NORTH CAROLINA

STUDY COMMISSION ON AGING

REPORT TO THE GOVERNOR AND THE 1999 GENERAL ASSEMBLY (2000 REGULAR SESSION)

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North Carolina
Study Commission On Aging

May 8, 2000

To: **Governor James B. Hunt, Jr.**
President of the North Carolina Senate
Speaker of the North Carolina House of Representatives
Members of the 2000 General Assembly

Attached is the Report to the North Carolina General Assembly, 1999 Session – (2000 Regular Session), from the North Carolina Study Commission on Aging, pursuant to North Carolina General Statute 120-187, which reads: "The Commission shall report to the General Assembly and the Governor the results of its study and recommendations."

The North Carolina Study Commission on Aging presents to you findings and recommendations based on extensive study and public hearings. Proposed legislation is contained within this report.

Respectfully submitted,

William R. Purcell
Senator William Purcell

Beverly Earle
Representative Beverly Earle

NORTH CAROLINA STUDY COMMISSION ON AGING
1999-2000
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EXECUTIVE SUMMARY

Executive Summary

The North Carolina Study Commission on Aging is an independent commission created by the Study Commission and Committees Act of 1987, Chapter 873, Section 13.1. The charge to the seventeen member Commission is to Study issues of availability and accessibility of health, mental health, social and other services needed by older adults.

The Commission met ten times, including three public hearings, since its last *Report to the Governor and the 1997 General Assembly (1998 Regular Session).* The Commission has worked to establish a substantial forum for North Carolina's concerns about older adults.

The Commission found that the primary areas of need were still in-home and caregiver and other community-based services. Meeting these needs is exacerbated by the lack of a long-term care plan for North Carolina. In its *Report to the Governor and the 1999 General Assembly*, the North Carolina Study Commission on Aging makes the following recommendations:

1. The Commission recommends that the 1999 General Assembly (2000 Regular Session) require that nursing homes and adult care homes ensure that employees and residents are immunized against influenza virus and that residents are also immunized against pneumococcal disease.

2. The Commission recommends that the 1999 General Assembly (2000 Regular Session) repeal the sunset on requirements pertaining to the reimbursement rate for the respite care program.

3. The Commission recommends that the 1999 General Assembly (2000 Regular Session) require establishments that prepare or serve food to twelve or more regular boarders or regular house guests comply with the State food sanitation requirements.

4. The Commission recommends the 1999 General Assembly (2000 Regular Session) make technical corrections to the General Statutes pertaining to the Medical Care Commission authority to adopt rules regulating adult care homes.

5. The Commission recommends that the 1999 General Assembly (2000 Regular Session) return the time requirements for the investigation of complaints under the Protection of the Abused, Neglected, or Exploited Disabled Adult Act to the original time requirements before being amended by S.L. 199-334.

NORTH CAROLINA'S OLDER ADULTS

Today's Older Population

In 1998, an estimated 961,419 of our State's 7,547,090 residents were age 65 and older (12.7%). Of these older adults, 104,270 were age 85 and older. While North Carolina ranked 11th nationally in total population in 1998, it ranked 10th in the number of persons age 50 and older as well as those age 65 and older. North Carolina also ranked 10th among states in the rate of growth of the population age 65 and older between 1990 and 1998, and 6th in the growth of this population in the most recently reported year (1998-99). Its rate of 17.5% for the period 1990 to 1998 far exceeded the national rate of 10.1%.

For 2000, projections show more than 999,200 persons age 65 and older, or 12.9% of the State's 7,734,400 residents.

The differences among seniors are as great as within any age group. Still, there are some defining features:

- Older women outnumber older men. They represent 60.5% of those 65 and older, and 74% of the 85 and older age group.
- About 17% are of a minority race, mostly African-American.
- Only about 5% live in institutions or group residences. In 1990, more than half (58%) lived with their spouse; almost 28% lived alone. More than 3 out of 4 of those living alone were women.
- Nearly 57% did not complete high school.
- About 47% live in rural areas.
- About 79% own their homes, but with 33% living in housing built before 1950.

- In 1990, about 23.2% of older adults had a problem with at least one of the activities of daily living--getting around inside the house, bathing, dressing, eating, or using the toilet--or with mobility (getting around outside the house).
- Although the state poverty rate for older adults appears to be shrinking over the course of the 1990s, it still remains relatively high. Averaged over the years 1995 to 1997, the poverty rate for older North Carolinians was 12.5%, making it the 15th poorest state. In 1997, about 29% of non-institutionalized older adults in the state had incomes below 150% of the poverty level. For the year 2000, the federal poverty level for an individual is $8,350 and $11,250 for a couple.

Our cities, counties, and regions are aging at varying rates. The table that follows this narrative gives the number and proportion of persons age 65 and older by county for 1998. This ranges from 25.6% in Polk County to 5.5% in Onslow County.

North Carolina's Demographic Shift

- Older adults are North Carolina's fastest growing population.
- By 2010, North Carolina's senior population is projected to number more than 1.2 million (14.1% of our State's population). By 2020, the number is projected to grow to more than 1.6 million (17.3%). By 2025, our senior population should exceed more than 2 million (21.4%).
- This aging of our population is also evident in the climbing median age, which today is 36.07 years and is expected to increase to 38.33 in 2010, and 39.25 by 2020.

➢ All states are projected to show a decline in the proportion of youth (under 20 years old) in their populations from 1995 to 2025. The percentage of North Carolina's population classified as youth is projected to decrease from 27.7 % in 1995 to 23.2 % in 2025. In contrast, the size of the older population is projected to increase in all states over this 30 year period. Our percentage of older adults in 1995 (12.5%) was slightly less than the national average (12.8%), ranking North Carolina 31st among states. Our projected increase to 21.4% by 2025 will rank us 11th in the highest proportion of older adults.

Why This Demographic Shift

While much of the aging of our State's population has been attributed to the aging of the Boomer cohort (those born between 1946 and 1964), the primary reason has to do with birth rates. Since the end of the baby boom in 1964, women have chosen, on average, to have two children as opposed to the three averaged during the baby boom period. To a smaller degree, improved life expectancy has also caused an increase in both our total population and our percentage of older adults.

A third factor in the aging of our population is migration. Like most of the other sunbelt states, North Carolina has attracted young and middle-aged workers who are aging in place here. However, we are especially likely to attract people who migrate after retirement. We expect North Carolina to retain its high national ranking of 3rd in net migration of retirees when the results of the year 2000 Census are known.

What Are the Implications of This Shift

While the aging of our society is a national trend, the impact is mor significant in North Carolina because of our high concentration of older adults. This is relevant to all areas of our public and private lives. Government faces decisions about the allocation of public resources from a tax base that may experience slowed growth. People must consider living and caregiving arrangements in light of smaller nuclear and extended families. The health, human service, and education systems must adapt to changes in interests and needs due to a sophisticated senior baby boomer and a consistently large rural senior population. The business, cultural, and other communities must identify and respond to the challenges and opportunities of these demographic shifts. Government agencies and service providers must overcome the barriers that tend to isolate many NC seniors who are living in rural areas, are non-English speaking, are illiterate, and have limited or no support systems within the proportionately smaller younger population.

There are large numbers of seniors today who contribute to our families and communities as well as some who must ask for help. Our current experience, though, is nothing like what we will encounter in the near future. We must respond to the challenges of today and prepare to meet tomorrow's.

ISSUES ASSIGNED TO THE COMMISSION

Besides its regular activities, the Commission was assigned a number of issues related to aging. The Legislative Research Commission under its statutory authority assigned four topics for study and S.L. 1999-334 (SB 10) assigned an additional four topics to the Commission for its analysis and recommendations. Below is the disposition of the eight assigned issues.

Topics Assigned by the Legislative Research Commission

1. **Immunization of Residents and Employees of Nursing Homes, Adult Care Homes and Adult Day Care Homes.** The Commission reviewed this topic at several meetings with the help of Older Adults Immunization Program within the Department of Health and Human Services. Evidence presented suggests that morbidity and mortality can be very high among the elderly institutionalized population who contracts influenza and/or pneumoccal disease. A suggested strategy to combat these types of outbreaks is to require adult care home and nursing homes to ensure that residents and employees of nursing homes and adult care homes be immunized against influenza virus. Adult care homes and nursing homes should also ensure that residents be immunized against pneumoccal disease. Therefore, included within this Report is a recommendation and a bill for the 1999 General Assembly (2000 Regular Session) to implement these findings

2. **Biannual inspection and Grading of Adult Care Homes.** The Commission has had a great interest in this topic over a number of years and welcomed the direction given by the Legislative Research Commission to more thoroughly analyze the possibility of such a system that would give consumers help in selecting an appropriate facility. To further this analysis, the Commission appointed a subcommittee to study the issues in some detail. It was learned by the subcommittee that a national research group is also studying the issues and is using North Carolina in this study. Therefore, the Commission has modified its schedule to parallel these national efforts. A report will be made to the 2001 General Assembly on this issue.

3. **Rationale and Appropriateness of Present Cost-Sharing of Nonfederal Costs of Medicaid.** The 1999 General Assembly directed the Secretary of the Department of Health and Human Services to develop a system that provides a continuum of long-term care for the elderly and disabled and to examine long-term care issues affecting older adults. The Institute of Medicine is conducting this study for the Secretary. The Commission believes that no financing issues should be

addressed until this long-term care plan is presented the General Assembly. Therefore, the Commission chose not to study the issue before the 1999 General Assembly (2000 Regular Session).

4. **Long-Term Care Facility Licensure Compliance.** The Commission took no action on this assignment. As mentioned above, the Commission awaits the Long-term care report from the Secretary before making any recommendations about how long-term care facilities should be regulated.

Topics Assigned by S.L. 1999-334 (SB 10)

1. **Need for Licensure of Adult Care Home Administrators.** The topic of licensure of adult care home administrators was assigned to the Commission by S.L. 1999-334. After S.L. 1999-334 was passed, the General Assembly considered and passed HB 512 that regulates this group of administrators. Therefore, there was no need for the Commission to study an issue already resolved by the 1999 General Assembly.

2. **Establishment of a Licensing Fee as Source of Revenue for the Temporary Management Contingency Fund.** Article 13 of G.S. Chapter 131E establishes procedures under which a court may appoint a temporary manager to ensure the proper operation of a long-term care facility when conditions in the facility create a substantial risk of death or serious physical harm to residents or patients or when other specified conditions exists. Due to constitutional concerns, S.L. 199-334 repealed the existing statutory language authorizing DHHS to finance its Temporary Management Contingency Fund from the proceeds of penalties imposed on nursing homes and adult care homes. Currently there is no source of funds for this Temporary Management Contingency Fund. Therefore Section 3.13 of S.L. 1999-334 requires the Commission to study licensing fees as a source of revenue for monitoring, staffing and temporary management of adult care homes.

   To undertake the investigation of this matter, the Commission appointed a subcommittee. The subcommittee met on February 17, 2000 to discuss the issue. It was learned that the General Assembly's historical policy has been not to charge a fee for State required inspection and licensing of facilities to protect the public health. After much discussion by the subcommittee, there was little support for recommending to the General Assembly that these activities be supported by a fee system but there was concern about finding a source of revenue for the Temporary Management Contingency Fund. In this light, the Commission determined

that an alternative funding source should be pursued. The Commission is requesting that the Department of Health and Human Services explore other sources of funds that could be used for the Temporary Management Contingency Fund and report back to the Commission by November 1, 2000 if legislative changes are needed. (See Appendix I).

3. **Current Regulatory System for Adult Care Homes.** There has been much concern about how adult care homes are regulated by the State and counties. It has been suggested that there is much overlap and overkill by this system and that certain agencies currently regulating these facilities may not be the appropriate ones to regulate. Therefore Section 3.13 of S.L. 1999-334 required the Commission to review these issues based upon the report required of the Department of Health and Human Services. This report was reviewed by the Commission on February 17, 2000.

   It was reported that the Department had already taken a number of steps intended to improve the efficiency of the regulatory process in place for monitoring adult care homes as well as improving the program management capacity of the Department related to licensure and monitoring of adult care homes. Several of these steps are in direct response to concerns raised in the State Auditor's 1998 performance audit of long-term care programs in North Carolina as administered by the Department of health and Human Services. Given that the steps already taken by the Department have been initiated within the past year, additional time is needed to evaluate the impact these changes have on the quality and efficiency of the Department's monitoring system for adult care homes. In spite of the steps taken, there are several known barriers that have not yet been addressed. There are no specific recommendations being made that require legislative action. There are, however, critical next steps that will be taken by the Department to assure that the barriers that continue to exist begin to be addressed so that the most efficient regulatory system possible for adult care homes can be achieved. The Commission will continue to monitor the situation. (See the report entitled "Building a More Efficient Regulatory System for Adult Care Homes" in Appendix J)

4. **Admission of Persons whose Behavior Poses a Threat.** While this topic was assigned to the Commission, S.L. 1999-334 also assigned a similar topic to the Mental Health Study Commission. The Commission determined that this topic was more appropriate for the Mental Health Study Commission.

FINDINGS AND RECOMMENDATIONS

RECOMENDATION 1

The Commission recommends that the 1999 General Assembly (2000 Regular Session) require that nursing homes and adult care homes ensure that employees and residents are immunized against influenza virus and that residents are also immunized against pneumococcal disease. (See Appendix B and Appendix C)

The aging of the US and the North Carolina population has occurred steadily over the last century, and this dramatic trend is expected to continue in the coming decades. In 1995, 33 million people aged 65 and older compromised 13% of the US population. As we enter the 21st century, we can expect the number of North Carolinians age 65 and older to grow to 1,005,000. This also represents 13% of the State's population. There will be a marked increase in those 85 years and older. This will significantly impact long-term care and medical management in the nursing homes and adult care homes because a large portion of these older people will require long-term care.

Pneumonia and influenza are the leading causes of death attributable to infection in patients aged 65 and older and in the long-term care setting pneumonia accounts for 13 to 48% of infections with mortality rates as high as 44%.

The Commission asked the Older Adults Immunization Program within the Department of Health and Human Services to brief the Commission about the situation within North Carolina. The following are facts learned by the Commission.

- Although preventable by safe and effective immunizations, influenza and pneumonia are major public health problems in North Carolina, especially among senior citizens;
- In 1997, there were 2457 deaths attributable to influenza and pneumonia;
- 88% of these deaths were in older adults aged 65 years and older; and
- A significant difference exists between Caucasian and African-American immunization rates and mortality rates.

The public health forces are doing an excellent job in adult immunization by increasing the demand for vaccination through provider and public awareness and by increasing the capacity of the health care delivery system to effectively deliver vaccines to adults. Although these are excellent strategies, the Commission believes from the evidence presented that the residents and employees of adult care homes and nursing homes are a special population and more vulnerable to outbreaks of these diseases with increased chances of morbidity and mortality. A suggested strategy to combat these types of outbreaks is to require adult care home and nursing homes to ensure that residents and

employees of nursing homes and adult care homes be immunized against influenza virus. Adult care homes and nursing homes should also ensure that residents be immunized against pneumoccal disease. No individual within these two types of long-term care facilities would be required to receive either an influenza vaccine or pneumoccal vaccine if the vaccine is medically counterindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

RECOMMENDATION 2

The Commission recommends that the 1999 General Assembly (2000 Regular Session) repeal the sunset on requirements pertaining to the reimbursement rate for the respite care program. (See Appendix D and Appendix E).

G.S. 143B-181.10 establishes a respite care program administered under the auspices of the Division of Aging. Respite care is part of the continuum of care for impaired older adults to enable families to care for members in their homes and to prevent or delay institutionalization. The following respite services and activities are allowable: temporarily placing the person out of his home to provide the caregiver total respite when the mental or physical stress on the caregiver necessitates this type of respite; personal care services, including meal preparation for the patient of the caregiver; counseling and training in the caregiver role, including coping mechanisms and behavior modification techniques; counseling and accessing available local, regional, and State services; support group development and facilitation; assessment and care planning for the patient of the caregiver; and attendance and companion services for the patient in order to provide release time for the caregiver. Allowable out of home placements outlined in G.S. 143B-181.10 include a hospital, intermediate or skilled nursing facility, adult care home adult day health care center, and adult day care center.

Out of home respite is also referred to as "institutional respite" and is one of the seventeen services available under the Home and Community Care Block Grant. Some typical examples of how this service is used by families include:

- a full-time family caregiver needs a weekend break and has no other family/friend to count on to give them such relief;
- a caregiver needs to have a medical procedure performed and needs a short recovery period prior to resuming caregiving duties;
- a full-time family caregiver needs a weekend break to visit a sick family member or attend a family function.

This type of short-term relief can mean the difference between caregivers being able to continue providing care for an older adult or having to consider a long-term out of home placement. Prior to 1998, the amount of program funds that could be used to pay for out of home respite placement was limited to "the current maximum monthly rate for adult care home care that may be charged to public assistance recipients. In no other program within the Community Care Block Grant was the reimbursement rate set in statute.

In response to requests from individuals and agencies that the maximum reimbursement rate for out of home respite be lifted, the Commission recommended to the 1998 General Assembly that this cap be lifted. Subsequently, Senator Bob Carpenter introduced SB 1149. The purpose was to encourage this form or respite to become a more viable service. Limiting the reimbursement rate of out of home respite to the adult care home rate paid by the State appeared to discourage the utilization of out of home respite.

As the bill worked its way through the committees, concern was expressed that since the Community Care Block Grant was a limited amount of money, lifting the cap on out of home respite might adversely affect some other service offered through the Community Care Block Grant. Therefore, attached to the final version of the bill was a sunset and a requirement directing the Division of Aging to report to the North Carolina Study Commission on Aging regarding the impact of the repeal of the statutory limitation on the reimbursement rate for out of home placement on Respite Care Program services and funds.

Indications, as reported by the Division of Aging, as of this date are that the removal of this cap is a move in a positive direction; having the rate approximate market rate for care does not appear to lead to significant additional expenditure of funds. Therefore, based upon this report, the Commission believes that the sunset imposed by SB 1149 should be lifted. Appendix C contains a copy of the Report entitled "An Analysis of the Impact of Removing the Maximum Reimbursement Rate for Out-of Home Respite on Respite Care Services and Funding" and Appendix D contains a copy of the proposed bill.

RECOMMENDATION 3

The Commission recommends that the 1999 General Assembly (2000 Regular Session) require establishments that prepare or serve food to twelve or more regular boarders or regular house guests comply with the State food sanitation requirements. (See Appendix F).

Housing is a vital factor in determining the quality of life for older persons. A well-designed and suitably located residence can increase opportunities for

social contact and ease the burdens of disability that often accompany aging. North Carolina and the Commission have been increasingly concerned with the issues of housing for the State's growing aging population. While the State has been involved with various kinds of housing with services such as adult care homes, assisted living and other kinds of subsidized and regulated housing, the private market has also begun to provide unlicensed elderly housing developments, some of which offer services such as meals.

The State, currently classifies unlicensed elderly housing developments that serve meals to residents as boarding homes. As such, these properties are exempt from inspections under the current statute, G.S. 130A-250 which governs the sanitation of restaurants and other food-handling establishments. The Commission believes that this is an unintended consequence of the rapid development of housing with services within the last ten years. These facilities who rent to the elderly are not the kind of facility envisioned in the statutory definition of "establishments that prepare or serve food or provide lodging to regular boarders or permanent house guests". These facilities exempted by the statute are the old-fashioned "boarding homes" that once were a fixture in every town in North Carolina.

The State has for many years regulated sanitation in restaurants, schools, nursing homes, adult care homes and other types of facilities that serve food to the public or vulnerable populations. There are a number of exemptions to this regulation including private clubs and establishments that prepare or serve food to regular boarders or permanent house guests. The Commission believes that these new types of housing developments that serve meals for the elderly are not like the old "boarding homes" and should be required to have their food preparation facilities inspected just as any other restaurant. Scientists suggest that the elderly along with children, are more vulnerable to food-born diseases than the general population.

It appears that amending the statute to require such facilities to meet State sanitation standards would primarily affect private-pay elderly housing properties. The Division of Aging conducted a search and identified fifty private-pay elderly housing developments in North Carolina that provide meals to residents. These represent at least 2,629 units-apartments, villas or other type of living arrangements. These numbers are not conclusive. These fifty developments do not include Continuing Care Retirement Communities but it is assumed that since the definition of a CCRC requires one of its components to be licensed, most of its food preparation facilities are already inspected. It is also likely that other facilities exist of which the Division of Aging is not aware that meet these criteria. It is difficult to get a complete number since these facilities are not licensed and no record is kept.

RECOMMENDATION 4

The Commission recommends the 1999 General Assembly (2000 Regular Session) make technical corrections to the General Statutes pertaining to the Medical Care Commission authority to adopt rules regulating adult care homes. (See Appendix G)

S.L. 1999-334 (SB 10) amends G.S. 143B-153, G.S. 143B-165 and several provisions in G.S. Chapter 131D to transfer from the Social Services Commission to the Medical Care Commission rule-making authority with respect to the licensure, inspection, and operation of adult care homes and personnel requirements for adult care home staff. Although the General Assembly's intent was to transfer all rule-making authority with respect to adult care homes from the Social Services Commission to the Medical Care Commission, S.L. 1999-334 failed to amend G.S. 131D-4.3, which authorizes the Social Services Commission to adopt rules with respect to the assessment of adult care home residents, independent case management for adult care home residents, training requirements for personal care aides employed by adult care homes, monitoring and supervision of adult care home residents, oversight of and quality of care in adult care homes, and adult care home staffing requirements. The Social Services Commission would still retain authority over case management and client assessment for public assistance programs such as State/County Special Assistance. (See Section 3 of the bill in Appendix G.

Also, S.L. 1999-334 gave authority both to the Secretary of the Department of Health and Human Services and the Medical Care Commission to make rules concerning the transfer and discharge of residents in adult care homes. The attached bill would delete the rule-making authority of the Social Services Commission in G.S. 131D-4.3 and the Secretary in G.S. 131D-21(17) and place sole rule-making authority with the Medical Care Commission for adult care homes.

RECOMMENDATION 5

The Commission recommends that the 1999 General Assembly (2000 Regular Session) return the time requirements for the investigation of complaints under the Protection of the Abused, Neglected, or Exploited Disabled Adult Act to the original time requirements before being amended by S.L. 1999-334. (See Appendix H)

G.S. 131D-26 requires county departments of social services to investigate complaints alleging violations of the Adult Care Home Residents' Bill of Rights. Since there were no time frames listed in the statute in which an investigation

had to take place, S.L. 1999-334 amended G.S. 131D-26 to establish new time frames for the investigation of complaints involving the care or safety of residents. Complaints alleging life-threatening situations must be investigated immediately. Investigations of complaints alleging abuse of a resident must be initiated within twenty-four hours of receipt of the complaint; investigations involving the neglect of a resident must be initiated within forty-eight hours. All other investigations must be initiated within two weeks of the date the complaint is received. County social services departments must complete all investigations within thirty days.

Article 6 of Chapter 108A protects adults who are abused, neglected, or exploited. This act which was passed in 1973 and has primarily been applied in the noninstitutional setting. In an attempt to make G.S. 131D-26 and 108A-103 parallel, S.L. 1999-334 changed the time frames in G.S. 108-103 to mirror the time frames established in 131D-26.

The Division of Social Services came before the Commission and suggested that, in fact, these two statutes were not parallel and that the time frames within G.S. 108A-103 should be returned to the wording before the enactment of S.L. 1999-334. After reviewing both statutes and the function of each, the Commission believes that G.S. 108A-103 should be returned to the wording before the passage of G.S. 1999-334.

APPENDIX-A

Older Adults in North Carolina In 1998						
State Totals: 961,419 State Percent: 12.74%						
County	**Age 65+**	**%**		**County**	**Age 65+**	**%**
ALAMANCE	19,120	15.72%		JOHNSTON	13,398	12.44%
ALEXANDER	4,006	12.56%		JONES	1,383	14.93%
ALLEGHANY	2,043	20.73%		LEE	7,052	14.46%
ANSON	3,842	15.99%		LENOIR	8,668	14.79%
ASHE	4,504	19.01%		LINCOLN	7,292	12.34%
AVERY	2,494	16.28%		MCDOWELL	6,331	15.78%
BEAUFORT	6,834	15.69%		MACON	6,753	23.99%
BERTIE	3,031	15.13%		MADISON	3,290	17.51%
BLADEN	4,720	15.34%		MARTIN	3,911	15.26%
BRUNSWICK	11,582	17.21%		MECKLENBURG	58,953	9.44%
BUNCOMBE	32,158	16.64%		MITCHELL	2,852	19.50%
BURKE	12,029	14.30%		MONTGOMERY	3,291	13.31%
CABARRUS	15,709	13.02%		MOORE	16,352	23.09%
CALDWELL	10,229	13.57%		NASH	11,161	12.67%
CAMDEN	926	14.52%		NEW HANOVER	19,883	13.40%
CARTERET	9,401	15.86%		NORTHAMPTON	3,757	18.10%
CASWELL	3,555	15.88%		ONSLOW	8,238	5.53%
CATAWBA	16,936	12.87%		ORANGE	9,936	9.09%
CHATHAM	7,216	15.71%		PAMLICO	2,329	19.25%
CHEROKEE	4,653	20.42%		PASQUOTANK	4,943	14.22%
CHOWAN	2,677	18.61%		PENDER	5,731	15.04%
CLAY	1,800	21.85%		PERQUIMANS	2,122	19.38%
CLEVELAND	13,361	14.55%		PERSON	4,859	14.59%
COLUMBUS	7,625	14.62%		PITT	12,385	9.78%
CRAVEN	11,423	12.83%		POLK	4,269	25.61%
CUMBERLAND	22,356	7.64%		RANDOLPH	15,916	12.82%
CURRITUCK	2,232	13.00%		RICHMOND	6,549	14.39%
DARE	3,435	12.21%		ROBESON	12,382	10.82%
DAVIDSON	18,289	12.94%		ROCKINGHAM	13,504	15.06%
DAVIE	4,942	15.37%		ROWAN	19,129	15.34%
DUPLIN	6,350	14.35%		RUTHERFORD	9,579	15.95%
DURHAM	19,795	9.86%		SAMPSON	7,961	14.93%
EDGECOMBE	6,949	12.70%		SCOTLAND	3,994	11.35%
FORSYTH	37,868	13.07%		STANLY	8,205	14.76%
FRANKLIN	5,563	12.52%		STOKES	5,283	12.23%
GASTON	22,868	12.63%		SURRY	10,820	15.93%
GATES	1,429	14.30%		SWAIN	1,995	16.40%
GRAHAM	1,312	17.58%		TRANSYLVANIA	6,136	21.67%
GRANVILLE	5,520	12.40%		TYRRELL	696	17.87%
GREENE	2,502	13.64%		UNION	10,766	9.78%
GUILFORD	49,494	12.75%		VANCE	5,399	12.95%
HALIFAX	8,151	14.71%		WAKE	45,794	7.97%
HARNETT	10,052	12.03%		WARREN	3,720	19.67%
HAYWOOD	10,696	20.72%		WASHINGTON	2,011	15.35%
HENDERSON	18,883	23.35%		WATAUGA	4,758	11.62%
HERTFORD	3,306	15.33%		WAYNE	12,683	11.19%
HOKE	2,968	9.88%		WILKES	9,215	14.55%
HYDE	954	16.62%		WILSON	9,270	13.36%
IREDELL	15,548	13.70%		YADKIN	5,584	15.66%
JACKSON	4,514	15.27%		YANCEY	3,081	18.58%

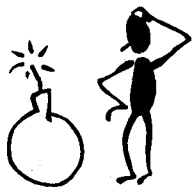
Report for the North Carolina Study Commission on Aging

Increasing Influenza and Pneumococcal Immunization Rates for Older Adults in North Carolina

Susan B. Morgan, M.H.A
Director, Older Adult Immunization Program

Presentation Date: February 17th, 2000

What's the Problem?

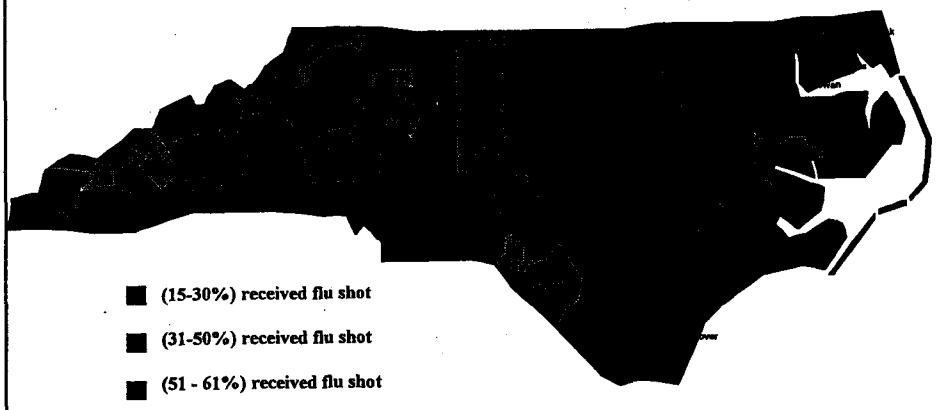


- Although preventable by safe and effective immunizations, influenza and pneumonia are major public health problems in North Carolina, especially among senior citizens;
- In 1997, there were 2,457 deaths attributable to influenza and pneumonia;[1]
- 88% of these deaths were in older adults (age 65 years and older;[1]); and
- A significant difference exists between Caucasian and African-American immunization rates and mortality rates.

[1] - North Carolina State Center for Health Statistics - 1997 Mortality Statistics

1998 Influenza Immunization Rates for North Carolina Medicare Beneficiaries Age 65 and Older

State Average = 46.1%



- (15-30%) received flu shot
- (31-50%) received flu shot
- (51 - 61%) received flu shot

Note: 1997 National Average= 44.04%
Healthy People 2010 Goal: Increase immunization rate to 90% for adults ≥ 65 years of age.

Influenza:

- Viral illness that spreads from infected persons to the nose or throat of others;
- Symptoms:
  - fever, cough, chills, sore throat, headache, muscle aches;
- Complications include bronchitis and pneumonia;
- Influenza vaccine can prevent influenza.

U.S. Dept. of Heath and Human Services, Centers for Disease Control and Prevention, National Immunization Program

Who should get influenza vaccine?

- Everyone age 65 and older;
- Residents of Long-term Care Facilities housing persons with chronic medical conditions;
- Anyone who has a serious long-term health problem;
- Anyone whose immune system is weakened;
- Anyone age 6 months to 18 years on long-term aspirin treatment;

U.S. Dept. of Heath and Human Services, Centers for Disease Control and Prevention, National Immunization Program

Who should get influenza vaccine? (continued)

- Women who will be past the 3rd month of pregnancy during flu season; and
- Physicians, nurses, family members, or anyone else in close contact with people at risk of serious influenza.

U.S. Dept. of Heath and Human Services, Centers for Disease Control and Prevention, National Immunization Program

Pneumococcal Disease

- Bacterial illness that kills more people in the United States each year than all other vaccine-preventable diseases combined;
- Complications of Pneumococcal Disease include:
  - infections of the lung (pneumonia), the blood (bacteremia), and the covering of the brain (meningitis);
- The PPV vaccine protects against 23 types of Pneumococcal bacteria.

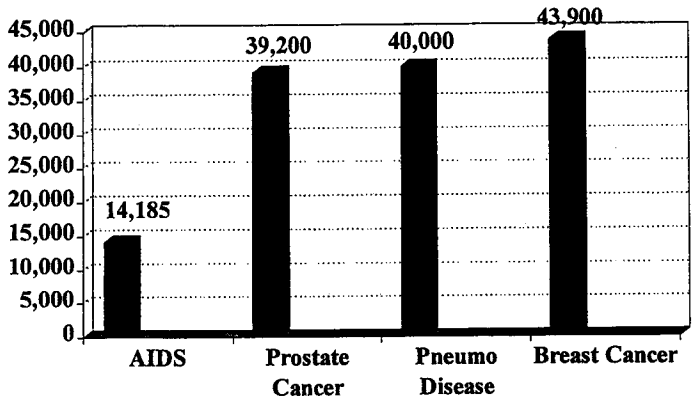
U.S. Dept. of Heath and Human Services, Centers for Disease Control and Prevention, National Immunization Program

Who should get Pneumococcal vaccine?

- All adults age 65 or older;
- Anyone over 2 years of age who has a long-term health problem;
- Anyone over 2 years of age who has a weakened immune system;
- Anyone over 2 years of age who is taking any drug that lowers the body's resistance to infection; and
- Alaskan Natives and certain Native American populations.

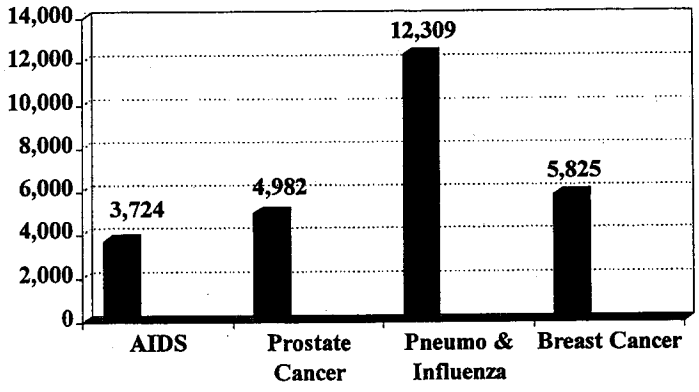
U.S. Dept. of Heath and Human Services, Centers for Disease Control and Prevention, National Immunization Program

Comparison of Annual U.S. Deaths



References: AIDS-Centers for Disease Control and Prevention: Estimated incidence of AIDS and deaths of persons with AIDS, adjusted for delays in reporting , by quarter-year of diagnosis/death, United States, January 1985 through June 1997, HIV/surveillance Report 9(2):, 19, December 1997. Prostate Cancer and Breast Cancer- American Cancer Society: Estimated new cancer cases and deaths by sex for all sites, in *Cancer Facts & Figures*- 1998, New York, American Cancer Society, 1998, p.4. Pneumoccal Disease- Centers for Disease Control and Prevention: Prevention of pneumoccal disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR 46(RR-8):1-24, April 4, 1997.

Comparison of North Carolina Deaths 1994 - 1998



Source: 2000 North Carolina County Data - N.C. State Center for Health Statistics

"Reported Resons for Not Receiving Influenza and Pneumococcal Vaccination--United States, 1996":

Influenza vaccination:

1. "I did not know the shot was needed";
2. "Did not think of it/ missed it";
3. "Thought flu shot would cause the flu";
4. "Thought flu shot would have side effects"; and
5. "Did not think it would prevent the flu".

CDC - MMWR Weekly Report October 08, 1999/48(39);556-890

"Reported Reasons for Not Receiving Influenza and Pneumococcal Vaccination--United States, 1996":

"Don't like shots!"...#6

Pneumococcal vaccination:

1. "I did not know the shot was needed";
2. "Doctor did not recommend it";
3. "Did not think of it/missed it";
4. "Did not think it would prevent pneumonia "; and
5. "Thought I was not at risk of catching pneumonia".

How are we addressing the issue?

- Kate B. Reynolds Charitable Trust Fund has provided funding to the Department of Health and Human Services, Division of Public Health to establish the Older Adult Immunization Program (OAIP).
- In collaboration with Medical Review of North Carolina, a Senior Vaccination Season (SVS) Coalition has been established.

Senior Vaccination Season:

- First statewide collaborative effort was held for one day on November 3, 1996 and called Senior Vaccination Sunday;
- In 1997, the effort was extended to 2 weeks in October and renamed *Senior Vaccination Season*;
- During 1998 and 1999 SVS was held during the month of October with all 100 Local Health Departments participating in 1999.

1999 SVS Strategies:

- All SVS coordinators were provided a SVS guidebook in June, 1999;
- 45 Public Service Announcements were mailed to N.C. TV and radio stations;
- Letter from Division of Public Health's Director mailed to private physicians, nursing home administrators, and adult day care administrators, encouraging them to provide adult influenza and pneumococcal immunizations;
- A study to research potential areas for state policy development conducted through UNC-Chapel Hill; and
- Local Health Departments provided over 120,000 influenza and more than 11,000 pneumococcal immunizations to older adults during SVS '99.

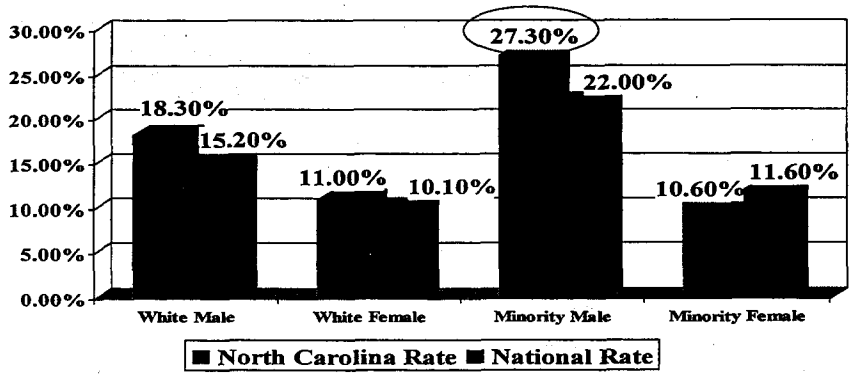
Hurricane Floyd!

- 5,813 doses in three North Carolina health departments were destroyed;
- Division of Public Health staff requested and received FEMA vaccine worth $36,000; and
- FEMA vaccine was distributed to SVS coordinators in 27 Flood-Effected counties.

Future Focus

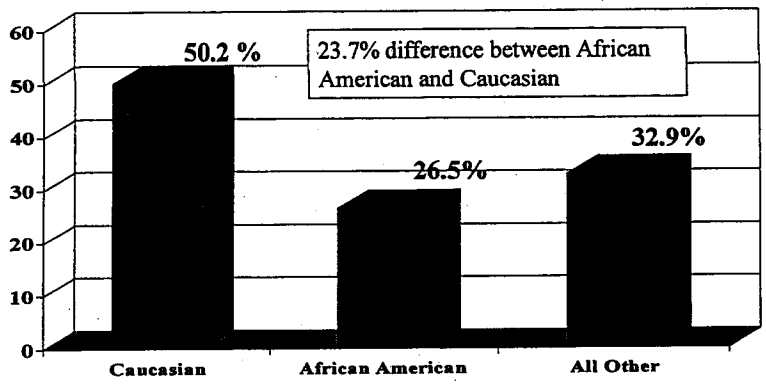
- Increasing rates to reach HP 2010 goals;
  - Increase rate of non- institutionalized adults age 65 and older to *90%;*
  - Increase rate of high-risk, non-institutionalized adults age 18-64 years of age to *60%;* and
  - Institutionalized adults (persons in long-term care or nursing homes) to *90%.*
- Focusing on Professional Education;
- Surveillance and tracking; and
- Conduct research in order to address Immunization and Mortality Disparities.

North Carolina and National 1996 Pneumonia/Influenza Mortality Rates



Source: North Carolina Health Statistics Pocket Guide - 1997, N.C. Center for Health Statistics
Deaths per 100,000 population.

North Carolina Medicare Beneficiaries By Race Receiving Influenza Immunization in 1998



Source: 1998 Medicare Beneficiary Data - Medical Review of North Carolina, Inc.

Cost-effectiveness of Vaccination against Pneumococcal Bacteremia among Elderly People (Sisk, J.E. etal, JAMA, October 22, 1997:

*Pneumococcal Vaccination Improved Health and Saved Net Medical Costs**

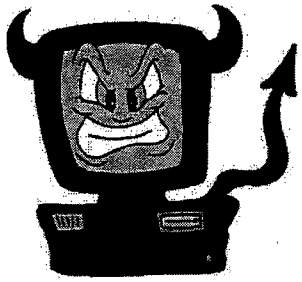
Vaccination of the 23 million people indicated, would have gained 78,000 years of life, and saved *$194 million dollars.*

Group	Total Cost ($)	Total Effectiveness (Quality-Adjusted Life-Years**)	Incremental Cost ($)	Incremental Quality-Adjusted Days Gained
Age ≥ 65 years				
No vaccination	96.69	6.22811		
Vaccination	88.42	6.22978	-8.27	+1.21
Age 65-74 years				
No Vaccination	98.45	7.88752		
Vaccination	91.77	7.89157	-6.68	+1.48
Age75-84 years				
No Vaccination	98.38	4.65384		
Vaccination	87.47	4.65650	-10.91	+0.97
Age ≥ 85 years				
No vaccination	82.48	2.31720		
Vaccination	73.90	2.31879	-8.58	+0.58

*Base-case analysis for persons ≥ 65 years of age vaccinated in 1993

** Quality-adjusted life-years consisted of increased years of life attributed to preventing pneumococcal bacteremia, minus any adverse vaccine effects and minus reductions to reflect less-than-perfect health during surviving years

HOT!
Adult Immunization Websites:



- Http://www.nfid.org/ncai/
- Http://www.nfid.org/
- Http://medicare.gov/fightflu/fightflu.html/
- Http://immunofacts.com/

Proposed Action Plan:

- *Increase* the demand for vaccination by improving *provider* and *public* awareness.
- *Increase* the capacity of health care delivery system to effectively deliver vaccines to adults.
- *Expand* financing mechanisms to support the increased delivery of vaccines to adult.
- *Monitor* and *Improve* the performance of the State's Adult Immunization Program.
- *Conduct* research on all vaccine-preventable diseases of adults.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H **D**

99-LNZ-213A(3.17.00)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Long Term Care Residents/Immuniz. Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT ADULT CARE HOMES AND NURSING HOMES ENSURE THAT RESIDENTS AND EMPLOYEES ARE IMMUNIZED AGAINST INFLUENZA VIRUS AND THAT RESIDENTS ARE ALSO IMMUNIZED AGAINST PNEUMOCOCCAL DISEASE.

The General Assembly of North Carolina enacts:

Section 1. Effective September 1, 2000, Article 1 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-3.9. Immunization of employees and residents of adult care homes.**

(a) Except as provided in subsection (f) of this section, an adult care home licensed under this Article shall require residents and employees to be immunized against influenza virus and shall require residents to also be immunized against pneumococcal disease.

(b) Upon admission, an adult care home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against influenza virus and pneumococcal disease.

(c) An adult care home shall notify every employee of the immunization requirements of this section and shall request that the employee agree to be immunized against influenza virus.

(d) An adult care home shall document the annual immunization against influenza virus and the immunization against pneumococcal disease for each resident and each employee, as required under this section. Upon finding that a resident is lacking one or both of these immunizations or that an employee has not been immunized against influenza virus, or if the adult care home is unable to verify that the individual has received the required immunization, the adult care home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(e) For an individual who becomes a resident of or who is newly employed by the adult care home after November 30 but before March 30 of the following year, the adult care home shall determine the individual's status for the immunizations required under this section, and if found to be deficient, the adult care home shall provide the immunization immediately.

(f) No individual shall be required to receive either an influenza vaccine or pneumococcal vaccine if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(g) As used in this section, 'employee' means an individual employed by the adult care home, whether directly, by contract with another entity, or as an independent contractor, on a part-time or full-time basis."

Section 2. Effective September 1, 2000, Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-113. Immunization of employees and residents.**

(a) Except as provided in subsection (f) of this section, a nursing home licensed under this Part shall require residents and employees to be immunized against influenza virus and shall require residents to also be immunized against pneumococcal disease.

(b) Upon admission, a nursing home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against influenza virus and pneumococcal disease.

(c) A nursing home shall notify every employee of the immunization requirements of this section and shall request that the employee agree to be immunized against influenza virus.

(d) A nursing home shall document the annual immunization against influenza virus and the immunization against pneumococcal

disease for each resident and each employee, as required under this section. Upon finding that a resident is lacking one or both of these immunizations or that an employee has not been immunized against influenza virus, or if the nursing home is unable to verify that the individual has received the required immunization, the nursing home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(e) For an individual who becomes a resident of or who is newly employed by the nursing home after November 30 but before March 30 of the following year, the nursing home shall determine the individual's status for the immunizations required under this section, and if found to be deficient, the nursing home shall provide the immunization immediately.

(f) No individual shall be required to receive either an influenza vaccine or pneumococcal vaccine if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(g) As used in this section, 'employee' means an individual employed by the nursing home, whether directly, by contract with another entity, or as an independent contractor, on a part-time or full-time basis."

Section 3. The Department of Health and Human Services shall make available to Nursing Homes and Adult Care Homes educational and informational materials pertaining to vaccination against influenza virus and pneumococcal disease.

Section 4. This act is effective when it becomes law.

An Analysis of the Impact of Removing the Maximum Reimbursement Rate for Out-of-Home Respite on Respite Care Services and Funding

Introduction

Senate Bill 1149 ratified by the 1998 Session of the General Assembly directed the Division of Aging to report to the North Carolina Study Commission on Aging no later than October 1, 1999, regarding the impact of the repeal of the statutory limitation on the reimbursement rate for out-of-home placement on Respite Care Program services and funds. In response to this requirement, the Division of Aging has analyzed the impact of removal of the cap on the rate of reimbursement for out-of-home respite care on Respite Care Program services and funding and has summarized the impact in this report.

Background

G.S. 143B-181.10 establishes a respite care program administered under the auspices of the Division of Aging. Respite care is part of the continuum of care for impaired older adults to enable families to care for members in their homes and to prevent or delay institutionalization. The following respite services and activities are allowable: temporarily placing the person out of his home to provide the caregiver total respite when the mental or physical stress on the caregiver necessitates this type of respite; personal care services, including meal preparation for the patient of the caregiver; counseling and training in the caregiving role, including coping mechanisms and behavior modification techniques; counseling and accessing available local, regional, and State services; support group development and facilitation; assessment and care planning for the patient of the caregiver; and attendance and companion services for the patient in order to provide release time to the caregiver. Allowable out of home placements outlined in G.S. 143B-181.10 include a hospital, intermediate or skilled nursing facility, adult care home, adult day health care center, and adult day care center.

Out-home-respite also referred to as "institutional respite," is one of the seventeen services allowable under the Home and Community Care Block Grant. Some typical examples of how this service is used by families include:

- A full-time family caregiver needs a weekend break and has no other family/friends to count on to give them such relief.
- A caregiver needs to have a medical procedure performed and needs a short recovery period prior to resuming caregiving duties.
- A full-time family caregiver needs a weekend break to visit a sick family member or attend a family function.

This type of short-term relief can mean the difference between caregivers being able to continue providing care for an older adult or having to consider a long term out-of-home

placement. Prior to the ratification of Senate Bill 1149, the amount of program funds that could be used to pay for an out-of-home respite placement was limited to "the current maximum monthly rate for domiciliary care that may be charged to public assistance recipients." Effective August 14, 1998, the maximum monthly reimbursement rate for out-of-home respite care services was repealed.

Repeal of the Statutory Limitation on the Maximum Reimbursement Rate for Out-of-Home Respite

In response to requests from individuals and agencies that the maximum reimbursement rate for out-of-home respite be lifted, Senate Bill 1149 was introduced and ratified by the 1998 Session of the General Assembly in order to encourage this form of respite to become a more viable service. Limiting the reimbursement rate of out-of-home respite to the adult care home rate paid by the State appeared to discourage the utilization of out-of-home respite. Concern was expressed about the difficulty agencies interested in providing this service had in finding facilities willing to accept the maximum reimbursement rate (i.e., the adult care home monthly reimbursement rate).

Some adult care homes were reluctant to serve residents needing short-term respite for the public assistance rate, because admission and adjustment problems are usually the most staff intensive at the beginning of a resident's stay. Some caregivers were not likely to want to put their family members in a double room for a short time, because adjustment to a roommate might be stressful for both individuals needing long-term placement and short-term respite care. Some families whose family members needed respite care may have required more supervision than was available in the adult care home, and the cost of other types of placements in nursing homes or hospitals would exceed the cost of adult care homes.

Impact of Removal of the Cap on Respite Care Program Services and Funding

Counties decide the services that they will offer for older adults through the Home and Community Care Block Grant. County commissioners must approve the services to be provided, funding levels, projections of persons to be served and reimbursement rates for Home and Community Care Block Grant services. Out-of-home respite is one of seventeen (17) services that may be funded through the Home and Community Care Block Grant.

The Division of Aging has analyzed out-of-home respite services and funding provided through the Home and Community Care Block Grant from State Fiscal Year 1997-98 through projections for State Fiscal Year 1999-00. The table on the following page summarizes out-of-home respite care services through the Home and Community Care Block Grant.

Out-of-Home Respite Care Services Provided Through the Homes and Community Care Block Grant: State Fiscal Year 1997-98 Through 1999-00

SFY	Number of Counties Providing Out-of-Home Respite	Number of Clients Served	Number of Hours of Out-of-Home Respite Care Provided	Total Funds Expended for Out-of-Home Respite
97-98 (actual)	5	132	57,517	$252,213
98-99 (actual)	4	132	56,399	$271,864
99-00 (projection)	4	122	51,823	$272,082

The above table summarizes data regarding the number of counties providing out-of-home respite for older adults through Home and Community Care Block Grant funds, the number of older adults receiving this service, the number of hours of out-of-home respite service provided, and total Home and Community Care Block Grant expenditures for this service for SFY 1997-98, 1998-99, and 1999-00 projected expenditures.

Historically, only a few counties have funded out-of-home respite with Home and Block Care Block Grant funds. The last fiscal year for which a cost limitation was placed on out-of-home respite was 1997-98. Since the cap on reimbursing out-of-home respite was repealed, the number of counties providing this service has remained relatively unchanged. From State Fiscal Year 1997-98 to 1998-99, expenditures for this service increased approximately 8%. This fiscal year's projections reflect a .08% increase in expenditures for out-of-home respite.

The high demand for Home and Community Care Block Grant core services such as in-home aide, adult day care, transportation, and nutrition services limits the counties being able to provide new (or additional or other) services to a great extent. Increased utilization of Adult Day Care funds has also helped to meet the needs of caregivers who might otherwise request out-of-home respite services for their elderly family member.

Division of Aging staff have followed up with local service and area agency on aging personnel in regions that provide out-of-home respite. Although the total number of counties offering out-of-home respite has not grown and the amount of out-of-home respite has not increased to date, those persons contacted observed that lifting the cost limitation has had a positive effect on utilization of the service in several areas. One local aging agency has contracts with several facilities on a space available basis, generally, paying the private rate for a short term stay. Caregivers have a choice in selecting where their loved one will stay, making the choice

based on availability of bed, location of facility, and level of care needs. Since many of the families requiring respite are caring for persons with Alzheimer's Disease, they are more likely to find staff trained in dementia care if choices exist for families. Due to the fact that out-of-home respite is a short-term placement (usually for a week), the admitting agency conducts an assessment and home visit, screening both the facility and the family to assure a best possible "fit" for the impaired individual in the new environment. One of the directors of an area agency on aging has said that continuing to limit the cost for this service to the maximum monthly rate for adult care would eventually have discouraged counties from offering the service altogether.

In another region that utilizes out-of-home respite, the county aging service agency had a contract with the local hospital for respite in a step-down wing on a space available basis. When these beds were no longer readily available, the agency was able to successfully negotiate with a nursing home for elderly adults who needed this service. Availability of out-of-home respite for elderly adults to provide relief for caregivers has helped families to continue to provide care for loved ones. Two additional counties in this region have explored the institutional respite care option for the current year; as of yet, these counties have not initiated out-of-home respite due to other staffing and service demands.

One of the four counties that provide out-of-home respite for older adults utilizes out-of-home respite funds for adult day services, which is an allowable block grant service. Many participants in adult day services throughout the state attend in order to provide respite for their family caregivers as well as stimulation and socialization for themselves.

Conclusions

The cost limitation for out-of-home respite has been lifted for only one full fiscal year. Since the cap on reimbursing out-of-home respite was repealed, the number of counties providing this service has remained relatively unchanged. Out-of-home respite is a complex service to offer. Due to waiting lists for other essential services, agencies continue to fund these core areas. This may account for the slow development of other services such as out-of-home respite care services. Indications as of this date are that the removal of this cap is a move in a positive direction; having the rate approximate market rate for care does not appear to lead to significant additional expenditures of funds.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H D

99-LNZ-212(3.17.00)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Respite Care Program No Sunset. Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE SUNSET ON REQUIREMENTS PERTAINING TO THE REIMBURSEMENT RATE FOR THE RESPITE CARE PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. Section 3 of S.L. 1998-97 reads as rewritten:

"Section 3. This act is effective when it becomes ~~law and expires July 1, 2000.~~ law."

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H D

99-LNZ-216B(3.30.00)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Food Estab./Sanit. Reqments. Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ESTABLISHMENTS THAT PREPARE OR SERVE FOOD TO A CERTAIN NUMBER OF REGULAR BOARDERS OR PERMANENT HOUSE GUESTS COMPLY WITH STATE FOOD SANITATION REQUIREMENTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 130A-250 reads as rewritten:

"**§ 130A-250. Exemptions.**

The following shall be exempt from this Part:

(1) Establishments that provide lodging described in G.S. 130A-248(a1) with four or fewer lodging units.

(2) Condominiums.

(3) Establishments that prepare or serve food or provide lodging to regular boarders or permanent house guests ~~only.~~ only, except that food sanitation requirements of G.S. 130A-248 apply to establishments that prepare or serve food to 12 or more regular boarders or permanent house guests.

(4) Private homes that occasionally offer lodging accommodations, which may include the providing of food, for two weeks or less to persons attending special events, provided these homes are not bed and breakfast homes or bed and breakfast inns.

(5) Private clubs.

(6) Curb markets operated by the State Agricultural Extension Service.

(7) Establishments that prepare or serve food or drink for pay no more frequently than once a month for a period not to exceed two consecutive days, including establishments permitted pursuant to this Part when preparing or serving food or drink at a location other than the permitted locations.

(8) Establishments that put together, portion, set out, or hand out only beverages that do not include those made from raw apples or potentially hazardous beverages made from raw fruits or vegetables, using single service containers that are not reused on the premises.

(9) Establishments where meat food products or poultry products are prepared and sold and which are under inspection by the North Carolina Department of Agriculture and Consumer Services or the United States Department of Agriculture.

(10) Markets that sell uncooked cured country ham or uncooked cured salted pork and that engage in minimal preparation such as slicing, weighing, or wrapping the ham or pork, when this minimal preparation is the only activity that would otherwise subject these markets to regulation under this Part.

(11) Establishments that only set out or hand out beverages that are regulated by the North Carolina Department of Agriculture and Consumer Services in accordance with Article 12 of Chapter 106 of the General Statutes.

(12) Establishments that only set out or hand out food that is regulated by the North Carolina Department of Agriculture and Consumer Services in accordance with Article 12 of Chapter 106 of the General Statutes."

Section 2. This act becomes effective July 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H **D**

99-LNZ-217B(4.2.00)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Medical Care Commn./Rules Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES PERTAINING TO MEDICAL CARE COMMISSION AUTHORITY TO ADOPT RULES REGULATING ADULT CARE HOMES AND SOCIAL SERVICES COMMISSION AUTHORITY TO ADOPT RULES PERTAINING TO PUBLIC ASSISTANCE PROGRAMS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131D-4.3 reads as rewritten:

"**§ 131D-4.3. Adult care home rules.**

(a) Pursuant to G.S. ~~143B-153, the Social Services~~ 143B-165, the North Carolina Medical Care Commission shall adopt rules to ensure at a minimum, but shall not be limited to, the provision of the following by adult care homes:

(1) Client assessment and independent case management;

(2) A minimum of 75 hours of training for personal care aides performing heavy care tasks and a minimum of 40 hours of training for all personal care aides. The training for aides providing heavy care tasks shall be comparable to State-approved Certified Nurse Aide I training. For those aides meeting the 40-hour requirement, at least 20 hours shall be classroom training to include at a minimum:

a. Basic nursing skills;

b. Personal care skills;

c. Cognitive, behavioral, and social care;
d. Basic restorative services; and
e. Residents' rights.

A minimum of 20 hours of training shall be provided for aides in family care homes that do not have heavy care residents. Persons who either pass a competency examination developed by the Department of Health and Human Services, have been employed as personal care aides for a period of time as established by the Department, or meet minimum requirements of a combination of training, testing, and experience as established by the Department shall be exempt from the training requirements of this subdivision;

(3) Monitoring and supervision of residents;

(4) Oversight and quality of care as stated in G.S. 131D-4.1; and

(5) Adult care homes shall comply with all of the following staffing requirements:

a. First shift (morning): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents (licensed capacity or resident census) plus 3.0 hours for all other residents, whichever is greater;

b. Second shift (afternoon): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents (licensed capacity or resident census), whichever is greater;

c. Third shift (evening): 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census).

In addition to these requirements, the facility shall provide staff to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this subdivision, the term 'heavy care resident' means an individual residing in an adult care home who is defined 'heavy care' by Medicaid and for which the facility is receiving enhanced Medicaid payments for such needs."

Section 2. G.S. 131D-21(17) reads as rewritten:

"**§ 131D-21. Declaration of residents' rights.**

Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

. . .

"(17) To not be transferred or discharged from a facility except for medical reasons, the residents' own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the Secretary, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. ~~The Secretary shall adopt rules pertaining to the transfer and discharge of residents that offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes.~~"

Section 3. G.S. 143B-153(2) reads as rewritten:

. . .

"(2) The Social Services Commission shall have the power and duty to establish standards and adopt rules and regulations:

a. For the programs of public assistance established by federal legislation and by Article 2 of Chapter 108A of the General Statutes of the State of North Carolina with the exception of the program of medical assistance established by G.S. 108A-25(b);

b. To achieve maximum cooperation with other agencies of the State and with agencies of other states and of the federal government in rendering services to strengthen and maintain family life and to help recipients of public assistance obtain self-support and self-care;

c. For the placement and supervision of dependent juveniles and of delinquent juveniles who are

placed in the custody of the Office of Juvenile Justice, and payment of necessary costs of foster home care for needy and homeless children as provided by G.S. 108A-48; and

d. For the payment of State funds to private child-placing agencies as defined in G.S. 131D-10.2(4) and residential child care facilities as defined in G.S. 131D-10.2(13) for care and services provided to children who are in the custody or placement responsibility of a county department of social ~~services.~~ services; and

e. For client assessment and independent case management pertaining to the programs of public assistance authorized under paragraph a. of this subdivision."

Section 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S/H D

99-LNZ-214(3.17.00)
(THIS IS A DRAFT AND NOT READY FOR INTRODUCTION)

Short Title: Adult Prot. Svce/Complaint Invest. Public

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT PERTAINING TO TIME REQUIREMENTS FOR THE INVESTIGATION OF COMPLAINTS UNDER THE PROTECTION OF THE ABUSED, NEGLECTED, OR EXPLOITED DISABLED ADULT ACT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 108A-108(d) reads as rewritten:

"**§ 108A-103. Duty of director upon receiving report.**

. . .

(d) The director shall initiate the evaluation described in subsection (a) of this section as follows:

(1) Immediately upon receipt of the complaint if the complaint alleges a ~~life-threatening situation.~~ danger of death in an emergency as defined in G.S. 108A-101(g).

(2) Within 24 hours if the complaint alleges ~~abuse of a resident~~ danger of irreparable harm in an emergency as defined by G.S. ~~131D-20(1).~~ 108A-101(g).

(3) Within ~~48 hours if the complaint alleges neglect of a resident as defined by G.S. 131D-20(8).~~ 72 hours if the complaint does not allege danger of death or irreparable harm in an emergency as defined by G.S. 108A-101(g).

~~(4) Within two weeks in all other situations.~~

~~The investigation shall be completed within 30 days.~~ The evaluation shall be completed within 30 days for allegations of abuse or neglect and within 45 days for allegations of exploitation."

Section 2. This act is effective when it becomes law.

APPENDIX - I

Building a More Efficient Regulatory System for Adult Care Homes

Submitted to:

The North Carolina Study Commission on Aging
As Required By Chapter 334 of the 1999 Session Laws

By:
The North Carolina Department of Health and Human Services
Division of Facility Services

Date
February 1, 2000

Purpose

Section 3.12 of Senate Bill 10 (Chapter 334 of the 1999 Session Laws) requires the Department of Health and Human Services to recommend, to the Study Commission on Aging, a more efficient regulatory system for adult care homes to ensure clear delineation of regulatory authority and streamline the functions carried out by state government. This report addresses these reporting requirements.

Background Information

As of January 6, 2000 there was a total of 1,719 freestanding adult care homes (ACH) in the state with a corresponding bed capacity of 42,951. In addition to these beds, as of December 30, 1999 there were 209 nursing homes that also had licensed adult care home beds and seven hospitals with licensed adult care home beds for a total licensed capacity of 48,496. Adult care homes, which fall into the categories listed below, are licensed by the Division of Facility Services (DFS).

Free-standing Facilities by Type	Number of Licensed Facilities	Bed Capacity
ACH --family care homes (2-6 beds)	817	4,556
ACH -- 7+ beds	673	37,079
ACH- group homes for the developmentally disabled adults	229	1,316
Sub-Total:	1,719	42,951
Combination Facilities		
Nursing homes w/adult care beds	209	5,394
Hospital based beds	7	151
Grand Total	**1,935**	**48,496**

Considering free-standing facilities alone, the number of adult care homes statewide has grown 18% between March 1998 and January 2000. The number of beds licensed in these facilities has grown by 51% from an average of 14.5 facilities and 284 beds per county to an average of 17 facilities and 429 beds per county. This growth has occurred in spite of the moratorium on development of new adult care beds, which began in August 1997 and continues at least through September 30, 2000. The moratorium allows for certain exclusions including: projects submitting plans for approval prior to May 18, 1997; projects that submitted plans for approval after May 18, 1997 if property was purchased (or a binding contract to purchase property or enter into a lease agreement existed) on or before August 25, 1997; projects seeking new beds in a county where the vacancy rate is less than 15%; and instances where county commissioners determine that a substantial need for new beds exists in the county. It is also worth noting that the moratorium does not apply to group homes for the developmentally disabled or adult care home beds in Continuing Care Retirement Communities (CCRC's).

Although the licensing of adult care homes is the responsibility of the Division of Facility Services, responsibility for the monitoring of these facilities is shared by the Division of Facility Services and the Division of Social Services (DSS). The major roles and responsibilities carried out by each division are outlined on page 3. It is important to note that most of the activities conducted under the purview of the Division of Social Services are carried out by Adult Home Specialist staff who are employed by county

departments of social services. The Division of Facility Services has state employees who work out of either the central office in Raleigh or the Western office in Asheville.

Overview of Major Roles and Responsibilities by Division

Division of Facility Services	Division of Social Services
1. Develop policies, procedures, and licensure rules for consideration by the Medical Care Commission.	1. Rulemaking authority, through the Social Services Commission, for the State/County Special Assistance Program, adult care home case management, adult placement services and resident evaluation.
2. Issue, deny, revoke licenses of adult care homes and impose negative action (e.g. suspension of admissions, provisional licensure, fines, summary suspension of license, temporary management of facilities, etc.).	2. Review and assure completion of initial and renewal licensure application material prior to submitting to DFS for action.
3. Survey facilities to enforce compliance (i.e. licensure action) when facilities fail to come into compliance as a result of county monitoring activities as a "look behind" of county monitoring, and upon the request of county departments when specialized staff are determined to be needed.	3. Provide consultation and technical assistance to adult care home licensees and administrators, monitor and document facility compliance with licensure requirements, facilitate corrective action for violations and recommend negative action to the Division of Facility Services as appropriate. Counties are also responsible for monitoring all adult care homes at least once every two months.
4. Provide oversight and follow-up of county departments of social services, at least quarterly, to assure that county departments of social services are carrying out their monitoring duties.	4. Conduct all routine complaint investigations, document findings and make recommendations to the Division of Facility Services for negative action as appropriate.
5. Provide training for county department of social services staff on an array of topics such as: licensure requirements; policies; procedures; resident's rights; etc.	5. Assure that staff are adequately trained in all aspects of adult care home licensure.
6. Investigate complaints against adult care homes on a limited basis, document findings, initiate and pursue negative action as appropriate.	6. Investigate unlicensed facilities to determine if such facilities are subject to adult care home licensure by DFS or required to register with DFS as a multi-unit housing with services facility.
7. Provide consultation, technical assistance and support services to county DSS's and adult care home providers.	7. Provide information and consultation to regional long-term care Ombudsman and community advisory committees in cooperation with the Division of Aging.

Current Staffing Levels

The Division of Facility Services currently has 18 full-time professional positions directly responsible for monitoring adult care homes (i.e. monitor county adult home specialist staff; provide training, technical assistance and consultation; investigate complaints as appropriate; etc.). Among the 18 full-time staff are 13 licensure consultants, 3 pharmacists, and 2 registered dieticians.

As of March 1998, there were 51 full-time (38%) and 84 (62%) part-time county adult home specialists statewide. The average percentage of time dedicated to the part-time positions is not known. Some part-time adult home specialists are known to be assigned to this role for as little as 10% time.

Steps Taken Toward A More Efficient Regulatory System

During State Fiscal Year (SFY) 1998-99, the Department took a number of steps to create a more efficient and effective regulatory system for adult care homes. The steps listed below have been implemented (are being implemented) with the intent of streamlining and strengthening the monitoring of adult care homes.

1. The Division of Facility Services developed a new policy and procedures manual for the licensing and monitoring of adult care homes which was published in August 1998. The new manual was developed to achieve the following:
   - standardize the way county adult home specialists document complaint investigations;
   - incorporate new statutory requirements pertaining to adult care homes (e.g. adult care homes must conduct criminal background checks of all unlicensed personnel);
   - standardize how homes are reviewed to determine overall compliance with requirements through a standardized annual assessment process and tool;
   - standardize development of monitoring plans for use in all facilities. Monitoring plans developed for each facility will be based on findings from the annual facility assessment to ensure that adult home specialists focus on problem areas in a particular facility; and
   - standardize procedures used by adult home specialists to document findings for negative action(s) and prepare penalty recommendations.

   Note: Updating the procedures manual as well as some of the specific intended achievements listed above also respond to a recommendation contained in the 1998 State Auditors Performance Audit of Long-Term Care Programs in North Carolina as administered by the Department of Health and Human Services.

2. The Division of Facility Services hired two full-time pharmacists to provide training and consultation to adult home specialists and adult care homes to address the high rate of medication errors in these facilities. This staff also conducts compliance surveys in adult care homes related to medication administration issues.

3. The Division of Facility Services is hiring a third full-time pharmacist to work with county adult home specialists and facilities, again with the goal of reducing medication administration errors. This position will also help implement new rules regarding medication competency evaluation requirements for staff administering medications (e.g. development of written competency exams, clinical skills verification procedures, etc.)

4. The Division of Facility Services is now only hiring RN's as adult care home licensure consultants as opposed to social workers or other generalists. This step was taken to ensure that licensure consultant staff have the appropriate technical skills to deal with the level of frailty/complexity of needs experienced by residents currently residing in adult care homes and to enable the Division of Facility Services to provide skill building training to adult home specialists to improve their monitoring capacity.

5. The Division of Facility Services has implemented a standardized annual facility assessment, monitoring process and monitoring plan document for use by county adult home specialists to monitor adult care homes.

6. The Division of Facility Services is now conducting, at a minimum, quarterly reviews of county departments of social services staff responsible for monitoring adult care homes using a uniform performance review tool. Subsequent quarterly follow-up meetings with county adult home specialists and their supervisors are also being held to discuss findings from the quarterly review conducted by state

licensure consultants. This effort will bring management staff at county departments of social services into the process of improving adult home specialist capabilities. Use of a uniform performance review tool by DFS licensure consultants will ensure that counties are using the standardized procedures and tools developed for assessing and monitoring adult care homes. In addition, use of a uniform review tool by licensure consultants will enable DFS to automate performance review findings by county. This data can improve overall program management by helping to identify training needs for adult home specialist staff and facilitate analysis of the overall effectiveness of county monitoring efforts. The uniform tool also captures information about the experience level and full-time equivalent status of each adult home specialist. This will provide the information needed to determine statewide staffing capacity on an annual basis. In addition, the Department will also be able to identify those instances where insufficient staff appears to be impacting the quality and timeliness of monitoring conducted by counties.

7. The Division of Facility Services develops and conducts quarterly training for adult home specialist staff. Quarterly training for 1999 was targeted to address several critical training needs of adult home specialists as identified by either Division of Facility Services staff and/or county adult home specialists themselves. Quarterly training topics for 1999 included: medication administration and monitoring food service issues; complaint investigation techniques and documentation requirements; overview of the new adult care home procedures manual; and an overview of the new annual assessment instrument to be used to monitor homes and use of the new monitoring plan document to be used by all adult home specialists.

   Note: This training initiative also responds to a recommendation contained in the 1998 State Auditors Performance Audit of Long-Term Care Programs in North Carolina as administered by the Department of Health and Human Services.

8. To comply with requirements contained in Senate Bill 10, the Division of Facility Services has developed competency requirements for persons hired to administer medications in adult care homes and their supervisors. Related to this initiative, the Division of Facility Services is developing competency testing instruments to be administered to persons who have passed the clinical skills portion of competency test. An automated system for test development, scoring, and maintenance of a registry of persons meeting initial and on-going competency requirements is being developed to strengthen monitoring efforts of adult care homes in the critical area of medication administration. Once fully operational, state and county staff responsible for monitoring adult care homes as well as adult care home administrators will be able to access information from the registry to verify the current competency status of persons employed and those seeking employment as a medication aide in an adult care home.

9. The Division of Facility Services has developed and is implementing a comprehensive automated data base to track a variety of licensure and compliance data pertaining to adult care homes. Some of the key data elements the automated system will track include:
   - licensure application data (demographic information, bed capacity, census, special care unit designation, owner/affiliates, administrator, etc.);
   - compliance history of owners and affiliates;
   - negative actions taken against a facility (penalties, fines, provisional licensure, etc.);
   - alleged and substantiated complaints against facilities reported directly to the Division of Facility Services, tracking complaints referred to counties, timeliness of complaint investigations, etc.; and
   - capacity to track other data elements that will/may be needed in the future (e.g. accreditation status of facilities).

Once fully operational, this automated data will enable the Division to more efficiently and effectively comply with new responsibilities resulting from passage of Senate Bill 10 and Senate Bill 198. In addition, this comprehensive automated system will strengthen the overall monitoring and program management capability of the Division of Facility Services through the development and analysis of a wide variety of automated program management reports (both routine and special reports) as well as sort data by a number of key variables (e.g. facility, owner, county, state). This new automated capacity will also enable the Division to have an accurate and readily retrievable historical record of licensure and monitoring related activities.

10. The Department of Health and Human Services sought and received funding, beginning in SFY 99-2000 (January 1, 2000), for 70 additional full-time county department of social services staff to ensure that adult care homes are assessing residents and developing appropriate care plans as required by Senate Bill 10. In addition to the county positions, the Division of Social Services will hire 5 additional full-time staff and the Division of Facility Services will hire 3 additional full-time staff. Related to the assessment effort for all adult care home residents, a uniform assessment tool is being prepared. The Division of Social Services has developed plans to pilot the resident assessment tool with the ultimate goal of implementing a uniform resident assessment for use in all adult care homes.

11. The Department convened a committee to make a recommendation regarding the need to reclassify county adult home specialist positions as a result of changes in the scope of work assigned to this staff. These positions are currently considered entry level positions and classified as Social Worker II's. The committee, comprised of county department of social services staff, representatives of DHHS Personnel, and the Divisions of Social Services and Facility Services, completed their work in December 1999. It was the consensus of the committee that these positions should be upgraded to Social Worker III positions. Department of Health and Human Services personnel staff are currently conducting desk reviews to verify the scope of duties performed by adult home specialists and are expected to make final determination regarding the appropriate classification for these positions by February 2000.

Key barriers remaining to an efficient and effective monitoring system for adult care homes

In spite of the steps listed above, there are several barriers that compromise the overall quality of the monitoring system needed to assure facility compliance with adult care home licensure rules and regulations. These barriers include the following:

1) There is an inadequate number of adult home specialist staff statewide to effectively and efficiently carry out the monitoring roles and responsibilities assigned to county departments of social services. While some counties are able to assign the staff necessary to effectively and efficiently carry out their monitoring roles, some counties do not have sufficient staff to carry out this responsibility in a satisfactory manner.

   Factors contributing to this problem:

   a. These positions are funded through a capped and dwindling resource (i.e. Social Services Block Grant funds). County departments of social services also rely on these funds to staff other mandated program areas (e.g. adult protective services, guardianship and child welfare services). Thus, staff assigned to monitor adult care homes often have other duties. In fact, 62% of all adult home specialists in 1998 were assigned to this responsibility on a part-time basis. This can result in the adult care home monitoring process being short-changed.

   b. The number of licensed beds and facilities is growing. More than 17,000 new adult care home beds have been approved since the moratorium was initially put in place in August 1997. This growth will only exacerbate the consequences of the existing staffing shortage for this

responsibility at the county level since there is no staffing standard in place to ensure that enough full-time equivalent staff are assigned to carry out adult home specialist responsibilities.

c. There is considerable turnover in these positions as illustrated by the following:
   - a 1998 statewide survey indicated that 33% of adult home specialists had less than 2 years of experience; and
   - a review of new quarterly monitoring data collected from 21 counties during the second half of 1999 indicated that approximately 40% of adult home specialists in these 21 counties had 2 years experience or less.

Inexperienced and/or insufficient staff can effect the quality of monitoring conducted and the ability of counties to carry out required monitoring activities. This conclusion is substantiated by the following facts:

1) Of a total of 58 new adult home specialists registered for basic orientation training in November and December 1999, 14% did not attend this training.

2) Many counties are not represented at regular quarterly training sessions conducted by the Division of Facility Services. These training sessions are important to helping ensure the competence of county staff and to apprise county staff of changes in procedures, licensing requirements/regulations and address areas of concern raised by adult home specialists themselves.
   - 48 counties attended less than all 4 of the quarterly training sessions held in 1999. Of these:
     - 5 counties had no representation at any of the training sessions*
     - 6 counties were represented at only one session
     - 12 counties were represented at 2 of the 4 sessions
     - 25 attended 3 of the 4 sessions

     ** while 4 of the 5 counties do not have operational beds, they all have beds in the pipeline and/or approved for development under the moratorium. Thus, it is important that these counties be prepared to assume monitoring responsibilities with trained staff.*

   - Of particular concern is the number of counties unable to have representation at the 2 quarterly training sessions developed in response to specific monitoring problems/issues (i.e. the high medication error rate; and procedures for conducting complaint investigations which was identified as a training need by the adult home specialists themselves).
     - 23 counties had no representation at the training session held to address monitoring of medication errors
     - 24 counties had no representation at the training session regarding complaint investigation and documentation

3) State staff had to take the lead in initiating negative action against facilities to ensure proper protocols were met 38% of the time such action was needed between July and December 1999 -- in spite of the fact that this should have been initiated at the county level.

4) No routine monitoring is done of adult care home beds in combination facilities. This was mentioned as a concern by the State Auditor in the April 1998 Long-Term Care performance audit. Thirteen positions were requested for this purpose in the Department's 1999-01 expansion budget but they were not funded by the General Assembly. DFS does not currently have the staff necessary to monitor these facilities on a routine basis. As such, DFS is limited to investigating complaints made against adult care beds in combination facilities.

5) There is currently no automated system in place to track complaints received (and investigated) by county adult home specialists. Thus, the Department of Health and Human Services is not able to obtain a comprehensive picture of what is happening in these homes locally with regard to numbers/types of complaints made, percentage of substantiated complaints, whether complaints are investigated in a timely manner, etc. This type of data is, however, being automated for complaint information received by the Division of Facility Services.

Conclusion

The Department has already taken a number of major steps intended to improve the efficiency of the regulatory process in place for monitoring adult care homes as well as improving the program management capacity of the Department related to the licensure and monitoring of adult care homes. Several of these steps are in direct response to concerns raised in the State Auditor's 1998 performance audit of Long-Term Care programs in North Carolina as administered by the Department of Health and Human Services. Given that the steps already taken (or being implemented) by the Department have been initiated within the past year, additional time is needed to evaluate the impact these changes have on the quality and efficiency of the Department's monitoring system for adult care homes. In spite of the steps taken there are several known barriers that have yet to be addressed. There are no specific recommendations being made that require legislative action. There are, however, critical next steps that will be taken by the Department of Health and Human Services to assure that the barriers that continue to exist begin to be addressed so that we can achieve the most efficient regulatory system possible for adult care homes.

Critical Next Steps

1) The Department will make any modifications needed to standardized tools, new monitoring procedures and/or automated systems once an evaluation of the new monitoring improvements has been completed.

2) The Department needs to consider development of a recommended staffing standard for adult home specialist positions. Developing a staffing standard (case load size) would provide counties with guidance regarding the number of full-time equivalent adult home specialists expected to be needed to effectively and efficiently carry out their monitoring responsibilities. Consideration should be given to including both the number of free-standing facilities in the county as well as the average number of beds per facility.

3) Building upon the automated complaint tracking system already being implemented by the Division of Facility Services, the Department needs to develop a plan for collecting complaint information received by county adult home specialist staff. This will give the Department a complete picture of the number and type of complaints received, the numbers of substantiated complaints and the timeliness of complaint investigations. Automating county data will also enable data analysis for improved state and county program management. Consideration will need to be given to keying this data at the state level, at least initially, to ensure that counties have the capacity to automate this information locally and transfer the data to the Division of Facility Services.

4) The Department of Health and Human Services will complete its job study of county adult home specialist positions to determine the appropriate classification for these positions based on their current scope of responsibility. If it is determined that these positions need to be upgraded, such action should help to reduce the turnover in these positions and contribute to a more stable and experienced workforce responsible for monitoring adult care homes at the county level.

5) The Department needs to ensure that adult care home beds in combination facilities are monitored on a routine basis. As funding is identified, the Department needs to address the issue of inadequate monitoring in these facilities.