NORTH CAROLINA

STUDY COMMISSION ON AGING

REPORT TO THE
GOVERNOR AND THE 2010 REGULAR SESSION OF THE
2009 GENERAL ASSEMBLY

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North Carolina
Study Commission On Aging

May 11, 2010

To: Governor Beverly Perdue
Lieutenant Governor Walter Dalton, President of the North Carolina Senate
Senator Marc Basnight, President Pro Tempore of the North Carolina Senate
Representative Joe Hackney, Speaker of the North Carolina House of Representatives
Members of the 2010 Regular Session of the 2009 General Assembly

Attached is a report from the North Carolina Study Commission on Aging submitted pursuant to North Carolina General Statute §120-187. The report contains recommendations and proposed legislation from the North Carolina Study Commission on Aging based on study conducted after the adjournment of the 2009 Regular Session of the General Assembly.

Respectfully submitted,

_____	_____
Senator A.B. Swindell, IV	Representative Jean Farmer-Butterfield
Co-Chair	Co-Chair

North Carolina Study Commission On Aging

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2009-SHZ-26 AN ACT TO UPDATE AND CLARIFY NORTH CAROLINA'S GENERAL STATUTES ON OLDER ADULTS AND LONG-TERM SERVICES AND SUPPORTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

2009-SHZ-27 AN ACT TO DIRECT THE DIVISION OF AGING AND ADULT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO STUDY THE ISSUE OF CRIMINAL HISTORY RECORD CHECKS FOR CURRENT AND PROSPECTIVE OWNERS, OPERATORS, AND VOLUNTEERS OF ADULT DAY CARE PROGRAMS AND ADULT DAY HEALTH SERVICES PROGRAMS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

PREFACE

Chapter 120, Article 21, of the North Carolina General Statutes, charges the North Carolina Study Commission on Aging 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, and eight are appointed by the President Pro Tempore of the Senate. 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 of the North Carolina Study Commission on Aging during the 2009-2010 interim. The Commission met on seven occasions and held public hearings in Jamestown, and Charlotte. The public hearings were conducted during March and April and provided citizens with an opportunity to speak to Commission members about programs and services for older adults. Based on reports and presentations received by the Commission, and comments expressed by citizens, the Study Commission on Aging presents the recommendations contained in this report.

EXECUTIVE SUMMARY

The North Carolina Study Commission on Aging met seven times and conducted two public hearings during the 2009-2010 interim. In response to the study and evaluation of services to older adults, the North Carolina Study Commission on Aging makes the following recommendations to the Governor and the 2010 Session of the 2009 General Assembly:

Recommendation 1: Maintain HCCBG Funding

The Study Commission on Aging recommends the General Assembly and the Governor maintain funding levels appropriated for FY 2010-2011 to the Department of Health and Human Services for the Home and Community Care Block Grant (HCCBG).

Recommendation 2: Maintain Funding for Senior Centers, Project C.A.R.E., and Other Vital Support Programs and Services

The Study Commission on Aging recommends the General Assembly and the Governor maintain current funding levels for senior centers and Project C.A.R.E. as well as many other vital programs that provide aging services and support systems for older adults and their families.

Recommendation 3: Hearing Loss Treatment Task Force

The Study Commission on Aging recommends the General Assembly direct the Hearing Aid Dealers and Fitters Board to coordinate a task force including representatives of the Division of Services for the Deaf and Hard of Hearing in the Department of Health and Human Services, the Consumer Protection Division of the Office of Attorney General, and other interested stakeholders, to: 1) develop recommended guidelines for consumers seeking assistance in the treatment of hearing loss, 2) make recommendations on the best way to disseminate these guidelines, and 3) report to the Study Commission on Aging on or before October 15, 2010.

Recommendation 4: Review of Nurse Aide Training Requirements

The Study Commission on Aging recommends the General Assembly direct the Division of Health Service Regulation, Department of Health and Human Services (DHHS), to coordinate a review involving an equal number of representatives from the Division of Aging and Adult Services, DHHS; the NC Board of Nursing; the Direct Care Workers Association; NC Health Care Facilities Association; NC Hospital Association; NC Home and Hospice Care Association; and representatives of residents in long-term care; to assess the current training requirements for nurse aides and to recommend any necessary changes to the Study Commission on Aging on or before November 1, 2010.

Recommendation 5: Long-Term Care Partnership Program

The Study Commission on Aging recommends the General Assembly enact legislation to develop a Long-Term Care Partnership (LTCP) program for North Carolina and direct the Division of Medical Assistance, Department of Health and Human Services, to pursue a State Plan amendment allowing the operation of the LTCP program.

Recommendation 6: Include Dentist on the Commission on Children with Special Health Care Needs

The Study Commission on Aging recommends the General Assembly expand the membership of the Commission on Children with Special Health Care Needs to include a dentist.

Recommendation 7: Special Needs Dental Care Workforce Development

The Study Commission on Aging recommends the General Assembly direct the North Carolina Area Health Education Centers (AHEC) Program to: 1) work with the dental schools at The University of North Carolina – Chapel Hill and East Carolina University, the North Carolina Community College System, and current special care dental providers to increase the available workforce willing to treat North Carolina special care populations; 2) work with the NC State Board of Dental Examiners to explore the feasibility of allowing dental students, dental hygiene students, and assisting students the opportunity to receive training in long-term care facilities under the direction of non-profit special care dental organizations; and 3) report to the Study Commission on Aging on or before August 1, 2011.

Recommendation 8: Medicaid Dental Services

The Study Commission on Aging recommends the General Assembly maintain Medicaid funding for dental services and direct the Division of Medical Assistance and the Division of Public Health to: 1) explore the feasibility of expanding Medicaid dental services to include reimbursement for evidenced-based fluoride and periodontal therapies for high risk adults with special health care needs, 2) explore the implementation of facility code policies that would allow certified providers to bill for each patient seen in a long-term care facility or group home on the date of service, and 3) report on or before November 15, 2011 to the Study Commission on Aging.

Recommendation 9: Additional Mobile Dental Units

The Study Commission on Aging recommends the Department of Health and Human Services and the special care mobile dental providers explore private grants and public federal government funding options for the purchase of additional mobile dental units to serve special care populations.

Recommendation 10: Refining Aging and Long-Term Care Statutes in NC

The Study Commission on Aging recommends the General Assembly update and refine North Carolina's General Statutes on aging and long-term care.

Recommendation 11: Adult Day Care Participant Protection

The Study Commission on Aging recommends the General Assembly amend North Carolina's General Statutes to strengthen the authority of the Department of Health and Human Services to ensure that unfit individuals are prohibited from operating or working in adult day care programs.

AGING NORTH CAROLINA:
The 2008 Profile, Updated

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

North Carolina's Demographic Shift: North Carolina remains in the midst of a significant demographic change as the State's 2.3 million baby boomers (those born between 1946 and 1964) are beginning to enter retirement age. Today, the proportion of the State's population who are seniors, ages 65 and older, is 12.3 percent. By 2029, when the youngest baby boomers are retirement age, the proportion should reach 15.2 percent or 1.9 million older North Carolinians, including the surviving boomers who will be between ages 65 and 83. Figure A shows the milestones of the baby boomers expressed in terms of some major federal and State age-related programs (eligibility age in parenthesis). For example in 2006, the oldest boomers (i.e., born in 1946) became eligible to receive services under the Older Americans Act, and as of January of 2008, some of the oldest boomers began receiving their first Social Security payments.

Figure A: Baby Boomer Milestones

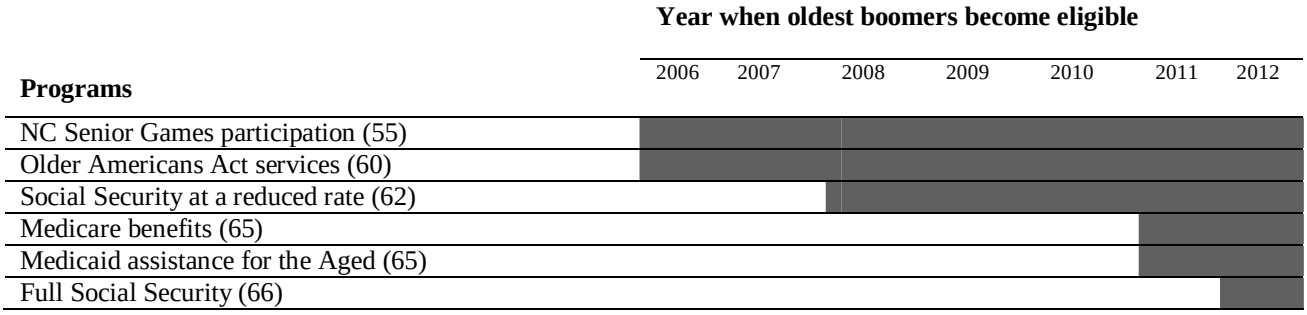
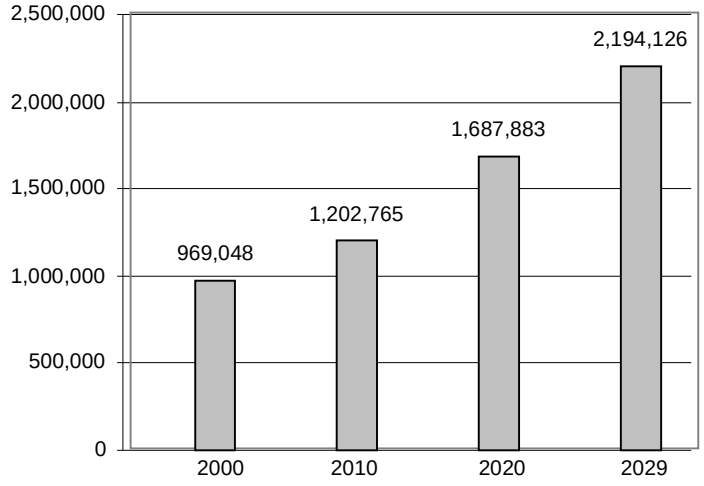


Figure B: Growth of Older North Carolinians Age 65+ (2000-2029)

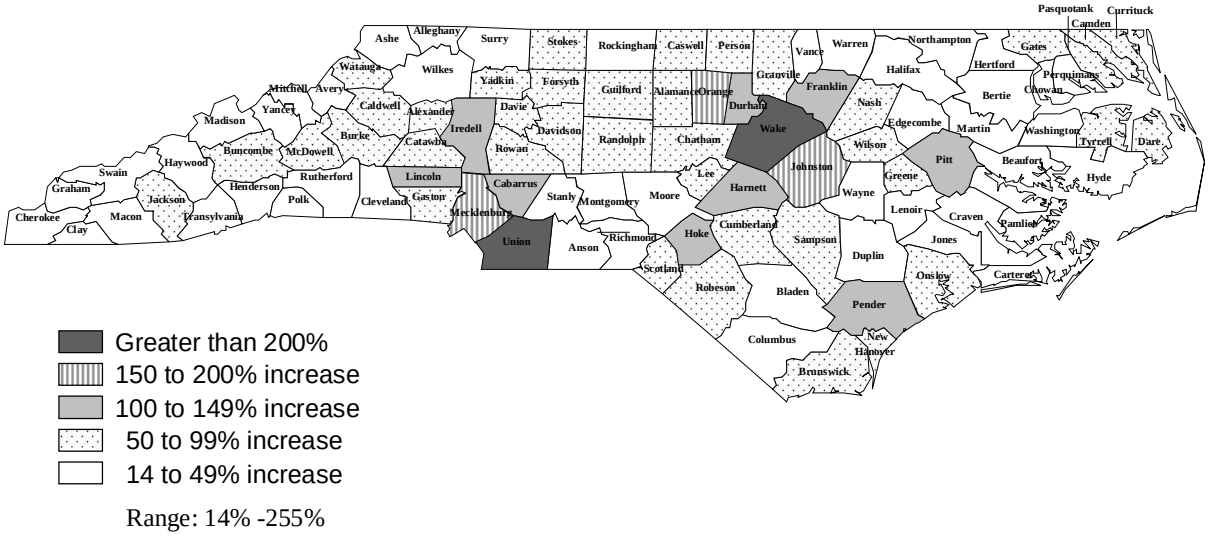


Based on 2008, Demographic Unit, Office of State Budget and Management, projections April 2000-July 2029

The impact of the aging baby boomers is clearly indicated in the projected growth of North Carolinians age 65+ between 2010 and 2029 as shown in Figure B. [1]

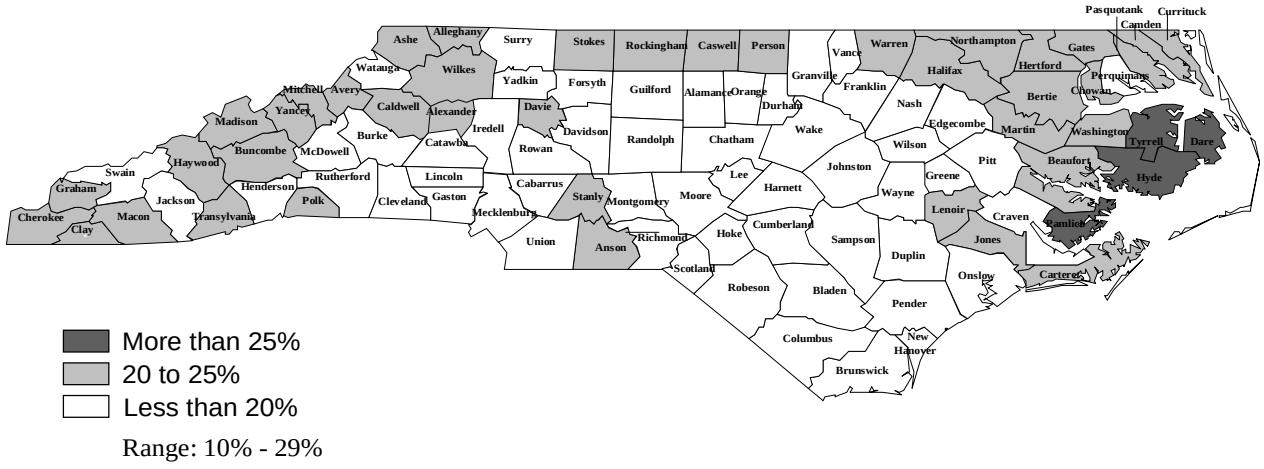
Figure C shows the projected growth of the older population by county between 2008 and 2029. During this period, growth for the State as a whole is projected at 38 percent, while the population 65 and older is expected to grow 93 percent, and the population 85 and older, 54 percent. [1] The two counties with more than 200 percent growth, Wake, and Union, and the three counties with 150 to 161 percent growth, Johnston, Mecklenburg, and Orange are experiencing rapid growth in their overall population as expanding parts of metropolitan areas.

Figure C. Projected Growth of Population Ages 65 and Older from 2008 to 2029



Source: Based on 2008 and 2029 projections from Office of State Budget and Management, September 2009

Figure D. Percent of County Population Projected to be Ages 65 and Older in 2029



Source: Based on 2029 projections from Office of State Budget and Management, September 2009

Figure D shows the counties that will have the largest concentration of older adults in 2029. The proportion of the State population made up of older adults aged 65+ for the State is 17%. Most of them are in areas attractive to retirees, but many are also counties that will continue to lose younger residents because of modest economic opportunities.

Although decreases in both fertility and mortality are the major factors in the aging of the State's population, migration also plays a key role. Several factors contribute to the different rates of aging of the State's 100 counties.

- 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, and are experiencing greater growth.
- A large number of older adults with higher incomes are retiring in some western and coastal counties and other counties with attractions to specific groups of older adults (e.g., golf courses).
- Some of the counties are also experiencing an increase in the immigrant and refugee population. [2]

Along with other Sunbelt states (Florida, South Carolina, Texas, Tennessee, Georgia, and Virginia), North Carolina remains a popular destination for people of all ages, including seniors. [3]

The table below compares later-life migrants, both those native to North Carolina and those born outside the State, to resident seniors. Later-life migrants are non-institutionalized persons over the

age of 60 who reportedly have moved across state lines. In 2006, among non-institutionalized North Carolinians aged 60 and older, an estimated 27,606 had arrived from out of State within the previous year. The data suggest that later-life migrants born outside North Carolina are somewhat younger, less likely to be disabled, nearly twice as likely to have a college degree, and report substantially higher family income. [4]

Table 1. Demographic Profile of Later-Life Migrants and Resident Seniors for North Carolina as a Whole, 2006

	Aged 60-64	Aged 65-74	Aged 75 and older	Diabled	Married	College Degree	White	Homeowner	Median Family Income
Later-life Migrants, non-natives	30.8%	42.8%	26.4%	37.5%	49.2%	34.5%	84.1%	48.4%	$56,800
Later-life Migrants, NC natives	50.8%	33.7%	15.4%	34.4%	41.1%	25.4%	64.3%	68.0%	$42,000
Resident Seniors	28.8%	39.5%	31.7%	39.4%	59.4%	19.0%	82.1%	80.8%	$45,000
Source: 2006 American Community Survey Public Use Microdata Sample (PUMS)									

The contributions of Dr. Don Bradley from East Carolina University to this report highlight aspects of later-life migration and suggest important implications for North Carolina of retirees moving to our State and within our State.

According to the most recent life tables from the NC State Center for Health Statistics, if age-specific mortality remains unchanged, babies born today in North Carolina are expected to live, on average, to the age of 77.1 years. The North Carolinians who are age 60 today are expected to live, on average, an additional 22.2 years to almost 82 years old. Generally, women live longer than men and whites live longer than persons of other racial groups. However, at the oldest ages, African Americans, in particular, have a life expectancy that is the same or slightly greater than that of whites. This is known as the "crossover effect." [5]

Table 2. Life Expectancies (in Years) by Age Group, Gender, and Race

	NC	White		African-American	
Age Groups	Combined	Male	Female	Male	Female
(At Birth)	77.1	75.3	80.5	69.8	76.7
60-64	22.2	20.8	24.0	18.1	22.3
65-69	18.4	17.1	19.9	15.1	18.7
70-74	15.0	13.7	16.1	12.4	15.5
75-79	11.9	10.8	12.7	10.1	12.4
80-84	9.2	8.4	9.6	8.3	9.8
85+	7.1	6.6	7.2	6.9	7.7

Source: NC Center for Health Statistics. *Life Expectancy in North Carolina, 2005-2007*

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 the seniors of today and tomorrow. The business and faith communities as well as others must identify and respond to the challenges and opportunities of these demographic shifts.

In the 2003-2007 State Aging Services Plan, the NC Division of Aging and Adult Services introduced a new initiative–Livable and Senior-Friendly Communities–to raise awareness of the aging of our population. The initiative was also designed to encourage North Carolina's communities toward becoming more senior-friendly as well as livable for all people through collaboration among citizens, agencies, organizations, and programs, in both the public and private arenas. This initiative formed the core around which the 2007–2011 State Aging Services Plan was organized. A livable and senior-friendly community in North Carolina will draw on the talents and resources of active seniors while enhancing services for those who are vulnerable because of their health, economic hardships, social isolation, or other conditions. A livable and senior-friendly community will work to address a wide range of issues and concerns (e.g., air quality, housing, long-term services and supports, employment, enrichment opportunities) that, as a whole, affect the quality of life of seniors and others in the community. Also, a livable and senior-friendly community will assure good stewardship of its resources to meet the needs of today's seniors, while helping baby boomers and younger generations prepare for the future.

Demographic Highlights

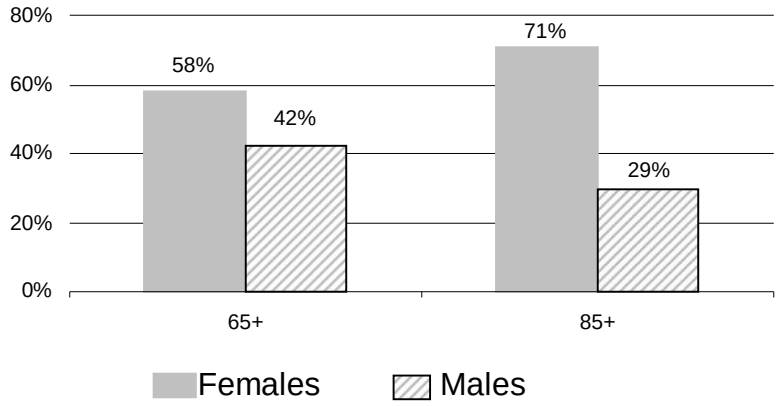
***Population*:** North Carolina ranks tenth among states in the number of persons age 65 and older and tenth in the size of the entire population. [6] The fast pace of growth of the State's older population is evident in a US Census Bureau's release in which North Carolina was ranked fourth nationally in the increase of the number of persons age 65+ (47,198 in NC) between April 2000 and 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, North Carolina continues to maintain an overall healthy demographic balance among the generations, as it is thirty-sixth among states in the proportion of the population over 65. [7]

- Estimated NC population age 65+ in 2008: 1,139,468 (12.3 percent of total population)
- Estimated NC population age 85+ in 2008: 138,632 (1.5 percent of the total population)

Diversity and Disparity: 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 NC's older adults relate to gender, marital status, ethnicity/race, poverty, residence, rurality, disability, health status, grandparents raising grandchildren, and veteran status.

Gender: Older women represent 57.7 percent of the 65+ age group and 70.6 percent of the 85+ age group in 2008. [8] The higher rate of poverty among older women remains a primary issue today. For example, women age 75+ are twice likely to be poor as men the same age. [9]

Figure E. Percentage of Older Adults by Gender and Age



Marital Status: Since women live longer than men, aging brings the increasing likelihood of widowhood, for women. Because men have shorter life expectancy, and because they tend to marry younger women, at ages 65 and older, women are more than twice as likely to be unmarried as men in their age group. Data show that being unmarried (widowed, divorced, separated, or never married) increases a woman's vulnerability to poverty. [10]

Table 3. Unmarried Older Adults by Gender and Age Group

	Age 65-74	Age 75-84	Age 85+
Unmarried Women in NC	47.1	67.4	91.5
Unmarried Men in NC	24.6	29.4	49.7

Source: American Community Survey (2008). *Table B12002.*

Ethnicity/Race: Altogether 19.1 percent of persons age 65+ are members of ethnic minority groups in North Carolina. Compared to the nation as a whole, North Carolina's population age 65+ includes a larger proportion who are African American (15.6 percent in NC compared to 8.3 percent nationally) and a smaller proportion of Latinos (1.5 percent in NC compared to 6.8 percent nationally). American Indians, Asian Americans, and other ethnic groups account for 2.0 percent of the age group 65 and older. [11]

Poverty: In North Carolina as well as nationally, older adults from most ethnic minority groups show both a higher poverty rate and a lower life expectancy when compared with the non-Latino white population. Poverty rates for the two largest racial groups are shown in the table below. (See the Demographic Shift section for the information on life expectancy). [12]

Table 4. Percent Below Poverty Level for the Older Population of North Carolina by Gender, Race, and Age Group

	White		African American	
	Male	Female	Male	Female
Age Group 65 - 74	5.3	8.5	11.3	22.1
Age Group 75+	7.1	15.1	20.2	33.1

Source: American Community Survey (2008). *Table B17001A, B17001B*

Immigrants/Refugees: North Carolina has also been experiencing a rise in the immigrant population. Many immigrants are settling in urban areas, though other rural counties are also becoming their destination. In 2007, the State ranked 13th in the size of the foreign-born population and ranked 15th in the number of newly admitted immigrants in 2006. Between 2000 and 2007, 282,000 immigrants arrived to the State. [13] The number of refugees arriving to the State has also increased. About 4,292 refugees from different countries arrived between 2005 and 2007. [14] There is lack of data of exact numbers of older adults of these various immigrant groups. Many of them face language barriers, social isolation, problems in accessing health care and other programs/services. [15]

Residence: The 2000 Census showed that in North Carolina, 81.4 percent of householders ages 65 and older owned their homes (with or without mortgage), yet among homeowners in that age group, over 61,000 reported incomes for 1999 that were below poverty. This figure means that 11.8 percent of the homeowners over age 65 were poor, compared to 7.5 percent for homeowners of all age groups. [16] This has implications for both helping some older adults be responsible for their own needs (e.g., through reverse mortgages) and for the need for property tax relief to older adults. Among renters age 65+ who provided information, 63.2 percent, or 72,739 households, spent more than 30 percent of their household income on rent. [17] Furthermore, 5,000 North Carolina homeowners and renters age 65+ lacked complete plumbing facilities in their homes. [18]

Rurality: Among all age groups, 39.8 percent of North Carolina residents live in rural areas compared to only 21.0 percent for the country as a whole. [19] The percentage among older adults is no doubt higher (based on the percentages of older adults in the predominantly rural counties), but there is no age-specific figure available. In 2000, North Carolina's rural population (3,202,238) was almost as large as Texas's (3,647,747), 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 percent) 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 percent to 61.8 percent, 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. At the same time North Carolina has made the transition away from an agricultural economy so that only 1.1 percent of its people live on farms, only slightly more than the 1.0 percent for the nation as a whole. A 2002 report from *Making a Difference in Communities* (MDC) highlights a long list of challenges that 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. [20]

Disability: In North Carolina, 39.8 percent of the non-institutionalized civilian population age 65 and older reported having one or more disabilities by the US Census definition—41.4 percent of women and 37.9 percent of men, according to the 2008 American Community Survey. [21] The Census Bureau defines disability as "a long-lasting physical, mental, or emotional condition that makes 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." This definition is very broad and leads to counting a number of people who, indeed, have difficulties but are able to function independently and would not meet the average person's perception of a person with a disability.

Health Status: Heart disease is the leading cause of death among older adults both nationwide and in North Carolina with cancer and stroke, coming second and third on the list. [22] In particular, the coastal plain region of North Carolina has the fourth highest stroke death rate in the nation and is labeled by some as the Buckle of the Stroke Belt. [23] African Americans and other racial minorities are at substantially higher risk for certain chronic conditions such as heart disease, stroke, and diabetes (a major contributor to heart disease, stroke, and other conditions). [24] Diabetes mellitus is the sixth leading cause of death for North Carolina's older population in general, but like stroke, it is a more serious threat to the African American community, being the fourth highest cause of death in African Americans of all ages in our State. [22]

Table 5. Five Leading Causes of Death among North Carolinians Age 65+

Rank	Cause
1	Heart diseases
2	Cancer
3	Cerebrovascular diseases
4	Chronic lower respiratory diseases
5	Alzheimer's disease

Source: NC Center for Health Statistics (2009). *Leading Causes of Death – 2008.*

An important factor in health status is physical activity. A sedentary life-style is known to increase a person's risk of heart disease, diabetes, and other chronic conditions. Fortunately, more older adults in NC have been engaging in physical activity lately. The 2008 Behavioral Risk Factor Surveillance System (BRFSS) shows that 68.7% of older adults age 65+ have participated in physical activities or exercise other than their regular jobs, in the past month. The survey also shows that among people age 65+, only 19.5% said that their general health status is fair and 11.5% as poor. [25]

According to the 2008 American Community Survey 99% of older adults 65 and over (civilian non-institutionalized) had health insurance coverage and 70% of them had private health insurance. [26]

Grandparents Raising Grandchildren: According to the 2008 American Community Survey there were 97,784 NC grandparents who reported that they had one or more grandchildren living with them under 18 years old *for whom they were responsible*. This represents nearly half of all grandparents whose grandchildren live with them. Some 38 percent of NC grandparents responsible for their grandchildren are African American; 4 percent are Hispanic/Latino; 2 percent are American Indian or Alaskan Native; and 57 percent are White. Given the relative sizes of these populations, it is clear that this is an even larger issue in the African-American community than

among other ethnic groups. [27]

Veteran Status: Of the estimated 746,259 veterans living in NC in 2008, over 260,236, or 35 percent, were age 65 and older. [28] The group of veterans from the Vietnam era contains proportionally more disabled members than survivors of earlier wars due to quicker and more advanced medical treatment. The Veterans Administration has frequently written about the aging of the veterans as a major challenge to its health care system in coming years. [29]

In summary, North Carolina has a large, economically and ethnically diverse older population. With this diversity come both special assets and special challenges. Even the most vulnerable older adults often give as much to their communities as they receive. Nevertheless, we must be aware that those who face disabilities, disparities of income and health care, and the responsibilities of caring for grandchildren are more likely to need public services and supports. While meeting these disparate needs of today's older adults, our State is also witnessing the first minor steps of the transition of the baby boomers into retirement ages. This will transform the age structure of the State and bring a new generation of older adults with some of the same historic issues, but also new attitudes, new challenges, new opportunities, and new resources.

Sources of Information

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[16] US Census Bureau (2003). *Census 2000 Summary File 3.* Tables HCT2 and HCT24

[17] US Census Bureau (2003). *Census 2000 Summary File 3.* Table H71

[18] NC State Library (2003). Special tabulation from the Census 2000 data as requested by the NC Division of Aging and Adult Services.

[19] US Census Bureau (2003). *Census 2000 P5 (Summary File 3).*

[20] Making a Difference in Communities in the Sought (MDC) (2002). *State of the South 2002*.

[21] US Census Bureau (2008). *2008 American Community Survey.* Table B18001.

[22] NC State Center for Health Statistics (2009). *Leading Causes of Death-2008 http://www.schs.state.nc.us/SCHS/deaths/lcd/2008/pdf/TblsA-F.pdf.*

[23] Tri-State Stroke Network. (2006) Facts and Statistics: Stroke in the United States http://www.tristatestrokenetwork.org/facts.html#buckle

[24] NGA Center for Best Practices (2004). *Measuring the Years: State Aging Trends & Indicators.*

[25] NC State Center for Health Statistics (2008). *Behavioral Risk Factor Surveillance Calendar Year 2008 Results. Exercise; Health Status; http://www.schs.state.nc.us/SCHS/*

[26] US Census Bureau (2008). *2008 American Community Survey.* Table B18001.

[27] US Census Bureau (2008). *2008 American Community Survey.* Table B10051, B10051A-I

[28] US Census Bureau (2008). *2008 American Community Survey.* Table B21001.

[29] US Department of Veterans' Affairs (2002) *VA History in Brief http://webpages.charter.net/wisconsinlegion-7thdistrict/VA_History.htm#Vietnam_War*

Pertinent Web Sites for Related Information

- NC Division of Aging and Adult Services (http://www.dhhs.state.nc.us/aging/demo.htm)
- Demographics Unit, NC Office of Budget and Management (http://demog.state.nc.us/)
- NC State Center for Health Statistics (http://www.schs.state.nc.us/SCHS/)
- US Census Bureau (http://www.census.gov)

COMMISSION PROCEEDINGS

January 7, 2010

The North Carolina Study Commission on Aging met on Thursday, January 7, 2010, at 10:00 a.m. in Room 544 of the Legislative Office Building. Senator A.B. Swindell presided. Following introductions, Theresa Matula, Commission staff, provided an overview of older adults in North Carolina. Her presentation focused on: who they are, how many there are, where they live, and what types of programs and services are available for older adults in North Carolina. The presentation included data on changes in the North Carolina population which depict the probability of significant growth in the older adult population. The presentation included a brief summary of the range of services provided in the State which include: Senior Games, Senior Centers, Adult Day Care and Adult Day Health Care, State/County Special Assistance, the State/County Special Assistance In-Home Program, the services provided by Home and Community Care Block Grant funds, the Community Alternatives Program for Disabled Adults (CAP/DA), assisted living, Multiunit Assisted Housing with Services, Adult Care Homes, Nursing Homes, Continuing Care Retirement Communities, and Medicare/Medicaid. Ms. Matula ended her presentation by mentioning additional information and resources including the Area Agencies on Aging and various divisions within the Department of Health and Human Services that serve older adults.

Shawn Parker, Commission staff, then presented a document containing summaries of substantive legislation related to older adults that was enacted during the 2009 Session. Mr. Parker was followed by Melanie Bush, Commission staff, who provided an overview of 2009-2011 legislative budget actions and special provisions. Sara Kamprath, Commission staff, presented an overview of the Commission's responsibilities and statutory authority. Next the Commission heard from Shawn Parker, Commission staff, who presented a status report of the Study Commission on Aging's recommendations to the Governor and the 2009 General Assembly. The last presentation was the tentative meeting schedule for the interim, and the Commission's budget which was approved.

For a period of time, the agenda and handouts for this meeting are available on the internet at: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38. (Look under 2009-10 Interim Commission Meetings.) Minutes for each meeting are on file in the Legislative Library.

January 21, 2010

The North Carolina Study Commission on Aging met Thursday, January, 21, 2010, at 10 a.m. in Room 544 of the Legislative Office Building. Representative Jean Farmer-Butterfield presided. Presentation topics included: aging services and programs, an overview of the adult care home star rating program, and the expansion of the star rating program.

Dennis Streets, Director, Division of Aging and Adult Services, Department of Health and Human Services (DHHS), discussed the State resources available for older adults, funding sources for services, and concerns regarding the present system of services. Mr. Streets listed a few concerns the Division has in relation to service needs. They are:

- Increase in Adult Protective Services Reports
- Growth of the Wait List for Home and Community Services
- Status of Home and Community Care Block Grant
- Increase in Public Guardianship Cases
- Uncertainty Within Alzheimer's Support Network
- The NC Roadmap

Mr. Streets then presented reasons to remain optimistic through examples of volunteers, workers, and individuals that provided extraordinary care to North Carolina's aging population.

Next Megan Lamphere, Facility Survey Consultant, Adult Care Licensure Section, Division of Health Service Regulation (DHSR), DHHS, presented a report in response to S.L. 2007-544, Section 3(g) on the Adult Care Home Star Rated Certificate Program. This program was initiated by the Commission in response to citizens of North Carolina who voiced the need for increased availability of public information regarding the care provided in adult care facilities. The North Carolina Medical Care Commission developed rules for the rating program with input from residents and families in adult care homes, advocacy groups, providers and others.

The last presentation was given by Jeff Horton, Acting Director, Division of Health Service Regulation, DHHS. Mr. Horton discussed the expansion of the Star Rated Certificate Program in response to S.L. 2007-544, Section 3(f). The Division identified the following four categories of other facilities (non-adult care homes) and services licensed and certified by DHHS to be considered for inclusion in a rated certificate program:

- Acute and home care facilities and agencies,
- Nursing homes,
- Mental health, developmental disabilities and substance abuse services, and
- Adult day services.

Mr. Horton informed the Commission that the Centers for Medicare and Medicaid Services (CMS) provides quality information on their website for nursing homes and hospitals. Mr. Horton stated that although home care agencies are required to be inspected every three years, the Division does not currently have sufficient staff to conduct the inspections every three years. With regard to Mental Health, Developmental Disabilities and Substance Abuse Services facilities, Mr. Horton indicated that making inspection information available would not require changes to the statutes or the rules, but would require additional personnel. For adult day services, significant challenges to the creation of an effective rated certificate system exist and it was concluded that the cost outweighs the benefit at this time.

For a period of time, the agenda and handouts for this meeting are available on the internet at: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38. (Look under 2009-10 Interim Commission Meetings.) Minutes for each meeting are on file in the Legislative Library.

February 4, 2010

The North Carolina Study Commission on Aging met on Thursday, February 4, 2010, at 10:00 a.m. in Room 544 of the Legislative Office Building. Senator A.B. Swindell was the presiding Co-Chair. The meeting was devoted to three issues impacting older adults: hearing loss, Medicaid changes, and adult day care sustainability.

Ms. Jan Withers, Director of the Division of Services for the Deaf and Hard of Hearing (DSDHH), Department of Health and Human Services (DHHS), briefed the Commission on the impact of hearing loss in older adults in North Carolina. She reported on the results of the study undertaken as a result of S.L. 2008-181, Sec. 12.1. During her presentation, Ms. Withers reviewed significant aspects of the report and presented the following three recommendations to the Commission:

- Establish a task force to assess the feasibility of developing and implementing a formal system that optimizes consumer capacity to fully evaluate quality of hearing aid services prior to and during the process of purchasing hearing aids.
- Enact legislation that would require all hearing aid dispensers to provide a minimum 30-day trial period with a money back guarantee and instructions on the function of the telecoil and

its use.

- Consider legislation requiring hearing aid health insurance coverage for all ages from any private agency providing health insurance and doing business in North Carolina and from any public agency providing medical insurance coverage assistance.

Next, Dr. Larry Nason and Dr. Karen Feasel, from the Division of Medical Assistance, DHHS, gave a presentation on Medicaid changes and the impact on older adults. Dr. Nason gave a basic overview of the Medicaid Personal Care Services (PCS) Program and the scope of authorized services under the program. He highlighted differences between PCS provided under a 1915(c) Waiver versus PCS provided as an optional service under the State Medicaid Plan; discussed the dramatic and steady increase in PCS participation, utilization and costs; and reviewed the General Assembly's budget reduction goals for PCS for State fiscal years 2009-2010 and 2010-2011. Dr. Feasel provided information on the PCS compliance reviews conducted by The Carolinas Center for Medical Excellence and reported on eight specific actions planned by DMA. These actions are an effort to implement changes to the PCS benefit that are mandated by Session Law 2009-451 to achieve budgeted reductions. Dr. Feasel also reviewed the history of the CAP/DA slot allocations and explained the pending reduction in PCS slot allocations under this program.

Lastly, Ms. Teresa Johnson from the North Carolina Adult Day Services Association presented a five year post study follow-up on adult day care sustainability. She reviewed various reimbursement methodology changes, as well as training and technical assistance initiatives implemented at the recommendation of a national adult day services resource center under contract with DHHS. Ms. Johnson concluded that these changes have made our adult day centers healthier and established North Carolina as a leader in the adult day services industry.

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February 25, 2010

The North Carolina Study Commission on Aging met on Thursday, February 25, 2010 at 10:00 a.m. in Room 544 of the Legislative Office Building. Representative Farmer-Butterfield was the presiding Co-Chair. The Commission members heard presentations on nurse aide preparation and older driver safety.

Jesse Goodman, Acting Chief Operating Officer, Division of Health Service Regulation, DHHS presented information on types of aides, current requirements, locations of employment, and other related information. His presentation included: the federally defined definition of a nurse aide, the State and federal requirements for Nurse Aide I registry listing, the federally required content for Nurse Aide I Training Programs, information on State approved training programs, federal requirements for competency evaluation, passing rates by test taker groupings, supply and demand for nurse aides, and the typical duties of a nurse aide. According to Mr. Goodman, in 2006, there were 72,130 Home Health Aides employed, 21,780 Nurse Aides, and 18,350 Personal and Home Care Aides. Over the next ten years, the demand for aides employed in each of these three categories is anticipated to increase as follows: 30% for Nurse Aides, 39% for Home Health Aides, and 76% for Personal and Home Care Aides. Mr. Goodman also provided the following breakdown by employment setting for Nurse Aides:

- Home Health/Home Care - 24%
- Private Duty, Military/VA, Schools, Adult Day Care, Rehab, Native American Reservations – 21%
- Nursing Homes – 20%
- Hospital/Hospice/Mental Health – 15%
- Not Employed in Health Care – 10%

- Adult/Family Care Home – 6%
- Clinics – 3%

During this meeting the Commission also heard presentations from the following: Saundra Spillman, Executive Director, Direct Care Workers Association of NC; Linda Burhans, Director Education/Practice, NC Board of Nursing, and LeRoy King and Elizabeth Todd Beal, Friends of Residents in Long-Term Care. Dr. Spillman presented information on the benefits of a career lattice approach and on the Direct Care Workers Association's collaborative efforts to provide a conference aimed at reducing turnover and increasing job satisfaction. Dr. Burhans, NC Board of Nursing, presented information on Medication Aide qualifications, tasks, and education programs, and on the qualifications, task lists, education programs, and employment settings for the Nurse Aide II. Dr. King and Ms. Beal provided the Commission with federal regulations for training programs and information showing that more than half of the states have training requirements that exceed the federal regulations.

Information on older drivers was presented by David Harkey, Executive Director, UNC Highway Safety Research Center; Susan Stewart, Medical Evaluation Program, NC Division of Motor Vehicles; and Phyllis Bridgeman, Cochair of the Older Drivers Task Force. Mr. Harkey provided national and State demographic and safety data for older drivers as well as aging driver safety strategies. Mr. Harkey reported that older driver safety is trending in a positive direction and that in-person renewal correlates to a reduction in fatality rates for older drivers. Ms. Stewart reported that the Driver Medical Evaluation program, in the Division of Motor Vehicles (DMV), is administered with medical counsel and individual case recommendations provided by physicians and physician extenders. Ms. Stewart also reported that drivers are referred to the DMV by concerned physicians, family members, drivers license examiners, and law enforcement officers. Ms. Bridgeman presented recommendations from the Older Drivers Task Force which included: improved signage at non-standard intersections; building capacity to accommodate the needs of older drivers; strengthening DMV training to identify drivers at increased risk of crashing; increasing public awareness of older driver issues and resources; engaging law enforcement in implementing older driver safety initiatives; and implementing older driver safety initiatives by engaging physicians and other health care providers.

For a period of time, the agenda and handouts for this meeting are available on the internet at: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38. (Look under 2009-10 Interim Commission Meetings.) Minutes for each meeting are on file in the Legislative Library.

March 4, 2010

The North Carolina Study Commission on Aging met on Thursday, March 4, 2010, at 10 a.m. in Room 544 of the Legislative Office Building. Senator A.B. Swindell presided.

Carla Obiol with the North Carolina Seniors' Health Insurance Information Program (SHIIP), Department of Insurance, presented a report required by S.L. 2006-66, Section 10.10 on the development of the North Carolina Long-Term Care Partnership (LTCP) program. Ms. Obiol explained that the number one reason for establishing a LTCP program is the increase in the number of baby boomers seeking long-term care and the potential for the long-term care needs of baby boomers to overwhelm Medicaid's pay-as-you-go financing. The LTCP program is a public-private program between state Medicaid agencies and private insurers that is designed to encourage the purchase of long-term care insurance. The LTCP program is aimed at middle- and upper-income individuals who want to protect their assets while allowing access to long-term care benefits through the state Medicaid program. Policy holders who exhaust their private coverage but still need long-term care benefits can access Medicaid without the usual spend down routes.

Both the North Carolina Department of Insurance and the North Carolina Division of Medical Assistance, DHHS support the establishment of a LTCP program in North Carolina. Carolyn McClanahan, Division of Medical Assistance, Department of Health and Human Services, explained that the amount of benefits used on the long-term care policy will not be counted in determining Medicaid eligibility. She also mentioned that other states who have recently implemented an LTCP program have reported no fiscal impact so no fiscal impact is expected for Medicaid in North Carolina.

Next the Commission heard a report required by S.L. 2009-100 that directed the Department of Health and Human Services, Division of Public Health, DHHS, in collaboration with the Division of Medical Assistance, the Division of Aging and Adult Services, the University of North Carolina-Chapel Hill (UNC-CH) and the East Carolina University (ECU) Schools of Dentistry, the North Carolina Dental Society, and providers of special care dentistry services, to examine the current dental care options for populations that require special care dentistry services and suggest ways to improve the availability of those dental services.

Dr. Kevin Buchholtz, Oral Health Section, Division of Public Health, DHHS and Dr. Bill Milner, Access Dental Care, highlighted several recommendations from the report, *Special Care Oral Health Services: A north Carolina Commitment*. The report and the presentation define patients with special needs, existing dental care options, consumer issues, provider/payer issues, systems issues, and a vision to address the gaps. The report contains a total of 16 recommendations, many of which were highlighted during the presentation. Due to the number of recommendations and the economic challenges faced by the State, the Commission requested a prioritized list of recommendations. This list was provided to the Co-Chairs and staff following the meeting and contained six recommendations that did not require funding and three recommendations that do require funding.

- Direct the Division of Health Service Regulation to collaborate with the Division of Public Health, NC Board of Nursing, National Association of Directors of Nursing Administration, NC Health Care Facilities Association, NC Non-Profit Nursing Home Association, UNC School of Public Health, Friends of Residents of Long-Term Care, NC Ombudsman Association, and special care dental providers to determine the current status of daily oral hygiene conditions in long-term care residents, existing effective programs, health and financial issues related to systemic infection, facilities issues related to program implementation and make recommendations.
- Appoint a dentist to the Commission on Children with Special Health Care Needs.
- Support the NC Commission on Children with Special Health Care Needs' Oral Health Work Group, NC Family Council for Children and Youth with Special Health Care Needs, Family Voices, the NC Council on Developmental Disabilities, and the NC Office on Disability and Health to develop a central point of communication for families with intellectual or developmental disabilities and oral health issues.
- Direct NC AHEC, UNC-CH and ECU Schools of Dentistry, NC Community College system, and current special care dental providers to create a plan of action to produce the necessary workforce manpower to care for NC special care populations.
- Direct the NC State Board of Dental Examiners to investigate changing existing laws to allow dental, dental hygiene, and assisting students to receive training in long-term care facilities under the direction of non-profit special care dental organizations.
- Direct the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to develop a business plan to provide in-house and community dental services at each of its psychiatric hospitals, developmental and neuron-medical centers.
- Maintain Medicaid dental services for adults and consider expanding the services to include

reimbursement for evidenced-based chemotherapeutic agents (fluoride therapies, periodontal therapies, etc.) for high-risk adults with special health care needs.

- Direct the Division of Medical Assistance to implement the facility code (CDT code D9410) policies to allow certified providers to bill for each patient seen on a date of service in a nursing home, group home, or other long-term care facility.
- Fund an additional mobile dental program that provides onsite comprehensive dental care for residents in nursing homes, group homes, assisted living centers, adult day health care centers, and to certain individuals with special health care needs in the community.

For a period of time, the agenda and handouts for this meeting are available on the internet at: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38. (Look under 2009-10 Interim Commission Meetings.) Minutes for each meeting are on file in the Legislative Library.

March 24, 2010

The North Carolina Study Commission on Aging conducted a public hearing on March 24, 2010, at 10:00 a.m. in the town hall in Jamestown, North Carolina. Senator Swindell presided over the public hearing. At this hearing, the Commission heard from thirty-five (35) speakers. Issues mentioned most frequently at this hearing were: Maintain/Increase Home and Community Grant (HCCBG) Funding, Maintain/Increase Funding for Project C.A.R.E., Maintain/Increase Funding and Support for Adult Day Care, and Maintain/Increase Funding for New and Existing Special Care Dental Programs. Appendix A contains a frequency distribution of the public hearing comments.

April 1, 2010

The North Carolina Study Commission on Aging met on Thursday, April 1, 2010, at 10:00 a.m. in Room 544 of the Legislative Office Building. Representative Jean Farmer-Butterfield presided.

Dennis Streets, Director of the Division of Aging and Adult Services (DAAS), DHHS, presented an interim report on Preparing for Older Adults, consistent with S.L. 2009-407, Section 2. The report highlighted the ways DAAS and the University of North Carolina Institute on Aging (IOA) are working together to help the state prepare for the aging of the baby boomer population and the growing number of in-migrating retirees. Progress includes significant collaboration between DAAS and IOA since August 2009; working closing with the Governor's Office and Governor's Advisory Council on Aging, to outline roles and tasks; conversations with various stakeholders from the UNC School of Government, directors of the state's 17 Area Agencies on Aging, and staff of the North Carolina Association of County Commissioners; construction of a survey instrument to assess the level of awareness and preparation for North Carolina's aging population across state government agencies; the planning of six regional roundtables, in coordination with the Governor's Office, area agencies on aging, local providers and others, to discuss major issues and best practices; and a web-based survey of local home and community service providers.

Mr. Streets also announced the Governor's Executive Order No. 54, Assessment of the State's Readiness for Aging Population, which supports the regional roundtables; presented a summary of the Haywood Community Connections toolkit designed to increase knowledge of county resources, increase volunteerism, and provide local resources and supportive services; presented a draft amendment to General Statute 143B-181.3 to help North Carolina pursue state and federal funding for long-term care, and announced that North Carolina received $1 million in federal Living Healthy Program funds. He also reminded the members of the Commission that DAAS does not receive the results of criminal background checks of adult day care employers or employees, and asked the Commission to consider making changes to this policy.

Next, Theresa Matula, Commission staff, presented draft recommendations for the Commission's consideration. The draft recommendations represented a range of issues presented to the Commission during the interim. Ms. Matula presented 11 recommendations with background information for each and explained that once the Commission approved recommendations, they would be compiled in a report, including bill drafts as applicable, for the 2010 General Assembly. During the meeting, the Commission unanimously approved the 11 recommendations.

For a period of time, the agenda and handouts for this meeting are available on the internet at: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38. (Look under 2009-10 Interim Commission Meetings.) Minutes for each meeting are on file in the Legislative Library.

April 22, 2010

The North Carolina Study Commission on Aging conducted a second public hearing on April 22, 2010 at 1:00 p.m. at the Tyvola Senior Center, Charlotte, North Carolina. Representative England presided over the public hearing and the Commission heard from twenty-five (25) speakers. The two issues mentioned most frequently at this hearing were: Maintain/Increase Funding for Project C.A.R.E. and Maintain/Increase HCCBG Funding. Appendix A contains a frequency distribution of the public hearing comments.

May 11, 2010

The North Carolina Study Commission on Aging met on Tuesday, May 11 at 10:00 a.m. in Room 544 of the Legislative Office Building. Senator Swindell was the presiding Co-Chair. During the meeting, Ms. Susan Barham, Commission staff, presented an overview of the items mentioned most frequently during the two public hearings. Commission staff also reviewed the Commission's draft report to the Governor and the 2010 Regular Session of the 2009 General Assembly.

For a period of time, the agenda and handouts for this meeting are available on the internet at: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=38. (Look under 2009-10 Interim Commission Meetings.) Minutes for each meeting are on file in the Legislative Library.

COMMISSION RECOMMENDATIONS

The North Carolina Study Commission on Aging makes the recommendations presented in this report to the Governor and the 2010 Session of the 2009 General Assembly. Each recommendation is followed by background information and any corresponding legislative proposals appear in Appendix B of this report.

Recommendation 1: Maintain HCCBG Funding

The Study Commission on Aging recommends the General Assembly and the Governor maintain funding levels appropriated for FY 2010-2011 to the Department of Health and Human Services for the Home and Community Care Block Grant (HCCBG).

Background 1: Maintain HCCBG Funding

During the meeting on January 21, 2010, the Commission heard a presentation from Dennis Streets, Director, Division of Aging and Adult Services, DHHS, on the status of Aging Services and Programs. Mr. Streets mentioned that the service system is stressed as service needs grow. One of the areas mentioned was the growth of the wait list for home and community services. With regard to home and community services, Mr. Streets pointed out the following:

- Access to and intensity of services has weakened
- Service needs and wait lists are substantial
- Providers are frugal, stressed, conscientious, and innovative
- Clients are becoming more vulnerable.
- Mr. Streets provided the following status on the Home and Community Care Block Grant (HCCBG):
- Overall funding has increased about 20% over the past 10 years – taking into account non-recurring reductions for SFY 2009-10.
- The Statewide utilization/expenditure rate remains very high – 99.8% in SFY 2008-09.
- Service costs have increased.
- There was a decrease in the number of clients served (6.9%) and in total service units (14.1%) between July 1, 2000 and June 30, 2009. During this period, the NC population age 60+ and 75+ grew by 29% and 18%.

The HCCBG, established by G.S.143B-181.1(a)(11), includes federal funds, State funds, local funds, and a consumer contribution component. It gives counties discretion, flexibility, and authority in determining services, service levels, and service providers; and streamlines and simplifies the administration of services. The focus of the HCCBG is to support the frail elderly that are cared for at home; improve and maintain the physical and mental health of older adults; assist older adults and their caregivers with accessing services and information; provide relief to family caregivers so that they can continue their caregiving; and allow older adults to remain actively engaged with their communities.

With input from older adults, County Commissioners approve an annual funding plan that defines services to be provided, the funding levels for these services, and the community service agencies to provide these services. Counties can select from among 18 eligible services including: Adult Day Care, Adult Day Health Care, Care Management, Congregate Nutrition, Group Respite, Health Promotion and Disease Prevention, Health Screening, Home Delivered Meals, Housing and Home Improvement, Information and Assistance, In-Home Aide, Institutional Respite Care, Mental Health Counseling, Senior Center Operations, Senior

Companion, Skilled Home (Health) Care, Transportation, and Volunteer Program Development. Counties decide which services to provide, however congregate nutrition and home-delivered meals are provided in almost every county under the HCCBG.

The Study Commission on Aging recommends that the General Assembly and the Governor maintain funding levels appropriated for FY 2010-2011 for the Home and Community Care Block Grant (HCCBG). The Governor's Advisory Council on Aging and the Senior Tar Heel Legislature both support funding for the HCCBG. Maintain and increase HCCBG funds was also one of the most frequently mentioned issues during the public hearings conducted during March and April.

Recommendation 2: Maintain Funding for Senior Centers, Project C.A.R.E., and Other Vital Support Programs and Services

The Study Commission on Aging recommends the General Assembly and the Governor maintain current funding levels for senior centers and Project C.A.R.E. as well as many other vital programs that provide aging services and support systems for older adults and their families.

Background 2: Maintain Funding for Senior Centers, Project C.A.R.E., and Other Vital Support Programs and Services

During the January 21, 2010 meeting, the Commission heard a presentation from Dennis Streets, Director, Division of Aging and Adult Services, DHHS. During this presentation Mr. Streets shared information on items that are essential to future systems for aging services and supports. His points were as follows:

- Easy and reliable access to information and assistance to facilitate personal responsibility.
    - Efforts include: North Carolina's "No Wrong Door" approach, nccarelink.gov, senior centers, and Community Resource Connections for aging and disabilities.

- Effective holistic and collaborative management of chronic conditions.
    - Efforts include: Community Care Connections, Programs of All-Inclusive Care for the Elderly (PACE), person-centered and consumer-directed approaches to chronic care, pursuing a stronger connection with the Veterans Administration, following the NC Roadmap for Healthy Aging, and falls prevention programs.

- Timely protection and intervention for vulnerable individuals.
    - Efforts include: adult protective services reform, the Institute of Medicine Task Force on co-locating different populations in adult care homes, Relay for Extra Help, and Project C.A.R.E. (Caregiver Alternatives to Running on Empty). (Project C.A.R.E. provides the following assistance to caregivers of people with dementia: in-home needs assessments; counseling; information; assistance finding and selecting respite; funds for in-home personal care, adult day services, and respite; training and educational resources; and connections with Area Agencies on Aging and Alzheimer's Association Chapters.)

- An awareness that successful aging involves more than health and human services.
    - Efforts include: Enactment of S.L. 2009-407 (SB 195) Preparations for Aging Baby Boomers, strengthening the Governor's Advisory Council on Aging,

aging video on careers in aging services, NC Center for Public Policy Research, NC Complete Count (2010 Census), and 2011 Reauthorization of the Older Americans Act.

The Study Commission on Aging recommends that the General Assembly and the Governor maintain current funding levels for senior centers, Project C.A.R.E., and other vital programs that provide aging services and support systems for older adults and their families. The Governor's Advisory Council on Aging and the Senior Tar Heel Legislature both support funding for the Project C.A.R.E. and Senior Centers. Additionally, maintain and increase funds for Project C.A.R.E. was one of the most frequently mentioned items during the two public hearings.

Recommendation 3: Hearing Loss Treatment Task Force

The Study Commission on Aging recommends the General Assembly direct the Hearing Aid Dealers and Fitters Board to coordinate a task force including representatives of the Division of Services for the Deaf and Hard of Hearing in the Department of Health and Human Services, the Consumer Protection Division of the Office of Attorney General, and other interested stakeholders, to: 1) develop recommended guidelines for consumers seeking assistance in the treatment of hearing loss, 2) make recommendations on the best way to disseminate these guidelines, and 3) report to the Study Commission on Aging on or before October 15, 2010.

Background 3: Hearing Loss Treatment Task Force

S.L. 2008-181, Sec. 12.1, directed the Department of Health and Human Services (DHHS) to study the impact of hearing loss on North Carolina's older adult population and to report to the Commission.

On February 4, 2010, Jane Withers, Director, Division of Services for the Deaf and Hard of Hearing, DHHS presented a report to the Commission. The report pointed out that, "Hearing loss in an older adult tends to happen gradually and is not always identified, and less often treated." The report points out that while hearing aids are one of the most effective treatments, they range in price from $1,400 to $5,000 and that they are not normally covered by health insurance. Based on the study, the Division of Services to the Deaf and Hard of Hearing, DHHS, recommended: establishing a task force to assess the feasibility of developing and implementing a system to evaluate hearing aid services; requiring all hearing aid dispensers provide a 30-day trial period; and asking the General Assembly to require health insurance providers to cover hearing aids.

With regard to trial periods, the report provided the following:

> "The Federal Trade Commission which monitors the business practices of hearing aid dispensers allows trial period mandates to be determined by each state. In the State of North Carolina, there is not a 30-day trial period mandated. Most dispensers in the state do provide a minimum 30-day trial period as a gesture of good customer service though no law requires them to do so."

While the current economic climate would make required health insurance coverage of hearing aids a challenge for the State and for many employers, the Commission does recognize the importance of hearing aid availability, proper fit, and consumer education. As such the Commission believes that the most feasible option at this time is to direct the Hearing Aid Dealers and Fitters Board to coordinate a task force that will develop recommended guidelines for consumers seeking assistance in the treatment of hearing loss, to make recommendations on the best way to disseminate the guidelines, and to report to the NC Study

Commission on Aging. The task force should include representatives from the Division of Services for the Deaf and Hard of Hearing (DHHS), the Consumer Protection Division of the Office of Attorney General, and other interested stakeholders. Therefore, the Commission recommends the General Assembly enact 2009-SHz-20.

Recommendation 4: Review of Nurse Aide Training Requirements

The Study Commission on Aging recommends the General Assembly direct the Division of Health Service Regulation, Department of Health and Human Services (DHHS), to coordinate a review involving an equal number of representatives from the Division of Aging and Adult Services, DHHS; the NC Board of Nursing; the Direct Care Workers Association; NC Health Care Facilities Association; NC Hospital Association; NC Home and Hospice Care Association; and representatives of residents in long-term care; to assess the current training requirements for nurse aides and to recommend any necessary changes to the Study Commission on Aging on or before November 1, 2010.

Recommendation 4: Review of Nurse Aide Training Requirements

On February 25, 2010, the Commission heard a presentation by the Division of Health Service Regulation on types of aides, current requirements, locations of employment, and other related information. The Division presented the following information: federally defined definition of a nurse aide, the State and federal requirements for Nurse Aide I registry listing, the federally required content for Nurse Aide I Training Programs, information on State approved training programs, federal requirements for competency evaluation, passing rates by test taker groupings, supply and demand for nurse aides, and the typical duties of a nurse aide. According to the Division of Health Service Regulation, the majority of Home Health Aides, Personal and Home Care Aides, are also Nurse Aides. In 2006, there were 72,130 Home Health Aides employed, 21,780 Nurse Aides, and 18,350 Personal and Home Care Aides. Over the next ten years, the demand for aides employed in each of these three categories is anticipated to increase: 30% for Nurse Aides, 39% for Home Health Aides, and 76% for Personal and Home Care Aides.

The Division also reported the following Nurse Aide I employment breakdown by employment setting:

- Home Health/Home Care - 24%
- Private Duty, Military/VA, Schools, Adult Day Care, Rehab, Native American Reservations – 21%
- Nursing Homes – 20%
- Hospital/Hospice/Mental Health – 15%
- Not Employed in Health Care – 10%
- Adult/Family Care Home – 6%
- Clinics – 3%

During the February meeting, the Commission also heard presentations from representatives of the Direct Care Workers Association of NC, NC Board of Nursing, and Friends of Residents in Long-Term Care.

- The Direct Care Workers Association presented information on their Association, collaborative efforts to provide a conference aimed at reducing turnover and increasing job satisfaction, and the benefits of a career lattice approach.
- The NC Board of Nursing presented the following information on the Nurse Aide II: qualifications, task lists, education programs, and employment settings. In addition

they presented information on Medication Aide qualifications, tasks, and education programs.

- Representatives from Friends of Residents in Long-Term Care presented information on federal regulations for training programs, information that more than half of the states have training requirements that exceed the federal regulations, and the citations for nurse aide training requirements for all 50 states and the District of Columbia.

The Study Commission on Aging recognizes the importance of nurse aides, the care they provide, and the anticipated labor market shortages. The Commission recommends a review of the current training requirements for nurse aides and requests recommendations on the appropriateness of training requirements. The review should be coordinated by the Division of Health Service Regulation, (DHHS), and should include an equal number of representatives from the Division of Aging and Adult Services, DHHS; the NC Board of Nursing; the Direct Care Workers Association; NC Health Care Facilities Association; NC Hospital Association; NC Home and Hospice Care Association; and representatives of residents in long-term care. The Commission urges the General Assembly to enact 2009-SHz-21.

Recommendation 5: Long-Term Care Partnership Program

The Study Commission on Aging recommends the General Assembly enact legislation to develop a Long-Term Care Partnership (LTCP) program for North Carolina and direct the Division of Medical Assistance, Department of Health and Human Services, to pursue a State Plan amendment allowing the operation of the LTCP program.

Background 5: Long-Term Care Partnership Program

S.L. 2006-66, Sec. 10.10, directed the Department of Health and Human Services (DHHS) to develop a North Carolina Long-Term Care Partnership Program. The program was to be developed in accordance with section 1917(b) of the Social Security Act (42 USC § 1396p(c)), as amended by Public Law 109-171 effective January 1, 2007. The purpose of the program is to reduce future Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid. The goal of the program is to offer incentives to individuals to ensure against the substantial costs of providing for their long-term care needs. DHHS was required to submit a report to the General Assembly.

During the meeting on March 4, 2010, the Commission heard a presentation on a Long-Term Care Partnership (LTCP) program in North Carolina provided by representatives of the Seniors' Health Insurance Information Program (SHIIP), located in the Department of Insurance, and the Division of Medical Assistance, in the Department of Health and Human Services. The presentation explained that a LTCP program allows a special resource disregard and resource protection at Estate Recovery for an individual who: 1) purchases a LTCP policy, 2) utilizes the benefits of the policy, and 3) applies for Medicaid. The amount of resource disregard and the Estate Recovery resource protection is equal to the amount of benefits paid out by the LTCP policy prior to the application for Medicaid. The presentation and the report covered: 1) requirements of long-term care partnership, 2) policy disclosure requirements, 3) agent training, 4) data collection, 5) consumer protection, 6) fiscal impact, and 7) recommendations.

The Department of Insurance and the Department of Health and Human Services requested the Commission recommend establishment of a Long-Term Care Partnership program in North Carolina to the General Assembly. The report and subsequent conversations with the Department of Health and Human Services have indicated no anticipated fiscal impact.

The Study Commission on Aging believes that it is in the best interest of the State and its

citizens to encourage personal responsibility and planning for long-term care. As such, the Study Commission on Aging recommends the General Assembly enact legislation to develop a Long-Term Care Partnership program and direct the Division of Medical Assistance, Department of Health and Human Services, to pursue a State Plan amendment allowing the operation of the LTCP program. As such, the Commission recommends enactment of 2009-SHz-25.

Recommendations 6, 7, 8 and 9

Recommendation 6: Include Dentist on the Commission on Children with Special Health Care Needs

The Study Commission on Aging recommends the General Assembly expand the membership of the Commission on Children with Special Health Care Needs to include a dentist.

Recommendation 7: Special Needs Dental Care Workforce Development

The Study Commission on Aging recommends the General Assembly direct the North Carolina Area Health Education Centers (AHEC) Program to: 1) work with the dental schools at The University of North Carolina – Chapel Hill and East Carolina University, the North Carolina Community College System, and current special care dental providers to increase the available workforce willing to treat North Carolina special care populations; 2) work with the NC State Board of Dental Examiners to explore the feasibility of allowing dental students, dental hygiene students, and assisting students the opportunity to receive training in long-term care facilities under the direction of non-profit special care dental organizations; and 3) report to the Study Commission on Aging on or before August 1, 2011.

Recommendation 8: Medicaid Dental Services

The Study Commission on Aging recommends the General Assembly maintain Medicaid funding for dental services and direct the Division of Medical Assistance and the Division of Public Health to: 1) explore the feasibility of expanding Medicaid dental services to include reimbursement for evidenced-based fluoride and periodontal therapies for high risk adults with special health care needs, 2) explore the implementation of facility code policies that would allow certified providers to bill for each patient seen in a long-term care facility or group home on the date of service, and 3) report on or before November 15, 2011 to the Study Commission on Aging.

Recommendation 9: Additional Mobile Dental Units

The Study Commission on Aging recommends the Department of Health and Human Services and the special care mobile dental providers explore private grants and public federal government funding options for the purchase of additional mobile dental units to serve special care populations.

Background 6, 7, 8, 9: Special Care Dentistry Issues

S.L. 2009-100 was a recommendation from the Commission and required the Division of Public Health, DHHS, to collaborate with the Division of Medical Assistance, the Division of Aging and Adult Services, the University of North Carolina at Chapel Hill and the East Carolina University Schools of Dentistry, the North Carolina Dental Society, and current providers of special care dentistry services, to examine current dental care options for special care populations. The collaboration of these groups and the report they prepared was presented to the Commission on March 4, 2010.

The report estimated that NC may be the home of 450,000 individuals requiring special care

dentistry services. This number includes individuals with intellectual and/or other developmental disabilities, those with long term needs due to a Traumatic Brain Injury, and older adults living with Alzheimer's disease or other types of dementia. However, the report estimates there are only a small number of dental facilities and practices that employ providers with the skills and abilities to safely serve dental patients with special health care needs. The range of service providers includes: State dental clinics serving primarily patients of psychiatric hospitals, developmental centers, and neuro-medical centers, hospital inpatient services, two non-profit mobile programs, approximately 150 pediatric dentists that may accept Medicaid, a limited number of general dentists that treat patients with special needs, UNC School of Dentistry, and the ECU School of Dentistry which will have a suite dedicated to patients with special needs in the year 2012. Barriers to care are significant and include access to care, financial dependency, inadequate care, limited capacity, limited professional training, limited financial compensation, and no special care dentistry infrastructure to address concerns.

The presentation to the Commission highlighted a number of the recommendations. On March 4th, the presenters were asked to prioritize recommendations for the Commission. These prioritized recommendations are the basis for the special care dentistry recommendations from the Study Commission on Aging to the 2010 Session of the General Assembly to enact 2009-SHz-22, 2009-SHz-23, and 2009-SHz-24 .

Recommendation 10: Refining Aging and Long-Term Care Statutes in NC

The Study Commission on Aging recommends the General Assembly update and refine North Carolina's General Statutes on aging and long-term care.

Background 10: Refining Aging and Long-Term Care Statutes in NC

At the Commission's meeting on April 1, 2010, members received suggestions for updating and refining language in the North Carolina Statutes that provides a statement of principles and policy for long-term care and the programs and services for older adults. The information provided by the Department focused on amendments to Chapter 143B, Article 3, Part 14A. Policy Act for the Aging, and Part 14B. Long-term Care. The current statutes are provided below.

Part 14A. Policy Act for the Aging.

§ 143B-181.3. Statement of principles.

To utilize effectively the resources of our State, to provide a better quality of life for our senior citizens, and to assure older adults the right of choosing where and how they want to live, the following principles are hereby endorsed:

(1) Older people should be able to live as normal a life as possible.
(2) Older adults should have a choice of life styles which will allow them to remain contributing members of society for as long as possible.
(3) Preventive and primary health care are necessary to keep older adults active and contributing members of society.
(4) Appropriate training in gerontology and geriatrics should be developed for individuals serving older adults.
(5) Transportation to meet daily needs and to make accessible a broad range of services should be provided so that older persons may realize their full potential.
(6) Services for older adults should be coordinated so that all their needs can be served efficiently and effectively.
(7) Information on all services for older citizens and advocacy for these services should be available in each county.
(8) Increased employment opportunities for older adults should be made available.

(9) Options in housing should be made available.
(10) Planning for programs for older citizens should always be done in consultation with them.
(11) The State should aid older people to help themselves and should encourage families in caring for their older members.

§ 143B-181.4. Responsibility for policy.

Responsibility for developing policy to carry out the purpose of this Part is vested in the Secretary of the Department of Health and Human Services as provided in G.S. 143B-181.1 who may assign responsibility to the Assistant Secretary for Aging. The Assistant Secretary for Aging shall, at the request of the Secretary, be the bridge between the federal and local level and shall review policies that affect the well being of older people with the goal of providing a balance in State programs to meet the social welfare and health needs of the total population. Responsibilities may include:

(1) Serving as chief advocate for older adults;
(2) Developing the State plan which will aid in the coordination of all programs for older people;
(3) Providing information and research to identify gaps in existing services;
(4) Promoting the development and expansion of services;
(5) Evaluation of programs;
(6) Bringing together the public and private sectors to provide services for older people.

Part 14B. Long-Term Care.

§ 143B-181.5. Long-term care policy.

The North Carolina General Assembly finds that the aging of the population and advanced medical technology have resulted in a growing number of persons who require assistance. The primary resource for long-term care provision continues to be the family and friends. However, these traditional caregivers are increasingly employed outside the home. There is growing demand for improvement and expansion of home and community-based long-term care services to support and complement the services provided by these informal caregivers.

The North Carolina General Assembly further finds that the public interest would best be served by a broad array of long-term care services that support persons who need such services in the home or in the community whenever practicable and that promote individual autonomy, dignity, and choice.

The North Carolina General Assembly finds that as other long-term care options become more available, the relative need for institutional care will stabilize or decline relative to the growing aging population. The General Assembly recognizes, however, that institutional care will continue to be a critical part of the State's long-term care options and that such services should promote individual dignity, autonomy, and a home-like environment.

§ 143B-181.6. Purpose and intent.

It is the North Carolina General Assembly's intent in the State's development and implementation of long-term care policies that:

(1) Long-term care services administered by the Department of Health and Human Services and other State and local agencies shall include a balanced array of health, social, and supportive services that promote individual choice, dignity, and the highest practicable level of independence;
(2) Home and community-based services shall be developed, expanded, or maintained in order to meet the needs of consumers in the least confusing manner and based on the desires of the elderly and their families;
(3) All services shall be responsive and appropriate to individual need and shall be delivered through a seamless system that is flexible and responsive regardless of funding source;
(4) Services shall be available to all elderly who need them but targeted primarily to the most frail, needy elderly;
(5) State and local agencies shall maximize the use of limited resources by establishing a fee system for persons who have the ability to pay;
(6) Institutional care shall be provided in such a manner and in such an environment as to promote maintenance or enhancement of the quality of life

of each resident and timely discharge to a less restrictive care setting when appropriate; and

(7) State health planning for institutional bed supply shall take into account increased availability of other home and community-based services options.

The Study Commission on Aging supports efforts to ensure that statutory language supports service and program delivery goals and efforts through the enactment of 2009-SHz-26.

Recommendation 11: Adult Day Care Participant Protection

The Study Commission on Aging recommends the General Assembly amend North Carolina's General Statutes to strengthen the authority of the Department of Health and Human Services to ensure that unfit individuals are prohibited from operating or working in adult day care programs.

Background 11: Adult Day Care Participant Protection

On April 1, 2010, the Commission received information on the need to strengthen the Department's authority to safeguard adult day care and adult day health care program participants.

G.S. 131D-6 provides for the certification of adult day care programs. G.S. 131D-6(b) defines an adult day care program as the provision of group care and supervision in a place other than their usual place of abode on a less than 24-hour basis to adults who may be physically or mentally disabled. On an annual basis, the Department of Health and Human Services is required to inspect and certify all adult day care programs under the rules adopted by the Social Services Commission.

G.S. 131D-6(b) requires the Social Services Commission to adopt rules to protect the health, safety, and welfare of persons in adult day care programs. The rules are required to include minimum standards relating to management of the programs, staffing requirements, building requirements, fire safety, sanitation, nutrition, and program activities.

Administrative Rule, 10A NCAC 06R .0305(a)(3), requires a statewide criminal history records search of all newly-hired employees of adult day programs for the past five years conducted by an agency approved by the North Carolina Administrative Office of the Courts.

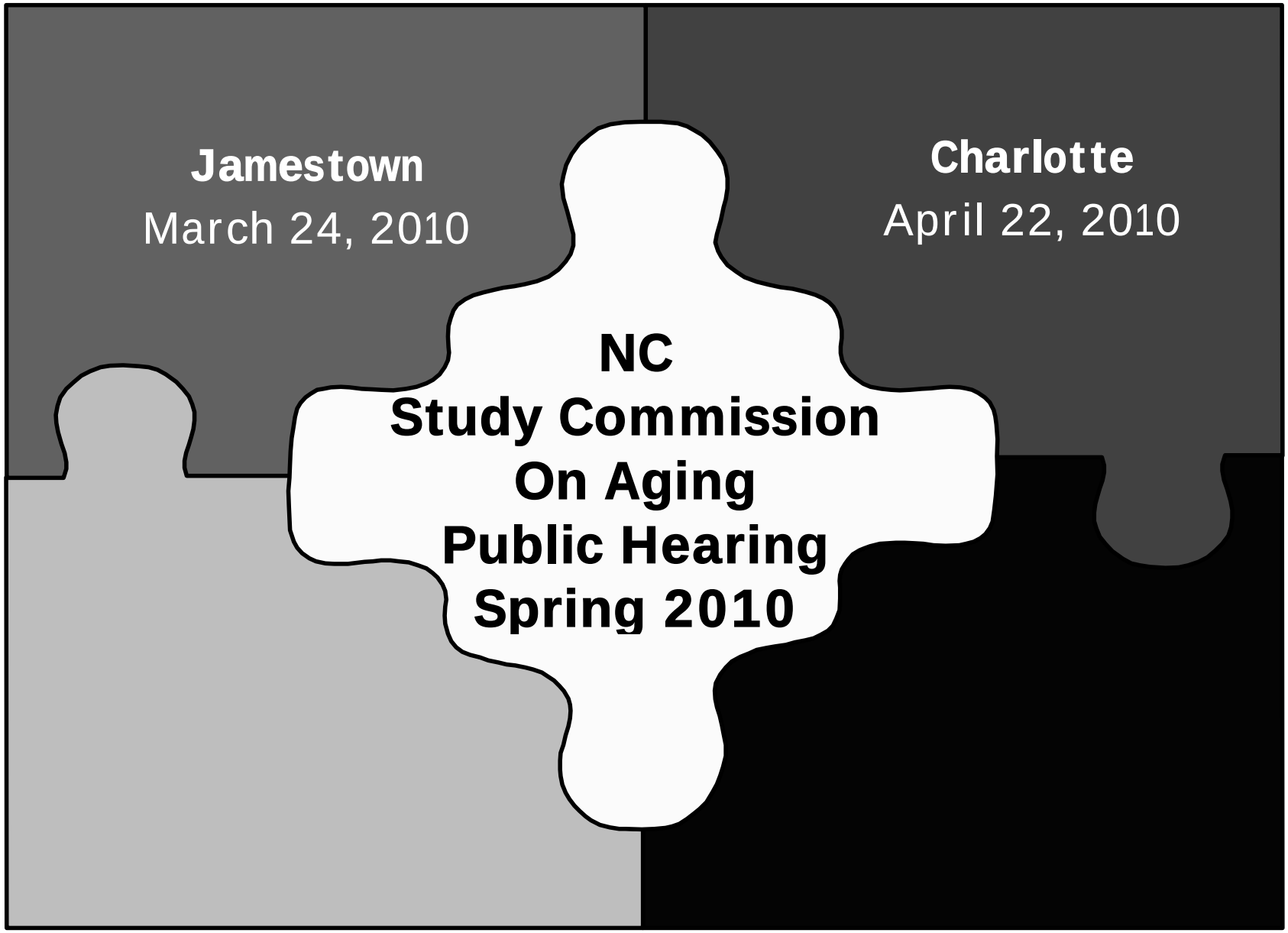
Administrative Rule, 10A NCAC 06R .0508(b)(8)(B) requires an adult day care program to keep individual personnel records on all staff members including evidence of a state criminal history check on each employee providing direct care for a minimum of six years.

G.S. 131D-6(c) permits the Secretary to impose a civil penalty not to exceed one hundred dollars ($100) for each violation on a person, firm, agency, or corporation who willfully violates any provision of the section or any rule adopted by the Social Services Commission.

The Study Commission on Aging supports thorough background checks and other efforts to ensure the safety of elderly and disabled residents and recommends the General Assembly strengthen the statutes accordingly by enacting 2009-SHz-27.

APPENDICES

APPENDIX A


Jamestown
March 24, 2010
Charlotte
April 22, 2010
NC
Study Commission
On Aging
Public Hearing
Spring 2010

Background Information

The North Carolina Study Commission on Aging is created 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. This study shall be a continuing one and the evaluation ongoing, as the population of older citizens grows and as old problems faced by older citizens magnify and are augmented by new problems. (G.S. 120-180)

The Commission may hold public meetings across the State to solicit public input with respect to the issues of aging in North Carolina. (G.S. 120-185)

Spring 2010 Public Hearings

Date	Location	Number of Speakers
March 24, 2010	Jamestown, NC	35
April 22, 2010	Charlotte, NC	25

The issues mentioned with the greatest frequency at both public hearings were:

- **Maintain/Increase Home and Community Care Block Grant Funds (21)**
- **Maintain/Increase Funding for Project C.A.R.E. (21)**
- **Increase Funds/Support for Adult Day Care (11)**

Frequency of Issues Expressed by Speakers

	JAMESTOWN	CHARLOTTE	TOTAL
ISSUES	FREQUENCY	FREQUENCY	FREQUENCY
Maintain /Increase HCCBG Funding	15	6	21
Maintain/Increase Funding for Project C.A.R.E.	12	9	21
Maintain/Increase Funding and Support for Adult Day Care	8	3	11
Support Funding for Medicaid Personal Care Services (PCS)	4	4	8
Maintain/Increase Funding for New & Existing Special Care Dental Programs	4	2	6
Maintain/Increase Senior Center Funds	3	2	5
Support for Senior Games	1	4	5
Support for Long-Term Care Partnership Program	2	2	4
Increase Homestead Exemption/ Property Tax Relief for Seniors	2	1	3
Support Funding for Medicaid Community Alternatives Programs (CAP-DA)	0	3	3
Support Increasing Medicaid Personal Needs Allowance	1	2	3
Provide Appropriate Housing for Mentally Ill, No Mixing of Elderly and Mentally Ill	1	1	2
Support for Home and Hospice Care	0	2	2
Drug Testing for Employees in Adult Care Homes	1	1	2
Increase Transportation Funding for Seniors	0	1	1
Address Issues Related to Mentally Ill in Adult Care Homes/ Mixing Populations	1	0	1
Additional Protection for the Elderly: Consumer Protection, Lifeline for Seniors	1	0	1

APPENDIX B

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U **D**

BILL DRAFT 2009-SHz-20 [v.2] (04/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/26/2010 3:55:56 PM

Short Title: Consumer Guidelines for Hearing Aid Purchases.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE HEARING AID DEALERS AND FITTERS BOARD TO COORDINATE A TASK FORCE THAT WILL DEVELOP GUIDELINES FOR CONSUMERS TO USE WHEN PURCHASING A HEARING AID, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Hearing Aid Dealers and Fitters Board shall coordinate a task force which shall develop recommended guidelines for consumers seeking information and assistance in the treatment of hearing loss and the purchase of a hearing aid. The task force shall include representatives of the Hearing Aid Dealers and Fitters Board; the Division of Services for the Deaf and Hard of Hearing, Department of Health and Human Services; the Consumer Protection Division, Office of the Attorney General; and may include other interested stakeholders.

SECTION 1.(b) The Hearing Aid Dealers and Fitters Board shall report the findings and recommendations of the task force, along with recommendations on methods to disseminate hearing aid purchasing guidelines, to the North Carolina Study Commission on Aging on or before October 15, 2010.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U **D**

BILL DRAFT 2009-SHz-21 [v.2] (04/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/29/2010 2:41:43 PM

Short Title: Nurse Aide Training Review.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF HEALTH SERVICE REGULATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO COORDINATE A REVIEW OF THE EDUCATION AND TRAINING REQUIREMENTS FOR NURSE AIDES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a). The Division of Health Service Regulation, Department of Health and Human Services, shall coordinate a review of the education and training requirements for nurse aides. In conducting the review, the Division shall include an equal number of representatives from the Division of Health Service Regulation; Division of Aging and Adult Services; the North Carolina Board of Nursing; the Direct Care Workers Association of North Carolina; the North Carolina Health Care Facilities Association; the North Carolina Hospital Association; the Association for Home and Hospice Care of North Carolina; and individuals representing residents in long-term care. The review shall include an evaluation of the current education and training requirements for nurse aides.

SECTION 1.(b). The Division of Health Service Regulation shall report findings and recommendations on the appropriate levels of education and training for nurse aides to the North Carolina Study Commission on Aging on or before November 1, 2010.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U **D**

BILL DRAFT 2009-SHz-25 [v.7] (04/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/29/2010 4:52:59 PM

Short Title: Implement LTC Partnership Program.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT THE LONG-TERM CARE PARTNERSHIP PROGRAM, TO ENSURE THAT NORTH CAROLINA'S LONG-TERM CARE INSURANCE LAWS COMPORT WITH THE LONG-TERM CARE PARTNERSHIP PROVISIONS IN THE FEDERAL DEFICIT REDUCTION ACT OF 2005, AND TO AUTHORIZE THE SHARING OF CONFIDENTIAL INFORMATION BETWEEN THE NORTH CAROLINA DEPARTMENT OF INSURANCE, ENTITIES THAT CONTRACT WITH THE FEDERAL GOVERNMENT, AND OTHER GOVERNMENTAL AGENCIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. Part 6, Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-70.4. Long-Term Care Partnership Program.**

(a) As used in this section, the terms:

(1) "Asset" means resources and income.

(2) "Department" means the Department of Health and Human Services, Division of Medical Assistance.

(3) "Estate recovery" means the placing of a statutory claim pursuant to 108A-70.5 on the estate of the deceased Medicaid recipient.

(4) "Long-term care partnership policy" means a long-term care insurance policy approved by the North Carolina Department of Insurance as meeting all of the regulations and requirements of the model Act promulgated by the National Association of Insurance Commissioners.

(5) "Medicaid" means the federal medical assistance program established under Title XIX of the Social Security Act.

(6) "Resource" means cash or its equivalent and or real or personal property that is available to the applicant or recipient.

(7) "Resource disregard" means the amount of resources owned by the long-term care Medicaid applicant that is equal to the amount of benefits paid by a long-term care partnership policy for the applicant which will not be counted when determining long-term care Medicaid eligibility.

(8) "Resource protection" means an amount equal to the resource disregard given to the recipient at long-term care Medicaid eligibility that will be deducted from the total estate value at estate recovery.

(b) Since the Deficit Reduction Act of 2005 repealed the restrictions to resource protection contained in the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, 107 Stat.312, there is established the North Carolina Long-Term Care Partnership Program to be administered by the Department with assistance from the North Carolina Department of Insurance. The North Carolina Long-Term Care Partnership Program shall:

(1) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources.

(2) Provide counseling services to individuals planning for their long-term care needs.

(3) Alleviate the financial burden on the State's medical assistance program by encouraging the pursuit of private insurance.

(c) In the case of an individual who has received benefits under a long-term care partnership policy, an equal amount of resources shall not be considered by the Department during the determination of the following:

(1) Eligibility for long-term care Medicaid.

(2) Any subsequent recovery by the State from a deceased recipient's estate for payment of Medicaid paid services.

(d) The Department shall promulgate necessary rules and amendments to the State Plan to allow for resource disregard at long-term care Medicaid eligibility determination and resource protection at estate recovery. To provide resource disregards for purchases of a long-term care partnership policy, the Department shall count insurance benefits paid under the policy prior to the date of the first application for long-term care Medicaid made after the implementation of the program toward resource disregard and resource protection to the extent the payments are for covered services under the long-term care partnership policy.

(e) After January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later, a qualified long-term care partnership policy shall contain a disclosure detailing in plain language the current law pertaining to resource disregard and resource protection. A duplicate disclosure shall be given to the insured individual with the delivery of the policy document.

(f) The Department shall enter into a reciprocal agreement with other states that enter into a national reciprocity agreement to extend the resource disregard and resource

protection to residents of the State who purchased, or purchased and used, a qualified long-term care policy in another state.

(g) The Department and the Department of Insurance are authorized to adopt rules to implement the provisions of this program for its administration.

(h) In the case of an individual that has received benefits under a long-term care partnership policy, the provisions of G.S. 108A-70.5 remain in effect for purposes of estate recovery, with the exception of the definition of "estate" under G.S. 108A-70.5(b)(2). In accordance with Title XIX of the Social Security Act, 42 U.S.C. § 1396p(b)(4)(B), the definition of "estate" for an individual who has received benefits under a long-term care partnership policy includes any other real or personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement."

SECTION 2. G.S. 108A-70.5 reads as rewritten:

"**§ 108A-70.5. Medicaid Estate Recovery Plan.**

(a) There is established in the Department of Health and Human Services, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid for the recipient. The Department shall administer the program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 U.S.C. § 1396(p).

(b) As used in this section:

(1) "Medical assistance" means medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient:

a. If the recipient of any age is receiving medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and cannot reasonably be expected to be discharged to return home; or

b. If the recipient is 55 years of age or older and is receiving one or more of the following medical care services:

1. Nursing facility services.
2. Home and community-based services.
3. Hospital care.
3a. Prescription drugs.
4. Personal care services.
5 through 9. Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007.

(2) "Estate" means all the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1. For individuals who have received long-term care benefits as described in G.S. 108A-70.4, "estate" also includes any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the

extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(3) Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fifth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate; provided, however, that judgments in favor of other fifth-class creditors docketed and in force before the Department seeks recovery for medical assistance shall be paid prior to recovery by the Department.

(d) The Department of Health and Human Services shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance.

(e) Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007."

SECTION 3. Article 55 of Chapter 58 of the General Statutes is amended by designating G. S. 58-55-1 through G.S. 58-55-50 as "Part 1. General Provisions."

SECTION 4. Article 55 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 2. Long-Term Care Partnership.

"**§ 58-55-55 Long-Term Care Partnership.**

(a) A long-term care partnership policy is a long-term care insurance policy including a certificate issued under a group insurance contract.

(b) A long-term care partnership policy must satisfy all of the following requirements:

(1) The policy must be a qualified long-term care insurance contract, as defined in section 7702B of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(b)) and must provide insurance benefits on a reimbursement, case benefit basis, indemnity insurance basis or on a per diem or other periodic basis.

(2) The effective date of the coverage is on or after January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later.

(3) The policy covers an insured who was a resident of North Carolina or another state that has entered into a reciprocal agreement with North Carolina when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of North Carolina or another state that has entered into a reciprocal agreement with North Carolina when coverage under the earliest policy became effective.

(4) The policy meets the federal consumer protection requirements of section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A). In addition, the policy must:

(a) Provide the insurer will issue a 90 day notice prior to exhaustion of a long-term care partnership policy. The notice shall instruct the insured to go to his local department of social services to apply for Medicaid.

(b) The policy must designate a third party who shall receive premium due notices in addition to the insured, including the notice required in G.S. 58-55-55(4)(a) to prevent loss of benefits due to non-payment.

(5) The policy is issued with and retains inflation coverage which meets the following inflation coverage limitations:

(a) Policies or certificates issued to an individual who is under 61 years old must provide compound annual inflation protection.

(b) Policies or certificates issued to an individual who is 61 to 76 years old must provide some level of inflation protection. This may include simple interest or compound inflation protection.

(c) For purchasers 76 years old or older, inflation protection may be offered but in not required.

(6) The policy states that it is intended to be a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.

(7) The policy is issued in North Carolina or issued for delivery in North Carolina and shall include a "Partnership Status Disclosure Notice". The notice shall state the following in at least 12-point font:

"At the time of issuance, this long-term care insurance policy qualifies as a– North Carolina Long-Term Care Partnership Program policy. For Medicaid applicants applying for help with the cost of long-term care, this means that an amount of your resources equal to the dollar amount of long-term care insurance benefits paid to you or on your behalf under this policy may be disregarded for purposes of determining your eligibility for long-term care Medicaid. The amount that will be disregarded at eligibility will be equal to the amount of the long-term care partnership benefits paid out prior to the time you apply for long-term care Medicaid. As a result, you may qualify for coverage of the cost of your long-term care needs under Medicaid without first being required to substantially exhaust you personal resources. If you are already a recipient of long-term care Medicaid, this policy will not allow a resource disregard or estate recovery resource protection.

Please note that this policy may lose long-term care partnership program status if you move to a different state that does not recognize

North Carolina's Long Term Care Partnership Program or you modify this policy after issuance. This policy may also lose long-term care partnership program status due to changes in federal or state laws.

If you have questions regarding long-term care insurance and the North Carolina Long-Term Care Partnership Program, you may contact the Seniors' Health Insurance Information Program of the Department of Insurance at 1-800-443-9354.

In the case of a group insurance contract, such Notice shall be provided to the insured upon the issuance of the certificate. The Insurer shall include in that notice that the amount of the insured resources that will be disregarded at eligibility will be equal to the amount of long-term care partnership policy benefits paid prior to the time the insured applied for long-term care Medicaid. The Insurer shall also include in the notice a warning to the insured that the policy may lose long-term care partnership program status if the insured moves to another state that does not recognize North Carolina's Long-Term Care Partnership Program, or if the policy is modified after issuance."

"**§ 58-55-56. Compliance with Federal Regulation.**

(a) The Commissioner may adopt rules to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies.

(b) The tax-qualified long-term care provisions required of the Health Insurance Portability and Accountability Act of 1996, including subsequent amendments and editions, are hereby incorporated into Article 55 of Chapter 58.

(c) The long-term care partnership provisions required of the Deficit Reduction Act of 2005, including subsequent amendments and editions, are hereby incorporated into Article 55 of Chapter 58.

"**§ 58-55-57. Disclosure Notices.**

(a) Prior to an insured making a change to the policy that will result in the loss of long-term care partnership status, the insurer shall provide to the policyholder a written explanation of how such action impacts the insured and shall obtain the insured's signature indicating consent to the change.

(b) If a long-term care partnership plan subsequently loses long-term care partnership status, the insurer shall explain in writing to the policyholders the reason for the loss of status.

(c) The disclosures required in this section shall be provided to any insured who exchanges a policy for a long-term care partnership policy.

"**§ G.S. 58-55-58. Exchange of Long-Term Care Policies for Long-Term Care Partnership Policies.**

A long-term care insurance policy that does not qualify as a long-term care partnership policy and that was issued prior to January 1, 2011, or 60 days following approval of the

Medicaid State Plan amendment, whichever is later, shall be eligible for long-term care partnership status if those policies meet the federal requirements of a long-term care partnership policy. If an exchange occurs, the insurer shall notify the insured in writing that the new long-term care partnership policy may be subject to underwriting criteria and premium adjustment. The effective date of the long-term care partnership policy shall be the date the policy was exchanged."

SECTION 5. Article 55 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-55-36. Information sharing.**

(a) In order to assist in the performance of the Commissioner's duties under the long-term care partnership program specified in the federal Deficit Reduction Act of 2005, the Commissioner may:

(1) Share information, including identifying information, related to the long-term care partnership program with other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the Program, provided that the recipient agrees to maintain the confidentiality and privileged status of the information.

(2) Receive information, including identifying information, related to the long-term care partnership program from other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the Program, and shall maintain as confidential or privileged any identifying information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(3) Enter into agreements governing sharing and use of information consistent with this section.

(b) No waiver of an existing privilege or claim of confidentiality in the identifying information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (a) of this section.

(c) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section shall be available and enforced in any proceeding in, and in any court of, this State.

(d) As used in this section, "identifying information" has the same meaning as in G.S. 14-113.20(b)."

SECTION 6. The Department of Health and Human Services and the Department of ~~I~~insurance may adopt rules to implement the Long-Term Care Partnership Program in North Carolina.

SECTION 7. The Department of Health and Human Services shall pursue a Medicaid State Plan amendment to allow the Long-Term Care Partnership Program to operate in North Carolina.

SECTION 8. Sections 7 and 8 of this act are effective when they become law, the remainder of the act becomes effective January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U **D**

BILL DRAFT 2009-SHz-22 [v.1] (04/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/14/2010 1:22:29 PM

Short Title: Comsn. on Children with Special Needs-Dentist.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO ADD A LICENSED DENTIST TO THE COMMISSION ON CHILDREN WITH SPECIAL HEALTH CARE NEEDS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-682 reads as rewritten:

"**§ 143-682. Commission established.**

(a) There is established the Commission on Children With Special Health Care Needs. The Department of Health and Human Services shall provide staff services and space for Commission meetings. The purpose of the Commission is to monitor and evaluate the availability and provision of health services to special needs children in this State, and to monitor and evaluate services provided to special needs children under the Health Insurance Program for Children established under Part 8 of Article 2 of Chapter 108A of the General Statutes.

(b) The Commission shall consist of ~~eight~~ nine members appointed by the Governor, as follows:

(1) Two parents, not of the same family, each of whom has a special needs child. In appointing parents, the Governor shall consider appointing one parent of a child with chronic illness and one parent of a child with a developmental disability or behavioral disorder.

(2) A licensed psychiatrist recommended by the North Carolina Psychiatric Association;

(3) A licensed psychologist recommended by the North Carolina Psychological Association;

(4) A licensed pediatrician whose practice includes services for special needs children, recommended by the Pediatric Society of North Carolina;

(5) A representative of one of the children's hospitals in the State, recommended by the Pediatric Society of North Carolina;

(6) A local public health director recommended by the Association of Local Health Directors; and

(7) An educator providing education services to special needs children, recommended by the North Carolina Council of Administrators of Special Education.

(8) A licensed dentist who provides services to children with special needs, recommended by the North Carolina Dental Society.

(c) The Governor shall appoint from among Commission members the person who shall serve as chair of the Commission. Of the initial appointments, two shall serve one-year terms, three shall serve two-year terms, and three shall serve three-year terms. Thereafter, terms shall be for two years. Vacancies occurring before expiration of a term shall be filled from the same appointment category in accordance with subsection (b) of this section."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U **D**

BILL DRAFT 2009-SHz-23 [v.1] (04/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/14/2010 4:36:46 PM

Short Title: Develop Special Needs Dental Care Workforce.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE NORTH CAROLINA AREA HEALTH EDUCATION CENTERS (AHEC) PROGRAM TO COORDINATE WORKFORCE DEVELOPMENT EFFORTS TO INCREASE THE NUMBER OF DENTAL CARE PROVIDERS SERVING THE SPECIAL NEEDS POPULATION, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a). The North Carolina Area Health Education Centers (AHEC) Program shall coordinate efforts to increase the number of dental care providers serving the special needs population. These efforts shall include, but are not limited to, the following:

(1) Working with the dental schools at the University of North Carolina at Chapel Hill and East Carolina University, the North Carolina Community College System, and current dental providers serving the special needs population, to identify opportunities to increase the dental care workforce supply that is available and willing to treat the special needs population. These opportunities shall include, but are not limited to, options that could be undertaken without additional funding.

(2) Working with the North Carolina State Board of Dental Examiners to explore the feasibility of allowing dental students, dental hygiene students, and assisting students, the opportunity to receive training in long-term care facilities under the direction of non-profit special care dental organizations.

SECTION 1.(b). The North Carolina Area Health Education Centers (AHEC) Program shall report findings and recommendations to the North Carolina Study Commission on Aging on or before August 1, 2011.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U **D**

BILL DRAFT 2009-SHz-24 [v.2] (04/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/3/2010 3:51:35 PM

Short Title: Medicaid Dental/Special Needs Population. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF MEDICAL ASSISTANCE, AND THE DIVISION OF PUBLIC HEALTH, IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO EXPLORE ISSUES RELATED TO PROVIDING DENTAL SERVICES TO THE SPECIAL NEEDS POPULATION, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a). The Division of Medical Assistance, and the Division of Public Health, in the Department of Health and Human Services, shall explore issues that would facilitate dental care and improved dental outcomes for the special needs population. Issues explored must include, but are not limited to, the following:

(1) The feasibility and anticipated impact of expanding Medicaid dental services to include reimbursement for evidenced-based fluoride and periodontal therapies for high risk adults with special health care needs.

(2) The feasibility and anticipated impact of implementing facility code policies that would allow certified providers to bill for each patient seen in a long-term care facility or group home on the date of service.

SECTION 1.(b) The Department of Health and Human Services shall report findings and recommendations on the issues in this section on or before November 15, 2011 to the North Carolina Study Commission on Aging.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U **D**

BILL DRAFT 2009-SHz-26 [v.5] (04/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/26/2010 3:58:40 PM

Short Title: Update Long-Term Care Statutes. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO UPDATE AND CLARIFY NORTH CAROLINA'S GENERAL STATUTES ON OLDER ADULTS AND LONG-TERM SERVICES AND SUPPORTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

Whereas, the North Carolina General Assembly is committed to having North Carolina recognized as a leader in supporting long-term services and supports; and

Whereas, the State is building on the following federal and State supported person-centered initiatives: aging and disability resource centers or Community Resource Connections for Aging and Disabilities, evidence-based health promotion, caregiver supports for persons with Alzheimer's disease, lifespan respite programs, consumer-directed care, transitional care, and promotion of community living for persons who might otherwise become Medicaid eligible if placed in a skilled nursing facility;

Now therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Part 14A, Article 3, Chapter 143B of the General Statutes reads as rewritten:

"Part 14A. ~~Policy Act for the Aging.~~ Older Adults.

§ 143B-181.3. ~~Statement of principles.~~ Older adults findings; policy.

~~To utilize effectively the resources of our State, to provide a better quality of life for our senior citizens, and to assure older adults the right of choosing where and how they want to live, the following principles are hereby endorsed:~~

(a) The North Carolina General Assembly finds the following:

(1) Older ~~people~~ adults should be able to live as ~~normal a life~~ independently as ~~possible.~~ possible, and to live free of abuse, neglect, and exploitation.

(2) Older adults should have a choice of ~~life-styles~~ life-styles which will allow them to remain contributing members of society for as long as possible.

(3) Preventive and primary health care are necessary to keep older adults active and contributing members of society.

(4) Sufficient opportunities for ~~Appropriate~~ training in gerontology and geriatrics should be developed and readily available for individuals serving older adults.

(5) Transportation to meet daily needs and to make accessible a broad range of services should be ~~provided~~ available so that older ~~persons~~ adults may realize their full potential.

(6) Services for older adults should be person-centered and coordinated so that ~~all their~~ an individual's needs can be served ~~efficiently and effectively.~~efficiently, effectively, and in the least restrictive environment.

(7) Information should be readily available in each county on all programs and services for older adults. ~~citizens and advocacy for these services should be available in each county.~~

(8) Increased employment opportunities for older adults should be made available.

(9) A variety of housing options should be available in each county. ~~Options in housing should be made available.~~

(10) Older adults and their caregivers should have input in the planning and evaluation of programs and services for older adults, and they should have opportunities to advocate for these programs and services. ~~Planning for programs for older citizens should always be done in consultation with them.~~

(11) The State should ~~aid~~ assist older ~~people~~ adults who desire to remain as independent as possible ~~to help themselves~~ and should encourage and support families in caring for their older members.

(b) It is the policy of the State to effectively utilize its resources to support and enhance the quality of life for older adults in North Carolina."

SECTION 2. Part 14B, Article 3, Chapter 143B of the General Statutes reads as rewritten:

"Part 14B. Long-Term ~~Care.~~Services and Supports.

§ 143B-181.5. Long-term ~~care~~ services and supports - findings. ~~policy.~~

The North Carolina General Assembly finds that the aging of the population and advanced medical technology have resulted in a growing number of persons who require ~~assistance.~~ long-term services and supports. The primary resource for long-term ~~care provision~~ assistance continues to be the family and friends. However, these traditional caregivers are increasingly employed outside the home. There is growing demand for improvement and expansion of home and community-based long-term ~~care services to support and~~ services and supports to complement the ~~services~~ care provided by these informal caregivers.

The North Carolina General Assembly further finds that the public interest would best be served by a broad array of long-term ~~care~~ services and supports that ~~support~~ enable persons who need such services to remain in the home or in the community whenever practicable and that promote individual ~~autonomy, dignity, and choice.~~autonomy and dignity as these individuals exercise choice and control over their lives.

The North Carolina General Assembly finds that as other long-term ~~care~~ service and support options become more readily available, the ~~relative~~ need for institutional care will stabilize or decline relative to the growing ~~aging population.~~population of older adults and people living with disabilities. The General Assembly recognizes, however, that institutional care will continue to be a critical part of the State's long-term ~~care~~ service and support options and that such services should promote individual dignity, autonomy, and a home like environment."

"**§ 143B-181.6. Purpose and intent.**

~~It is the North Carolina General Assembly's intent in the State's development and implementation of long-term care policies that:~~The development and implementation of policies for long-term services and supports should reflect the intent of the North Carolina General Assembly as follows:

(1) Long-term ~~care~~ services and supports administered by the Department of Health and Human Services and other State and local agencies shall include a balanced array of health, social, and supportive services that are well coordinated to promote individual choice, dignity, and the highest practicable level of ~~independence;~~ independence.

(2) Home and community-based services shall be developed, expanded, or maintained in order to meet the needs of consumers in the least confusing and least restrictive manner and based on the desires of the ~~elderly~~ older adults, persons with disabilities, ~~and~~ their ~~families;~~families, and others that support them.

(3) All services shall be responsive and appropriate to individual need and shall be delivered through a uniform and seamless system that is flexible and responsive regardless of funding ~~source;~~ source through the effective use of Community Resource Connections for Aging and Disabilities as they are developed throughout the State.

(4) Services shall be available to all ~~elderly~~ persons who need them but targeted primarily to the most ~~frail,~~ frail and needy ~~elderly;~~citizens.

(5) State and local agencies shall maximize the use of limited resources by establishing a fee system for persons who have the ability to ~~pay;~~pay.

(6) ~~Institutional care~~ Care provided in facilities shall be ~~provided~~ offered in such a manner and in such an environment as to promote maintenance of health and ~~or~~ enhancement of the quality of life of each resident and timely discharge to a less restrictive care setting when ~~appropriate; and~~ appropriate.

(7) State health planning for institutional bed supply shall take into account increased availability of other home and community-based services options.

(8) In an effort to maximize the use of limited resources, State and local agencies shall invest in supports for families and other informal caregivers of persons requiring assistance.

(9) Emphasis shall be placed on offering evidence-based activities to promote healthy aging, prevent injuries, and manage chronic diseases and conditions.

(10) Individuals and families shall be encouraged and supported in planning for and financing their own future needs for long-term services and supports."

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

U **D**

BILL DRAFT 2009-SHz-27 [v.4] (04/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/3/2010 4:14:31 PM

Short Title: Adult Day Care Criminal Record Check Process. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF AGING AND ADULT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO STUDY THE ISSUE OF CRIMINAL HISTORY RECORD CHECKS FOR CURRENT AND PROSPECTIVE OWNERS, OPERATORS, AND VOLUNTEERS OF ADULT DAY CARE PROGRAMS AND ADULT DAY HEALTH SERVICES PROGRAMS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a). The Division of Aging and Adult Services, Department of Health and Human Services, shall study the issue of criminal history record checks for owners, operators, volunteers, and prospective owners, operators, and volunteers, in adult day care programs and adult day health services programs. The Department shall also ensure the current process used for adult day care employee criminal history record checks is incorporated into the study. In conducting the study, the Division of Aging and Adult Services shall seek input from the North Carolina Adult Day Services Association. The study shall include the following elements:

(1) Identifying the positions that warrant a criminal history record check.
(2) Developing a process for conducting the criminal history record check.
(3) Designating the entity responsible for requesting the criminal history record check.
(4) Designating the entity responsible for paying for the criminal history record check.
(5) Determining whether a State or a national criminal history record check, or both is performed.

(6) Defining the relevant offenses that indicate an individual's fitness to have responsibility for the safety and well-being of program participants.

(7) Any other issues deemed appropriate.

SECTION 1.(b). The Department of Health and Human Services shall report findings and recommendations to the North Carolina Study Commission on Aging on or before November 1, 2010.

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