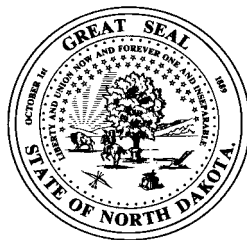


**Report
of the
Task Force on
Long-Term Care Planning**

September 2000



North Dakota

Report of the Task Force on Long-Term Care Planning

Presented to
Edward T. Schafer, Governor
of the State
of North Dakota

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Acknowledgment

The Department of Health and the Department of Human Services wish to extend sincere thanks to all who participated in this effort. Your attendance at the many meetings, your knowledge of the complicated issues, and your insight relating to opportunities for reforming the long-term care system in North Dakota are sincerely appreciated.

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Introduction

North Dakota has a long and proud history of providing a wide range of financial, health and social services for older persons and persons with disabilities. This commitment is important to preserve the dignity and well being of these individuals.

Many older persons enjoy relatively good health, and many persons with disabilities do not require any type of assistance to meet their needs. Others, however, due to reduced physical or mental capacities, require assistance provided through long-term care services.

Over the past several decades these services have been provided through the use of institutional care with emphasis on the use of the highest cost service, nursing facility care. The issue surrounding the provision of long-term care services is further complicated by North Dakota's unique demographics that create significant challenges in our ability to meet the needs of persons with disabilities and the elderly population.

Public policy is often influenced by the manner in which programs, such as Medicaid, are financed. From its inception in 1965, the federal government provided matching funds to pay for institutional long-term care services. This commitment led to the rapid growth of the nursing facility industry as the primary resource for the delivery of long-term care services, in the United States.

The federal government has taken other steps that further complicated the financing of long-term care services. In 1987, Congress eliminated the intermediate care designation of nursing homes. This level of care required that a nurse be on site for only eight hours per day. Intermediate care costs were about two-thirds the cost of skilled nursing care. All intermediate care beds licensed in North Dakota were converted to nursing facility beds. In some cases, extensive renovation was necessary and staffing patterns were increased. Costs for operation of these facilities increased accordingly. This change further complicated the delivery of long-term care services because it resulted in the placement of many individuals in a level of care that exceeded their actual needs.

In the early 1980s, the federal government became concerned about the cost of providing long-term care services in institutional settings. In response, a waiver option was developed that allowed states to provide nonmedical home and community-based services to recipients who would otherwise require nursing facility services. The purpose of the waiver was to reduce costs and provide services in the least restrictive environment based on the individual needs of each recipient. Currently, North Dakota has three operational waivers that include the elderly and disabled, developmentally disabled, and traumatic brain-injured.

The June 1996 Task Force Report stated that North Dakota institutionalized about 1.3 percent of our elderly population, the highest percentage in the country. The report also stated that North Dakota had about 75.6 beds per thousand elderly over age 65, whereas the national average was about 50. Despite the availability of waivers, North Dakota has continued to rely heavily on the use of nursing facility care. We continue to maintain and finance a large number of nursing facility beds when compared to the national average.

Home and community-based services (HCBS) provide an opportunity to reduce the reliance on the use of institutional care by offering quality services in alternative settings. Statutory definitions of both institutional care and community-based services inhibit movement toward a more seamless delivery process, and service delivery in these settings is often fragmented and lacks systematic coordination. If we intend to utilize these services to reduce the need for institutional care, it will be necessary to provide adequate incentives to encourage the development of appropriate alternatives to meet the needs of older persons and persons with disabilities. It will also be necessary to encourage conversion of significant portions of existing institutional capacity to alternative service modes.

From 1990 to 2000 nursing home Medicaid expenditures increased \$52.8 million for an average annual increase of 8.4% per year (Exhibit 1). Since 1994 North Dakota's nursing facility Medicaid expenditures continued to increase even though the number of beds occupied by Medicaid individuals decreased. From 1994 to 1999 the number of beds occupied by individuals eligible for Medicaid decreased 488 beds from 3,954 beds to 3,466 beds (Exhibit 2) for an average annual decrease of 2.5%. During the same time period, Medicaid expenditures increased \$18.8 million from \$93.8 million to \$112.8 million (Exhibit 1) for an average annual increase of 4%. Licensed capacity during the same period has decreased only 3.0% in comparison to a 6.9% decrease in total occupancy (Exhibit 3).

Exhibits 4 and 5 provide a comparison of the monthly average Medicaid eligible recipients and total expenditures for Medicaid eligible individuals. From 1996 to 2000 nursing facility expenditures have continued to climb while the number of Medicaid recipients has decreased. This is in contrast to basic care and home and community-based services where expenditures have increased in conjunction with the number of recipients served. From 1996 to 2000 the cost of caring for a nursing facility resident has increased an average of \$128 per year in comparison to a \$32 per year average increase for basic care and home and community-based services (Exhibit 6).

The challenge of the future will be to provide the services necessary to care for the baby boomer generation. This challenge will become more difficult as the number of elderly needing services increases and the workforce available to care for these individuals decreases. The State of North Dakota must continue to strive to provide older persons and persons with disabilities with a real choice of long-term care service options and allow them to receive services in the least restrictive, most cost-effective setting possible.

History of Task Force

The North Dakota Department of Health and the North Dakota Department of Human Services convened a long-term care working group during the summer of 1993. The purpose of this working group was to provide assistance to the State Health Council in developing a policy under which the Council would review applications for Certificate of Need for long-term care institutional bed capacity. In January 1994, the working group presented proposed policies to the Council. These proposals were adopted by the Council in March of 1994, and with minor revisions, served as guidelines for consideration of long-term care applications until repeal of the Certificate of Need statute by the Fifty-Fourth Legislative Assembly.

The nature of the investigation conducted by this working group led directly to identification of several issues and situations unique to North Dakota. This investigation also required a thorough examination of the environment, federal and state policies, and the demographics that drive our system of long-term care. Much of the information developed by the working group was conveyed to the legislature.

The legislation repealing the Certificate Of Need program (CON) also provided for a two-year moratorium on the licensing of additional long-term care bed capacity. This legislation (Senate Bill 2460) directed that a study of long-term care be conducted and a comprehensive report prepared by the Legislative Council in conjunction with the State Health Council and the Department of Human Services. The State Health Officer and the Executive Director of the Department of Human Services appointed a Task Force on Long-Term Care Planning to facilitate the study prescribed by Senate Bill 2460. The report of the 1993 working group and the guidelines adopted by the Health Council provided the background and starting point for the Task Force, which began its work in September of 1995.

The Task Force, 1995-1996

The Fifty-Fifth Legislative Assembly was very receptive to the recommendations of the Task Force. Most of the legislation recommended by the Task Force was enacted. Pilot projects on conversion of existing long-term care bed capacity to serve the Alzheimer's and related dementia population and to test expanded case management are under way and will continue into the coming biennium as a result of this legislation. Asset protection provided to spouses of institutionalized individuals was extended to spouses of recipients of home and community-based services. Insurance coverage for persons with long-term care insurance providing a home benefit was broadened to include services rendered by Qualified Service Providers. The entire collection of long-term study recommendations was adopted in the form of concurrent study resolutions and all of these resolutions (HCR 3003, HCR 3004, HCR 3005 and HCR 3006) were selected for study during the 1997-1998 interim. All four resolutions were assigned to the Budget Committee on Long-Term Care by the Legislative Council. The examination of basic care rate equalization required by House Bill 1012 was similarly assigned.

The Task Force, 1997-1998

Governor Edward T. Schafer reappointed the Task Force on Long-Term Care Planning in June of 1997 to assist the Departments of Health and Human Services in providing the Legislative Council with meaningful input in response to the study resolutions.

The Task Force again assembled and reviewed available data and studies from across the country in response to the issues identified in the various study resolutions. A presentation was made regarding the national agenda for long-term care and federal entitlement programs by the Deputy Director of the National Association of State Units on Aging.

The Task Force again formed several Ad Hoc committees to investigate the several issues identified in the study resolutions. The committees, which began their work in October of 1997, received the following study assignments:

1. Financing and Payment Incentives
2. Residential Services, Definitions and Funding Reorganization
3. Geropsychiatric Services
4. Case Management, Service Availability and Qualified Service Provider Training
5. Native American Long-Term Care Service System

The Ad Hoc committees concluded their studies in late April 1998 and issued reports to the Task Force during April and May. A report issued in June 1998 summarized the committees' findings and the adopted recommendations of the Task Force.

The Task Force, 1999-2000

Governor Edward T. Schafer reappointed the Task Force on Long-Term Care Planning in September 1999. The Task Force met for the first time on October 14, 1999. The Task Force formed Ad Hoc committees to review the following areas:

1. Senate Bill 2036 directed the Department of Human Services and the Department of Health to prepare a recommendation for consideration by the Fifty-Seventh Legislative Assembly combining basic care and assisted living services into one system. This committee was also to review the Senior Mill Levy Match to determine if it could be used to expand or enhance home and community based services and was to make a recommendation on whether or not the moratorium on basic care bed capacity should be continued.

2. Care coordination/case management, to determine if North Dakota needs to provide this service on a comprehensive statewide basis for individuals in need of long-term care services.
3. Study the manner in which long-term care services are provided to Native American elderly and disabled and recommend ways to improve the delivery of long-term care services to this population.
4. Swing bed usage in acute care hospitals, to determine if any changes need to be made in the manner that hospitals provide services to individuals in need of long-term care.
5. The current nursing facility rate equalization policy, to determine if any changes need to be made.

In addition to the areas studied by the Ad Hoc committees, the Task Force requested updates on end-of-life issues and the loan and grant program that was established by Senate Bill 2168 to develop alternatives to nursing facility care. The Ad Hoc committees concluded their studies in July of 2000 and issued reports to the Task Force during July and August. This report summarizes the committees' findings and the adopted recommendations of the Task Force.

Recommendations

Nursing Facility Rate Equalization

In 1987 the Legislature passed a law requiring nursing facility rates be equalized and a case-mix payment system be developed. The equalized rate/case-mix system was implemented on January 1, 1990. After the 1987 legislation passed, a comprehensive study was conducted to develop the new payment system. The industry, government, and consumers all participated in the study.

The study resulted in a system with the following features: 16 levels of care; expenses were divided into four types of cost categories, direct care, other direct care, indirect care and property costs; each cost category, except property had a maximum limit; an incentive payment up to \$2.60 per resident day would be provided to efficient facilities; each facility would receive a 3% operating margin on direct and other direct care costs; and costs and limits would be adjusted annually by Data Resources Incorporated (DRI) indices. The payment system expanded the number of levels of care from 16 to 34 in 1999.

From 1990 to 2000, nursing home Medicaid expenditures to nursing facilities have increased from \$62.9 million to \$115.7 million, an 84% increase in 10 years. There continues to be only one other state with an equalized rate system, Minnesota.

Since the equalized rate/case mix system has been in existence for 10 years, the Task Force decided it should review the merits of this public policy. The Task Force appointed the President of the North Dakota Long-Term Care Association (NDLTCA) and a representative of the American Association of Retired Persons (AARP) to co-chair the Equalization of Rates Ad Hoc Committee. The Ad Hoc Committee was comprised of seven consumers, five industry representatives and one government representative.

The group concluded unanimously that equalization of rates was a good, fair public policy and should be continued. The Ad Hoc Committee decided the payment system may need some adjusting and they directed their efforts at evaluating the adequacy of the current payment system. After a review of the current payment system, another recommendation was made altering the payment system.

In 1994, when the state suffered a budget shortfall, nursing facilities were at risk because the Medicaid program was not adequately funded. With rate equalization, private pay revenues are also effected. Therefore, if the equalized rate system is to be successful, funding for nursing facility resident care must be consistent, fair, and periodically reviewed.

The Ad Hoc Committee recommended changes in the current payment system to better address inflation and more frequent updating of costs.

The Ad Hoc Committee recommended that rate setting for nursing facility be amended to include using the 95th percentile for Direct Care (99th currently), the 90th percentile for Other Direct Care (85th currently) and the 75th percentile for Indirect Care (75th currently) to establish limits, use only DRI for inflation (currently use the average of DRI and CPI), to rebase the limit rates every even cost reporting year beginning with June 30, 2000 (currently costs were re-based in 1994 and 2000 using June 30, 1992 and June 30, 1996 costs, respectively); to eliminate the incentive and include a 3% operating margin on the Indirect Care cost category (currently the operation margin is only on Direct Care and Other Direct Care costs). This motion was passed unanimously by the Ad Hoc Committee.

The Ad Hoc Committee also studied rates charged for private rooms. After review of the different charges, no recommendation was made.

The Ad Hoc Committee made their recommendations to the Task Force. The Task Force accepted the recommendation to continue the equalized rate policy but did not accept the Ad Hoc committee's recommendation to change the way the payment rates were calculated.

Recommendations for the Fifty-Seventh Legislative Assembly

1. Rate equalization should be continued and funding should be consistent, fair and periodically reviewed.

Basic Care and Assisted Living

Senate Bill 2036 directed the Department of Human Services and the Department of Health to prepare a recommendation for consideration by the Fifty-Seventh Legislative Assembly describing the conversion of current basic care and assisted living services into an integrated long-term housing and service system entitled assisted living. While the Task Force believes the current licensing requirements for basic care facilities could be modified to include assisted living facilities, the Task Force recommends the two types of facilities not be integrated into one long-term housing and service system. Assisted living services are provided in an apartment-like setting where clients make choices regarding the type of care received. Basic care is provided in a congregate setting and provides the same basic services/cares to all residents of the facility including meals, activities and personal care services.

The Task Force adopted several recommendations relating to basic care or assisted living services. While the Task Force does not believe assisted living facilities should be subject to the same regulation as basic care facilities, it does recommend that assisted living facilities be required to register with the Department of Human Services and be licensed by the Department of Health under the same food and lodging licensing standards required of motels and hotels. Registration and licensure should be mandatory and would require entities to provide information about the facility to the Departments.

The registration process should enable individuals to collect long-term care insurance benefits when they reside in an assisted living facility. Currently, some long-term care insurance policies will not pay for services if the individual is residing in an unlicensed assisted living facility. The Task Force believes that registering assisted living facilities should resolve this issue and would permit payment of long-term care insurance benefits as the insurance industry would view registration as a form of licensure by the state.

The Task Force recommends that the Department of Human Services receive complaints related to assisted living and forward the complaints to the appropriate agency for investigation. Establishing the Department as the agency to receive complaints and requiring assisted living facilities to register and comply with food and lodging licensure requirements should provide additional assurances to the public and state about the condition of the facilities and quality of services provided.

Currently basic care facilities are not charged a licensure fee. The Task Force recommends that basic care facilities be charged a licensing fee and assisted living facilities be charged a registration fee. Fees collected should be applied to costs incurred by the departments in handling complaints and in registering or licensing the facilities.

The Task Force recommends that a rent subsidy be established to make assisted living more affordable to individuals eligible for assistance. Currently, many individuals eligible for assistance cannot afford to live in assisted living facilities because the cost of rent exceeds the medically needy income level. If individuals eligible for assistance could afford to access assisted living facilities where twenty-four hour services are available, individuals may be able to maintain their independence for a longer period of time and could possibly delay or prevent the need for nursing facility care in the future.

The Task Force recommends that the moratorium on basic care beds be repealed. The Task Force believes that because of the moratorium on basic care beds, there are facilities providing basic care services and holding themselves out as assisted living facilities. The moratorium should be repealed so that these facilities can be licensed and be properly regulated based on the type of services they provide.

The provision for pilot projects set forth in Senate Bill 2036 sunsets on June 30, 2001. If the above Task Force recommendations are implemented, the Task Force then recommends that except for units in nursing facilities, Alzheimer's and related dementia projects and twenty-four hour care projects created under Senate Bill 2036 be licensed as basic care facilities. If the above recommendations are not implemented, the Alzheimer's and related dementia projects and twenty-four hour care projects created under Senate Bill 2036 should be allowed to continue as pilot projects.

On June 28, 2000 the Task Force recommendations on basic care and assisted living were presented to the Interim Budget Committee on Health Care. The Budget Committee questioned whether the Task Force recommendations complied with the requirements of Section 3 of 1999 Senate Bill 2036 since the position of the Task Force is that basic care and assisted living should not be combined. The Task Force decided to present their recommendations and the Department of Human Services and the State Department of Health should prepare a separate report integrating basic care and assisted living.

Recommendations for the Fifty-Seventh Legislative Assembly

1. The following recommendations regarding assisted living and basic care should be implemented together:
 - a. Retain basic care as it is currently defined and regulated.
 - b. Require the Department of Human Services to register assisted living facilities and charge a registration fee.
 - c. Require mandatory registration of assisted living facilities that meet the modified definition of the current definition, which would include meeting food and lodging licensing requirements under NDCC 23-09 if appropriate.
 - d. Amend NDCC 23-09 as appropriate to allow the Department of Health to license assisted living facilities under the food and lodging regulations.
 - e. Have the Department of Human Services receive complaints related to assisted living and forward them to the appropriate agency for investigation.
 - f. Exclusive of units in nursing facilities, Alzheimer's (memory care or special needs) facilities and other pilot project facilities must be licensed and operated as basic care facilities.
2. Establish a rent subsidy program for assisted living. Rent should be subsidized to a maximum of \$750. Thirty percent of the medically needy income level should be applied to rent when determining the rent subsidy. A maximum of \$2.5 million not to exceed the amount of general fund dollars saved if the personal care option is added to the state plan and provided in basic care facilities. (See Exhibit 7 for Fiscal Impact Projections for the 2001-2003 Biennium)
3. Establish a licensing fee for basic care facilities.
4. Repeal the moratorium on basic care beds.

Personal Care Services

Currently the State of North Dakota does not have the Medicaid personal care service option as part of its State plan. The Health Care Financing Administration (HCFA) has revised the requirements for Medicaid coverage of personal care services. Because of these revisions, the personal care services option is now a more viable option to the State because it can be better implemented with the State's existing programs. Using the personal care option will promote the development of alternatives to nursing facility care. Personal care service for individuals residing in their own home will continue to be financed through the Medicaid waiver program.

Recommendations for the Fifty-Seventh Legislative Assembly

1. The State should add the Medicaid personal care service option to the State Plan.
2. Limit the personal care service option to certain provider types, such as basic care or assisted living.

Senior Mill Levy Match

North Dakota Century Code 57-15-56 directs the Department of Human Services to disburse Senior Mill Levy Match funds to counties or cities that levy funding for senior programming. The law was originally approved by the 1971 Legislative Assembly. In 1991 the legislature amended the law and restricted the types of expenses for which mill levy funds can be spent. These funds are intended for a variety of services designed to assist senior citizens in maintaining independence including home-delivered meals, transportation, outreach assistance, congregate dining, and health-related services.

An organization needs to be incorporated as nonprofit under state law to be eligible to receive Senior Mill Levy Match Funds. Most of the dollars are distributed by county or city commissioners to agencies that contract with the Department of Human Services to provide services under Title III of the Older Americans Act.

The original appropriation for the Senior Mill Levy Match program was \$1.6 million and was sufficient to provide dollar-for-dollar match of amounts levied at the county or city level. The appropriation for the 1999-2001 biennium was \$1,262,895, which equates to a match of about 46 cents for every dollar levied locally.

Because these dollars are used to serve an at-risk population in the least restrictive setting, they are an integral part of the continuum of long-term care services in North Dakota. Many older residents of small towns throughout the state rely on Title III providers as one of the few alternatives to institutional care.

Recommendations for the Fifty-Seventh Legislative Assembly

1. The Task Force on Long Term Care Planning recognizes the importance of this funding source in the overall provision of services to the senior citizens of our state and recommends the legislature restore the Senior Mill Levy Match to a dollar-for-dollar match as included in the original appropriation.

Native American Long Term Care Needs

The June 1996 Report of the Task Force on Long Term Care Planning recommended a continuing study of Native American long-term care needs and access to appropriate services; in addition to recommending to the Fifty-Fifth Legislative Assembly the establishment of effective case management of long-term care services. This study issue was held over to the next biennium. The Fifty-Sixth Legislative Assembly passed House Concurrent Resolution 3002 (Appendix B), directing the Legislative Council to study Native American long-term care needs and access to appropriate services and the functional relationship between state service units and the Native American reservation service systems. The Legislative Council referred the study to the Task Force on Long Term Care Planning.

Input meetings were held on each of the 4 Indian Reservations in North Dakota (Turtle Mt. Band of Chippewa Indians; Spirit Lake Nation; Standing Rock Nation; and Three Affiliated Tribes) to gather information regarding the most significant long-term care needs of local tribal elders. In addition, written input was received from Trenton Indian Service Area. The input meetings were attended by Tribal Chairmen and Councilmen, service providers, and elders. In total, 264 individuals attended input meetings or provided written input. See Appendix C for information regarding the input meetings.

The primary identified needs included economic assistance, elder abuse, health care, nutritional needs, home care, housing, and transportation. The input results were also identified as to whether they are issues that are pertinent to the federal government, state government, or tribal government. Although the identified needs were specific to each Reservation and Indian Service Area, there were common issues statewide. Despite the fact that 2 or 3 of the Tribal Councils have expressed interest in developing nursing homes, this was not a primary need expressed during the input meetings.

Additional information was also gathered from the Center for Rural Health and the National Resource Center on Native American Aging at the University of North Dakota; the Department of Human Services Research and Statistics staff; the Indian Affairs Commission; and the Health Department. Ad Hoc Committee members committed to follow-up meetings on each Reservation and assigned lead agencies or individuals for each recommendation presented to the Task Force on Long Term Care Planning. The following recommendations were approved by the Task Force.

Recommendation for the Fifty-Seventh Legislative Assembly

No recommendations for legislative action.

Other Recommendations

1. The unmet transportation needs of tribal elders be jointly addressed by local Tribal officials, the Department of Transportation, the Aging Services Division and Medical Services Division of the Department of Human Services, and the Regional office of the Administration on Aging.
2. The Indian Affairs Commission take the lead to facilitate development of elder councils on each reservation, to serve as a liaison to the Tribal Council and as an advocate for older persons.
3. Inter-agency communication at the local level be strengthened, and inter-agency meetings be held for the purpose of sharing information and addressing unmet needs of tribal elders.
4. Issues and needs identified as specific to either the federal government or the tribal government will be brought to their attention by the Task Force on Long Term Care Planning.
5. The Governor's Committee on Aging be expanded to include a representative from each of the Tribal Nations (possibly as a sub-group), rather than the current one representative. The role of the Governor's Committee be examined and strengthened to include greater authority in the areas of public policy and planning.
6. Public education efforts be increased, through workshops and other methods, to create greater awareness of the following: Senior Health Insurance Counseling Program; Older Americans Act outreach services; Home Extension Services; In Home and Community Based Services; Indian Health Service programs; Medicaid and Medicare; Public Health; County and Tribal Social Service programs, and others.

7. A template be developed outlining the structure and funding sources of various health services available to Tribal members. The template could be used as an educational document for higher education, the Legislature, and the public.
8. A request be sent to the Administration on Aging asking that additional resources be allocated to provide technical assistance and training to Title VI Older Americans Act service providers.
9. Diabetes Education efforts need to be coordinated among the various agencies and organizations dealing with diabetes to better serve the affected population.
10. Appropriate state agencies work with the Tribal Governments and agencies regarding a continuum of living arrangements, including tribal and public housing, assisted living and congregate living, nursing home and basic care services (including discussion on the moratorium on nursing homes) to ensure the safety, comfort, and preferences of the elders.
11. A follow-up meeting be held on each Reservation and Indian Service Area to discuss how the long-term care needs of Tribal elders, brought forward during the input meetings, have been addressed.

Care Coordination/Case Management

The study of case management as a key component in the assessment of client needs, assisting clients in accessing needed services provided by a multitude of agencies and providers, and ensuring that services and funding are targeted to individuals most in need of assistance was initially highlighted in the June 1996 Report of the Task Force on Long Term Care Planning. The Report pointed out that, "Case management for older adults and persons with physical disabilities in North Dakota is currently provided to a limited number of individuals." The Report went on to state that, "Individuals and their families who are searching for long-term care services often find it difficult and confusing to navigate their state's network of services. For many people, this means that they spend too much money on inappropriate services; cannot afford services at all; or end up in a nursing home when their needs could likely have been met with in-home and community based services. This can be very costly for the individuals and the state." As a result of the Task Force recommendations, the Fifty-Fifth Legislative Assembly approved the following: 1) a pilot project(s) testing the expanded case management system; and 2) include the uniform comprehensive assessment in the pilot project(s) with all applicable agencies in the service area included in the testing. The objective of the pilot project(s) was to test a case management system design for individuals in need of long term care services that would offer assistance to citizens in identifying and securing appropriate, cost effective services in the least restrictive environment, while protecting the rights of the individual to make their own decisions.

The 1998 Report of the Task Force on Long-Term Care Planning recommended continuation of the Expanded Case Management (ECM) pilot projects with a final report of the results to be issued no later than June 30, 2000. In addition, recommendations were made to: 1) authorize the Department of Human Services to implement a Targeted Case Management Program for elderly and persons with disabilities at risk of entering a nursing facility or needing other long-term care services; and 2) to require that any individual eligible for the Medicaid Program must, prior to entering a nursing facility or accessing other long-term care services, obtain a pre-admission needs assessment to determine the type of services necessary. The Targeted Case Management and pre-admission assessment recommendations were included in Senate Bill 2037, which was defeated in the Fifty-Sixth Legislative Assembly.

The Expanded Case Management Pilot Projects; which included an urban site (Burleigh County Social Services) and a rural site (Kidder-Emmons Senior Services), have been reviewed on a quarterly basis, as well as reporting regularly to the Care Coordination/Case Management Ad Hoc Committee. See Appendix D for the Expanded Case Management report to the Task Force. The Burleigh County ECM project contracted with a marketing firm to conduct a survey of the public to determine the value of case management to the individual or their family member(s), the terminology most acceptable, and willingness to pay for case management. A summary of the survey results is included as Exhibit 8. In addition, information was received from other states and national programs, as well, as meeting with state legislators.

Exhibit 9 shows the projected cost of implementing Targeted Case Management and Expanded Case Management for 2001-2003 Biennium. The exhibit separately shows the cost of implementing each program as well as the combined cost of implementing both programs. Expanded Case Management would cover individuals who are not eligible for Medicaid and Targeted Case Management would cover Medicaid eligible individuals. Exhibit 10 shows the impact to the general fund to provide case management to the two different groups. Exhibit 10 shows that if Targeted Case Management were added to the state plan there would be general fund savings of approximately \$445,432 for the biennium, even though more individuals were served. The savings would occur because federal dollars would be used to pay for a portion of case management services currently provided in existing programs and funded with 100% general fund dollars.

Recommendation for the Fifty-Seventh Legislative Assembly

1. An optional Targeted Case Management service be added to the Medicaid State Plan for Medicaid eligible recipients who are elderly or persons with physical disabilities at risk of long-term care services including but not limited to SPED and Expanded SPED eligible recipients. (SPED - Service Payments for Elderly and Disabled)
2. Statewide funding for expanded case management.

Other Recommendations

1. As a matter of public policy, Information and Assistance/Referral should be available under case management service to older persons and persons with physical disabilities.
2. Funding from public/private resources be obtained to pay for a statewide education campaign geared to discharge health professionals, and the general public regarding service options and life planning for older persons and persons with physical disabilities. To accomplish this recommendation, a steering committee composed of the ND Long Term Care Association, ND Health Care Association; ND Department of Human Services, and the ND Health Department needs to take the lead in this education effort.
3. Core case management components for the elderly and persons with physical disabilities be consistent with the ND Department of Human Services Case Management Workgroup recommendations.
4. No formal mandatory pre-admission assessment; except for federally required pre-admission screening and resident review (PASRR). Emphasis will be placed on Information and Assistance/Referral, outreach, case management, and public education to address many of the same concerns as pre-admission assessment had previously intended to cover.
5. The Governor's Committee on Aging take the lead role to facilitate agencies to coordinate and collaborate with each other in service delivery to common clients.
6. Case Management service be housed within the geographical area of the client and be provided by a neutral party who knows the core components of case management, knows the community resources and has the ability to network with those resources. A licensed social worker currently performs this function under current HCBS state statute funding sources within the County Social Service Board service delivery structure. It is recommended that this established practice continue. It is further recommended that this method be reviewed in the future.

Swing Bed Facilities

The Task Force on Long Term Care Planning directed the study of swing bed service usage in the state of North Dakota. A Swing Bed Ad Hoc Committee was developed to study this issue. Members of the Committee included the North Dakota Healthcare Association, North Dakota Long Term Care Association, Department of Health and Department of Human Services staff, long term care facility representatives, and a consumer representative. A swing bed occupancy data survey and a survey relating to

minimum data set (MDS) in critical access hospitals was conducted. The result of the surveys indicated there continues to be a decline in the number of swing bed residents, particularly residents staying over 30 days, as well as a growing number of hospitals with swing bed services seeking critical access hospital status.

Recommendation for the Fifty-Seventh Legislative Assembly

No recommendations for legislative action.

Other Recommendations

Whereas, there continues to be a decline in the number of swing bed residents, particularly residents staying over 30 days, as well as a growing number of hospitals with swing bed services seeking critical access hospital status. The Task Force recommends the following:

1. Do not mandate the use of the Minimum Data Set (MDS) by all hospitals providing swing bed services.
2. The North Dakota Long Term Care Association, the North Dakota Healthcare Association, and the Department of Health work together to provide training to hospitals with swing bed services related to federal Medicare Conditions of Participation and Quality of Care issues.
3. The swing bed occupancy survey be repeated in January 2001. If the Task Force on Long Term Care is not reconstituted, the report should go to the State Health Council.

Statewide Needs Assessment

Senate Bill 2168 established the North Dakota Health Care Trust Fund. Loans and grants are available from the trust fund to develop alternatives to nursing facility care which include basic care services, assisted living services and HCBS services.

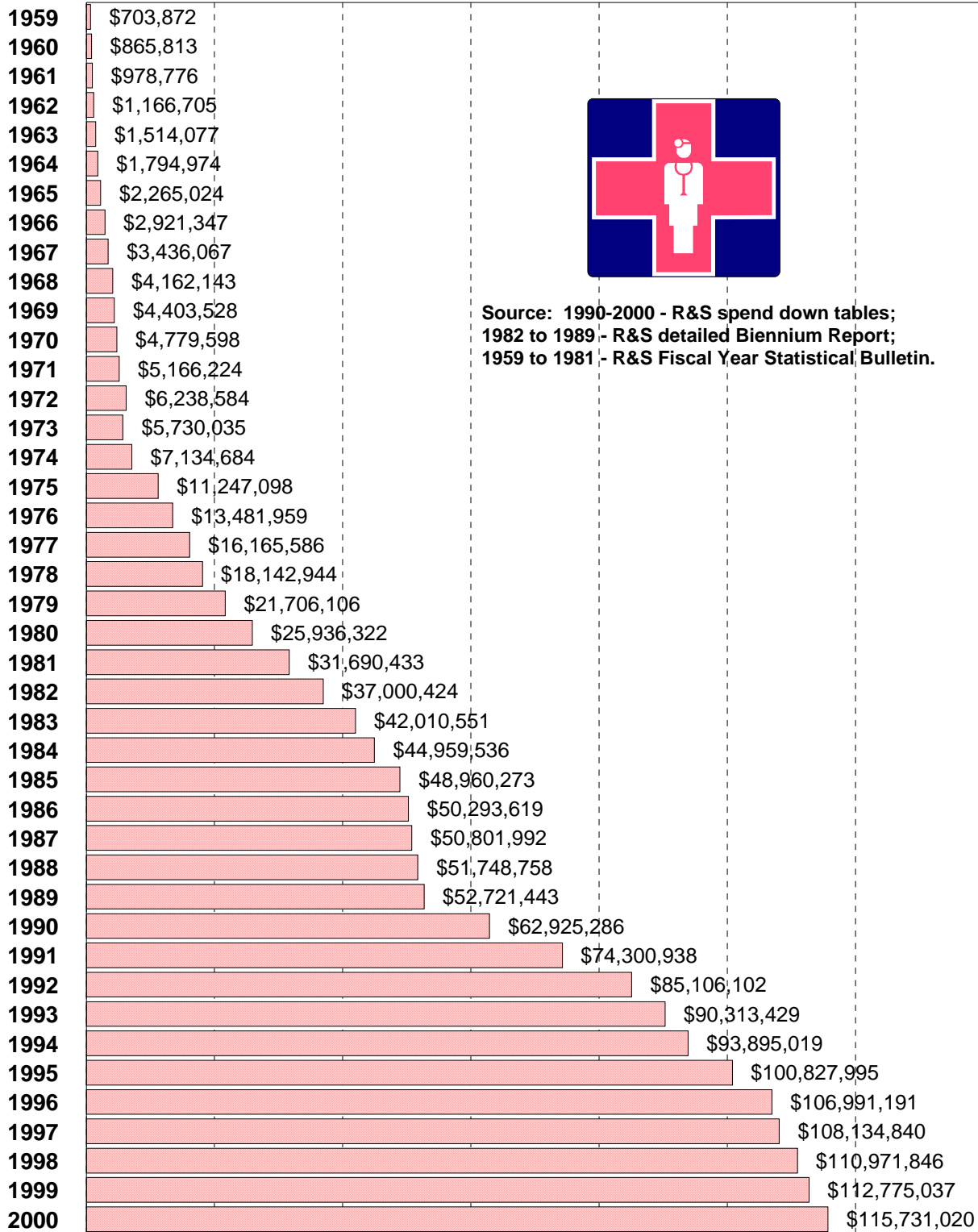
The Department of Human Services who is responsible for administering the loan and grant program provided updates to the Task Force. The Department indicated that information showing the appropriate number of assisted living units, nursing facility and basic care beds needed throughout the state would be very beneficial when determining which projects should be awarded loans and grants. Currently, applicants submitting an application complete their own needs assessment. The Department is concerned that overbuilding may occur if projects are approved based on individual assessments because studies may overlap service areas.

The Task Force supports using funds from the North Dakota Health Care Trust Fund to complete a statewide needs assessment that includes determining the appropriate number of assisted living units, nursing facility and basic care beds needed throughout the state. This study would provide the Department guidance in approving loans and grants and could also be used by the departments and the Legislature in making decisions regarding the future of healthcare in North Dakota. The Task Force also supports having the University of North Dakota and North Dakota State University work together to complete the study since they have the expertise and are familiar with the demographic challenges of North Dakota. The Task Force contacted representatives from the two universities to discuss what a statewide needs assessment might entail. The university representatives indicated that a study of this magnitude could take up to three years to complete. They did say that while the study might not be completed for three years, the study would be completed in stages and the completed portions could be made available to the departments and the Legislature. The university representatives were asked to provide the Task Force with a rough draft of what a statewide needs assessment might entail and how much it might cost. (See Appendix E for preliminary proposal presented to the Task Force.)

APPENDIX A

EXHIBITS

EXHIBIT 1
North Dakota Department of Human Services
Nursing Care Facilities
Fiscal Years 1959 - 2000



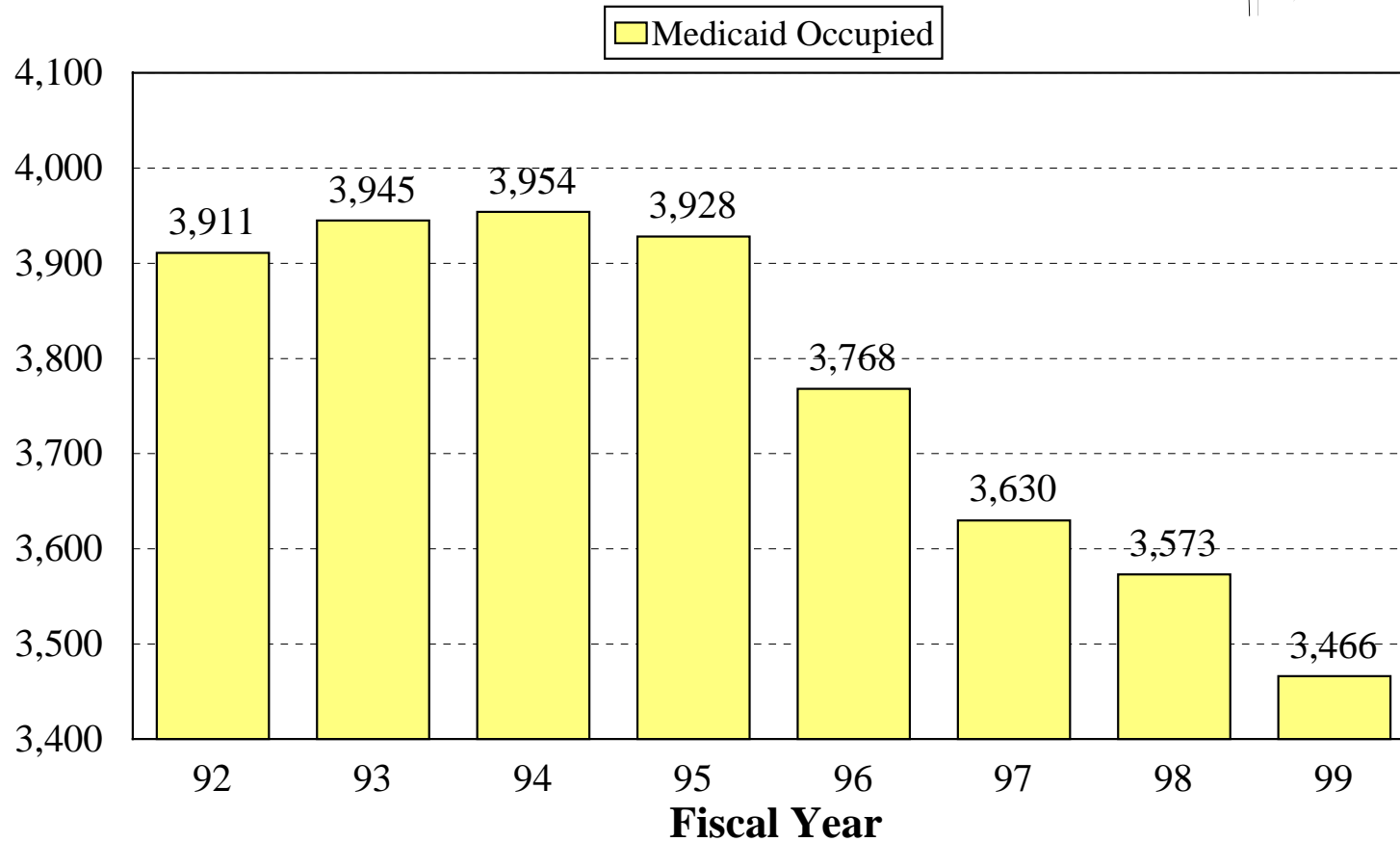
Source: 1990-2000 - R&S spend down tables;
 1982 to 1989 - R&S detailed Biennium Report;
 1959 to 1981 - R&S Fiscal Year Statistical Bulletin.

Excludes ICF-MR

Exhibit 2
North Dakota
Department of Human Services



Nursing Facilities: Number of Beds



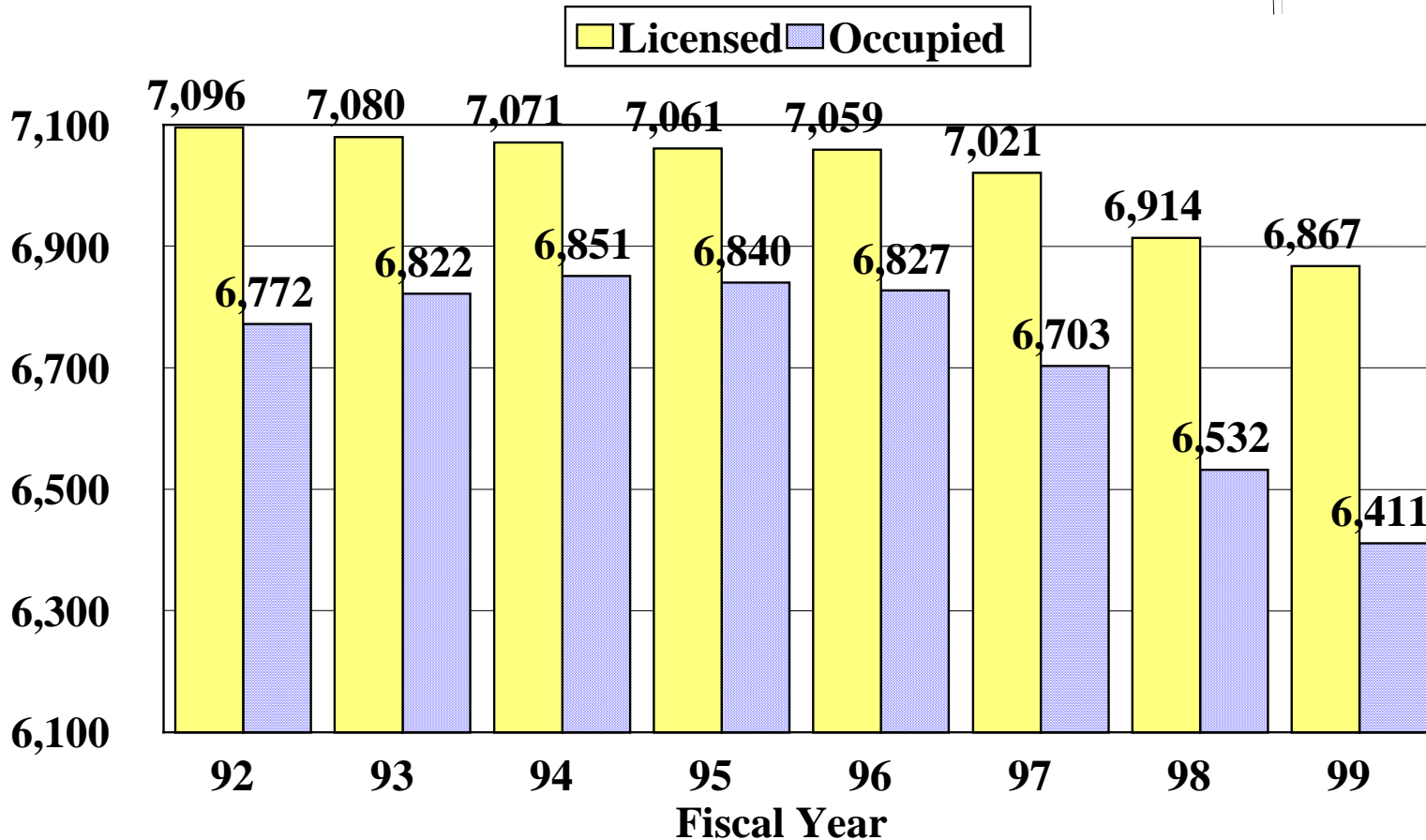
Source: Occupancy Information per Census Reports as of June 30 of each year
(Excludes Swing Beds, Medicare Coinsurance, and Out of State Services)

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Exhibit 3
North Dakota
Department of Human Services



Nursing Facilities: Number of Beds



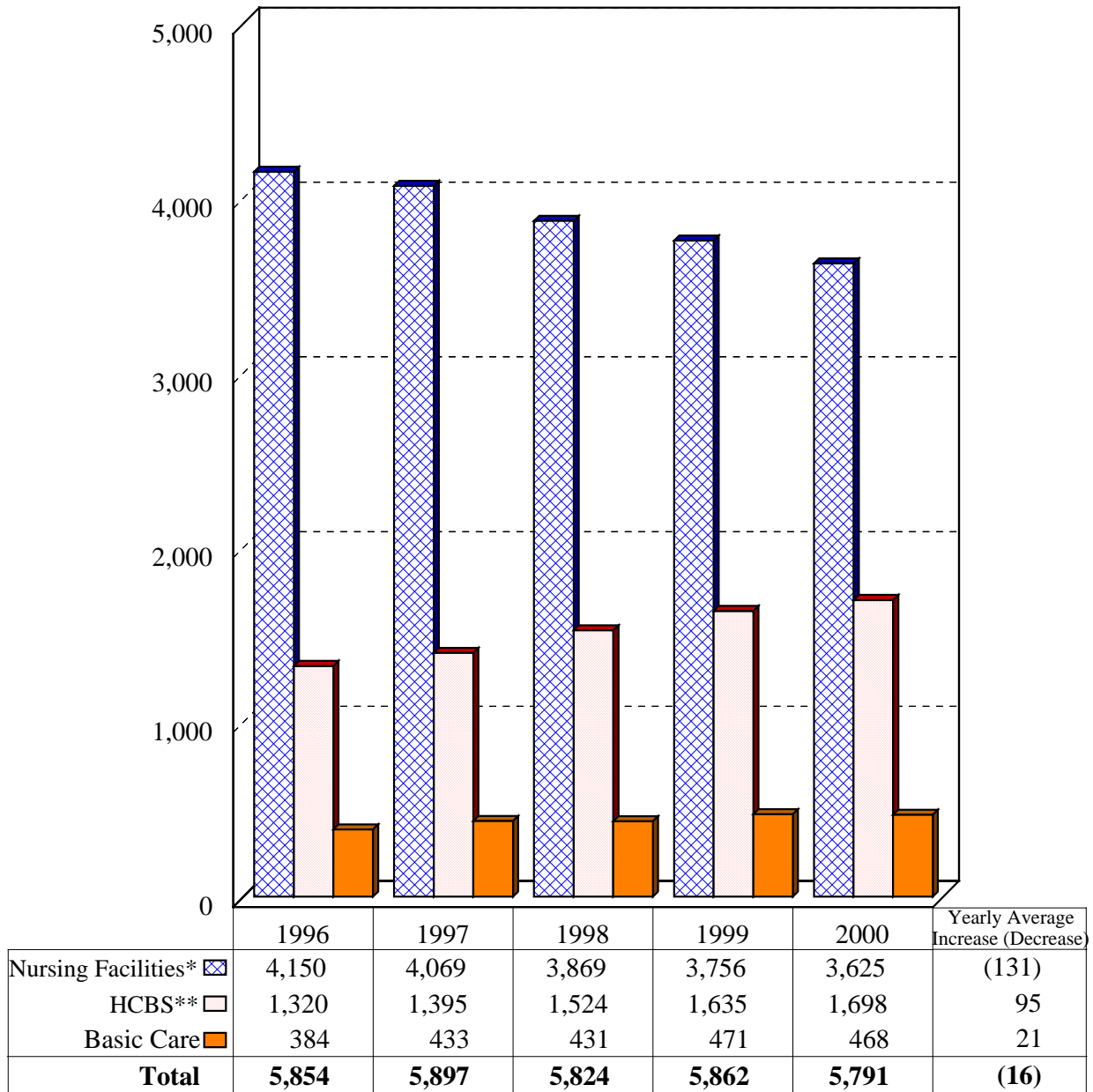
Source: Occupancy Information per Census Reports as of June 30 of each year
 (Excludes Swing Beds, Medicare Coinsurance, and Out of State Services)

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Exhibit 4
North Dakota
Department of Human Services



Monthly Average
Medicaid Eligible Recipients



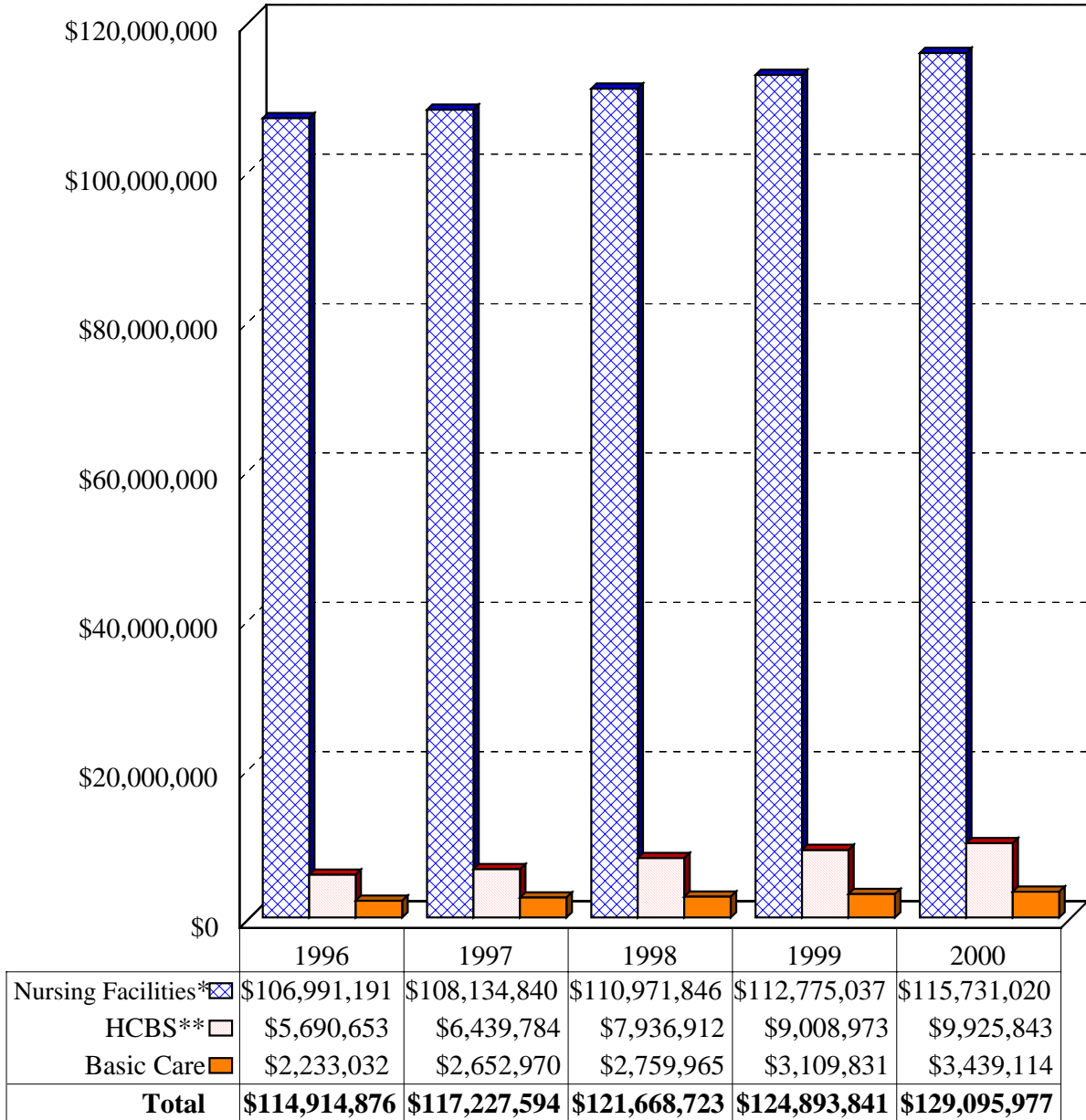
*Includes Swing Beds, Medicare Coinsurance, and Out of State Services

** Includes SPED, Expanded SPED, and Medicaid Waiver - Aged and Disabled

Exhibit 5
North Dakota
Department of Human Services



**Total Expenditures For
 Medicaid Eligible Individuals**



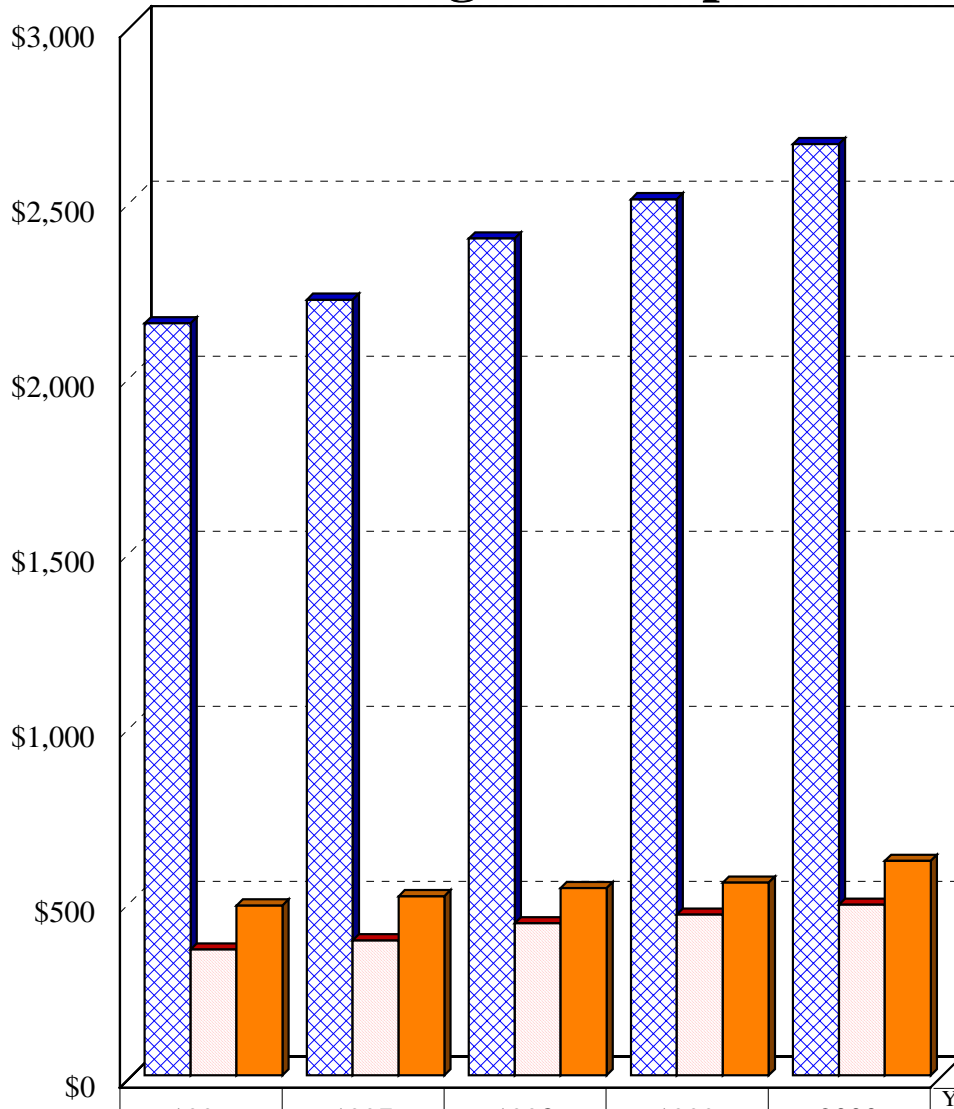
*Includes Swing Beds, Medicare Coinsurance, and Out of State Services

** Includes SPED, Expanded SPED, and Medicaid Waiver - Aged and Disabled

Exhibit 6
North Dakota
Department of Human Services



**Average Cost Per
 Medicaid Eligible Recipient**



	1996	1997	1998	1999	2000	Yearly Average Increase
Nursing Facilities*	\$2,148	\$2,215	\$2,390	\$2,502	\$2,660	\$128
HCBS**	\$359	\$385	\$434	\$459	\$487	\$32
Basic Care	\$485	\$511	\$534	\$550	\$612	\$32

*Includes Swing Beds, Medicare Coinsurance, and Out of State Services

** Includes SPED, Expanded SPED, and Medicaid Waiver - Aged and Disabled

Exhibit 7

**Fiscal Impact of Rent Subsidy for Assisted Living
2001-2003 Biennium**

- Assumptions:**
- * 300 individuals will qualify for maximum subsidy
50 individuals will use subsidy at beginning of biennium
25 individuals will be added every quarter of biennium
 - * 30% of Medically Needy Income level (MNIL) is applicable to rent
 - * Medically Needy Income level is increased by 2% per calendar year
 - * Maximum rental amount is not increased by inflation

Scenario 1: Current Medically Needy Income level of \$455; Rent subsidized to \$750

	Subsidy	No. of Individuals	Months	Total
July-Sept 2001	611	50	3	\$91,650
Oct-Dec 2001	611	86	3	\$157,638
Jan-Mar 2002	608	122	3	\$222,528
Apr-Jun 2002	608	158	3	\$288,192
July-Sept 2002	608	194	3	\$353,856
Oct-Dec 2002	608	230	3	\$419,520
Jan-Mar 2003	605	266	3	\$482,790
Apr-Jun 2003	605	300	3	\$544,500
				\$2,560,674

Scenario 2: Current Medically Needy Income level of \$455; Rent subsidized to \$800

	Subsidy	No. of Individuals	Months	Total
July-Sept 2001	661	50	3	\$99,150
Oct-Dec 2001	661	86	3	\$170,538
Jan-Mar 2002	658	122	3	\$240,828
Apr-Jun 2002	658	158	3	\$311,892
July-Sept 2002	658	194	3	\$382,956
Oct-Dec 2002	658	230	3	\$454,020
Jan-Mar 2003	655	266	3	\$522,690
Apr-Jun 2003	655	300	3	\$589,500
				\$2,771,574

Incremental cost of \$50 subsidy at MNIL of \$455 **\$210,900**

Scenario 3: Medically Needy Income level at 100% of Poverty Level - \$696; Rent subsidized to \$750

	Subsidy	No. of Individuals	Months	Total
July-Sept 2001	537	50	3	\$80,550
Oct-Dec 2001	562	86	3	\$144,996
Jan-Mar 2002	558	122	3	\$204,228
Apr-Jun 2002	558	158	3	\$264,492
July-Sept 2002	558	194	3	\$324,756
Oct-Dec 2002	558	230	3	\$385,020
Jan-Mar 2003	553	266	3	\$441,294
Apr-Jun 2003	553	300	3	\$497,700
				\$2,343,036

Scenario 4: Medically Needy Income level at 100% of Poverty Level - \$696; Rent subsidized to \$800

	Subsidy	No. of Individuals	Months	Total
July-Sept 2001	587	50	3	\$88,050
Oct-Dec 2001	587	86	3	\$151,446
Jan-Mar 2002	583	122	3	\$213,378
Apr-Jun 2002	583	158	3	\$276,342
July-Sept 2002	583	194	3	\$339,306
Oct-Dec 2002	583	230	3	\$402,270
Jan-Mar 2003	578	266	3	\$461,244
Apr-Jun 2003	578	300	3	\$520,200
				\$2,452,236

Incremental cost of \$50 subsidy at MNIL of \$696 **\$109,200**

Exhibit 8

BURLEIGH COUNTY CASE MANAGEMENT SURVEY RESULTS SUMMARY

Age Group			Education		
36-45	114	16.29%	Grade 1-8	72	10.29%
46-55	179	25.57%	Grade 9-12	232	33.14%
56-65	164	23.43%	College/Grad	396	56.57%
66-75	145	20.71%			
76+	<u>98</u>	14.00%			
	700				

Income			
0 – 10,000	72	10.29%	
10,001 – 20,000	158	22.57%	
20,001 – 30,000	148	21.14%	
30,001 – 40,000	116	16.57%	
40,001 – 50,000	70	10.00%	
50,001 or more	136	19.43%	

Program Name	Strongly Agree/Agree		Disagree/Strongly Disagree		No Opinion	
Case Management	388	55%	172	25%	140	20%
Care Management	463	66%	85	12%	152	22%
Service Coordination	300	43%	169	24%	231	33%
Care Coordination	405	58%	87	12%	208	30%

Case Management would be of value to you or a loved one.					
Yes	543	77.57%	No	141	20.14%
			Not Specified	16	2.29%

Amount willing to pay for service per hour.				Other Category	
Less than \$10/hr	163	23.29%		\$0.00	19 2.71%
\$10.01 - \$15/hr	283	40.43%		\$5.00	4 0.57%
\$15.01 - \$20/hr	149	21.29%		\$5.15	1 0.14%
\$20.01 - \$25/hr	31	4.43%		\$7.00	1 0.14%
\$25.01 - \$30/hr	25	3.57%		\$8.00	4 0.57%
\$30.01 - \$35/hr	1	0.14%		\$10.00	5 0.71%
\$35.01 - \$40/hr	3	0.43%		\$12.00	1 0.14%
\$40.01 - \$45/hr	0	0.00%		\$15.00	4 0.57%
\$45.01 - \$50/hr	1	0.14%		\$20.00	2 0.29%
				\$22.50	1 0.14%
				\$25.00	1 0.14%
				\$30.00	1 0.14%

Have you or a loved one used Case Management services now or in the past?					
Yes	133	19.00%	No	545	77.86%
			Not Specified	22	3.14%

Exhibit 9

North Dakota Department of Human Services Expanded Case Management (ECM) Proposal

ELIGIBILITY CRITERIA FOR EXPANDED CASE MANAGEMENT ARE:

- Under age 65 years, meet Social Security disability criteria, OR
- Over age 65, and
- Do not have case management system already available to them (i.e. not MR or MI), and
- Considered to have need for Long Term Care (LTC) service

National research studies suggest there are 2-3 people in the community with characteristics like those being served. For purposes of determining the estimated population for ECM, the Department conservatively estimates one person in the community not receiving services who would benefit from same for each person already receiving services. Therefore, data from the current long-term care system is the basis for the estimates that follow.

	Average Monthly Population in Long Term Care System	Estimated Expanded Case Management Population	Comments
Nursing Home Residents	6,308	4,636	Equivalent Nursing Home population less the 253 Aged and Disabled Waiver, 769 SPED recipients served at home and 650 MA Eligible recipients.
Basic Care Residents	1,254	450	Equivalent Basic Care population less the 176 Expanded SPED, 513 SPED, and 115 Specialized Basic Care for MI/DD recipients served at home.*
SPED Recipients	1,282	X	Already receiving case management.
Expanded SPED Recipients	176	X	Already receiving case management.
Aged and Disabled Waiver Recipients	253	X	Already receiving case management.
TOTAL	9,273	5,086	TOTAL ESTIMATED ECM POPULATION
Persons Expected to Seek Assistance	X	2,034	Annual number of persons expected to seek assistance is 40% of total estimated ECM population.

*115 Specialized Basic Care for MI/DD recipients is the total of residents at G. F. St. Anne's (55), Jamestown Bethel (26), and Wilton (34).

	FISCAL YEAR 2002						FISCAL YEAR 2003						Biennium Total
	Expanded Case Management FY 2002					FY 2002 Total	Expanded Case Management FY 2003					FY 2003 Total	
	Clients	Rate	State	Federal	Other		Clients	Rate	State	Federal	Other		
Private Pay	68	\$205			13,940	\$13,940	90	\$205			18,450	\$18,450	\$32,390
State Pays	1,412	\$205	289,460			\$289,460	1,883	\$205	386,015			\$386,015	\$675,475
Partial Pay	46	\$205	7,590		1,840	\$9,430	61	\$205	10,065		2,440	\$12,505	\$21,935
Total	1,526	615	297,050	0	15,780	\$312,830	2,034	615	396,080	0	20,890	\$416,970	\$729,800

Note: Expanded Case Management assumes gradation of recipients to reach 75% of the estimated population in the first year.

	Targeted Case Management FY 2002						Targeted Case Management FY 2003						Biennium Total
	Clients	Rate	State	Federal	Other	FY 2002 Total	Clients	Rate	State	Federal	Other	FY 2003 Total	
MA Eligible	325	\$205	20,361	46,264		\$66,625	325	\$205	20,361	46,264		\$66,625	\$133,250
Basic Care	500	\$205	31,324	71,176		\$102,500	500	\$205	31,324	71,176		\$102,500	\$205,000
30% SPED	613	\$450	84,300	191,550		\$275,850	613	\$450	84,300	191,550		\$275,850	\$551,700
Ex SPED	242	\$450	33,280	75,620		\$108,900	242	\$450	33,280	75,620		\$108,900	\$217,800
Total	1,680		169,265	384,610		\$553,875	1,680		169,265	384,610		\$553,875	\$1,107,750
Grand Total			466,315	384,610	15,780	\$866,705			565,345	384,610	20,890	\$970,845	\$1,837,550

Exhibit 10

Projected Impact on the General Fund to Implement Case Management for the 2001-2003 Biennium

General Fund Expenditures For Case Management Services Provided In Existing Programs	Program Implemented		
	Targeted Case Management	Expanded Case Management	Both
Total SPED Program Expenditures (Exhibit 9)	\$551,700	\$0	\$551,700
Total Expanded SPED Expenditures (Exhibit 9)	217,800		217,800
Basic Care Projection, 2001 - 2003 Biennium ***	14,462		14,462
Total Current General Fund Expenditures	\$783,962	\$0	\$783,962
Total Projected General Fund Expenditures To Implement Program			
Fiscal Year 2002	\$169,265	\$297,050	\$466,315
Fiscal Year 2003	169,265	396,080	565,345
Total General Fund Expenditures	\$338,530	\$693,130	\$1,031,660
Net Savings (Cost) to the General Fund	\$445,432	(\$693,130)	(\$247,698)

*** Amount appropriated for the 1999-2001 Biennium for Basic Care Functional Assessments

APPENDIX B

HOUSE CONCURRENT RESOLUTIONS

Fifty-sixth Legislative Assembly, State of North Dakota, begun in the Capitol in the City of Bismarck, on Tuesday, the fifth day of January, one thousand nine hundred and ninety-nine

HOUSE CONCURRENT RESOLUTION NO. 3002
(Legislative Council)
(Budget Committee on Long-Term Care)

A concurrent resolution directing the Legislative Council to study American Indian long-term care and case management needs, access to appropriate services, and the functional relationship between state service units and the North Dakota American Indian reservation service systems.

WHEREAS, the 1995-96 Task Force on Long-Term Care Planning reported that in the area of long-term care service inventory, distribution, and alternatives, long-term care services within North Dakota American Indian service areas and reservations vary widely, ranging from a nursing facility that is not owned or operated by a tribe to unlicensed facilities and home-based care provided under several entitlement programs; and

WHEREAS, coordination and application of various American Indian long-term care programs and service components are directed by tribal policy and organizational structure; and

WHEREAS, various noninstitutional care components appear to be available on reservations, but service arrangement and delivery may not be adequately coordinated and case management services for elderly reservation residents, if available, could result in a significant increase in the effectiveness of service delivery for that population; and

WHEREAS, during the 1997-98 interim, the Department of Human Services and the Department of Health formed a Task Force on Long-Term Care Planning to study American Indian long-term care and case management needs, access to services, and the functional relationship between state service units and American Indian reservation service systems; and

WHEREAS, the Task Force on Long-Term Care Planning was unable to establish a subcommittee, composed of representatives from each North Dakota American Indian reservation, to carry out these provisions during the 1997-98 interim; and

WHEREAS, the Task Force on Long-Term Care Planning has determined that a separate working group needs to be established on each reservation in order to successfully carry out these provisions;

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF NORTH DAKOTA, THE SENATE CONCURRING THEREIN:

That the Legislative Council study American Indian long-term care and case management needs, access to appropriate services, and the functional relationship between state service units and the North Dakota American Indian reservation service systems; and

BE IT FURTHER RESOLVED, that the Legislative Council report its findings and recommendations, together with any legislation required to implement the recommendations, to the Fifty-seventh Legislative Assembly.

APPENDIX C

**INFORMATION PROVIDED BY THE NORTH
DAKOTA INDIAN AFFAIRS COMMISSION
REGARDING INPUT MEETINGS HELD TO
DETERMINE THE MOST SIGNIFICANT LONG-
TERM CARE NEEDS OF LOCAL TRIBAL ELDERS**

**ELDERS DAY OUT
SPIRIT LAKE NATION
FEBRUARY 29, 2000**

The input forum on the long-term care needs of Native American elders was held at the Spirit Lake Casino Bingo Hall, Ft. Totten, in conjunction with the monthly Elders Day Out event. (See attached agenda)

One hundred three (103) attended the meeting, including Tribal Chairman Phillip "Skip" Longie and Councilman Vincent Greyhorn. Ad hoc committee members present were Cindy Mala, Director, Indian Affairs Commission; Gary Garland, State Health Department and Linda Wright, Director, Aging Services Division, DHS. Also attending was Theresa Snyder, Tribal Liaison for the Department of Human Services.

A total of 36 individuals submitted written responses in regard to the question of "What are the most important long term care needs that you have?" The results are as follows:

Home repairs - 3
General assistance - 1
More outreach workers - 4
Elderly drivers in Tokio - 3
Loans - 2
More financial resources - 15
No T.E.R.O. permit for elders businesses - 1
Elderly/school children meet once a month to tell old stories & legends to students - 1
More help & funding from IHS – 5
Local home/care ctr. for the elderly - 3
Physical therapy for uninsured – 1
Better health services - 3
More transportation - 7
Homemaker/chore services - 3
Nursing home - 2
Better elderly housing - 1
More care for elderly - 1
Swing bed facility - 1
Handicap accessible homes - 1 (washer/dryer main floor; bathroom)
Washer & dryer - 2 (in home, at Ft Totten housing)
Funding for eye glasses - 3
Funding for hearing aids - 1
Recreation for elderly - 2
Home health care - 2
Chimney cleaning - 1
Green Thumb workers - 1
Referral for other health services - 3
Consistency on issues regarding assistance - 1
Waiting long hours at the clinic - 1

Long-term basic/chronic care - 1
Help paying for phone services - 1

In addition, elders shared verbal concerns regarding the lack of home repairs; concerns, with lack of housing; appliances that don't work; and need for washers and dryers.

Chairman Longie discussed a new facility for which the tribe has already broken ground. Blueprints were available for review. The facility was referred to in various ways, including swing bed and residential care.

The elders asked for follow-up on the areas they are concerned about.

**Standing Rock Tribal Chambers
Fort Yates, North Dakota
Friday, March 24, 2000**

"Tribal Elders meeting to discuss the long-term care service needs"

- Indian Health Service representation at meetings
- Elders waiting too long to be seen
- Community Health Representatives to assist
- Tribal council need to sincerely address elders' needs
- Possible elder representative from each district
- JTAC dollars should supplement utility payment, elders' income
- Elder veterans
- Threatened to be put in nursing homes
- Expand E.P. to provide extend assistance for elder
- Financial exploitation of elder income
- Keep elders at home and on the reservation
- Need strong leaders
- Council passed resolution for \$65,000 to be available for elders for propane and utilities
- Elders need drivers to drive them to their appointments, four cars (transportation issue) June budget for tribal council
- Community Health Representative - Change in policy to reflect need of community, check on everyone
- School to work
- Welfare Reform
- Housing for elders, not institutions

- Telephones for elders to access someone when they need help
- Incorporate an elder worker for every program/service
- Housing Plan needs elder input
- More education, health, lifestyles
- Income - tribe should be taking care of elders, providing housing, food and transportation
- Write a formal letter to the council
- Council needs to respond to requests, on the radio or public forums Home health care services
- North Dakota and South Dakota boundaries

What is an "Elder", age definition

Age 65 vote 4

Age 60 vote 14

Age 55 vote 7

(council on record)

- Access to alternative medicine
- Different view of Human Body, Wellness, herbal remedies, Chinese healers
- JTAC plans for a retirement home
- Provide feed back in writing from council, state and federal government
- Rent - 15% of income -\$175.00 for a one bedroom
- Health needs (dental, hearing aid, eyeglasses, rehabilitation)
- CHIP- Healthy Steps
- Cheyenne River Elder Services
- Standing Rock should establish a "Commission on Aging"
- Elder group "Elder Services Director"
- Payment for Health Care and Education

**Notes received during the Elders Meeting
Three Affiliated Tribes in New Town 3/7/2000**

Miscellaneous

1. Does the state have model organizational documents to share with the elders - Linda will mail these
2. What about the burial needs of those living off the Reservation? It is not a traditional way to have cremation.
3. The elders are alone - how do they get assistance to go to the grocery store or to do wash or get help with cleaning?
4. What happens with handicapped and what ~ with those that live alone out in the districts.

Coordination of Tribal programs

1. How to ensure the cultural integrity of tribal members is maintained.
2. No tribal elder program to coordinate these services.
3. Need more preventive practices
4. Being persistent and demanding services means being verbally abusive to friends and relatives
5. No matter where the Natives are they are wards of the government.
6. Meet with Tribal and health services.
7. AARP chapter on the FBIR
8. Library Services - Large print books - books on tape - crafts and hobbies
9. Prayer Meetings needed

CHR

1. CHR is a good thing, but not enough of them- what happens on weekends? How do they transport in a medical need?
2. There should be a woman who is a CHR- natives are very private people
3. Get woman CHR- strange to address a man. Not our culture.
4. Serve TV dinners on the days when the cook is on leave or a Tribal Holiday.
5. Have some TV dinners on hand especially for us diabetics.
6. More CHR's in each community
7. To whom it may concern; I think the CHR should go and check on everyone and see the meds are ok or if there is anything else or if a need for a ride to the clinic and the elderly need a lot of help.
8. Injured in an accident in 1988 - went home from nursing home in a wheelchair- no one to check on me- to this day no one comes to my house. I am disabled from the accident, they have meals but no one brings a meal to me, they take these meals to other homes where the elder is living - I live in town my house needs repair - they tell me there are molds that are bad for my health. I did finally walk after 7 years of crying and bitching, with no help from CHR.
9. Elders who live alone or with an aging spouse, need someone to check on them daily by phone and weekly by visitation.
10. Need homemaker service

11. Make CHR's more accountable
12. CHR for Elderly only
13. Home care aides for Elderly
14. Meals - need to be for the elderly - no chili or spicy foods,

Glasses

1. Need assistance with payment for glasses
2. The glasses program- we don't have a glasses program on each reservation - who pays for these?
3. Did not have anyone to help her when she had to go in for an eye appointment - they gave her eye drops and she had to drive home.
4. We need more resources for dental, glasses, and housing for the elderly.

Health Care

1. Emergency response system
2. After leaving the reservation if you get sick you can't get back to the reservation to get the services there.
3. Would Jr. Bell get help any place because he is a diabetic? He lost his little toe because of his diabetes. He stays at my house, he don't have a place to go. I take care of him.
4. How do we get health care for the Indians not living on the Reservation?
5. Do they need their own doctor of gerontology?
6. After 5 pm on Friday you must go to Minot for healthcare.
7. No ambulance system owned by the tribe
8. No 24hr care and no doctor available
9. A suggestion was made to have Senior citizens group look into having the dialysis patients fed,
10. Educate people about diabetes.
11. Some one said it was against state law to have an eating place in the dialysis center, now they don't visit after they are done and they don't eat.
12. A complaint was made to administrator of dialysis unit when the unit took the tables away where the patients ate. Also when the patients have an appointment if it isn't dialysis related the unit says she will not have the patient transported even though they are in extreme pain.
13. We need more resources for dental, glasses, and housing for the elderly.
14. Aftercare for surgery patients

Financial

1. Need for more resources
2. Need to go to the United Nations like the Canadian Indians do. Need for more financial resources.
3. More financial resources needed
4. Why do we have to get generic Medicare? Other units all have the best. Don't we have the money?
5. Education on how to live well on a fixed income - IRS help

Transportation

1. Dialysis problems during transportation to and from the unit. Distance is a factor with no food till after they get home.
2. We need transportation for the seniors to come to the meetings. There are people that are unable to drive and would like to attend, especially on Senior Days at the Casino. Most of the Seniors are shut-ins and would love to visit each other. It would be so healthy for the shut-ins to be able to see people they never get to see and visit.
3. Whenever there are meetings for senior citizens, they need the transportation provided. Many don't have cars or can't find a ride. It would be good for them to visit with relatives and friends.
4. Rides to physician services and after care rides home

Housing

1. Get some safety rails in the housing for the elders.
2. House in total disrepair - Bathroom especially. House approximately 20 years old with 5 adults living there. Need better housing immediately.

Dental Program

1. We need more resources for dental, glasses, and housing for the elderly.
2. Dental Care - how do we get care for the elders and their teeth.
3. Tooth ache - needed 2 teeth pulled - got penicillin. Problem is there are 200 people on a waiting list for dental care. To me this situation is uncalled for, when in Trenton you can call one week in advance, and get partials.

Needs Identified by Turtle Mountain Seniors/Adults at the Meeting at the Retirement Home on February 28, 2000

**# OF
VOTES**

- 12 Nursing Home (*7 votes from elders, 5 votes from staff*)
- 9 CHR program needs more funding for transportation needs of senior adults
- 9 Transportation (rides)
- 6 Home Health Care - more to serve Reservation and County
- 4 Backup electrical generator for Retirement Home
- 4 More meals served at the Retirement Home
- 4 New Retirement Home (replace present home)
- 3 In home therapy
- 2 On site CHR coverage 7 days/week at the Retirement Home
- 2 Basic Care Unit
- 2 Respite Care
- 1 Financial support for meals paid by Seniors (at least \$1 per meal)
- 1 More activities at the Retirement Home
- 1 Help from the Commodity Warehouse for people who are not able to lift commodities
- 1 Dietician services to entire Senior population (special diets – i.e. Diabetic)
- 1 New and separate retirement living quarters for younger retirees.
- 1 Improved security at Retirement Home
- 1 Relaxed guidelines for retirees for Economic Assistance Programs (LIHEAP & Commodities)
- 1 More Attendant Care
- 1 Assistance with forms, benefit information, mail for Seniors (i.e. SHIC Program)
- 1 Daily shuttle for medications and medical service
- 1 Heater in bathroom and a new bathtub
- 1 Continuing education for Seniors for computer use and computer literacy
- 1 Extended case management for vulnerable adults (abuse/neglect of elderly adults)
- 1 Funding for Adult Protective Services (abuse/neglect of elderly adults)
- 1 Adult Daycare
- 1 Method of bringing Seniors together from all 4 districts of the Reservation at regular intervals
- 1 More planned facilities to meet different level of care needs
- 1 Fix leaky roof at the Retirement Home
- * Meals on Wheels for sick and diseased
- * Need a gym to the Retirement Home
- * More money to have better meals
- * More Homemaker services over reservation
- * Advocate for the elderly who can provide information and referral services
- * Funding for guardianship
- * Representatives of Social Security Veterans Administration establish onsite regular schedule
- * Monthly health care assessments

**TRENTON INDIAN SERVICE AREA TRIBAL COUNCIL, TRIBAL AGENCIES
AND ELDERS RESPONSES**

What are the 2 most important long-term care needs for elders of the Trenton Indian Service Area?

Transportation- 10

Meals on Wheels- 7

Frozen - 2

Help with Medication - 5

Daily checks - 4

In Home Care/Housecleaning - 3

Doctor Care - 3

Nursing Home/Retirement Home - 3

Blood Pressure Checks - 1

Commodities - 1

Housing -1

Medicaid when needed - 1

APPENDIX D

EXPANDED CASE MANAGEMENT REPORT

**REPORT TO THE NORTH DAKOTA
GOVERNOR'S TASK FORCE ON LONG TERM CARE PLANNING
EXPANDED CASE MANAGEMENT**

ORIGINAL SOURCE REFERENCE: May 1996 Report of the Task Force on Long-Term Care
Planning

CURRENT SOURCE REFERENCE: JUNE 1998 Report of the Task Force on
Long-Term Care Planning

INTRODUCTION:

In 1995, Governor Schafer established the North Dakota Task Force on Long-Term Care Planning. The Executive Director of the Department of Human Services and the State Health Officer has chaired this Task Force since September 1995. The Task Force was formed to facilitate the Department's involvement in studies mandated by the Fifty-Fourth Legislative Session. The Task Force's report issued in May of 1996 included the following recommendations relating to expanded case management (ECM):

1. Approve a pilot project(s) testing the expanded case management system;
and
2. Include the uniform comprehensive assessment in the pilot project(s) with all applicable agencies in the service area included in the testing.

The objective of the pilot project(s) is to test a case management system design for individuals in need of long-term care services which would ensure that all service options are explored before placement is made in an institutional setting; and which provides "one-stop" accessibility for individuals and their families.

HYPOTHESIS

Individuals and their families who are searching for long-term care services often find it difficult and confusing to navigate the state's network of services. The results are costly to the individuals and the state and federal government as money is spent on inappropriate services; service needs are not met or nursing home placement is made at a time when other service options could meet the individual's needs. An expanded case management service delivery system would offer assistance to citizens in identifying and securing appropriate, cost effective services in the least restrictive environment.

DEFINITIONS

Case Management: Means a process in which a professional case manager assesses the needs of the client and arranges, coordinates, monitors, and evaluates for services and advocates to meet the specific client's needs in the least restrictive environment.

Information and Assistance/Referral (I & A/R):

Information and Assistance means helping the caller to identify possible resources they are seeking including follow up to determine if they actually were able to make contact and receive or achieve the results desired.

Information and Referral means providing the caller with the desired information they are seeking, however, not completing any follow up to determine/measure outcome.

Long-Term Care: Means a full continuum of service options from minimal limited support services to extensive skilled nursing care. Examples include but are not limited to, homemaker service, home delivered meals, in-home personal care services, public health nursing, transportation, basic care, swing bed care, nursing home care.

Single Entry Point: A publicly recognized access point for information, assessment, and case management service which provides accessibility for individuals and their families to the continuum of long-term care service options.

Expanded Case Management Pilot Project Administrative Organizations:

- **Burleigh County Social Services**, URBAN service area: Burleigh County
 - December, 1997 to present
- **Devils Lake Senior Meals & Services**, RURAL service area: Benson, Eddy, Ramsey, and Towner Counties
 - January, 1998 to June, 1999
- **Kidder/Emmons Senior Services**, RURAL service area: Kidder and Emmons Counties
 - July 1999 to present

This report represents recommendations resulting from findings gained during the pilot project efforts of Expanded Case Management (ECM). The Ad Hoc Committee on Care Coordination / Case Management supports the recommendations made to the Governor's Task Force on Long Term Care Planning. Thank you for the opportunity to submit these recommendations.

ACCESS TO SERVICE:

The legislative intent of ECM was to provide an avenue for persons needing long term care services to access such service. The ECM pilots 'tested' and pursued a number of different avenues to making the general public **aware** of case management for persons in need of long term care services. Examples of efforts included written advertisements, radio spots, public TV spots, public speaking, meetings with discharge planners, brochures, pens and other 'promotional' items typically used to raise the awareness of a service or product.

RECOMMENDATION: For urban areas referrals from hospitals has generated the greatest single referral source to ECM. In rural areas, word of mouth and public health nursing have provided for the greatest single referral sources to ECM. Although limited numbers of contacts to ECM have actually come from the various methods tested to generate self-referrals, it has been determined critical that routine and regular ‘advertising’ is required to assure the general public is continuously made aware of the availability of a service like ECM for purposes of long term care service access, planning, and implementation.

Access to 7 day per week ECM was ‘tested’. In the pilot projects actual demand for “after normal business hours” access to ECM was minimal. The availability of 24 hour telephone answering service (voice mail) did result in a few ECM cases being handled on the weekends, on a holiday, or during evening hours.

RECOMMENDATION: ECM service is not generally perceived to be an emergency response service delivery system. Therefore, 24-hour access to ECM can be adequately served through the availability of a voicemail system that is accessible 24 hours a day, 365 days per year. The entity providing a service like ECM will have an established procedure for routinely and regularly responding to after hours, weekend, and holiday ECM inquires.

Another perspective of legislative intent with ECM was to provide access to a “ONE-STOP” opportunity to seek long term care service intervention and guidance. Both the urban and rural ECM pilots have been able to demonstrate that “one-stop” access is possible. This has been accomplished by the ability to directly respond to single question issues all the way to assuring appropriate service delivery has been implemented as well as legal arrangements, if required, have been processed.

RECOMMENDATION: The concept of “one-stop” access to answers, solutions, and guidance to all your needs is currently being promoted by many different types of businesses and organizations. Through appropriate public education ECM can serve the general public as a “one-stop” FIRST contact for accessing long term care services. Critical to the success of “one-stop” concept will be the establishment of a publicly recognized entity within each community or county that people will know to contact for their long term care questions.

INTERAGENCY COLLABORATION AND COORDINATION:

Legislative intent of ECM was to promote the establishment and enhancement of interagency collaboration and coordination. This effort would reduce the number of people a person seeking long term care service may have to encounter for base line data gathering as well as assistance in weaving through the myriad of complex service delivery systems to address their specific care questions and needs.

Some initial first contact indications resulted in hesitancy on the part of common client agencies/organizations to enter into interagency agreements with the ECM pilots. However, after interagency discussions to clarify purpose and function, interagency agreements were successful. Interagency agreements were suggested to include such items as timeliness of the referral process, efforts to avoid duplication of information and service(s), release of information process, and probability of transmittal of information electronically.

RECOMMENDATION: The ECM pilots have concluded it is essential to the success of a service like ECM to establish formal interagency collaborative and coordination agreements. Without such agreements, it is very difficult to fully give credence to a person in need of long term care service(s), the least intrusive and most uniformly consistent access to their choices within the long-term care service delivery system.

AFFECT ON DEMOGRAPHICS OF INSTITUTIONAL PERSONS:

Legislative intent suggests a service like ECM will theoretically delay institutionalization for persons at the time they make application to enter a nursing home. This is possible when the identification and arrangement for appropriate social support service intervention is available. Although very difficult to statistically validate, the ECM pilots have demonstrated that approximately 25% of the persons who were on the path to nursing home placement were able to make choices to remain in their own home as a result of ECM service.

RECOMMENDATION: Individuals in need of long term care service(s) and their families have consistently requested the opportunity to remain in their own home and community for as long as reasonably possible. A publicly recognized service like ECM can make this a reality for a certain percentage of the population requiring long-term care service(s).

SCREENING FOR EVERY PERSON TO MEASURE NURSING HOME ELIGIBILITY:

The ECM pilots were charged with the task of attempting to measure the potential of nursing home 'eligibility' for every person who sought ECM service. Between 25 and 35% of all ECM pilot service recipients met nursing home screening criteria. Obviously this means the majority of ECM clients, who did indeed need long term care service(s), would not qualify for nursing home placement, even if they would have wanted to choose that option to meet their long term care needs.

RECOMMENDATION: ECM pilot results are consistent with national studies which have concluded that very few people in the general public, actually require nursing home care. However there continues to be the general public perception that all older people, who require long term care service(s) must be in a nursing home to receive such support care. It is essential that public education efforts be made to inform the general public of the availability of options to meet their long-term care needs.

CLIENT SATISFACTION:

The ECM pilots were required to use a client satisfaction survey instrument to document client and family member satisfaction with the provision of ECM service. Consistently high survey return rates were realized. Overwhelmingly, the returned client satisfaction surveys identified client and family members were well satisfied with ECM service.

RECOMMENDATION: The overwhelming satisfaction survey results suggest strong support for a service like ECM in both the rural and urban counties.

ADDITIONAL PERSONS SERVED:

Each ECM pilot was asked to identify how many “additional persons were served” during each quarterly period. **“Additional persons served”** reflects those individuals who can be documented as otherwise not traditionally been served. Also, in the urban ECM pilot site, beginning July 1, 1999 the ECM provider was asked to target nursing facility Medicaid residents screened for short term stays and Medicaid recipients aged 80 years and over residing in their own home setting. The intent was to try to determine if targeting these specific groups would increase the number of additional persons served.

The rural ECM pilot has identified between 1 and 5 “additional persons served” during the course of their quarterly reporting periods. The urban ECM pilot has averaged between 25 and 30 “additional persons served” during their quarterly reporting periods.

The targeting objective in the urban ECM pilot has not been running long enough to measure conclusively yet if the targeting does indeed result in a greater number of “additional persons served.”

IMPACT ON OTHER AGENCIES IN THE COMMUNITY:

ECM pilots were asked to identify the number of different agency contacts and/or referrals made to other agencies. The list of different agencies “touched” by ECM is extensive. The primary contacts include but are not limited to the following:

- County Social Service Office Programs
- Home Health Agency Services
- Senior Center Service Providers
- Medical Care / Clinics
- Insurance Assistance Programs
- Support Group Programs
- Legal Services
- Church Parish Nurse Programs
- Public Health Nursing
- Housing Assistance Programs
- Meal Service Providers
- Financial Assistance Programs
- Mental Health Service Programs
- Transportation Service Programs
- Services for Developmentally Disabled

The ECM pilots have found the “reception, attitude and response” by these agencies to accepting referrals to be excellent. The ECM pilots were not able to document any measurable resistance to referrals.

RECOMMENDATION/CONCLUSION: It is essential that well-established lines of communication be established with community resources. Positive reflective contact results in substantial trust and a continued service support base for persons seeking long term care services.

SINGLE COMPUTERIZED INTAKE (ASSESSMENT) INSTRUMENT:

The legislature required the ECM pilots develop and test a computerized generic intake form (or assessment) document. The ECM pilots successfully accomplished this task with statewide implementation of the use of the instrument January 1, 2000. Providers currently using this generic intake form statewide are all County Social Service Offices and all contracted Older Americans Act Senior Service Provider entities. The generic intake form is called the **Adult Service Intake Form (ASIF)**.

Ideal efficiency of a computerized ASIF includes the use of a laptop computer to be able to directly input client data on-site at the location of the client. Early anticipation was that clients may have a resistive position to having their intake data captured on laptop computer. However, that interpretation was quickly extinguished when virtually **ALL ECM** pilot clients actually expressed ease with the use of the laptop computer. Several ECM clients commented or were observed to be “more at ease” with the laptop being used to gather important information from them, rather than to have someone sitting and writing a lot of information down on “papers”.

Two other specific ECM pilot ‘test’ efforts related to the ASIF were (1) to determine how many different agencies would be willing/able to use a common generic instrument such as the ASIF, and (2) could the data be transmitted with relative ease electronically. After numerous meetings and discussions with several different agencies and organizations as well as much debate at Task Force on Long Term Care Planning AD-HOC committee meetings, the following results were realized:

- Release of Information for electronically transmitted personal information is of great concern to all involved parties (client, family members, and professional agency personnel). Additional research must be done to determine the most efficient and allowable means to accomplish the protection of such private personal information.
- Every agency/organization contacted to potentially use the ASIF instrument expressed the fact that through administrative policy, state or federal rules, regulation, or law they are required to capture certain select specific information on the client in common with ECM service. A considerable amount of the information captured via use of the ASIF is generically beneficial information for all parties concerned. However, funding sources such as insurance coverage and federal and state laws and regulation often require select data on a client that only applies when a specific agency/organization is the provider of select service(s).

RECOMMENDATION: The computerized ASIF document is a valuable generic tool for use in the provision of a service like ECM. The use of the ASIF instrument should continue and be improved over time based on actual use and experience by providers. It is not feasible, at this time, to expect to require all agencies/organizations of common clients to use exclusively the ASIF instrument. However, whenever and wherever possible information captured by more than one agency/organization on a common client should not have to be repeatedly captured from the client by numerous different provider representatives. This lends to the potential for considerable confusion and unnecessary repetition for the client.

TERMINATION OF EXPANDED CASE MANAGEMENT SERVICE:

The ECM pilots were asked to identify when it is important, necessary, or required to terminate the provision of a service like ECM. Terminations are appropriate under the following circumstances:

- At the request of the client.
- Death of the client.
- After the client has entered an institutional setting and there is no probability of discharge.
- At such time when it has been concluded that the case is determined “stable” and there is no anticipation of immediate additional long term care service intervention required.
- The client moved out of the service area.

RECOMMENDATION: Endorsement of the above.

INITIAL REFERRAL IMPACT ON CLIENT:

The ECM pilots were asked to identify how many clients initial referral to ECM came at the time the client was in their own home, in the hospital, in a nursing home, or in an crisis/emergency situation. In addition, the ECM pilots were asked to identify if the point/location of contact influences the client’s decision making.

The vast majority of the referrals came when the client was in their own home. Next was a hospital or other institutional setting, and the least likely setting at initial referral to ECM service, was when the client was in a crisis/emergency situation.

RECOMMENDATION/CONCLUSION: The findings under this category conclude it is preferable to reach or have initial contact with the client in their home setting with a high preference that the contact is well ahead of the time when critical or crisis type intervention for long term care is required.

CLIENT’S RIGHT TO SELF-DETERMINATION AND LEAST RESTRICTIVE ENVIRONMENT:

The ECM pilots made every effort possible to fully inform all referred clients of the different choices and options available to them for their specific situational circumstances. This was primarily accomplished through face to face or telephone verbal conversation and interview. Additionally, written information was made available to ECM referrals on the descriptions of service(s) and how to contact applicable service provider entities. If and when direct assistance was important to accomplish the exploration of all possible options/choices for the client, that process was used.

The ECM pilots were able to document that when family members or significant others are involved, the family member has a tendency to significantly influence the decision making of the client. The most common influential family member is the spouse (when there is a spouse). If there is no spouse, the most common influential family member is an adult child. It is documented that when a family member influences the client’s decision making, the client has a tendency to choose a more restrictive environment than what would be essential. When an ECM client has the full capacity to make their own choice of options, they tend to almost exclusively select the least restrictive environment.

RECOMMENDATION/CONCLUSION: It has been well documented through the ECM pilots that it is critical for individuals to have the opportunity to learn of ALL options and choices available to them for their specific situation. In addition it is critical that each individual be allowed to make their own decision without undue influence of others. As a society, we tend to want to “over protect people”, thus reducing one’s ultimate preference of reasonable choice.

FISCAL:

The ECM pilots were asked to determine what the market would be willing to pay for a service like case management. Also to be measured is the client’s/family members willingness to pay for case management service and whether or not the cost of the service influences the use of such service.

Refer to the attached Section 1 from the ECM survey report findings.

BARRIERS:

The ECM pilots were asked to identify barriers that prevent or discourage North Dakota citizens from seeking a service like case management service in planning for and accessing long-term care services.

One barrier was that a number of persons with sufficient financial resources tend to prefer to NOT spend their money for preventative or interventive support service to delay or prevent nursing home placement. Another barrier identified is the general public tends NOT to self inform about long term care planning or services. They don’t care until the need is there, so they just want to know who to call or where to call when the need arises (they face a crisis situation).

RECOMMENDATION: Uniform efforts must be taken to educate the general public about the importance of planning and learning about long term care options and services in North Dakota. The education needs to start at a very young age and most certainly well before an individual or loved one faces a crisis scenario often forcing a more restrictive service delivery option than is actually required to meet the client care needs.

OTHER REPORT RECOMMENDATIONS and CONSIDERATIONS:

[1] The ECM pilot Case Managers spent a substantial amount of time providing Information and Assistance/Referral (I & A/R) Service.

RECOMMENDATION: Avenues must be sought to assure that I & A/R Service is included in reimbursement sources for case management service or that I & A/R is a recognized “stand alone” service advertised and readily available to the general public via toll free telephone number and/or the internet.

[2] Public Education: The general public is highly uninformed and seems to be very unconcerned about learning about and planning for long term care needs.

RECOMMENDATION: Public education efforts must be supported and offered regularly at strategic geographical locations throughout the state.

[3] Self / Private Pay: Individuals with personal financial means have a tendency to resist paying for preventative or interventive planning and long term care needs.

RECOMMENDATION: Public education efforts must be supported and offered regularly at strategic geographical locations throughout the state to encourage persons with personal financial means to prepare to “invest” in planning and utilization of their resources for long term care needs.

APPENDIX E

STATEWIDE NEEDS ASSESSMENT

TASKS FOR THE STATEWIDE ASSESSMENT

The following tasks represent an initial response to a proposed statewide needs assessment for long term care in North Dakota.

1. Service Area Model

Develop a model that delineates service areas. Boundaries will be defined based on analysis and feedback from facility administrators, Health Department staff, and location analysis using Geographic Information Systems (GIS). Factors that will be considered include: a) relational boundaries (e.g., zip codes), b) trade market analysis, c) service delivery systems. This will be an initial effort that establishes boundaries for future data sets and analyses. It will require professional time, travel expenses for collaboration, and funds for a survey of providers. Estimated time line is 3 months.

2. Elderly Demand Model

Develop elderly population estimates and projections for geographic areas that will best reflect the characteristics of the local service areas. Preliminary estimates can be designed using existing data along with early releases of the 2000 Census. These estimates will be used to address the following issues: A) What is the distribution of elderly using 5 year cohorts up to age 85 and over? B) Is there evidence of a significant return migration at the most advanced age levels? C) Are there cohort anomalies in the population that jeopardize informal caregiving. Evidence of cohort out-migration by younger cohorts during difficult economic times may have left local populations short of adult children to rely on for informal caregiving. D) Can we identify demographically challenged areas with unique needs for alternative care?

Demographic analysis will begin at the onset of the project and continue as data from the 2000 Census becomes available. A more detailed population projection model will be designed to encompass service areas after release of the detailed population data from the 2000 Census. This model will seek to build on zip code level data for aggregating demographic data and will become the standard for aggregating survey data developed as part of this study. This model will be flexible and able to respond to competition and overlapping service areas. This effort will require professional time and expenses for computer modeling and mapping. Estimated time - 3 years.

3. Labor Demand Model

Assess the labor supply and demand issues for each service area. This will be accomplished through a series of surveys that address various dimensions of the labor force including availability, recruitment, education, and retention. These surveys may dovetail with other in the project and include: a) labor availability and underemployment survey (i.e., random household survey), b) providers labor needs survey, and c) student survey of career intentions and residential preferences. Sources of existing data to be used in the analysis include North Dakota Job Service, the MDS (minimum data set) from the State Health Department, public instruction, and higher education data on placements for graduates. Others might be added to the list of potential sources. Input will be solicited from analysts and administrators in other state agencies where these issues appear relevant. Secondary analysis of data from other units will begin during the first months of year one. Assessment of data management and analysis will be ongoing and could be expected to flow into year 2. Costs include funding for statewide survey, professional time, and providers survey. Estimated time required - 18 months.

4. Elderly Profile

Conduct a state public sample survey to assess the extent of need as measured by ADLs (Activities of Daily Living), IADLs (Instrumental Activities of Daily Living), Chronic diseases and direct expressions of need. This survey will also include data on public interest in alternative forms of care for the future and people's expression of their plans for the future regarding retirement and residence. A sample of people 50 and over may be appropriate. Possible sampling frames may be obtained from the AARP. A stratified sample will be used to minimize urban numbers and over represent small, frontier counties where the under serviced is the norm.

The use of optical scanning using custom instruments will be explored if a large scale mailing campaign is used for data collection. The advantage of the scanner is that the data input is automated eliminating data entry errors present in manual data entry.

The data from the survey will be used to produce prevalence rates for chronic diseases, ADLs, IADLs and other agreed upon indicators. This provides a picture of present conditions and can be used with population projections to gain an estimate of future need for services. Additional data from a second administrator survey will provide information on the extent to which needs are met with formal services, available in the area and the adequacy of the services. The principle outcome of this effort is to develop a clear sense of the level of need in the population and to determine the extent to which it remains unmet through either formal or informal services. The public survey will address informal care. This activity will begin after the designation of service areas.

The Long Term Care Association lists 112 facilities with 68 in rural areas. The resolution service areas for the rural and urban areas should be addressed prior to designing the survey sample. We may elect to concentrate only on the rural facilities as they represent the bulk of underserved communities. The time flow for this component will begin at month 4 and continue over the 3 year duration of the project. The public survey will begin in the fourth month of year 1. Instrument development, identification of benchmark data and approval of design must occur before the survey can be reproduced in machine readable form. The instrument should be completed and produced by the end of the first year with data collection beginning promptly at the beginning of the second year. The sample will need to be drawn and a mailing prepared with preaddressed return envelopes taking an additional month. Response time and follow-up is expected to take approximately 3 months. During the remainder of year two the data will be compiled and analyzed. The applied nature of this work is such that we should anticipate the analysis to also be on-going for several months with an interactive process allowing the data to be queried and a series of reports developed in response to questions especially looking at applying prevalence rates from the survey to the population forecasts. Data and reports would be made available on a continuing basis.

5. Provider and Facilities Profile

A survey of nursing home administrators will be conducted to measure their experience with labor force issues, recruitment and retention concerns along with a small survey of staff to assess factors that lead to successful recruitment and retention. Administrators will be asked about their thoughts regarding policies that have worked for them or policies they would like to see as possible solutions. This survey will be done after service areas are defined. Estimated time – one year.

This effort will be a collaborative project between UND and NDSU. A steering committee will be organized to guide the conceptual and analytical development of the project.

As a vision of output for survey results, we have been using a process that results in local survey data on general health status, chronic diseases, ADLs, IADLs, vision, hearing, dental problems, health behaviors (smoking, diet, exercise, drinking, weight, and social involvement), service use and demographic background items. We extracted the items from a variety of national surveys and have sought to maintain compatibility with these national data sets for purposes of comparison. The national benchmarks are presented along with local data in order to help people evaluate the meaning of each finding. Additionally, we produce an aggregate file of all people surveyed for comparison. In this case we could do the state and of course we can aggregate both survey and census data in a variety of ways. This presentation has been very well received and a version of it will be recommended for this study. An application of survey based prevalence rates will be added to the population data to obtain estimates of the numbers and changes in numbers of people likely to experience different chronic diseases and disabilities.

TENTATIVE BUDGET ITEMS: 3 YEAR

Elderly Survey

Materials costs for survey: 10,000 respondents with two mailings.

20,000 machine readable instruments from NCS	\$ 3,500
Envelopes (20,000 each, outgoing and return)	\$ 11,000
Postage	\$ 7,000
Total	\$ 21,500

Labor Availability Survey

Telephone survey @ \$17/respondent for 2,500	\$ 42,500
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Providers Survey

Telephone survey @ \$17/respondent for 112	\$ 1,904
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Subtotal for Surveys \$ 65,904

PERSONNEL (in scientific man years)

Service Area Model	Months 1-3	.15 SMY
Elderly Demand Model (Population analysis)	Months 1 – 36	.75 SMY
Labor Demand Model & Secondary data analysis	Months 1-18	.30 SMY
Elderly Profile	Months 1 – 36	.75 SMY
Survey of Admin & personnel	Months 1-12	.25 SMY
Total		2.20 SMY

Estimated costs for 2.20 SMY @ average annual salary of \$55,000	\$ 121,000
Fringe benefits @ 25%	30,250

Subtotal for Personnel \$ 151,250

General supplies and travel @ 2,000 per year	\$ 6,000
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GROSS ESTIMATE OF DIRECT COSTS FOR 3 YEARS \$ 223,154

Indirect Costs @ 8%	\$ 17,852
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GRAND TOTAL \$ 241,006

APPENDIX F

MEMBERSHIP ROSTERS

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APPENDIX G

GLOSSARY

GLOSSARY OF TERMS

Alzheimer's and Related Dementia (ARD) – A condition characterized by a decline in mental function, disorientation, hallucination and loss of communication in otherwise awake and alert individuals. Some forms, including Alzheimer's, are irreversible.

Assisted Living – Defined currently in North Dakota at North Dakota Century Code 50-24.5-01-2 as “an environment where a person lives in an apartment-like unit and receives services on a twenty-four hour basis to accommodate that persons' needs and abilities to maintain as much independence as possible.”

Basic Care Facility – A congregate care facility licensed by the Department of Health under North Dakota Century Code 23-09.3 which provides room and board and may provide assistance with activities of daily living and limited nursing care as required.

Case Management – A process in which a professional case manager assesses the needs of the client and arranges, coordinates, monitors, and evaluates for services and advocates to meet the specific client's needs in the least restrictive environment.

Case-Mix System – A process of classifying a nursing facility resident based on the intensity of nursing care and services provided. An individual receiving more care and services will pay a higher rate than an individual with fewer care or service needs.

Expanded SPED – Provides an alternative array of services in the community for persons found to meet the screening criteria for entry into a basic care facility.

Home and Community-Based Services (HCBS) – A continuum of services adequate to appropriately sustain individuals in their own homes and in their communities and to delay or prevent institutional care.

Hospital Swing Beds – Hospital beds licensed under North Dakota Century Code 23-26 and certified under the Federal Medicare and Medicaid programs to “swing” between hospitals (acute) and nursing home care. These are generally limited to rural facilities.

Long-Term Care Insurance – Coverage designed to pay for some or all long-term care costs, reducing the risk that the policy holder will need to deplete assets to pay for long-term care services.

Medicaid Waiver – A program authorized by federal law enabling states to provide, under waiver of several Medicaid requirements, specific services to special population groups at risk of institutionalization. The Department of Human Services currently administers three Medicaid Waivers: one for the Aged and Disabled, one for Traumatic Brain-Injured, one for the Developmentally Disabled.

Minimum Data Set (MDS) – A core set of screening, clinical and functional status elements, including common definitions and coding categories, that forms the foundation of an assessment of the needs for all residents of long-term care facilities certified to participate in Medicare or Medicaid.

Nursing Facility – Facilities licensed under North Dakota Century Code 23-16 by the Department of Health to provide long-term care, including 24-hour nursing care in a congregate institutional environment. In North Dakota virtually all such facilities are certified to participate in the federal Medicare or Medicaid programs.

Older Americans Act – Public Law 89-73, enacted in 1965, provides assistance in the development of new or improved programs to help older persons through grants to the states and to Indian tribes. The various titles of the Older Americans Act fund services which include home-delivered meals, congregate meals, transportation, outreach, chore service, education and advocacy, health maintenance services, legal assistance, ombudsman, elder abuse prevention, information and referral, training, research and development, and other community-based services adequate to appropriately sustain older people in their communities and in their homes.

Qualified Service Provider (QSP) – Providers of home and community-based long-term care services qualified under criteria developed by the Division of Aging Services of the Department of Human Services.

Rate Equalization – A system whereby all residents of a nursing facility, regardless of whether they pay for their own care or have care paid by Medicaid or private insurance, are charged the same daily rate for comparable care and services.

Service Payments For Elderly and Disabled (SPED) Program – A program authorized by state law under which a Qualified Service Provider may be reimbursed by the Department of Human Services for the provision of covered in-home and community-based services provided to eligible aged and disabled persons.

APPENDIX H

ACRONYMS

ACRONYMS

- AARP – American Association of Retired Persons**
- CHR – Community Health Representative**
- CON – Certificate of Need**
- CPI – Consumer Price Index**
- DRI – Data Resources Incorporated**
- ECM – Expanded Case Management**
- HCBS – Home and Community-Based Services**
- HCFA – Health Care Financing Administration**
- HCR – House Concurrent Resolution**
- LTC – Long-Term Care**
- MDS – Minimum Data Set**
- MNIL – Medically Needy Income Level**
- NDLTCA – North Dakota Long-Term Care Association**
- PASRR – Pre-admission Screening and Resident Review**
- QSP – Qualified Service Provider**
- SPED – Service Payments for the Elderly and Disabled**