ISSUES AND OPTIONS IN DEVELOPING A SYSTEM OF CASE-MANAGED HOME AND COMMUNITY CARE FOR NORTH CAROLINA'S OLDER ADULTS

Report of the Committee on Case Management and Long-Term Care of the Elderly

North Carolina Institute of Medicine

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Introduction

Policymakers, legislators, and the citizens of North Carolina are becoming aware of something that many elderly individuals and their families have known for some time. People who need community-based health and social services with the onset of chronic illness and disability in later years often find barriers to appropriate, affordable, and accessible care. They are often met by a confusing, unplanned, and unorganized "nonsystem" of long-term care services.

Decisions as to appropriate care are often made on the basis of available services or places for care rather than on the basis of objective criteria obtained through the application of a comprehensive, standardized assessment. Issues of affordability are complicated by an array of semiautonomous funding sources with conflicting eligibility criteria. Still other individuals who need long-term care services are found to be neither poor enough to qualify for the limited resources offered though public programs nor rich enough to pay for the cost of care completely on their own. Finally, if appropriate care is identified and money is not a serious barrier, elderly people may find that the kind of services most needed are in short supply or are unavailable in their communities. Case management is one mechanism that has been developed to assist those with long-term care needs in overcoming these barriers. It is through case management that the complex health and social service system is "managed" on behalf of the individual. It should be emphasized that it is the health and social service system which requires management, not elderly individuals or their families.

This position paper outlines issues, options, and principles associated with implementing a coordinated, case-managed system of community-based long-term care in North Carolina. This paper is organized into four sections. First, the research method we employed is described. Second, drawing on nearly three decades of research on home and community care, we identify models, goals, and outcomes associated with that care in order to present a framework for discussing the issues associated with and options for devising a system of coordinated home and community care in North Carolina. Third, we present a description of the practice of case management itself, along with a discussion of standards for the training of professional case managers who can serve as the linchpin for helping elderly North Carolinians gain access to affordable and appropriate care within the context of a larger, organized system. Finally, in light of recent state legislative initiatives and the prior discussion of options and issues in this area, we identify specific principles of policy and practice to guide the development of a case-managed system of home and community care for the elderly in North Carolina.

This background position paper and the principles identified in it serve as the foundation for more specific recommendations for developing a program of case-managed home and community care. This paper and a second paper outlining specific programmatic recommendations have been prepared by the North Carolina Institute of Medicine with the assistance of the Center for Aging Research and Educational Services.

Research Method

The method employed to specify issues, options, and recommendations throughout the paper is three-fold. First, we conducted an extensive review of the published and unpublished research literature on case management and home and community care, making special effort to identify model state programs so that North Carolina's policymakers might have a sense of the options exercised by other states in developing their systems. The discussion of case management in other states draws heavily from a series of publications by the National Governors Association, particularly the publication *State Long Term Care Reform* (NGA, 1988). Although additional materials were gathered and providers from several additional states interviewed, none of the additional data they supplied have called into question the basic findings in the National Governors Association's publication.

Second, the practice of case management and the system of long-term care in North Carolina itself were explored through an analysis of private and public documents on the subject and the collection and analysis of relevant secondary data. Individual states, including North Carolina, have produced innovations that have enhanced their programs, and many of these variations are rooted deeply in each state's unique historical and political context. The major lesson of these variations has been the importance of weighing all decisions in light of our own state's political, social, and economic realities.

Finally, we conducted in-depth, focused interviews with key individuals in North Carolina's long-term care network. The purpose of these interviews was to obtain a unique North Carolina perspective on options available as the state seeks to develop a case-managed system of home and community care. The individuals we interviewed were drawn from the major state and local government agencies and from both public and private sectors of long-term care. In addition, a representative from a leading long-term care advocacy group was interviewed. Upon completion of the interviews, these individuals were brought together in a Consensus-Building Workshop to identify those points and principles upon which there was agreement regarding the development and implementation of a comprehensive case-managed system of home and community care in North Carolina. Despite the wide range of experiences and interests represented, the participants evidenced a strong measure of consensus, and their suggestions are reflected in the specific principles presented at the conclusion of this paper.

Community-Based Long-Term Care and Case Management

The principal goal of community-based long-term care is, as suggested in the introduction, the provision of accessible, affordable, and appropriate health and social services to the disabled elderly and their families. The core function of case management—obtaining essential resources on behalf of clients in collaboration with formal and informal sources—is rooted in social casework, community health counseling, and related practice (White, 1987). The early community-based long-term care demonstration projects under Medicaid/Medicare Waivers, the subsequent long-term care reform efforts and rise of community care systems in several states, and the recent interest of

private insurers have complicated the more traditional methods of social casework. Issues of service targeting and delivery, financing, provider efficiency, and quality assurance have made the job of managing social and health services for the disabled elderly both complex and demanding. The proliferation and popularity of case management in all manner of health care and social service settings that focus on geriatric clients is testimony to the growth of an aging population and the increased complexity of the long-term care service network. Continuing debate also reflects a failure of any one identified model of case management to suit all situations.

Programs of long-term case management may be designed to focus on one of two subsidiary goals: the stabilization or amelioration of the client's condition or the increased cost-effectiveness of services provided. The design of programs generally reflects which of these two goals is paramount, and each requires different types of case management.

The client-centered approach involves extensive direct contact with the client. The case manager screens the client's basic level of care needs, conducts a comprehensive assessment, recommends and arranges a plan of care, monitors services provided to the client, conducts periodic reassessments, and performs follow-up or continuing care when the client is ready for discharge. In addition to the general goal of obtaining access to affordable and appropriate community services for the client, other goals encompass improvements in health and psychosocial outcomes that may include increased survival rates, better physical and mental functioning, enhanced life satisfaction and social interaction, and reductions in unmet needs and caregiver burden.

Programs that emphasize cost-effectiveness usually have as a goal the substitution of less expensive, case-managed community care for more expensive nursing home or hospital care. Such programs often minimize case managers' contact with their clients. These programs, often sponsored by major health care reimbursers, frequently provide payment for services that are considered standard treatments for the presenting condition. A telephone consultation with a client who needs home care upon discharge from the hospital may be sufficient to make such determinations.

The effectiveness of either sort of model can be judged from both points of view: Does the program enhance the client's quality of life? Does the program reduce the cost of care? Elderly North Carolinians, not unlike the elderly throughout the nation, desire to remain in their own homes and communities for as long as they are able. From the point of view of these clients, case management may be considered a success only to the extent that it gives individuals access to affordable and appropriate services while they remain in their own homes. However, community-based long-term care may be judged for cost-effectiveness, and in this instance, case management may be considered a success to the extent that it offers a cost-effective alternative to institutional care.

The largest point of resemblance among elements of the potpourri of case management programs has been a focus on the individuals needing care, but there is a general lack of focus on the system of care itself. Carol Austin (1983) suggests that case management may be so widely "accepted" because it is not seen "as a systemic reform, but as a function that can be incorporated into ongoing delivery systems without changing structural relationships among service providers" (p. 17). Falcone and Jaeger (1988) take this point a step further in a recent edition of the Duke University Center for the Study of Aging *Advances in Research*: "Case management in some form is likely to be indispensable in any system of care we are likely to devise. . . . One thing that is fairly certain, however; a satisfactory solution will have to concentrate on care systems, not just individuals needing care. . . . From this standpoint, case management and managed care within a system of care must go hand in hand for either to work" (p. 3). Disagreements and quibbling over the definition

and practice of case management itself by its different providers may be, in part, a smokescreen—a way of delaying structural reforms of the care system that would reassign key sections of provider and organizational turf.

A brief review of the findings obtained from studies of community and home-based care demonstrations across the nation is included in this report. This is intended to shed light on that mix of financial and client-specific goals by which the state may want to direct and evaluate its case management initiatives. Over the past two decades there has been extensive research on the benefits of home and community care. See, for example, Greenberg, Doth, and Austin (1981); Strassen and Hallahan (1981); Hughes (1985); Berkeley Planning Associates (1985); Applebaum, Harrigan, and Kemper (1986); Capitman (1986); Harder, Gornick, and Burt (1986); and Hedrick and Inui (1986). Of particular interest is Weissert, Cready, and Pawelak (1988), who reviewed the extensive research on home and community care for the elderly in an effort to assess both financial benefits as well as impacts upon health and mental health status and psychosocial outcomes. Research and demonstrations projects reviewed in these summary works and by the authors of this paper include: National Channeling Programs (financial and basic); Triage; On Lok; Access Medicare/Medicaid; South Carolina; New York Nursing Home without Walls; Wisconsin CC/Milwaukee; Project Open, and many others. An analysis of the experiences and outcomes associated with these major home and community care demonstrations point to probable goals and outcomes that could be expected with the development of case-managed community long-term care programs in North Carolina.

A review of studies of the impact of home and community care programs on clients' physical and mental health status and psychosocial benefits yields mixed results. Findings show more positive results for psychosocial benefits than for improved physical and mental health. Increased life satisfaction, feelings of contentment, and improved morale have been consistently reported in community care demonstrations. Other psychosocial benefits found in community care include increases in social interaction; improvements in well-being for informal caregivers; and reduction in unmet needs in physical functioning (ADL/IADL), socialization, medical care, social services, and/or health education (Weissert, Cready, and Pawelak, 1988). In a review of health status outcomes in 31 studies of home and community care, Weissert, Cready, and Pawelak (1988) also found the results mixed for measures of survival, physical functioning (ADL/IADL), and mental functioning, and concluded that such programs have not produced significant improvements in physical and mental health status for disabled participants. However, an analysis of subgroup variations in health status outcomes suggests that younger, less disabled clients and those with social support were more likely to benefit from home and community care than older, more severely disabled clients.

Psychosocial benefits associated with home and community care show more promise than outcomes for cost-effectiveness or changes in health status. Most home and community care programs have not achieved cost savings through reduced institutionalization or hospitalization. Targeting, which has usually been designed to reach those who are imminently at risk of being institutionalized, has been difficult for most programs. Two exceptions to these findings are the South Carolina and National Channeling Financial Programs, where targeting was enhanced by focusing on individuals who had actually applied for nursing home care or who were already in nursing homes. Other projects, such as the New York Access program, have achieved some success by targeting those at high risk of hospital use with nursing home as well as home and community care. In summarizing savings associated with reduced institutionalization through home and community

care demonstrations, Weissert, Cready, and Pawelak (1988: 60–61) suggest that greater cost-effectiveness might be achieved by the following:

- coupling home and community care programs with nursing home preadmission-screening programs;
- making efforts to reduce treatment costs, by better planning to avoid excess capacity and utilization control, especially with respect to total volume and duration of care;
- closer attention to control of outlier cases—those characterized by unusually high costs and service utilization;
- steadfastly avoiding treatment decisions that increase hospital use unless patients will clearly benefit;
- further investigation of congregate housing as an efficient setting for delivering home and community care.

In summary, the findings on community and home-based care point to a number of real and potential benefits for instituting a case-managed home and community care program in North Carolina. The findings on costs associated with community and home-based care, however, suggest tempering notions of saving money and replacing them with the more realistic goal of providing services to targeted subgroups of disabled elderly in the most efficient and cost-effective manner possible. Findings on health and mental health status offer some promise and suggest goals of rehabilitation and prevention for the younger, less dependent elderly and perhaps goals of maintaining as well as rehabilitating physical and mental health functions for the older, more severely disabled elderly. Finally, findings on psychosocial benefits of improved life satisfaction, decreased caregiver burden, and unmet needs underscore the pertinence of these goals for the most disabled elderly. These findings also suggest what may be the most plausible rationale for developing case-managed home and community care programs—they meet unmet needs and they improve the quality of life for older people and for their family caregivers.

The North Carolina Experience

In North Carolina, particularly in the long-term care sector, many agencies and service providers are engaged in the practice of case management, however defined, and still others are interested in getting into what is apparently a growth industry. There are, however, only a few well-articulated and well-developed models of case management for the elderly currently operating in the state. The various models of case management operating in North Carolina differ among themselves in four key ways: 1) target populations; 2) the production of and access to formal and informal services; 3) organizational aegis and service delivery structure; and 4) financing and creative use of funding resources.

In the public sector, the most well-developed case management model is the Medicaid Waiver Community Alternative Program for Disabled Adults (CAP/DA). The CAP/DA program provides community-based services for clients aged 18 and older who qualify for skilled or intermediate nursing home care. Forty-one of the 100 counties in the state have a CAP/DA program. Case management services are also provided by other public agencies including county Departments of Social Services (DSSs) and regional Area Agencies on Aging (AAAs). In 1987 the North Carolina

Division of Aging developed standards, including a sample assessment, and training guidelines for case management (NC, 1987), but these measures went largely unpublicized. In recent years, county Health Departments and Community Mental Health Centers have begun to develop case management programs for their adult clientele. Although not developed specifically for the elderly, these initiatives do affect many older clients.

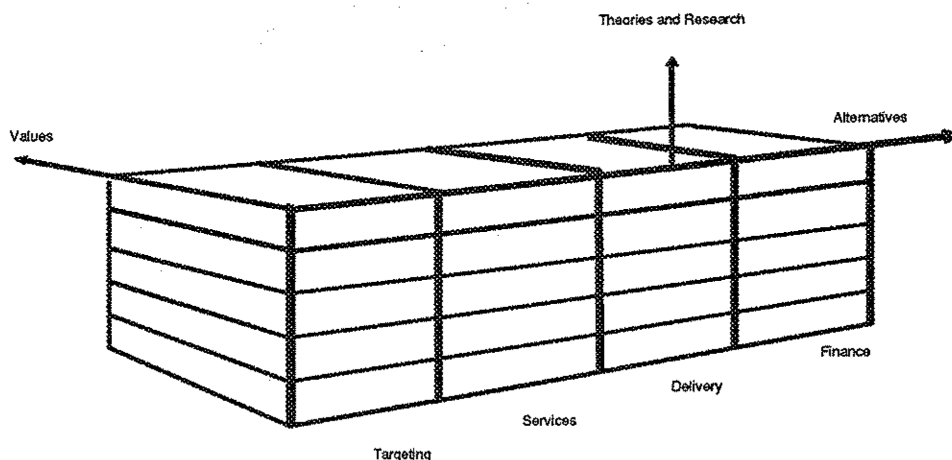
In recent years North Carolina has seen limited but noteworthy experimentation in case management programs for the elderly in both the private profit and nonprofit sectors. In Charlotte, the Mecklenburg County Health Care Cost Management Council has implemented a Physician-Directed Case Management project. In New Bern, the Craven Hospital, with support from the Robert Wood Johnson Foundation, has implemented a hospital-based case management model. In the city of Durham, the Senior Coordinating Council has an established record of offering community-based case management services to the elderly. In the corporate sector, IBM has also implemented a model of information and referral services for retired IBM employees in several North Carolina communities.

Some other states are experimenting with the incorporation of private insurance into their models of case management and long-term care (most notably Washington and Connecticut) and others with social health maintenance organizations that support a per capitated model of long-term care. There has so far been no meaningful discussion of such models in North Carolina. While hospitals throughout the state are obviously engaged in discharge planning and are increasingly interested in hospital-based home health services, they have only begun to experiment with offering case management services. The advent of private practitioners of case management, which is beginning in other states, is but a glimmer in the eye of a few entrepreneurs in North Carolina (Interstudy, 1987). Nevertheless, it is only a matter of time before the growth of case management programs in the private sector will begin to increase.

Existing structural relationships must be appraised realistically as North Carolina tries to forge a coordinated system of care. A central question is whether or not the state's interest in developing

Figure 1

Case Management and Long-Term Care:
Dimensions of Choice



comprehensive coordinated care for the disabled elderly is best served by promoting competing providers of case management services within the public and private sectors or by developing a model of case-managed care that specifies overriding goals for and structural reform in the way we deliver and finance services. This paper takes the position that case management can only be successful in a system of care in which the goals are clear and where policy choices have been made by legislators regarding who is to be targeted for services, what services need to be supplied for case managers to manage, how the service of case management is to be delivered, and how this system of care is to be financed. Essentially, in developing a system of care in which case management is embedded as a practical method for reaching overall system goals, the state must make basic policy choices within a framework that highlights decisions about issues of targeting, services, delivery, and financing. Figure 1, modified from Gilbert and Specht (1986: 38), provides a spatial illustration of this typology. Building on that model, this paper reviews issues and options along these different dimensions of choice and makes recommendations on the basis of research in the field of long-term care, options and models pursued by other states in building community-based long-term care, and findings from the Consensus-Building Workshop attended by representatives of North Carolina's long-term care network.

Issues and Options

Service targeting, provision, delivery, and financing are the focus of this discussion of issues and options. For each of these dimensions we begin with a description of the North Carolina policy and service environment and then identify the options exercised by other states with model home and community care programs. It is in relation to these issues and options that the Consensus-Building Workshop, comprised of key actors in North Carolina's long-term care network, recommended policy and practice principles to guide the development of a case-managed system of home and community care.

Targeting Service Populations

The targeting of case-managed home and community care services is an attempt to answer the question, "Who will receive these services?" The majority of older adults, including many who are quite frail, do not need formal case management services. In many cases what they may need is information on how to access and coordinate services for themselves. This information could be obtained from various community settings frequented by older people. Formal case management services are neither advisable for all older adults nor are they affordable. Legislators and the general public will need to make decisions about the priority given to specific subsets of the elderly population for case-managed home and community care services.

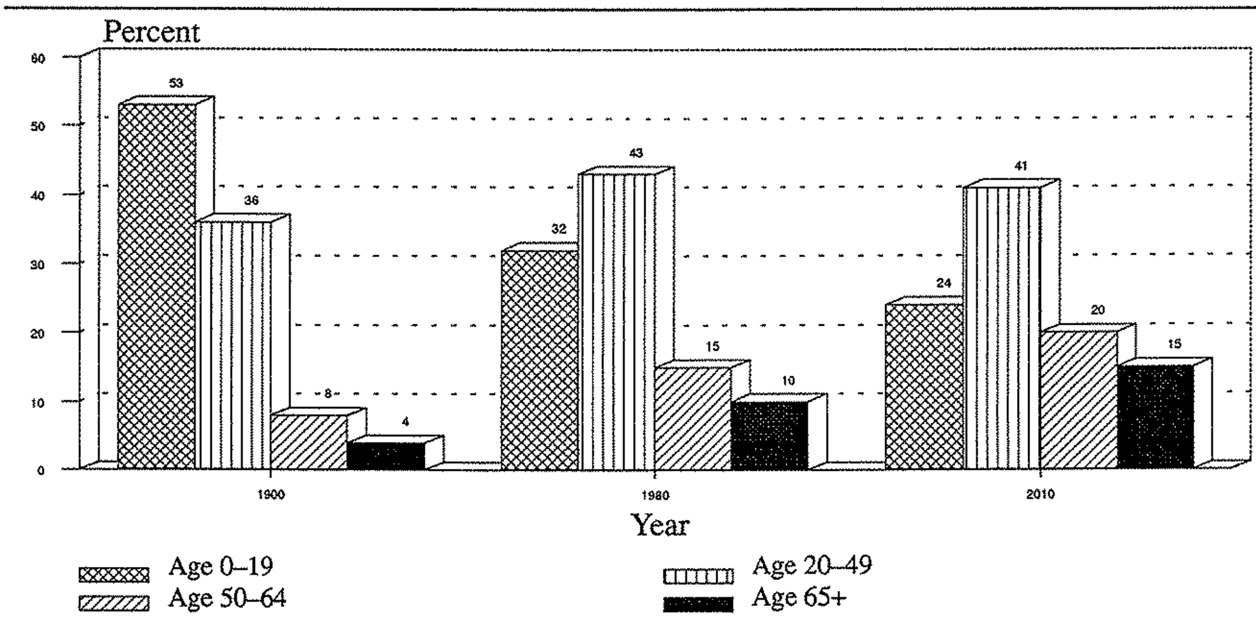
Service Needs in North Carolina

Decisions on who will receive case-managed home and community care need to be made in light of a general understanding of the long-term care needs of North Carolina's growing elderly

population. In 1980 North Carolina ranked only thirty-fifth among the 50 states in the percentage of its population 65 or over. However during the period 1970 to 1980, North Carolina experienced a growth rate in the population 65 or over that was the eighth fastest nationwide. The aging of the state's population is part of an ongoing historical trend, which is illustrated in figure 2. In the year 1900, 53 percent of the state's population was under the age of 19 and only 4 percent over the age of 65. By the year 2010, little more than two decades away, the percentage of the population who are young will have decreased to 24 percent and the percentage that are older will have increased to 15 percent.

Figure 2

**Distribution of Population,
North Carolina 1900, 1980, and 2010**



While the growth of the older population, in general, has significant implications for the demand for health and social services, it is the growth of the oldest segment of the population, those over 85, that is most significant. In fact, the fastest growing segment of North Carolina's overall population are those in that age cohort. The projected increase in the overall state population between the years 1980 and 2000 has been estimated at 19 percent. This compares to an estimated growth rate, during the same period, for the 65 or older population of 56 percent and a growth rate for those 85 or older of 128 percent. Figure 3 captures the actual and projected growth for North Carolina's "oldest old." Note that the number of those 85 and older in North Carolina will more than double in the 20 year period from 1990 and 2010, increasing from 74,034 to 168,028.

The importance of the growth of the elderly population for projecting future needs for health and social services can be found in measures of physical and mental impairments associated with aging. While aging is not to be equated with impairment or need per se, the incidence of impairments in self-care activities does increase with age. Figure 4 shows estimates of the incidence of physical impairment in personal care activities and mobility associated with advancing age in North Carolina's elderly population (methodology by Unger and Weissert, 1983).

Figure 3

Actual and Projected Increase in the Population 85 Years and Older

North Carolina, 1900—2010

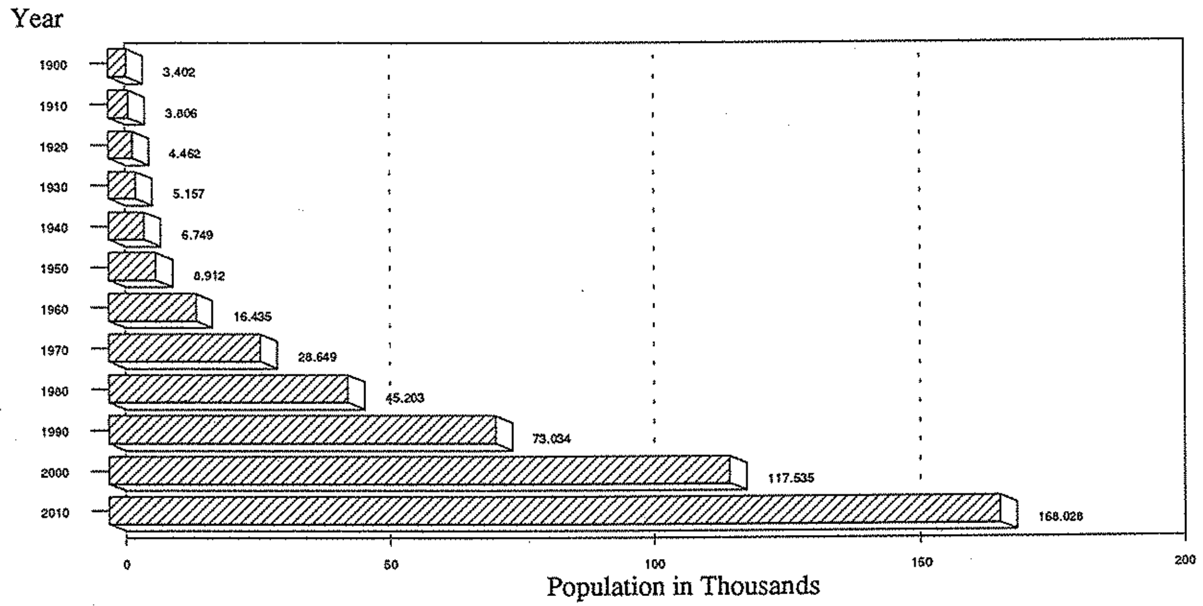
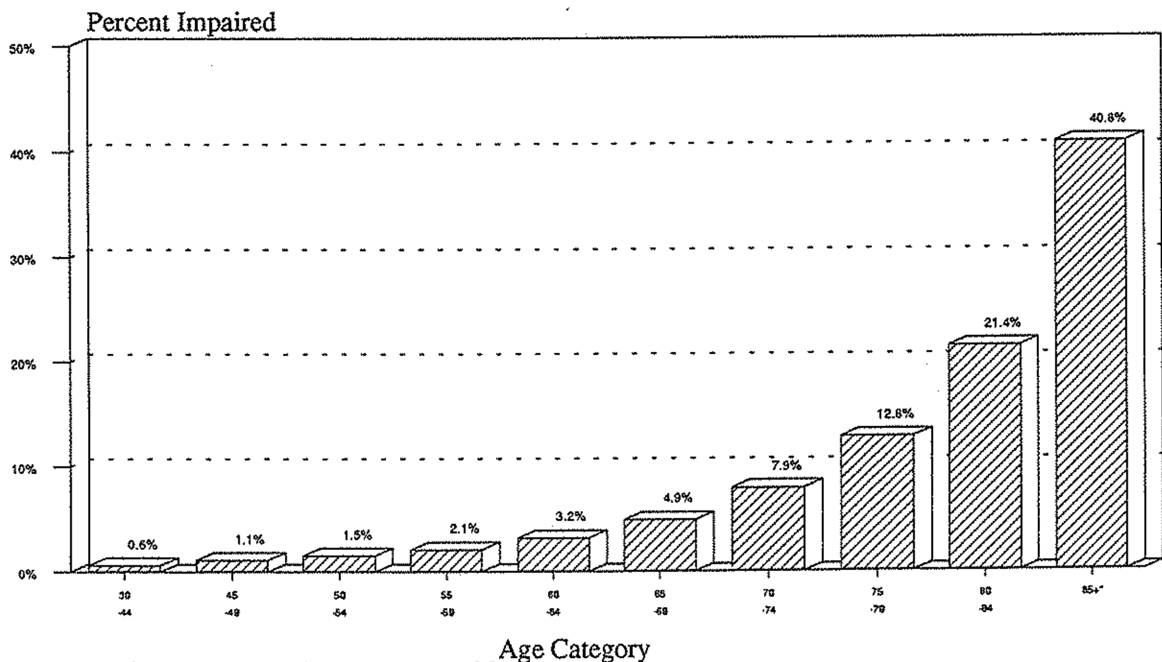


Figure 4

Estimated Rate of Functional and Mobility Impairment, by Age Group



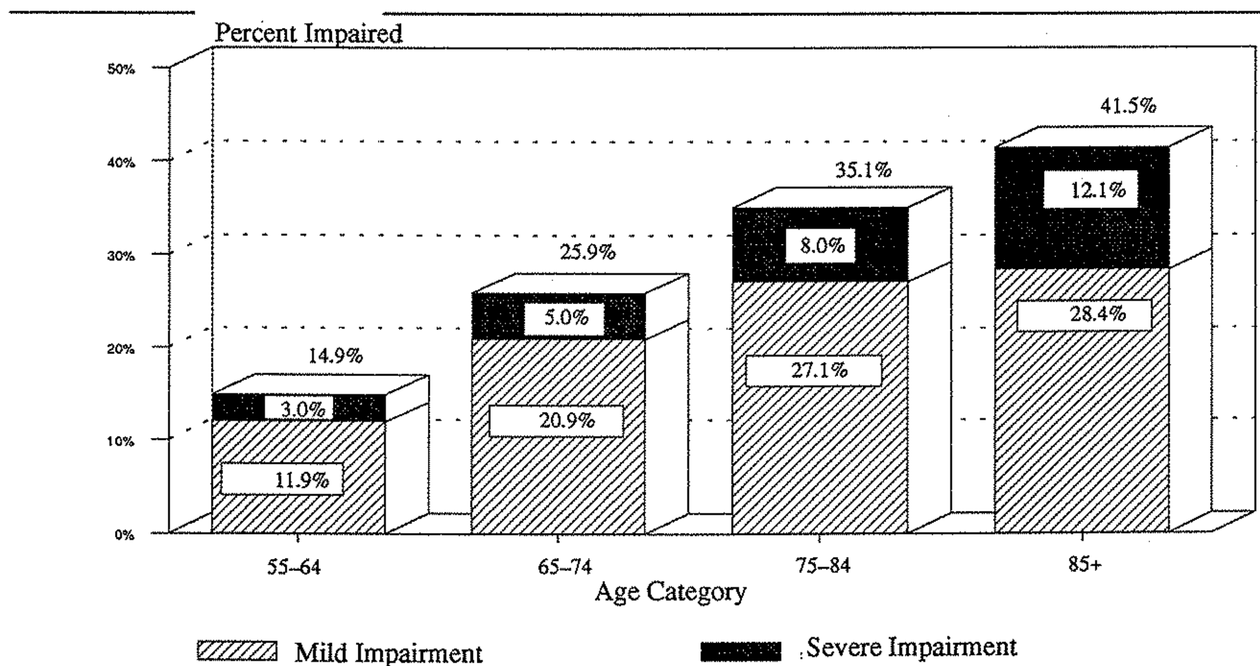
* Assumes 90 as a midpoint for open interval 85+

Methodology by Unger and Weissert, 1983

Impairments in mental status, particularly cognitive impairment, are also strong indicators of need for home and community care services. The most widely heralded cause of cognitive impairment is Alzheimer's disease, which destroys the mental capabilities of the victim and wreaks havoc on family caregivers. The incidence of cognitive impairment, Alzheimer's and other types, increases with age. A Duke University survey of elderly individuals in five North Carolina counties, known as the Piedmont ECA Study, revealed an incidence of mild to severe cognitive impairment increasing from 14.9 percent for those 55 to 64, to 35.1 percent for those 75 to 84, and reaching a high of 41.5 percent for those 85 and older (George et al., 1988). (See figure 5.)

Figure 5

Prevalence of Cognitive Impairment by Age, in Five North Carolina Counties



Linda George et al., 1988

An additional indicator of need for case-managed home and community care services is poverty. The poor and near poor are at greater risk for nursing home placement than the better off elderly (Barney, 1973; Vincente, Wiley, and Carrington, 1979; and Butler and Newacheck, 1981). Wealthier individuals are seen as being better able to secure privately the needed home and community care services, thereby preventing or delaying institutionalization. Economic resources and the associated ability to maintain housing, pay for medications, and obtain necessary supportive services to offset the disabilities of old age are important determinants of whether or not the individual will be able to remain in the community.

In North Carolina, the incidence of poverty among those over the age of 65 stands at 24 percent, nearly double the national average of 14 percent. The incidence of poverty also varies according to different subsets of the elderly population. Poverty rates for North Carolina's older adults range from a low of 20 percent among whites, to 38.2 percent for all rural elderly, to 41 percent for blacks (see figure 6). In the population most likely to be at risk of nursing home placement and in need of

case-managed home and community care services—those 75 or over who are living alone—the statewide poverty rate in 1980 stood at 48 percent. Poverty rates for this population vary dramatically from county to county, with 29 of North Carolina's 100 counties experiencing poverty rates exceeding 70 percent for those 75 and over and living alone. (See figure 7.)

Figure 6

Poverty Rate by Race for People over 65, North Carolina, 1979 Income

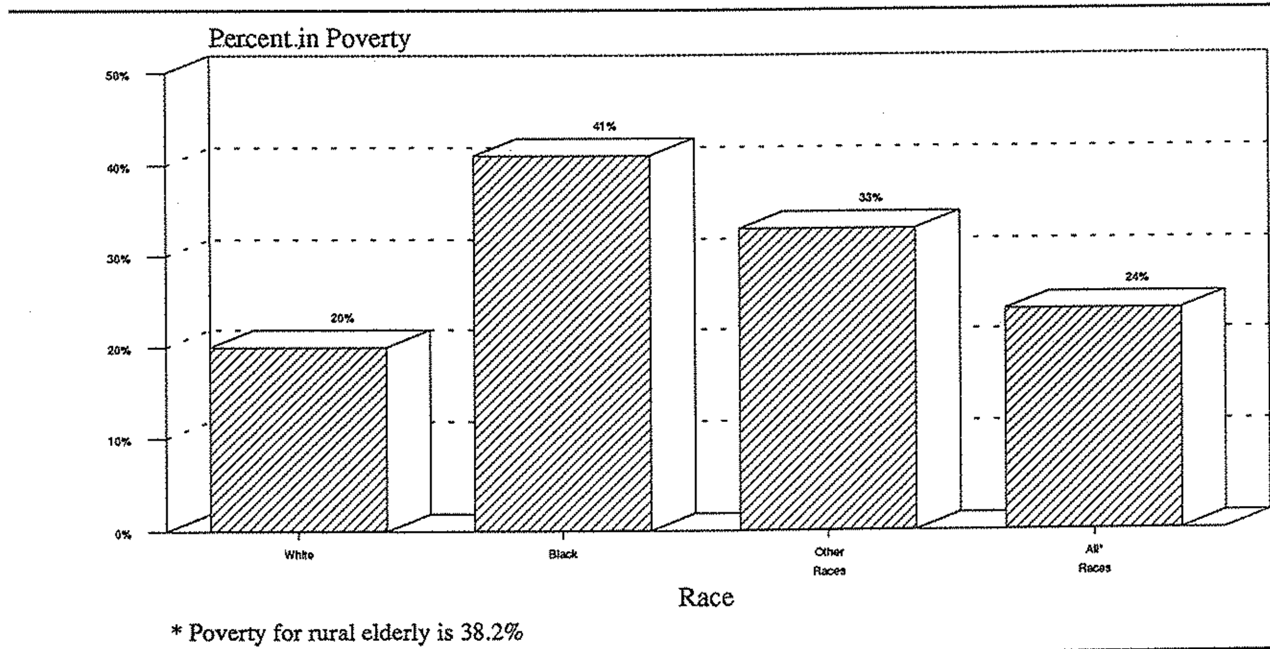
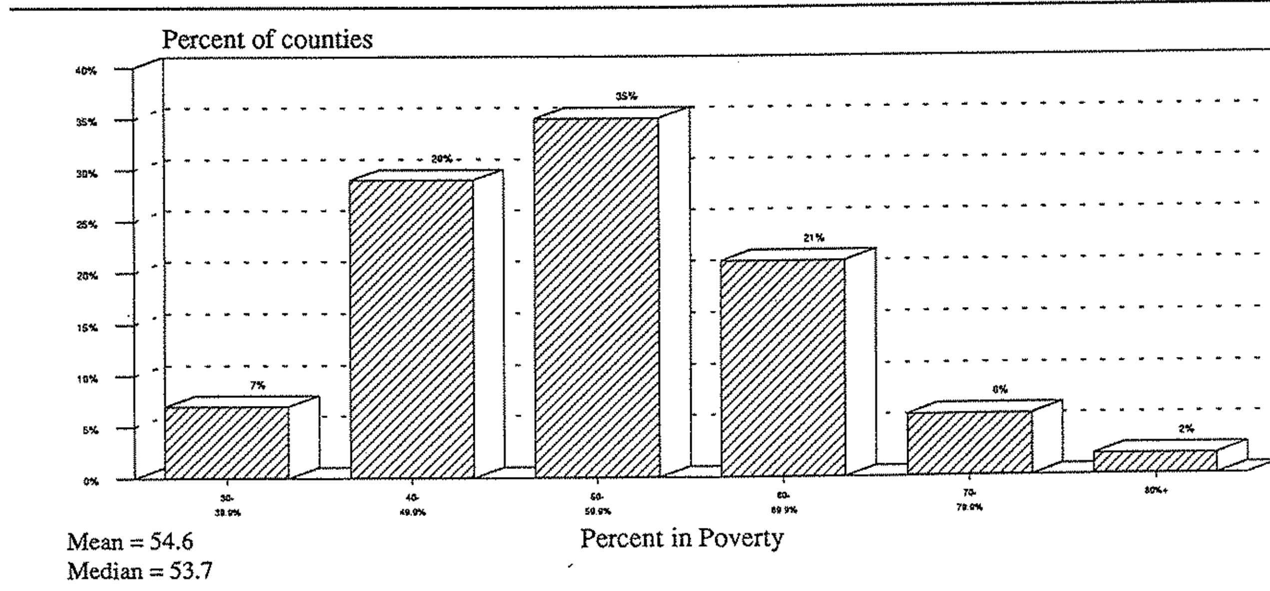


Figure 7

County Distribution of 1979 Poverty Rates for People 75 Years and Older Who Live Alone



State Service Targeting Options

In designing community-based care systems, states are exercising a number of similar policy options in targeting services to the elderly. These options generally fall into three areas: 1) financial eligibility; 2) functional eligibility; and 3) preadmission screening programs for nursing home care (NGA, 1988: 67). In the context of this analysis, targeting decisions are integral components of any statewide case-managed home and community care system.

Financial Eligibility.

Financial eligibility criteria reflect policy choices based on perceptions of the state's responsibility to finance long-term care services; decisions as to whether to create a system that can be accessed by older persons in need, with higher-income persons paying a larger share or all of their support costs; and the amount of state resources available to support such a system coupled with the estimated degree of unmet need for these services (NGA, 1988). Determination of financial eligibility is a major policy tool used by states to give priority to those segments of the population felt to be most in need of subsidized home and community care. The targeting decisions of the states we studied were shaped in part by their endorsement of three basic goals: 1) strengthening the families' ability to care for the elderly; 2) expanding services to moderate-income individuals through partially subsidized care; and 3) financing care for low-income individuals. Table 1 depicts the financial eligibility criteria for the principal programs that fund long-term care in these states.

Table 1

Individual Monthly Financial Eligibility Criteria for Selected Long-Term Care Funding Sources, in Dollars (1987)

State	Medicaid Categorical Eligibility	Medicaid Medically Needy	Medicaid Waiver	SSBG	OAA	State Funds
Arkansas	370	108	na	779	wri	573
Illinois (varies)	267	292	na	wri	na	
Maine	412	336	340	dk	wri	na
Massachusetts	488	455	485	dk	wri	1,000
Maryland	360	334	na	1,230	wri	1,323
Oregon	360	355	342	na	wri	na
South Carolina	360	na	340	dk	wri	*
Washington	388	368	368	dk	wri	dk
Wisconsin	462	442	442	789	wri	na

wri: Without regard to income
dk: Do not know–staff was unable to learn
na: Not Applicable
* Financial eligibility figures are not reported for the AAA project, but only for the Waiver project.

Among the states whose programs we reviewed for this study, there has been no real debate over whether or not services should be provided on the basis of ability to pay. Rather, the question has been how to translate this decision into operational program policy. In answering this question, Wisconsin has taken a unique approach. That state has demonstrated an explicit commitment to extending access to case management and long-term care services beyond the poor to include private clients. This is accomplished by providing assessments and care planning free of charge to all functionally impaired individuals as a public entitlement, with direct services provided on a sliding scale basis.

State approaches to setting income eligibility criteria vary depending on the characteristics of the population to be served and the state's ability to finance that care. States like North Carolina, with higher proportions of low-income persons, are faced with greater unmet needs and realistic barriers to expanding access to services beyond the poor. Arkansas, 28 percent of whose older population lives in poverty, has chosen to focus its energies primarily on serving the low-income elderly through a program funded by Medicaid. By contrast, Massachusetts, through its largely state-funded Home Care Program, has extended entitlements to functionally impaired individuals up to a financial income ceiling of $18,000 for an elderly couple.

In struggling to extend service eligibility, states have adopted a number of common strategies that reflect the following principles: cost sharing has been favored over eligibility cut-offs and continuous financial eligibility criteria have been constructed from one program to the next to maximize available resources for home and community care.

Cost-sharing policies have been favored by state officials for a number of reasons. First, such policies can give visible priority to low-income persons by establishing a floor below which services will be fully subsidized but above which persons with moderate incomes may access services through cost sharing. Secondly, cost sharing through sliding fee scales counters the negative image that welfare evokes in many older Americans. Third, this policy makes individuals more aware of the expense of services by having them share in offsetting the true costs. This principle is in direct contrast to Medicaid rules that make income eligibility an all-or-nothing proposition, under which participants must either be poor to start with or spend down and relinquish all their resources before becoming eligible for services (NGA, 1988).

The other principle that characterizes state efforts to develop case-managed home and community care programs has been the attempt to link financial eligibility cut-offs in such a way that when one program's income ceiling is reached another begins. The foundation or starting point in this approach is Medicaid, which serves the poorest clients, followed by Social Service Block Grant funds, the Older Americans Act, and state-generated revenues.

Policy choices under Medicaid are yet more difficult for states like North Carolina that have high poverty rates among the elderly and low participation rates in Medicaid due to stringent eligibility criteria. The annual income eligibility criteria for aged, blind, and disabled Medicaid recipients in North Carolina in 1987 was set at $2,800 for an individual and $3,600 for a couple. Individual resource and asset tests were set at $1,500 for an individual and $2,250 for a couple. Federal regulations allow states either to accept as categorically needy all individuals found eligible for the Supplemental Security Income (SSI) program or to set eligibility criteria that are even more restrictive than SSI standards. North Carolina has chosen the more restrictive option, making it a "209(b)" state, so called for the regulatory citation explaining the option. North Carolina also

possesses a Section 2176 Waiver (CAP/DA). The CAP/DA Medicaid Waiver funds services to allow adults (age 18 and older) who qualify for either skilled or intermediate nursing home care to remain in the community. The CAP/DA program is currently operational in 41 of North Carolina's 100 counties. CAP/DA financial eligibility guidelines are somewhat more liberal than for Medicaid outside this program.

In the future North Carolina may choose from a number of options under its Medicaid program to increase the access of the elderly poor to home and community care. The option with the most far-reaching effects would be the elimination of the 209(b) provision, thereby making all elderly individuals who qualify for SSI categorically eligible for Medicaid. This decision, however, is complicated by the fact that it would expand not only the financial eligibility for the elderly poor, but of all poor individuals in North Carolina. If a state expands eligibility by eliminating the 209(b) provision for the elderly, it must also do so for those who receive Aid to Families with Dependent Children (AFDC).

Other options includes a more purposeful use of Social Services Block Grant (SSBG) and Older American Act (OAA) funds. SSBG funds for the elderly are administered primarily by the North Carolina Division of Social Services through the affiliated Adult Services Programs in county Departments of Social Services. Historically, SSBG funds have been targeted to support the social services needs of low-income individuals. Current guidelines allow for flexibility in extending services to moderate-income individuals. In fact, a limited number of counties are using SSBG resources to provide services without regard to income.

Older American Act resources, administered by the North Carolina Division of Aging through its regional Area Agencies on Aging, are not means-tested. One funding option would be to pool the available SSBG and OAA resources through a case-managed home and community care program at the county level for individuals who qualify for these services but do not qualify for those funded by Medicaid.

In reality, however, both OAA and SSBG funds are limited federal appropriations, and there is little anticipation of increased federal funding. State funds are obviously essential to any expansion of service eligibility for the poor elderly, either through an increase in state Medicaid matching funds or an expansion of services to low- and moderate-income elderly through a combination of SSBG, OAA, and state resources.

Functional Eligibility.

Functional eligibility criteria pertain largely to the assessment of client limitations in activities of daily living such as bathing, dressing, and eating. States vary in how focused their functional targeting criteria are (see table 2). The majority of states with model community long-term care programs have focused on targeting services to individuals with functional impairments at least equivalent to those impairment levels which would qualify them for nursing home care. By tying service targeting to its preadmission nursing home screening program, South Carolina reaches a narrow population, one most likely to represent a true substitute for nursing home care. At the other end of the spectrum, Massachusetts targets individuals with two or more functional impairments in activities of daily living. These broader criteria extend services to more people, some of whom

would not necessarily seek nursing home placement. Wisconsin targets services to individuals who qualify for nursing home care and those afflicted with Alzheimer's disease or other severe chronic mental illnesses.

Nevertheless, most states, including Massachusetts, have in recent years moved to tighten their targeting criteria to reach only individuals at risk of nursing home placement. The closer the fit between characteristics of a community and home care population and those of a nursing home population, the greater the likelihood of substituting less expensive home care for more expensive nursing home care and the greater the short-run likelihood of containing costs.

Table 2

Service Targeting and Functional Eligibility

State	Functional Eligibility Requirements
Arkansas	Individuals at risk of nursing home placement (Medicaid personal care services)
Illinois	Individuals who qualify for nursing home admission
Maine	Individuals who qualify for nursing home admission
Massachusetts	Individuals with two or more ADL impairments
Maryland	Both those who qualify for nursing home admission and those with less significant functional impairments
Oregon	Individuals who qualify for nursing home admission
South Carolina	Individuals who qualify for nursing home admission (1 ADL impairment and 1 condition or need for technological assistance requiring skilled care or 2 ADL impairments)
Washington	All Waiver clients and substantiated protective services clients over 60 years old in state—local option may extend case management to other vulnerable older adults.
Wisconsin	Individuals who qualify for nursing home admission and those with Alzheimer's disease or other severe chronic mental illnesses.

Several points characterize the way in which these states determine functional eligibility. First, most states have developed standardized assessments. Oregon, Illinois, and New York have developed the most specific measures—their assessments are structured to produce a numerical score for determining eligibility cut-offs. Wisconsin also uses a standardized screening instrument to determine program eligibility, rather than an assessment. Once program eligibility is established, another assessment is used to develop individual care plans. This screening also helps to identify

individuals who might best be helped by information and referral as well as those requiring further and more detailed assessment.

Standardized screenings and assessments are seen as important tools for making equitable, targeted judgments on program eligibility and care plan service needs. As such, standardized screens and assessments are seen as important to containing overall program costs through a systematic rationing of scarce public long-term care resources. All those states studied with model home and community care programs, with the exception of Wisconsin, used a standardized assessment tool to determine eligibility for most services. Wisconsin, while not using a standardized assessment, does specify criteria by which local counties are to develop their assessment tools and it has a standardized screening protocol to determine program eligibility as well as an assessment to develop care plans.

States use both social workers and nurses in the performance of assessments and ongoing case management functions. The more frequent practice appears to be to use social workers for assessments and case management functions and to involve nurses more often for consultation regarding the physical health needs of clients, particularly in cases where the client has significant medical needs. Illinois, Maryland, Massachusetts, and Oregon allow assessments to be performed solely by social workers. Arkansas, which relies solely on the Medicaid personal care funding sources, uses registered nurses rather than social workers, due in part to the more medical orientation of Medicaid. Wisconsin and South Carolina use a social worker/nurse team for purposes of assessment and case management. Massachusetts is looking increasingly to the use of nurse consultation in cases where there is more medical involvement; and Washington provides for consultation with nurses and other health professionals.Table 3 summarizes state assessment practices.

Table 3

State Assessment Practices

State	Standardized Assessments	Assessment Staffing
Arkansas	Yes	Nurse
Illinois	Yes	Social Worker
Maine	Yes	Social Worker (RN reviews)
Massachusetts	Yes	Social Worker
Maryland	Yes	Social Worker
Oregon	Yes	Social Worker
South Carolina	Yes	Nurse/Social Worker team*
Washington	Yes	Case Worker**
Wisconsin	Modified	Nurse/Social Worker team

* Statewide program uses team, AAA project uses either individually in routine cases.

** Requires a BA in social work, gerontology, counseling, or related field and 2 years of experience in human services.

Preadmission Screening Programs.

Preadmission screening programs are designed to ascertain the appropriateness of individuals for nursing home care. These programs have been extended to clients seeking nursing home placement from both the hospital as well as from the community. Active education programs are needed in these instances to ensure the cooperation of physicians and hospital discharge planners. Preadmission programs are seen as vital components of state community care systems, linking individuals seeking nursing home care to alternative home and community care services. Again the linkage of case-managed home and community care programs to preadmission screening policies increases the overall cost-effectiveness of the effort by promising a higher rate of substitution of community for institutional care.

Admission decisions may be binding or advisory and may be limited to Medicaid participants or extended to individuals who may be eligible for Medicaid within 60, 90, or 180 days of nursing home placement. The majority of states with model home and community care programs have preadmission screening programs, although the characteristics of these programs vary. Oregon is an example of a state that has used preadmission screening as an important part of its overall home and community care effort. Oregon's preadmission program is targeted at those who are eligible for Medicaid or will be so within 90 days. Mandatory participation results in binding decisions on placement. Oregon's case managers also actively work with individuals already in nursing homes under a program to facilitate their return to the community care programs.

Home and Community Care Services

The policy dimension involving services raises the question of the type and quantity of services needed for an effective case-managed home and community care program. A case management program in which the supply of basic services is inadequate will not be able to meet the challenge of assuring elderly individuals alternatives to hospital and institutional care. The development of a comprehensive case-managed home and community care program calls for decisions regarding both the type and supply of basic aging services available throughout North Carolina's 100 counties.

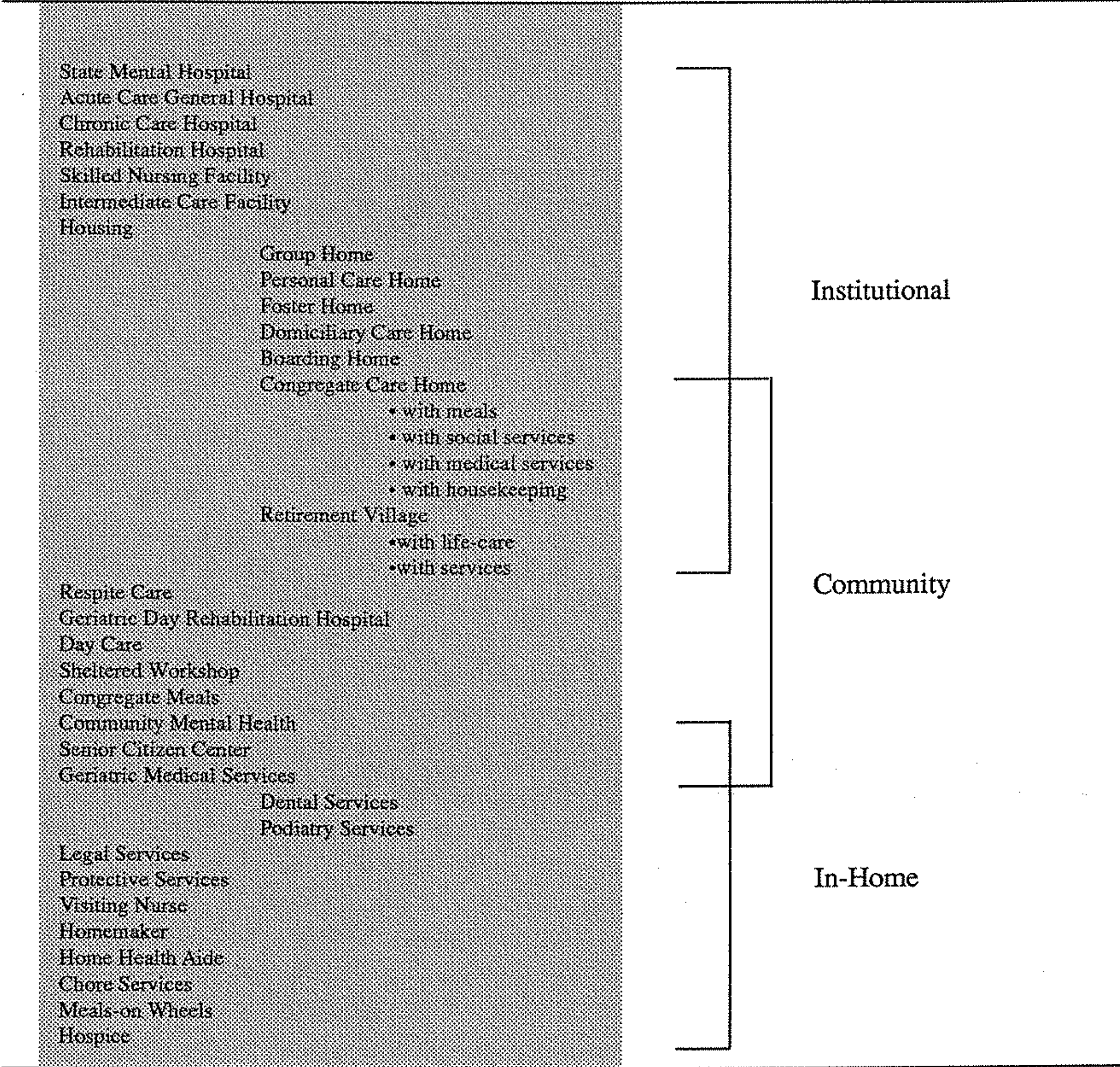
Services in North Carolina's Continuum of Long-Term Care

Many elderly individuals will, over their life-time, need different types of services and levels of care that can be presented as a continuum. Levels of care along this continuum can generally be grouped into three categories. Institutional care, the most restrictive level, can include placement in a state psychiatric hospital, an acute care hospital, a skilled or intermediate nursing home, or a domiciliary/rest home facility. Community-based care includes services offered to elderly individuals in settings outside the home: senior centers, adult day care programs, and community mental health centers, among others. In-home care involves those services offered in the least restrictive setting, the individual's home. Common types of in-home services include homemaker and chore services, home health aide services, personal care, and meals-on-wheels. A glossary of service terms is included in Attachment A of this document.

Figure 8 shows one version of the continuum of long-term care. Case management, in that it involves the assessment of clients' needs, seeks to ensure that the elderly individual receives services at the appropriate level of care. In that it includes an ongoing monitoring of care, case management also involves the reassessment of clients' needs to assist them to move among the different levels of care as their needs change.

Figure 8

The Continuum of Long-Term Care



Institutional Services

The major institutional settings where services are offered to North Carolina's elderly population include state psychiatric hospitals, acute care general hospitals, and skilled and intermediate nursing

homes. Settings that overlap the more restrictive definition of institutional care and less restrictive notion of community-based care include domiciliary care (rest homes), life care retirement communities, and publicly assisted housing.

There are currently four state-operated psychiatric facilities in North Carolina. In decades past, the elderly census in state hospitals has been much higher. With the advent of the deinstitutionalization, many elderly individuals have ended up either in nursing homes, rest homes, or the community. In fiscal year 1986, there were approximately 1,448 individuals over the age of 65 in the state's four psychiatric hospitals. The elderly comprised 26.6 percent of all persons served in state hospitals during that period. A smaller number of people over 65 were served in the state's five mental retardation centers (88), three alcohol rehabilitation centers (73), and the North Carolina Special Care Center (148) in that year.

A census of the utilization of the state's acute care hospitals by the elderly is harder to obtain. However, an analysis of national research on days of hospital use and hospital discharges shows dramatic increases with age. Kane and Kane (1987) found that days of hospital care per 1,000 persons per year increase from 1,461 for individuals ages 45 to 64 to 6,798 for individuals 85 and older. Similarly, annual hospital discharges per 1,000 persons increase from 192 for individuals ages 45 to 64 to 615 for individuals 85 and older. Expected increases in the use of acute care hospitals by the elderly over the next two decades are significant in the nation as a whole, and the increases for North Carolina are likely to be even more substantial. While nationally it is estimated that there will be an 11 percent increase in hospital days of care for the elderly, the expected rate of increase for North Carolina (24 percent) is double the national rate (U.S. Public Health Services, 1987).

In general, we find that the term "institutional care" most commonly refers to skilled and intermediate nursing home care. In 1988 there were 23,680 nursing home beds, and 11,432 skilled and 12,248 intermediate care beds, located in 241 homes spread across 86 North Carolina counties. The occupancy rate generally holds at around 90 percent, with nursing home beds being very difficult to come by in many North Carolina communities. New facilities are in varying stages of construction. The growth of North Carolina's elderly population signifies a potential for major increases in nursing home expenditures over the next several decades.

The terms "domiciliary care" and "rest home" are often used interchangeably in North Carolina. Rest homes are generally seen as service alternatives for individuals who are no longer able to remain in the community without supervision but are not impaired enough to need nursing home care. Rest homes in North Carolina include homes for developmentally disabled adults, family care homes, and homes for the aged. Homes for the developmentally disabled are targeted to adults over the age of 18, but not specifically the elderly, whereas family care homes and homes for the aged serve a predominantly elderly population. In 1988 there were 20,893 domiciliary care beds in North Carolina (17,528 beds in homes for the aged and 3,365 beds in family care homes). They are spread throughout 1,105 different homes in 96 North Carolina counties. The occupancy rate averages around 85 percent.

Other settings that do not fit the strict definition of institutional care but do offer housing outside of the usual living arrangements for older adults include publicly assisted housing and life care retirement facilities. Public housing facilities in the state are faced with a population that has aged in place and is increasingly in need of long-term care services to remain in the community. In 1980 there were an estimated 20,269 public housing units for the elderly and handicapped in North Carolina. (A separate, age-specific count of these public units is not available.)

In recent years, North Carolina has also experienced a growth in life care retirement communities. Many such communities offer a package arrangement of social and health services, as well as housing, for the remainder of the individual's life. In 1988 there were 19 life care retirement facilities in North Carolina, with the potential of serving 2,328 individuals.

Community-Based Services

Community-based services are those offered outside the home or in an institutional setting. The primary and perhaps best-known examples of such services are adult day care, out-of-home respite, community mental health services, and senior centers. Adult day care is a term applied to a variety of programs that offer a range of services in a congregate setting to functionally impaired and/or isolated individuals. Adult day care may follow day-health or social-care models, with health models emphasizing more active programs of physical and mental rehabilitation. Adult day-care programs in North Carolina are at present quite limited. There are approximately 60 programs currently operating, serving an estimated 1,429 adults in 37 of North Carolina's counties. Most adult day-care programs are funded through County Departments of Social Services.

Respite care is a service that allows the provision of relief for family members engaged in the care of an elderly disabled individual. Respite care can be offered in two basic forms, out-of-home ("institutional") respite and in-home respite. Data on the provision of institutional respite care services in North Carolina is presently unavailable. Institutional respite care can be financed through the state's Medicaid Waiver program. In such instances, a nursing home may set aside a bed for institutional respite for an elderly person as a way of providing a few days of relief for family caregivers. Where they have been developed, institutional respite services may also be secured privately by individuals who can afford them.

North Carolina has 41 area Community Mental Health Centers covering the state's 100 counties. As in other states, the elderly's access to utilization of community mental health services is limited. In fiscal year 1986, only 4.1 percent of all persons served by the area programs were over age 65, some 3,037 clients. Only one program, the Caswell-Alamance Community Mental Health Center, had a specialized service unit for the elderly.

Another major community-based program for the elderly in North Carolina is its senior center program. In 1988, there were 110 senior centers spread across 90 counties (Aging Policy Plan, 1988). Senior centers often serve as community focal points for services ranging from information and referral to a broad array of recreation and supportive community services. Major funding sources for the state's senior centers have been the Older Americans Act and, more recently, the state of North Carolina through its general funds. OAA resources are administered by the state Division of Aging and its regional Area Agencies on Aging.

In-Home Services

The primary in-home services offered in North Carolina include home health and hospice services, personal care services, chore and homemaker services, and in-home respite care. Additional services include, but are not limited to, transportation, home-delivered meals, and protective services. A major funding source for a comprehensive array of in-home services is the Medicaid Waiver Community Alternatives Program for Disabled Adults (CAP/DA). In addition to the regular Medicaid services, CAP/DA clients, who are primarily elderly, may receive screening/assessment,

case management, chore services, homemaker services, home mobility aides, home-delivered meals, respite, and telephone alert services. CAP/DA served approximately 1,500 individuals in 41 North Carolina counties in fiscal year 1987.

Home health services are provided to North Carolina's elderly through both Medicare and Medicaid. In 1988, there were 120 Medicare-certified home health agencies operating in North Carolina. An unknown number of uncertified home health agencies also provide services. Approximately 70 percent of the Medicare home health population is over age 65. County Health Departments are also provide home health services, primarily to the low-income elderly. Currently there are 70 Medicare-certified hospice programs providing services for the terminally ill in North Carolina. In early 1988, Medicaid also began reimbursing hospice services.

The provision of personal care services under Medicaid began in January 1986. Personal care services are those which assist the disabled individual in the performance of medically necessary personal care activities of daily living. Chore and homemaker services are provided to the elderly through the Social Services Block Grant (SSBG) administered by county Departments of Social Services, and under the Older Americans Act through the state's Area Agencies on Aging. Chore and homemaker services are services to assist disabled individuals in the performance of activities of daily living that are not connected to a medical condition.

In-home respite services are optional for county Departments of Social Services under SSBG funding. Area Agencies on Aging fund in-home respite services through Older Americans Act and state-generated funds. Additional services such as transportation and home delivered meals are supported by both the AAA and the county Departments of Social Services through OAA, SSBG, and Medicaid funds.

The distribution of home health, hospice, and key in-home services across North Carolina's 100 counties has not been analyzed. Current data on these various services is difficult to come by and is untabulated. The perceptions of service providers and advocates for the elderly suggest that such services are generally more available to older people in the more affluent urban counties and unavailable or insufficient in the poorer, more rural counties in the state.

State Service Options: Case-Managed Home and Community Care

Turning to examine what other states have done in this area, we see that a number of those states which have developed case-managed home and community care programs have attempted to increase access to services through the establishment of single entry points. Many states have also attempted to instill equity into the receipt of services through the standardization of client assessments and the specification of explicit financial eligibility criteria within a model of case-managed care. Although assessment and eligibility are standardized, diversity and informality have been stressed in service delivery. States have also stressed the development of nonmedical services to address chronic long-term care needs, leaving the provision of skilled home health services and primary or acute care for long-term clients to Medicare and Medicaid-funded physician services, hospitals, nursing homes, or home health agencies (NGA, 1988).

In developing comprehensive systems of home and community care for the disabled elderly, these states have purposefully opted for personalized, nonmedical services to meet individualized needs. With near uniformity, they have elected to support four major services in their home and community care programs. These services are: 1) case management; 2) in-home services; 3) adult

day care; and 4) services provided in alternative living arrangements. Table 4 portrays the major home and community care services for the states studied.

Table 4

Major Services Supported by States:
Home and Community Care Programs

State	Case Management	In-Home Services	Adult Day Care	Services in Alternative Living Arrangements?
Arkansas	Yes	Personal Care	Limited	Yes
Illinois	Yes	Housekeeping	Limited	dk
		Chore		
		Homemaker		
Maine	Yes	Personal Care	Demonstration	Yes
Massachusetts	Yes	Limited Homemaker	Yes	dk
Maryland	Yes	Personal Care	Major	Yes
		In-Home Aide	Emphasis	Yes
Oregon	Yes	Home Care	Limited	Yes
South Carolina	Yes	Personal Care	Yes	Limited
Washington	Yes	Personal Care	Limited	No
		Chore		
		Homemaker		
Wisconsin	Yes	Supportive Home Care	Limited	Yes

dk Do not know–staff was unable to learn.

Case Management

Case management is the chief technique employed to guide the use of public and private resources to support disabled elderly individuals in all nine states studied. While there is some variation, there is general agreement on the functions of case management in home and community care. Case management in the states under study includes screening and intake, assessment, care planning and service authorization, service monitoring, and reassessment and follow-up. There is significant support for involving families and other informal caregivers in the care planning process.

In-Home Services

In-home services such as personal care, chore, and homemaker services are the backbone of the emerging state home and community care programs. These largely nonprofessional social supports are central to meeting the nonmedical long-term needs of disabled elderly individuals. States deliver

home care services through agency providers, providers employed by clients, and family caregivers. Each method of delivery raises its own set of legal, philosophical, and quality-of-care issues. States that rely heavily on agency providers, as does Illinois, must address questions of agency selection and quality assurance procedures. States such as Oregon and Maine that rely on providers employed by the client have to contend with legal issues including the definition of what constitutes such a provider, laws governing the minimum wage, and the responsibilities of the employer and the client for payment of social security taxes and workers' compensation.

Issues of quality assurance become even more complicated in the instances where family members are paid as providers of in-home services. Oregon, Maine, Maryland, and Wisconsin rely on a combination of providers of in-home services including the payment of families as caregivers. The payment of family caregivers raises philosophical issues over using public resources to subsidize what are believed to be family obligations. In states where family caregivers are paid, such payment is often linked to financial hardships that result because family members have become caregivers and is the option of last resort.

Adult Day Care

Adult day care can serve as a respite service for family caregivers, a means for therapeutic treatment, an outlet for socialization, or some combination of all of these things. Perhaps because of its expense, it is one of the less-developed service alternatives in the states under review. While Illinois has promoted adult day care as a potential source of support for Alzheimer's victims and their families, only Maryland, among those states studied, has extensively developed this resource, using a combination of state general revenues and Medicaid. Start-up and development costs, which are often dependent on state revenues, serve to limit the availability of such programs. Economies of scale and the need for a stable source of ongoing financing point to the need to expand adult day care programs to include the participation of private clients who pay for services themselves.

Services in Alternative Living Arrangements

Some states have seen a need to develop linkages between home and community care programs and such alternative living arrangements as public housing and rest home/domiciliary care facilities. Public housing complexes are increasingly occupied by a disabled elderly population as the initial residents have aged in place. Nenno et al. (1986) have estimated that 24 percent of the nation's elderly residents in federally assisted housing were vulnerable to moving to more dependent facilities. Holshouser (1986) has in turn estimated that 9,000 elderly persons move to nursing homes each year from public housing. In examining residents in North Carolina's family care homes and homes for the aged, Nelson (1986) found that 28 percent were moderately to severely impaired in activities of daily living and 23 percent were suffering from dementia.

Both Maine and Maryland have developed active service programs for frail residents of public housing. Target populations are residents with moderate impairments. The same assessment tool that is used for community residents is used to determine need for residents in public housing. Oregon and Arkansas provide financial supplements for residential or domiciliary care facility operators for at-risk, disabled elderly residents. The supplements are used to secure necessary supportive services. Clients are responsible for paying for room and board costs.

Quality Assurance

Although none of the states studied have adopted Medicare's extensive quality assurance procedures for skilled home health care, all have implemented a number of practices to ensure quality home and community care services. These are a heavy reliance on case management as a mechanism for ensuring quality care, attempts to assess program performance, careful selection of providers, external quality assurance committees, and procedures for handling clients' grievances.

In their role as assessors of client need, care planners, and authorizers and monitors of services, case managers are perhaps the front line of quality assurance in home and community care programs. Well-trained case managers and clear case management procedures are essential to quality home and community care.

Several states are experimenting with performance measures of quality care. Oregon has ventured beyond process measures of quality to examine program performance based on outcome measures. In examining client care, a sample of clients is drawn annually for review. Case review is supplemented by interviews with clients in their own homes to determine whether appropriate services were authorized and whether or not the client was satisfied with those services. Illinois has moved to assess past program performances of competitively selected service providers as part of its quality assurance activities. Agency compliance reviews and documented complaints are compared and service history scores are developed to assist in the agency's selection process.

States have also moved to experiment with external quality assurance committees and client grievance procedures. Maine has required Area Agencies on Aging to develop a Quality Assurance Committee for its Home Based Care Program. Such committees are often headed by a home health agency and include state-mandated membership from the physician community, a nursing home representative, a hospital discharge planner, and an adult protective services manager. Annual reports are submitted to the Bureau of Maine's Elderly regarding the quality of the state's local program efforts. Other states have developed external grievance procedures. In most of these states, the long-term care ombudsman programs, which have the responsibility for complaints emanating from nursing homes and domiciliary care facilities, have had their responsibilities expanded to handle grievances and complaints associated with home and community care.

Delivery of Case-Managed Home and Community Care

In the United States, long-term care has been generally considered to refer to two types of services: institutional care, meaning primarily nursing home care, and "alternative" care, referring to home and community-based care. All services delivered in a nursing home are considered long-term. It might follow that those services characterized as alternatives to nursing home care should also be considered long-term care, assuming that individuals receiving them were bound for a nursing home. The problem is that such alternative long-term care services encompass a host of often discrete health, social service, and even housing programs (Kane and Kane, 1983). Such a diverse assortment of services includes adult day care, transportation assistance, multipurpose senior centers, chore and homemaker services, and congregate and home-delivered meals, to name only a few.

The administrative benefit of nursing home long-term care services is that they can be delivered under one roof. The administrative challenge associated with home and community long-term care services is that where such services exist, they are often scattered across neighborhoods, communities, counties or even regions of a state. The task of coordinating services for elderly individuals in nursing homes would seem infinitely easier than the task of coordinating services in the community, where individuals face differing service packages, eligibility criteria, and funding sources.

Case management is held out by some to be the way to bind together the fragmented home and community care "nonsystem." Yet in the absence of system reform, case management by itself cannot promise or deliver a system purged of major inefficiencies and absurdities. Accordingly, states that have begun to develop case-managed systems of home and community care have also focused on a combination of administrative policy changes and reforms. One very important set of reforms concerns state and local administrative delivery issues associated with the provision of case-managed home and community care. In a system of coördinated, comprehensive care for the elderly, case management is only one—albeit important—component of that system (NGA, 1988).

Major Features of Home and Community Care in North Carolina

To argue that home and community care programs for the elderly in North Carolina should be reformed is not the same as saying that nothing in the current system works. North Carolina has a long tradition of service-oriented county government, which has engendered a measure of creativity in social and health service programs at the local level. The strong county role in social and health service programming has also fostered a degree of accountability and responsiveness that is in keeping with the state's cultural and regional diversity. On the other hand, the strong county role and tradition in this area has at times made it difficult to establish specific social and health service minimums that would meet the needs of all citizens irrespective of county of origin. A very important factor in this regard is the widely divergent economic abilities of counties to launch and support needed services for their citizens.

North Carolina also has a history of service innovation in its Medicaid program. Despite, or perhaps as a counterweight to, the very restrictive Medicaid eligibility criteria, the Medicaid program in North Carolina has been innovative in its support of certain optional services for the disabled elderly. The operation of the CAP/DA program in 41 counties and the recent initiation of reimbursement for personal care services in 1986 are two very important services for the state's poor elderly.

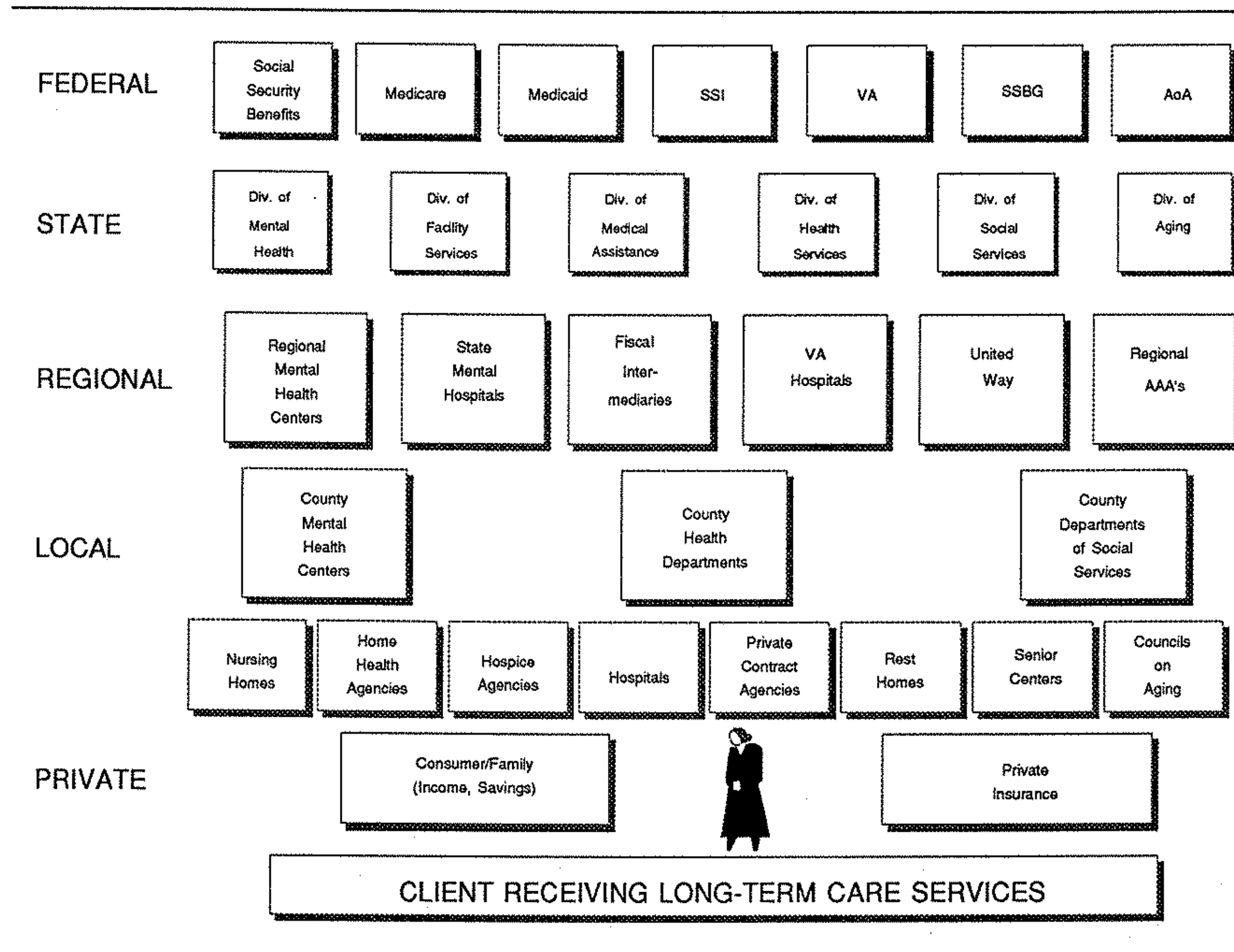
What is problematic about the state's delivery of home and community care services to the elderly is not unique to North Carolina. The fragmentation of services, the administrative overlap in programs, the gaps in coverage, and the general confusion among older adults and their families as to what services are available to meet their needs results in an organizational maze out of which only the hardiest or most fortunate emerge. These and other problems serve as barriers to many elderly individuals in North Carolina as they seek to access appropriate and affordable services.

While it is easy to bandy the terms "service fragmentation," "service gaps," and "duplication of services," it is more difficult to obtain a full understanding of how elderly consumers and their families experience the current home and community care system in North Carolina. With the exception of case anecdotes, research on the consumer's perspective on the current state of affairs is virtually nonexistent. Perhaps one way to identify the current difficulties with home and

community care is to examine the funding and service delivery maze that confronts older North Carolinians and to outline problems associated with that system. Figure 9 presents a thumbnail sketch of the major (not all) federal, state, and local programs in long-term care in North Carolina.

Figure 9

Funding/Delivery Maze for Long-Term Care Services



For purposes of condensation, and at the risk of simplification, the problems facing the disabled elderly and their families in the current system can be grouped into three areas: 1) problems in obtaining information about existing services; 2) access to appropriate and affordable care; and 3) confusing, sometimes parallel, sometimes overlapping systems of care.

How do the elderly and their families find their way to and through the array of programs and services shown in figure 9? In reality, many older people simply lack the necessary information about what services are available to them in the community. Family members, lawyers, physicians, and clergy, to whom the elderly individual may turn for information, are in many cases no better informed. When one examines the array of services involved in the delivery of some component of long-term care, it is not difficult to see why potential clients become confused. As discovered in research conducted by the American Association of Retired Persons, older adults are also often

woefully misinformed about their current entitlements, both through private insurance and Medicare. Many believe that Medicare or their private insurance will cover both their institutional and community long-term care needs when in fact such benefits are very limited.

Disabled older adults often learn about what is and is not available to them only by coming into direct contact with local agencies and providers. However, those currently aged 65 and over were not born in a generation that instilled a sense of entitlement, and they frequently have difficulty seeking help outside of the family. Therefore, in addition to the confusing maze of service programs and entitlements, there is often a predisposition on the part of these older adults against seeking help from public programs (Nuttbrock and Kosberg, 1980; O'Brien and Wagner, 1980).

Access to services is further complicated when potential clients find that each locality's service system is complex and often different from that of an adjoining locality, that services across programs are not standardized, that program eligibility criteria often conflict, that programs are often in a state of flux, and that services and resources are often in short supply. Access to appropriate services is also made difficult when programs focus on one of the client's needs and fail to recognize any others. An elderly disabled individual who is home-bound, depressed, and receiving chore services may also benefit from additional involvement with a mental health center, transportation, and participation in a senior center.

Programs and services in long-term care in North Carolina and elsewhere have been developed on a categorical basis, and funding has been secured for a discrete service or set or services for a particular categorical population. As pickets may eventually be joined to form a fence, these programs may eventually form a "system of care," but the individual programs are often uncoordinated—running parallel to one another, increasing the chance of duplication, and certainly contributing to confusion.

There are basically three major state divisions involved in the provision of home and community care in North Carolina. They are the Division of Social Services (through the local Adult Service programs in county Departments of Social Services), the Division of Aging (through its 18 regional Area Agencies on Aging), and the Division of Medical Assistance (through an array of Medicaid service providers). The most obvious parallel systems for the elderly in North Carolina are the Division of Aging, with its network of programs for the aging, and the Division of Social Services, with its county Adult Service programs. Each system operates a parallel network of home and community care services to an overlapping adult and elderly service constituency. Roughly 70 percent of all adult service clients are elderly. A majority of Medicaid CAP/DA programs are administered through county Departments of Social Services. Add county Home Health Departments, hospital discharge planners, Community Mental Health Centers, private and nonprofit home health services, and hospice programs, and the confusion becomes overwhelming.

State and Local Service Delivery Options

How programs are organized at the local level is related to how programs and responsibilities are allocated at the state level. Responsibility and authority for the delivery of home and community care services is currently scattered among the different players in North Carolina's long-term care network. The challenge to state and local officials is to find a way to integrate responsibility and authority for the administration and delivery of these programs at both state and local levels of government. "Ultimately, the goal of these coordination efforts is to create the continuum of care that each individual agency rhetorically has embraced but cannot itself achieve" (NGA, 1988: 46).

Coordination of State Efforts

When they began to develop coordinated, case-managed home and community care program, planners in many states wished that they had the luxury of starting from scratch. Designing a coordinated care system involves putting together health, social services, services for the aging, and elements of the mental health service system. The major obstacle to a coordinated system is that these service organizations are already in place, with established histories and ways of doing business. Developing a coordinated, case-managed system of care at the local level involves changing the way business is conducted at the state level.

Most state and local agencies now involved in long-term care were developed originally to fulfill other agendas. This can be seen if we examine the initial mandates of the three major state-level human service agencies involved in long-term care in North Carolina and in other states: the Division of Medical Assistance, which administers Medicaid; the Division of Social Services, which administers Social Service Block Grant funds; and the Division of Aging, which administers Older Americans Act funds.

Medicaid was created initially to address the acute health care needs of low-income families. Public social service agencies have established track records in income maintenance, food-stamp programs for the poor, and service programs for individuals and their families, primarily child welfare programs. Older Americans Act programs originated with a broad mandate to advocate and serve all older Americans. Pushed by the dramatic aging of the population over the past decade, each system has had to devote increasing time to problems of long-term care, which has become a major issue for state and local governments.

States that have experimented with case-managed home and community care programs have struggled with a number of issues and challenges: 1) developing a planning mechanism to bring about a coordinated system of care; 2) striking an appropriate balance between institutional and home and community care; 3) designing a single delivery system supported by multiple funding sources; 4) developing eligibility criteria for individual programs to ensure equitable treatment of clients according to their needs and resources; and 5) achieving a flexible mix of home and community services (NGA, 1988). In the states under review, three models of state agency delivery structure have emerged in response: 1) a consolidated model of long-term care; 2) an umbrella model; and 3) a cabinet model (NGA, 1988: iii). Each model involves differing degrees of collaboration between participating state agencies. Table 5 shows which models the states we examined employ.

The most far-reaching model of policy reform in the area of long-term care administration is represented by the consolidated model. In this model, all responsibilities for long-term care, both institutional and community, are consolidated into a single-purpose agency. Oregon is the only state in the country to adopt this model. All long-term care expenditures are placed in one budget. Resource trade-offs and interactions between community-based and institutional care in this model become both visible and direct. Responsibilities for Medicaid long-term care services, both nursing homes and community waivers, Adult and Family Services from social services, OAA programs, and state-generated resources are placed within a single agency, the Senior Services Division of the Oregon Department of Human Resources.

The second model, an umbrella agency model, is less far-reaching, in that it involves some internal shifting of responsibilities and increased interdivision coordination. Five of the nine states we

reviewed had chosen this option, and in each the responsibility for managing long-term care programs were divided between the Division of Aging, the Division of Social Services, and the Medicaid agency. Wisconsin, with its history of decentralized state responsibility and strong service-oriented system of county government, is similar to North Carolina in many respects, and can serve as a good example of how this model works. Like most of the states we reviewed, Wisconsin developed a state-level planning body to assist in the coordination its long-term care efforts. It created a Long-Term Care Support Management Reference Group to deal with such design issues as service mixes, financial and functional eligibility, designation of lead agencies standards and procedures, and financing. Consequently Wisconsin developed a new Bureau of Long-Term Support to administer its Community Options Program and to serve as the state focal point for the coordination of all home and community care services.

The third model, a cabinet agency model, basically retains the status quo within the administrative structure but establishes some sort of interagency committee to facilitate coordination among separate programs. Illinois, Maryland, and South Carolina most closely approximate this model. Maryland's perhaps best typifies this model, which has many features in common with current practices in North Carolina. In Maryland, Social Services, Aging, and Medicaid are all equally involved in providing case-managed community care services—no single agency or funding source dominates the community care system. The National Governors' Association concluded that "Maryland's coordination problems seem to result from the strengths of three separate systems, each created for purposes other than delivering long-term care services to the elderly, and each anxious to maintain and expand their current role" (1988: 54).

Table 5

State Models of Long-Term Care

State	Consolidated Model	Umbrella Model	Cabinet Model
Arkansas		X	
Illinois			X
Maine		X	
Massachusetts		X	
Maryland			X
Oregon	X		
South Carolina			X
Washington		X	
Wisconsin		X	

Coordination of Local Efforts

Local agency delivery systems, like the state agencies that oversee them, were created for a number of purposes—long-term care services to the disabled elderly being only one responsibility. However, as mentioned earlier, the organization of home and community care services is even more

important at the local level because it is with these local agencies that the elderly come into contact. Access to services is complicated because older adults and/or their caregivers must learn about and contact multiple agencies in order to receive services for which they are eligible. Confusion at the local level mirrors any lack of integration and direction at the state level.

The major characteristic of service delivery reform at the local level among all the states studied is the designation of one local lead agency to be responsible for organizing and providing case-managed home and community care. However, the selection of such an agency in each local jurisdiction within a state does not mean that it will be the only agency to provide case management services. Rather, it means that the lead agency may either provide such services directly or be responsible for organizing and standardizing the provision of case-managed home and community care services through other related service providers.

The designation of lead local agencies is one of the most important and fiercely debated decisions associated with the reform of home and community care. The nine states that have developed systems of case-managed care have differed in their approaches to this selection process. However, all states have based their decisions on an assessment of the strengths and weaknesses of various lead agencies to carry out their assigned functions. Five of the states studied selected Area Agencies on Aging as lead agencies—Arkansas, Oregon, Maine, Massachusetts, and Washington. Massachusetts has set up Home Care Corporations in conjunction with its Area Agencies on Aging to deliver case-managed home and community care services. South Carolina's statewide program is under a Health and Human Services Finance Committee, but it has an additional demonstration project under a single Area Agency on Aging. Wisconsin and Maryland, states similar to North Carolina in having strong, service-oriented county governments, required that the lead agency be part of county government. The designation of specific county agencies was left to local officials. Wisconsin selected primarily county Departments of Social Services, while Maryland selected a mix of local agencies—Area Agencies on Aging, Social Services, and Health Departments. Illinois chose its local lead agencies through a competitive bid process. Table 6 shows the local lead agencies in those states we reviewed.

Responsibilities assigned to local lead agencies shared some attributes among the states examined. The one that all these states agreed upon was, again, the notion of a single lead agency. In discharging this responsibility, the lead agencies have uniformly performed the functions of case management, client assessments, and, in most states, administering preadmission screening programs. All states have attempted to separate the service authorization from service delivery functions. The ability to authorize services is seen as key to facilitating cooperation among local service providers.

Beyond these central functions, there are some important differences and variations in the roles assigned to lead agencies. For instance, those in Oregon and Illinois function under a highly centralized state system, whereas Wisconsin has designed a structure that allows for more discretion by county government in the management of home and community care services—the county Long-Term Care Planning Committees help set service priorities and facilitate the coordination among provider agencies. A number of states have also required that their local lead agencies develop long-term care plans to guide their efforts. Area Agencies on Aging in Maine have had to develop regional long-term care plans and hold public hearings before they could receive funds for home-based care. Such a planning function is very much in keeping with the traditional responsibilities of Area Agencies on Aging. Finally, Arkansas has taken an unusual direction in developing staff positions

of Community Resource Developers with its Area Agencies on Aging Home and Community Care Program. The concern in Arkansas has been for the need to develop needed new services in what is a largely rural and relatively poor state, whereas other states have more fully established service infrastructures.

Table 6

Local Case Management Lead Agencies

State	AAA/ DOA	DSS	Health Department	Other Department
Arkansas	X			
Illinois	Case Coordination Units			
Maine	X			
Massachusetts	X			
Maryland	X	X	X	
Oregon	X			
South Carolina	X			Health and Human Services Finance Commission
Washington	Local Division of Aging			
Wisconsin		X		

Financing of Case-Managed Home and Community Care

The financing of home and community care services for the elderly mirrors the complexity of the present service delivery system. The maze of funding sources parallels the range of different federal, state, and local programs. An examination of Wisconsin's home and community care program revealed 35 different federal, state, and local sources of financing for services to the elderly. However, while the financing sources are many, major funding sources for case-managed home and community care are few. States are faced with difficult choices about how to use current resources most efficiently and new resources optimally.

Financing Home and Community Care Services in North Carolina

The fragmentation in programs for the elderly makes it difficult to obtain a clear picture of current spending for this population. There is no unified budget for the elderly to track program and

spending priorities. Accordingly, what follows is a description of expenditures for the major state programs that affect the elderly. The major programs examined include the Division of Aging and its affiliated aging network programs; the Division of Health Services; the Division of Medical Assistance; the Division of Mental Health, Mental Retardation, and Substance Abuse Services; and the Division of Social Services. Additional programs and budget expenditures for the elderly can be found in other divisions and departments of state and local government such as facility services, transportation, housing services, and services for the blind. Spending priorities and levels in these programs are very difficult to identify. New spending and program initiatives under Senate Bill 1559 will be discussed in the section on new initiatives.

The Division of Aging provides funding and oversight for its 18 Area Agencies on Aging. AAAs conduct planning and administrative functions related to the needs of the elderly and the programs designed to serve them. In fiscal year 1987 the program budget for the Division of Aging was $23,543,796. Nutrition programs, both congregate and home-delivered meals, constituted the primary spending priority, accounting for $11,662,079 (50 percent of the entire program budget). Title III social service expenditures, which include home- and community-based services such as transportation, legal services, chore, homemaker, and home health services, followed at $8,312,304 (35 percent). The Title V Senior Employment Program in turn accounted for $1,787,800 (8 percent), followed by Title III planning and administration services at $1,445,850 (6 percent); nursing home ombudsmen projects at $285,763 (1 percent); and a special initiative on Alzheimer's Disease at $50,000.

The Adult Health Services Section of the Division of Health Services funds and provides oversight to adult health programs administered primarily through county health departments. The Adult Health Services Section administers two classes of programs, Adult Health Promotion and Disease Prevention Programs ($4,235,186) and Adult Health Care programs ($6,031,026). Adult Health Promotion includes health screening and risk reduction programs. Adult Health Care includes home health services, cancer control, kidney disease support, and migrant health. Total Adult Health Service Section programs amounted to $10,266,212 in fiscal 1987. Age-specific expenditure data on adult health programs is not collected, with two exceptions—cancer control and kidney disease.

The elderly would appear to be an important segment of the overall Adult Health Services population, and yet, with the possible exception of home health services, they would appear to account for a small segment of the overall Adult Health service expenditures. In the two programs for which age-specific expenditure data are available, older adults accounted for roughly 10 percent ($196,962) out of a total of $2,051,039 in expenditures for cancer control and kidney disease. It is not possible to estimate additional expenditures for the elderly associated with the remaining Adult Health service programs.

Through Medicaid, the Division of Medical Assistance accounts for the largest long-term care expenditures in the state. Whereas in fiscal 1987 people over 65 constituted approximately 11 percent of the state's population, in that year they accounted for 18.2 percent of Medicaid recipients and 36.1 percent of all Medicaid expenditures. Nursing home expenditures, supported primarily by Medicaid, increased by 426 percent in North Carolina during the period 1975-84. The national mean increase during this period was 149.4 percent for all states (NCSL, 1987).

An estimated $297,349,193 was spent on elderly Medicaid recipients in fiscal 1987. Of this amount, 79 percent went for institutional care, primarily in skilled and intermediate nursing homes. Approximately $14,814,326 went to home and community care services for the elderly, roughly 5 percent of all elderly Medicaid expenditures. The remaining Medicaid expenditures were directed largely to outpatient hospital care, physician services, and medications.

While institutional expenditures under Medicaid were 16 times as great as home and community care services, alternatives to institutional care have been increasing. Medicaid alternatives to nursing home care include personal care services, begun in 1986; home health; and Medicaid waiver CAP/DA services. By 1987 personal care expenditures had increased to $4.9 million, home health expenditures had increased 135 percent between 1985-87; and CAP/DA services had increased 400 percent since 1985, from $1.5 to $7.5 million.

The Division of Mental Health, Mental Retardation, and Substance Abuse Services provides a range of mental health services through state-operated facilities and through its 41 regional Community Mental Health Centers programs. In fiscal 1988, its budget for all ages amounted to $452,953,065, of which $323,637,400 (71 percent) was for facility-based services and $129,315,665 (29 percent) for community-based services (excluding expenditures for the Willie M. program).

Mental health expenditures for the elderly in fiscal 1988 were predominantly focused on institutional care, most specifically in state hospitals: of the $57,497,760 spent for the elderly, $52,195,818 (nearly 91 percent) went to institutional care, and of that, some $41,267,506 was used to support older adults in the state's four psychiatric hospitals. Only 4.1 percent of all persons served at the community level were over the age of 65 in fiscal 1988, accounting for $5,301,942 in community-based mental health services. Mental health expenditures in general are directed to institutional services at a ratio of nearly 2.5 to 1, but the ratio of such expenditures for the elderly is nearly 10 to 1.

The final major state agency with responsibilities for the care of the elderly is the Division of Social Services. Social service expenditures for the elderly fall into two general categories of care, home- and community-based care and state/county assistance for rest homes, primarily family care homes and homes for the aged. County Social Service Departments additionally provide other program benefits through eligibility determination (e.g., food stamps and access to Medicaid), as well as serving as program sites for the majority of the CAP/DA programs. Some 32 county DSSs also serve as contractors for Medicaid personal care services.

The state Division of Social Services and its counterparts in local county departments divide their service responsibilities roughly into services for children and services for adults. Social service expenditures through both home- and community-based services and rest home care amounted to $96,694,447 in fiscal 1987. Of this amount, $49,092,260 (51 percent) went to home- and community-based services and $47,602,187 (49 percent) to state/county assistance for rest homes.

Using these two different categories of programs, social service expenditures for individuals over the age of 60 in fiscal 1987 amounted to $48,050,338. Of this amount, $18,953,171 (or 39 percent) went to home- and community-based services and $29,097,167 (or 61 percent) went to support older adults in rest homes. It is worth noting that nearly $10 million more in state and county funds were expended on rest home care for the elderly than on all home- and community-based services through county DSSs.

The Core North Carolina Budget for the Elderly

The core North Carolina budget for the elderly consists primarily of three programs: Medicaid, Social Services, and Aging. While mental health service expenditures are important, most of these expenditures in fact are derived from the Medicaid program. The overall budget for the elderly in North Carolina is primarily driven by Medicaid program priorities and expenditures.

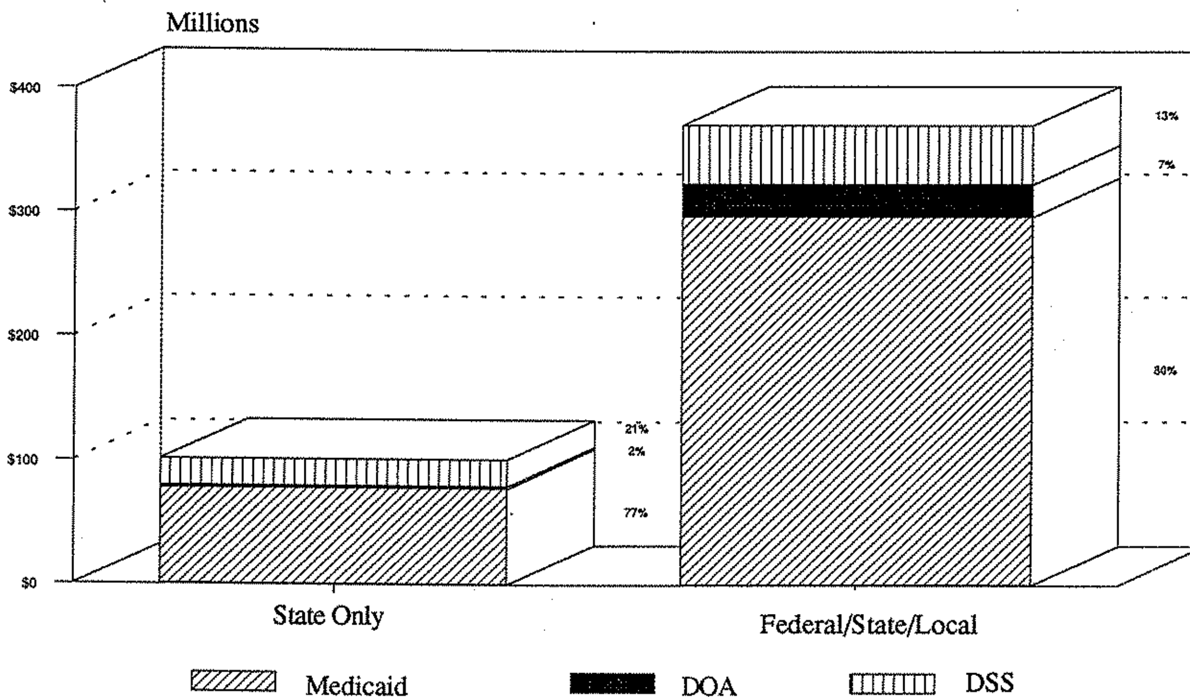
In fiscal 1987, the combined federal, state, and local expenditures for the elderly under all three of these programs amounted to approximately $371,932,498. Of this amount, 80 percent was accounted for by Division of Medical Assistance Medicaid expenditures, followed by 13 percent for social services--largely SSGB and rest home expenditures through the Division of Social Services--and 7 percent by the Division of Aging, primarily OAA expenditures.

State-generated revenues for the elderly under these programs come primarily in the form of a required state match for Medicaid, a state match for OAA programs, and state and county revenues for rest home care. State and local financing in fiscal 1987 for core agency programs amounted to roughly $101,399,608. Of this amount, 77 percent went to the state Medicaid match, 21 percent to social service expenditures (largely for rest home care), and 2 percent for matching OAA program funds. As this break-down suggests, state expenditures for the elderly, with the exception of those for rest home care, are limited primarily to matching requirements associated with federal programs for the elderly. Figure 10 shows the core North Carolina budget for the aging in fiscal 1987.

Figure 10

The Core North Carolina Budget for Aging*

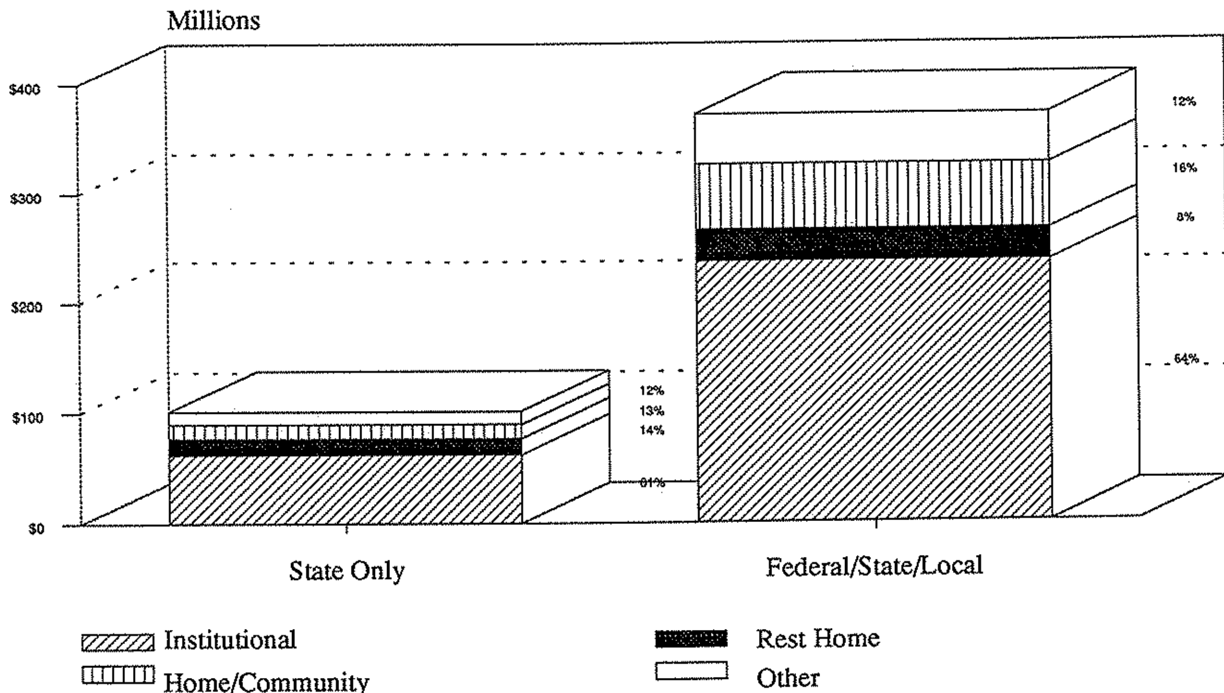
Fiscal Year 1987



* Includes only DSS Block Grant, State In-Home Services, Adult Day Care, Medicaid, and Division of Aging Funds.

Figure 11

North Carolina Long-Term Care Expenditures by Level of Care



Expenditures for Older Adults by Level of Care

The North Carolina core budget for the elderly can also be examined from the perspective of spending by level of care. Of the nearly $372 million in federal, state, and local expenditures for the elderly under Medicaid, Social Services and Aging for fiscal 1987, 64 percent went to institutional (primarily nursing home) care, 8 percent to rest home care, and 16 percent to home- and community-based care. The remaining 12 percent, primarily Medicaid funds, went to physicians, acute hospital care, and medications.

An examination of the state expenditures for the elderly, again primarily state matching requirements for federal programs, reveals that 61 percent went to institutional care, 14 percent to rest home care, 13 percent to home and community care, and 12 percent to other expenditures previously identified. It is interesting to note that state expenditures on rest homes, program sites that fit somewhere between community and nursing home care, received more state support than home and community care programs under Medicaid, Social Services, and Aging combined. The principal elective state-supported program for the elderly, based on these spending patterns, would appear to be rest homes (see figure 11).

State Options for Financing Home and Community Care

A major characteristic of state efforts to expand case-managed home and community care has been the need to choose a funding strategy. In turn, case management becomes an important method

for ensuring that services are provided within a defined budget. The case manager's ability to authorize service expenditures becomes an essential feature of effective case management.

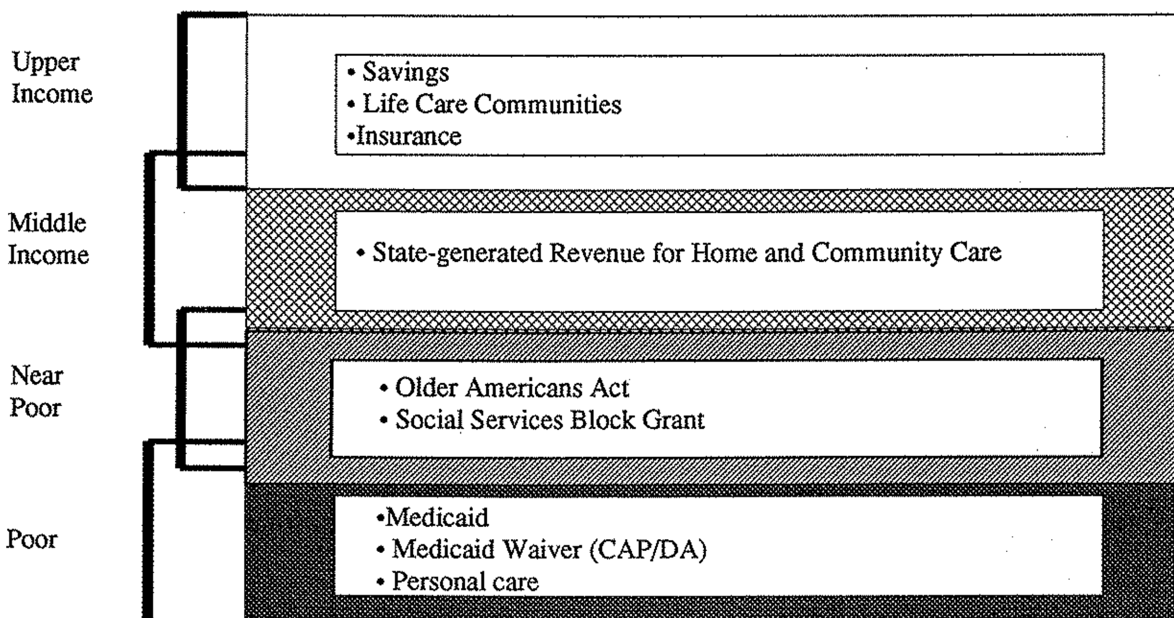
Financing strategies rely on working with and around five major public funding sources for case-managed home and community care: 1) current Medicaid authorities (i.e., for personal care and home health services); 2) Medicaid 2176 Waivers; 3) Social Service Block Grant funds; 4) Older Americans Act resources; and 5) state-generated revenues. In addition, client cost sharing and private insurance for the limited number individuals with long-term care coverage are important components of the overall financing picture.

The various public funding sources have different target populations, historical commitments, and limitations or opportunities for expansion. Medicaid is aligned with the health service needs of the poor. The Social Service Block Grant resources have historically targeted services to the poor and near poor. The Older Americans Act has been broadly targeted to those over 60 years old, with an emphasis on services to the low-income elderly and minorities.

While Medicaid is an entitlement program, both SSBG and OAA resources are capped federal funding programs with little prospect for meaningful expansion. States that have experimented with expanding case-managed home and community care beyond the poor have had to rely on new state-generated funds. Private income, savings, and insurance hold greater promise for middle- and upper-middle-income adults. State efforts to expand services to the disabled elderly have focused on efficiently integrating these various funding streams. Figure 12 shows the various funding sources and their fit with different elderly income groupings.

Figure 12

Integrated Funding Mechanisms for Case-Managed Home and Community Care for the Elderly



States have exercised different choices in developing their case-managed home and community care programs. Those with large low-income populations, such as Arkansas and South Carolina, have depended more on Medicaid funding strategies to support their programs. Arkansas's program is funded almost entirely through Medicaid personal care services, whereas South Carolina relies on its Medicaid Waiver program. Maine and Maryland rely on a combination of Medicaid, SSBG, OAA resources, and state revenues. Illinois, Massachusetts, and Wisconsin turned to programs heavily financed by the state as they have expanded services to moderate income individuals who are in need of services and able to contribute, but unable to pay the full cost. All states that have extensive service commitments to moderate-income individuals have made provisions for cost sharing. Wisconsin and Washington provide the case management functions of assessment and care planning free of charge to all who qualify for the program. In Wisconsin, services in the care plan are available on a sliding fee basis according to ability to pay. In Washington, services are provided under eligibility requirements governing specific programs or referrals are made for private clients. Only Oregon pools all the major funding streams through one centralized financial management system. Other states have experienced different degrees of success in integrating the various funding streams. Most have achieved a measure of success at integrating SSBG, OAA, and state resources. Table 7 reveals the contrasts among the states in either their primary or secondary reliance on various financial strategies and options for case-managed home and community care.

Table 7

Financing Case-Managed Home and Community Care Services

State	Current Medicaid Authority	Medicaid 2176 Waiver	SSBG	Older Americans Act	State Funds*	Client Cost Sharing
Arkansas	x	--	xx	xx	xx	--
Illinois	xx	xx	--	xx	xx	x
Maine	x	xx	xx	xx	xx	xx
Massachusetts	xx	xx	xx	xx	x	xx
Maryland	xx	--	xx	xx	xx	xx
Oregon	xx	x	xx	xx	xx	xx
South Carolina	x	x	S	A	A	na
Washington	na	xx	xx	xx	xx	na
Wisconsin	xx	xx	xx	xx	x	xx

* State-generated funds refer to funds generated in any significant amount beyond required matching requirements for other funding sources.
x Primary source
xx Secondary source
S Statewide program uses waiver only
A Demonstration project only
na No information available
— None

Case Management and Cost Management

Cost management, as indicated earlier, is an important part of the case manager's role. All states have used case managers to oversee and manage the provision of services against a defined budget limit. A number of states have set client spending limits for care plans as a means of controlling costs. In the case of Medicaid Waivers, limits are usually set in relation to the costs of nursing home care in that state. In Maine, case managers work with a financial allotment equal to the state's share of potential expenses for intermediate care facility (ICF) nursing home care. Arkansas, in contrast, limits its personal care service expenditures to a maximum of $442 per month, which means a maximum of 72 hours of personal care services per month. Wisconsin, while not setting specific maximums for individuals, sets an average payment level for counties and does not reimburse counties for expenditures beyond the contract level. County average client expenditures were $603 per month in fiscal 1987.

The Practice of Case Management

"Case management is a service function directed at coordinating existing resources to assure appropriate and continuous care for individuals on a case-by-case basis" (White, 1987). The discussion to this point has focused on the issues and options surrounding the development of a case-managed system of home and community care. What follows is a discussion of the practice of case management within a system of case-managed home and community care. The development of a comprehensive case-managed system of long-term care requires a uniform definition of the practice of case management, guidelines for the training of case managers, and standards of practice.

The Tasks of the Manager

There is near consensus as to the essential steps, activities, and tasks associated with the process of case management (Beatrice, 1986; Steinberg and Carter, 1983; Austin, 1983; Grisham, White, and Miller, 1983; White, 1987; and NICLC, 1988). These are listed in table 8.

Table 8

Case Management Steps and Activities

Step	Activities
Case finding	Outreach, screening, intake
Assessment	Comprehensive assessment of functioning Identifying problems
Care planning	Setting goals for clients' care Planning services
Care plan implementation	Coordinating and arranging for services
Monitoring	Monitoring services to clients
Reassessment	Reevaluating clients' needs
Follow-up or continuing care	

Case Finding

Case finding, as outlined by Steinberg and Carter (1983), is the process by which a case manager identifies and establishes contact with people who need the services of a community-based long-term care program. Contact or referrals may come from home health agencies, hospitals, mental health centers, or social service agencies contracting with the case management lead agency. If the target population consists of those at risk of nursing home placement, relevant screening protocols and instruments must be developed to ensure fair and accurate determinations of clients' eligibility for a given program. When eligibility is established for a specific program, financial eligibility must be determined in order to ensure a payment source for any ensuing care plan recommendations.

Assessment

After intake, a comprehensive assessment of the individual's needs and resources is performed. Assessment is different from screening in that the screening is conducted for the purposes of case finding and so is used in a larger population to target those who qualify for further assessment and probable case management services. Ideally, screening procedures should be brief and inexpensive. On the other hand, assessment involves a more detailed review of the client's functioning, which leads directly to diagnostic conclusions and an assignment of health and social service interventions (Kane and Kane, 1983).

Assessments are usually conducted by a social work or health professional or by a multidisciplinary team. Assessments for long-term care cover a number of functional domains, providing a "snapshot" of the individual's current functional status and some prognosis for the future. Domains that should be evaluated include the areas of social and economic resources, mental and physical health, physical and instrumental activities of daily living, and the home environment (George and Fillenbaum, 1985).

Assessment of social resources involves gathering information about the individual's caregivers, including the current level of assistance the individual receives and the presence or absence of stress or burden on the caregiver. Assessment of economic resources should provide information regarding the individual's expenses, income, and assets, as well as financial eligibility for needed supportive services.

Mental health assessment should determine the client's basic emotional status and include questions pertaining to social functioning, behavior, and affective feeling. It should also includes a measure of the client's cognitive functioning and judgment. Physical health status is ascertained through questions on subjects ranging from the client's perception of his or her own health to medical history and current symptoms, medications, and sensory abilities (e.g., hearing, vision, and speech).

Measures of physical and instrumental functioning, using standardized questions, captures the individual's ability to perform basic physical personal care activities (such as dressing and bathing) and instrumental abilities (such as money management and transportation).

Finally, the individual's home environment should be evaluated to identify possible hazards and necessary modifications or need for such devices as hand rails, ramps, or lifts in the home.

The assessment is the core of the case management process, providing the baseline against which services are recommended and progress or maintenance of functioning evaluated. Assessments should be standardized to ensure reliable and valid determinations of need as well as to enhance communication among the professionals involved in the individual's care.

Care Planning

After the assessment, the case manager compiles a list of problems in functioning and develops a plan of care to address those problems. The plan may be comprised of services from both informal and formal sources. It also reflects both the professional case manager's recommendations and the client's preferences for services. The plan should maximize the client's independence and self-reliance. Case managers who operate with an extensive knowledge of existing community resources and under instruction to make the best use of available resources are able to develop cost-efficient plans of care. For example, by working with a community's religious and civic organizations, case managers may develop a network of volunteers to provide short-term respite care to elderly and disabled individuals. Likewise, case managers operating under the admonition to use third-party reimbursers and other existing resources first can extend the impact of state and local resources to new services and clients.

Care Plan Implementation

Successful care plan coordination and implementation is dependent on the case manager's ability to follow through. It is the case manager's responsibility to make sure that the client receives the recommended services in a timely fashion. Care plan coordination and implementation may involve some or all of the following tasks for the case manager: 1) purchasing of services (if not provided by the agency); 2) serving as an advocate or ombudsman, when necessary, to obtain services for clients; 3) identifying and reporting barriers to service delivery; 4) mediating conflict between providers and clients; 5) performing all necessary paperwork; and 6) troubleshooting arrangements with landlords, utility companies, tax officials, and others (Steinberg and Carter, 1983).

Successful care plan coordination and implementation also involves working directly with clients and informal caregivers. Tasks associated with working with clients and caregivers include the following: 1) giving information about services to be provided; 2) modeling behaviors on how to secure certain services; 3) confronting clients with how they may be exacerbating their own problems; 4) engaging clients and others in the informal support network in helping to implement and monitor services in the home; and 5) preparing clients for changes, reductions, or terminations of services (Steinberg and Carter, 1983). Case management is dependent on the effective and efficient implementation of the care plan.

Monitoring

Monitoring of service provision by the case manager is important to ensuring the quality, continuity, and appropriateness of care. Findings from the National Channeling Demonstrations on case management point to potential problems with community services, most notably with homemaker/personal care workers who are often poorly trained and supervised (Applebaum and Christianson, 1988). Leading service problems were failure of these workers to keep appointments, late arrival for appointments, poor quality of services, incomplete services delivery, exploitation of clients, and high turnover among homemaker/personal care workers. Regular contacts with clients, including family members and service providers, helps to foster improved communication channels and early intervention when problems arise (White, 1987).

Reassessment

Reassessment involves the monitoring of the client's situation for responses to care and for changes in functional status. The primary purpose of reassessment is to determine if services need to be

changed in any fashion, possibly the termination of a service or services, the replacement of one service with another, or an increase or decrease in the intensity or frequency of a particular service. Many long-term care case management programs, like the Medicaid Waiver Program, opt for a standard minimum reassessment interval of six months. Standards for assessments should also seek to match the frequency of reassessment with the severity and instability of the client's disability, with the more disabled and unstable being more frequently reassessed. Reassessments may also be initiated when a new manager is assigned to the case.

Follow-up or Continuing Care

As Steinberg and Carter (1983) observe, follow-up may help to reinforce clients' achievements, track program results, and keep program access open to former clients. Some methods for conducting a follow-up include routine mailings of greetings at holiday or on the clients' birthday, periodic surveys of clients' satisfaction and evaluations of status; inclusion of clients who are longer eligible for services in ongoing programs of telephone reassurance or friendly visiting, or placing former clients on a mailing list for the program's newsletter. It is particularly important for case managers to follow up clients who are hospitalized or placed nursing homes, because their circumstances may change and they may need assistance in returning to the community.

Career Preparation

The career preparation of case managers and the standards associated with the provision of case management services constitute major determinants of quality care for those in need of home and community care services. The National Institute on Community-Based Long-Term Care (NICLC), a committee of the National Council on Aging (NCOA), under the leadership of Joan Quinn of Connecticut Community Care, Inc., and with the assistance of many people and organizations, has developed generic national standards for case management (NICLC, 1988; they refer case management as care management). These standards were subsequently reviewed by the leadership of NCOA's professional membership units. In addition to NICLC's guidelines, the North Carolina Division of Aging has developed a case management manual (NC, 1987) assisted by experts and organizations from across North Carolina. Both of these documents provide the basis for the discussion of career preparation and standards that follows.

Career Preparation and Training

Case managers are responsible for conducting, either alone or as part of a team, the various activities associated with case management. Table 9 shows the standards for education and training set by NICLC and by the North Carolina Division of Aging.

NICLC and the North Carolina Division of Aging also arrived at similar case management orientation and training guidelines. In developing a training outline for case managers, the Division of Aging calls for the following topics to be addressed through both a formal curriculum and orientation process: 1) an overview of the aging network; 2) orientation and review of the case management procedures manual; 3) review of the normal aging process; 4) training in prescreening and interviewing skills; 5) training in interviewing skills and specific knowledge relevant to

Table 9

Minimum Qualifications for Case Managers

NICLC	NC Division of Aging
A case manager should be a graduate of an accredited four-year college or university, with a degree in health, social services, gerontology, or other related area. A predetermined length of relevant experience may be used to substitute for some or all of the academic requirements in some types of programs. If funders, client condition, or other factors demand it, the academic requirements may be a master's level professional degree (e.g., in social work or nursing. A case manager should have a minimum of two year's experience in the human service field for persons with a bachelor's degree, and one year of experience for persons at the master's level. (NICLC, 1988: 16)	A case manager should have a bachelor's degree in social work, nursing, or other related field (e.g., gerontology, psychology, family relations, counseling, sociology) and preferably two years' experience in direct service provision. (NC, 1987)

assessment; 6) review of care planning techniques and processes; 7) review of techniques and procedures for ongoing case monitoring, follow-up, reassessment, and case closure; 8) coverage of funding and utilization of resources and services (both formal and informal); and 9) review of the administrative tasks of case management such as documentation and record keeping.

NICLC suggests that case managers should participate in a predetermined number of hours of in-service training each year. Training content should be based on the case manager's need for professional growth, upgrading of skills, and agency requirements. NICLC emphasizes in particular the importance of training case managers in skills associated with the use of a standardized assessment instrument. Case managers should also attend periodic assessment/reassessment refresher training sessions.

Supervision

In developing national case management standards, NICLC went to some length to affirm the importance of supervision for case managers. Case management supervisors should be especially knowledgeable of the role and function of case managers and possess advanced knowledge in the field of gerontology. Case management supervisors should also possess the ability to assume a

leadership role in directing and supervising case managers and undertaking special projects. Case management supervisors should exhibit the following characteristics (NICLC, 1988: 18-19):

- Supervisors should be accessible to case managers on a scheduled basis and as needed.
- Supervisors need to provide guidance on decisions requiring judgment, assistance with problem situations, and approval of care plans.
- Supervisors should explain goals, policies, and procedures and assist staff in adjusting to changes that occur.
- Supervisors should encourage the development of professional growth and upgrading of skills through access to training and current literature.
- Supervisors should evaluate case managers' performances based on established criteria. The evaluation should include a review of client records, observation of client visits, supervisory conferences, and productivity measures.

Quality supervision is a necessary ingredient of quality client care in all cases, but is particularly critical in those instances where the case manager lacks professional training.

Quality Assurance, Record Keeping, and Evaluation

The growth in the elderly population has increase demand for home and community care, but the vulnerability of those who receive health and social services in the home setting necessitates standards for quality assurance. Unfortunately, assuring quality home-based care is difficult because of problems in determining the current quality of care being provided to these individuals, a lack of consensus on definitions of quality of care in the home and community setting, and the fragmentation of services and service providers engaged in home care (ABA, 1986). As a service method for organizing and overseeing the provision of client care in the home, case management is a vital mechanism for ensuring the quality of that care.

Quality Assurance Issues

There are two major aspects of the problem of quality assurance in home- and community-based care. The first is the need for consumer protection. These consumers—the disabled clients and their families—may find it very difficult to make competent market judgments about accessing and paying for quality home care. The complexity and confusion surrounding the different delivery systems, products, and services associated with home and community care make it very difficult to secure of needed services on the basis of informed judgment. The frailty and relative incapacity of many home care clients makes this task even more difficult (ABA, 1986). Case managers can help to alleviate much of this confusion in their roles as sources of information and referral and through their active attempts to locate clients in need of services.

The second aspect has to do with the quality of the home and community-based services themselves. Here very little is known, other than through anecdote, about the current quality and the problems experienced in home care. The American Bar Association (1986) in its review of home care cites the following as present and potential problems: worker's nonappearance, tardiness, or failure to spend specified amount of time; inadequate or improper performance of duties; failure to perform duties; attitudinal problems toward the client (insensitivity, disrespect, intimidation, abusiveness, etc.); theft or financial exploitation; and physical injury to client, either intended or

accidental. Through the location of quality service providers, service monitoring, and their client advocacy role, case managers are in a good position to help ensure timely, safe, and high quality care (Quinn and Burton, 1988).

Additional issues of quality assurance, such as access to services, receipt of the appropriate level of care, respect for client's wishes, and quality of life are encountered and addressed in the performance of the case management role. The Medicare conditions of participation address many of these and other issues of quality care. Unfortunately, these conditions of participation legally apply only to those home health agencies certified to provide Medicare-reimbursed home health services. However, they can provide guidance to all providers of in-home services to the elderly. Some of the provisions pertaining to client rights under the Medicare Conditions of Participation, contained in the 1987 Reconciliation Budget, are worth highlighting as they apply to case-managed home and community care.

1. The right to be fully informed in advance about the care and treatment to be provided by the agency;
2. The right to voice grievances with respect to treatment or care without reprisal;
3. The right to confidentiality of client records;
4. The right to have one's property respected;
5. The right to be informed in advance of all items and services furnished by the agency; coverage available through other funding sources such as Medicare, Medicaid, OAA and SSBG; any charges for items and services not covered; and any changes in charges associated with the aforementioned.

Each of these provisions constitutes an important guideline to efforts to assure quality care for the disabled elderly and their families.

Record Keeping and Evaluation

Most health and social service professionals acknowledge the need for accountability in their practice. Most would subscribe to the notion that clients' records should provide a concise, usable account and documentation of the reasons clients came or were referred for services; what was found to be the presenting problem; what goals were developed; what interventions were planned and implemented; how clients responded to the intervention; and what, if any, follow-up was provided. In addition the records should document the cost of the service package and whether or not (or to what degree) clients were satisfied with the service.

Traditional health and social service records, particularly in the aging and social service networks, often fail to make such critical information readily available. Clients' records are also more likely to emphasize history or diagnosis rather than the clients' ability to function and the plans developed to prevent disability, rehabilitate, and/or maintain that ability. Connections between assessment and identification of specific problems and the treatment plans that follow are often obscure, leaving one to wonder about the relationship between each stage of treatment (Kane, 1974). Practice cannot be evaluated and improved, or the cost of care determined and compared to alternative plans of care, until such connections are made clear.

The case management record should capture salient information and decision points as they pertain to the care of the disabled elderly client. At a minimum, case managers should record the data on which assessment is based, noting any problems with those data, describe the intervention plans developed to address the clients' complaint, and specify the monitoring and assessment of outcomes associated with those interventions. Such documentation mirrors the original framework developed by Lawrence Weed (1964) for the problem-oriented record used by medical providers. By integrating concepts more germane to working with the chronically impaired, such as functional assessment, the basic elements of the problem-oriented record can be modified to incorporate and parallel the basic elements of the case management problem-solving framework outlined earlier.

Systematic record keeping and its utility for promoting quality care can be further enhanced through the development of program information systems. Such information systems, the foundation of which is the client case record, can help policymakers, administrators, and clinicians answer basic and very important questions. Some that need to be asked and answered include: What is the nature and the scope of the problems requiring action in home and community care? What interventions will significantly affect these problems? What do the interventions cost? What are costs of the interventions relative to their benefits? Systematic record keeping serves as an aid to practice. It promotes a measure of standardization from which policymakers can learn and develop norms of practice which, in turn, will assure the highest measure of benefit relative to agreed upon acceptable costs.

Case Management and Multidisciplinary Teams

There are few health and social service professionals who argue with the need for a multidisciplinary approach to meeting the needs of the disabled elderly. The scope and complexity of health, mental health, social, and economic problems faced by the disabled elderly truly make the case for a multidisciplinary approach. This approach can best be met through the use of a team.

While it is agreed that most elderly clients experience multiple problems of functioning that would be best handled by a multidisciplinary approach, multidisciplinary work with the disabled elderly is often not the result of team collaboration. Rather it is often the product of established and, at times, conflicting and overlapping work routines among the involved health professionals. At other times, even though a team approach is warranted, personnel with training in a relevant discipline may not be readily available, particularly in community-based settings. This state of affairs results primarily from our present disorganized system of care for the elderly. The system is made chaotic by conflicting issues of third-party reimbursement, fragmentation of care resulting from increased specialization, a bias toward institutional versus community-based care, and problems of status and professional turf rivalries.

There is, however, growing evidence of a strong commitment to the concept of teams in the geriatric literature (Campion et al., 1983; Croen et al., 1984; Schmitt, 1986). No single professional discipline or specialty approach, be it medicine, nursing, or social work, can alone address the multiple problems of the elderly (Pfeiffer, 1985). The use of multidisciplinary teams is increasing on a wide array of fronts ranging from long-term care facilities to acute care hospitals to community programs.

The core membership of case management teams in home and community care programs usually consists of a nurse and a social worker. Primary responsibility for case management on this

team may be determined by the nature of the client's problems. Close working relationships with the client's primary physician are essential to overall quality of care. Other specialists such as physical or occupational therapists, pharmacists, dentists, nutritionists, and health educators may be consulted as needed.

The effectiveness of a team approach to case-managed home and community care is based on a number of principles and assumptions, many of which have been previously outlined. Additional principles central to an effective team approach include the following: 1) each member of the case management team must be knowledgeable in his/her own general field; 2) team members must be knowledgeable of the special needs of the disabled elderly client; and 3) team members must be knowledgeable of the contributions and strengths of the various health and social service professionals involved in the care of the elderly (Nicholas, 1981).

Building on Recent Initiatives in Home and Community Care

Any recommendations for developing a comprehensive case-managed system of home and community care must be made in light of present and emerging needs of the state's older adults and current strengths and needs in the state's long-term care planning and service delivery structure. This position paper has addressed many of these issues. Any recommendations for reform should also take into account the recent legislation passed at the behest of the North Carolina Study Commission on Aging. Senate Bill 1559 was passed in the 1988 Session of the North Carolina General Assembly "to begin building an in-home and community based system of services for older adults" in North Carolina.

Senate Bill 1559

In its preamble, Senate Bill 1559 notes that the increase in the state's population 65 and older to nearly one million individuals is anticipated for the year 2000; that the growth rate of the population most in need of assistance, those 85 and older, was expected to double the growth rate of those 65 and older; that a disproportionate spending on institutional versus community-based care exists in the state; that an urgent need exists among the state's elderly for transportation, in-home services, and family caregiver support services; and that there is a need in the state for a coordinated in-home and community-based service system for the elderly. Senate Bill 1559 was designed to address these issues and, in its own words, "to lead to a more coordinated and visionary system of in-home and community-based care for older adults."

To date, Senate Bill 1559 has accomplished a number of things and has set other processes in motion. It funded additional in-home and community-based services, sought to enhance program-planning capacity of the regional Area Agencies on Aging, and funded seven information and referral/case management pilot projects. The Division of Aging was also requested to develop an evaluation report for the 1989 General Assembly concerning the respective roles of the Division of Aging, Social Services, and Medical Assistance.

Finally, Senate Bill 1559 also requested a recommendation from the Division of Aging as to whether or not the General Assembly should mandate that each county designate a focal point or lead agency for services for older adults. The Division of Aging was directed to present a written report summarizing its evaluations and recommendations to the General Assembly by March 1, 1989. Senate Bill 1559 has set the stage for a serious reconsideration of the options available to the state for delivering and financing coordinated home and community-based services for the elderly.

Consensus Building: Principles for Coordinated Care

The North Carolina Study Commission on Aging, in addition to shepherding the passage of Senate Bill 1559 in the summer of 1988, requested that the North Carolina Institute of Medicine develop a position paper or papers that outlined issues, options, and recommendations related to the development of a coordinated, case-managed system of home and community care services for the elderly. This position paper has examined the need for home and community care services; the current delivery and financing patterns and arrangements for long-term care services; and the present state of the art of case management practices in North Carolina. In addition, the position paper has outlined options available to the state as it seeks to develop a more coordinated, accessible, and efficient system of case-managed home and community care for the elderly.

As part of its effort to review and discuss options available to the state in this area, the Institute of Medicine also sought to identify areas of agreement among those in the state most responsible for setting central policies that govern case management and long-term care. To this end, a consensus-building forum for these policymakers was held in September 1988. The goals of this forum were to facilitate communication among the participants, forge a commitment to an ongoing dialogue on central case management planning and administrative issues in long-term care, and identify areas of consensus on crucial policy issues governing case-managed home and community care for the elderly.

The National Governors Association found that a key to significant state long-term care reform was the investment of "substantial blocks of time during the initial planning stages to the discussion of the philosophy and goals which were to govern that reform" (NGA, 1988). In an effort to begin this dialogue, the authors of this position paper interviewed more than 20 informants over a two-month period in the summer of 1988 and then brought the participants together for a day-long workshop in September 1988. Professions and organizations represented by these informants included physicians, nurses, social workers, Older Americans Act programs, rest home and nursing home associations, a long-term care consumer group, mental health, a local health department, and the North Carolina Hospice and Home Care Associations.

> Motto for the Consensus-Building Forum
>
> ***" . . . where collaboration was most successful, substantial blocks of time during the initial planning stages were devoted to discussing philosophy and goals."***
>
> —National Governors' Association, 1988

Individual interviews with informants were open-ended and fairly loosely structured, in order to allow for a free exchange of ideas. Questions in the interview guide varied from the very specific ("Should there be multiple points or a single point of entry in community-based long-term care for North Carolina?") to the philosophically broad ("What do you see as the central quality assurance issues for community-based long-term care in North Carolina?"). About a third of the questions focused on case management per se, while the remainder dealt with the larger context of the long-term care system and the quest for coordinated care.

The intention and effect of this slant towards system issues in the questions was to stimulate critical thinking about the larger context into which any model of case management must fit. The interviews and the subsequent forum were not intended as an opinion poll of a relatively naive public but rather were meant to foster an exchange of opinions with some of the best-informed people in the forefront of long-term care in the state. The goal was not to win or force an uncritical acquiescence on any point or points but to identify where there were areas of substantial agreement for achieving a more coordinated system of care.

The interview format resulted in a range of valuable ideas and a sense of the variation among informed perspectives within the state. It did not lead to quantifiable data of the "40 percent endorsed plan A" variety. However, it did give some sense of where there was agreement or concerns regarding particular points. It also set the stage for the identification of support for a set of principles on the basis of which more specific programmatic recommendations might be made for a coordinated system of home and community care.

One of the few questions with set response choices concerned the importance of case management. It asked, "Do you see case management as key to the provision of a coordinated system of community-based long-term care?" and provided response choices, "Key," "Important, but not key," and "Not important". All informants chose "key" or "important," dividing their answers almost evenly between the two. They were unanimous in endorsing case management as a service benefit, but quite disparate in their views about case management as a cost containment measure. Some believed it would help contain costs, while almost as many believed that a "woodwork" effect would operate to maintain or even increase costs. Further, informants were in disagreement about the politics of cost containment. Some felt that in this period of fiscal austerity, a program could only be offered to the legislature on the grounds of cost containment. Others felt that so many long-term care programs had promised cost containment, the very phrase would arouse skepticism, even if the program did eventually minimize expenditures.

Targeting was another issue that aroused strong interest but much surface disagreement. Despite the Institute of Medicine's explicit charge to investigate case management for older adults, several informants emphasized the need to deal with all adults who shared the same types of service needs. A few even felt that disabled children should be included in the same programs, although this was not a popular view. Functional impairment, in some form, was generally thought to be the principal criterion for targeting, although some informants expressed this in terms of risk for institutional placement and some as an interaction between functional status and social support. A few believed that people with lower-level functional impairment should be targeted to prevent unnecessary deterioration of their conditions. Similarly, all recognized financial status as appropriate to targeting efforts, but they disagreed on specific levels of need. Some felt that the state did not have the resources to plan for any but the truly indigent. Others expressed strong concern about

moderate income people who could afford to contribute to their own care but would quickly be impoverished if forced to bear the entire burden.

In general, informants believed that no progress would be made without the efforts of a "lead" agency. They were, nevertheless, extremely reluctant to suggest which agency it should be, citing issues of authority and jurisdiction among multiple agencies at three administrative levels (state, regional, and county). A minority endorsed the creation of a new agency. Many expressed concerns about not alienating existing agencies or losing the wisdom and expertise of agencies not selected for lead status.

In discussing the staffing of case management, the separation/integration of care planning and service delivery, and even the primary purpose of case management, informants displayed some common goals and some shared awareness of problems, but rather different ideas. Many of these ideas, however, were compatible. For example the most frequently identified roles for case management were pointing out gaps in services; appropriate allocation of services; improved efficiency of service delivery; client advocacy and assistance; and educating the professional and lay community about services. Although each of these ideas was volunteered only by a minority of respondents, most spoke in ways that would suggest endorsement of all of them.

With regard to quality assurance, three distinct points of view were offered on the subject: 1) the case manager should be a potential whistle blower, reporting any observed or suspected problems detected in the course of day-to-day activities, reassessment, and follow-up, but not explicitly monitoring for such problems; 2) the case manager should actively engage in monitoring--checking on delivery, reviewing records, interviewing family about satisfaction with services; and 3) quality assurance should not be the case manager's responsibility. Additional recommendations included a consumer hotline or other mechanism for confidential reporting of problems and consumer education/client advocacy.

Similar kinds of disagreements centered around staffing. The nurse-social worker team was the most commonly identified staffing choice, though a few suggested that the current nursing shortage might make such an arrangement difficult. A minority presented excellent arguments about using professionally supervised nonprofessional staff. Because nonprofessional salaries would be lower than those of professionals, the program should be able to hire enough managers to give good individualized service. Assessment would be carried on by a professional team. An equally vocal minority expressed the opposite view—that high-status professional level staff should be employed because of their increased "clout" with the people and organizations with which they would need to deal.

Several respondents had special concerns about case management that they wished to make clear. One group felt that case management need not always be a formal service if the care system were sufficiently coordinated for family members and professionals to use efficiently. A second concern, voiced by several respondents, was that sufficient services must be in place or case management is meaningless—"You can coordinate nothing all you want and you've still got nothing."

On the broader issues of the long-term care system, responses showed similar patterns of agreement and difference. Most informants agreed that current arrangements differ in terms of their scope, their nature, and their goals—from county to county and from program to program within counties. Many saw this variation as a serious barrier to coordinated care, but a substantial minority

stressed some advantages to the consumer in this variety, and believed that North Carolinians are quite purposeful in their system of county autonomy. However, most informants, even those who endorsed local autonomy most enthusiastically, believed that a minimum core of services should be locally accessible and that the State should assist in making that possible. Several informants stressed that local access should not be interpreted strictly to mean a separate system for every county, but should allow for neighboring counties to pool their resources for shared services—day care and respite, for example—as long as residents in each county had access within a reasonable distance. Informants recognized the complexity of county equity in services, and of improving cooperation/coordination among service providers within counties. However, when asked to give suggestions of the next step needed to ensure more efficient coordination of care, the twenty informants produced ten different answers. These ranged from "uniform, measurable standards and monitoring for compliance across interdivisional lines" to "letters of understanding among agencies."

Table 10

Principles Governing the Establishment of a System of Case- Managed Home and Community Care for the Elderly

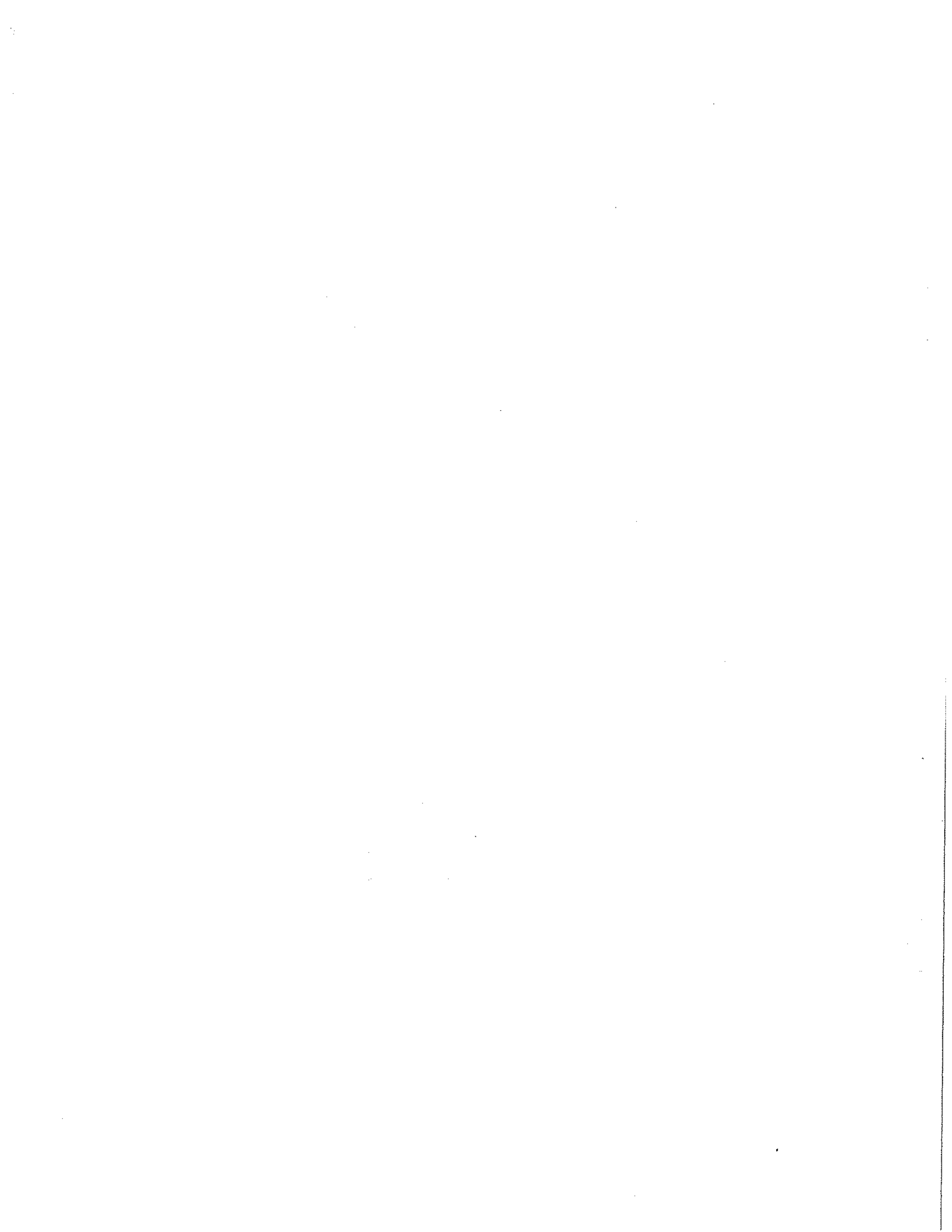
- A committee should be established at the state level with authority to plan and set standards and guidelines for a coordinated, case-managed system of long-term care.
- A lead agency should be designated in each county to assure the provision of case management and coordinated long-term care. The decision as to which should be the lead agency should be made locally.
- There should be a standardized assessment of functional need and provision of services. The goal of these services should be maintaining clients in the least restrictive environment of their choice.
- The case management functions of client assessment and care planning should be provided as universal services, free of charge, to all clients deemed appropriate for the service.
- Income eligibility guidelines for long-term care services should be expanded to ensure access to services for moderate-income clients on a sliding-scale basis.
- All North Carolinians should have access to a minimum set of long-term care services irrespective of county of residence.
- Case management services should be supported by public funding.
- A long-term care planning group should be charged with developing recommendations for optimizing the use of current resources and investigating new sources of financing.
- Quality assurance standards and guidelines should be established for the provision of case management services and the selection of service providers.

Upon completion of the individual interviews, the participants were subsequently called together at a day-long forum. Findings from their own interviews and from other states that have engaged in similar policy development were presented to the forum participants in written form. These findings were organized under four central issue headings, judged by the authors to be central to the development of a coordinated care system. These headings followed the framework presented in this work: a) administration; b) service targeting; c) services; and d) financing. Operating within this framework, participants discussed findings, issues, and options related to the development of a coordinated, case-managed home and community care program in North Carolina.

Substantive discussions were held in small groups, which addressed issues and perspectives unique to North Carolina, as well as those that reflected in the experiences of other states with model community care programs for the elderly. At the end of the day, participants gathered together to report decisions or principles which they thought to be central to the establishment of a coordinated, case managed system of care. These principles were envisioned as providing the foundation upon which more specific programmatic recommendations could be subsequently made. Consensus or near consensus was reached on the principles listed in table 10.

Summary

This monograph serves a background review of the needs, issues, and options related to development of a comprehensive, case-managed home an community care program for the state's elderly. In addition, it has outlined a set of principles central to the development of a coordinated system of care for the elderly, drawing on research, the experiences of other states, and the opinions of prominent actors in North Carolina's long-term care network. The principles contained here serve as the basis for a second position paper that makes specific programmatic recommendations for coordinated care of disabled older adults in North Carolina.



Glossary of Funding Sources and Resources for Older Adults

Adult Day Care (Social Model/Health Model). Adult day care is a generic term that applies to a variety of programs offering a range of services in a congregate setting to functionally impaired and/or isolated adults. Specific services may vary widely among programs, but include counseling, exercise, case management, health screening or monitoring, socialization, physical therapy, and occupational therapy. Adult day-care programs may be operated by hospitals, nursing homes, councils on aging, mental health centers, churches, and civic groups. Generally, day-care programs operate five days a week. Transportation may be provided to and from the program site. Health and Social Model day-care programs may provide similar participant activities; however, Health Model programs usually emphasize activities that address physical and mental health maintenance and rehabilitation. Funding for day care programs is provided through private sources (fees) or public sources, such as Social Services Block Grants (Social Model) or Medicaid (Health Model).

Case Management. Case management is a service method for organizing and coordinating the care of long-term-care clients. Case management practice involves seven elements or steps: screening, assessment, care planning, arranging services, service monitoring, reassessment, and discharge. Case management services are offered through a variety of private and public agencies, including county Departments of Social Services (DSSs) and local councils on aging.

Chore Worker. See **Homemaker**.

Classes / Demonstrations / Training (Older Adults / Caregivers). The types of classes offered may include topics such as nutrition and health education, benefits entitlement, energy conservation, employment, legal issues, consumer information, and community services. For caregivers, the classes may cover topics such as Alzheimer's disease, home nursing, psychosocial issues of aging, and minimizing caregiver stress. Classes for older adults and caregivers may be provided by a variety of public and private agencies, including community and technical colleges, public libraries, recreation centers, Agricultural Extension offices, senior centers, the American Red Cross, and the American Cancer Society.

Community Alternative Program (CAP/DA). The Community Alternatives Program (CAP) for disabled adults (DA) is a Medicaid Waiver program that provides community-based services to disabled adults who meet the medical criteria for nursing home-level care. CAP services may include traditional Medicaid home health services (nursing, physical therapy, home health aide) as well as services not generally available under Medicaid (home-delivered meals, respite care, chore services). The total cost for CAP community-based services for a given client must not exceed the average monthly nursing home care cost.

Durable Medical Equipment. Durable medical equipment (DME) is equipment prescribed by a doctor to serve a medical purpose. Examples of such equipment include wheelchairs, hospital beds, and bed-side commodes. For older adults who do not have health insurance coverage for DME or who need a particular DME item that their health insurance does not cover, community service DME programs may be able to meet these needs. The type of assistance these programs may provide can be financial assistance to purchase the equipment or a loan of the actual DME item to the adult. Examples of community agencies that may have DME programs are the Easter Seal Society and the American Cancer Society.

Emergency Assistance. Emergency assistance programs provide financial assistance for fuel, food, medicine, utilities, clothing, and rent for individuals and families in crisis situations. (Sometimes food, fuel, or clothing are directly provided.) Emergency assistance programs are operated through public agencies, churches, and private agencies, such as the Salvation Army.

Employment (General/Older Adults). Employment programs assist individuals in obtaining employment. These programs may provide actual jobs, job placement and follow-up services, and training. Employment programs of a generalized type, i.e., for all ages, can be found in agencies such as the Employment Security Commission and the Division of Vocational Rehabilitation. Specialized programs for the older adult are often operated by a local council on aging. Older adult employment programs are generally funded under the Older Americans Act and often involve training and job placement in community service-type positions.

Family Care Home. A family care home is a type of rest home ("domiciliary care facility") that provides residential care for 2 to 6 adults who, because of age or disability, require some personal care and supervision along with room and board to assure their safety and comfort. In North Carolina, family care homes are licensed by the Division of Facility Services.

Friendly Visitor. This is a program that provides volunteers who visit homebound or isolated adults on a regular basis, usually at least once a week. Friendly visitor programs may be sponsored by churches, civic clubs, or senior centers. Examples of friendly visitor activities include conversation, reading, playing cards and board games, letter writing, social outings, or running small errands.

Funding Sources

Food Stamps. The Food Stamp Program provides food coupons to income-eligible households. The monetary amount of the coupons received by the household is based on household size, income, and resources. These coupons enable household members to improve their nutritional intake by increasing the available household income with which to buy food. The Food Stamp Program is administered by the U.S. Department of Agriculture. Locally, the program is usually based in a county department of social services. Administrative costs for the program are shared by county, state, and federal governments.

Medicaid. The Medicaid Program pays the cost of health care services to low-income individuals. Eligibility for the Medicaid Program is based on individual income and resources. Although many Medicaid Program guidelines are set at the federal level, states have some flexibility with regard to categories of eligible populations and optional services. Medicaid Program costs are shared by county, state, and federal governments. Health care services funded under the North Carolina Medicaid Program include nursing home care, prescription drugs, hospital care, home health care, eye examinations/glasses, and dental care.

Medicare. Most persons aged 65 and over are eligible for Medicare. The Medicare Program has two parts: hospital insurance and medical insurance. The hospital insurance component helps pay for inpatient hospital care, rehabilitative nursing home care at the SNF level, home health care, and hospice care. The medical insurance component can help pay for physician services, home health services, and medical supplies. Many times a Medicare recipient must still bear some of the cost associated with medical care covered under Medicare. Eligibility determination for Medicare is the responsibility of the Social Security Administration.

Mental Health. Federal funding for community mental health centers began in 1963 under the Community Mental Health Centers Act. An amendment to this act in 1975 specifi-

cally required that community mental health centers provide a program of specialized services for the elderly. Mental health services for older adults funded under this act include both diagnostic and treatment services. Currently, community mental health center costs are shared by federal, state, and county governments.

Older Americans Act. The Older Americans Act (OAA) is the primary federal funding source for service programs targeted specifically to the adult aged 60 or older. (The Older Americans Act monies are sometimes referred to as Title III funds, because this Title is the primary portion of the OAA utilized for service program funding.) At the federal level, the Administration on Aging allocates OAA monies to states on a formula grant based on Census Bureau estimates of the population over 60 years of age in each state. The state Agency on Aging in turn allocates the funds regionally to Area Agencies on Aging. As a requirement for receiving funds, the Area Agency must submit a plan for utilizing the funds in its region. Because the Area Agency is expected to respond to its unique local needs, the specific services funded by OAA may vary among regions of the state. However, potential service programs that can be funded under OAA include congregate meals, home-delivered meals, chore services, information and referral, legal services, and respite care.

Social Security. Primarily, Social Security financial benefits are available to retired workers and their survivors as well as to disabled workers. A worker's (or survivor's) actual Social Security payment is computed by means of a complex formula reflecting actual earnings and adjustments for national changes in average wages.

Social Services Block Grant. Social Services Block Grant (SSBG) funds are provided to states by the federal government for social services programs. SSBG funds may be used to fund services directly beneficial to the older adult, such as homemaker service, home-delivered meals, transportation services, and home maintenance services. SSBG monies may also be used by states to fund services to children and families, such as day care, family planning, and adoption services.

State/County Special Assistance. State/County Special Assistance provides financial assistance to persons 18 and over in a Home for the Aged, Family Care Home, or a Group Home for the Developmentally Disabled. Eligibility for this program is based on income and financial resources. Recipients of this type of financial assistance must reside in one of the living arrangements noted above. Recipients of State/County Special Assistance are also eligible for Medicaid. The State/County Special Assistance Program is funded through a combination of state and county monies.

Supplemental Security Income. The Supplemental Security Income program (SSI) was designed to provide a minimum monthly income to financially needy individuals aged 65 and older and to financially needy blind or disabled individuals. An individual must have limited income and assets to qualify for SSI. The SSI program is administered by the Social Security Administration. However, it is not financed by payroll taxes.

Home Health Aide. Home health aides are trained paraprofessionals who perform services such as personal care (grooming, bathing), assistance with medications, assistance with ambulation and transfer, and essential household tasks (changing beds, laundry). Home health aides work under the supervision of a registered nurse and are usually employed by a home health agency or county health department.

Home Improvement/Modification. Home improvement/modification refers to the activities and materials necessary to repair or modify the existing home to meet current building standards and/or to better meet the housing needs of the occupants. Improvement or modifica-

tion might involve the addition of equipment for frail or handicapped persons (grab bars, wheelchair ramps, etc.), structural repairs, or weatherization. Low-interest loans for home improvement can be obtained through sources such as the Department of Housing and Urban Development or the Farmers Home Administration. Repair or weatherization may be arranged through local housing authorities, community action agencies, volunteer groups, and senior centers. These programs are often not specifically targeted to the older adult, but are targeted to households in a certain income range or geographic area.

Homemaker or Choreworker. Homemakers or chore workers are trained paraprofessionals who provide a range of services necessary to enable a functionally impaired person to remain at home. Services vary among programs and funding sources, but may include assistance with personal care and routine household tasks, such as shopping, cooking, cleaning, and laundering. Homemaker and chore worker services programs may be administered by a county department of social services, council on aging, Hospice, or private in-home services agency. Homemakers and chore workers receive professional supervision, usually from a registered nurse, social worker, or home economist.

Homes for the Aged. A type of rest home (or "domiciliary care facility") that provides residential care for seven or more adults who, because of age or disability, require some personal care and supervision, along with room and board to assure their safety and comfort. In North Carolina, Homes for the Aged are licensed by the Division of Facility Services.

Hospice. Hospice is a program that provides services and support to the terminally ill and their families. The program uses a team approach, involving physicians, nurses, social workers, volunteers, home health aides, and clergy, to both create and maintain a physical, psychological, and emotional support system for the patient and his family. Hospice programs are generally privately funded, but may include the provision of Medicare Hospice benefits.

Hospitals

Acute Care. Acute care hospitals diagnose and treat people with acute, severe illnesses or injuries, or chronic illnesses of recent onset.

Rehabilitation. Rehabilitation hospitals serve people following hospitalization for illness or injury in an acute care hospital. The emphasis in service is on specialized, individualized programs to assist individuals in regaining their previous level of functioning or in learning to compensate for permanently lost functions.

State Mental. A state mental hospital is a facility financed and administered by the state that serves the mentally ill population from a specific geographic ("catchment") area. North Carolina state mental hospitals include Broughton Hospital, John Umstead Hospital, Dorothea Dix Hospital, and Cherry Hospital.

Housing Programs

Congregate. Congregate housing services are usually an "add-on" to specially designed multi-unit rental apartments. Supportive services provided as a part of congregate housing services will vary among sites, but can include meals, housekeeping, transportation, supportive health care services, and social or recreational activities.

Construction. Construction housing programs are generally under the jurisdiction of the Department of Housing and Urban Development (HUD) (Section 202, Section 8 New Construction, Section 8 Substantial Rehab, Public Housing) and the Farmers Home Administration (FmHA) (Section 515). Projects developed under these programs may also include congregate services and/or rental assistance, such as reduced or subsidized rents. Some projects or units may be specifically targeted and constructed to meet the needs of the older adult.

Federally Sponsored. Federally sponsored housing programs include construction progams and rent subsidy programs. Generally these programs are not exclusively geared to older adults. However, when targeted to the older adult, federally sponsored housing programs have generally stressed rental housing rather than home ownership. Some federally subsidized housing programs are currently inactive or face uncertain futures.

Rental Assistance Only. Sometimes called "tenant-based subsidy" programs, these programs provide an eligible household with a certificate of eligibility. Certified households can search for suitable rental housing in their current units or other existing rental units in the community. Once a unit is secured, a rental assistance payment is made on a monthly basis to the owner on behalf of the tenant. If the tenant moves, the rent subsidy payment remains with the tenant (not the unit), provided the tenant continues to meet program eligibility requirements. The HUD Section 8 Existing Program is the most prominent example of this type of program.

Life Care Retirement Community. A life care retirement community is a type of housing development that offers a full range of accommodations and services, including independent living, congregate housing, comprehensive medical care (including nursing home care), home maintenance, and social and recreational services. Membership in a life care retirement community is considered life-long and generally requires a large initial entrance payment plus an ongoing monthly fee. Such communities are frequently sponsored by churches or private corporations.

Shared. Shared housing refers to a living arrangement program designed to provide group living in a home-like atmosphere. Each resident has a private or shared bedroom. All residents share living areas (including kitchen and bathrooms) and household expenses. Some arrangements require residents to share in household chores. In other programs, there may be a live-in housekeeper who cooks meals, provides transportation, and is responsible for upkeep of the home (cleaning, laundry).

Shelters for the Homeless. These shelters provide housing, usually on a temporary basis, for those without homes or adequate living arrangements. Food and clothing are often provided at such shelters. These programs are typically sponsored by community churches, the Salvation Army, rescue missions, and battered/abused women's programs.

Information & Referral (General/Older Adults). Information and referral (I&R) progams are designed to link people with services and resources appropriate to their needs. Referral may be done by phone or in person. Community I&R programs are often in the form of a telephone help-line or a published a community services directory. I&R programs serving older adults may be based in a senior center, funded through the Older Americans Act. Agencies or programs specifically designed to provide I&R services generally maintain up-to-date inventories of all services available in their areas.

Legal Services (General/Older Adults). Legal services refer to the provision of services by attorneys and paralegal personnel. Examples of legal services needed by older adults might include tax and financial counseling, advocacy on consumer concerns, and benefits entitlement. Publically funded legal services programs are limited but include those funded thorugh the Legal Services Corporation (Legal Aid) and the Older Americans Act. In some geographic areas, the American Bar Association encourages private attorneys to provide free or low-cost legal services to older adults.

Meal Programs

Congregate. Congregate meals refers to a nutrition program that provides meals in a group setting, five days a week, to older adults. These programs are often based in churches, schools, senior centers, or community recreation centers.

Opportunities for socialization or recreation are frequently provided along with the meals. Congregate meal programs are usually funded through the Older Americans Act.

Home-Delivered (Meals-on-Wheels). Home-delivered meals are a nutrition program that employs a network of volunteers to deliver at least one hot nutritious meal per day (generally, five days per week) to homebound adults. Special dietary needs can often be taken into consideration. These programs are typically organized through councils on aging or churches.

Mental Health Programs

Community Mental Health Centers (General/Older Adults). Community mental health centers offer a variety of out-patient psychiatric and psychological services, including crisis intervention; individual, group and family therapy; diagnostic services; consultation with other agencies; and day treatment. Community mental health center services are available to all adults on either a free or charged on a sliding fee scale. Public funds for community mental health center services are provided primarily through the Community Mental Health Services Act of 1975. This act specifically mandates services for persons aged 65 and older.

Other Counseling Programs. Other types of counseling programs available to older adults (besides those offered by community mental health centers) include geriatric mental health evaluation and treatment programs through family service agencies, private psychiatric hospitals, and university or community hospitals.

Nursing Homes

Skilled Nursing Facilities. A skilled nursing facility (SNF) provides 24-hour nursing care. The services of a registered nurse (RN) must be available on the day shift. On the other two shifts, the SNF is required to have either a registered nurse (RN) or a licensed practical nurse (LPN) available. To qualify for SNF care, a patient must require substantial nursing care and continuous medical supervision.

Intermediate Care Facilities. An intermediate care facility (ICF) is only required to have a nurse available during the day shift. ICF patients may require limited nursing services. They usually require assistance with tasks of daily living, such as eating, dressing, and ambulation.

Occupational Therapist. Occupational therapists (OTs) assist in rehabilitation through the design and implementation of individualized programs to improve or restore functions impaired by illness or injury. If a function has been permanently lost, occupational therapists help to improve the individual's ability to function as independently as possible by teaching task modification and/or the use of assistive devices.

Physical Therapist. Physical therapists (PTs) use a variety of physical methods (e.g. heat, massage, mechanical devices) to help an individual regain or maintain the greatest possible level of physical independence. Physical therapy is often used with those who have suffered an injury, stroke, or disease to assist them in recovering the maximum use of the affected areas, and includes training in the use of mobility aids and prostheses.

Protective Service. Provided through a county department of social services, protective service for adults focuses on protection of the disabled adult from abuse, neglect, or exploitation. Protective service social workers investigate reports of abuse, neglect, and exploitation. They may also arrange for provision of essential services, counsel with caregivers, and initiate legal action on behalf of an incompetent adult to ensure the adult's health and safety.

Registered Nurse. In community-based services, registered nurses (RNs) may perform health assessments, engage in health teaching, and perform nursing procedures (dressing changes, drug administration). In a community setting, registered nurses'services are usually offered through county health departments and home health agencies.

Respite Care (Out-of-Home/In-Home). Respite care refers to the time-limited provision of care to a functionally impaired person in order to give relief to that individual's primary caregiver. Respite care can be used to give the primary caregiver a "break" from the daily stresses of caregiving, time to attend to other responsibilities, time for a vacation, or relief in times of family emergencies. Out-of-home respite care is usually provided in a nursing home or rest home. In-home respite care is provided in the person's usual residence by a paraprofessional aide (respite care worker) who provides care to the impaired person.

Senior Centers. Senior centers are community facilities that provide a wide range of services and activities for older adults. Senior centers may offer recreational services (arts and crafts, music, dancing); social activities; health, legal, and financial counseling; transportation services; volunteer opportunities; congregate meals; outreach programs (friendly visiting, telephone reassurance). Senior centers are typically sponsored by a local council on aging and are often located in churches or housing projects, although some are independent of other organizations.

Speech Therapist. Speech therapists (STs) are involved in the evaluation and rehabilitation of disorders of speech, voice, language, or hearing. These disorders may be the result of an injury, stroke, or disease.

Support Groups (Older Adults/Caregivers). Support groups for older adults or their caregivers are groups that meet regularly to provide social and emotional support to individuals dealing with similar situations or issues. Groups are typically led by laypersons or a combination of laypersons and professionals. Support groups may be sponsored by or held at churches, community centers, libraries, or social service agencies. Examples of support groups topics or themes include bereavement, coping with arthritis/stroke, and caregiver support for Alzheimer patients.

Telephone Alert. A program that uses telephone lines to alert a central monitoring facility (often a hospital emergency room) of an emergency in the household. This service is predominantly used by older adults who live alone and are at risk for "medical emergencies." The system allows the adults to easily summon help in an emergency via an electronic device worn on their bodies.

Telephone Reassurance. A program in which volunteers provide regular telephone contact at a prearranged time to isolated older adults. The volunteer can give direct verbal assistance, refer the person to an appropriate community resource, and provide social contact. If the older adult's phone is not answered, help is sent immediately through a designated relative, friend, neighbor, or community emergency service.

Transportation

Public. Public transportation for the older adult is generally provided through the local transit authority, which operates on a fixed route/fixed schedule basis. In some areas, the transit authority charges reduced rates for older adults and may provide special vehicles (minibuses or vans equipped for the handicapped) for disabled and older adults.

Other. Transportation for older adults may be provided by the local taxi service, which may have vans equipped for the handicapped available. Other types of transportation programs may be administered by by churches and community agencies for disabled and older adults. Examples of community agencies that may operate transportation programs for older adults include local councils on aging and the American Red Cross.

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