

# A LONG-TERM CARE PLAN FOR NORTH CAROLINA: FINAL REPORT

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## EXECUTIVE SUMMARY

Submitted by The North Carolina Institute of Medicine  
Task Force on Long-Term Care to the  
North Carolina Department of Health and Human Services

January 2001

**NORTH CAROLINA INSTITUTE OF MEDICINE**

*Citizens dedicated to improving the health of North Carolinians*

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Chartered in 1983 by the North Carolina General Assembly, the North Carolina Institute of Medicine (NC IOM) is an independent nonprofit organization that serves as a non-political source of analysis and advice on issues of relevance to the health of North Carolina's population. The Institute is a convenor of persons and organizations with health-relevant expertise, a provider of carefully conducted studies of complex and often controversial health issues, and a source of advice regarding available options for problem solution.

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## ***EXECUTIVE SUMMARY***



No set of issues related to the health of North Carolinians is more important or more complicated than those dealing with long-term care for the state's older adults, people with disabilities, and their families. The proportion of older adults in North Carolina's population is increasing at a faster rate than in most other states. The number of older adults is expected to grow from 12.8% of the state's population in 1998 to 21.4% by 2025. Sixty percent of persons beyond the age of 65 will need long-term care services either in-home or in a residential setting sometime in their lives, as will many younger people with disabilities. In view of these facts, the North Carolina General Assembly in 1999 asked the Secretary of the North Carolina Department of Health and Human Services (DHHS) to develop a long-term care system that could provide a continuum of care for older adults, people with disabilities, and their families.<sup>1</sup> The Department was directed to report its progress to the General Assembly no later than January 2001.<sup>2</sup>

In the fall of 1999, the Secretary of the North Carolina Department of Health and Human Services, the Honorable H. David Bruton, M.D., asked the North Carolina Institute of Medicine (NC IOM) to convene a statewide task force to assist DHHS in developing a comprehensive long-term care plan. Robert A. Ingram, Chairman of Glaxo Wellcome Inc. agreed to co-chair the Task Force on Long-Term Care along with Secretary Bruton. The full Task Force, including 49 of the state's leading citizens and professionals, was appointed in the early fall. The group included members of the North Carolina General Assembly and representatives of county commissions, local governments, long-term care providers and industry associations, consumer advocacy groups, and businesses. In addition, the Task Force included agency directors within DHHS charged with the provision or oversight of long-term care services to older adults or people with disabilities. The Task Force began meeting in November 1999 and held 11 day-long meetings through December 2000.

The Task Force examined long-term care issues for both older adults and people with physical or cognitive disabilities. However, most of the focus was on the long-term care delivery and financing systems for older adults and people of other ages with acquired physical and cognitive disabilities (i.e., those disabilities that occurred after childhood).<sup>3</sup>

### **NORTH CAROLINA'S LONG TERM CARE POLICY**

Ideally, long-term care services would be provided by home and community-based programs or families on behalf of their loved ones. These services should enable individuals to live as independently as possible without casting them into poverty. Without adequate private long-term care insurance or public funding, some individuals in need of long-term care services are faced with three options: (1) find a family member to provide unpaid care; (2) pay a caregiver out-of-pocket; or (3) enter a long-term care facility where, as they more quickly use up their resources to pay for institutional care, they are more likely to qualify for public subsidies. This raises questions of the availability of services and financing needed for people to live independently without institutionalization.

*No set of issues related to the health of North Carolinians is more important or more complicated than those dealing with long-term care for the state's older adults, people with disabilities, and their families.*

The Task Force members determined that North Carolina needed a general statement of policy orientation to guide the future direction of long-term care policy development for all individuals in this state.<sup>4</sup> The state's long-term care policy should be *to support older adults and people with disabilities and their families in making their own choices with regard to living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care provided in the least restrictive setting.*<sup>5</sup> *The state's long-term care policies and program activities should strengthen the capacity of families to serve as caregivers;*<sup>6</sup> *however, individuals in need of additional long-term care services should have access to certain core long-term care services.*<sup>7</sup> *North Carolina's long-term care system should be accessible and understandable for both public and private pay consumers, and uniform for all in need of these services.*<sup>8</sup>

*The state's long-term care policy should be to support older adults and people with disabilities and their families in making their own choices with regard to living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care provided in the least restrictive setting.*

## **THE STRUCTURE OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

The Task Force realized the challenge facing the state in meeting the long-term care needs of the citizens of the state as the population ages. This challenge is made more difficult by the fragmentation within DHHS among the agencies delivering, financing, or regulating long-term care services. For example, within the DHHS, there are at least eight different Divisions that play a role in the long-term care system: Division of Aging; Division of Facility Services; Division of Information Resource Management; Division of Medical Assistance; Division of Mental Health, Developmental Disabilities and Substance Abuse Services; Division of Public Health; Division of Services for the Blind; Division of Social Services; and Division of Vocational Rehabilitation.

The multiplicity of governmental divisions at the state level has made it difficult in the past to develop a coordinated long-term care policy for the state. The NC IOM worked with the DHHS to develop a plan to enhance communication and coordination among the various divisions. With the full support and involvement of the directors of the various key divisions of the Department, the Task Force recommends that the Secretary establish a Long-Term Care Cabinet and an Office of Long-Term Care. The Office should establish a Forum on Long-Term Care to involve consumers and other key stakeholders in the development and implementation of the state's long-term care system.

## **ENTRY INTO THE SYSTEM OF LONG-TERM CARE**

The Task Force discovered how very complex the current patchwork of programs, services, providers, and state and federal laws can be when a person or family is confronted with the (often urgent) need for long-term care services. People needing information about long-term care services locate this information in multiple ways. They may call an agency requesting information and assistance or go to an agency requesting services. While most communities offer some form of information, referral, and assistance to older adults and their family caregivers, it is also clear that the amount and quality of this help varies enormously around the state.

Multiple agencies provide different types of long-term care services. Departments of Social Service; Councils and Departments on Aging; Area Programs on Aging; Health Departments, Area Mental Health, Developmental

Disability and Substance Abuse Programs; home health agencies; adult day care and day health centers; adult care homes; assisted living facilities; nursing homes; hospitals; group homes for people with developmental disabilities or mental illness; adult developmental vocational programs; and community respite facilities are some of the major providers of long-term care services. Some of these services are available to both publicly-funded and private-pay individuals; other services are limited to individuals with specific sources of payment. Persons seeking services may know of some of these agencies, but not others. Few individuals understand all the services available in a given community, or which agencies can help with payment for these services.

Agencies currently use a multiplicity of telephone screening, level of services eligibility, and care planning instruments. The use of multiple, and often incompatible, screening and assessment instruments by different agencies causes problems:

- There is little or no sharing of client assessment information across multiple agencies working with an individual and his or her family. Thus, individuals and families are often subjected to multiple assessments, and coordination of services between agencies may be lacking.
- Coordinated and continuous care planning and care management is limited. Care managers cannot monitor changes in functional or health status as individuals move throughout the long-term care system.
- It is difficult for public programs to plan for long-term care services because the state lacks data about the use of long-term care services and the functional or health status of people using different types of services.

Given the fragmentation and duplication within the current system and resulting confusion it causes for consumers, the Task Force concluded early in its deliberations that one of its goals would be to propose a system that would allow consumers to find their way into and through the system with ease, regardless of the consumer's source of payment for long-term care services. In addressing these issues, the Task Force recommends that the state establish a uniform portal of entry system for long-term care services. Individuals would be able to enter the system through multiple agencies—but would be asked for and provided similar information regardless of which agency they initially contacted. In addition, the Department should establish uniform screening, level of service, and care planning assessment instruments. With the client's consent, information obtained by one agency could be shared with another to reduce unnecessary assessments. Whatever system is developed will have to include confidentiality provisions that comply with the federal Health Insurance Portability and Accountability Act.

## **AVAILABILITY AND NEED FOR LONG-TERM CARE SERVICES**

The North Carolina General Assembly directed the DHHS to develop a system that provides a continuum of long-term care services for older adults and people with disabilities.<sup>9</sup> To address this requirement, the North Carolina Institute of Medicine Task Force on Long-Term Care examined what core long-term care services should be available to everyone in the state, the availability of existing services, the need for additional long-term care services, and local planning efforts needed to encourage the development of needed services.

*The current fragmentation and duplication within the long-term care system causes confusion for consumers. The Task Force recommends that the state establish a uniform portal of entry system for long-term care services to make the system more accessible to the public.*

*Certain “core long-term care services” should be available and accessible to consumers across the state.*

*Core long-term care services:* Ideally, every individual should have a choice of long-term care services that would best meet their needs and would result in high-quality, cost-effective care provided in the least restrictive setting. However, the Task Force recognized that it was not realistic to expect all of these services to be readily available throughout the state. Instead, the Task Force identified the “core services” that should be available and accessible to consumers both geographically and economically, including: long-term care information and assistance services; transportation; housing and home repair and modification; home delivered meals; durable medical equipment and supplies; medical alert or related services; nursing services; respite care/adult day care/day health or attendant care; in-home aide services; home health care; adult care homes (various types); nursing homes; and care management for high-risk or complex conditions.

According to a study commissioned for the NC IOM Task Force on Long-Term Care by Millennium Healthcare Solutions, 57% of older adults who have problems with one to two activities of daily living (ADLs) and 49% of those who have problems with three or more ADLs rely on informal (unpaid) support as their sole source of care. Another 23% and 46%, respectively, rely on both formal (paid) and informal support. The state has a critical interest in supporting family and informal caregivers so that they can continue to provide care to older adults and people with disabilities who need long-term care services.

*Availability of long-term care services:* The Task Force tried to determine the availability of existing long-term care services. Limited data are available for this purpose. Building on an earlier study,<sup>10</sup> the Task Force obtained utilization data for Medicaid personal care services (PCS), the Community Alternatives Program for Disabled Adults (CAP/DA), and Home and Community Care Block Grant (HCCBG) and Social Services Block Grant (SSBG) in-home aides, adult day care/adult day health, and home delivered meals.<sup>11</sup>

The availability of long-term care services varies greatly by county. For example, the rate of licensed nursing home beds per 1,000 older adults ranged from 25.4 in Brunswick county to 89.1 in Hyde county (state average: 42.2/1,000). There was even greater variation in utilization of CAP/DA services. Utilization varied from 8.39 individuals per 1,000 Medicaid aged and disabled in Johnston county to 200 per 1,000 in Avery county (state average: 36.0/1,000). The Task Force was unable to identify any consistent pattern of service availability across multiple categories of long-term care services.

Some of the counties that were low in the provision of in-home services among certain funding streams were the same counties that were higher in the provision of in-home services among other publicly-funded programs. Some providers are willing to participate in certain publicly-funded programs, but do not participate in others. There are different reasons why private agencies do not participate in Medicaid, such as low reimbursement rates or a lack of capacity to accept additional clients. However, the failure of these agencies to participate in all publicly-funded programs causes problems. First, individuals who are receiving services from one provider may be forced to switch to another provider if they change their source of public subsidy, which causes a disruption in the client’s continuity of care. In addition, this system is an inefficient way to use limited long-term care dollars. Ideally, Medicaid-eligible individuals would be covered by Medicaid funds; rather than through limited Home and Community Care Block Grant or Social Services Block Grant funds.

*Need for long-term care services:* While the Task Force was able to get some information about the existing array of services, it had limited capacity to determine the *need* for long-term care services; it was difficult to determine whether the existing array of services was adequate to meet the long-term care needs of older adults or people with disabilities today or in the future. The North Carolina Institute of Medicine contracted with a private consulting firm, Millennium Healthcare Solutions, to obtain projections of the need for in-home, community and residential long-term care services for the years 2000, 2005, and 2010. These projections suggest that there are currently 10,800 older adults 65 years of age or older who have unmet needs relating to activities of daily living.<sup>12</sup>

However, the Task Force recognized the limitations inherent in any estimates based, at least in part, on older national studies, which may or may not mirror the experience of North Carolinians. Therefore, the Task Force recommends that the state make arrangements to collect North Carolina-specific data to determine the need and demand for long-term care services in the state.

*Long-term care planning efforts:* A comprehensive planning process is needed statewide at both the state and local levels to encourage capacity building for long-term care services and the development of a consumer-friendly system of care and services. The state should provide technical assistance to county or regional planning bodies to: assist in the development of a consumer-centered system of care and services, encourage the “balanced” development of core services in counties or regions, and develop the readiness to work with standardized instruments and data sharing across agencies.

## **LONG-TERM CARE WORKFORCE**

North Carolina is in the midst of a long-term care workforce crisis. Efforts to design a long-term care system that ensures availability of services and high-quality care are somewhat meaningless, absent a supply of trained professional and paraprofessional staff—including nurse aides, nurses, doctors, and allied health professionals. The Task Force Report addresses workforce supply (shortage) issues pertinent to each of the major categories of long-term care professionals and paraprofessionals in our state.

Nurse aides and other paraprofessionals provide most of the direct long-term care services to individuals, whether at home or in a residential facility. These workers help individuals with their most basic needs—including bathing, dressing, eating, and toileting. In addition, paraprofessionals often help with housekeeping tasks, and may help administer medications, change bandages, or monitor changes in a person’s health status.

North Carolina, like the rest of the nation, is experiencing a severe shortage of paraprofessionals trained and willing to work in the long-term care industry. The annual turnover rate among aides who work in nursing homes exceeded 100% in 1999. The annual turnover rate was even higher among aides who work in adult care homes (140%). North Carolina will need more than 21,000 additional nurse aides and other paraprofessionals to meet the long-term care needs of older adults and people with disabilities over the next five years.

*North Carolina is in the midst of a long-term care workforce crisis. Efforts to design a long-term care system that ensures availability of services and high-quality care are somewhat meaningless, absent a supply of trained professional and paraprofessional staff—including nurse aides, nurses, doctors, and allied health professionals.*

There are a number of reasons for the problems in recruiting and retaining paraprofessionals, viz., low wages, few benefits, no career path, physically demanding work, lack of opportunity for meaningful input into client care, inadequate recognition and appreciation, and inadequate exposure to “real life” job demands during training.<sup>13</sup> The state’s low unemployment rate further exacerbates the current paraprofessional shortage in long-term care.

Clearly more needs to be done to address the shortage of trained paraprofessional and professional staff to provide long-term care services. The Task Force recommends that the state implement policies that would improve the training, salaries, and benefits offered to these staff. In addition, the industry has a role to improve the work environment and increase job satisfaction among long-term care paraprofessional employees statewide.

## **ASSURING THE QUALITY OF LONG-TERM CARE**

Long-term care has a number of characteristics that differentiate it from other levels and types of health care services. First, the *goals* of care may be very different than in other types of health care services. Second, the goals of long-term care may lack *clarity* or *societal consensus* because of the conjunction of therapeutic/clinical and social purposes of these services and programs. Many of the goals of long-term care may conflict with one another (as in the case of prolonging life versus controlling pain; freedom of movement versus safety). Some of the trajectories of physical or mental health among long-term care consumers may be inevitable and irreversible, therefore making conventional health outcomes largely irrelevant to the evaluation of long-term care quality. The measure of success may not necessarily include the goal of “improvement;” instead, “delaying decline” may be a significant achievement.<sup>14</sup>

The Task Force confronted the difficulty of addressing issues of quality in long-term care in a way that would be inclusive of structure, process, and outcome dimensions. The Task Force concluded that quality of care, to the client of these services, “...combines a *personal* and *internal* response to the events and conditions they experience with a basic expectation that the *technical quality* meets some standard.”<sup>15</sup> It is for this reason that measures of consumer satisfaction should be included as one of the ways of measuring the quality of long-term care; although consumer satisfaction is “an insufficient test of quality,” since there are some technical aspects of care consumers may be incapable to judge.<sup>16</sup>

One of the most challenging aspects of quality assurance, especially in long-term care, is the necessity of making “trade-offs” among different aspects of daily living arrangements, some having positive and some negative influence on the overall quality of life. For example, there is often a real dilemma in long-term care as decisions are made about the relative allowable freedom of movement for frail elders who are at risk of falls. The fact that such trade-offs are an unavoidable aspect of quality of care decision-making in long-term care is well recognized, but there are often insufficient arrangements for the inclusion of clients/residents/families in making such decisions. When shared decision making occurs, there can be a mutual understanding of the difficulty of achieving goals that may seem diametrically opposed, but also an appreciation of the unfairness of judging quality from one side or the other of such decision dilemmas.

*One of the most challenging aspects of quality assurance, especially in long-term care, is the necessity of making “trade-offs” among different aspects of daily living arrangements, some having positive and some negative influence on the overall quality of life.*

The Task Force on Long-Term Care takes the view that both sanctions and rewards are required to motivate efforts within this industry that will assure good quality of care. In recognition of the complexity of quality assessment issues in long-term care, the Task Force took note of suggestions that there is a need to reconsider how quality is defined, what standards are possible, how these standards are incorporated in assessment instruments and measures used by regulatory agencies (county, state, and federal), and how results of these assessments are shared with the general public. The Task Force recognized that past efforts at ensuring quality have been largely punitive, focusing on imposing penalties and correcting deficiencies among the few “bad” facilities; rather than trying to raise the level of quality among all facilities. More emphasis should be placed on providing incentives to all facilities to improve quality, and to remove regulatory and other barriers that impair these efforts. This effort should be a joint project between regulatory agencies, the long-term care industry, consumers, and other interested parties. In addition, as the growth of home and community-based services and consumer directed care is encouraged, adequate attention to defining and measuring quality for these services must be addressed.

## FINANCING LONG-TERM CARE SERVICES

The North Carolina General Assembly directed the DHHS to explore different ways to finance long-term care services. The Final Report of the Task Force on Long-Term Care divides the discussion of financing into three sections: (1) current public expenditures for long-term care services; (2) methods to expand public financing of long-term care services; and (3) methods to expand private financing of long-term care services and expenditures.

*Public financing:* Since 1991, the Division of Aging has produced a state/county expenditure profile of services provided to persons 60 and older. North Carolina spent \$1.3 billion in SFY 99 on publicly-funded long-term care services for older adults. This is an increase of 8% over SFY 98, and a 173% increase since 1990. Over this same period of time, the population of older adults in North Carolina increased by 19.4%.

Medicaid finances almost four-fifths of the long-term care expenditures for older adults in North Carolina. More than two-thirds of the long-term care expenditures for older adults are spent on institutional care (70.4%), which includes nursing homes, intermediate care facilities for the mentally retarded (ICF-MRs), mental health/substance abuse inpatient care, and mental retardation centers. Over the last nine years, there has been some shift in financing away from institutional care, such as from nursing homes, ICF-MRs, mental health/substance abuse inpatient care, and mental retardation centers, to adult care homes and home and community care services.

Similar trend data about publicly-financed long-term care services for younger adults with disabilities (18-59) are not routinely collected or reported. One of the Task Force’s recommendations is to ensure that these data are collected at the state and county level and shared with the counties for local planning purposes.

*Methods to expand public financing of long-term care services:* The Task Force explored different options to expand public funding of long-term care services. Medicaid appeared to be one of the most viable options since the federal government will pay approximately 62.5% of long-term care costs for

*The Task Force recommends expanding Medicaid coverage, since the federal government pays almost two-thirds of the long-term care costs for all Medicaid-eligible individuals. In contrast, the other major public programs are block grants—that is, they have fixed federal funding. Funding for these programs can be exhausted, leaving eligible individuals without access to needed services.*

Medicaid-eligible individuals. Medicaid is an entitlement program, which means that the federal government will pay its 62.5% share to meet the long-term care needs of *all* eligible individuals. In contrast, the other major public programs are block grants—that is, they have fixed federal funding. Funding for these programs can be exhausted, leaving eligible individuals without assistance with services.

The Task Force recognized that there are current inequities in Medicaid income eligibility rules. Individuals can qualify for institutional nursing home care or residential care with higher income limits than can individuals living at home. Further, not all individuals living at home are treated equitably. As a general policy, the Task Force wanted to strive toward more equitable treatment of all Medicaid-eligible individuals, whether living at home or in a residential facility. As the state expands Medicaid eligibility, it should first move to eliminate inequities in the treatment of individuals living at home and then move to eliminate any potential institutional bias.

The Task Force's top financing priority is to recommend expansion of the Medicaid "Medically-Needy Income Limits" up to 100% of the federal poverty guidelines to help expand eligibility to older adults or people with disabilities with high medical or long-term care expenses. In addition, the state should expand the number of people served through the Community Alternatives Programs (CAP). CAP provides services and supports to enable people who would otherwise need institutionalization to remain in their homes.

In addition to the expansion of Medicaid and the exploration of ways to leverage federal monies, the Task Force identified a need to expand state funding of home and community-based services for those individuals who are not Medicaid-eligible. If the state expanded the medically needy income limits it would free resources to use for the non-Medicaid eligibles. However, additional resources are still needed.

*The Task Force supported efforts to expand the purchase of private long-term care insurance, especially among younger "baby-boomers."*

*Private financing of long-term care services:* At the General Assembly's request, the Task Force explored the use of reverse mortgages, private long-term care insurance, medical savings accounts, changes in Medicaid eligibility and asset protection, and cost-sharing as a way to increase consumers' financial responsibility for long-term care. As a general rule, the Task Force did not view reverse mortgages or medical savings accounts as a viable means of financing long-term care. The Task Force also recommends against further restrictions in Medicaid eligibility rules. The current Medicaid eligibility rules are already a barrier for some older adults who are afraid to apply for Medicaid, CAP, or other long-term care services. Further, people who have a lot of assets can afford to buy legal advice about how to shelter their assets. The only people who are likely to be "caught" by new restrictions would be those with fewer resources.

In contrast, the Task Force does support efforts to expand the purchase of private long-term care insurance. Most long-term care policies provide coverage for home health, adult day care, and assisted living facilities in addition to nursing home care. Some policies also provide coverage of alternative benefits. For example, if the insurer can maintain the person in-home cheaper than in an institution, then they will pay to keep the person in the home if the provider, insurer, and insured agree. The purchase of private long-term care insurance offers two benefits: (1) it helps pay for needed services, thereby allowing the individual to preserve his or her assets; and (2) it provides people with a greater

choice of providers than people who rely on Medicaid or other public sources to pay for services.

The Task Force recognized that private long-term care insurance is not a significant financing source for long-term care services in the immediate future, nor is private long-term care insurance a panacea for everyone. If a person already has health problems that are likely to mean they will need long-term care, they may not qualify to buy a policy. Also, long-term care policies are expensive, especially for people who are already older adults. For these reasons, the Task Force recommends targeting public education campaigns to the “baby-boomers” who may be able to afford these policies at their present ages.

The Task Force also explored the idea of requiring individuals to share in the cost of long-term care services. The newly authorized Older American’s Act gives the states more flexibility to impose some cost-sharing, and the Task Force recommends that the Department use this flexibility to establish a sliding scale fee based on an individual’s ability to pay.

Finally, the Task Force explored ways to provide some financial support that recognizes the contributions of family caregiving. Some options include additional income tax relief for long-term care responsibilities and expenses, reform of Social Security to credit family caregiving, incentives for businesses to offer elder care, subsidized elderly care for low-income persons going from welfare to work, and direct cash payments or vouchers for use by family caregivers instead of receiving formal services. Some of these supports are state options, while others require policy changes at the federal level. The Task Force supported the need for further study of these options to determine what the state could do to support caregivers.

## **LOCAL INITIATIVES AND DEMONSTRATIONS**

Local communities and regional coalitions have been leaders in the effort to reform the long-term care delivery system. The Task Force learned about the efforts of many local communities to improve the long-term care system. In fact, many of the Task Force recommendations derive from the experiences of local communities. In many instances, local communities acted in advance of state policy changes so as to improve services and meet consumer demand. By acting as incubators of new long-term care systems change, these counties assumed a risk that their initiative would not be in-line with state long-term care policy. Yet, the Task Force wants to support these local leaders—in that their experiences at the local level have helped to inform and improve statewide policy efforts. Therefore, the Task Force recommends that the state provide transition support as well as capacity building funds to local communities to help them make the changes necessary to bring their programs in line with new state requirements. In addition, the Task Force recommends that the state invest in further pilots and demonstrations before statewide implementation of some of the Task Force recommendations.

## **NEXT STEPS TOWARD THE IMPROVEMENT OF LONG-TERM CARE FOR NORTH CAROLINIANS: TOP PRIORITIES**

Long-term care involves an important and complicated set of issues critical to the overall health of North Carolina’s population. The NC IOM Task Force on

*The state should provide local counties with transition support as well as capacity building funds to help them make the changes necessary to bring their programs in line with new state requirements.*

Long-Term Care has sought to understand, and then communicate through the chapters of this report, its analysis of the current and likely future issues facing our state with regard to this vital aspect of health and human services needed by our older adults and people with disabilities.

The Task Force has conducted lengthy discussions and analyses regarding entry into the long-term care system, the availability of and need for long-term care (now and over the coming decade), pressing workforce issues facing the long-term care industry of our state, efforts to assure quality in long-term care, financing options, and the need for local demonstration and pilot efforts that address critical issues for which there is inadequate current information to guide statewide long-term care policy.

The Task Force made a total of 47 recommendations to improve North Carolina's long-term care delivery, financing, and regulatory systems. Some of these recommendations require immediate action; others can wait and/or are contingent on the prior implementation of other recommendations. To help guide the work of the state's policy makers, the Task Force identified the most pressing recommendations—those that require more immediate action. These recommendations fall into four areas: (1) infrastructure; (2) quality; (3) workforce; and (4) access/financing.

*Infrastructure:* Early in its deliberations, the Task Force recognized the fragmentation that exists at the state level among the different agencies charged with delivering, financing, or regulating long-term care. Thus, one of the Task Force's top recommendations is for a more cohesive process to establish state-level long-term care policies and programs. The Task Force recommends the creation of a Cabinet for Long-Term Care within the Department of Health and Human Services comprised of all the Division Directors charged with financing, regulating, or providing long-term care services. In addition, the Secretary of the Department of Health and Human Services should create a new Office of Long-Term Care to staff the Cabinet, collect and analyze long-term care data and develop comprehensive, coordinated long-term care policies.<sup>17</sup> The creation of the new Office of Long-Term Care within the DHHS and the new Cabinet for Long-Term Care will help reduce the likelihood of overlapping and sometimes conflicting agendas among Divisions of DHHS.

As a corollary to the Department's reorganization, comprehensive long-term care planning should be encouraged at the local level. The North Carolina General Assembly should encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level. The Department of Health and Human Services should support these efforts by providing technical assistance and county-level data to assist the communities.<sup>18</sup> In addition, the General Assembly should provide one-time "transition support" to enable counties to implement the recommendations of the Task Force, and additional "capacity building" funds to help small rural counties develop the infrastructure and capacity necessary to implement statewide system changes.<sup>19</sup>

The Task Force also recommends the creation of a "uniform" portal of entry that would improve the process through which citizens could obtain needed long-term care services. The uniform portal of entry would ensure that multiple agencies serving clients use the same screening and assessment tools, and have information about all the available long-term care resources in their

*The Task Force recommends the creation of a Cabinet for Long-Term Care and a new Office of Long-Term Care within the Department of Health and Human Services. The goal is to develop comprehensive, coordinated long-term care policies across the various agencies charged with delivering, financing or regulating long-term care.*

*The Task Force also recommends the creation of a uniform portal of entry system.*

communities. To make this system work, the Task Force recommends that the state begin using uniform screening, level of service assessment, and care planning instruments; and that the state identify or help develop a computerized information and assistance system that can be used statewide.<sup>20</sup>

**Quality:** There is a need for a continuing dialogue about the standards of quality for long-term care services in our state. A start in this direction has been taken through the work of the Task Force, but this is an ongoing agenda the Task Force feels best passed on to the new Office of Long-Term Care, with active participation by the long-term care industry, consumer advocacy groups, regulators, and other interested stakeholders.<sup>21</sup> Much is already going on in this area, but the Task Force maintains that an emphasis on “quality improvement” would greatly enhance current efforts. As a beginning, the Office of Long-Term Care should explore methods to improve and reward quality and not limit actions solely to imposing penalties for deficiencies.<sup>22</sup> Similarly, the Department should develop a Quality Improvement Consultation program to assist providers in the development of quality improvement plans for each facility and program offering long-term care services.<sup>23</sup> A partnership arrangement with Medical Review of North Carolina and the state’s public and private universities in this regard is also recommended.<sup>24</sup>

**Workforce:** One of the major challenges facing the state is ensuring an adequate supply of trained professional and paraprofessional staff. With regard to workforce issues in long-term care, the major “crisis” is the current shortage of paraprofessional personnel in these facilities and programs. However, there are also issues related to the preparation of adequate numbers of physicians, dentists, nurses, and other health professionals with the skills and the commitment to work in long-term care. The Task Force recommends that the General Assembly increase appropriations for Medicaid funded in-home and adult care home Personal Care Services (PCS), and nursing home care by increasing the personal care service hourly rate and nursing home daily rate for direct care. This enhancement would be used for wages, benefits, and/or payment of shift differentials (e.g., nights/weekends). Providers would be required to submit additional cost data to ensure that these funds are used for their intended purpose.<sup>25</sup>

In addition to wage enhancements, the Task Force recommends that the General Assembly appropriate funds to develop a continuing education and paraprofessional development initiative,<sup>26</sup> as well as a career ladder for long-term care paraprofessionals.<sup>27</sup> To support these efforts, additional data collection and analysis is needed, for example—to examine the turnover and retention rates, wages and benefits of nurse aides.<sup>28</sup> The state should explore ways to establish a group health insurance purchasing arrangement for long-term care staff.<sup>29</sup> The General Assembly should also establish a Legislative Study Commission to examine long-term care workforce shortages among paraprofessionals and other professionals serving older adults and people with disabilities.<sup>30</sup>

Current efforts made by the long-term care industry to address the long-term care paraprofessional recruitment and retention issues should be applauded and further encouraged. The Task Force recognized that both the state and private industry have a role in addressing the current workforce shortages. Long-term care provider associations should develop plans to improve the recruitment and retention rates among paraprofessionals and professionals in the long-term care

*The Office of Long-Term Care should work with different stakeholders to improve and reward quality of long-term care services.*

*The state must act immediately to address the current workforce shortage in long-term care. One of the Task Force’s top recommendations is to implement a wage enhancement to increase wages, benefits and/or pay shift differentials for paraprofessional staff in long-term care settings.*

industry. The plans may include mechanisms to improve job satisfaction, increase pay, develop career paths or improve working conditions.<sup>31</sup>

*Expanding Access/Financing Long-Term Care Services:* One of the first steps the state should take in expanding publicly-financed long-term care services is to remove the current institutional bias in these programs. It is currently easier for older adults or people with disabilities to qualify for publicly-financed long-term care services in a nursing home or adult care home than it is to receive services at home. Two promising means of reducing the current institutional bias would be to increase the Medicaid medically needy income limits up to 100% of the federal poverty guidelines;<sup>32</sup> and to expand the number of people served by the CAP/DA and CAP-MR/DD Medicaid programs. Both of these approaches would enable people to receive long-term care services while living at home or a community setting.<sup>33</sup> In addition, the state should explore ways to support family caregivers, thereby reducing the risk for needing formal, publicly-financed services.<sup>34</sup>

*One of the first steps the state should take in expanding publicly-financed long-term care services is to remove the current institutional bias in these programs.*

The Task Force recognized the state's strong interest in maximizing the use of federal Medicaid dollars to financing long-term care services, as the federal government pays approximately 62% of all Medicaid service costs. As such, the Task Force recommends that the state explore ways to use existing resources as the state's match in further Medicaid expansions.<sup>35</sup> Another idea, successfully used in other states, is to ensure that Medicare pays for covered long-term care services for Medicare-eligible individuals.<sup>36</sup>

In addition, the state should launch an outreach effort targeted at "baby-boomers," to explain the different long-term care financing and payment options. The outreach effort should include information on what Medicare covers, what Medicaid covers, what individuals must pay on their own, and what private long-term care insurance can cover.

Despite several important limitations of this report (e.g., the limitations of available data on long-term care use, need and demand; the limited information about and attention given to the long-term care needs of persons with mental illness or developmental disabilities; and the inadequate attention given to the housing needs of older adults and people with disabilities), the Task Force hopes that its analyses of these complex issues will provide a framework for forward movement in addressing these issues in the interest of improving the health and well-being of all of North Carolina's citizens, particularly those in need of long-term care.

Due to the importance of the issues described in this report, it is the intention of the Board of Directors of the NC IOM to re-convene the Task Force one year from the date this report is published for the purpose of formulating an assessment of progress in relation to the report's major recommendations. At that time, certain recommendations may need reformulation on the basis of new and emerging data. Others may require extensions or deletions. A "report card" assessment of progress will help to guide further efforts in this area and help the Institute, the General Assembly, and the DHHS evaluate the efforts of the Task Force as a basis for further initiatives.



## RECOMMENDATIONS

The following is a summary of the recommendations made by the NC IOM Task Force on Long-Term Care. The priority recommendations are highlighted in boldface type. The full text of the recommendations is contained in the full report (page number cited in the chart below). The chart also indicates whether an appropriation is needed to support the recommendation, and if so, the estimated amount of the appropriation required.

<i>Recommendation</i>	<i>Report Page</i>	<i>Appropriations Required (\$)</i>
<b><i>Long-Term Care Policy Statement</i></b>		
<b>#1. North Carolina’s policy for long-term care is to support older adults and people with disabilities needing long-term care and their families, in making their own choices with regard to living arrangements and long-term care services that will result in appropriate, high-quality, cost-effective care provided in the least restrictive setting (priority).</b>	<b>26</b>	
<b><i>DHHS Organization for Long-Term Care</i></b>		
<b>#2. The Secretary of the DHHS should establish a Long-Term Care Cabinet and an Office of Long-Term Care should be created within the Office of the Secretary. The Office of Long-Term Care shall have responsibility for organizing and maintaining a new Forum on Long-Term Care (priority).</b>	<b>28</b>	
<b><i>Entry into the Long-Term Care System</i></b>		
<b>#3. North Carolina’s long-term care system should be accessible and understandable for both public and private pay consumers, and uniform for all in need of long-term care services (priority).</b>	<b>34</b>	
<b>#4. The North Carolina DHHS should develop a “uniform portal of entry” system for long-term care services in which confidentiality of information is ensured (priority).</b>	<b>40</b>	
<b>#5. The North Carolina DHHS should begin using uniform screening, level of service assessment, and care planning instruments based on the RAI family of instruments (priority).</b>	<b>40</b>	
<b>#6. As part of the uniform entry system, the Department should continue the development of a telephone-screening tool that is based on the RAI family of instruments and that can also be used for information and assistance purposes (priority).</b>	<b>41</b>	

<b><i>Recommendation</i></b>	<b><i>Report Page</i></b>	<b><i>Appropriations Required (\$)</i></b>
<b>#7. To further support the uniform entry system, the Department should develop or identify existing computerized information and assistance systems that can be used statewide. The goal is to have a comprehensive, professionally administered, and computerized information and assistance systems that work together with long-term care telephone-screening tools in local communities (priority).</b>	<b>42</b>	SFY 02: \$125,000 SFY 03: \$125,000
<b>#8. The Department should develop a level of services assessment instrument that is based on the RAI family of instruments that is tailored to North Carolina. The level of services assessment instrument should help consumers and providers determine the level and type of service needed or desired, and eventually be used to substitute for the existing level of services eligibility tools used by the state.</b>	<b>43-44</b>	
<b>#9. The Department should develop an assessment process using these new instruments that will help individuals make an informed choice and will assist in determining eligibility for state publicly-funded programs. The Department should develop procedures to ensure the assessments are done in a timely manner so as not to delay the receipt of necessary long-term care services.</b>	<b>44</b>	
<b>#10. The North Carolina General Assembly should appropriate funds to provide care management services to non-Medicaid eligible individuals age 18 or older who are at-risk of institutionalization.</b>	<b>46</b>	SFY02: \$3,888,000 SFY03: \$7,128,000
<b><i>Availability and Need for Long-Term Care Services</i></b>		
<b>#11. Every North Carolinian should have access, either in the county or within reasonable distance from the county, to certain core long-term care services (priority).</b>	<b>48</b>	
<b>#12. The Department's long-term care policies and program activities should be designed to strengthen the capacity of families to perform caregiving functions (priority).</b>	<b>49</b>	
<b>#13. The DHHS should explore the possibility of establishing uniform payment rates for in-home aide services across funding streams. The Department should explore the need, if any, for regional variations in reimbursement rates or shift differentials for these workers.</b>	<b>52</b>	
<b>#14. If the state establishes more uniform rates, the DHHS should consider requiring all licensed providers of long-term care services that participate in state-funded programs to provide some services to Medicaid clients.</b>	<b>52</b>	

<b><i>Recommendation</i></b>	<b><i>Report Page</i></b>	<b><i>Appropriations Required (\$)</i></b>
#15. The Department should collect North Carolina-specific data to determine the need and demand for long-term care services in the state.	57	
#16. The NC General Assembly should encourage county commissioners to designate a lead agency to organize a local long-term care planning process at the county or regional level. The Department should develop county data packages and provide technical assistance to the counties to assist them with their long-term planning process (priority).	58	
<b><i>Workforce</i></b>		
#17. The North Carolina General Assembly should increase appropriations for Medicaid funded in-home and adult-care home Personal Care Services (PCS) and to nursing home care by increasing the personal care service hourly rate and nursing home daily rate for direct care. This enhancement must be used for wages, benefits, and/or payment of shift differentials (e.g., nights/weekends). Providers would be required to submit additional cost data to ensure accountability for use of these funds as intended (priority).	64	SFY02: \$17,227,597 SFY03: \$23,460,713
#18. The North Carolina General Assembly should appropriate funds to develop a continuing education and professional development initiative for long-term care aides (priority).	64	SFY02: \$1,406,029 SFY03: \$2,097,301
#19. The North Carolina General Assembly should appropriate funds to develop a career ladder and associated curricula requirements and job category qualifications for long-term care aide workers (priority).	64	SFY02: \$100,000 SFY03: \$100,000
#20. The North Carolina General Assembly should appropriate funds to support on-going collection and analysis of data related to North Carolina's aide workforce. The analysis should include information on demographics, turnover and retention rates, wages/benefits, comparison of active versus inactive nurse aide registrants with regard to job stability and wages (priority).	65	SFY02: \$50,000 SFY03: \$50,000
#21. The North Carolina General Assembly should establish a Legislative Study Commission to examine workforce shortages among paraprofessionals and other professionals serving the older adults and people with disabilities (priority).	65	

<i>Recommendation</i>	<i>Report Page</i>	<i>Appropriations Required (\$)</i>
#22. The DHHS, along with the Department of Insurance, should explore ways to establish a group health insurance purchasing arrangement for staff, including paraprofessionals, in residential and non-residential long-term care facilities and programs (priority).	65	
#23. Long-term care provider associations should develop a plan to improve the retention rates among paraprofessional and professionals in the long-term care industry. The plan may include mechanisms to improve job satisfaction, increase pay, develop career paths, or improve working conditions, and should be reported to the NC General Assembly no later than March 15, 2001 (priority).	65	
<i>Assuring Quality of Long-Term Care</i>		
#24. Further quality of care initiatives should become a major responsibility of the Department. The Department should convene a Quality Standards Work Group with representatives from providers, consumers, long-term care Ombudsmen, state regulatory agencies, local Departments of Social Services and academics (priority).	73	
#25. Initial efforts to address quality issues in long-term care in North Carolina should include initiatives that can build upon the model quality improvement program developed by Medical Review of North Carolina, to include provider/consumer input to problem selection, data analysis, measurements appropriate to particular dimensions of quality (indicators), intervention design, implementation and evaluation. These efforts should utilize the expertise housed in the state's public and private universities and community colleges (priority).	74	
#26. The Department should explore methods to improve and reward quality and not limit their actions solely to imposing penalties for deficiencies (priority).	74	
#27. The Department should develop a Quality Improvement Consultation Program to assist providers in the development of quality improvement plans for each facility and program offering long-term care services to the public in North Carolina (priority).	75	
<i>Financing Long-Term Care</i>		
#28. The North Carolina General Assembly should appropriate funds to increase the Medicaid medically needy income limits up to 100% of the federal poverty guidelines (priority).	84	SFY02: \$43,151,156 SFY03: \$48,674,894

<b><i>Recommendation</i></b>	<b><i>Report Page</i></b>	<b><i>Appropriations Required (\$)</i></b>
<b>#29. The North Carolina General Assembly should expand the number of CAP/DA and CAP-MR/DD allocations to help individuals who would otherwise need institutionalization to remain in their homes or in the community (priority).</b>	<b>84-85</b>	CAP/DA: SFY02: \$ 5,690,691 SFY03: \$14,929,109 CAP-MR/DD: SFY02: \$ 2,976,584 SFY03: \$14,402,714
<b>#30. North Carolina should increase the Community Alternative Program (CAP) income eligibility limits to 300% SSI (currently \$1,536/month for an individual), and allow the individual to deduct an amount equal to 100% of the federal poverty guidelines to support a spouse living in the community.</b>	<b>86</b>	Estimates being developed
<b>#31. If permitted under federal law, North Carolina should increase the Medicaid income guidelines for older adults and people with disabilities up to the State-County Special Assistance income limits.</b>	<b>86</b>	Estimates being developed
<b>#32. North Carolina has a strong public interest in maximizing the use of federal dollars to fund long-term care services. The state should ensure that Medicare pays for covered services for Medicare-eligible individuals by appealing the denials of Medicare coverage of long-term care services (priority).</b>	<b>87</b>	
<b>#33. The DHHS should explore methods to use existing resources as the state's match in further Medicaid expansion to cover more older adults and people with disabilities, additional long-term care services, or to pay for long-term care administrative costs (priority).</b>	<b>87</b>	
<b>#34. The North Carolina General Assembly should appropriate funds to the Division of Aging to expand the availability of home and community services for non-Medicaid eligible older adults.</b>	<b>87</b>	SFY02: \$10,399,955 SFY03: \$10,399,955
<b>#35. The North Carolina General Assembly should appropriate funds to the Division of Social Services to expand the availability of home and community services for non-Medicaid eligible adults with disabilities between 18-59.</b>	<b>88</b>	SFY02: \$2,500,000 SFY03: \$5,000,000
<b>#36. The North Carolina General Assembly should appropriate funds to expand the state Adult Day Services Fund to increase the availability of respite services for family caregivers.</b>	<b>88</b>	SFY02: \$3,427,622 SFY03: \$3,427,622
<b>#37. The Task Force does not recommend that the General Assembly rely on reverse mortgages as a means of financing long-term care services.</b>	<b>89</b>	
<b>#38. The North Carolina General Assembly should provide funds for private long-term care insurance outreach efforts.</b>	<b>91</b>	SFY02: \$268,000 SFY03: \$268,000

<b><i>Recommendation</i></b>	<b><i>Report Page</i></b>	<b><i>Appropriations Required (\$)</i></b>
<b>#39.</b> The Task Force does not recommend that the General Assembly rely on Medical Savings Accounts as a means of financing long-term care services.	<b>92</b>	
<b>#40.</b> The General Assembly should pass a resolution to encourage the NC Congressional delegation to support federal incentives to purchase private long-term care insurance, such as federal tax credits or deductions, flexible savings accounts or cafeteria plans; and to eliminate the federal barriers to expansion of Medicaid long-term care partnership plans.	<b>93</b>	
<b>#41.</b> The Task Force does not support further restrictions in Medicaid through tightening transfer of assets provisions or estate recovery.	<b>95</b>	
<b>#42.</b> The Office of Long-Term Care, within the DHHS should establish a sliding scale fee based on an individual's ability to pay.	<b>96</b>	
<b>#43.</b> <b>The Department should explore ways to invest in family caregiving so that it can be sustained as the primary resource for long-term care, reducing the risk for needing formal, publicly-financed services (priority).</b>	<b>96</b>	
<b><i>Local Initiatives and Demonstrations</i></b>		
<b>#44.</b> <b>The General Assembly should provide special funds for one-time county “transition support” to enable counties to implement the recommendations of the Task Force on Long-Term Care and to make needed system improvements (priority).</b>	<b>97</b>	
<b>#45.</b> <b>The General Assembly should appropriate one-time “capacity-building” funds for small, rural counties to enable them to develop the infrastructure and capacity to implement statewide system changes (priority).</b>	<b>98</b>	
<b>#46.</b> The Department should establish a clearinghouse to gather information on successful initiatives, demonstrations and system improvements in North Carolina and other states; distribute information and provide technical assistance to local communities.	<b>98</b>	
<b>#47.</b> Participation in any state-supported demonstration should be open to all counties and/or regions via a competitive RFP (Request for Proposal) process. The State should set parameters required of all participants, but local communities should be allowed to meet specified parameters in a variety of ways. All state-supported demonstrations should be evaluated by an independent outside source, and should include outcome-focused evaluation measures.	<b>99</b>	



## NOTES AND REFERENCES

<sup>1</sup> The NC General Assembly directed the Department to develop a long-term care system that provides a continuum of care for older adults and disabled individuals and their families. Sec. 11.7A of the Session Laws 1999-237. The system was to include:

- a structure and means for screening, assessment, and care management across settings of care;
- a process to determine outcome measures of care;
- an integrated data system to track expenditures, consumer characteristics, and consumer outcomes;
- relationships between the Department and the state's universities to provide policy analysis and program evaluation support for the development of long-term care system reforms;
- an implementation plan that addresses the testing of models, the review of reviewing existing models, the evaluation of components, and the steps needed to achieve the development of a coordinated system; and
- provision for consumer, provider, and agency input into the system design and implementation development.

By January 1, 2001, the Department was to have a system in place that would:

- implement the initial phase of a comprehensive data system that tracks long-term care expenditures, services, consumer profiles, and consumer preferences; and
- develop a system of statewide long-term care services coordination and case management to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need.

The Department was also directed to pursue financing strategies that would shift the balance of financial responsibility for long-term care services from public to private sources by promoting public-private partnerships and personal responsibility for long-term care. Specifically, the Department was directed to explore:

- the flexible use of reverse mortgages;
- private insurance coverage for long-term care;
- tax credits or employment programs, such as medical savings accounts and deferred compensation plans, for long-term care; and
- changes in Medicaid eligibility and asset protection requirements that increase consumers' financial responsibility for their long-term care, such as revising the rules relating to the transfer of assets and estate recovery policies.

<sup>2</sup> The original legislation had a reporting date of April 15, 2000, but this was later extended to January, 2001. Sec. 11b of the Session Law 2000-67.

<sup>3</sup> Initially, the Task Force also tried examining the long-term care needs of people with mental illness or developmental disabilities. However, after the Task Force began its deliberations, two other groups were created that included, as part of its charge, an examination of the long-term care needs of people with mental illness and developmental disabilities: the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Reform and the N.C. Department of Health and Human Services' *Olmstead* planning efforts. The Task Force recognized that there are some people with mental illness and developmental disabilities who enter the long-term care settings discussed in this report; and that there is an ongoing dialogue about the appropriateness of these settings for the MI/DD population of younger adults (18-59). However, given the ongoing work of these other two groups, the Task Force decided to limit most of its focus on long-term care delivery and financing systems for older adults and people with acquired physical and cognitive disabilities.

<sup>4</sup> The Task Force used the long-term care principles enunciated by the North Carolina General Assembly in developing its long-term care policy statement. NCGS §143B-181.6. Specifically, the General Assembly established the following long-term care principles to guide the development of a long-term care system for older adults:

- 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 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 options.

<sup>5</sup> See Recommendation #1 on page 26 of the full Report.

<sup>6</sup> See Recommendation #12 on page 49 of the full Report.

<sup>7</sup> See Recommendation #11 on page 48 of the full Report.

<sup>8</sup> See Recommendation #3 on page 34 of the full Report.

<sup>9</sup> Sec. 11.7A(a) of the Session Laws 1999-237.

<sup>10</sup> Goins R. Turner and Leak SC. Distribution of Home and Community-Based Long Term Care Services for the Elderly in North Carolina. Occasional LTC Policy Paper Series. Duke Long Term Care Resources 1999 Nov;Program Paper No. 11.

<sup>11</sup> While these utilization data are a useful starting point - they have serious limitations. First, the state collects little information on the use or need for long-term care services in the private market. Second, while the state maintains information about the use of some publicly funded long-term care programs, they do not collect similar information on the extent to which these services are needed but not available (i.e. "unmet needs").

<sup>12</sup> 5,600 have unmet needs related to one or two ADLs; and 5,200 have unmet needs with three or more ADLs

<sup>13</sup> NC Division of Facility Services. Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers. September 1999.

<sup>14</sup> Kane RA, Kane RL, Ladd RC. 1998:190-195. The Heart of Long-Term Care. Oxford:New York.

<sup>15</sup> Kane RA, Kane RL, Ladd RC. 1998:189.

<sup>16</sup> Kane RA, Kane RL, Ladd RC. 1998:189.

<sup>17</sup> See Recommendation #2 on page 28 of the full Report.

<sup>18</sup> See Recommendation #16 on page 58 of the full Report.

<sup>19</sup> See Recommendations #44-45 on pages 97-98 of the full Report.

<sup>20</sup> See Recommendations #4-7 on pages 40-42 of the full Report.

<sup>21</sup> See Recommendation #24 on page 73 of the full Report.

<sup>22</sup> See Recommendation #26 on page 74 of the full Report.

<sup>23</sup> See Recommendation #27 on page 75 of the full Report.

<sup>24</sup> See Recommendation #25 on page 74 of the full Report.

<sup>25</sup> See Recommendation #17 on page 64 of the full Report.

<sup>26</sup> See Recommendation #18 on page 64 of the full Report.

<sup>27</sup> See Recommendation #19 on page 64 of the full Report.

<sup>28</sup> See Recommendation #20 on page 65 of the full Report.

<sup>29</sup> See Recommendation #22 on page 65 of the full Report.

<sup>30</sup> See Recommendation #21 on page 65 of the full Report.

<sup>31</sup> See Recommendation #23 on page 65 of the full Report.

<sup>32</sup> See Recommendation #28 on page 84 of the full Report.

<sup>33</sup> See Recommendation #29 on pages 84-85 of the full Report.

<sup>34</sup> See Recommendation #43 on page 96 of the full Report.

<sup>35</sup> See Recommendation #33 on page 87 of the full Report.

<sup>36</sup> See Recommendation #32 on page 87 of the full Report.

## **FREQUENTLY USED ACRONYMS**

ADL	Activity of Daily Living
CAP/DA	Community Alternatives Program for Disabled Adults
CAP-MR/DD	Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities
DFS	The North Carolina Division of Facility Services
DHHS	The North Carolina Department of Health and Human Services
DMA	The North Carolina Division of Medical Assistance
DMHDDSAS	The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services
DOA	The North Carolina Division of Aging
DSS	The North Carolina Division of Social Services
FPL	Federal Poverty Level
FFY	Federal Fiscal Year
HCCBG	Home and Community Care Block Grant
HCFA	Health Care Financing Administration
HIPAA	Health Insurance Portability and Accountability Act
IADL	Independent Activity of Daily Living
ICF-MR	Intermediate Care Facility for the Mentally Retarded
LPN	Licensed Practical Nurse
LTC	Long-Term Care
MR/DD	Mental Retardation or Developmental Disability
MSA	Medical Savings Account
N.C.G.S.	North Carolina General Statute
NC IOM	The North Carolina Institute of Medicine
NLTCS	National Long-Term Care Survey
PCS	Personal Care Services
RFP	Request for Proposals
RN	Registered Nurse
SA	State-County Special Assistance
SAB	Special Assistance for the Blind
SFY	State Fiscal Year
SHIIP	Seniors Health Insurance Information Program
SIPP	Survey of Income and Program Participation
SSBG	Social Services Block Grant
SSI	Supplemental Security Income
UNC	University of North Carolina
UNC-CH	University of North Carolina at Chapel Hill

## **ASSESSMENT AND CARE PLANNING TOOLS**

MDS	Minimum Data Set
RAI	Resident Assessment Instrument
RAI-AC	Resident Assessment Instrument-Acute Care
RAI-ALNC	Resident Assessment Instrument- Assisted Living North Carolina
RAI-AL	Resident Assessment Instrument-Assisted Living
RAI-HC	Resident Assessment Instrument-Home Care
RAI-MH	Resident Assessment Instrument-Mental Health
RAI-PAC	Resident Assessment Instrument-Post Acute Care
FL-2	State mandated tool for Nursing Home and Adult Care Home Admissions
NC SNAP	North Carolina Support Needs Assessment Profile
OASIS	Outcome and Assessment Information Set
PASARR	Preadmission Screening and Annual Resident Review
SOS	Service and Service Outcome Screen