ALZHEIMER'S AND DEMENTIA WORKFORCE ASSESSMENT TASK FORCE

Minutes of the 2nd Meeting of the 2019 Interim

August 1, 2019

Call to Order and Roll Call

The 2nd meeting of the Alzheimer's and Dementia Workforce Assessment Task Force was held on Thursday, August 1, 2019, at 10:00 AM, in Room 131 of the Capitol Annex. Representative Deanna Frazier, Chair, called the meeting to order, and the secretary called the roll.

Present were:

Members: Representative Deanna Frazier, Co-Chair; Senators Stephen Meredith and Reginald Thomas; Representatives Danny Bentley and Lisa Willner; Melissa Aguilar, Bill Cooper, Sherry Culp, Steven Davis, Buddy Hoskinson, Mackenzie Longoria, Andrea Renfrow, Mary Romelfanger, and Kelly Upchurch.

Guests: Steven D. Davis, Inspector General, Office of the Inspector General, Cabinet for Health and Family Services; Sherry Culp, State Long-Term Care Ombudsman, Nursing Home Ombudsman Agency of the Bluegrass, and Denise Wells, District Long-Term Care Ombudsman, Nursing Home Ombudsman Agency of the Bluegrass.

LRC Staff: Dana L. Simmons, Lead Staff, and Becky Lancaster.

Approval of Minutes

A motion to approve the minutes of the July 2, 2019 meeting was made by Senator Meredith, seconded by Mary Romelfanger, and approved by voice vote.

Evaluation of Current State of Long-Term Care Services

Steven D. Davis, Inspector General, Office of the Inspector General, Cabinet for Health and Family Services (CHFS), stated that there are different areas in which long-term care (LTC) is provided to individuals with Alzheimer’s and Dementia. LTC typically starts at home with the assistance of family or an informal caregiver. The next level of LTC consists of a home health agency and private nursing services, including provider types that do not provide skilled nursing, which assist individuals in their homes or other residential settings,. A residential care community will generally provide assistance with supervision and limited supports. The next level is a nursing facility or a skilled nursing facility that provides intermediate care such as an Alzheimer's focused nursing home. The

final level of LTC is a hospice provider. Medicare covers all hospice costs except room and board. Kentucky Medicaid covers room, board, and other services.

Mr. Davis stated that the National Center for Health Statistics confirmed that in 2016, 47.8 percent of nursing facility residents, 41.9 percent of residential care community residents, and 30.9 percent of adult day service center participants received care for Alzheimer's or dementia. In 2015, 44.5 percent of hospice patients and 32.3 percent of home health agency patients received care for Alzheimer's or dementia. There has been a dramatic increase in alternatives to nursing facility care in the residential care community setting due to the increasing costs of nursing facility care. Differing reimbursement structures depending on the level of care, avoidance of a nursing facility label, effective marketing with a controlled message by residential care providers, a flexible market with no certificate of need, significantly reduced regulatory burdens, the perception of greater resident independence, and a change in assisted living statutory definition in 2000, all contributed to the rise of the residential care. There have been significant differences in the approach nationwide for assisted living and other residential care settings. Most states define assisted living as a health care model, rather than a social model.

Effective on July 14, 2000, the Kentucky legislature amended the assisted living law by replacing voluntary certification with mandatory certification, developing additional standards, and moving away from a purely social model to a quasi-medical model. The current law still prohibits delivery of health services; however, some assisted living facilities have dedicated dementia units. Some facilities offer assistance with medication administration, Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), and provide nearly continuous supervision. Assisted living facilities no longer have the appearance of a purely social model. The course of illness is such that Alzheimer's and dementia clients will eventually need supervision, ADL assistance, and other supports due to the decline in cognition. Kentucky law does not fully embrace the provision of healthcare in an assisted living facility; although, many states do. Some states have moved past the purely private pay model to include covered services but not room and board. Kentucky is one of three states that do not provide any Medicaid funding for residential care.

Mr. Davis stated that Kentucky's assisted living standards do not adequately address the need for residential care for individuals who require limited health care supports but do not need high intensity nursing care, have an unstable medical condition, or require skilled care. Kentucky should modernize its residential community standards to enable individuals who enter care with nearly full cognition to age in place in a setting that meets their non-skilled needs. The focus should be on the continuum of care and should enable a resident to avoid discharge until clinically unstable or in need of high intensity nursing services. An option for change would be to combine current concepts in personal care homes and assisted living to create a single congregate care model that is tiered and focused on the provider's ability to manage care as the client ages in place.

Another option of care would be the extended congregate care model that could include a continued stay with exceptions to admissions criteria. The newly-designed assisted living provider type would share similarities with the existing assisted living and personal care home models but also include the provision of housing, meals, and one or more personal care services. Admission criteria would still require the resident to perform ADL with supervision if needed, be able to transfer with assistance if needed, be capable of taking medication unless the facility employs a trained nurse, not be bedridden, not be a danger, and not have any special needs that cannot be met by the facility. There would need to be statutory and regulatory adjustments to have these changes implemented.

In response to questions and comments from Mary Romelfanger, Mr. Davis stated that the Cabinet for Health and Family Services needs to boost telehealth programs. Telehealth is a great opportunity to fill some of the gaps for care. There is an initiative for the Department for Public Health and other areas to revitalize and modernize the telehealth concept. Telehealth could help in the limited mental health model to assist clients with mental health issues that reside in personal care homes. The clinical and psychiatric care are so different that the populations are not usually mixed unless there are no other resources.

In response to questions and comments from Senator Meredith, Mr. Davis stated that Kentucky does need another level of care and needs to more clearly define the scope of services that are offered in the other levels of care. Mr. Davis suggested reviewing the level of care below the nursing facility level. He stated that there is an infrastructure in place but redefining and tiering the levels of care could be reviewed before the next legislative session. The lower level revision could be handled in a short amount of time. Every level of care in LTC is exceeding or needing to exceed the scope of care that is in place. CHFS has been reviewing Florida's model of LTC for approximately a year and a half with limited staff. CHFS may want to create new standards according to the Florida model.

In response to questions and comments from Representative Wilner, Mr. Davis stated that Florida is a good model to review that has a four tiered program. CHFS could start the effort by putting personal care homes and assisted living under one tier and allowing patients to stay in one place to create a better continuum of care on the lower level. The workforce issue in a nursing facility differs from personal care and assisted living because there are not many heavy care clients in those homes. The crisis is with the workforce in the nursing facilities that have a multitude of complex care patients. With challenging standards and regulations, nurse aides do difficult work for low pay. CHFS would like to create supports and infrastructures outside of the nursing facility that will serve as resources for the nurse aides.

In response to questions and comments from Melissa Aguilar, Mr. Davis stated that capacity is difficult to change at the nursing facility level due to the certificate of need laws in place. It is difficult to move or create new bed capacity in LTC. New facilities that cater to memory care are being built in Kentucky. He stated that making lower level care more appealing to providers would increase capacity. There are more services that provide care, for example, adult day health programs, home health care, and private duty nursing services. However, there are laws that impact the ability of some providers. There is a critical issue with the workforce in the nursing facilities.

In response to questions and comments from Senator Thomas, Mr. Davis stated that regulations for personal care homes do not mention Alzheimer's or dementia and do not account for the condition of decline. Once a patient is in decline, a personal care home may not be the best place for that patient. Assisted living, which is not the health care model, does recognize special units that could be used for Alzheimer's and dementia, or hospice clients. There are potential problems because when units are locked down by regulations. Patients do not have the ability to self-exit in case of emergency when the patient is a danger to themselves. It becomes an unworkable solution for the patient. If assisted living was more of a model with a care continuum, it would be possible to create a facility that could focus solely on Alzheimer's and dementia patients. In the admission standards, there are protections built around assisted living that state a patient could not be a resident if they were bedridden unless it is a temporary condition. Senator Meredith stated that 14 days is a medical-necessity definition used for reimbursement.

In response to questions and comments from Mackenzie Longoria, Mr. Davis stated that in 2000, the authorization for units used for Alzheimer's and dementia patients were layered into a social model and created an inconsistency. A facility can be an Alzheimer's, and dementia unit, but staff are prohibited from providing any medical services to that patient. A patient must be referred out of the facility to have a medical service provided to the patient. It is the responsibility of the facility to advise all clients and family members when there is a limit of care for a patient. The only medical care that can be provided in assisted living is ADL, IADL, and assisting with medication. However, staff cannot leave a patient that is in distress that needs assistance or redirection. Under the law, the patient should be given a discharged notice. With Alzheimer's and dementia, a client may temporarily fall out of cognition or lose a range of motion but be able to come back. However, providers cannot provide assistance with that issue.

Buddy Hoskinson, Quality Assurance and Accountability Director, Department for Aging and Independent Living (DAIL), Cabinet for Health and Family Services, provided the committee with a fact sheet regarding the direct care workforce initiative from the Iowa Department of Public Health. He stated that it would be beneficial for Kentucky to create and provide a similar fact sheet.

Sherry Culp, State Long-Term Care Ombudsman, Nursing Home Ombudsman Agency of the Bluegrass, stated that a LTC ombudsman is a resident advocate for quality of care and quality of life of residents in LTC. The ombudsman provisions in the Older Americans Act (OAA) include investigating and resolving complaints, providing information to residents, families, and staff, and advocating for systemic changes to improve residents' care and quality of life. In financial fiscal year (FFY) 2018, Kentucky's ombudsmen investigated 6,025 complaints of which 27 percent were complaints about care. Complaints about staff represented 15 percent of the complaints. Many facilities do not want to admit people that may become medicaid eligible because the patients are entering without a payment source.

She stated that 50 percent of patients in LTC in Kentucky have Alzheimer's or a memory disorder. The Alzheimer's Association states that nationwide 70 percent of people with Alzheimer's or dementia have behaviors that are difficult to manage such as hitting, spitting, wandering, and cursing. Denise Wells, District Long-Term Care Ombudsman, Nursing Home Ombudsman Agency of the Bluegrass, stated that ombudsmen have a responsibility to act as the residents' voices. In 2018, care was the most widely cited complaint from residents. Failure to respond to requests for assistance represented eight percent of all complaints. The shortage of staff in a facility represented three percent of the complaints. Residents expressed that the nurse aides did not have enough training to provide adequate care.

Ms. Culp stated that PHI is a company that works to ensure quality care for older adults and people with disabilities by creating quality jobs for direct care workers. A 2018 PHI report stated that one in four Americans will be age 65 and older in 2060 and more than half will need long-term care at some point. The Alzheimer's Association declares that state officials can help the Alzheimer's crisis by increasing public awareness for early detection and diagnosis, increasing access to home and community-based services, building a dementia-capable workforce, and enhancing the quality of care in residential settings. Direct care workers assist older adults and people with disabilities with daily tasks, such as dressing, bathing, and eating. Direct care workers include personal care aides, home health aides, and nursing assistants. Nursing assistants also perform clinical tasks, such as blood pressure readings and assistance with range-of-motion exercises. She stated that nurse aides have some of the highest rates of injuries on the job.

Ms. Culp stated that it does not matter what laws and regulations are in place, if the care is from a for-profit or a not-for-profit organization, if the amount of money being paid is from an individual or paid by Medicaid, the experience of the older adult patient is determined by his or her interactions with the direct care worker. Nursing home residents throughout the country explained that the most important elements of quality in their day-to-day lives were the accessibility, attitude, and training of the direct care worker. The direct care workforce totaled 4.3 million workers in 2017. The home care worker is among the fastest growing occupations and have added one million jobs between 2016 and 2017,

more than any other single occupation. However, wages for home care workers have remained stagnant in the last decade. One in four direct care workers is an immigrant, totaling one million workers nationwide. Immigrants are a valuable part of the direct care workforce. Men make up roughly half of the United States labor force yet only 14 percent work in LTC.

Direct care workers are a key segment of the eldercare workforce and would benefit from improved geriatrics training. In May, the Geriatrics Workforce Improvement Act was introduced in the United States Senate, paving the way for strengthening the health care sector's ability to support older Americans. The United States House of Representatives passed the Educating Medical Professionals and Optimizing Workforce Efficiency and Readiness (EMPOWER) Act which would continue funding for geriatric workforce enhancement programs that are based in home and community-based settings and nursing homes. There should be more employment support, peer to peer support, and effective supervision for nurse aides and other workers who work in LTC.

In response to comments and questions from Representatives Frazier, Ms. Wells stated that in Kentucky there is not a minimum staffing law for LTC. Research has been done to suggest that residents need 4.1 hours of direct care per day to avoid negative outcomes. The Centers for Medicare & Medicaid Services (CMS) website lists the average number of hours of direct care that each nursing home provides to patients daily and in Kentucky the average is approximately 3.9 hours per day.

In response to comments and questions from Melissa Aguilar, Ms. Culp stated that she does not work with programs that certify individuals to work specifically with patients that have Alzheimer's and dementia.

Adjournment

There being no further business, the meeting was adjourned at 12:00 PM.