Challenging the MYTHS of Long-Term Care in North Dakota

North Dakota Long Term Care Association
INTRODUCTION

Aging and disability are difficult topics for everyone. Any elder who can safely live in the community should do so, but when nursing home care is necessary, our state’s nursing homes provide medically-sophisticated, high-quality care.

When nursing facilities were developed over 100 years ago, they were the nation’s long-term care system – serving as homes for elders without a place to live or a safe guard for families unable to provide care. Since that time, much has changed.

Today, nursing facilities provide 24-hour care to elders and disabled individuals with extensive medical needs, and additional options have emerged for those with lesser care needs. Home and community-based services have expanded significantly, and basic care and assisted living facilities dot the landscape. North Dakota continues to improve and expand care options for the elderly and disabled. Many nursing facilities in North Dakota are at the forefront of providing community-based services such as adult day care and assisted living. In the meantime, our state and nation struggle with how to develop and manage a true continuum of long-term care services for an over-85 population that is expected to increase by 59% in North Dakota in the next fourteen years.

Some myths have emerged that are creating misconceptions for elders and their families, policymakers, and the general public. The truth is that both nursing facility care and home and community-based services are important, and it is not necessary to choose between the two.

All seniors in North Dakota deserve to have access to the most appropriate long-term care services to meet their needs. This means both home and community-based services and nursing facility care.

Seniors and their families, armed with good information about the available options, can be trusted to make the right choices. The challenge for state policymakers, long-term care providers and elder advocates is to ensure that consumers know their rights and have access to the most accurate and complete information possible.

The North Dakota Long Term Care Association is committed to working cooperatively with all parties to develop the best possible long-term care system for our state and its citizens. It is our hope that this report will dispel some of the myths and advance discussion of the real issues that face us.

Sincerely,

Kurt Stoner
Chairman
North Dakota Long Term Care Association

Shelly Peterson
President
North Dakota Long Term Care Association
LONG TERM CARE MYTHS

**Myth #1:**
There are a lot of people in North Dakota nursing facilities who don't need to be there.

**Myth #2:**
It is too costly to care for someone in a nursing facility.

**Myth #3:**
Caring for a frail elder at home is less expensive than nursing facility care.

**Myth #4:**
Once you enter a nursing facility, you never go back home.

**Myth #5:**
Discharge planners and physicians readily discharge individuals to nursing facilities without first examining and considering home and community based services.

**Myth #6:**
Caregivers admit family members to a nursing facility before it is really necessary and appropriate.

**Myth #7:**
Nursing facility care and home and community based care are both delivered under the medical model.

**Myth #8:**
There are no limits to nursing facility spending and Medicaid pays whatever it costs to care for someone in a nursing facility.

**Myth #9:**
All Medicaid providers are treated the same.

**Myth #10:**
The most common reason a North Dakotan care recipient does not use a service is because they don't know about the service or how to access it.
CHALLENGING THE MYTHS ABOUT LONG TERM CARE IN NORTH DAKOTA

Long Term Care Myths & Realities

**Myth #1:** There are a lot of people in North Dakota nursing facilities who don’t need to be there.

**REALITY:**
Nursing facilities care for a severely impaired patient population, most of whom have already exhausted home and community based services. Seventy-five percent of nursing facility patients need help in three or more activities of daily living, such as bathing, dressing, toileting, ambulatory, transferring and eating. The typical ND patient is female, 84 years of age, widowed, receiving 4.34 hours of nursing care a day, and on 11 different medications.

North Dakota requires all Medicaid elders being admitted from the community or already in the facility and converting to Medicaid be screened in clinical need for nursing facility level of care. Medicaid individuals screened not in need of this level of medical acuity will not be allowed admission. Nursing facilities are not involved in making these clinical eligibility determinations. Elders are coming to nursing facilities at a much later stage in their illness. Families are providing a tremendous amount of support and care and only when their nursing care needs can no longer be safely and effectively provided at home does a nursing home placement occur.

North Dakota has the fifth highest private pay population residing in a nursing facility. These are individuals with sufficient income, assets, and resources who can select a multitude of care options and choose to live in and pay a nursing facility to meet their nursing needs.

The reality is nursing home admissions are driven by need. Placement of a loved one in a nursing facility is not done for the sake of convenience. It is done because the individual's needs are so profound that they can no longer be met safely and cost effectively in less intensive settings.
Myth #2: It is too costly to care for someone in a nursing facility.

REALITY:
In 2006, the average daily cost to care for an elder in a North Dakota nursing home is $152.33, or $6.35 per hour of care. This rate covers room, meals, nursing care, nursing case management, rehabilitative nursing, personal care services, activities, social services, OTC drugs, pharmacy oversight and all administrative costs.

The typical individual in need of nursing facility care is female, age 84, widowed and living alone prior to admission. Many suffer from a variety of medical conditions, including cerebrovascular disease, congestive heart failure, cancer, emphysema, COPD, fractures due to falls and neurological disorders such as multiple sclerosis and Parkinson’s disease. Nearly half of all North Dakota nursing facility residents suffer from Alzheimer’s disease or a related dementia. Many are chair bound and unable to walk without assistance.

In addition to their growing ADL dependencies, North Dakota nursing home residents require extensive nursing services. Complex nursing services such as wound care, ostomy care, trach care and suctioning, dialysis, tube feedings, and extensive physical and occupational therapy are becoming the norm in today’s nursing home. Caring for an elder with complex medical needs requiring 24-hour availability of nursing care is cost effectively delivered in the nursing facility setting.

Myth #3: Caring for a frail elder at home is less expensive than nursing facility care.

REALITY:
Caring for a frail elder at home is less expensive than nursing facility care when the care is intermittent, provided by non-medical personnel (QSP), nursing needs are limited and care can be supplemented by unpaid, informal supports such as families. Currently, the vast majority of care received by elders at home is provided by unpaid family members.

For today’s nursing facility patients who need 24-hour availability of nursing care, nursing facility care is actually less expensive than comparable home-based care. Currently the average nursing facility rate is $152.33 a day, which includes 4.34 hours of nursing care, with 1.17 hours of care provided by a nurse and 3.16 hours of care provided by a certified nurse assistant (CNA). Nursing care is administered with oversight, supervision and management of a residents care by a multi-disciplinary healthcare team and personal physician.

Besides nursing care, the daily rate also includes housing, food, activities, social services, over the counter drugs, pharmacy oversight of medication, transportation to medical appointments and administration (insurance, accounting, etc).
To purchase just the nursing services at home through the Medicaid home health program, it would cost $73.54, per visit of nursing. As a result, just the 4.35 hours of nursing time provided throughout the day in the nursing home amounts to $319.90 a day at home, already exceeding the entire nursing facility daily rate of $152.33. For Medicaid home health one rate is paid for nursing care regardless if the service is provided by a CNA, LPN, or RN. The per visit fee does not dictate the length of the service. It could be as short as 15 minutes or as long as 2 hours. Those delivering home health indicate the average visit time is an hour. As the additional cost of essential non-nursing services, such as meals, housing, transportation, social services and activities are added to the cost of home-based nursing care, it is clear that 24-hour nursing facility care can be more cost effective than home-based care.

In the last three bienniums, the appropriation for home and community-based services (HCBS) has been in double digits. During this same time the nursing facilities budget has continued to grow. Expansion of HCBS does not appear to be putting a dent in the need for nursing facility care and the necessary appropriation. A study conducted by Joshua M. Wiener of the Urban Institute found, “The most persistent dream in long term care is that the expansion of home care and other nonmedicalized residential long term care services could reduce overall long term care expenditures. The fundamental hope has been that lower-cost home care could replace more expensive nursing home care. However, there is substantial, rigorous research to suggest that expanding home care is more likely to increase rather than decrease total long term care costs.”

A January 22, 2006 article in the Pittsburg Post-Gazette highlighted this issue for Pennsylvania. In the space of three years, the near doubling of the number of people receiving home services has boosted the program’s cost by more than $200 million. Expansion was planned in hopes that expenditures for nursing home patients would stop climbing in excess of $100 million a year as more people received care in their own homes. That equation turned out to be incorrect. State officials said they need to focus enrollment in the HCBS program on those people who would clearly be in a nursing home if not for waiver services. Otherwise, new enrollees become costly instead of stretching dollars. The cost associated with large increases in home care is not making an impact on lowering nursing home costs or use.

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<th>Long Term Care Appropriation, 1999-2007</th>
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REALITY:
For the past two years, discharge rates from the nursing home to home have been consistent; individuals are going back home. In 2005 over 4,400 residents were discharged from North Dakota nursing facilities. Of this number, twenty-five percent returned to their own home and one-third returned home or to a lower level of care, such as basic care, assisted living, adult foster care or to the home of a family member.

Residents are also staying for shorter periods of time, thus saving Medicaid dollars. Admissions: An individual admitted in 2006 will average only 98 days in a nursing facility. Discharges: When we consider all residents discharged in 2005, their total length of stay averaged 1.18 years.

**Nursing Facilities Discharges in 2005**
*Destination after Discharge*

- **Death**: 2,224 or 50%
- **Home**: 1,083 or 25%
- **Hospital/Swing Bed**: 483 or 11%
- **Nursing Facility**: 296 or 7%
- **Assisted Living Facility**: 167 or 4%
- **Basic Care Facility**: 167 or 4%
- **Family**: 40 or 1%
- **Other**: 44 or 1%

Myth #4:
Once you enter a nursing facility, you never go back home.

**REALITY:**
Twelve percent of all residents admitted to a nursing facility return to their own home.

Myth #5:
Discharge planners and physicians readily discharge individuals to nursing facilities without first examining and considering home and community based services.

**REALITY:**
Most hospital discharge planners are either social workers, nurses or both. Hospitals have a process of identifying patients who may need care after discharge. A patient in need of healthcare services after discharge is identified early in the hospitalization. The discharge planners meet with the patient and family, identify the patient’s needs after discharge, discuss available service options, and ask the patient or family which option they prefer. This preference is followed whenever possible.

The patient’s primary physician is responsible to see that the patient receives the needed healthcare services after discharge. These services often can be provided in a variety of settings, including home health care, home and community based services, a family member’s home, a nursing facility, or in other living facilities. Only a small percent of hospital elderly discharges are to nursing facilities.
Myth #6:
Caregivers admit family members to a nursing facility before it is really necessary and appropriate.

REALITY:
Family members report months and sometimes years of intense caregiving prior to ultimately choosing nursing facility care. North Dakota families, representing over thirty residents from large and small, rural and urban facilities, shared their experiences through focus groups conducted by the NDLTCA. When asked what level of service would be required to make it possible for their loved one to live with them or back in the community with services, all reported the need for 24-hour care. Realistically most believed their family member could not move back home. Most spoke of a heart wrenching decision that left them guilty, especially spouses unable to continue caring for each other. Caregivers recalled exhaustion, frustration, physical and mental limitations, constant physician and hospital visits, calls at all hours of the night and other family members telling them they couldn’t continue. Family members indicate that placement was delayed for as long as possible and replicating the care they receive today with the care they received at home “would not be possible.”

Myth #7:
Nursing facility care and home and community based care are both delivered under the medical model.

REALITY:
The reality is only nursing facility care follows the medical model. Residents are admitted under physician orders and nursing assessments and comprehensive care plans by a multi-disciplinary care team are required. Restorative nursing and physical and occupational therapy are the mainstay of almost all nursing facilities. All CNA’s are under the supervision of nurses and must pass a comprehensive course and test to work in a nursing facility. Residents are on special diets, receive complex treatment and are continually assessed for changing conditions. Elders are coming to nursing facilities at much later stages in their illness and diseases, and their medical needs are complex.

Home and community-based services are delivered by Qualified Service Providers (QSP), self-employed individuals and agencies. QSPs are not nurses or CNAs, nor must they take classes or pass a test to perform their work. They are not allowed to administer medication or assist with eye drops or medicated lotions. QSPs can assist with bathing, dressing, cleaning, cooking, and paying bills. Individual, self-employed QSPs don’t have a supervisor and their service within the home is intermittent and non-medical.

North Dakota HCBS clients (under the Medicaid waiver) experience higher acute care costs than nursing facility residents. Acute care costs are 31% higher for HCBS clients than for nursing facility residents in North Dakota. Higher acute care costs in the community are a common phenomena. Prior to placement in a nursing facility, many families report numerous clinic visits, emergency room visits, and acute care admissions.
Myth #8: There are no limits to nursing facility spending and Medicaid pays whatever it costs to care for someone in a nursing facility.

REALITY:
Nursing home rates are controlled by the legislature and the legislature is the only entity that can increase rates for nursing homes. The North Dakota Century Code establishes limits on what nursing facilities will be paid for caring for an individual in a nursing facility. These limits affect all resident’s rates except those established by the federal government, thus the state sets the limits for 95% of the payment system, with the federal government setting the remaining 5%. In 2005, the legislature determined the limits (the maximum that will be paid) would be increased by 2.65% in 2006 and in 2007. In 2007, the legislature will again determine the yearly increases for 2008 and 2009.

North Dakota has equalization of rates so it is illegal to charge more even though your costs may have increased by double-digit inflation. Even though the cost to deliver resident care may increase dramatically, the amount paid could be far less. If nursing facilities find it necessary to spend more than the rate allows, they must fundraise or dip into their reserves to pay the bills. If nursing facilities continue to spend more than the established limit, they will not remain financially viable.

Myth #9: All Medicaid providers are treated the same.

REALITY:
Medicaid providers include numerous health care providers, such as dentists, optometrists, nursing homes, hospitals, physicians, home health agencies, etc. Each of these providers has a unique payment system. Nursing homes are the only North Dakota Medicaid providers mandated in the NDCC to have equalization of rates. Equalization of rates means nursing facilities are prohibited from charging private paying residents more than the rate set by Medicaid. Medicaid controls and sets the rate for all nursing home residents except the 5% controlled by Medicare. If the legislature sets the rate below the cost to delivery quality care or hire and pay sufficient staff, this could be detrimental for all, especially the frail residents in need of 24-hour nursing care. The closest Medicaid provider that mirrors the Equalization of rates system are DD providers. Nearly 99% of their residents are receiving Medicaid, thus by default they have equalized rates.
REALITY:
In 2002, Aging Service Division of the Department of Human Services commissioned a study on North Dakota caregivers. The study was conducted by NDSU. The study found the majority of caregivers were 65 years of age or older and almost half were spouses. Of these caregivers in the study, the vast majority, 93% did not receive any monetary compensation for services. Caregivers reported it was difficult to accept support or assistance because of “their duty to caregiving.” The most common reason a care recipient does not use a service is because caregivers reported, “they did not need it.” Our experience with caregivers is that they provide extensive care and support, and only after all other options have been utilized and explored do they consider a nursing facility placement for their loved one.

Reference Sources
• MDS Data Report on 4,969 residents from 12-1-05 to 2-28-06, ND Dept. of Human Services
• Nursing Facility Payment System Study by Myers & Stauffer LC, Oct. 2002
• Caregivers: 2002 Phone Survey, May 2003 by ND State Data Center, NDSU
• Informal Caregivers: 2002 Outreach Survey, May 2003 by ND State Data Center, NDSU
• Long Term Care Appropriations, 2006 by ND Dept. of Human Services
• Home Health Revenue Codes, 2006 by ND Dept. of Human Services
• Annual Report of HCBS Waivers, Aged & Disabled Waiver, ND Dept. of Human Services
• Discharge Destination & Length of Stay 2005, NF Survey Results, NDLTCA
• Admission Rates & Length of Stay 2005, NF Survey Results, NDLTCA
• NF Cost Report Data from 6-30-05, Dept. of Human Services, compiled from Eide Bailly
• Medicare Current Beneficiaries Survey 2002, CMS
• Discharge Planning Process, Rodger Wetzel of St. Alexius Medical Center, Bismarck, ND
• Challenging the Myths About Long Term Care in Massachusetts, Nov. 2003
• Joshua M. Weiner, Urban Institute
• Rising Costs for Older People Squeeze Pennsylvania by Gary Rotstein, Pittsburg Post-Gazette, 1-22-06
The North Dakota Long Term Care Association (NDLTC) is a non-profit trade association representing long term care facilities in North Dakota. Membership includes nursing facilities, basic care facilities and assisted living facilities. NDLTCA began operating in 1977 and currently represents 141 nursing, basic care and assisted living facilities.

NDLTCA works closely with State and Federal government agencies along with other professional associations in its efforts to advocate on behalf of long term care and promote sound legislation and regulatory policies.

NDLTCA is an affiliate of the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL). AHCA and NCAL, located in Washington, D.C., are the largest organizations of long term care facilities in the nation.

NDLTCA is governed by a 13 member Board elected by the membership. Overall policy of the NDLTCA is the responsibility of the Board.

NDLTCA is dedicated to serving our members who strive to maintain the highest quality of care for the elderly and disabled.

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Mission Statement
We are a professional association of community and long term care providers who enhance the lives of people we serve through collaboration, education and advocacy.

Vision Statement
The North Dakota Long Term Care Association is recognized as an innovative leader and pioneer in the continuum of care, which has a positive impact on the health and well being of the people of North Dakota.

Core Values
We value:
• Competence
• Honesty
• Integrity
• Responsiveness
• Trust