ALZHEIMER'S AND DEMENTIA WORKFORCE ASSESSMENT TASK FORCE

Minutes of the 1st Meeting
of the 2019 Interim

July 2, 2019

Call to Order and Roll Call

The 1st meeting of the Alzheimer's and Dementia Workforce Assessment Task Force was held on Tuesday, July 2, 2019, at 10:00 AM, in Room 131 of the Capitol Annex. Senator Robby Mills, Chair, called the meeting to order, and the secretary called the roll.

Present were:

Members: Senator Robby Mills, Co-Chair; Representative Deanna Frazier, Co-Chair; Senators Stephen Meredith and Reginald Thomas; Representative Lisa Willner; Bill Cooper, Buddy Hoskinson, Mackenzie Longoria, Devon McFadden, Andrea Renfrow, Mary Romelfanger, and Phillip Travis.

Guest: Steven Davis, Inspector General.

LRC Staff: Dana Simmons and Jennifer Luttrell.

Introduction of Members

Senator Mills asked each member to introduce themselves and give their agency name, area of expertise, and issues that may pertain to the charge of the task force. Each member gave a brief overview of their backgrounds and how they could be of service to this task force.

Charge and Duties of the Task Force

The Legislative Research Commission authorized the Alzheimer’s and Dementia Task Force by memorandum and set forth the charge and duties. The charge is to study health care workforce needs and the long-term care services and supports infrastructure, including long-term care facilities used to provide care to individuals diagnosed with Alzheimer’s or dementia. The task must submit findings and strategies to LRC by November 29, 2019.

The duties include assessing the health care workforce to identify current or anticipated workforce shortages and possible steps to ameliorate any shortages, evaluating the effectiveness of current initiatives to develop, recruit, and retain highly skilled direct care workers, geriatricians, gerontologists, neurologists, and other professionals involved in providing care and treatment to individuals diagnosed with Alzheimer’s or dementia, evaluating the current state of long-term care services and supports infrastructure and providing recommendations for improvement, and examining existing workforce training initiatives and making recommendations to improve career mobility and retention among health care workers, including continuing education requirements and the current credentialing process.

State of Long-Term Care Services and Supports Infrastructure

Mackenzie Longoria, Director of Public Policy, Greater Kentucky and Southern Indiana Chapter of the Alzheimer's Association, discussed long-term care services and the supports infrastructure.

In 2007, SJR 6 directed the Office on Alzheimer's Disease and Related Disorders (AD Office) and the Alzheimer's Disease and Related Disorders Advisory Council (AD Council) to assess the current and future impact of Alzheimer's disease on Kentuckians and state systems, programs, and services. This assessment was updated in 2017 with new and revised recommendations.

Several of the recommendations address the AD Office, which as of June 2019, exists in name only and is not funded or staffed.

The association is realistic about costs and is willing to work with the Department for Aging and Independent Living (DAIL) to serve as the de facto AD Office.

The first recommendation was to:

a) Increase and improve support for family caregivers by requesting an increase in the Alzheimer's Program Development and Implementation line item in the state budget but no increases have occurred.
b) Utilize the AD council and stakeholder community to revise the current definition, eligibility, and service requirements for the provision of respite care. Kentucky provides respite care through Title III-E. Ad Districts (AAAs) can provide respite care, but funding limitations and or prioritization play a big part in funding allocation. Most caregivers are unaware of the availability of respite care.
c) Maintain a system of care coordinators and benefit counselors in each of the 15 AAAs. There is no system in place.
d) Develop incentives beyond tax incentives for caregivers. There is no tax incentive for caregivers and no measures beyond tax incentives.
e) Support legislation for a caregiver tax credit for people who provide in-home care for dependent relatives who have little to no income and have been diagnosed with Alzheimer's or related dementia. Although attempted, no such legislation has been passed.
f) Develop a demonstration to test the feasibility and cost-effectiveness of adult day care clients receiving services in other long-term care settings traditionally considered institutional in order to expand access to accommodate anticipated

growth in demand. Many adult day services, especially social models, have been cut due to funding issues as federal funding moved to the medical model. There has been no demonstration or pilot program of traditionally institutional services for the purpose of expanding Home- and Community-Based Services (HCBS) care.

The second recommendation was to monitor a statewide data collection system by collecting and monitoring, at minimum, the following:

a) The prevalence of dementia-related diseases across the commonwealth. In 2012, 2015, and 2016, the association applied to be included in the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance Survey (BRFSS). In 2016, it was funded in part with help from DAIL and currently represents the most up-to-date statistics. BRFSS cognitive model collects demographic, geographic, and socioeconomic data related to cognitive decline. There is also a caregiver module which focuses on collecting data regarding caregivers' personal health and greatest care needs. This is the most important piece of data that can be collected to ensure accurate information about individuals in Kentucky experiencing cognitive decline and their caregivers. However, the association was unable to be included in the upcoming 2019 BRFSS module due to lack of funding. The cost for including the six necessary questions is $30,000, which now rests solely on the association.
b) The prevalence of dementia-related diseases by county. BRFSS, nor any other data system, captures this information.
c) The prevalence of early-onset dementia and related diseases across the commonwealth. BRFSS, nor any other data system, captures this information.
d) The prevalence of inpatient geriatric psychiatry beds. BRFSS, nor any other data system, captures this information.
e) The availability of geriatric services and specialists. Kentucky is behind in the availability of such services and specialists. The American Geriatrics Society estimates that an additional 23,750 geriatricians should be trained by 2030 in order to meet the demands of an aging U.S. population, however, as of 2017, there are currently only 6,910 certified geriatricians practicing nationwide, and it is estimated that the United States has approximately half the number of certified geriatricians that it currently needs. Researchers also estimate that the United States will need 19 percent more neurologists by 2025 in order to meet the increasing demand. In 2017 Kentucky was identified as one of the twenty states that were deemed "neurology deserts" due to a projected shortage of neurologists, combined with an expected rapid rise in Alzheimer's disease and other dementias.
f) The availability of assessment services for Alzheimer's and related dementias. Assessment services for Alzheimer's and related dementias depend largely on an individual's Point Of Care (POC) and/or information available at their local health department or AAA. While 82 percent of seniors say it is important to have their thinking and memory checked, only 16 percent say they receive regular cognitive assessments. There is a Medicare billing code for care planning but since its

implementation in 2017, less than one percent of doctors utilize the code, partly because of the low reimbursement rate. Congressman Guthrie has introduced a second version of this code called I-HOPE at the federal level that providers can use for care planning. Cognitive assessment is covered by the Medicare annual wellness visit, but most seniors are unaware of the benefit and therefore do not ask for it. Kentucky does collect information through Software Asset Management (SAM), a statewide data system on services provided by AAAs, but currently lists that information pertaining to Alzheimer’s and dementia under a “Disability” title.

g) The number and location (county) of Kentuckians who are currently providing care in their home to a family member. The association does not collect data related to the number and location of Kentuckians providing care to a family member in their home. BRFSS collects data related to the percentage of adults 18 years or older who self-report as being a caregiver to a person with a health problem or disability; relationship between the caregiver and the care recipient; health problem or disability of the care recipient; if the caregiver assists with household tasks; if the caregiver assists with personal tasks; average hours of caregiving provided per week; length of time as a caregiver; type of assistance most needed by the caregiver that they do not receive (question included for years 2015–2018); if the care recipient has Alzheimer’s disease or another dementia in addition to another health problem or disability (question added in 2019); and the percentage of adults aged 18 years or older who are not caregivers who expect to be caregivers in the next two years.

The third recommendation was to establish state protocol on appropriate interface and choices for individuals with Alzheimer’s and their families by requiring the AD Council to utilize a protocol detailing how to interface with individuals with Alzheimer's and related dementias and their families. The protocol should include appropriate placement care options based on the stages of Alzheimer’s and related dementias. DAIL provides resources for case managers and serves as a resource for family members. Department for Medicaid Servies (DMS) through the Division of Community Alternatives (DCA) has a manual for HCBS providers and case managers and is working on improving the ways in which they can be a resource for families, through the 1915(c) waiver redesign. The Alzheimer's Association is working on a request for an Alzheimer's specific 1915c waiver. The association has given public comments with recommendations as it relates to case managers and care planning. However, there is no singular official “handbook” or “protocol” for interfacing with individuals with Alzheimer’s and their families.

The fourth recommendation was to explore options to increase insurance coverage for individuals with Alzheimer’s and related dementias by:

a) Supporting and protecting Medicaid eligibility and Alzheimer’s specific waivers for individuals with early-onset Alzheimer’s disease. Kentucky uses the federal Medicaid financial eligibility requirements for HCBS and sets the functional eligibility requirements as: (1) are elderly or have a physical disability and (2) meet

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    the Level of Care defined by KAR 1:022 and would be admitted to a nursing facility if no have waiver services. This has the potential to prevent individuals with early onset to qualify for HCBS services.
    b) Advocating for integrated systems of healthcare and support that support mental health parity and are effective for individuals with Alzheimer's disease and their families (e.g.: disease management strategies, practice guidelines, HCBS care, hospice care, and chronic care management). Efforts to integrate mental health care are slowly being addressed within hospital systems, but disparity between levels of care causes disruptions and confusion with disease management strategies and care planning.

The fifth recommendation was to enhance state policies and procedures to provide additional support to ensure the health, safety, and welfare of individuals with Alzheimer's disease and related dementia by:

a. Utilizing the AD Council to evaluate state regulations on home care, adult day, and home health, to assure they are "dementia friendly." When time provides, the council attempts to evaluate said regulations, but are limited by time and funding constraints.
b. Monitoring and giving recommendations that address persons with dementia ability to remain in their current living environment despite a change in their condition (i.e.: challenging behaviors or other disease symptoms) that under existing regulations might otherwise promote their move to a different level of care. This protocol should ensure that the provider can adequately demonstrate that the person's care needs can be safely and effectively met without the disruption of moving. The association is actively working on this issue through participation in the 1915(c) waiver redesign and with recommendations for training and case management for individuals with Alzheimer's or related dementias utilizing HCBS.
c. Supporting a pilot demonstration project to address the problem of facility discharges of residents exhibiting challenging behaviors. There is no such pilot program in place. Currently, there is a 22 percent hospital readmission rate for dementia patients.
d. Reviewing the current Kentucky Medicaid programs to ensure "dementia friendly" approaches and policies, and identify challenges to admission and eligibility requirements. The association is actively working on this issue through participation in the 1915(c) waiver redesign and with recommendations for training and case management for individuals with Alzheimer's or related dementias utilizing HCBS, as well as the financial and functional eligibility requirements.
e. Supporting and encouraging the evolution and application of best practice for persons with dementia living in personal care homes and assisted living facilities. With Personal Care Homes (PCs) being licensed by the Office of the Inspector General (OIG) and Assisted Living Facilities (ASLs) being certified by DAIL, there is a disparity in the education and training requirements, as well as policies, rules and or regulations regarding best practices for individuals with Alzheimer's or related dementias in those settings.

The goals and recommendations of the state plan to address Alzheimer's align with the association's overall policy goals and priorities to increase public awareness, build a dementia-capable workforce, increase access to home- and community-based services, and enhance the quality of care in residential settings.

The Kentucky statistics include the number of Kentuckians living with Alzheimer's or related dementia, from 73,000 to 86,000 by 2025. This is an increase of nearly 17 percent over the next six years. Alzheimer's and related dementias were responsible for 1,765 deaths in 2017. The number of caregivers in Kentucky - 273,000 → 300,000 by 2025 with 311 million total hours of unpaid care is valued at $3.9 million with $197 million in higher healthcare costs for caregivers. Costs associated with caring for the disease include $23,703/per capita Medicare spending, $778 million in Medicaid costs for people with dementia, 20.6 percent increase expected from 2019 to 2025, and 22.2 percent hospital readmission rate for dementia patients. The 2016 BRFSS data says that in Kentucky, one in eight of those aged 45 and over report they are experiencing confusion or memory loss that is happening more often or is getting worse ("subjective cognitive decline"); 55.9 percent say it has created "functional difficulties;" more than half have not discussed these problems with a healthcare professional; 90.4 percent of those reporting cognitive decline are also managing another chronic condition (i.e.: diabetes, heart disease, COPD, etc.); nearly one in four Kentuckians are caregivers who provide at least 20 hours per week of unpaid care.

In Kentucky, the two entities that are responsible for licensure and/or certification of long-term care (LTC) facilities through the Cabinet for Health and Family Services (CHFS) are DAIL, which includes Home-And-Community-Based-Services (HCBS) with Adult Day and Respite Care also under CHFS/DAIL, by way of DMS and the DCA and the OIG, Division of Healthcare. Assisted Living Facilities (ASL) are certified by DAIL. Personal Care (PC) Homes and Nursing Homes/Facilities (NF) are licensed by OIG.

HCB services are authorized through the 1915(c) Medicaid Waiver Program: "A Kentucky Medicaid program established pursuant to and in accordance with 42 U.S.C. 1396n(c)." This waiver program provides Medicaid-paid services and supports to the elderly or to adults and children with physical disabilities to help them to live at home rather than in an institutional setting. Services include:

1. Adult Day Health Care - A place for persons 21 and older to receive skilled nursing care, routine personal and healthcare needs, meals, and to be part of daily activities.
2. Attendant Care - Help with tasks a person cannot do on his or her own due to being aged or because of a physical disability. This service includes help with bathing, dressing, grooming, light housework, laundry, and meal planning and preparation
3. Environmental and Minor Home Adaptation - Changes to a person's home that ensure their health, safety, and welfare, increase independence and allow them to continue to live at home.

4. Home Delivered Meals.
5. Non-Specialized and Specialized Respite Care - Provides a short term break for a person's primary, unpaid caregiver.

A person may qualify for HCBS / 1915(c) if they are elderly or have a physical disability; meet nursing facility level of care as defined in Kentucky Administrative Regulation 907 KAR 1:022 and would be admitted to a nursing facility if the person did not have waiver services; and meet the federal financial qualifications for Medicaid. KRS 205.520(3) authorizes CHFS to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. HCBS compliance with federal law is monitored by DAIL, via CHFS, DMS, and DCA. HCBS includes Alzheimer's respite care and Alzheimer's/Adult Day Care.

Assisted Living Facilities (ASLs) must be certified initially and annually by DAIL and are considered private business entities (910 KAR 1:240). As such, no public funding is available for services provided in this setting (i.e.: no Medicaid reimbursement). Clients must be ambulatory or mobile non-ambulatory and not a danger to self or others. ASLs in Kentucky means a number of living units on the same site, operated as one business entity and certified to provide services for five or more adults. Services that can be performed in ASLs include Assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) such as housekeeping, scheduled daily activities, and assistance with self-administration of medication as directed in KRS 194A.705(1)(d): "Assistance with self-administration of medication in accordance with (ibid), which, for medications not preset in a medication organizer or single dose unit container as described in KRS 194A.700(3)(a), may include but shall not exceed the following staff actions if the client requests assistance:

1. providing the client with a medication reminder;
2. reading the medication label to the client and confirming that the medication is being taken by the client for whom it is prescribed and;
3. opening the medication container or dosage package, but not handling or removing the medication.

For certification, an ASL must complete the DAIL application; provide a copy of a blank lease agreement; a copy of written material used to market the proposed ASL, including material that markets offered special programming (ex: Alzheimer's and dementia care), staffing or training; a floor plan; and a nonrefundable application fee of $40 per unit (plus additional fees depending on the size of the facility). The certification process is annual and absent a formal complaint against the facility, the state does not conduct any oversight and monitoring of the quality of care in the facility.

Personal Care Homes (PCs) are licensed as LTC facilities by the OIG. Services in a PC may be reimbursed from the state general fund but there is no reimbursement for Medicaid services. Clients may be ambulatory or mobile non-ambulatory and whose care needs do not exceed the PC’s capability (i.e.: residents must be able to manage most of their ADLs). PCs in Kentucky means an establishment located in a permanent building, which has resident beds. Services that can be performed in PCs include continuous supervision; basic health/health-related services (supervision of self-administration of medications, storage and control of medications, when necessary); personal care services; and social/recreational activities. For complete details of the licensure process, see 902 KAR 20:008.

Nursing Facilities (NFs) are licensed by OIG and are legally responsible for the facility and compliance with all federal, state, and local laws and regulations pertaining to the operation of the facility. NFs are often the final stop on the continuum of care. NFs “shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life” (902 KAR 20:300). Before admission to an NF, the facility “shall make a comprehensive assessment of the resident's needs, which describes the resident’s capacity to perform daily life functions and significant impairments in functional capacity” (902 KAR 20:300). Kentucky has administrative regulations for “nursing facilities” (902 KAR 20:300) but also “nursing homes” (902 KAR 20:048).

Nursing homes are defined as “establishments with permanent facilities that include inpatient beds” and “services provided may include medical services and continuous nursing services. Patients in a nursing home facility require inpatient care but do not currently require inpatient hospital services” (902 KAR 20:048).

Nursing facilities are defined as “a nursing facility licensed pursuant to this reg and 902 KAR 20:008 (which relates to license procedures and fee schedules).

902 KAR 20:048: “(b) When the patient's condition exceeds the scope of services of the facility, the patient, upon physician's orders (except in cases of emergency), shall be transferred promptly to a hospital or a skilled nursing facility, or services shall be contracted for from another community resource.”

Program staff at a certified adult-day center shall include trained and experienced staff who shall be present each day of operation and at least two staff members at the adult-day center at times when there is more than one client in attendance. Staffing ratios shall be one staff to one client; two staff if two to 10 clients; three staff if 11 to 15 clients; one staff member for each five additional clients over 15; one staff member certified in CPR; and a director that meets the qualifications laid out in 910 KAR 1:160 (9)(a)1.

Prior to assuming duties, paid and volunteer personnel shall receive a minimum of six hours of orientation including program objectives; policies and procedures; health, sanitation, emergency procedures; client confidentiality; and personnel policies.

Within three months of employment, staff shall be provided a minimum of 34 hours of basic training that includes one hour of the aging process; seven hours of recognizing and reporting suspected adult abuse neglect or exploitation; nine hours of dementia training, including causes and manifestations of dementia and managing a client with dementia; 10 hours of crisis intervention with a combative client; and 11 hours of effects of dementia on the caregiver. Staff shall receive a minimum of eight hours of annual training to review and update knowledge and skills. HCBS providers must also ensure compliance with federal Medicaid laws and training.

According to KRS 194A. 717, staffing in an assisted-living community shall be sufficient in number and qualification to meet the 24-hour scheduled needs of each client pursuant to the lease agreement and functional needs assessment; one awake staff member shall be on site at all times; an assisted-living community shall have a designated manager who is at least 21 years of age, has at least a high school diploma or GED and has demonstrated management or administrative ability to maintain the daily operations; and no employee who has an active communicable disease.

According to KRS 194A.719: In-service Education for Staff and Management, ASL staff and management shall receive orientation education (within 90 days of hire) on the following topics as applicable to the employee's assigned duties: Alzheimer's disease and other types of dementia and the aging process. Staff and management shall receive annual in-service education applicable to their assigned duties that address no fewer than four of the topics listed above.

The ASL must maintain a description of any dementia-specific training that is provided, including, at a minimum, the content, the number of offered and required hours, the schedule, and the staff who are required to complete the training.

According to 902 KAR 20:036(8), each facility must have an administrator who is responsible for the facility's operation and who must delegate such responsibility in his/her absence, and one attendant shall be awake and on duty on each floor in the facility at all times.

According to 902 KAR 20:036(8), all employees shall receive in-service training to correspond with the duties of their respective jobs. Shall include but not be limited to one to three hours of policies/services/procedures; four hours of reporting cases of adult abuse, neglect, or exploitation; five hours of methods of assisting patients to achieve maximum abilities in ADLs; six hours of methods for proper application of physical restraints; and nine hours of the aging process training.

According to 902 KAR 20:036(g), the number of personnel required shall be based on the number of patients, amount and kind of PC, and the supervision and program needed to meet the needs of residents.

Only 902 KAR 20:048 (Nursing Homes) lays out staffing requirements. The facility shall have adequate personnel to meet the needs of the patients on a 24-hour basis. The number and classification of personnel required shall be based on the number of patients and the amount and kind of personal care, nursing care, supervision, and program needed to meet the needs of the patients as determined by medical orders and by services required by this administrative regulation. When the staff to patient ratio does not meet the needs of the patients, the Division for Licensing and Regulation shall determine and inform the administrator in writing how many additional personnel are to be added and of what job classification and shall give the basis for this determination. A responsible staff member shall be on duty and awake at all times to assure prompt, appropriate action in cases of injury, illness, fire, or other emergencies. Volunteers shall not be counted to make up minimum staffing requirements. The facility shall have a director of nursing service who is a registered nurse and who works full time during the day, and who devotes full time to the nursing service of the facility.

902 KAR 20:048 (Nursing Homes) also lays out orientation and in-service requirements. Orientation program - the facility shall conduct an orientation program for all new employees to include review of all facility policies (that relate to the duties of their respective jobs), services, and emergency and disaster procedures. In-service training - all employees shall receive in-service training and ongoing education to correspond with the duties of their respective jobs. All nursing personnel shall receive in-service or continuing education programs at least quarterly.

Because NFs take Medicaid, there are federal training and education requirements. 42 CFR 483.95 – Training requirements: “A facility must develop, implement and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to communication; resident's rights and facility responsibilities; and abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that, at a minimum, educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12; procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property; dementia management and resident abuse prevention; required in-service training for nurse aides. In-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year and include dementia management training and resident abuse prevention training.

There is a KRS provision, 216.595, that sets out requirements for “assisted living facilities and long-term care facilities claiming to provide special care for person’s with

Alzheimer’s disease or other brain disorders.” (1) (a) Any assisted-living community as defined by KRS 194A.700 or long-term care facility as defined in KRS 216.535 that claims to provide special care for persons with a medical diagnosis of Alzheimer's disease or other brain disorders shall maintain a written and current manual that contains the information specified in subsection (2) of this section. This manual shall be maintained in the office of the community's or facility's director and shall be made available for inspection upon request of any person. The community or facility shall make a copy of any program or service information contained in the manual for a person who requests information.
The community or facility shall maintain and update written information on the following:
(a) The assisted-living community's or long-term care facility's mission or philosophy statement concerning the needs of residents with Alzheimer's disease or other brain disorders;
(b) The process and criteria the assisted-living community or long-term care facility uses to determine placement into services for persons with Alzheimer's disease or other brain disorders;
(c) The process and criteria the assisted-living community or long-term care facility uses to transfer or discharge persons from special services for Alzheimer's or other brain disorders;
(d) The supervision provided for residents with a medical diagnosis of Alzheimer's disease or other brain disorders;
(e) The family's role in care;
(f) The process for assessing, planning, implementing, and evaluating the plan of care for persons with Alzheimer's disease or other brain disorders;
(g) A description of any special care services for persons with Alzheimer's disease or other brain disorders;
(h) Any costs associated with specialized services for Alzheimer's disease or other brain disorders; and
(i) A description of dementia or other brain disorder-specific staff training that is provided, including but not limited to the content of the training, the number of offered and required hours of training, the schedule for training, and the staff who are required to complete the training.

KRS 216B.072 provides the training/education requirements for these facilities. A long-term care facility as defined in KRS 216.535, except for a personal care home (note: there are Alzheimer’s personal care facilities all over the state, yet no specific statutes), that advertises to provide special care for persons with a medical diagnosis of Alzheimer's disease or other related disorders or maintains an identifiable unit for the treatment of persons with a medical diagnosis of Alzheimer's disease or other related disorders shall provide training to all staff members in the care and handling of Alzheimer's disease or other related disorders as follows at least eight hours of orientation related to Alzheimer's disease or other related disorders to include the following:
(a) Facility policies;
(b) Etiology and treatment;

(c) Disease stages; (d) Behavior management; and
(e) Residents' rights; and
(2) Annual continuing education of at least five (5) hours related to Alzheimer's disease or other related disorders.

According to the State Long-Term Care Ombudsman, there are only two nursing facilities in Kentucky that operate under these statutes.

In response to a question from Representative Thomas about the lack of data and the possibility of partnering with universities to collect data, Ms. Longoria said the association has considered partnering with the universities to solicit funds for the 2020 BRFS by giving a gift that could be split between the University of Kentucky and the University of Louisville to make up the gap in funding. It’s not a guarantee and it’s not in their charge to provide funding for data collection because the universities do research. It would have to be in the form of a major gift.

In response to a question from Ms. Romelfanger, Ms. Longoria replied that the association’s region nine, which includes Kentucky, Indiana, and Illinois, has also reached out to the development staff and medical schools at both of the universities concerning a major gift.

Senator Meredith stated that data collection is important, but that the main focus of the task force should be access to care, accessing care, and funding of care. He also added that he would like to hear from the caregivers and what their obstacles are and what would make their lives better.

In response to a question from Representative Frazier about the statistic from the 2016 BRFSS data that says one in eight of those aged 45 and over report they are experiencing confusion or memory loss, Ms. Longoria said that she thought it was broken down by gender but that she would have to get back with that information. She added that women are two-thirds more likely, African-American women are two-thirds more likely, and Hispanic women are one half more likely to develop the disease.

In response to a question from Representative Willner concerning receiving information about how other states are handling these issues, Ms. Longoria said that Barry Lewis, Director of Programming, and others at the national office would know more and that she would find out and get back to the task force with that information.

Ms. Romelfanger pointed out that there is a diagnostic code that many care providers are not aware of and do not use. She added that another focus of the data collection should be a knowledge base of caregivers in a professional setting. Ms. Longoria added that Congressman Guthrie has continued to push this issue and Hal Rogers has signed on as a cosponsor.

Mr. Travis added that Wellington Parc accepted Title 19/Medicare money which defines it as skilled care. It started in 1992 as an Alzheimer's facility that did not accept Medicare or Medicaid as a private pay only facility of 60 beds. Twenty private rooms were added in 1997 which are NF certified so two licenses are needed to be renewed every year. It was allowed to participate in the Title 18/Medicaid program so now both state and federal governments are involved. Most facilities are duly certified.

Mr. Hoskinson added that he believes there is not a consistent number of hours for continuing education. CNAs actually have more required hours of training. He would like the task force to look at the consistency of continuing education across the state.

Senator Mills asked Mr. Davis, Inspector General, CHFS, to speak. Mr. Davis gave a brief overview of his background and the history, certification rules, reimbursement structure, and obstacles of ASLs, NFs, and PCs.

Senator Mills told the members the meeting dates for the rest of the interim and asked them to come up with experts to testify before the task force during the next five meetings.

Adjournment

There being no further business, the meeting was adjourned at 11:45 a.m.