NORTH CAROLINA

STUDY COMMISSION ON AGING

REPORT TO THE
GOVERNOR AND THE 2004 REGULAR SESSION OF THE
2003 GENERAL ASSEMBLY

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North Carolina
Study Commission On Aging

April 27, 2004

To: Governor Michael Easley
Lieutenant Governor Beverly Perdue, President of the North Carolina Senate
Senator Marc Basnight, President Pro Tempore of the North Carolina Senate
Representative James Black, Speaker of the North Carolina House of Representatives
Representative Richard Morgan, Speaker of the North Carolina House of Representatives
Members of the 2003 General Assembly, Regular Session 2004

Attached is a report from the North Carolina Study Commission on Aging submitted to you pursuant to North Carolina General Statute §120-187. The North Carolina Study Commission on Aging presents to you findings and recommendations based on study conducted after the adjournment of the 2003 Regular Session of the 2003 General Assembly. Proposed legislation is contained within this report.

Respectfully submitted,

_____
Senator A.B. Swindell, IV
Co-Chair

_____
Representative Debbie A. Clary
Co-Chair

_____
Representative Edd Nye
Co-Chair

North Carolina Study Commission On Aging

2004 Membership List

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Senator Charlie S. Dannelly

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(SWz-33) AN ACT TO ESTABLISH THE LEGISLATIVE STUDY COMMISSION ON STATE GUARDIANSHIP LAWS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

(SHz-11) AN ACT TO APPROPRIATE FUNDS AND TO REQUIRE THE SOCIAL SERVICES COMMISSION TO ADOPT A RATE INCREASE FOR ADULT DAY SERVICES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

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 2003 Session of the 2003 General Assembly until the convening of the 2004 Session of the 2003 General Assembly. The Study Commission on Aging met on five occasions to study a variety of topics concerning older adults including: guardianship, a long-term care insurance tax credit, caring for the mentally ill in long-term care facilities, prescription drug assistance, disease management, elder care housing, the long-term care workforce, adult day services, the Home and Community Care Block Grant, and criminal history record checks of long-term care employees. During the course of its study, the Commission also heard presentations by representatives from fourteen (14) organizations advocating on behalf of older adults in North Carolina.

EXECUTIVE SUMMARY

North Carolina General Statutes Chapter 143B, Article 3, Parts 14A. and 14B. establish North Carolina's Policy Act for the Aging, and Long-Term Care. The principles of the Policy Act for the Aging are to effectively utilize the resources of the State, to provide a better quality of life for senior citizens, and to assure older adults the right of choosing where and how they want to live. The Long-Term Care policy recognizes that traditional caregivers are increasingly employed outside the home and create a growing demand for improvement and expansion of home and community-based long-term care services to support and complement the services provided by informal caregivers. The long-term care policy provides that the public interest would best be served by a broad array of long-term care services that support persons who need services in the home or in the community whenever practicable, and that promote individual autonomy, dignity and choice. The provision also provides that institutional care will continue to be a critical part of the State's long-term care options and that services should promote individual dignity, autonomy, and a home-like environment.

The current size of North Carolina's older adult population, and trends indicating that this segment of the population will increase, indicate the importance of an intense and sustained focus on the support systems and services that North Carolina has in place for older adults. Study efforts undertaken during the 2003-2004 interim by the North Carolina Study Commission on Aging, sought to evaluate the existing system of services to older adults and to recommend improvements. In response to this study, the North Carolina Study Commission on Aging makes the following recommendations to the Governor and the 2004 Session of the 2003 General Assembly:

Recommendation 1
The North Carolina Study Commission on Aging recommends that the General Assembly repeal the sunset on the Long-Term Care Insurance Tax Credit.

Recommendation 2
The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

Recommendation 3
The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.

Recommendation 4
The North Carolina Study Commission on Aging recommends that the General Assembly establish a pilot program to conduct national criminal history record checks of persons seeking employment to provide direct care in adult care homes or contract agencies of adult care homes.

Recommendation 5
The North Carolina Study Commission on Aging recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.

Recommendation 6
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.

Recommendation 7
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.

Recommendation 8
The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to study whether the State's Medicaid Program has a bias that favors support for individuals in institutional settings over support for individuals living at home; and to recommend ways to alleviate this bias, if such a bias exists.

Recommendation 9
The North Carolina Study Commission on Aging recommends that the General Assembly establish a Legislative Study Commission to study State guardianship laws.

Recommendation 10
The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.

OLDER ADULTS IN NORTH CAROLINA: A PROFILE

Prepared by the Department of Health and Human Services, Division of Aging and Adult Services

Older Population Today

North Carolina ranks tenth among states in the number of persons age 65 and older and eleventh in the size of the entire population.[i] The fast pace of growth of the State's older population is evident in a recent US Census Bureau's release in which North Carolina was ranked fourth nationally in the increase of the number of older persons age 65+ (47,198 in NC) between April 2000 to July 2003. Only three other states (California, Texas, and Florida) reported a greater increase among their older populations. Even so, when combined with the equally strong growth in other age groups, the State continues to maintain an overall healthy demographic balance among the generations. Currently, North Carolina ranks thirty-third nationally in the percentage of the population that is 65 years of age and older (65+).

- North Carolina population age 65+ in 2004: 1,016,214 (12.1% of total population)
- North Carolina population age 85+ in 2004: 118,511 (1.4% of the total population)

North Carolina is rich in diversity, but its citizens face challenges because of the disparity that exists among all populations, including older adults. Some important differences among the State's older adults relate to gender, marital status, race/ethnicity, residence, rurality, disability, health status, and veteran status.

- Gender: Older women represent 59.8% of the 65+ age group and 74.0% of the 85+ age group.[ii] The higher rate of poverty among older women remains a primary issue today. For example, women age 75+ are twice as likely to be poor as men the same age.[iii]

- Marital Status: At age 65 and older, women are more than twice as likely to be unmarried as men in their age group.[iv] Data show that being unmarried (widowed, divorced, separated, or never married) increases a woman's vulnerability to poverty. According to the Social Security Administration, 50% of unmarried women rely on Social Security for 80% of their income and 25% rely on Social Security as their sole source of income.[v]

	Age 65-74	Age 75-84	Age 85+
Unmarried Women in NC	45.4%	65.8%	76.5%
Unmarried Men in NC	18.7%	25.2%	39.4%

Source: NC Division of Aging and Adult Services (2003). The Aging of North Carolina: The 2003-2007 North Carolina Aging Services Plan

- Ethnicity/Race: Altogether 18.1% of persons age 65+ are members of ethnic minority groups in North Carolina.[vi] Compared to the nation as a whole, North Carolina's population age 65+ includes a larger proportion who are African American (15.3% in NC to 8.3% nationally) and a smaller proportion of Latinos (0.6% in NC to 4.7% nationally). American Indians, Asian Americans, and other ethnic groups each account for 1% or less of the age group 65+. The statistics for African American and other older adults who are minority group members, in North Carolina as well as nationally, show both a higher poverty rate and a lower life

expectancy when compared with the white population.

	65+	White		Minority	
	Total	Male	Female	Male	Female
Below Poverty	13.2%	6.5%	12.9%	21.7%	30.3%
"Near Poor"(101-200% Poverty)	23.2%	–*	–*	–*	–*
Life Expectancy at Birth (years)	75.6	73.8	79.6	68.0	75.8
Life Expectancy at Age 65 (years)	17.1	15.4	18.9	13.8	17.8

**Information currently not available.*
Source: NC Division of Public Health (2002). Healthy Life Expectancy in North Carolina, 1996-2000.

- Residence: In North Carolina, 23.8% of all homeowners are age 65+, yet among older homeowners, over 61,000 reported incomes for 1999 that were below poverty.[vii] This figure represented 38% of the homeowners of all ages with income below poverty and exceeded the national average of 32.7%. Among renters age 65+ who provided information, 53%, or almost 48,000, spent more than 30% of their household income on rent. Furthermore, 5,000 North Carolina homeowners and renters age 65+ lacked complete plumbing facilities in their homes.[viii] Even more disturbing news is found in the statistics of emergency shelters—where the largest increase among the homeless between 2001 and 2002 in North Carolina were among those 55+.[ix] While the total population of homeless reported by shelters increased by 5% during this period, the elder homeless grew by 71% (totaling 3,494 persons in 2002).

- Rurality: Although the United States Census Bureau has not yet released figures specifically for the older population residing in rural areas, it is expected to easily exceed 39.8%, the rate for the total population.[x] In 2000, North Carolina's rural population (3,199,831) was almost as large as the one in Texas (3,647,539), the state with the largest number of rural residents in the nation. Not only was North Carolina's rural population among the largest in terms of numbers, but the state also reported the highest proportion (39.8%) of rural population among the 20 most populous states in the nation. While 11 other states reported higher proportions of rural population, ranging from 40.7% to 61.8%, all of these states are much smaller in total population than North Carolina. Thus, North Carolina is unique among more populous states in having so large a rural contingent. A 2002 report highlights a long list of challenges rural residents and their communities face—isolation by distance, lagging infrastructure, sparse resources that cannot adequately support education and other public services, and weak economic competitiveness.[xi]

- Disability: In North Carolina, 45.7% of the non-institutionalized civilian population age 65+ reported having one or more disablities• 47.5% of women and 43.2% of men, according to the 2000 Census.[xii] The Census defines disability as "a long-lasting physical, mental, or emotional condition. This condition can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. This condition can also impede a person from being able to go outside the home alone or to work at a job or business."

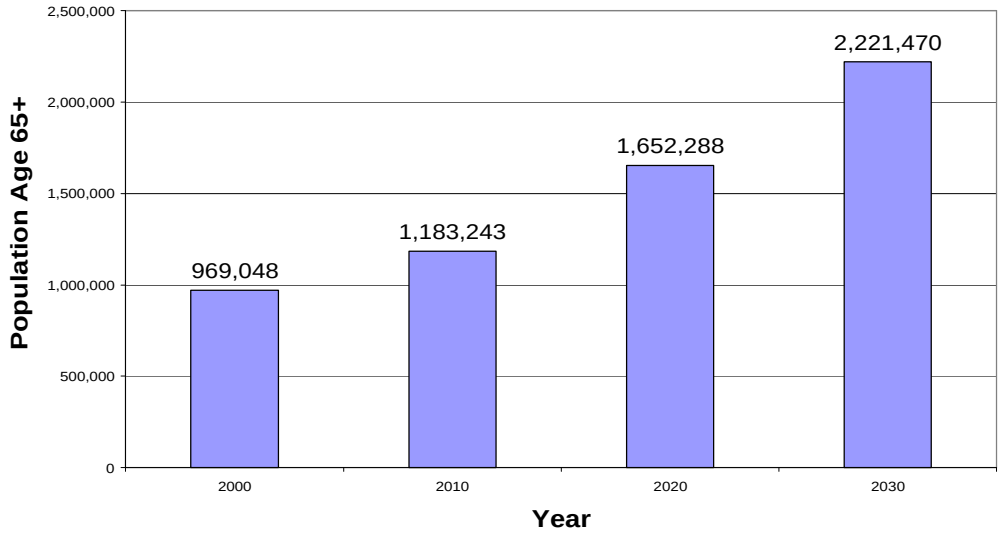
- Health Status: In a statewide survey, over one third of people age 65+ say that their general health status is fair or poor, ranging from 34.1% for white women to 49.3% for minority women.[xiii] In the same survey, 18.4% (highest) of minority women and 4.4% (lowest) of white men age 65+ said that there was a time they could not see a doctor due to medical cost.

- Veteran Status: Of the 779,393 veterans living in North Carolina, 263,102, or 34%, were age 65 and older in 2000. Another 34% were Vietnam-era veterans (between 43 and 57 years old in 2000). The population of veterans of the Vietnam-era contains proportionally more disabled members than the veterans' populations of earlier wars.[xiv] The Veterans Administration cites the aging of the veterans as a major challenge to its health care system in coming years.[xv]

North Carolina's Demographic Shift

Older adults are North Carolina's fastest growing population. By 2030, our senior population should exceed more than 2.2 million, comprising 17.9% of total population.[xvi] The median age climbs from 35.3 years in 2000 to 38.4 years in 2030.

Projected Growth of Population Age 65+ (2000 – 2030)



Why This Demographic Shift

A combination of improved life expectancy and lower birth rates contributes to a society's "aging". In North Carolina, as anywhere in the nation, the aging of the "Baby Boomers" (born between 1946 and 1964) will greatly accelerate this societal aging in coming years. Another factor in the State's aging is migration. North Carolina ranked sixth among the states with a net migration rate of 22.1 per 1,000 among persons age 65+, in the five-year period between 1995 and 2000. [Note: A positive net migration indicates that more older adults moved to North Carolina than left during that time.] Along with other Sunbelt states, North Carolina remains a popular destination for people of all ages, including seniors. Other southern states with high positive net migration among older adults include: Florida (56.9); South Carolina (33.6); Georgia (18.1); and Tennessee (15.2).

There are other important factors influencing the diverse experiences in demographic shifts among the State's 100 counties.[xvii] In 83 counties, the rate of increase among citizens age 65+ (22%) is expected to exceed the growth of the total population (18%).

- Rural-to-urban migration of young adults continues to age rural counties.
- Large metropolitan counties attract large numbers of persons from outside the State as well as from rural counties.
- The large metropolitan counties are experiencing greater growth among younger adults than

they are among older adults.
- A large number of older adults with higher incomes are retiring in some western and coastal counties.

What Are the Implications of This Shift?

The aging of the population is a national and international trend, and North Carolina, like the rest of the world, must be prepared to reap the benefits and face the challenges of an older population. Government faces decisions about the allocation of public resources from a tax base that may experience slowed growth, especially in many aging rural counties. People must consider living and caregiving arrangements in light of smaller nuclear and extended families. The health, human service, employment, and education systems must adapt to the changing needs and interests of seniors of today and tomorrow. The business, faith communities, and others must identify and respond to the challenges and opportunities of these demographic shifts.

In the 2003-2007 State Aging Plan, the North Carolina Division of Aging and Adult Services introduced a new initiative–Senior-Friendly Communities–to raise awareness of the aging of our population and to promote the North Carolina communities becoming senior-friendly through collaboration among citizens, agencies, organizations, and programs, in both the public and private arenas. A senior-friendly community in North Carolina will draw on the talents and resources of active seniors while enhancing services for those are vulnerable because of their health, economic hardships, social isolation, or other conditions. A senior-friendly community will bring together a wide range of issues and concerns (e.g., air quality, housing, long-term care services, employment, enrichment opportunities) that, as a whole, affect the quality of life of seniors and others in the community. Also, a senior-friendly community will assure stewardship of its resources to meet the needs of today's seniors, while helping baby boomers and younger generations prepare for the future.

For additional information on North Carolina aging demographics, please refer to Appendix A.

Sources of Information

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COMMISSION PROCEEDINGS

February 10, 2004

The North Carolina Study Commission on Aging met on Tuesday, February 10, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Representative Edd Nye was the presiding Co-Chair. Following Commission member introductions and approval of the budget, Theresa Matula, Commission staff, provided an overview of the statutory basis for the Commission and its charge. By law, the Commission is required to study and evaluate the existing system of delivery of State services to older adults and to recommend an improved system of delivery to meet the present and future needs of older adults. Mrs. Matula pointed out the specific duties of the Commission as they appear in G.S. 120-181, and the reporting requirements contained in G.S. 120-187.

Theresa Matula and Dianna Jessup, Commission staff, reviewed the status of the Commission's recommendations to the 2003 Session of the 2003 General Assembly and presented an overview of other legislation of interest to older adults Appendix B.

Karen Gottovi, Director, Division of Aging and Adult Services, Department of Health and Human Services (DHHS), presented an overview of the services available for older adults in North Carolina Appendix C. Mrs. Gottovi also presented *The Aging of North Carolina*, the 2003-2007 North Carolina Aging Services Plan. The Plan was submitted to the North Carolina General Assembly on March 1, 2003. Mrs. Gottovi pointed out that the 2003-2007 Plan builds upon the achievements of the 1999-2003 Plan as well as three other earlier plans developed in the 1990s (1991, 1993, and 1995) and provides a foundation for new developments. The Aging Services Plan is required by G.S. 143B-181.1A and the federal Older American Act.

John Saxon, Professor of Public Law and Government, University of North Carolina at Chapel Hill gave a presentation on guardianship laws. Appendix D. The presentation outlined the legal history of guardianship reform, the current law and issues that may need to be addressed, as well as and overview of the Uniform Guardianship and Protective Proceedings Act (UGPPA).

The North Carolina tax credit for long term care insurance expired for taxable years beginning on or after January 1, 2004. As a result, the Commission heard from Carla Obiol with the Department of Insurance's Seniors' Health Insurance Information Program (SHIIP), who gave an overview of long term care insurance. Her handouts included: *A Shopper's Guide to Long-Term Care Insurance* and *Facts About Long-Term Care Insurance In North Carolina* . Additionally, Karl Knapp from the Tax Research Division, and Nancy Pomeranz from the Personal Taxes Division, of the North Carolina Department of Revenue, made presentations on the tax treatment of long-term care insurance in selected states, and on the number of long-term care tax credits claimed in North Carolina Appendix E. Ms. Pomeranz discussed the error rate experienced on the long-term care tax credit and the Department's efforts to reduce that error rate. Some of the Department's efforts include informing taxpayers who made errors, and working with software vendors to improve the long-term care tax credit information in their programs.

The final item on the agenda concerned adult care home rules and caring for the mentally ill. The Commission heard presentations from Jim Upchurch, Division of Facility Services, Department of Health and Human Services Appendix F; Dottie Harrison, Board Member, NC National Alliance for the Mentally Ill (NAMI); and Lou Wilson, NC Association of Long Term

Care Facilities. Ms. Harrison addressed the consequences of the lack of appropriate housing for mentally ill individuals and her concerns for adequate staffing and training to care for mentally ill individuals in long-term care facilities. Ms. Wilson mentioned the use of the Geriatric Mental Health Specialty Teams and provided recommendations for improvement.

March 9, 2004

The North Carolina Study Commission on Aging met on Tuesday, March 9, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Senator A.B. Swindell was the presiding Co-Chair. Topics of this meeting included brief remarks by organizations advocating on behalf of older adults in North Carolina; disease management; NC Senior Care; the new Medicare prescription drug program; and geriatric mental health specialty teams.

The Commission heard from fifteen (15) individuals that represent, or advocate on behalf of, older adults in North Carolina. Each representative was allowed approximately three minutes to make a brief presentation on the issues affecting older adults in North Carolina. Staff presented the Commission members with a *Summary of Presentations by Organizations Representing Older Adults* Appendix G during the March 23, 2004 meeting. The legislative priorities/issues of concern that were mentioned with the greatest frequency were: Access to National Criminal Record Checks (6 responses); Restoration of the LTC Insurance Tax Credit (4 responses); Support for and/or Restoration of Funding for the home and Community Care Block Grant (HCCBG) (3 responses); Support for/and or Restoration of Funding for Senior Centers (3 responses); and Maintaining the Viability of the Community Alternatives Program for Disabled Adults (CAP/DA) (3 responses) Appendix G.

Alan Dobson, Chairman of Cabarrus Community Care; Chairman of Physician Advisory Group; and President/CEO of Cabarrus Family Medicine delivered a presentation on disease management. Community Care of North Carolina focuses on improved quality, utilization and cost effectiveness with thirteen (13) networks with more than 2,000 physicians and 417,000 enrollees. Dr. Dobson indicated that the primary goals of Community Care of North Carolina are to: Improve the care of the Medicaid population while controlling costs; and to Develop community based networks capable of managing populations. He pointed out that these goals are achieved by making sure people get the care when they need it; increasing local provider collaboration; obtaining quality care; implementing best practice guidelines; and managing Medicaid costs. Key program efforts for the aged and disabled include: diabetes, poly-pharmacy in skilled nursing facilities, poly-pharmacy for the disabled, and therapy services.

Michael Keough, from the Department of Health and Human Services, gave a presentation on the North Carolina Senior Care program. He first gave an overview of the program, which is designed specifically to provide assistance to North Carolina seniors (age 65 or older), diagnosed with one of three diseases (diabetes mellitus, cardiovascular disease, and chronic obstructive pulmonary disease); have an annual household income at or below 200% of the federal poverty level and no other prescription drug coverage. As of March 2004, there were 32,600 enrollees, representing all 100 counties. Outreach efforts include the distribution of 400,000 enrollment applications and an outreach grant with the General Baptist State Convention. Mr. Keough also presented information on the Medication Assistance Program in which 23 grantees cover 60 sites in 60 counties. The key components of the Medication Assistance Program include: Prescription Assistance (facilitating use of pharmaceutical manufacturers' free and low cost drug programs), and Medication Management including pharmacist evaluation of individual senior's drug

regimens. NC Senior Care is reviewing options to coordinate coverage with the recently enacted changes to the Medicare program.

Carla Obiol, Deputy Commissioner, Seniors' Health Insurance Information Program (SHIIP) made a presentation to the Commission on the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Act). Ms. Obiol gave an overview of the timetable of benefits, information on the Medicare Prescription Drug Discount Card and the Transitional Assistance Program, the discount card sponsor qualifications, Medicare Part D: Prescription Drug Plan (PDP), and outreach efforts by SHIIP and the Centers for Medicare & Medicaid Services (CMS). Provisions of the Act include a Medicare-approved Prescription Drug Discount Card, a Transitional Assistance Program, and Medicare Advantage from 2004-2005. It is anticipated that Medicare Part D: Prescription Drug Plan will be in place by 2006. Details are continuing to evolve and Ms. Obiol recommended the following resources: the Medicare Program: http://www.medicare.gov/ or http://www.cms.gov/ or 1-800-MEDICARE; and SHIIP http://www.ncshiip.com./ (*see Senior Citizens heading*).

This meeting concluded with a presentation on Geriatric Mental Health Specialty Teams from Dr. Bonnie Morell, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Health and Human Services. According to Dr. Morell, the Geriatric Mental Health Specialty Teams were developed to provide expertise and services throughout the State in recognition of the need for greater local capacity to address and serve the needs of older adults with mental illness. According to information presented, "The purpose of these teams is to increase the ability of older adults with mental illness to live successfully in their communities by: 1) assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals, and 2) providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization." Appendix F

March 23, 2004

The North Carolina Study Commission on Aging met on Tuesday, March 23, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Representative Debbie Clary was the presiding Co-Chair. Presentation topics for this meeting were elder housing, the long-term care workforce, adult day services, the Home and Community Care Block Grant (HCCBG), a report on CAP/DA, and criminal history record checks.

Bob Kucab, Executive Director of the North Carolina Housing Finance Agency, spoke to the Commission about the work of the agency. The purpose of the agency is to finance housing for persons who are not served by the private market. The agency helps seniors by improving their existing housing and by working to develop new apartments where seniors can have affordable rents, good living environments, and connections to community services. While the agency is involved in a number of projects, applications for funding exceed available capital by 3 to 1. Mr. Kucab requested an increase in the $3 million State appropriation for the Housing Trust Fund to aid the agency in its efforts.

Susan Harmuth from the Office of Long Term Care and Family Services, Department of Health and Human Services (DHHS), updated the Commission on the Department's long-term care workforce initiatives. She reported that employee turnover has been decreasing since 2000, but it is still high. The Department is working on a variety of projects to combat this turnover. One

of these projects is The Better Jobs/Better Care Demonstration. Under this demonstration, the State's Better Jobs/Better Care Partner Team is working to develop a uniform (and voluntary) set of expectations and criteria for use across home care, adult care homes and nursing facilities that relate to issues impacting the recruitment and retention of direct care workers. Major domain areas include safe and balanced workloads, training and career advancement opportunities, supportive workplaces, worker empowerment, peer mentoring, orientation, management support, coaching supervision, and reward and recognition.

Following Ms. Harmuth's presentation, the Commission heard several presentations concerning adult day and adult day health services. Nancy J. Cox, Director of Partners in Caregiving, Wake Forest University School of Medicine, presented information concerning the predictors of success for adult day programs from a marketing, financing, and programming perspective. Created in 1987 by The Robert Wood Johnson Foundation, Partners in Caregiving is a national adult day services program. The focus of Partners in Caregiving is to teach non-profit adult day centers the principles of business and marketing to be financially self-sufficient and not rely on grants. She presented the results of a recent national study of adult day services that showed the need for adult day service capacity building at the State level in three areas: increased public awareness in underutilized areas, increased availability in areas where the service is not currently an option for caregivers, and increased knowledge at the provider level regarding predictors of success.

Suzi Kennedy from the Life Enrichment Center of Cleveland County, Inc. spoke about the challenges of operating a successful adult day program. Ms. Kennedy showed pictures of the facilities in her area and presented the "Menu for Financial Success for the Life Enrichment Center." This Menu included: 1) a strong Board with effective committees; 2) diversified revenue streams (operating and non-operating); 3) a diversified population; 4) unbundling the services (i.e. transportation, personal care services, hair care); and 5) pre-billing for enrollment rather than attendance, for the levels of care, and for ancillary services. Ms. Kennedy stated that, "Without financial stability there can be no social good," and she pointed out that public reimbursement rates are often insufficient to cover the costs of running a program.

Steve Freedman from the Division of Aging and Adult Services, DHHS, was the final speaker on the subject of adult day services Appendix I. Mr. Freedman stated that there are currently 113 certified adult day and adult day health programs in the State, a decrease from the peak of 125 programs in 2000. The programs are currently located in 60 counties. The Division of Aging and Adult Services has been working with the North Carolina Adult Day Services Association to develop fiscal training for adult day programs. According to the Division, the aim of this project is to assist adult day programs with budgeting and help increase their understanding of service costs. Mr. Freedman also addressed reimbursement rates. Currently, the maximum reimbursement rate for adult day services is $26.07 per day, and $33.00 per day for adult day health services. According to the North Carolina Adult Day Services Association, the average cost to operate an adult day program is $31.00 per day, and for adult day health programs it is $44.00 per day. In the 2003 budget bill, the General Assembly directed the Social Services Commission to consider adopting rules to increase these rates within existing funds. A rate increase has not occurred.

Next, Dennis Streets from the Division of Aging and Adult Services, DHHS presented information concerning the Home and Community Care Block Grant Appendix H. The Home and Community Care Block Grant (HCCBG) was established by the General Assembly in 1992.

By consolidating several funding sources (i.e. the Older Americans Act, the Social Services Block Grant in support of respite care, portions of the State In-Home and Adult Day Care funds, and other relevant State appropriations), the HCCBG helps to coordinate the service delivery system to meet the needs of seniors. The focus of the HCCBG is to support the frail elderly at home, assist with access to services and information, provide family caregiver relief and help seniors remain active. While there have been some increases in federal funds, State support has decreased. According to Mr. Streets, there are more than 6,500 unmet service needs, especially for home-delivered meals and in-home aide services.

Gary Fuquay, Division of Medical Assistance, DHHS, presented a report on the Community Alternatives Program for Disabled Adults (CAP/DA), required by S.L. 2003-284, Sec. 10.29B(b) and (c). The section basically required the Department to conduct a cost analysis of CAP/DA and the State/County Special Assistance In-Home program in relation to the per client cost of nursing homes and adult care homes. While the report attempted to provide cost comparisons, Mr. Fuquay warned that it is difficult to draw conclusions from the data because one cannot compare level of care indicators.

The Commission next heard from various speakers concerning national criminal history records checks of long-term care workers. John Aldridge from the North Carolina Attorney General's Office gave an overview of current law regarding who can receive the results of national criminal history records checks and for what purposes. Jackie Sheppard from the Office of Long-Term Care and Family Services, DHHS, gave an overview of what the state of Mississippi is doing to address this issue. Roger Manus, representing Friends of Residents in Long-Term Care, urged the Commission to look at Florida's system for conducting background checks. Stacy Flannery, representing the NC Health Care Facilities Association, presented the providers' concerns about this issue.

Finally, the meeting concluded with a brief presentation summarizing Appendix G the association presentations from the March 9 meeting. Chief among the issues raised by the associations was the current moratorium on national criminal history records checks of long-term care workers.

April 13, 2004

The North Carolina Study Commission on Aging met on Tuesday, April 13, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Senator A.B. Swindell was the presiding Co-Chair. During this meeting, the Commission heard a presentation from Jackie Franklin with the Division of Aging and Adult Services, Department of Health and Human Services, on the State/County Special Assistance In-Home program. The Commission discussed and initially approved recommendations to the Governor and the General Assembly. The Commission also directed the staff to prepare a draft report for review at the final meeting.

April 27, 2004

The North Carolina Study Commission on Aging met on Tuesday, April 27, 2004 at 10:00 a.m. in Room 643 of the Legislative Office Building. Members discussed and approved the Commission's Report to the Governor and to the 2004 Session of the 2003 General Assembly.

COMMISSION RECOMMENDATIONS

The North Carolina Study Commission on Aging makes the recommendations presented in this section to the Governor and the 2004 Session of the 2003 General Assembly. Each recommendation is followed by background information, and corresponding legislative proposals appear in Appendix J of this report.

Recommendation 1

The North Carolina Study Commission on Aging recommends that the General Assembly repeal the sunset on the Long-Term Care Insurance Tax Credit.

Background

In 1997, the North Carolina Study Commission on Aging recommended that the 1997 General Assembly enact a 15% tax credit, up to a maximum of $350, on the premiums paid by the purchaser of long-term care insurance policies. According to the 1997 Commission report, the Office of State Budget and Management estimated that a 15% tax credit up to a maximum of $350 may result in a revenue loss of $17 million. The report further stated that, the average premium was $1,600, thus a 15% credit would be equal to $240. The report acknowledged that it was difficult to estimate the offsetting benefits of the tax credit in terms of reduced Medicaid payments, but that the cost of a year's stay in a North Carolina nursing home was $40,000. The Commission recommended this tax credit again in 1998, and the credit became Section 29A.6 of Session Law 1998-212. The tax credit was effective for taxable years beginning on or after January 1, 1999, and expired for taxable years beginning on or after January 1, 2004.

On January 16, 2003, the Department of Revenue prepared a memorandum for the Revenue Laws Study Committee on the status of the tax credit for premiums paid on long-term care insurance. The memorandum outlined the Department's review of some of the returns on which the credit was claimed. During this review, auditors found that some taxpayers, who were not eligible for the tax credits, claimed the tax credits; and that some taxpayers claimed long-term care credits greater than the cap of $350. The Department found that, "Of the 2,155 returns reviewed, only 192 contained allowable long-term care credits. Taxpayers were not eligible for the credits claimed on the remaining 1,963 returns in this group. As a group, therefore, over 90% of the returns incorrectly claimed the credit." Because this represented a sample, the Department indicated that they did not know the error rate for all returns claiming the credit. They attributed the high error rate to two possible factors: "One factor is the complicated nature of the credit and the other is confusion of this credit with the repealed child health insurance credit." Additionally, the memorandum indicated that, for tax year 2001, the credit reduced tax revenue by $10,367,883.

The 2003 North Carolina Study Commission on Aging recommended repealing the sunset on the long-term care insurance tax credit. In its 2003 report, the Commission expressed agreement with a statement from a Division of Aging's report, *Increasing Personal Responsibility for Long Term Care through Private Long Term Care Insurance.* The Division's report stated 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." S.L. 1998-212, Section 29A.6(d) made

the credit for premiums paid on long-term care insurance effective for taxable years beginning on or after January 1, 1999, and sunset the credit effective January 1, 2004. The Commission's bills repealing the sunset were introduced during the 2003 Session, but were not successful and the tax credit was allowed to sunset. As a result, the tax credit is not currently in place for the 2004 tax year.

During the February 10, 2004 meeting, the Commission heard a presentation on long-term care insurance from Carla Obiol with the Seniors' Health Insurance Information Program (SHIIP), and presentations on issues related to the tax credit from Department of Revenue employees Karl Knapp, Tax Research Division, and Nancy Pomeranz, Personal Taxes Division Appendix E. Carla Obiol with the Department of Insurance's Seniors' Health Insurance Information Program (SHIIP), gave an overview of long-term care insurance. Her handouts included: *A Shopper's Guide to Long-Term Care Insurance* and *Facts About Long-Term Care Insurance In North Carolina* . Karl Knapp from the Tax Research Division, and Nancy Pomeranz from the Personal Taxes Division, of the North Carolina Department of Revenue, made presentations on the tax treatment of long-term care insurance in selected states, and on the number of long-term care tax credits claimed in North Carolina Appendix E. Ms. Pomeranz discussed the error rate experienced on the long-term care tax credit and the Department's efforts to reduce that error rate. The Department indicated that they had made progress in reducing the error rate on the long-term care insurance tax credit. Commission staff also obtained a chart Appendix E from the American Association of Health Plans-Health Insurance Association of America (AAHP-HIAA) depicting those states in the United States that offer tax incentives for the purchase of long-term care insurance. AAHP-HIAA is a national trade association representing the private sector in health care. The chart from AAHP-HIAA shows that 6 states offer tax credits and 16 states offer tax deductions. *(Note: The information in the AAHP-HIAA chart does vary from the Department of Revenue's information, which could be the result of different compilation dates.)*

According to information received by the Commission staff, on June 5, 2003, the Department of Revenue reported that they had audited 2,372 returns for the tax year 2002, and adjusted 650 to disallow the credit, representing a 27% error rate. This error rate was down considerably from the 90% error rate on the 2001 returns reported earlier by the Department. The Department attributed the decrease to: 1) informing tax preparers of the appropriate use of the credit; 2) clarifying instructions about eligibility for the credit; 3) improving the verbiage in software developers' tax packages; and 4) communicating with taxpayers whose credit was disallowed in 2001, to inform them of the eligibility criteria for the tax credit. An additional $279,628 was assessed on the 650 returns adjusted, and returns continue to be audited as resources permit. On November 3, 2003, the Department reported that they had processed 3,574,530 returns: 2,158,850 paper and 1,415,680 efiled. Of the total, there were 35,936 on which a credit for long-term care insurance was claimed for a total of $19,110,623.

The North Carolina Study Commission on Aging has supported the long-term care insurance tax credit since its inception and the current Commission continues to support it. The Commission scheduled presentations on this issue at the first meeting this interim, and restoration of the long-term care insurance tax credit was an item mentioned frequently during presentations on March 9, 2004, by organizations representing older adults in North Carolina. The Commission recommends that the General Assembly repeal the sunset on the long-term care insurance tax credit.

Recommendation 2

The North Carolina Study Commission on Aging recommends that the General Assembly

require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

Background

On February 10, 2004, the Commission heard presentations on adult care home rules and caring for the mentally ill from Jim Upchurch, Division of Facility Services, Department of Health and Human Services (DHHS); Dottie Harrison, Board Member, NC National Alliance for the Mentally Ill (NAMI); and Lou Wilson, NC Association Long Term Care Facilities. On March 9, 2004, the Commission heard a presentation on Geriatric Mental Health Specialty Teams from Bonnie Morell, Community Policy Section, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Health and Human Services (DHHS). Appendix F

During her presentation, Ms. Wilson mentioned the use of the Geriatric Mental Health Specialty Teams. She indicated that while the intent of the program was positive, she believed, "The State has provided very little guidance for area mental health programs as to how the teams should be operated, thus the program has floundered in many areas of the state." She also stated that, "Area programs all over the State have developed criteria, protocol, policies and procedures that are unique to their area program. As a result, consumers and providers of services are expected to muddle through a system of inconsistency."

According to information provided by DHHS, Geriatric Mental Health Specialty Teams were developed to increase the ability of older adults with mental illness to live successfully in their communities by: 1) assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals; and 2) providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization. Currently, the Teams serve individuals 60+ years of age who are preparing to enter a nursing home or an adult care home, who currently reside in a nursing home or adult care home, and who are living in their own home or with family members. Individuals with geriatric-like needs are also served. Dr. Morell noted that, "This is a fairly new program that is being implemented during a time of change in the public mental health system. Focus will be on identifying ways in which to support the work that is being done by the teams that have been put in place."

During her presentation on February 10, 2004, Ms. Wilson shared a recommendation for legislation. Ms. Wilson's recommendations include: 1) renaming the Teams to Long Term Care Facility Specialty Teams; 2) requiring all licensed adult care homes and nursing homes that serve individuals with a mental illness to participate in the program; 3) deleting the age requirement and the restrictions for residents to be at risk of psychiatric hospitalization and making services available for all persons with a mental illness who reside in adult care homes and nursing homes; 4) increasing the number of professionals on each team and/or decreasing the geographic areas that each team covers; 5) developing standardized criteria; 6) fully funding the program to support the individuals and facilities eligible for services; and 7) repealing the current adult care home special unit rule for persons with mental illnesses and create a new licensure law and rules that are more realistic.

According to information provided by staff in the General Assembly's Fiscal Research Division, the Geriatric Mental Health Specialty Teams are a contracted service through the Local Management Entities (LME). There are 20 Teams across North Carolina and each one contracts with one or more LME's. These are funded with Mental Health Trust Fund dollars, and these non-recurring funds are being replaced by recurring funds made available through mental hospital downsizing. As a Team delivers services to a facility, they file for reimbursement with the LME, which in turn seeks reimbursement from DHHS. Currently, DHHS cannot report specific cost data on the Geriatric Mental Health Specialty Teams.

Based on the information presented to the Commission, the Commission recommends that the General Assembly require the Department of Health and Human Services to continue to provide support and training for long-term care providers caring for residents with mental illnesses by conducting a study on expanding the mission of Geriatric Mental Health Specialty Teams; and by standardizing criteria across the Teams and tracking utilization and expenditure data.

Recommendation 3

The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.

Background

On February 10, 2004, the Commission heard presentations concerning caring for mentally ill individuals in long-term care facilities. One of the presenters was Dottie Harrison, Board Member, NC National Alliance for the Mentally Ill (NAMI). Ms. Harrison questioned whether adult care homes were appropriate housing options for mentally ill individuals, and she questioned the appropriateness of staffing and training at these facilities. Specifically, Ms. Harrison supported training on the appropriate administration of psychiatric medications, and training on appropriate interaction with residents based on their particular mental illness. Another presenter at the February meeting, Lou Wilson, Executive Director of the North Carolina Association of Long Term Care Facilities, stated that adult care home providers, "simply do not know how to muddle through the complex mental health systems, develop good rapports with mental health providers, provide mental health training for staff and recognize issues when specific residents are having difficulty." Ms. Wilson requested training for adult care home staff that will enable them to recognize symptoms of mental illness and urged the State, advocates, and the industry, to work together to ensure that individuals with mental illnesses receive the services they are entitled to receive.

During the March 9, 2004 meeting, Dr. Bonnie Morell shared information with the Commission on the Geriatric Mental Health Specialty Teams Appendix F. One of the purposes of these Teams is to provide support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization. Currently, the Teams serve individuals 60+ years of age who are preparing to enter a nursing home or an adult care home, who currently reside in a nursing home or adult care home, and who are living in their own home or with family members. Individuals with geriatric-like needs are also served.

In addition to other recommendations, Lou Wilson also requested the creation of a new licensure law and rules that are more realistic. During discussions at the April 13, 2004 meeting,

Commission members voiced support for examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities. They also supported examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support resident's freedom of choice, and whether they support the autonomy, dignity and independence philosophy of assisted living.

The Commission supports quality care for mentally ill individuals and elderly individuals and recommends that the General Assembly require the Department of Health and Human Services to work with long-term care providers and advocates for the elderly and the mentally ill to study issues related to mentally ill individuals residing in long-term care facilities.

Recommendation 4

The North Carolina Study Commission on Aging recommends that the General Assembly establish a pilot program to conduct national criminal history record checks of persons seeking employment to provide direct care in adult care homes or contract agencies of adult care homes.

Background

State law currently requires criminal history record 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 must 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 has made it difficult for providers to comply with State law. As a result, a moratorium on national criminal history record checks was instituted in S.L. 2002-126, Sec. 10.10C for applicants for positions in nursing homes and home care agencies other than those involving direct patient care and for applicants for all staff positions in adult care homes, until January 1, 2004. Session Law 2003-284, Sec. 10.8E extended the moratorium to January 1, 2005.

Access to national criminal history record checks was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina. On March 23, 2004, the Commission heard a presentation from John Aldridge of the North Carolina Attorney General's office on this issue. He reiterated that unless federal law provides otherwise, the results of a national criminal history record check can only be released to a governmental agency. Currently, federal law only permits these results to be released to nursing homes and home care agencies on applicants for positions that involve direct patient care. Therefore, in order to be able to conduct national criminal history record checks on applicants for positions in nursing homes and home care agencies that do not involve patient care and on applicants for positions in adult care homes, current State law would have to be changed to direct that the results be sent to a governmental agency.

The Commission recognizes that long-term care advocates and providers have legitimate concerns about the current status of national criminal history record checks. Roger Manus,

President of Friends of Residents in Long Term Care, pointed out during the Commission's meeting on March 23, that people living in long-term care facilities are the vulnerable frail elderly and disabled that cannot defend themselves, and many cannot communicate when they perceive a threat. Worst of all, they spend the night in these facilities when staffing levels decrease even further with greater potential and opportunity for abuse. It is important to ensure the safety of this vulnerable population. On the other hand, the Commission recognizes that employee turnover is high in long-term care facilities. It is important that providers be able to fill positions quickly and not have to wait an inordinate amount of time for a determination to be made by an agency about whether an applicant is disqualified because of the applicant's criminal background. Questions arose during the Commission's deliberations about the State's technological and staffing capacity to be able to turn around a determination of disqualification quickly.

The Commission recommends moving this issue forward by establishing a pilot program to conduct national criminal history record checks of workers in adult care homes and contract agencies of adult care homes who provide direct resident care and requiring the Department of Health and Human Services to collect information and meet regularly with providers and others to monitor the progress of the pilot to determine what is needed in order to fully implement the national criminal history record checks as the General Assembly intended.

Recommendation 5

The North Carolina Study Commission on Aging recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.

Background

Senior Centers are resources within communities that typically provide nutrition, recreation, social and educational services, and comprehensive information and referral. The National Institute of Senior Centers defines a senior center as a place where "older adults come together for services and activities that reflect their experience and skills, respond to their diverse needs and interests, enhance their dignity, support their independence, and encourage their involvement in and with the center and the community." Prior to the 2002 Session, State funds for Senior Centers were $1,365,316. During the 2002 Session, funds were reduced by $381,000. During the 2003 Session, $100,000 was restored, and the local match requirement was increased.

Support for and/or restoration of funding for Senior Centers was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina Appendix G. To fully restore State funding to the prior level, an additional $281,000 would be needed. Therefore, the Commission recommends that the General Assembly support Senior Center development and outreach, and restore funding to the 2002 level, by appropriating $281,000 for the 2004-2005 fiscal year.

Recommendation 6

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.

Background

The Housing Finance Agency mission is to create affordable housing opportunities for North Carolinians whose needs are not met by the market. This mission is accomplished through helping older individuals age in place by improving existing housing, and by working to develop new apartments for older adults. In the March 23, 2004 presentation, Bob Kucab, Executive Director, stated that applications for funding requests currently exceed available capital by 3:1. State funds help bring in outside funding because the Housing Finance Agency is able to leverage $5 in development from every $1 the State invests. According to Mr. Kucab, all State funds that they administer are invested in bricks and mortar; staff costs are paid from their revenue. Mr. Kucab reported that, State appropriations are currently down to $3 million from a high of $9 million.

The Commission recognizes the need for new apartments with affordable rent, where older adults can enjoy safe and comfortable living environments, and connections to community services. Therefore, the Commission recommends that the General Assembly appropriate $1,000,000 to the Housing Trust Fund for the 2004-2005 fiscal year to be used for independent housing with services.

Recommendation 7

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.

Background

On March 23, 2004, Dennis Streets, Division of Aging and Adult Services, DHHS, made a presentation to the Commission on the Home and Community Care Block Grant (HCCBG) Appendix H. His presentation gave an overview of the program; eligibility criteria; and information on program utilization, availability, and needs. The HCCBG is established by G.S. 143B-181.1(a)(11). Mr. Streets pointed out that by "consolidating 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)—some of which traditionally went to separate organizations—the HCCBG represented an important step toward establishing a well coordinated service delivery system to meet the needs of a rapidly growing older population." The HCCBG includes federal funds, State funds, local funds, and a client cost sharing component. The two principal purposes of the HCCBG are to give counties greater discretion, flexibility and authority in determining services, service levels and service providers; and to streamline and simplify the administration of services. The HCCBG focuses on: supporting frail elderly in their preference to be cared for at home; improving and maintaining the physical and mental health of older adults; assisting older adults and their caregivers with accessing services and information; providing relief to family caregivers so that they can continue their caregiving; and allowing older adults to remain actively engaged with their communities.

Any person age 60 and older is eligible for services under the HCCBG. The HCCBG program places an emphasis on reaching those most in need of services (the Older Americans Act (OAA) gives 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 these individuals).

State appropriations for the HCCBG were $25,128,469 for the 2002-2003 fiscal year. State appropriations were cut by $1,055,690 to $24,072,799 for the 2003-2004 fiscal year. State appropriations are currently slated to be reduced to $24,026,079 for the 2004-2005 fiscal year. An increase in federal Older Americans Act funds has helped to offset the decrease in State funding and overall funding of the program was down from the previous year only $341,603 for 2003-2004. However, the Division anticipates a decrease in federal funding for 2004-2005, which would leave the overall total down another $389,974. Unless the General Assembly increases State appropriations, the total net funding for HCCBG would be down $731,577 for the period from 2002-2003 to 2004-2005.

Support for and/or restoration of funding for the HCCBG was an item mentioned frequently during presentations on March 9, 2004, by organizations representing, or advocating on behalf of, older adults in North Carolina Appendix G. The Commission recognizes the vital services that are provided under the HCCBG and recommends that the General Assembly appropriate $1,000,000 for the Home and Community Care Block Grant for the 2004-2005 fiscal year.

Recommendation 8

The North Carolina Study Commission on Aging recommends that the General Assembly require the Department of Health and Human Services to study whether the State's Medicaid Program has a bias that favors support for individuals in institutional settings over support for individuals living at home; and to recommend ways to alleviate this bias, if such a bias exists.

Background

The Final Report by The North Carolina Institute of Medicine Task Force on Long-Term Care reported an institutional bias in Medicaid eligibility rules. The report states that a reason public funding is weighted toward institutional care is that Medicaid and other public program rules make it easier for people to qualify for financial assistance with institutional or residential care than for services provided at home or in the community. Under existing laws, individuals can qualify for either nursing home care or State-County Special Assistance for adult care homes with higher monthly incomes than they can if they want to obtain Medicaid coverage for health services provided in their own home. With these different income eligibility limits, individuals living at home who may have too much income to qualify for Medicaid coverage as long as they remain in their home, may qualify if they move into a more costly institutional or residential setting.

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 ADA. The Commission recognizes that the law favors caring for an individual in the community rather than in an institution, and institutional care may be more costly than residential care. Therefore, the Commission recommends that the General Assembly direct the Department of Health and Human Services to study whether an institutional bias in Medicaid eligibility rules do in fact exist and if they do exist, to determine how to alleviate the bias.

Recommendation 9

The North Carolina Study Commission on Aging 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.

On February 10, 2004, the Commission heard a presentation on "Guardianship Reform in the Twenty-First Century" Appendix D by John Saxon, Professor of Public Law and Government, UNC Chapel Hill. According to his presentation, the last substantive revision to the guardianship law was in 1977, and the last consolidation and clarification was enacted in 1987. Since 1987, there have been efforts to review and revise the statutes, but none resulted in change. Current law consists of an assortment of statutes, some of which date back to the 1800s. As a result, there are a number of issues in the guardianship statutes that need review and updating, including interstate jurisdiction, the definition and standard of incapacity, due process, guardianship alternatives, limited guardianship, the guardian's powers, and the role of human service agencies.

Professor Saxon suggested that as an alternative to rewriting current law, North Carolina could adopt the Uniform Guardianship and Protective Proceedings Act (UGPPA). The UGPPA has been enacted in four states. The UGPPA authorizes two types of legal proceedings: guardianship proceedings to appoint guardian (guardian of the person) for a minor or incapacitated person; and protective proceedings regarding the property of a minor or a missing, absent, detained, or incapacitated person, including proceedings seeking the appointment of a conservator (i.e. guardian of the estate). Under the UGPPA, guardianship and conservatorship is viewed as last resort. A guardian or conservator may be appointed only if there are no other lesser restrictive alternatives that will meet the respondent's needs, and limited guardianship or conservatorship should be used whenever possible. According to Professor Saxon, the UGPPA is advantageous because it is modern, comprehensive, legally adequate, balanced, proven, and could be customized to address any issues that are unique to North Carolina.

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 17 years. Therefore, the Commission recommends the General Assembly establish a Legislative Study Commission on State Guardianship Laws.

Recommendation 10

The North Carolina Study Commission on Aging recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.

Background

North Carolina General Statute 131D-6 provides that adult day care enables people who would otherwise need full-time care away from their own residences to remain in their residences as long as possible. An adult day care program provides group care and supervision for physically or mentally disabled adults in a place other than their usual place of abode on a less than 24-hour

basis. Adult day services include a social model and a health model. Both models provide a community setting that promotes social interaction, and physical and emotional well-being. Adult day health programs also offer health care services to meet the needs of individual participants. Nutritional meals and snacks are provided and transportation to and from the program may be provided or arranged when needed. Often these programs provide a safe stimulating environment while a primary caregiver is at work. Providers of adult day care must meet North Carolina State Standards for Certification. The Social Services Commission sets these standards and the reimbursement rates paid for adult day and adult day health services.

During the March 23, 2004 meeting, the Commission heard from Nancy J. Cox, Director of Partners in Caregiving, Wake Forest University School of Medicine; Suzi Kennedy from the Life Enrichment Center of Cleveland County, Inc.; and Steve Freedman from the Division of Aging and Adult Services, DHHS Appendix I. The Commission received information on the predictors of success for adult day programs from a marketing, financing, and programming perspective; the challenges of operating a successful adult day program, particularly the insufficiency of public reimbursement rates to cover the costs of running a program; and the status of adult day programs across the State. During this meeting, Suzi Kennedy from the Life Enrichment Center of Cleveland County, Inc. spoke about the challenges of operating a successful adult day program and presented her menu for success at the Life Enrichment Center. Ms. Kennedy stated that, "Without financial stability there can be no social good," and she pointed out that public reimbursement rates are often insufficient to cover the costs of running a program.

Based on a survey conducted by the North Carolina Adult Day Services Association, in conjunction with the Division of Aging and Adult Services, the average cost to operate an adult day program in North Carolina is $31.00 per day for social models and $44.00 per day for health models. Rates established by the Social Services Commission, effective December 8, 1997, provided the maximum reimbursement rate for the purchase of adult day services at $565 per month ($26.07 per day). Of this amount, $500 per month ($23.07) is for daily care and $65 per month ($3.00 per day) is for round trip transportation. The maximum reimbursement rate for the purchase of adult day health services is $715 per month ($33 per day). Of this amount, $650 per month is for daily care ($30.00 per day) and $65 per month ($3.00 per day) is for round trip transportation. In 1999, the Division of Aging and Adult Services considered approaching the Social Services Commission about a rate increase; however, the Division was advised that there was little chance of a rate increase without an overall increase in the State Adult Day Care fund, since a rate increase without a budget increase would result in a cut to services. S.L. 2003-284, Section 10.58 required the Social Services Commission to consider adopting rules increasing the rates for adult day centers and adult day health centers. However, any rate increase adopted by the Commission for adult day centers and adult day health had to be implemented within existing funds.

The Commission supports adult day and adult day health programs and understands the important role they play in our communities. Therefore, the Commission recommends that the General Assembly appropriate funds and require the Social Services Commission to adopt a rate increase of no less than five dollars ($5.00) per day for adult day and adult day health services.

APPENDICES

APPENDIX A

North Carolina
Demographics of Aging

	NC	County Range
Total population, 2002[i]	8,323,946	4,170 - 734,403
Projected total population, 2020[ii]	10,966,139	4,706 - 1,102,003
Population age 60+, 2002[iii]	1,338,075	858 - 84,420
Population age 85+, 2002[3]	116,922	88 - 7,567
Baby boomers (as % of total population), 2000[3]	27.8%	20.6% - 32.4%
Rural population for all ages (as % of total population), 2000[iv]	39.8%	3.9% - 100%
Persons age 65+ without HS diploma (as % of age group), 2000[v]	41.6%	21.0% - 61.9%
Persons age 45-64 without HS diploma (•), 2000[5]	19.9%	8.7% - 36.7%
Persons age 65+ with graduate school education (•), 2000[5]	5.5%	1.1% - 18.7%
Persons age 45-64 with graduate school education (•), 2000[5]	8.8%	2.4% - 32.4%
Persons age 65+ with limited or no English (•), 2000[vi]	0.5%	0% - 3.8%
Grandparents raising grandchildren age less than 18, 2000[vii]	79,810	31 – 5,985
Veterans age 65+ (as % of age group), 2000[viii]	26.8%	16.2% - 37.7%

Distribution by Age[1, 2]	0-17	18-49	50-64	65-84	85+
Age groups, 2002	24.5%	47.6%	16.0%	10.5%	1.4%
Projection for 2020	23.1%	43.0%	18.8%	13.3%	1.7%
Growth, 2002-2020	124.3%	119.2%	155.5%	166.8%	162.4%

Distribution by Race/ Hispanic Origin[ix]	White	African American	Native American	Asian	Hispanic/ Latino
Population age 60+ (as % of age group), 2000	82.0%	16.0%	0.7%	0.5%	0.7%
Population age 45-59 ("), 2000	77.2%	18.9%	1.1%	1.2%	1.7%

Healthy Aging

	NC	County Range
Persons age 65+ in community with 0 disabilities* (as % of age group), 2000[x]	54.3%	40.2% - 66.8%
Persons age 65+ in community with 1 disability* (•), 2000[10]	20.6%	14.9% - 26.4%
Persons age 65+ in community with 2 or more disabilities* (•), 2000[10]	25.1%	17.0% - 34.6%

* The US Census Bureau defines disability as "a long-lasting physical, mental, or emotional condition. This condition can make it difficult for persons to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering."

Medicare beneficiaries immunized for influenza, 2000[xi]	43.5%	17.2% - 63.5%
Persons age 65+ living alone (•), 2000[xii]	28.3%	21.0% - 34.6%

Long-Term Care and Aging

	NC	County Range
Men age 65+ in nursing homes, 2000[xiii]	11,207	0 – 674
Women age 65+ in nursing homes, 2000[13]	33,630	0 – 2,445
Persons age 65+ in nursing homes per 1000, 1999[xiv]	42.2	25.4 – 89.1
Persons age 65+ in adult care homes per 1000, 1999[14]	36.5	0.0 – 67.8
CAP/DA* clients age 18+ per 1000 Medicaid eligibles, 1999[14]	36.0	8.4 – 200.0
PCS** clients age 18+ per 1000 Medicaid eligibles, 1999[14]	57.7	0.0 – 199.1
Adult day care/health clients age 60+ served per 1000, 1999[14]	1.0	0.0 – 5.0
In-home aides clients, age 60+ per 1000, 1999[14]	9.9	2.0 – 51.5
Medicaid-eligible persons age 65+, SFY 2002[xv]	152,300	131 – 7,198
Total Medicaid expenditures for persons age 65+, SFY 2002[16]	$1,665,538,382	$1,151,121- $79,755,555
The amount Medicaid spent on home-based care (CAP/DA, CAP/MR, home health, and PCS) for every $100 spent in nursing homes for clients age 60+, SFY 2002[xvi]	$41.5	$6.9 - $278.4
Special Assistance (SA) expenditures for persons age 60+ in adult care homes, SFY 2002[16]	$90,695,940	$37,987 - $4,035,646

Economic Security

	NC	County Range
Median household income for age group 55-64, 1999[xvii]	$42,250	$26,582 - $62,759
Median household income for age group 65-74, 1999[17]	$28,521	$16,335 - $41,540
Median household income for age group 75+, 1999[17]	$19,303	$11,195 - $33,822

Poverty	**Age 55-64**	**Age 65-74**	**Age 75+**
Persons below poverty (as % of age group), 1999 (NC) [xviii]	9.5%	10.5%	16.9%
Persons in 100-199% of poverty (•), 1999 (NC)[18]	12.9%	20.4%	27.1%

Social Security	**NC**	**County Range**
Total Social Security (SS) benefits for beneficiaries age 65+, 2000[xix]	$722 million	$0.4 – 50.7 million
SS beneficiaries age 65+ (as % of age group), 2000[xx]	94.8%	73.1% - 100.0%
Average monthly SS amount received by beneficiaries age 65+, 2000[19,20]	$786	$620 - $889

Medicare/Medicaid		
Medicare Part A enrollees age 65+ (as % of all enrollees), 2000[xxi]	77.0%	65.7% - 86.1%
Medicare/Medicaid dually eligible persons age 65+, 2001[xxii]	140,535	109 – 6,609

Labor Force		
Persons age 45-59 in labor force* (as % of total labor force), 2000[xxiii]	27.7%	21.7% - 35.8%
Persons age 60-64 in labor force* (•), 2000[23]	3.6%	2.5% - 6.9%
Persons age 65+ in labor force* (•), 2000[23]	3.5%	2.2% - 8.8%
Persons age 65+ In labor force* (as % of age group), 2000[23]	14.4%	8.9% - 21.1%
Unemployed persons age 65+ (as % of population age 65+ in labor Force*), 2000[23]	8.3%	0.0% - 40.7%

*Include both employed and job seekers

Senior-Friendly Communities

	NC	County Range
Homeowners age 45-64 (as % of age group), 2000[xxiv]	80.3%	70.9% - 89.6%
Homeowners age 65+ (•), 2000[24]	82.0%	72.0% - 91.4%
Households with persons age 60+ and without complete plumbing, 2000[xxv]	8,184	Undisclosed – 343
Home-delivered meals served to persons age 60+ per 1000, 1999[14]	18.6	0 – 58.5

Food Stamps		
Food Stamp clients age 60+, SFY 2001[xxvi]	66,832	66 – 3,893
Total Food Stamp expenditures for clients age 60+, SFY 2001[26]	$39,628,877	$23,963 - $3,177,499
Monthly Food Stamp expenditure per client age 60+, SFY 2001[26]	$49	$35 - $68

Transportation		
Householder age 55-64 without car (as % of age group), 2000[xxvii]	6.0%	1.0% - 15.9%
Householder age 65-74 without car (•), 2000[27]	9.0%	4.0% - 22.7%
Householder age 75+ without car (•), 2000[27]	21.3%	7.5% - 33.6%

Persons Providing Care	**Age 18-44**	**Age 45-64**	**Age 65+**
Persons providing regular care for adults age 60+ (as % of age group), 2000* [xxviii]	14.5%	23.8%	15.7%

*Only statewide information available at present

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APPENDIX B

North Carolina Study Commission on Aging
Recommendations
to the
2003 North Carolina General Assembly, 2003 Regular Session

Prepared by Staff for the
North Carolina Study Commission on Aging

February 9, 2004

Recommendation Status Report
North Carolina Study Commission on Aging

RECOMMENDATIONS	BILLS INTRODUCED	RESULTS
RECOMMENDATION 1 **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 **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 S 1196	**S.L. 2002-180, Sec. 5.2 (SB 98, Sec. 5.2)** **Group Health Insurance for Long-Term Care Staff Study** 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 **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 S 1199	**S.L. 2002-180, Sec. 5.1 (SB 98, Sec. 5.1)** **Prescription Drug Access/Coordination** 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: (1) A description of the various coordination and facilitation methods considered. (2) A description of the coordination and facilitation methods of other states.

		(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 **The Commission recommends the General Assembly establish a Legislative Study Commission on State Guardianship Laws.**	H 246 S 179	No action taken on this issue.
RECOMMENDATION 5 **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 S 1264	**S.L. 2002-180, Sec. 2.1A (SB 98, Sec. 2.1A)** **Study Issues Related to Criminal History Record Checks of Employees of Long-Term Care Providers** 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: (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. (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. (3) Solutions adopted by other states to effectively and efficiently implement criminal record check requirements, including costs to the State in implementing these solutions. (4) Other issues relevant to State requirements for criminal history record checks in long-term care facilities. 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

2003 Session

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

February 10, 2004

Enacted Legislation

Continuing Care Retirement/Technical Changes

S.L. 2003-193 (HB 253) makes various technical changes to the statutes that regulate continuing care retirement communities (CCRCs). These facilities provide housing and health-related services either for life or for a period in excess of one year. CCRCs provide independent living and also offer nursing home or adult care home level of care. Because CCRCs include contractual requirements where, for certain fees, the facility agrees to provide health care coverage over a given period of time, they are considered an insurance product and are regulated by the Department of Insurance under Article 64 of Chapter 58.

The act makes the following changes to the statutes:

- Repeals an unused, and likely unusable, provision allowing for a continuing care retirement facility that is accredited under a process approved by the Commissioner to be issued a license based on that accreditation.
- Replaces the word "facility" with "provider" to clarify that it is the provider that operates the facility that is responsible for meeting the various statutory requirements.
- Clarifies language governing operating reserves for continuing care retirement facilities and providers, including:
  1. Changing the wording to reflect the fact that a provider is to calculate and maintain a separate operating reserve for each continuing care facility operated by the provider.
  2. Changing the words "annual statement" to "disclosure statement."
  3. Changing the words "invested cash" to "cash equivalents."
- Makes the following changes governing the rights of residents of continuing care retirement facilities to organize:
  4. Changes "registered under this Article" to "operated by a provider licensed under this Article" in G.S. 58-64-40(a). No entity is "registered" under G.S. 58-64.
  5. Makes gender neutral corrections.
  6. Clarifies that the governing body of a provider must hold semi-annual meetings with the residents of each facility operated by the provider.
- Makes various changes governing supervision, rehabilitation and liquidation of continuing care retirement providers including:
  7. Replacing the word "projected" with "forecasted".
  8. Amending the statute as necessary to accommodate the fact that a provider can own or operate more than one facility.
- Amends the provision on receiverships, to reflect the fact that the Commissioner would be appointed as receiver for a provider not a facility.
- Replaces the word "agreements" with "contracts" for consistency of wording within Article 64.
- Removes unnecessary language to conform with the removal of the "accredited facility" provision.
- Amends the provision, governing civil liability, to:
  9. Remove the misleading words "facility, or person violating this Article" because the provider is the entity entering into a contract for continuing care, not the facility or other person.
  10. Remove the words "or person liable" because the provider is the only entity that is required to deliver a disclosure statement to the contracting party.
  11. Remove the words "facility, or person" since payment is made to the provider, and the provider is the entity responsible for the dissemination of the disclosure statement.

This act became effective June 12, 2003. (DJ)

Senior Cares Program Administration

S.L. 2003-284, Sec. 10.5 (HB 397, Sec. 10.5) provides that the Department of Health and Human Services may administer the "Senior Cares" prescription drug access program approved by the Health and Wellness Trust Fund Commission and funded from the Health and Wellness Trust Fund.

This section became effective July 1, 2003. (TM)

Effective Date of Long-Term Care Criminal Record Checks for Employment Positions

S.L. 2003-284, Sec. 10.8E (HB 397, Sec. 10.8E) continues the suspension of the requirements of G.S. 131E-265 for nursing homes and G.S. 131D-2 for adult care homes to conduct national criminal history checks for certain employees until January 1, 2005. These requirements were also suspended during the last biennium.

This section became effective July 1, 2003. (DJ)

Implement a Pilot Project for Long-Term Care Community Service Coordination

S.L. 2003-284, Sec. 10.8F (HB 397, Sec. 10.8F) requires the Department of Health and Human Services to implement a communications and coordination initiative to support local coordination of long-term care, and to pilot the establishment of local lead agencies to facilitate the long-term care coordination process at the county or regional level. The initiative must 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. For those counties that voluntarily participate, the local long-term care coordination initiative must aid in the development of core services, coordinate local services, and streamline access to services. The Department of Health and Human Services must submit an interim report on the pilot project for local long-term care coordination to the North Carolina Study Commission on Aging by October 1, 2004 and a final report by October 1, 2005.

The Institute of Medicine Long-Term Care Task Force found 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 this finding, and a report presented in accordance with S.L. 2001-491, Part XXII, the North Carolina Study Commission on Aging's 2003 report to the General Assembly and the Governor made a recommendation that the General Assembly fund a pilot project on long-term care local lead agencies. This provision is in response to that recommendation.

This section became effective July 1, 2003. (TM)

Medicare Enrollment Required

S.L. 2003-284, Sec. 10.27 (HB 397, Sec. 10.27) directs the Department of Health and Human Services to require Medicaid recipients who qualify for Medicare to enroll in Medicare in order to pay medical expenses that qualify for payment under Medicare Part B. Medicare is the federally sponsored health insurance program for persons aged 65 or older and for certain disabled persons under age 65. Medicare Part B pays for doctors' services, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care. In order to obtain coverage under Medicare Part B, an eligible person must pay a premium. Requiring eligible persons to enroll in Medicare will shift health care costs from the Medicaid program (which is paid in part with State and local funds) to the Medicare program (which is paid entirely with federal funds).

This section became effective July 1, 2003. (DJ)

Medicaid Assessment Program for Skilled Nursing Facilities

S.L. 2003-284, Sec. 10.28 (HB 397, Sec. 10.28) directs the Secretary of Health and Human Services to implement a Medicaid assessment program for skilled nursing facilities effective October 1, 2003. The assessment program applies to skilled nursing facilities licensed under Chapter 131E of the General Statutes and must be imposed in a manner consistent with federal regulations under 42 C.F.R. Part 433, Subpart B. Funds realized from assessments imposed shall:

- Be used only to draw down federal Medicaid matching funds for implementing the new reimbursement plan for nursing homes and for increasing nursing facility rates in accordance with the plan,
- Be used to pay 100% of the nonfederal share for the new reimbursement plan for nursing homes; and
- Not be used to supplant State funds appropriated for nursing facility services.

This section became effective July 1, 2003. (TM)

Rename North Carolina Heart Disease and Stroke Prevention Task Force

S.L. 2003-284, Sec. 10.33B (HB 397, Sec. 10.33B) renames the North Carolina Heart Disease and Stroke Prevention Task Force. The new name is the Justus-Warren Heart Disease and Stroke Prevention Task Force.

This section became effective July 1, 2003. (SA)

Senior Center Outreach

S.L. 2003-284, Sec. 10.42 (HB 397, Sec. 10.42) provides that the funds appropriated to the Department of Health and Human Services, Division of Aging, for the 2003-2005 fiscal biennium, shall be allocated by October 1 of each fiscal year and used by the Division of Aging to enhance senior center programs in the following ways:

- To expand the outreach capacity of senior centers to reach unserved or underserved areas; or
- To provide start-up funds for new senior centers. However, prior to funds being allocated for start-up funds for a new senior center, the county commissioners of the county in which the new center will be located shall:
  12. Formally endorse the need for such a center;
  13. Formally agree on the sponsoring agency for the center; and
  14. Make a formal commitment to use local funds to support the ongoing operation of the center.

Additionally, State funding shall not exceed 75% of reimbursable costs.

This section became effective July 1, 2003. (TM)

Adult Care Home Model for Community-Based Services

S.L. 2003-284, Sec. 10.43 (HB 397, Sec. 10.43) requires the Department of Health and Human Services to develop 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. The model must be designed for implementation on a pilot basis and address the following:

- Services that will be provided by the facility or under contract with the facility, including assistance with daily medication.

- Access of clients to mental health, developmental disabilities, and substance abuse services provided in the community, including transportation to services outside of the client's residence in the adult care home facility.
- Physical plant additions or changes necessary to provide for independent living of residents.
- Methods for assuring quality of services, resident safety, and cost-effectiveness.
- Consistency with the Department's Olmstead plan, other policies on community-integration, and disability plans adopted by the State.

The Department must submit a final report on the development of the model 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 on or before March 1, 2004. The report shall address the following:

- Proposed time and location for implementation of the pilot.
- Proposed number of residents to be placed and services to be provided directly by the facility or under contract with the facility.
- Method for evaluating the pilot, including services provided, on a regular basis.
- A description of the living environment for each resident and a comparison of how the living environment compares to that of other residents in the adult care home.
- Changes to State law necessary to implement the pilot.
- Projected cost to the State for pilot and statewide implementation.

This section provides that the development of this model is in response to the State policy to provide appropriate services to clients in the least restrictive and most appropriate environment and with the United States Supreme Court Decision in Olmstead vs. L.C. & E.W.

This section became effective July 1, 2003. (TM)

Special Assistance In-Home Program

S.L. 2003-284, Sec. 10.51 (HB 397, Sec. 10.51) allows the Department of Health and Human Services to use funds from the existing State-County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals with in-home living arrangements. These payments may be made for up to 800 individuals during the 2003-2004 fiscal year and the 2004-2005 fiscal year. The standard monthly payment to individuals enrolled in the Special Assistance in-home program shall be 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. For State fiscal year 2003-2004, qualified individuals shall not receive payments at rates less than they would have been eligible to receive in State fiscal year 2002-2003. The Department must implement Special Assistance in-home eligibility policies and procedures to assure that in-home program participants are those individuals who need and, but for the in-home program, would seek placement in an adult care home facility; and shall include the use of a functional assessment. This in-home option must be available to all counties on a voluntary basis; and to the maximum extent possible, the Department shall consider geographic balance in the dispersion of payments to individuals across the State.

The Department is required to report on or before January 1, 2004, and on or before January 1, 2005, to the cochairs of the House of Representatives Appropriations Committee, the House of Representatives Appropriations Subcommittee on Health and Human Services, the cochairs of the Senate Appropriations Committee, and the cochairs of the Senate Appropriations Committee on Health and Human Services. This report shall include the following information:

- A description of cost savings that result from allowing individuals eligible for State-County Special Assistance the option of remaining in the home.
- A complete fiscal analysis of the in-home option to include all federal, State, and local funds expended.
- How much case management is needed and which types of individuals are most in need of case management.
- The geographic location of individuals receiving payments under this section.

- A description of the services purchased with these payments.
- A description of the income levels of individuals who receive payments under this section and the impact on the Medicaid program.
- Findings and recommendations as to the feasibility of continuing or expanding the in-home program.
- 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.

Additionally, the Department shall incorporate data collection tools designed to compare quality of life among institutionalized versus 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. These provisions are based on recommendations from the North Carolina Study Commission on Aging.

This section became effective July 1, 2003. (TM)

State/County Special Assistance Transfer of Assets

S.L. 2003-284, Sec. 10.53 (HB 397, Sec. 10.53) codifies the provision adopted in last year's budget providing that Supplemental Security Income (SSI) policy concerning transfer of assets and estate recovery applies to applicants for State-county Special Assistance and repeals current codified law on the issue. The provision also requires the Department of Health and Human Services to continue reviewing whether policy for State-county Special Assistance should be changed to permit an assisted living facility to accept from a family member of a resident who qualifies for State-county Special Assistance payment for the difference in the monthly rate for room, board, and services available. The Department must report its activities on this policy review by March 1, 2004 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.

This section became effective July 1, 2003. (DJ)

Social Services Commission Rules on Rate-Setting For Adult Day Centers and Adult Day Health Centers

S.L. 2003-284, Sec. 10.58 (HB 397, Sec. 10.58) provides that the Social Services Commission shall consider adopting rules increasing the rates for adult day centers and adult day health centers and that any rate increase shall be implemented within existing funds.

This section became effective July 1, 2003. (TM)

Nursing Home/Medication Errors

S.L. 2003-393 (SB 1016) requires every nursing home to establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The Advisory Committee will have the following duties:

- Assess the facility's pharmaceutical management system and practices and identify areas at high risk for medication-related errors.
- Review the facility's pharmaceutical management goals and ensure these goals are being met.
- Review, investigate, and respond to facility incident reports and resident grievances.
- Identify goals and recommendations for the implementation of best practices.
- Develop recommendations for the establishment of a mandatory, nonpunitive, confidential reporting system.

- Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the NC Nursing Practice Act.
- Develop specifications for self-administration of drugs by qualified patients in accordance with law.

As part of its requirement to minimize risk of medication-related error, the act requires every nursing home quality assurance committee to undertake the following:

- Educate and make the patient and the patient's family members aware of all the medications the patient is using.
- Increase prescription legibility.
- Minimize confusion in prescription drug labeling and packaging.
- Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.
- To the extent practicable, implement proven medication safety practices.
- Educate facility staff engaged in medication administration.
- Implement a system to accurately identify recipients before any drug is administered.
- Implement policies and procedures designed to improve accuracy in medication administration and in documentation.
- Implement policies and procedures for the self-administration of medication.
- Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.
- Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices.

The act also requires nursing home to provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors for all nonphysician personnel involved in direct patient care.

A new statute enacted in this act requires consultant pharmacists of nursing homes to undertake certain drug regimen reviews, make reports concerning drug irregularities, drug product defects and adverse drug reactions, ensure proper documentation of allergies and adverse effects, and ensure that drugs that are not specifically limited as to duration of use or number of doses are controlled by automatic stop orders.

Finally, the act requires the Secretary of Health and Human Services to contract with a public or private entity to develop and implement a Medication Error Quality Initiative. As part of the Initiative, each nursing home must report annually on the nursing home's medication-related errors. The report submitted by each nursing home would not contain information that would identify the patient, individual reporting the error, or other persons involved in the occurrence. The contracting entity would analyze the reports to determine trends in the incidence of medication-related errors in nursing homes. Information released to the contractor would retain its confidentiality and would not be subject to discovery or use in any civil action as provided under the act.

This act becomes effective January 1, 2004. (DJ)

Audit of CAP/DA Programs by State Auditor

S.L. 2003-284, Sec. 10.29B (HB 397, Sec. 10.29B) directs the State Auditor to perform an audit of the Community Alternatives Program for Disabled Adults (CAP/DA), provided that State funds are appropriated for this purpose. The audit shall build upon the results of the study conducted by the North Carolina Institute of Medicine, in accordance with Section 10.16(c) of S.L. 2002-126, and 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.

This section also directs the Department of Health and Human Services to review, on a pilot basis, a selected number of CAP/DA programs to determine compliance with eligibility requirements for the program. Additionally, the Department shall continue to examine aspects of CAP/DA including: the current assessment process; an analysis of per-client costs in CAP/DA to per-client costs in nursing

homes and adult care homes; per-participant costs for the State-County In-Home Program; an analysis of per-person costs for personal care services through Medicaid; the monitoring of quality of care for CAP/DA clients; the current waiting list procedures. The Department is required to make a report of its findings to the North Carolina Study Commission on Aging by January 1, 2004.

This section became effective July 1, 2003. (TM)

Staff Contributing to this publication: Sandra Alley (SA), Dianna Jessup (DJ), and Theresa Matula (TM).

Studies and Reports Related to Aging

Study/Report	Entities Involved	Reporting Date	Reference
Report on the pilot project for local long-term care coordination.	DHHS to Aging Study Commission	Interim report 10/1/04 Final report 10/1/05	S.L. 2003-284 (HB 397), Sec. 10.8.F.(b)
Report on examination of CAP/DA that includes certain cost comparisons	DHHS to Aging Study Commission	1/1/04	S.L. 2003-284 (HB 397), Sec. 10.29B.
Report on development of the adult care home model for community-based services	DHHS to HHS and FRD	3/1/04	S.L. 2003-284 (HB 397), Sec. 10.43.(b)
Report on the Special Assistance In-Home Demonstration Program	DHHS to HHS	1/1/04 and 1/1/05	S.L. 2003-284 (HB 397), Sec. 10.51(b)
DHHS to review whether policy for Special Assistance should be changed to permit an assisted living facility to accept from a family member of a resident who qualifies for the program payment for the difference in the monthly rate.	DHHS to HHS and FRD	3/1/04	S.L. 2003-284 (HB 397), Sec. 10.53(c)
DHHS to review activities and costs related to the provision of care in adult care homes and determine what costs may be considered to properly maximize allowable reimbursement available through Medicaid and may transfer funds from DSS to DMA to draw down federal Medicaid funds.	DHHS to HHS and FRD	As funds are transferred and rates are modified	

Abbreviations:
DHHS: the Department of Health & Human Services
FRD: Fiscal Research Division
HHS: House of Representatives Appropriations Subcommittee on Health and Human Services & Senate Appropriations Committee on Health and Human Services

APPENDIX C

Overview of Aging Services & State Aging Plan

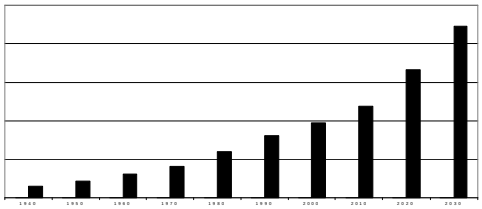
N.C.G.S. 143B-181.1A

prepared by
Division of Aging, N.C. Department of Health and Human Services
for the
Study Commission on Aging

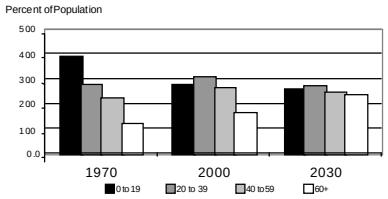
The Aging of North Carolina—General Organization of Plan

- Aging NC
- Healthy Aging
- Long-Term Care and Aging
- Economic Security
- Senior-Friendly Communities
- Priorities of Senior Advocates
- State Agencies—Major Activities and Future Directions

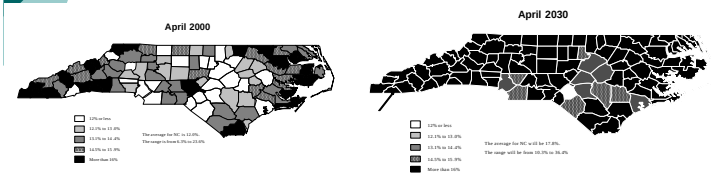
Actual and Projected Population Age 65 and Older, North Carolina, 1940 to 2030



The Aging of North Carolina's Population, 1970 to 2030



Percent of Population Age 65+ in NC



State Plan Themes

- *Draw upon the talents and resources of active seniors*
- *Enhance services for vulnerable seniors*
- *Value diversity while addressing disparity*
- *Be responsible stewards of resources*
- *Help baby boomers prepare for their future.*

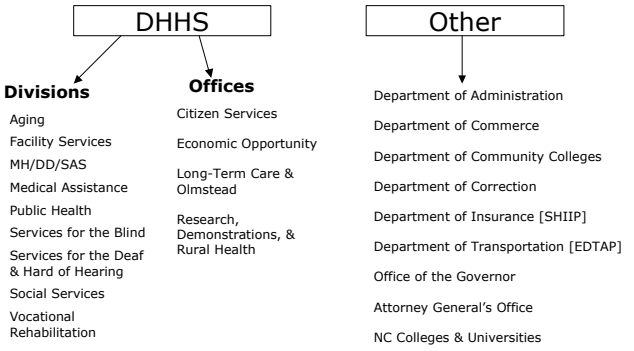
Healthy Aging

Healthy aging is the development and maintenance of optimal *physical, mental, and social well-being and function* in older adults. *Individuals, government, and communities* share responsibilities in promoting and maintaining *attitudes and behaviors* known to advance and preserve health and well-being among older adults by providing or using health and other appropriate services effectively to *prevent or minimize the impact of acute and chronic disease on function.*

Economic Security

Economic security is the capacity to sustain a relatively stable economic status given a normal decline of functioning and health over old age. This view was well expressed by a senior advocate: "In my opinion, we seniors are economically secure when we are free from fear or doubt about our ability to pay for necessities such as health and long-term care expenses, housing, and leisure and enrichment activities."

State Resources for Older Adults



Expenditures by Agency

Agency	Total FY 02-03 Expenditures	Percent of Total Expenditures
Medical Assistance	$2,128,691,981	84.0%
Mental Health	$ 170,974,608	6.8%
Social Services	$ 162,341,632	6.4%
Aging	$ 60,279,814	2.4%
Other Agencies	$ 11,619,234	< 1%
TOTAL	$2,533,907,269	100%

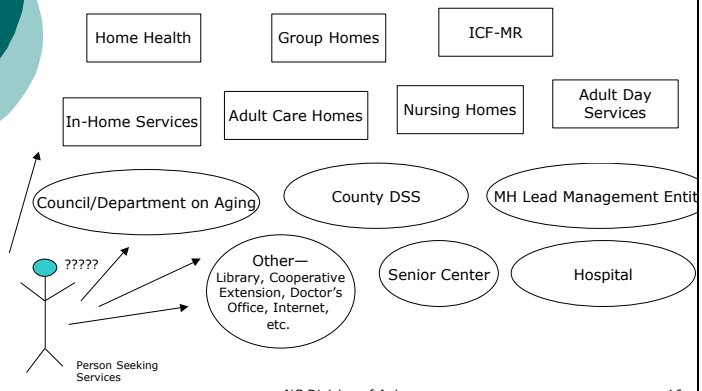
Long Term Care

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.*

Senior Advocate Priorities

- Maintain CAP-DA as a viable service
- Implement national criminal background checks for LTC employees
- Support the Home and Community Care Block Grant
- Make permanent the State Income Tax Credit for LTC insurance premiums
- Support Senior Centers

How Citizens Learn about and Locate Services and Supports



Senior-Friendly Communities

A *senior-friendly community* offers a wide range of social and economic opportunities and supports for seniors; values their contributions to the community; is serious about physical layout and local planning; respects and supports seniors' desire and effort to live independently; and acknowledges the primary role that families, friends, and neighbors play in the lives of older adults and enhances their capacity for caring.

APPENDIX D

Guardianship Reform in the Twenty-First Century

John L. Saxon
Institute of Government
The University of North Carolina at Chapel Hill
February, 2004

Guardianship Reform: Where Have We Been?

Legal History

- 1837
  - Idiots & lunatics
- 1868
  - Clerk of superior court
- 1879
  - Inebriates & asylum inmates

Legal History

- 1933
  - Sterilization of mentally retarded
- 1973
  - Adult protective services

Legal History

- 1977
  - G.S. Ch. 35, Art. 1A
    - Rud Turnbull, Institute of Government
  - First substantive reform
    - Due process
    - Modernized definitions & standards
    - Introduced limited guardianship
    - Human services agencies
  - Partial & incomplete reform

Legal History

- 1982
  - DHR Task Force
- 1984
  - AOC & DSS Study Committee
- 1987
  - G.S. Ch. 35A enacted
    - Consolidated & clarified existing laws
    - Extended 1977 guardianship reform
    - Few substantive changes

Legal History

- 1990-94
  - AOC & DHR Task Force
  - LRC Study Committee
  - H 451
- 2001
  - Proposed legislative study

Guardianship Reform: Where Are We Now?

Current Law

- G.S. Ch. 35A
  - Minors
    - "Standby" guardians
  - Incompetent adults
    - Legal standard & due process
    - Priorities & qualifications; public agencies
    - Powers & duties; limited guardianship
    - Bond & accounting; estate management

Current Issues

- Statutory authority
  - Legal hodge podge
    - Piece-meal revision
    - Some statutes date back to 1800s
- Jurisdiction
  - Interstate
- Incapacity
  - Definition & standard

Current Issues

- Due process
  - Role of GAL/attorney
- Guardianship alternatives
  - Least restrictive alternative
- Limited guardianship
  - Partial incapacity
  - Rights retained by ward

Current Issues

- Guardian's powers
  - Person vs. property
  - Standard for decisionmaking
  - End of life
- Human services agencies
  - Conflict of interest
  - Funding

Guardianship Reform: Where Should We Go?

UGPPA

- Uniform Guardianship & Protective Proceedings Act (UGPPA)
  - 1982: NCCUSL
  - 1997 revised
    - Prof. Rhoda Billings (Wake Forest Law)
    - ABA Task Force on Guardianship Reform
    - Enacted by four states (AL, CO, MN, MT)

UGPPA

- Scope
  - Minors & incapacitated adults
  - Guardians & conservators
- Intent
  - Guardianship is last resort
    - Least restrictive alternative
  - Limited guardianship preferred
    - Tailored to ward's incapacity
  - Input from ward when possible

UGPPA

- Incapacitated person
  - Functional definition
    - Unable to receive & evaluate info or make or communicate decisions to extent that lacks ability, even with appropriate assistance, to provide for personal health, safety, or care
    - Unable to manage property & business affairs due to impaired ability to receive & evaluate info or make decisions

UGPPA

- Jurisdiction
  - Domicile
    - Interstate
- Authority to appoint
  - Court
  - Spouse or parent
    - Unless objection

UGPPA

- Due process
  - Court-appointed visitor
    - Appointment of counsel
  - Professional evaluation
  - Respondent must be present
    - Unless excused by court
  - Clear & convincing evidence
    - No jury

UGPPA

- Court-appointed guardian
  - Priorities
    - Existing guardian, nominee, agent, spouse, child, etc.
    - Public or nonprofit agency if no one else is available and agency is not providing other services to ward
- Emergency guardian
  - Temporary substitute guardian

UGPPA

- Guardian's powers
  - Expend income for ward's care
  - Bring action for ward's support
  - Consent to medical treatment
  - Consent to marriage or divorce
  - Delegate authority (limited time)
  - May not revoke health care directive
  - May not commit to mental institution

UGPPA

- Conservator's powers
  - Make or revoke will or gifts
    - With court approval
  - Invest
  - Sell, lease, or exchange property
    - Without court approval

UGPPA

- Decisionmaking
  - Ward's expressed wishes
  - Substituted judgment when known
    - What would ward have done?
  - Best interest
  - Prudent investor
- Monitoring
  - Guardians & conservators

UGPPA

- Advantages
  - Modern
  - Comprehensive
  - Legally adequate
  - Balanced
  - Proven
  - Can be customized
- Disadvantages
  - Lack of interest
  - No champion
  - Preference for what is known & familiar
  - Preference for incremental reform vs. overhaul
  - Need to pull all players together

Guardianship Reform in the Twenty-First Century

John L. Saxon
Institute of Government
The University of North Carolina at Chapel Hill
February, 2004

APPENDIX E

Tax Treatment of Long-term Care Insurance in Selected States

State	Deduction Or Credit	Covered Payments	Percentage Limitation	Cap	Refundable
North Carolina	**Credit**	**Premiums for taxpayer, spouse, or dependent that were not deducted from Federal income.**	**15%**	**$350 per insurance contract**	**No**
Colorado	Credit	Premiums for taxpayer and spouse. Tapayers must have an income of less than $50,000 if filing for one policy, or $100,000 if filing for two policies.	25%	$150 per policy	No
Kentucky	Deduction	Premiums paid that were not deducted from Federal income.	No	No	---
Maine					
Individual	Deduction	Premiums paid for insurance meeting Federal definition or approved by Bureau of Insurance that were not taken as an itemized deduction.	No	No	---
Employers	Credit	Employer payments on behalf of employees for insurance meeting Federal definition or approved by Bureau of Insurance.	20%	$5000 or $100 per employee	No
Maryland	Credit	Premiums for taxpayer or spouse/parent/child, but insured must be Maryland resident.	No	Age <41 - $240 Age 41-50 -$450 Over 50 - $500	No
Minnesota	Credit	Premiums paid on policies with a lifetime benefit of $100,000 or more for taxpayer or spouse that were not deducted from Federal income.	25%	$100 per beneficiary	No
Missouri	Deduction	Nonreimbursed payments that were not deducted from Federal income	50%	No	---
Oregon					
Individual	Credit	Premiums paid for taxpayer or taxpayer's dependents/parents that were not deducted from Federal income.	15%	$500	No
Employers	Credit	Employer payments on behalf of employees.	15%	$500	No
New York	Credit	Premiums paid for policies approved by Insurance Department	10%	No	No
Utah	Deduction	Premiums paid that were not deducted from Federal income.	No	No	---
Wisconsin	Deduction	Premiums paid for insurance for taxpayers or spouse that were not taken as an itemized deduction. The portion covering the spouse is not allowed if it was taken as part of the federal self-employed health insurance deduction.	No	No	---

LONG-TERM CARE CREDITS CLAIMED FOR TY 2002*

	Single		Married, Joint/Widow		Married, Separate		Head of Household		Total	
NC Taxable Income**	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***
0 or less	521	$122,988	935	$295,118	17	$3,275	127	$16,975	1,600	$438,356
$1 - $2000	417	$91,505	392	$110,394	17	$1,920	109	$16,821	935	$220,640
$2001 - $4000	401	$81,932	450	$123,518	7	$1,486	242	$34,600	1,100	$241,536
$4001 - $6000	335	$64,486	415	$117,418	8	$843	251	$39,057	1,009	$221,804
$6001 - $10000	577	$114,324	773	$201,165	28	$3,568	644	$101,203	2,022	$420,260
$10001 - $10625	113	$22,203	133	$38,802	6	$1,576	91	$13,376	343	$75,957
$10626 - $12750	267	$48,472	412	$113,027	21	$1,908	362	$57,707	1,062	$221,114
$12751 - $15000	277	$53,355	456	$120,152	16	$1,695	319	$46,949	1,068	$222,151
$15001 - $17000	263	$44,718	376	$95,461	10	$1,718	254	$35,211	903	$177,108
$17001 - $20000	354	$61,156	556	$150,371	20	$2,172	273	$39,757	1,203	$253,456
$20001 - $21250	145	$22,816	221	$57,884	10	$795	102	$17,726	478	$99,221
$21251 - $25000	350	$59,508	597	$142,818	25	$3,404	210	$31,092	1,182	$236,822
$25001 - $30000	455	$69,995	867	$208,483	26	$4,588	235	$30,818	1,583	$313,884
$30001 - $40000	645	$97,010	1,611	$344,770	45	$5,437	277	$32,122	2,578	$479,339
$40001 - $50000	442	$69,741	1,528	$307,054	21	$2,656	116	$15,595	2,107	$395,046
$50001 - $60000	295	$45,488	1,330	$259,031	28	$4,697	74	$8,288	1,727	$317,504
$60001 - $75000	263	$35,965	1,525	$290,962	13	$2,355	36	$4,261	1,837	$333,543
$75001 - $100000	218	$36,240	1,688	$322,404	9	1,158	38	$4,492	1,953	$364,294
$100001 or more	194	$34,722	2,590	$582,046	14	1,630	28	$2,215	2,826	$620,613
Total	**6,532**	**$1,176,624**	**16,855**	**$3,880,878**	**341**	**$46,881**	**3,788**	**$548,265**	**27,516**	**$5,652,648**

* As of 6/4/2003

** NC Taxable Income is net of deductions and exemptions, and so generally is lower than Federal Adjusted Growth Income.

*** The total credits figure does not equate to the revenue loss resulting from the credits. For some taxpayers, the loss of revenue is less than the amount claimed because the taxpayers' tax liabilities are less than the amount of credit claimed.

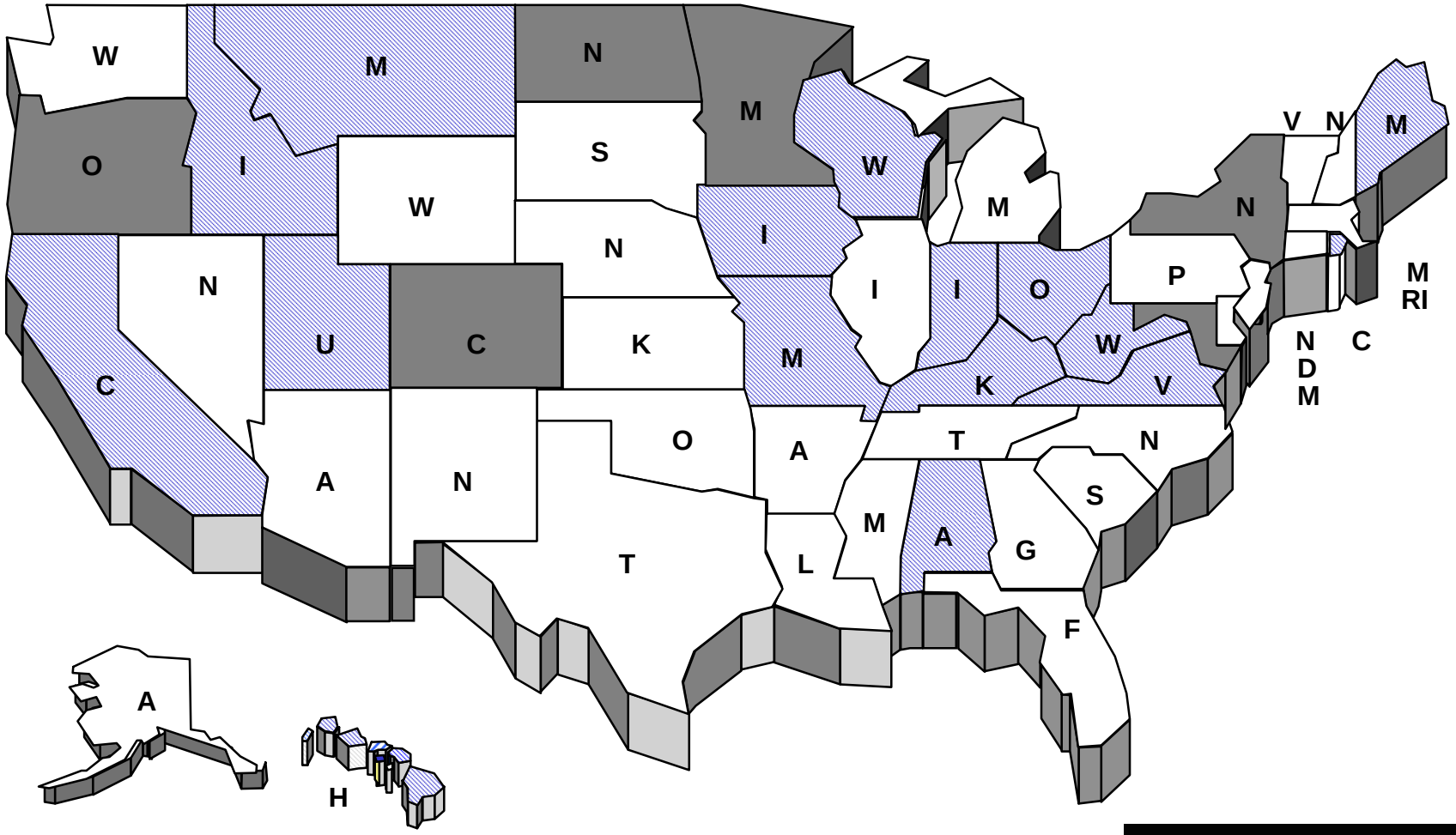
	TY 1999		TY 2000		TY 2001		TY 2002*	
NC Taxable Income**	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***	Number of Returns	Total Long-Term Care Credits***
0 or less	660	$158,224	943	$213,424	1,649	$371,479	1,600	$438,356
$1 - $2000	534	$111,716	847	$184,369	1,253	$248,366	935	$220,640
$2001 - $4000	650	$123,884	1,046	$198,996	1,686	$323,110	1,100	$241,536
$4001 - $6000	652	$127,916	995	$209,193	1,827	$361,001	1,009	$221,804
$6001 - $10000	1,360	$267,030	2,295	$469,771	3,854	$744,112	2,022	$420,260
$10001 - $10625	194	$37,588	357	$78,495	603	$118,452	343	$75,957
$10626 - $12750	659	$130,533	1,207	$247,471	2,036	$395,327	1,062	$221,114
$12751 - $15000	719	$138,890	1,176	$236,633	2,202	$433,797	1,068	$222,151
$15001 - $17000	604	$107,037	1,038	$211,505	1,756	$342,794	903	$177,108
$17001 - $20000	828	$159,257	1,380	$264,818	2,541	$513,190	1,203	$253,456
$20001 - $21250	348	$64,353	538	$105,361	954	$181,526	478	$99,221
$21251 - $25000	981	$179,826	1,526	$286,941	2,603	$511,179	1,182	$236,822
$25001 - $30000	1,254	$238,298	1,951	$377,389	3,225	$637,547	1,583	$313,884
$30001 - $40000	2,093	$393,524	3,110	$594,739	5,534	$1,089,419	2,578	$479,339
$40001 - $50000	1,716	$333,050	2,461	$454,831	4,569	$888,289	2,107	$395,046
$50001 - $60000	1,410	$255,631	1,887	$358,738	3,543	$697,196	1,727	$317,504
$60001 - $75000	1,521	$281,700	1,885	$370,370	3,670	$717,692	1,837	$333,543
$75001 - $100000	1,797	$365,488	1,614	$368,173	3,319	$663,873	1,953	$364,294
$100001 or more	3,049	$707,509	2,950	$743,398	5,135	$1,129,534	2,826	$620,613
Total	21,029	$ 4,181,454	29,206	$ 5,974,615	51,959	$ 10,367,883	27,516	$ 5,652,648

* As of 6/4/2003

** NC Taxable Income is net of deductions and exemptions, and so generally is lower than Federal Adjusted Growth Income.

*** The total credits figure does not equate to the revenue loss resulting from the credits. For some taxpayers, the loss of revenue is less than the amount claimed because the taxpayers' tax liabilities are less than the amount of credit claimed.

State Tax Incentives for Purchase of LTCI



AAHP-HIAA

APPENDIX F

Population Data for Adult Care Homes (7 or more beds)								
	18-24	**25-34**	**35-49**	**50-64**	**65-74**	**75-84**	**85+**	**ALL**
MI	60	219	1143	1500	992	689	315	4918
MR/DD	33	97	314	544	321	153	54	1516
TOTALS	93	316	1457	2044	1313	842	369	6434

Total licensed beds from adult care home data	**33,729**
Total residents in adult care homes	**24,811**
Percentage of residents with an MI diagnosis	**19.82%**
Percentage of Residents with MR/DD diagnosis	6.11%
Combined Percentage for both diagnoses	25.93%
Total number of reporting adult care homes	**606**
Number of adult care homes with MI residents	**428**
Percentage of adult care homes with MI residents	**70.63%**
Number of adult care homes with MR/DD residents	348
Percentage of adult care homes MR/DD residents	57.43%
Number of adult care homes with either diagnosis	538
Percentage of adult care homes with either diagnosis	88.78%

Population Data for Family Care Homes (2-6 beds)								
	18-24	**25-34**	**35-49**	**50-64**	**65-74**	**75-84**	**85+**	**ALL**
MI	46	103	452	360	161	60	18	1200
MR/DD	27	63	176	198	87	28	5	584
TOTALS	73	166	628	558	248	88	23	1784

Total licensed beds from family care home data	**3503**
Total residents in family care homes	**2797**
Percentage of residents with an MI diagnosis	**42.90%**
Percentage of Residents with MR/DD diagnosis	20.88%
Combined Percentage for both diagnoses	63.78%

Total number of reporting family care homes	**624**
Number of family care homes with MI residents	**392**
Percentage of family care homes with MI residents	**62.82%**
Number of family care homes with MR/DD residents	261
Percentage of family care homes MR/DD residents	41.83%
Number of family care homes with either diagnosis	479
Percentage of family care homes with either diagnosis	76.76%
Total licensed beds from all care home data	**37,232**
Total residents in all care homes	**27,608**
Percentage of residents with an MI diagnosis	**22.16%**
Percentage of Residents with MR/DD diagnosis	7.61%
Combined Percentage for both diagnoses	29.77%
Total number of reporting all care homes	**1230**
Number of all care homes with MI residents	**820**
Percentage of all care homes with MI residents	**66.67%**
Number of all care homes with MR/DD residents	609
Percentage of all care homes MR/DD residents	49.51%
Number of all care homes with either diagnosis	1017
Percentage of all care homes with either diagnosis	82.68%

Adult Care Rules Related to Mentally Ill Residents

Admission of Residents (10A NCAC 13G .0701)

- Prohibits admission of persons for treatment of mental illness
- Prohibits admission of persons who pose direct threat to the health or safety of others

Medical Examination (10A NCAC 13G .0702)

- Have to arrange for examination by physician of any new resident who was an inpatient of a psychiatric facility within the 12 months prior to admission

Personal Care Training and Competence (10A NCAC 13G .0502

- 80 hour training
- 25 hour training (Family Care Homes only)

Training includes 5 hours training on interventions to reduce behavioral problems

Special Care Units* for Mental Health Disorders (10A NCAC 13F .1401)

- Provides for a closed unit for up to 12 beds for persons with a mental health disability
- Requires additional training for staff
- Requires assessment and care planning review and case management by area mental health program

*Currently none licensed in N.C.

Provided by Jim Upchurch, Division of Facility Services, DHHS

Geriatric Mental Health Specialty Teams

North Carolina Study Commission on Aging
March 9, 2004

Bonnie Morell, Dr.PH, Community Policy Section, Division
MH/DD/SAS, Dept of Health and Human Services

Background

- 20 programs were given start-up MH Trust Funds in FY 02-03 as part of the preparation to increase community capacity to serve older adults prior to reducing the number of geriatric beds in State Psychiatric hospitals.

Purpose of the teams

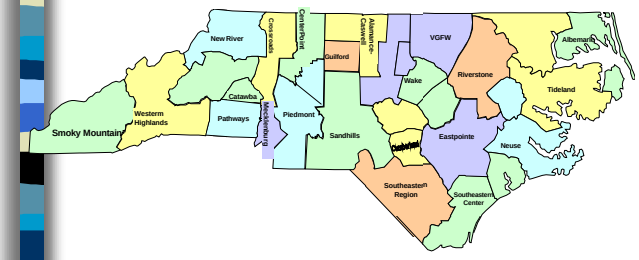
- Assist with transition to the community
- Provide consultation and technical assistance to nursing facilities and adult care homes regarding the needs of older persons with mental illness
- Link individuals with ongoing treatment or case management needs with local mental health services

Services are provided to

- Older adults who are returning to the community from State hospital geriatric units that are to be closed
- Older adults who are currently in the community who have mental health treatment needs who may be at risk of hospitalization

Location of teams

- Teams provide services in more than one local program in order to make services available throughout the State.



Background and training

- Each team is to have a nurse and a masters level mental health clinician with geriatric experience
- Two meetings have been held this year to identify training needs
- Resource information about training and networking opportunities will be put on the web

Effectiveness and Feedback

- Division of Mental Health is collecting data about the types of services being provided
- Feedback indicates that the teams have linked with the Aging Ombudsman staff, contributed to successful returns to the community, and provided help to facilities regarding residents' needs and behaviors.

Next Steps

- This is a fairly new program that is being implemented during a time of change in the public mental health system.
- Focus will be on identifying ways in which to support the work that is being done by the teams that have been put in place.

Geriatric Mental Health Specialty Team Model and Guidelines

Background: A need for greater local capacity to address the needs of older adults with mental illness was recognized as plans were developed to increase community capacity to serve older adults and to reduce reliance on State hospital services in SFY 02-03. At that time, funding was provided to develop twenty community-based geriatric mental health specialty teams that would be available to provide expertise and services throughout the State.

Purpose: The purpose of these teams is to increase the ability of older adults with mental illness to live successfully in their communities by:

1. assisting with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals, and
2. providing holistic support services and technical assistance to nursing homes, adult care homes, and other agencies and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization.

This is to be accomplished by providing training and consultation to the staff serving the identified individuals, developing linkages with community providers serving older individuals and providing time limited specific direct services to the identified individuals.

Team Description: The teams are to consist minimally of a registered nurse and a masters prepared therapist and are to supplement current area program/LME capacity to serve adults, age 60 and over. The teams are to provide the majority of services where the individual lives rather than in an office/clinic setting. Team duties and activities may be assigned based on each team member's professional skills and abilities. Team members may perform some activities together when the situation calls for the professional skills of more than one team member. Team members must have the ability to communicate frequently and to meet face to face as needed.

Target Population: The target population includes:

1. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness, who are in a state psychiatric hospital and who are preparing to return to the community to reside in a nursing home, adult care home or family residence
2. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness, currently residing in a nursing home or adult care home who have mental health service/treatment needs and who may be at risk of psychiatric hospitalization.
3. Individuals who are 60 years of age or older (younger must have geriatric-like needs) with mental illness who have significant mental health service or treatment needs and who may be at risk of psychiatric hospitalization and who are living with in their own home or with family members.

Team Activities:
Examples of the types of activities the team may provide ***to assist with the successful reintegration of older adults into the community when they are discharged from State psychiatric hospitals*** include, but are not limited to, the following:

- provide information to AP/LME and state hospital regarding strengths and capabilities of nursing homes and adult care homes for individual discharge planning;
- assist in discharge planning with hospital staff and area program/LME and referral to identified service providers that have the ability to provide specific treatments, rehabilitative services and/or residential setting that are needed by the individual.
- provide consultative support to staff in the transition of individuals from state hospital to facility;
- provide consultation with staff, individual and family identifying interventions to ensure transition to community, alleviate behaviors that may threaten placement
- providing crisis-oriented face-to-face to the individual or phone support during normal work hours and liaison with crisis services as needed to prevent hospitalization or disruption of placement

Examples of the types of activities the team may provide ***to assist nursing homes, adult care homes, and other agencies or caregivers/families*** that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization include, but are not limited to, the following:

- provide case consultation with staff, individual and family regarding behaviors that may result in hospitalization or need for more intensive services
- assist staff to assess behaviors;
- provide input and support in the development of intervention plans;
- model for staff appropriate implementation of intervention plans as needed;
- provide services such as referrals to community services, assistance with obtaining benefits, time limited case management and/or time limited treatment and support services
- review of medication regime and educate staff in communication with psychiatrist, physician and pharmacist
- educate facility staff, other agencies and families on issues on such topics as recognizing symptoms of mental illness, behavioral interventions, communication issues, and medication issues;
- establish linkages with community providers serving the geriatric population for the purpose of increasing community opportunities for the gero-psychiatric population
- provide resource information and identify ongoing training resources for staff
- provide a session of new staff orientation on such topics as individual rights;

Note: These funded Gero Specialty Teams are <u>not</u> expected to be primarily providers of direct services such as case management, community based service (CBS) or treatment services, but may do so on a time limited basis to assist in the transition to the community or to prevent hospitalization. If the individual requires on going direct services, the team will contact the area program/LME and request the individual be referred to a provider of such services whenever such a provider is available in the community. The Gero Specialty Team intent is not to replace needed treatment, rehabilitative or support services. These time limited direct services will be provided

only for identified individuals (i.e. those who meet age and diagnostic criteria and/or have been discharged from a state hospital).

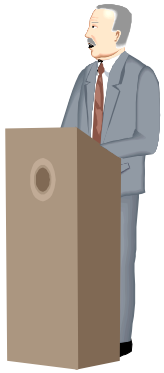
Area Program/LME responsibilities. Each of the area programs/LMEs that received State funding for a Geriatric Mental Health Specialty Team is responsible for:

- ensuring that the team, whether as an area program service or as a contracted service, provides and documents services in a way that is consistent with all Division requirements including, but not limited to, human rights, training, confidentiality, client records, and reporting
- having an identified AP/LME person who is responsible for the team's operation, if operated by the AP/LME or having a primary contact person who is responsible for communication, problem solving, prompt payment, and oversight if the team is contracted out.
- establishing an agreement about how team services will be made available to other catchment area(s) if the allocation indicated that the team is to serve more than the funded area program/LME. This agreement should specify access to service parameters including how referrals will be made to the team and expectations regarding reporting, documenting, and billing for client specific direct services.

Questions about the Geriatric Mental Health Specialty Team model and guidelines from AP/LMEs should be directed to Debbie Webster, NC Div MH/DD/SAS, Community Policy Section, Best Practice Team, 3005 Mail Service Center, Raleigh, NC 27699-3005
Phone 919 715-2774
Email Debbie.Webster@ncmail.net

APPENDIX G

Summary of Presentations
by
Organizations Representing Older Adults



Prepared for the
North Carolina Study Commission on Aging

March 23, 2004

The following organizations made brief presentations on March 9, 2004, to the North Carolina Study Commission on Aging

Friends of Residents
June Brotherton

NC Assisted Living Association
Jerry Cooper

NC Adult Day Services Association
Teresa Johnson

NC Senior Games
Cindy Trumbower

Governor's Advisory Council on Aging
Ann Johnson

National Association of Social Workers – NC Chapter, Aging Unit
Kathy Lowe

Alzheimer's Association, Mountain Region
Joe Connolly

Alzheimer's Association, Eastern Region
Alice Watkins

AARP
Von Valletta

NC Coalition on Aging
Jean Reaves

NC Health Care Facilities Association
Stacy Flannery

NC Senior Citizens Association
Tom Southern

NC Senior Tar Heel Legislature
Vernon Dull

NC Dental Society – Committee on Aging/Access Dental Care
Bill Milner

Association for Home and Hospice Care of North Carolina
Jim Edgerton

ISSUE FREQUENCY

Each organization's legislative priorities/issues of concern are summarized and presented in a table format on the following pages.

The number of organizations that mentioned the issue is in parentheses ( ) next to the issue.

The individual issues presented were grouped in the following broad categories: Community-Based Issues, Facilities Issues, Workforce Issues, and Other.

For Summary Purposes, the issues with the highest frequency were:

- **Access to National Criminal Record Checks** (*6*)
- **Restoration of the LTC Insurance Tax Credit** (*4*)
- **Support for and/or Restoration of Funding for the Home and Community Care Block Grant (HCCBG)** *(3)*
- **Support for and/or Restoration of Funding for Senior Centers** *(3)*
- **Maintaining the Viability of the Community Alternatives Program for Disabled Adults (CAP/DA)** *(3)*

	Friends of Residents	AARP	NC Assisted Living Assoc.	NC Coalition on Aging	NC Adult Day Services Assoc.	NC Health Care Facilities Assoc.	NC Senior Games	NC Senior Citizens Assoc.	Governors Advisory Council on Aging	NC Senior Tar Heel Legislature	National Assoc. of Social Workers – NC Chapter, Aging Unit	NC Dental Society – Com on Aging/Access Dental Care	Alzheimer's Association, Mountain Region	Assoc. for Home and Hospice Care of NC	Alzheimer's Association, Eastern Region
COMMUNITY-BASED ISSUES															
Support for/Restoration of Funding HCCBG *(3)*				x					x	x					
Support for/Restoration of Funding for Senior Centers *(3)*									x	x	x				
Maintain the Viability of CAP/DA *(3)*				x					x	x					
Funding Support for Home Care Services in the Medicaid Program *(1)*														x	
Support SA In-home *(1)*														x	
Remove Institutional Bias *(1)*														x	
Expand Use of Medicaid Funds for Adult Day Services *(2)*				x	x										
Funding Support for NC Senior Games *(1)*							x								
Support for Respite Care Programs *(2)*													x		x
Support for Community-Based Assistance Programs *(1)*															x
FACILITIES ISSUES															
Expressed Concern Over Mixed Populations in LTC Facilities *(1)*	x						*								
Discharge Rules-Maintain Due Process for Adult Care Home Residents *(1)*	x														
Maintain Licensure Rule Enforcement Consistency From County to County *(1)*			x												
Concern Over Professional Liability Insurance Increases for Providers *(1)*			x												
Increased Funding for Individuals in Alzheimer's/Dementia Units *(1)*			x												
WORKFORCE ISSUES															
Access to National Criminal Record Checks *(6)*	x	x		x		x			x	x					
Increase Salaries and Benefits for Direct Care Workers *(2)*		x							x						
Examine the Shortage of Nursing Workforce (Nursing Asst. to RN) *(1)*						x									
Support for Nurse Aide Training *(1)*						x									
Insure Adequate LTC Staffing Levels *(1)*	x														

	Friends of Residents	AARP	NC Assisted Living Assoc.	NC Coalition on Aging	NC Adult Day Services Assoc.	NC Health Care Facilities Assoc.	NC Senior Games	NC Senior Citizens Assoc.	Governors Advisory Council on	NC Senior Tar Heel Legislature	National Assoc. of Social Workers – NC Chapter, Aging Unit	NC Dental Society – Com on Aging/Access Dental Care	Alzheimer's Association, Mountain	Assoc. for Home and Hospice Care of NC	Alzheimer's Association, Eastern Region
OTHER ISSUES															
Restore LTC Insurance Tax Credit *(4)*		x		x					x	x					
Guardianship Mediation Initiative *(1)*									x						
Establish Creative Funding Options for Direct Care Dental Services*(1)*												x			
Establish Task Force to Review Oral Health Standard of Care for Special Care Populations *(1)*												x			
Increase State Revenues to Provide Services for the Elderly and Disabled *(2)*		x							x						
Establish Governor's Commission on Efficiency and Effectiveness *(1)*								x							
Enact a Taxpayer's Bill of Rights *(1)*								x							
Malpractice Reform (1)								x							
Tax Reform – Consumption Sales Tax to Replace Income Tax *(1)*								x							
Ensure execution of DHHS Plan for Information and Assistance is Supportive of Older and Disabled Adults *(1)*									x						
Establish DHHS Office to Address Housing Needs of Vulnerable Citizens *(1)*									x						
Transportation Services for the Elderly *(1)*											x				
Professional Care Coordination - Emphasis on Social Workers*(1)*											x				
Prescription Drug Assistance *(1)*											x				
Strengthen LTC Ombudsman Program *(1)*									x						
Maintain funding for State & Regional Ombudsmen, Case Managers, & Adult Care Spec. *(1)*	x														
Maintain Medicare/Medicaid Funding *(1)*	x														
Oppose Cap-non-economic damages for victims of medical malpractice & to shielding nursing home inspection reports from use as evidence*(1)*		x													
Payday loans – longer repayment, lower interest, allow installment payments *(1)*		x													
Support "Transfer on Death" to Facilitate Securities Transfer *(1)*		x													

** On March 24, 2004, the NC Health Care Facilities Association asked to be added to the line indicating that this item was an issue of interest to them.*

APPENDIX H

Presentation to NC Study Commission on Aging
March 23, 2004

Overview of Home and Community Care Block Grant (HCCBG)

- General Assembly established HCCBG in July 1992
- Combined federal Older Americans Act, SSBG in support of respite, and relevant State Appropriations
- Gave counties greater discretion and authority in determining services, service levels, and providers
- Counties choose from among 18 eligible services
- Focus is on supporting frail elderly at home, improving physical & mental health, assisting with access to services & information, providing family caregiver relief, and helping seniors remain active

Making a Difference—Who Is Served?

- 71% are women
- 33% are minority
- 68% are age 75+
- 46% live alone
- 66% are at risk of malnutrition
- 67% are unable to manage on their own
- 26% have 2+ ADL limits; 13% are very frail
- 50% reportedly low income

Making a Difference—Are the funds used wisely?

- Of the 18 services, 13 are clearly 'core' long-term care services
- 92% of the funds over which counties have discretion go to 'core' LTC services
- The relationship between need and service is strong—the services profile is logical
- Providers are efficient and accountable
- Performance outcome measures are positive

Status of Funding, Utilization, Service Availability, and Need

- Some Federal increase since 2000 while State support has decreased; $343,000 decrease in Federal Funds for FFY 04-05
- Statewide utilization/expenditure rate is very high
- Service unit costs have generally increased
- Decline in clients served and service units; some decrease in counties offering services
- More than 6,500 unmet service needs, especially for home-delivered meals and in-home aide services

Forces Affecting Future of HCCBG

- Demographics—growth in # of seniors—changing family structure
- Movement toward supporting people in least restrictive setting
- Federal budget deficit and effect on domestic programs

What It Will Take to Respond—What Happens If We Don't

- $9.3 million needed to address current wait list
- Efforts to assure effective screening and targeting of resources and cost-sharing
- Could affect other services and funding sources
- Could undermine existing provider infrastructure in face of growing need

Advocates' View

"Restore the $1 million in funding cut in 2003 from the Home and Community Care Block Grant."—

Governor's Advisory Council on Aging and NC Senior Tar Heel Legislature

Facts about the Home and Community Care Block Grant (HCCBG)

History and Purpose of HCCBG

In effect since July 1, 1992, the Home and Community Care Block Grant (HCCBG) was established by the General Assembly (G.S. 143B-181.1(a)(11), on the recommendation of the DHHS Advisory Committee on Home and Community Care and with the support of the N.C. Association of County Commissioners. By consolidating 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)—some of which traditionally went to separate organizations—the HCCBG represented an important step toward establishing a well coordinated service delivery system to meet the needs of a rapidly growing older population. By offering a broad range of services designed to improve the quality of life of older adults, the HCCBG has explicitly focused on:

1. supporting frail elderly in their preference to be cared for at home;
2. improving and maintaining the physical and mental health of older adults;
3. assisting older adults and their caregivers with accessing services and information;
4. providing relief to family caregivers so that they can continue their caregiving; and
5. allowing older adults to remain actively engaged with their communities.

The two principal purposes of the HCCBG are to:

- *Give counties greater discretion, flexibility, and authority* in determining services, service levels, and service providers. 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 agencies to provide these services. Counties can select from among the following 18 eligible services under the HCCBG (see pages 8-11 for a description of these services):

Adult Day Care	Health Screening	Mental Health Counseling
Adult Day Health Care	Home Delivered Meals	Senior Center Operations
Care Management	Housing and Home Improvement	Senior Companion
Congregate Nutrition	Information and Assistance	Skilled Home (Health) Care
Group Respite	In-Home Aide (levels I-IV)	Transportation (General and Medical)
Health Promotion and Disease Prevention	Institutional Respite Care	Volunteer Program Development

In advocating for the HCCBG, Patrice Roesler of the N.C. Association of County Commissioners stated that it “accomplishes a long-range goal of the Association in that it gives counties decision-making authority in regards to funding and services for the elderly, and allows county commissioners direct participation in determining the needs and priorities for their areas.” She adds that "it gives Commissioners the opportunity to coordinate this money with other resources to maximize the effect."

- *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 02-03, 97.9% of allocated funds were expended.

In establishing the HCCBG, the General Assembly also amended G.S. 143B-181.1(a)(10) in 1992 to require the Division of Aging to use *a sliding fee scale, based on the client's ability to pay for home and community-based services*. Effective 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. As stipulated by State statute, these contributions are used to extend the availability of in-home and community-based services. This policy is still in effect, and in SFY 02-03 resulted in contributions of nearly $2.4 million.

HCCBG's Track Record

Emphasis on Core LTC Services

While the HCCBG funds support a wide range of activities designed to develop and maintain optimal physical, mental, and social well-being and function in older adults—ranging from senior centers and health screening to in-home aide and home-delivered meals—counties are continuing to emphasize services to those who are most in need of home and community care to remain living independently. *As of fiscal year 2002-03, counties 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%.*

Of the 18 fundable HCCBG services, 13 are clearly among the "Core Services" as identified in Recommendation #11 of the 2001 Institute of Medicine Long-Term Care Plan for North Carolina (see page 12). The other services (i.e., Congregate Nutrition, Senior Centers, Health Promotion and Disease Prevention, Health Screening, and Volunteer Program Development) are arguably supportive of persons needing long-term care as well as their family caregivers. For example, results from a 2001 survey of senior centers in North Carolina show that nearly a quarter (23%) of senior center participants are 80 and older; about 1 in 12 participants (8%) need help to get around (i.e., use a walker, wheelchair, or help from another person); and about 5% reportedly have some dementia. More than half of the state's senior centers report an increase in frail participants.

The following findings from the Division's 2002 Performance Outcome Measurements Project also illustrate the importance of nutrition services, including 'non-core' congregate meals, for the physical health and emotional well-being of vulnerable seniors:

- 87% of congregate site participants were at risk of malnutrition, including 33% at high risk; 100% of those receiving home-delivered meals were found to be at risk, including 77% at high risk.
- 66% of congregate participants report that the meal they receive represents at least half of their daily consumption.

- 83% of congregate participants say visiting with friends is a major reason for their participation, and 72% of home-delivered clients cite interacting with the person who delivers the meal as important to them.

These additional findings from the Performance Outcome Measurements Project show the vulnerability of many HCCBG clients:

- 21% of congregate and 78% of home-delivered meal clients have difficulty going outside the house for shopping or doctors' offices. 21% of congregate participants cannot drive a car.
- 36% of congregate and 72% of home-delivered meal clients have problems walking.
- 30% of congregate and 72% of home-delivered meal clients cannot do their own housework.

Emphasis on Serving the Most Needy

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%). Additionally, the HCCBG provides $42,930 annually to each county as its equal base allocation. The formula's rural factor and its base allocation are generally considered helpful in directing funds to the sparsely populated rural counties and in reducing abrupt fluctuations in funds allocation.

State service standards for the HCCBG also give priority to serving Adult Protective Services (APS) 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.

Nearly half (49.5%) of the 60,621 different clients receiving at least one HCCBG service in SFY 02-03 were reportedly low income. 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 (41%). 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 02-03).

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 2002-03 suggests the success of this targeting:

- 71% of HCCBG participants are women;
- 33% are minority;
- 68% are age 75 or older;
- 46% live alone;
- 50% are low income;
- Nearly two-thirds (64%) are at risk of malnutrition; and
- Two-thirds (67%) are unable to manage on their own because of inability to perform basic self-care tasks (e.g., dressing, bathing, eating), limitations in instrumental activities of daily living (e.g., shopping, housekeeping, preparing meals), and/or cognitive impairment. 26% have 2 or more ADL limitations while 13% have 3 or more ADL limitations that suggests they are very frail [much higher for such services as in-home aide and home-delivered meals].

Access Services and Information

A major frustration for many people is not knowing whom to call when there is a question or problem. Their frustration is made worse when they are referred from one organization to another and still are not helped. Thus, it is not surprising to find from the Division's 2002 survey of family caregivers (cited below) that more than two-thirds (69%) want a central place to call for information, and more than half (57%) want help dealing with agencies/bureaucracies to get services. For seniors themselves, such experiences can create personally devastating consequences. This is why the state's Long-Term Care Plan, Olmstead Plan, and Aging Services Plan have made development of a more effective system for information and assistance (I&A) a priority. Support of I&A in the HCCBG, though, has been minimal because of other pressing demands. In fact, the HCCBG funds for I&A declined by 4% between SFY 2001-02 ($1.7 million in expenditures) and SFY 2002-03 ($1.6 million, budgeted). The number of counties using HCCBG funds for I&A dropped from 44 in SFY 2001-02 to 36 currently. A similar decline of 3% in funding is evident in Care Management, another important access service. On the other hand, transportation, another, albeit different form of access service, increased by 4% from $6 million in SFY 2001-02 to $6.25 million in SFY 2002-03.

Relieve Family Caregivers

Families are the key providers of care, but there are many stresses associated with this caregiving. Results from a Division-sponsored question in the 2003 NC Behavioral Risk-Factor Surveillance System (BRFSS) Survey show that more than 1 in 4 adults report providing regular care or assistance to an older family member or friend. Nearly 1 in 5 HCCBG clients (19.5%) report that the services they receive provide some relief to their caregivers. While some clients do not have a caregiver, this is believed to be a very conservative figure for those who do.

The following findings from the Division's 2002 Performance Outcome Measurements Project illustrate the importance of HCCBG services for caregivers as well as seniors:

- *'Not enough time for self' or 'family' and 'stress' are major burdens for at least 30% of the caregivers helped by HCCBG services.*
- Various forms of in-home aide services (including respite), care management, and information about services are the principal HCCBG services provided to caregivers. 94% are satisfied with the services they receive, including 66% who are 'very satisfied.'
- *97% of caregivers report that the services help them to be a better caregiver, with 84% saying 'they help a lot.'*
- *88% of caregivers report that the services enable them to provide care for a longer time*, which is important to avoiding more costly and restrictive interventions.
- More than one-third of caregivers want additional help with housekeeping (49%), respite or adult day services (39%), help with ADLs/personal care (38%), and transportation (35%).

Active Engagement

The primary means of supporting active engagement through the HCCBG are through general transportation, congregate meal site, senior centers, and volunteer development. The importance of this support is evident in the aforementioned statistics on congregate meal participants. More than one in five congregate participants cannot drive and have difficulty navigating outside the house, and 83% of congregate participants say visiting with friends at the site is very important to them.

While support of activities to allow older adults to remain actively engaged is an important goal and can be accomplished through a number of means, it certainly appears that counties make the difficult choice to put priority on HCCBG services that help the most at risk.

Profile of HCCBG Services

Below is a list of the services funded under the HCCBG for which clients are reported to the Division of Aging through its Aging Resources Management System (ARMS). The information that describes the "average client" is based on at least 50% of the older adults receiving the HCCBG service. Under the HCCBG, 'economically needy' is self-reported by clients based on whether their income is at or below the federal poverty level ($8,980 for 2003). Clients are also assessed using several functional criteria that include: activities of daily living (ADLs), which describe basic self-care tasks (e.g., bathing, dressing, grooming, moving around the house, and eating; and instrumental activities of daily living (IADLs), which describe basic tasks essential to living independently (e.g., cooking meals, housekeeping, laundry, paying bills, shopping, and using the telephone.)

Adult day care (ADC) provides an organized program of services during the day in a community group setting to support the personal independence of older adults and promote their social, physical, and emotional well-being. *The average client is 81 years old, female, economically needy, has limitations with 1+ ADLs and 3+ IADLs, and is at risk of malnutrition.* 37% are cognitively impaired. Among ADC clients, 65% report that the services they receive relieve their caregiver. 46 counties currently fund ADC under the HCCBG.

Adult day health (ADH) services are similar to adult day care in providing an organized program of services during the day in a community group setting to support the personal independence of older adults and promote their social, physical, and emotional well-being. In addition, ADH providers offer health care services to meet the needs of individual participants. *The average client is 85 years old, female, economically needy, has limitations with 2+ ADLs and 3+ IADLs, and is at risk of malnutrition.* 45% are cognitively impaired. Among ADH clients, 73% report that the services they receive relieve their caregiver. 31 counties currently fund ADH under the HCCBG.

Care management incorporates case finding, assessment, care planning, negotiation, care plan implementation, monitoring, and advocacy to assist clients and their families with complex needs in obtaining appropriate services. *The average client is 81 years old, female, has limitations with 3+ ADLs and 3+ IADLs, and is at risk of malnutrition.* 10 counties currently fund care management under the HCCBG.

Congregate nutrition is a service where a meal (typically lunch), offering one-third of the recommended daily dietary allowance, is provided in a group setting. *The average client is 76 years old, female, and does not have limitations in ADLs or IADLs.* Nearly half (46%) live alone and 44% are at risk of malnutrition. 99 counties currently fund congregate meals under the HCCBG.

Group respite is a service that trains volunteers to offer temporary, part-time relief to unpaid, primary caregivers of cognitively or physically impaired older adults and to provide meaningful social and recreational activities for those receiving care. *The average client is 82 years old, female, has limitations with 1+ ADLs and 3+ IADLs, and is cognitively impaired and at risk of malnutrition.* Nearly half are economically needy (48%). 8 counties currently fund group respite.

Home-delivered meals is a service that provides a meal (typically lunch), offering one-third of the recommended daily dietary allowance, to a home-bound older adult. *The average client is 81 years old, female, has limitations with 1+ ADLs and 3+ IADLs, and is at risk of malnutrition.* Nearly half (49%) live alone, and 57% are economically needy. 97 counties currently fund home-delivered meals under the HCCBG.

Home health is skilled health care prescribed by a physician that is provided in the home of an older adult in need of skilled nursing; physical, occupational, and/or speech therapy; medical social services; and/or nutrition care. *The average client is 81 years old, female, economically needy, has limitations with 2+ ADLs and 3+ IADLs, and is at risk of malnutrition.* One county currently funds home health under the HCCBG.

Housing and home improvement is a service that assists older adults with obtaining or retaining adequate housing and basic furnishings, by providing information about available options for housing and housing with services and how to finance them; assisting with finding and relocating to alternative housing; and providing labor and/or materials for minor renovations and/or repair of dwellings to remedy conditions that create a risk to personal health and safety. *The average client is 77 years old, female, economically needy, has limitations with 2+ ADLs and 2+ IADLs, and is at risk of malnutrition.* 38% live alone. 36 counties currently fund this service.

In-home aide (level 1) is a service that provides assistance with basic home management tasks, such as housekeeping, cooking, shopping, and bill paying to enable the older adult to remain at home as long as possible. *The average client is 82 years old, female, lives alone, has limitations with 3+ IADLs, and is at risk of malnutrition.* 29% are cognitively impaired, and 48% are economically needy. 76 counties currently fund level 1 under the HCCBG.

In-home aide (level 2) is a service that provides support to persons/families who predominately require assistance with basic personal care (bathing, shaving, toileting, and personal hygiene) and associated home management tasks. *The average client is 82 years old, female, has limitations with 2+ ADLS and 3+ IADLs, and is at risk of malnutrition.* 37% are cognitively impaired, 39% live alone, and 45% are economically needy. 88 counties currently fund level 2.

In-home aide (level 3) is a service that provides intensive education and support to persons/families in carrying out home management tasks and improving family functioning skills, or provides substantial ADL support to individuals/families who require assistance with health and personal care tasks. *The average client is 81 years old, female, has limitations with 3+ ADLs and 3+ IADLs, and is at high risk of malnutrition.* 34% are cognitively impaired, 26% live alone, and 43% are economically needy. 49 counties currently fund level 3 under the HCCBG.

In-home aide (level 4) is a service that provides a wide range of educational and supportive services to persons/families who are in crisis or who require long-term assistance with complex home management tasks and family functioning skills. *The average client is 75 years old, female, economically needy, has limitations in 1+ ADLs and 3+ IADLs, and is cognitively impaired and at risk of malnutrition.* One county currently funds level 4 under the HCCBG.

Institutional respite is a service that temporarily places older adults, who require constant care and/or supervision, out of their homes to provide their unpaid, primary caregiver with relief from caregiving responsibilities. *The average client is 82 years old, female, has limitations in 1+ ADLS and 3+ IADLs, and is cognitively impaired and at risk of malnutrition.* 49% are economically needy. One county currently funds this service under the HCCBG.

The Senior Companion program offers a part-time stipend volunteer opportunity for low-income persons 60 years of age or older who provide support, task assistance, and/or companionship to other adults with exceptional needs (developmental disabilities, functional impairments, or persons who have other special needs for companionship).

The average senior companion is 78 years old, female, economically needy, lives alone, and is at risk of malnutrition. 7 counties currently fund this program under the HCCBG.

General transportation is a service that provides travel to and/or from community resources, nutrition sites, and other places where older adults need access to services and activities necessary for daily living. *The average client is 78 years old, female, economically needy, lives alone, has limitations in 1+ IADLs, and is at risk of malnutrition.* 97 counties currently fund this program under the HCCBG.

Medical transportation is a service that provides travel to medical appointments. *The average client is 78 years old, female, economically needy, lives alone, has limitations in 1+ ADLs and 1+ IADLs, and is at risk of malnutrition.* 50 counties currently fund this service under the HCCBG.

Other HCCBG Services [non-unit]

Health Screening is a service that provides general medical testing, screening, and referral to promote the early detection and prevention of health problems in older adults. Two counties currently fund this service under the HCCBG. This service is also supported in some counties under Title III-D of the Older Americans Act.

Health Promotion and Disease Prevention is a service category that promotes the health and wellness of eligible older adults. One county currently funds this under the HCCBG; however, many counties receive funds under Title III-D of the Older Americans Act for this purpose.

Information and Assistance is a service that assists older adults, their families, and others acting on their behalf in their efforts to acquire information about programs and services and to assist older persons with obtaining appropriate services to meet their needs. 36 counties currently fund this service under the HCCBG.

Mental Health Counseling is a service that incorporates care consultation, evaluation, and outpatient treatment to older adults who are experiencing mental health problems. No counties currently fund this service under the HCCBG.

Senior Center Operation supports provision of a broad spectrum of services and activities for older adults. The primary objectives of a multipurpose senior center are: the centralized provision of services that address the special needs of older adults; opportunities for older adults to become more involved in the community; and the prevention of loneliness and premature institutionalization by promoting personal independence and wellness. 51 counties currently fund the operation of senior centers under the HCCBG.

Volunteer Program Development supports the development and operation of a systematic program for volunteer participation. The service involves volunteers of all ages in providing services to older adults while also providing community service opportunities for older adults. 9 counties currently fund this service under the HCCBG.

HCCBG Services and LTC 'Core Services'

HCCBG Services	***LTC Core Services[1]***
Adult Day Care	*Adult Day Care*
Adult Day Health	*Adult Day Health*
Care Management	*Care Management for High-Risk or Complex Conditions*
Congregate Nutrition	
Group Respite	*Respite Care*
Home Promotion and Disease Prevention	
Health Screening	
Home-Delivered Meals	*Home-Delivered Meals*
Home Health	*Home Health*
Housing & Home Improvement	*Housing & Home Repair and Modification*
Information & Assistance	*LTC Information & Assistance*
In-Home Aide {Levels 1, 2, 3 and 4}	*In-Home Aide Services*
Institutional Respite	*Respite Care*
Senior Centers	
Senior Companion	*Respite/Attendant Care*
Transportation, General	*Transportation*
Transportation, Medical	*Transportation*
Volunteer Program Development	
	Adult Care Homes
	Durable Medical Equipment and Supplies
	Medical Alert or Related Services
	Nursing Homes
	Adult Protective Services
	Guardianship

[1] The Institute of Medicine Long-Term Care Task Force recommended that every North Carolinian should have access, either in the county of residence or within reasonable distance from the county, to the services identified in the right-hand column of the table. In addition, the Task Force said that "older adults and people with disabilities need other medical, mental health, dental, vision, and hearing services to meet specific health and functional needs. Individuals who have functional, medical, or cognitive impairments may also need guardianship services or protective services to ensure that their long-term care needs are being met." [Recommendation #11 in the Task Force's Final Report]

Summary of Home and Community Care Block Grant Bugeted Funding SFY 99-00 through SFY 04-05
Federal, State, Local Funding & Client Cost Sharing
Division of Aging and Adult Services
March, 2004
July 1, 1999 through June 30, 2005

	99-00		00-01		01-02		02-03		03-04		04-05		00-05 % Variance
Fed. Older Americans Act	14,774,992	30.01%	15,684,346	31.24%	17,660,615 *	34.64%	18,333,029	34.80%	19,081,277	36.45%	18,738,003	36.06%	126.82%
Fed. Social Services Block Grant	1,909,077	3.88%	1,909,077	3.80%	1,834,077	3.60%	1,834,077	3.48%	1,834,077	3.50%	1,834,077	3.53%	96.07%
State Appropriations	25,533,005	51.87%	25,418,695	50.62%	24,191,821 **	47.45%	25,128,469	47.69%	24,072,779 ***	45.99%	24,026,079	46.24%	94.10%
Required Local Match	4,690,786	9.53%	4,779,124	9.52%	4,854,057	9.52%	5,032,842	9.55%	4,998,681	9.55%	4,998,681	9.62%	106.56%
Client Cost Sharing	2,321,695	4.72%	2,421,185	4.82%	2,446,052	4.80%	2,360,150	4.48%	2,360,150 ****	4.51%	2,360,150	4.54%	101.66%
Total	49,229,555	100.00%	50,212,427	100.00%	50,986,622	100.00%	52,688,567	100.00%	52,346,964	100.00%	51,956,990	100.00%	105.54%
Unduplicated Clients Served	66,253		63,809		61,790		60,601		58,921 ****				
Total Units Provided	8,333,217		8,132,622		7,952,080		7,804,632		7,281,380 ****				

* $1,000,000 in FFY 03 OAA funds allocated to offset loss of $1,008,273 in state appropriations

** SFY 01-02 state appropriations reduced by $1,008,273 in 3/02 reduction was non-recurring

*** Includes recurring reduction of $1,000,000 in state appropriations effective July 1, 2003

**** Projections of 03-04 client cost sharing, clients served, and units to be provided reflect annualized estimates based on December 03 activity

APPENDIX I

Adult Day Services in Brief

Adult day care and adult day health services are part of the continuum of long-term care for older and disabled adults in North Carolina. They offer a means for an impaired adult to get out of the house during the day into a safe and supervised environment, an opportunity for group involvement and individually planned services, and activities directed toward stabilization or improvement of self-care. The programs also provide a critical period of respite for family caregivers, enabling them to continue their responsibilities more effectively.

Definition

- Day care services for adults is the provision of an organized program of services during the day in a community group setting for the purpose of supporting adults' personal independence, and promoting their social, physical, and emotional well-being. Services must include a variety of program activities designed to meet the individual needs and interests of the participants, a nutritious meal and snacks as appropriate to the program, and referral to and assistance in using other community resources.

- The health care component of adult day health services distinguishes it from adult day care, which also provides a structured program of activities and services during the day for aging, disabled and handicapped adults. As part of the structured program of activities and services, participants enrolled in adult day health also require daily nursing supervision. Participation in adult day health can enable such persons to achieve and maintain their optimum level of independence and can support family members and other caregivers who are providing full-time care to frail adults living at home.

- Adult day health care programs and combination adult day care/adult day health programs include an on-site RN or LPN for a minimum of 4 hours daily.

- Providers of adult day services must meet North Carolina state Standards for Certification, which are administrative rules (10A NCAC 06R and 10A NCAC 06S) set by the Social Services Commission and enforced by the Division of Aging and Adult Services.

Program Information

- There are currently 113 certified programs in the state (3/17/04).
  - 57 are adult day care programs
  - 54 are combination adult day care and adult day health programs
  - 2 are adult day health programs
- Certified adult day services are located in 60 counties.
- On any given week day approximately 3272 slots for participants are available at adult day services in North Carolina.

History/Development

- Adult day service has grown in North Carolina from two programs in 1973 to its peak of 125 programs in 68 counties in 2000. The number of programs began to level off at 116 and remained stable at that number for a time. Although some programs would close, others would open. In many cases, the program that closed reopened under a new organization. However, during the latter part of 2002, several programs closed which have not reopened. Additionally, several of these programs have closed in counties where it was the only service of this type. As a result, we now have 113 programs in 60 counties. The majority of growth in adult day care at this time is in the larger metropolitan areas such as Mecklenburg and Guilford counties.
- In 1999 the Division of Aging considered approaching the social services commission about a rate increase, however were advised by DHHS budget and analysis that there was little chance of a rate increase without an overall increase in the State Adult Day Care fund since a rate increase without a budget increase would result in a cut to services.

Funding Information

Adult Day Care Expenditures **SFY 02-03**

Proration of In-Home Services for agreement with BD-701, dated 6/29/03 03/17/2004

Home and Community Care Block Grant

 # Funded Providers as of 3/17/04: 59

	Federal	State	Local	Total	Exp. %	Clients Over 60
Adult Day Care	857,023	536,744	154,863	1,548,630	52.44%	652
Adult Day Health	777,269	486,795	140,452	1,404,516	47.56%	516
	1,634,292	1,023,539	295,315	2,953,146	100.00%	1,168
	55.34%	34.66%	10.00%	100.00%		

State Adult Day Care Fund

 # Funded Counties as of 3/17/04: 65

	Federal	State	Local	Total	Exp. %	Clients Under 60	Clients Over 60	Clients Total
Adult Day Care	1,534,080	521,540	293,660	2,349,280	74.15%	242	811	1,053
Adult Day Health	534,808	181,818	102,375	819,001	25.85%	72	295	367
	2,068,888	703,358	396,035	3,168,281	100.00%	314	1,106	1,420
	65.30%	22.20%	12.50%	100.00%				

Adult Day Services Total

	Federal	State	Local	Total	Exp. %	Clients Under 60	Clients Over 60	Clients Total
Adult Day Care	2,391,103	1,058,284	448,523	3,897,910	63.68%	242	1,463	1,705
Adult Day Health	1,312,077	668,613	242,827	2,223,517	36.32%	72	811	883
	3,703,180	1,726,897	691,350	6,121,427	100.00%	314	2,274	2,588
	60.50%	28.21%	11.29%	100.00%				

Funding Information *(continued)*

- The maximum reimbursement rate for the purchase of adult day services is $565 per month ($26.07 per day). Of this amount, $500 per month ($23.07) is for daily care and $65 per month ($3.00 per day) is for round trip transportation.
- The maximum reimbursement rate for the purchase of adult day health services is $715 per month ($33 per day). Of this amount, $650 per month is for daily care ($30.00 per day) and $65 per month ($3.00 per day) is for round trip transportation.
- These rates were established by the Social Services Commission effective December 8, 1997.

Cost Information

According to the North Carolina Adult Day Services Association, the average cost to operate an adult day program in North Carolina was $31.00 per day for social programs and $44.00 per day for health models.[1] Public reimbursements fall short of that amount, leaving a deficit for non-private pay participants of sometimes 50% or more. Businesses such as adult day care programs must charge fees equal to or greater than their cost to at least break even.

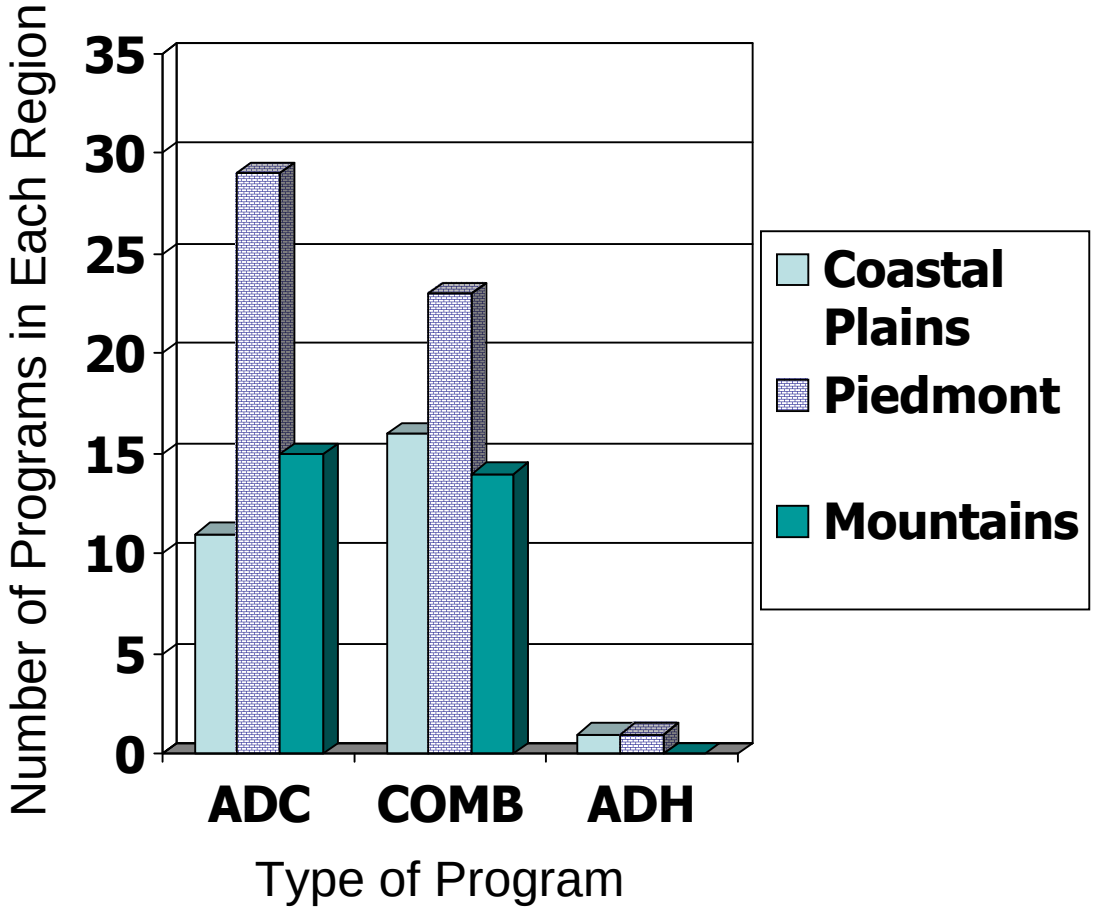
Current Initiatives

- In 2003 a special provision was introduced to the North Carolina General Assembly (House Bill 397) as follows: "The Social Services Commission shall consider adopting rules increasing the rates for adult day centers and adult day health centers. Any rate increase adopted by the Social Services Commission for adult day centers and adult day health centers shall be implemented within existing funds."

- The Division of Aging has been working closely with the North Carolina Adult Day Services Association to develop fiscal training for adult day programs. The aim of this project is to assist adult day programs with budgeting and help increase their understanding of service costs. Adult day care programs who have participated in the training will mentor other programs to understand the revenue stream and develop a business plan to balance their budget.

The Types of Programs and Geographic Location in North Carolina

- Adult Day Care Programs (57)
- Combination Adult Day Care and Adult Day Health Programs(54)
- Adult Day Health Programs (2)



Staffing Ratios

The 2001 session of the General Assembly Senate Bill 1115 requested a report on staffing requirements in long-term care facilities, including adult day service programs. In response, the Division of Aging and Adult Services prepared a report, the highlights of which are below.

Number of staff required per resident [participant]

Adult Day Care Homes 1:6
Adult Day Care Centers 1:8
Adult Day Health Centers and Adult Day Health Homes 1:5
Adult Day Care/Day Health Combination Programs 1:6

A national study of Adult Day Services conducted by the Robert Wood Johnson Foundation found the following national staffing averages:

Social model 1:7.3
Medical model 1:7.8
Combination 1:7.4

History, Rationale and Justification for Existing Ratios

The North Carolina Adult Day Care Services Standards for Certification, which dictate the existing staff ratios, were adapted from child day care regulations and originally in place in 1974, prior to mandatory certification. In 1986, legislation passed requiring the certification of all adult day care programs. The social services commission was responsible for establishing the initial rules and regulations. During this time, the Division of Social Services served as the certifying agency and responded to any concerns with regard to program certification and/or operation. This responsibility transferred to the Division of Aging in July of 1998.

The current rationale and justification is based on the Standards and Guidelines for Adult Day Services determined by the National Adult Day Services Association. In the revised 1997 recommendations, this guideline suggests a MINIMUM of 1:6 for programs offering "core services" (comparable to adult day care services) and suggests a staff--participant ratio of 1:4 when providing "enhanced and/or intensive services" (comparable to adult day health and adult day care/day health combination services.) Furthermore, the North Carolina ratios are in keeping with the national average as evidenced by the Robert Wood Johnson Foundation study previously cited.

Staff Requirements

The Standards for certification do not detail specific staff requirements except for the program director and the health care coordinator. The health care coordinator, a RN or LPN, is only required to be present 4 hours per day in programs that have the health care component. Other staff positions are not mandated by the Standards and will vary from program to program.

Adult Day Services
Program Closings 2001 - 2003

Adult Day Services	County	Closing Date	Reason Provided for Closing
*DayBreak Adult Day Services (ADC/ADH)	Lenoir	1/31/2001	Not cost effective.
Quality Life Center (ADC)	Harnett	2/28/2001	Not financially feasible to stay open.
Abundant Life Community Outreach (ADC)	Onslow	3/29/2001	Decided not to recertify. No participants. Budget would not allow program to operate.
Sumtymers Adult Day Health Center (ADC/ADH)	Haywood	5/31/2001	Closed for personal and financial reasons.
The Day Center at Stanly Manor (ADC/ADH)	Stanly	5/11/2001	Continued financial losses and lack of adequate funding sources.
Mabel's Hope (ADC)	Montgomery	8/17/2001	Program could not comply with standards and decided to discontinue the service.
Covington House (ADC)	New Hanover	11/1/2001	Program closed because they did not submit recertification documents.
Loving Years ADHC, Inc. (ADC)	Cabarrus	11/30/2001	Not financial feasible.
Emma's Loving Care (ADC)	Randolph	11/30/2001	Program was not operating according to standards. The operator had to close the business.
Adult Development Center (ADC)	Warren	12/31/2001	Financial reasons.
Day Star ADHC (ADC/ADH)	Forsyth	2/1/2002	Closed because continued violation of standards (rules).
Richmond Adult Day Health Center (ADC/ADH)	Richmond	3/4/2002	Financial reasons.
Creative Choices (ADC/ADH)	Wayne	3/31/2002	Financial reasons. Low participant enrollment.
Adult Life Program-Newton (ADC/ADH)	Catawba	6/30/2002	Had to relocate.
*Jackson County Adult Day Care (ADC)	Jackson	7/31/2002	The parent organization indicated that it was not financially feasible to continue program.
Bethel PALS (ADC/ADH)	Mecklenburg	8/31/2002	Low enrollment, freeze on CAP-DA program.
*Blue Ridge Adult Day Care (ADC/ADH)	Yancey	10/31/2002	The owner stated that the operation could not support itself.
Gem Recreation (ADC)	Dare	11/1/2002	Financial reasons -- decided to open as a respite program instead.
Penick-Elder Kare (ADC/ADH)	Moore	11/15/2002	It is no longer financial feasible to support the program

Adult Day Services
Program Closings 2001 - 2003
(Continued)

Adult Day Services	County	Closing Date	Reason Provided for Closing
Southern Wake Adult Day Care (ADC)	Wake	12/31/2002	The director stated that he could not financially maintain the program any longer
Tender Care Adult Day Health (ADC/ADH)	Craven	1/31/2003	Financial reasons. Program losing money
Helping Hands (ADC/ADH)	Cherokee	6/30/2003	Financial reasons (The parent organization was struggling financially)
Rex Adult Day Center (ADC/ADH)	Wake	6/30/2003	Financial reasons
Grace Unity Adult Day Care (ADC)	Robeson	9/30/2003	Decided not to recertify
Adult Quality of Life Center (ADC)	Stokes	10/02/2003	Financial reasons

* Indicates that the program has reopened under new ownership or organization

ADULT DAY SERVICES FUNDING FACT SHEET

The following is a list of possible funding sources for certified programs. This is a general list and all sources may not apply or be available in your area. **Automatic funding is not guaranteed.**

NORTH CAROLINA HOME AND COMMUNITY CARE BLOCK GRANT

- Older Americans Act funding and other state and local funds are combined into this block grant to support home and community-based services.
- Available for participants age 60 and older.
- Administered through Area Agencies on Aging.
- Contact the lead agency in your county or your regional Area Agency on Aging.

NORTH CAROLINA STATE ADULT DAY CARE FUND

- Funds allocated to counties by the North Carolina Division of Aging.
- Administered through county Departments of Social Services to purchase Adult Day Services for eligible participants.
- Contact your local Department of Social Services for more information.

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

- This program reimburses non-residential adult day programs designed to meet the needs of the frail elderly and functionally impaired adults for nutritious meals and snacks. Facilities can be public or private non-profit organizations. The nutritional plan must follow USDA standards.
- Program payments are based on individual enrollee income eligibility as determined by USDA guidelines.
- Administered by the North Carolina Division of Women's and Children's Health.
- Contact the Special Nutrition Programs Unit at the NC Division of Public Health at 919-715-1926 for more information.

PRIVATE PAY / OUT OF POCKET PAYMENTS

- Set the top fee equal to or greater than the cost of services.
- Give everyone the opportunity to pay what the service actually costs, allowing for discounts on a case by case basis.

MEDICAID – COMMUNITY ALTERNATIVES PROGRAM (CAP)

- Certified Adult Day Programs with the Day Health component are possibly eligible for reimbursement under CAP for Disabled Adults (CAP/DA), Mental Retardation/Developmental Disabilities (CAP/MR-DD), or AIDS (CAP/AIDS).
- Administered by the North Carolina Division of Medical Assistance (DMA). Contact DMA at 919-733-6775 for more information.

VETERANS ADMINISTRATION

For Adult Day Health only.

- Administered through area Veterans Administration Hospitals and/or outpatient clinics.
- Contracted reimbursement for qualifying veterans.
- Contact your area VA for more information.

MEDICARE PART B

- This covers only the services listed below. It does not cover the daily cost of Adult Day Care/Day Health services.
- Covers out-patient or partial hospitalization mental health services by licensed clinical social workers or psychologists for assessment and psychotherapeutic treatment.
- Covers out-patient restorative and functional maintenance rehabilitation by licensed physical therapists, occupational therapists, and/or speech therapists or approved personnel.
- Covers psychiatrist and physician visits.

UNITED WAY

- Contact the local agency for specific requirement for obtaining funds and/or becoming a member agency.

TITLE V (SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM, SCSEP)

- This program is designed to address the income and employment needs of economically disadvantaged individuals age 55 and older.
- Title V workers can be employed in an adult day service center as long as the adult center is not-for-profit.
- This program is administered by various agencies. Contact your regional Area Agency on Aging for more information.

GRANTS AND FOUNDATION FUNDING

- Start up, operating, capital and special projects funding.
- For more information, contact The Foundation Center, 79 Fifth Avenue, Dept. MF, New York, NY 10003-3076, (800) 424-9836. This organization publishes the National Guide to Funding in Aging.
- Check for a local foundation center or library which carry many publications on funding opportunities.

COMMUNITY DEVELOPMENT BLOCK GRANTS

- Administered through city governments.
- The Housing and Community Development Act of 1974 authorizes some funding for the construction and improvement of facilities.
- Contact the area field office of the US Department of Housing and Urban Development for more information.

AREA MENTAL HEALTH/ DEVELOPMENTAL DISABILITIES/ SUBSTANCE ABUSE PROGRAMS (MH/DD/SA)

- Adult day centers can possibly contract with Area MH/DD/SA Programs who reimburse for adult day services for the older and younger MR/DD population.
- Some Area Programs are especially interested in the health services provided in adult day centers.

CITY/ COUNTY GENERAL FUNDS

- Many localities use discretionary money to fund human services agencies. Call your local government office for more information.

CHURCHES / CIVIC ORGANIZATIONS

- These organizations may offer sponsorship, space or scholarships for clients.

APPENDIX J

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SWz-32 [v.2] (3/22)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/24/2004 4:31:49 PM

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

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE SUNSET ON THE LONG TERM CARE INSURANCE TAX CREDIT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. Section 29A.6(d) of Chapter 212 of the 1998 Session Laws 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 for taxable years beginning on or after January 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SHz-13 [v.3] (3/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2004 10:17:24 AM

Short Title: Care for the Mentally Ill in LTC Facilities.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO PROVIDE SUPPORT AND TRAINING FOR LONG-TERM CARE PROVIDERS CARING FOR RESIDENTS WITH MENTAL ILLNESSES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall study expanding the mission of the Geriatric Mental Health Specialty Teams to assist long-term care facilities in serving all residents who are within the targeted populations, as identified in the State Plan developed pursuant to G.S. 122C-102. As part of this study, the Department shall consider renaming the Geriatric Mental Health Specialty Teams to LTC Mental Health Specialty Teams to reflect the expanded mission.

SECTION 2. While undertaking the study, the Department of Health and Human Services shall proceed with implementation of the following:

(1) Standardizing these criteria across all Geriatric Mental Health Specialty Teams:
   a. Team purpose,
   b. Eligibility for services,
   c. Screening processes,
   d. Referral processes,
   e. Forms, Training Manuals, Service Orders, and Authorizations.

(2) Tracking expenditure data for each Team and each Area Program/Local Management Entity.

(3) Tracking the number of facilities served, the number of clients served, and the types of services provided by each Team.

SECTION 3. The Department of Health and Human Services shall submit an interim report to the North Carolina Study Commission on Aging by October 30, 2004, on its efforts to standardize criteria; track expenditure data; and track the number of facilities served, clients served, and services provided by each Team. The Department shall submit a final report on its standardization and tracking efforts, and the results of its study, to the North Carolina Study Commission on Aging by October 30, 2005.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SHz-16 [v.2] (4/16)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/19/2004 5:32:35 PM

Short Title: Study Mentally Ill LTC Resident Issues.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES RELATED TO MENTALLY ILL RESIDENTS IN LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall work with long-term care providers and advocates for the elderly, and the mentally ill, to study issues concerning the care of mentally ill individuals residing in long-term care facilities. The study shall include:

(1) Examining whether current State statutes and Departmental rules adequately address the populations served by long-term care facilities.

(2) Exploring the development of separate licensure categories within the adult care home and nursing home designations to address the various populations being served.

(3) Examining adult care home rules to determine whether they are easy to understand, attainable under current staffing patterns, give appropriate guidance to facility operators according to the needs and characteristics of residents served, support resident's freedom of choice, and whether they support the autonomy, dignity and independence philosophy of assisted living.

(4) Determining the most effective way to identify mentally ill individuals that have mental health treatment needs.

(5) Examining the criteria for admission of mentally ill individuals to long-term care facilities to ensure that the health and safety of all residents are safeguarded.

(6) Providing recommendations for improving the quality of care for mentally ill individuals in adult care homes and nursing homes including the potential cost associated with implementing the recommendations.

SECTION 2. The Department shall report its findings and recommendations to the North Carolina Study Commission on Aging by October 1, 2005. The Department of Health and Human Services shall include in this report how it defines "mentally ill" for purposes of this study.

SECTION 3. The Department of Health and Human Services may use up to one hundred fifty thousand dollars ($150,000) of funds appropriated to it for the 2004-2005 fiscal year to contract for the study required in this act.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SWz-37 [v.7] (4/8)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/12/2004 4:09:46 PM

Short Title: Adult Care Homes Criminal Records Check/Pilot.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A PILOT PROGRAM TO CONDUCT NATIONAL CRIMINAL HISTORY RECORD CHECKS OF PERSONS SEEKING EMPLOYMENT TO PROVIDE DIRECT CARE IN ADULT CARE HOMES AND CONTRACT AGENCIES OF ADULT CARE HOMES, AND TO MAKE CONFORMING CHANGES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall establish a pilot program to review the criminal history records of applicants for positions not requiring an occupational license but requiring direct resident care in adult care homes and contract agencies of adult care homes. Pursuant to this program, criminal history record checks for the employees of adult care homes and contract agencies of adult care homes shall be conducted as provided in G.S. 131D-40, except for the following:

(1) At the time it submits the request for the criminal history record check to the Department of Justice, the adult care home or contract agency of the adult care home shall provide a copy of the request to the Department of Health and Human Services, Division of Facility Services. If the adult care home or contract agency of the adult care home receives the criminal history information from a private entity, then within two business days of receiving the criminal history information, the adult care home or contract agency shall forward the information to the Department of Health and Human Services, Division of Facility Services, for a determination as to whether the applicant should be disqualified from employment.

(2) Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for

employment positions not covered by Public Law 105-277 and State criminal history record checks to the Department of Health and Human Services, Division of Facility Services. Within five business days of receipt of the criminal history of the person, the Department of Health and Human Services, Division of Facility Services shall determine whether the applicant should be disqualified from employment, unless the Department is unable to determine within five business days the disposition or accuracy of the criminal history information obtained by the Department, in which case the Department shall make the determination as soon as possible after verifying the disposition or accuracy of the criminal history information. By the next business day following its determination, the Department shall notify the adult care home or contract agency of its determination, and shall also notify the applicant a written statement as to the Department's determination and the basis on which it was made. An applicant shall be disqualified from employment if the applicant's criminal history shows that:

(a) The applicant was convicted of any of the offenses of Homicide under Article 6 of Chapter 14 of the General Statutes or Rape and Other Sex Offenses under Article 7A of Chapter 14 of the General Statutes, or equivalent offenses under the laws of another state.

(b) The applicant was convicted of any other offenses listed in G.S. 131D-40(d) within 10 years prior to the date of application for employment, or equivalent offenses under the laws of another state.

(3) If the criminal history of the applicant reveals a conviction of any of the other offenses listed in G.S. 131D-40(d) more than 10 years prior to the date of application for employment, the Department of Health and Human Services shall obtain the public record document reflecting the offense and shall provide the public record of the conviction to the adult care home or contract agency of the adult care home, and the adult care home or contract agency shall determine whether the applicant should be employed after considering the factors contained in G.S. 131D-40(b).

(4) If the adult care home or contract agency of the adult care home disqualifies an applicant or terminates a conditional employee based on the Department's determination or on its own consideration, then the adult care home or contract agency may disclose public criminal history information or public information that in the Department's determination is relevant to the disqualification but shall not provide the criminal record check to the applicant. All information that the Department receives through checking the criminal history is privileged information and is not a public record but is for the

exclusive use of the Department and those persons authorized under this act and under federal law to receive the information.

(5) An adult care home or contract agency of an adult care home may employ an applicant conditionally prior to obtaining the Department's determination or making its own determination, but shall terminate immediately the conditional employment of an applicant upon receiving notification from the Department that the applicant is disqualified or upon making its own determination that the applicant is disqualified.

(6) The pilot program shall include notices to the applicant of the criminal history record check and of the applicant's right to appeal the Department's determination as a final agency decision pursuant to Chapter 150B of the General Statutes.

SECTION 2.(a) The Department of Health and Human Services shall collect the following information during the pilot program:

(1) The number of persons whose criminal histories were reviewed by the Department.

(2) The number of persons who were disqualified by the Department and nature of the disqualifying offenses.

(3) The cost of the pilot program.

(4) The length of time between initial requests for criminal history record checks and the notices sent from the Department as to its determination.

SECTION 2.(b) The Department of Health and Human Services shall convene a workgroup that shall include representatives of the Department of Justice, nursing homes, adult care homes, home care agencies, and contract agencies of nursing homes and adult care homes. The Department shall conduct meetings at least monthly during the pilot program to discuss the progress of the pilot programs and any problems encountered in conducting the program.

SECTION 2.(c) The Department shall report the information required under this section and report the progress of the pilot program and the activities of the workgroup, including any statutory changes needed to fully implement G.S. 131D-40 and G.S. 131E-265, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and to the North Carolina Study Commission on Aging on or before January 15, 2005.

SECTION 3. Section 10.8E of S.L. 2003-284 reads as rewritten:

"SECTION 10.8E. Notwithstanding any other provision of law to the contrary, the requirements of G.S. 131E-265 for nursing homes to conduct national criminal history record checks for employment positions other than those involving direct patient care shall become effective no earlier than ~~January 1, 2005.~~July 1, 2005. Notwithstanding any other provision of law to the contrary, the requirements of G.S. 131D-2 for adult care homes to conduct national criminal records checks for all staff

positions except for staff positions involving direct care of residents shall become effective no earlier than ~~January 1, 2005.~~July 1, 2005."

SECTION 4. There is appropriated from the General Fund to the Department of Health and Human Services for the 2004-2005 fiscal year the sum of one hundred fifty thousand dollars ($150,000) to implement the pilot program in this act.

SECTION 5. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SHz-6 [v.5] (3/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:23:32 AM

Short Title:	Senior Center Funds.	(Public)
Sponsors:	.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR SENIOR CENTER DEVELOPMENT AND OUTREACH, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging, the sum of two hundred eighty-one thousand dollars ($281,000) for the 2004-2005 fiscal year, for senior center outreach and development. State funds shall not exceed seventy-five percent (75%) of reimbursable costs.

SECTION 2. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SHz-7 [v.4] (3/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:24:19 AM

Short Title: Senior Adult Housing Funds.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR SENIOR ADULT HOUSING, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Housing Finance Agency the sum of one million dollars ($1,000,000) for the 2004-2005 fiscal year. These funds shall be used to provide independent housing with services for senior adults and shall be used to maximize federal funds.

SECTION 2. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SHz-8 [v.5] (3/26)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:25:15 AM

Short Title: HCCBG Funds.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE HOME AND COMMUNITY CARE BLOCK GRANT, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Aging, the sum of one million dollars ($1,000,000) for the 2004-2005 fiscal year, for the Home and Community Care Block Grant.

SECTION 2. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SWz-34 [v.5] (3/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/27/2004 10:41:38 AM

Short Title: DHHS Study/Medicaid Institutional Bias.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CONTRACT WITH A THIRD PARTY TO STUDY WHETHER AN INSTITUTIONAL BIAS EXISTS IN THE STATE'S MEDICAID PROGRAM, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall contract with an independent third party to study whether the State's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and if a bias is found, to determine and recommend ways to alleviate the bias. The independent third party with whom the Department shall contract shall have documented experience in conducting similar studies. The study shall include consideration of all in-home services paid under the State's Medicaid program, including CAP/DA, home health and personal care services. The Department shall report the results of the study to the North Carolina Study Commission on Aging by January, 2005.

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services the sum of one hundred fifty thousand dollars ($150,000) for the 2004-2005 fiscal year to fund the study in this act.

SECTION 3. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SWz-33 [v.8] (3/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/27/2004 10:40:47 AM

Short Title:	Legislative Study Comm./Guardianship.	(Public)
Sponsors:	.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE LEGISLATIVE STUDY COMMISSION ON STATE GUARDIANSHIP LAWS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

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 15 members as follows:

(1) Four members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) Four members of the Senate appointed by the President Pro Tempore of the Senate.

(3) The Director of the Administrative Office of the Courts, or the Director's designee.

(4) The Director of the Division of Aging in the Department of Health and Human Services, or the Director's designee.

(5) A county director of social services appointed by the President Pro Tempore of the Senate.

(6) A clerk of superior court appointed by the Speaker of the House of Representatives.

(7) A physician who specializes in geriatrics appointed by the President Pro Tempore of the Senate.

(8) An attorney who has experience in guardianship matters appointed by the Speaker of the House of Representatives.

(9) A representative of the Governor's Advocacy Council for Persons With Disabilities.

In addition, representatives designated by the following organizations shall serve as ex-officio, nonvoting members of the Commission:

(a) The North Carolina Bar Association.
(b) The Arc of North Carolina.
(c) North Carolina Guardianship Association.
(d) Alzheimer's Association – Western Chapter.
(e) Alzheimer's Association – Eastern Chapter.
(f) Carolina Legal Assistance.
(g) The Area Agencies on Aging.
(h) County Departments of Aging.

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 2005 General Assembly not later than the convening of the 2005 General Assembly, and shall make its final report to the 2005 General Assembly, Regular Session 2006 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 2004-2005 fiscal year and the sum of thirty thousand dollars ($30,000) for the 2005-2006 fiscal year to carry out the purposes of this act.

SECTION 5. This act becomes effective July 1, 2004.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U **D**

BILL DRAFT 2003-SHz-11 [v.4] (3/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/8/2004 11:17:48 AM

Short Title: Adult Day Care Rate Increase.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS AND TO REQUIRE THE SOCIAL SERVICES COMMISSION TO ADOPT A RATE INCREASE FOR ADULT DAY SERVICES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services an amount sufficient to increase the current minimum rates by no less than five dollars ($5.00) per day for adult day and adult day health services provided to clients.

SECTION 2. The Social Services Commission shall adopt rules increasing the minimum rates by five dollars ($5.00) per day for adult day centers, and by five dollars ($5.00) per day for adult day health centers.

SECTION 3. This act becomes effective July 1, 2004.