Legislative Committee on Health Care’s Task Force to
Develop a State Plan to Address Alzheimer’s Disease
(Assembly Concurrent Resolution No. 10 [File No. 42,
Statutes of Nevada 2011])

Quality of Care and Regulations Workgroup
Summary and Goals
September 5, 2012

Introduction:

Recognizing that statistics show that the projected population growth of those 85 and older from 2012 to 2030 in Nevada will be 145 percent, it is imperative that planning must occur for the most fragile of that demographic, those afflicted with Alzheimer’s Disease and Related Dementias.

Many conversations were held by our workgroup and a large collection of best practice documents from other states were shared by the members. Through these conversations and collaborative calls, it became clear that as a state, we do not have a true grasp on the extent of the population that is being served by facilities and that more data needs to be acquired to properly plan for the financial incentives, regulatory revisions and educational incentives to ensure needs are forecasted, integrated and properly addressed.

The Legislative Task Force’s Quality of Care and Regulations Workgroup established two primary goals. Due to time constraints, this submission is not complete but the “bones” to build on for the goals identified. We selected one of the template models shared by Casey Catlin. It is recognized this template may evolve but the content focus is transferrable.

This work group remains committed to work beyond the development of the State Plan to build a collaborative to move forward the initiatives of the Plan.

**GOAL: To develop, enhance and improve the variety and supply of informal and formal supports for persons with Alzheimer’s disease and Related Dementias and their caregivers.**

**Objective 1:**
- Explore new service options, such as a Medicaid Home and Community Based Care waiver for persons with Alzheimer’s and other dementias, Program for All-Inclusive Care of the Elderly (PACE) and Medicaid’s health care home initiative
- Strategy:
  1. Analyze expenses related to caregiver ratio’s in Assisted Living (6:1 ratio).
     - Preliminary analysis indicates a waiver would need to reimburse $155-$160, a $10-$15 dollar-a-day saving for Medicaid over a skilled nursing reimbursement rate.
More data analysis needed to prepare waiver proposal with a cost comparison vs. service package between skilled nursing and assisted living settings

2. Expand evaluation of other programs and missed opportunities of past efforts and future potential (PACE, etc.)

Indicator:
Funding:

Objective 2:
- Expand services which provide relief for caregivers, such as adult day care and respite services

Strategy:
1. Evaluate expansion of waiver programs to fund for the more complex individuals

Indicator:
Funding:

Objective 3:
- Address affordability of services for persons with Alzheimer’s and other dementias, such as sliding fee scales and other cost sharing mechanisms

Strategy:

Indicator:
Funding:

Objective #4: Develop and sustain care coordination, care planning, education and support for all persons with Alzheimer’s, especially for those with MCI or early dementia

Strategy:
1. Evaluate use of evidence based screening assessments (Appendix #1)

Indicator:
Funding:

Objective #5: Promote the provision of services in a culturally appropriate manner

Strategy:
Indicator:
Funding:

Objective #6: Explore the use of volunteers to provide support to family caregivers by partnering with community organizations and faith based groups

Strategy:
Indicator:
Funding:
Objective #1: To develop a mechanism to ensure integration of and access to education in evidence based care across academic and caregiver training programs that target professional and nonprofessional participants.

Strategies:

1. Conduct a needs assessment of dementia education within the Nevada System of Higher Education to identify and address gaps between the curricula of academic programs and the dementia care training needs of Nevada’s workforce.
2. Incorporate training in best practices related to dementia in classroom and clinical education within gerontology and healthcare programs across Nevada.
3. Facilitate a continuing dementia education program in best practices for professionals caring for persons with dementia.
4. Promote partnerships between Nevada’s community colleges, universities, dementia advocacy groups and accrediting bodies for the advancement of evidence based dementia care.
5. Disseminate information regarding best practices and educational opportunities in dementia care and family caregiver support.

Indicators:

1. Assemble a task force to design and conduct a needs assessment of dementia education within the Nevada System of Higher Education.
2. Establish a working group of representatives from Nevada’s colleges and universities to evaluate curriculum objectives and educational gaps in dementia education. The work group will generate recommendations for curricula consistent with best practice and accreditation standards in order to improve the Nevada’s ability to meet the healthcare and social services needs of Nevadans with dementia and their family caregivers.
3. Convene a working group of expert dementia educators to develop continuing education opportunities in evidence-based dementia care for professionals including nurses, physicians, social workers, psychologists and others providing services to persons with dementia and their family caregivers.
4. Develop a comprehensive virtual statewide clearinghouse to disseminate information regarding best practices, research, and educational opportunities focused on dementia and family caregiver support services.
5. Develop and provide training and clinical experience in inter-professional geriatric healthcare and social service within academic programs to effectively prepare professionals to work within the field of dementia care.
Funding:

1. Faculty across the Nevada System of Higher Education (NSHE) are actively involved in education, research, and community outreach related to the care of persons with dementia and family caregivers and the training of healthcare providers in evidence-based practices. Participation on state and community advisory committees and the design and implementation of new curriculum initiatives are consistent with the role statements of faculty within the NSHE.

2. Explore grant funding through public and private agencies that are dedicated to promoting training, dissemination, and research in evidence-based practice including the U.S. Health Resources and Services Administration, U.S. Substance Abuse and Mental Health Services Administration, and the National Institutes of Health.

**Objective #2:** To expand awareness of the increasing scope of individuals with Alzheimer’s Disease and Related Dementias and minimize regulatory barriers to development of facilities to provide care and services.

**Strategy:**
- Creation of a tool for evaluating the scope/magnitude of individuals in community-based care settings that have a diagnosis of Alzheimer’s and other dementia’s (Appendix #2)
- Utilize Health Division Biostatistician data regarding diagnosis in long term care setting to identify current population trends
- Utilize data from out of state placement report (Appendix #3)
- Utilize current data for trends of aging and Long Term Care needs (Appendix #4)
- Evaluate statutory and regulatory limitations for placement options and initiate action to reduce those barriers based on current trends

**Indicator:**

**Funding:**

**Objective #3:** To create a collaborative effort to promote the use of evidence-based person-centered approaches to preventing and treating difficult behaviors of Alzheimer’s individuals that result in out of state placement rather than in state.

**Strategies:**

1. Provide training, consultation, and guided practice in positive behavioral and restraint free approaches to preventing and reducing difficult behaviors in order to promote quality of life and behavioral health and prevent excess disability in persons with dementia
2. Provide healthcare and social services professionals with training in positive behavioral approaches that address the underlying reasons difficult behaviors occur in order to enhance the quality of life of persons with dementia and their caregivers
3. Provide training in least restrictive alternatives for the prevention and treatment of difficult behaviors in persons with dementia
4. Provide training in evidence based methods for assessing and promoting behavioral health in persons with dementia
5. Educate healthcare providers in how to distinguish between expected and abnormal behavior change in persons with dementia and how to intervene when abnormal behavior change is observed
6. Explore if there are regulatory or financial barriers to providers who might otherwise be willing to establish behavioral units
7. Explore if there are unmet training and resource needs among providers who might otherwise be willing to establish behavioral units
8. Connect with other initiatives regarding the use of psychotropic medications and non-pharmacological treatments for managing behaviors (such as CMS “Partnership to Improve Dementia Care” initiative, the UNR Department of Psychology Nevada Caregiver Support Center’s Compassionate Care Project, and other evidence based best approaches to person centered care for preventing and treating difficult behaviors)
9. Establish a database of out of state residential placements of Nevadans with dementia in order to track the effectiveness of efforts to eliminate out of state placements*

* This type of database may already be established. I was not sure if the state documents and monitor reasons persons with dementia are placed out-of-state (other than no facility would accept them)

**Indicators:**

1. Reduce out of state placements due to difficult behaviors by 90% within the next 5 (?) years
2. Support the inclusion of professionals trained in evidence based behavioral approaches to preventing and reducing difficult behaviors in state supported healthcare facilities that provide care to persons with dementia.
3. Monitor rates of off-label psychotropic medication prescriptions for the treatment of difficult behaviors in persons with dementia within state supported healthcare facilities
4. Convene a panel of dementia and behavioral health experts from medicine, nursing, pharmacy, and clinical psychology to establish a definition of “chemical restraint” to be applied within state supported healthcare facilities in Nevada that provide care to persons with dementia (definitions of chemical restraint are included within guidelines for behavioral support issued by state aging and disability services divisions in several states)
5. Explore the feasibility of developing professional review committees to assist healthcare facilities when the administration of a prescribed psychotropic medication meets all of the following criteria: a) the primary purpose of the medication is a response to problem behavior rather than a physical health condition; and b) the prescribed medication is a drug or dosage that would not otherwise be administered to the person as part of a regular medication regimen; and c) the prescribed medication has potential side effects of impairing the individual’s functioning by causing disorientation, confusion, or reductions in adaptive functioning including impairment in mobility, verbal abilities, and/or socialization.
6. Establish behavior support guidelines for healthcare providers receiving state funds to promote consistent use of evidence based person centered approaches to treating difficult behaviors in persons with dementia across Nevada

Funding:

1. Promote the use of Medicare coding to reimburse physicians, nurses, and allied health professionals for care planning meetings and family conferences that educate and support caregivers in learning least restrictive alternatives to treating difficult behaviors, long-term care planning, advocacy, and solution focused strategies to promote quality of life.

2. Support financial incentives such as a Behavioral Specialty Care Services rate to increase the number of residential care facilities willing to accept Medicaid recipients with dementia whose behaviors warrant increased staff intervention and specialized programs to manage their care.

3. Provide grants that promote the dissemination of evidence based restraint free behavioral interventions for managing difficult behaviors through partnerships between Nevada’s universities, colleges, state agencies, and community advocacy groups.

4. Explore grant funding through public and private agencies that are dedicated to promoting training and research in evidence-based practice including the U.S. Health Resources and Services Administration, U.S. Substance Abuse and Mental Health Services Administration, and the National Institutes of Health.
APPENDIX

1. Evaluate use of evidence based screening assessments

2. Creation of a tool for evaluating the scope/magnitude of individuals in community based care settings that have a diagnosis of Alzheimer’s and other dementia’s

3. Utilize data from out of state placement report

4. Utilize current data for trends of aging and Long Term Care needs
APPENDIX 1

Evaluate use of evidence based screening assessments
Nevada’s Alzheimer’s Care Consortium
Evidence-Based Screening Instruments
<table>
<thead>
<tr>
<th>Instrument</th>
<th>Function</th>
<th>Description</th>
<th>Source</th>
<th>Responsible Discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mini-Mental State Examination (MMSE)</td>
<td>Client Assessment</td>
<td>30 item measure of cognitive impairment</td>
<td>Published instrument</td>
<td>Social Work or Trained Technician</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Initial Screening Other: At reassessment</td>
</tr>
<tr>
<td>Montreal Cognitive Assessment (MoCA)</td>
<td>Client Assessment</td>
<td>30 point measure of cognitive impairment</td>
<td>Published instrument</td>
<td>Social Work or Trained Technician</td>
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<td></td>
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<td></td>
<td></td>
<td>Initial Screening Other: At reassessment</td>
</tr>
<tr>
<td>Geriatric Depression Scale (GDS)</td>
<td>Client Assessment</td>
<td></td>
<td>Published instrument</td>
<td>Social Work or Trained Technician</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Initial Screening Other: At reassessment</td>
</tr>
<tr>
<td>Burden Interview (Zarit)</td>
<td>Caregiver Assessment</td>
<td>29 item interviewer administered assess degree of burden felt by caregivers. Areas: psychological well-being, finances, social life &amp; relationship with impaired person. 20 item version has undergone psychometric testing</td>
<td>Published instrument</td>
<td>Social Work or Trained Technician</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Initial Screening Other: At reassessment</td>
</tr>
<tr>
<td>Caregiver Burden Inventory (CBI: Novack &amp; Guest)</td>
<td>Caregiver Assessment</td>
<td>24 item scale designed to assess experience of caregivers of cognitively impaired older persons. Assesses 5 domains: time-dependence, developmental, physical, social, &amp; emotional. Scored on a 4 point scale.</td>
<td>Published instrument</td>
<td>Social Work or Trained Technician</td>
</tr>
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<td></td>
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<td></td>
<td>Initial Screening Other: At reassessment</td>
</tr>
<tr>
<td>Patient-Caregiver Functional Unit Scale (PCFUS: Fredman &amp; Daly)</td>
<td>Functional Assessment</td>
<td>Interview administered questionnaire assessing client-caregiver for 14 ADLs &amp; IADLs. Caregiver respondents indicate client functional ability, whether caregiver assists with task &amp; whether caregiver has emotional difficulty assisting with task</td>
<td>Published instrument</td>
<td>Social Work, OT or Trained Technician</td>
</tr>
<tr>
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<td></td>
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<td></td>
<td>Initial Screening Other: At reassessment</td>
</tr>
<tr>
<td>Caregiver Strain Index (CSI: Robinson)</td>
<td>Post Illness Measure</td>
<td>13 item screening tool to identify strain among caregivers for recently hospitalized patients aged 65 &amp; over.</td>
<td>Published instrument</td>
<td>Social Work or Trained Technician</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>If there has been a recent hospitalization</td>
</tr>
</tbody>
</table>
APPENDIX 2

Creation of a tool for evaluating the scope/magnitude of individuals in community based care settings that have a diagnosis of Alzheimer’s and other dementia’s Behavioral Risk Factor Surveillance System Optional Impact of Cognitive Impairment Module.
Behavioral Risk Factor Surveillance System
Optional Impact of Cognitive Impairment Module

Introduction: The next few questions ask about difficulties in thinking or remembering that can make a big difference in everyday activities. This does not refer to occasionally forgetting your keys or the name of someone you recently met. This refers to things like confusion or memory loss that are happening more often or getting worse. We want to know how these difficulties impact you or someone in your household.

1. During the past 12 months, have you experienced confusion or memory loss that is happening more often or is getting worse?*

   (1) Yes                       (2) No

2. How many adults 18 years or older in your household experienced confusion or memory loss that is happening more often or is getting worse during the past 12 months?

3. Of these people, please select the person who had the most recent birthday. How old is this person?

4. During the past 12 months, how often have you/has this person given up household activities or chores you/they used to do, because of confusion or memory loss that is happening more often or is getting worse?

   (1) Always                     (4) Rarely
   (2) Usually                    (5) Never
   (3) Sometimes

5. As a result of your/this person’s confusion or memory loss, in which of the following four areas do you/does this person need the most assistance?

   (1) Safety                     (5) Needs assistance, but not in those areas
   (2) Transportation            (6) Doesn’t need assistance in any area
   (3) Household activities
   (4) Personal care

6. During the past 12 months, how often has confusion or memory loss interfered with your/this person’s ability to work, volunteer, or engage in social activities?

   (1) Always                     (3) Sometimes
   (2) Usually                    (4) Rarely
(5) Never

7. During the past 30 days, how often has a family member or friend provided any care or assistance for you/this person because of confusion or memory loss?

   (1) Always   (4) Rarely
   (2) Usually   (5) Never
   (3) Sometimes

8. Has anyone discussed with a health care professional, increases in your/this person's confusion or memory loss?

   (1) Yes
   (2) No [End of module]

9. Have you/Has this person received treatment such as therapy or medications for confusion or memory loss?

   (1) Yes
   (2) No

10. Has a health care professional ever said that you have/this person has Alzheimer's disease or some other form of dementia?

    (1) Yes, Alzheimer's Disease
    (2) Yes, some other form of dementia but not Alzheimer's disease
    (3) No diagnosis has been given

*Note: This module is designed to ask questions #4-10 of the individual who answers the phone or a member of their household. The individual is asked the questions if he/she answers "yes" to question #1. If the individual answers "no" to question #1 then questions #4-10 are asked of a member of the household who is experiencing confusion or memory loss.
APPENDIX 3

Utilize data from out of state placement report
Alzheimer’s State Plan Task Force – Subcommittee Report
On Out-of-State Placement
ALZHEIMER’S STATE PLAN TASK FORCE
Subcommittee Report on Out of State Placement
Sally Ramm, Aging & Disability Services

The purpose of this report is to give subcommittee members a history of how this subject has been discussed in the past. In March, 2006, Judge Frances Doherty formed a Northern Nevada Task Force on out-of-state placement. The task force began with 14 members and at the most had 25 members. Many people were at some of the meetings to discuss a specific issue, so the overall contribution of people from around the state cannot be accurately described in numbers.

Two incidents prompted the formation of this task force. The first, which happened in 2004, was an older man suffering from dementia who threatened his wife with a knife. The police were called. They could not find a suitable place to take him, so he ended up in jail, charged with a crime. He was in jail for at least two months, when the judge said that he could not be kept in jail for one more day. He was released back to his home, where the knife incident was an anomaly, and his wife felt that she could care for him. A task force on mental health for the elderly was formed, and their work informed some of the work done by this subsequent task force. The second was an older man who lived in the same house for 35 years, was nearly blind, was suffering from dementia, and had serious health problems. He was taken to the hospital, against his will, where he used is cane to keep people away from him. He was released to rehab, and was actually in four different facilities in two months before being sent to Utah. He died two weeks later.

I am attaching two papers that will give subcommittee members a good idea of the work that was done in the nearly two years and one legislative session during which this task force worked. Following is some chronological background information, taken from my files:

2003 Legislative Committee on Health Care report to legislature:
- No nursing facilities in Nevada accept residents with severe behavior problems.
- 72 residents in out of state nursing facilities, all with “severe behavioral problems.”
- Approximately one or two new out of state placements per month.
- Nevada facilities refused a higher reimbursement rate to care for people with behavioral issues.
• It costs an average of $97 per day to place 60 of the 72 persons out of state, and an average of $121 per day to keep them in Nevada. The other 12 out of state placements require a high level of care and average cost is $250 per day.

Methods to address this problem:
• Convince an out of state facility to open a facility in Nevada.
• Develop a team to identify behavioral interventions necessary to address the needs of an individual and enhance patient safety. The team would be readily available to assist nursing facilities when a resident exhibits behavioral problems.
• Use state-owned mental health facilities for serving individuals with severe behavior problems.

2006: Everyone is talking about out of state placement in conjunction with mental health. Alzheimer's disease and other forms of dementia are not considered a mental health issue, but the conversation continued to be centered on mental health as though "behavioral issue" is synonymous with "mental health issue" and includes persons with any form of dementia causing behavior problems as a mental health issue.

2006, 2007, 2008: Task force meeting topics:
• Meeting with Mike Willden, Director Health & Human Services, and Mary Liveratti, Deputy Director, Programming.
  ➢ What is state doing to entice a behavioral unit provider?
  ➢ Possibly 20 beds in Dini-Townsend facility available to be used for population with behavior issues. (Mike Willden)
  ➢ Industry does not want to use existing funds (federal and facility taxes) to pay for increased behavioral rate.
• Meeting with Dr. Carlos Brandenburg, Administrator, Mental Health and Developmental Services and then with Senator Randolph Townsend.
  ➢ Statutory change to allow greater access to mental health services for mentally ill seniors who also suffer from dementia. Suggested including dementia in definition of mental illness to allow for emergency treatment. Dr. Brandenburg said he would have to put a $5 million fiscal note on this to build necessary capacity.
  ➢ One-shot funding ($800,000) for a behavioral health provider public/private venture to open a new facility in Nevada.
  ➢ Increasing the $121 regular daily rate to long-term care facilities by $261 per day for residents with behavioral issues.
  ➢ Increasing waiver services under the group home waiver.
  ➢ Create a Program for Assertive Community Treatment (PACT using mental health professionals to assist in providing assessment and case management
in jails, emergency rooms, and long-term care facilities. This would be an incentive for long-term care facilities to accept these residents, as it would give them assistance and training in dealing with aggressive behaviors.

- Attached is a proposal to establish a multi-disciplinary Community Team as a short-term stopgap measure. Proposal from Washoe County Public Guardian’s office.

2009: Legislative Health Committee work session document for the 2009 Legislature.

Among other issues, this Committee drafted a letter to Division for Aging Services requesting they work with the Bureau of Licensing and Certification and Medicaid to support and encourage on-going training for existing care staff to transition and stabilize residents diagnosed with dementia, and to create industry incentives and remediation of potential misperception of licensing challenges encountered by facilities housing individuals diagnosed with dementia, as requested by Judge Frances Doherty.

The Committee also decided to amend the definition of mental illness pursuant to NRS 433A. to include Alzheimer’s disease. They did not act on this, as it would be too expensive.

This is a brief overview of the work of many people over more than two years to try to find solutions to the problem of sending Nevada residents out of state for care and treatment. Unfortunately, the only thing that happened was to provide skilled nursing facilities with $261 per day plus the regular daily fee for accepting residents with behavioral issues. They do not take advantage of this.

Sally Ramm
Aging & Disability Services Division
August 28, 2012
APPENDIX 4

Utilize current data for trends of aging and Long Term Care needs
Growing Demand for Long-Term Care in the United States
Growing Demand for Long-Term Care in the U.S. (Updated)

In 2011, the largest generation in history—the baby boomers—began turning 65. The U.S. population is also living longer, often with chronic illness and disabling conditions. Given these demographic trends, we can anticipate significant growth in the demand for long-term care.

This fact sheet describes trends that contribute to the growing demand for long-term care among Americans. All the references accessed to produce this fact sheet are provided for further review.

- The number of Americans who need long-term care is expected to increase from approximately 12 million today to 27 million in 2050.\(^1\)

- Baby boomers (those born between 1946 and 1964) will turn 65 between 2011 and 2029.\(^2\) During this time, 10,000 Americans will turn 65 every day.\(^3\)

- By 2030 when the last baby boomers turn 65, the number of Americans age 65 and older is projected to be about 72 million, or about 19% of the total U.S. population (up from over 40 million or 13% in 2010, See Figure 1).\(^4\)

- By 2050 when the last baby boomers turn 85, the number of Americans age 65 and older is projected to increase to almost 89 million, or about 20% of the total U.S. population (See Figure 1).\(^4\)

![Older Americans as a Percentage of the Total U.S. Population, 2010-2050](chart)

• The percentage of the U.S. population that is age 85 and older—those having the most likely need for supportive services—is expected to grow by more than 25% by 2030 and by 126% by 2050 (See Figure 1).\(^4\)

• The states with the greatest projected population growth of those age 85 and older from 2010 to 2030 are: Alaska (+217%), Nevada (+147%), Arizona (+119%). The District of Columbia is projected to experience a 10 percent decline in the number of Americans age 85 and older during that period (See Figure 2).\(^5\)

![Projected Growth of Americans Age 85 and Older from 2010 to 2030](image)

**Source:** U.S. Census Bureau, Population Division. Interim State Population Projections, 2005

• Life expectancy in the U.S. has increased dramatically over the last century and is expected to continue to increase. For individuals born in 2010, the projected average life expectancy is 79 years, compared to almost 52 years in 1910.\(^6\)\(^7\)

• Life expectancy is higher for women than men. For those born in 2010, projected life expectancy for women is about 81 years, compared to 76 years for men.\(^6\)

• Between 2000 and 2030 the number of Americans with chronic conditions will have increased by 37%, an increase of 46 million people.\(^8\)
• Twenty-seven million individuals with chronic conditions in the general U.S. population also have functional impairment.9

• As of 2012, 5.2 million people age 65 and older have Alzheimer’s Disease. By 2025, the number of people age 65 and older with Alzheimer’s disease is estimated to increase by 30% to 6.7 million. By 2050, this number may triple to a projected 11 million to 16 million.10

References


