Running the Numbers

A Periodic Feature to Inform North Carolina Health Care Professionals About Current Topics in Health Statistics

Long-Term Services and Supports: How Does North Carolina Compare?

As in the proverb of the blind men describing an elephant, what you see when you evaluate a state's long-term services and supports (LTSS) system depends on where you focus your attention. A new report based on research sponsored by AARP (formerly the American Association of Retired Persons), the Commonwealth Fund, and the SCAN Foundation is designed to provide a snapshot of the whole picture. This report, titled *Raising Expectations 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* [1], defines LTSS as assistance with activities of daily living (such as bathing, dressing, or feeding) and with instrumental activities of daily living (such as shopping, laundry, food preparation, housekeeping, medications, and finances). The scorecard focuses on services that are provided to older people and other adults with disabilities who cannot perform these activities on their own because of a physical, cognitive, or chronic health condition that is expected to continue for longer than 90 days.

The scorecard ranks all 50 states and the District of Columbia across 5 key dimensions of a high-performing LTSS system: affordability and access; choice of setting and provider; quality of life and quality of care; support for family caregivers; and effective transitions. Using 26 indicators for which there are comparable data across all states, the scorecard evaluates each state's LTSS system from the consumer's point of view: Can I find the services I need, and are they affordable? Do I have a choice about where I receive services and who provides them? Can I maintain the quality of life I want, and are services of high quality? Do family caregivers get the support they need to provide help without burning out? Are services organized in a way that avoids disruptive transitions across care settings and promotes transitions to home and community-based settings?

In North Carolina, the answers to these questions reveal areas of both good and poor performance. Overall North Carolina falls near the middle of the states, with a ranking of 28, but its performance is markedly higher in some areas than in others. Table 1 shows the state's overall ranking and its rankings across all 5 dimensions of the LTSS system. Clearly, North Carolina is performing much better on choice and transitions than it is on quality and support for family caregivers. But even within each dimension, performance varies considerably.

TABLE 1.
North Carolina's Rankings on Key Dimensions of Long-Term Services and Supports

Dimension measured	Ranking[a]
Affordability and access	24
Choice of setting and provider	19
Quality of life and quality of care	35
Support for family caregivers	31
Effective transitions	21
Overall ranking	**28**

[a]Among the 50 states and the District of Columbia.
Source: Data are from Reinhard et al [1].

What Is Working Well

Despite its generally middle-of-the-road rankings, North Carolina performs well in several areas.

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Address correspondence to Ms. Enid Kassner, AARP Public Policy Institute, 601 E St NW, Washington, DC 20049 (ekassner@aarp.org).

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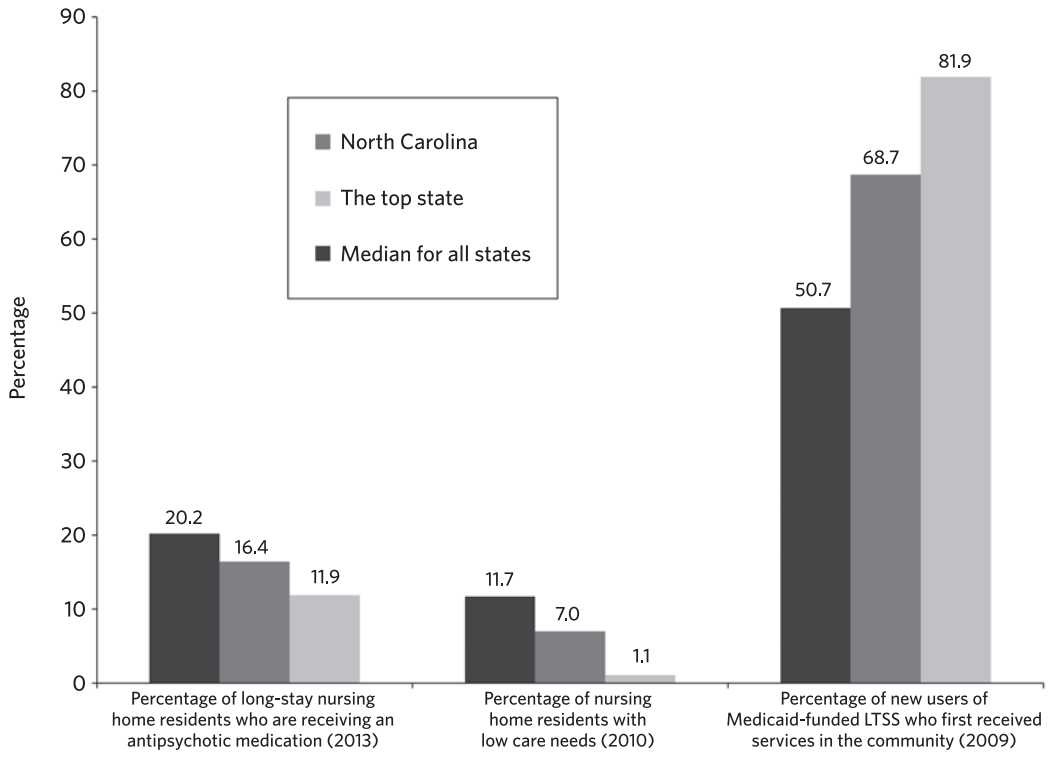
(Figure 1 shows North Carolina's performance in these areas in comparison to the best performing state and to the median for all states.) A new indicator in the 2014 scorecard was the use of antipsychotic medications in nursing homes. North Carolina ranked 5th in the nation on this measure, although nursing homes in the state still prescribed these medications to 16.4% of residents (excluding those with diagnoses such as schizophrenia, which may require treatment with such medications). Although North Carolina's performance was below that of the top state (Hawaii, where antipsychotic medications were prescribed to only 11.9% of residents), North Carolina's performance was notably better than the national median of 20.2%.

North Carolina is also working to keep people who need only a low level of care out of nursing homes, as these individuals may be good candidates for care in a community-based setting. The state ranked 9th on this measure, with only 7% of North Carolina nursing home residents having low care needs. The scorecard shows that North Carolina has improved on this indicator; 8.1% of residents had low care needs in the 2011 scorecard [2], compared with 7% in 2014. But the state still has much room for improvement; the top state in the 2014 report was Maine, where only 1.1% of nursing home residents had low care needs.

On a related indicator, North Carolina also ranked 9th in terms of providing new users of Medicaid-funded LTSS with home- or community-based care rather than institutional care. Nearly 69% of new Medicaid users in the state received home- and community-based services, compared with a national median of 50.7%. Again, there is still substantial room for improvement; in the top-ranked state (Alaska), nearly 82% of new Medicaid users received home- or community-based services.

FIGURE 1.
North Carolina Compares Favorably on 3 Measures of Long-Term Services and Supports (LTSS) Performance



Source: Data are from Reinhard et al [1].

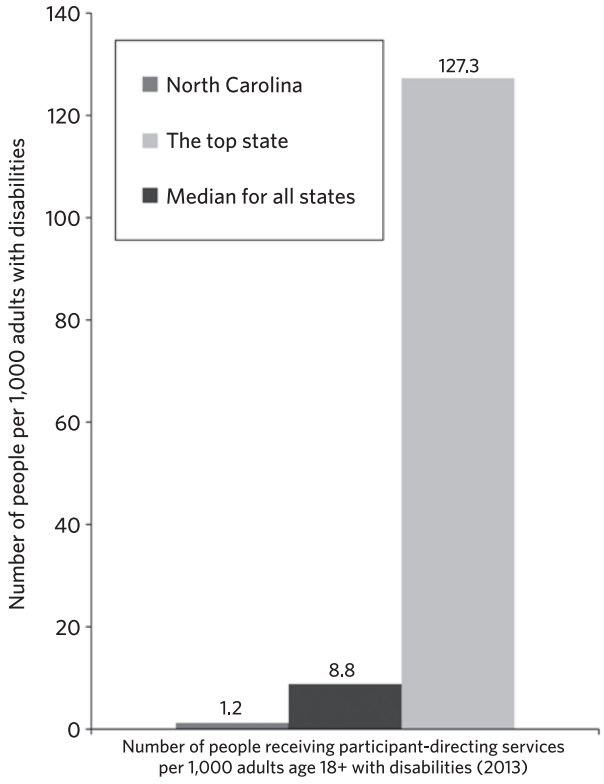
Where Improvement Is Needed

Despite North Carolina's generally good performance on allowing consumers to choose their care setting and provider, the state performed poorly in some areas. The state ranked 46th on allowing consumers to direct their own services in public programs. Among people with disabilities, only 1.2 of every 1,000 adults 18 years of age or older had the option of choosing their service provider and directing how their services were delivered. This rate is well below the national median of 8.8 per 1,000 adults with disabilities (see Figure 2).

North Carolina also ranked poorly (44th) in terms of the percentage of high-risk nursing home residents who have pressure sores (stage 2, 3, or 4). Pressure sores can lead to dangerous, life-threatening infections and are often avoidable with good-quality care. The incidence of pressure sores among high-risk nursing home residents in North Carolina was 7.2%, which is more than double the rate in the top-ranked state (Hawaii), where this incidence was only 3% (see Figure 3).

The scorecard does not capture every aspect of a state's LTSS system; it includes only those measures on which all states can be compared. Thus North Carolina does not get credit for its exemplary network of family caregiver specialists in the state's Area Agencies on Aging [3]. On a caregiver support indicator that *was* measured by the report—legal and system supports for family caregivers—North Carolina ranks 29th. This ranking may be partly due to the fact that the state does not go beyond the federal requirements of the Family and Medical Leave Act of 1993 [4, 5]. North Carolina also does not require employers to offer paid family leave or paid sick days to family caregivers, and it does not have policies that protect family caregivers from employment discrimination.

FIGURE 2.
Number of People per 1,000 Adults (Aged 18 Years or Older) With Disabilities Whose Long-Term Services and Supports Were Participant-Directed in 2013

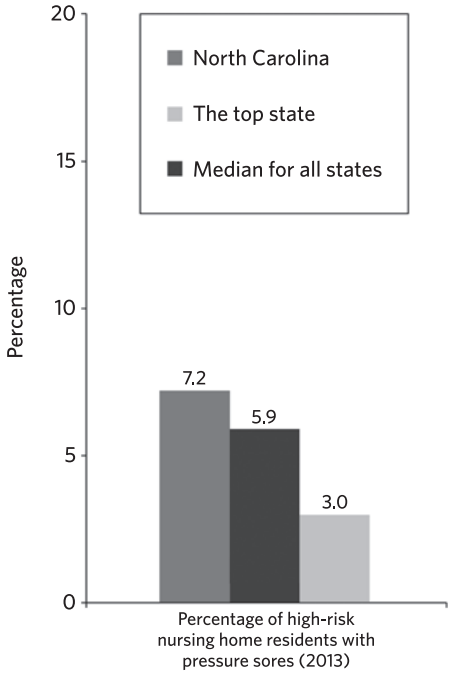


Source: Data are from Reinhard et al [1].

Where Is the Low-Hanging Fruit?

Budgets for public services are tight everywhere, and state legislators often are reluctant to increase funding for Medicaid or other public services. But there is one area in which a simple change could help family caregivers and could save money both for the government and for consumers—specifically, loosening restrictions regarding which tasks nurses can delegate to paid home care workers. There are a number of health maintenance tasks that nurses are allowed to delegate to family members, but in most states, nurses are prohibited from delegating many of those same tasks to paid home care workers. The scorecard looked at 16 such tasks, which range from the administration of oral medications, eye drops, or ear drops to more complex tasks, such as performing intermittent catheterization or ventilator respiratory care. Nine states allow nurses to delegate all 16 tasks, but

FIGURE 3.
Percentage of High-Risk Nursing Home Residents With Pressure Sores (Stage 2, 3, or 4) in 2013



Note. High-risk patients are those who are impaired in bed mobility or transfer, comatose, or malnourished or at risk of malnutrition.
Source: Data are from Reinhard et al [1].

North Carolina allows nurses to delegate only 6 of the 16 tasks measured. In North Carolina, nurses are prohibited from delegating the administration of eye drops, ear drops, suppositories, nebulizer treatment, or any medications. Employed family caregivers often must rush home during the day to perform these tasks, which causes stress and disrupts their work schedules. Loosening restrictions about which tasks nurses can delegate to paid home care workers could reduce costs both for families and for state Medicaid programs, which currently must pay licensed nurses to perform these tasks instead. Some states have enabled greater delegation by developing new regulations consistent with the Nurse Practice Act or by passing legislation to amend this act.

To sum up, the scorecard found that most states are making progress to improve their LTSS systems, but they need to accelerate the pace of change. Although North Carolina showed meaningful improvement on 5 performance indicators, its performance remained virtually stagnant on the other 14 indicators for which trend data were available. The scorecard provides tools to help policy makers target the areas in which improvement is most needed. North Carolina needs to act now if the state hopes to be ready to meet the needs of the baby boomers, who will begin reaching their 80s in just 12 years. NCMJ

Enid Kassner, MSW vice president, Livable Communities/Long-Term Services and Supports, AARP Public Policy Institute, Washington, District of Columbia.

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