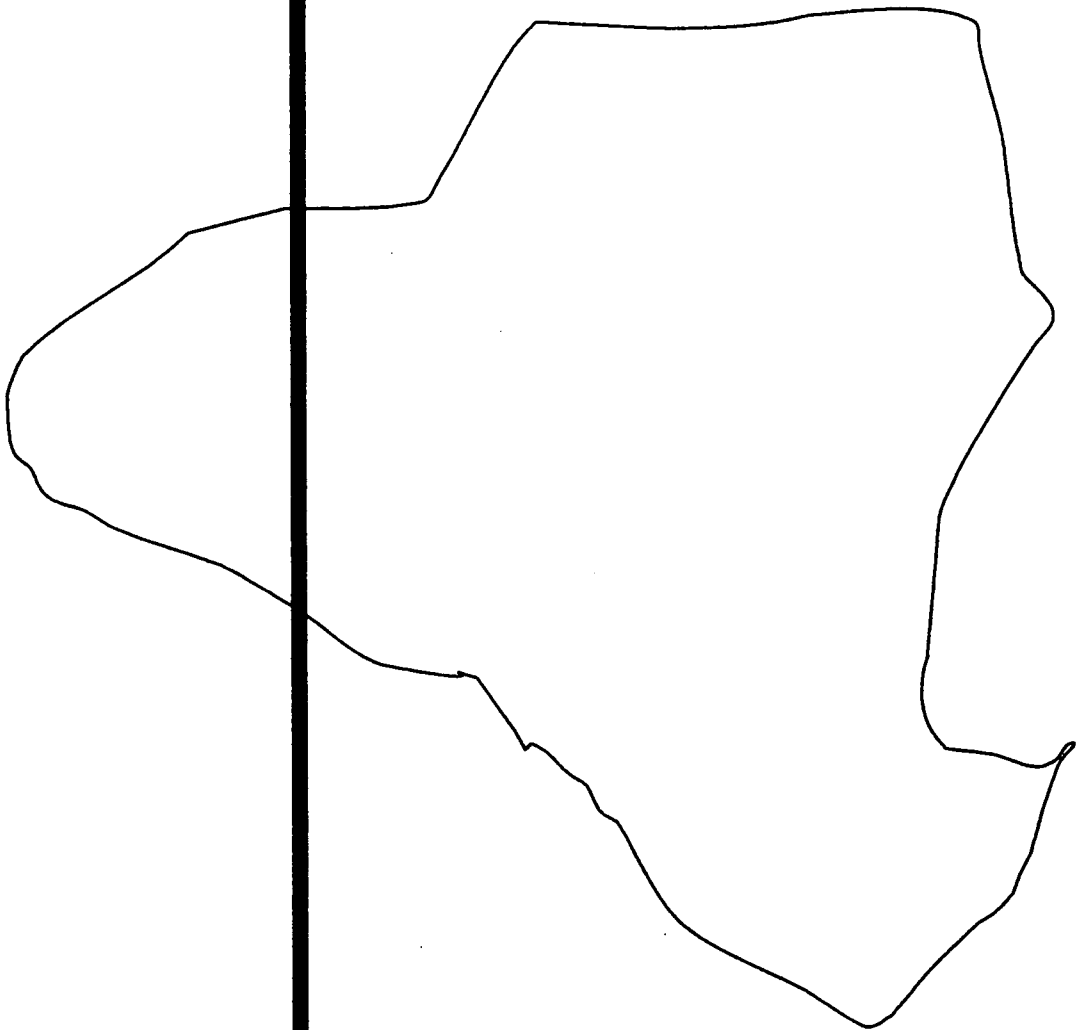
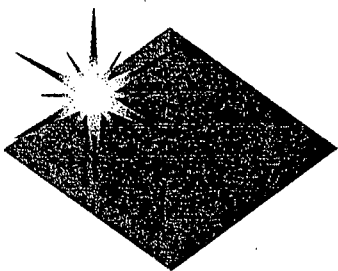
Figure 8.3. Satisfaction of Families with Children's Services





EVALUATION FINDINGS (CONT.)

- ◆ Community Representatives were more positive concerning the response of the public agency.
- ◆ Attitudes of the workers were more positive.



Types of Maltreatment in Initial and Subsequent Reports in Pilot and Comparison Areas during the Baseline Period

Type of Initially reported maltreatment (n=4,709 families with any subsequent report)	Types of maltreatment in subsequent hotline reports (n=10,189 subsequent report categories used)							
	1 SPA	2 LSA	3 SAI	4 CLB	5 HMN	6 PDR	7 LSC	8 LCE
1. Severe physical abuse (SPA)	9	11	1	6	7	14	16	1
2. Less severe physical abuse (LSA)	13	333	129	178	71	505	345	57
3. Sexual abuse or sexual injury (SAI)	3	107	220	134	44	250	266	59
4. Children lack basic necessities (CLB)	17	262	161	962	236	604	826	224
5. Health and medical needs untended (HMN)	6	111	56	206	117	206	227	78
6. Poor or damaging relationship (PDR)	28	622	341	554	215	1391	975	225
7. Lack of supervision or proper care (LSC)	24	432	292	909	241	1047	1631	321
8. Lack of proper concern for education (LCE)	0	47	47	182	61	153	202	232

*Richard Matt
Deputy Director, SS
Division of Family Service
May 28, 1998
3*

Family Assessment and Response Demonstration Impact Evaluation Findings Executive Summary

Major findings

- The safety of children was not jeopardized and in certain types of cases it was improved.
- Children were made safer sooner.
- Hotline reports declined in pilot areas.
- The percentage of reported incidents in which some action was taken increased.
- Cooperation of families improved.
- Needed services were delivered more quickly.
- Investigations were not adversely affected; but may have been enhanced.
- There was greater utilization of community resources.
- Recidivism decreased overall.
- Removal of children from homes neither increased nor decreased.
- Children spent less time in placement in counties with both Family Assessment and Family-Centered Out-of-Home demonstrations.
- Families were more satisfied and felt more involved in decision making.
- The demonstration was a catalyst for other initiatives in pilot communities.
- Community representatives preferred the family assessment approach.
- Workers judged the family assessment approach to be more effective.
- The impact of the demonstration was mitigated by large caseloads and limited resources.

Description of the Demonstration

The Family Assessment and Response Demonstration was mandated by the Missouri State Legislature through Senate Bill 595 in 1994. The bill required the Department of Social Services to pilot a new, more flexible response to reports of child abuse and neglect (CA/N). In pilot areas, hotline reports were screened into two groups, investigation and family assessment. Certain kinds of incidents were specifically defined in the law as requiring an investigation, because of their relative severity and potential to involve criminal violations. Other reports could be screened for family assessment and kept out of the central CA/N registry. The family assessment response was meant to be nonaccusatory and supportive, offering needed services as soon as possible without the trauma, stigma, or delay of the investigative process, and to involve the family in a collaborative relationship in addressing problems and needs. An important element of the new approach involved establishing stronger ties to resources within the community able to assist children and families.

The demonstration was piloted in three areas of the state consisting of 14 small and medium-sized counties and in parts of the City and County of St. Louis. For the purposes of the evaluation comparison areas were selected that included 14 other outstate counties and selected parts of St. Louis City and County. By July 1, 1995, the family assessment approach was implemented in each of the 16 pilot sites, and this date was taken as the start of the demonstration for evaluation purposes.

The evaluation was conducted by the Institute of Applied Research in St. Louis. The research design consisted of two central elements: an analysis of baseline data covering the 24-month period prior to the start of the demonstration versus data from the first 24 months of the demonstration period, and a pilot versus comparison site analysis.

Discussion of Findings

Safety of Children. The first and most important finding was that child safety was not compromised in the Family Assessment demonstration.

In addition, certain improvements were discovered:

- In cases of neglect of children's basic needs, lack of supervision and proper care, and less serious physical and verbal abuse, the safety of children was found to be improved. These were the types of families that were very likely to be screened into the assessment response.
- More children in pilot areas were made safe in such cases, and they were made safe earlier (within the first 30 days of cases).
- There was no worsening or improvement in safety found for cases of sexual abuse and very serious physical abuse. These were the types of cases that were virtually always investigated.
- There was evidence indicating an overall improvement in the comprehensiveness of investigations in pilot areas, and there was an increase in the percentage of cases involving severe injury referred to prosecutors.

Hotline Reports. Reports alleging child abuse or neglect in pilot counties declined during the demonstration. They were 8.6 percent below what they were expected to be, given the rate of reported incidents in comparison areas. The primary reason for this appears to lie in the changing relationship between the child welfare agency and the community, especially schools. In some sites in particular, caseworkers and school staff worked jointly with families in addressing problems such as educational neglect, thereby heading off the need for a report to be filed.

Service Provision Effects. Despite the decline in reported incidents, there was an overall increase in the percentage of reports in which child welfare workers provided some assistance to families or children.

More specifically, there were increases in assistance to three types of families:

- Those who lacked basic needs.
- Those in which children experienced milder forms of physical abuse.
- Those in which there were conflicts between parents and older children.

These unplanned, latent effects were taken to be positive outcomes of the demonstration. They show an increase in attention paid to types of families that traditionally have received few services due to the intense demands of a relatively small number of very serious and time-consuming cases. This and other evidence indicates a system shift from an approach that primarily emphasizes remediation to one that places increased attention on primary prevention.

Screening. Sixty-nine percent of hotline reports in pilot areas were screened for family assessment; thirty-one percent were investigated. These screening percentages varied somewhat from one pilot county to another. Some of this variation was attributable to differences in incident type and family characteristics, but a greater amount was due to differences in the manner in which the demonstration was implemented and differences in service-versus-policing orientation in initial contacts with families.

Timeliness and Appropriateness of Services. The period between incident and first service in pilot counties (17 days) was half that in comparison counties (34 days).

Other findings included:

- The shortest service response time occurred in family assessment cases, but the time between incident and first service was reduced in pilot-area investigations as well.
- Comparison families experienced longer service delays on average, and a greater proportion of families in these areas experienced such delays.
- In cases in which the safety of the child was less threatened, the level of cooperation of families with the child welfare agency was greater in pilot areas.
- No difference in cooperation was found for families in more severe cases, which in pilot areas were more likely to experience an investigative response.
- The analysis revealed an increase in pilot areas in the delivery of basic necessities to families, including food, clothing, shelter, medical care and the like. Other services, including those provided directly by workers, remained at about the same level in both pilot and comparison areas.
- Individual workers in pilot areas were more likely to possess comprehensive knowledge of families on caseloads due to greater case continuity.

Formal Services. There was an overall decline in the percentage of families who received formal, family-centered intervention by the public child welfare agency. This was due to the number of times the family assessment resulted in sufficient intervention, and assistance and contact with the family was ended short of a formal case opening. The average length of time families were in contact with the agency declined by 35 days (15 percent), without a reduction in child safety or services to families.

Utilization of Community Resources. Workers in pilot areas were more likely to link client families to community resources overall than were comparison area workers.

- There were differences, sometimes large ones, in the patterns of referrals made by workers in different pilot sites. These were primarily due to:
 - Variation in the resource base with which each office worked.
 - Differences in the way workers and offices approached families—some more narrowly, focusing primarily on the incident, and others more broadly, considering a wider set of needs and underlying conditions.
- Workers in pilot areas were more likely to know the names of contact persons at specific resources in the community and to have met them. This was particularly the case with schools, churches, providers of early childhood services, job-related agencies, and neighborhood organizations.

Addressing Central Problems. Workers in pilot areas were more likely to provide some assistance targeted at central problems identified in families. In particular, they more frequently provided information about and made referrals to available resources within the community. While no differences were found in the level of positive change in specific family problems by the time the worker made the last contact with the family, the positive change that did occur in pilot areas was accomplished within a shorter time span overall.

Recidivism: Later Reports of Abuse or Neglect. Recidivism was reduced in pilot areas. The simple frequency of repeat CA/N hotline reports in pilot counties declined relative to comparison counties.

More specifically, there was less recidivism involving:

- Children lacking basic necessities such as food, proper clothing, hygiene, and safe and secure shelter.
- Lack of supervision or proper care of children.
- Lack of proper concern by parents for the educational welfare of their children.

Preserving the Integrity of the Family. No differences were found between pilot and comparison areas in the percentage of families with children placed outside their homes or families that were reunited.

- No differences were found in:
 - The number of children placed after the initiating incident.
 - The number of new placements after the child was reunified with the family.
 - Placements where reunification was not a goal.
 - The number of days in placement with a relative as a proportion of all days in out-of-home placement.
- However, children in pilot areas on average spent less time in placement during the demonstration period. This was found to be related to the experience of children in the Family-Centered Out-of-Home (FCOOH) project. Evidence indicated that FCOOH operated more effectively in offices where it was combined with the Family Assessment demonstration.

Family Satisfaction. Pilot families expressed satisfaction more often than comparison families with the way they were treated and with the help they received from the child welfare agency.

- Pilot families were also more likely to feel their children were better off because of the involvement of the child welfare agency, and they were more likely to report they were involved in decisions that affected them.
- Both pilot and comparison area families appreciated and responded to expressions of genuine compassion and concern from workers. They strongly objected to being accused of wrongdoing at the start of their interaction with workers, and they expressed a need for recourse when they perceived inequities.
- Families tended to express needs for practical assistance, needs they often saw as remaining unmet, while workers were seen as focusing on traditional forms of assistance, such as counseling.
- Overall, families tended to respond positively and favor an approach that represents the philosophy and policy of the family assessment approach, whether they experienced this approached in pilot or comparison areas.

Based on family feedback, it was apparent that some workers in comparison areas were perceived as approaching families in ways similar to what was expected in family assessment, and that some pilot area workers were seen as not applying the assessment approach fully or effectively. Differences found in this study were obtained despite this, and findings were probably mitigated by it.

Worker Perceptions of Worker-Family Relations. Workers in pilot areas versus those in comparison areas saw families as:

- More satisfied overall with the child welfare agency.
- More likely to view the child welfare agency as a resource and source of assistance.
- More likely to see families as better off as a result of agency intervention.

These differences between the two groups of workers were attributable to the family assessment approach. In addition, workers saw families who received the assessment approach in pilot areas as more receptive to intervention by the child welfare agency than similar families in comparison areas.

Community-Related Initiatives. The demonstration was a catalyst for a number of initiatives in pilot areas. Often these involved new relationships with other community agencies, organizations, and institutions (frequently schools). Other efforts included establishing or joining multi-agency collaboratives to improve working relationships between major service systems and community organizations, and outstationing workers to form closer ties with local communities. The establishment of linkages with community resources was reduced by limited staff expertise in community development and time to devote to such activities.

Attitudes of Community Representatives. Community representatives in pilot areas were more positive in their evaluation of the child welfare agency overall.

- They were more likely than those in comparison areas to see the agency as a source of services and assistance to families and as more effective in protecting children at risk of physical abuse and neglect.
- They described worker-family relationships as more supportive and less adversarial, and reported families as more satisfied with the way they were treated by caseworkers.
- Pilot area respondents also said that child welfare agency workers made better use of available resources in the area.
- Respondents in St. Louis City and County, where both the new and traditional approaches were monitored, were consistently more positive in their responses regarding the family assessment versus traditional approach.
- The most positive evaluation of the family assessment approach overall came from professionals who worked in both pilot and comparison counties and had first-hand knowledge of both the new and traditional approaches.
- A majority of respondents in pilot areas would like to see the family assessment approach expanded statewide.

Organizational Impact. The attitudes of pilot-area workers toward the family assessment approach tended to be positive.

- There was some resistance in certain areas from workers with longer tenure, and the demonstration appeared to produce some worker turnover in pilot areas.
- The potential of the family assessment approach was viewed by a number of workers to be blunted by caseload size, the overwhelming demands of certain cases, particularly Alternative Care cases, and limited resources.

- Overall, workers in joint Family Assessment/ FCOOH demonstration areas expressed the highest level of satisfaction with the child welfare agency. These workers were more likely to report that they were able to intervene effectively with children and families and that the system was more effective in protecting children at risk of either abuse or neglect.

Conclusion. The findings of the evaluation indicated that the safety of children and the wellbeing of families are better safeguarded by an approach in which:

- The response is immediate, without a time lag between initial family contact and the subsequent intervention.
- The worker approaches families not just with reference to a particular incident but with sensitivity to broader problems and underlying conditions.
- The worker's attitude is positive and supportive rather than accusatory and police-like, seeking to gain the participation of families in identifying sources of support and in facing their problems and needs.
- The local community is actively engaged in a collaborative effort with the child welfare agency to support families and protect children.

While most measures indicated a positive impact of the family assessment approach across the spectrum of dimensions investigated, and no findings favored the traditional approach, the relative impact of the demonstration was often modest and mitigated by caseload size and limited resources, that is, restrictions in the time workers were able to devote to individual families and the amount and kind of assistance workers were able to provide families and children.

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Minutes May 28, 1998 Afternoon Meeting

The Joint Appropriations Subcommittee on Human Resources reconvened on Thursday, May 28, 1998 at 12:35 p.m. Representative Charlotte Gardner presided and at the request of Representative Gardner, Representative Clary chaired the latter part of the meeting. Five Senators were present. The following House members attended:

Representative Charlotte Gardner
Representative Debbie Clary
Representative Bill Hurley

Representative Lanier Cansler
Representative Martha Alexander

Staff members present were: Susan Sabre, Gann Watson, Karen Hammonds-Blanks and Romona Burton.

Representatives from the Sheriff's Office of Manatee County, Florida and the Florida Department of Children and Family Services were introduced and presented information on how child protective services are being offered in Manatee County.

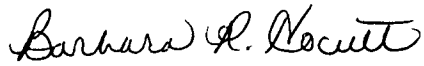
Ms. Margaret Fender, Operations Manager of the Florida Department of Children and Family Services gave a slide presentation on the organization of Child Protective Services in the State of Florida and an explanation of the contract the department has with the Manatee County Sheriff's Office to partner with the Manatee County Department of Social Services to furnish these services. (See Attachment #1.)

Captain Connie Shingledecker of the Manatee County Sheriff's Office explained the way the joint investigations of child abuse and neglect are held. (Attachment #2, a folder containing the work agreement, contract, legislation and statistical information.)

Representative Hurley said he was very impressed and wanted the committee to make a recommendation to move forward with this kind of Child Protective System. Representative Gardner hopes some pilot programs can be implemented using the information the National Conference of State Legislatures has provided. She said she likes the Missouri approach of using pilot programs and evaluating in comparison with traditional programs. Senator Martin said he hoped that more than one model can be used and evaluated. NCSL said that several states were using the Missouri model: South Carolina, Virginia, Nevada and Iowa were among those mentioned. Senator Phillips expressed a desire to move slowly on changes and be sure the community is involved.

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Minutes
May 28, 1998, p.m.

The meeting was adjourned after congratulations and appreciation to the Florida team making the presentation. Representative Gardner reminded members of the Block Grant Hearing on Monday, June 1, 1998 at 4:00 p.m.



Barbara R. Hocutt, Clerk



Representative Charlotte Gardner, Co-Chair

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

MAY 28, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Paula A. Hoff.	Covenant w/ NC's Children
Sharon Hirsch	NCAABSD
Myrna M. H.	NASW-NC
Gary Gold	Cleveland County Sheriff's Office
J Ann Lamm	DHHS-DSS
Paul Haniel	DHHS-DSS
Pam Bright	Cleveland Co. DSS
Bob Hemmley	Cleveland Co. DSS
LORENE ROGERS	Cleve Co. DSS
Kristen Guillory	DHHS-DSS
Jan McAllister	NC DHHS - DSS
Da Allen	DHHS-DSS
Chuck Harris	DHHS-DSS
Lee Killebrew	DHHS

May 28, 1998 p.
Doreen J. Fender, p. Mgr.
St. Dept of Children + Family
Services

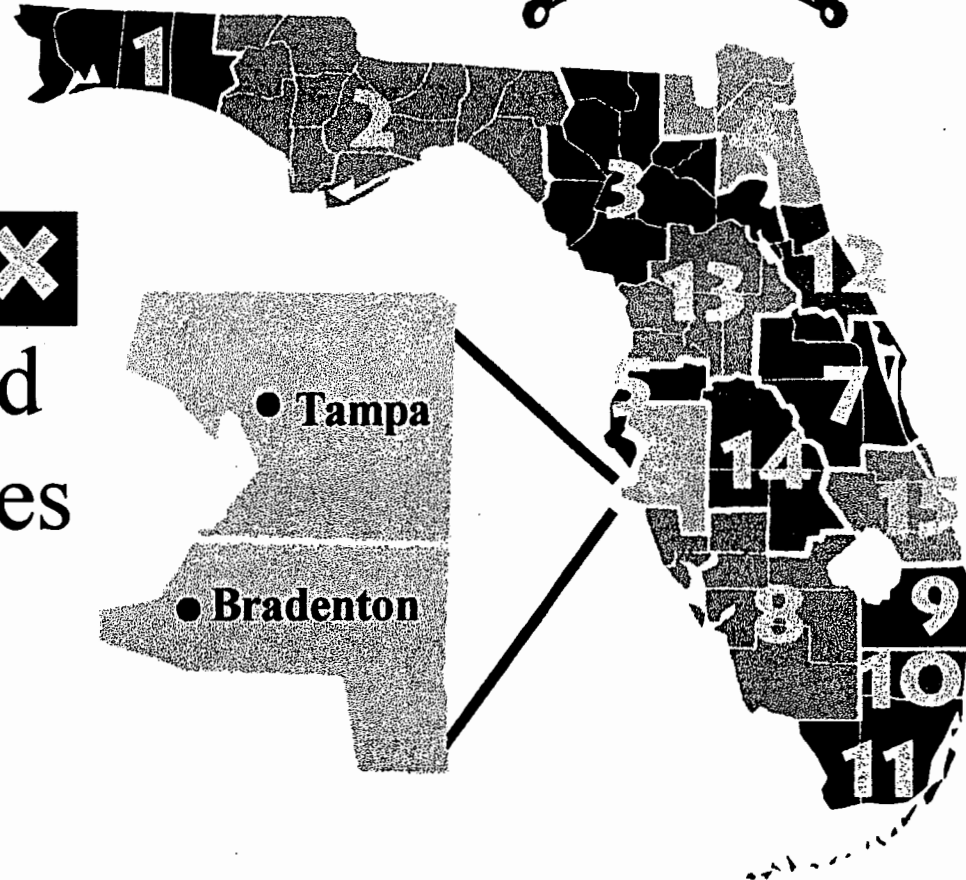


FLORIDA DEPARTMENT OF
**CHILDREN
& FAMILIES**



DISTRICT SIX

Hillsborough and
Manatee Counties



STATE OF FLORIDA CHILD WELFARE SERVICES

- **State Directed**
- **Department Of Children And Families**
- **Family Safety And Preservation Program Office**
- **15 Districts Covering 67 Counties**
- **Statewide Centralized Abuse Hotline**
1-800-96-ABUSE
- **Calls Forwarded From The Hotline To District**
- **District Investigates And Inputs Data Into Statewide Computer System**

PROGRESSION OF PARTNERSHIP

1993

LEGISLATIVE REVISION TO CHILD ABUSE STATUTES

“Within existing resources, a district, with the approval of the district health and human services board, and the secretary of the department may enter into an agreement with a county sheriff’s office or local police department that is jurisdictionally responsible, to allow such law enforcement entity to assume partial or full responsibility for conducting certain components of protective investigations under ss. 415.502-415.514, that are related to cases involving a criminal investigation.”

1994

Working Agreement between the Manatee County Sheriff’s Office and the Department for Child Protective Investigations is signed. The agreement specifies that the Department still conducts child abuse investigations, however, gives law enforcement the lead in investigations in which a criminal investigation is also being conducted.

1995

Juvenile Detectives co-located at the Department of Children and Families Service Center in Manatee County.

1997

Contract between the Department and the Manatee County Sheriff’s Office is signed giving the Sheriff’s Office responsibility for conducting child abuse investigations.

WHY MANATEE COUNTY?

- **Manageable Size • Population: 233,160 (1995)**
- **Support From Community Partners**
 - **Legislative Delegation**
 - **Juvenile Judge**
 - **State Attorney**
 - **Office Of The Attorney General**
 - **Child Protection Team**
 - **Guardian Ad Litem**
 - **Law Enforcement Agencies**
- **Support From Manatee County Sheriff • Charles Wells**
- **Expertise Of Manatee County Sheriff's Office**
Captain Connie Shingledecker
- **Support From Local And State Department Of**
Children & Families Administration
- **Problems With Staff Turnover And Morale**
In Manatee County Child Protective Investigations

CONTRACT

**Manatee County Sheriff's Office
Child Protective Investigations**

BUDGET

**9/5/97-6/30/98
\$606,673**

PROVISIONS

- **Receive Investigations From The Hotline**
- **Capability Of Responding 24 Hours/Day, 7 Days/Week**
- **Complete Investigations In Compliance With Statutes**
- **Enter Information Into Statewide Computer System**
- **Transfer Computers, Furniture, Equipment To Provider**
- **Transfer Budget For Existing Program**
- **Salary And Benefits**
- **Expenses**

MONITORING

- **Daily Through Review Of Statewide Computer Management Screens**
 - Reports Received
 - Reports Assigned
 - Reports Commenced
 - Victims Seen/Not Seen
 - Reason Reports Still Open After 30 Days
 - Reports Closed
 - Final Report Of Investigation
- **Monthly At Submission Of Invoice**
- **Annual Administrative Contract Monitoring**
- **Annual Programmatic Contract Monitoring**
- **Annual Quality Assurance Review**

Bill
Coxmii Shingfeda
Attachment #2

House Bill 3217e1

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

HB 3217, First Engrossed

1 A bill to be entitled
2 An act relating to the privatization of foster
3 care and related services; amending s.
4 409.1671, F.S.; providing legislative intent;
5 defining the terms "privatize," "related
6 services," and "eligible lead community-based
7 provider"; requiring the Department of Children
8 and Family Services to develop a plan to
9 accomplish statewide privatization within a
10 specified time period and to submit the plan to
11 the Governor and to designated legislative
12 officials by a specified date; providing plan
13 requirements; requiring the department to state
14 whether and why privatization cannot be
15 accomplished in a particular district or
16 portion of a district and how the department
17 will address the obstacles to privatization;
18 providing for legal services; requiring that
19 child welfare legal services be provided by
20 specified providers; providing for case
21 management responsibilities; providing for
22 quality assurance; providing requirements for

23 and restrictions upon funding for
24 privatization; creating s. 415.5071, F.S.;
25 providing for a model program for child
26 protective investigative services, to be
27 initiated in specified districts; requiring the
28 department to contract with sheriffs in those
29 districts; providing responsibilities of the
30 department; requiring a report; providing for
31 funding; providing for the creation of a

1

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HB 3217, First Engrossed

1 specified committee which shall submit a
2 required report; providing an effective date.
3
4 Be It Enacted by the Legislature of the State of Florida:
5
6 Section 1. Section 409.1671, Florida Statutes, is
7 amended to read:
8 409.1671 Foster care and related services;
9 privatization.--
10 (1)(a) It is the intent of the Legislature that ~~to~~
11 ~~encourage~~ the Department of Children and Family Services shall
12 privatize the provision of ~~to contract with competent~~
13 ~~community-based agencies to provide~~ foster care and related
14 services statewide. As used in this section, the term
15 "privatize" means to contract with competent, community-based

16 agencies. The department shall submit a plan to accomplish
17 privatization statewide, through a competitive process, phased
18 in over a 3-year period beginning January 1, 2000. This plan
19 is to be submitted by July 1, 1999, to the President of the
20 Senate, the Speaker of the House of Representatives, the
21 Governor, and the minority leaders of both houses. This plan
22 must be developed with local community participation,
23 including, but not limited to, input from community-based
24 providers that are currently under contract with the
25 department to furnish community-based foster care and related
26 services, and must include a methodology for determining and
27 transferring all available funds, including federal funds that
28 the provider is eligible for and agrees to earn and that
29 portion of general revenue funds which is currently associated
30 with the services that are being furnished under contract. The
31 methodology must provide for the transfer of funds

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HB 3217, First Engrossed

1 appropriated and budgeted for all services and programs that
2 have been incorporated into the project, ~~including all~~
3 ~~management, capital (including current furniture and~~
4 ~~equipment), and administrative funds to accomplish the~~
5 ~~transfer of these programs. This methodology must address~~
6 ~~expected workload and at least the 3 previous years'~~
7 ~~experience in expenses and workload. With respect to any~~
8 ~~district or portion of a district in which privatization~~

9 cannot be accomplished within the 3-year timeframe, the
10 department must clearly state in its plan the reasons the
11 timeframe cannot be met and the efforts that should be made to
12 remediate the obstacles, which may include alternatives to
13 total privatization, such as public private partnerships. As
14 used in this section, the term "related services" means ~~By~~
15 ~~privatizing these services, the support and commitment of~~
16 ~~communities to the reunification of families and care of~~
17 ~~children and their families will be strengthened, and~~
18 ~~efficiencies as well as increased accountability will be~~
19 ~~gained. These services may include family preservation,~~
20 independent living, emergency shelter, residential group care,
21 foster care, therapeutic foster care, intensive residential
22 treatment, ~~postadjudication legal services,~~ foster care
23 supervision, ~~postadjudication~~ case management, postplacement
24 supervision, permanent foster care, and family reunification,
25 ~~the filing of a petition for the termination of parental~~
26 ~~rights, and adoption. Unless otherwise provided for, beginning~~
27 in fiscal year 1999-2000, either the state attorney or the
28 Office of the Attorney General shall provide child welfare
29 legal services, pursuant to chapter 39 and other relevant
30 provisions, in Sarasota, Pinellas, Pasco, and Manatee
31 Counties. Such legal services shall commence and be

3

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HB 3217, First Engrossed

1 effective, as soon as determined reasonably feasible by the

2 respective state attorney or the Office of the Attorney
3 General, after the privatization of associated programs and
4 child protective investigations has occurred. When a private
5 nonprofit agency has received case management
6 responsibilities, transferred from the state under this
7 section, for a child who is sheltered or found to be dependent
8 and who is assigned to the care of the privatization project,
9 the agency may act as the child's guardian for the purpose of
10 registering the child in school if a parent or guardian of the
11 child is unavailable and his or her whereabouts cannot
12 reasonably be ascertained. The private nonprofit agency may
13 also seek emergency medical attention for such a child, but
14 only if a parent or guardian of the child is unavailable, his
15 or her whereabouts cannot reasonably be ascertained, and a
16 court order for such emergency medical services cannot be
17 obtained because of the severity of the emergency or because
18 it is after normal working hours. However, the provider may
19 not consent to sterilization, abortion, or termination of life
20 support. If a child's parents' rights have been terminated,
21 the nonprofit agency shall act as guardian of the child in all
22 circumstances.

23 (b) As used in this section, the term "eligible lead
24 community-based provider" means a single agency with which the
25 department shall contract for the provision of child
26 protective services in a community that is no smaller than a
27 county. To compete for a privatization project, such agency
28 must have:

29 1. The ability to coordinate, integrate, and manage
30 all child protective services in the designated community in
31 cooperation with child protective investigations.

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HB 3217, First Engrossed

1 2. The ability to ensure continuity of care from entry
2 to exit for all children referred from the protective
3 investigation and court systems.

4 3. The ability to provide directly, or contract for
5 through a local network of providers, all necessary child
6 protective services.

7 4. The willingness to accept accountability for
8 meeting the outcomes and performance standards related to
9 child protective services established by the Legislature and
10 the Federal Government.

11 5. The capability and the willingness to serve all
12 children referred to it from the protective investigation and
13 court systems, regardless of the level of funding allocated to
14 the community by the state, provided all related funding is
15 transferred.

16 6. The willingness to ensure that each individual who
17 provides child protective services completes the training
18 required of child protective service workers by the Department
19 of Children and Family Services.

20 (2) The department may contract for the delivery,
21 administration, or management of protective services, the
22 services specified in subsection (1) relating to foster care,
23 and other related services or programs, as appropriate. The
24 department shall retain responsibility for the quality of
25 contracted services and programs and shall ensure that
26 services are delivered in accordance with applicable federal

27 and state statutes and regulations.

28 (3)(a) The department shall establish a quality
29 assurance program for privatized ~~the privatization of~~
30 services. The quality assurance program may be performed by a
31 national accrediting organization such as the Council on

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HB 3217, First Engrossed

1 Accreditation of Services for Families and Children, Inc.
2 (COA) or the Council on Accreditation of Rehabilitation
3 Facilities (CARF). The department shall develop a request for
4 proposal for such oversight. This program must be developed
5 and administered at a statewide level. The Legislature intends
6 that the department be permitted to have limited flexibility
7 to use funds for improving quality assurance. To this end,
8 effective January 1, 2000, the department may transfer up to
9 0.125 percent of the total funds from categories used to pay
10 for these contractually provided services, but the total
11 amount of such transferred funds may not exceed \$300,000 in
12 any fiscal year. When necessary, the department may establish,
13 in accordance with s. 216.177, additional positions that will
14 be exclusively devoted to these functions. Any positions
15 required under this paragraph may be established,
16 notwithstanding ss. 216.262(1)(a) and 216.351. ~~The quality~~
17 ~~assurance program must include standards for each specific~~
18 ~~component of these services.~~ The department, in consultation
19 with the community-based agencies that are undertaking the

20 privatized projects, shall establish minimum thresholds for
21 each component of service, consistent with standards
22 established by the Legislature. Each program operated under
23 ~~pursuant to~~ contract with a community-based agency must be
24 evaluated annually by the department, ~~or by an objective~~
25 ~~competent entity designated by the department under the~~
26 ~~provisions of the quality assurance program. The evaluation~~
27 ~~must be financed from cost savings associated with the~~
28 ~~privatization of services~~. The department shall submit an
29 annual report regarding quality performance, outcome measure
30 attainment, and cost efficiency to the President of the
31 Senate, the Speaker of the House of Representatives, the

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HB 3217, First Engrossed

1 minority leader of each house of the Legislature, and the
2 Governor no later than January 31 of each year for each
3 project in operation during the preceding fiscal year.
4 ~~beginning in 1998. The quality assurance program must be~~
5 ~~funded through administrative savings generated by this act.~~
6 (b) ~~The department shall establish and operate a~~
7 ~~comprehensive system to measure and report annually the~~
8 ~~outcomes and effectiveness of the services that have been~~
9 ~~privatized.~~ The department shall use these findings in making
10 recommendations to the Governor and the Legislature for future
11 program and funding priorities in the child welfare system.
12 (4)(a) The community-based agency must comply with

13 statutory requirements and agency rules ~~regulations~~ in the
14 provision of contractual services. Each foster home,
15 therapeutic foster home, emergency shelter, or other placement
16 facility operated by the community-based agency or agencies
17 must be licensed by the Department of Children and Family
18 Services under chapter 402 or this chapter. Each
19 community-based agency must be licensed as a child-caring or
20 child-placing agency by the department under this chapter. The
21 department, in order to eliminate or reduce the number of
22 duplicate inspections by various program offices, shall
23 coordinate inspections required pursuant to licensure of
24 agencies under this section.

25 ~~(b) A community based agency providing contractual~~
26 ~~services under this section may be issued a Medicaid provider~~
27 ~~number pursuant to s. 409.907 to enable the agency to maximize~~
28 ~~federal support for these services under the state's Medicaid~~
29 ~~plan. A community based agency must also participate in and~~
30 ~~cooperate with any federal program that will assist in the~~
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1 ~~maximization of federal support for those services, as~~
2 ~~directed by the department.~~

3 (5) Beginning January 1, 1999, and continuing at least
4 through December 31, 1999, the Department of Children and
5 Family Services shall privatize all foster care and related

6 services in district 5 while continuing to contract with the
7 current model programs in districts 1, 4, and 13, and in
8 subdistrict 8A, and shall expand the subdistrict 8A pilot
9 program to incorporate Manatee County. Planning for the
10 district 5 privatization shall be done by providers that are
11 currently under contract with the department for foster care
12 and related services and shall be done in consultation with
13 the department. A lead provider of the district 5 program
14 shall be competitively selected, must demonstrate the ability
15 to provide necessary comprehensive services through a local
16 network of providers, and must meet criteria established in
17 this section. Beginning in fiscal year 1996-1997, the
18 ~~Department of Children and Family Services shall establish a~~
19 ~~minimum of five model programs. These models must be~~
20 ~~established in the department's districts 1, 4, and 13, in~~
21 ~~subdistrict 8A, and in a fifth district to be determined by~~
22 ~~the department, with the concurrence of the appropriate~~
23 ~~district health and human services board. For comparison of~~
24 ~~privatization savings, the fifth model program must be~~
25 ~~contracted with a competent for-profit corporation. Providers~~
26 ~~of these model programs may be selected from a single source~~
27 ~~pursuant to s. 287.057(3)(c) and must be established,~~
28 ~~community-based organizations within the district or~~
29 ~~subdistrict. Contracts with organizations responsible for the~~
30 model programs must ~~shall~~ include the management and
31 administration of all privatized services specified in

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1 subsection (1), ~~except for funds necessary to manage the~~
2 ~~contract.~~ However, the department may use funds for contract
3 management only after obtaining written approval from the
4 Executive Office of the Governor. The request for such
5 approval must include, but is not limited to, a statement of
6 the proposed amount of such funds and a description of the
7 manner in which such funds will be used. If the
8 community-based organization selected for a model program
9 under this subsection is not a Medicaid provider, the
10 organization shall be issued a Medicaid provider number
11 pursuant to s. 409.907 for the provision of services currently
12 authorized under the state Medicaid plan to those children
13 encompassed in this model and in a manner not to exceed the
14 current level of state expenditure.

15 (6) Each district and subdistrict that participates in
16 the model program effort or any future privatization effort as
17 described in this section must thoroughly analyze and report
18 the complete direct and indirect costs of delivering these
19 services through the department and the full cost of
20 privatization, including the cost of monitoring and evaluating
21 the contracted services.

22 Section 2. Section 415.5071, Florida Statutes, is
23 created to read:

24 415.5071 Sheriffs of Pasco, Manatee, and Pinellas
25 Counties to provide child protective investigative services;
26 procedures; funding.--

27 (1) As described in this section, the Department of
28 Children and Family Services shall, by the end of fiscal year
29 1999-2000, transfer all responsibility for child protective

30 investigations for Pinellas County, Manatee County, and Pasco
31 County to the sheriff of that county in which the child abuse,

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1 neglect, or abandonment is alleged to have occurred. Each
2 sheriff is responsible for the provision of all child
3 protective investigations in his or her county. Each
4 individual who provides these services must complete the
5 training provided to and required of protective investigators
6 employed by the Department of Children and Family Services.
7 (2) During fiscal year 1998-1999, the Department of
8 Children and Family Services and each sheriff's office shall
9 enter into a contract for the provision of these services.
10 Funding for the services will be appropriated to the
11 Department of Children and Family Services, and the department
12 shall transfer to the respective sheriffs for the duration of
13 fiscal year 1998-1999, funding for the investigative
14 responsibilities assumed by the sheriffs, including federal
15 funds that the provider is eligible for and agrees to earn and
16 that portion of general revenue funds which is currently
17 associated with the services that are being furnished under
18 contract, and including, but not limited to, funding for all
19 investigative, supervisory, and clerical positions; training;
20 all associated equipment; furnishings; and other fixed capital
21 items. The contract must specify whether the department will
22 continue to perform part or none of the child protective

23 investigations during the initial year. The sheriffs may
24 either conduct the investigations themselves or may, in turn,
25 subcontract with law enforcement officials or, with properly
26 trained employees of private agencies to conduct
27 investigations related to neglect cases only. If such a
28 subcontract is awarded, the sheriff must take full
29 responsibility for any safety decision made by the
30 subcontractor and must immediately respond with law
31 enforcement staff to any situation that requires removal of a

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1 child due to a condition that poses an immediate threat to the
2 child's life. The contract must specify whether the services
3 are to be performed by departmental employees or by persons
4 determined by the sheriff. During this initial year, the
5 department is responsible for quality assurance, and the
6 department retains the responsibility for the performance of
7 all child protective investigations. The department must
8 identify any barriers to transferring the entire
9 responsibility for child protective services to the sheriffs'
10 offices and must pursue avenues for removing any such barriers
11 by means including, but not limited to, applying for federal
12 waivers. By January 15, 1999, the department shall submit to
13 the President of the Senate, the Speaker of the House of
14 Representatives, and the chairs of the Senate and House
15 committees that oversee departmental activities a report that

16 describes any remaining barriers, including any that pertain
17 to funding and related administrative issues. Unless the
18 Legislature, on the basis of that report or other pertinent
19 information, acts to block a transfer of the entire
20 responsibility for child protective investigations to the
21 sheriffs' offices, the sheriffs of Pasco County, Manatee
22 County, and Pinellas County, beginning in fiscal year
23 1999-2000, shall assume the entire responsibility for such
24 services, as provided in subsection (3).

25 (3) (a) Beginning in fiscal year 1999-2000, the
26 sheriffs of Pasco County, Manatee County, and Pinellas County
27 have the responsibility to provide all child protective
28 investigations in their respective counties.

29 (b) The sheriffs of Pasco County, Manatee County, and
30 Pinellas County shall operate, at a minimum, in accordance
31 with the performance standards established by the Legislature

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1 for protective investigations conducted by the Department of
2 Children and Family Services.
3 (c) Funds for providing child protective
4 investigations in Pasco County, Manatee County, and Pinellas
5 County must be identified in the annual appropriation made to
6 the Department of Children and Family Services, which shall
7 award grants for the full amount identified to the respective
8 sheriffs' offices. Funds for the child protective

9 investigations may not be integrated into the sheriffs'
10 regular budgets. Budgetary data and other data relating to the
11 performance of child protective investigations must be
12 maintained separately from all other records of the sheriffs'
13 offices.

14 (d) ~~Program performance evaluation shall be based on~~
15 criteria mutually agreed upon by the respective sheriffs and a
16 committee of seven persons appointed by the Governor and
17 selected from those persons serving on the Department of
18 Children and Family Services District 5 Health and Human
19 Services Board and District 6 Health and Human Services Board.
20 Two of the Governor's appointees must be residents of Pasco
21 County, two of the Governor's appointees must be residents of
22 Manatee County, and two of the Governor's appointees must be
23 residents of Pinellas County. Such appointees shall serve at
24 the pleasure of the Governor. The individuals appointed must
25 have demonstrated experience in outcome evaluation, social
26 service areas of protective investigation, or child welfare
27 supervision. The committee shall submit an annual report
28 regarding quality performance, outcome-measure attainment and
29 cost efficiency, to the President of the Senate, the Speaker
30 of the House of Representatives, and to the Governor no later
31 than January 31 of each year the sheriffs are receiving

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1 general appropriations to provide child protective

2 investigations.

3 Section 3. This act shall take effect July 1 of the
4 year in which enacted.

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Florida's Children At A Glance

Population 1995

• Total Population	14,149,317		
	Total	White	Nonwhite
• Number of Children <18	3,239,446	2,431,953	807,493
• Age 0-4	983,056	718,428	264,628
• Age 5-9	921,284	701,107	220,177
• Age 10-14	874,933	664,561	210,372
• Age 15-17	460,173	347,857	112,316
• Age 15-19	812,447	621,444	191,286
• Age 20-24	874,336	682,920	191,416

Birth Indicators 1995

	Total	White	Nonwhite
• Number of Births	188,535	141,848	46,555
• Birth Rate (per 1,000 population)	13.3	12.0	19.8
• Births to Unwed Mothers	67,422 (35.8%)	37,625 (26.5%)	29,742 (63.9%)
• Births to Unwed Mothers <20	20,438 (10.8%)	10,962 (7.7%)	9,465 (20.3%)
• Births to Unwed Mothers 20	46,972 (24.9%)	26,659 (18.8%)	20,271 (43.5%)
• Births to Mothers Age <20	25,804 (13.7%)	15,771 (11.1%)	10,020 (21.5%)
• Teen Birth Rate Age 15-17	44.4	33.8	76.6
• Teen Birth Rate Age 15-19	63.1	51.4	99.9
• Births Receiving Early Prenatal Care	154,421 (82.6%)	121,112 (85.9%)	33,215 (72.4%)
• Low Birthweight Births	14,505 (7.7%)	9,061 (6.4%)	5,437 (11.7%)
• Number of Infant Deaths	1,402	840	562
• Infant Mortality Rate	7.4	5.9	12.1

Child Well-Being 1995

• Child Deaths Ages 1-14	778
• Teen Violent Deaths Ages 15-19	505
• Teen Violent Death Rate Ages 15-19 (per 10,000)	6.2
• Dissolutions of Marriage with Children Affected	33,176
• Children Affected by Dissolutions of Marriage	54,666
• Number of Runaways	52,896

Education 1995/96

• Student Enrollment (Pre-K to 12 [Fall Count])	2,176,930
• Graduation Rate	73.2
• Number of Non-Promotions	96,753
• Number of Dropouts	28,235
• Number of Disciplinary Actions	
• Corporal Punishments	15,161
• In-School Suspensions	206,548
• Out-of-School Suspensions	200,726
• Alternative Disciplinary Actions	4,574
• Percent Passing HSCT Math (Oct/95)	77
• Percent Passing HSCT Communications (Oct/95)	89
• Students Eligible to Participate in Free/Reduced Lunch	957,422 (44.0%)

Children in Poverty 1990 Census

• Children in Poverty <6	201,237 (20.3%)
• Children in Poverty <18	525,446 (18.7%)

Youth and the Law 1995/96

	Total Cases (Youths)	White Cases (Youths)	African American Cases (Youths)
• Delinquency Cases Received	171,101 (105,370)	98,193 (63,931)	71,012 (40,147)
• Juvenile Detentions	30,925 (20,722)	14,999 (10,361)	15,622 (10,135)
• Transfers to Adult Court	7,100 (5,242)	3,182 (2,346)	3,861 (2,847)

Manatee County's Children At A Glance

Population 1995

• Total Population	233,160		
	Total	White	Nonwhite
• Number of Children <18	45,734	38,048	7,686
• Age 0-4	13,993	11,561	2,432
• Age 5-9	13,135	10,849	2,286
• Age 10-14	12,355	10,386	1,969
• Age 15-17	6,251	5,252	999
• Age 15-19	10,672	9,050	1,622
• Age 20-24	10,772	9,072	1,700

Birth Indicators 1995

	Total	White	Nonwhite
• Number of Births	2,834	2,385	449
• Birth Rate (per 1,000 population)	12.1	11.2	20.7
• Births to Unwed Mothers	1,081 (38.1%)	765 (32.1%)	316 (70.4%)
• Births to Unwed Mothers <20	372 (13.1%)	257 (10.8%)	115 (25.6%)
• Births to Unwed Mothers 20	709 (25.0%)	508 (21.3%)	201 (44.8%)
• Births to Mothers Age <20	473 (16.7%)	351 (14.7%)	122 (27.2%)
• Teen Birth Rate Age 15-17	59.8	54.3	87.5
• Teen Birth Rate Age 15-19	88.0	77.8	144.1
• Births Receiving Early Prenatal Care	2,122 (75.0%)	1,851 (77.7%)	271 (60.5%)
• Low Birthweight Births	215 (7.6%)	161 (6.8%)	54 (12.0%)
• Number of Infant Deaths	26	22	4
• Infant Mortality Rate	9.2	9.2	8.9

Child Well-Being 1995

• Child Deaths Ages 1-14	8
• Teen Violent Deaths Ages 15-19	6
• Teen Violent Death Rate Ages 15-19 (per 10,000)	5.6
• Dissolutions of Marriage with Children Affected	412
• Children Affected by Dissolutions of Marriage	699
• Number of Runaways	1,343

Education 1995/96

• Student Enrollment (Pre-K to 12 [Fall Count])	31,796
• Graduation Rate	61.2
• Number of Non-Promotions	1,517
• Number of Dropouts	466
• Number of Disciplinary Actions	
• Corporal Punishments	0
• In-School Suspensions	2,192
• Out-of-School Suspensions	3,525
• Alternative Disciplinary Actions	45
• Percent Passing HSCT Math (Oct/95)	79
• Percent Passing HSCT Communications (Oct/95)	90
• Students Eligible to Participate in Free/Reduced Lunch	13,939 (43.8%)

Children in Poverty 1990 Census

• Children in Poverty <6	2,744 (18.9%)
• Children in Poverty <18	7,259 (18.2%)

Youth and the Law 1995/96

	Total	White	African American
	Cases (Youths)	Cases (Youths)	Cases (Youths)
• Delinquency Cases Received	3,305 (1,995)	1,992 (1,311)	1,264 (645)
• Juvenile Detentions	527 (368)	249 (185)	276 (181)
• Transfers to Adult Court	158 (106)	64 (43)	93 (62)

MANATEE COUNTY SHERIFF'S OFFICE
CHILD PROTECTION SPECIALIST SECTION
CPS UNITS 755 AND 758

MANATEE COUNTY CHILD ABUSE REPORTS

<u>MONTH</u>	<u>TOTAL CASES</u>	<u>MSO HANDLED</u>	<u>DCF CASES</u>
JANUARY	167	123	44
FEBRUARY	188	126	62
MARCH	190	135	55
APRIL	179	133	46
MAY	_____	_____	_____
JUNE	_____	_____	_____
JULY	_____	_____	_____
AUGUST	_____	_____	_____
SEPTEMBER	_____	_____	_____
OCTOBER	_____	_____	_____
NOVEMBER	_____	_____	_____
<u>DECEMBER</u>	_____	_____	_____
YTD TOTALS	724	517	207

**MANATEE COUNTY SHERIFF'S OFFICE
CHILD PROTECTION SPECIALIST SECTION
CPS UNITS 755 AND 758**

MANATEE COUNTY CHILD ABUSE REPORTS

<u>MONTH</u>	<u>TOTAL CASES</u>	<u>MSO HANDLED</u>	<u>DCF CASES</u>
JANUARY	164	N/A	164
FEBRUARY 1-20	133	N/A	133
FEBRUARY 21-28	66	32	34
MARCH	182	143	39
APRIL	166	122	44
MAY	184	154	30
JUNE	154	111	43
JULY	147	94	53
AUGUST	145	80	65
SEPTEMBER	212	146	66
OCTOBER	200	150	50
NOVEMBER	194	141	53
<u>DECEMBER</u>	<u>132</u>	<u>99</u>	<u>33</u>
YTD TOTALS	2079	1272	807

Average total of 173 cases per month, for the county.
Average total of 124 cases per month, for MSO units.

Connie
Shunfederer
attachment #2

WORKING AGREEMENT
MANATEE COUNTY SHERIFF'S OFFICE
AND THE
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
CHILD PROTECTIVE INVESTIGATIONS

I. Purpose

- A) This coordinated agreement has been developed jointly by the Manatee County Sheriff's Office and the Department of Health and Rehabilitative Services. The purpose of the agreement is to establish operational protocols for the investigation of child abuse reports involving criminal allegations in order to:

- o maximize resources through a joint investigation process,
- o minimize the number of interviews for child victims of abuse,
- o allow for the orderly collection of evidence in the criminal investigative process, and
- o ensure the provision of appropriate services when deemed necessary for children and their families.

- B) Committee Substitute/House Bill 593, with an effective date of October 1, 1993, states:

"Within existing resources, a district, with the approval of the district health and human services board, and the secretary of the department may enter into an agreement with a county sheriff's office or local police department that is jurisdictionally responsible to allow such law enforcement entity to assume partial or full responsibility for conducting certain components of protective investigations under ss. 415.502-415.514, that are related to cases involving a criminal investigation."

II. Operational Procedures

- A) After several meetings were held to discuss the roles of HRS and the MCSO in child abuse investigations, it was agreed that all reports of child abuse and neglect taken by the abuse hotline will continue to be transmitted to the local HRS office in Manatee County responsible for child protective investigations. The HRS child protective investigator retains the responsibility for notifying the state attorney and the Manatee County Sheriff's Office, as required by s 415.505, immediately upon receipt of a report alleging, or immediately upon learning in the course of providing services that:

A child died as a result of abuse or neglect;

Working Agreement, Manatee County Sheriff's Office and the
Department of Health and Rehabilitative Services
Child Protective Investigations

A child is a victim of aggravated child abuse as defined in s 827.03;

A child is a victim of sexual battery or of sexual abuse as defined in s 415.503; or

A child is a victim of institutional abuse as defined in s.415.503.

- B) It is agreed that, whenever feasible, joint investigations will be conducted by HRS and the MCSO; however, in the four categories of child abuse reports listed above, the MCSO will take the lead in the investigation. (Taking the lead in the investigation is defined as determining who will conduct interviews with subjects of a report and when and where the interviews will be conducted.) All documented notes and interviews will be shared between the two agencies. Each agency will make an effort to document the appropriate report number on information shared so the receiving agency can ensure that the information is appropriately filed (HRS will record the MCSO report number on information being forwarded to MCSO and MCSO deputies or detectives will record the HRS report number on information they are sending to HRS).
- C) A child who is alleged to be dependent may be taken into custody pursuant to an order of the circuit court, by a law enforcement officer or an authorized agent of the department if the officer or agent has reasonable grounds to believe that the child has been abandoned, abused, or neglected, is suffering from illness or injury, or is in immediate danger from his surroundings and that his removal is necessary to protect the child (ss. 39.401, (1) (a)&(b)). Under the terms of this agreement, MCSO and HRS staff conducting the joint investigation shall consult with each other regarding whether a child is in immediate danger from his surroundings or if the child's removal is necessary to protect him. Any disagreements will be handled up the chain of command of both agencies.
- D) In all other reports received by HRS, the protective investigator should commence the investigation. If the investigator finds an injury for which the explanation is not consistent or if a child discloses sexual abuse, then the investigator should immediately call the MCSO to request that a deputy respond. In child neglect cases, the MCSO may be contacted if the protective investigator finds that the neglect is so severe that criminal charges may be filed.
- E) In institutional abuse/neglect reports, the HRS investigator shall immediately contact the MCSO and the state attorney as required by law. MCSO will take the lead in institutional abuse investigations in which it is alleged that a child died as a result of abuse or neglect, is a victim of aggravated child

Working Agreement, Manatee County Sheriff's Office and the
Department of Health and Rehabilitative Services
Child Protective Investigations

abuse, or is a victim of sexual battery or sexual abuse. In all other institutional reports, MCSO will make the decision as to whether a joint investigation should be conducted or whether HRS shall respond to the report and initiate the investigation.

- F) In the process of investigating a criminal child abuse allegation, the MCSO deputy/detective who has the lead will take into account the requirement in ss. 415.505 (1)(g) that "No later than 30 days after receiving the initial report, the local office of the department shall complete its investigation and classify the report as proposed confirmed or unfounded or close the report without classification and notify the parent or guardian of the child; the child, if appropriate; and the alleged perpetrator." regular meetings between HRS and MCSO to discuss the status of joint investigations shall be initiated.
- G) The Child Protection Team (CPT) in Manatee County shall be utilized to supplement the protective investigation and can be accessed by either the HRS child protective investigator or investigating MCSO staff. The services that the child protection team shall be capable of providing include, but are not limited to those described in ss. 415.5055 (1) (a)-(j) and (2) (a)-(h) (Attachment I).
- H) At any time, the protective investigator may call the MCSO and request that a deputy respond to protect him/her in a situation where there is concern for personal safety. This request to respond for protection should be specifically stated when the call is made and reiterated to the deputy when they arrive.
- I) Anytime a deputy responds to a call and determines that a child has been abused or neglected or has reasonable cause to suspect that a child has been abused or neglected, a report must immediately be made to the Florida Abuse Hotline at 1-800-96ABUSE (1-800-962-2873). The deputy may also call the local HRS office to request immediate assistance and inform the local office that a report has been made to the abuse hotline.

III Automated Information

- A) It is agreed that HRS will install a computer with access to the HRS Client Information System and the Florida Abuse Hotline information system at a secure site in the Manatee County Sheriff's Office which will be available to designated MCSO staff and HRS protective investigators. This will assist HRS in that the MCSO is centrally located in a safe environment that is open 7 days a week, 24 hours a day. It will also assist MCSO deputies and detectives in the quick receipt of information from the hotline report. The ability to access information for the computer will only be allowed by specifically designated MCSO employees and the MCSO will ensure that the information received

Working Agreement, Manatee County Sheriff's Office and the
Department of Health and Rehabilitative Services
Child Protective Investigations

be kept confidential in compliance with Florida laws. The name of the individual who made a report of child/abuse neglect will not be accessible.

IV Hours of Operation

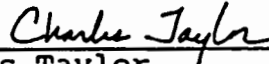
- A) The Manatee County HRS Child Protective Investigations Office is open from 8:00 a.m. to 5:00 p.m. Monday through Friday. Child protective investigator staff are assigned on an on-call basis after hours and on the weekends and holidays. A copy of the on-call schedule will be shared with a designated person at the MCSO in the event that immediate access to the protective investigator is needed. This list of HRS staff phone numbers shall not be publicly posted or distributed. Specific telephone numbers may be released by the designated MCSO staff to a deputy or detective who are investigating a specific child abuse case and have a need to contact a child protective investigator at home immediately.
- B) The MCSO Juvenile Detective Division is operational from 8:00 a.m. to 5:00 p.m. Monday through Friday. After hours and on the weekend and holidays detectives are on-call. During normal working hours if there is a report of a child death due to abuse or neglect the Juvenile Detective Division should immediately be contacted. After hours or on the weekends, the patrol division should be contacted to assist and determine whether the on-call Juvenile Division Detective should be notified. For all other abuse and neglect reports and for any request to accompany a protective investigator for the purpose of safety or protection, the patrol division should be called.

V Implementation and Amendments

- A) This agreement shall be valid from the date of the signatures of the Manatee County Sheriff and the HRS District Administrator. This agreement may be amended at anytime upon agreement by both parties.



Charles B. Wells,
Manatee County Sheriff



Charles Taylor,
District Administrator

Date: 8-9-94

Date: 8-9-94

ATTACHMENT I

415.5055 Child protection teams; services; eligible cases.—The department shall develop, maintain, and coordinate the services of one or more multidisciplinary child protection teams in each of the service districts of the department. Such teams may be composed of representatives of appropriate health, mental health, social service, legal service, and law enforcement agencies.

(1) The department shall utilize and convene the teams to supplement the protective investigation and protective supervision activities of the children, youth, and families program of the department. Nothing in this section shall be construed to remove or reduce the duty and responsibility of any person to report pursuant to s. 415.504 all suspected or actual cases of child abuse or neglect or sexual abuse of a child. The role of the teams shall be to support activities of the program and to provide services deemed by the teams to be necessary and appropriate to abused and neglected children upon referral. The specialized diagnostic assessment, evaluation, coordination, consultation, and other supportive services that a child protection team shall be capable of providing include, but are not limited to, the following:

(a) Medical diagnosis and evaluation services, including provision or interpretation of X rays and laboratory tests, and related services, as needed, and documentation of findings relative thereto.

(b) Telephone consultation services in emergencies and in other situations.

(c) Medical evaluation related to abuse or neglect, as defined by department policy or rule.

(d) Such psychological and psychiatric diagnosis and evaluation services for the child or his parent or parents, guardian or guardians, or other caregivers, or any other individual involved in a child abuse or neglect case, as the team may determine to be needed.

(e) Short-term psychological treatment. It is the intent of the Legislature that short-term psychological treatment be limited to no more than 6 months' duration after treatment is initiated, except that the appropriate district administrator may authorize such treatment for individual children beyond this limitation if the administrator deems it appropriate.

(f) Expert medical, psychological, and related professional testimony in court cases.

(g) Case staffings to develop, implement, and monitor treatment plans for children whose cases have been referred to the team. A child protection team may provide consultation with respect to a child who has not been referred to the team, but who is alleged or is shown to be abused, which consultation shall be provided at the request of a representative of the children, youth, and families program or at the request of any other professional involved with a child or his parent or parents, guardian or guardians, or other caregivers. In every such child protection team case staffing, consultation, or staff activity involving a child, a children, youth, and families program representative shall attend and participate.

(h) Case service coordination and assistance, including the location of services available from other public and private agencies in the community.

(i) Such training services for program and other department employees as is deemed appropriate to enable them to develop and maintain their professional skills and abilities in handling child abuse and neglect cases.

(j) Educational and community awareness campaigns on child abuse and neglect in an effort to enable citizens more successfully to prevent, identify, and treat child abuse and neglect in the community.

(2) The child abuse and neglect cases that are appropriate for referral by the children, youth, and families program to child protection teams for support services as set forth in subsection (1) include, but are not limited to, cases involving:

(a) Bruises, burns, or fractures in a child under the age of 3 years or in a nonambulatory child of any age.

(b) Unexplained or implausibly explained bruises, burns, fractures, or other injuries in a child of any age.

(c) Sexual abuse of a child in which vaginal or anal penetration is alleged or in which other unlawful sexual conduct has been determined to have occurred.

(d) Venereal disease, or any other sexually transmitted disease, in a prepubescent child.

(e) Reported malnutrition of a child and failure of a child to thrive.

(f) Reported medical, physical, or emotional neglect of a child.

(g) Any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse or neglect, when any sibling or other child remains in the home.

(h) Symptoms of serious emotional problems in a child when emotional or other abuse or neglect is suspected.

JOINT INVESTIGATIONS OF CHILD ABUSE / NEGLECT

by Connie Shingledecker

Over the past two years, with the increased attention that has focused on the investigation of child abuse and neglect cases, there have been sweeping changes for Law Enforcement and the Department of Children and Families. The escalation in both the number and severity of abuse and neglect cases has citizens, child advocacy groups and law makers demanding changes. One of the most recent significant changes for law enforcement is an increased emphasis on joint investigations.

This article examines the key elements for success in investigations conducted jointly by law enforcement and social services. It provides a discussion of the overall benefits of joint investigations, an overview of the innovative programs that have been implemented throughout the state, and an example of how a basic child abuse case would be jointly investigated.

In 1986 the Crimes Against Children's Unit at the Manatee County Sheriff's Office developed a very close working relationship with the, previously titled, Department of Health and Rehabilitative Services. This working relationship became the foundation for the joint investigation program that exists in our county today. The formula for success between the agencies was developed out of four key elements. Those key elements are; Commitment and Cooperation; Understanding the Roles of Participants; Training and Coordinating; and Exchange of Information.

KEY ELEMENT ONE: Commitment and Cooperation

The commitment for joint investigations must come from the top and be an expressed goal of the agency. The top administrators and executive staff of both law enforcement and the social service agency must understand and support the joint investigation effort, and be willing to dedicate the resources that will ensure that the key elements can be carried out. Top administrators should express their commitment by signing written agreements that outline their role and responsibility in the effort to provide a more comprehensive and thorough child abuse and neglect

joint investigation.

Pursuant to Section 415.5018, F.S., the Department of Children and Families, in conjunction with representatives from Florida law enforcement agencies and social services organizations, developed a standard written agreement called the Memorandum of Understanding (see appendix). This document can be adopted by any law enforcement agency in Florida and adapted to fit its needs. Its development and use will help foster the commitment and cooperation necessary for effective integration of joint investigations of child abuse and neglect cases. Thus encouraging joint social service and law enforcement efforts.

KEY ELEMENT TWO: Understanding the Roles of Participants

In order to facilitate respect and cooperation between law enforcement officers and social service workers, it is important for law enforcement to have a basic understanding of the role and responsibility of the Child Protection Worker in the investigation of child abuse and neglect cases. It was discovered early on in our program that most patrol level officers did not have a clear understanding of what a Child Protection Worker was responsible for doing at a child abuse/neglect investigation.

The patrol officers thought the Child Protection Worker was going to perform the criminal investigation. With this mind set, the responding officer was confused as to why they were needed; that officer would stand around, act irritated, take no notes, make no report, and at times even hinder the Child Protection Worker from doing their job. It became clear, to insure cooperation and an effective response, that patrol officers needed to understand that the Child Protection Worker is performing a dependancy investigation under the requirements of Chapter 415, F.S.

Patrol officers working joint investigations will need in-service training that explains the role and responsibility of the Child Protection Worker and the statutes that they operate under. Law enforcement officers then need to know what their role is. It should be clear that any criminal statutes that may be violated would be the responsibility of law enforcement. This means initiating a criminal investigation which should include but not be limited to the following:

- Gathering information from witnesses, victims, and suspects
- Collecting evidence that is pertinent to the case by obtaining photographs of injuries, seizing the item used to injure the child
- Documenting medical findings
- Making an arrest of a suspect if probable cause exists

Conversely, the Child Protection Workers must understand the role of law enforcement in these types of investigation and particularly the basic principles of criminal investigation, to include but not be limited to:

- The importance of victim, witness, and suspect interviews to law enforcement
- Why law enforcement needs to be involved in decisions made about the initial interview of the suspect
- The importance of evidence to the criminal investigation
- How to identify and not destroy evidence that would be important to the criminal investigation

It is critical that both law enforcement investigators and Child Protection Workers understand the differences between the two types of investigations and the distinct court systems under which each operates. For example, a judge will decide a dependency case, and the burden of proof is based upon a “preponderance of the evidence”. On the other hand, a jury may decide the criminal case, and the burden of proof is “beyond a reasonable doubt”. The evidence and testimony presented in dependency and criminal court can be the same, but, because the focus and the burden of proof is different, the outcome in dependency and criminal often differs as well. For example there may be a finding of dependency in a case that the State Attorney does not feel there is enough to file a criminal charge.

With the law enforcement officer and the social service worker understanding each other’s role and responsibility, we foster a better working relationship, encourage respect for each other and prevent mistakes that could potentially damage either investigation. When each participant begins to respect and understand the other, we build the foundation for a joint investigation or team approach.

KEY ELEMENT THREE: Training and Coordination

The success of the preceding key element is contingent upon the training and coordination of services by both law enforcement and the Department of Children and Families. Each agency must assure its personnel receives training that explains the roles and responsibilities previously mentioned. Subsequently, each agency must provide their personnel with procedures and rules under which they will operate under in joint investigations.

During this training phase, it is important to include all affected support sections. For law enforcement, such training should involve:

- Patrol Officers and Supervisors
- Field Training Officers
- Academy Instructors and In service Instructors
- Criminal Investigations
- Specialized Investigators, e.g. Narcotics Detectives
- Communications Personnel
- Records Personnel
- School Resource Officers
- Public Information Officers

The Department of Children and Families should also involve a variety of work units including:

- Shelter Care Units
- Foster Care Units
- Legal Units
- Secretarial / Support staff

The areas outside the traditional authority of both agencies that should be provided with enhanced training include:

- Academy Instructors
- State Attorney's Office
- Public Defender's Office
- Probation Officers
- School Board Employees (Principal, teacher, counselor)
- Child Protection Team

- Domestic Violence Centers and other related service providers

It has often been said that “once is not enough”. This is especially true in the area of training. In Manatee County, we found our training had the best results if it was provided in the following order and repeated as necessary.

1. Supervisor level training
2. Squad/Unit level training
3. Joint training (law enforcement and social service together)
4. Support Units within each agency
5. Other entities outside the two agencies
6. Specific individuals identified through reports or complaints
7. Periodic training as needed for identified problems or new procedures

Our formula for success has been anchored in communication and repetition, as well as joint and ongoing training for both agencies. This formula has assisted in providing training to new hires, transfers, and individuals that had problems adjusting to the joint investigation concept.

Regular meetings between participants also served to identify specific problems and the focus for further training. These meetings should be scheduled once a month and attended by:

- Law Enforcement
- Department of Children and Families
- State Attorney’s Office
- Shelter Home
- Child Protection Team
- Other involved social service providers

These groups provide a forum in which problems can be discussed, success stories shared, and training issues identified. Agencies should be encouraged to have open, honest dialogue, and asked to leave their feelings and territoriality at the door in order to facilitate progress in the joint investigation effort.

KEY ELEMENT FOUR: Exchange of Information

In the past, it was traditional that law enforcement and the Department of Children and Families were reluctant to share information from each other's investigation. Each held their information to be confidential and there were laws in place to prevent an easy exchange. Little did we know that law enforcement and social services were practically passing each other on the sidewalk, so to speak, as we dealt with the same families.

Law enforcement is dealing with domestic violence, child abuse, substance abuse, disturbance calls and a variety of other issues that are pertinent to the social service worker involved with this family. It seems obvious that we need to find a way to share the information each of us has, to facilitate the protection of children within our jurisdictions. For instance, law enforcement agencies could find a way to provide reports to social workers in a reasonable and timely manner. If this information assists the caseworker in making an appropriate decision about the removal of a child for their protection, we might prevent a homicide. The money the agency spends in providing reports could be saved in personnel hours that would have been expended working a more serious crime against a child.

The benefits of information exchange cannot be one-sided. The Department of Children and Families can provide reports to law enforcement that give a more in depth social history of the family. This piece is often missing in the criminal investigation as we focus our investigation on the incidents leading up to the crime. In order to properly prosecute these cases it is important to show any ongoing pattern of neglect or abuse often best reflected by reports made to the department.

We have recently realized the need for information sharing to understand the total dynamics of the family and child in the area of serious delinquency. The Serious Habitual Offender Comprehensive Action Plan(SHOCAP), has capitalized on this very idea. The direct correlation between habitual juvenile offenders, truancy, domestic violence, mental health, substance abuse, neglect, and abuse is clear. As we get the information from the schools system, law enforcement, the court system, mental health, and social services we begin to see the dynamics involving the child and the family. As Juvenile Assessment Centers open throughout the state we realize the importance of sharing this type of information between agencies in order to prevent and more effectively deal with juvenile crime..

An important part of information sharing is accessibility. When our agency signed

the first agreement with the Department of Children and families in 1994, it spelled out which agency would take the lead in a joint investigation. We recognized the importance of accessibility and exchanged after hour pager numbers and on call schedules. The road supervisors and detectives were provided with the pager numbers and schedules for on call protective investigators. The Department supervisors were provided with pager numbers for detectives and detective supervisors. This allowed immediate access and exchange of information when a serious child abuse case was being investigated.

This exchange of information is carried over in meetings with:

- Child Protection Team
- Child Death Investigation Teams
- Child Death Review Boards
- Multi-Agency Joint-Investigation Meeting

Law enforcement and social service agencies have stopped working from the old information holding perspective - how can I keep from providing that information - to the information sharing perspective - how can I provide that information to all involved agencies.

Significantly, recent legislative changes have allowed for local law enforcement to provide immediate criminal history information on suspects during joint investigations. That same criminal history information provided to the social worker can be critical in preventing the Department of Children and Families from releasing or placing a child in the custody of a potential child abuser. In the past, criminal history information could only be provided to the DC&F after the Florida Department of Law Enforcement received a written request, along with payment. This was costly and time consuming.

In keeping with the philosophy of a more open exchange of information, work is currently being done to allow DCF to release the name of the abuser to law enforcement. In the past this information has only been able to be provided to the State Attorney's Office. These types of issues should continue to be identified and recommendations made for the improvement to all agencies involved in child abuse and neglect investigations.

BENEFITS OF JOINT INVESTIGATIONS

Many of the agency benefits have already been mentioned, however listed below are some of the benefits to both law enforcement and Department of Children and Families. This list deals with the most obvious benefits and may not include all those that are specific to each district or jurisdiction because of their unique situations.

Law Enforcement Agency Benefits

- **Evidence:** Law enforcement often complains that evidence is either destroyed or lost when officers are not present at the initial contact; at the crime scene, with the victim, with witnesses, and most importantly, with the suspect. Joint investigations assure both law enforcement presence and the training of social services personnel in this critical investigative stage.
- **Interviews:** It is essential for law enforcement to be involved in the initial interviews of all suspects, witnesses and victims. All too often, for any number of reasons, the victim's information changes, and this is viewed as inconsistent, which damages the criminal case. Joint investigations allow for these interviews to be done jointly, which minimizes the conflicting statements as well as trauma to the victim and witnesses.

The suspect interview is probably the most critical to the criminal investigation, especially when there is little or no physical evidence. Law enforcement needs the element of surprise and total knowledge of all available information on the case when confronting the suspect. Joint investigations allow for law enforcement to have control over the date, time, and location of the interview with the suspect.

- **Exchange of Information:** The joint investigation provides an avenue by which each agency can exchange information that would be valuable to the other. The signed written agreement takes care of any legal confidentiality issues that would otherwise prevent this exchange from taking place. Most importantly, investigators have a better

chance of a successful conclusion if all information known to each agency is shared and the case worked jointly.

- **Access to Investigators After Hours:** The written protocol of a joint investigation can allow for the exchange of pager numbers and after hour call schedules and access to supervisors from each discipline. This assures that there will be accessibility and accountability at all times , not just during regular business hours.
- **Deterrence of False Information:** The law enforcement presence can deter the false reporting of child abuse and neglect. Some reporters may feel less inclined to give false information to a law enforcement officer taking a report in a potential criminal matter than they would to a social service worker involved in a dependency case.
- **Safety:** The law enforcement presence also provides a safety factor for the Department of Children and Families worker that cannot be overlooked during these sensitive and potentially volatile situations.

One final factor that benefits both the dependency and the criminal investigation, whose importance cannot be overlooked, is the successful conclusion of the investigation. When an investigation is performed jointly, the likelihood of a successful conclusion is increased. A successful conclusion is critical to both the dependency and the criminal investigation and starts with discovering the truth about the abuse.

If we can determine the truth about who did what to the child, the social service agency can make the most appropriate decision about what services to put into place to ameliorate the problem. Law enforcement can identify the abuser and file the necessary charges or make the appropriate arrests. Without the truth, many children are placed back into abusive environments, the abuser is free to continue the abuse, and there is often no positive resolution to the case (the child gets little or no professional treatment or emotional support and there is no consequence for the abuser).

PILOT PROGRAM OVERVIEW

In 1995 four pilot programs were approved to demonstrate effective paradigms for collaborative working relationships between law enforcement and the Department of Children and Families in the investigation of child abuse and neglect cases.

Manatee, Dade, Palm Beach and jointly Volusia/Flagler counties were the selected pilot program sites, and implementation began October 1, 1995. The following information is an overview of each of the four programs.

Project Start Off Smart in Dade County is a collaborative effort between the Department of Children and Families District Eleven and the Homestead Police Department. The pilot was proposed with the purpose of being a holistic, family focused approach to assist families with problems. The emphasis is on coordination of efforts and services by using a holistic approach supported by community resources. Strong linkages between law enforcement, the Department, Dade County Housing and Urban Development Office, and community health came together under one umbrella in order to implement a comprehensive prevention/intervention program that addressed both abusive and neglectful situations.

The Manatee County Sheriff's Office and the Department of Children and Families District Six have been working together to resolve difficult issues that arise in the investigation of child abuse and neglect cases. As a result of an already successful relationship, this proposal provided for multi-jurisdictional law enforcement coordination and called for the development of a plan which would eventually co-locate law enforcement staff and Department staff responsible for the investigation of child abuse and neglect reports.

This pilot has since been expanded. The Manatee County Sheriff's Office, as of February 1997, contracted with the Department of Children and Families to provide the child protection investigation as required in F.S. 415. The Sheriff's Office has employed Protective Workers to perform the function of child protection investigations that was once handled by the Department. This pilot, which was phased in over a six month period, went into full operation in September of 1997.

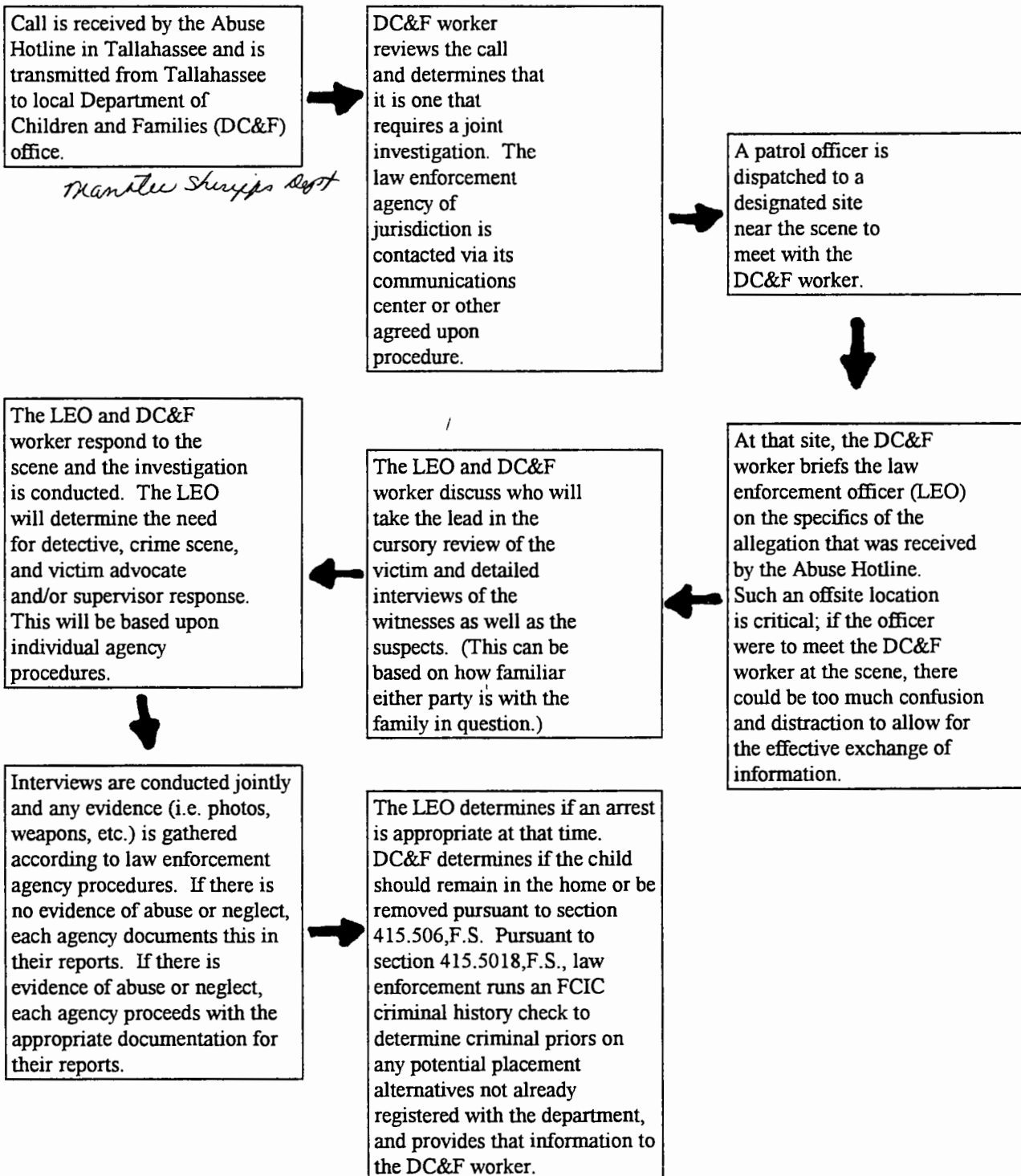
Palm Beach County District Nine building on the implementation of the Family Services Response System, proposed to transition the majority of responsibility for Chapter 415, Florida Statutes, Part IV to the Palm Beach County Sheriff's Office within one year of implementation. They also proposed the development of a Rapid Response Team, which would include law enforcement and Department staff, to provide for more immediate assessment on 75% of children and families referred by law enforcement and medical professionals. The site also made the commitment to increase the number of working relationships with other community entities which would enhance innovative flexible responses to the reports of abuse and neglect.

The Volusia County Child Advocacy Center in collaboration with the Department, I-Care, law enforcement, State Attorney, and the Young Women's Christian Association joined together to imitate a less traumatic means of investigating reports of possible child sexual abuse and serious physical abuse. The center allows for all cases of sexual abuse (caretaker and non-caretaker) and serious physical abuse to be handled in a less intrusive, more organized efficient manner. Components include a designated neutral facility which provides a non-threatening environment, a case review process, joint investigations conducted by law enforcement and the Department's protective investigators, a case tracking system, medical examination and evaluation, mental health treatment, victim advocate support services, training, and community education. Having all parties co-located promotes increased cooperation and communication, and provides for a less traumatic experience for the child.

Are joint investigations a "fad" of the 90's or a necessity? Many agencies are finding that they are not a fad, but in fact an evolutionary process not yet complete. These collaborations will continue as we strive to perform investigations that are thorough, result in accurate conclusions, and cause the least amount of trauma for children and families. Children's lives depend on it.

Example of a Typical Joint Investigation

So how is a typical joint investigation handled after a call is received by the Abuse Hotline?



MEMORANDUM OF UNDERSTANDING/WORKING AGREEMENT

Manatee County Sheriff's Office and the Department of Children and Families

The agencies named in this document agree to the following:

A. PURPOSE

The purpose of this Memorandum of Understanding is to coordinate services to the families of **Manatee County** through cooperation, collaboration, and the sharing of appropriate information by agencies within this jurisdiction. Specifically, this agreement establishes operational protocols for the joint investigation of abuse reports involving criminal allegations in order to:

- provide standard, consistent and thorough investigations
- maximize the resources through a joint investigative process
- minimize the number of interviews for children who are victims of abuse or neglect
- allow for the orderly collection of evidence in the criminal investigative process
- ensure the provision of appropriate services when deemed necessary for children and their families
- provide a forum for on-going communication and resolution of issues involving family safety in this community and foster an effective collaboration among
 - law enforcement
 - state attorney
 - judiciary
 - domestic violence providers
 - child protection team
 - local school system
 - Department of Juvenile Justice
 - Department of Children and Families (DCF)

B. DEFINITIONS

"Child Abuse/Neglect": Harm or threatened harm to a child's physical or mental health or welfare by the acts of omissions of a parent, adult household member, or other person responsible for the child's welfare, or, for purposes of reporting requirements, by any person. [415.503(3), F.S.]

"Criminal Investigation": An investigation conducted by an appropriate law enforcement agency for the purpose of uncovering evidence which may lead to an individual's prosecution for adult abuse, neglect, or exploitation, or child abuse, neglect, or abandonment, or other appropriate criminal charges.

"Domestic Violence": means any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit.

"Emergency Placement - Child": The temporary care of a child who is alleged to be or who has been found to be dependent, pending further disposition, before or after adjudication or after execution of a court order. The placement may be with a relative, non-relative or state licensed home or facility.

"Family or household member": means spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a

family, and persons who have a child in common regardless of whether they have been married or have resided together at any time.

"Joint Investigation": Two agencies conducting concurrent criminal and protective investigations.

"Protective Investigation": A fact finding and emergency service engagement process with the primary goal of protecting children, disabled adults or elderly persons.

C. **INVESTIGATIVE PROCEDURES**

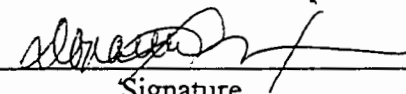
1. The Florida Abuse Hotline shall be responsible, as required by Section 415.504(2)(a), F.S., for transferring all calls with information that a child has been harmed by a non-caretaker to the Sheriff (or other single designated law enforcement entity) of the county in which the harm occurred.
 - a. The Sheriff will be responsible for establishing procedures for accepting such information including any follow-up hard copy report from DCF, and transferring it to any other appropriate law enforcement jurisdiction.
 - b. The law enforcement agency designated to receive non-caretaker abuse calls for **Manatee County is Manatee County Sheriff's Office**; the phone number is **(941) 747-3011/911**. Hard copies of DCF reports documenting child-on-child sexual allegations will be forwarded to **Manatee County Sheriff's Office, Lieutenant Ron Couch 515 11th Street West, Bradenton, Florida 34205** within 48 hours of receipt.
2. Unless otherwise specified in this written agreement or required by law, all reports of alleged abuse or neglect of a child, elderly person, or disabled adult taken by the DCF Abuse Hotline for the area under the jurisdiction of the law enforcement agency signing this agreement will be transmitted to the local Department of Children and Families Office in Manatee County.
3. The Department of Child and Families protective investigator retains the responsibility for notifying the **Manatee County Sheriff's Office** as required by Sections 415.5018 and 415.505, Florida Statutes, immediately upon receipt of a report alleging or immediately upon learning during the course of investigation when providing services that:
 - a. the immediate safety or well-being of a child is endangered;
 - b. the family is likely to flee;
 - c. a child received an observable injury as a result of abuse/neglect;
 - d. a child has a medically diagnosed internal injury as a result of abuse/neglect;
 - e. a child has died as a result of abuse or neglect;
 - f. a child is the victim of aggravated child abuse as defined in Section 415.503.F.S.;
 - g. a child is the victim of sexual battery or of sexual abuse as defined in Section 415.503,F.S.;
 - h. a child is the victim of institutional abuse as defined in Section 827.03,F.S.
4. The protective investigator shall immediately notify, by either telephonic or electronic means, the **Manatee County Sheriff's Office** that the Department of Children and Families has received a report or learned of a situation covered by Section C.3. of this agreement. A written copy of the report will be delivered to the **Manatee County Sheriff's Office** within one working day.
5. The **Manatee County Sheriff's Office** is responsible for assessing and responding to potential criminal allegations enumerated under Section C.3 above. As required by Section 415.5018,F.S., the **Manatee County Sheriff's Office** will assume lead in conducting any potential criminal investigations involving children in cases specified in Section C.3 above. The protective

investigation will be coordinated with the criminal investigation. Evidence gathered in criminal investigations will be handled according to the policies and procedures of **Manatee County Sheriff's Office**.

6. The agencies agree to conduct joint investigations. During the course of such investigations, the agencies agree to share information on an on-going and continuous basis. Both agencies understand that the safety of the victim is of primary concern and that the request for protective investigation by the Department of Children and Families must be responded to by DCF within 24 hours of receipt of the report.
7. If the **Manatee County Sheriff's Office** requests that the alleged perpetrator not be interviewed by the protective investigator, that request shall be honored. The Department of Children and Families case record must document the date and time of the request, the person making the request and the reason for the request. The **Manatee County Sheriff's Office** agrees to advise the Department of Children and Families when and if a protective interview can be conducted and, when appropriate, share the results of any interview conducted by the **Manatee County Sheriff's Office**.
8. The Department of Children and Families will be responsible for assessing the immediate safety of the child and taking the necessary actions that will ensure the continued safety of the child. The Department will also be responsible for determining and implementing necessary services to support the family.
9. The Department of Children and Families and **Manatee County Sheriff's Office** shall develop, implement, and provide training on joint investigative protocols and protocols for the assessment of family violence during abuse investigations and the assessment of abuse during family violence investigations.
10. To the extent set forth in this Memorandum of Understanding/Working Agreement or the written protocol which is attached to and incorporated by reference, the **Manatee County Sheriff's Office** has assumed partial or full responsibility for conducting certain components of protective investigation under Sections 415.502-415.514, F.S., related to cases involving criminal investigations and assures that it will be in compliance with the procedural requirements of Section 415.502-415.514, F.S.
11. This Memorandum of Understanding/Working Agreement will be effective only when accompanied by a written protocol which meets the specifications and requirements as set forth in Section 415.5018(3), F.S. and if not otherwise included in this Memorandum of Understanding, including:
 - Any needed specific information governing response to reports of abuse or neglect or investigations
 - Assessment of Risk
 - Communication and involvement with the State Attorney
 - Utilization of the Child Protection Team
 - Storage and maintenance of records and other information
 - Description of any transition of responsibility that assures the integrity and continuity of protective investigationsAdditional protocol language should include a procedure for resolving any conflict in the interpretation of this Memorandum of Understanding and its working protocols.

D. SHARING OF INFORMATION

1. Pursuant to Section 415.5018, F.S., and within statutory guidelines, **Manatee County Sheriff's Office** is authorized to share with assigned Department of Children and Families protective investigators, Florida criminal history information accessed through the Florida Crime Information Center and not otherwise exempt from Section 119.07(1), F.S.
 - a. Such information may be used only in the furtherance of a specific child protective investigation, including the emergency placement of an endangered child. The agencies will clearly define those investigations specified under this section.
 - b. Such information will be provided without charge.
 - c. Such information may be provided by the assigned criminal investigator or through **Child Protection Investigator Unit**.
 - d. The release of such information will be documented in accordance with applicable FDLE FCIC procedures.
2. Within statutory guidelines, **Manatee County Sheriff's Office** will, upon request, provide to the designated child protective investigator a copy of all initial law enforcement reports relating to a domestic violence incident, including a narrative description of the incident, and any subsequent, supplemental, or related reports.
 - a. Such reports shall be clearly defined as part of this agreement but shall include those in which children are present when family violence occurs.
 - b. Such reports shall be used only for the purpose of child protective investigations and placement of children under DCF care.
3. Within statutory guidelines, the law enforcement agency shall develop procedures to allow access to or otherwise share all appropriate local criminal information on an individual under investigation with the assigned protective investigator.
4. Within statutory guidelines, the Department of Children and Families will provide to the law enforcement agency copies of protective investigation reports during criminal investigations. Any reports shall be provided without cost to the law enforcement agency. Copies of these reports shall include the identity of the reporter which remains confidential pursuant to Section 415.51, F.S.
5. All information, reports, documents, etc, provided under the provisions of this agreement shall retain any confidential status provided under law and shall not be distributed outside the undersigned agencies unless otherwise mandated by law.

<u></u> Signature	<u>10/21/97</u> Date	<u></u> Signature	<u>12-4-97</u> Date
<u>Sheriff</u> Title		<u>Acting District Administrator</u> Title	
<u>Manatee County Sheriff's Office</u> Manatee County Sheriff's Office		<u>Department of Children and Families</u> Department of Children and Families	
<u>Captain Connie Shing-Ledeker</u> 941- 747-3011 EXT. 2504 Designated Contact		 Designated Contact	

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

Legislative Office Building - Room 643

Monday, June 1, 1998

4:00 p.m.

Opening Remarks

Senator Bill Martin, Co-Chair
Representative Charlotte Gardner, Co-Chair
Representative Lanier Cansler, Co-Chair
Representative Debbie Clary, Co-Chair

Overview of DHHS State Plans

Low Income Energy Assistance
Program

Pheon Beal, Division of Social Services
DHHS

Community Services Block Grant

Lawrence Wilson, Office of Economic
Opportunity

Open Public Hearing

Close Public Hearing

Committee Discussion

Next Meeting

Adjourn

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 1, 1998
Block Grant Hearing

The Joint Appropriations Subcommittee on Human Resources held a public hearing on two Block Grants on Monday afternoon June 1, 1998 at 4:00 p.m. in Room 643. Representative Charlotte Gardner presided. Three Senators were present and the following House members were in attendance:

Representative Charlotte Gardner

Representative Edd Nye

Representative Julia Howard

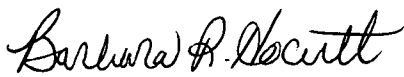
The following staff were present: Karen Hammonds-Blanks, Ramona Burton, and Carol Shaw.

Representative Gardner called on Al Adams for comment on the LIHEAP Block Grant. (See Attachment #1.)

Pheon Beal, Division of Social Services, presented the Low Income Energy Assistance Program (LIHEAP). (See attachment #2.)

Lawrence Wilson, Office of Economic Opportunity, gave information on the Community Service Block Grant. (See attachment #3.) Al Adams offered a statement prepared by Roberta Faison on the Community Service Block Grant proposal in which she recommended the department allocations. (See attachment #4.)

There being no further comments, the meeting was adjourned with the announcement of the 8:30 a.m. meeting of the committee tomorrow.



Barbara R. Hocutt, Clerk



Representative Charlotte Gardner, Co-Chair

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES PUBLIC HEARING

JUNE 1, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

NEES ROSELAND

OSBM

Lee H. Hup

DHHS

ANGIE McMillan

DHHS

Sharon Gensove

DSS

Nona Reeves

HSP

William Wong

Intern

Stacey Slaughter

Intern

J. L. Hup

NCPR

Amy Jo Bain

Smith Anderson

Kevin Fitzgibbon

NC DSS

MICHELLE COTTON

DHHS - MA/DO/SHS

Terry Stelle

DMH/DOSAS

Mary Greene

OSBM

by Farmer

NC DHHS - DCD

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES PUBLIC HEARING

JUNE 1, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Debbie Moyer, Easter Seals, 2315 Myron Dr, R-1	Easter Seals
Megan Souter	Easter Seals
Rochyn Smith	Lobbyist
Jerry Kemp	N.C. Division of Voc. Rehab Services
Barbara A. Mann	WAKE OPPORTUNITIES INC
Mike Juby	WAKE COUNTY OPPORTUNITY INC
Eddy Clement	WAKE COUNTY OPPORTUNITIES, INC
Lawrence Wilson	NC DHHS - Office of Economic Opportunity
Perry A. Carter	Energy Division
Chuck Elstrom	Energy Division
Deborah Hamm	Energy / Commerce
Alice Smith	DHHS Department of Health / Human Services
B. Watts	DHHS - Social Services
Chenbeal	PHHS / PSS



NORTH CAROLINA

COMMUNITY ACTION ASSOCIATION

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June 1, 1998
Al Adams
1

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1998 LIHEAP BLOCK GRANT LEGISLATIVE PUBLIC HEARING

PUBLIC COMMENTS

TO THE

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

FROM THE

N.C. COMMUNITY ACTION ASSOCIATION

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

PUBLIC HEARING COMMENTS

JUNE 1, 1997

COMMITTEE CHAIRS, MEMBERS OF THE COMMITTEE, SECRETARY BRUTON/HUMAN RESOURCE STAFF, LEGISLATIVE AND FISCAL STAFF; ON BEHALF OF THE N.C. COMMUNITY ACTION ASSOCIATION, PROVIDERS OF NORTH CAROLINA'S RESIDENTIAL ENERGY CONSERVATION ASSISTANCE PROGRAM (KNOWN TO YOU BEST AS THE WEATHERIZATION ASSISTANCE PROGRAM), A RECIPIENT OF CRUCIAL LIHEAP FUNDING, WE THANK YOU FOR THIS OPPORTUNITY TO COMMENT ON THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM.

FOR THE PAST THREE YEARS, THIS COMMITTEE HAS APPROVED A BALANCE WITHIN THE LIHEAP PROGRAM OF 75% CASH ASSISTANCE PAYMENTS AND 25% FOR THE WEATHERIZATION ASSISTANCE PROGRAM; 15% DIRECTLY TO WEATHERIZATION AND 10% DIRECT VIA A WAIVER PROCESS APPLICATION TO U.S. DEPT. OF HHS. THIS PAST YEAR, 7.6% WAS DECIDED UNANIMOUSLY BY THIS COMMITTEE UPON IN MUTUAL AGREEMENT BY N.C. DEPT. HUMAN RESOURCES, THE N.C. DIVISION OF ENERGY AND MEMBERS OF THIS COMMITTEE. THIS WAIVER REQUEST, ALLOCATING 22.6% (1997-98) OF THE STATE'S L.I.H.E.A.P. BLOCK GRANT TO WEATHERIZATION WAS AN IMPORTANT STEP IN RECOGNIZING THE NEED TO ADDRESS THE ROOT PROBLEM OF HIGH ENERGY COSTS IN A MORE COMPREHENSIVE AND EXTENSIVE MANNER. THE IMPLEMENTATION OF WAIVER REQUESTS FROM THE FEDERAL GOVERNMENT TO INCREASE THE PERCENTAGE OF L.I.H.E.A.P. BLOCK GRANT FUNDS FOR WEATHERIZATION IS DUE IN LARGE PART TO THE OVERWHELMING DATA TO DOCUMENT LONG TERM ENERGY SAVINGS AS A BETTER MEANS TO SUPPLEMENT THE LOW

INCOME'S ENERGY NEEDS AND PERCENTAGE OF INCOME SPENT ON HEATING/COOLING.

UPON RECOMMENDATION FROM THE U.S. DEPT. OF HHS, STAFF OF THE N.C. DEPT. HHS, THE N.C. DIVISION OF ENERGY AND ITS PROGRAM PROVIDERS, FOR THIS AND SUBSEQUENT YEARS WE DESIRE TO APPROPRIATE AS A PERMANENT BUDGET ITEM 15% DIRECTLY TO WEATHERIZATION AND 7.6% INTO CRISIS ASSISTANCE DIRECTLY FOR THE HEATING APPLIANCE REPAIR AND REPLACEMENT PROGRAM. THIS PROCEDURAL CHANGE IS BEING RECOMMENDED DUE TO THE ADMINISTRATIVE TIME NECESSARY TO COMPLETE THE WAIVER PROCESS AND FEDERAL STATUTES WHICH ALLOW HEATING REPAIR AND REPLACEMENT PROGRAM SERVICES TO BE PROVIDED IN OTHER LIHEAP BUDGET CATEGORIES. ADDITIONALLY, WE SHOULD ADD THAT ALL LIHEAP PROGRAM ENTITIES HAVE MET TO DISCUSS THIS ISSUE AND ARE IN MUTUAL AGREEMENT OF ITS MERIT.

HEATING REPAIR REPLACEMENT PROGRAM IF YOU WILL RECALL IS A SPECIAL PART OF THE RESIDENTIAL ENERGY CONSERVATION ASSISTANCE PROGRAM. THE WEATHERIZATION NETWORK IS A LEADER IN DEVELOPING CONSERVATION TECHNOLOGIES. THROUGH THIS, WE HAVE PIONEERED MECHANISMS FOR THE IDENTIFICATION AND RESOLUTION OF PROBLEMS RELATING TO HOME HEALTH AND SAFETY.. IN NORTH CAROLINA ONE IN TEN HOMES ELIGIBLE FOR WEATHERIZATION HAVE SIGNIFICANT LEVELS OF CARBON MONOXIDE. THREE TIMES AS MANY HOMES HAVE SIGNIFICANT LEVELS OF NITROGEN DIOXIDE. BOTH GASES ARE DANGEROUS. CARBON MONOXIDE IS A SILENT, DEADLY KILLER. NITROGEN DIOXIDE CAN CAUSE LONG TERM CHRONIC ILLNESS. THESE ARE SERIOUS HEALTH AND SAFETY ISSUES CAUSING POTENTIAL DEATHS AND IN CERTAIN PROBABILITY HEALTH PROBLEMS WHICH REFLECT UPON THE INDIGENT HEALTH CARE COSTS IN ALL 100 COUNTIES.

CURRENTLY WE HAVE A STATEWIDE H.A.R.R.P. WHICH ALLOWS US TO EVALUATE, REPAIR OR REPLACE FAULTY HEATING SYSTEMS THAT POSE HEALTH AND SAFETY RISKS.

IN A REPORT BY THE NATIONAL CONSUMER LAW CENTER, LOW INCOME NORTH CAROLINIANS CAN SPEND UP TO 35% OF THEIR INCOME ON ENERGY. THE 90'S HAVE BROUGHT ABOUT AN INCREASE IN THE NUMBER OF WORKING POOR WHO HAVE MINIMUM WAGE, SERVICE SECTOR JOBS. ONE IN FIVE NORTH CAROLINIAN FAMILIES SUBSIST ON AN INCOME BELOW 150% OF THE POVERTY LEVEL. TWO THIRDS OF OUR COUNTIES IN NORTH CAROLINA HAVE SEEN POPULATION RATES OUTPACE JOB GROWTH. IN MOST COUNTIES OF NORTH CAROLINA LOW WAGE JOBS ARE THE NORM, RATHER THAN THE EXCEPTION. THESE LOW WEALTH FAMILIES FREQUENTLY OCCUPY OLDER HOUSING STOCK BUILT WITHOUT ENERGY CONSERVATION IN MIND. THE WORKING POOR, WHO ARE marginally ABLE TO MAKE IT ON THEIR INCOME, ARE PARTICULARLY ASSISTED BY OUR PROGRAM OF WEATHERIZATION.

ENERGY REMAINS A HIGH COST ITEM FOR LOW INCOME FAMILIES AND WEATHERIZATION IS A LONG TERM SOLUTION WHICH HELPS ALLEVIATE THIS PROBLEM WHILE ALSO REDUCING THE NEED FOR FUEL ASSISTANCE PAYMENTS. WEATHERIZATION GREATLY REDUCES THIS BURDEN. THE WEATHERIZATION ASSISTANCE PROGRAM ACTUALLY IMPROVES THE ENERGY EFFICIENCY OF THE HOME, THEREBY LOWERING CLIENTS MONTHLY FUEL BILLS. REDUCTIONS IN FUEL BILLS ARE ESPECIALLY IMPORTANT TO LOW INCOME FAMILIES WHO WALK THE LINE BETWEEN PAYING FOR HOUSING AND BEING HOMELESS. A 30% REDUCTION IN A MONTHLY FUEL BILL MAKES A SIGNIFICANT IMPACT FOR LOW INCOME FAMILIES STRUGGLING TO PAY FOR NECESSITIES. DOLLARS SAVED ON FUEL BILLS CAN THEREFORE BE DIRECTED TO THESE OTHER NECESSITIES, REDUCING DEPENDENCY ON OTHER FEDERAL AND STATE PROGRAMS. WEATHERIZATION IS A SOLUTION RATHER THAN A QUICK FIX, PROVIDING LONG TERM BENEFITS TO LOW INCOME FAMILIES. OUR EXPECTED "LIFETIME OF ENERGY

REDUCTION" IS BASED ON A TWENTY YEAR TIME LINE.

INVESTMENT IS A KEY WORD DESCRIBING THE FEDERAL DOLLARS SPENT IN THE WEATHERIZATION PROGRAM. DUE TO INCREASED TECHNOLOGY, WE ARE NOW BETTER THAN EVER ABLE TO ACCURATELY DETERMINE THE AMOUNT OF ENERGY SAVED FROM THE PROGRAM. SINCE 1989 NEW TECHNOLOGIES AND PROGRAM IMPROVEMENTS HAVE INCREASED OUR COST EFFECTIVENESS. IN NORTH CAROLINA, FOR EVERY \$1 INVESTED IN 1997 THERE WAS A RETURN OF \$ 2.14 (ENERGY SAVINGS TO INVESTMENT RATIO). WE BELIEVE THAT A \$3 RETURN ON INVESTMENT IS POSSIBLE WITHIN LESS THAN 5 YEARS. THESE SAVINGS ARE DRAMATIC AND CONTINUE TO ACCUMULATE OVER THE LIFE TIME OF THE UNIT WEATHERIZED. 4,013 UNITS COMPLETED IN 1997 @ \$413.10 IN SAVINGS PER HOUSEHOLD EQUATES TO A SAVINGS OF 16.9 MILLION DOLLARS OVER THE LIFE OF THE UNITS WHICH IS 20 YEARS. KEEP IN MIND THIS IS JUST FOR THE UNITS LAST YEAR. WE HAVE WEATHERIZED OVER 82,000 UNITS SINCE THE BEGINNING OF THE PROGRAM. THE MATH ON THOSE NUMBERS IS OVERWHELMING. ANOTHER AMAZING STATISTIC OTHER THAN THE REAL DOLLAR SAVINGS IN ENERGY COST IS THE NET DOLLAR VALUE OF NON-ENERGY IMPACTS. EXTENDING THE LIFE OF THE DWELLING \$171, REDUCED FIRES \$4, REDUCED ARREARAGES \$44, FEDERAL TAXES GENERATED BY DIRECT EMPLOYMENT \$75, INCOME GENERATED BY DIRECT EMPLOYMENT \$688, AVOIDED COSTS OF UNEMPLOYMENT BENEFITS \$112, ENVIRONMENTAL EXTERNALITIES \$234 FOR A TOTAL OF \$1,328 DOLLARS IN ADDITIONAL ECONOMIC BENEFITS. THIS IS WHY WE ARE SO PASSIONATE ABOUT OUR PROGRAM. NORTH CAROLINA, WE ARE PROUD TO SAY HAS ONE OF THE MOST EFFECTIVE IF NOT THE MOST EFFECTIVE AND EFFICIENT PROGRAMS IN THE NATION. WE THINK THAT IT SHOWS IN THIS DATA.

ANOTHER EXTREMELY IMPORTANT AND SOMETIMES OVER LOOKED BENEFIT OF THE WEATHERIZATION ASSISTANCE PROGRAM IS ITS ECONOMIC IMPACT ON LOCAL AND STATE ECONOMIES, FOR WEATHERIZATION CREATES AND SUSTAINS JOBS. 52 INDIVIDUALS ARE DIRECTLY EMPLOYED AND 22 JOBS ARE INDIRECTLY SUPPORTED FOR EVERY ONE MILLION DOLLARS INVESTED INTO THE PROGRAM. THAT EQUATES TO 32 MILLION IN ECONOMIC OUTPUT GENERATED EACH YEAR. IN A TIME OF GREAT SKEPTICISM ABOUT THE EFFECTIVENESS OF PUBLIC PROGRAMS, WEATHERIZATION IS AN EXAMPLE OF A FEDERAL/STATE/ COMMUNITY PARTNERSHIP THAT RETURNS MORE VALUE THAN THE TAXPAYER INVESTS AND DELIVERS MEASURABLE AND LONG-LASTING RESULTS.

COMMUNITY ACTION'S PRIMARY GOAL IS TO ASSIST FAMILIES ACHIEVE ECONOMIC SELF SUFFICIENCY, PROVIDING SERVICES TO MOVE THEM ABOVE THE POVERTY LEVEL. ECONOMIC SELF SUFFICIENCY PROGRAMS REMOVE THE BARRIERS THAT MAY BE KEEPING FAMILIES IN POVERTY. WASTED ENERGY BRINGS HUGE ENERGY COSTS, CREATES MANY POTENTIAL EVICTION SITUATIONS, AND CAUSES MANY TO CHOOSE BETWEEN HEATING, EATING, OR BUYING NECESSARY MEDICATION. 65% OF WEATHERIZATION SERVICES ARE PROVIDED TO LOW INCOME HOMEOWNERS IN OLDER HOUSING. IMPROVEMENTS IN HOUSING STOCK SUCH AS INSULATION AND FURNACE MODIFICATIONS REMAIN WITH A HOME AND BENEFIT LOW INCOME CLIENTS FOR MANY YEARS, THEREBY PRESERVING HOUSING STOCK AND ENERGY EFFICIENCY. ITS EFFECT IN MANY AREAS IS VERY PRONOUNCED WHERE WEATHERIZATION SERVICES CAN REPRESENT THE ALTERNATIVE TO ABANDONMENT. 23% OF UNITS WEATHERIZED ARE FOR THE ELDERLY. THESE SERVICES OFTEN ALLOW SENIORS TO REMAIN IN THEIR HOMES LONGER REDUCING THE NEED FOR

GOVERNMENT SUBSIDIES ON LONG TERM CARE IN EXPENSIVE NURSING OR REST HOMES. 35% OF WEATHERIZATION SERVICES ARE PROVIDED TO RENTERS OF WHICH LANDLORDS MUST CONTRIBUTE 10% IN CASH TOWARD THE COST OF SINGLE FAMILY DWELLINGS AND 25% FOR MULTI-FAMILY DWELLINGS. THESE FUNDS ARE RETURNED TO THE WEATHERIZATION PROGRAM TO INCREASE THE NUMBER OF UNITS WEATHERIZED.

WEATHERIZATION IS A COMPREHENSIVE PROGRAM THAT PROVIDES ECONOMIC BENEFITS TO LOW INCOME AMERICANS WHILE CONTRIBUTING TO ENERGY CONSERVATION, LESSENING ENVIRONMENTAL DEGRADATION CAUSED BY THE BUILDUP OF CARBON DIOXIDE IN THE ATMOSPHERE AND STIMULATES LOCAL ECONOMIES. IT IS THE TRUEST EXAMPLE OF THE KIND OF ASSISTANCE PROGRAM TO LOW INCOME FAMILIES THAT LEADS THEM TO ECONOMIC INDEPENDENCE SOUGHT BY THE STATE IN ITS EFFORTS OF WELFARE REFORM.

June 1, 1998
Phon Seal
#2

**DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM BLOCK GRANT
(LIHEAP)

For state fiscal year 1998-99, the total state Low Income Energy Program allocation is currently estimated to be \$18,460,000 based on current projections that the FFY 99 award will be this amount.

GENERAL DESCRIPTION

The purpose of the Low Income Home Energy Assistance Program Block Grant is to provide funds to help low income families cope with cost increases of heating fuel and to provide energy assistance. There are two components:

1. Low Income Home Energy Assistance Payments - Funds are used to provide a one-time payment to eligible households to help pay heating bills.
2. Crisis Intervention Assistance - There are two programs funded under this component. The Crisis Intervention Program uses funds to assist low income people when a heating or cooling related crisis occurs. Allocations are provided to county departments of social services to make direct payments, vendor payments, or to provide in-kind services for eligible households. Funds are also sent to the Department of Commerce to partially fund the Heating Appliance Replacement and Repair Program. This program replaces and repairs heating appliances. This funding will only be used to replace or repair unsafe appliances that are health risks to the families.

RECOMMENDATIONS

1.	Allocation for Low Income Energy Assistance payments.	\$ 6,350,240
2.	Allocation for the Crisis Intervention Program.	\$ 6,461,000
3.	Allocation to be transferred to the Department of Commerce for the Heating Appliance Replacement and Repair Program.	\$ 1,402,960
4.	Allocation to the Department of Commerce for the Weatherization Program.	\$ 2,769,000

5.	Allocation for application taking by the Commission on Indian Affairs.	\$ 33,228
	Sub-total	\$17,016,428
6.	Allocation for county administrative cost of the Low Income Energy Assistance Payments Program and the Crisis Intervention Program.	\$ 144,358
7.	Allocation for state administrative cost of the Low Income Energy Assistance Payments Program and the Crisis Intervention Program.	\$ 1,299,214
	Subtotal Administration	\$ 1,443,572
	TOTAL	<u>\$18,460,000</u>

SOURCE OF FUNDS
LIEAP Block Grant FY 1999.

DIVISION OF SERVICES
Analysis of Low Income Energy Assistance Program Block Grant (LIEAP)
SFY 1998-1999

Item Number	Title	Actual SFY 96-97	Appropriated SFY 97-98 (SB 352)	Recommended Amount SFY 98-99	Appropriated/Recommended Difference	Explanation of Difference
1	Allocation for Low Income Energy Assistance Payments	4,775,931	6,284,055	6,350,240	66,185	Pro rata increase to maintain funding at 34.4 % of grant.
2	Allocation for the Crisis Intervention Program	6,226,185	6,393,661	6,461,000	67,339	Pro rata increase to maintain funding at 35 % of grant.
3	Allocation to the Department of Commerce for the Weatherization and Home Heating Appliance Replacement and Repair Program	4,670,461	4,128,479	4,171,960	43,481	Pro rata increase to maintain funding at 22.6% of grant.
4	Allocation for application taking by the Commission on Indian Affairs	0	33,022	33,228	206	Pro rata increase to maintain funding at .18 % of grant.
5	Allocation for county and state administrative cost of the Low Income Energy Assistance Payments and the Crisis Intervention Program	1,424,171	1,428,386	1,443,572	15,186	Pro rata increase to maintain funding at 7.8% of grant.
	TOTAL	17,096,748	18,267,603	18,460,000	192,397	

June 1, 1998
Lawrence Wilson
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**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 1998-1999**

GENERAL DESCRIPTION

For State Fiscal Year 1998-99, funds available through the Community Services Block Grant Program (CSBG) for appropriation are projected to be \$12,859,274. CSBG funds are projected to be available October 1, 1998.

Since 1981, the Community Services Block Grant Program has made federal funds available to states to provide a range of services designed to assist low-income persons attain the skills, knowledge, and motivation necessary to achieve self-sufficiency.

The primary providers of services under this grant, as required by federal law, are the thirty-six Community Action Agencies (CAAs) in the state. Other grantees are seven Limited Purpose Agencies (LPAs) who were recipients of similar funds prior to the inception of the Community Services Block Grant Program. CAAs operate programs under the Community Services Block Grant in coordination with other federal, state, and local programs such as Head Start, Job Training Partnership Act (JTPA), Weatherization, and Section 8 Rental Assistance.

In August 1995, the federal Community Services Block Grant Monitoring and Assessment Task Force produced a National Strategic Plan which endorsed a results-oriented management approach for the Community Services Network. The plan includes a set of six broadly stated umbrella national goals, with suggested measures to assess progress towards the goals. States and local agencies are required to address these goals and measures in their program planning and reporting.

The six national goals of the Community Services Network are:

- Goal 1. Low-income people become more self-sufficient.
- Goal 2. The conditions in which low-income people live are improved.
- Goal 3. Low-income people own a stake in their community.
- Goal 4. Partnerships among supporters and providers of services to low-income people are achieved.
- Goal 5. Agencies increase their capacity to achieve results.
- Goal 6. Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other support systems.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 1998-1999**

Community Services Block Grant funds are used to provide a wide variety of services in local communities to serve identified needs of poor families. Programs allowed under the Community Services Block Grant Act are those which provide activities designed to assist low-income participants including the elderly poor:

- to secure and retain meaningful employment;
- to attain an adequate education;
- to make better use of available income;
- to obtain and maintain adequate housing and a suitable living environment;
- to obtain emergency assistance through loans or grants to meet immediate and urgent individual and family needs, including the need for health services, nutritious food, housing, and employment-related assistance;
- to remove obstacles and solve problems which block the achievement of self sufficiency;
- to achieve greater participation in the affairs of the community; and
- to make more effective use of other programs related to promoting the well being of the low-income population.

The specific services operated in each local community are determined by the local agency as a result of an assessment of the needs of low-income individuals and families in their service area which is used to develop a multi-year plan for services.

As required by the Community Services Block Grant Act, ninety per cent of the funds received are distributed to the thirty-six Community Action Agencies (CAAs) located throughout the state. Five percent, which is the maximum allowed by federal law, is used by the Department to administer the Program. The remainder is used to fund seven non-profit organizations known as Limited Purpose Agencies (LPAs).

Over twenty-four thousand low-income individuals are served annually by the North Carolina Community Services Block Grant Program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF ECONOMIC OPPORTUNITY COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 1998-1999

RECOMMENDATIONS

ALLOCATION

1. Allocate \$642,964 to the Department of Human Resources to administer the grant. Staff renders technical assistance and monitors the Community Action Agencies and Limited Purpose Agencies for compliance with federal laws and regulations.	\$642,964
2. Allocate \$11,573,346 to the 36 Community Action Agencies (CAAs) which serve 86 counties for the purpose of providing administrative costs and to assist low-income families with housing, emergency assistance, education, energy, nutrition, income management, information and referral, and outreach. Federal rules require that 90% of the grant be allocated to CAAs.	\$11,573,346
3. Allocate the remaining 5% of the grant in the amount of \$642,964 to Limited Purpose Agencies which are agencies that address a specific need or population. The allocation and agency is as follows: - Telamon which provides assistance to seasonal and migrant farm workers (\$80,370) - Low Income Housing Development Corporation (LIHDC) which assists non-profit agencies in packaging loans for housing construction and rehabilitation (\$98,373) - N.C. Rural Fund for Development (NCRFD) which provides technical assistance to credit unions and cooperatives which serve low-income individuals and families (\$234,039)	\$642,964

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 1998-1999**

- N.C. Senior Citizens Federation
which sponsors statewide activities
for low-income senior citizens
(\$117,019)
- Western Economic Development Organization
(WEDO) which assists organizations serving
low-income and handicapped individuals secure
manufacturing contracts (\$61,725)
- United Senior Services which provides
activity programs for senior citizens in
Craven County (\$24,433)
- N.C. Commission of Indian Affairs which
provides programs for low-income Native
Americans in the state in coordination
with local tribal organizations (\$27,005)

TOTAL FUNDING SFY 1998-99	\$12,859,274

SOURCE OF FUNDS:

BLOCK GRANT FUND FFY 1998	\$3,214,818

BLOCK GRANT FUND FFY 1999	\$9,644,456

OFFICE OF ECONOMIC OPPORTUNITY
Analysis of Community Services Block Grant
SFY 1998-1999

Item Number	Title	Actual SFY 96-97	Appropriated SFY 97-98 (SB 352)	Recommended Amount SFY 98-99	Appropriated/ Recommended Difference	Explanation of Difference
1	Admin	\$392,309	\$641,446	\$642,964	\$1,518	Administration is limited to 5% of the grant award and varies based on the award amount.
2	CAAs	\$9,210,287	\$11,546,034	\$11,573,346	\$27,312	Funds awarded to CAAs must be 90% of the total allocation and is based on award amount.
3	LPAs	\$510,718	\$641,446	\$642,964	\$1,518	Funds awarded to LPAs is 5% of the grant award and varies based on the award amount.
TOTAL		\$10,113,314	\$12,828,926	\$12,859,274	\$30,348	Difference represents the expected increase in federal grant award for this period.

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

Legislative Office Building - Room 643

Tuesday, June 2, 1998

8:30 a.m.

Opening Remarks

Senator Bill Martin, Co-Chair
Representative Charlotte Gardner, Co-Chair
Representative Lanier Cansler, Co-Chair
Representative Debbie Clary, Co-Chair

Overview of DHHS State Plans

Child Care Development Fund and Block Grant

Stephanie Fanjul, Division of Child Development

Maternal and Child Health Block Grant

Ann Wolfe/Kevin Ryan, Division of Women's &
Children's Health,

Preventive Health Block Grant

Leah Devlin, Division of Community Health

Social Services Block Grant

Kevin Fitzgerald, Division of Social Services

TANF Block Grant

Kevin Fitzgerald, Division of Social Services

Mental Health Block Grant

Bonnie Morrell, Division of Mental Health

Substance Abuse Block Grant

Starlene Scott-Robbins, Division of Mental Health

Committee Discussion

Next Meeting

Adjourn

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 2, 1998

8:30 a.m.

The Joint Appropriations Subcommittee on Human Resources met on Tuesday, June 2, 1998 at 8:30 a.m. in Room 643. Representative Gardner presided. The following House members were present:

Representative Bill Hurley	Representative Edd Nye
Representative Alma Adams	Representative Charlotte Gardner
Representative Debbie Clary	Representative Henry Aldridge
Representative Martha Alexander	Representative Cindy Watson
Representative Lanier Cansler	

There were 6 Senators present. The following staff members were in attendance: Susan Sabre, Ramona Burton, Karen Hammonds-Blanks, and Carol Shaw.

Child Care Development Fund and Block Grant

Ms. Stephanie Fanjul, Chief of the Division of Child Development, presented the Child Care Development Fund and Block Grant (see attachment #1). There was extensive discussion about the 3 model early childhood centers located on 3 community college campuses in Eastern, Piedmont and Western North Carolina. The community colleges are Pitt, Davidson and Tri-County in Murphy. Dr. Teresa Banks of the Department of Community Colleges answered the members' questions. Representative Gardner wanted to know the numbers of children involved, and Dr. Banks will get that figure for her.

Senator Martin and Representative Adams requested more information about why these centers are models and what qualifies them as unique. Representative Gardner said the members are trying to understand why these are "model" programs. Dr. Banks said she could furnish the members a list of the applicants and information on how each center was chosen. Dr. Adams said she would like to see the proposals, and Representative Gardner said she would be interested in that information for the committee.

Senator Dannelly wanted to know the mix of Work First recipients in day care. He said a model ought to reflect what it is modeling for, and Ms. Fanjul said she would get that information for him.

Senator Forrester said he would like to know the total amount spent on child care throughout the budget. Representative Gardner said she thought the rest of the committee would have an interest in the answer to that question. Senator Forrester asked about administrative costs, and Ms. Fanjul said she would get more detail for the committee.

Minutes, 6-2-98, a.m.

Mental Health Block Grant

Bonnie Morrell of the Division of Mental Health presented the Mental Health Block Grant (see attachment #2) Senators Clark and Forrester had questions about administrative costs and the proportion of state and local money funding the program.

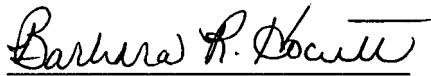
Maternal and Child Health Block Grant

Dr. Ann Wolfe and Kevin Ryan of the Division of Women's and Children's Health presented the Maternal and Child Health Block Grant. Representative Nye questioned the amount of money spent on flyers, billboards, ads, pamphlets and wants an evaluation of their level of success. Ms. Leah Devlin of the Community Health Division will get that information.

Representative Gardner wanted to know the total amount of money spent on children with special needs. Karen Hammonds-Blanks thinks about \$20 million goes to these children. Dr. Wolfe said she doesn't know the amount of state funding for the 18 special needs centers. Representative Gardner asked the staff to get the total amount. The committee needs to know what we are buying for these different pots of money.

Senator Clark asked Dr. Wolfe for the local Evaluation Centers' annual budgets, and she will make them available. Representative Adams was told there was a formula determining how much money is distributed to local health departments for the Healthy Mothers-Healthy Children Block Grant, and they decide how the money is spent. The formula has been accepted by the Public Health Director's Association, according to Dr. Wolfe. Representative Adams asked how many children and mothers are actually being reached, and Dr. Wolfe said she would get the number of women and children being served by state and federal funding in Guilford County for her.

Representative Gardner said the committee will meet again in the afternoon after the last session adjourns. The meeting was adjourned.


Barbara R. Hocutt, Clerk


Representative Charlotte Gardner, Co-Chair

CAG:brh
attachments

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

JUNE 2, 1998 ^{am}

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Roslyn Jandt	McChild Care Coalition
Bill Coy	DHHS
Kevin Fitzgerald	NC DSS
Patrice Reuter	NCACE
John Kuntz	NCFPC
Terry Hockley	NC Association of Food Banks
Pheon Beal	DHHS/DSS
Dickie Stuart	PPAB
Amey Jo Bain	Smith Anderson
W. H. Kelly	NCHLA
by Farmer	NC DHHS - DCD
Byron K. Harris	OSBM
Martha Plummer	YATO - DCD
Lee Kitzinger	OHHS
DAVE Beckton	OHHS

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

JUNE 2, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Joni Jones	DHHS - TB Control Branch
Harleen Sattokhuis	DMH/DD/SAS
Susan A. Crocker	DMH/DD/SAS
Suzanne Brown	DMH/DD/SAS
Megan Syster	Easter Seals/Coalition 2001
Debbie Moyer	Easter Seals - Raleigh
Jane Smith	NC DSS
Bonnie Moull	NC DMH/DD/SAS
Paula L. Wolf	Covenant w/NC's Children
Mike Thatcher	Governor's office of substance abuse
Cecelia R. Valrie	Governor's Substance abuse compilation office
Sharon Hurd	Social Services Consortium
Myrna Milen	NASW-NC
Terry Stelle	DMH/DD/SAS
ATCHELLE COTTON	DMH/DD/SAS

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

JUNE 2, 1998

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Marci White	DMH ODSAS
NELS ROSELAND	OSBM
Mary Greene	OSBM
STAN Music	DWCH / DHHS
Barry Goldstein	DHHS / DWCH
Ann S. Wafer	DHHS / DWCH
Ken Ry	DHHS / DWCH
John De Luca	DHHS
HUGH TILSONI	NCHA
Adrian Seary	NCHAC
Tommy Holt	Cardinal HealthCare System
Lauren Widen	DHHS / OEO
Jerry Kemp	DHHS / voc. Rehab Services
C. L. Cochran	UCPNC - (C-2001)
Ron Penney	DHHS / div of child devel.

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APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

JUNE 2, 1998^{AM}

Name of Committee

Date

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FIRM OR AGENCY AND ADDRESS

Jean Carole	DOA/ NCLFW
Joyce Allen	" "
Edne Henry	DHHS- Mental Health
Pam Deardorff	YAIO- DOA
Marian Nartman	DD Council
Ann Lamm	DHHS - DSS
Jim Lipchurch	DHHS - DFS
Jackie Sheppard	DHHS - DFS
Mark Ediger	DHHS - DFS
Glenn MWells	DHHS - DCH
Peter Andersen	DHHS / DCH
Lee Dulin	DHHS - DCH
Dwayne Patterson	DHHS - Budget & Analysis
Pam Kiepatnick	DHHS - Budget & Analysis
Lisa Abatemarco	DHHS BP&A

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APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

JUNE 2, 1998^{a.m.}

Name of Committee

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Patricia A. Yang	APPCNC/
Brenda Seemmes	NC Equity
Chuck Harris	DHAR ISS
Wayne Wilham	OSBM
Ben Alexander	DYS
Ken Foster	DYS
John Bowditch	Zeb Alley P.A.
Cam Cree	BPMAL
Sue Schmidt	NCJCDC
Annette Ethridge	Governor's Office
Steve Owen	Ne Med. Spr.
Don Duma	NEPA

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APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

JUNE 2, 1998

Name of Committee

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NAME _____

FIRM OR AGENCY AND ADDRESS

[illegible]

January 2 a.m.
#1 Stephanie Sanyal

**DIVISION OF CHILD DEVELOPMENT
BLOCK GRANT PLANS FOR SFY 98-99**

PURPOSE FOR SUBMITTING TWO SEPARATE PLANS

Due to the concurrent administration of two separate grants, the **Child Care and Development Block Grant (CCDBG)** and the **Child Care and Development Fund (CCDF)**, the Division of Child Development (DCD) finds it necessary to submit two separate block grant plans. DCD will have access to and must plan for expenditures of both the old CCDBG and the new CCDF. The two grants are completely separate and are subject to different federal requirements, therefore a plan is submitted for each of the two grants.

The first plan is for the CCDBG. The Division received its last CCDBG award of \$26,046,174 on September 30, 1996. DCD expects to obligate the remaining portion of this grant in SFY 98-99. A second plan for expenditures of the CCDF is also attached.

DIVISION OF CHILD DEVELOPMENT CHILD CARE AND DEVELOPMENT BLOCK GRANT PLAN FOR SFY 98-99

GENERAL DESCRIPTION

For State Fiscal Year 1998-99, funds available through the Child Care and Development Block Grant for appropriation are projected to be \$1,597,879. This amount represents the unobligated balance from the FFY 1995 and 1996 awards. No additional funding is anticipated.

Federal Welfare Reform

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 was signed into law on August 22, 1996. The law contains several provisions pertaining to child care, the most comprehensive of which eliminated entitlements to child care subsidies for working families. A second clause consolidated all federal child care programs, including the Child Care and Development Block Grant, Family Support Act, and At-Risk child care, into the Child Care and Development Fund (CCDF). Welfare reform marks the end of the CCDBG. However, the grant award received on September 30, 1996 can be expended until September 30, 1999.

The Child Care and Development Block Grant was designed to provide federal funds for activities to improve the availability, quality and affordability of child care. The grant is divided into four categories, each designated for specific purposes and funding.

Child Care Subsidies

Categories A and B comprise the 75% Reserve, so called because 75% of the total grant award must be allocated to it. Category A is designated for the provision of child care subsidies, and requires at least 90% of the Reserve amount. All administrative expenses of providing these services, as well as general grant administrative costs, must be paid from Category B, which receives the remainder of the 75% Reserve funds. Additionally, activities to improve the quality and availability of care may be funded in Category B.

Quality and Availability Initiatives

Similarly, the 25% Reserve of the grant is divided into two funding segments. Category C is intended to increase the availability of certain types of child care, Category D proposes to improve the quality of care. Category C must receive from 18.75% to 20.0% of the total grant and is restricted to activities to establish or expand early childhood development programs and before- and after-school services. Category D, which is eligible to receive between 5% and 6.25% of the total grant, is designated for use in any of five specific quality improvement activities. These activities include operating resource and referral programs, providing training and technical assistance to providers, making loans available to providers, monitoring improvement, and increasing salaries and other compensation for child care teachers.

DIVISION OF CHILD DEVELOPMENT CHILD CARE AND DEVELOPMENT BLOCK GRANT PLAN FOR SFY 98-99

FINAL CCDBG RECOMMENDATIONS

ALLOCATION

1. Reserve \$.85 million for activities to build child care capacity. These funds will also provide for the continuation of existing projects to increase the availability of care for special needs children and school-age children.	\$ 845,598
2. Designate \$.75 million for quality improvement activities. Initiatives will include resource and referral services, provider training and enhanced compensation, and monitoring improvement.	\$752,281

TOTAL REQUIREMENTS

\$1,597,879

SOURCE OF FUNDS

FFY 1995 CCDBG	\$ 143,478
FFY 1996 CCDBG	\$1,454,401

DIVISION OF CHILD DEVELOPMENT
Analysis of the Child Care and Development Block Grant
SFY 1998-1999

Item Number	Title	Actual Expenditures SFY 96-97	Appropriated SFY 97-98 (SB 352)	Recommended Amount SFY 98-99	Appropriated/Recommended Difference	Explanation of Difference
01.	Before and After School Child Care and Early Childhood Development Programs	\$ 4,678,276	\$ 1,750,000	\$ 845,598	\$ (904,402)	Recommended amt. represents total available balance
02.	Quality Improvement Activities	\$ 777,098	\$ 740,000	\$ 752,281	\$ 12,281	Recommended amt. represents total available balance
03.	Child Care Services	\$ 5,383,281	\$ 17,581,167	\$ -	\$ (17,581,167)	We expect to spend all remaining CCDBG funds eligible for subsidy before the end of SFY 1998
04.	Administrative Expenses & Quality and Availability Initiatives	\$ 1,341,076	\$ 488,366	\$ -	\$ (488,366)	No CCDBG funds will be used for administrative costs in the current fiscal year or subsequently
	Total	\$ 12,179,731	\$ 20,559,533	\$ 1,597,879	\$ (18,961,654)	

DIVISION OF CHILD DEVELOPMENT CHILD CARE AND DEVELOPMENT FUND PLAN FOR SFY 98-99

GENERAL DESCRIPTION

For State Fiscal Year 1998-99, funds available through the Child Care and Development Fund for appropriation are projected to be \$170,983,954. Funding for FFY 1999 is estimated to be \$171,470,159. CCDF funds are anticipated to be available on October 1, 1998. In addition, DHHS is proposing to transfer \$55,075,185 in federal Temporary Assistance for Needy Families (TANF) funds to the Child Care and Development Fund.

Child Care Subsidies

The purpose of the Child Care and Development Fund is to improve the availability, quality and affordability of child care. The CCDF is comprised of three funding streams: Mandatory, Matching and Discretionary. The legislation requires that a preponderance of the Mandatory and Matching Funds be used to provide child care assistance for families who are receiving public assistance, families who are attempting through work activities to transition off of such assistance, and families who are at-risk of becoming dependent on such assistance. The law further instructs that a substantial portion of the Discretionary funds be used to provide assistance to low-income working families.

Welfare reform, known as Work First in North Carolina, will require more people to go to work, resulting in an increased demand for child care subsidies. The Division of Child Development is now charged with administering all subsidized child care programs, including those previously administered by the Division of Social Services (DSS) to provide subsidized child care to Work First participants.

During the past year we witnessed a significant growth in the number of Non-Work First families receiving subsidized child care, while simultaneously experiencing a drop in the number of Work First families. This trend translates into lower welfare caseloads and increased child care demand. Expanding child care subsidies for low-income working families could effectively decrease the likelihood that they will need public assistance. In light of this relationship, DHHS is proposing to transfer \$55 million of TANF funds to the Child Care and Development Fund. Transferred funds will supplement the Discretionary funding stream, reserved for low-income working families. Coordination with DSS will continue as Work First is further implemented.

In addition to these subsidy restrictions, the PRWORA limits administrative costs (as defined by the Federal Administration for Children and Families) to 5% of the total CCDF allocation, and retains minimum health and safety standards for all providers caring for subsidized children.

Quality and Availability Initiatives

Under the new welfare law, states are required to reserve at least 4% of their total CCDF allocation for quality and availability initiatives. While sufficient capacity to serve children who require out-of-home care is essential to welfare reform, the need for quality care is just as critical. Recent studies have demonstrated the importance of brain development in the first three years of

DIVISION OF CHILD DEVELOPMENT
CHILD CARE AND DEVELOPMENT FUND PLAN FOR SFY 98-99

life. A safe and nurturing environment which provides the opportunity to learn is critical to fostering healthy brain development and establishing the foundation for success later in life.

Since 1991, North Carolina has supported quality initiatives such as child care resource and referral, Head Start wrap-around care, and a revolving loan fund for providers with federal funds. Additional activities were funded in subsequent years, including the inclusion of children with special needs, school-age child care, and teacher education, training, and compensation.

Although DCD anticipates continued funding for certain projects including resource and referral, special needs inclusion and monitoring improvement, it also welcomes proposals for new and innovative initiatives to meet the state's changing needs. One area guaranteed to receive more attention is consumer education. CCDF initiatives will supplement projects already underway, such as our Resources in Child Care on-line database of child care facilities, a statewide child care health and safety resource center and hotline, and an on-line catalog of DCD programs and services. The Division has also created a home page on the Internet to enable parents and other interested persons to access information about available child care subsidies, as well as learning about child care regulation in North Carolina.

DIVISION OF CHILD DEVELOPMENT CHILD CARE AND DEVELOPMENT FUND PLAN FOR SFY 98-99

CCDF RECOMMENDATIONS
ALLOCATION

1. Allocate \$108.6 million to local agency services support and the provision of child care subsidies for low income working and other needy families.	\$108,625,251
2. Federal law requires states to reserve at least 4% of their CCDF allotment for activities to improve the quality and increase the availability of child care. These funds will provide for the continuation of existing projects, as well as support new initiatives to enhance the quality of child care in North Carolina. Anticipated projects include increasing the availability of care for children with special needs and school-age children, expanding resource and referral services and consumer education, promoting provider education and training, and improving the monitoring of child care facilities.	\$4,774,736
3. Limit administrative costs of lead agency and local agencies which administer the child care subsidy program to 5% of the total CCDF allocation.	\$5,968,420
4. Transfer \$55.1 million from TANF to CCDF. The majority of the TANF funds will be used for child care subsidy and support. The transferred funds are subject to the same requirements that apply to CCDF (minimum 4% for quality improvement; 5% cap on administration).	\$55,075,185
5. Transfer \$.5 million from the TANF Block Grant for the development of child care centers at community colleges.	\$500,000
Designate \$51.6 million in state funds to maximize available federal funds for child care services and activities.	\$51,615,547
TOTAL REQUIREMENTS	\$226,559,139

SOURCE OF FUNDS

FFY 98 CCDF	\$29,612,041
FFY 99 CCDF	\$89,756,366
TANF Transfer	\$55,575,185
State Maintenance of Effort (MOE)	\$37,927,282
State Matching	\$13,688,265

DIVISION OF CHILD DEVELOPMENT
Analysis of the Child Care and Development Fund
SFY 1998-1999

Item Number	Title	Actual Expenditures SFY 96-97	Appropriated SFY 97-98 (SB 352)	Recommended Amount SFY 98-99	Appropriated/Recommended Difference	Explanation of Difference
01.	Child Care Services	\$ 53,260,260	\$ 99,845,334	\$ 108,625,251	\$ 8,779,917	Recommended amt. includes 25 % of 1998 grant plus 75 % of anticipated 1999 grant which can be used for this purpose
02.	Quality and Availability Initiatives	\$ 342,853	\$ 4,388,806	\$ 4,774,736	\$ 385,930	Recommended amt. is 4 % of CCDF funds
03.	Administrative Expenses	\$ 1,017,366	\$ 5,486,007	\$ 5,968,420	\$ 482,413	Recommended amt. is 5 % of CCDF funds
04.	Transfer from TANF Block Grant for Child Care Services and Support	\$ -	\$ 5,599,759	\$ 55,075,185	\$ 49,475,426	Work First Business Plan recommends increase in funds for Child Care.
05.	Transfer from TANF Block Grant for the Development of Child Care Centers at Community Colleges	\$ -	\$ 500,000	\$ 500,000	\$ -	
	Totals	\$ 54,620,479	\$ 115,819,906	\$ 174,943,592	\$ 59,123,686	
	State Requirements			\$ 51,615,547		
	Total Requirements			\$ 226,559,139		

June 2, 1998
2
Bonnie Marshall

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities
and Substance Abuse Services
Mental Health Block Grant
(MHBG) SFY 1999

FUNDING LEVEL

Federal funding available to North Carolina is \$6,238,341 for FFY 98 and an estimated amount of \$6,238,341 for FFY 99. The proposed MHBG plan utilizes the remaining FFY 98 amount of \$2,549,000 plus \$3,689,341 from the anticipated FFY 99 award.

GENERAL DESCRIPTION

The MHBG provides federal financial assistance to states for the provision of community-based services for people with mental illness. Services provided through the use of the block grant must be those described in the State's Plan in accordance with Federal P.L. 102-321. These services include outpatient, day treatment, psychosocial rehabilitation, emergency services, residential services, etc. for adults and children.

SIGNIFICANT FEDERAL REQUIREMENTS

The primary Federal requirements related to the MHBG are that funds must be used for services specified within the States' Plan in accordance with P.L. 102-321 and that at least 10% of service dollars must go toward child mental health services. As the attached schedule shows, the Division allocates 29% of its MHBG funds to child services.

	PROPOSED MHBG EXPENDITURE PLAN for SFY 99	ALLOCATION
I	Adult Mental Health Plan	
	Allocate funds to local programs to provide community-based services for adults with severe and persistent mental illness in accordance with the NC Community Mental Health Services Plan and Block Grant Application. Community-based programs provide an array of services, including crisis stabilization designed to divert individuals from institutional admission; liaison and case management services which facilitate the discharge of individuals from the state's psychiatric hospitals; special programs for the hearing impaired; and training activities.	\$3,794,179
II	Child Mental Health Plan	
	Continuation of Child Mental Health services in accordance with the North Carolina Community Mental Health Services Plan and Block Grant Application such as programs for adolescent sex offenders, respite services, family preservation programs, group homes, specialized foster care, therapeutic homes, professional parenting programs, and training	\$1,819,931
III	Administration	
	Applicable to the 5% Administrative Cap (Monitoring, Data Collection, Budgeting, Payments and Accounting)	\$305,552
	Not Applicable to the 5% Administrative Cap (Contracts for non-administrative Activities and Technical Assistance to Service Providers)	\$318,679
	TOTAL REQUIREMENTS	\$6,238,341
	Source of Funds	
	MHBG FFY 98	\$2,549,000
	MHBG FFY 99	\$3,689,341
	TOTAL FUNDS	\$6,238,341

ITEM NUMBER	TITLE	CERTIFIED BUDGET SFY 97-98	RECOMMENDED AMOUNT SFY 98-99	DIFFERENCE	EXPLANATION OF DIFFERENCE
1	Adult Mental Health	\$3,794,179	\$3,794,179	0	
2	Child Mental Health	1,819,931	1,819,931	0	
3	Administration	624,231	624,231	0	
	TOTAL	\$6,238,341	\$6,238,341	0	

June 2, 1998
#3 Dr. Wolfe

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WOMEN'S AND CHILDREN'S HEALTH
MATERNAL AND CHILD HEALTH BLOCK GRANT**

MCH Block Grant Funding for State Fiscal Year 1998-99 is projected at \$16,529,945. This represents \$14,311 more than the amount available in Fiscal Year 1997-98.

GENERAL DESCRIPTION

The purpose of the Maternal and Child Health Block Grant is to assist states in assuring that mothers and children, particularly those with low income or limited availability to health services have access to quality maternal and child health services. These services are aimed at (1) reducing maternal and infant mortality; (2) reducing the incidence of preventable disease and disabling conditions among children; (3) promoting the health of mothers and children; and (4) maximizing the health status of children with disabilities. The MCH Block Grant consolidated five programs for which the state received categorical funding. The five programs were (1) Maternal and Child Health, (2) Children's Special Health Services, (3) Supplemental Security Income for Disabled Children, (4) Sudden Infant Death Syndrome, and (5) Lead Based Paint Poisoning Prevention.

RECOMMENDATIONS

ALLOCATIONS

1. Allocate \$9,838,074 in Healthy Mothers/Healthy Children Block Grants to local health departments. The proposed allocation is equal to the amount allocated in FY 1997-98. Under this funding concept, local health departments have responsibility for deciding how to use maternal and child health funds to best meet local needs. County and district health departments may use Healthy Mothers/Health Children Block Grants to provide prenatal care, preventive and primary care services for children and preventive health services for women of childbearing age. None of the proposed Healthy Mothers/Healthy Children Block Grant allocation is used for state administrative costs.	\$9,838,074
2. Allocate \$1,722,869 for technical assistance to local health departments, high-risk maternity clinics, perinatal education and training, public information and education, and childhood injury prevention. The proposed allocation is equal to the amount allocated in FY 1997-98. From the funds available, the Department proposes to use approximately \$115,000 for state administrative costs. This amount includes the salary and fringe benefits, of accounting, personnel and computer support staff within the Division of Women's and Children's Health, and associated indirect cost charges.	\$1,722,869

3. Allocate \$4,969,002 for services to children with chronic illnesses, genetic disorders, or developmental disabilities. This also includes the identification, follow-up and testing of infants and young children at risk for developmental delays. The proposed allocation is \$14,311 more than the amount allocated in FY 1997-98. From the funds allocated, the Department proposes to use approximately \$135,000 for state administrative costs. This amount represents indirect cost charges. \$4,969,002

TOTAL FUNDS AVAILABLE - SFY 1998-99 **\$ 16,529,945**

SOURCE OF FUNDS

MCH BLOCK GRANT FEDERAL FY 1998 **\$ 4,132,486**

MCH BLOCK GRANT FEDERAL FY 1999 **\$ 12,397,459**

DIVISION OF Women's and Children's Health
 Analysis of Maternal and Child Health (Title of Block Grant)
 SFY 1998-1999

Item Number	Title	Actual SFY 96-97	Appropriated SFY 97-98 (SB 352)	Recommended Amount SFY 98-99	Appropriated/Recommended Difference	Explanation of Difference
#1	Healthy Mothers/Healthy Children Block Grants to Local Health Departments	\$9,838,074	\$9,838,074	\$9,838,074	0	
#2	High Risk Clinics, Perinatal Education and Training, Public Information and Education, Injury Prevention, and Technical Assistance to Local Health Departments	\$1,810,112	\$1,722,869	\$1,722,869	0	
#3	Services for Chronically Ill and Developmentally Delayed Children	\$5,065,331	\$4,954,691	\$4,969,002	+\$14,311	Title V of the Social Security Act requires states to expend 30% of their MCH Block Grant allocation on services for children with special health care needs. This increase will ensure North Carolina meets the statutory requirements.

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

Legislative Office Building - Room 643

Tuesday, June 2, 1998

8:30 a.m.

Opening Remarks

Senator Bill Martin, Co-Chair
Representative Charlotte Gardner, Co-Chair
Representative Lanier Cansler, Co-Chair
Representative Debbie Clary, Co-Chair

Overview of DHHS State Plans

Child Care Development Fund
and Block Grant

Stephanie Fanjul, Division of Child Development

Maternal and Child Health Block
Grant

Ann Wolfe/Kevin Ryan, Division of Women's &
Children's Health,

(1) Preventive Health Block Grant

Leah Devlin, Division of Community Health

(2) Social Services Block Grant

Kevin Fitzgerald, Division of Social Services

(3) TANF Block Grant

Kevin Fitzgerald, Division of Social Services

Mental Health Block Grant

Bonnie Morrell, Division of Mental Health

(4) Substance Abuse Block Grant

Starlene Scott-Robbins, Division of Mental Health

Committee Discussion

Next Meeting

Adjourn

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOUCES

June 2, 1998
Afternoon Meeting

The Joint Appropriations Subcommittee on Human Resources met on Tuesday afternoon on June 2, 1998 in Room 643 LOB. Representative Charlotte Gardner presided and the following House members were in attendance:

Representative Julia Howard
Representative Edd Nye
Representative Henry Aldridge
Representative Debbie Clary

Representative Bill Hurley
Representative Cindy Watson
Representative Lanier Cansler
Representative Charlotte Gardner

There were six Senators present. Ramona Burton and Karen Hammonds-Blanks of Fiscal Staff were present as were Susan Sabre and Gann Watson of Legal Staff.

Preventive Health Block Grant

Leah Devlin of the Division of Community Health presented the Preventive Health Block Grant proposed budget (see attachment #1). Representative Gardner asked if there was any recommendations to consolidate these services by the domestic violence study commission but was told by staff there was no recommendation to consolidate but rather to streamline and coordinate. She wanted try to look into what we get for the money.

Representative Nye questioned the use of the money in item #2 Ms. Devlin gave Representative Nye the information about the injury prevention program and the use of that funding for brochures he had requested during the morning meeting. The amount of funding is \$297,000, and it is not used for pamphlets or brochures.

Representative Gardner questioned the training of water managers and wanted a specific breakout for cost of training of water managers which Ms. Devlin said she would get for Representative Gardner.

Representative Howard questioned items # 5 and #8. Representative Gardner asked the staff to put together the information about the 3 pots of money for AIDS.

Social Services Block Grant

Kevin Fitzgerald, Director of Social Services, presented the budget for the Social Services Block Grant (see attachment #2). Representative Gardner asked about the possibility of cuts in the Social Services Block Grant to pay for the Federal Intermodal Transportation Act. Senator Martin agreed that Social Services will experience the \$7.6 million cut, and the information being presented is not very helpful. The committee needs to know what the budget might look like without this amount. He also asked for an evaluation of the impact of other cuts that are being proposed. Mr. Fitzgerald said the counties may

experience a greater impact than the state. Representative Gardner was assured there are no cuts in this budget because money from TANF has been transferred to the various programs. She asked if this type of transfer would continue when the \$7.6 million is cut by the Feds. She said there was no use to continue the presentation because the committee is dealing with a \$7.6 million deficit, and therefore the Senate, now working on the budget, would be interested in hearing a reevaluation in light of the very good possibility of a cut in the Social Services Block Grant funding.

Representative Nye questioned the transfer of the TANF and enhancement of the Employee Assistance Program costing \$1 million. Mr. Fitzgerald called on Starleen Scott-Robbins from the Division on Mental Health to respond. She said the \$1 million dollars is the same money they received last year but it has just been taken out of TANF and put into the Social Services Block Grant. On follow-up Starleen Scott Robbins told Representative Nye, she was the lead on the Work First substance abuse initiative for the section and that 30 Area Mental Health Authorities have EAP programs which are separate from the enhanced program. Roy Sonovick is the Branch Head of EAP.

TANF Block Grant

Kevin Fitzgerald, Director of Social Services, presented the TANF Block Grant proposed Budget (see attachment #3) which represents the distribution of only the federal TANF money and is about 63% of the total Work First Funding. The rest, 37%, is split between the local and the county. He summarized the recommendations for the distribution of TANF dollars.

Representative Howard questioned item #7 in the proposed budget for the TANF Block Grant. Her information showed a discrepancy in the number of Work First recipients. Ms. Howard's figures show there are 68,000 and Mr Fitzgerald's figures assert there are 84,000 Work First recipients. Starleen Scott-Robbins said, in answer to this question, the division's number reflected the distribution from the last fiscal year. Since caseloads are down, Representative Howard asked her to explain why last year's figures are being used and why the division is asking for an additional allocation. Ms. Scott Robbins said, of the 68,000 estimated caseload now, 25 % are child-only cases which leaves 51,000 adult head-of-household cases. Their estimates are that 35% of this population or 17,850 adult-head-of-households would have some substance abuse impairment preventing them from with getting a job or keeping it. Representative Howard said their information needs to be re-addressed so the committee will know what you are talking about and where these 17,000 adults are to determine where these counselors need to be allocated. Right now the money is split into 4 pots, and they need the right numbers to make a good budgetary decision, according to Ms. Howard. Representative Howard asked for this year's figures of the families in the catchment areas less the child-only cases. Ms Scott-

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Robbins said they were working on a distribution list for this year's numbers and would be glad to make that available. Representative Gardner also asked for the revised figures.

Senator Nye asked what the \$750,000 in proposal item #14 buys, and Mr. Fitzgerald will furnish a detailed list of items being purchased.

Dr. Forrester questioned the possibility of overlap in items #11 and 15 in services relating to out-of-wedlock births but was assured by Dr. Kevin Ryan of the Women's Health Section they were different type of services. The funding will expand the program which has had success in reducing out-of-wedlock pregnancies. Representative Gardner asked about federal funds for states that did a better job in this area and how North Carolina might faring in that relation. Dr. Ryan said that preliminary figures show North Carolina is among the top 4 or 5 states in the running for about \$20-25 million federal allocation. Representative Adams asked about the process for applying for this money.

Substance Abuse Block Grant

Ms. Starlene Scott-Robbins presented the Federal Substance Abuse Prevention and Treatment Block Grant (see attachment #4). Senator Forrester said that in item #4, IV Drug Abusers, there wasn't information specific to which services the \$4.8 million were allocated whether to treatment or to prevention. Ms. Scott-Robbins said she didn't know the specific services offered but would get that information for him.

Representative Gardner asked about item #6, TANF Demonstrations Funds, and said she needed more information about their use. She asked if the bonus money of \$893,811 would continue to be used for demonstration projects and where the demonstration projects are. Ms. Scott-Robbins will get the information about where the other projects are and if they are operating.

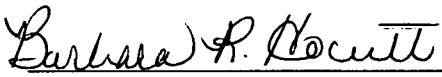
Susan Crocker of Substance Abuse Services answered Representative Gardner's question about item #2. She wanted to know how much federal money was released and where the money to continue the program was found before the federal money arrived. Ms. Crocker said that the federal money arrived in a timely fashion and there was no need to find additional funds. Ms. Crocker explained to Representative Gardner how the percentages of children buying cigarettes are determined.

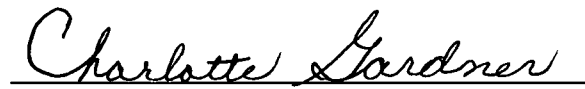
Senator Phillips asked about the success of the program with children abusing alcohol and drugs. He was told by Ms. Scott-Robbins that there was increased abuse of these drugs as well as prescription drugs. She will get information on the success rates of the

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programs that treat these children. She did not know the number of children being treated but will get that information also. Regarding prescription drug abuse, she did not know the number of men involved but with the women it is a big problem. Senator Martin asked for information on developmental disabilities related to prescription drug abuse. Ms. Scott-Robbins did not know specifically the answer to this query

Representative Gardner announced the committee would meet tomorrow morning to hear a presentation on the Whitaker School. Time permitting they will review the answers to questions posed by the members to the department. The meeting was adjourned.


Barbara R. Hocutt, Clerk


Charlotte A. Gardner, Co-Chairman

CAG:brh
Attachments

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Name of Committee

JUNE 2, 1998

Date

pm

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MICHELLE COTTON	DMH / DD / SHS
Shanese Ransone	DSSS
Jane Smith	DSS
Glenn Wilk	DHHS - DCH
Karen Gotti	DHHS Aging
Lee Kethrup	DMH
Kevin Fitzgerald	NC DSS
Mary Greene	OSBM
Kim Foster	DYS
Peter Andersen	DHHS / DCH
Bill Coy	DHHS
LAURA DELAPP	INTERN - REP. ALDRIDGE
Pam Kiepatnick	DHHS Budget & Analysis
NEUS ROSELAND	OSBM
Jim Upchurch	DHHS - DFS
Jackie Shypert	DHHS - DFS
Mike Eddins	DHHS - DFS

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APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Name of Committee

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NAME

FIRM OR AGENCY AND ADDRESS

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C Parker

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United Way of NC & Covenant w/NC's Children

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NC Child Care Coalition

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John De Luca
Joyce AllenDHHS/Div. Services for the Blind
DOA/CACW

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Name of Committee

JUNE 2, 1998

Date

P.M.

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME

FIRM OR AGENCY AND ADDRESS

Barlene J. J. J.

NC Commission of Indian Affairs

Terry Stelle

NC DMHDDAS

June 2, 1998pm
Leah Butler
#1

Department of Health and Human Services
Division of Community Health

Preventive Health Services Block Grant
Federal Fiscal Year 1998-99 Plan

GENERAL DESCRIPTION

The Preventive Health Services Block Grant (PHSBG) Plan assumes that federal financial assistance for Federal Fiscal Year (FFY) 1999 will be \$5,253,687. This is the same level of funding as available in Federal Fiscal Year 1998.

The Rape Crisis/Rape Prevention Program funding level of \$190,134 for FFY 1999 is set at the federal level consistent with a set aside provision in the PHSBG legislation.

The Rape Prevention and Education Program is authorized under the Violence Against Women Act (Crime Bill) which amended the PHSBG authorizing legislation in 1996. The FFY 1999 funding level for this component of the plan is estimated at \$1,144,957.

State Fiscal Year 1998-1999 continuation PHSBG funding is based on 25% of the FFY 1998 and 75% of the FFY 1999 award. As in prior years, a transfer from the Social Services Block Grants will be used to support the plan. The plan assumes the transfer amount from the SSBG will be \$280,067. Of the total SSBG transfer, \$213,128 will provide support for the Division of Facility Services. Emergency Medical Services program and \$ 66,939 will be used to support HIV/AIDS Education, Testing, and Counseling Services.

The Preventive Health Services Block Grant provides support for services which reduce preventable illness and early death and which improve the quality of life of North Carolina's residents through better health. Areas in which Preventive Health Services Block Grant funding are to be used are described in the following section.

RECOMMENDATIONS

ALLOCATIONS

1. Allocate funds to support local health departments and agencies for health education, risk reduction programs and services to persons at risk of developing adverse health conditions or behavior patterns. Funds will also be used to develop and implement a health promotion and disease prevention training and resource development program to build a core capacity of central, regional, and local expertise in community health promotion and disease prevention services. Increased emphasis will be placed on improving financial and service data collection and reporting, resource development, and improving access to services by older adults. \$ 3,320,637
2. Allocate funds to the Dental Health Section to assist towns and schools to provide technical assistance and train local personnel in the development of fluoridated water systems, and to support basic preventive dental activities. \$ 213,308
3. Allocate funds to the N.C. Council on Women to support local governmental and private non-profit agencies to provide assistance and support to victims of rape and to provide education in rape prevention. \$ 190,134
4. Per the requirements of P.L. 102-531 allocate funds to support rape prevention and education programs conducted by rape crisis centers or similar non-profit entities. Activities may include educational seminars, operation of hotlines, training of professionals, preparation of informational materials and efforts to increase awareness in underserved racial, ethnic, and language minority communities. Twenty-five percent of grant funds are to be devoted to education programs targeted for middle, junior high and high school students. \$ 1,144,957

5. Allocate funds to local health departments to support personnel and programs for AIDS/HIV education, counseling, and testing. The local health departments emphasize AIDS education and testing efforts to reach those at highest risk, persons in AIDS high prevalence groups, to ensure that these efforts will be maximally effective in controlling the epidemic.

\$ 66,939

6. Allocate funds to the Division of Facility Services for Emergency Medical Services. These funds are used to ~~provide grants and special services to rescue squads and local governments and to support the Regional EMS Councils and their programs.~~ Funds will also be used to support the Statewide Trauma Registry.

\$ 213,128

7. Allocate funds to support an Office of Minority Health and a Minority Health Advisory Council.

\$ 177,442

8. Administrative Costs.
The authorizing legislation for the block grant caps administrative costs at 10% of the state allocation.

\$ 207,210

TOTAL FOR STATE FISCAL YEAR 1998-99

\$5,533,754

SOURCE OF FUNDS:

FFY 98 Preventive Health Services Block Grant	\$1,313,422
FFY 99 Preventive Health Services Block Grant	\$3,940,265
Transfer from Social Services Block Grant	<u>\$ 280,067</u>

TOTAL FFY 1998-99 FUNDS

\$5,533,754

DIVISION OF Community Health
Analysis of Preventive Health Services Block Grant
SFY 1998-1999

Item Number	Title	Actual SFY 96-97	Appropriated SFY 97-98 (SB 352)	Recommended Amount SFY 98-99	Appropriated/Recommended Difference	Explanation of Difference
1	Statewide Health Promotion (includes Hypertension from 96-97 and 97-98 plans)	\$3,280,753	\$3,489,737	\$3,320,637	(\$169,100)	Reduction in funding from grantor
2	Dental Health/Fluoridation	\$210,269	\$224,170	\$213,308	(\$10,862)	Reduction in funding from grantor
3	Assistance to Victims of Rape and Sexual Abuse	\$187,110	\$187,110	\$190,134	\$3,024	Increase in funding from grantor
4	Rape Prevention and Education	\$1,335,126	\$935,552	\$1,144,957	\$209,405	Increase in funding from grantor
5	Office of Minority Health	\$174,915	\$186,478	\$177,442	(\$9,036)	Reduction in funding from grantor
6	Administrative Cost	\$199,048	\$217,762	\$207,210	(\$10,552)	Reduction in funding from grantor
7	AIDS/HIV Education, Counseling and Testing	\$66,939	\$66,939	\$66,939	\$0	
8	Emergency Medical Services	\$213,128	\$213,128	\$213,128	\$0	

June 2, 1998
Keren Fitzgerald
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**DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES**

**SOCIAL SERVICES BLOCK GRANT
(SSBG)**

For the State Fiscal Year 1998-99 the Social Services Block Grant (SSBG) funding level is projected to be \$70,851,405 as is shown on page 3. This includes three fourths (75%) of the FFY 99 block grant (\$46,951,124), one fourth (25%) of the FFY 98 block grant (\$15,650,375), and a transfer from the Temporary Assistance for Needy Families (TANF) Block Grant in the amount of \$8,249,906. We have estimated the FFY 99 Social Services Block Grant funding level at the same level as FFY 98, \$62,601,499. The President's budget includes a considerable decrease for the SSBG but, due to uncertainty regarding that proposal, we have not projected the impact of that funding reduction in this plan.

GENERAL DESCRIPTION

The Social Services Block Grant is intended to provide federal funds which support helping people achieve or maintain a greater degree of economic self-support or self-sufficiency, preventing abuse or exploitation of children and adults who are unable to protect their own interests, and preventing inappropriate institutional care or securing appropriate institutional care when other forms of care are not appropriate.

The primary providers of these services are the one hundred county departments of social services. Part of the funds within this block grant have been used to help meet the rapidly growing demand for day care services for children and in-home services for the elderly. Because North Carolina has more working mothers than any state in the union, it is vitally important that these services be available. Also, with a growing number of citizens over 65, more and more requests are being made for in-home services to help enable our senior citizens to remain in their own homes. In-home services include In-Home Aide Services, Adult Day Care, Preparation and Delivery of Meals, and Housing and Home Improvement. Thirteen services are mandated to be provided in every county. Five of these are required by State law: Foster Care Services for Adults and Children, Protective Services for Adults and Children, and Adoption Services. Other services may be provided at the discretion of state and local governments.

RECOMMENDATIONS

1.	Allocation to the 100 county departments of social services for basic/mandatory services.	\$	30,395,663
2.	Allocation for in-home services provided by county departments of social services.	\$	2,101,113

3.	Allocation to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services for residential treatment, day treatment, ADAP, and developmental day care services, related cost of administration, and Community Living Skills Program.	\$	4,764,124
4.	Allocation to the Division of Services for the Blind for case management, chore and independent living services, and related costs of administration.	\$	3,205,711
5.	Allocation to the Division of Youth Services for therapeutic residential, therapeutic camping, intensive treatment program (STEP), and One-on-One volunteer services.	\$	950,674
6.	Allocation to the Division of Facility Services for group licensing and domiciliary care staff .	\$	343,341
7.	Allocation to the Division of Aging for the Home and Community Care Block Grant for persons age 60 and older, for training and education, and for respite care services.	\$	1,915,234
8.	Allocation to the Division of Child Development for the purchase of day care by county departments of social services and state level contracts.	\$	13,853,152
9.	Allocation to the Division of Vocational Rehabilitation Services - United Cerebral Palsy.	\$	71,484
10.	Allocation to the Division of Social Services to support direct and indirect state and regional administration.	\$	1,954,237
11.	Allocation to the Division of Social Services for the Child Medical Evaluation Program.	\$	238,321
12.	Allocation to county departments of social services for Adult Day Care Services.	\$	2,255,301
13.	Allocation to county departments of social services for Child Abuse/Prevention and Permanency Planning	\$	394,841
14.	Transfer to the Preventive Health Block Grant for the Emergency Medical Services Program in the Division of Facility Services, including the Trauma Registry.	\$	213,128

15.	Transfer to the Preventive Health Block Grant for AIDS education, counseling and testing.	\$	66,939
16.	Transfer to the Department of Administration for the N.C. Commission of Indian Affairs In Home Services Program for the elderly.	\$	203,198
17.	Allocation to the Division of Vocational Rehabilitation - Easter Seals Society.	\$	116,779
18.	Allocation to the Division of Social Services for the UNC-CH CARES Program for training and consultation services.	\$	247,920
19.	Allocation to the Maternal and Child Health Block Grant for community based services designed to reduce maternal and infant mortality and morbidity and to promote the health of mothers and children.	\$	239,261
20.	Allocation to the Office of the Secretary - Office of Economic Opportunity for N.C. Senior Citizens' Federation for outreach services to low-income elderly.	\$	41,302
21.	Allocation to county departments of social services for Child Welfare improvement initiatives.	\$	2,211,687
22.	Allocation to DMH/DD/SAS for juvenile substance abuse offenders	\$	1,182,280
23.	Allocation to DMH/DD/SAS for Enhanced Employee Assistance Programs for Work First participants and other low-income employees	\$	1,000,000
24.	Transfer from individual county's Work First Block Grant for preventive activities not allowed under TANF funding - funding for homeless services and school-based pregnancy prevention activities	\$	885,715
25.	Allocation to the Division of Women & Children's Health for activities to prevent teen pregnancy.	\$	2,000,000
TOTAL		\$	70,851,405
SOURCE OF FUNDS:			
	SSBG FFY 1998	\$	15,650,375
	SSBG FFY 1999	\$	46,951,124
	Transfer from TANF	\$	8,249,906

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SERVICES BLOCK GRANT ANALYSIS
SFY 98-99

Item Number	Title	Actual SFY 96-97	Appropriated SFY 97-98 SB 352	Recommended Amount SFY 98-99	Appropriated/Recommended Difference	Explanation of Difference
1	County Departments of Social Services	32,514,770	30,395,663	30,395,663	0	
2	Allocation for In-Home Services provided by County Departments of Social Services	2,101,113	2,101,113	2,101,113	0	
3	Division of Mental Health, Developmental Disabilities and Substance Abuse Services	4,748,976	4,764,124	4,764,124	0	
4	Division of Services for the Blind	3,358,468	3,205,711	3,205,711	0	
5	Division of Youth Services	984,090	950,674	950,674	0	
6	Division of Facility Services	343,341	343,341	343,341	0	
7	Division of Aging - Home and Community Care Block Grant	1,938,167	1,915,234	1,915,234	0	
8	Division of Child Development -Day Care Services	15,694,900	13,853,152	13,853,152	0	
9	Division of Vocational Rehabilitation - United Cerebral palsy	76,403	71,484	71,484	0	
10	State Administration (Includes \$83,495 to be transferred to DFS for Adult Care Home licensing staff, and funding for DIRM and Controller's Office)	1,330,906	1,954,237	1,954,237	0	
11	Child Medical Evaluation Program	232,676	238,321	238,321	0	
12	Adult Day Care Services	599,551	2,255,301	2,255,301	0	
13	County Departments of Social Services for Child Abuse/Prevention and Permanency Planning	394,841	394,841	394,841	0	
14	Transfer to Preventive Health Block Grant for Emergency Medical Services	151,347	213,128	213,128	0	
15	Allocation to Preventive Health Block Grant for AIDS Education, Counseling and Testing.	71,546	66,939	66,939	0	
16	Transfer to Department of Administration for the N.C. Commission of Indian Affairs In Home Services Program for the elderly.	177,895	203,198	203,198	0	
17	Division of Vocational Rehabilitation - Easter Seals Society.	124,816	116,779	116,779	0	
18	UNC-CH CARES Program for training and consultation services	247,920	247,920	247,920	0	
19	Transfer to the Maternal and Child Health Block Grant for community based services designed to reduce maternal and infant mortality and morbidity and to promote the health of mothers and children.	304,782	239,261	239,261	0	
20	Office of the Secretary - Office of Economic Opportunity for N.C. Senior Citizens' Federation for outreach services to low-income elderly persons	37,638	41,302	41,302	0	
21	County DSS for Child Welfare Improvement	0	2,211,687	2,211,687	0	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SERVICES BLOCK GRANT ANALYSIS
SFY 98-99

Item Number	Title	Actual SFY 96-97	Appropriated SFY 97-98 SB 352	Recommended Amount SFY 98-99	Appropriated/Recommended Difference	Explanation of Difference
22	DMH/DD/SAS - Juvenile Offenders	0	1,182,280	1,182,280	0	
23	DMH/DD/SAS - EAP for Work First	0	0	1,000,000	1,000,000	Funding for Enhanced EAP Services. Services are targeted toward Work First clients, but other employees will be served so funding needs to come from SSBG rather than directly from TANF
24	Transfer from individual county's Work First County Block grants for prevention activities.	0	0	885,715	885,715	Counties wish to fund activities designed to prevent individuals from entering Work First. In many cases, the recipients of these services would not currently qualify for Work First, so the activity cannot be paid directly from TANF funds.
25	Women & Children's Health for services to prevent teen pregnancy	0	0	2,000,000	2,000,000	Transfer funds from TANF to expand teen pregnancy prevention services as a preventive measure for Work First.
	Grand Total Expenditures	65,434,146	66,965,690	70,851,405	3,885,715	
	FFY 98 SSBG Grant		16,878,071	15,650,375	(1,227,696)	
	FFY 99 SSBG Grant		48,605,339	46,951,124	(1,654,215)	
	Transfer from TANF		1,482,280	8,249,906	6,767,626	Increase transfer from TANF for: Enhanced EAP; restore funding reduction; Work First preventive activities in counties; teen pregnancy prevention.
	TOTAL SOCIAL SERVICES BLOCK GRANT		66,965,690	70,851,405	3,885,715	
	Difference		0	0	0	

June 2, 1998
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Kevin Fitzgerald

**DEPARTMENT OF HUMAN RESOURCES
DIVISION OF SOCIAL SERVICES**

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES BLOCK GRANT
(TANF)

The Temporary Assistance for Needy Families (TANF) Block Grant is a two year-old grant from the Federal government created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). The grant was created by combining several formerly entitlement programs into one capped grant: Aid To Families With Dependent Children (AFDC), Job Opportunities and Basic Skills (JOBS), AFDC Emergency Assistance cash and services (AFDC-EA), and AFDC state and county administration. Amounts provided to states were determined based on FFY 1995 expenditures for the programs combined into the TANF grant, with additional funds provided to states, including North Carolina, which have above-average population growth and below-average cash benefit levels per recipient.

For the State Fiscal Year 1998-99 the TANF Block Grant funding level is projected to be \$376,251,898 as is shown on page 3.

GENERAL DESCRIPTION

The Temporary Assistance for Needy Families Block Grant is intended to provide federal funds which support helping people achieve and maintain a greater degree of economic self-sufficiency, through a combination of cash assistance; case management, employment and training services; system automation and administrative expenses in support of service delivery; and other activities intended to reduce and prevent welfare dependency and promote self-sufficiency. As a result of the inclusion of the former AFDC-Emergency Assistance program, the TANF block grant also funds a significant portion of North Carolina's child welfare system.

The primary providers of the services proposed to be funded by the TANF Block Grant are the one hundred county departments of social services. Part of the funds within this block grant are proposed to be used to help meet the rapidly growing demand for day care services for children of families moving to work. Because child care is critical to assisting families to enter employment it is vitally important that these services be available. In addition, since many families suffer from substance abuse which poses a barrier to employment, we have proposed significant reinvestment into substance abuse screening, testing and treatment. We have also proposed funding efforts by local health departments to prevent out-of-wedlock births, as called for in the federal legislation.

In order to test innovative strategies for assisting families to achieve self-sufficiency, we have proposed the development of a special fund to be awarded on a grant basis to counties and other providers interested in conducting special demonstrations and projects. We have also proposed funding for an evaluation of North Carolina's welfare reform efforts and funding for staff development to train State and county staff on welfare reform policies and procedures.

Federal regulations for the TANF grant allow transfers of up to 30% of the grant per year to the Child Care Development Fund and to the Social Services Block Grant. We propose to transfer funds to these other block grants, as detailed in the following recommendations.

RECOMMENDATIONS:

1.	Allocation to the state Division of Social Services for payment of cash assistance benefit payments to Work First families. Also for allocation to county Departments of Social Services as partial funding for block grants to counties. Within flexible, locally developed plans, counties will use funds to provide for program eligibility determination and case management services, emergency assistance cash and services, employment and training services, child welfare services, and administration of the program. Balance of county block grant funding to come from State and county funds. Allocations for Work First Family Assistance held constant at SFY 97-98 level.	\$267,536,621
2.	Transfer to Social Services Block Grant (SSBG) as request of three county Departments of Social Services to permit activities of a preventive nature for both Work First eligible families and individuals and individuals and families who are <i>potentially</i> eligible for Work First.	\$ 885,715
3.	Awards to counties and other providers for special demonstrations of innovative approaches to assisting families achieve self-sufficiency	\$ 2,600,000
4.	Transfer to the Child Care Development Fund for child care centers at community colleges	\$ 500,000
5.	Transfer to the Child Care Development Fund for child care subsidies for Work First participants, former Work First participants, and potential Work First participants.	\$ 55,075,185
6.	Transfer to Social Services Block Grant (SSBG) to restore federal funding reduction taken in funds available to pay for child care for children in protective custody.	\$ 2,881,911
7.	Allocation to the Division of Mental Health/Development Disabilities/ Substance Abuse Services for substance abuse treatment, testing, and counseling services for Work First participants who require such treatment in order to achieve and maintain employment.	\$ 7,585,126

8. Transfer to Social Services Block Grant for allocation to the Division of Mental Health/Developmental Disabilities/Substance Abuse Services to award to small-to-medium sized companies who agree to hire Work First participants to develop Enhanced Employee Assistance Programs. \$ 1,000,000
9. Allocation to the State Division of Social Services to provide funds to contract for a short-term and long-range evaluation of North Carolina's implementation of federal welfare reform requirements and the Work First program. \$ 400,000
10. Allocation to the State Division of Social Services to provide funds to train state and county staff on operational changes as a result of Work First and federal welfare reform. \$ 500,000
11. Allocation to the Division of Women's and Children's Health for funds to reduce out-of-wedlock births. \$ 1,600,000
12. Transfer to the Social Services Block Grant for substance abuse services for juveniles. \$ 1,182,280
13. Transfer to the Social Services Block Grant to fund the Special Children Adoption Fund \$ 300,000
14. Transfer to the Employment Security Commission for the First Stop job registration program. \$ 750,000
15. Transfer to the Social Services Block Grant for activities designed to prevent teen pregnancy. \$ 2,000,000

Total Expenditures: \$ 344,796,838

Carry-forward federal fund availability to FY 1999-2000 as permitted by federal legislation. \$ 31,455,060

Total Planned Expenditures and Carryforward \$376,251,898

Base TANF Block Grant	\$302,240,000
Federal Supplemental Funds	15,380,000
Carry-Forward from FY 98	58,631,898
Total Funds Available:	<u>\$376,251,898</u>

DIVISION OF SOCIAL SERVICES
Analysis of Temporary Assistance for Needy Families (TANF) Block Grant
SFY 1998-99

Item Number	Title	Actual SFY 96-97	Appropriated SFY 97-98 SB 352	Recommended Amount SFY 98-99	Appropriated/Recommended Difference	Explanation of Difference
1	Work First Family Assistance (cash) benefits for Work First families and partial funding for Block Grants to County DSS for case management & eligibility determination; emergency cash & services; employment & training ; administration	258,224,843	302,029,076	267,536,621	(34,492,455)	Projected reduction in needed expenditures for Work First Family Assistance; partially offset by increase in county's Work First Services Block Grant. Electing County allocations held at SFY 98 level.
2	Transfers from County's Work First Block Grants to Social Services Block Grant for activities of a general preventive nature			885,715	885,715	Three counties have requested to transfer funds to SSBG to permit activities of a preventive nature to be offered to TANF eligible and <i>potentially</i> TANF eligible families.
3	Award to counties and other providers for special demonstrations of innovative approaches to assisting families to achieve self-sufficiency.			2,600,000	2,600,000	New strategy to fund demonstration projects to learn from innovative ideas
4	Transfer to CCDF for child care centers at community colleges		500,000	500,000	0	
5	Transfer to CCDF for Work First child care subsidies		5,599,759	55,075,185	49,475,426	Additional funds projected to be required to meet increase child care subsidy demands as a result of Work First families going to work or engaging in work activities.
6	Transfer to SSBG for child care subsidies		0	2,881,911	2,881,911	Offset reduction in SSBG. Funds used for child care for children in protective custody, regardless of income restrictions.
7	Allocation to DMH/DD/SAS for Work First substance abuse treatment, testing and counseling services	0	5,300,000	7,585,126	2,285,126	Provide additional funding to permit hiring at least one Qualified Substance Abuse Professional (QSAP) per county.
8	Transfer to SSBG for allocation to DMH/DD/SAS for Enhanced EAP Services for Work First clients.		0	1,000,000	1,000,000	Division will offer grants to small-to-medium sized companies who agree to hire Work First recipients.
9	Allocation to the Division of Social Services for evaluation	0	400,000	400,000	0	

DIVISION OF SOCIAL SERVICES
Analysis of Temporary Assistance for Needy Families (TANF) Block Grant
SFY 1998-99

Item Number	Title	Actual SFY 96-97	Appropriated SFY 97-98 SB 352	Recommended Amount SFY 98-99	Appropriated/Recommended Difference	Explanation of Difference
10	Allocation to the Division of Social Services for State and county staff development	0	500,000	500,000	0	
11	Allocation to Division of Women's & Children's Health for the reduction of out-of-wedlock births	0	1,600,000	1,600,000	0	
12	Transfer to SSBG for substance abuse services for juveniles	0	1,182,280	1,182,280	0	
13	Transfer to SSBG to establish the Special Children Adoption Fund	0	300,000	300,000	0	
14	Transfer to Employment Security Commission for First Stop program.	0	0	750,000	750,000	To provide funding for 1st Stop job registration program for WF applicants.
15	Transfer to SSBG for Teen Pregnancy Prevention program in Women's & Children's Health	0	0	2,000,000	2,000,000	To provide funding to expand work to prevent teen pregnancy as a prevention effort for Work First.
16	DMH/DD/SAS EA Services	27,880,064				
17	State Administration	6,151,328				
Total Planned Expenditures			317,411,115	344,796,838	27,385,723	
Planned for Carryforward to Subsequent FY				31,455,060	31,455,060	
Total Planned for Expenditure/Carryforward			317,411,115	376,251,898	58,840,783	
Available Funds:						
Base TANF Block Grant			302,240,000	302,240,000	0	
TANF Supplemental Funds			6,520,000	15,380,000	8,860,000	
Carry-Forward from Prior Fiscal Year			8,651,115	58,631,898	49,980,783	
Total TANF Block Grant			292,256,235	376,251,898	58,840,783	

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

June 2, 1998 pm
#4

***Substance Abuse Prevention & Treatment Block Grant
(SAPTBG) SFY 1999***

FUNDING LEVEL

Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funding available to North Carolina is \$29,096,347 for FFY98 and an estimated amount of \$29,096,347 for FFY 99. The proposed plan utilizes the remaining FFY 98 amount of 11,270,866 plus 20,594,184 from the FFY99 award.

GENERAL DESCRIPTION

The ADAMHA Reorganization Act of 1992 (P.L. 102-321) split the Alcohol, Drug, and Mental Health Services Block Grant (ADMBG) creating the new Block Grant for Substance Abuse Prevention & Treatment. The SAPTBG provides federal financial assistance to state for the provision of prevention and treatment of alcohol and drug abuse.

SIGNIFICANT FEDERAL REQUIREMENTS

Federal requirements begun in 1993 continue into 1999. Congress authorized a special appropriation, Section 105 (d) (2) of Public Law (P.L.) 104-121, of \$50 million for fiscal years (FY) 1997 and 1998. "The conferees expect that states will use funds made available under this provision to provide treatment to current and former Supplemental Security Income (SSI) recipients as their first priority." North Carolina will receive \$1,123,757. Federal requirements related to SAPTBG include:

1. State will expend not less than 35% of the allocation for alcohol and drug respectively.
- 2) Not less than 20% of the funds are to be set aside for prevention programs for individuals who do not require treatment for substance abuse to reduce the risk for such abuse. Prevention programs will include strategies to discourage the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such products. The Synar Amendment requires that each state adopt and enforce laws prohibiting sale or distribution of tobacco products to those younger than 18 years of age. Effective October 1, 1994, if the Secretary of HHS determines that a state has failed to comply with the law, the State will lose significant federal funding from the SAPTBG (totaling 10% of the block grant funds in the first year, 20% in the second year, 30% in the third year, and 40% in the fourth and subsequent years). Final rules were published on January 19, 1996 (45 CFR Part 96).

- 3) The state will spend not less than 10% of grant monies to increase the availability of treatment services for pregnant women and women with dependent children with the provision that prenatal and child care be provided to those women while they are in treatment.
- 4) Interim services must be provided to those individuals in need of treatment for intravenous substance abuse if they cannot be admitted to treatment within 14 days.
- 5) The state will require treatment entities receiving funds under the grant to make available tuberculosis services to each individual receiving treatment.
- 6) States such as North Carolina where the rate of AIDs is 10 or more per 100,000 must spend at least 5% of the total award to provide early intervention services for person with or at risk for HIV/AIDs.

PROPOSED EXPENDITURE PLAN	ALLOCATION

1. Adult Substance Abuse

Continuation of community and ADATC based alcohol and drug services including prevention, intervention, treatment, rehabilitation, and detoxification. Funding to support intervention and treatment services for offenders who remain in the community. Funds will be used to provide treatment services for offenders with substance abuse problems in community punishment programs. Continue support for group homes for recovering substance abusers. Tuberculosis services will be provided to all program participants. Special services for the deaf will be provided at the ADATC in Greenville, NC, with outpatient services for the deaf established in each region. Programs will be required to screen clients for TB and other infectious diseases.

\$11,502,939

2. Child Substance Abuse

Continue services to children and adolescent including prevention, high risk intervention and regional residential services. Services will include treatment for children in detention and training schools. Prevention activities will include strategies to discourage use of alcoholic beverages and tobacco

\$6,264,093

products by individuals to whom it is unlawful to sell or distribute such products. Services will be delivered in accordance with the 1993 Mental Health Study Commission Child and Adolescent Alcohol and Other Drug Abuse Plan. Legislative action increased service to young offenders and established a therapeutic community for troubled adolescents

- 3. Women's Substance Abuse**
Continuation of services for pregnant women and women with dependent children. Specialized services will be provided at the ADATCs for women.

5,065,766
- 4. Intravenous (IV) Drug**
Continuation of services to IV drug abusers and others at risk for HIV disease. Special services for IV drug users will be provided at the ADATCs.

4,843,456
- 5. Supplemental Security Income (SSI)**
The State will make treatment available to current and former SSI recipients whose disability is the result of alcoholism and drug dependence. 5% HIV spending requirement applies. Funds sunset in 1999.

1,123,757
- 6. Substance Abuse to TANF Participants**
TANF Demonstrations Funds will be used to provide substance abuse treatment, workplace treatment for TANF participants and their children.

893,811
- 7. Administration**
Applicable to 5% Administrative Cap (Planning, Quality Assurance, Development of new treatment and prevention services and training for providers receiving Block Grant funds.)

1,454,812
- Not applicable to 5% Administrative Cap (Statutory requirement to identify those populations, areas, and localities with a need for substance abuse services). State shall document the extent to which the need for substance abuse services is

716,416

greater than the availability of such services by locality. Increase will be used to hire three (3) positions to develop and oversee an outcome evaluation system for 20-25 community based prevention programs for youth 9 -17.

TOTAL REQUIREMENTS	\$31,865,050
Source of Funds	
SAPTBG FFY 98	11,270,866
SAPTBG FFY 99	20,594,184
TOTAL FUNDS	<u>\$31,865,050</u>

SUBSTANCE ABUSE PREVENTION TREATMENT BLOCK GRANT FOR SFY 99

ITEM NUMBER	TITLE	CERTIFIED BUDGET SFY 97-98	RECOMMENDED AMOUNT SFY 98-99	DIFFERENCE	EXPLANATION
1	Adult Substance Abuse	10,935,939	11,502,939	567,000	Expansion funds will be used to provide specialized outpatient alcohol and drug treatment for the deaf and hard of hearing and to provide treatment for offenders in cooperation with the Division of Adult Probation and Parole.
2	Child Substance Abuse	6,264,093	6,264,093		
3	Women's Substance Abuse	5,060,076	5,065,766	5,690	Estimated 4% salary increase at ADATCs for federally funded positions.
4	IV Drug Services	4,836,407	4,843,456	7,049	Estimated 4% salary increase at ADATCs for federally funded positions.
5	Supplemental Security Income	1,123,757	1,123,757	0	
6	Treatment for TANF participants	893,811	893,811	0	
7	Administration	1,841,742	2,171,228	329,486	Expansion will be used for data support activities, increased monitoring of area programs, the development of clinical standards, and to hire three (3) positions to develop and oversee an outcome evaluation system for 20-25 community based prevention programs for youth 9-17.
	TOTAL	30,955,825	31,865,050	909,225	

ITEM NUMBER	TITLE	ACTUAL SFY 96-97	APPROPRIATED SFY 97-98	AUTHORIZED SFY 97-98	RECOMMENDED SFY 98-99
1	Adult Substance Abuse	10,201,506	10,935,939	10,974,261	11,502,939
2	Child Substance Abuse	5,447,965	6,264,093	6,279,102	6,264,093
3	Women's Substance Abuse	4,987,386	5,060,076	5,085,469	5,065,766
4	IV Drug	5,036,870	4,836,407	4,838,424	4,843,456
5	Supplemental Sec. Income	-	1,123,757	1,123,757	1,123,757
6	Sub. Abuse to TANF part.	-	893,811	893,811	893,811
7	Administration	1,841,059	1,841,742	1,841,742	2,171,228
TOTAL		27,514,787	30,955,825	31,036,566	31,865,050

The Difference between the Appropriated and Authorized amounts are due to carryover revisions 11-160 (\$ 61,355), 11-171 (\$14,105), and 11-200 (\$ 5,281) for a total of \$ 80,741.

Joint Health and Human Services Appropriations Subcommittee

AGENDA

June 3, 1998 8:30 a.m.

Whitaker School Replacement Facility Report

Don Willis, Division of Mental
Health, DD, and Substance Abuse Services

Sears, Hackney, Keener & Williams, Inc.
Architects/Planners

Healthy Start

Dr. Stewart Bondurant

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Wednesday, June 3, 1998

Minutes

The Joint Appropriations Subcommittee on Human Resources met on Wednesday, June 3, 1998 at 8:30 a.m. in Room 643. Senator Bill Martin presided. There was no roll taken.

The agenda included the Report about the Whitaker School replacement, the responses to questions the members had asked the department and a report on Healthy Start by Dr. Stewart Bondurant.

Whitaker School Report

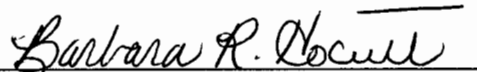
Mr. Terry Steele was called on first to begin the report on the Whitaker School replacement. He introduced Mr. Bill Sears, a member of the architectural firm of Sears, Hackney, Keener and Williams retained by the department to devise the plan, who presented the report. He said they were commissioned to find the most efficient and economical option available for the replacement of the Whitaker School (See attachment #1).

Representative Gardner asked what plans the department had for the detention center and the Willie M. program which is housed at Whitaker School location also. Dr. Steele suggested the three programs be housed in the same building and all take advantage of the new facility. Representative Gardner said the committee needs better direction from the department because we can't just look at the Whitaker School. We have to know what is going to happen with the other two programs.

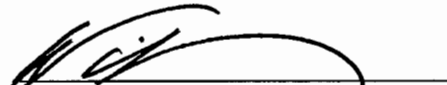
Healthy Start

Dr. Stewart Bondurant made a report on Healthy Start Foundation explaining its history, function and success in reducing the infant mortality rate in North Carolina (See Attachment #2).

Senator Martin announced there would not be an afternoon meeting. The answers to the questions the members asked the department were handed out to the members (see attachment #3). The meeting was adjourned.



Barbara R. Hocutt, Clerk


Senator Bill Martin, Chairman

WJM:brh
Attachments

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES JUNE 3, 1998

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	Lynne M. Perrin	DHHS
2.	D. Lynn	DMA-DHHS
3.	W. Travis Porter	Porter + Steel
4.	Robert Benfante	Healthy Start Foundation
5.	Terry Wilkinson	Div. Women & Children's Health
6.	Jamce Freedman	NC Healthy Start Foundation
7.	Barry Goldstein	DHHS/DWCH
8.	Sandra King	HSF
9.	Kevin Ryan	DWCH/DHHS
10.	Alcie Lenoir	DWCH/DHHS
11.	Melvin Kellchuk	Univ. of North Carolina at Chapel Hill
22.	Peggy Ball	DED/DHHS
23.	Lynne McDaniel	DHHS/DFS
24.	Marion Hartman	DD Council
25.	Pam Olearoff	Youth Advoc. & Invol./DOA
26.	Terry Hardesty	Food Banks
27.	Eric Johnson	ECU School of Nursing
28.	Lesley Feal	Project Challenge
29.	DW Willy	DW/DHHS
30.	Joseph Muzby Director	Whitaker School
31.	MICHELLE Cotton	DW/DHHS

VISITOR REGISTRATION SHEET

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES JUNE 3, 1998

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1. <u>M. J. J. J.</u>	<u>OSBM</u>
2. <u>John Lail</u>	<u>DHHS</u>
3. <u>Lisa Abatemarco</u>	<u>DHHS, BP & A</u>
4. <u>Lee D. McKeen</u>	<u>DHHS</u>
5. <u>Dr. Brubaker</u>	<u>DHHS</u>
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
22. _____	_____
23. _____	_____
24. _____	_____
25. _____	_____
26. _____	_____
27. _____	_____
28. _____	_____
29. _____	_____
30. _____	_____
31. _____	_____

The North Carolina Healthy Start Foundation

The NC Healthy Start Foundation was established in 1989 in conjunction with the Commission on Reduction of Infant Mortality to address a state-wide problem of high infant illness and death:

NC had the highest infant mortality rate in the US in 1989: 12.6 infant deaths per 1000 births. The result has been high costs in terms of:

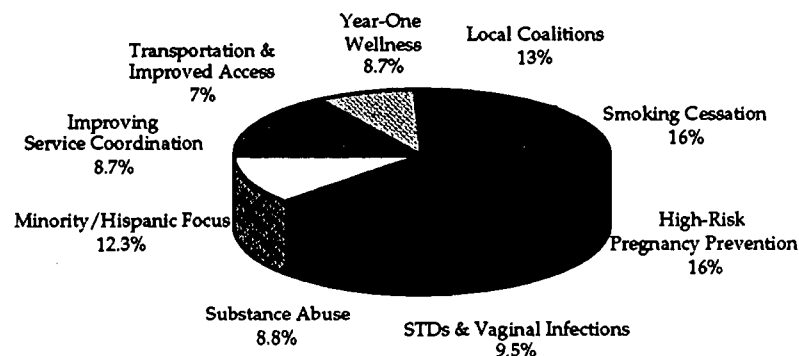
- ♦ Hospital costs for critically ill babies -- \$14,000 to \$30,000 for each premature baby.
- ♦ Premature births -- in FY 1990 \$108,800,000 in medical bills alone.
- ♦ Low birth weight babies w/developmental delays - averaging \$22,600 per year.
- ♦ Lost productivity when parents cope with a seriously ill baby.
- ♦ Costs to employers for increased insurance coverage.

Foundation efforts to lower infant mortality have been accomplished through:

- ♦ Public/private partnership with state agencies;
- ♦ State-wide media campaigns;
- ♦ Involvement of business and industry;
- ♦ Development of local coalitions, and
- ♦ Small grant support to community groups in counties across the state.

Much work has been done over the past eight years:

- ♦ Community coalitions have been established in 64 of North Carolina's 100 counties.
- ♦ Active involvement of numerous diverse groups: schools, churches, health departments, social services, housing authorities, and substance abuse offices.
- ♦ Participation of more than 50% of N.C.'s top employers.
- ♦ Over \$2 million in grants distributed to 144 public and private agencies in 88 counties.



The North Carolina Healthy Start Foundation Board of Directors:

Charles A. Sanders, MD --Chair

Stuart O. Bondurant, MD
Stephen A. Munshower

Howard Fitts, EdD
W. Travis Porter, Esq.

Phillip J. Kirk, Jr.
Glyn Young

- 



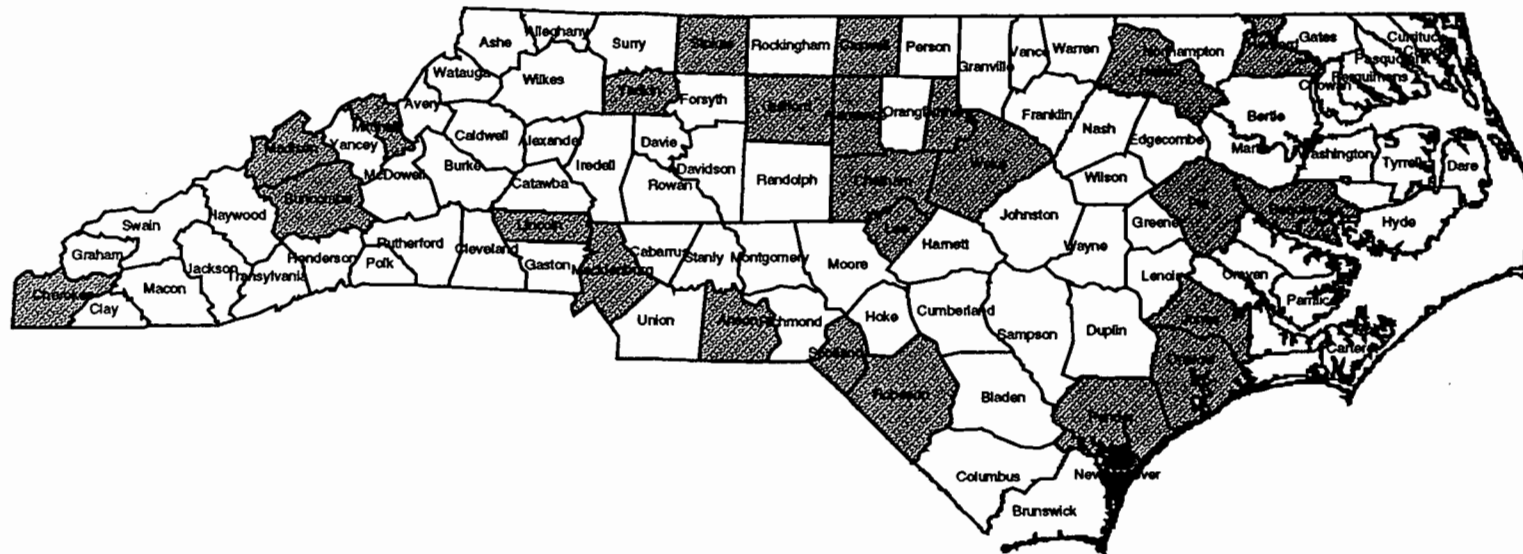
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North Carolina Healthy Start Foundation Community Grants Program

Twenty-Six Counties with Excellent Proposals Go Unfunded
Due to Insufficient Funds in 1997 or 1998



Additional funding required to fund these proposals : \$1,204,255

*Cecil G. Sheps Center for Health Services Research Program on Child Health Services
University of North Carolina at Chapel Hill*

North Carolina Healthy Start Foundation

Community Grants Program

Funding to Date

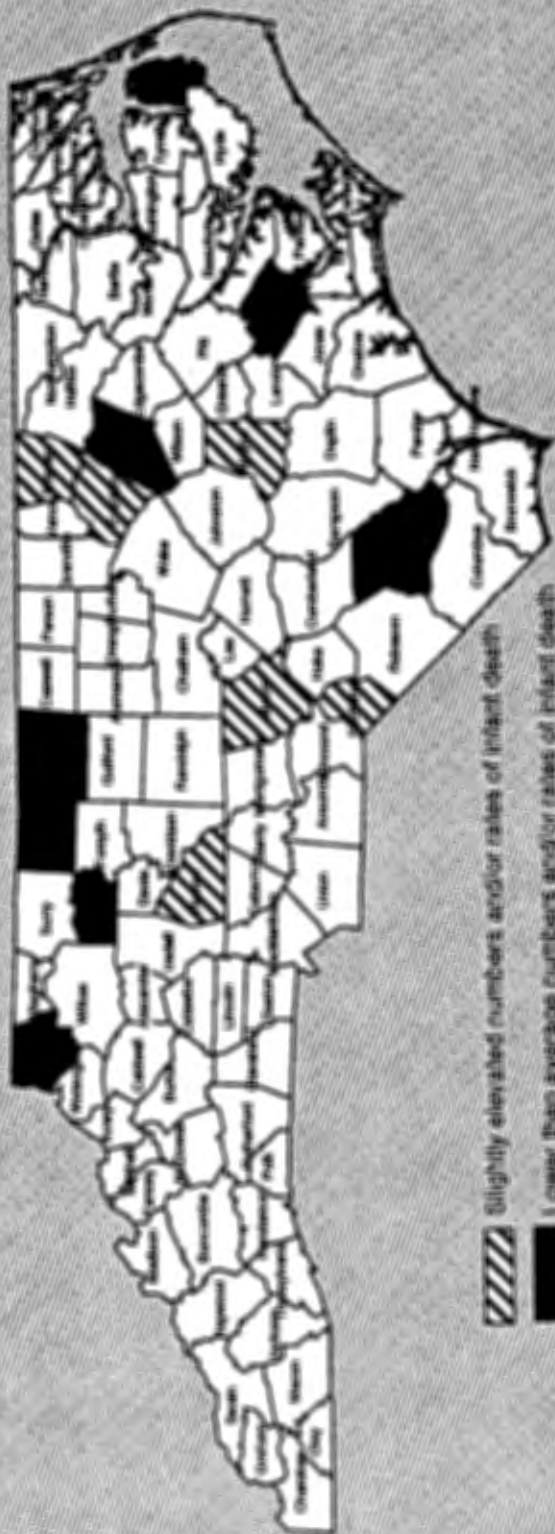
Alamance	23,000	Forsyth	80,500	Onslow	75,000
Alexander	18,500	Franklin	none to date	Orange	66,000
Alleghany	13,000	Gaston	102,000	Pamlico	170,000
Anson	64,000	Gates	18,000	Pasquotank	1,300
Ashe	none to date	Graham	79,000	Pender	95,000
Avery	13,000	Granville	3,000	Perquimans	13,000
Beaufort	55,000	Greene	50,000	Person	15,000
Bertie	37,000	Guilford	45,000	Pitt	36,000
Bladen	none to date	Halifax	244,000	Polk	26,000
Brunswick	39,000	Harnett	29,000	Randolph	8,000
Buncombe	57,000	Haywood	52,000	Richmond	33,000
Burke	1,000	Henderson	43,000	Robeson	65,000
Cabarrus	49,000	Hertford	140,000	Rockingham	none to date
Caldwell	23,000	Hoke	44,000	Rowan	none to date
Camden	13,000	Hyde	98,000	Rutherford	26,000
Carteret	4,000	Iredell	15,000	Sampson	17,000
Caswell	10,000	Jackson	93,000	Scotland	none to date
Catawba	27,000	Johnston	46,000	Stanly	36,000
Chatham	87,000	Jones	15,000	Stokes	none to date
Cherokee	73,000	Lee	45,000	Surry	15,000
Chowan	26,000	Lenoir	20,000	Swain	108,000
Clay	47,000	Lincoln	41,000	Transylvania	26,000
Cleveland	66,000	McDowell	66,000	Tyrrell	41,000
Columbus	5,000	Macon	25,000	Union	4,400
Craven	none to date	Madison	62,000	Vance	18,000
Cumberland	79,500	Martin	26,000	Wake	192,000
Currituck	24,000	→Mecklenburg	135,000	Warren	none to date
Dare	none to date	Mitchell	30,000	Washington	147,000
Davidson	3,000	Montgomery	16,000	Watauga	25,000
Davie	7,500	Moore	none to date	Wayne	none to date
Duplin	112,000	Nash	none to date	Wilkes	41,000
Durham	83,000	New Hanover	38,000	Wilson	20,000
Edgecombe	46,000	Northampton	2,500	Yadkin	none to date
				Yancey	25,000

**North Carolina Healthy Start Foundation
Community Grants Program
1997-98 Accomplishments**

- Improved coordination of prenatal or other human resource services by overcoming system level barriers — improving transportation, expansion of outreach-worker models, extending clinic hours, expanding lay advisers, peer and other mentoring programs, strengthening case management approaches.
- Improved contraceptive services for high-risk women — direct services or education about the risks of childbearing “too young, too old, too close, too soon”; use of mentoring models, care coordination, community outreach workers; expansion of clinic hours to reach priority populations.
- Established programs in workplace settings (especially those employing a large proportion of minority women) — provision of perinatal risk assessments; pregnancy testing; HIV testing; referrals for care; use of lay advisors within the workplace; and training of shop stewards to identify, educate, and refer high-risk co-workers.
- Improved diagnosis and treatment of sexually transmitted diseases and vaginal infections in high-risk women; reduction of prematurity and improvement of birth outcomes through identifying and appropriately managing vaginal infections in pregnancy.
- Reduced exposure of women and their fetuses to alcohol, drugs, and other harmful substances — through improving access to existing services; increasing outreach beyond current service areas; strengthening linkages between existing services; or adding ancillary services (transportation/ social services) to existing clinical services.
- Expanded services and community-based initiatives for pregnant minority women for whom the rates of low birth-weight, prematurity, and infant mortality are disproportionately high, or who face special barriers to prenatal and obstetric services because of linguistic, social, or economic barriers.
- Improved services for mothers and babies in the first year of life — Sudden Infant Death Syndrome (SIDS) prevention programs; parenting classes that focus on prevention of child abuse/neglect and improved use of safety and well child care services.

North Carolina Healthy Start Foundation Community Grants Program

Only fourteen counties have never received HSF Funding (as of 2005)



Cecil G. Sheps Center for Health Services Research
Program on Child Health
University of North Carolina at Chapel Hill



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

June 3, 1998

MEMORANDUM

TO: Mary Ellen Sylvester, Fiscal Analyst
Division of Fiscal Research

FROM: ^{AW}Ann Wolfe, M.D., MPH, Director

SUBJECT: FY1998-99 MCH Block Grant Plan

At the June 2, 1998 presentation of the MCH Block Grant Plan for FY1998-99, members of the Joint Appropriations Subcommittee requested some information that required Division of Women's and Children's Health follow-up. Attached is the information requested.

Please let me know if I can be of further assistance.

cc: James B. Edgerton
Lee D. Kittredge
Mary Greene



DIVISION OF WOMEN'S AND CHILDREN'S HEALTH

MATERNAL AND CHILD HEALTH BLOCK GRANT

- 1. How many people receive maternal health, child health and women's preventive health services statewide from local health departments?**

The following figures are for the twelve month period January 1 - December 31, 1997.

Local health departments provided clinical and/or support services to 65,150 pregnant and postpartum women; preventive, primary care and/or support services to 146,141 children; and preventive health services to 136,019 women of childbearing age. Support services include home visits, maternity care coordination, childbirth and parenting classes, medical nutrition therapy, etc.

- 2. How many people receive maternal health, child health and women's preventive health services from the Guilford County Health Department?**

The following figures are for the twelve month period January 1 - December 31, 1997.

The Guilford County Health Department provided clinical and/or support services to 3,353 pregnant women; preventive, primary care and/or supportive services to 6,483 children; and preventive health services to 10,214 women of childbearing age.

- 3. What is the total level of funding for the Developmental Evaluation Centers?**

The FY1997-98 authorized budget for the Developmental Evaluation Centers is \$26.1 million. Of that amount, \$18.93 million is State appropriations; \$1.97 million is MCH Block Grant; and \$5.2 million comes from Medicaid, patient and other receipts.

- 4. What is the budget of the Asheville Developmental Evaluation Center?**

The Asheville DEC's budget allocation for FY1997-98 is \$1.18 million.

- 5. Of the total amount of MCH Block Grant funds allocated for Childhood Injury Prevention, how much is expended for flyers, billboards, and ads?**

The Division of Community Health administers the Injury Prevention Program. Subsequent to the MCH Block Grant presentation by Dr. Ann Wolfe, Dr. Leah Devlin, Division Director of the Division of Community Health, gave an overview of the Preventive Health Services Block Grant. Her overview to the Joint Appropriations Subcommittee included information on how the Injury Prevention Program utilizes MCH Block Grant funds.



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

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Lee D. Kittredge
Mary Greene



DIVISION OF WOMEN'S AND CHILDREN'S HEALTH

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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

Memorandum

To: Joint Legislative Health and Human Services Committee

Through: Carol Shaw
Fiscal Research

From: Jim Edgerton
Lee Kittredge *JK*

Date: May 26, 1998

Attached are the Department's responses to questions asked at the HHS Committee Meeting May 13, 1998. Only questions that were not answered at the meeting are attached. The questions were related to DHHS expansion requests. A description of the expansion item and the item number are listed followed by the questions and responses.

Increase Staffing in Child Support Enforcement (ITEM #6)

What are the State operated County Offices and counties covered.

Response has been forwarded.

Criminal Records Checks Needs Assessment (ITEM #9)

What will be the new turnaround time after this is implemented?

Over the last few years state and federal law changes have required criminal record checks for child care employees, foster parents, adult care, and nursing home employees. Divisions in the Department of Health and Human Services have responded by accumulating and processing data needed to perform the criminal records. The Department has been working closely with SBI in examining the backlog problem. To address this issue the Department wants to examine duties, procedures, processing time, etc. in order to determine if any changes are needed in divisions' business practices and in automation of these functions. The exact benefits cannot be determined until the procedural examination is completed and an implementation plan is put into place to make business practice and/or automation changes.

New Systems for Year 2000 (ITEM #10)

How many characters will be added to solve this problem?

14.886 BILLION characters

Emerging Health Issues Risk Assessment (ITEM #16)

What is the million dollar pfisteria contract buying?

The contract funds a large prospective cohort study - via contract with a medical consortium (including UNC, ECU, and Duke medical schools) - that is coordinated with other states (including Maryland, Virginia and Delaware) that will tell us whether or not there are human health effects from exposure to our estuaries and what the cause is likely to be. It also allows for the staffing of a public health response to the threat of Pfiesteria and related organisms by funding a hotline and information exchange, coordination with local doctors and affected county health departments, a web page with daily updates re fish kills and their locations, the safety of the state's rapid response teams, etc. The contract it is expected to continue for several years, subject to the dictates of the US Congress.

IMMUNIZATION AGAINST CHICKENPOX AND HEPATITIS B (ITEM #19)

What is the annual influx (from out of state) of children per year?

From 1980-1990 the total number of persons 0-17 years of age who moved into North Carolina is 102,880. This figure takes into account all the people aged 0-17 who moved out, so 102,880 represents a total net effect of immigration and emigration. Stated another way, approximately 10,288 children aged 0-17 come into the state each year. It should be noted that the majority of states in the US have implemented a Hepatitis B infant vaccination

program. Such programs been in place since 1994 and 1995. Thus, children two or three years of age who move into the state are already likely to be vaccinated against Hepatitis B.

Heart Disease and Stroke Prevention Initiative (ITEM #21)

What type of prevention work is done with this money, what types of results (impact) has this program generated, and can we get more information on Strike Out Stroke?

Here is the requested information on Strike Out Stroke.

There are 3 components to the prevention work:

1) Public awareness:

Many hypertensives are not aware of their hypertension. Others are not treated, and among those who are treated, many are not controlled. So there are messages that must get out, particularly among those population groups with the highest rates of high blood pressure (and therefore, stroke).

- a) Know your numbers
- b) See your doctor if your BP is at or above 140/90
- c) Lifestyle changes can help lower BP and reduce need for medications
- d) If medicines are prescribed - take them!

There is also another, newer piece to this. There are two types of stroke. 80% are ischemic - ie caused by a clot. The rest are hemmorrhagic - caused by bleeding into the brain. Ischemic strokes can be treated and possibly reversed if the patient gets to appropriate care within 3 hours of onset of symptoms. They have to have a CT scan to establish the type of stroke and are then given "clot buster" drugs such as TPA. But the 3 hour window means we have to get the word out to:

- a) Recognize the warning signs of stroke
- b) Stroke is an emergency that may be able to be treated if you get there in time - call 911 at once.

(Studies have shown that the critical factor in awareness about stroke symptoms is that people around the victim must recognize what is happening and know what to do about it.)

2) Professional Education

A needs assessment done at the beginning of the NIH funded Strike Out Stroke project found that many professionals in all clinical settings did not know how to accurately measure blood pressure. Furthermore, many places are using inadequate or uncalibrated equipment. It is important to note that BP is often measured by nurses and aides. Phase I of SOS in NC did a great deal of training of Pub. Health professionals, but, due to turnover, there is need for ongoing work with this. And there is a need to ensure that health care professionals in all settings are using accurate and well calibrated equipment.

With the advent of the new therapy for stroke, we cannot tell the public that they must recognize the warning signs and get to treatment without ensuring that they will receive the appropriate care when they get there. This means that EMS people must know what to do and where to take people within that 3 hour window, and the system must be prepared to deal with patients appropriately when they show up.

3) Patient Education

Phase I of SOS developed, printed and disseminated low literacy, culturally sensitive patient education materials and continues to have requests from Local Health Departments and Community Health Centers for these materials. In addition, we have been requested to make these electronically available for downloading at clinical sites around the state.

Results of Phase I:

The materials and training were very well received and we have on-going requests for both that we are unable to meet. A targeted Awareness Campaign was developed and delivered through Webb Patterson Communications, but it dealt with BP only - the stroke treatment piece is new.

There is a full final report available for review that details numbers trained and volume of printed materials distributed, along with community level activities. But this was not a research project and there was not sufficient funding for a strenuous evaluation with pre- and post- measures of awareness in targeted populations, etc.

Diabetes (ITEM #22)

What counties are federal dollars used in? and verify that federal grant is \$328K.

The local health departments receiving federal Diabetes Control Program funds for Diabetes Today projects have been:

1994-95	Robeson, Graham-Swain
1995-96	Macon, Forsyth, Caswell, Chatham, Bertie
1996-97	Union, Ashe, Wilkes, PPCC
1997-98	Wilkes, PPCC, Gaston, Rockingham

The award for the Diabetes Control Program this year is \$328,821

HEALTHY START FOUNDATION (ITEM #24)

The committee needs more information on Healthy Start Foundation.

See attached report.

Study on Access to Dental Care (ITEM #25)

Does the North Carolina institute of Medicine receive any State funds?

The Institute of Medicine does not receive state funds. According to Gordon DeFries, Director, Cecil Shepp Center for Health Services Research, the Institute received \$25,000 in state appropriation in 1983 and has not received state funding since.

Support for Long Term Care Systems Reform (ITEM #27)

The committee needs a lot more information about this.

Response has been forwarded.



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

May 21, 1998

MEMORANDUM

To: Carol Shaw, Fiscal Analyst
Fiscal Research Division

From: Lee D. Kittredge, Director *LDK*
Division of Budget, Planning and Analysis

Re: Staff for State Operated Child Support Enforcement Offices

I am forwarding a worksheet which outlines the type and location of the positions requested for the state operated Child Support Enforcement Offices

If you have any questions or need additional information, please contact me at 733-6396.

Attachment

cc: James B. Edgerton
Kevin FitzGerald
Nina Yeager

Positions requested in the 1998 Short Session								
Number of Request	IV-D Prg.	Grade	Classification	Effective Date	1998-99 Total Positions	Annual Salary	Budgeted Salary	Function (Brief description of work, such as, policy development, consultation, etc.)
Total Positions in Expansion Budget								
	Multiple	67	CSE Supvs II	10/1/98	6	33,148	149,166	Supv. local child support office
		65	CSE Agents	10/1/98	78	30,358	1,775,976	Case management (local)
		70	Program Consultant II	10/1/98	4	37,888	113,664	Assist county operations
		59	Office Assistant IV	10/1/98	12	23,604	212,436	Clerical (local)
		59	Client Services <i>OFFICE</i>	10/1/98	8	23,604	141,624	Central office customer service unit
			Total		108			
Allocation of Positions to the State Operated IV-D Programs								
5	Ahoskie	65	CSE Agents	10/1/98	4	30,358	91,072	
		59	Office Assistant IV	10/1/98	1	23,604	17,703	
4	Albemarle	65	CSE Agents	10/1/98	4	30,358	91,072	
8	Anson/ Richmond	67	CSE Supv II	10/1/98	1	33,148	24,861	
		65	CSE Agents	10/1/98	5	30,358	113,840	
		59	Office Assistant IV	10/1/98	2	23,604	35,406	
1	Boone	65	CSE Agent	10/1/98	1	30,358	22,768	
4	Bryson City	65	CSE Agents	10/1/98	4	30,358	91,072	
2	Carteret	65	CSE Agents	10/1/98	2	30,358	45,536	
9	Cumberland	67	CSE Supv II	10/1/98	1	33,148	24,861	
		65	CSE Agents	10/1/98	7	30,358	159,376	
		59	Office Assistant IV	10/1/98	1	23,604	17,703	

3	Franklin	65	CSE Agents	10/1/98	3	30,358	68,304
4	Harnett	65	CSE Agents	10/1/98	4	30,358	91,072
5	Manteo	67	CSE Supv II	10/1/98	1	33,358	24,861
		65	CSE Agents	10/1/98	3	30,358	68,304
		59	Office Assistant IV	10/1/98	1	23,604	17,703
33	Mecklenburg	67	CSE Supv II	10/1/98	3	33,358	74,583
		65	CSE Agents	10/1/98	26	30,358	591,968
		59	Office Assistant IV	10/1/98	4	23,604	70,812
3	New Bern	65	CSE Agents	10/1/98	2	30,358	45,536
			Office Assistant IV	10/1/98	1	23,604	17,703
6	Pender	65	CSE Agents	10/1/98	5	30,358	113,840
		59	Office Assistant IV	10/1/98	1	23,604	17,703
4	Randolph	65	CSE Agents	10/1/98	4	30,358	91,072
5	Union	65	CSE Agents	10/1/98	4	30,358	91,072
		59	Office Assistant IV	10/1/98	1	23,604	17,703
			Total		96		



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

May 21, 1998

MEMORANDUM

To: Carol Shaw, Fiscal Analyst
Fiscal Research Division

From: Lee D. Kittredge, Director 
Division of Budget, Planning and Analysis

Re: Senator Dannelly's Request

During a Senate Appropriation Subcommittee on Health and Human Services meeting Senator Dannelly asked for a breakdown on positions in the expansion requests by function or type. The attached list includes information on all of the requested positions excluding the 7 positions for Children's Health Insurance which were approved during the Special Session.

If you have any questions or need additional information, please contact me at 733-6396.

Attachment

cc: James B. Edgerton
Nina Yeager

Positions Requested in the 98 Short Session

Division	Grade	Classification	Effective Date	1998-99 Total Positions	Annual Salary	Budgeted Salary	Function (Brief description of work, such as, policy development, consultation, etc.)
Child Support Enforcement for State Offices							
DSS	67	Child Support Enforcement Supvs II	10/1/98	6	33,148	149,166	Supervise local child support office
DSS	65	Child Support Enforcement Agents	10/1/98	78	30,358	1,775,976	Case management (local)
DSS	70	Program Consultant II	10/1/98	4	37,888	113,664	Assist county operations
DSS	59	Office Assistant IV	10/1/98	12	23,604	212,436	Clerical (local)
DSS	59	Office Assistant IV	10/1/98	8	23,604	141,624	Central office customer service unit

Adoptive Parent Criminal Record Checks

DSS	59	Office Assistant IV	10/1/98	1	23,604	17,703	Manage the criminal records check process

Subtotal Social Services

109

Criminal Records Check Needs Assessment

CA	72	Business Analyst - Time limited	7/1/98	2	41,358	82,716	Analyze & redesign criminal record checks process
CA	74	Project Manager - Time limited	7/1/98	1	45,279	45,279	Analyze & redesign criminal record checks process

Subtotal Central Management and Support

3 Time limited

Emerging Health Issues Risk Assessment

EPI	75	Public Health Nurse Cons. II	7/1/98	1	37,304	37,304	Risk assessment/evaluation of human exposure to environmental issues
EPI	4	Public Health Physician II SER	7/1/98	1	82,962	82,962	Risk assessment/evaluation of exposure
EPI	8	Public Health Physician III	7/1/98	2	85,083	170,166	Risk assessment/evaluation of exposure
EPI	72	Public Health Epidemiologist II	7/1/98	3	32,656	97,968	Risk assessment/evaluation of exposure
EPI	77	Industrial Hygiene Consultant	7/1/98	3	40,855	122,565	Risk assessment/evaluation of exposure
EPI	70	Computer Consultant II SER	7/1/98	1	30,038	30,038	Risk assessment/evaluation of exposure
EPI	73	Computer Consultant III (GIS) SER	7/1/98	1	38,475	38,475	Risk assessment/evaluation of exposure
EPI	73	Applications Progr. II (GIS) SER	7/1/98	1	38,475	38,475	Risk assessment/evaluation of exposure
EPI	73	Statistician II SER	7/1/98	1	37,476	37,476	Risk assessment/evaluation of exposure
EPI	81	Environmental Toxicologist	7/1/98	2	49,013	98,026	Risk assessment/evaluation of exposure
EPI	68	Info. & Comm. Spec. II	7/1/98	1	27,557	27,557	Risk assessment/evaluation of exposure
EPI	59	Processing Assistant IV	7/1/98	3	19,138	57,414	Clerical support for risk assessment/ evaluation
EPI	59	Office Assistant IV	7/1/98	2	19,138	38,276	Clerical support for risk assessment/ evaluation
EPI	59	Accounting Clerk IV	7/1/98	1	19,138	19,138	Clerical support for risk assessment/ evaluation

Subtotal Epidemiology

23

Positions Requested in the 98 Short Session

Division	Grade	Classification	Effective Date	1998-99 Total Positions	Annual Salary	Budgeted Salary	Function (Brief description of work, such as, policy development, consultation, etc.)
Improve Health and Safety of Residents and Regulatory Compliance							
DFS	75	Facility Architect II	10/1/98	3	47,411	106,675	Facility plan reviews/safety inspections
DFS	77	Building Systems Engineer II	10/1/98	4	51,975	155,925	Facility plan reviews/safety inspections
DFS	57	Processing Assistant II	10/1/98	1	21,897	16,423	Clerical support for Construction Sect.
DFS	75	Facility Architect II	1/1/99	4	47,411	94,822	Facility plan reviews/safety inspections
DFS	77	Building Systems Engineer II	1/1/99	4	51,975	103,950	Facility plan reviews/safety inspections
DFS	57	Processing Assistant II	1/1/99	1	21,897	10,949	Clerical support for Construction Sect.
DFS	72	Facility Survey Consultant I	10/1/98	4	35,000	105,000	Investigate allegations re health workers
DFS	72	Nurse Consultant	10/1/98	8	35,000	210,000	Investigate complaints/monitor facilities
DFS	72	Nurse Consultant	1/1/99	8	35,000	140,000	Investigate complaints/monitor facilities
Subtotal Facility Services				37			
Total New Positions*				172			

* Excludes the 7 positions for Children's Health Insurance which were approved during the Special Session.

NORTH CAROLINA HEALTHY START FOUNDATION
Annual Report - Calendar Year 1997

The North Carolina Healthy Start Foundation (the "Foundation") was created in 1990 with a \$5 million pledge over five years from Glaxo Inc. (now Glaxo Wellcome Inc.). Its programs included the funding of the Governor's Commission on Reduction of Infant Mortality (the "Commission") and the First Step Campaign ("First Step"). The Foundation also sponsored a grants program, in which they funded 129 projects, in 85 counties in North Carolina. By the end of 1995, the Foundation provided more than \$2 million in funding through this grants program. The Foundation also sponsored successful individual business initiatives and industry-wide initiatives (with the latter funded by Burroughs Wellcome). Until 1995, neither the Foundation nor First Step received any state funds for operating expenses. Throughout its existence, the Commission never received any state funds.

At its inception, the Foundation was due to be terminated as a programmatic entity in 1995. However, due to the success of its programs, the Foundation requested a state appropriation to continue its activities. The General Assembly appropriated \$200,000 in 1995 for First Step, and \$650,000 in both 1996 and 1997 for First Step and a smaller scaled grants program. As a condition of receiving these funds, the General Assembly required that the Foundation provide this report to the Joint Legislative Commission on Governmental Operations. This report will focus on the efforts of First Step and of the Community Grants Program.

The Commission was terminated as of December 31, 1995 which meant an end to the Commission's activities and Commission staff's employment. Remaining First Step members continue to administer First Step from the Foundation office. Janice Freedman, Director of the First Step Campaign has prepared a summary of First Step Campaign activities for 1997 and a preview of goals for 1998, which is included as Attachment A.

The Foundation has contracted with the Sheps Center at the University of North Carolina at Chapel Hill to manage the Community Grants Program. Dr. Milton Kotelchuk and Dr. Julia Skatrud from the Sheps Center have prepared a report on the Community Grants Program, which is included as Attachment B.

A copy of the Compliance Reports, which include the latest audit for year ending December 31, 1996, as prepared by KPMG Peat Marwick, is included as Attachment C.

Copies of Statements and Expenses are included as follows:

Attachment D	1996 - 1997 First Step Campaign Budget
Attachment E	1997 - 1998 First Step Campaign Budget
Attachment F	First Step Contract
	Immunization Contract
	Video Contract



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

May 14, 1998

H. David Bruton, M.D., Secretary

MEMORANDUM

TO: Carol Shaw
Fiscal Research Division
NC General Assembly

THROUGH: Lee D. Kittredge, Director *LDK*
Division of Budget, Planning and Analysis

FROM: Lynne M. Perrin, Assistant Secretary for Aging, Disability
and Long Term Care *Lynne M. Perrin*

SUBJECT: Support for Long Term Care Systems Reform

In response to Representative Gardner's request for additional information about Expansion Item 27, "Support for Long Term Care Systems Reform," I am attaching a description of the process that will be utilized in awarding the Long Term grants, eligibility for funding, major criteria to be included in the Request for Proposals, selection process, project evaluation, and the Department's project management strategy. If you have any additional questions, please let me know.

LD/wm

Attachment

cc: James B. Edgerton
Nina Yeager
Karen Gottovi
Bonnie Cramer

LONG TERM CARE GRANTS

Governor Hunt's 1997-99 biennial budget includes funding of \$1.2 million to provide annual grants to counties to support long term care system reforms with emphasis on multi-county systems serving both physically disabled and elderly adults. Grant funds are to provide staff support as well as funding for technology and automation strategies to implement automated screening and assessment tools and to enhance the use of automated data across agencies.

1. Purpose

To move North Carolina's long term care system reform efforts further ahead by providing financial and technical support to counties in the forefront of long term care systems change. These grants will fund counties that commit to take major steps to alter the way in which long term care services are delivered. They are not intended to fund solely planning and/or consensus building efforts.

Primary Objectives:

- Encourage multi-county partnerships based on minimum population of older and disabled adults and geographic alignment for provision of intake, information and referral, eligibility determination, quality assurance and access to long term care services.
- Simplify consumer access to information about long term care services and supports through:
 - the establishment of centralized I&R/Case Assistance systems and access to long term care services and supports (initially access to home and community care —ultimately adult care home and nursing home care).
- Build upon managed care concepts for the provision of long term care services to:
 - improve coordination of health and long term care services
 - promote home and community care whenever possible
 - constrain the growth of public costs for long term care through (ultimately) risk based contracting with provider networks that are locally developed and operated by public or non-profit entities
 - use standardized and automated screening and assessment tools for access to Medicaid, non-Medicaid, or fully private pay long term care services.

2. How will grants be awarded?

Grants will be awarded through a competitive Request for Proposal (RFP) process.

3. Who is eligible for funding?

- County Government — only one proposal per county may be submitted
- All proposals must be endorsed by the County Commissioners
- Multi-county proposals must be endorsed by County Commissioners from all project counties

4. How will funds be awarded?

- \$1.2 million will be awarded — a 10% match will be required from each project
- DHHS will award funds directly to selected projects
- Up to 8 projects will be funded
- Up to a maximum of \$250,000 per county/project awarded per year
- Recommend that initial projects selected be funded for 3 years based on progress in meeting goals. After 3 years, a new RFP process would be implemented with first round projects eligible to compete for additional funds.

5. What major criteria will be included in the RFP?

A. General Criteria

- capacity to implement a centralized I&R/Case Assistance system
- capacity to test/use a standardized and automated client assessment tool
- evidence of developed provider networks tied to long term care reform efforts

- demonstrated linkages with the health care delivery system
- demonstrated readiness to take significant steps leading to a managed long term care delivery system
- capacity to implement long term care reforms for Medicaid, non-Medicaid, and private pay consumers
- capacity to incorporate telehealth supports

* Priority will be given to projects with capacity to implement multi-county projects and/or include both aging and disabled adult populations.

B. Key Administrative Responsibilities to be Carried Out:

Projects must designate a public or non-profit entity responsible for:

- Providing/arranging a centralized system for:
 - providing I&R/Case assistance and client advocacy functions for consumers, family caregivers, health care providers and others
 - determining eligibility for Medicaid/non-Medicaid funded home and community based long term care services (ultimately to include adult care home and nursing home care)
 - conducting screening and assessments for home and community based services using a standardized and automated assessment tool issued by state
- Monitoring the quality of home and community based long term care services provided to Medicaid, non-Medicaid and fully private pay clients through a provider network for the delivery of long term care services.

C. Key Service Delivery Responsibilities Required:

- Establishment of a provider network for the provision of an array of home and community based services administered by a public or private non-profit organization:
 - network would be expected to have capacity to move toward accepting risk for provision of services to publicly supported clients
 - must have capacity to provide an array of home and community based services needed to support older adults at home for Medicaid, non-Medicaid, and fully private pay persons
- Automated data collection and reporting capacity for network of providers including encounter data client demographic, client profile and functional capacity information, etc.
- Use of telehealth concepts -- specific strategies to be used will be identified in proposal

6. How will projects activities be linked to the Health Care system?

Projects will have to describe the role of:

- rural and community health care providers relative to project activities
- local and/or regional hospitals relative to project activities

7. What will the selection process be?

- A selection committee will be established to review proposals and make decisions regarding projects to be funded.
- Expect grants to be awarded by mid-fall. Applicants would be given 45-60 days to complete RFP.

7. How will project evaluation be handled?

- Each project will be responsible for conducting/arranging an evaluation of project activities in accordance with state issued criteria.

8. What will DHHS's project management strategy be?

- The Long Term Care Policy Office, in consultation with the Assistant Secretary for Aging, Disability and Long Term Care, will have leadership responsibility for this effort and will work closely with the Office of Rural Health and the Medicaid Demonstration effort to build upon concepts being tested in the demonstration sites (i.e. global budget, standardized assessment tool, etc.)



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

June 3, 1998

MEMORANDUM

TO: Mary Ellen Sylvester, Fiscal Analyst
Division of Fiscal Research

FROM: ^{AW} Ann Wolfe, M.D., MPH, Director

SUBJECT: FY1998-99 MCH Block Grant Plan

At the June 2, 1998 presentation of the MCH Block Grant Plan for FY1998-99, members of the Joint Appropriations Subcommittee requested some information that required Division of Women's and Children's Health follow-up. Attached is the information requested.

Please let me know if I can be of further assistance.

cc: James B. Edgerton
Lee D. Kittredge
Mary Greene



DIVISION OF WOMEN'S AND CHILDREN'S HEALTH

MATERNAL AND CHILD HEALTH BLOCK GRANT

- 1. How many people receive maternal health, child health and women's preventive health services statewide from local health departments?**

The following figures are for the twelve month period January 1 - December 31, 1997.

Local health departments provided clinical and/or support services to 65,150 pregnant and postpartum women; preventive, primary care and/or support services to 146,141 children; and preventive health services to 136,019 women of childbearing age. Support services include home visits, maternity care coordination, childbirth and parenting classes, medical nutrition therapy, etc.

- 2. How many people receive maternal health, child health and women's preventive health services from the Guilford County Health Department?**

The following figures are for the twelve month period January 1 - December 31, 1997.

The Guilford County Health Department provided clinical and/or support services to 3,353 pregnant women; preventive, primary care and/or supportive services to 6,483 children; and preventive health services to 10,214 women of childbearing age.

- 3. What is the total level of funding for the Developmental Evaluation Centers?**

The FY1997-98 authorized budget for the Developmental Evaluation Centers is \$26.1 million. Of that amount, \$18.93 million is State appropriations; \$1.97 million is MCH Block Grant; and \$5.2 million comes from Medicaid, patient and other receipts.

- 4. What is the budget of the Asheville Developmental Evaluation Center?**

The Asheville DEC's budget allocation for FY1997-98 is \$1.18 million.

- 5. Of the total amount of MCH Block Grant funds allocated for Childhood Injury Prevention, how much is expended for flyers, billboards, and ads?**

The Division of Community Health administers the Injury Prevention Program. Subsequent to the MCH Block Grant presentation by Dr. Ann Wolfe, Dr. Leah Devlin, Division Director of the Division of Community Health, gave an overview of the Preventive Health Services Block Grant. Her overview to the Joint Appropriations Subcommittee included information on how the Injury Prevention Program utilizes MCH Block Grant funds.

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1997-98 Session

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State Abortion Fund
Youth Services

DIANNA JESSUP, Staff Attorney
Day Care
Foster Care/Adoption
Human Resources (shared with Watson)
Medicaid
Public Health Care Facilities
Smart Start
Social Services (shared with Watson)
Special Education
Vocational Rehabilitation
Welfare Reform

AGENDA
Joint Appropriations Subcommittee on Health & Human Services

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

LUNCH (12:00 - 1:00)

1:00 School-Based Health Centers (Cleveland County)

2:00 AIDS Program

3:00 Updates: Forensic Unit

Efficiency Study of Psychiatric Hospitals

Early Intervention Funding

Child Care Subsidy

County Commissioners' Letter on Medicaid Cost-Sharing

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

11:00 Food Bank Presentation

11:30 Impact of Budget Cuts on Psychiatric Hospitals

LUNCH (12:00 - 1:00)

1:00 Welfare Reform

■ 5-Year Business Plan/Reinvestment Strategy

■ Status of 1997-98 Funding

■ Implementation of Substance Abuse Initiatives

■ Initiatives to Reduce Out-of-Wedlock Births

3:00 Progress Report on Thomas S. Cost Containment

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

9:45 Status of Environmental Health Division

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 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	Jim Edgerton, Assistant Secretary for Budget, Management, & Planning <i>and</i> Peter Leousis, Assistant Secretary for Human Services and Education Policy, DHHS
	■ 5-Year Business Plan/Reinvestment Strategy	
	■ Status of 1997-98 Funding	
	■ 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

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

December 16-18, 1997

Room 544 - Legislative Office Building

Tuesday, December 16th, 10:00 - 4:00 pm

10:00 State Children's Health Insurance Program
Summary of the New Federal Program

Carol Shaw
Fiscal Research Division

11:00 State Children's Health Insurance Program
Other States' Proposals

Carol Shaw
Fiscal Research Division

LUNCH (12:00 - 1:00)

1:00 Task Force on Child Health Insurance Final Report

Dr. Gordon DeFriesse
NC Institute of Medicine

2:00 Department of Health & Human Service's Proposal
for Implementing the State Children's Health
Insurance Program

Dr. H. David Bruton, Secretary
Health & Human Services

3::30 State Employee's Health Plan - A Potential Option
Authorized by Federal Law

Dave DeVries
State Employee Health Plan

Joint Appropriations Subcommittee on Health & Human Services

December 16-18, 1997

Room 544 - Legislative Office Building

Wednesday, December 17th, 9:00 - 4:00 pm

9:00 Smart Start Program Update

Ashley Thrift, Chair
NC Partnership for Children
Board of Directors

David Walker, Executive Director
NC Partnership for Children, Inc.

Karen Ponder, Program Director
NC Partnership for Children, Inc.

11:00 Smart Start Program Evaluation

Donna Bryant, Ph.D., Director
Family and Child Care Research Program
Frank Porter Graham Child Development
Center

LUNCH (12:00 - 1:00)

1:00 Child Care Subsidy: An Investment
Strategy for NC

Sue Russell, Executive Director
Day Care Services Association, Inc.

2:00 Child Care and Work First

Peter Leousis, Assistant Secretary for
Human Services and Education Policy

3:00 Implementation of Senate Bill 929
("Enhance Child Care")

Stephanie Fanjul, Director
Division of Child Development

Joint Appropriations Subcommittee on Health & Human Services

December 16-18, 1997

Room 544 - Legislative Office Building

Thursday, December 18th, 900 - 12:00 pm

9:00	Medicaid Growth Reduction Plan Update	Dick Peruzzi, Director Division of Medical Assistance
10:00	Medicaid Dental Program	Dick Peruzzi, Director Division of Medical Assistance
10:45	Pharmaceutical Assistance Programs for the Low-Income Elderly	Stuart Bratesman, Jr. Duke Long Term Care Resources
11:15	Options for Making Prescription More Affordable for Older Adults	Lynne Perrin, Assistant Secretary Health & Human Services Bonnie Crammer, Special Assistant Health & Human Services

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

November 18-20, 1997
Room 414-Legislative Office Building

Tuesday, November 18th, 9:00 - 4:00 p.m.

SITE VISITS: *(board bus at Legislative Office Building at 9:00 a.m.)*

- C.A. Dillon Training School
- Vance/Granville/Franklin/Warren Area Authority
Henderson, N.C.

Wednesday, November 19th, 9:00 - 4:00 p.m.

2	DHHS Reorganization/Organizational Changes	Dr. D. Bruton, DHHS Stephanie Bass, DHHS
1	ABC's Plan for DHHS Residential Schools	Peter Leousis, DHHS Craig Green, DHHS
3	DHHS Audits & Response	Stan Wesner, Auditor's Office DHHS Staff

LUNCH

Disproportionate Share (DSH) Update	Allen Gamble, DHHS
Medicaid Growth Reduction Plan Update	Dick Peruzzi, DHHS

Thursday, November 20th. 9:00 - 12:00 p.m.

Human Services Delivery System Alternatives

- Wake County Human Services Department

Maria Spaulding,
Director

- Work First/Women's Health Initiative

Bruce Handley,
Mission St. Joseph's

Margerie Gram,
Asheville Housing
Authority

Carolyn Colvarde,
Buncombe DSS

Kaye Clark, R.N.
Mission St. Joseph's

- Regional Public Health Department (TBA)

Ron Levine, DHHS

Subcommittee Discussion Regarding December Meetings

Adjourn

Fiscal Research Division
November 13, 1997

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

November 18-20, 1997
Room 414-Legislative Office Building

Tuesday, November 18th, 9:00 - 4:00 p.m.

SITE VISITS: *(arrive at DHHS Butner Training Facility 9:00 a.m.
directions will be provided)*

- Vance/Granville/Franklin/Warren Area Authority
Henderson, N.C.
- Dillon Training School
- Whitaker School

Wednesday, November 19th, 9:00 - 4:00 p.m.

DHHS Reorganization/Organizational Changes

Dr. D. Bruton, DHHS

(review prior organization & current; review KPMG recommendations and status of implementation of recommendations, if any, long-term plans for organizational changes; compliance with Section 11 of SB 352 (use of consultant to assist in changing the organizational environment); changes in internal management practices (e.g., management reviews); report regarding recent management retreat; Where there was any significant variation from KPMG recommendations, have HHS indicate their rationale for doing so, and how it will lead to more efficiency and coordination and cooperation between divisions and other agencies so as to better serve clients. -WNM.

ABC's Plan for DHHS Residential Schools

Peter Leousis, DHHS

(discuss current status, including student performance at GMS and schools for the deaf) Let's include a presentation from the four schools as to their vision for the next five years - their realistic expectations as to what unique areas of excellence and fulfillment of public need can spring forth from each—WNM.

Wednesday, November 19th, 9:00 - 4:00 p.m.

LUNCH

Disproportionate Share (DSH) Update

Allen Gamble, DHHS

(what it is & History of DSH) & 1997 federal actions impact on NC) comprehensive presentation - WNM.

Medicaid Growth Reduction Plan Update

Dick Peruzzi, DHHS

(quantify budget reductions needed to meet 8% reduction goal; list & discuss reductions already implemented & their projected savings to federal, state & local; list all other reductions under consideration (short-term and long-term) and their projected savings to all levels of government; list and discuss productivity improvements and system changes which may impact the 8% reduction goal; discuss issues regarding limitations on medications & the impact on institutionalization; any other relevant information.)
Potential impact of changes in Medicare rules related to Home Health Reimbursement - LC.

DHHS Audits & Response

State Auditor's Office
DHHS Staff

Thursday, November 20th. 9:00 - 12:00 p.m.

Human Services Delivery System Alternatives

- Wake County Human Services Department
- St. John's Health Care System/Work First Initiative
- Regional Public Health Department (????)

Maria Spaulding,
Director

?????

????

Division of Aging: Review of Performance &
Program Budgeting

DHHS Staff

(provide description of service population and providers {demographics, numbers served; issues/special challenges regarding serving this population}; coordination between divisions; coordination at the local level; issues regarding governance; projections regarding future needs; list & discuss outcome measures)

Subcommittee Discussion Regarding December Meetings
(which will include Smart Start & Child Care)

Adjourn

Fiscal Research Division
November 3, 1997



North Carolina General Assembly
House of Representatives
State Legislative Building
Raleigh 27601-1096

REPRESENTATIVE CHARLOTTE A. GARDNER
35TH DISTRICT

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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

November 10, 1997

MEMORANDUM

TO: House Appropriations Subcommittee on Human Resources
Members

FROM: Representative Charlotte A. Gardner, Representative Lanier
Cansler and Representative Debbie Clary

SUBJECT: Field Trip to Butner

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES
FIELD TRIP*

DATE: Tuesday, November 18, 1997 - 9:00 a.m. to 5:00 p.m.

***Please Note:** Time change on Tuesday, November 18 to accommodate itinerary
planned by the Department of Health and Human Resources.

PLACE: Meet the bus at the front entrance of the Legislative Office
Building (LOB) on Lane Street.

If you have any questions about the field trip, please contact the Fiscal Staff: Karen
Hammonds-Blanks and Mary Ellen Sylvester. (919-733-4910)

P.S. On Wednesday and Thursday, November 19 and 20, the committee will meet in
Room 414 as published in the previous notice.

Barbara R. Hocutt, Clerk, 919-715-3017





North Carolina General Assembly
House of Representatives
State Legislative Building
Raleigh 27601-1096

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October 30, 1997

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, November 18, 19 and 20, 1997

**JOINT APPROPRIATIONS/SUBCOMMITTEE ON HUMAN RESOURCES
MEETING***

DATES: Tuesday, November 18, 1997 - 10 a.m. to 4 p.m.
Wednesday, November 19, 1997 - 9 a.m. to 4 p.m.
Thursday, November 20, 1997 - 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)

*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)



AGENDA

Joint Appropriations Subcommittee on Health & Human Services

October 21-23, 1997

Room 414-Legislative Office Building

Tuesday, October 21 10:00 a.m.

(Full Appropriations meets in Room 643)

(Subcommittee Meeting Begins Approximately 10:30 a.m. in Room 414)

- Welcome Co-Chairs
- Subcommittee Discussion
 - Goals for Interim Subcommittee Work
 - Planning & Instructions to Staff
- DHHS Organizational Changes & Related Issues Dr. David Bruton, Secretary
-KPMG Peat Marwick Report DHHS
-Key Staff Changes
- DHHS Updates (on legislative initiatives in SB 352) Jim Edgerton, DHHS
-NC ACTS and Title IVA-EA retroactive claims)

LUNCH 12:00 - 1:00 p.m.

- DHHS Lawsuits Update Marc Lodge, DHHS
- Child Welfare Expansion Report & Update Kevin FitzGerald, DHHS
- Report on Status of ABC's Plan for DHHS Residential Schools Peter Leousis, DHHS
- Report on Governor's Juvenile Crime Commission Dr. D. Bruton, DHHS
- Adult Care Homes Report Lynda McDaniel, DHHS

Wednesday, October 22nd. - 9:00 a.m.

- Caring for Children Program Overview Kathy Higgins, Acting Director
- Children's Health Insurance Gordon DeFries
Dr. D. Bruton
- Welfare Reform Report DHHS Staff
 - Overview & Status of Implementation
 - TANF Block Grant Special Initiatives
- Welfare-to-Work Initiative Pheon Beal, DHHS

LUNCH 12:00 - 1:00 p.m.

Wednesday, October 22nd. - 1:00 p.m.

- Area Mental Health Programs' Audits/Performance Reviews John Baggett, DHHS
 - Division's future plans Dick Peruzzi, DHHS
 - Overview of federal HHS required audits & findings
- Report on Medicaid & Related Programs/Issues Dr. D. Bruton, DHHS
 - Growth Reduction Plan Report Dick Peruzzi, DHHS
 - Carolina Access, Carolina Alternatives & DSH Update Allen Gambill, DHHS

Thursday, October 23rd. - 9:00 a.m.

- Report on Re-organization & Incorporation of New Public Health Divisions Dr. Ron Levine, DHHS
- Future Subcommittee Meetings

Adjourn

Fiscal Research Division



North Carolina General Assembly
House of Representatives
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Raleigh 27601-1096

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October 2, 1997

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, October 21, 22, 23, 1997

**JOINT APPROPRIATIONS/SUBCOMMITTEE ON HUMAN RESOURCES
MEETING***

DATES: Tuesday, October 21, 1997 - 10 a.m. to 4 p.m.
Wednesday, October 22, 1997 - 9 a.m. to 4 p.m.
Thursday, October 23, 1997 - 9 a.m. to 1 p.m.

PLACE: Room 424 LOB

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)





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October 2, 1997

COMMITTEES:

APPROPRIATIONS
CHAIRMAN: HUMAN RESOURCES
ENVIRONMENT
HUMAN RESOURCES: AGING
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WELFARE REFORM

STUDY COMMISSION ON MENTAL HEALTH,
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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, October 21, 22, 23, 1997

**JOINT APPROPRIATIONS/SUBCOMMITTEE ON HUMAN RESOURCES
MEETING***

DATES: Tuesday, October 21, 1997 - 10 a.m. to 4 p.m.
Wednesday, October 22, 1997 - 9 a.m. to 4 p.m.
Thursday, October 23, 1997 - 9 a.m. to 1 p.m.

PLACE: Room 424 LOB

If you have any questions about these meetings contact Fiscal Staff: Karen Hammonds-Blanks and Mary Ellen Sylvester. (919-733-4910)

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Barbara R. Hocutt
Committee Clerk
919-715-3017 (Thursdays)



Reporting Requirements, Senate Bill 352

SECTION XI. Department of Health & Human Services

<u>Section</u>	<u>Topic</u>	<u>Committee</u>	<u>Due Date</u>
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 Final Report	Appns./FRD General Assembly	Quarterly 5/18/98
11.60	ABC's Plan for DHR Schools Interim Report Final Report	Jt. Leg. Ed. Oversight	10/1/97 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

PLEASE USE THE BELOW SCHEDULE UNTIL AN OFFICIAL INTERIM CALENDAR HAS BEEN POSTED. Official notifications, cancellations, and changes of committee meetings are sent out by the Committee Clerks of the various committees.

INTERIM CALENDAR

Date: October 9, 1997 - 2:45 pm

Mon. - Thurs. October 6-9, 9:00 a.m. - Auditorium - Court of Appeals
Friday, October 10, 10:00 a.m. - Room 1027; 12:00 noon - Rooms 1228, 1425, and 1124 - Governor's Commission on Juvenile Crime and Justice
Tuesday, October 14, 10:00 a.m., Room 421LOB - House Select Com. on Education Grants
Tues.-Thurs. October 14-17, 8:00 a.m. -Room 1124 - Museum of Natural Science
Wednesday & Thurs., October 15&16, 10:00 a.m. Room 1228 - House Select Com. On Personnel Review
Thursday, October 16, 2:15 - Room 415 - ISD
Friday, October 17, 10:00 a.m., Room 1228 - Courts Commission
Mon. - Thurs. October 20-24, 9:00 a.m. - Auditorium - Court of Appeals
Tuesday, October 21, 10:00 a.m. - Room 1028- Beverly Adams - Wellness Fair
Tuesday, October 21, 10:00 a.m.
Room 1228 - Joint Appropriations Transportation Subcommittee
Room 421 - Joint Appropriations Education Subcommittee
Room 415 Joint Appropriations General Government Subcommittee
Room 414 Joint Appropriations Human Resources Subcommittee
Room 612 Joint Appropriations Justice & Public Safety Subcommittee
Room 605 Joint Appropriations Natural & Economic Resources Sub.
Wed. & Thurs., October 22-23, 9:00 a.m. All Joint Appropriations Subcommittees
(See Room listings above)
Thursday, October 23, 8:00 - 1:00 - Room 544 LOB - Rep. Miner
Friday, October 24, 10:00 a.m. - Room 1027; 12:00 noon - Rooms 1228, 1425, and 1124 - Governor's Commission on Juvenile Crime and Justice
Mon. - Thurs. October 27-30, 9:00 a.m. - Auditorium - Court of Appeals
Mon. & Tues. October 27 & 28, Room 1228 - House Select Com. On Personnel Review
Tues. & Wed. October 28-29 - Room 421 - Education Oversight
Thursday, October 30, 10:00 a.m. - Room 421 - House Select Com. On Education Grants
Tuesday, November 4, 2:00 p.m. - Rooms 612, 421, 605, & 415 Gov Ops Subcommittees
Wednesday, November 5, 9:00 a.m. - Room 643 - Governmental Operations
Friday, November 7, 10:00 a.m. - Room 1027; 12:00 noon - Rooms 1228, 1425, and 1124 - Governor's Commission on Juvenile Crime and Justice
Wed. & Thurs. Nov. 12-13 - Room 421 - Education Oversight

Barbara Hocutt (Rep. Gardner)

To: Human Resources Subcommittee
Cc: Beverly Adams
Subject: Appropriation Subcommittee on Human Resources

MEMORANDUM

TO: JOINT APPROPRIATIONS/Subcommittee on Human Resources
FROM: Representative Charlotte A. Gardner
Representative Debbie Clary
Representative Lanier Cansler
DATE: October 2, 1997
SUBJECT: Meetings, October 21, 22, 23, 1997

**JOINT APPROPRIATIONS/SUBCOMMITTEE
ON HUMAN RESOURCES
MEETING***

DATES: Tuesday, October 21, 1997- 10 a.m. to 4 p.m.
Wednesday, October 22, 1997 - 9 a.m. to 4 p.m.
Thursday, October 23, 1997 - 9 a.m. to 4 p.m.

Place:Room 424 LOB

If you have questions about this meeting contact Fiscal Staff: Karen Hammonds-Blanks and/or Mary Ellen Sylvester. (919-733-4910)

*According to the memo sent from Senator Plyler and Representative Holmes, the subcommittee is to meet the third week of the month on Tuesdays, Wednesdays and Thursdays beginning October, 1997 and continuing through April, 1998.

Barbara R. Hocutt
Committee Clerk
733-3017(Thursdays)