SPECIAL ARTICLE

Expanding Access to Health Care in North Carolina:
The NCIOM Health Access Study Group

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Editor's Note: *This special article covers the work of a recent North Carolina Institute of Medicine Task Force. In the past we have devoted whole issues of the NCMJ to NCIOM reports; however access to health care is a topic studies frequently by the NCIOM and was the subject of a 2006 NCMJ issue. Due to the proximity of the 2006 issue and the relevance of the topic of the current issue, we have decided to include this special article here*

In 2006-2007, approximately 18.9% of North Carolinians, or more than 1.5 million people, lacked health insurance coverage.[a] With the downturn in the economy and the subsequent loss of jobs and benefits, estimates indicate that since 2007 the state has seen a 3.1 percentage point increase in the proportion of North Carolinians who are uninsured.[1] The total number of North Carolinians lacking health insurance coverage has likely grown to approximately 1.8 million people, or 22% of the population. While some North Carolinians were experiencing barriers to health care before the economic crisis began, the dramatic change in the economy has highlighted and exacerbated the need to expand access to appropriate and affordable health care services for all North Carolinians.

Access is a complex term that describes the ability of people to use health services. It includes the availability and adequate supply of services and providers and the ability to utilize and afford those services. It also includes things that make it possible for people to recognize when and where to go for care. The best measure of access is the ability to obtain care when needed. Everybody should see a caregiver from time to time for checkups and preventive services but use may increase as a person becomes ill, is injured, or the need for surveillance increases with age or condition.

Between 2000 and 2007, the percentage of people in the state reporting that they could not see a doctor when they needed to because of costs increased from 12% to 17.1%.[2,3] There are many factors that can keep a person from seeing a caregiver when they need to: lack of sufficient numbers or types of health care practitioners in a community, language or cultural

Compared to other states, North Carolina has experienced the largest percent growth of uninsured due to the recent economic downturn, 22.5% between 2007 and 2009.

a Unless otherwise noted, data on the uninsured are based on internal North Carolina Institute of Medicine analysis of the Current Population Survey's Annual Social and Economic Supplement, published by the US Census Bureau.

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barriers, transportation issues, and limited health literacy.[4-6] However, the lack of health insurance is one of the primary barriers to accessing health care. People without insurance in North Carolina are four times more likely than people with insurance coverage to report not seeking necessary medical care due to costs (47% vs. 10%) or having no usual source of care (59% vs. 14%). In addition, they are almost three times more likely than the insured to have not had a check-up in the last two years (35% vs. 12%).[3] The uninsured are less likely to get preventive screenings or receive ongoing care for medical conditions and, as a result, are more likely than the insured to receive care in the emergency department and/or be diagnosed with severe health conditions (such as late stage cancer).[7] Ultimately, uninsured adults are 25% more likely than insured adults to die prematurely.[7]

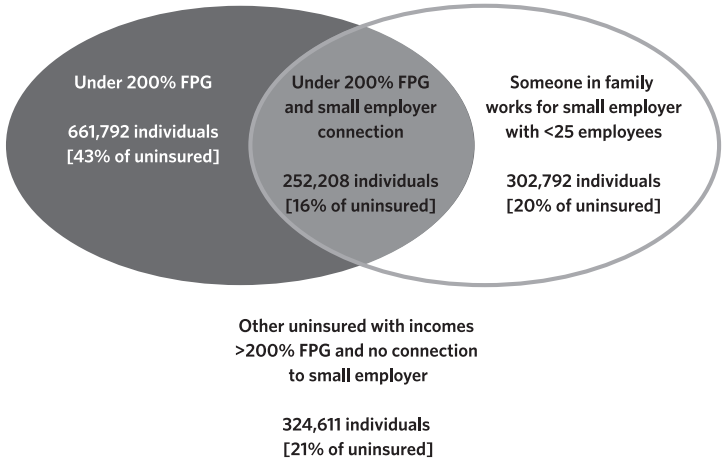
Insufficient access to health care has broad consequences. Workers in poor health are more likely to miss work, decreasing the productivity of the workforce. Students in poor health have more difficulty learning in school.[8] In addition, the uninsured only pay about one-third of their medical bills out-of-pocket. The remaining costs—known as uncompensated care—are often shifted to other payers through higher taxes and insurance premiums. In 2005, the cost of unpaid out-of-pocket costs of care for the uninsured in North Carolina was $1.3 billion.[9] To help cover the cost of uncompensated care, people with individual coverage in North Carolina pay, on average, an additional $438 more a year and families pay an additional $1,130 a year on increases in health insurance premiums.[9]

North Carolina has experienced more rapid growth in the proportion of its residents lacking health insurance than the rest of the nation. Between 1999-2000 and 2006-2007, North Carolina saw a 29% increase in the uninsured rate, which is more than double the 12% increase experienced by the nation as a whole. A major contributor to the increase in the number of uninsured has been the significant drop in employer-sponsored insurance (ESI). Between 1999-2000 and 2006-2007, North Carolina saw a 12.5% decrease in ESI. During the same time period, the nation saw an average decrease of only 6.8%. This decline in ESI is due to both a reduction in the proportion of businesses—especially small employers—that offer coverage to employees and the decline in the number of employees who purchase coverage for themselves or their families when offered. In addition, recent estimates show that North Carolina has experienced the largest percent growth of uninsured due to the recent economic downturn, 22.5% between 2007 and 2009.[1] This recent growth is due, in large part, to the rapid growth in North Carolina's unemployment rate.

From mid-2007 to early 2009, North Carolina had the second largest growth in the unemployment rate in the nation, at five percentage points (from 4.7% to 9.7%). Nationally, changes in unemployment rates have been linked directly to changes in the numbers of uninsured. Between December 2007 and May 2009, the national unemployment rate increased by 4.5 percentage points. This increase is estimated to have led to 11.1 million people losing ESI, Medicaid/Children's Health Insurance Program (CHIP) enrollment increasing by 4.5 million people, and the number of uninsured increasing by 4.9 million people.[10]

The uninsured include individuals from all income levels and all racial, ethnic, and age groups.[b] However certain populations are more likely to be uninsured than other populations; low-income individuals and people connected to small employers with less than 25 employees are at greater risk of being uninsured (see Figure 1). The majority (79%) of the uninsured in North Carolina fall into one or more of three groups: (1) children in families with incomes below 200% of the federal poverty guidelines (FPG) (14%),[c] (2) adults with incomes below 200% FPG (46%), and (3) people with a family connection to a small employer with less than 25 employees (36%). Because these are the people most likely to be uninsured, and because lack of insurance is one of the greatest barriers to health care, focusing limited expansion

Figure 1.
Uninsured in North Carolina: Primarily Low-Income or Family Connection to a Small Employer



Source: North Carolina Institute of Medicine. Internal analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement, 2006-2007.

b Some people over 65 may not be eligible for Medicare.
c In 2009, 200% of the federal poverty guidelines is $44,100/year for a family of four.

strategies on these populations has the potential to make the greatest difference in expanding access to care.

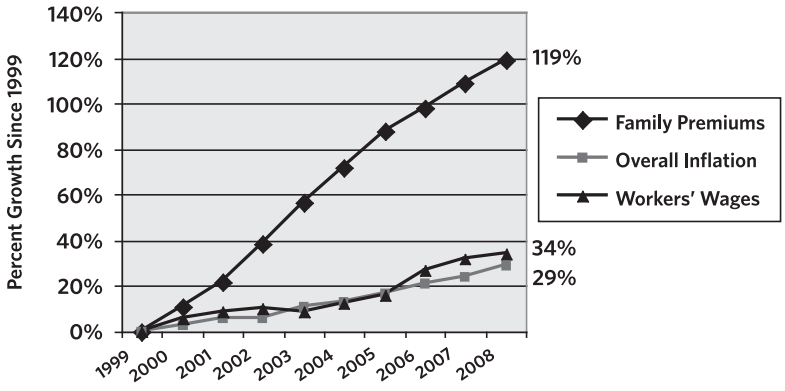
In 2008, the North Carolina General Assembly instructed the North Carolina Institute of Medicine (NCIOM) to convene a study group to examine problems of access to health care and recommend options to improve access where it is lacking.[d] This study built off of three recent NCIOM reports on covering the uninsured, the North Carolina health care safety net, and provider supply.[11-13] The NCIOM Health Access Study Group was co-chaired by Representative Hugh Holliman, Senator Tony Rand, and L. Allen Dobson Jr., vice president of clinical practice development at Carolinas HealthCare System. It included 38 additional study group and steering committee members, including policymakers, health care professionals, insurers, foundation representatives, advocates, uninsured individuals, and other interested individuals. A list of the members is included in the acknowledgements section at the end of this article. The Study Group met a total of five times over a period of five months. The full report detailing the work and recommendations of the Study Group is available on the NCIOM website at http://www.nciom.org. In this article, priority recommendations of the Study Group are presented in bold.

Health Care Costs, Coverage, and Quality

Health insurance premiums in the United States have increased exponentially over the past decade, increasing much more rapidly than wages or general inflation (see Figure 2). Between 1999 and 2008, premiums increased 119% compared to 34% for wages and 29% for overall inflation.[14] The chief reason people lack coverage is cost. "Affordability" is subjective, but using various potential measures, researchers found that between 25% and 75% of the uninsured nationally couldn't afford care in 2000.[15] Given the doubling of premiums since then, health insurance is less affordable. In 2005, more than 80% of the uninsured couldn't afford care.[16] The rapid growth in premiums has also led to the decrease in the availability of ESI.[17] Even people with insurance are being adversely affected by rising premiums, deductibles, copayments, and coinsurance.[18] Policymakers and other health leaders need to understand what factors contribute to rising health care costs in order to design strategies to make health care and health insurance coverage more affordable.

Premium growth has been spurred by increases in underlying medical costs, including the higher cost and utilization of medical technologies and prescription medications, growth in the prevalence of chronic diseases, and increased uncompensated care for the uninsured.[19-23] In particular, new medical technologies have been estimated to account for a large portion of the increase in health care expenditures,[19] with some studies suggesting it is responsible for one-half or more of real spending growth.[24] Unless ways to reduce rising health care costs can be identified, we will never be able to afford coverage for anyone in the state—much less extend coverage to all of the uninsured. In addition, North Carolina needs to examine and further utilize its promising programs aimed at reducing costs and improving quality (e.g., Community Care of North Carolina and the North Carolina Healthcare Quality Alliance).[e,f] Efforts to expand access must be built on the strengths of the current health care delivery system. More work is needed to examine the issues of cost, quality, and

Figure 2.
Cumulative Changes in Health Insurance Premiums are Greater than Changes in Inflation and Wages (United States, 1999-2008)



Source: Kaiser Family Foundation and Health Research and Education Trust. *Employer Health Benefits Annual Survey, 2008.* http://ehbs.kff.org/pdf/7790.pdf. Accessed January 14, 2009.

d Section 31 of Session Law 2008-181.

e Community Care of North Carolina (CCNC) is a medical home model for the state Medicaid population. The 14 CCNC networks, consisting of community health care professionals and health organizations, manage the care of the enrolled population. Evaluations have shown the program to lower costs and increase quality. (Dobson LA Jr, Hewson DL. Community Care of North Carolina—an enhanced medical home model. *NC Med J.* 2009;70(3):219-224.)

f The North Carolina Healthcare Quality Alliance is an initiative to promote high quality, evidence-based health care in North Carolina through the use of quality measures, performance feedback, and practice support. (Willson C. The governor's initiative to improve health care: taking measure of medical care in North Carolina. *NC Med J.* 2008;69(2):98-99.)

coverage in order to identify strategies for North Carolina to rein in rising health care costs, enhance health care quality, and improve population health.

While it will be difficult for the state to expand coverage without first addressing costs, it will also be difficult for the state to address costs without first ensuring everyone has coverage. Voluntary insurance systems are marked by adverse selection, where individuals with pre-existing health problems and/or greater health risks are more likely than healthy individuals to purchase insurance. Because the insurance pool has a greater proportion of unhealthy and at-risk individuals, average premium costs are higher than if everyone had coverage. An individual mandate requiring all North Carolinians to purchase coverage, if it is affordable, has the potential to lower costs and, more importantly, provide all North Carolinians with health insurance coverage. This is essentially what Massachusetts did in their universal coverage plan.[25] The Study Group recommended that the North Carolina General Assembly institute an individual mandate to require all North Carolinians to purchase health insurance coverage, once the state has developed subsidies or other mechanisms to ensure that health insurance coverage is affordable to anyone with an income up to 300% FPG.

Expanding Coverage to Low-Income Children, Low-Income Adults, and Small Employers

Nearly four-fifths of the uninsured in North Carolina are either low-income children, low-income adults, or have a family connection to a small employer with less than 25 employees. Due to the limited amount of time given for this study, the Health Access Study Group focused on options for expanding coverage for these three groups most at risk for being uninsured and in need of access to health care.

Low-Income Children

Children ages 0-18 comprised approximately 20% of the 1.5 million uninsured in North Carolina in 2006-2007. Uninsured children are more likely to forego or delay needed care and are less likely to have a personal physician than insured children.[26,27] Low-income children are the most likely to be uninsured, with more than two-thirds of uninsured children having family incomes below 200% FPG. Yet most of these children are currently eligible for public coverage through Medicaid or NC Health Choice (North Carolina's CHIP).[g] In fact, approximately three out of every five uninsured children in North Carolina are currently eligible for, but not enrolled in, Medicaid or NC Health Choice. This inconsistency is a result of ineffective outreach, administrative complexity, and poor retention of those who are eligible. Other states experiencing this problem have implemented successful outreach and administrative simplification strategies to increase enrollment and retention, including presumptive eligibility, rolling renewals, web-based renewals, administrative verification, coordination with other public programs, and outstationing of eligibility workers.[h] In order for North Carolina to increase health insurance coverage for children already eligible for public programs, it needs to utilize some of these same strategies. The Health Access Study Group recommended that **the North Carolina Division of Medical Assistance (DMA) simplify the eligibility determination and recertification process to facilitate the enrollment of eligibiles into Medicaid and NC Health Choice, as well as expand outreach efforts to identify and enroll eligibles. In addition, the Department of Public Instruction and Local Education Agencies should work to promote health insurance coverage to eligibles, in coordination with outreach efforts for other public programs.**

While low-income children are the most likely to be uninsured, there has been a recent increase in the percentage of uninsured children with family incomes between 200%-300% FPG. In the 2008 session, the North Carolina General Assembly gave DMA the authority to implement NC Kids' Care, a public insurance program for uninsured children with family incomes between 200%-250% FPG.[i] This program would cover an additional 9% of uninsured children with a total additional 14% covered with an expansion to 300% FPG. However, the program has yet to be implemented. During the same 2008 session, the North Carolina General Assembly continued a seven year pattern of placing enrollment growth caps on the NC Health Choice Program, which could restrict outreach, recertification, or other expansion strategies. The Health Access Study Group recommended that **the North Carolina General Assembly remove the cap on coverage of eligible children for NC Health Choice and continue**

g Children eligible for Medicaid or the Children's Health Insurance Program (CHIP) are citizen children with family incomes no greater than 200% of the federal poverty guidelines.

h Presumptive eligibility is temporary enrollment for children who appear to be eligible for Medicaid or the Children's Health Insurance Program while the family completes eligibility determination. Rolling renewals allow for families to renew their applications at any time in the year. Web-based renewals are an online, multi-program application process that allows families to renew coverage at any time of day. Administrative verification allows the Department of Social Services to use administrative databases to verify information the family would otherwise need to provide for the application. Coordination with other public programs could include instituting referrals between programs, combining enrollment (so that when a child is enrolled for one program they are enrolled for Medicaid or CHIP as well), and/or sharing administrative information to facilitate administrative verification. Outstationing eligibility workers refers to having eligibility workers at federally qualified health centers and hospitals with a large number of uninsured or Medicaid patients to reach more eligibles. More information is available in the North Carolina Institute of Medicine Health Access Study Group Report, available at http://www.nciom.org/projects/access_study08/HealthAccess_FinalReport.pdf

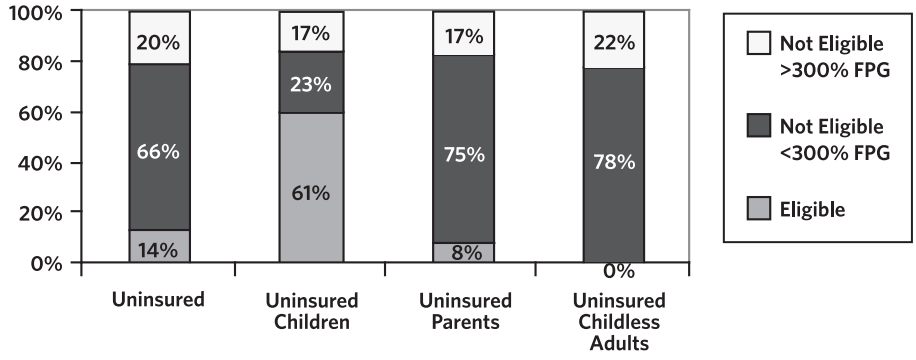
i Section 10.12(c) of Session Law 2008-107.

implementation of NC Kids' Care up to 250% of FPG (300% if funding allows). A targeted expansion of Medicaid coverage for children with disabilities in families up to 300% FPG would also help cover children with higher family incomes.[j]

Low-Income Adults

Nearly half of those who are uninsured in North Carolina are low-income adults with incomes below 200% FPG. Unlike low-income children, the majority of low-income adults in North Carolina are not currently eligible for public coverage (see Figure 3). To qualify, adults must meet certain categorical, income, and resource eligibility criteria. The current federal Medicaid laws limit eligibility to certain categories of low-income adults. Unless a person is either a pregnant woman, parent of a dependent child under age 19, disabled, or at least 65 years old, he or she does not qualify for coverage, regardless of income. Removing these categorical restrictions would allow North Carolina to expand coverage to all low-income adults. Without categorical changes, the state could expand Medicaid to cover more uninsured adults by increasing the income thresholds for those individuals who are otherwise categorically eligible.[k]

Figure 3.
Most Adults are Not Eligible for Existing Public Programs in North Carolina



Source: North Carolina Institute of Medicine. Internal analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement, 2006-2007.

The Health Access Study Group recognized the difficulties of seeking additional state funds to expand Medicaid in the midst of a major recession. Medicaid's enrollment grows during a recession as people lose their jobs and health insurance. In North Carolina, the monthly Medicaid enrollment grew 7% from 1,280,588 (June 2008) to 1,370,917 (June 2009).[28] This growth puts additional strain on the state, which—because of the recession—has less revenue to pay for its share of Medicaid costs. The study group recognized the need for additional federal support to help pay for the increased Medicaid costs during the recession. Since publication of the Study Group report, Congress provided temporary fiscal relief to the states as part of the American Recovery and Reinvestment Act of 2009.[l] As a result of this change, the federal government will now pay 74.51% of all Medicaid claims costs (up from 64.60%) in SFY 2009.

As with children, there are some adults who are currently eligible for Medicaid but are not enrolled. Increased outreach, simplification of application and recertification procedures, changes in resource requirements, and extension of the certification period could help identify, engage, and enroll these adults into Medicaid. The Health Access Study Group recommended that **DMA conduct outreach activities and simplify the eligibility and recertification process to facilitate the enrollment of adults into Medicaid, as well as explore other options to facilitate enrollment of adults into Medicaid.**

While the state could expand Medicaid coverage up to 200% FPG for low-income parents, North Carolina would still be responsible for paying the state match to cover individuals who became eligible through the expansion. Instead, the study group supported expansion to all low-income adults through a Medicaid Section 1115 waiver. A Medicaid Section 1115 waiver allows states to use a limited benefit package, cap program expenditures and, if necessary, limit expansion to a certain number of enrollees—all of which would limit the cost of expansion. To further limit the costs, the state could enroll new Medicaid recipients into Community Care of North Carolina (CCNC) and offer a premium assistance program to leverage an enrollee's existing access to ESI. The Health Access Study Group recommended that **the North Carolina General Assembly direct DMA to seek a Medicaid Section 1115 waiver to cover more low-income adults. The waiver should be**

j The Family Opportunity Act allows states to provide wrap-around Medicaid coverage for children who have private insurance coverage in order to provide better coverage to meet the special health care needs of children with disabilities.

k The state sets resource and income limits.

l The American Recovery and Reinvestment Act (ARRA) of 2009 (Pub L N. 111-005) provides fiscal relief to the state to help pay for increasing Medicaid enrollment. As a result of ARRA, the Federal Medical Assistance Percentage rate (FMAP)—the amount that the federal government contributes to cover the health care costs—increased from 64.60% to 74.51% (for SFY 2008-09), from 65.16% to 74.98% (for SFY 2009-2010), and from 65.56% to 75.36% (for SFY 2010-2011). This translates into an additional $2.255 billion over the 18 months of the ARRA. (Bush M. Medicaid overview. General Assembly of North Carolina website. http://www.ncleg.net/fiscalresearch/frd_reports/ frd_reports_pdfs/ Session%20Briefings/2009%20Medicaid%20Overview.pdf. Accessed March 11, 2009.)

implemented in two phases (up to 100% FPG and then up to 200% FPG), offer a limited benefit package, develop a premium assistance program, and enroll participants in a low-cost insurance product utilizing the CCNC model.

Unfortunately, it generally takes several years to obtain waiver approval from the US Centers for Medicare and Medicaid Services. In the interim, North Carolina should expand coverage to low-income women who have had a prior high-risk birth. Currently, Medicaid pays anywhere from 8 to 15 times more for high-risk births than for normal births, and having a prior high-risk birth is one of the strongest predictors of having a subsequent high-risk birth.[29,30] Improving interconceptional care for women with prior preterm births can improve subsequent birth outcomes.[31] The Health Access Study Group recommended that **the North Carolina General Assembly direct DMA to seek a Medicaid Section 1115 waiver or implement other Medicaid options to provide interconceptional coverage to women with incomes below 185% FPG who have had a previous high-risk birth.**

Another option to expand coverage to a small subset of high-cost, high-need adults is to provide a subsidy to individuals eligible for North Carolina's high risk pool. North Carolina is one of 35 states with a health insurance risk pool. Inclusive Health (also known as the North Carolina Health Insurance Risk Pool) provides coverage to individuals who cannot obtain affordable health insurance in the non-group market due to a pre-existing medical condition. Premiums for Inclusive Health are 175% of what a healthy adult of the same age, sex, and geographic location would be charged. This premium is often too high for people with a pre-existing condition to afford. In response to high premiums in health insurance risk pools, some states have provided subsidies to help people with low-to-moderate incomes pay their premiums. The Study Group recommended a similar subsidy program.

Small Employers

Uninsured workers are disproportionately employed by firms with fewer than 50 employees, which are much less likely to offer health insurance to their workers than larger firms. In North Carolina, more than 98% of full-time employees working in firms with more than 50 employees are offered ESI, compared to less than 50% of employees in firms with fewer than 10 employees. The primary reason for this difference is that small firms face higher premium costs than larger firms. In 2005-2006, small firms (<50 employees) in North Carolina paid, on average, $313 more for an individual premium than firms with more than 50 employees ($4,151 vs. $3,838).[32,33] Higher premiums are largely due to higher administrative costs, higher risk for adverse selection, and fewer people in the insurance pool to spread the risk.[34] In addition, small firms in North Carolina are less likely to offer insurance coverage to their employees than small firms in the rest of the nation.[35] However, when offered, employees of small firms in North Carolina are about equally as likely to enroll in ESI. Thus, the primary strategy for increasing ESI for employees of small firms is to encourage more small firms to offer coverage. The Health Access Study Group supports the option of public subsidies to lower the cost of health insurance for small employers, in order to increase the offer rate among small firms.

Strengthening the Safety Net

Although a lack of health insurance creates significant obstacles to accessing health care, people who are uninsured can receive care from the numerous safety net organizations in the state that provide free or reduced-cost care to people based on need. Many of these organizations provide preventive and primary care, as well as chronic disease management, while others provide more specialized services. These organizations, however, do not currently have the funding or the capacity to care for the growing number of uninsured. The NCIOM estimated that in 2003 only 25% of the uninsured were receiving services through primary care safety net organizations[12,36] and similar estimates are obtained using more recent data from 2008.[m] In 2005, the North Carolina General Assembly created the North Carolina Community Health Center Grants program to expand the infrastructure and the availability of safety net services across the state.[37] However the majority of funding has been non-recurring. Safety net organizations need recurring funds to expand capacity to serve the growing number of uninsured. To address this, the Health Access Study Group recommended that **the North Carolina General Assembly increase funding to expand the safety net capacity by appropriating new recurring funds for the Community Health Center Grants program.**

In addition to lacking the capacity to provide care to all in need, care received at safety net organizations is often fragmented. Communities can provide more effective care by developing systems of care that include specialty, diagnostic, hospitalization, medications, and disease/care management services. The North Carolina General Assembly began funding HealthNet in 2008 to support the development of these community collaborations for the uninsured.[37] However, additional funding is needed to expand the number of community collaborations. The Health Access Study Group recommended that **the North Carolina General Assembly increase funding to expand safety net community collaborations by appropriating new recurring funds to HealthNet program.**

Provider Supply

While health insurance is a key component to expanding access to health care, ensuring that everyone has coverage will not, in itself, guarantee that everyone has access. North Carolina must also ensure that the state has an adequate

m Holmes M. Unpublished data based on internal NCIOM analyses. 2008.

supply of health care professionals to provide the preventive, primary, and specialty care services needed to maintain and improve the health of the population. Due to time restraints, the Study Group was only able to examine the supply of physicians, nurse practitioners, and physician assistants in the state. North Carolina is predicted to experience a shortage of physicians, nurse practitioners, and physician assistants in the next 10 to 20 years.[5,38] This predicted shortage is due to the combination of an increased demand for services (due to the growth and aging of the population and the increase in the number of people with chronic illnesses) and a decline in the number of practicing professionals (as a large cohort of professionals reach retirement age).[38] Not only is North Carolina expected to experience an overall health professional shortage, the state is also expected to experience even greater shortages among certain specialty areas including primary care, psychiatry, general surgery, and professionals who deliver babies (i.e., family practice, obstetricians, and certified nurse midwives). While these specialties are very important for the health of the state, their appeal is waning with United States-trained medical graduates.[38] Primary care providers are among the lowest paid physician specialties and many medical graduates are choosing specialties with higher salaries and/or more controllable lifestyles.[38] In addition, there is already a maldistribution of health care providers across the state, especially in rural areas. Maldistribution is likely to be exacerbated as the overall provider supply declines. In order to ensure that the state has an adequate supply of health professionals, North Carolina needs to increase the number of health care professionals entering the workforce as well as recruit and retain health care providers in underserved areas and specialties. Specifically, North Carolina needs to maintain and increase reimbursement levels, particularly those for primary care practitioners. The Health Access Study Group recommended that **the North Carolina General Assembly continue to support CCNC, continue Medicaid reimbursement levels at 95% of Medicare rates, and increase payment for primary care providers practicing in health professional shortage areas. The North Carolina General Assembly should fund technical assistance for practices in underserved areas and financial incentives for professionals practicing in underserved areas.**

The Health Access Study Group recognized that North Carolinians face many challenges in accessing high quality, affordable health care. Although the uninsured face the biggest challenges, even the insured are experiencing increasing barriers. Rising health care costs affect everyone, and the expected physician shortage will result in worsening access problems in the future. The Study Group also realized that during this economic crisis, a stepwise approach to expanding access to health care would be a preferred and effective approach. Therefore, the Study Group proposed a plan for phasing in the recommendations, with each phase corresponding with a two-year legislative cycle. This plan emphasizes a multifaceted approach incorporating public and private coverage strategies, increased support for the health care safety net, and investments in the health professional workforce. Ultimately, everyone stands to benefit from improved access to health care. Although solutions are not always easy, a deliberate, stepwise approach will be more successful than waiting until the situation becomes much worse. **NCMJ**

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