# NORTH CAROLINA

# STUDY COMMISSION ON AGING


## REPORT TO THE GOVERNOR AND THE 2003 SESSION OF THE 2003 GENERAL ASSEMBLY

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# *North Carolina*
# *Study Commission On Aging*

January 28, 2003

To: Governor Michael F. Easley
President of the North Carolina Senate
President Pro Tempore of the North Carolina Senate
Speaker of the North Carolina House of Representatives
Members of the 2003 General Assembly, Regular Session 2003

Attached is a report from the North Carolina Study Commission on Aging submitted to you pursuant to North Carolina General Statute §120-87, which states, "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 study conducted following the adjournment of the 2001 General Assembly. Proposed legislation is contained within this report.

Respectfully submitted,

_____
Senator William R. Purcell
Co-Chair

_____
Representative Beverly M. Earle
Co-Chair

# North Carolina Study Commission On Aging

## 2001-2002 Membership List

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Senator. James Forrester

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Senator Albin B. Swindell, IV

Ex Officio:
Ms. Lynda McDaniel, Assistant Sec. for
Long Term Care and Family Services
Department of Health and Human Services

Clerk:
Ann Raeford

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(SHz-3) AN ACT TO IMPLEMENT A LONG-TERM CARE WORKFORCE IMPROVEMENT PROGRAM FOR DIRECT CARE WORKERS EMPLOYED BY ADULT CARE HOMES AND HOME CARE AGENCIES IN AN EFFORT TO INCREASE SKILL LEVELS, JOB SATISFACTION, AND RETENTION RATES.

(SWz-6) AN ACT TO APPROPRIATE FUNDS FOR LABOR ENHANCEMENT PAYMENTS FOR NURSE AIDES IN NON-INSTITUTIONAL SETTINGS.

(SWz-9) AN ACT DIRECTING THE STATE AUDITOR TO PERFORM AN AUDIT OF THE COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA) AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CONTINUE ITS EXAMINATION OF CAP/DA AND REPORT TO THE NORTH CAROLINA STUDY COMMISSION ON AGING.

(SHz-4) AN ACT TO IMPLEMENT A PILOT PROJECT FOR LOCAL LONG-TERM CARE PLANNING.

(SWz-5) AN ACT TO EXPAND THE STATE/COUNTY SPECIAL ASSISTANCE IN-HOME DEMONSTRATION PROJECT BY PERMITTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INCREASE THE NUMBER OF INDIVIDUALS WHO MAY BE ENROLLED IN THE PROJECT.

(SWz-4) AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY THE IMPLEMENTATION OF A REMEDIATION PROGRAM FOR LONG-TERM CARE FACILITIES.

(SWz-8) AN ACT TO ESTABLISH A GROUP WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ENSURE THAT FELONS ARE NOT EMPLOYED BY LONG-TERM CARE FACILITIES AND HOME CARE AGENCIES AND TO REPEAL THE MORATORIUM ON THE EFFECTIVE DATE OF LONG-TERM CARE CRIMINAL CHECKS.

(SHz-1) AN ACT TO ESTABLISH A LEGISLATIVE STUDY COMMISSION ON STATE GUARDIANSHIP LAWS.

(SWz-7) AN ACT TO REPEAL THE SUNSET ON THE LONG-TERM CARE INSURANCE TAX CREDIT.

# PREFACE

As outlined in Chapter 120, Article 21 of the North Carolina General Statutes, the North Carolina Study Commission on Aging is charged with studying and evaluating the existing system of delivery of State services to older adults and recommending an improved system of delivery to meet the present and future needs of older adults. The Commission consists of 17 members. Of these members, eight are appointed by the Speaker of the House of Representatives, eight are appointed by the President Pro Tempore of the Senate, and the Secretary of the Department of Health and Human Services or the Secretary's designee serves as an ex officio, non-voting member.

This report represents the work performed by the North Carolina Study Commission on Aging from the conclusion of the 2002 Session of the 2001 General Assembly until the convening of the 2003 Session of the 2003 General Assembly. The Study Commission on Aging met on six occasions regarding a variety of topics concerning older adults, including the effects of budgetary constraints on services to the aging, CAP/DA, prescription drug access, and the long-term care workforce.

# EXECUTIVE SUMMARY

Older adults represent the fastest growing segment of North Carolina's population. According to the Division of Aging in the North Carolina Department of Health and Human Services, North Carolina's senior population is projected to number nearly 1.2 million (12.5 percent of the State's population) by 2010. By 2020, this number is projected to grow to almost 1.7 million (15.1 percent), and by 2030, the senior population should exceed more than 2.2 million (17.9 percent).

The North Carolina Study Commission on Aging is responsible for studying the issues of availability and accessibility of health, mental health, social and other services needed by older adults. This report reflects the Commission's focus on (I) Long-Term Care Workforce Related Issues, (II) Community Based Initiatives, (III) Long-Term Care Facilities, and (IV) Additional Issues of vital importance. The North Carolina Study Commission on Aging makes the following recommendations to the Governor and the 2003 Session of the 2003 General Assembly:

## I. Long-Term Care Workforce Related Issues

**Recommendation 1**
**The Commission recommends that the General Assembly provide a workforce improvement program for direct care workers employed in adult care homes and home care situations.**

**Recommendation 2**
**The Commission recommends that the Department of Health and Human Services implement initiatives to increase and promote the availability of nurse aide training and competency programs.**

**Recommendation 3**
**The Commission recommends that the Department of Health and Human Services work with the NC Board of Nursing, the Community College System and representatives from the NC Health Care Facilities Association to implement a pilot program using medication aides and geriatric aides in skilled nursing facilities.**

**Recommendation 4**
**The Commission recommends that the General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings.**

## II. Community Based Initiatives

**Recommendation 5**
**The Commission recommends that the General Assembly fund the Community Alternatives Program for Disabled Adults (CAP/DA) at a level sufficient to preserve the availability of community-based services offered through the program.**

**Recommendation 6**
**The Commission recommends that the General Assembly direct the Office of the State Auditor to conduct a full audit of the CAP/DA program.**

**Recommendation 7**
**The Commission recommends that the General Assembly direct the Department of Health and Human Services to continue its examination of the CAP/DA program.**

**Recommendation 8**
**The Commission recommends that the General Assembly fund a pilot project on long-term care local lead agencies.**

**Recommendation 9**
**The Commission recommends that the General Assembly maintain the Home and Community Care Block Grant services for impaired older adults at the current level and under the current administrative structure that allows flexibility to counties to offer those services chosen by the county.**

**Recommendation 10**
**The Commission recommends that the General Assembly expand the State/County Special Assistance in-home component by permitting the Department of Health and Human Services to increase the number of individuals who may be enrolled in the project. The Commission also recommends that the project be made available to all counties on a voluntary basis.**

## III. Long-Term Care Facilities

**Recommendation 11**
**The Commission recommends that the Department of Health and Human Services study the implementation of a remediation program similar to the Collaborative Remediation Project in Michigan.**

**Recommendation 12**
**The Commission recommends that a group within the Department of Health and Human Services be established to ensure that felons are not employed by long-term care facilities and home care agencies and that the moratorium on the effective date of long-term care criminal checks established in S.L. 2002-126, Section 10.10C be repealed.**

# IV. Additional Issues

**Recommendation 13**
**The Commission recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.**

**Recommendation 14**
**The Commission recommends that the Secretary of the Department of Health and Human Services define the duties and responsibilities of the Assistant Secretary of Long-Term Care and Family Services to include only those responsibilities related to long-term care.**

**Recommendation 15**
**The Commission recommends that the Secretary of the Department of Health and Human Services continue efforts to coordinate and simplify public access to the myriad drug prescription programs for low and moderate income older adults.**

**Recommendation 16**
**The Commission recommends that the tax credit for long-term care insurance be made permanent.**

# NORTH CAROLINA'S OLDER ADULTS: A PROFILE *

**Today's Older Population**

In 2000, 969,048 (12.0 percent) of the State's residents were age 65 and older, with 105,461 (1.3 percent of the total population) age 85 and older. Although North Carolina ranked 11th nationally in total population in 2000, it ranked 10th in the number of persons age 50 and older as well as for those age 65 and older. While this number indicates that North Carolina is a leader in the numbers of people age 65 and older, it is 36th among the 50 states in the percentage of the population that is 65 or older. Thus, North Carolina maintains a healthy balance among the generations, unlike some of the northern states that have very high percentages due to the exit migration of younger citizens (e.g. Pennsylvania, 15.6 percent; West Virginia, 15.3 percent; Iowa, 14.9 percent; North Dakota, 14.7 percent; Rhode Island, 14.5 percent; Maine, 14.4 percent; and South Dakota, 14.3 percent) or Florida, the leader in retirement migration, with 17.6 percent of its population age 65 or older.

From 1990-2000, the number of persons 65+ years of age in North Carolina increased by 20.5%, the 12th largest rate of increase among the 50 states and substantially higher than the national rate of 12.0%.

The differences among seniors are as great as those within any age group. However, some typical group characteristics such as gender, ethnicity, education, and place of residence vary either across the lifespan or among cohorts, so that older adults as a group differ from the general population. All examples below are based on the 2000 census:

- Older women outnumber older men. In 2000, they represent 59.8 percent of the 65+ age group and 74.3 percent of the 85+ age group.
- Altogether 18.1 percent of the 65+ older adults are members of ethnic minority groups. Of those, 87.5 percent are African-American (15.9 percent of the total population 65+). Latinos, American Indians, and other ethnic groups each account for 1 percent or less of the population in that age group. By contrast, members of ethnic minorities make up nearly 40 percent of children ages 0 to 17 in the state.
- Only about 6.2 percent lived in group residences in 2000—4.7 percent in institutions and 1.5 percent in other group settings. Altogether 28.3 percent of people age 65 and older outside of group quarters lived alone, of whom the majority (77.6 percent) were women.
- Among people over 65 in 2000, 41.6 percent did not complete high school.
- The Bureau of the Census has released figures for the rural and urban distribution of the total population, by county, but has not yet released figures for the older population alone. In 2000, 39.8 percent of North Carolina residents lived in rural areas. In applying county-specific rates of rural residence to the 2002 county population projections of people age 60 and older, the NC Division of Aging estimates that 43.9 percent of people age 60 and older are living in rural areas.
- Among all households where the head of household is age 65 or older, 87.4 percent own their homes, but 21.2 percent of these owner-occupied homes were built before 1950, as were 23.3 percent of the homes occupied by older renters.

- While many older adults experience some vision or hearing loss, 14.6 percent were either blind, deaf, or had severe hearing or vision impairments. Nearly a third (30.8 percent) report that they have a condition lasting 6 months or more that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying. More than one in five (21.6 percent) have trouble going out alone to shop or visit the doctor's office, while 10.8 percent have trouble bathing, dressing, or getting around inside the house. About 12.6 percent have a condition that affects their ability to learn, remember, or concentrate. Of course, many people have more than one disability. Altogether 45.7 percent of people over 65 in North Carolina have one or more of these disabilities—47.5 percent of women and 43.2 percent of men.

- The percent of those over 65 below the poverty level in 1999 (as reported in the 2000 census) was 13.2 percent, while an additional 11.4 percent were at "near poverty" with incomes between 100 and 149.9 percent of the poverty level. Although this represents an improvement from 1990, it still means that almost 1 in 4 older North Carolinians struggles with very low income. It should also be noted that for statistical purposes such as these, the Bureau of the Census uses a different poverty threshold for people age 65 and older than it does for younger people. To be considered below the poverty level, an older adult who lived alone in 1999 had to have income under $7,990 and a couple had to have income less than $10,075.

The State's cities, counties, and regions are aging at varying rates. Tables One through Five illustrate this variance among counties in the number and proportion of persons age 65 and older**.** **Appendix A**. For example, the percent of persons age 65 and older for the year 2000 ranges from 23.6 percent in Polk County to 6.3 percent in Onslow County.

Though people in North Carolina will continue to age, the number of older adults (65+ years) will not rapidly increase until 2011, when the "Baby Boomers" begin reaching 65 years of age. While North Carolina's overall population is projected to increase by 16 percent between 2010 and 2020, its population age 65 and older during that same time period is expected to grow by 40 percent.

**North Carolina's Demographic Shift**

- Older adults are North Carolina's fastest growing population.

- By 2010, North Carolina's population age 65+ is projected to number nearly 1.2 million (12.5 percent of our State's population). By 2020, the number is projected to grow to almost 1.7 million (15.1 percent). By 2030, our senior population should exceed more than 2.2 million (17.9 percent).

- This aging of the State's population is also evident in the climbing median age, which in 2000 was 35.3 and is expected to increase to 36.9 in 2010, 37.6 by 2020, and 38.4 by 2030.

- According to State demographic projections, the number of children 0 to 17 will increase 44.0 percent from 2000 to 2030, but the number of adults 65 and older will increase 129.1 percent during that time.

**Why This Demographic Shift**

While much of the aging of our State's population has been attributed to the aging of the "Baby 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 the State's population to grow.

Another factor in the aging of the State's population is migration. Like most of the other Sunbelt states, North Carolina has attracted young and middle-aged workers who are aging in place in this State. However, the State is especially likely to attract people who migrate after retirement. North Carolina is expected to retain its high national ranking of 3rd in net migration of retirees. In the 2000 census, 14.8 percent of the people over age 5 living in North Carolina reported that they were living outside the State 5 years ago (12.2 percent in a different state and 2.6 percent outside the United States). By comparison, in the United States as a whole, 11.3 percent were living outside the state where they lived in 2000 (8.4 in a different state and 2.9 outside the United States.) These figures are not yet available by age group.

Some other factors influencing the diverse experiences of the State's 100 counties are:

- Rural-urban migration of young adults continues to age rural counties.
- Large metropolitan counties attract large numbers of persons from outside the State as well as from rural counties. These counties are experiencing greater growth among the younger adults than they are among older adults.
- A large number of affluent older adults are retiring in some western and coastal counties.

**What Are the Implications of This Shift?**

The aging of the population is a national and international trend, and North Carolina, like the rest of the world, must be prepared to reap the benefits and face the challenges of an older population. 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 especially in many aging rural counties. People must consider living and caregiving arrangements in light of smaller nuclear and extended families. The health, human service, 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 also must overcome barriers that tend to isolate many of North Carolina's 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. There is reason to be optimistic that the boomers who will become tomorrow's older adults will have a wider range of skills, education, and interests that will help their communities, and they may need less assistance due to improvements in education, income, and health. However, their sheer numbers will have both positive and negative impacts on the State. This presents a challenge to which the State must respond.

***** *Prepared by the Department of Health and Human Services, Division of Aging, with technical assistance from the Center for Aging Research and Educational Services, School of Social Work, University of North Carolina at Chapel Hill and editing by the staff of the North Carolina Study Commission on Aging.*

# COMMISSION PROCEEDINGS

## November 12, 2002

The North Carolina Study Commission on Aging met on Tuesday, November 12, 2002 at 10:00 a.m. in Room 415 of the Legislative Office Building. Senator William Purcell was the presiding Co-Chair. Theresa Matula, a staff member to the Commission, began the meeting with a review of the results of the Commission's recommendations to the 2002 Session of the 2001 General Assembly. **Appendix B.** Of the Commission's five recommendations, all but one were acted upon by the General Assembly. Dianna Jessup, a staff member to the Commission, then followed with an overview of other legislation affecting seniors that passed during the 2002 Session. **Appendix B**. In addition to enacted legislation, Ms. Jessup informed the Commission that the General Assembly considered "no call registry " (House Bill 1612) and "payday lending" (Senate Bill 104) bills, but these bills were not enacted. Susan Morgan of the Fiscal Research Division and a staff member to the Commission explained the 2002 budget provisions that could potentially affect older adults.

Mr. Dennis Streets, Planning, Budget, & Systems Supports Section Chief, Division of Aging, Department of Health and Human Services (DHHS), presented a report on the effect of the current fiscal situation on programs within the Division of Aging (Division). **Appendix C.** Cuts to the Division for FY 2002-2003 totaled $926,000, which equaled 3.1% of the Division's appropriation for the fiscal year. There were three areas of reductions: (1) State administration, (2) Area Agencies on Aging (AAA), and (3) Senior Center General Purpose and Outreach. While the Division has been able to replace most of the cut in funds to State administration with federal support under the Older Americans Act, the largest negative impact of the cut has been the lack of available funds necessary to match many private and public grants. Area Agencies on Aging have also been able to offset most of the State funds lost with increased federal AAA planning and administration funds under the Older Americans Act, but reduced State support has resulted in a loss of capacity to secure private and public grants that require a match. With a reduction in Senior Center General Purpose and Outreach funding, some senior centers have had to reduce the variety of activities and services they offer, reduce operating hours or days, close satellite locations, reduce outreach to elderly in remote areas, and delay needed maintenance and repairs to facilities and equipment.

Karen Gottovi, Director of the Division of Aging, DHHS, highlighted the accomplishments of the Division over the past year and the initiatives the Division is currently undertaking. **Appendix C.** During 2001-2002, the Division initiated a Family Caregiver Support Program, implemented long term care reform efforts, aided in implementing the Senior Care Prescription Drug Assistance Program, strengthened multipurpose Senior Centers as a community resource, and leveraged resources to expand programs. Initiatives currently underway include Project Caregiver Alternatives to Running on Empty (Project C.A.R.E.), Senior Farmer's Market, a Performance Outcomes Measures Project to measure customer satisfaction of caregiver support, and Senior Medicare Patrol to educate seniors concerning health care discrepancies and the importance of reviewing benefits summary statements. New initiatives include outreach methods to improve Food Stamp participation among older adults, a nutrition initiative called More than a Meal, the development of a consumer direction reform agenda, development of a framework for a computerized information and assistance database to provide consumers with information concerning service options, and partnering with the Division of Public Health to

expand collaboration between health and aging agencies to increase public awareness about the importance of healthy aging.

Dennis Streets introduced the Department of Health and Human Services' new long term care website, designed to give individuals, families, providers and others access to information about the work in support of long term care by DHHS. The website provides access to DHHS plans and reports, highlights DHHS initiatives to strengthen the direct care work force, provides user-friendly information to consumers, and contains links to other useful websites. The URL is http://www.dhhs.state.nc.us/ltc/.

Susan Harmuth, Workforce Development Coordinator, Office of Long Term Care and Family Services, DHHS, described current grant activities to support programs for older adults. DHHS has received three grants from the federal government to support home and community based care options for persons needing long-term care. The three grants are: 1) a Real Choice grant that focuses exclusively on direct care workforce issues 2) a Community Personal Assistance Services and Supports grant to support development of directed care and 3) a Nursing Home Transition grant to assist persons residing in nursing homes who desire and are able to transition to the community. Strategies for workforce development being pursued include developing a career ladder for nonlicensed staff and a bonus structure for aides taking service training (modeled after the TEACH program for child care workers).

## November 19, 2002

The North Carolina Study Commission on Aging met on Tuesday, November 19, 2002 at 10:00 a.m. in Room 415 of the Legislative Office Building. Representative Beverly Earle was the presiding Co-Chair. Topics of this meeting included Medicaid asset policies, home and community based services in other states, CAP/DA, and prescription drug assistance for seniors.

Marjorie Morris, Chief of the Medicaid Eligibility Unit of the Division of Medical Assistance, DHHS, reviewed some recent changes to the Medicaid program that will impact cases effective December 1, 2002. Specifically, in the 2002 budget bill (Senate Bill 1115), changes were made to the asset test for determining eligibility for Medicaid. The two changes apply to income producing property and tenancy in common property. Both of these changes will primarily affect persons in long-term care.

The first change concerns the counting of equity for income producing property. For income producing property, the policy has been that as long as the property produced income to equal 6% of its equity value (or tax value) then the value of the entire property was not counted in the asset test for purposes of determining eligibility for Medicaid. Now, if a person owns income-producing property, the equity or tax value, minus $6,000, will be counted.

The second change involves transfers of tenancy in common property. Prior to the change, a loophole existed that allowed a person to make property tenancy in common by giving a 1% interest away. Usually this one percent interest was less than the $4,200 average private nursing facility rate in North Carolina. To be penalized for transfers, there had to be a transfer of property for an amount over $4,200. After a person transferred the 1%, the person could transfer the other 99% without being penalized because this property was considered tenancy in common and Medicaid policy did not count this property or any transfers of this property. With the change, Medicaid will penalize a person for transferring the other 99% of the equity (tax value) in a tenancy in common property. However, if the transfer is to an allowable person, then there

will be no penalty. Transfers are allowed to a legal spouse, natural or adopted child under 21, blind/disabled child of any age, sibling who is co-owner of the home and has lived in the home for at least one year before the person entered long-term care, and a child age 21 or older who resided in the home for at least two years before the person entered long-term care and provided care to the person to allow him or her to live at home during those two years. Tenancy in common property will still not count in determining a person's assets.

The Commission then received an update on the Community Alternatives Program for Disabled Adults (CAP/DA) from Nina Yeager, Director of the Division of Medical Assistance (DMA), DHHS, and Bruce Steele, Chief, Community Care Section, DMA, DHHS. In October 2001, admission to CAP/DA was frozen because of a lack of available funds, and people leaving CAP/DA could not be replaced by new clients. At the time the "freeze" was put into effect, the caseload in CAP/DA was 10,230. Between October 2001 and August 2002, the caseload in CAP/DA had decreased to 8,049. In August 2002, it was determined that there were sufficient funds to permit new enrollees to replace people leaving CAP/DA. New enrollees were then authorized by DMA on a case-by-case basis. In November 2002, because of new funding by the General Assembly, new slots were added to CAP/DA and allotted to the counties. A copy of the presentation on this issue, including a table of the CAP/DA Caseload History from October 1, 2001 through October 31, 2002, is attached as **Appendix D.**

Because CAP/DA is designed to allow persons to stay at home rather than in a nursing facility, it would seem that the freeze in the Program would have caused an increase in nursing home admissions. However, nursing home admissions actually decreased during the freeze. DMA did see an increase in the use of personal care services under Medicaid during the freeze.

As a continuation of the Commission's efforts to explore home and community based services, Dianna Jessup, Commission staff, gave an overview and distributed a report of activities being undertaken in other states.

Mary Bethel, Manager of Consumer Affairs, Division of Aging, DHHS then gave an update on prescription drug assistance programs. **Appendix E.** Ms. Bethel reported that there is not a program available that provides comprehensive coverage, but people are piecing coverage together. The Division of Aging has conducted 10 training sessions geared to local service providers to help answer questions and make sure people are knowledgeable about prescription drug assistance programs.

Finally, Michael Keough, Program Coordinator, North Carolina Senior Care, described the State's newest prescription drug assistance program to the Commission. The program, called Senior Care, is available to persons aged 65 and older who are North Carolina residents with annual incomes below 200% of the federal poverty level and who have a need for prescription drugs for heart disease, chronic lung disease, and diabetes. For eligible persons, Senior Care pays for 60% of the first $1,000 of the cost for prescription drugs and insulin for the treatment of cardiovascular disease, chronic obstructive pulmonary disease and/or diabetes, and members pay the remaining 40% plus a per-prescription service fee of $6.00. Members of the program receive a card that they present to the provider. So far, Senior Care has received 6,000 applications and has processed over 1,000 prescriptions. In addition, as of January 1, 2003, Medication Management Centers will be available to help seniors review their medications and give them advice on proper medication use. **Appendix F.**

## December 10, 2002

The North Carolina Study Commission on Aging met on Tuesday, December 10, 2002 at 10:00 a.m. in Room 415 of the Legislative Office Building. Senator William Purcell was the presiding Co-Chair. During this meeting, the Commission heard from speakers on the issues of long-term care workforce development, coordination of long-term care efforts, and temporary management of nursing homes and adult care homes.

Susan Harmuth, who spoke to the Commission on November 12, 2002 concerning grant activities, returned to speak to the Commission concerning efforts being undertaken to develop the long-term care workforce, particularly nurse aides. **Appendix G.** Like most states, North Carolina officials recognize that shortages are a major issue, with employee turnover rates of greater than 100% for workers in nursing homes and adult care homes. Major activities being undertaken by states to combat the shortages include providing wage benefits and incentives, developing career ladders and providing training, and establishing commissions to develop strategies for building a workforce.

Lynda McDaniel, Assistant Secretary, Office of Long Term Care and Family Services, DHHS, described how DHHS uses the Office of Long Term Care to coordinate long-term care efforts both within DHHS and between DHHS and other departments. Performance teams have been established within DHHS to work on issues in particular areas, e.g. workforce issues. These teams are comprised of stakeholders, providers, State employees, and others interested in the particular issue. In addition, the Long-Term Care Cabinet meets once a month to share information.

During the prior meeting of the Commission, members requested information concerning temporary management of nursing homes and adult care homes as a remedy to address deficiencies and to avoid closing facilities and moving clients. Phyllis Daw and Jim Upchurch of the Division of Facility Services, DHHS, provided anecdotal information concerning what they have done in the past to address serious deficiencies in nursing homes or adult care homes and what remedies are available to them to address deficiencies. Temporary management has not been used, mostly because it is difficult to get someone to agree to be a temporary manager under the circumstances typically presented in these situations. Amy Currie, Research Assistant, Research Division, NCGA, followed with information concerning temporary management in other states and a summary of an AARP-commissioned paper on the topic. **Appendix H.** She found that temporary management is not used often for a variety of reasons, including lack of facility funds, divergent views on operational authority, the absence of clear statutory triggers, lack of experience with this remedy, lack of qualified candidates available to serve as temporary managers, lack of judicial understanding of temporary management, and regulatory confusion. Michigan has used the remedy more than other states through its Collaborative Remediation Project (Project). The Project assists long term care providers in the achieving and maintaining compliance with licensure and certification requirements. As a result, the Project has dramatically reduced the number of civil monetary penalties. The Project appears to be unique among states and may serve as a useful demonstration project regarding the application of temporary managers.

The meeting concluded with a discussion of the recent ice storm and how seniors may have fared during the power outages. The Commission requested follow-up information on this topic.

## January 7, 2003

The North Carolina Study Commission on Aging met on Tuesday, January 7, 2003 at 10:00 a.m. in Room 415 of the Legislative Office Building. Representative Earle was the presiding Co-Chair. During this meeting, the Commission received various reports and heard presentations on issues raised during previous meetings.

The Department of Health and Human Services (DHHS) presented the following reports:

- *Long-Term Care Local Lead Agency (S.L. 2001-491, Part XXII)* - The General Assembly, at the request of the Commission, directed DHHS to study whether counties should designate local lead agencies to organize a local long-term care planning process, as described in Recommendation #10 of the Institute of Medicine's (IOM) Long-Term Care Task Force Interim Report of June 30, 2000 (Recommendation #16 in the Institute's final report in January 2001). The IOM recommended that the General Assembly encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level and suggested how local planning processes should be organized. Karen Gottovi from the Division of Aging reported on the Division's approach to conducting this study and its findings and conclusions. The results of the Division's study are attached as **Appendix I.**
- *Prescription Drug Access/Coordination (S.L. 2002-180, Sec. 5.1)* - Pursuant to the recommendation of the Commission last session, the General Assembly directed DHHS to study ways to coordinate and facilitate public access to public and private free and discount prescription drug programs for senior citizens. Michael Keough, Project Director for NC Senior Care, presented the results of that study. In determining what course of action the State should take in improving access to prescription drug programs, DHHS looked at the MedBank program underway in Maryland and local efforts around the State. As a result, DHHS recommended a local/State partnership called Medication Management Centers, which would be locally based. These centers would be staffed by a Prescription Assistance Coordinator and a Pharmacist who would assist patients with both prescription assistance and medication management. A more thorough explanation of the study and DHHS' recommendations are included in **Appendix J.**
- *Group Health Insurance for Long-Term Care Staff Study (S.L. 2002-180, Sec. 5.2)* –Upon the recommendation of the Commission, DHHS was directed to study ways to establish a group health insurance purchasing arrangement for staff, including paraprofessionals, in residential and nonresidential long-term care facilities and agencies, as described in Recommendation #22 of the Institute of Medicine's (IOM) Long-Term Care Task Force Final Report of January 2001. Susan Harmuth from the Office of Long Term Care and Family Services in DHHS reported the results of this study. She reported that DHHS, in consultation with the Department of Insurance, looked at different approaches to the issue. It was determined that no real cost savings would result because regardless of the purchasing arrangement, individual employee risk would still be assessed and premiums priced in accordance with that risk assessment.
- *Special Assistance Demonstration Project (S.L. 2001-424, Sec. 21.29)* – In 1999, the General Assembly authorized DHHS to use funds from the existing State/County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. John Tanner, Division of Social Services, DHHS, provided the Commission with an update of this program. Currently, this program is available in 22 counties. Individuals participating in the program are assessed using the Residential Assessment Instrument (RAI), and the information from the RAI is

sent to a centralized database. From that database, DHHS is able to determine the characteristics of the individuals in the program and what services are being purchased. Based on the comparison of the relative costs of in-home payments versus payments to adult care homes, DHHS recommended expanding this program both geographically and programmatically to include more individuals. Excerpts of the materials provided Mr. Tanner are contained in **Appendix K.**

At a prior meeting of the Commission, the Commission requested an analysis of the relative costs for CAP/DA, adult care homes, and nursing facilities. Nina Yeager, Director of the Division of Medical Assistance, DHHS, provided preliminary data on this issue. That data is attached as **Appendix L.**

Susan Morgan, Fiscal Research Division, then presented two budget issues for the 2003 session for the Commission's consideration. Both relate to the Home and Community Care Block Grant (HCCBG). First, Ms. Morgan suggested that DHHS should require that a formal eligibility process based on income be incorporated into current programs funded by State resources in HCCBG. Ms. Morgan noted that this would result in restricting some of the flexibility afforded to counties in administering HCCBG funds. Ms. Morgan also suggested that if reductions to HCCBG are made, that priority should be given to preserving those services that allow individuals to remain in their home.

During the previous Commission meeting, Commission members discussed the recent ice storm and power loss and its impact on seniors. During the January 7, 2003 meeting, the Commission heard from three speakers concerning this subject. Bill Warren, Chief of the Construction Section, Division of Facility Services, DHHS, provided the Commission with the requirements for family care homes, adult care homes, and nursing homes with regard to power outages. Only nursing facilities are required to have the capacity to generate power and provide heat during a power outage. Mr. Warren described the difficulty in requiring all long-term care homes to have backup power. Dr. Ken Taylor, Director of Emergency Management, Department of Crime Control and Public Safety, described the State's role during natural disasters like ice storms and some of the issues that arise with respect to seniors such as persuading seniors to go to shelters. Finally, Lieutenant Colonel Deal of the North Carolina National Guard related the Guard's efforts after the ice storm. Following the ice storm, Governor Easley activated National Guard personnel to go door to door to provide assistance where needed. Colonel Deal told the Commission some of what they found, including a couple that had been without food for three days and a woman whose oxygen had run out and who needed emergency assistance. He felt that the Guard had saved lives as a result of their efforts.

The Commission then turned to a discussion of possible legislative recommendations for the coming session. After a short discussion of recommendations presented by Representative Earle, the Commission decided that more time was needed to decide on possible recommendations. Therefore, a meeting was set for the following week.

## January 16, 2003

The North Carolina Study Commission on Aging met on Thursday, January 16, 2003 at 10:00 a.m. in Room 415 of the Legislative Office Building. Senator William Purcell was the presiding Co-Chair. During this meeting, the Commission discussed and approved possible Commission

recommendations and directed the Commission staff to prepare a draft report for review prior to the final meeting of the Commission.

## January 28, 2003

The North Carolina Study Commission on Aging met on Tuesday, January 28, 2003 at 1:00 p.m. in Room 415 of the Legislative Office Building. Members discussed and approved the Commission's Report to the Governor and to the 2003 Session of the 2003 General Assembly and heard a report from the Institute of Medicine (IOM). The IOM's report was in response to S.L. 2002-126 (S 1115) Section 10.16(c), which required a study of the Community Alternatives Program for Disabled Adults (CAP/DA) administered by the Department of Health and Human Services and to recommendations for ways of improving the administration of CAP/DA.

# COMMISSION RECOMMENDATIONS

The North Carolina Study Commission on Aging makes the recommendations outlined below. Each recommendation is followed by background information, and any corresponding legislative proposals appear in **Appendix M** of this report.

## I. Long-Term Care Workforce Related Issues

**Recommendation 1**
**The Commission recommends that the General Assembly provide a workforce improvement program for direct care workers employed in adult care homes and home care situations.**

**Background**
On December 10, 2002, the Commission heard a presentation **Appendix G** from Susan Harmuth, Department of Health and Human Services, which focused on why the long-term care workforce is a public policy issue. Ms. Harmuth pointed out that: 1) Long-term care is a major financial investment for states, 2) Direct care workers are the backbone of the long-term care system, 3) Serious shortages already exist, and 4) Aging boomers will increase demand. The distribution of the direct care workforce in 2000 was 17% Personal and Home Care Aides, 25% Home Health Aides and 58% Nurse Aides, Orderlies, and Attendants. Unfortunately wages among direct care workers are low and turnover rates are high. From the year 2000 to 2010, the United States Bureau of Labor Statistics projects that the direct care workforce will need 874,000 additional workers, or 1.2 million workers including replacements. For comparison, the growth of the direct care workforce is projected to be 36.3% while growth in the overall workforce is projected to be 15.2%. During her presentation, Ms. Harmuth mentioned several approaches to reducing direct care worker turnover, among them was the WIN-A-STEP UP program.

WIN-A-STEP-UP stands for Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance. It is a workforce improvement program that includes continuing education and payment incentives for nursing assistants. The program is designed to reduce turnover, and to enhance skill base while providing incentives for continuing education. At least 570 nurse aides employed in nursing homes currently participate in the WIN-A-STEP-UP project offered by the UNC Institute on Aging. http://www.aging.unc.edu/research/winastepup/index.html The program for nurse aides in nursing homes is paid for with civil penalty money (which can only be used for nursing homes.)

The Commission recommends that the General Assembly expand the opportunity for a workforce improvement program to include direct care workers employed in adult care homes and home care situations.

**Recommendation 2**
**The Commission recommends that the Department of Health and Human Services implement initiatives to increase and promote the availability of nurse aide training and competency programs.**

**Background**

In response to the information presented on December 10, 2002, **Appendix G,** the Commission is interested in a variety of methods that will address the projected shortage of direct care workers.

In addition to the information shared by Ms. Harmuth, the Employment Security Commission of North Carolina (ESC) projects that the Service Occupational group will be the second fastest job growth occupation after the White Collar group during the period from 1998 to 2008. Included among this group are such fast growing occupations as Nursing Aides and Orderlies and Home Health Aides. The table below was extracted from a larger table prepared by the ESC, and it provides data for North Carolina Occupational Trends in regards to selected Service Occupations Employment in 1998 and projected to 2008.

| Major Occupational Group | 1998 Emp. | 2008 Emp. | Annualized Change |
|---|---|---|---|
| Home Health Aides | 18,110 | 26,990 | 4.07 |
| Nursing Aides, Orderlies, Attendants | 43,750 | 62,140 | 3.57 |
| Personal and Home Care Aides | 6,280 | 9,870 | 4.63 |

As well as data clearly showing the need for additional direct care workers, Commission Members have independently received complaints about the availability of nurse aide training programs. As such, the Commission supports on-going efforts to increase and promote the availability of nurse aide training programs.

**Recommendation 3**

**The Commission recommends that the Department of Health and Human Services work with the NC Board of Nursing, the Community College System and representatives from the NC Health Care Facilities Association to implement a pilot program using medication aides and geriatric aides in skilled nursing facilities.**

**Background**

In her presentations to the Commission on November 12, 2002 and December 10, 2002 **Appendix G**, Susan Harmuth reported that one of the initiatives being undertaken to increase the availability and skill level of the long-term care workforce is the development of a career ladder for nurse aides in facilities that would encourage and reward specialization in medication administration and geriatric care. The Commission finds that the use of medication aides and geriatric aides in skilled nursing facilities would produce positive outcomes for patients, nursing staff and facility operations. Therefore, the Commission recommends the implementation of a pilot program using medication aides and geriatric aides in skilled nursing facilities.

**Recommendation 4**

**The Commission recommends that the General Assembly appropriate funds for labor enhancement payments for workers in Medicaid-reimbursed, non-institutional settings.**

**Background**

Wage comparisons presented on December 10, 2002, **Appendix G,** highlighted that direct care workers make lower median hourly and annualized wages than any of the following: dental assistants, manicurists, school bus drivers, file clerks or hairdressers. For 2000, direct care

workers had a median hourly wage rate of $7.86 per hour and an annualized wage of $16,349. For this reason, the Commission recommends that the General Assembly appropriate funds to enhance the wages for nurse aides employed by non-institutional Medicaid providers and that counties be held harmless for their share of the rate increase.

According to the Division of Medical Assistance, the NCHCFA conducts annual wage surveys of nursing homes to determine wages that nursing facilities expect to pay during the coming year. DMA uses the survey information to estimate the inflation rate that is used to determine the reimbursement rates for nursing facilities. The 2001 wage survey (survey was not conducted during 2002) identified an hourly pay rate of $9.67 for nurse aides in an institutional setting and $7.51 for nurse aides in a non-institutional setting. (Note that DMA review of PCS and CAP-DA cost reports submitted by providers primarily for SFY2001 identified an average hourly pay rate of $7.77 for nurse aides.) The NCHCFA survey was the basis for Medicaid rate increases to nursing facilities that became effective October 1, 2000. While these rate increases were not a targeted wage pass-through, the increases resulting from the wage survey were included as a component in the direct care cost rates. Because direct care costs are settled to actual through DMA audit of nursing facility cost reports, the rate increases would not be paid by DMA unless they were given to nurse aides by the providers. Similar rate increases were not made for non-institutional care Medicaid providers (most notably those who provide personal care services to patients at home, in community alternative programs [CAP], and in adult care homes). These types of providers face increasing difficulty in the recruitment and retention of nurse aides. The purpose of this recommendation is to provide funds necessary to support increased aide wage rates for those employed by this group of providers.

## II. Community Based Initiatives

**Recommendation 5**
**The Commission recommends that the General Assembly fund the Community Alternatives Program for Disabled Adults (CAP/DA) at a level sufficient to preserve the availability of community-based services offered through the program.**

**Background**
According to the Division of Medical Assistance, Department of Health and Human Services, the Community Alternatives Program for Disabled Adults (CAP/DA) started in July 1982, and operates under a Medicaid Home and Community-Based Services (HCBS) waiver. For individuals who qualify for Medicaid, and who would otherwise require care in a nursing facility, the CAP/DA program provides the opportunity to be cared for at home.

A case manager is assigned to each CAP/DA client and is responsible for arranging and monitoring services and care. Services available under the CAP/DA program include: Adult Day Health Care, In-Home Aide Services, Waiver Supplies, Home Delivered Meals, Home Mobility Aids, Respite Care (In-Home and Institutional), and Telephone Alert (Emergency Response Systems). Of these services, in-home aides are used by 98-99% of the clients and constitute 90-91% of the CAP/DA dollars expended. During the most recent "waiver year", October 2000 through September 2001, there were 177,078 individuals age 65 and over that were eligible for Medicaid. Of these 177,078 individuals, 43,412 were nursing facility patients and 12,243 were CAP/DA clients. The most recent five-year trend, from waiver year 1996-1997 to 2000-2001,

shows the number of nursing facility patients actually decreasing for a three-year period, but ultimately registering a 3.08% increase from 1996-97 to 2000-01. For the same five-year period, the number of CAP/DA clients has increased 40.7%.

The total Medicaid cost for home care must not exceed the comparable Medicaid cost for institutional care, and the Division of Medical Assistance is required to prove that the program remains cost effective. During the last five waiver years, the average cost per patient for care in a nursing facility has ranged from $76 per day to $88 per day. During this same time, the CAP/DA average cost per client has ranged from $48 per day to $57 per day. Thus, over the last five years, CAP/DA average costs have been $28 to $31 per day per client less than nursing facility care costs.

CAP/DA is a statewide program administered by the lead agency in each county. The total number of persons served under a waiver is approved by the Centers for Medicare and Medicaid Services. Counties request CAP/DA allocations. The Division of Medical Assistance (DMA) approves allocations based on the availability of in-home aides and case managers, the county's performance and rationale for the request, and the State's overall allocation limit. These allocations do not represent openings that can be filled and refilled. Instead, they represent a count of the maximum number of individuals that may be served each waiver year.

On November 19, 2002, the Commission received an update on the Community Alternatives Program for Disabled Adults (CAP/DA) from Nina Yeager, Director of the Division of Medical Assistance (DMA), DHHS, and Bruce Steele, Chief, Community Care Section, DMA, DHHS. ***Appendix D*** On September 27, 2001, the Division of Medical Assistance directed, "that effective October 1, 2001, no individuals may be added to the Community Alternatives Program for Disabled Adults (CAP/DA). In addition, there will be no new allocations to counties at this time, and no increases in the plan of care cost limits." Additionally, CAP/DA managers, supervisors and case managers were asked to consider additional ways that they could reduce CAP/DA expenditures. As of the date of that letter, the CAP/DA program was forecasted to exceed its FY 01-02 budget by $20,000,000. On January 30, 2002, DMA gave notification that the freeze on participation in the CAP/DA program could not be lifted due to the "continuing problems with the Medicaid budget and the overall State budget situation." At the time the "freeze" was put into effect, the caseload in CAP/DA was 10,230. Between October 2001 and August 2002, the caseload in CAP/DA had decreased to 8,049. In August 2002, it was determined that there were sufficient funds to permit new enrollees to replace people leaving CAP/DA. New enrollees were then authorized by DMA on a case-by-case basis. In November 2002, because of new funding by the General Assembly, new slots were added to CAP/DA and allotted to the counties.

The NC Study Commission on Aging supports the CAP/DA program for the following reasons:

- In Olmstead v. L.C., the United States Supreme Court concluded that inappropriate institutionalization of a person with a mental disability may be discrimination under the ADA. In response to the U.S. Supreme Court's decision, the North Carolina Department of Health and Human Services is working to ensure compliance and has drafted an interim plan. Chapter 3 of the NC Interim Plan, dated December 28, 2000, addresses the frail elderly and people with acquired disabilities.
- The Institute of Medicine's Long Term Care Task Force recommended the following Long-Term Care Policy Statement: North Carolina's policy for long-term care is to support older adults and people with disabilities needing long-term care and their families, in making their own choices with regard to living arrangements and long-term

care services that will result in appropriate, high-quality, cost-effective care provided in the least restrictive setting.

- Chapter 675 of the 1981 Session Laws (HB 405) established effective procedures to enable certain elderly persons in need of care to stay at home and to provide the in-home services necessary to care for them. The availability of in-home and community-based services has continued to increase since that time. The demographic shift and increasing numbers of older adults in North Carolina necessitate the importance of maintaining the in-home and community-based services infrastructure.

**Recommendation 6**
**The Commission recommends that the General Assembly direct the Office of the State Auditor to conduct a full audit of the CAP/DA program.**

**Background**
The North Carolina Study Commission on Aging supports the desire of older adults to live in their communities in the least restrictive setting and receive high-quality, cost-effective care. It is unclear whether individuals, for whom CAP/DA is not available, choose nursing facility care and if so whether this is a cost-effective choice.

On January 7, 2003, Nina Yeager, Director of the Division of Medical Assistance, DHHS, provided preliminary data in response to the Commission's request for an analysis of the relative costs for CAP/DA, adult care homes, and nursing facilities. **Appendix L** Unfortunately, clear data comparisons are not readily available, and a definitive answer to the question of cost-effectiveness remains unanswered. Additionally, it is felt that Institute of Medicine's CAP/DA report in response to S.L. 2002-126 (S1115) Section 10.16(c) does not fully contemplate the issues that an audit would explore. Therefore, the Commission recommends that the State Auditor conduct a full audit of the CAP/DA program.

**Recommendation 7**
**The Commission recommends that the General Assembly direct the Department of Health and Human Services to continue its examination of the CAP/DA program.**

**Background**
S.L. 2002-126 (S1115) Section 10.16(c) required the North Carolina Institute of Medicine to conduct a study of the CAP/DA program administered by the Department of Health and Human Services and to recommend ways of improving the administration of CAP/DA. The North Carolina Institute of Medicine was directed to report its findings and recommendations to the 2003 General Assembly upon its convening. In conducting the study, the Institute was to consider the following:

(1) Whether the lead agency for CAP/DA should also be a provider of direct services under CAP/DA.
(2) Whether case managers should be employed by the provider agency.
(3) Whether funds for CAP/DA should be reduced below the ninety percent (90%) maximum that currently exists.
(4) Review current policy for service requirements, management, and supervision as it pertains to strengthening the family and case manager and agency requirements.
(5) Whether case managers and provider agencies should have increased responsibility for upholding guidelines.
(6) Whether oversight of CAP/DA by the Division of Medical Assistance needs strengthening.

(7) Alternative funding sources for CAP/DA.
(8) Determination of funding needs for CAP/DA based on corroboration with long-term care policy initiatives.
(9) What changes should be made to CAP/DA to reduce cost of services per person in order to serve more individuals within existing funds.
(10) Any other matters the North Carolina Institute of Medicine considers pertinent to the study.

The Institute of Medicine reported preliminary findings and recommendations to the Commission on January 28, 2003. Because continued evaluation of the CAP/DA program is of vital importance, the Commission recommends that the General Assembly direct the Department of Health and Human Services to continue its examination of the CAP/DA program, particularly as it relates to the assessment process and program costs.

**Recommendation 8**
**The Commission recommends that the General Assembly fund a pilot project on long-term care local lead agencies.**

**Background**
The Commission recommended to the 2001 General Assembly that DHHS conduct a study based on the IOM Long-Term Care Task Force finding that "long-term care services are often fragmented, duplicative, complex, and not consumer-friendly and that many counties lack needed core long-term care services." In response to the Commission's recommendation, the General Assembly directed DHHS to study whether counties should designate local lead agencies to organize a local long-term care planning process, as described in Recommendation #10 of the Institute of Medicine's (IOM) Long-Term Care Task Force Interim Report of June 30, 2000 (Recommendation #16 in the Institute's final report in January 2001). The IOM had recommended that the General Assembly should encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level and suggested how local planning processes should be organized. This provision was included in the 2002 Studies Bill (S.L. 2001-491, Part XXII) and the Department of Health and Human Services, Division of Aging was directed to study whether counties should designate local lead agencies to organize a local long-term care planning process.

On January 7, 2003, Karen Gottovi, Director of the Division of Aging, Department of Health and Human Services presented a report in response to S.L. 2001-491, Part XXII ***Appendix I***. In response to this report, the Commission recommends that the General Assembly fund a pilot project on long-term care local lead agencies.

**Recommendation 9**
**The Commission recommends that the General Assembly maintain the Home and Community Care Block Grant services for impaired older adults at the current level and under the current administrative structure that allows flexibility to counties to offer those services chosen by the county.**

**Background**
On January 7, 2003, the Commission heard a report from Commission staff member, Susan Morgan, Fiscal Research Division, NCGA. Ms. Morgan's presentation was on budget issues for

the 2003 legislative session, including issues that may impact the Home and Community Care Block Grant.

According to the Division of Aging, Department of Health and Human Services, the Home and Community Care Block (HCCBG), in effect since July 1, 1992, was established by the General Assembly (G.S. 143B-181.10) on the recommendation of the DHHS Advisory Committee on Home and Community Care and with the support of the North Carolina Association of County Commissioners. The Division believes that the HCCBG represented an important step toward establishing a well-coordinated service delivery system to meet the needs of a rapidly growing older population through the consolidation of several funding sources (i.e., the Older Americans Act, the Social Services Block Grant in support of respite care, portions of the State In-Home and Adult Day Care funds, and other relevant State appropriations). According to the Division, the two principal purposes of the HCCBG are to:

- Give counties greater discretion, flexibility, and authority in determining services, service levels, service providers, and clients. With direct input from older adults in the planning and decision-making process, county commissioners approve an annual funding plan that defines services to be provided, the funding levels for these services, and the community service agencies to provide these services.
- Streamline and simplify the administration of services, seen as especially important as aging budgets are reduced or become static while demand for services grows. This includes establishing a single set of policies and procedures for in-home and community-based services funded under the HCCBG (e.g., uniform definitions and standards for services, consolidated reporting on services and units, and consistent eligibility requirements). It is also a process intended to ease re-budgeting locally and statewide to assure maximum use of available resources. In SFY 01-02, 99.58% of allocated funds were expended.

On July 1, 1992, the Division of Aging instituted a voluntary cost-sharing policy for the HCCBG that includes use of a sliding fee scale to guide participant contributions that support the publicized cost of the service. The Division reports that this policy is still in effect, and in SFY 01-02 resulted in contributions of nearly $2.4 million.

According to information supplied by the Division of Aging, $52 million is budgeted for the HCCBG, from the following sources:

| **Source** | **Budgeted Funds** | **Percent of Total** |
|---|---|---|
| Older Americans Act | $18,006,923 | 34.45% |
| Social Services Block Grant | $1,834,077 | 3.51% |
| Required State Match | $1,111,632 | 2.13% |
| Other State Appropriations | $23,997,654 | 45.91% |
| Required Local Match | $4,994,477 | 9.55% |
| Current Participant Cost Share | $2,328,190 | 4.45% |
| **Total** | **$52,272,953** | **100.0%** |

The Division of Aging reports that the emphasis for the HCCBG is placed on the 14 "Core Services as identified in Recommendation #11 of the 2001 Institute of Medicine Long-Term Care Plan for North Carolina. The remaining four services (i.e., Congregate Nutrition, Senior Centers, Health Screening, and Volunteer Program Development) are arguably supportive of persons needing long-term care as well as their family caregivers." According to data supplied by the Division, as "of the current fiscal year (2002-03), counties have elected to use 80% of the HCCBG funds to support 'core LTC services.' If you exclude the funds for congregate nutrition, which are required by the Older Americans Act, the percent targeted to core LTC services increases to 92%. Counties elect to use the majority (57%) of the remaining funds to support the operation of Senior Centers."

The following information was also supplied by the Division of Aging:

- *While any person age 60 and older is eligible for services under the HCCBG, the program places an emphasis on reaching those most in need of services. This begins with the requirement of the Older Americans Act (OAA) to give priority to serving the "socially and economically needy" (with particular attention to low-income minority elderly and older individuals residing in rural areas). Additionally, the OAA calls for reaching out to older individuals with severe disabilities, limited English-speaking ability, and Alzheimer's disease or related disorders (and caregivers of such individuals). In fact, the HCCBG funding formula, approved by the U.S. Administration on Aging, is based on the following criteria: # of persons age 60 and older (50%), # of 60+ who live at or below poverty (30%), # of non-white persons 60+ (10%), and # of 60+ persons who live in rural areas (10%). State service standards for the HCCBG also give priority to serving Adult Protective Services clients, those at risk of APS, and those who otherwise are most impaired. Providers use these various screening and targeting criteria in determining whom to serve with available resources. Finally, in allocating additional funds for the HCCBG, the General Assembly has indicated its support of serving older persons who are not eligible for Medicaid and who are on the waiting list for these services. Currently, the HCCBG waiting list includes nearly 11,400 service needs.*

- *Nearly half (49%) of the 61,790 different clients receiving at least one HCCBG service in SFY 01-02 were reportedly low income. This figure rises to 58% among those receiving core LTC services. At the time of registering for HCCBG services, clients are informed of the federal poverty figure. Those who self-report their income as less than this amount are considered 'low income.' Those receiving congregate meals are the least likely to report living at or below poverty (40%). Significantly, congregate participants contribute the most to the cost of service through voluntary cost-sharing under the HCCBG (providing more than $1 million, or about 14% of the total expenditure for this service in SFY 01-02).*

- *It is believed that many of the other recipients of HCCBG services are among the so-called "near poor"-those with income just above the poverty level, making them ineligible for Medicaid but having to struggle with paying for such necessities as prescription drugs and utilities. This is the group that the General Assembly has especially wanted to reach through their additional appropriations to the HCCBG. According to the 2000 Census, 13.2% of North Carolinians age 65 and older (and 11.13% of 60+) had incomes below the poverty level in 1999 ($7,990 for an individual; $10,075 for a couple). An additional 36% were at "near poverty" with incomes between 100 and 200% of poverty.*

*Even though HCCBG providers do not substantiate income information, service statistics suggest that HCCBG services are reaching a high percentage of poor and near-poor elderly. A higher percentage of women, minorities, older-old, rural residents, those living alone, and the frail have low income. The following HCCBG service profile from SFY 2001-02 suggests the success of this targeting:*

*71% of HCCBG participants are women;*
*33% are minority;*
*59% are age 75 or older;*
*47% live in rural areas;*
*46% live alone;*
*14% have 3 or more ADL limitations (e.g., eating, bathing, using toilet, moving around), which means they are very frail [even higher for the two largest services: in-home aide (35%) and home-delivered meals (25%)];*
*32% are at risk of malnutrition.*

The Commission recommends that the General Assembly maintain the Home and Community Care Block Grant services for impaired older adults at the current level and under the current administrative structure that allows flexibility to counties to offer those services chosen by the county.

**Recommendation 10**
**The Commission recommends that the General Assembly expand the State/County Special Assistance in-home component by permitting the Department of Health and Human Services to increase the number of individuals who may be enrolled in the project. The Commission also recommends that the project be made available to all counties on a voluntary basis.**

**Background**
On January 7, 2003, the Commission heard a report from John Tanner, Division of Social Services, Department of Health and Human Services on the Special Assistance Demonstration Project. In 1999, the General Assembly authorized DHHS to use funds from the existing State/County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. Currently, this program is available in 22 counties. Individuals participating in the program are assessed using the Residential Assessment Instrument (RAI), and the information from the RAI is sent to a centralized database. From that database, DHHS is able to determine the characteristics of the individuals in the program and what services are being purchased. Based on the comparison of the relative costs of in-home payments versus payments to adult care homes, DHHS recommended expanding this program both geographically and programmatically to include more individuals.

Based on the report presented, the Commission recommends that the General Assembly expand the Special Assistance in-home component by increasing the number of slots and expanding availability to all counties on a voluntary basis.

# III. Long-Term Care Facilities

**Recommendation 11**
**The Commission recommends that the Department of Health and Human Services study the implementation of a remediation program similar to the Collaborative Remediation Project in Michigan.**

**Background**
The Commission heard presentations on December 10, 2002, on temporary management of nursing homes and adult care homes. No state was found to have a clearly superior method of handling these issues, but Michigan has a remediation program that seems to work well. The Collaborative Remediation Project (CRP) assists long term care providers in the achievement and maintenance of compliance with licensure and certification requirements. Through the CRP, remediators enter into a contract with a facility to provide directed in-service trainings, coordinate a directed plan of correction, or serve as clinical advisors or temporary managers.

The Michigan Department of Consumer & Industry Services (MDCIS) created the Collaborative Remediation Project (CRP). Funds from civil monetary penalties, the nursing home industry, and state general fund appropriations serve as the foundation for this endeavor. The impetus for creating the CRP came from many sources such as:

- Complaints about the punitive nature of nursing home enforcement.
- Michigan having a higher number of nursing homes cited for deficiencies than the national average.
- The large number of civil penalties used to force compliance.
- The belief that non-compliance in many cases resulted from lack of education and training.

The remediations provided by CRP are directed at facilities that have serious compliance problems or are chronic poor performers. The CRP provides (1) assistance to long-term care providers in the achievement and maintenance of compliance with licensure and certification requirements; (2) education to residents and their families regarding appropriate care and rights; and (3) administration of criteria for the Continuous Quality Improvement Program (CQIP) which awards providers with significant quality improvement initiatives.

The services provided by CRP include:

- Directed Plan of Correction and Directed In-service Trainings
- Accreditation for Long-Term Care Professionals Able to Serve as Temporary Managers, Administrative Advisors and Clinical Advisors
- Resident and Family Education Programming
- Consultation and Continuous Quality Improvement

The North Carolina Study Commission on Aging recommends that the Department of Health and Human Services study the implementation of a remediation program similar to the Collaborative Remediation Project in Michigan.

**Recommendation 12**
**The Commission recommends that a group within the Department of Health and Human Services be established to ensure that felons are not employed by long-term care facilities**

**and home care agencies and that the moratorium on the effective date of long-term care criminal checks established in S.L. 2002-126, Section 10.10C be repealed.**

**Background**

In 2002, the North Carolina Study Commission on Aging recommended that the General Assembly pursue ways in which national criminal record checks may be obtained and reviewed by long-term care facilities to effectuate State policy and to protect facility residents. This recommendation was based in part on the fact that members of the public expressed concern about abuse and neglect in long-term care facilities during public hearings conducted by the Commission in March and April 2002.

State law currently requires criminal history checks of all applicants for employment with nursing homes, home health care agencies and adult care homes. If the applicant has been a resident of North Carolina for less than five years, the criminal history record check would include both a national and a State criminal history record check. If the applicant has been a resident of North Carolina for five years or more, only a State criminal history record check is required. However, under federal law, the FBI may release results of national criminal history checks directly to nursing homes and home health care agencies on applicants for positions that involve direct patient care. Otherwise, results of criminal history checks performed by the FBI can only be released to a state agency and cannot be released directly to a provider. This made it difficult for providers to comply with the State law. As a result, a moratorium on the national criminal history checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes other than those involving direct patient care and for applicants for all staff positions in adult care homes until January 1, 2004.

The Commission recognizes the importance of conducting a thorough background check of potential employees of these facilities to prevent the employment of persons who are unsuitable to work with the elderly in these facilities. As such, the Commission recommends that a group within the Department of Health and Human Services be established to ensure that felons are not employed by long-term care facilities and home care agencies and that the moratorium on the effective date of long-term care criminal checks established in S.L. 2002-126, Section 10.10C be repealed.

## IV. Additional Issues

**Recommendation 13**

**The Commission recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.**

**Background**

Guardianship is a legal relationship in which a person or agency (the guardian) is appointed by a court to make decisions and act on behalf of another person (the ward) with respect to the ward's personal or financial affairs because the ward, due to a specific mental or physical impairment, lacks sufficient capacity to make or communicate important decisions concerning his or her person, family, or property or lacks sufficient capacity to manage his or her personal or financial affairs. Laws regarding guardianship for incapacitated adults attempt to strike a balance between preserving the legal rights, freedom, and autonomy of individuals vs. society's duty (parens patriae) to protect individuals who are unable to protect or care for themselves.

According to the Institute of Government, guardianship was seriously studied for the first time in 1977. Prior to 1977, the laws were out-of-date, incomplete and unclear. The 1977 amendments improved procedures and increased legal protections for the respondent. In 1987, G.S. Chapter 35A was recodified and minor substantive changes were made. In 1995, a Legislative Research Commission study and report focused primarily on guardianship services provided by local human service agencies; however, the recommendations were not enacted.

The North Carolina Study Commission on Aging recognizes that the laws pertaining to guardianship are important for the protection of citizens who are unable to make personal decisions due to impairment or incapacity and that these laws have not been thoroughly reviewed in twelve years. Therefore, the Commission recommends the General Assembly establish a Legislative Study Commission on State Guardianship Laws.

**Recommendation 14**
**The Commission recommends that the Secretary of the Department of Health and Human Services define the duties and responsibilities of the Assistant Secretary of Long-Term Care and Family Services to include only those responsibilities related to long-term care.**

**Background**
This Commission recommendation is consistent with Recommendation #2 in the final report from the Institute of Medicine (IOM) Task Force on Long-Term Care submitted to the Department of Health and Human Services (DHHS) in January 2001.

The IOM Long-Term Care Task Force Final Report has a chapter devoted to restructuring the coordination of Divisions within DHHS that deliver, finance, or regulate long-term care services. The Task Force found that fragmentation among these different Divisions has hindered the State's ability to meet the long-term care challenges facing the State as the population ages. The Task Force cited a number of reasons for this fragmentation including the multiplicity of Divisions within DHHS that play a role in the long-term care system. In order to enhance communication and coordination among the various Divisions, the Task Force recommended that a new Long-Term Care Cabinet and an Office of Long-Term Care be created within the Office of the Secretary. The Long-Term Care Cabinet would be charged with articulating a vision for long-term care in the State and with assuring the activities of DHHS are consistent with that vision. The Office of Long-Term Care would be responsible for interagency long-term care planning, policy analysis, data analysis, evaluation and research, and public communications. An expert in long-term care policy would be selected to direct the Office of Long-Term Care.

The Commission agrees with the findings of the IOM Long-Term Care Task Force regarding the restructuring of Divisions within DHHS to improve communication and coordination to develop the State's long-term care system. The Secretary endorsed this recommendation, and a Long-Term Care Cabinet/Office of Long-Term Care has been created. The Assistant Secretary of Long-Term Care and Family Services was selected to head the office/Cabinet, and concerns were raised by members of the Commission that the Assistant Secretary has job responsibilities covering multiple service areas, thus hindering the ability of the Assistant Secretary to carry out the responsibilities of the office as recommended by the Task Force. Therefore, the Commission recommends that the Secretary of DHHS limit the duties and responsibilities of the Assistant Secretary to those related to long-term care.

**Recommendation 15**

**The Commission recommends that the Secretary of the Department of Health and Human Services continue efforts to coordinate and simplify public access to the myriad drug prescription programs for low and moderate-income older adults.**

## Background

In the 2002 report to the Governor and the General Assembly, the NC Study Commission on Aging recommended that the General Assembly direct the Department of Health and Human Services to study ways the State can coordinate and facilitate public access to public and private free and discount prescription drug programs for senior citizens. The 2002 recommendation was in response to the lack of coordination among prescription drug programs and the difficulty older adults face in trying to access information on prescription drug programs for which they may be qualified. The complexity of the situation became evident during March 18, 2002 presentations on prescription drug programs by the Department of Health and Human Services, Lilly, Pfizer, GlaxoSmithKline, and Novartis. Through those presentations, the Commission realized the numerous public and private free and discount drug programs that are available for senior citizens, but also the lack of a comprehensive coordination and outreach effort to educate and assist seniors in accessing these programs.

In 2002, the General Assembly responded to the Commission's recommendation with S.L. 2002-180, Section 5.1 that directed the Department of Health and Human Services to study was to coordinate and facilitate public access to public and private free and discount prescription drug programs for senior citizens.

On January 7, 2003, Michael Keough, Project Director for NC Senior Care, presented the results of that study to the NC Study Commission on Aging. **Appendix J.** In determining what course of action the State should take in improving access to prescription drug programs, DHHS looked at the MedBank program underway in Maryland and local efforts around the State.

During his presentation, Mr. Keough pointed out that a February 2002 Kaiser Family Foundation Study found that: 1) nearly 38% of non-instutionalized elderly are without drug coverage and 2) there has been an increase of 29% in Medicare beneficiaries average annual out-of-pocket costs from $813 in 2000 to $1,051 in 2002. Additionally, Mr. Keough stated that there are over 50 drug companies sponsoring over 150 programs.

The Department of Health and Human Services believes the solution to the problem lies in Medication Management Centers, which will be locally based and part of the NC Senior Care program. The target effective date for the first referrals to the Centers is February 3, 2003. It is anticipated that the Medication Management Centers will be locally based centers open to all seniors and low income patients in the community, they will be staffed by a Prescription Assistance Coordinator and a Pharmacist, they will utilize Office of Rural Health Medication Access and Review Program (MARP) software, and the Centers will be able to order and dispense free medications. There will be 24 Centers that include 62 counties in their local service areas, and phone medication evaluation services are being developed for high risk Senior Care enrollees in the remaining 38 counties.

The Commission appreciates the information presented by Department of Health and Human Services and is supportive of the NC Senior Care program, including the Medication Management Centers. Additionally, the Commission appreciates all of the local entities that

have responded to the dilemma surrounding prescription drug assistance and medication management. However, the Commission remains committed to continued efforts to coordinate and simplify access to prescription drug programs for low and moderate-income older adults. The Commission believes that the success of Medication Management Centers will depend on the public's awareness, accessibility, and utilization of the Medication Management Centers. Since the Health and Wellness Trust Fund's commitment is for three years, the Commission is concerned about the long-term funding of these Medication Management Centers. Additionally, the Commission supports equal access for all North Carolinians and is deeply concerned about the population of the 38 counties not served by the NC Senior Care Medication Management Centers. Therefore, the Commission recommends that the Secretary of the Department of Health and Human Services continue efforts in coordinating and simplifying the process to access the myriad drug prescription programs for low and moderate income older adults.

**Recommendation 16**
**The Commission recommends that the tax credit for long-term care insurance be made permanent.**

**Background**
North Carolina G.S. 105-151.28 contains the tax credit for long-term care insurance that became effective for tax years beginning on or after January 1, 1999, and that is scheduled to expire for tax years beginning on or after January 1, 2004. According to the Department of Revenue, "the credit is allowed for premiums paid on qualifying long-term care insurance contracts that provide insurance coverage for a taxpayer or a taxpayer's spouse or dependent. The credit is 15% of the premiums paid, not to exceed $350 for each qualified long-term care insurance contract for which a credit is claimed. A long-term care insurance contract is defined in section 7702B of the Internal Revenue Code as any insurance contract under which the only insurance protection provided is for coverage of qualified long-term care services. Qualified long-term care services are those services required by a chronically ill individual and provided under a plan of care prescribed by a licensed health care practitioner."

On January 16, 2003, the Commission received a copy of a memorandum from the Department of Revenue to the Revenue Laws Study Committee expressing concerns arising from the Department's review of a limited number of returns claiming the credit. During this review, the Department found that the vast majority of the credits claimed on the returns were claimed in error. As such, the Department recommended to the Revenue Laws Study Committee that a thorough analysis of the credit be performed before considering an extension or removal of the current sunset on the credit.

The Department of Health and Human Services, Division of Aging produced a report entitled, *Increasing Personal Responsibility for Long Term Care through Private Long Term Care Insurance*. The Division of Aging asserts that individuals purchase long-term care insurance for a variety of reasons including: to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. The Division also believes that long-term care insurance can be expensive, and may not be appropriate for everyone. As such the Long-Term Care in North Carolina website, http://www.dhhs.state.nc.us/ltc/, sponsored by the Division, provides a list of issues to consider before purchasing long-term care insurance. The Division suggests the free counseling and information available through the Seniors' Health Insurance Information Program (SHIIP) of the North Carolina Department of Insurance, and a

video entitled: " What is Long-Term Care." The video produced by SHIIP and the Division of Facility Services includes information about home and community-based services, residential/facility services, and information about paying for long-term care-- including private financing options with a focus on long-term care insurance as well as some general information about publicly funded services.

The conclusion of the report by the Division of Aging states that, "North Carolina State government has a responsibility to take immediate, sustained and visible action to help North Carolina's baby boomers and younger adults to position themselves to pay privately to meet their long-term care needs to the greatest extent possible. Given the impact aging baby boomers could have on increased demand for publicly funded long-term care services, such an effort is necessary to preserve the future economic security of the state by reducing reliance on publicly funded long-term care services particularly Medicaid. Long-term care insurance holds the greatest promise for positioning a larger segment of the state (and nation's) population to pay privately for future long-term care needs." The North Carolina Study Commission on Aging agrees with the Division's report which states that, "in addition to the public benefit of having a much larger segment of the adult population positioned to pay privately for long-term care in terms of the state's economic health, consumers and families benefit from the ability to pay privately through increased choice and flexibility in terms of the range of services and settings of care available." Therefore, the North Carolina Study Commission on Aging recommends that the tax credit for long-term care insurance be made permanent.

# APPENDICES

# APPENDIX A

| Table One, Older Adults in North Carolina: 2000 | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |
| **County** | **Age 65+** | **% of Total** | | **County** | **Age 65+** | **% of Total** |
| Alamance | 18,464 | 14.10% | | Johnston | 11,973 | 9.80% |
| Alexander | 3,996 | 11.90% | | Jones | 1,603 | 15.40% |
| Alleghany | 2,053 | 19.20% | | Lee | 6,345 | 12.90% |
| Anson | 3,641 | 14.40% | | Lenoir | 8,734 | 14.60% |
| Ashe | 4,377 | 18.00% | | Lincoln | 7,350 | 11.50% |
| Avery | 2,698 | 15.70% | | Macon | 6,666 | 22.40% |
| Beaufort | 7,128 | 15.90% | | Madison | 3,129 | 15.90% |
| Bertie | 3,160 | 16.00% | | Martin | 3,894 | 15.20% |
| Bladen | 4,598 | 14.20% | | McDowell | 6,009 | 14.30% |
| Brunswick | 12,380 | 16.90% | | Mecklenburg | 59,724 | 8.60% |
| Buncombe | 31,776 | 15.40% | | Mitchell | 2,917 | 18.60% |
| Burke | 11,986 | 13.40% | | Montgomery | 3,745 | 14.00% |
| Cabarrus | 15,164 | 11.60% | | Moore | 16,271 | 21.80% |
| Caldwell | 10,259 | 13.30% | | Nash | 10,882 | 12.40% |
| Camden | 933 | 13.60% | | New Hanover | 20,567 | 12.80% |
| Carteret | 10,227 | 17.20% | | Northampton | 3,840 | 17.40% |
| Caswell | 3,060 | 13.00% | | Onslow | 9,499 | 6.30% |
| Catawba | 17,425 | 12.30% | | Orange | 9,931 | 8.40% |
| Chatham | 7,530 | 15.30% | | Pamlico | 2,429 | 18.80% |
| Cherokee | 4,787 | 19.70% | | Pasquotank | 4,911 | 14.10% |
| Chowan | 2,606 | 17.90% | | Pender | 5,780 | 14.10% |
| Clay | 1,988 | 22.70% | | Perquimans | 2,192 | 19.30% |
| Cleveland | 12,965 | 13.50% | | Person | 4,890 | 13.70% |
| Columbus | 7,538 | 13.80% | | Pitt | 12,828 | 9.60% |
| Craven | 12,263 | 13.40% | | Polk | 4,325 | 23.60% |
| Cumberland | 23,395 | 7.70% | | Randolph | 15,802 | 12.10% |
| Currituck | 2,186 | 12.00% | | Richmond | 6,349 | 13.60% |
| Dare | 4,124 | 13.80% | | Robeson | 12,291 | 10.00% |
| Davidson | 18,774 | 12.80% | | Rockingham | 13,616 | 14.80% |
| Davie | 4,807 | 13.80% | | Rowan | 18,205 | 14.00% |
| Duplin | 6,316 | 12.90% | | Rutherford | 10,067 | 16.00% |
| Durham | 21,574 | 9.70% | | Sampson | 7,706 | 12.80% |
| Edgecombe | 6,963 | 12.50% | | Scotland | 4,082 | 11.30% |
| Forsyth | 38,549 | 12.60% | | Stanly | 8,265 | 14.20% |
| Franklin | 5,194 | 11.00% | | Stokes | 5,278 | 11.80% |
| Gaston | 23,985 | 12.60% | | Surry | 10,973 | 15.40% |
| Gates | 1,514 | 14.40% | | Swain | 1,982 | 15.30% |
| Graham | 1,436 | 18.00% | | Transylvania | 6,283 | 21.40% |
| Granville | 5,545 | 11.40% | | Tyrrell | 668 | 16.10% |
| Greene | 2,294 | 12.10% | | Union | 11,148 | 9.00% |
| Guilford | 49,476 | 11.80% | | Vance | 5,415 | 12.60% |
| Halifax | 8,571 | 14.90% | | Wake | 46,372 | 7.40% |
| Harnett | 9,447 | 10.40% | | Warren | 3,468 | 17.40% |
| Haywood | 10,272 | 19.00% | | Washington | 2,125 | 15.50% |
| Henderson | 19,341 | 21.70% | | Watauga | 4,683 | 11.00% |
| Hertford | 3,567 | 15.80% | | Wayne | 13,109 | 11.60% |
| Hoke | 2,598 | 7.70% | | Wilkes | 9,246 | 14.10% |
| Hyde | 953 | 16.40% | | Wilson | 9,507 | 12.90% |
| Iredell | 15,150 | 12.40% | | Yadkin | 5,144 | 14.20% |
| Jackson | 4,560 | 13.80% | | Yancey | 3,237 | 18.20% |
| | | | | | | |
| **NORTH CAROLINA** | 969,048 | 12.00% | | | | |
| | | | | | | |

**Table Two: Total and 65+ Years of Age Populations by County, State: 1990-2020***

| | Year | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **County/State** | **1990** | | **2000** | | **2010** | | **2020** | |
| | **65+** | **Total** | **65+** | **Total** | **65+** | **Total** | **65+** | **Total** |
| ALAMANCE | 15,908 | 108,213 | 18,464 | 130,800 | 20,538 | 154,914 | 26,589 | 181,031 |
| ALEXANDER | 3,032 | 27,544 | 3,996 | 33,603 | 5,401 | 39,786 | 7,471 | 45,754 |
| ALLEGHANY | 1,771 | 9,590 | 2,053 | 10,677 | 2,463 | 11,735 | 3,111 | 12,625 |
| ANSON | 3,643 | 23,474 | 3,641 | 25,275 | 3,854 | 26,843 | 4,941 | 28,221 |
| ASHE | 3,782 | 22,209 | 4,377 | 24,384 | 5,240 | 26,297 | 6,701 | 27,757 |
| AVERY | 2,171 | 14,867 | 2,698 | 17,167 | 3,350 | 18,906 | 4,385 | 20,250 |
| BEAUFORT | 6,294 | 42,283 | 7,128 | 44,958 | 8,410 | 47,316 | 11,232 | 49,033 |
| BERTIE | 2,971 | 20,388 | 3,160 | 19,773 | 3,248 | 18,946 | 4,024 | 18,047 |
| BLADEN | 4,067 | 28,663 | 4,598 | 32,278 | 5,446 | 35,942 | 7,359 | 39,170 |
| BRUNSWICK | 7,457 | 50,985 | 12,380 | 73,143 | 18,916 | 93,776 | 26,896 | 112,992 |
| BUNCOMBE | 28,064 | 174,778 | 31,776 | 206,330 | 36,899 | 238,793 | 50,272 | 271,754 |
| BURKE | 9,802 | 75,740 | 11,986 | 89,148 | 14,623 | 101,781 | 19,178 | 114,870 |
| CABARRUS | 12,998 | 98,935 | 15,164 | 131,063 | 18,217 | 166,897 | 25,776 | 205,495 |
| CALDWELL | 8,508 | 70,709 | 10,259 | 77,415 | 12,485 | 83,035 | 16,196 | 87,948 |
| CAMDEN | 822 | 5,904 | 933 | 6,885 | 1,128 | 7,905 | 1,458 | 8,991 |
| CARTERET | 7,469 | 52,553 | 10,227 | 59,383 | 13,327 | 64,467 | 18,310 | 68,320 |
| CASWELL | 2,933 | 20,693 | 3,060 | 23,501 | 3,656 | 26,307 | 4,994 | 29,019 |
| CATAWBA | 14,104 | 118,412 | 17,425 | 141,685 | 21,204 | 165,424 | 28,949 | 189,630 |
| CHATHAM | 5,564 | 38,759 | 7,530 | 49,329 | 9,466 | 59,806 | 13,379 | 70,524 |
| CHEROKEE | 3,790 | 20,170 | 4,787 | 24,298 | 6,318 | 28,012 | 8,473 | 31,106 |
| CHOWAN | 2,380 | 13,506 | 2,606 | 14,526 | 2,854 | 15,448 | 3,582 | 16,369 |
| CLAY | 1,459 | 7,155 | 1,988 | 8,775 | 2,589 | 10,043 | 3,521 | 11,040 |
| CLEVELAND | 11,446 | 84,713 | 12,965 | 96,287 | 14,992 | 106,530 | 19,540 | 117,092 |
| COLUMBUS | 6,619 | 49,587 | 7,538 | 54,749 | 8,782 | 59,745 | 11,502 | 64,302 |
| CRAVEN | 9,117 | 81,613 | 12,263 | 91,436 | 15,028 | 97,513 | 20,272 | 102,080 |
| CUMBERLAND | 16,781 | 274,713 | 23,395 | 302,963 | 29,476 | 334,040 | 41,067 | 366,204 |
| CURRITUCK | 1,708 | 13,736 | 2,186 | 18,190 | 2,990 | 22,644 | 4,396 | 27,126 |
| DARE | 2,830 | 22,746 | 4,124 | 29,967 | 5,860 | 36,681 | 9,001 | 42,940 |
| DAVIDSON | 15,160 | 126,677 | 18,774 | 147,246 | 23,129 | 166,833 | 30,927 | 186,335 |
| DAVIE | 3,796 | 27,859 | 4,807 | 34,835 | 6,148 | 41,932 | 8,587 | 48,979 |
| DUPLIN | 5,543 | 39,995 | 6,316 | 49,063 | 7,342 | 59,294 | 9,792 | 70,251 |
| DURHAM | 19,356 | 181,854 | 21,574 | 223,314 | 25,301 | 257,367 | 37,397 | 292,639 |
| EDGECOMBE | 6,998 | 56,692 | 6,963 | 55,606 | 7,260 | 53,987 | 9,489 | 52,079 |
| FORSYTH | 32,380 | 265,878 | 38,549 | 306,067 | 44,602 | 347,165 | 60,262 | 390,124 |
| FRANKLIN | 4,797 | 36,414 | 5,194 | 47,260 | 6,323 | 58,726 | 9,374 | 70,660 |
| GASTON | 20,931 | 175,093 | 23,985 | 190,365 | 27,080 | 204,156 | 35,990 | 216,822 |
| GATES | 1,350 | 9,305 | 1,514 | 10,516 | 1,759 | 11,516 | 2,281 | 12,533 |
| GRAHAM | 1,152 | 7,196 | 1,436 | 7,993 | 1,810 | 8,679 | 2,326 | 9,212 |
| GRANVILLE | 4,740 | 38,341 | 5,545 | 48,498 | 6,849 | 58,132 | 9,661 | 67,790 |
| GREENE | 1,891 | 15,384 | 2,294 | 18,974 | 2,698 | 22,817 | 3,704 | 26,718 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| GUILFORD | 41,133 | 347,420 | 49,476 | 421,048 | 58,253 | 497,365 | 80,978 | 577,081 |
| HALIFAX | 7,885 | 55,516 | 8,571 | 57,370 | 9,157 | 58,072 | 11,631 | 58,544 |
| HARNETT | 7,898 | 67,833 | 9,447 | 91,025 | 11,515 | 116,559 | 16,388 | 144,266 |
| HAYWOOD | 8,509 | 46,942 | 10,272 | 54,033 | 12,472 | 60,247 | 15,629 | 65,994 |
| HENDERSON | 15,087 | 69,326 | 19,341 | 89,173 | 23,772 | 108,029 | 30,620 | 126,523 |
| HERTFORD | 3,286 | 22,523 | 3,567 | 22,601 | 3,964 | 22,649 | 5,111 | 22,522 |
| HOKE | 2,086 | 22,856 | 2,598 | 33,646 | 3,281 | 46,193 | 4,976 | 59,949 |
| HYDE | 897 | 5,411 | 953 | 5,826 | 1,047 | 6,141 | 1,327 | 6,396 |
| IREDELL | 12,210 | 92,935 | 15,150 | 122,660 | 19,034 | 153,883 | 26,835 | 186,890 |
| JACKSON | 3,693 | 26,846 | 4,560 | 33,121 | 6,186 | 38,332 | 8,686 | 43,000 |
| JOHNSTON | 10,237 | 81,306 | 11,973 | 121,965 | 15,609 | 167,240 | 23,653 | 215,863 |
| JONES | 1,347 | 9,414 | 1,603 | 10,381 | 1,843 | 11,010 | 2,448 | 11,574 |
| LEE | 5,374 | 41,370 | 6,345 | 49,040 | 7,255 | 57,492 | 9,758 | 66,327 |
| LENOIR | 7,813 | 57,274 | 8,734 | 59,648 | 9,630 | 61,142 | 12,258 | 62,016 |
| LINCOLN | 5,849 | 50,319 | 7,350 | 63,780 | 9,719 | 77,592 | 13,954 | 91,525 |
| MCDOWELL | 5,134 | 35,681 | 6,009 | 42,151 | 7,339 | 48,664 | 9,842 | 54,957 |
| MACON | 5,255 | 23,499 | 6,666 | 29,811 | 8,378 | 35,909 | 10,915 | 41,849 |
| MADISON | 2,825 | 16,953 | 3,129 | 19,635 | 3,732 | 22,129 | 5,042 | 24,479 |
| MARTIN | 3,610 | 25,078 | 3,894 | 25,593 | 4,206 | 25,808 | 5,374 | 25,872 |
| MECKLENBURG | 47,576 | 511,481 | 59,724 | 695,454 | 75,506 | 894,288 | 116,677 | 1,102,003 |
| MITCHELL | 2,547 | 14,433 | 2,917 | 15,687 | 3,400 | 16,557 | 4,211 | 17,268 |
| MONTGOMERY | 3,180 | 23,352 | 3,745 | 26,822 | 4,542 | 30,347 | 6,136 | 33,937 |
| MOORE | 12,164 | 59,000 | 16,271 | 74,769 | 19,749 | 89,533 | 25,099 | 104,051 |
| NASH | 9,450 | 76,677 | 10,882 | 87,420 | 12,511 | 97,505 | 17,526 | 107,585 |
| NEW HANOVER | 15,075 | 120,284 | 20,567 | 160,307 | 27,666 | 196,508 | 40,604 | 231,402 |
| NORTHAMPTON | 3,471 | 20,798 | 3,840 | 22,086 | 4,173 | 22,851 | 5,155 | 23,560 |
| ONSLOW | 6,660 | 149,838 | 9,499 | 150,355 | 12,806 | 157,963 | 18,393 | 166,376 |
| ORANGE | 8,083 | 93,851 | 9,931 | 118,227 | 13,037 | 140,287 | 21,750 | 161,605 |
| PAMLICO | 1,898 | 11,368 | 2,429 | 12,934 | 2,946 | 14,143 | 3,819 | 15,108 |
| PASQUOTANK | 4,322 | 31,298 | 4,911 | 34,897 | 5,526 | 37,864 | 7,265 | 40,628 |
| PENDER | 4,095 | 28,855 | 5,780 | 41,082 | 8,103 | 52,976 | 11,796 | 64,845 |
| PERQUIMANS | 1,901 | 10,447 | 2,192 | 11,368 | 2,597 | 12,127 | 3,236 | 12,830 |
| PERSON | 4,257 | 30,180 | 4,890 | 35,623 | 5,798 | 40,777 | 7,999 | 45,898 |
| PITT | 10,575 | 108,480 | 12,828 | 133,798 | 15,408 | 154,787 | 22,885 | 175,749 |
| POLK | 3,540 | 14,416 | 4,325 | 18,324 | 5,052 | 21,939 | 6,480 | 25,599 |
| RANDOLPH | 12,955 | 106,546 | 15,802 | 130,454 | 19,822 | 155,600 | 27,432 | 181,727 |
| RICHMOND | 6,272 | 44,518 | 6,349 | 46,564 | 6,575 | 47,816 | 8,107 | 48,889 |
| ROBESON | 11,168 | 105,170 | 12,291 | 123,339 | 14,580 | 140,932 | 20,860 | 158,459 |
| ROCKINGHAM | 12,276 | 86,064 | 13,616 | 91,928 | 15,171 | 96,969 | 19,491 | 101,475 |
| ROWAN | 16,809 | 110,605 | 18,205 | 130,340 | 19,751 | 150,967 | 25,825 | 173,269 |
| RUTHERFORD | 8,850 | 56,919 | 10,067 | 62,899 | 11,538 | 68,277 | 14,721 | 73,404 |
| SAMPSON | 6,747 | 47,297 | 7,706 | 60,161 | 9,144 | 74,290 | 12,379 | 89,194 |
| SCOTLAND | 3,741 | 33,763 | 4,082 | 35,998 | 4,825 | 37,991 | 6,661 | 39,671 |
| STANLY | 7,544 | 51,765 | 8,265 | 58,100 | 9,150 | 64,281 | 11,789 | 70,662 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| STOKES | 4,256 | 37,223 | 5,278 | 44,711 | 7,068 | 51,798 | 9,935 | 58,560 |
| SURRY | 9,119 | 61,704 | 10,973 | 71,219 | 12,914 | 80,329 | 16,301 | 89,424 |
| SWAIN | 1,727 | 11,268 | 1,982 | 12,968 | 2,386 | 14,640 | 3,175 | 16,336 |
| TRANSYLVANIA | 4,701 | 25,520 | 6,283 | 29,334 | 8,029 | 32,419 | 10,176 | 34,908 |
| TYRRELL | 686 | 3,856 | 668 | 4,149 | 681 | 4,460 | 821 | 4,706 |
| UNION | 8,094 | 84,210 | 11,148 | 123,677 | 16,082 | 166,838 | 24,855 | 212,811 |
| VANCE | 5,039 | 38,892 | 5,415 | 42,954 | 6,028 | 47,140 | 8,137 | 51,370 |
| WAKE | 33,051 | 426,301 | 46,372 | 627,846 | 67,277 | 851,771 | 115,214 | 1,088,545 |
| WARREN | 3,086 | 17,265 | 3,468 | 19,972 | 3,853 | 22,431 | 5,010 | 24,824 |
| WASHINGTON | 1,928 | 13,997 | 2,125 | 13,723 | 2,378 | 13,285 | 3,037 | 12,741 |
| WATAUGA | 3,938 | 36,952 | 4,683 | 42,695 | 5,939 | 46,810 | 8,418 | 50,311 |
| WAYNE | 10,665 | 104,666 | 13,109 | 113,329 | 15,347 | 121,901 | 20,121 | 130,553 |
| WILKES | 7,792 | 59,393 | 9,246 | 65,632 | 11,461 | 71,488 | 15,115 | 76,673 |
| WILSON | 8,325 | 66,061 | 9,507 | 73,814 | 10,845 | 81,430 | 14,635 | 88,836 |
| YADKIN | 4,526 | 30,488 | 5,144 | 36,348 | 6,166 | 42,646 | 7,958 | 49,249 |
| YANCEY | 2,648 | 15,419 | 3,237 | 17,774 | 3,960 | 19,819 | 5,294 | 21,639 |
| **NORTH CAROLINA** | 800,449 | 6,632,448 | 969,048 | 8,049,313 | 1,183,243 | 9,491,372 | 1,652,288 | 10,966,139 |

*Source: Office of State Planning: 12-27-02

**Table Three: The Percentage of Populations who are 65+ Years of Age by County and State: 1990-2020***

| | Year | | | |
|---|---|---|---|---|
| **County/State** | **1990** | **2000** | **2010** | **2020** |
| ALAMANCE | 15% | 14% | 13% | 15% |
| ALEXANDER | 11% | 12% | 14% | 16% |
| ALLEGHANY | 18% | 19% | 21% | 25% |
| ANSON | 16% | 14% | 14% | 18% |
| ASHE | 17% | 18% | 20% | 24% |
| AVERY | 15% | 16% | 18% | 22% |
| BEAUFORT | 15% | 16% | 18% | 23% |
| BERTIE | 15% | 16% | 17% | 22% |
| BLADEN | 14% | 14% | 15% | 19% |
| BRUNSWICK | 15% | 17% | 20% | 24% |
| BUNCOMBE | 16% | 15% | 15% | 18% |
| BURKE | 13% | 13% | 14% | 17% |
| CABARRUS | 13% | 12% | 11% | 13% |
| CALDWELL | 12% | 13% | 15% | 18% |
| CAMDEN | 14% | 14% | 14% | 16% |
| CARTERET | 14% | 17% | 21% | 27% |
| CASWELL | 14% | 13% | 14% | 17% |
| CATAWBA | 12% | 12% | 13% | 15% |
| CHATHAM | 14% | 15% | 16% | 19% |
| CHEROKEE | 19% | 20% | 23% | 27% |
| CHOWAN | 18% | 18% | 18% | 22% |
| CLAY | 20% | 23% | 26% | 32% |
| CLEVELAND | 14% | 13% | 14% | 17% |
| COLUMBUS | 13% | 14% | 15% | 18% |
| CRAVEN | 11% | 13% | 15% | 20% |
| CUMBERLAND | 6% | 8% | 9% | 11% |
| CURRITUCK | 12% | 12% | 13% | 16% |
| DARE | 12% | 14% | 16% | 21% |
| DAVIDSON | 12% | 13% | 14% | 17% |
| DAVIE | 14% | 14% | 15% | 18% |
| DUPLIN | 14% | 13% | 12% | 14% |
| DURHAM | 11% | 10% | 10% | 13% |
| EDGECOMBE | 12% | 13% | 13% | 18% |
| FORSYTH | 12% | 13% | 13% | 15% |
| FRANKLIN | 13% | 11% | 11% | 13% |
| GASTON | 12% | 13% | 13% | 17% |
| GATES | 15% | 14% | 15% | 18% |
| GRAHAM | 16% | 18% | 21% | 25% |
| GRANVILLE | 12% | 11% | 12% | 14% |

| | | | | |
|---|---|---|---|---|
| GREENE | 12% | 12% | 12% | 14% |
| GUILFORD | 12% | 12% | 12% | 14% |
| HALIFAX | 14% | 15% | 16% | 20% |
| HARNETT | 12% | 10% | 10% | 11% |
| HAYWOOD | 18% | 19% | 21% | 24% |
| HENDERSON | 22% | 22% | 22% | 24% |
| HERTFORD | 15% | 16% | 18% | 23% |
| HOKE | 9% | 8% | 7% | 8% |
| HYDE | 17% | 16% | 17% | 21% |
| IREDELL | 13% | 12% | 12% | 14% |
| JACKSON | 14% | 14% | 16% | 20% |
| JOHNSTON | 13% | 10% | 9% | 11% |
| JONES | 14% | 15% | 17% | 21% |
| LEE | 13% | 13% | 13% | 15% |
| LENOIR | 14% | 15% | 16% | 20% |
| LINCOLN | 12% | 12% | 13% | 15% |
| MCDOWELL | 14% | 14% | 15% | 18% |
| MACON | 22% | 22% | 23% | 26% |
| MADISON | 17% | 16% | 17% | 21% |
| MARTIN | 14% | 15% | 16% | 21% |
| MECKLENBURG | 9% | 9% | 8% | 11% |
| MITCHELL | 18% | 19% | 21% | 24% |
| MONTGOMERY | 14% | 14% | 15% | 18% |
| MOORE | 21% | 22% | 22% | 24% |
| NASH | 12% | 12% | 13% | 16% |
| NEW HANOVER | 13% | 13% | 14% | 18% |
| NORTHAMPTON | 17% | 17% | 18% | 22% |
| ONSLOW | 4% | 6% | 8% | 11% |
| ORANGE | 9% | 8% | 9% | 13% |
| PAMLICO | 17% | 19% | 21% | 25% |
| PASQUOTANK | 14% | 14% | 15% | 18% |
| PENDER | 14% | 14% | 15% | 18% |
| PERQUIMANS | 18% | 19% | 21% | 25% |
| PERSON | 14% | 14% | 14% | 17% |
| PITT | 10% | 10% | 10% | 13% |
| POLK | 25% | 24% | 23% | 25% |
| RANDOLPH | 12% | 12% | 13% | 15% |
| RICHMOND | 14% | 14% | 14% | 17% |
| ROBESON | 11% | 10% | 10% | 13% |
| ROCKINGHAM | 14% | 15% | 16% | 19% |
| ROWAN | 15% | 14% | 13% | 15% |
| RUTHERFORD | 16% | 16% | 17% | 20% |

| | | | | |
|---|---|---|---|---|
| SAMPSON | 14% | 13% | 12% | 14% |
| SCOTLAND | 11% | 11% | 13% | 17% |
| STANLY | 15% | 14% | 14% | 17% |
| STOKES | 11% | 12% | 14% | 17% |
| SURRY | 15% | 15% | 16% | 18% |
| SWAIN | 15% | 15% | 16% | 19% |
| TRANSYLVANIA | 18% | 21% | 25% | 29% |
| TYRRELL | 18% | 16% | 15% | 17% |
| UNION | 10% | 9% | 10% | 12% |
| VANCE | 13% | 13% | 13% | 16% |
| WAKE | 8% | 7% | 8% | 11% |
| WARREN | 18% | 17% | 17% | 20% |
| WASHINGTON | 14% | 15% | 18% | 24% |
| WATAUGA | 11% | 11% | 13% | 17% |
| WAYNE | 10% | 12% | 13% | 15% |
| WILKES | 13% | 14% | 16% | 20% |
| WILSON | 13% | 13% | 13% | 16% |
| YADKIN | 15% | 14% | 14% | 16% |
| YANCEY | 17% | 18% | 20% | 24% |
| **NORTH CAROLINA** | 12% | 12% | 12% | 15% |

***Source: Office of State Planning: 12-27-02**

**Table Four: Percent Changes in the 65+ Years of Age Populations and the Total Populations by County and State: 1990-2020***

| | 1990-2000 | | 2000-2010 | | 2010-2020 | |
|---|---|---|---|---|---|---|
| **County/State** | **65+** | **Total** | **65+** | **Total** | **65+** | **Total** |
| ALAMANCE | 16% | 21% | 11% | 18% | 29% | 17% |
| ALEXANDER | 32% | 22% | 35% | 18% | 38% | 15% |
| ALLEGHANY | 16% | 11% | 20% | 10% | 26% | 8% |
| ANSON | 0% | 8% | 6% | 6% | 28% | 5% |
| ASHE | 16% | 10% | 20% | 8% | 28% | 6% |
| AVERY | 24% | 15% | 24% | 10% | 31% | 7% |
| BEAUFORT | 13% | 6% | 18% | 5% | 34% | 4% |
| BERTIE | 6% | -3% | 3% | -4% | 24% | -5% |
| BLADEN | 13% | 13% | 18% | 11% | 35% | 9% |
| BRUNSWICK | 66% | 43% | 53% | 28% | 42% | 20% |
| BUNCOMBE | 13% | 18% | 16% | 16% | 36% | 14% |
| BURKE | 22% | 18% | 22% | 14% | 31% | 13% |
| CABARRUS | 17% | 32% | 20% | 27% | 41% | 23% |
| CALDWELL | 21% | 9% | 22% | 7% | 30% | 6% |
| CAMDEN | 14% | 17% | 21% | 15% | 29% | 14% |
| CARTERET | 37% | 13% | 30% | 9% | 37% | 6% |
| CASWELL | 4% | 14% | 19% | 12% | 37% | 10% |
| CATAWBA | 24% | 20% | 22% | 17% | 37% | 15% |
| CHATHAM | 35% | 27% | 26% | 21% | 41% | 18% |
| CHEROKEE | 26% | 20% | 32% | 15% | 34% | 11% |
| CHOWAN | 9% | 8% | 10% | 6% | 26% | 6% |
| CLAY | 36% | 23% | 30% | 14% | 36% | 10% |
| CLEVELAND | 13% | 14% | 16% | 11% | 30% | 10% |
| COLUMBUS | 14% | 10% | 17% | 9% | 31% | 8% |
| CRAVEN | 35% | 12% | 23% | 7% | 35% | 5% |
| CUMBERLAND | 39% | 10% | 26% | 10% | 39% | 10% |
| CURRITUCK | 28% | 32% | 37% | 24% | 47% | 20% |
| DARE | 46% | 32% | 42% | 22% | 54% | 17% |
| DAVIDSON | 24% | 16% | 23% | 13% | 34% | 12% |
| DAVIE | 27% | 25% | 28% | 20% | 40% | 17% |
| DUPLIN | 14% | 23% | 16% | 21% | 33% | 18% |
| DURHAM | 11% | 23% | 17% | 15% | 48% | 14% |
| EDGECOMBE | -1% | -2% | 4% | -3% | 31% | -4% |
| FORSYTH | 19% | 15% | 16% | 13% | 35% | 12% |
| FRANKLIN | 8% | 30% | 22% | 24% | 48% | 20% |
| GASTON | 15% | 9% | 13% | 7% | 33% | 6% |
| GATES | 12% | 13% | 16% | 10% | 30% | 9% |
| GRAHAM | 25% | 11% | 26% | 9% | 29% | 6% |
| GRANVILLE | 17% | 26% | 24% | 20% | 41% | 17% |

| | | | | | | |
|---|---|---|---|---|---|---|
| GREENE | 21% | 23% | 18% | 20% | 37% | 17% |
| GUILFORD | 20% | 21% | 18% | 18% | 39% | 16% |
| HALIFAX | 9% | 3% | 7% | 1% | 27% | 1% |
| HARNETT | 20% | 34% | 22% | 28% | 42% | 24% |
| HAYWOOD | 21% | 15% | 21% | 12% | 25% | 10% |
| HENDERSON | 28% | 29% | 23% | 21% | 29% | 17% |
| HERTFORD | 9% | 0% | 11% | 0% | 29% | -1% |
| HOKE | 25% | 47% | 26% | 37% | 52% | 30% |
| HYDE | 6% | 8% | 10% | 5% | 27% | 4% |
| IREDELL | 24% | 32% | 26% | 25% | 41% | 21% |
| JACKSON | 23% | 23% | 36% | 16% | 40% | 12% |
| JOHNSTON | 17% | 50% | 30% | 37% | 52% | 29% |
| JONES | 19% | 10% | 15% | 6% | 33% | 5% |
| LEE | 18% | 19% | 14% | 17% | 35% | 15% |
| LENOIR | 12% | 4% | 10% | 3% | 27% | 1% |
| LINCOLN | 26% | 27% | 32% | 22% | 44% | 18% |
| MCDOWELL | 17% | 18% | 22% | 15% | 34% | 13% |
| MACON | 27% | 27% | 26% | 20% | 30% | 17% |
| MADISON | 11% | 16% | 19% | 13% | 35% | 11% |
| MARTIN | 8% | 2% | 8% | 1% | 28% | 0% |
| MECKLENBURG | 26% | 36% | 26% | 29% | 55% | 23% |
| MITCHELL | 15% | 9% | 17% | 6% | 24% | 4% |
| MONTGOMERY | 18% | 15% | 21% | 13% | 35% | 12% |
| MOORE | 34% | 27% | 21% | 20% | 27% | 16% |
| NASH | 15% | 14% | 15% | 12% | 40% | 10% |
| NEW HANOVER | 36% | 33% | 35% | 23% | 47% | 18% |
| NORTHAMPTON | 11% | 6% | 9% | 3% | 24% | 3% |
| ONSLOW | 43% | 0% | 35% | 5% | 44% | 5% |
| ORANGE | 23% | 26% | 31% | 19% | 67% | 15% |
| PAMLICO | 28% | 14% | 21% | 9% | 30% | 7% |
| PASQUOTANK | 14% | 11% | 13% | 9% | 31% | 7% |
| PENDER | 41% | 42% | 40% | 29% | 46% | 22% |
| PERQUIMANS | 15% | 9% | 18% | 7% | 25% | 6% |
| PERSON | 15% | 18% | 19% | 14% | 38% | 13% |
| PITT | 21% | 23% | 20% | 16% | 49% | 14% |
| POLK | 22% | 27% | 17% | 20% | 28% | 17% |
| RANDOLPH | 22% | 22% | 25% | 19% | 38% | 17% |
| RICHMOND | 1% | 5% | 4% | 3% | 23% | 2% |
| ROBESON | 10% | 17% | 19% | 14% | 43% | 12% |
| ROCKINGHAM | 11% | 7% | 11% | 5% | 28% | 5% |
| ROWAN | 8% | 18% | 8% | 16% | 31% | 15% |
| RUTHERFORD | 14% | 11% | 15% | 9% | 28% | 8% |

| | | | | | | |
|---|---|---|---|---|---|---|
| SAMPSON | 14% | 27% | 19% | 23% | 35% | 20% |
| SCOTLAND | 9% | 7% | 18% | 6% | 38% | 4% |
| STANLY | 10% | 12% | 11% | 11% | 29% | 10% |
| STOKES | 24% | 20% | 34% | 16% | 41% | 13% |
| SURRY | 20% | 15% | 18% | 13% | 26% | 11% |
| SWAIN | 15% | 15% | 20% | 13% | 33% | 12% |
| TRANSYLVANIA | 34% | 15% | 28% | 11% | 27% | 8% |
| TYRRELL | -3% | 8% | 2% | 7% | 21% | 6% |
| UNION | 38% | 47% | 44% | 35% | 55% | 28% |
| VANCE | 7% | 10% | 11% | 10% | 35% | 9% |
| WAKE | 40% | 47% | 45% | 36% | 71% | 28% |
| WARREN | 12% | 16% | 11% | 12% | 30% | 11% |
| WASHINGTON | 10% | -2% | 12% | -3% | 28% | -4% |
| WATAUGA | 19% | 16% | 27% | 10% | 42% | 7% |
| WAYNE | 23% | 8% | 17% | 8% | 31% | 7% |
| WILKES | 19% | 11% | 24% | 9% | 32% | 7% |
| WILSON | 14% | 12% | 14% | 10% | 35% | 9% |
| YADKIN | 14% | 19% | 20% | 17% | 29% | 15% |
| YANCEY | 22% | 15% | 22% | 12% | 34% | 9% |
| **NORTH CAROLINA** | 21% | 21% | 22% | 18% | 40% | 16% |

***Source: Office of State Planning: 12-27-02**

**Table Five: Population Estimates of Age Groupings for Persons 55+ Years of Age by County, State: 2002***

| | Age Grouping | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **County/State** | **55-59** | **60-64** | **65-74** | **75-84** | **85-94** | **95+** | **All Ages** | **55+** | **60+** | **65+** | **Med-Age** |
| ALAMANCE | 7,282 | 5,598 | 9,605 | 6,744 | 2,228 | 170 | 136,034 | 31,627 | 24,345 | 18,747 | 36.30 |
| ALEXANDER | 2,152 | 1,701 | 2,423 | 1,302 | 409 | 25 | 34,626 | 8,012 | 5,860 | 4,159 | 37.04 |
| ALLEGHANY | 766 | 694 | 1,147 | 661 | 260 | 21 | 10,866 | 3,549 | 2,783 | 2,089 | 43.49 |
| ANSON | 1,428 | 1,109 | 1,717 | 1,363 | 484 | 43 | 25,496 | 6,144 | 4,716 | 3,607 | 37.15 |
| ASHE | 1,704 | 1,548 | 2,387 | 1,533 | 559 | 42 | 24,970 | 7,773 | 6,069 | 4,521 | 42.69 |
| AVERY | 1,118 | 931 | 1,528 | 960 | 310 | 15 | 17,844 | 4,862 | 3,744 | 2,813 | 38.94 |
| BEAUFORT | 3,184 | 2,521 | 3,996 | 2,407 | 802 | 55 | 45,566 | 12,965 | 9,781 | 7,260 | 40.97 |
| BERTIE | 1,136 | 921 | 1,713 | 1,089 | 377 | 26 | 19,753 | 5,262 | 4,126 | 3,205 | 39.73 |
| BLADEN | 2,078 | 1,565 | 2,576 | 1,574 | 495 | 35 | 32,819 | 8,323 | 6,245 | 4,680 | 38.26 |
| BRUNSWICK | 6,188 | 5,544 | 8,660 | 3,987 | 857 | 68 | 78,822 | 25,304 | 19,116 | 13,572 | 42.84 |
| BUNCOMBE | 12,729 | 9,881 | 16,100 | 11,719 | 3,954 | 351 | 212,044 | 54,734 | 42,005 | 32,124 | 39.17 |
| BURKE | 5,278 | 4,357 | 6,711 | 4,031 | 1,358 | 111 | 90,485 | 21,846 | 16,568 | 12,211 | 37.33 |
| CABARRUS | 7,357 | 5,381 | 8,355 | 5,410 | 1,808 | 130 | 139,811 | 28,441 | 21,084 | 15,703 | 35.32 |
| CALDWELL | 4,736 | 3,997 | 5,934 | 3,443 | 1,134 | 79 | 78,237 | 19,323 | 14,587 | 10,590 | 38.14 |
| CAMDEN | 459 | 375 | 549 | 317 | 88 | 5 | 7,170 | 1,793 | 1,334 | 959 | 39.69 |
| CARTERET | 4,471 | 3,629 | 6,094 | 3,531 | 953 | 78 | 60,157 | 18,756 | 14,285 | 10,656 | 43.51 |
| CASWELL | 1,551 | 1,160 | 1,723 | 1,092 | 320 | 28 | 24,014 | 5,874 | 4,323 | 3,163 | 38.86 |
| CATAWBA | 8,501 | 6,355 | 9,871 | 6,278 | 1,861 | 119 | 147,428 | 32,985 | 24,484 | 18,129 | 36.33 |
| CHATHAM | 3,190 | 2,335 | 3,927 | 2,832 | 943 | 66 | 51,964 | 13,293 | 10,103 | 7,768 | 39.09 |
| CHEROKEE | 1,940 | 1,700 | 2,695 | 1,684 | 570 | 57 | 25,082 | 8,646 | 6,706 | 5,006 | 44.64 |
| CHOWAN | 858 | 766 | 1,319 | 942 | 320 | 29 | 14,602 | 4,234 | 3,376 | 2,610 | 40.38 |
| CLAY | 773 | 610 | 1,062 | 701 | 269 | 34 | 9,139 | 3,449 | 2,676 | 2,066 | 47.51 |
| CLEVELAND | 5,765 | 4,525 | 6,977 | 4,504 | 1,520 | 125 | 97,921 | 23,416 | 17,651 | 13,126 | 37.01 |
| COLUMBUS | 3,315 | 2,692 | 4,275 | 2,511 | 830 | 48 | 55,401 | 13,671 | 10,356 | 7,664 | 37.56 |
| CRAVEN | 4,833 | 3,905 | 7,227 | 4,214 | 1,078 | 100 | 92,602 | 21,357 | 16,524 | 12,619 | 35.11 |
| CUMBERLAND | 12,106 | 9,570 | 14,722 | 7,442 | 1,957 | 139 | 304,855 | 45,936 | 33,830 | 24,260 | 30.10 |
| CURRITUCK | 1,193 | 989 | 1,359 | 739 | 210 | 15 | 19,293 | 4,505 | 3,312 | 2,323 | 38.86 |
| DARE | 2,117 | 1,779 | 2,706 | 1,384 | 325 | 28 | 31,812 | 8,339 | 6,222 | 4,443 | 41.22 |
| DAVIDSON | 9,012 | 7,055 | 10,716 | 6,554 | 2,032 | 135 | 151,125 | 35,504 | 26,492 | 19,437 | 37.61 |
| DAVIE | 2,294 | 1,828 | 2,739 | 1,743 | 533 | 66 | 36,883 | 9,203 | 6,909 | 5,081 | 38.61 |
| DUPLIN | 2,584 | 2,161 | 3,563 | 2,141 | 707 | 37 | 50,703 | 11,193 | 8,609 | 6,448 | 34.78 |
| DURHAM | 10,540 | 7,416 | 10,980 | 7,936 | 2,791 | 262 | 231,434 | 39,925 | 29,385 | 21,969 | 32.18 |
| EDGECOMBE | 2,968 | 2,324 | 3,740 | 2,360 | 757 | 46 | 54,630 | 12,195 | 9,227 | 6,903 | 36.84 |
| FORSYTH | 16,817 | 12,823 | 20,908 | 13,662 | 4,468 | 450 | 314,540 | 69,128 | 52,311 | 39,488 | 36.24 |
| FRANKLIN | 2,689 | 2,016 | 2,899 | 1,815 | 588 | 59 | 49,946 | 10,066 | 7,377 | 5,361 | 36.09 |
| GASTON | 11,105 | 8,327 | 13,252 | 8,338 | 2,541 | 153 | 192,603 | 43,716 | 32,611 | 24,284 | 36.76 |
| GATES | 651 | 524 | 818 | 525 | 179 | 16 | 10,609 | 2,713 | 2,062 | 1,538 | 39.10 |
| GRAHAM | 579 | 498 | 827 | 491 | 161 | 17 | 8,108 | 2,573 | 1,994 | 1,496 | 42.33 |
| GRANVILLE | 2,802 | 2,070 | 3,222 | 1,865 | 597 | 45 | 50,638 | 10,601 | 7,799 | 5,729 | 36.60 |
| GREENE | 997 | 803 | 1,273 | 761 | 273 | 25 | 19,443 | 4,132 | 3,135 | 2,332 | 35.48 |
| GUILFORD | 22,578 | 16,851 | 26,173 | 17,497 | 5,824 | 568 | 432,412 | 89,491 | 66,913 | 50,062 | 35.03 |
| HALIFAX | 3,145 | 2,674 | 4,424 | 3,057 | 980 | 80 | 57,227 | 14,360 | 11,215 | 8,541 | 38.08 |
| HARNETT | 4,408 | 3,556 | 5,402 | 3,228 | 1,001 | 63 | 96,293 | 17,658 | 13,250 | 9,694 | 32.65 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HAYWOOD | 3,829 | 3,392 | 5,694 | 3,689 | 1,113 | 108 | 55,240 | 17,825 | 13,996 | 10,604 | 42.85 |
| HENDERSON | 5,980 | 5,367 | 9,798 | 7,366 | 2,373 | 215 | 93,430 | 31,099 | 25,119 | 19,752 | 42.94 |
| HERTFORD | 1,376 | 1,089 | 1,829 | 1,247 | 422 | 34 | 22,235 | 5,997 | 4,621 | 3,532 | 40.18 |
| HOKE | 1,367 | 1,076 | 1,632 | 845 | 228 | 19 | 36,140 | 5,167 | 3,800 | 2,724 | 30.29 |
| HYDE | 332 | 279 | 496 | 305 | 147 | 14 | 5,784 | 1,573 | 1,241 | 962 | 40.56 |
| IREDELL | 7,308 | 5,717 | 8,710 | 5,343 | 1,711 | 127 | 130,869 | 28,916 | 21,608 | 15,891 | 36.77 |
| JACKSON | 2,295 | 1,783 | 2,704 | 1,525 | 491 | 47 | 34,196 | 8,845 | 6,550 | 4,767 | 36.86 |
| JOHNSTON | 6,749 | 5,002 | 7,018 | 4,241 | 1,240 | 64 | 132,293 | 24,314 | 17,565 | 12,563 | 34.11 |
| JONES | 626 | 491 | 877 | 580 | 186 | 14 | 10,384 | 2,774 | 2,148 | 1,657 | 40.16 |
| LEE | 2,689 | 2,130 | 3,433 | 2,222 | 659 | 52 | 50,195 | 11,185 | 8,496 | 6,366 | 36.06 |
| LENOIR | 3,554 | 2,836 | 4,829 | 3,043 | 897 | 57 | 59,526 | 15,216 | 11,662 | 8,826 | 38.84 |
| LINCOLN | 4,026 | 3,075 | 4,297 | 2,520 | 794 | 65 | 66,790 | 14,777 | 10,751 | 7,676 | 36.93 |
| MCDOWELL | 2,577 | 2,223 | 3,404 | 2,104 | 682 | 47 | 43,500 | 11,037 | 8,460 | 6,237 | 38.29 |
| MACON | 2,316 | 2,038 | 3,634 | 2,345 | 791 | 65 | 31,042 | 11,189 | 8,873 | 6,835 | 45.56 |
| MADISON | 1,297 | 1,078 | 1,643 | 1,063 | 419 | 39 | 20,047 | 5,539 | 4,242 | 3,164 | 39.78 |
| MARTIN | 1,552 | 1,217 | 2,112 | 1,351 | 440 | 33 | 25,397 | 6,705 | 5,153 | 3,936 | 39.35 |
| MECKLENBURG | 34,010 | 22,924 | 32,686 | 21,321 | 6,887 | 691 | 734,390 | 118,519 | 84,509 | 61,585 | 33.18 |
| MITCHELL | 1,152 | 948 | 1,603 | 1,014 | 324 | 27 | 15,950 | 5,068 | 3,916 | 2,968 | 42.72 |
| MONTGOMERY | 1,602 | 1,324 | 1,991 | 1,343 | 414 | 33 | 27,348 | 6,707 | 5,105 | 3,781 | 37.13 |
| MOORE | 4,739 | 4,431 | 8,369 | 6,274 | 1,784 | 159 | 77,862 | 25,756 | 21,017 | 16,586 | 42.40 |
| NASH | 5,049 | 3,707 | 5,863 | 3,892 | 1,157 | 81 | 89,396 | 19,749 | 14,700 | 10,993 | 36.88 |
| NEW HANOVER | 9,855 | 7,523 | 11,597 | 7,401 | 2,196 | 189 | 167,542 | 38,761 | 28,906 | 21,383 | 36.66 |
| NORTHAMPTON | 1,421 | 1,152 | 1,967 | 1,394 | 448 | 49 | 22,112 | 6,431 | 5,010 | 3,858 | 40.82 |
| ONSLOW | 4,839 | 4,105 | 6,273 | 2,966 | 737 | 58 | 149,546 | 18,978 | 14,139 | 10,034 | 24.68 |
| ORANGE | 5,762 | 3,852 | 5,382 | 3,614 | 1,182 | 121 | 123,162 | 19,913 | 14,151 | 10,299 | 31.08 |
| PAMLICO | 916 | 834 | 1,426 | 778 | 229 | 33 | 12,996 | 4,216 | 3,300 | 2,466 | 43.86 |
| PASQUOTANK | 1,976 | 1,443 | 2,415 | 1,770 | 606 | 73 | 35,354 | 8,283 | 6,307 | 4,864 | 36.52 |
| PENDER | 2,902 | 2,275 | 3,552 | 1,953 | 484 | 45 | 43,300 | 11,211 | 8,309 | 6,034 | 39.27 |
| PERQUIMANS | 799 | 765 | 1,215 | 768 | 240 | 23 | 11,612 | 3,810 | 3,011 | 2,246 | 43.21 |
| PERSON | 2,143 | 1,684 | 2,691 | 1,712 | 523 | 52 | 36,661 | 8,805 | 6,662 | 4,978 | 38.60 |
| PITT | 6,053 | 4,407 | 7,092 | 4,485 | 1,449 | 138 | 137,260 | 23,624 | 17,571 | 13,164 | 31.03 |
| POLK | 1,247 | 1,078 | 2,018 | 1,667 | 680 | 68 | 19,186 | 6,758 | 5,511 | 4,433 | 45.10 |
| RANDOLPH | 7,961 | 5,947 | 8,926 | 5,367 | 1,782 | 138 | 134,813 | 30,121 | 22,160 | 16,213 | 36.50 |
| RICHMOND | 2,603 | 2,117 | 3,357 | 2,278 | 665 | 49 | 46,712 | 11,069 | 8,466 | 6,349 | 35.93 |
| ROBESON | 6,224 | 4,836 | 6,966 | 4,244 | 1,231 | 81 | 126,052 | 23,582 | 17,358 | 12,522 | 32.31 |
| ROCKINGHAM | 5,570 | 4,422 | 7,185 | 4,848 | 1,605 | 124 | 92,392 | 23,754 | 18,184 | 13,762 | 39.03 |
| ROWAN | 7,240 | 5,598 | 9,123 | 6,629 | 2,273 | 189 | 133,922 | 31,052 | 23,812 | 18,214 | 36.67 |
| RUTHERFORD | 3,855 | 3,241 | 5,218 | 3,596 | 1,282 | 105 | 63,955 | 17,297 | 13,442 | 10,201 | 38.87 |
| SAMPSON | 3,281 | 2,629 | 4,269 | 2,578 | 913 | 65 | 62,456 | 13,735 | 10,454 | 7,825 | 35.00 |
| SCOTLAND | 2,081 | 1,530 | 2,218 | 1,390 | 472 | 32 | 35,991 | 7,723 | 5,642 | 4,112 | 35.14 |
| STANLY | 3,408 | 2,699 | 4,409 | 2,982 | 941 | 50 | 59,418 | 14,489 | 11,081 | 8,382 | 37.46 |
| STOKES | 2,866 | 2,174 | 3,090 | 1,809 | 610 | 44 | 46,027 | 10,593 | 7,727 | 5,553 | 37.82 |
| SURRY | 4,296 | 3,525 | 5,790 | 3,926 | 1,371 | 106 | 72,415 | 19,014 | 14,718 | 11,193 | 38.34 |
| SWAIN | 882 | 699 | 1,121 | 664 | 238 | 14 | 13,364 | 3,618 | 2,736 | 2,037 | 39.24 |
| TRANSYLVANIA | 2,134 | 2,015 | 3,436 | 2,227 | 705 | 74 | 29,699 | 10,591 | 8,457 | 6,442 | 44.83 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TYRRELL | 214 | 194 | 348 | 228 | 83 | 5 | 4,184 | 1,072 | 858 | 664 | 39.26 |
| UNION | 6,929 | 5,043 | 7,048 | 3,851 | 1,170 | 99 | 136,056 | 24,140 | 17,211 | 12,168 | 34.05 |
| VANCE | 2,405 | 1,870 | 2,978 | 1,852 | 610 | 49 | 44,097 | 9,764 | 7,359 | 5,489 | 35.22 |
| WAKE | 31,516 | 20,419 | 27,511 | 16,460 | 5,184 | 525 | 680,571 | 101,615 | 70,099 | 49,680 | 32.93 |
| WARREN | 1,243 | 1,056 | 1,862 | 1,184 | 389 | 39 | 20,256 | 5,773 | 4,530 | 3,474 | 40.36 |
| WASHINGTON | 894 | 701 | 1,150 | 719 | 261 | 29 | 13,566 | 3,754 | 2,860 | 2,159 | 39.99 |
| WATAUGA | 2,216 | 1,793 | 2,650 | 1,574 | 522 | 59 | 43,160 | 8,814 | 6,598 | 4,805 | 30.75 |
| WAYNE | 5,783 | 4,760 | 7,732 | 4,492 | 1,173 | 79 | 114,170 | 24,019 | 18,236 | 13,476 | 35.16 |
| WILKES | 4,258 | 3,493 | 5,312 | 3,126 | 1,045 | 81 | 66,716 | 17,315 | 13,057 | 9,564 | 39.05 |
| WILSON | 4,192 | 3,183 | 5,257 | 3,411 | 1,020 | 69 | 75,192 | 17,132 | 12,940 | 9,757 | 36.57 |
| YADKIN | 2,188 | 1,847 | 2,910 | 1,719 | 573 | 57 | 37,278 | 9,294 | 7,106 | 5,259 | 37.99 |
| YANCEY | 1,209 | 1,040 | 1,750 | 1,144 | 408 | 37 | 18,215 | 5,588 | 4,379 | 3,339 | 42.40 |
| **NORTH CAROLINA** | 449,163 | 345,140 | 538,160 | 340,806 | 108,170 | 9,103 | 8,336,829 | 1,790,542 | 1,341,379 | 996,239 | 35.58 |

***Source: Office of State Planning: 12-27-02**

# APPENDIX B

# *Recommendation Status Report*

North Carolina Study Commission on Aging
Recommendations
to the
2001 North Carolina General Assembly, Regular Session 2002

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

***November 12, 2002***

# *Recommendation Status Report*
# *North Carolina Study Commission on Aging*

| RECOMMENDATIONS | BILLS INTRODUCED | RESULTS |
|---|---|---|
| **RECOMMENDATION 1**<br>**The Commission finds that the Community Alternative Program for Disabled Adults (CAP/DA) is the cornerstone of community-based care for older adults and recommends that the General Assembly fund the program at a level sufficient to preserve the availability of community-based services offered through the program.** | N/A | CAP/DA funds for the 02/03 fiscal year are $255,000,000, funds were increased by approximately $61,000,000 last session. |
| **RECOMMENDATION 2**<br>**The Commission recommends that the 2002 Session of the 2001 General Assembly direct the Department of Health and Human Services to study ways to establish a group health insurance purchasing arrangement for long-term care staff.** | H 1559<br>S 1196 | **S.L. 2002-180, Sec. 5.2 (SB 98, Sec. 5.2)**<br>**Group Health Insurance for Long-Term Care Staff Study**<br>The Department of Health and Human Services, in consultation with the Department of Insurance, shall study ways to establish a group health insurance purchasing arrangement for staff, including paraprofessionals, in residential and nonresidential long-term care facilities and agencies, as described in Recommendation #22 of the Institute of Medicine's (IOM) Long-Term Care Task Force Final Report of January 2001. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging on or before January 1, 2003. |
| **RECOMMENDATION 3**<br>**The Commission recommends that the General Assembly direct the Department of Health and Human Services to study ways the State can coordinate and facilitate public access to public and private free and discount prescription drug programs for senior citizens.** | H 1560<br>S 1199 | **S.L. 2002-180, Sec. 5.1 (SB 98, Sec. 5.1)**<br>**Prescription Drug Access/Coordination**<br>The Department of Health and Human Services shall study ways the State can coordinate and facilitate public access to public and private free and discount prescription drug programs for senior citizens. In undertaking this study, the Department shall consider the coordination and facilitation methods being implemented by other states. On or before January 1, 2003, the Department shall report its findings and recommendations to the North Carolina Study Commission on Aging. The report shall include the following:<br>(1) A description of the various coordination and facilitation methods considered. |

| | | |
|---|---|---|
| | | (2) A description of the coordination and facilitation methods of other states.<br>(3) A recommendation as to the best way to coordinate and facilitate access in this State, which shall include the reasons for the recommendation, a fiscal analysis of the cost of the recommendation, and whether any legislation is necessary to implement the recommendation. |
| **RECOMMENDATION 4**<br>**The Commission recommends the General Assembly establish a Legislative Study Commission on State Guardianship Laws.** | H 246<br>S 179 | No action taken on this issue. |
| **RECOMMENDATION 5**<br>**The Commission recommends the General Assembly pursue ways in which national criminal record checks may be obtained and reviewed by long-term care facilities to effectuate State policy and to protect facility residents.** | H 1561<br>S 1264 | **S.L. 2002-180, Sec. 2.1A (SB 98, Sec. 2.1A)**<br>**Study Issues Related to Criminal History Record Checks of Employees of Long-Term Care Providers**<br>The Legislative Research Commission may study how federal law affects the distribution of national criminal history record check information requested for nursing homes, home care agencies, adult care homes, assisted living facilities, and area mental health, developmental disabilities, and substance abuse services authorities, and the problems federal restrictions pose for effective and efficient implementation of State-required criminal record checks. The study may include the following:<br>(1) Ways in which national record checks may be obtained and reviewed for these facilities to effectuate State policies and protections of facility residents, and the advantages, disadvantages, and costs of various approaches to implementation.<br>(2) A review of ways in which national record checks are obtained by the Division of Child Development, Department of Health and Human Services, and other State agencies, and related costs to the State.<br>(3) Solutions adopted by other states to effectively and efficiently implement criminal record check requirements, including costs to the State in implementing these solutions.<br>(4) Other issues relevant to State requirements for criminal history record checks in long-term care facilities.<br>For each of the topics the Legislative Research Commission decides to study, the Commission may report its findings, together with any recommended legislation, to the 2003 General Assembly. |

# Summary of Substantive Legislation Related to Aging

North Carolina General Assembly

**2002 Session**

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

**November 12, 2002**

# Enacted Legislation

## Senior Prescription Drug Program

S.L. 2002-126, Sec. 6.8 (SB 1115, Sec. 6.8) authorizes the Health and Wellness Trust Fund Commission (Commission) to expend up to $3,000,000 of reserved funds from the Health and Wellness Trust Fund to develop and implement a Senior Prescription Drug Access Program for persons aged 65 years and older. The purpose of the Program is to reduce costs of and improve access to and use of prescription drugs for seniors by providing assistance with accessing private and public prescription drug assistance programs, making pharmacist evaluators available to review prescriptions to promote compliance and identify potential adverse effects from drug interactions, and using drug software to guide patients through the complexities of all drug coverage options. Program services will be made available to all seniors, though some seniors may be charged a fee by pharmacist evaluators for prescription reviews. The Commission must include in its annual report to the Joint Legislative Commission on Governmental Operations and to the Legislative Health Care Oversight Committee the use of funds for and activities of the Program and an evaluation of the Program's usage and effectiveness.

This section became effective July 1, 2002. (DJ)

## Review of Long-Term Care Staffing Requirements

S.L. 2002-126, Sec. 10.3 (SB 1115, Sec. 10.3), as amended by S.L. 2002-159, Sec. 73 (SB 1217, Sec. 73), requires the Office of Long Term Care in the Department of Health and Human Services (Department) to review the staffing requirements in adult day and adult day health programs, including how those requirements compare to the staffing requirements in other states and to the staffing requirements for adult care homes, assisted living facilities, and nursing homes in this State. The Department must report the results of its review, including any recommended changes to existing staffing policies, to the House and Senate Appropriations subcommittees on Health and Human Services by February 15, 2003 (previously December 1, 2002).

Section 10.3 of S.L. 2002-126 became effective July 1, 2002.

Section 73 of S.L. 2002-159 became effective October 11, 2002. (DJ)

## Report on Services Provided to Older Adults

S.L. 2002-126, Sec. 10.4 (SB 1115, Sec. 10.4) requires the Office of Long Term Care in the Department of Health and Human Services to report on services provided to older adults (adults age 60 and older). The report shall include identification of all State agencies that provide services, the resources available to fund these services, and plans to consolidate and reduce administration of the services. The Office must consult with long-term care experts to develop a plan to streamline services for older adults at the local level. The Department shall submit the report by February 1, 2003 to the House and Senate Appropriations subcommittees on Health and Human Services and the Fiscal Research Division.

This section became effective July 1, 2002. (DJ)

## Effective Date Of Long-Term Care Criminal Check For Employment Positions

S.L. 2002-126, Sec. 10.10C (SB 1115, Sec. 10.10C) delays the provision in law that requires employers to conduct a national criminal history record check of employees of nursing homes and adult care homes for employment positions other than those involving direct patient care until no earlier than January 1, 2004.

This section became effective July 1, 2002. (DJ)

See table at the end for a summary of S.L. 2002-180, Sec. 2.1A authorizing the Legislative Research Commission to study issues related to criminal history record checks of employees of long-term care providers.

## Community Alternatives Programs

S.L. 2002-126, Sec. 10.16 (SB 1115, Sec. 10.16) requires the Department of Health and Human Services (Department) to administer all Community Alternatives Program (CAP) waivers in the most economical and efficient manner possible to support within funds appropriated the maximum number of persons meeting participation requirements under the waivers, including amending the waivers if necessary to accomplish this objective. Not later than November 1, 2002, the Department is required to submit a report that outlines efficient use of funds appropriated and that demonstrates the participation requirements, payment and service limits, and other administrative actions to support the maximum number of persons to be served in the applicable State fiscal year. The report is to be submitted to the Senate and House Appropriations subcommittees on Health and Human Services and the Fiscal Research Division.

This section also directs that Community Alternatives Program for Disabled Adults (CAP/DA) services shall be provided for the 2002-2003 fiscal year to any eligible person who entered a nursing facility on or before June 1, 2002, notwithstanding that the availability of CAP/DA services may be suspended for that fiscal year.

Finally, the section requires the North Carolina Institute of Medicine to conduct a study of the CAP/DA administered by the Department of Health and Human Services and recommend ways to improve the administration of CAP/DA and report its findings and recommendations to the 2003 General Assembly upon its convening.

This section became effective July 1, 2002. (DJ)

## Long-Term Care Reimbursement Methodology

S.L. 2002-126, Sec. 10.19A (SB 1115, Sec. 10.19A) makes certain requirements of the Division of Medical Assistance (DMA) when establishing a new reimbursement methodology for long-term care services (including nursing facilities, ICF-MRs, and adult care homes). The requirements include:

- Using the latest cost data available;
- Establishing reimbursement rates that will allow Medicaid long-term care providers to comply with certification requirements, licensure rules, or other mandated quality or safety standards;
- Considering available data related to long-term care industry costs and losses; and
- Considering the effect on future viability and sustainability of financially vulnerable long-term care providers.

Additionally, DMA and any contract agencies are required to consult with provider organizations including the North Carolina Health Care Facilities Association, the Long-Term Care Facilities Association of North Carolina, the North Carolina Assisted Living Association, the North Carolina Developmental Disabilities Facilities Association, and the North Carolina Association of Non-Profit Homes for the Aging.

The section also requires the Department to report on the reimbursement methodology not later than January 1, 2003, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

This section became effective July 1, 2002. (TM)

## State/County Special Assistance

S.L. 2002-126, Sec. 10.36 (SB 1115, Sec. 10.36) rewrites Section 21.44 (d) of S.L. 2001-424 to specify that the maximum monthly rate for residents in adult care home facilities shall be one thousand ninety-one dollars ($1,091) per month per resident (previously, $1,120 per month per resident).

This section became effective July 1, 2002. (TM)

## Adult Care Home Model for Community-Based Services

S.L. 2002-126, Sec. 10.38 (SB 1115, Sec. 10.38) rewrites Section 21.54(b) of S.L. 2001-424 to require the Department of Health and Human Services to submit a final report on the development of a model project for delivering community-based mental health, developmental disabilities, and substance abuse housing and services through adult care homes that have excess capacity on March 1, 2003 (previously, March 1, 2002).

This section became effective July 1, 2002. (TM)

## Adult Care Home Resident Assessment Service Program Repealed

S.L. 2002-126, Sec. 10.39 (SB 1115, Sec. 10.39) repeals Section 21.35 of S.L. 2001-424 which required that funds appropriated to the Department of Health and Human Services, Division of Social Services, for adult care home positions in the Department and in county departments of social services be used for personnel trained in the medical and social needs of older adults and disabled persons in adult care homes to evaluate individuals requesting State/County Special Assistance to pay for care in adult care homes. Section 21.35 of S.L. 2001-424 had required these personnel to develop and collect data on the appropriate level of care and placement in the long-term care system, including identifying individuals who pose a risk to other residents and who may need further mental health assessment and treatment. Additionally, it had required technical assistance to be provided to adult care homes on how to conduct functional assessments and develop care plans and shall assist in monitoring the Special Assistance Demonstration Project.

This section became effective July 1, 2002. (TM)

## State/County Special Assistance Transfer of Assets Policy

S.L. 2002-126, Sec. 10.41B (SB 1115, Sec. 10.41B) applies Supplemental Security Income (SSI) policy applicable to transfer of assets and estate recovery to applicants for State/County Special Assistance. The Section also requires the Department of Health and Human Services (DHHS) to continue to review conditions on family contributions to the resident's cost of care in an assisted living facility, if that resident qualifies for State/County Special Assistance. DHHS must report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division by March 1, 2003 regarding their review on family contributions to a resident's cost of care.

The section that applies federal transfer of assets policy to applicants for State/County Special Assistance became effective November 1, 2002. The section regarding the DHHS review and report became effective July 1, 2002. (AC)

*Staff Contributing to this publication: Amy Currie (AC), Dianna Jessup (DJ), and Theresa Matula (TM).*

# Studies and Reports Related to Aging

| Study/Report | Entities Involved | Reporting Date | Reference |
|---|---|---|---|
| **Data on the number of persons who received services, fees authorized, and geographic distribution for Senior Prescription Drug Access Program services** | Health and Wellness Trust Fund Commission to Gov Ops and to the chairs of Health Oversight | By 11/1 each year | S.L. 2002-126 (SB 1115), Sec. 6.8(c) |
| **Staffing requirements of Adult Day Care programs and Adult Day Health programs** | DHHS-Office of Long-Term Care to HHS and FRD | No later than 2/15/03 | S.L. 2002-126 (SB 1115), Sec. 10.3 |
| **Report on services provided to older adults including the identification of all State agencies that provide services, all funds and personnel that provide services, and plans for reducing administration** | DHHS-Office of Long-Term Care to HHS and FRD | No later than 2/1/03 | S.L. 2002-126 (SB 1115), Sec. 10.4 |
| **Status report on expenditures for acute care and long-term care services under Medicaid** | DHHS to FRD and OSBM | Quarterly reports due no later than the 3rd Thurs. of the month following each quarter | S.L. 2002-126 (SB 1115), Sec. 10.11(a) |
| **Efficient use of funds appropriated under the CAP waivers that ensure the maximum number of persons are being served** | DHHS to HHS and FRD | No later than 11/1/02 | S.L. 2002-126 (SB 1115), Sec. 10.16(a) |
| **Recommended ways to improve the administration of CAP/DA** | NC Institute of Medicine to GA | Upon convening of the 2003 GA | S.L. 2002-126 (SB 1115), Sec. 10.16(c) |
| **Establishing a new reimbursement methodology for long-term care services, including nursing facilities, ICF-MRs, and adult care homes** | DHHS to HHS and FRD | No later than 1/1/03 | S.L. 2002-126 (SB 1115), Sec. 10.19A |
| **Development of the adult care home model for community-based services including the time and location for pilot implementation, changes to State law necessary to implement the pilot, and projected costs for Statewide implementation** | DHHS to HHS and FRD | Final report by 3/1/03 | S.L. 2002-126 (SB 1115), Sec. 10.38 |
| **Current policy for State/County Special Assistance and whether it should be changed to permit an assisted living facility to accept from a family member of a resident payment for the difference in the monthly rate for room, board, and services available** | DHHS to HHS and FRD | No later than 3/1/03 | S.L. 2002-126 (SB 1115), Sec. 10.41B(b) |
| **Heart Disease and Stroke Prevention Task Force's Plan to reduce the occurrence of and burden from heart disease and stroke in the State, including the amount of funds expended and anticipated funding needs of recommended plans and programs** | Task force to the Governor and GA | By 6/30/03 | S.L. 2002-126 (SB 1115), Sec. 10.45 |
| **Issues related to criminal history record checks of employees of long-term care providers** | LRC to the 2003 GA | N/A | S.L. 2002-180 (SB 98) Sec. 2.1A of SB 98 |
| **Study ways the State can coordinate and facilitate public access to public and private free and discount prescription drug programs for senior citizens** | DHHS to the NC Study Commission on Aging | On or before 1/1/03 | S.L. 2002-180 (SB 98) Sec. 5.1 of SB 98 |
| **Ways to establish a group health insurance purchasing arrangement for staff, including paraprofessionals, in residential and nonresidential long-term care facilities and agencies** | DHHS, in consultation with the Dept. Of Insurance to the NC Study Commission on Aging | On or before 1/1/03 | S.L. 2002-180 (SB 98) Sec. 5.2 of SB 98 |

*Abbreviations:*
*DHHS: the Department of Health & Human Services* *GA: General Assembly* *Health Oversight: Joint Legislative Health Care Oversight*
*OSBM: Office of State Budget and Management* *LRC: Legislative Research Commission* *Gov Ops: Joint Legislative Commission on Governmental Operations Committee*
*HHS: House of Representatives Appropriations Subcommittee on Health and Human Services & Senate Appropriations Committee on Health and Human Services*

# APPENDIX C

## Effect of Difficult Fiscal Times on Division of Aging Programs

Cuts to the Division of Aging from this past legislative session totaled $926,000, which equals 3.1% of our FY 2002-03 state appropriation. The reductions were as follows:

- $175,000 in Division of Aging Administration, which includes a reduction of $6,000 for the North Carolina Senior Tar Heel Legislature and $4,000 for the Governor's Advisory Council on Aging;
- $370,000 in support of Area Agencies on Aging; and
- $381,000 for Senior Center General Purpose and Outreach.

Attached are two tables that show trends in state resources available to support major Division of Aging (DOA) programs, including services delivered through the Home and Community Care Block Grant. Below is an explanation and discussion of these tables.

**State Administration**
The Division of Aging (*State Administration*) has maintained a fairly constant level of personnel throughout its existence (first established as a division in 1977). In 1998-99, the division received two positions from the Division of Social Services when DOA assumed full responsibility for administration of adult day care and day health services (including statewide certification of these programs), preparation and delivery of meals, housing and home improvement, and in-home aide for older and disabled adults. SFY 2000-01 began the period of curtailing all but "mission critical" activities. The division lost a full-time, 100% state-funded position in FY 2001-02 and had several vacant positions frozen following staff departures. In addition, the division lost $50,000 for contractual services, which was important because of its small number of staff [the Division currently has a staff of 34 positions--no more than it had in 1977.] For FY 2002-03, the General Assembly cut an additional $165,000 in operational funds. The DOA has been able to replace the most recent cut because of an increase in federal support under the Older Americans Act. The largest negative effect of the reduction in State support is the lack of available funds necessary to match many private and public grants. The Division has had to overlook several important grant opportunities without a way to produce the necessary match.

In addition to the reduction of $165,000 in support for the Division of Aging, the General Assembly also reduced administrative support for the *North Carolina Senior Tar Heel Legislature* (by $6,000, two-thirds of their state funds) and the *Governor's Advisory Council on Aging* (by $4,000, half of their state funds.)

**Elder Rights/Ombudsman Program**
Funding for the *Elder Rights/Ombudsman Program*, which includes State administration and positions statewide at the Area Agencies on Aging, has remained relatively constant during the past six years. The drop in actual funds spent in FYs 2000-01 and 2001-02 were due to vacant positions and curtailment of travel, supplies, and other expenses. The slight increase in the

budget figure for 2002-03 is necessary to meet the required match for Older Americans Act funding. The Ombudsman Program has not received an increase in State appropriations since 1994, when the General Assembly added $318,275 to expand it. Since that time, the number of complaints has increased 100% and technical consultations to providers, residents, families and others have increased over 900%. Based on the 1995 recommendation of the National Institute of Medicine's Study of the Long Term Care Ombudsman Program, North Carolina is short nearly 21 full-time positions at the AAA level from what is needed for essential practice.

**Home and Community Care Block Grant**

FY 1998-99 was the last time that the General Assembly increased the appropriation (by $4.1 million) for the *Home and Community Care Block Grant* (HCCBG), especially targeted for non-Medicaid older adults waiting for services. The drop in funding in FY 2001-02 was due to a required reversion of funds to meet the State's budgetary shortfall, some of which was softened by the increase in federal Older Americans Act funding. The decrease in state expense also reflected the cautious management of funds at the state, regional, and local levels. While there has not been any direct reduction in State appropriations for the HCCBG, as reflected in the budget for 2002-03, there is still cautiousness because of the economic uncertainty, the reduced allotments, and possible need to revert additional state funds again this year. As a result of the zero-growth in state support of the HCCBG, even with some increase in federal funds, there has actually been a decline in services as evidenced in several ways. *Table 2* shows this:

- There is a decline between 2000-2002 in the number of counties offering certain services under the HCCBG (i.e., adult day care, housing and home improvement, in-home aide, and medical transportation). All of these services are considered "core services" under the Long-Term Care Plan for North Carolina. Under the HCCBG, counties have greater discretion to choose which services to fund on an annual basis. It is also interesting to note that a few more counties decided to support Senior Centers under the HCCBG. This may be their attempt to compensate for State cuts in Senior Center support.
- More significantly, there is a general decline in both the number of clients served and in the units of service. As the costs of doing business have increased, there has not been a corresponding increase in funding. As of November 8, 2002, the number of older adults waiting for HCCBG services totaled 11,225. This is a conservative estimate because providers are not currently required to report this information. The list includes about 3,860 waiting for home-delivered meals and more than 5,175 needing the assistance of an in-home aide. These services support the independence of very vulnerable elderly, as evidenced by the fact that nearly 40% of home-delivered meals recipients are at risk of malnutrition and nearly 30% of in-home aide recipients are at risk of institutionalization because they are unable to perform 3 or more activities of daily living (i.e., bathing, dressing, grooming, moving around the house, and eating.) This need is surely compounded as other sources of support are curtailed (e.g., Medicaid personal care services, CAP-DA).

*Increased funding for the HCCBG is a 2002-03 priority of the North Carolina Senior Tar Heel Legislature.* The Division estimates that over $15 million is required to meet the service needs of those on the HCCBG waiting list.

**Legal Services and Health Promotion**

Funding for legal services and health promotion, both required under the Older Americans Act (OAA), has varied only because of the match necessary for changes in federal OAA funding and in curtailment of expenses during the state's budget difficulties.

**Area Agencies on Aging**

The last six-year period saw a large swing in State support of *Area Agencies on Aging* (AAAs). At the recommendation of the Study Commission on Aging, the General Assembly increased support of AAAs in 1998 by $900,000, recognizing their responsibility for monitoring the HCCBG and other services and for local and regional planning and program development. In the last two legislative sessions, AAAs have lost $570,000 in recurring funds ($200,000 in 2001-02 and $370,000 in 2002-03.) The reduced support in 2001-02 directly affected staffing at 8 AAAs, and hampered all AAAs in their planning, monitoring, and resource development activities (32 counties still use AAAs as the local lead agency for planning and administering the Home and Community Care Block Grant.) The Division of Aging was able to largely offset the additional cut in 2002-03 with increased federal AAA planning and administration funds under the Older Americans Act, which is available when the state is allocated additional OAA Title III funding. In preparing the 2002 study of AAAs required by the General Assembly in Section 21.32 (a) of S.L. 2001-424 (S.B. 1005), the Division of Aging discovered and reported that North Carolina's AAAs are already "bare-boned" operations as compared to AAAs in eight other southeastern states. For example, NC's AAAs rank second lowest in the average number of FTE personnel, while are second highest in the number of service providers for which they are responsible. Similar to that experienced at the state level, the biggest negative effect of reduced State support will be a loss in capacity to secure private and public grants that require a match. All AAAs have used their State funds to secure other resources to expand local programs and services (e.g., elderly housing and senior pharmacy initiatives) and to participate in special federal initiatives (e.g., Medicare Senior Patrol and the Performance Outcomes Measures Project). During the past two years, AAAs secured more than $9.6 million in additional public and private grants for local aging projects. This does not include the more than $2.7 million recently awarded to six AAAs for the Medication Management component of the North Carolina Senior Care program.

**Senior Centers**

At the recommendation of the Study Commission on Aging, State support of Senior Centers increased in 1998 by a $1 million non-recurring appropriation. That same year Senior Centers received $1.5 million in one-time capital improvement funds. Because of the state's budgetary difficulties in 2001-02, some Senior Center funds were frozen and then reverted. For 2002-03, the General Assembly cut Senior Center General Purpose and Outreach funds by $381,000. *Senior Center Development (General Purpose) funding* provides existing and developing senior centers with resources to meet operational needs ranging from building maintenance and improvements to salaries for center directors and program managers. Currently, funding is provided to 158 senior centers in 95 counties (5 counties do not have a senior center.) In 2001, the Division of Aging established a voluntary certification program to recognize centers of "excellence" and "merit" and encourage overall strengthening of senior centers as vital community pipelines for information and services for seniors and their families. Currently the Division has certified 30 centers—20 Senior Centers of Excellence and 10 Senior Centers of

Merit. These quality centers have been rewarded with additional general purpose funding during the past few years. *Senior Center Outreach funding* allows senior centers to provide services and activities at the center or in a remote location to unserved and under-served elderly. As Senior Centers have experienced the reduction in State support, many are also experiencing loss of local and private support. With cuts in funding, some centers have had to:

- reduce the variety of activities and services they offer;
- reduce operating hours or days;
- close satellite locations due to loss of personnel and funds;
- reduce outreach to elderly in remote areas, including transportation for the most isolated elderly; and
- delay needed maintenance and repairs to facilities and equipment.

A recent example of the pressure experienced by Senior Centers is that of the Charlotte-Mecklenburg Senior Center, which has been in operation since 1984. The Center's GrandCare Program, which assists grandparents raising grandchildren, is especially at risk because it also depended on funds from Smart Start that received a State cut. With more than 5,175 grandparents in the Charlotte area raising their minor grandchildren, the center is aggressively seeking corporate and other private support. *Increased funding for the development and operation of Senior Centers is a 2002-03 priority of the North Carolina Senior Tar Heel Legislature.*

**Senior Games and Alzheimer's Support**

Funding for *Senior Games* has remained constant during the past six years. At the recommendation of the Study Commission on Aging, funds for the Alzheimer's Chapters increased by $50,000 in 1999, and have since remained constant. The *Alzheimer's funds* support the two *Alzheimer's Chapters* that cover the state ($150,000) and the *Duke Family Support Program* ($50,000), which supports the Alzheimer's Chapters and consumers and providers statewide with application of current evidenced-based research in education, training, and consultation. The State support of Alzheimer's enabled North Carolina to meet the matching requirements for a three-year $1+ million federal demonstration grant to support families caring for persons with dementia.

**Table # 1**
**Division of Aging**
**State Funding Comparison of Major Programs**

| Description | Budget 2002-2003 | Actual 2001-2002 | Actual 2000-2001 | Actual 1999-2000 | Actual 1998-1999 | Actual 1997-1998 |
|---|---|---|---|---|---|---|
| State Administration | $ 629,106 | $ 739,400 | $ 767,152 | $ 825,801 | $ 843,315 | $ 713,628 |
| Elder Rights/Ombudsman | 438,320 | 419,780 | 421,092 | 442,664 | 433,913 | 420,641 |
| Home & Community Care Block Grant | 25,109,286 | 23,263,277 | 25,390,829 | 25,009,266 | 25,039,843 | 20,774,279 |
| Legal Services | 19,184 | 18,131 | 18,913 | 19,889 | 17,432 | 17,132 |
| Health Promotion | 33,425 | 30,338 | 27,386 | 24,194 | 23,671 | 23,001 |
| AAA's Planning & Administration | 688,925 | 1,012,083 | 1,217,913 | 1,187,123 | 1,115,394 | 312,535 |
| Senior Center Gen'l Purpose & Outreach | 984,000 | 1,223,623 | 1,338,914 | 1,355,451 | 2,386,097 | 1,335,799 |
| Senior Center Capital Improvements | | | | | 1,500,000 | |
| Senior Games | 175,000 | 175,000 | 175,000 | 175,000 | 175,000 | 175,000 |
| Alzheimer's Support | 200,000 | 200,000 | 200,000 | 200,000 | 150,000 | 150,000 |

**Changes in Services under Home and Community Care Block Grant, FYs 1999-2000 and 2001-2002**
**[includes federal, state, and required local match]**

| Service | Counties | | | Expenditures | | | Clients/Participants | | | Units | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2002 | % change | 2000 | 2002 | % change | 2000 | 2002 | % change | 2000 | 2002 | % change |
| Adult Day Care | 42 | 41 | **-2%** | $1.6m | $1.5m | **-6%** | 710 | 587 | **-21%** | 66,589 | 59,231 | **-12%** |
| Adult Day Health | 28 | 31 | 11% | $1.2m | $1.2m | 0% | 429 | 446 | 4% | 37,414 | 37,805 | 1% |
| Congregate Nutrition | 99 | 99 | 0% | $7.5m | $7.6m | 1% | 30,199 | 28,382 | **-6%** | 2,400,843 | 2,323,376 | **-3%** |
| Home-Delivered Meals | 94 | 95 | 1% | $7.5m | $7.7 | 3% | 18,592 | 16,945 | **-10%** | 2,734,747 | 2,575,242 | **-6%** |
| Housing & Home Improvement | 44 | 37 | **-19%** | $798,328 | $714,980 | **-12%** | 1,172 | 1,035 | **-13%** | 1,454 | 1,377 | **-6%** |
| In-home Aide Level 1 | 78 | 77 | **-1%** | $5m | $5m | 1% | 4,406 | 3,863 | **-14%** | 446,658 | 413,291 | **-8%** |
| In-home Aide Level 2 | 89 | 89 | 0% | $8.5m | $8.7 | 3% | 4,198 | 3,873 | **-8%** | 713,995 | 709,749 | **-1%** |
| In-home Aide Level 3 | 52 | 51 | **-2%** | $2.7m | $2.9m | 7% | 1,206 | 1,083 | **-11%** | 211,605 | 207,394 | **-2%** |
| In-home Aide Level 4 | 1 | 1 | 0% | $14,725 | $11,207 | **-31%** | 16 | 15 | **-1%** | 1,077 | 599 | **-80%** |
| Institutional Respite | 4 | 4 | **0%** | $282,958 | $203,186 | **-39%** | 127 | 86 | **-48%** | 56,745 | 35,708 | **-59%** |
| Transportation, General | 94 | 95 | 1% | $4.7m | $5m | 7% | 12,274 | 11,572 | **-6%** | 1,342,604 | 1,231,095 | **-9%** |
| Transportation, Medical | 53 | 49 | **-8%** | $1.1m | $938,651 | **-17%** | 5,318 | 3,964 | **-34%** | 120,794 | 95,627 | **-26%** |

# 2001-2002 Accomplishments of the Division of Aging

**Initiated Family Caregiver Support Program**

While North Carolina has a history of supporting family and friends in their caring of loved ones, the start of the national Family Caregiver Support Program (FCSP) in 2001 presented an unparalleled opportunity of which North Carolina took full advantage. North Carolina was only one of five states (and the only southeastern state) chosen by the U.S. Administration on Aging and The Lewin Group to be highlighted in AoA's recently released NFCSP Resource Guide designed to offer practical information to the national aging network to help implement the new caregiver program. The work of the North Carolina Division of Aging, its Area Agencies on Aging, and their many partners was highlighted in this report [http://www.aoa.gov/carenetwork/nfcsp-resource-guide.html].

**Implemented Long Term Care Reform Efforts**

Although the State's budget difficulties hindered implementation of many recommendations in the 2001 Long Term Care Plan for North Carolina, prepared by the Task Force of the Institute of Medicine, the Division of Aging contributed substantially in laying progress for future reform. Its efforts included:

- Developing North Carolina's new, nationally recognized Family Caregiver Program that is referenced above.

- Leading development of a special long-term care web-site for DHHS that includes input from all relevant state agencies [http://www.dhhs.state.nc.us/ltc/].

- Securing a $1+ million federal grant to promote respite and supplemental services for caregivers of seniors with Alzheimer's disease and another grant to examine the relevancy of consumer-directed care for seniors and their family caregivers.

- Leading efforts to strengthen Information and Assistance as a valuable service for older and disabled adults and their families.

- Educating citizens about long term care and long-term care insurance, which included co-producing the brochure *It's about You, Your Children & Your Parents: Planning Today for Tomorrow*.

**Aided in Implementing the NC Senior Care Prescription Drug Assistance Program**

The start-up of the NC Senior Care Prescription Drug Assistance Program on October 1, 2002, marked achievement of one of top priorities of Governor Easley and Lieutenant Governor Perdue. This program is designed specifically to provide assistance to North Carolina seniors diagnosed with a covered disease condition, who meet the income guidelines, and who are coping with the rising costs of prescription medicine. The Division

of Aging has provided input and direct assistance in planning and implementing this program.

**Strengthened Multipurpose Senior Centers as a Community Resource**

Despite cuts in State funding for senior centers, the Division of Aging continued its investment in this important community resource. It did this in two primary ways. First, the division promoted the voluntary certification of Centers of Merit and Excellence, using the nationally recognized customer focused criteria and process that it has created. North Carolina now has 20 centers of excellence and 10 centers of merit. Second, in 2001, the Division of Aging initiated a certificate training program for senior center managers and leaders. The program is named in honor of North Carolina's own Ann Johnson, a nationally recognized aging advocate and champion of senior centers. Ms. Johnson is also current chair of the Governor's Advisory Council on Aging.

**Leveraged Resources To Expand Programs**

Faced with cuts in State administrative and service funds, the Division of Aging was proactive in looking for ways to operate efficiently and still move forward with initiatives to help North Carolina prepare for the need of the increasing numbers of seniors. Our successes in leveraging resources included:

- Securing $846,218 in special federal grants that focused on testing performance outcome measures for home and community services, helping eligible seniors receive food stamps, providing vouchers to seniors for use at farmers' markets, enlisting seniors to help identify waste in Medicare and Medicaid expenditures, and offering respite and other assistance to family caregivers of persons with Alzheimer's disease

- Securing $293,643 from the U.S. Administration on Aging in unspent funds of other states for use in support of home and community care services

*Making use of videoconferencing, on-line discussion forums, and other means to continue training and communications with the statewide aging network without requiring travel and other expenses*

**Review of Resource and Project Development Initiatives**

**Division of Aging, DHHS**

Faced with diminished State resources to support its work and that of the 17 Area Agencies on Aging, the Division of Aging has aggressively and strategically pursued opportunities to secure grants, especially ones not requiring a match in funds. While securing these grants typically means additional work for existing personnel, the Division accepts this responsibility in view of the pressing issues facing our aging society.

**Continuation Initiatives**

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

The Division has begun its second year of a three-year competitive grant from the U.S. Administration on Aging, which provides $350,000 each year to assist people caring for loved ones with dementia. Originally, North Carolina was only one of nine states to receive this demonstration grant. The project operates at three project sites [Forsyth, four counties in Western NC (Henderson, Transylvania, Polk, and Rutherford), and Mecklenburg.] The Division has been able to meet the grant's high matching requirement by effectively partnering with the Western Alzheimer's Association Chapter, the Mecklenburg County DSS, the Duke Family Support Program, and the AAAs in the affected regions. During the first year, the project met all of its goals, including spending 50% of the grant funds directly on respite services. In addition to respite services, multiple training and educational programs were conducted. The project served more than 225 families through 39 different providers. The project is an integral part of the Division's Family Caregiver Support Program. Division contact persons: Karisa Derence and Chris Urso.

- **Senior Farmer's Market**

The Division was awarded a second competitive grant of $54,000 from the USDA to provide congregate nutrition attendees in participating counties with $15.00 in vouchers to use at their local Farmers' Market. Last year the Division piloted the project in six counties (Columbus, Guilford, Halifax, Northampton, Robeson, and Wake). This year the Division has added Alamance, Haywood, Iredell, Lee, Stokes, Watauga, and Yancey. The Division expects to serve more than 3,700 older adults in these 13 counties. At the federal level, the program was included in the Farm Bill and should continue for at least six more years. Division contact person: Audrey Edmisten.

- **Performance Outcomes Measures Project**

The Division has received a one-year competitive grant of $45,000 to participate in the Performance Outcomes Measures Project (POMP) of the U.S. Administration on Aging. This follows two other POMP grants focused on nutrition services and caregiving that the Division successfully completed. With support from the UNC School of Social Work, which is providing the match, the Division will be conducting customer satisfaction surveys for caregiver support

(follow-up interviews based on the previous statewide survey), transportation (statewide), in-home aide (in regions I and N), and information and assistance (in Johnston County). Division contact person: Phyllis Stewart.

- **Senior Medicare Patrol**

The Division has received $180,000 to continue the third and final year of a competitive grant from the U.S. Administration on Aging to educate older Medicare and Medicaid beneficiaries about health care discrepancies and the importance of reviewing their benefits summary statements. The Division has partnered with the Seniors' Health Insurance Information Program (SHIIP), of the Department of Insurance, and with the 17 AAAs in taking the project—named Medicare Lookout—statewide. North Carolina's use of educational theatre has brought it national recognition. Division contact person: Susan Sabre.

**New Initiatives**

- **Food Stamp Participation**

In partnership with the Division of Social Services, the Division was awarded $217,218 for a two-year competitive grant (100% federal) from the U.S.D.A. to test different outreach methods to improve Food Stamp participation among older adults. The Division was the only state unit on aging to receive this grant nationally. Currently, only about 26% of eligible older adults in North Carolina take advantage of this 100% federally funded benefit. The project is being conducted in Region F (Anson, Gaston, Iredell, Mecklenburg, and Rowan counties). Division contact persons: Audrey Edmisten and Harold Berdiansky.

- **More than a Meal**

The Division was awarded a second USDA competitive grant of $52,198 (50% federal match) through a partnership with the North Carolina Nutrition Network. The project is a comprehensive nutrition education initiative to improve the nutrition knowledge and skills of the aging network statewide. The primary target population is the staff members who work with the Senior Nutrition Program. The initiative involves regional orientation workshops, an annual statewide training highlighting current issues, a quarterly newsletter distributed to all levels of the nutrition network, and food safety workshops for the staff in 10 pilot counties. Division contact person: Audrey Edmisten.

- **Consumer-Directed Care**

The Division, in partnership with the DHHS Office of Long Term Care and Olmstead, received a $2,250 competitive (no match) grant from the National Association of State Units on Aging (NASUA) to develop a "consumer direction reform agenda." North Carolina was one of only five states to receive these funds. "Consumer direction" is generally used to describe programs and services where people are given maximum choice and control. Under the grant, the Division (working in conjunction with Real Choice staff and the N.C. Coalition on Aging) is assessing the home and community-based service system for older and disabled adults through a survey developed by NASUA. In addition, the Division is holding public forums and using focus groups to educate about consumer-directed care and to help it identify opportunities for increasing consumer choice and direction within existing programs. The Division is also using the grant to provide additional resources and connections for the larger Real Choice grant of the

DHHS, which is developing pilot programs for consumer-directed care. Division contact person: Julie Bell.

- **Information and Assistance**

The Division has been allocated $100,000 from the Mental Health Trust Fund to lead an interagency effort to develop a framework for a computerized information and assistance system that takes advantage of existing systems throughout the state. This is a priority recommendation of the Institute of Medicine's Long Term Care Plan and also a critical component of the state's *Olmstead* Plan. Once developed, the I&A system would provide consumers with information on a full range of service options via the internet or through assistance from trained I&A personnel. Division contact person: Heather Burkhardt.

- **Health Promotion**

The Division of Aging collaborated with the Older Adult Health Branch in the Division of Public Health to help it secure a small grant from the Chronic Disease Directors Association to expand collaboration between health and aging agencies in North Carolina, to increase public awareness about the importance of healthy aging, and to develop resource materials on healthy aging. These materials, which will include information on nutrition, physical activity, preventive screenings, and healthy choices, will be distributed through local aging agencies, health departments, cooperative extension service programs, parks and recreation departments, and AARP. Dr. Betty Wiser, head of the Older Adult Health Branch, was recently honored for two years of work chairing the Health and Aging Ad Hoc Advisory Committee of the Chronic Disease Directors Association. Division of Aging contact person: Mary Bethel.

**Future Interest**

**Local Long-Term Care Planning**

With support from the N.C. Association of County Commissioners, the Division submitted a competitive grant application to the federal DHHS Office of the Assistant Secretary for Planning and Evaluation. The proposal sought $45,000 in federal funds (with a $5,000 state match) to support two counties in implementing a local planning process for long term care (LTC), as outlined in priority recommendation 16 of the Institute of Medicine Long Term Care Plan. Important components of the project include conducting an evaluation of core LTC services at the local level and developing strategies to facilitate creation of a streamlined and comprehensive LTC system for older and disabled adults. Although the grant was not awarded, the application was favorably reviewed and the Division is encouraged to continue its work to establish a "Communications and Planning Network to Support Families in Their LTC Roles." While the Division will seek counties to volunteer, it will also continue to pursue funding to support the initiative. Division contact persons: Steve Freedman and Julie Bell.

2101 Mail Service Center, Raleigh, NC 27699-2101
919-733-3983
www.dhhs.state.nc.us/aging/home.htm

# APPENDIX D

## CAP/DA Events

**October 2001 –** Admission Frozen
Caseload = 10,230

**August 2002 –** Partial Thaw
Replacements Allowed
Caseload = 8,049 (a decline of 21%)

1

## CAP/DA Events

**November 2002 –** New Slots Added

- Counties Received 1,599 Slots
- 3 Slots for Every 4 Persons Lost
- Monthly Caseload = 9,600 +

**As of 11-15-02 –** There were 348 replacements + 60 new slots used – *a total of 408 new participants*

2

## Other DMA Activities

- Solicited and evaluated input from the local programs on operational, procedural and policy changes
- Strengthened the guidance to local programs on planning, authorizing and monitoring CAP services

3

## Other DMA Activities – *Con't*

- Reviewed each CAP service to determine if it is essential to the program and appropriately defined – the work is continuing
- Evaluated requiring more frequent reviews of a client's level of care to be sure that each client is appropriate for the program

4

## Other DMA Activities – *Con't*

- Strengthened on-site review procedures and priorities
- Implemented internal controls for CAP slot use
- Providing information and input to the Institute of Medicine in support of its study of the program

5

## CAP/DA Caseload History
## October 1, 2001 through October 31, 2002

| County | Caseload | | Caseload Decrease | | # of Clients Replaced | Additional Slots as of | Total Slots as of |
|---|---|---|---|---|---|---|---|
| | Oct-01 | Aug-02 | Number | % | 8/1-10/31/02 | 11/01/02 | 11/01/02 |
| ALAMANCE | 71 | 55 | 16 | 22.5% | 2 | 12 | 64 |
| ALEXANDER | 61 | 55 | 6 | 9.8% | 0 | 4 | 54 |
| ALLEGHANY | 57 | 49 | 8 | 14.0% | 4 | 6 | 54 |
| ANSON | 81 | 68 | 13 | 16.0% | 0 | 10 | 70 |
| ASHE | 157 | 129 | 28 | 17.8% | 8 | 21 | 150 |
| AVERY | 203 | 169 | 34 | 16.7% | 7 | 25 | 197 |
| BEAUFORT | 118 | 95 | 23 | 19.5% | 4 | 17 | 113 |
| BERTIE | 183 | 151 | 32 | 17.5% | 0 | 23 | 166 |
| BLADEN | 119 | 91 | 28 | 23.5% | 4 | 21 | 118 |
| BRUNSWICK | 54 | 40 | 14 | 25.9% | 1 | 10 | 50 |
| BUNCOMBE | 204 | 164 | 40 | 19.6% | 6 | 29 | 197 |
| BURKE | 262 | 214 | 48 | 18.3% | 8 | 35 | 235 |
| CABARRUS | 282 | 212 | 70 | 24.8% | 10 | 51 | 244 |
| CALDWELL | 202 | 153 | 49 | 24.3% | 3 | 36 | 182 |
| CAMDEN | 13 | 9 | 4 | 30.8% | 0 | 3 | 13 |
| CARTERET | 112 | 80 | 32 | 28.6% | 3 | 23 | 103 |
| CASWELL | 47 | 33 | 14 | 29.8% | 0 | 10 | 40 |
| CATAWBA | 137 | 105 | 32 | 23.4% | 10 | 23 | 125 |
| CHATHAM | 44 | 41 | 3 | 6.8% | 0 | 2 | 43 |
| CHEROKEE | 130 | 106 | 24 | 18.5% | 2 | 18 | 122 |
| CHOWAN | 55 | 41 | 14 | 25.5% | 4 | 10 | 49 |
| CLAY | 46 | 39 | 7 | 15.2% | 1 | 5 | 42 |
| CLEVELAND | 102 | 88 | 14 | 13.7% | 4 | 10 | 97 |
| COLUMBUS | 198 | 160 | 38 | 19.2% | 3 | 28 | 175 |
| CRAVEN | 123 | 97 | 26 | 21.1% | 5 | 19 | 113 |
| CUMBERLAND | 164 | 120 | 44 | 26.8% | 2 | 32 | 149 |
| CURRITUCK | 24 | 17 | 7 | 29.2% | 0 | 5 | 22 |
| DARE | 8 | 4 | 4 | 50.0% | 0 | 3 | 7 |
| DAVIDSON | 80 | 62 | 18 | 22.5% | 3 | 13 | 72 |
| DAVIE | 103 | 81 | 22 | 21.4% | 5 | 16 | 94 |
| DUPLIN | 89 | 70 | 19 | 21.3% | 1 | 14 | 81 |
| DURHAM | 84 | 72 | 12 | 14.3% | 1 | 9 | 79 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| EDGECOMBE | 85 | 65 | 20 | 23.5% | 2 | 15 | 80 |
| FORSYTH | 130 | 102 | 28 | 21.5% | 4 | 21 | 117 |
| FRANKLIN | 110 | 84 | 26 | 23.6% | 1 | 19 | 100 |
| GASTON | 101 | 77 | 24 | 23.8% | 2 | 18 | 95 |
| GATES | 44 | 32 | 12 | 27.3% | 0 | 9 | 41 |
| GRAHAM | 84 | 68 | 16 | 19.0% | 4 | 12 | 79 |
| GRANVILLE | 62 | 47 | 15 | 24.2% | 0 | 11 | 58 |
| GREENE | 42 | 36 | 6 | 14.3% | 2 | 4 | 41 |
| GUILFORD | 276 | 209 | 67 | 24.3% | 16 | 49 | 257 |
| HALIFAX | 96 | 75 | 21 | 21.9% | 5 | 15 | 88 |
| HARNETT | 97 | 73 | 24 | 24.7% | 1 | 18 | 91 |
| HAYWOOD | 116 | 89 | 27 | 23.3% | 1 | 20 | 111 |
| HENDERSON | 76 | 56 | 20 | 26.3% | 7 | 15 | 71 |
| HERTFORD | 114 | 98 | 16 | 14.0% | 8 | 12 | 110 |
| HOKE | 70 | 53 | 17 | 24.3% | 4 | 12 | 63 |
| HYDE | 24 | 23 | 1 | 4.2% | 0 | 1 | 20 |
| IREDELL | 154 | 113 | 41 | 26.6% | 5 | 30 | 139 |
| JACKSON | 86 | 67 | 19 | 22.1% | 4 | 14 | 85 |
| JOHNSTON | 40 | 26 | 14 | 35.0% | 2 | 10 | 34 |
| JONES | 43 | 34 | 9 | 20.9% | 1 | 7 | 41 |
| LEE | 106 | 82 | 24 | 22.6% | 0 | 18 | 99 |
| LENOIR | 77 | 63 | 14 | 18.2% | 1 | 10 | 72 |
| LINCOLN | 78 | 57 | 21 | 26.9% | 3 | 15 | 76 |
| MACON | 75 | 51 | 24 | 32.0% | 2 | 18 | 65 |
| MADISON | 16 | 11 | 5 | 31.3% | 2 | 4 | 15 |
| MARTIN | 57 | 42 | 15 | 26.3% | 3 | 11 | 52 |
| MCDOWELL | 48 | 31 | 17 | 35.4% | 0 | 12 | 42 |
| MECKLENBURG | 424 | 338 | 86 | 20.3% | 16 | 63 | 397 |
| MITCHELL | 98 | 81 | 17 | 17.3% | 5 | 12 | 93 |
| MONTGOMERY | 34 | 32 | 2 | 5.9% | 2 | 1 | 32 |
| MOORE | 76 | 59 | 17 | 22.4% | 2 | 12 | 68 |
| NASH | 85 | 69 | 16 | 18.8% | 1 | 12 | 77 |
| NEW HANOVER | 98 | 86 | 12 | 12.2% | 4 | 9 | 96 |
| NORTHAMPTON | 61 | 50 | 11 | 18.0% | 3 | 8 | 59 |
| ONSLOW | 129 | 95 | 34 | 26.4% | 6 | 25 | 119 |
| ORANGE | 69 | 47 | 22 | 31.9% | 4 | 16 | 63 |
| PAMLICO | 49 | 38 | 11 | 22.4% | 2 | 8 | 44 |
| PASQUOTANK | 73 | 58 | 15 | 20.5% | 1 | 11 | 68 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PENDER | 136 | 112 | 24 | 17.6% | 0 | 18 | 120 |
| PERQUIMANS | 34 | 23 | 11 | 32.4% | 0 | 8 | 29 |
| PERSON | 37 | 29 | 8 | 21.6% | 0 | 6 | 35 |
| PITT | 91 | 78 | 13 | 14.3% | 2 | 10 | 87 |
| POLK | 43 | 35 | 8 | 18.6% | 1 | 6 | 41 |
| RANDOLPH | 151 | 109 | 42 | 27.8% | 5 | 31 | 136 |
| RICHMOND | 33 | 29 | 4 | 12.1% | 1 | 3 | 36 |
| ROBESON | 418 | 354 | 64 | 15.3% | 8 | 47 | 395 |
| ROCKINGHAM | 341 | 269 | 72 | 21.1% | 20 | 53 | 322 |
| ROWAN | 157 | 120 | 37 | 23.6% | 4 | 27 | 140 |
| RUTHERFORD | 62 | 45 | 17 | 27.4% | 9 | 12 | 60 |
| SAMPSON | 37 | 26 | 11 | 29.7% | 1 | 8 | 34 |
| SCOTLAND | 108 | 84 | 24 | 22.2% | 2 | 18 | 99 |
| STANLY | 76 | 56 | 20 | 26.3% | 1 | 15 | 70 |
| STOKES | 72 | 58 | 14 | 19.4% | 0 | 10 | 62 |
| SURRY | 134 | 104 | 30 | 22.4% | 3 | 22 | 127 |
| SWAIN | 76 | 59 | 17 | 22.4% | 3 | 12 | 66 |
| TRANSYLVANIA | 47 | 35 | 12 | 25.5% | 3 | 9 | 45 |
| TYRRELL | 13 | 10 | 3 | 23.1% | 0 | 2 | 10 |
| UNION | 67 | 52 | 15 | 22.4% | 7 | 11 | 59 |
| VANCE | 25 | 19 | 6 | 24.0% | 1 | 4 | 22 |
| WAKE | 321 | 251 | 70 | 21.8% | 7 | 51 | 281 |
| WARREN | 19 | 17 | 2 | 10.5% | 0 | 1 | 18 |
| WASHINGTON | 60 | 48 | 12 | 20.0% | 1 | 9 | 55 |
| WATAUGA | 72 | 59 | 13 | 18.1% | 6 | 10 | 70 |
| WAYNE | 35 | 25 | 10 | 28.6% | 0 | 7 | 34 |
| WILKES | 168 | 126 | 42 | 25.0% | 9 | 31 | 158 |
| WILSON | 113 | 85 | 28 | 24.8% | 6 | 21 | 111 |
| YADKIN | 90 | 81 | 9 | 10.0% | 4 | 7 | 89 |
| YANCEY | 78 | 64 | 14 | 17.9% | 3 | 10 | 68 |

# APPENDIX E

## Resources for Assistance with Prescription Drugs

Prepared by N.C. Division of Aging

If you qualify for **Medicaid**, prescription drugs are covered under this program. Contact your county department of social services, the agency in your county that determines eligibility for Medicaid, about this program.

If you are hospitalized, **Medicare** will cover drugs furnished by the hospital during your stay. Medicare does not cover most outpatient prescription drugs. Congress is currently debating legislation which, if passed, would create a prescription drug program for seniors on Medicare.

On December 13, 2001, the **North Carolina Health and Wellness Trust Fund Commission** voted to utilize $32 million in tobacco settlement funds to start a prescription drug assistance program for persons 65 and older who have income below 200% of the federal poverty level ($17,720 for an individual and $23,880 for a couple) and do not have third party insurance. This program called North Carolina Senior Care began in November of 2002 and will pay 60% of the cost of prescription drugs up to a maximum of $1,000 in drugs each year for cardio-vascular disease, diabetes mellitus, and chronic obstructive pulmonary disease. Persons interested in receiving more information about the program can call 1-866-226-1388. The Trust Fund Commission also voted to use $3 million in settlement funds for medication education and counseling programs for seniors. These medication management programs will begin in January of 2003.

Numerous communities in our state have developed **local prescription drug assistance programs**. These programs generally rely on donated samples of medications or on contributions from local sources to purchase prescriptions. Contact your local aging agency, health department or department of social services to find out if such a program is available in your county.

Many of the **pharmaceutical manufacturing companies** have developed **patient assistance programs** whereby they make certain prescription drugs available in limited quantities to those who can not afford to pay for them. The pharmaceutical companies generally work through local doctors to administer these programs. Talk with your doctors to see if any of the drugs you take are covered under such a program and if the doctors can assist you in getting medicine through these assistance programs. There are currently several programs available through the Internet which can provide information about drugs covered under the manufacturers' patient assistance programs and can assist in providing form letters to present to your doctors to aid in receiving assistance.

In the last few months, several of the manufacturing companies have expanded their assistance program efforts by developing **senior prescription drug discount card programs**.

Eligibility for these programs and the discount available varies (25% to 40% savings off retail drug cost to a flat cost of $12 per prescription) from one manufacturer to another. Manufacturers known to have discount card programs are listed:

| Manufacturer | Name of Discount Card Program | Number to Call for Information or Application |
|---|---|---|
| GlaxoSmithKline | **Orange Card** | 1-888-672-6436 |
| Novartis | **Care Card** | 1-866-974-2273 |
| Pfizer | **Share Card** | 1-800-717-6005 |
| Eli Lilly | **LillyAnswers Card** | 1-877-795-4559 |

Several drug companies (Abbott, Astro Zeneca, Aventis, Britol-Myers-Squibb, GlaxoSmithKline, Janssen, Novartis, and Ortho-McNeil) have joined together to offer a joint discount card called **Together Rx**. The toll free number to call for information about this card is 1-800-865-7211.

Military retirees who have served at least 20 years are eligible for free or low-cost prescriptions with a small co-pay (as are their dependents) through the **TRICARE for Life** program. Retirees must be registered with the Defense Enrollment Eligibility Reporting System to participate. Contact TRICARE at 1-877-363-6337 or www.tricare.osd.mil for information.

The **Veterans Administration** (VA) provides a prescription benefit to veterans who are enrolled with the VA, seen by a VA doctor and receive prescriptions from VA hospitals or pharmacies. Contact the VA at 1-877-222-8387 or www.va.gov for information.

Some persons with large prescription bills save on their costs by **shopping around** for the best price. There is great variance in what the same prescription costs at pharmacies. Many people also save by switching to a **generic brand** of a drug when possible. Another cost saving strategy that is utilized by some persons is to purchase prescriptions, particularly drugs that do not change in strength or frequency, from **mail order companies**.

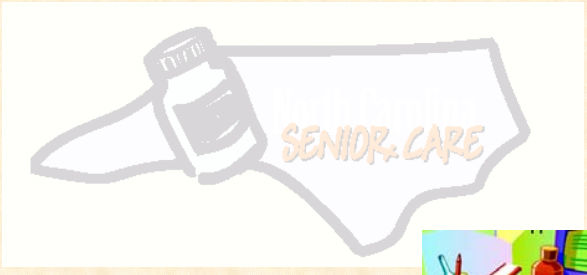
Some of the **Medicare supplement policies** that are on the market have prescription drug benefits. The premiums for these policies are generally higher than for policies without a prescription benefit, however, some people with large drug bills save by having a supplement policy with a prescription benefit. The Seniors' Health Insurance Information Program (SHIIP) in the N.C. Department of Insurance (1-800-443-9354) can provide information about Medicare supplement policies.

**Managed care plans** or **preferred provider organization plans** sometimes cover some prescription drug costs as a part of their benefits package. The SHIIP program can also provide information about managed care plans that offer prescription benefits.

# APPENDIX F

# NORTH CAROLINA

# SENIOR CARE




November 19, 2002

NC Study Commission on Aging Presentation

# ELIGIBILITY QUALIFICATIONS:

## You Qualify for Senior Care if you are:

65 years of age or older
**AND**
A resident of North Carolina
**AND**
Your annual household income during 2001 was **$17,180** or less if you are single or widowed or **$23,220** or less if you are married.
**AND**
You have no other prescription drug insurance including Medicaid.
**AND**
You have a need for prescription drugs for the treatment of the following illnesses:

- Angina (Chest Pain)
- Arrhythmia (Irregular Heart Beat)
- Asthma
- Bronchitis
- Diabetes mellitus (High Blood Sugar)
- Emphysema
- Heart failure
- Hyperlipidemia (High Cholesterol)
- Hypertension (High Blood Pressure)

# How does Senior Care work?

- Traditional drug benefit program

- Program pays for sixty percent (60%) of the first $1,000 (i.e., up to $600 per year State expenditure) of the cost for prescription drugs and insulin for the treatment of cardiovascular disease, chronic obstructive pulmonary disease and/or diabetes

- Program members pay the remaining forty percent (40%) of the cost for covered drugs, along with a per-prescription service fee of $6.00

# COVERED DRUGS:

- Drugs that require a prescription (including all insulins)
- Drugs that are for outpatient use
- Drugs that are specific treatments for the following disease states (applicants must certify that they have one of the following disease states to qualify for the plan):
  - Diabetes Mellitus
  - Heart Failure
  - Emphysema
  - Bronchitis
  - Asthma
  - Hypertension
  - Hyperlipidemia
  - Angina
  - Arrhythmia

# 2002 Senior Care Income Guidelines:

Seniors must report their income in Section 2 of the application. "Income" includes total annual household income from 2001 (both taxable and nontaxable).

| Marital Status | Income must be below: |
|---|---|
| Single | $ 17,180 |
| Married* | $ 23,220 |

*Married applicants MUST include their spouse's income…

# KEY DATES

- **September 25: Program website www.ncseniorcare.com available**
- **September 30: Toll-free hotline 1-866-226-1388 staffed**
- **October 1: Applications available at local pharmacies, aging agencies, departments of public health, departments of social services, hospitals and community health centers throughout the state; online at www.ncseniorcare.com; and by request from the Senior Care hotline at 1-866-226-1388**
- **November 1: Benefits begin for accepted seniors; initial drug claims processed**

## Internet Access to Senior Care

- Program information
- FAQ's
- "What's New"
- Send email with questions
- Fill out application online and print out for mailing

* Website available Sept. 25th
* Applications available online October 1st

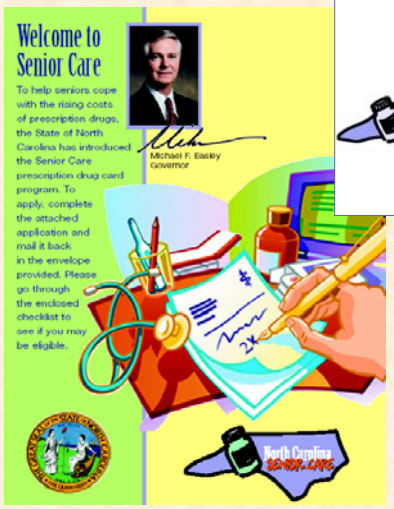
**http://www.ncseniorcare.com**

## Senior Care and Free or Discount Drug Programs

Manufacturers' free drug programs exclude from eligibility those seniors who are eligible for a State prescription drug assistance program. Although some manufacturers have agreed to coordinate benefits with Senior Care, others will exclude Senior Care members from receiving drugs through their programs.

Given this restriction, seniors need to be carefully counseled on how to maintain their free drug eligibility. The Senior Care application includes a question as to whether the senior is currently receiving drugs through a free drug program. Senior Care Program representatives will attempt to call and advise those seniors who affirmatively answer this question of their coverage options before deeming them eligible for Senior Care.

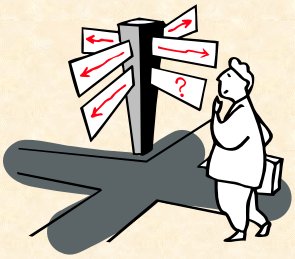
## COMPLETING THE APPLICATION AND HEALTH QUESTIONNAIRE…





Each pre-printed color application brochure packet comes with a postage-paid return envelope.

## Where can seniors get help with their applications?



Call Senior Care toll-free at **1-866-226-1388!**

In addition, as of January 1st, 2003, Medication Management Centers across the state will be available to serve seniors who need face-to-face assistance.

## Medication Management Centers

MMC's are being established throughout the state to assist seniors with medication and health issues.

Beginning January 1st, 2003, they will offer "brown bag" counseling sessions during which seniors can bring in all of their current medications and receive advice on proper medication use, including such topics as what medications may be potentially dangerous if used together.

Seniors will be referred to MMC's if their answers on the Health Questionnaire suggest potential instances of misuse or drug interactions.

## Medication Management Centers

- Will provide medication evaluation by an on-site pharmacist
- Will provide assistance in accessing free drugs programs using the services of an on-site Prescription Assistance Coordinator
- Overall technical assistance provided through a Health and Wellness Trust Commission agreement with the Office of Rural Health
- Training provided for the pharmacists through a Health and Wellness Trust Commission agreement with AHEC
- Software for both medication evaluation and prescription assistance provided by ORH

# NC Senior Care
# Medication Management Centers By County

| Name of Organization | Counties Served |
|---|---|
| Alamance Regional Medical Center | Alamance, Caswell |
| Bladen HealthWatch | Bladen |
| Caldwell Senior Center | Caldwell |
| Cape Fear Council of Government AAA | New Hanover, Brunswick, Columbus, Pender |
| Cherokee County Health Department | Cherokee, Clay, Graham |
| Cumberland County Hospital System, Inc. | Cumberland |
| Eastern Carolina Council AAA | Carteret, Duplin, Greene, Lenoir, Craven, Onslow, Pamlico, Jones, Wayne |
| Gaston Family Health Center | Gaston, Lincoln |
| Guilford County Health Department | Guilford |
| Isothermal Planning AAA | Rutherford, Cleveland, Polk, McDowell |
| Lumber River Council of Governments | Robeson, Bladen, Hoke, Richmond and Scotland |
| Martin-Tyrrell-Washington District Health Department | Washington, Martin, Tyrrell |
| MedAssist | Mecklenburg |
| Mid-East Commission AAA | Beaufort, Bertie, Hertford and Pitt |
| Mission St. Joseph | Buncombe, Madison, Yancey, Mitchell |
| NC Commission of Indian Affairs | Bladen, Columbus, Cumberland, Harnett, Hoke, Sampson |
| Piedmont Triad Council of Government AAA | Montgomery, Randolph |
| Resources for Seniors, Inc. | Wake, Franklin, Johnston, Lee |
| Rural Health Group, Inc. | Halifax, Northampton |
| Senior PHARMAssist, Inc. | Durham |
| The Hunger Coalition | Ashe, Avery, Watauga |
| Wilson Community Health Center | Wilson, Nash |
| Winston-Salem Urban League* | Forsyth |
| | |

# North Carolina Senior Care Program Members by County

| County | Number of Members | County | Number of Members |
|---|---|---|---|
| Alamance | 82 | Johnston | 114 |
| Alexander | 35 | Jones | 12 |
| Alleghany | 12 | Lee | 35 |
| Anson | 18 | Lenior | 70 |
| Ashe | 34 | Lincoln | 90 |
| Avery | 11 | Macon | 15 |
| Beaufort | 34 | Madison | 3 |
| Bertie | 23 | Martin | 28 |
| Bladen | 33 | McDowell | 29 |
| Brunswick | 70 | Mecklenburg | 234 |
| Buncombe | 93 | Mitchell | 28 |
| Burke | 88 | Montgomery | 23 |
| Cherokee | 1 | Moore | 71 |
| Cabarrus | 115 | Nash | 109 |
| Caldwell | 85 | New Hanover | 150 |
| Camden | 3 | Northampton | 38 |
| Carteret | 20 | Onslow | 43 |
| Caswell | 15 | Orange | 19 |
| Catawba | 147 | Pamlico | 13 |
| Chatham | 48 | Pasquotank | 9 |
| Cherokee | 22 | Pender | 40 |
| Chown | 11 | Perquimans | 7 |
| Clay | 29 | Person | 31 |
| Cleveland | 87 | Pitt | 68 |
| Columbus | 87 | Polk | 8 |
| Craven | 70 | Randolph | 125 |
| Cumberland | 77 | Richmond | 18 |
| Currituck | 10 | Robeson | 64 |
| Dare | 5 | Rockingham | 111 |
| Davidson | 147 | Rowan | 125 |
| Davie | 19 | Rutherford | 42 |
| Duplin | 80 | Sampson | 117 |
| Durham | 48 | Scotland | 26 |
| Edgecombe | 61 | Stanly | 69 |
| Forsyth | 132 | Stokes | 42 |
| Franklin | 41 | Surry | 98 |
| Gaston | 210 | Swain | 4 |
| Gates | 8 | Transylvania | 4 |
| Graham | 5 | Tyrrell | 2 |
| Granville | 54 | Union | 72 |
| Greene | 9 | Vance | 29 |
| Guilford | 214 | Wake | 231 |
| Halifax | 85 | Warren | 22 |
| Harnett | 79 | Washington | 8 |
| Haywood | 29 | Watauga | 17 |
| Henderson | 35 | Wayne | 98 |
| Hertford | 15 | Wilkes | 63 |
| Hoke | 27 | Wilson | 51 |
| Hyde | 5 | Yadkin | 43 |
| Iredell | 83 | Yancey | 10 |
| Jackson | 5 | Z-Other | 144 |

***As of 11/21/02***

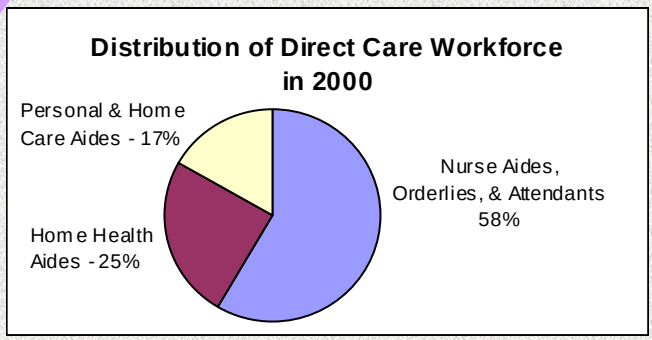
# APPENDIX G

Direct Care Workers

Challenging Careers, Compassionate Hearts

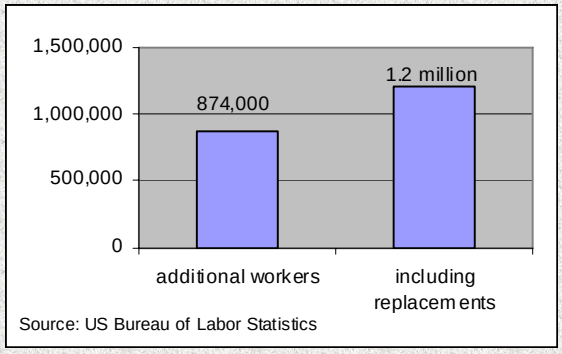
## Why is this Workforce a Public Policy Issue?

- LTC major financial investment for states
- Direct care workers backbone of LTC system (many places)
- Serious shortages already exist
- Aging boomers will increase demand



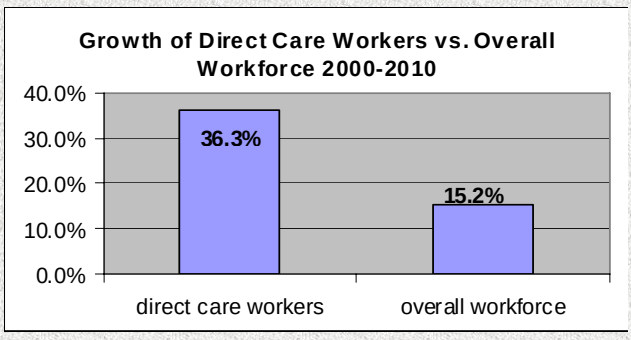

Source: US Bureau of Labor Statistics

## Projected Growth of the Direct Care Workforce 2000 - 2010




Source: US Bureau of Labor Statistics

## Another Point to Consider




Source: US Bureau of Labor Statistics

## Impact of Economic Downturn on State Initiatives

- 86% of states said shortages still a major issue
- 11 states reported changes to programs/initiatives
- 2 other states said 1 or more initiatives in jeopardy of change

## NC Wage Comparison -- 2000

| Category | Median Hrly. | Annualized |
|---|---|---|
| dental assts. | $12.84 | $26,707 |
| manicurists | $10.40 | $21,632 |
| school bus dr. | $ 9.79 | $20,363 |
| file clerks | $ 9.04 | $18,803 |
| hairdressers | $ 8.53 | $17,742 |
| **direct care** | **$ 7.86** | **$16, 349** |

Source: Bureau of Labor Statistics

## Wages, Turnover & Stability

- **Turnover rates**

| | 2000 | 2001 |
|---|---|---|
| NH | 100% | 102% |
| ACH | 119% | 113% |
| HC | 50% | 50% |

- **Wages**

| | 1998 | | 2001 | |
|---|---|---|---|---|
| Active NA's | $11,358 | (1.89) | $12,877 | (2.30) |
| Inactive NA's | $14,425 | (1.05) | $17,359 | (1.95) |

## So, What are States Doing?

## Major Areas of State Action

- Wages/benefits
- Training & Career Ladders
- Task Forces & Commissions
- Recognition/Public Education, Awareness
- data collection/data analysis
- staffing ratios

## Wages & Benefits

- Wage Pass Throughs
- Reimbursement increases
- Quality of Care incentive payments
- State established shift differentials --for hard to staff shifts
- Access to health insurance coverage
- Incentives to address retention

## Training & Career Ladders

- Develop new job categories
- Expanded scope of duties
- Add- on training to move to new level
- Standardize job training/competency requirements for similar workers
- scholarships, grants, loan forgiveness, etc.

## Task Forces & Commissions

- 35 states known to have established a task force or commission
- 17 of the 35 states have issued a report

## Recognition, Public Education & Awareness

- Statewide direct care worker associations being formed
- Recruitment efforts

## What Else is Changing?

- More data collection/analysis being done
- More routine collection of turnover data using uniform methodology
- More consumer directed care

## NC Initiatives and Goals

CATEGORIES

- Career ladder dev.
- Financial Incentives
- Public Education and Awareness
- Recruitment/Retention
- Data collection/analysis
- Consumer directed care

GOALS

- Improve jobs and reduce turnover
- Broaden pool of potential workers
- Enhance public appreciation of this workforce

## Providers Must Do their Part too (and they are)

Some Examples

- Addressing "corporate culture" issues
- Access to Health Insurance coverage
- Supporting career ladder opportunities
- developing in-house "temp" staff capacity
- assuring full-time work for home care

## Conclusion

- It's not just a money issue
- Most states taking action
- Need to track and evaluate range of state efforts for effectiveness
- **NC has a blue print for action and is proceeding on some fronts in spite of state budget situation. (IOM Report)**

# APPENDIX H

# Temporary Management of Nursing Homes: Summary of AARP-Commissioned Issue Paper

**Publication Title and Author:** "Termination and Closure of Poor Quality Nursing Homes: What Are the Options?" by Erica F. Wood, Associate Staff Director, of the American Bar Association Commission on Legal Problems of the Elderly. The issue paper was commissioned by the Long-Term Care and Independent Living Team of the Public Policy Institute of AARP and was published in March of 2002. Additional Copies of the report are available at no cost from the AARP Public Policy Institute by contacting 202-434-3860.

**Study Objective:** The paper profiles seven (out of 33) facilities throughout the country that were involuntarily terminated from participation in the Medicare/Medicaid program and then closed between 1997 and 2000. It explores what led to termination, how termination might have been avoided, and the consequences for the residents. In addition, it makes recommendations concerning the use of temporary management, receivership, and other sanctions, as well as steps to mitigate the harm in transferring residents. This presentation focuses on the use of temporary management.

**Definition and Authority:** The federal Nursing Home Reform Act mandates sanctions when nursing homes fail to provide care that complies with federal standards. Temporary management is one of several Federal intermediate sanctions available for nursing home enforcement. "Intermediate sanctions" is a term used to describe a range of remedies between the extremes of termination to passively permitting poor care to continue. Federal law provides for appointment of a temporary manager "to oversee the operation of the facility and to assure the health and safety of the facility's residents: while (1) a facility is being closed; or (2) changes are being made to bring the facility into compliance." Temporary management is a creation of both federal and state law. For Medicare-certified facilities, the state survey agency recommends, and the Centers for Medicare and Medicaid Services (CMS) regional office imposes, a temporary manager. For Medicaid-only facilities, the state Medicaid agency imposes a temporary manager. CMS requires each state to compile a list of individuals who are eligible to serve as temporary managers. These lists primarily consist of current or former facility administrators and, occasionally, nurses. In practice, temporary management seems to be a fluid term covering a wide range of interventions. For example, it may be voluntary or involuntary. A facility may choose to hire a consultant to help improve compliance and may call the consultant a temporary manger. On the other hand, CMS or a state agency may impose a temporary manger as part of a settlement agreement; or may petition a court to impose the sanction. **See p.p. 25-27**

* At the time of the publication of this paper, the Health Care Financing Administration (HCFA) had not yet changed its name to the Centers of Medicare and Medicaid Services so HCFA references appear in the actual report.

**State Laws:** Many states have enacted temporary management provisions. The only state statute found, based on research via Westlaw, that mandates the use of temporary management is the state of Alaska. **See handout entitled, Temporary Management- State Statutory Provisions**.

**Frequency of Use:** Most cases of temporary management in the last two years were voluntary and the estimated total (federal and state) was about 25 to 30 cases. Michigan has used the remedy more than other states through its Collaborative Remediation Project (Project). The

Project was not created by statute, but as part of the State's Nursing Home Resident Protection Initiative (Initiative). The Michigan Department of Consumer & Industry Services (MDCIS) introduced the Initiative after more than six months of collaboration with representatives from all aspects of the State's nursing home industry and various advocates. MDCIS, along with the Michigan Public Health Institute (MPHI), created the Collaborative Remediation Project as a component of the Initiative. The Project assists long term care providers in the achievement and maintenance of compliance with licensure and certification requirements. When MDCIS identifies a facility in trouble, it often chooses to refer the facility for remediation instead of imposing other enforcement remedies. As a result, the Project has dramatically reduced the number of civil monetary penalties. Through the Project, remediators would enter into a contract with the facility to provide directed in-service trainings, coordinate a directed plan of correction, or serve as clinical advisors or temporary managers. The State has imposed 10 temporary managers, 16 clinical advisors, and 3 administrative advisors between 1997 and 1999. **See http://www.mphi.org/ltc.aspx**, the Center for Long Term Care of the Michigan Public Health Institute website for more information.

**Barriers to Temporary Management:** The paper identifies several barriers to explain the minimal use of temporary management including:

- Lack of funds: Resources must be available to pay for the temporary manager's salary and to allow the temporary manager to hire staff, make any structural improvements, and pay for supplies and any staff training. The facility may be failing financially and may not have available funds. **See p.p. 30-31**
- Divergent views on operational authority: Federal guidelines require complete relinquishment of financial and operational control to the temporary manger, but state temporary management sanctions may not require such a complete transfer of control. When the temporary manager does not have complete control and he or she and the administrator have different goals and management approaches, a difficult situation may result, particularly for staff of the facility. **See p.31**
- No clear triggers: Federal and state regulators express uncertainty about when to use this remedy. **See p. 32**
- Lack of experience: Temporary management is a vague and ill-defined remedy that works differently in different states and different federal regions. No one knows what to expect from this remedy. **See p.p. 32-33**
- Lack of qualified candidates available to quickly serve as temporary managers. **See p. 33**
- Lack of judicial understanding: Obtaining court approval of temporary management can be difficult. **See p. 33**
- Regulatory confusion: The report identifies numerous areas in which regulatory decision-making on temporary management may need to be clarified or strengthened. **See p.p. 33-34**

# APPENDIX I

**Report to the North Carolina Study Commission on Aging on Designating Local Lead Agencies to Lead a Local Long-Term Care Planning Process**

**Legislative Request:** At the recommendation of the Legislative Study Commission on Aging, which became Section 22.1 of S.B. 166 (H.B. 161), the Department of Health and Human Services, Division of Aging, was directed to study whether counties should designate local lead agencies to organize a local long-term care (LTC) planning process, as described in Recommendation #10 of the Institute of Medicine's (IOM) Long Term Care Task Force Interim Report of June 30, 2000 (Recommendation #16 in the Institute's final report in January 2001). Further, the Department was to consider how a lead agency for local LTC planning would relate to other requirements for county planning and LTC, specifically addressing the IOM Task Force recommendation pertaining to local planning and LTC services. The study is due to the North Carolina Study Commission on Aging before the convening of the 2003 General Assembly.

**Background:** The primary impetus for the Legislative Study Commission's recommendation and S.B. 166 was the NC Institute of Medicine's *Long-Term Care Plan for North Carolina* and specifically recommendation #16 in the Institute's *Final Report*. The Institute's Task Force on Long-Term Care recommended that "the General Assembly should encourage county commissioners to designate a lead agency to organize a local LTC planning process at the county or regional level." Recommendation #16 specifies that local LTC planning initiatives should include 18 stakeholder groups with interests in the LTC system for older and disabled adults. In addition, the Task Force suggested that local planning processes should be required to (1) review and analyze service utilization data through county data packages; (2) track the flow of consumers from referral to disposition through core service agencies; (3) identify barriers to a comprehensive system of care and services; (4) determine how to design a uniform portal of entry; (5) determine the need for additional core LTC services; and (6) communicate findings to local, state, and federal policymakers. While the Task Force did not specifically recommend funding for local planning, it did set as priorities funding of counties for "transition support" and capacity-building" to support them in implementing the Task Force's recommendations and in making needed system improvements.

Soon after the *Final Report* was released, the Robert Wood Johnson Foundation introduced its Community Partnerships for Older Adults Program, which is designed to help communities develop and sustain comprehensive LTC planning bodies and supportive service systems to meet the needs of their vulnerable older adult populations. This grant program emphasizes planning for LTC at the local level, and 21 communities in North Carolina applied to the Foundation for funding. While none of North Carolina's applicants were funded during the initial 2001 grant cycle, their efforts showed that many communities in North Carolina see the need for and resulting benefits of local planning for LTC.

**Approach:** To conduct the requested study, the Division of Aging completed the following activities:

1. **Researched current activities at the local level related to planning for older and disabled adults:** In February 2002, the Division of Aging contacted representatives from state agencies to learn more about the required and voluntary planning activities counties and regions currently undertake based on state and/or federal programs and policies. The

responding State agencies included: the Division of Medical Assistance CAP-DA unit, the Division of Services for the Deaf and Hard of Hearing, the Division of Services for the Blind, the Division of Mental Health/Developmental Disabilities/Substance Abuse Services, the Council on Developmental Disabilities, the Division of Social Services, the Division of Public Health (and the Healthy Carolinians organization), and the Division of Vocational Rehabilitation Services. In addition, groups such as the NC Association of Area Agencies on Aging and the Governor's Advisory Council on Aging were asked to provide input on other types of planning being conducted in counties across the state (Appendix D offers a summary of local planning entities). This research led the Division to believe that it was important to develop a conceptual framework that would better integrate existing planning activities in a way that is consistent with the Institute of Medicine Task Force's recommendation.

2. **Developed a local LTC planning proposal:** The Division of Aging has developed a concept paper for local LTC planning that is based on Recommendation #16 of the Institute of Medicine's Final Report and on input received from various groups and individuals (please see Appendix A for a copy of the grant proposal submitted to the US Assistant Secretary for Planning and Evaluation's State Innovations grant program, which explains the concept in detail, and Appendix B for a letter of support from the NC Association of County Commissioners). The Division sought funding for the proposal from the Assistant Secretary for Planning and Evaluation's State Innovations grant program. The project is called "*A Communications and Planning Network to Support Families in Their LTC Roles*" and will connect state and local interests committed to LTC planning and reform. The goals of the Network include:

    1. supporting local planning for LTC and its role in accomplishing many of the recommendations outlined in the Institute of Medicine's final report;
    2. learning more about the availability and capacity of LTC core services and client outcomes (at the local level);
    3. facilitating a continuous dialogue and information exchange between the state and communities interested in LTC planning; and
    4. informing and inspiring a joint commitment to action between the local and the state levels to improve the current LTC system.

    The proposed project blends the interests and needs of diverse population groups and governmental units. Many entities will contribute to organizing and implementing the *Communications and Planning Network* in participating counties, including local lead agents and planning teams, a new State Team, and the LTC Cabinet composed of directors of all affected DHHS divisions. The Division of Aging expects to work with two or three counties or multi-county regions in the first year of the project, with additional counties participating in subsequent years. It anticipates that county or regional entities could serve as lead agents. To be considered for participation, interested counties/regions will submit a Statement of Interest and an endorsement letter from their County Commissioners. Participating counties will be selected by the State Team.

    The *Communications and Planning Network* has been favorably reviewed by a diverse set of stakeholders. The proposed project has been presented to the LTC Cabinet, the Governor's Advisory Council on Aging, the DSS Adult Services Committee, and to a group at the NC

Conference on Aging. The project was also discussed with State and regional DSS personnel and at a meeting of the NC Association of Area Agencies on Aging. Lynda McDaniel, Assistant Secretary for LTC and Family Services, distributed a copy of the ASPE grant proposal to various groups in November 2002 and asked for comments on the *Communications and Planning Network* (please see Appendix C for a summary of the comments received). The proposal continues to be refined based on input from interested groups and individuals.

**Major Findings:**

1. **Concurrent health and human services planning is occurring at the local level.** In North Carolina, counties already have established infrastructures for planning efforts, but these efforts are typically segmented. A variety of planning bodies responsible for different aspects of LTC services for older and disabled adults are found in counties throughout the state (see Appendix D for a description of these various local planning efforts). Each of these planning bodies works under different LTC funding streams. While some local planning bodies work well together to accomplish similar goals as well as specific projects, planning at the local level is generally not well coordinated. A few counties and regions have begun integrating planning efforts with some success. Still, most local planning bodies concentrate primarily on their specific areas of responsibility, and thus no planning body is coordinating the "big picture" of local LTC services, which can result in duplication of efforts and services as well as ineffective resource utilization and fragmentation for consumers.
2. **Counties are continually facing increasing needs.** Local communities are being asked to do "more with less" as the older and disabled adult populations increase while at the same time the service budgets remain constant or, sometimes, decrease. Depending on the county's size, it is now spending hundreds of thousands, if not millions, of dollars on LTC. The escalating public cost of LTC is a serious concern. It is essential that counties understand all aspects of their local systems for LTC and have effective and coordinated strategies for tackling barriers to appropriate, quality, and cost-effective care that supports individuals and families in making choices. Effective local planning efforts will help counties address these major service system issues.
3. **There is a lack of information related to local planning for LTC.** There are few places where counties can go to get useful and detailed information for developing local LTC planning processes that cut across population groups and health and social service programs. Counties in North Carolina need a comprehensive, coherent, and accessible resource for information on developing LTC planning processes, consolidating existing planning processes for efficiency, conducting a needs assessment, creating strategic plans, and sharing innovative strategies for tackling common LTC issues.
4. **Effective local planning does require leadership and the commitment of resources.** Previous experience with local human services planning shows that counties must be prepared to commit the time and resources necessary to support an inclusive, comprehensive and analytical process necessary for systems change. The process also requires accountable leadership. Even without a special funding stream to support local planning, with local will and leadership, some counties and regions have developed planning initiatives that have been quite successful.

**Principal Conclusions**

1. **Counties should be encouraged, rather than required, to designate local lead agencies to organize a local LTC planning process.** Mandating counties to designate local lead agencies to organize a local LTC planning process without any new funding would likely be counterproductive. Counties must be ready and eager to undertake LTC planning processes in order for their efforts to be useful and effective. Requiring counties who are not ready to begin this process, or who do not have adequate resources to put towards the process, will likely result in resentment and wasted resources and time as well as inadequate planning results. However, designation of a local lead agent(s) that would coordinate a LTC planning process should be strongly encouraged in order to help those counties that are ready to begin the process to realize the benefits related to planning at the local level. In addition, state agencies and policies must provide support and technical assistance to counties that are interested and ready to begin the process. These communities that move forward with local LTC planning can serve as mentors for other communities.
2. **Any efforts to promote lead agencies and local LTC planning should take into account the existing infrastructure for planning already present in counties across the state.** Counties will likely be more responsive to building on existing activities rather than developing completely new planning bodies that do not take into account or assist with other mandated planning activities (such as CAP-DA, HCCBG, and DSS planning bodies). Many state agencies require local advisory/planning committees. State agencies must support the idea that a multi-purpose LTC planning process can serve as the required advisory/planning committee for various specific programs. In addition, flexibility and innovation at the state level may be necessary to tackle any "roadblocks" in state policy that impose restrictions on planning at the local level. The Network's State Team and the LTC Cabinet will have important roles in examining how best to integrate relevant planning activities in support of local LTC planning.
3. **The Division of Aging should work with the LTC Cabinet to implement the *Communications and Planning Network to Support Families in Their LTC Roles*.** The Network must be implemented on a strictly voluntary basis in counties who have indicated a strong interest in participating. The proposed Network will give interested counties the structure and technical assistance necessary to implement effective planning processes. The LTC Cabinet's role in the Network is vital to the success of the project. The LTC Cabinet will provide direction and assistance with policy issues related to developing comprehensive LTC systems in the counties. The LTC Cabinet will also provide guidance on accomplishing the goals and outcomes of the project and help resolve state policy and program barriers.
4. **The possibility of providing State funding to counties to designate local lead agencies and undertake LTC planning processes should be considered in the future, when the timing is right.** While the Division of Aging proposes to initiate the *Communications and Planning Network* with volunteer counties, it will continue to pursue grants and other sources of support to aid local efforts and facilitate participation by the State Team. The Department will also encourage and support counties in their pursuit of funds for planning and development activities. The LTC Cabinet will further support participating counties by giving them special consideration for future initiatives and grants as they become available.

# Appendix A:
# The Division of Aging's Proposal to the Assistant Secretary for Planning and Evaluation's (ASPE) State Innovations Grant Program

## A. Abstract

The Division of Aging (DOA), North Carolina Department of Health and Human Services (NC DHHS), is requesting $45,000 in funding under Track 2 of the DHHS ASPE State Innovation grant program to plan and implement a *Communications and Planning Network to Support Families in Their Long Term Care Roles (the Network).* Demonstrating the importance of this initiative, the NC DHHS Assistant Secretary for Long Term Care and Family Services will commit 5% ($5,000) of her time to the project. The Network is comprised of four major groups:

1. Two local planning teams led by a lead agent(s): Two communities will be selected via an RFP procedure to implement a local, multi-disciplinary and collaborative long term care (LTC) planning process and communicate extensively with the State Team (below);
2. The NC Division of Aging: NC DOA will manage and facilitate the project. NC DOA will provide hands-on technical assistance to the two pilot communities as well as coordinate the activities of the State Team;
3. The State Team: A State Team will be developed, with representatives from all NC DHHS Divisions and other offices with LTC responsibilities and/or interests, consumers, advocacy groups, and other stakeholders. The State Team will interact on a regular basis with the local planning teams to address policy and programmatic issues acting as barriers to a comprehensive and coordinated LTC system;
4. The NC Long-Term Care Cabinet: The Long-Term Care Cabinet, composed of directors of relevant NC DHHS Divisions and chaired by the Assistant Secretary for Long Term Care and Family Services, will provide overall policy direction and support to the project.

In this initial innovative phase, the Network will:

1. Develop local LTC planning processes in two pilot communities that can be replicated in other communities;
2. Complete a core LTC services evaluation in the pilot communities. The core LTC service evaluation will assess the availability, adequacy, accessibility, efficiency, effectiveness, equity, and quality of core LTC services. After the core service evaluation, both communities will develop a strategic plan to reform their local LTC system; and
3. Develop a mechanism to enhance communication between state and local interests to tackle common barriers and policy issues related to LTC reform.

The Network will help identify and initiate strategies to strengthen LTC services for older and disabled adults in two pilot communities and will create a model for increased communication between state and local interests. This project is consistent with the NC DHHS 2001 North Carolina Long Term Care and Olmstead Plans and the expressed goals of the State's General Assembly and the NC Association of County Commissioners. Results of the project, as well as planning tools and resources created for use during the project, will be available to any community or state interested in developing a local LTC planning process and communication mechanisms to address issues and barriers in their LTC systems. All parties to the NC project will actively participate in all State Innovation process evaluation activities, under the direction of and with assistance from HHS and its contractor, provide any needed data to HHS and its contractor, and field test process evaluation strategies over the course of the project.

## B. Goals, Objectives, and Usefulness of the Project

**Problem Statement:** In North Carolina, as in many other states, there are a variety of barriers to a coordinated long-term care (LTC) system. Effective local planning for LTC services as well as cooperation and collaborative problem-solving between local and state interests are essential to developing a client-centered, coordinated, and efficient LTC system. The NC Institute of Medicine's Task Force on LTC recognized the importance of local planning for LTC in its report to the NC Department of Health and Human Services in January 2001. One of the Task Force's recommendations calls on the General Assembly to "encourage county commissioners to designate a lead agency to organize a local LTC planning process at the county or regional level."[1] In addition, in NC Senate Bill 166, the State General Assembly mandated that the Division of Aging study whether counties should designate local lead agencies to organize LTC planning processes. Among the challenges that states and local communities currently face related to planning for LTC are:

- ***Disjointed health and human services planning at the local level:*** In North Carolina, a variety of planning bodies responsible for different aspects of LTC services for older and disabled adults are found in all 100 counties, including CAP-DA Boards (one of NC's Medicaid waiver programs), Social Service Boards, Area Mental Health/Developmental Disabilities/Substance Abuse Boards, and aging planning bodies (primarily responsible for allocation of Older Americans Act funds). In addition, many counties have Healthy Carolinians Task Forces and Mayors' and Local Committees for People with Disabilities. Each of these planning bodies works under different LTC funding sources. While some local planning bodies work well together to accomplish similar goals, planning at the local level is by no means coordinated. Most local planning bodies concentrate primarily on their specific areas of responsibility, and thus no planning body is coordinating the "big picture" of local LTC services, often resulting in duplication of efforts and services as well as ineffective resource utilization.
- ***Lack of an effective vehicle for communication between state agencies and local communities:*** Although much is currently done by partnerships between state agencies and local communities to address barriers and issues related to LTC, more can be done. Local communities need an accessible communication vehicle to ensure that their problems reach all appropriate state agencies and will be taken seriously and addressed cooperatively by all state Division with jurisdiction or experience in the matter. In addition, state agencies need a structured way to communicate with local communities to determine what policy and programmatic changes must be accomplished in order to create a comprehensive, coordinated, and adequate system of LTC at the local level.
- ***Increased burden on local communities:*** Local communities are being asked to do more with less as the older and disabled adult populations increase while at the same time the service budgets remain constant or, more recently, decrease. Depending on the county's size, it is now spending hundreds of thousands, if not millions, of dollars on LTC. The escalating public cost of LTC is a serious concern. It is essential that counties understand all aspects of their local systems for LTC and have effective and coordinated strategies for addressing barriers to appropriate, quality, and cost-effective care that supports individuals and families in making choices.

[1] NC Institute of Medicine, "A Long-Term Care Plan for North Carolina: Final Report," January 2001: p. 58.

- ***Lack of information related to local planning for LTC:*** There are few places where communities can go to get useful and detailed information on developing local LTC planning processes that cut across population groups and health and social services. Communities in North Carolina need a comprehensive, coherent, and accessible resource for information on developing LTC planning processes, consolidating existing planning processes for efficiency, conducting a needs assessment, creating strategic plans, and sharing innovative strategies for tackling common LTC issues.

In response to the above challenges, the NC Division of Aging, in cooperation with the State's Long Term Care Cabinet, has designed a *Communications and Planning Network to Support Families in Their Long Term Care Roles* (termed "the Network" throughout the rest of this proposal). The Network will connect state and local interests who are committed to reform of the LTC system and use, integrate, and simplify the exchange of information, ideas, and activities to create more coordinated and efficient LTC systems. An emphasis will be placed on assisting two pilot communities to develop local planning processes to analyze the current state of LTC in their community and in developing a strategic plan to resolve barriers and issues.

**Goals:** The goals of the Network are to:

1. Pilot test and replicate county planning processes designed to evaluate core LTC services and identify strengths, unmet needs, and possible opportunities for collaboration within the LTC service delivery system as well as to develop strategic plans to provide a map for reforming local LTC systems;
2. Foster innovative approaches to LTC service delivery through cooperation;
3. Link local findings to state policy bodies and inspire a joint commitment to action between the local and state levels to produce a more efficient, coordinated, and adequate LTC system; and
4. Develop a set of tools that can be used by other states and localities to implement local LTC planning processes, evaluate core LTC services, and increase communication.

**Objectives:** The objectives of the Network are to:

- Increase commitment at the state and local levels to improve the current LTC delivery system;
- Increase opportunities for local communities interested in LTC planning to learn about planning methods, interact with other sites to gain knowledge and share information, and collectively solve common problems;
- Improve communications between local communities and state;
- Increase partnerships among LTC providers at the local level;
- Increase the participation of consumers at the local level in reform of LTC;
- Increase understanding about the availability, accessibility, adequacy, quality, efficiency, equity, and effectiveness of LTC services in the two pilot communities for strengthening the local system; and
- Share knowledge within the state and nation regarding best practices, common local LTC planning elements, barriers to the planning process and delivery system, and strategies to overcome barriers to planning and service delivery at the local level.

**Usefulness of the Model:** After the grant period is complete, NC DOA will share the results of the project with all NC counties and other states. Communities with an interest in developing a LTC planning process can learn from the experiences of local communities under this grant project and use the resources and tools developed to expedite the planning process. Other states can share the project with any of their communities with an interest in LTC planning and can use the model developed under the grant to create a mechanism for increased communication between their state and local communities.

## C. Methodology and Design

The Network is designed to provide a cyclical process of information exchange, feedback, technical assistance, and the like among communities implementing local LTC planning processes, the NC Division of Aging, a State Team, and the Long-Term Care Cabinet. Below is a brief description of each group involved in the Network and their primary responsibilities:

1. ***Two Local Planning Teams Led by a Lead Agent(s):*** The NC Division of Aging (DOA) will release a Statement of Interest form to communities across the state at the beginning of the grant project. Interested communities will submit a statement of interest through their respective County Commissioners (an endorsement letter from the communities' respective County Commissioners is a requirement of the Statement of Interest) for review by the State Team. The Statement of Interest will help NC DOA and State Team members identify two counties or multi-county areas that are interested in participating in the project for at least one year and that have the infrastructure in place to develop and implement a successful local LTC planning initiative. Selected counties will have a strong interest in aging and disabled adult services, the potential for strong leadership at the local level, and a willingness to commit to accomplishing the goals and objectives of the project. Please see Appendix A for the draft Statement of Interest form.

   Local planning teams may evolve out of existing planning bodies, such as CAP-DA Boards, County Boards of Social Services, Aging Planning Groups, Healthy Carolinians Task Forces, or they may begin as a completely new county structure. However, whether a community decides to revamp an existing group or develop a new body, each planning team must include at least one representative from the following stakeholders:

   - The older and disabled adult populations;
   - Family and informal caregivers;
   - Area Agencies on Aging;
   - Faith based organizations;
   - Community leaders;
   - County Health and Social Services Departments;
   - Home and Community Care Block Grant lead agencies;
   - Hospitals;
   - Medicaid CAP-DA lead agencies;
   - Home health agencies;
   - Nursing homes;
   - Assisted living facilities;

- Adult day services;
- Group homes for people with mental illness or developmental disabilities;
- Independent living facilities;
- Advocates; and
- Local government officials.

A local agent, or agents, must lead each local planning team. The lead agent(s) has numerous responsibilities; which include coordinating the entire planning process at the local level, providing administrative support to the process and general direction to the planning team, assuring adequate representation from all stakeholder groups, retaining the momentum of the group, coordinating the collection of any needed primary data from the local level, mediating any local conflicts, providing and/or arranging for any necessary training for the planning teams, and acting as a liaison with NC DOA and the State Team. The lead agent(s) must also agree to participate in all ASPE process evaluation activities. The lead agent(s) must dedicate at least 50% of a staff person's time to manage the local planning process. When the community submits its Statement of Interest to NC DOA, the prospective lead agent(s) must sign a Statement of Commitment (please see Appendix A) that outlines its responsibilities.

2. ***NC Division of Aging (NC DOA):*** NC DOA will facilitate the project. NC DOA will have many responsibilities, including facilitating and coordinating the State Team's efforts, providing technical assistance to local planning teams, conducting training and forums for interaction (such as teleconferences and project-related information on the Department's LTC web site[2]), leading any ASPE process evaluation activities for the project, and producing and distributing data useful to local planning for LTC. Once the two local communities are chosen, NC DOA will work with the State Team to develop baseline data, including demographic information and client and service delivery profiles. NC DOA will also be responsible for developing common tools for use by the planning teams (such as a core LTC service evaluation and a "Planning Basics" notebook for lead agents), developing training as needed by local planning teams, and documenting the project. Many of these tasks will be accomplished with significant input and assistance from State Team members. Julie Bell, Steve Freedman, and Dennis Streets will be the primary project staff at NC DOA (please see Section D for background information on key personnel), although all NC DOA staff will be available to assist when issues arise that require their expertise. In addition, committees housed at NC DOA, such as the Provider Performance Review Committee (consisting of representatives of home and community based services) and the to-be-established Steering Committee for the National Family Caregiver Support Program in North Carolina may be utilized in analyzing and addressing issues.

3. ***State Team*****:** The State Team will include representatives from all NC Department of Health and Human Services' Divisions with an interest in, experience with, and/or jurisdiction over LTC programs and policies for older and disabled adults, including (in addition to Aging):

    - the NC Division of Medical Assistance;

[2] http://www.dhhs.state.nc.us/ltc/

- the NC Division of Facility Services;
- the NC Division of Social Services;
- the NC Council on Developmental Disabilities;
- the NC Division of Public Health;
- the NC Division of Mental Health/Developmental Disabilities/Substance Abuse Services;
- the NC Division of Vocational Rehabilitation;
- the NC Division of Services for the Blind;
- the NC Division of Services for the Deaf and Hard of Hearing;
- the Office of Minority Health and Health Disparities; and
- the Office of Research, Demonstrations and Rural Health Development.

The State Team will also include older and disabled consumers, family caregivers, and other stakeholder groups including the NC Alzheimer's Association, the NC Institute of Medicine, the NC County Commissioner's Association, the NC Coalition on Aging, the Governor's Advisory Council on Aging, the ARC of NC, the Association for Home and Hospice Care, the Alliance for the Mentally Ill, and various LTC facility and provider groups.

The State Team will be responsible for supporting a project focus that considers *all* aspects of a comprehensive LTC system for older and disabled adults, reacting to and analyzing LTC data and its implications for state and community planning, providing strategies to help implement changes at the local level, responding to issues and questions that affect local and state system reform efforts, participating in local mediation efforts, providing policy analysis, and acting as a liaison with the LTC Cabinet. The State Team will also participate in any relevant ASPE process evaluation activities. NC DOA will staff the State Team, which will be chaired by the DOA Director, Karen Gottovi. In addition, the State Team may appoint work teams as necessary to address specific issues.

4. ***The NC Long-Term Care Cabinet:*** The NC LTC Cabinet, composed of directors from each of the Divisions and Offices identified above, will provide direction and assistance with policy issues related to a comprehensive LTC system. The LTC Cabinet will also provide guidance on accomplishing the goals and objectives of the project. Lynda McDaniel, Assistant Secretary for LTC and Family Services, chairs the LTC Cabinet which was established in 2001 by NC DHHS Secretary Carmen Hooker Odom when she set LTC as one of her administration's top four priorities (see http://www.dhhs.state.nc.us/ltc/foard.htm).

***The Communications and Planning Network to Support Families in Their LTC Roles:*** The *Communications and Planning Network to Support Families in Their LTC Roles* depicted in Appendix B includes three major components: 1) two pilot projects to develop local LTC planning processes; 2) evaluation of core LTC services in the pilot communities; and 3) the creation of a mechanism to prompt purposeful communication between local and state interests:

1. **Pilot projects to develop local LTC planning processes:** The actual local planning process developed and implemented may vary between the two pilot communities, depending on their individual characteristics. However, both local planning teams will be required to develop and implement a structured planning process with significant technical assistance

and guidance from NC DOA and the State Team. The primary outputs of the planning processes in each of the two communities will be the completion of an evaluation of the core LTC services in their respective communities (see #2 below) and the development of a strategic plan to guide each community's efforts towards addressing barriers and creating a more coordinated and efficient LTC system. Strategic plans may include policy changes, new program development, coordination of funding streams, and system redesign that would likely require State-level actions as well. Planning teams will spend approximately seven months on the core service evaluation tool and three months developing a strategic plan. It is anticipated that the planning and implementation processes will continue long after the grant project is complete. The comprehensive LTC planning process may well reduce the need for several of the other planning bodies in the communities to meet. This consolidation will reduce duplication, increase efficiency, and promote cooperation and communication among local stakeholders.

The approaches used by the pilot projects will be shared with other localities and states (via a special section on Department's new LTC web site [http://www.dhhs.state.nc.us/ltc/] and printed evaluation materials and/or reports) so that others can learn from the experiences of the two pilot sites. In addition, NC DOA will draw from its extensive experience in planning to create a Planning Basics notebook with information for lead agents on facilitating meetings, mediating conflicts, effective communication techniques, social marketing and working with the media, and other activities/skills required to facilitate an effective planning process. The Planning Basics notebook will be available on the LTC web site.

2. **Evaluation of core LTC services in the pilot communities:** The first output from the local planning processes will be the evaluation of core LTC services in the two pilot communities. Core LTC services, as outlined by the NC Institute of Medicine's "A Long-Term Care Plan for North Carolina: Final Report,"[3] are services that all North Carolinians should have access to either in their county of residence or within a reasonable distance. Core LTC services include information and assistance, transportation, housing and home improvement, home-delivered meals, durable medical equipment, nursing services, medical alert, respite, in-home aide services, home health care, adult residential care, nursing facilities, and care management for complex conditions. In addition, access to other medical, mental, and social services is necessary, such as hearing and vision services, acute medical care, and adult protective services. Many of the core LTC services cut across funding streams and current local planning bodies. Local planning teams will decide whether they want to evaluate any additional services in addition to those prescribed by the NC Institute of Medicine.

   NC DOA, with significant assistance from the State Team, will develop a core service evaluation planning tool with a variety of questions, based on a 5-point Likert Scale, that will enable communities to assess seven aspects of each of the core LTC services within their community, including:

   - Availability (Do the services exist and how available are they?);
   - Adequacy (How sufficient is the supply of services for all who need them?);

[3] NC Institute of Medicine, "A Long-Term Care Plan for North Carolina: Final Report," January 2001; p. 48.

- Accessibility (How obtainable are the services for those most in need, taking into account those with low-income and who otherwise face barriers to service?);
- Efficiency (How reasonable are the service costs and are there possible options for streamlining services to make them more efficient?);
- Effectiveness (To what extent do the services meet the needs of those using them?);
- Equity (How available are the services for all who need them without bias?); and
- Quality (How successful are the services in addressing clients' needs?).

Based on the evaluation of each service and the overall LTC system according to the seven attributes above, planning teams will prioritize services and needed reform efforts for inclusion in the strategic plan. Completing the core service evaluation will require a variety of LTC data. Currently, LTC data are spread across state Divisions and are not reported in a comprehensive manner. It can be difficult for local communities to find and access the data. During this project, NC DOA, with guidance and help from the State Team, will produce a Data Kit with data specialized to the pilot communities as well as data that allow the communities to compare themselves to other similar communities across the state. The Data Kit will include LTC data from all NC DHHS Divisions and select federal agencies. Examples of data to be included in the Data Kit include demographic information on the older and disabled adult populations, expected population changes over the coming years, information on funding and service delivery of core LTC services, waiting lists, information on LTC core service clients, nursing facility utilization rates, case mix data, and caregiver information. The Data Kit will include a chart to assist communities in determining which data to analyze during various steps of the planning process and core service evaluation. Local planning teams will evaluate the Data Kit for usefulness during the project and the Kit will be revised as needed.

The core service evaluation tool and the Data Kit will be helpful to other communities and states that want to evaluate their LTC systems and determine strategies to make their systems more efficient and better coordinated to serve clients and make optimal use of public funds. The core service evaluation tool and Data Kit template will be available on the Department's LTC web site for other communities and states to download and use.

3. **Creation of a mechanism to prompt purposeful and organized exchange between local and state interests:** Every other month (and at other times as necessary during the project), the two local planning teams, NC DOA, and the State Team will come together to form the *LTC Community Interest Group*. The LTC Community Interest Group will provide a forum for cooperative dialogue between local and state interests in regard to local planning and LTC system reform. During meetings of the LTC Community Interest Group, local planning teams will be able to interact with each other, exchange information with and receive technical assistance from the State Team on common issues and barriers, discuss best practices, and receive training. In addition, State Team members will hear about LTC system issues firsthand from front-line providers and consumers. Local planning teams will bring information gained from participation in the LTC Community Interest Group back to their local communities for use in planning and implementing their comprehensive LTC system. Meetings of the LTC Community Interest Group will be conducted through various means, primarily through teleconferences, but also making use of listserves, face-to-face meetings,

and website interactions (all methods will be facilitated and organized by DOA with considerable input from the State Team). Other methods of interaction may be identified in the early stages of the project and all methods will be evaluated and refined as needed over time. This link of giving local communities direct access to all NC DHHS Divisions at once is currently missing in the NC LTC system and is expected to contribute greatly to problem-solving and successful LTC policy and program implementation.

NC DOA will communicate all minutes and information from the LTC Community Interest Group through the Department's LTC web site so that all counties and regions not involved in the Network may also benefit from the Network's experience.

The State Team will provide a liaison to the DHHS Long-Term Care Cabinet to update the Cabinet on the project and receive suggestions. The DHHS Long-Term Care Cabinet will ensure that the process is consistent with the IOM recommendations, Olmstead Plan, and other state goals; give policy direction to the planning process; and assure that relevant issues raised by the LTC Community Interest Group are addressed.

The entire *Communications and Planning Network to Support Families in Their LTC Roles* is designed to provide constant, circular feedback and assistance among all groups involved. Information and ideas can start at any level of the network and work their way up or down. The Network has numerous benefits to participating communities, including:

- direct participation in state policy discussions that have implications for them and other communities;
- direct access to a State Team of professionals committed to addressing any problems or issues that the community identifies as barriers to its efforts to improve the LTC system;
- assistance from the State Team in the pursuit of private or federal funds to implement local LTC reforms identified in their strategic plans; and
- first choice in testing new tools, processes, or policies that NC DHHS proposes to use with counties to simplify access to services and ease management (such as client screening and assessment tools and strategies to address workforce shortages).

Thus, local and state efforts will all be combined resulting in the development of successful local and state LTC reform efforts. Other states will be able to use the communication model to promote collaboration in LTC and in other health and human service issues.

During all aspects of the project, quality control will be maintained by oversight of the NC LTC Cabinet. Project staff will report to the NC LTC Cabinet at various intervals. In addition, the NC LTC Cabinet will ensure that all State Team representatives fulfill their responsibilities and the State Team will monitor lead agent(s) for adherence to their Statement of Commitment (Appendix A).

## Grant Appendix A: Lead Agent(s) Statement of Commitment

I/we commit to serving as lead agent(s) to guide and support the work of the local planning team for at least one year. The responsibilities of serving as lead agent(s) may include the following:

- Providing adequate staff time to lead the local planning efforts;
- Convening the planning team at regular intervals;
- Managing the administrative tasks involved in the local planning process, which may include documenting the steps taken/best practices/barriers/etc. in developing the community initiative, researching issues, taking minutes, mailing meeting announcements, etc;
- Helping keep the planning team energized and working towards established outcomes (established by the Long-Term Care Cabinet) and goals;
- Working with local organizations, leaders, and government officials to ensure that all groups required by IOM Recommendation #16, as well as any other groups that should be involved in evaluating LTC services and developing a comprehensive community LTC system, are included in the planning team;
- Mediating any conflicts that arise during the planning process;
- Attending meetings and teleconferences related to the project. Participating on any listserves, websites, etc. that are created to help communities interact with each other and with State professionals;
- If needed, researching local, state, and national funders for possible grants to help fund any local initiatives that result from the planning process and assuming a major role in applying for potential funds;
- Providing or arranging for needed training for the planning team on special population issues, the IOM recommendations, planning processes, data utilization, etc.;
- Assisting with evaluating the usefulness of LTC data available under the Network;
- If determined necessary, ensuring that local data collection is completed according to guidelines;
- Sharing information with the State Team and the LTC Community Interests Group (meetings of all participating communities, State Team members, and others interested in local planning for LTC) regarding the planning process;
- Ensuring that the interests of all affected populations are adequately represented in the planning team; and
- Assisting with evaluating the usefulness of the Network.

_____ _____

Printed Name and Signature Date

_____ _____

Printed Name and Signature if more than one lead agent Date

## Statement of Interest
## A Communications and Planning Network to Support Families in Long Term Care

Area To Be Served by Planning Efforts: _____

Lead Agent(s): _____

Contact Person(s): _____

Address: _____

Phone: _____

Fax: _____

Email: _____

**Please briefly answer the following questions in the space provided:**

1. Why is your community interested in participating in the *Communications and Planning Network to Support Families in Long Term Care*?

2. What local human-services and health planning processes are already in place for your community? In what ways will this new planning process work with those established planning groups?

3. What are the most pressing issues and/or barriers of your community's current LTC system?

4. What do you expect to be the end-result of the planning process for your community?

5. What other agencies and individuals do you expect to participate in the planning process?

| Representatives from: | Name(s) and Title(s) | Agency (if applicable) |
|---|---|---|
| Department of Social Services | | |
| Health Department | | |
| Area Mental Health Program | | |
| Aging Councils or Departments | | |
| HCCBG Lead Agency | | |
| CAP-DA Lead Agency | | |
| Hospitals | | |
| Home Health, Home Care, and Hospice Agencies | | |
| Nursing Homes | | |
| Assisted Living Facilities | | |
| Adult Day Care/Adult Day Health Agencies | | |
| Group Homes | | |
| Independent Living Programs and Facilities | | |
| Area Agencies on Aging | | |
| Long-Term Care Ombudsman Programs | | |
| Community Advisory Committees | | |
| County Government | | |
| Older Adults | | |
| Persons with Disabilities | | |
| Family Caregivers | | |
| Advocates | | |
| Other | | |

6. What types of information and technical assistance do you think would best help your community in evaluating its LTC services and in designing strategies to develop a comprehensive LTC system?

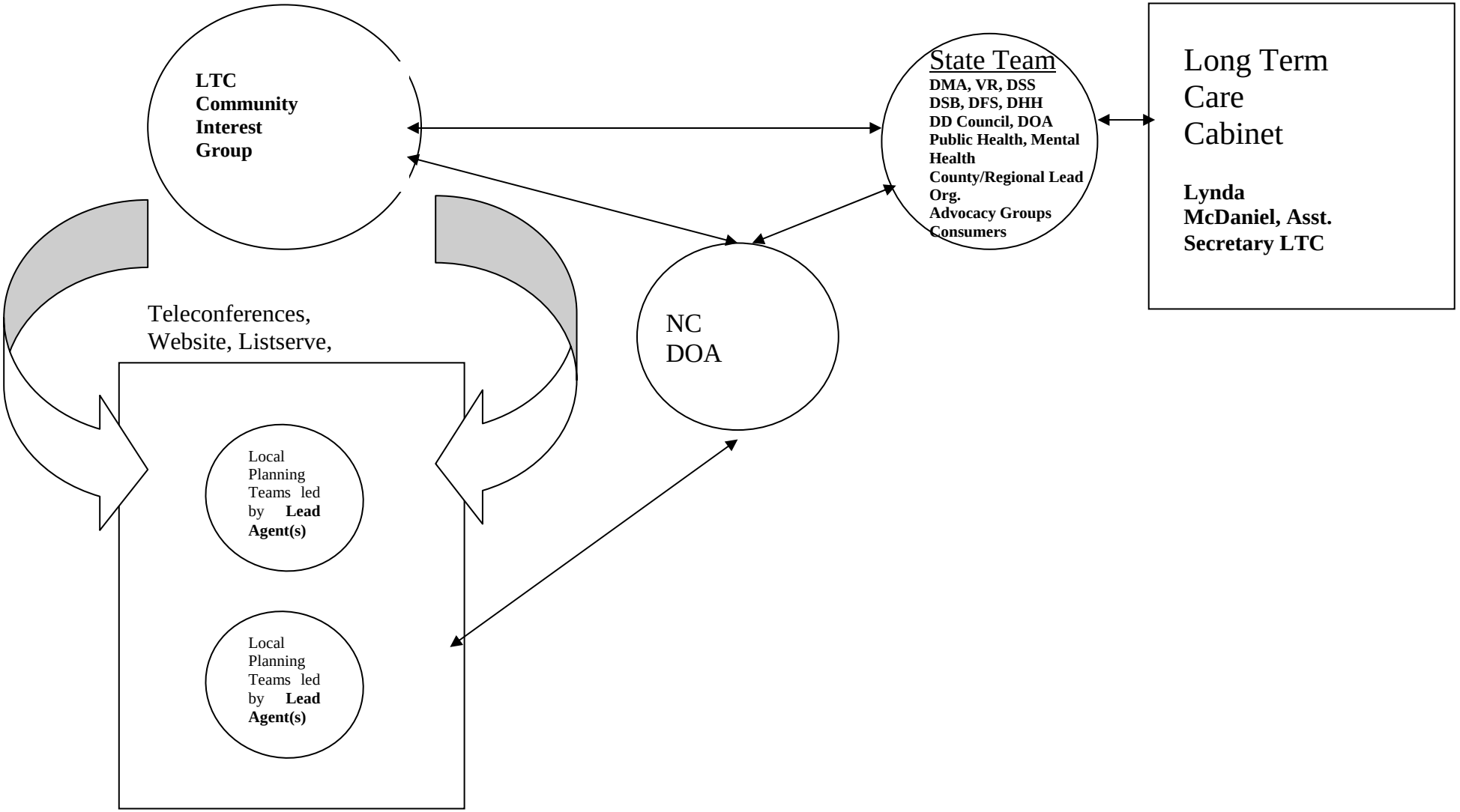
7. Please include a letter from your County Commissioners (each set if serving more than one county) naming you or your organization(s) as lead agent(s) and indicating their support of your community's Statement of Interest.

Thank you for your interest in participating in *a Communications and Planning Network to Support Families in Their Long Term Care Roles*. If you have any questions, please contact Julie Bell at the NC Division of Aging, 919-733-0440 or julie.bell@ncmail.net.

**PLEASE SUBMIT YOUR STATEMENT OF INTEREST TO THE NC DIVISION OF AGING BY _____.**

**ATTN: Julie Bell**
**NC Division of Aging**
**2101 Mail Service Center**
**Raleigh, NC 27699-2101**
**Fax: (919) 733-0443**
julie.bell@ncmail.net

## Grant Appendix B: Model of the Network



## Grant Appendix C: Sample Ratings Comparison Sheet (Core Service Evaluation)

| Service | Overall Existence Rating | Overall Adequacy Rating | Overall Accessibility Rating | Overall Efficiency/ Duplication Rating | Overall Equity Rating | Overall Effectiveness/ Quality Rating | Service Average |
|---|---|---|---|---|---|---|---|
| Adult Care Homes | 4 | 4 | 2 | 2 | 4 | 2 | **3.00** |
| Adult Day Services | 4 | 4 | 1 | 1 | 4 | 2 | **2.67** |
| Adult Protective Services (APS) and Guardianship | 5 | 5 | 1 | 1 | 2 | 2 | **2.67** |
| Care Management | 2 | 2 | 1 | 1 | 5 | 1 | **2.00** |
| Dental Services | 3 | 3 | 2 | 3 | 3 | 3 | **2.83** |
| Durable Medical Equipment (DME) | 4 | 5 | 5 | 5 | 5 | 3 | **4.50** |
| Home-Delivered Meals | 5 | 5 | 4 | 5 | 5 | 4 | **4.67** |
| Home Health Care | 5 | 4 | 2 | 4 | 4 | 4 | **3.83** |
| Housing and Home Improvement | 4 | 4 | 2 | 2 | 5 | 2 | **3.17** |
| Information and Assistance (I&A) | 5 | 5 | 5 | 5 | 5 | 4 | **4.83** |
| In-Home Aide Services | 5 | 4 | 5 | 4 | 5 | 1 | **4.00** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Medical Alert | 4 | 5 | 1 | 1 | 3 | 3 | **2.83** |
| Mental Health Services | 3 | 4 | 2 | 1 | 1 | 2 | **2.17** |
| Nursing Facility Care | 5 | 4 | 3 | 3 | 5 | 2 | **3.67** |
| Respite | 4 | 5 | 1 | 2 | 5 | 2 | **3.17** |
| Services for the Deaf and Hard of Hearing | 4 | 5 | 1 | 2 | 4 | 1 | **2.83** |
| Transportation | 5 | 4 | 1 | 1 | 4 | 2 | **2.83** |
| Vision Services | 5 | 5 | 1 | 1 | 4 | 1 | **2.83** |
| **Dimension Average** | **4.2** | **4.3** | **2.2** | **2.4** | **4.1** | **2.3** | |
| **Patterns Noted:** | | | | | | | |

# Appendix B:
# Letter of Support for the ASPE Grant Request from the North Carolina Association of County Commissioners

North Carolina Association of County Commissioners
*Mailing Address:* P. O. Box 1488, Raleigh, NC 27602-1488
*Street Address:* Albert Coates Local Government Center, 215 N. Dawson Street, Raleigh, NC 27603
*Telephone:* 919-715-2893 • *Fax*: 919-733-1065 • *Email:* ncacc@ncacc.org
*Home Page Address:* http://www.ncacc.org

July 15, 2002

Michael J. Loewe, Deputy Grants Management Officer
Grants Management Branch
National Institute of Child Health and Development
U.S. Department of Health and Human Services
6100 Executive Boulevard, Room 8A01
Bethesda, Maryland 20892-7510

Dear Mr. Loewe:

On behalf of the North Carolina Association of County Commissioners, I am pleased to write this letter of support for a proposal being submitted to your office by the North Carolina Division of Aging. The proposal is to develop a Communications and Planning Network to Support Families in Their Long Term Care Roles (the Network). The Network will create a means to look systematically at long term care in two pilot counties. With the cooperation of the state Department of Health and Human Services, this project will provide useful models, information, and resources to counties and other states wishing to develop coordinated and efficient long-term care systems for older and disabled adults.

Planning at the county level, with support from the state division, is essential in addressing challenging long-term care issues that face us all. Currently, planning for long-term care services in many counties is more accidental than by design. This can result in costly duplication of services and efforts. The aging of North Carolina's population and the rising public cost of long term care, including Medicaid, are matters of great importance to our county governments.

Creative methods of service delivery at the local level often require changes in state policies and effective problem solving. The Network's communication mechanism will offer counties and multi-county areas direct access to state professionals dedicated to addressing issues that counties face in reforming their local long-term care system. County input will be extremely helpful to state agency divisions as they consider long-term care reform and its effect on providers and county governments as well.

I hope that the Office of the Assistant Secretary for Planning and Evaluation can support this project for our counties, state and nation. The North Carolina Association of County Commissioners is prepared to offer consultation and technical assistance to the project personnel and will help promote the project to the counties of North Carolina.

Sincerely,

C. Ronald Aycock

C. Ronald Aycock
Executive Director

# Appendix C:
# Comments on the
# *Communications and Planning Network to Support Families in Their LTC Roles*

## A Summary of Comments Received on the *Communications and Planning Network to Support Families in Their LTC Roles*

Section 10.4 of S.L. 2002-126 (S.B. 1115), requires the Department of Health and Human Services, Office of Long-Term Care, to consult with experts in long term care (LTC) to develop a plan for streamlining services for older adults at the local level. This interest appears consistent with Section 22.1 of the Studies Act of 2001 [S.L.2001-491 (S166)], which directed the Division of Aging to "study whether counties should designate local lead agencies to organize a local long-term care planning process."

In November 2002, Lynda McDaniel, Assistant Secretary for LTC and Family Services, invited the following groups to review the Division of Aging's concept paper/grant proposal on local LTC planning and lead agencies (see Appendix A for the concept paper/grant proposal):

- Duke Long Term Care Resources Program;
- Friends of Residents in Long Term Care;
- Governors' Advisory Council on Aging;
- NC AARP;
- NC Association of Area Agencies on Aging;
- NC Association of County Directors of Social Services and its Adult Services Committee;
- NC Association on Aging;
- NC Coalition on Aging;
- NC Institute of Medicine;
- NC Senior Tar Heel Legislature;
- UNC-CH School of Social Work, CARES Program; and
- Long-Term Care Cabinet (composed of the DHHS Secretary, DHHS Deputy Secretary, DHHS Assistant Secretary for LTC and Family Services, DHHS Assistant Secretary for Health, the DHHS Workforce Development Coordinator, and Directors of the Division of Aging, Division of Information Resource Management, Division of Mental Health/DD/SAS, Division of Vocational Rehabilitation, Division of Services for the Blind, Division of Deaf and Hard of Hearing, Division of Budget and Analysis, Division of Facility Services, Division of Public Health, Division of Social Services, Division of Medical Assistance, and the Council on Developmental Disabilities).

Respondents were supportive of the local planning and lead agent(s) concept and agreed that counties should participate voluntarily rather than as a mandate, especially without State funding. Previously, the NC Association of County Commissioners had reached the same conclusions (see Appendix B for NCACC letter). A summary of these supportive comments is provided below:

- Local LTC planning is an essential ingredient in the achievement of a coordinated and comprehensive LTC system.
- The concept correctly recognizes that the involvement of the County Commissioners is crucial to the success of any local LTC planning process.
- The concept will provide an opportunity to test the planning process, determine funding needs and service gaps, and inform DHHS on what will be required to assist counties in designating lead agents and developing local LTC planning processes.

- The use of a 'lead agency' has worked well in previous local planning efforts (such as HCCBG planning, CAP-DA planning, DSS planning, and Healthy Carolinians Task Forces).
- The planning concept is very clear in its call for flexibility, which is essential to accommodate varying local interests, needs and capabilities.
- The core services evaluation section is excellent. It is easily understandable and will be important at both the local and state levels.

In addition, those responding also shared ideas to strengthen the conceptual approach to support local LTC planning:

- Clarify the definition of "local level." This definition should include the possibility of benefits from a regional approach to maximize leadership capabilities, provide staffing efficiencies, and open the door to more resources. More than one group cited the strong role that Area Agencies on Aging (AAAs) and Lead Regional Organizations (LROs) and their regional advisory councils have played in local and regional planning processes in the past. It was also noted that the Geographic Information Service (GIS) found in most LROs can be a useful planning tool to help identify where consumers are living and where unmet needs are within a county.
- Expand the number of projects to include one additional county/site so that the project could include one rural county, one urban county, and a multi-county area, and specifically identify an eastern and western county to gain an appreciation of the challenges faced in different areas of North Carolina.
- Build on the planning that is already being conducted in counties. Before selection of the project counties, DHHS should determine what is already occurring. It follows that the selected counties might be counties that have shown, without special external incentives, the desire and will to plan. County Commissioners will be more responsive to a project that builds on the existing infrastructure rather than forcing something completely new.
- Review past efforts at LTC reform, such as the Unifour and Sail initiatives, to learn from these experiences.
- Replace the lead agency language. Because many existing groups already call for a "lead agency," one group worried that this term has different meanings for different networks. The group encouraged use of a new term, such as "Collaboration Team Chairperson," that would have its own distinct meaning and encourage a fresh start.
- Encourage greater collaboration at the state level to allow for more flexibility and innovation in planning at the local level. There are many state agencies that require local agencies to have advisory/planning committees. Without clear direction from the state agencies that multipurpose planning groups can serve as advisory/planning entities for specific programs (such as HCCBG, CAP-DA, etc.), both regional and local groups will find it difficult to merge these initiatives.
- Support development of a core set of services in every county in North Carolina.

# Appendix D:
# Local Planning Entities

# Local Planning Entities

**Aging Planning (under the Division of Aging):** In North Carolina, 17 Area Agencies on Aging (AAAs) are located within regional Councils of Government (COGs). The Older Americans Act mandates planning as a required AAA function. AAAs are responsible for developing four-year plans to establish and maintain networks of local service providers to ensure a continuum of home and community-based services for older adults. AAAs also develop, support, and sometimes facilitate extensive county-based planning processes to allocate Home and Community Care Block Grant (HCCBG) funds. Planning processes for HCCBG funds are different from AAA to AAA, and from county to county within an AAA's service region. County Commissioners determine the lead agency for HCCBG planning in their county. Ten AAAs serve as lead agency for a total of 32 counties across the state. Other types of lead agencies include county DSSs, local service providers, and County Managers' offices. Some local aging planning groups have expanded beyond HCCBG and are also involved in aging policy for the county, long range county aging plans reflecting diversified funding streams, monitoring quality and improving services of providers, and advocacy on behalf of older adults. Other planning groups, with AAA support, have expanded still further to begin planning processes for the disabled adult population.

**Area Mental Health/Developmental Disabilities/Substance Abuse Services Local Management Entities and Local Consumer and Family Advisory Committees (under the Division of MH/DD/SAS)*:*** The *State Plan 2001: Blueprint for Change*, a 5-year plan to transform the present MH/DD/SAS system, calls for the development of two major entities related to local planning for services:

1. *Local Management Entities:* County Commissioners in each county must appoint an agency, the Local Management Entity (LME), to develop and manage the local MH/DD/SAS system. Counties must decide whether to appoint an LME that serves only their county, or to join a group of counties that receives services from a multi-county LME. Only three counties have chosen to have a single-county LME - Durham, Mecklenburg, and Pitt Counties. LMEs do not provide direct services. Instead, LMEs collaborate with community partners to develop a business plan for services, assess local needs for services, address unmet needs, evaluate statistical data about service usage, troubleshoot issues of access and treatment, and establish a Consumer and Family Advisory Committee (explained below).
2. *Local Consumer and Family Advisory Committees:* Local Consumer and Family Advisory Committees are designed to provide input into LME's activities and policies, make recommendations on service development, educate elected officials on issues, and monitor activities to improve quality. Committees must be composed entirely of consumers and family members representing all MH/DD/SAS disability groups.

**Community Alternatives Program for Disabled Adults (CAP-DA) Committees (under the Division of Medical Assistance):** Medicaid waiver rules require CAP-DA lead agencies to have an advisory committee. Membership often includes local officials, service providers, and consumers. In general, committees offer guidance and support to the program and the lead agency. The committees do not have funding or oversight authority; however, they are used as a way to keep community members involved in the CAP-DA program and to bring new ideas and suggestions to the lead agency.

**County Boards of Social Services (under the Division of Social Services):** State law requires all county Departments of Social Services to have a County Board of Social Services. General Statute 108A-9 defines the duties and responsibilities of County Boards of Social Services, including advising county and municipal authorities in developing policies and plans to improve the social conditions of the community and establishing policies for public assistance and social services programs consistent with federal and state laws, regulations, and policies. County Boards of Social Services have either three or five members, appointed for a three-year term by the county's commissioners, the state Social Services Commission, and other members of the Board. State law requires County Boards of Social Services to meet at least once a month.

**Healthy Carolinians Task Forces (under the Division of Public Health/State Health Director):** Healthy Carolinians Task Forces are community-based coalitions of diverse partners who work together to identify and address their communities' major health issues. There are over 70 Healthy Carolinians Task Forces across the state, 64 of which are certified. To become a certified Task Force, groups must conduct various planning activities, including establishing a steering committee and a community partnership group, performing a community health assessment using established data and community surveys/focus groups/forums, and developing an action plan. While many Task Forces focus on broad health concerns that affect the general population (such as smoking cessation and seatbelt use), many are actively working to improve the health of older and disabled adults in their communities. For example, Ashe County worked to strengthen its End of Life program, Bladen County established a Parish Nursing Program, and Cabarrus County developed mobile dental services for residents of LTC facilities.

**Mayors' and Local Committees for People with Disabilities (under the Division of Vocational Rehabilitation):** NC has one of the largest networks of Mayors' and Local Committees in the United States, with 25 committees across the state. Often the groups are formed by someone in a community with a disability and membership includes persons with a disability, human service professionals, local employers, and other interested individuals. These committees work to improve the quality of life and participation of persons with disabilities in the workforce and in society through mostly advocacy and education activities.

# APPENDIX J

# Helping Seniors Obtain the Medicines they Need

A Report to the North Carolina Study Commission on Aging

Michael Keough

January 7, 2003

## Prescription Drugs for the Elderly - Scope of the Problem

February 2002, Kaiser Family Foundation Study:

- Nearly 38% of non-institutionalized elderly are without drug coverage
- Increase of 29% in Medicare Beneficiaries Average Annual Out-of-Pocket Costs from $813 in 2000 to $1,051 in 2002

## Insurance Coverage Options

- Medicare does not cover prescription drugs for most eligibles
- NC Medicaid offers coverage for Aged up to 100% FPL
- Medigap covers 50% up to $1250-$3000 under standardized policies H, I, and J for $116-$366/month (www.ncship.com)
- TriCare for retired unformed service personnel (20 years service) for $3-$9 copay at network pharmacies (www.tricare.osd.mil
- VA provides veterans with free and low cost ($7 copay) prescriptions through a VA doctor and pharmacy

## Non-Insurance Coverage Options

- NC Prescription Drug Assistance Program covers 1800 dual Medicaid/Medicare eligibles (funded thru June 2002)
- 400 community, state and federal sponsored PDA programs
- Drug Company Sponsored Cards
  - Eli Lilly: $12 copay/30 day Lilly covered prescription
  - Novartis: $12 copay/30 day Novartis covered drug (6/1)
  - Pfizer: $15 copay/30 day Pfizer covered drug
  - Together Rx: 15%-40% discount (6/1)
  - Glaxo Orange Card 25% - 40% discount
  - Novartis Care Card 25% - 40% discount

## Drug Company Cards

- Chance for qualifying Seniors to lower their prescription drug costs
- Simpler application process
- Some have substituted for free drug programs
- Eligibility Coordination with other “Third Party” Coverage

## Prescription Assistance Programs

- Over 50 drug companies sponsor over 150 programs
- Specific company brand drugs
- Require completion of application signed by M.D.
- Drugs delivered to doctor’s office although some have coupons to use at local drug store
- Free or with small patient copay
- Provide from 2-12 months of free prescriptions

## Maryland MedBank

• State Funded Effort to Facilitate Access to Drug Manufacturer Prescription Assistance Programs

• Patient Calls in to Toll Free Number

• Staff Member Interviews Patient and Completes Database with Information to Fill-In Relevant PAP applications.

• MedBank Mails the Application to the member to sign and then faxes to the doctor to sign.

• MedBank submits the applications to the PAPs

• PAPs mail the medications to the patient's doctor's office for pick-up

• MedBank reorders the medication after 30-90 days

## Maryland MedBank

Strengths:

• Centralized administration and control

• Patients can access the service by phone

• Efficient - do everything by phone and fax

• Software program used to index 160 PAPs

## Maryland MedBank

Weaknesses:

• Lacks local face to face presence

• Relies on physician's offices to receive and distribute free meds

• Resource intense: 22 staff in largest region, five regions total

• No medication management component

## Local NC Programs

• About 50 local programs around the state mostly though not exclusively located in urban areas

• 15% serve seniors only, the rest serve broader low income population

• All do prescription assistance, some (about 20%) also do medication management using a pharmacist

• At least 80% are clinic or practice based and serve only their patients.

•Various organizational types including, community health centers, free clinics, hospitals, Healthy Carolinians' Projects, and independent not for profits

• Most use some type of software to complete PAP forms

## Local NC Programs

Strengths:

• Locally based knowledge of their patients

• Close cooperation and coordination with patients' physicians

• Designed to meet specific local objectives with available volunteer and paid staff

## Local NC Programs

Weaknesses:

• Reliance on self-trained or volunteer staff

• Individualized local efforts that lack easy access to centralized databases or economies of scale

• Generally inefficient prescription assistance software

• Most lack pharmacist resources and medication management

# NC Senior Care Medication Management Centers

• Locally Based Centers open to all seniors and low income patients in the community for face to face encounters

• Staffed by a Prescription Assistance Coordinator and a Pharmacist

• Utilizing Office of Rural Health Medication Access and Review Program (MARP) software, PAP database and technical support

• Both Prescription Assistance and Medication Management provided by trained personnel in each center

• Centers can order and dispense free medications

# NC Senior Care Medication Management Centers

• $3M in funding from Health and Wellness Trust Fund Commission per year over three years

• 24 centers that include 62 counties in their local service areas

• Phone medication evaluation service being developed for high risk Senior Care enrollees in remaining 38 counties

• "High risk" enrollees based on Senior Care enrollment medication questionnaires to be referred by ACS to centers

• Target effective date of February 3rd for first set of referrals

• Performance Evaluation of effectiveness by UNC SPH

# Why Medication Management Centers?

## The Best of Both Worlds

Local strengths:

- Local know how and ownership
- Face to face evaluations
- Knowledge of the patient
- Relationships with physicians
- Local dispensing options

# Why This Approach?

## Statewide Strengths:

• Centralized PAP database and software

• ORH software development and training

• ORH technical assistance and consulting on organizational development, staff hiring, service delivery and performance evaluation

• AHEC pharmacist training

# Why This Approach?

## Other Strengths:

•Access for all patients who need prescription assistance services and all MDs who wish to use it for their patients

• Leverage Trust funding to maximize ROI

• Medication Management with a focus on High Risk

• Coordination with Senior Care enrollment process

# APPENDIX K

***EXCERPT****

# *Special Assistance Demonstration Project Pursuant S.L. 2001-424*

***Final Report***
***To***
***House of Representatives Appropriations Committee***
***and***
***House of Representatives Appropriations Subcommittee On Health and Human Services***
***and***
***Senate Appropriations Committee***
***and***
***Senate Appropriations Committee On Health and Human Services***

***January 2003***

***Prepared by***
***North Carolina Department of Health and Human Services***
***Division of Social Services***

*Special Assistance In-Home Demonstration Project*

**Final Report**

**Executive Summary**

**Background**
A. Legislation
B. Project Counties

**SA/In-Home Clients**
A. Basic Demographics
B. Living Arrangements
C. Vision
D. Hearing
E. Cognitive Patterns
F. Mental Health Needs
G. Activities of Daily Living
H. Instrumental Activities of Daily Living
I. Health Conditions
J. Medications

**III. Caregivers**

**IV. Use of SA/In-Home Payments**

**V. Medicaid Services**

**VI. Cost Analysis**

**VII. Case Management**

**VIII. Recommendations**

## Executive Summary

### Legislation

The General Assembly authorized the Department of Health and Human Services (DHHS) to carry out a demonstration project to provide Special Assistance for up to 400 eligible individuals living at home for a limited time period. The demonstration ends on June 30, 2003.

### Project Counties

Twenty-two county departments of social services (DSS) participated in the demonstration project. These counties include a statewide geographical distribution and participation by small, medium, and large county DSS agencies. A list of the DSS agencies participating in the project is in Section I of this report.

### Special Assistance In-Home Clients

A total of 377 individuals received Special Assistance at home during the September 2000 – August 2002 period. The term "SA/In-Home" payments is used throughout this report to refer to these Special Assistance payments. The data shown in the charts and graphs included in this report describes the individuals who received Special Assistance payments at home during this two-year period. The data in the charts and graphs was collected by the case managers completing the RAI-Home Care assessment instrument.

The assessment data for all project recipients was compiled to show the characteristics and functioning levels of the SA/In-Home recipients. With this data, we have a description of the types of individuals receiving these funds and using them to live at home rather than entering an adult care home.

The charts and graphs show information about the demographics, living arrangements, vision and hearing status, cognitive patterns, mental health needs, ability to carry out activities of daily living and the instrumental activities of daily living, health conditions, number of medications taken, and other characteristics of these individuals.

### Caregivers

The role of caregivers is very important in whether an older adults or an adult with disabilities is able to live at home instead of going to an adult care home. Caregivers include relatives, friends, and neighbors. Eighty four percent of the SA/In-Home recipients have a primary caregiver. These caregivers provided a range of help to these individuals – including assisting with activities of daily living, instrumental activities of daily living, advice, and emotional support. Caregivers provided an average of 41 hours per week or 6 hours per day of help to these recipients during the September 2000 – August 2002 period.

**Use of SA/In-Home Payments**

Based on findings from the client assessments, planning with the clients and family members or other members of their informal support network, and planning with physicians and local service providers, the case managers developed care plans designed to meet the needs of the clients and enable them to live at home rather than move to an adult care home. Part of the care plan addressed how the SA/In-Home payments would be used to enable the client to live at home safely. The SA payments were used for a variety of things – all of which are basic needs for people living at home. A primary issue for these individuals is that they do not have sufficient income to meet their needs – and that, among other factors, has put them at risk of having to leave home and move to an adult care home. The average monthly income for the SA/In-Home recipients was $539. The average monthly SA/In-Home payment was $184 per recipient.

The SA/In-Home payments were used for a variety of basic needs: housing, health care, food, personal care, clothing, and transportation. The most prevalent use was for housing-40% of the payments were used for housing. The housing category includes utilities, home modifications, furniture, rent, appliances, heating and cooling repairs, and property taxes.

**Medicaid Services**

A condition for participation in the SA/In-Home demo is that individuals be eligible for Medicaid. The income level for Medicaid for Aged, Blind, and Disabled Adults in private living arrangements is 100% of the federal poverty level (currently $739 per month for an individual). Anyone with income above 100% of the federal poverty level is not eligible to receive SA/In-Home payments.

The Division of Medical Assistance provided data about the types and costs of Medicaid services provided to SA/In-Home recipients as well as to SA/Adult Care Home recipients for the September 2000 – August 2002 period. This data provides a comparison of the Medicaid services and costs for the two groups of recipients. The data is for claims billed to Medicaid for services provided to both groups of SA recipients.

The average cost for all Medicaid services used by 365 of the 377 SA/In-Home recipients during this two-year period was $1,842 per recipient. The average cost for all Medicaid services used by 331 of the 377 SA/Adult Care Home recipients during this two-year period was $2,158 per recipient.

The top three Medicaid services with the highest level of expenditures for each group were Personal Care Services, Prescription Drugs, and Physician Services & Hospitalization.

**Cost Analysis**

## A. Special Assistance

Special Assistance payments supplement an individual's income so that he/she will have sufficient income to pay for care in an adult care home, or during this demonstration, to live safely at home. The individual must need adult care home level of care, as verified by a physician and documented on the FL-2, in order to qualify for either payment.

The need standard (eligible income level) for the SA/In-Home payment is 100% of the federal poverty level. Currently, the federal poverty level is $739 per month for a family of one. If an individual's income is below this level, he/she may be eligible for an SA/In-Home payment.

The payment standard for the SA/In-Home payment is 50% of the amount that an individual can receive to pay for care in an adult care home. Eligible individuals receive a monthly cash payment for an amount up to the payment standard, depending upon their specific needs that are identified through a comprehensive assessment and development of a care plan.

During the September 2000 – August 2002 period, 377 individuals received SA/In-Home payments. The average payment was $184 per month. A total of $1,045,880 was paid to these 377 individuals during this two-year period.

The need standard and payment standard for the SA/Adult Care Home payment, which pays for care in adult care homes, are one-and-the-same. The current standard is $1,147 per month ($1,091 for room and board + $36 for personal needs allowance). This is 153% of the federal poverty level. If an individual's income is below this level, he/she may be eligible for an SA payment for care in an adult care home. Eligible individuals receive a monthly cash payment for an amount that is the difference between the need/payment standard and their personal income.

During the September 2000 – August 2002 period, the average Special Assistance payment made to individuals in adult care homes was $426 per month. Based on this average payment amount, total payments of $3,854,448 were paid to 377 Special Assistance recipients living in adult care homes during this two-year period.

A comparison of $1,045,880 in SA/In-Home expenditures for 377 individuals and $3,854,448 in SA/Adult Care Home expenditures for 377 individuals shows that the cost of providing Special Assistance to individuals in adult care homes was $2,808,568 higher than providing the payments to individuals living in their own homes. The average monthly payment of $426 to adult care home recipients was $242 higher than the $184 monthly payment to individuals in their own homes. The average annual payment of $5,112 to adult care home recipients was $2,904 higher than the average annual payment of $2,208 to recipients in their own homes.

## B. **Medicaid**

The average cost per recipient for all Medicaid services used by the 365 of the 377 SA/In-Home recipients was $1,842 per recipient for the two-year period. The average cost per recipient for all Medicaid services used by the 331 of the 377 SA/Adult Care Home recipients during this same time period was $2,158 per recipient.

A full conclusion cannot be drawn from this data about the Medicaid costs for these two groups of recipients. The Medicaid costs for 12 of the SA/In-Home recipients and for 46 of the SA/Adult Care Home recipients have not been reported to the Division of Medical Assistance. Medicaid providers have one year from the date of service to submit claims. Thus, there is a lag time for reporting Medicaid expenditures.

### Case Management

In this demo, case managers at the county departments of social services conducted comprehensive assessments to identify the nature and extent of the needs of individuals requesting Special Assistance payments and how the factors affected their ability to live at home. A comprehensive assessment instrument known as the Resident Assessment Instrument for Home Care (RAI-HC) was used by the case managers working with these clients.

Using the assessment information, the case managers worked directly with the clients and their families and other caregivers to develop a care plan that would enable the client to live at home rather than move to an adult care home. The case managers also established the amount of the SA/In-Home payment, worked with the client to determine how the payments would be used, and monitored use of the payments to assure that they were used for the intended purpose.

The case managers role was an essential one for helping the clients remain at home. In addition to the care planning, arranging for services, and monitoring, the case managers also leveraged community resources that had not been available to the client and that made a critical difference in the client's ability to live at home. The case managers mobilized churches, civic clubs, scout troops, and individual volunteers to provide free labor and materials for minor renovations and repairs to client homes and for a variety of other tasks.

An average of 1½ hours of case management were provided to each of the SA/In-Home recipients per month. Existing case managers in the county departments of social services provided the case management. No state funds are used to provide this Medicaid case management program that is known as At-Risk Case Management Services.

This report contains case examples from each of the demo counties. They illustrate the types of individuals who received SA/In-Home payments and show how the case managers worked with the clients and their families and how the SA/In-Home payments made it possible for them to remain at home rather than move to an adult care home.

**Recommendations**

The demonstration project has shown that providing Special Assistance payments to individuals enables them to continue living at home and is an effective approach for providing an alternative to adult care homes.

Making the SA/In-Home payments available in all counties of the state would provide older adults and adults with disabilities the option of living in their own homes in the community instead of moving to an adult care home. Several issues must be taken into account to make this option available in all counties.

- **Number of Recipients** – It is not known how many individuals will want to use the In-Home component of the SA Program, if it becomes available in all counties. It is likely that individuals would apply for the program on a graduated basis and that enrollment would increase over time as people learned that the program was available as an alternative to placement in adult care homes. This was the experience in the twenty-two counties participating in the demonstration project.

- **Cost/Cost Savings**– The cost or cost savings that could occur as a result of making the In-Home component available in all counties of the state is difficult to estimate. It is possible that there would be no increase in the SA budget as a result of adding this option. One requirement for receiving SA payments at home is that a physician authorize that adult care home level of care is needed. It is likely that some eligible individuals who need adult care home level of care would opt to stay at home rather than choosing SA payments to go to an adult care home. If this occurred, there would be no increase in the SA budget. In fact, if some individuals chose the live-at-home option, this would result in cost savings for the SA budget. The SA/In-Home payments currently average $2,904 per recipient per year less than the SA/Adult Care Home payments ($184 per month for In-Home payments versus $426 per month for adult care home payments).

  On the other hand, it is possible that there could be an increase in the SA budget. If individuals who need adult care home level of care do not apply for SA/Adult Care Home Payments simply because they do not want to enter an adult care home, should decide to apply for and qualify for SA/In-Home payments, this could result in a growth in the Special Assistance budget. This is sometimes referred to as a "woodwork effect".

  Safeguards exist for addressing a "woodwork effect". These safeguards include physician approval for adult care home level of care, client and family decision to stay at home rather than enter an adult care home, and the case manager's approval of a care plan that assures living at home safely. In addition, the state can use a federally approved method to limit the number of slots available for Special Assistance payments to individuals living at home without affecting Medicaid coverage. The method is known as Assistance Based on Need or ABON.

  SA/In-Home recipients are eligible for Medicaid and Medicaid-covered services, whether or not they receive SA payments at home. Thus, there are no significant increases in the Medicaid budget due to the availability of SA/In-Home payments.

The Food Stamp benefits paid to these individuals were relatively small ($38 per month). These benefits are 100% federally funded and do not impact the state budget.

- **Case Management** – Case management is essential to the successful implementation of the In-Home component of the Special Assistance program. This case management is funded through a Medicaid case management service known as At-Risk Case Management. Currently, it is funded with 64% federal Medicaid dollars and 36% county dollars. No state funds are used to provide this case management. County departments of social services can continue to provide the non-federal share of the cost of providing this case management for the SFY03-05 biennium.

- **Phased-In Approach** – 400 slots were available for the demo in 22 counties. It is recommended that 800 slots be made available for use in additional counties for each year of the SFY03-05 biennium.

  This approach would set a limit on the number of slots that could be used statewide for the In-Home component of the Special Assistance program. It would also allow for a graduated increase in the number of individuals who may choose this option. County departments of social services can utilize existing staff to provide the case management for this number of people and use existing computer hardware and software to serve this number of recipients. The Division of Social Services can use existing staff to implement this component in all counties of the state.

**Olmstead Plan**

An In-Home component of the State/County Special Assistance Program would be an important part of the DHHS Olmstead Plan that would provide options for adults with disabilities to live in the least restrictive setting possible.

**Consumer Directed Care**

The In-Home component also incorporates the principles of consumer directed care which allows individuals with disabilities to exercise as much control over managing daily living as they are able and willing to do.

# APPENDIX L

**Cost Comparison for CAP/DA, ACH, and NF**

**Paid Claims for SFY '02 for Sample of 75 Individuals**

Preliminary Data

| | | *CAP/DA Intermediate Level* | *Nursing Facilities Intermediate Level* | *Adult Care Home* |
|---|---|---|---|---|
| Pharmacy | | $ 295,181.00 | $ 232,931.00 | $ 366,016.00 |
| MH/MR-DD Services | | $ 2,720.00 | $ 1,536.00 | $ 660,625.00 |
| NF/Hospital Payments | | $ 288,062.00 | $ 2,187,415.00 | $ 141,576.00 |
| CAP Case Management | | $ 94,972.00 | $ - | $ - |
| Adult Day Health | | $ 20,117.00 | $ - | $ - |
| Home Health Nursing | * | $ 63,910.00 | $ - | $ 58,954.00 |
| In Home/Personal Care Aide | ** | $ 1,276,419.00 | $ - | $ 256,332.00 |
| Home Health Supplies | | $ 42,868.00 | $ - | $ 9,642.00 |
| Medical Procedures & Testing | | $ 40,221.00 | $ 3,661.00 | $ 90,098.00 |
| Physician Visits | | $ 30,432.00 | $ 10,041.00 | $ 52,476.00 |
| Dental | | $ 3,186.00 | $ 6,838.00 | $ 11,174.00 |
| All Other Claims (labs, vision, DME) | | $ 158,543.00 | $ 7,429.00 | $ 179,998.00 |
| Medicaid Paid Claims | | $ 2,316,447.00 | $ 2,449,627.00 | $ 1,821,891.00 |
| Special Assistance | | | | $ 386,992.00 |
| **TOTAL PAID** | | **$ 2,316,447.00** | **$ 2,449,627.00** | **$ 2,208,883.00** |

* 8.7 Average visits per year per individual

** 1223 Average hours per year per individual

Prepared by:
Division of Medical Assistance
12/31/2002

Page 1

**Cost Comparison for CAP/DA, ACH, and NF**

Preliminary Data

**Paid Claims for SFY '02 for Sample of 75 Individuals**

## Total Cost Comparison Analysis by Payor Type

| | *CAP/DA Intermediate Level* | *Nursing Facilities Intermediate Level* | *Adult Care Home* |
|---|---|---|---|
| ***MEDICAID CLAIMS**** | | | |
| Federal (61.46%) | $ 1,423,688.00 | $ 1,505,541.00 | $ 1,119,734.00 |
| **State (32.76%)** | **$ 758,868.00** | **$ 802,498.00** | **$ 596,851.00** |
| **County (5.78%)** | **$ 133,891.00** | **$ 141,588.00** | **$ 105,305.00** |
| ***SPECIAL ASSISTANCE*** | | | |
| **State (50%)** | **$ -** | **$ -** | **$ 193,496.00** |
| **County (50%)** | **$ -** | **$ -** | **$ 193,496.00** |
| **TOTAL PAID** | **$ 2,316,447.00** | **$ 2,449,627.00** | **$ 2,208,883.00** |

** Includes all Medicaid services used by the sample population*

Prepared by:
Division of Medical Assistance
12/31/2002

**Cost comparison for CAP/DA, ACH, and NF**

Preliminary Data

**Paid claims for SFY '02 for sample of 75 individuals**

***COST PER RECIPIENT***
***ANALYSIS BY PAYOR***

| | ***CAP/DA Intermediate Level*** | ***Nursing Facility Intermediate Level*** | ***Adult Care Home*** |
|---|---|---|---|
| ***SELECTED CATEGORY AVERAGES*** | | | |
| Pharmacy | $ 3,936.00 | $ 3,106.00 | $ 4,814.00 |
| MH/MR-DD Services | $ 36.00 | $ 20.00 | $ 8,808.00 |
| NF/Hospital Payments | $ 3,787.00 | $ 29,158.00 | $ 1,697.00 |
| CAP Case Management | $ 1,266.00 | $ - | $ - |
| Adult Day Health | $ 268.00 | $ - | $ - |
| Home Health Nursing | $ 852.00 | $ - | $ 786.00 |
| In-Home/Personal Care Aide | $ 17,019.00 | $ - | $ 3,418.00 |
| Home Health Supplies | $ 572.00 | | $ 129.00 |
| Medical Procedures & Testing | $ 536.00 | $ 49.00 | $ 1,201.00 |
| Physician Visits | $ 406.00 | $ 134.00 | $ 700.00 |
| Dental | $ 42.00 | $ 91.00 | $ 149.00 |
| All Other Claims | $ 2,114.00 | $ 99.00 | $ 2,400.00 |
| Special Assistance | $ - | $ - | $ 5,160.00 |
| **Total Annual Cost Per Recipient** | **$ 30,886.00** | **$ 32,662.00** | **$ 29,452.00** |
| ***COST PER RECIPIENT ANALYSIS BY PAYOR*** | | | |
| Federal | $ 18,983.00 | $ 20,074.00 | $ 14,930.00 |
| **State** | **$ 10,118.00** | **$ 10,700.00** | **$ 10,538.00** |
| **County** | **$ 1,785.00** | **$ 1,888.00** | **$ 3,984.00** |

Prepared by:
Division of Medical Assistance
12/31/2002

# APPENDIX M

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2003**

**S** **D**

**BILL DRAFT 2003-SHz-3 [v.8] (1/14)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**1/22/2003 8:18:58 AM**

| | |
|---|---|
| Short Title: LTC Workforce Improvement Program. | (Public) |
| Sponsors: . | |
| Referred to: | |

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT A LONG-TERM CARE WORKFORCE IMPROVEMENT PROGRAM FOR DIRECT CARE WORKERS EMPLOYED BY ADULT CARE HOMES AND HOME CARE AGENCIES IN AN EFFORT TO INCREASE SKILL LEVELS, JOB SATISFACTION, AND RETENTION RATES.

The General Assembly of North Carolina enacts:

**SECTION 1.** The Department of Health and Human Services shall implement the Workforce Improvement for Nursing Assistants: Supporting Training, Education, and Payment for Upgrading Performance (WIN A STEP UP) program, or a similar workforce improvement program, for direct care workers employed by adult care homes and home care agencies.

**SECTION 2.** The Department shall monitor the progress of direct care workers participating in this program and shall make an interim report on program outcomes to the North Carolina Study Commission on Aging by October 1, 2004 and a final report by October 1, 2005. The reports shall include the change in skill base and the level of job satisfaction of program participants employed by adult care homes and home care agencies as compared to those participants employed by nursing homes that participate in the WIN A STEP UP program. The report shall also include turnover rates for program participants as compared to the general direct care population, as well as a measure of employers' satisfaction with the program, and whether employers increased wages or awarded retention bonuses to direct care workers following completion of the training.

**SECTION 3.** There is appropriated to the Department of Health and Human Services the sum of four hundred seventy-nine thousand five hundred and sixty-five dollars ($479,565) for 500 participants for the 2003-2004 fiscal year and the sum of four hundred thirty thousand nine hundred and ninety-nine dollars ($430,999) for the second group of 500 participants for the 2004-2005 fiscal year. The program shall be made

available to direct care employees of adult care homes and home care agencies employed in diverse settings and geographic locations across North Carolina.

**SECTION 4.** The act becomes effective July 1, 2003.

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2003**

**S** **D**

**BILL DRAFT 2003-SWz-6 [v.6] (1/15)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**1/21/2003 11:06:52 AM**

| | |
|---|---|
| Short Title: Long-Term Care/Enhancement Funds. | (Public) |
| Sponsors: . | |
| Referred to: | |

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR LABOR ENHANCEMENT PAYMENTS FOR NURSE AIDES IN NON-INSTITUTIONAL SETTINGS.

The General Assembly of North Carolina enacts:

**SECTION 1.** There is appropriated from the General Fund to the Department of Health and Human Services the sum of twenty-eight million five hundred eighty thousand three hundred three dollars ($28,580,303) for the 2003-2004 fiscal year and the sum of fifty-seven million seven hundred twenty-four thousand three hundred twenty dollars ($57,724,320) for the 2004-2005 fiscal year. These funds shall be used to match federal Medicaid funds to provide a thirty-two and seven hundredths percent (32.07%) labor enhancement payment for Medicaid-reimbursed long-term care services. These funds shall be in addition to funds provided for routine inflationary increases in Medicaid reimbursements for long-term care services. The funds appropriated in this act shall be used only to increase wages or benefits for long-term care aide workers in non-institutional settings, or to provide for shift differential payments for long-term care aides in non-institutional settings who work during hard-to-fill working hours or shifts. Counties shall not be required to pay any of the funds required to match the federal Medicaid funds for the labor enhancement payments authorized by this act.

**SECTION 2.** Funds appropriated in this act shall be allocated in accordance with the following:

(1) The amount of the labor enhancement benefit shall be allocated equitably among the various care settings.

(2) Long-term care facilities and agencies that receive labor enhancement funds shall have the flexibility to determine whether labor enhancement funds are used for wages, benefits, or shift differentials, or any combination thereof.

(3) If labor enhancement funds are used to enhance wages, the long-term care facility or agency shall determine which aides receive wage increases and the amount of the increase provided. The determination shall be based on local market wage demands, rewarding longevity of service by the worker, and other wage-related needs of the agency or facility.

(4) Long-term care facilities and agencies that receive labor enhancement funds shall, as a condition of receiving the funds, submit reports and information required by the Department for the purpose of verifying use of the labor enhancement funds. Reports and information provided by facilities and agencies shall include for each facility and agency information needed to determine annual labor turnover rates in the agency or facility, including data on prelabor enhancement turnover rates and turnover rates at the end of each fiscal year for which labor enhancement funds are received.

**SECTION 3.** Not later than January 15, 2004, the Department of Health and Human Services shall report to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the North Carolina Study Commission on Aging on the use of labor enhancement funds appropriated under this act. The report shall include detailed information on:

(1) The amount of funds used for wages, for benefits, and for shift differentials.

(2) Comparative information on average hourly wages paid to aides and turnover rates by setting for fiscal year 1999-2000 through fiscal year 2003-2004.

**SECTION 4.** This act becomes effective July 1, 2003.

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2003**

**S** **D**

**BILL DRAFT 2003-SWz-9 [v.6] (1/16)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**1/30/2003 12:52:21 PM**

Short Title: CAP/DA Audit/DHHS Report. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT DIRECTING THE STATE AUDITOR TO PERFORM AN AUDIT OF THE COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS (CAP/DA) AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CONTINUE ITS EXAMINATION OF CAP/DA AND REPORT TO THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

**SECTION 1.** (a) The State Auditor shall perform an audit of the Community Alternatives Program for Disabled Adults (CAP/DA). The audit shall build upon the results of the study conducted in accordance with S.L. 2002-126, Part X by the North Carolina Institute of Medicine and shall provide information necessary to determine whether CAP/DA is operating within waiver guidelines and program goals. The State Auditor shall report the results of the audit to the North Carolina Study Commission on Aging by January 1, 2004.

(b) There is appropriated to the Office of State Auditor the sum of one hundred fifty thousand dollars ($150,000) for the 2003-2004 fiscal year to fund the CAP/DA audit prescribed in this section.

**SECTION 2.** The Department of Health and Human Services shall continue to examine CAP/DA and shall make a report of its findings to the North Carolina Study Commission on Aging by January 1, 2004. The report shall include the following information:

(1) A review of the current assessment process for CAP/DA clients, including an explanation of how assessments are conducted and a comparison of the assessment process for CAP/DA clients with the assessment process for nursing home and adult care home clients.

(2) A description of total program costs to the State and counties for clients receiving CAP/DA payments and an analysis of per client costs in CAP/DA to per client costs in nursing homes and adult care homes.

This analysis shall include the costs of all forms of assistance received by CAP/DA clients, such as food stamps and housing assistance.

(3) A description of the monitoring of quality of care for CAP/DA clients.

(4) An evaluation of the current waiting list procedures.

**SECTION 3.** This act becomes effective July 1, 2003.

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2003**

**S** **D**

**BILL DRAFT 2003-SHz-4 [v.6] (1/16)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**1/22/2003 4:58:52 PM**

| | |
|---|---|
| Short Title: Local LTC Planning Pilot Project. | (Public) |
| Sponsors: . | |
| Referred to: | |

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT A PILOT PROJECT FOR LOCAL LONG-TERM CARE PLANNING.

The General Assembly of North Carolina enacts:

**SECTION 1.** In response to Recommendation #16 in the final report from the Institute of Medicine Task Force on Long-Term Care and the study report recommendations resulting from S.L. 2001-491, Part XXII (SB 166), the Department of Health and Human Services shall implement a communications and planning initiative to support local planning for long-term care, and shall pilot the establishment of local lead agencies to facilitate the long-term care planning process at the county or regional level. For those counties that voluntarily participate, the local long-term care planning initiative shall aid in the development of core services, coordinate local planning, and streamline access to services. The initiative shall eliminate fragmentation and barriers to information and services; provide a seamless connection among State agencies and local entities, regardless of funding sources; and allow consumers to efficiently and effectively navigate among long-term care services.

**SECTION 2.** The Department shall submit an interim report on the pilot project for local long-term care planning to the North Carolina Study Commission on Aging by October 1, 2004 and a final report by October 1, 2005.

S**ECTION 3.** There is appropriated to the Department of Health and Human Services the sum of seventy thousand dollars ($70,000) for the 2003-2004 fiscal year and ninety thousand dollars ($90,000) for the 2004-2005 fiscal year to fund the pilot project established in this act.

**SECTION 4.** The act becomes effective July 1, 2003.

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2003**

**S** **D**

**BILL DRAFT 2003-SWz-5 [v.5] (1/14)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**1/16/2003 1:58:50 PM**

| | |
|---|---|
| Short Title: Expand Special Assistance Demo Project. | (Public) |
| Sponsors: . | |
| Referred to: | |

A BILL TO BE ENTITLED

AN ACT TO EXPAND THE STATE/COUNTY SPECIAL ASSISTANCE IN-HOME DEMONSTRATION PROJECT BY PERMITTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INCREASE THE NUMBER OF INDIVIDUALS WHO MAY BE ENROLLED IN THE PROJECT.

The General Assembly of North Carolina enacts:

**SECTION 1.** (a) The Department of Health and Human Services may use funds from the existing State/County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. These payments may be made for up to a two-year period beginning July 1, 2003 and ending June 30, 2005. The standard monthly payment to individuals enrolled in the Special Assistance demonstration project shall be fifty percent (50%) of the monthly payment the individual would receive if the individual resided in an adult care home and qualified for Special Assistance, except if a lesser payment amount is appropriate for the individual as determined by the local case manager. The Department shall implement Special Assistance in-home eligibility policies and procedures to assure that demonstration project participants are those individuals who need and, but for the demonstration project, would seek placement in an adult care home facility. The Department shall make this demonstration project available to all counties on a voluntary basis. To the maximum extent possible, the Department shall consider geographic balance in the dispersion of payments to individuals across the State. The Department shall make an interim report to the cochairs of the House of Representatives Appropriations Committee, the cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services and the cochairs of the Senate Appropriations Committee, the Chair of the Senate Appropriations Committee on Human Resources by June 30, 2004 and a final report by January 1, 2005. The final report shall also be sent to the North Carolina Study Commission on Aging. This report shall include the following information:

(1) A description of cost savings that could occur by allowing individuals eligible for State/County Special Assistance the option of remaining in the home.

(2) Which activities of daily living or other need criteria are reliable indicators for identifying individuals with the greatest need for income supplements for in-home living arrangements.

(3) How much case management is needed and which types of individuals are most in need of case management.

(4) The geographic location of individuals receiving payments under this section.

(5) A description of the services purchased with these payments.

(6) A description of the income levels of individuals who receive payments under this section and the impact on the Medicaid program.

(7) Findings and recommendations as to the feasibility of continuing or expanding the demonstration program.

(8) The level and quantity of services (including personal care services) provided to the demonstration project participants compared to the level and quantity of services for residents in adult care homes.

(9) A fiscal analysis and programmatic results of increasing the demonstration project participant's monthly assistance payment to fifty percent (50%) of the Special Assistance monthly payment.

(10) A fiscal analysis of the budgetary impact of any increases in staff responsibility resulting from utilization of the Demonstration Program.

(b) The Department shall incorporate data collection tools designed to compare quality of life among institutionalized vs. noninstitutionalized populations (i.e. an individual's perception of his or her own health and well-being, years of healthy life, and activity limitations). To the extent national standards are available, the Department shall utilize those standards.

(c) The Department shall expand its report of the Demonstration Program in order to fully assess the success of the pilot. The Department shall contract with an independent consultant to develop an evaluation design that ensures that the evaluation includes an assessment of the impact of the Program on the economic security, health, and well-being of the participants.

**SECTION 2.** The Department of Health and Human Services shall use funds appropriated to it for the 2003 biennium for the Special Assistance payments authorized in Section 1 of this act.

**SECTION 3.** This act becomes effective July 1, 2003.

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2003**

**S** **D**

**BILL DRAFT 2003-SWz-4 [v.3] (1/14)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**1/21/2003 11:18:11 AM**

| | |
|---|---|
| Short Title: Long-term Care Remediation/Study. | (Public) |
| Sponsors: . | |
| Referred to: | |

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY THE IMPLEMENTATION OF A REMEDIATION PROGRAM FOR LONG-TERM CARE FACILITIES.

The General Assembly of North Carolina enacts:

**SECTION 1.** The Department of Health and Human Services shall study the feasibility of implementing a remediation program for long-term care facilities in this State that is similar to the Collaborative Remediation Project in Michigan, in which long-term care providers are furnished assistance in achieving and maintaining compliance with licensure and certification requirements. In undertaking this study, the Department shall consult with providers of long-term care and other long-term care interest groups. The Department shall report its findings and recommendations, including implementation costs and any necessary statutory changes, to the North Carolina Study Commission on Aging on or before April 1, 2004.

**SECTION 2.** This act is effective when it becomes law.

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2003**

**S** **D**

**BILL DRAFT 2003-SWz-8 [v.3] (1/16)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**1/21/2003 11:58:56 AM**

Short Title: DHHS/Ensure No Felons Emp. in Long-Term Care. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A GROUP WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ENSURE THAT FELONS ARE NOT EMPLOYED BY LONG-TERM CARE FACILITIES AND HOME CARE AGENCIES AND TO REPEAL THE MORATORIUM ON THE EFFECTIVE DATE OF LONG-TERM CARE CRIMINAL CHECKS.

The General Assembly of North Carolina enacts:

**SECTION 1.** The Department of Health and Human Services shall establish a group within the Department to ensure that convicted felons are not employed by nursing homes, adult care homes and home care agencies. If the Department determines that statutory changes are needed in order to execute this mandate, the Department shall report proposed statutory changes and the fiscal impact of those changes to the North Carolina Study Commission on Aging on or before April 1, 2004. In connection with this mandate, the moratorium on the effective date of long-term care criminal checks established in S.L. 2002-126, Section 10.10C, is repealed.

**SECTION 2.** There is appropriated to the Department of Health and Human Services the sum of one hundred thirty-three thousand three hundred twenty-eight dollars ($133,328) for the 2003-2004 fiscal year and the sum of one hundred fifty-three thousand seven hundred seventy dollars ($153,770) for the 2004-2005 fiscal year to implement this act.

**SECTION 3.** This act becomes effective July 1, 2003.

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2003**

**S** **D**

**BILL DRAFT 2003-SHz-1 [v.3] (1/13)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**1/17/2003 1:42:06 PM**

| | | |
|---|---|---|
| Short Title: | Guardianship Study. | (Public) |
| Sponsors: | Unknown. | |
| Referred to: | | |

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A LEGISLATIVE STUDY COMMISSION ON STATE GUARDIANSHIP LAWS.

Whereas, State laws pertaining to guardianship and powers of attorney are important for the protection of citizens who are unable to make personal decisions due to mental or physical impairment or incapacity; and

Whereas, by virtue of an increasing elderly population, the number and circumstance of persons who currently need or may need in the future alternate decision makers to act in their best interest is also increasing; and

Whereas, the State's guardianship laws have not been thoroughly reviewed in more than 12 years to determine if changes in content or policy are needed to strengthen the efficiency and effectiveness of these laws; Now, therefore,

The General Assembly of North Carolina enacts:

**SECTION 1.(a)** There is created the Legislative Study Commission on State Guardianship Laws. The purpose of the Commission is to review State law pertaining to guardianship and its relationship to other pertinent State laws such as the health care power of attorney, the right to a natural death, and durable power of attorney.

**SECTION 1.(b)** The Commission shall consist of 14 members, seven members appointed by the Speaker of the House of Representatives, at least four of whom shall be members of the House of Representatives, and seven members appointed by the President Pro Tempore of the Senate, at least four of whom shall be members of the Senate. The public members appointed by the Speaker and the President Pro Tempore shall be such persons as have experience with the State guardianship laws, including court administrators, attorneys, judges, public or private guardians, or representatives of the interest of elderly and disabled persons. The Speaker shall designate one Representative as cochair and the President Pro Tempore shall designate one Senator as cochair. Vacancies on the Commission shall be filled by the same

appointing authority as made the initial appointment. The Commission shall expire upon delivering its final report.

The Commission, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Commission may meet at any time upon the joint call of the cochairs. The Commission may meet in the Legislative Building or the Legislative Office Building. The Commission may contract for professional, clerical, or consultant services as provided by G.S. 120-32.02.

The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Commission in its work. The House of Representatives' and the Senate's Supervisors of Clerks shall assign clerical staff to the Commission, and the expenses relating to the clerical employees shall be borne by the Commission. Members of the Commission shall receive subsistence and travel expenses at the rates set forth in G.S. 120-3.1, 138-5, or 138-6, as appropriate.

**SECTION 1.(c)** In conducting the study, the Commission shall consider the following:

(1) Whether guardianship should be a remedy of last resort used only if less restrictive alternatives are insufficient.
(2) The definition of incompetency.
(3) Whether courts should be required to make express findings regarding the extent of a person's incapacity and limit the scope of the guardianship accordingly.
(4) Legal rights retained or lost as a result of being adjudicated incompetent.
(5) The proper role of attorneys and guardians ad litem in guardianship proceedings.
(6) The role of public human services agencies in providing guardianship services.
(7) Legal procedures and protections in guardianship proceedings.
(8) Public monitoring of guardianship.
(9) Funding for guardianship services provided by public and nonprofit agencies.
(10) Educating citizens with respect to guardianship and alternatives to guardianship.
(11) Prudent investor rules.
(12) Powers, duties, and liabilities of guardians.
(13) Review of the State's adult protective services law.
(14) Enactment of the Uniform Guardianship and Protective Proceedings Act (UGPPA).
(15) Whether guardianship statutes need revision to provide greater protection of the health and welfare of incapacitated adults.
(16) Whether the State should track the number of people under private guardianship and, if so, proposed methods for the tracking.

**SECTION 2.** The Legislative Study Commission on State Guardianship Laws may make an interim report to the 2003 General Assembly not later than the

convening of the 2003 General Assembly, 2004 Regular Session, and shall make its final report to the 2005 General Assembly upon its convening.

**SECTION 3.** All State departments and agencies and local governments and their subdivisions shall furnish the Commission with any information in their possession or available to them.

**SECTION 4.** There is appropriated from the General Fund to the General Assembly the sum of thirty thousand dollars ($30,000) for the 2003-2004 fiscal year and the sum of thirty thousand dollars ($30,000) for the 2004-2005 fiscal year to carry out the purposes of this act.

**SECTION 5.** This act becomes effective July 1, 2003.

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2003**

**S** **D**

**BILL DRAFT 2003-SWz-7 [v.2] (1/16)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**1/30/2003 12:54:30 PM**

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|---|---|
| Short Title: Repeal Long-Term Care Ins. Tax Credit Sunset. | (Public) |
| Sponsors: . | |
| Referred to: | |

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE SUNSET ON THE LONG-TERM CARE INSURANCE TAX CREDIT.

The General Assembly of North Carolina enacts:

**SECTION 1.** Section 29A.6(d) of S.L. 1998-212 reads as rewritten:

"(d) Subsection (a) of this section is effective for taxable years beginning on or after ~~January 1, 1999, and expires for taxable years beginning on or after January 1, 2004.~~ January 1, 1999. The remainder of this section is effective when it becomes law. ~~G.S. 105-160.3(b)(7), as enacted by this act, is repealed effective for taxable years beginning on or after January 1, 2004.~~"

**SECTION 2.** This act is effective when it becomes law.