

HEALTH REFORM IN NORTH CAROLINA

The Missing Piece in Health Reform: Long-Term Care

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As the intensity of discussion increases around the prospect for significant change in the structure and function of US health care, it is interesting to note that so little of this discussion gives focus to long-term care and rehabilitative services, especially care provided in skilled nursing facilities, such as nursing homes. Lamenting the enormity of total US investment in health care is meaningless without considering the nearly \$130 billion spent annually on nursing home care, or more than 42% of national Medicaid expenditures and 51% of the \$42 billion spent by Medicare for long-term care (despite the very limited number of days of care available to Medicare beneficiaries following an in-hospital stay).¹

President Obama's recent efforts to bring all elements of the nation's health care industry into the discussion of options for health care system reform are laudable. But the focus of these deliberations seems to have overlooked the large and growing need for specialized services offering long-term medical, nursing, and rehabilitative care, especially for America's increasing numbers of older adults.

There are four aspects of long-term care needing attention as the nation undertakes what may be the most important health care system reform in a generation. These are:

Long-Term Care Insurance Coverage in the United States is Very Low

North Carolina, like 29 other states and the District of Columbia, once offered tax incentives (as a tax credit) for the purchase of long-term care insurance. Yet a very small proportion of adults older than age 50 have insurance for their long-term care needs other than the 100 days of post-hospitalization care that is covered under the Medicare program for persons older than age 65. Therefore, when the need for such care arises, most people are faced with the necessity of covering the cost of such care out-of-pocket or establishing their eligibility for coverage under the state's Medicaid program.

Efforts to increase the extent of long-term care insurance coverage have proven to be relatively ineffective when compared to other forms of health insurance. For example, when the North Carolina State Employees and Teachers Health Plan offered such coverage as an elective benefit, only about 3,000 out of some 750,000 employees chose to exercise this option. The initial vendor for this coverage withdrew from the North Carolina market after a five-year period, necessitating arrangements with another third-party carrier.

The financial implications of long-term care for most families, when extended periods of long-term care are required, make attention to this gap in personal insurance for health care a serious matter of both personal and policy significance. It would be wise for policymakers who are now engaged in considering the restructuring of American health care to consider an approach like that introduced in Israel following the major reform of that national system in which a small incremental payment for future long-term care was added to conventional health insurance premiums assessed through one's employer. As a consequence, approximately 80% of Israel's population has long-term care insurance (for covering services in either public or private sector nursing facilities), even though a large proportion of the Israeli population report not knowing that they have such coverage until such time as it is required. Having such a significant segment of the US population entering the years when long-term care is so much more likely to be needed is a matter of considerable importance to the effort to reduce the possibility of health care financial risk to individuals and families, underlying the effort to restructure and reform the nation's health care system. Thus, employer incentives to offer such coverage should be considered as part of any national health reform proposals.

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Long-Term Care Physical Facilities are in Need of Modernization

Many of the physical facilities now providing skilled nursing care in this country were built in the 1980s or early 1990s. While they have stood the test of time, the design concepts embedded in the physical plant of many nursing homes are not consistent with current needs or the preferences of the older adults now being served. Prospective residents of these facilities will expect single rooms, in most cases with in-suite bathrooms, and many will be resistant to eating every meal in a large dining room some distance from their residential unit.

In recognition of these changes in expectations, and out of a conviction that residential life in long-term care facilities need not be so sterile and divergent from living accommodations older adult clients have been accustomed to prior to nursing home admission, there are a number of innovative designs for residential living in long-term care. We need a cadre of architects who are attuned to the need for new concepts in facility design for long-term care and who are willing to work in tandem with leaders in this field to create a vision of a new generation of such facilities.

One of the impediments to these movements toward better physical facility design in America's long-term care field are certain rules and regulations that make significant changes in the way nursing homes are constructed or operated more difficult than necessary. This industry could benefit from the services and insights of professionals in the legal profession who can assist with future efforts to simplify these rules and regulations, while at the same time facilitating the attention of this industry to the needs and desires of those who seek these services.

An Increase in the Professional Workforce Supply is Needed to Serve the Nation's Growing Population of Older Adults

This includes geriatric medicine, dentistry, and nursing; use of mid-level practitioners; long-term care administration; and psychiatry and physical therapy. Despite the growing number of older adults in this country and the coming numbers of persons born just after World War II (the so-called "baby boomers"), there is a continuing problem of too few professionals being trained with special expertise in treating the health and medical care issues among the older adult population. Health reform that focuses almost entirely on reimbursements and insurance coverage will be only a partial solution to our future health care issues in this country if there are inadequate numbers of professionals trained and prepared to focus some significant portion of their practices on service to older adults. We already have serious shortages of specialists in geriatric medicine, psychiatry and rehabilitative medicine, dentistry, nursing, and physical therapy, but there are also too few young people who are choosing careers in the field of long-term care administration. A national health reform effort that leaves out provisions for increasing the supply of persons with training in these fields or incentives for entering practice in service to older adults will have missed the mark.

Here in North Carolina we have seen the benefit of employing nurse practitioners in long-term care. Recent demonstrations in our state have shown that nurse practitioners can save money in acute care management, while enhancing the quality of overall nursing and medical care in long-term care facilities.² Emerging policies for health reform, at the state and federal levels, should offer incentives for nursing homes to hire nurse practitioners to complement their current clinical staffing.

Organized Approaches to Transitional Care are Needed

One of the major shortcomings of our current health care delivery system is the fragmentation that currently exists and the tendency of categories of health care service providers to function in and through a number of virtual "silos" with little or no integration. Among the most important facets of the current system of care that needs some attention as "reform" takes place is this lack of system integration. The current situation, depending on where one lives and seeks care, can seem anything but "patient-centered."

As policymakers contemplate the kind of health care system we would want to have in the future, it will be important to consider the mechanisms through which we might assure that providers of care at any level are forced (or incentivized) to work in tandem with providers operating at other levels of care.

Nowhere is the need for this type of incentive more evident than in the transitions of patients from hospitals to long-term care, be it home and community-based services or skilled nursing facilities such as nursing homes and rehabilitation facilities. Because there are, and will increasingly be, pressures to reduce the length of hospital stays, nursing homes and rehabilitation facilities are being asked to take responsibility for phases of overall care that might have remained within the clinical purview of hospitals, but still require highly complex types of care as patients recover from surgery or other conditions for which a prior hospitalization experience occurred. The coordination of care between the hospital and skilled nursing facility is one aspect of the coordination that should occur, but there are also complexities of reimbursement that must be addressed as well. Hospitalization itself is a risk factor for some conditions, like decubitus ulcers, especially for frail elders. So, it is not unexpected that many patients transferred from hospital to nursing home will arrive with these conditions. Working out the collaborative and shared funding of this continuing care in an equitable way between different levels of care providers will be an important element of system reform as we move forward.

The nation is now embarking on a most important set of policy deliberations, with the implications of this process being significant for every level of our health care system. Long-term care, whether explicitly included or not in these deliberations, will be consequential to the overall impact and outcome of this policy development process. Including long-term care as a critical element of national health care systems at the outset of these discussions will assure that appropriate and effective provision is made for both the inputs as well as the long-term outputs of the health care system as a whole.

REFERENCES

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- 2 Community Care of North Carolina and NC Department of Health and Human Services; Demonstration took place at Wilkes Senior Village in North Wilkesboro, NC, 2008-2009.

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