



State Plan for Alzheimer's and Related Disorders Working Group

LTC Sub-Group

9:00 – 10:30 pm
Wednesday, April 17, 2013
Elmhurst Extended Care
50 Maude Street
Providence, RI 02908

Agenda

1. Review of Subgroup Work from Past Several Months
2. Discussion of Recommendations – Reactions to Skeleton Outline (outline provided below)
3. Subgroup Planning
 - a. April – May: The process for drafting and editing will begin after this meeting. A draft will be sent out to the participants for comment and feedback and the first draft will be presented at the June 6, 2013 Full Group meeting.
 - b. Other Needs or Concerns?
4. Public Comment
5. Adjourn

LTC Subgroup Skeleton Outline

Recall of the Subgroup's Internal Goals:

- Leave business “hats” at the door
- Approach every meeting/idea as if we're discussing where you or your own mother would be placed for care
- Think big; start small
- Encourage free thinking
- Be respectful

(reminder) Jurisdiction for Residential Care [“LTC”] Subgroup:

1. Quality improvement across the spectrum of facility-based care
2. Non-residential services
 - a. Adult day care and night care programs
3. Home Care in residential settings and in the home
4. Adequate capacity – are there concerns around capacity within the state to meet the need?
5. Do we have appropriate care settings in the state?
6. Transitions
7. Payment & Delivery reform

▪ **1 – Quality Improvement**

○ Needs:

- Need to review how other states are measuring quality and how they determine best practices
 - Pose this question to Alz. Association and Trade Associations (AHCA, ALFA, Leading Age, Home Care, and others)

○

- Need to improve physician outreach and education about disease process
 - Are any insurers, hospitals or physician practices including ALZ in their info on disease processes on a web site or other format?

○ Recommendations:

- Encourage adoption of culturally competent food, language, practices, accommodations
 - Consider community partnership to accomplish efficiently
- CNA and Med Tech training on dementia are not required as part of the training curriculum but be voluntarily offered in some settings. This training should have some uniformity to it and be done more widely.

- Use recertification and relicensure as trigger to incorporate dementia training into staff education
 - Include consideration of Activities Directors – what type of activities most appropriate for AD population
 - Staff education should be hands on, inserted into morning and evening meetings to enable quick disseminated across shifts and across time
 - Create a “library of experiences” to assist taking education to the floor
 - ABC: antecedent; behavior, consequences. Environment, education and communication create the right environment.
 - Empathy training – how is this done? Work with task-focused staff to change approach.
 - Incorporate chores into daily activity of staff and residents to reduce time away from staff/resident interactions
 - Starts with management: learn by leadership
- Encourage use of EMR and other electronically-based patient health records and communication tools to nursing home and assisted living settings
 - Improve systems in place to share resident status updates, histories and preferences.
- **2 – Non-residential services**
 - Needs:
 - Early onset population is underserved and not being “networked” into supports by their physician/specialist. Need additional programming here, but what?
 - Adult Day costs are well over level of funding. This impacts their ability to serve as well as affordability to families.
 - Recommendations:
 - Family Supports/Network –
 - AA-like meetings on monthly basis: same time, same place, peer mentors, knowledgeable staff to help navigate the system;
 - E-mail listserv for caregivers to access Q&A in “real time”;
 - EMS Special Needs registry model
 - Use of “Family-to-Family” Class model (NAMI) as model for family support and education [12-week course];
 - Support programming must be focused on educational/planning and preparation needs rather than “sympathy” or “support”
 - Adult Day

- Awareness “campaign” of full range of services and benefits provided by adult days; care management, education, support groups, etc.
 - Also eases transition from home to assisted living
 - Respite
 - Awareness and targeted outreach to caregivers to avail themselves of respite
 - Streamline on-boarding process for short-term respite: i.e., over night care once a week but over the course of months
 - Challenges: nh: federal requirements involved. Assisted living perhaps more efficient.
 - Need options
 - Caregiver leave home for the night vs. placing person with dementia in the residence for the night or having respite worker in home simultaneous with family caregiver
 - Adult Supportive Care
 - Five or fewer adults
 - Closed unit in nh?
 - Assessment process is in regulation – has not been considered before. There is room to work with here.
 - What is the business model?
- **3 – Home Care**
 - Needs:
 - Need a back-up system for family caregivers – if family member is unable to attend, what is the back-up system?
 - Respite, protective services, what else fills this gap?
 - MFP – storms/disasters are a challenge if provider cannot make it what is the Plan B for the family to get to the person living with AD?
 - Need more culturally competent care and workforce with language skills – workforce here is thin so if one person speaking patient’s language is out, no back-up
 - **Need solution to forcing the “skilled need” game**
 - Companion care companies – not currently licensed under home care
 - PCA bill
 - Home care does not have tools it needs to take any “next steps” if concerned about a patient
 - DEA or Alliance referral
 - Role of home care, particularly with AD population will take on growing role
 - Specialization – dementia specifically, minority communities and language abilities, etc.
 - Payment challenges

- Recommendations:
 - Encourage better continuity of care among urgent care centers and physician offices, ED and other transitions of care
 - Improvements must be made to the transmittal of the continuity of care form – behavioral, systematic, technological
 - Uniformity of acuity level: derivation of cognitive status is currently unclear and assessments vary. Form does not specify assessment or specifics to acuity level.
 - South County example - need more information

- **4 – Capacity**

- **5 – Appropriate care settings**
 - Needs:
 - Night Care needed
 - Chartercare is exploring ability to have home care providers provide care a bit differently than usually in order to provide night care services – encourage adoption across other providers
 - Traditional night care program modeled in the Bronx is difficult to replicate outside of an urban center – is there another approach we can adopt in rural RI?
 - Adult Day statute in RI defines it as “daytime hours” – consider amending

 - Recommendations:
 - Housing with supports: encourage continuous progress towards home-based care –
 - What is the existing criteria to measure ability to be safe alone vs. need for some kind of supervisory arrangement?

- **6 – Transitions**
 - Needs:
 - Families need assistance in determining when to make transitions with full context of person’s wellbeing and future prognosis
 - Who’s role is this - it takes a Village! Care teams/health homes, etc.
 - PC and hospice consults are a part of this, but timing of PC consults are challenging with Alzheimer’s cases.
 - PC house calls – need more information

 - Recommendations:
 - Encourage adoption and dissemination of FAST model among providers and stakeholders

- Healthcentric Advisors has care transitions program (ongoing for past 4 years); includes all acute care hospitals, home care programs, many nursing homes and 5 community coalitions.
- Focus is on individuals at the highest risk for burdensome transitions (multiple admissions over last 3 mos./near end of life or other demographics) –perhaps Geri Psych Evals disseminate lessons pertinent to:
 - Increased focus on medication reconciliation, especially for those with AD
 - Increased attention to ADRC and community care transitions teams
 - Readmissions numbers have improved and best practices incorporated – get these out to larger provider community
- **7 - Payment & Delivery Reforms**
 - Identify vision of future of long term care in RI
 - Identify any regulatory constraints or opportunities
 - Tackle the issue of task oriented payment vs. supervisory or custodial (clarify with Deb Castelano comments)
 - Keep looking for a vehicle to offset “housing costs” in the residential setting
 - Build capacity (leadership, funding, process) for achievement

Additional Recommendations:

- Develop training curriculum
 - **Video-based training:**
 - Engage URI to develop a series of videos made available in multiple languages for professional caregivers and family members.
 - Make videos will be available for distribution through **The Point**.
 - Upload videos onto future online portal
 - **Mandate** (via licensure, CE) all professional care providers (MDs, RNs, LPNs, C.N.A.s, etc.) to participate in training curriculum.
 - **Develop a post-test** (one page competency certification).
- Emphasize decreased reliance upon medication as the first response and incorporate lessons learned from Healthcentric’s Nursing Home Quality Collaborative.
 - Identify certain behaviors of people living with dementia (i.e., repetitive language, excessive searching/walking, calling out for deceased loved ones, etc., are expressions of unmet needs, as the person is seeking something comfortable and familiar that is not present in their immediate environment).

- Train all caregivers to recognize and help assuage these needs
- Support and augment The Point as a navigation system for families of community-based people living with dementia, to assist in identifying resources.
- Create local community support systems to keep people living in the familiarity of their homes.
 - Develop local network of trained volunteers from religious groups and civic organizations, who can assist with companionship, transportation and errands.
- Utilize telehealth applications to maintain safety in the home
 - Encourage insurance coverage of dementia-related diagnosis for telemedicine

Future State

- **A model long term care setting within urban center** (a city block in Providence?)
 - Potential partnership among progressive-minded organizations or corporations willing to provide sponsorship
 - Create self-contained, safe, residential setting for people living with dementia
 - Include day care and night care facilities
 - Provide permanent housing
 - Establish outdoor memory garden complete with plants, flowers, water fountains, handicapped-accessible walkways, park benches, bird houses/feeders and picnic tables.
 - Identify grant money from a variety of sources.
 - Holistic team approach (family, nutrition, activities and more)
- **Require that any new care setting for people living with dementia offer private rooms only**
 - Reduce and ultimately eliminate the practice of hospital-style or dormitory-style living for elders
 - Measure decrease in medication error rates and infection rates, which will substantially reduce costs by resulting in fewer hospitalizations and transfers of people living with dementia between care settings
- **Establish a statewide accrediting body as an adjunct to the RI DOH**
 - Use this agency to accredit all dementia care settings across the state
 - Enable providers that voluntarily obtain & maintain accreditation to experience reduction in costs associated with regulatory compliance and surveys

