June, 2017

The hotline

NORTH CAROLINA CONTINUING CARE RESIDENTS ASSOCIATION

NorCCRA ANNUAL BOARD OF DIRECTORS MEETING
WELL SPRING, GREENSBORO, NC
THURSDAY MAY 25, 2017

President Brenda Tremoulet called the meeting to order at 10:05am. She introduced Mr. Tutterow, CEO/COO of Well Spring Life Care Community. He welcomed us to the facility and shared that we will have lunch upstairs in the Weaver Dining Room. Brenda presented him with a check for their benevolence fund as a thank you for providing the facility and lunch. It was established that we had a quorum.

She then introduced Bill Gentry from Croasdaile Village who will be acting as our parliamentarian. He shared that as parliamentarian he did not have a vote or voice. He asked, that due to health issues with the representative from Croasdaile Village, if we would allow him to be the voting member from Croasdaile as well. He was given permission.

Brenda shared that there are 19,949 individuals living in CCRCs in North Carolina. She encouraged all of us to be good stewards and be involved in the legislative process so that our voices could be heard.

The Treasurer's report and Secretary minutes from May 3, 2016 were accepted as presented. Voice vote approved.

Need for Officers was then presented by Brenda Tremoulet, President. At this time Western Region has no acting officers as none were nominated at the Western Region meeting in April. Central Region does not have acting officers either at this time. Eastern Region, by using the concept of all officers are from the same CCRC has a full slate at this time. In October, State Officers will be needed for President, Vice President and Treasurer. As Brenda has traveled the state she has visited all but one CCRC and has encouraged members to understand that living in a CCRC is a large investment and informed them of the things the organization has been able to accomplish. A major concern is that 17 CCRCs are below 90% occupancy and this affects their ability to be in good financial standing.

Sindy Barker, Carol Woods, Legislative Committee Chair shared that we were able to assist in getting the medical deduction bill through the legislature but it is not in Trump's current budget. The US House has kept the 7½% in their budget but according to the bill it should go up to 10% this year. She has requested that members of her legislative committee present this to their members and consequently several letters have been sent to Senators and Representatives. Another concern at this time is the question of receiving Medicare services following a hospital visit. We are asking that any hospital stay of 3 nights be the base line. This would mean no difference in being able to receive Medicare services following an Observation or Hospitalization stay. On the state level, 10 CCRCs have shown interest in providing Medicare Home Health Services. At this time this requires a Certificate of Need and these are difficult to receive. 25 states have eliminated this requirement for a CON. Presently the state says this could be possible but it would not take place until 2025. There is a House Bill in committee for CCRCs to have a waiver to provide Medicare Home Health services. Leading Age has supported this bill but there is some objection from the Hospital Groups and they are well funded. At this time the bill is in committee and there is no guarantee that it will come out of committee. Sindy has asked that any CCRC that is actively supporting its political representative to let her know how and what they have done.

NorCCRA/NaCCRA task force presented a report to this meeting in written form. It stated that as North Carolina CCRCs were having difficulty getting people to serve NorCCRA there is some concern about asking our members to be members of NaCCRA as well. Also NaCCRA is in a reorganization phase and we need to wait and see what happens. Brenda thanked the members of the committee for their work. This led to a lively discussion. Ben Leach of Pennybyrn asked to have an explanation about whether NaCCRA was an organization supporting individuals or CCRCs. Walt Boyer, Deerfield and member of the NaCCRA board answered that the group is moving toward individual memberships but several state groups like ours are members of NaCCRA. There are currently 9 member states to NaCCRA. Herb Wile, Plantation Village, spoke to the concern about asking members to join 2 separate groups and could we just add $2 to our dues to pay for the state membership. This lead to several others sharing concerns regarding levels of membership within NaCCRA, comment

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that NaCCRA dues are tax deductible and NorCCRA dues are not and whether we need to do as the report asks and wait for NaCCRA to come back with additional information as to dues structure. Randall Edwards, Piedmont Crossing, spoke to the fact that the national group is very important and we need to give them time to relook at their structure and finances. We are a member state of the organization. Brenda felt after the discussion that we are not ready at this time to make a decision regarding NaCCRA membership and we need to wait to hear from NaCCRA.

We next had a discussion on Regions. In 2012 there was a task force that looked at strategic plans. Regarding regions, Randall Edwards, Piedmont Crossing, shared some of his committees' thoughts at that time. He looked at leadership and volunteerism. We continue to struggle with getting leadership. It was suggested that we look at the by-laws and what they say about regional levels and be more permissive in how they do business. Possibly not have a need for 4 officers, possibly hire some part time help to keep up the membership rolls and other paperwork and looking at the purpose and need for regional groups. A motion was made by Randall Edwards, Piedmont Crossing, and seconded by Art Cooper, Glenaire. **We recommend that the NorCCRA Executive Committee establish a committee with representation from all regions to consider and further refine these recommendations and develop an implementation and transition proposal for presentation to the full membership at an annual meeting.** Brenda will address this at the next Executive Committee meeting in June.

At this time in the meeting, Steve Fleming, CEO of Well Spring Corp and incoming board chair of LeadingAge was introduced. He shared that he feels that LeadingAge is trying to be the voice of reason and that reform needs to be done regarding Medicaid but this will be difficulty if funds are cut in today's political climate. We need to show a vested interest in long-term care for the elderly. The national group feels that they will be addressing the need to reduce regulations particularly in skilled nursing care. He used the term Life Plan Community and Sherman Poultney, Galloway Ridge asked for a clarification of the term.

CALENDAR

8/11/17 Deadline for September *Hotline*

10/3/17 NorCCRA annual meeting, Greensboro

11/10/17 Deadline for December *Hotline*

CCRCs and Life Plan Communities are the same thing. It was mentioned that the present NC statute uses Continuing Care not Life Plan. Steve mentioned that the statute may need to be changed not only due to this but also because currently it is tied to occupancy. Brenda stated that this could be discussed at the October meeting when not only LeadingAge will be represented but also the insurance department for the state.

JoAnne Harrell, Carolina Meadows, moved that the resolution from Eastern Region be accepted. Art Cooper, Glenaire, seconded the motion. **It proposed that the current price of $80 for a single NorCCRA Lifetime Membership be reduced for couples purchasing two Lifetime Memberships at the same time. It is proposed the current price for two Lifetime Memberships purchased by a couple at the same time be reduced to $135 for both memberships.**

JoAnne Harrell, Carolina Meadows, spoke to the resolution concerning dues which came from the Eastern Region. They presented the resolution because of the difficulty of getting residents to join NorCCRA as life time members. They felt that if we gave a discount to couples we might get more members. They felt that life members give the organization secured income and if couples buy lifetime memberships it reduces the need for reps to go to each resident every year to talk about dues. Several comments were made. Jill Connery, Trinity Oaks, is finding that newer residents are choosing lifetime memberships. Others have not sold any lifetime memberships because residents are not sure what the organization has done for them in the past year. Kitty Barnes, Friends Home West, stated that residents do not always remember they are members and suggested that we have membership cards. There was a statement in the packet of information from the state treasurer that stated that she was not in favor of this proposal. Vote was called for. Each CCRC and the officers had one vote. Twelve voted in favor and ten were opposed. **Resolution passed and is now in effect.** Art Cooper, Glenaire , suggested that the treasurer look at how the lifetime dues were amortized and possibly make it a lesser time.

During this discussion the question was raised "What has the organization done for me lately?" Carol Woods had Steve Johnson, from the state insurance department, come and speak to all residents regarding how the insurance department sees CCRCs and what they have done to support CCRCs. Also it was shared that NorCCRA needs to be ready to respond to legislative needs of the elders in our state and the United States.

Motion to adjourn meeting at 11:50 made by Sherman Poultney, Galloway Ridge, and seconded by Art Cooper, Glenaire.

Respectfully submitted
Catie Webb, Recording Secretary

LEGISLATIVE REPORT

Sindy Barker

National and State Legislative Update

From time to time, the NC Continuing Care Residents Association (NorCCRA) Legislative Committee provides an update on the current legislative issues at the state and national level. Our goal is to keep residents in CCRCs informed on issues which will impact them directly. There are two national issues which are currently getting the NorCCRA Legislative Committee's attention – the proposed elimination of the IRS medical expense deduction and proposed legislation on hospital observation versus admission.

Elimination of Medical Expense Deduction

President Trump introduced his one page budget outline on April 27 which included the elimination of the medical expense deduction. Traditionally this earliest version of the budget is known as "the skinny" budget because it focuses primarily on discretionary spending. A fuller administration budget will be completed in May and will include tax policy and spending on entitlement programs such as Social Security and Medicare.

In response to the President's proposal to eliminate the medical expense deduction, the NorCCRA Legislative Committee sent a letter to all CCRCs asking them to write their US Congressmen and Senators as well as Steven Mnuchin, Secretary of the Treasury, and Gary Cohn, Director of the National Economic Council, requesting that the medical expense deduction not be eliminated.

Three years ago, Congress passed legislation to raise the medical expense deduction from 7.5% to 10% of adjusted gross income for anyone under 65. This year that legislation would apply to seniors as well. Now, any medical expense deduction is in jeopardy because of the budget proposed by President Trump. Note: The House of Representatives introduced **HR 1628, Budget Resolution** on March 20. It includes a provision that the 7.5% of the adjusted gross income for seniors would remain intact through December 31, 2017. We will continue to keep you posted on this issue.

Hospital Observation Versus Admission

The second issue is **Hospital Observation versus Admission** which affects all Medicare beneficiaries whether they live in a CCRC or in the broader community.

Observation versus Admission has been the Medicare solution for reducing their portion of hospital costs for over ten years. Whether observed or admitted, the Medicare beneficiary has to meet their annual deductible. However, when patients are on Observation status, they are covered under Medicare Part B which means they are responsible for paying 20% of the Medicare-approved amount for doctor services. They are also required to pay a co-payment for each hospital service. For example, a $1500 MRI could cost the patient $300. Patients who are admitted to a hospital are covered under Medicare Part A which covers all hospital services. If an audit of hospital records finds that a patient should have been observed rather than admitted, the hospital is declared in violation and required to return all Medicare payments related to the violation.

Patients are placed in Observation status when doctors are not sure whether they are sick enough for formal admission or well enough to be sent home. On October 1, 2013, Medicare adopted the two-midnight rule. The patient is only admitted to the hospital if the admitting practitioner expects the patient will need to stay at least two midnights. Doctors assign status based on a set of national guidelines published in the *Medicare Benefit Policy Manual.* It has been said that not only are the guidelines vague and complex, but they can change annually. For that reason, most hospitals use services that publish criteria to help them apply guidelines to each patient. One such service is Executive Health Resources which provides physician-to-physician assessment of the patient's symptoms to ensure that the medical staff has assigned the patient to the correct status.

Patients placed under Observation status are generally expected to be discharged within 24 to 48 hours. However, last year the Center for Medicare Advocacy heard from beneficiaries who have been hospitalized on Observation status as long as 14 days.

It is often unclear to the patient and their families as to whether the patient is being observed or admitted. He or she may actually be placed in a hospital room, eat regular meals and receive nursing care. Many larger hospitals now have special Observation Units where the patients can stay a few hours or a few days. Patients in Observation Units can bring regular medications from home and are thus able to avoid the higher cost of having them supplied by the hospital.

One of the quirks of Observation versus Admission is that an admitting doctor can place you on Admission status, but the hospital can reverse the decision based on a review by the hospital utilization review committee. As of March 8 this year, hospitals must provide a written notice to patients within 36 hours of being placed on Observation status. This notice is called the Medicare Outpatient Observation Notice or MOON.

The number of Medicare beneficiaries entering hospitals under Observation status doubled between 2006 and 2014. By 2014, the number had reached 1.9 million.

There is another midnight rule that Medicare beneficiaries should probably be more concerned about. A patient must be admitted to the hospital for three midnights in order to be eligible for follow-up Medicare coverage in a skilled nursing facility. For example, if a patient comes to the Emergency Department on a Friday, he is probably under observation and therefore not officially admitted. If he is admitted on Saturday, he must stay Saturday, Sunday and Monday

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midnights in order to qualify for the three-midnight rule and be eligible for Medicare Part A skilled nursing benefits. His Friday night observation does not count. In short, if your admission does not meet the three midnight minimum, Medicare will not pay for skilled nursing care.

Another driving factor in the debate over Observation versus Admission is the "bounce back" of patients returning to the hospital within 30 days of discharge. Under the Affordable Care Act, hospitals are penalized if admitted patients return within that 30 day period. However, observed patients do not count in the "bounce back" equation because they are never admitted to the hospital.

Many CCRCs provide annual "free days" in their health center. This means that if a resident does not meet the three-midnight rule in the hospital, he/she can still get full skilled nursing care in their CCRC health center until their "free" days run out. If the three-midnight rule is met, the "free" days can be saved for future use. In addition, it is advantageous to the CCRC if a resident qualifies for Medicare coverage since the CCRC is then reimbursed for services rendered.

In 2010, Medicare held a "listening" session at which time more than 2200 hospital administrators, physicians, patient advocates and others called to express their opinion that placing patients on Observation status was harmful and should be ended. Nothing came of it and the Center for Medicare Advocacy filed a class-action lawsuit against Medicare. Nothing has come of the lawsuit, either.

Since 2009, bipartisan bills have been introduced into Congress that would require all the time spent in the hospital, whether under Observation or Admission, to count toward the three midnight qualifying hospital stay. Patients under Observation would still be responsible for the 20% co-pay, but if the combined total of nights met the three-midnight rule, the patient could be admitted to a skilled nursing facility and be covered by Medicare.

Each year, these companion bills have a lot of co-sponsors and support, but not enough to get passed. This year the bill numbers are **S568/H1421, Improving Access to Medicare Coverage Act of 2017**. Over the next few weeks, the NorCCRA Legislative Committee will be getting in touch with residents in CCRCs asking them to contact their Congressmen and Senators, requesting them to support these bills. Since the bills have been assigned to committees, residents will also get a list of congressional committee members serving on those committees and will be asked to urge them to take up the issue.

CAROL WOODS' EMERGENCY DEPARTMENT (ED) ESCORT PROGRAM

Mary Eldridge

"Common sense and compassion are all one needs to do this job," proclaims Andree Woosley, as she leads two new volunteers through the ED waiting room at UNC Hospitals during their orientation session. Andree is the vibrant chair of the Carol Woods ED Escort Program, which provides resident volunteers who accompany fellow residents to the ED when no relative or close friend is available. Andree is quick to point out that while we train to carry out a well-developed procedure, there are always "exceptions." Exceptions are usually resolved by the previously mentioned common sense. Each volunteer is given an orientation at the UNC Manning Drive Hospital ED and also is given two items at their orientation session: (1) a detailed procedure of the escort event (see next page) and (2) a checklist that escorts use to ensure that they are personally prepared for the potentially 4-7 hour visit to the ED (see below).

Over six years ago, the need to accompany an ailing resident to the ED was recognized by the Health and Social Services Committee (now the Health and Well-being Committee, which includes both staff and residents). Providing escorts in a crisis situation so that no one goes to the Emergency Department alone should be a joint resident and staff project. Initially, the program had nine members, whose experiences over the next year or so were invaluable in developing the operating procedures reproduced at the end of this article. With several years of experience, the program is functioning well, and chair Andree Woosley has provided consultation to residents of two other Continuing Care Communities that are interested in providing a similar service for their residents.

Today, the Carol Woods ED volunteer escort program has 25 members who are called in rotating order when a resident needs to be accompanied to the UNC ED. With so many volunteers willing to help a neighbor, volunteers generally escort only once or twice a year. The list of volunteers, updated after each ED visit, ensures that the escort need is shared by all. Of course, a volunteer can always decline the request if it is not a good time, and the next person on the list is called.

After each escort, the volunteer writes a report that is shared with all other volunteers and key staff. Vital to the success of the ED Escort program is the communication and coordination between the volunteer group and Carol Woods staff from the Health and Well-Being, Communications, and Security departments.

(See below an Escort Report and Comments from a resident who was supported.

Procedures
Carol Woods Emergency Department (ED) Escort Program (continued)

Checklist to go to UNC Hospitals Emergency Department

_____ Resident documents (the "envelope")
_____ Cell phone
_____ Cell phone charger
_____ Something to occupy time
(for example book, iPad)
_____ Charger for electronic device (if used)
_____ Snack/water
_____ Light jacket or sweater
_____ Personal medications if needed during your escort
_____ Small amount of cash (for vending machine)
_____ Notepad and pen
_____ Emergency Room Escort Information guidelines
_____ This checklist (for phone numbers)
_____ Name badge

Important telephone numbers
Carol Woods Communications Desk 919-918-xxxx (24 hours)
Carol Woods Clinic 919-918-xxxx
Carol Woods Health Center 919-918-xxxx (Communications)
Carolina Taxi Shuttle 919-883-xxxx

Volunteer Escort Report, July 1, 2016

Called by the Communications Desk at 9:50am. Picked up packet at clinic and proceeded to UNC Emergency Department. Resident had fallen at an off-campus site and then called Carol Woods Security who, after talking with the resident, ordered an ambulance to take resident to UNC Emergency Department. Resident was already in Emergency Department bay when I arrived about 10:30. The resident was in significant pain but alert and awake throughout most of the day. After X-rays and orthopedic review of the X-rays, resident received pain treatment and was placed in a sling that would support the break during healing.

During the day I advocated for resident with nurses about pain intensity and comfort levels. I also placed several calls to her family and to other residents at Carol Woods for her. I recommended that she go to Health Center rather than return to her apartment, because of continuing pain and the effect of medications. Resident agreed. Called Karen in Clinic who requested Health Center room and notified Security to come pick up resident. I stayed with resident until she was placed in the Security van in a wheelchair. We all left UNC about 4 o'clock. *Bill Rickard*

Comments from the Resident Bill Escorted

The pain and shock of falling, as I did in my daughter's yard last July, disappeared when I was wheeled into the Emergency Room and learned that a Carol Woods companion was already there. Although I had never met Bill, I was immediately comforted by his presence. He quietly assumed a steady watch over me, asking questions of the medical personnel when I was unable, and eventually calling my out of town daughter. Through it all he smiled, read his book, had his lunch, and never left until I did.
Jean O'Barr

FROM THE NorCCRA ANNUAL BOARD OF DIRECTORS MEETING
WELL SPRING, GREENSBORO, NC
THURSDAY MAY 25, 2017

From left:

Bob Hunt, President, Well Spring Retirement Community, Greensboro

Steve Fleming, Chairman-elect of LeadingAge Board of Directors

Alan Tutterow, Executive Director of Well Spring Retirement Community

Inpatient or outpatient hospital status affects your costs

Your hospital status—whether you're an inpatient or an outpatient—affects how much you pay for hospital services (like X-rays, drugs, and lab tests). Your hospital status may also affect whether Medicare will cover care you get in a skilled nursing facility (SNF) following your hospital stay.

You're an inpatient starting when you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.

You're an outpatient if you're getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays, or any other hospital services, and the doctor hasn't written an order to admit you to a hospital as an inpatient. In these cases, you're an outpatient even if you spend the night in the hospital.

Note

Observation services are hospital outpatient services you get while your doctor decides whether to admit you as an inpatient or discharge you. You can get observation services in the emergency department or another area of the hospital.

The decision for inpatient hospital admission is a complex medical decision based on your doctor’s judgment and your need for medically necessary hospital care. An inpatient admission is generally appropriate when you’re expected to need 2 or more midnights of medically necessary hospital care. But, your doctor must order such admission and the hospital must formally admit you in order for you to become an inpatient.

Here are some common hospital situations and a description of how Medicare will pay. Remember, you pay your deductible, coinsurance, and copayment.

Situation	Inpatient or outpatient	Part A pays	Part B pays
You're in the Emergency Department (ED) (also known as the Emergency Room or "ER") and then you're formally admitted to the hospital with a doctor's order.	Outpatient until you’re formally admitted as an inpatient based on your doctor’s order. Inpatient following such admission.	Your inpatient hospital stay	Your doctor services
You visit the ED and are sent to the intensive care unit (ICU) for close monitoring. Your doctor expects you to be sent home the next morning unless your condition worsens. Your condition resolves and you're sent home the next day.	Outpatient	Nothing	Your doctor services

You come to the ED with chest pain, and the hospital keeps you for 2 nights. One night is spent in observation and the doctor writes an order for inpatient admission on the second day.	Outpatient until you're formally admitted as an inpatient based on your doctor's order. Inpatient following such admission.	Your inpatient hospital stay	Doctor services and hospital outpatient services (for example, ED visit, observation services, lab tests, or EKGs)
You go to a hospital for outpatient surgery, but they keep you overnight for high blood pressure. Your doctor doesn't write an order to admit you as an inpatient. You go home the next day.	Outpatient	Nothing	Doctor services and hospital outpatient services (for example, surgery, lab tests, or intravenous medicines)
Your doctor writes an order for you to be admitted as an inpatient, and the hospital later tells you it's changing your hospital status to outpatient. Your doctor must agree, and the hospital must tell you in writing—while you're still a hospital patient before you're discharged—that your hospital status changed.	Outpatient	Nothing	Doctor services and hospital outpatient services

Note

Remember, even if you stay overnight in a regular hospital bed, you might be an outpatient. Ask the doctor or hospital. You may get a Medicare Outpatient Observation Notice (MOON) that lets you know if you're an inpatient or outpatient in a hospital or critical access hospital. You must get this notice if you're getting outpatient observation services for at least 24 hours. The MOON will tell you why you're an outpatient getting observation services, instead of an inpatient. It will also let you know how this may affect what you pay while in the hospital, and for care you get after leaving the hospital.

Note

The copayment for a single outpatient hospital service can't be more than the inpatient hospital deductible. However, your total copayment for all outpatient services may be more than the inpatient hospital deductible.

The *Hotline* is published quarterly, March, June, September and December by Bernard S. Coleman, Deerfield Episcopal Retirement Community, Asheville, NC,
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Submissions to the *Hotline* and other *Hotline*-related communications should be addressed to the editor,
Bernard S. Coleman (gothic63@charter.net).

NORTH CAROLINA CONTINUING CARE RESIDENTS ASSOCIATION

www.NCCCRA.org

The NorCCRA* home page is your source for information.

Check it out!

***** pronounced Norkra

Membership Application

One-year membership is $12 for an individual, $20 for a couple. Life membership is $80 for an individual and $135 for a couple.

Checks should be made payable to NorCCRA and **given to your community's NorCCRA representative**, so he or she can keep an accurate tally of members. Please indicate whether you are a renewing or new member. If you are not sure who your community's NorCCRA representative is, you may find out by contacting NorCCRA President,
Brenda Tremoulet, 16 Salisbury Drive, #7116, Asheville, NC 28803; (828) 505-1719;
brenda.tremoulet@gmail.com.
If your community does not have a representative, mail checks to:
NorCCRA, c/o Susan Rhyne, 3913 Muhlenberg Court, Burlington, NC 27215.

APPLICATION FORM (please print or type) *For membership year* 2017

_____ _____
(Your name) (Spouse's name, if applicable)

Community_____

Address_____

_____

Email_____

Status (please check one): ☐Renewal ☐New member

Enclosed is payment for (please check one):

One year: ☐$12 single ☐$20 couple **Life**: ☐$80 individual. ☐$135 couple